A Study on the Socio-economic and Health Status of Children of Victim Families by Armed Conflict Situation in four Valley Districts of Manipur

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All the staffs of Wide Angle has been very helpful and I would personally like to express my sincere gratitude for supplying me lots of information required to start the study. I would thank to all the district co-ordinators of Imphal West, Imphal East, Thoubal and Bishnupur districts and the College of Social Work, who have significantly contributed to complete the primary data collection. Finally the successful completion of the present work deeply owes to all my fellow Assistant Researchers who have assisted me in every aspect in the smooth functioning of the study. Last but not the least I am expressing my sincere gratitude to those families who are victims of the armed conflict situation in Manipur whose names are not mentioned here though and without whose co-operation the study might not have been so successful.

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SUMMARY

The effect of armed conflicts across the world has resulted in the gross violation of child rights and millions of children have been deprived of their basic rights to health and education. Necessary steps towards improvement of the delivery system required to maintain the basic rights of these victim children. The victim children in the state of Manipur where the conflict between the rebel groups and the government took place during the past two decades or more are no exception.

A formal study to assess the present socio economic and health status of the victim families in the four valley districts of Manipur is carried out based on primary data collected from the families using semi-structured questionnaire. Other relevant information are also gathered from government as well as non government organization in order to supplement the findings.

One of the most common symptoms of sickness reported by the families is mental or psychological problems, where once the family members are traumatized in the conflict. The health infrastructure in the state needs to be further strengthened in order to provide basic health requirements to those victim families.

The challenges faced by the victim families to educate their children needs to be assessed properly so that those who are deprived of their basic rights to education could be restored.

The delivery system of the government in terms of food supply and basic amenities are very poor. For example the public distribution system might have reached to a complete failure due to lack of seriousness of the government machineries. These have greatly affected the victim families.

Long-term assistance programmes should be flexible and should adopt a developmental approach to enhance local capacities to meet the community's food needs. More efforts and resources should be concentrated on conflict resolution to prevent such situations from occurring.

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1. Introduction

1.1 An Overview of the Armed conflicts across the World

We are witnessing a series of different armed conflicts all across the world since the 20th century. By armed conflict it does not merely mean the conflicts between two countries or nations, it also includes conflicts between the rebel groups and their government within the same country. As a result of armed conflicts in the past decade, an estimated 2 million children have been killed, three times as many have been seriously injured or permanently disabled, and countless others have witnessed or taken part in violent acts. Even greater numbers have died from malnutrition and disease during such crises. The destruction of food crops, water supplies, health services, families and communities takes a heavy toll on children. In 1995 alone, 30 major armed conflicts raged within different states around the world (Machel, 1996).

Concerned by the miserable plight and suffering of children during armed conflicts, the United Nations General Assembly, at its forty-eighth session in December 1993, requested that a comprehensive study be undertaken on the impact of armed conflict on children. The study was to include recommendations for the amelioration of this grave situation. FAO contributed to the effort by assessing the impact of armed conflicts on the nutritional status of children (FAO, 1996).

The FAO study took account of the broad causes of malnutrition such as inadequate household food security resulting from disruption of agriculture and food distribution systems and lack of access to food; poor health care and environmental sanitation; disruption of families and their caring practices; and socio-economic and nutritional vulnerability. Coping strategies employed by the households were also examined. The breakdown of the family unit was given particular attention, since this predicament most seriously impedes the provision of food, nutrition, health services and care to children. The FAO analysis was based on discussions with United Nations organizations and non-governmental organizations (NGOs), a review of the existing literature and field experiences in several African countries.

Wars are dramatically altering the lives of children around the world. UNICEF (2006) reports that conflicts in the last decade have killed an estimated 2 million children and have left another 6 million disabled, 20 million homeless, and over 1 million separated from their parents. The changing tactics and technology of warfare have magnified hazards to children. Wars are increasingly fought within states and involve non-state actors, such as rebel or terrorist groups which are less likely to be aware of, or abide by, humanitarian laws providing for the protection of civilians (Stichick & Bruderlein, 2001). As a result, modern 'wars of destabilization' (Stichick & Bruderlein, 2001) often rupture the fabric of life that supports healthy child development. Wars sever families and extended social networks, interrupt services systems and often feed deep ethnic and political divides.

1.2 Manipur – A Perspective

Manipur is a small state with a population of 27.21 lakhs (2011 Census) and a land area of 22,327 sq. km with an international boundary of 358 km. with Myanmar. The state has 9 districts, 33 Community Development Blocks and 2,182 villages. The average literacy rate is 86.49 per cent for males and 73.17 per cent for females. The sex ratio as per 2011 census is 987 females for every 1000 males.

1.2.1 Insurgency in Manipur

Kingdom of Manipur was merged with the Indian Union on 15 October 1949. However, only after a protracted agitation interspersed with violence, it was declared a separate state in 1972. The emergence of insurgency in Manipur is formally traced to the emergence of the United National Liberation Front (UNLF) on 24 November 1964. The alleged 'forced' merger of Manipur and the delay in the conferring of full-fledged statehood to it was greatly resented by the people of Manipur. Since then several other outfits, like the People's Liberation Army (PLA), founded on September 25, 1978, People's Revolutionary Party of Kangleipak (PREPAK) set up on October 9, 1977 and the Kangleipak Communist Party (KCP) that came into being in April, 1980 have emerged in the valley areas consisting of four districts of the State. All these insurgent groups have been demanding a separate independent Manipur, (cdpcindia.org, 2012).

1.2.2 Drug trafficking and abuse

Manipur is geographically very close to the notorious 'Golden Triangle'. Due to its proximity to the 'Golden Triangle' with perforated borders. Manipur became an alternative route for illegal international drug trafficking in the late Seventies and early Eighties. Soon Manipur become a 'User state' by the early eighties. Pure heroin, which is in the injectable form locally known as 'No. 4' is easily available. The problem of heroin addiction reached an explosive situation in 1984 when many gruesome murders connected with drugs occurred in the states.

1.2.3 Armed Conflict in Manipur

Today, Manipur is one of the worst affected states in the Northeast where at least 12 insurgent outfits are active at present. A report of the State Home department in May 2005 indicated that 'as many as 12,650 cadres of different insurgent outfits with 8830 weapons are actively operating in the State'. According to government sources, the strength of those concentrated in the valley districts, is assessed at around 1500 cadres for the Revolutionary People's Front (RPF) and its army wing, the PLA, 2500 cadres for the UNLF and its army wing Manipur People's Army (MPA), 500 cadres for the PREPAK and its army wing Red Army, while Kanglei Yawol Kanna Lup (KYKL) and its Yawol Lanmi army is assessed as having a strength of 600 cadres. The Kangleipak Communist Party (KCP)'s strength is assessed at 100 cadres, (cdpcindia.org, 2012).

In Manipur, the valley-based outfits have remained active and the security force operations have made little difference to their capabilities. The UNLF, PLA, KYKL, PREPAK and the KCP have been involved in some of the serious attacks on security forces. The insurgents have an avowed policy of not targeting the state police personnel, unless circumstances demand it. The practice of directing their attack on the Army and the central para-military personnel is an attempt to create a divide between Manipur and India and to secure vital popular support.

Unlike other conflict theatres of the Northeast, not many 'surrenders' have been reported from Manipur, though recently some surrender theatres have been observed under the banner of Home Coming Ceremony by the Chief Minister O. Ibobi Singh, thus indicating the tight control that the outfits have maintained over their cadres. Armed with an extremely

efficient intelligence network and superior fire power, the militants have been able to carve out a number of liberated zones across the State. By the end of 2007, however, the security forces had managed to dislodge the militants from most of such zones except for one in the New Somtal area in Chandel district. The reign of terror has manifested in other forms as well, since the rule of the insurgents has combined with a complete retreat of civil governance. The insurgents continue to terrorize and extort with impunity, and people have little option but to obey their diktats.

Generations of children in the valley grew up in tumultuous historical periods marked by political instabilities, wars, military invasions, foreign occupations and subjugations throughout the nineteenth – twentieth century. The situation of the next generation of children was no better. They only emerge in an intensifying internal armed conflict and utter socio-political and culturally chaos situation caused by global market and war economy under Indian Union in the twenty-first century. The Armed Forces Special Power Act, 1958 came in force in the state since 1980 and resultant armed conflict with insurgent groups, the associated war economy and corruptions in the system under the tidings of globalization processes created sum total of culturally uprooted and hopeless situation in the 21st century of India for the children in Manipur. Many women and children suffered in this continuing political and economic internal war situation without discrimination. Children at both ends of economic status; the large poor and helpless, and those rich and over-cared children were equally affected by the violent systems and practices.

The AFSPA continues to be in place while the level of violence has shown a declining curb over the last one year the central government has been investing huge budget in social welfare and infrastructural development, and security sector in the state. Flagship programs socio-economic development programs Sarba Shiksa Abhiyan (SSA: Education for all), Integrated Child Development Scheme (ICDS), National Rural Health Mission (NRHM), National Rural Employment Generation Scheme (NREGS) and Jawaharlal Nehru Urban Renewal Mission (JNURM) under new legislations and policies such as Right to Information (RTI 2005), National Policy on Voluntary Sector (2007), Right to Education (RTE) have been affecting the situation of children in the state also.

1..2.4 HIV/ AIDS in Manipur

While talking any issues of peace, development or more particularly conflicts the HIV AIDS scenario in Manipur cannot be overlooked as it has intermingled to every aspects of livelihood affecting from the poorest to the most privileged section of the society. AIDS has emerged as a new and serious public health emergency in Manipur. The first HIV positive case in Manipur was reported in February 1990 from the blood samples of a cluster of Injecting Drug users (IDUs). As of January, 2011, a total of 38016 HIV positive cases (10,109 females) and 4,724 AIDS cases (658 deaths) was reported out of 84,097 blood samples screened, amounting to a sero-positivity rate of 802 per 1000 blood samples screened as against the all India figure of 40.63. Manipur with a hardly 0.2 percent of India's population is contributing to nearly 8 per cent of India's total HIV positive cases. According to the Epidemiological Report published by National AIDS Control Organization (NACO), Government of India, Manipur ranks third highest as regards the total number of HIV positive cases – the first being the state of Maharashtra and the second Tamil Nadu. However, if we calculate the sero-prevalence rate per one million populations, the sero-prevalence rate of Manipur is at least 6 times higher than that of Maharashtra and 20 times higher than that of Tamil Nadu. The HIV sero-prevalence rate among IDUs in Manipur had increased from 0 to 50per cent in just one year during 1990-91. As per preliminary reports of the Sentinel Surveillance conducted during February-March 1994,1995,1996 and 1997; the sero-prevalence rate among IDUs in Manipur increased from 59.9 per cent in percent in1994 to 80.70 per cent in 1997. However, it showed a declining trend from 1998 onwards with a sero-prevalence rate of 72.78 per cent in 1998, 66.02 per cent in 2000 and 56.27 per cent in 2001. The sero positivity rate has declined around 2004 – 2007 to 20%. However, it is found that the rate increases to 28.64% in 2008. Still, the sero-prevelence rate among IDUs in Manipur is one of the highest in the world.

However, it is a matter of grave anxiety that the HIV/AIDS epidemic in the state is now no longer confined to the IDUs. The infection has now spread to the female sexual partners of IDUs and their children. The state is now witnessing to waves and waves of HIV positives among pregnant women. It has increased from 0.8 per cent during 1997 and 1.69 per cent in 1999 to 2.04 per cent in 2001. The sero prevalence rate among pregnant women as sentinel surveillance report of 2004-2007 shows that it is above1%. However the report of 2008 shows that it is reduced to 0.5%. The sero-prevalence rate among pregnant women in

Bishnupur and Thoubal districts were found to be aroud 2.5 per cent, whereas in Moreh, it was around 3 percent and in Tamenglong, it was aroud 1 per cent. There is now a generation of young widows, below 25 years of age and some even below 21 years of age, whose husbands have already died of AIDS. Similarly, a generation orphaned by AIDS has also come into being. How to prevent infection of women and children is major challenge faced by the Manipur State AIDS Control society.

2. Literature Review

The evidence based on prevention and intervention efforts to improve the situation of children in armed conflict remains nascent (Machel, 1996, 2001; Betancourt & Williams, 2008). Recent years have brought increased research attention to the topic (Barenbaum, Ruchkin, & Schwab-Stone, 2004; Bayer, Klasen, & Adam, 2007; Bolton et al., 2007; Lustig et al., 2004; Vinck, Pham, Stover, & Weinstein, 2007). The paper examines the concept of resilience in the context of children affected by armed conflict with particular attention to potentially modifiable protective processes which may be the targets of intervention. Though various definitions of resilience arise in the literature (Cicchetti & Garmezy, 1993; Gordon & Song, 1994; Kaufman et al., 1994; Luthar, 1993; Luthar & Cushing, 1999; Masten, Best, & Garmezy, 1991, Masten, 1994; Rutter, 1985, 1987, 1990; Stouthamer-Loeber et al., 1993; Tarter & Vanyulov, 1999; Tolan, 1996), they used the following definition of 'resilience': the attainment of desirable social outcomes and emotional adjustment, despite exposure to considerable risk (Luthar, 1993; Rutter, 1985). Though there are a variety of ways that risk may be defined (Resnick & Burt, 1996), we use the following definition of 'risk': a psychosocial adversity or event that would be considered a stressor to most people and that may hinder normal functioning (Masten, 1994). In order to understand resilient outcomes among children and families in adversity, one must identify protective factors and subsequent protective processes influencing successful outcomes despite specified risks (Luthar, 1993; Rutter, 1985). 'Protective factors' refer to often exogenous variables whose presence is associated with desirable outcomes in populations deemed at risk for mental health and other problems (Werner, 1989). The dynamic processes that foster resilient outcomes (in this case psychosocial and developmental outcomes) in youths are defined as 'protective processes'. Scholars define protective processes as those operating in the family, peer group, school, and community (Benard, 1995) which serve to decrease the likelihood of negative outcomes (Cowan, Cowan, & Schulz, 1996).

Orphans are a part and parcel of all communities irrespective of their caste and creed. The AIDS epidemic as reported by Barnett and Whiteside (2002) has resulted in 13.2 million orphans globally. Barnett and Whiteside (2002) define orphans as children who lose their mother or both parents because of AIDS before the age of 15 years. In a follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS, UNAIDS researchers noted that nearly 40 percent of countries that are suffering from a generalized AIDS epidemic lack a national policy to support children orphaned or made vulnerable by AIDS (Joint United Nations Programme, 2003). Recent (2004) Demographic and health surveys (DHS) indicated that in Uganda, Malawi, Mozambique, Zambia, and Zimbabwe, nearly 15 percent of all children under age 15 years have lost one or both parents.

The concern for the orphans in general and AIDS orphans in particular has been raised in many documents because of the care needed to ensure that they grow up as normally as possible. The extended family, government, and non-government organizations have tried to cope up with the orphan problem. The government of Uganda tried to pay school fees for the orphans since 1980 to ensure that the orphans get education (Hunter, 1990). When a parent died of AIDS in USA, surviving children face an uncertain future about their custody arrangements and financial benefits (Levine,1995). The situation is worse in sub Saharan countries with reports of dispossession of orphan's properties, stigmatization of HIV positive children and general poverty of rural areas (Ntozi and Mukiza-Gapere, 1995). Fiawoo (1978) reports that in some parts of Ghana, children are distributed to the agnatic kin of the deceased man. This practice was also common in Zimbabwe. Irrespective of which parent dies, the maternal extended family takes care of the child rather than the extended paternal family.

3. Rationale of the Study

The wounds inflicted by armed conflict on children - physical injury, gender-based violence, psychosocial distress, are affronts to every impulse that inspired the United Nations Convention on the Rights of the Child. Armed conflict affects all aspects of child development - physical, mental and emotional. Such effects accumulate and interact with each other. To be effective, assistance must take account of each. The impact of armed conflict cannot be fully understood without looking at the related effects on women, families and the community support systems that provide protection and a secure environment for

development. Children's well-being is best ensured through family and community-based solutions that draw on local culture and an understanding of child development.

The state of Manipur have started witnessing a generation of children and families affected by armed conflict since the beginning of conflict between the government and the insurgent outfits. Despite the various welfare and aid schemes and programmes such as SSA(RTE), ex-gratia, Rajiv Gandhi Foundation Fellowship Programme etc. it is of little knowledge to the concerned non-state organization to understand the effectiveness of these programmes. In this regard it is high time to look into the matter so that these families are really getting benefits out of the welfare programmes taken up as such.

3.1 Objective of the Study

The objectives of the study include

i) To assess the present needs of the children of victim families in terms of their socio-economic, health and education in the four valley districts of Manipur.

ii) To explore the ability and appropriateness of the support and services provided by Government and non-government organizations in the area.

iii) To identify the socio economic challenges faced by the parents/caregivers of children.

iv) To assess the adequacy and effectiveness of the public distribution system (PDS) and their delivery system to the victim families.

v) To measure the effectiveness of NRHM, NREGS etc, as benefitted by the victim families.

3.3 Research Questions

The primary research questions to be answered in the present study includes:

i) What are the present needs of the Victim children to get their basic rights in terms of their health and education?

ii) Whether the service providers (Government and Non govt.) are capable of addressing the present needs of these children?

iii) How appropriately the services are delivered to the target groups?

iv) What are the socio-economic challenges faced by the care givers of the orphans?

v) How the care givers manage to cope up with the challenges?

vi) Are the service delivery system and public distribution system functioning properly?

4. Research Methodology

The present study is based on a sample of households with one household comprising of members sharing a common kitchen as one primary unit, collected from the field. The sampling frame consists of all households in the four valley districts of Imphal West, Imphal East, Thoubal and Bishnupur and some adjoining villages, which are identified as victim families of armed conflict in the state of Manipur. The frame (list of families) is obtained from related project undertaken by Wide Angle Social Development Organization. A sample of 282 families or households is selected by using the method non probability sampling. Each of the selected households are first visited to collect information on their location and name of any member who could be used to spot the family at the time of interview. The person is usually the head of the family or the main care giver of the child. Each of the respondent are interviewed personally by using semi-structured questionnaire (Appendix 1) to extract information on their socio-economic, health, psychological and other related status. The interview questionnaire is designed in order to minimize highly sensitive questions and also to utilize a reasonably short period of time. On the average the detail interview requires 30 – 45 minutes depending the prompt response of the respondents.

4.1 Coverage

The four valley districts of Manipur comprises of Imphal West, Imphal East, Thoubal and Bisnupur in which the type of settlement includes both urban and rural areas. Each district is further subdivided into administrative blocks, panchayats consisting of smaller localities. Those areas in the districts which are under the purview of Municipal Councils and are considered urban settlements otherwise the settlements are considered rural.

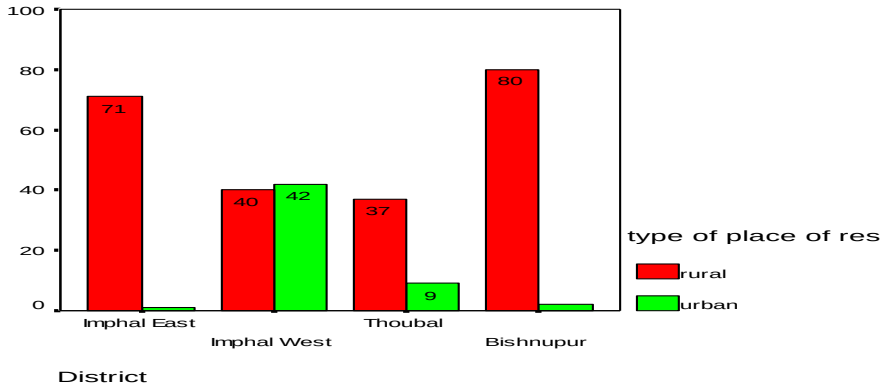
The present study covers the four valley districts of Manipur and the number of households included in the survey are as given in following Table 1. In Imphal East district 72 households are interviewed out of which 71 households are from rural area and only one household from urban. In Imphal west district 82 households are interviewed out of which 40 households are from rural area and 42 are from urban. In Thoubal and Bishnupur

districts most of the households interviewed are from rural area- 37 rural and 9 urban families in Thoubal and 80 rural and 2 urban families from Bishnupur district.

Table 1: Distribution of Families by District and Place of Residence

Place of residence	District				Total
	Imphal East	Imphal West	Thoubal	Bishnupur	
Rural	71	40	37	80	228
Urban	1	42	9	2	54
Total	**72**	**82**	**46**	**82**	**282**

Chart 1: Rural/Urban classification in Different districts



5. Data Analysis

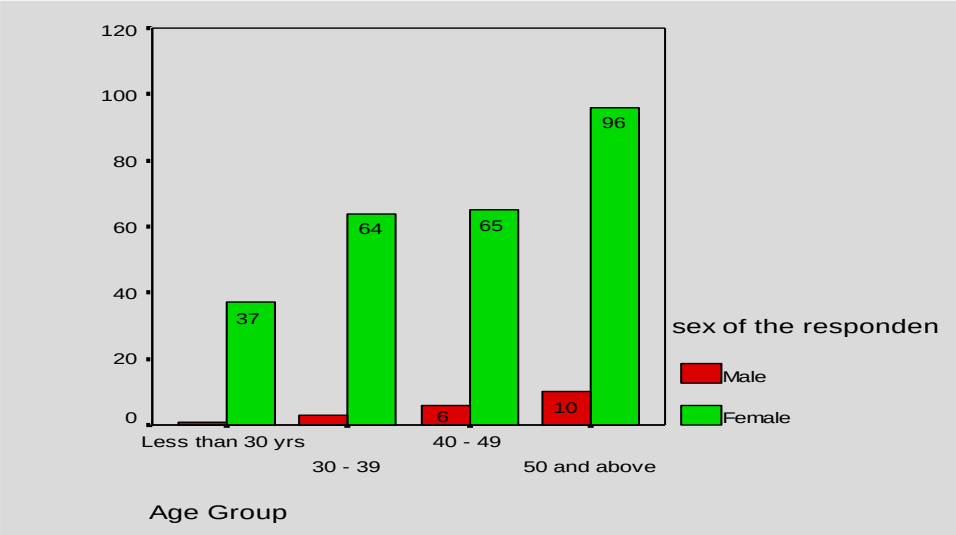
5.1 Demography of Respondent's family

A sample of households comprising of 282 victim families have been interviewed to provide information on their socio-economic and health status of their families. The respondents are either care givers of children who are victims of armed conflict or the main bread earner in the family. The youngest respondent interviewed is 14 years old and the oldest respondent is 74 years old. Most of the respondents that is about 49% belong to the age group 30 – 49 years. However, another 37% of the respondents are in the age range 50 years and above. Female respondents constitute about 92% of all and 8% of the respondents are male. Table 2 presents the age and sex distribution of respondents interviewed and for ready reference the corresponding figures are shown as bar diagrams in Chart 2.

Table 2: Age and sex distribution of the respondent

Sex	Age Group				Total
	Less than 30 yrs	30 - 39	40 - 49	50 and above	
Male	1	3	6	10	20
Female	37	64	65	96	262
Total	**38**	**67**	**71**	**106**	**282**

Chart 2: Age and sex distribution of the respondent

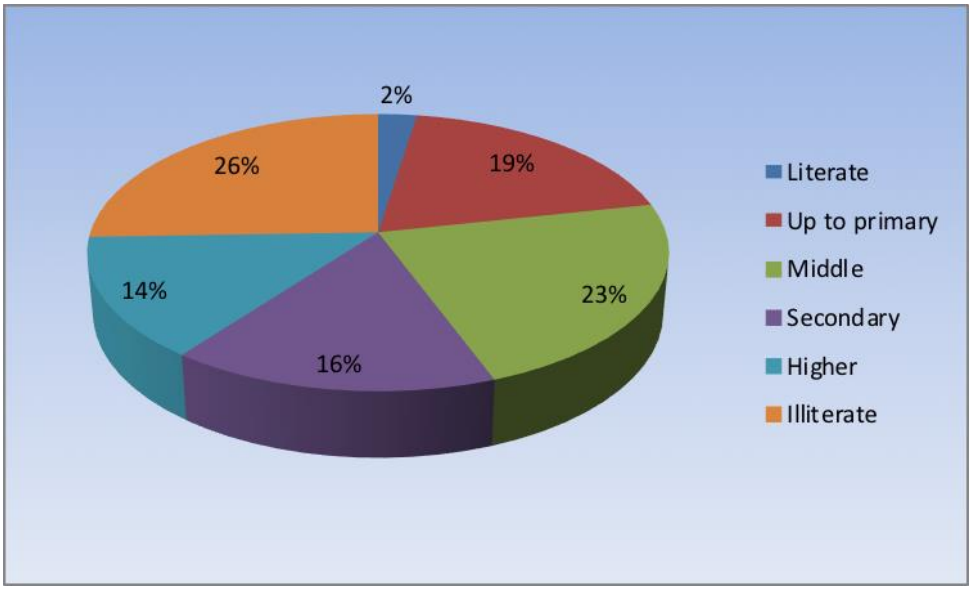


The educational levels of respondents are shown in table 3 and chart 3. Approximately 26% of the respondents are illiterate and 2.5% are simply literate and not having any educational degree. Other figures for education of respondents are:- Up-to Primary- 19%, Up-to Middle (class Viii) - 23%, Up-to Matric- 16% and those whose educational levels are beyond matric constitute 14% of all respondents.

Table 3: Level of qualification

Level of Education	No. of Respondents	Percent	Cumulative Percent
Literate	7	2.5	3.3
Up to primary	54	19.1	29.0
Middle	64	22.7	59.5
Secondary	45	16.0	81.0
Higher	40	14.2	100.0
Illiterate	72	25.5	
Total	**282**	**100.0**	

Chart 3: Educational Level of respondents



The following table (Table 4) shows the marital status of respondents. Most of the respondents are either widow or widower which constitute about 72% of all respondents. Nearly 23% are currently married that is both spouses are living together in the same household. Those respondents who are not married yet (single) or divorced (separated) constitute about 5% of all respondents.

Table 4: Marital status of respondents

Marital Status	No. of Respondents	Percent	Cumulative Percent
Currently married	66	23.4	23.4
Single	7	2.5	25.9
Divorced /Separated	6	2.1	28.0
Widow(er)	203	72.0	100.0
Total	**282**	**100.0**	

Table 5: Basic Statistics for family size, No. of Males and Females

Basic Statistics	Family size	No. of males	No. of females
No. of families	282	282	282
Mean Family size	5	2	3
Std. Error of Mean	0.119	0.078	0.077
Median	5.00	2.00	3.00
Range	10	8	7
Minimum	2	0	1
Maximum	12	8	8
Total Members	**1354**	**577**	**777**

Sex Ratio = 134 females per 100 males.

Age structure of families

No. of Children below 18 years of age = 516

No. of orphans = 324

No. of adults above 18 years = 838

No. of aged persons above 65 years = 81

Age dependency ratio = 71%

For every 100 members in the productive age group (18 – 64) there are 71 members who depend on them.

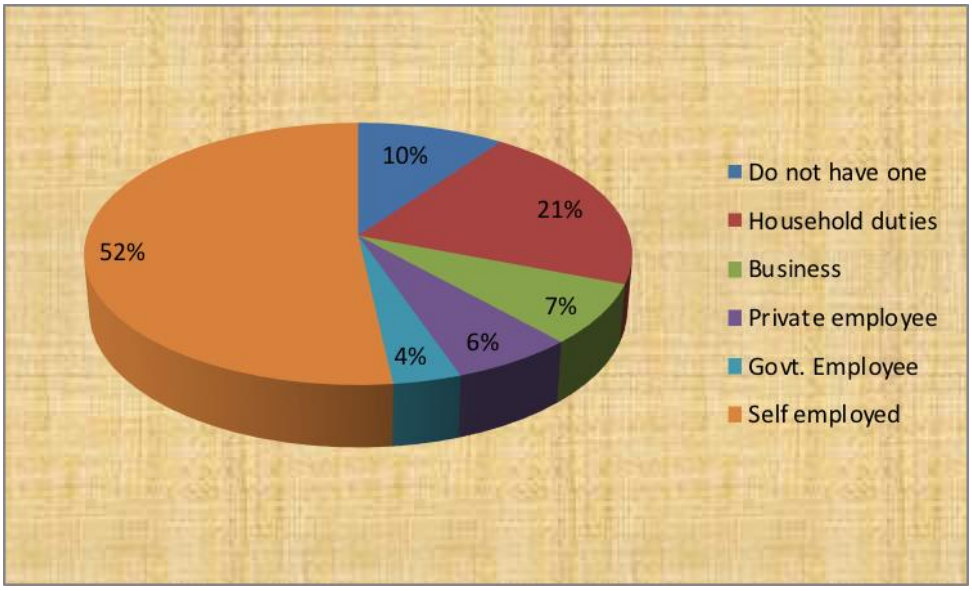
5.2 Occupation and Income

In Table 6 the primary occupations which the respondents are currently engaging are shown. It is quite unfortunate to note that nearly 10% of the respondents who cares at least one child as victim of the armed conflict do not have any occupation. Majority of the respondents reported that they are either self employed or doing household duties only. The self employed respondents are commonly engaged in embroidery, vendors, poultry, shoe making, food stuff packaging etc. About 52% of the respondents are self employed and 21% are in household duties. Few of the respondents are either government employees (3.5%) or employed in a private organization (6.4%). The rest of the respondents that is nearly 7% reported that they are running a small business like a shop.

Table 6: Respondent's primary occupation

Type of occupation	Respondents	Percent	Cumulative Percent
Do not have one	28	9.9	9.9
Household duties	59	20.9	30.9
Business	21	7.4	38.3
Private employee	18	6.4	44.7
Govt. Employee	10	3.5	48.2
Self employed	146	51.8	100.0
Total	**282**	**100.0**	

Chart 4: Respondents primary occupation



In table 8 we present the distribution of families according to the monthly gross income and in Table 7 the number of families having at least one earner in the family except the respondent are shown. About 55.7% of the families i.e. exactly 157 families have earning members other than the respondent itself. However, in 125 families there is no other earning members than the respondent which means that the respondent is the sole income earner in the family. The monthly income classification shows that there are some families who earns less than Rs 1000/- per month. Nearly 21% of the families reported that their monthly income is above Rs. 4000/- per month. The rest of the families have less than 4000/- per month.

Table 7: Other members earned in the family

Earning member	Frequency	Percent	Cumulative Percent
No	125	44.3	44.3
Yes	157	55.7	100.0
Total	**282**	**100.0**	

Table 8: Total gross income per month

Income range	Frequency	Percent	Cumulative Percent
Up to 1000	28	9.9	9.9
1000 – 2000	99	35.1	45.0
2000 – 3000	64	22.7	67.7
3000 – 4000	32	11.3	79.1
4000 +	59	20.9	100.0
Total	**282**	**100.0**	

5.3 National Rural Employment Guarantee Scheme

The Mahatma Gandhi National Rural Employment Guarantee Scheme aims at enhancing the livelihood security of people in rural areas by guaranteeing hundred days of wage-employment in a financial year to a rural household whose adult members volunteer to do unskilled manual work. The Scheme is implemented as a Centrally-Sponsored Scheme on a cost sharing basis between the Center and the State in the ratio of 90 and 10 percentages. This scheme can be availed by adult members of any rural household who are willing to do public work-related to unskilled manual work at a minimum wage of **Rs.100 per day**. The unemployed adults are required to contact the Gram Panchayat in order to avail the scheme.

In this section we analyse data related to the National Rural employment guarantee scheme (NREGS), where the rural households in this study might have been benefitted from the scheme. The objective is to assess the outcome of the scheme in terms of improving the family income of the rural households of the victim families included in the study. Out of a total of 282 victim families, 54 families are categorized to live in urban areas and these families are not entitled to get the benefit of NREGS. The remaining 228 families are asked questions on the particular scheme and information were collected for analysis. In rural areas of Manipur NREGS is popularly known as “Job Card” as this scheme issued a card for those who are engaged to do work under the scheme for identification of the particular individual.

It is quite encouraging that the popularity of the NREGS is quite significantly at a very high level and the almost 96% of the respondents are aware of the scheme. However, despite the knowledge on the scheme, approximately 73% of the families are

currently benefitted from the scheme as 166 respondents (out of 228) are issued a job card which allow them to do work under the scheme.

Table 9: Distribution of respondents according to NREGS awareness

Aware on NREGS	No. of respondents	Percent	Valid Percent	Cumulative Percent
No	9	3.2	3.9	3.9
Yes	219	77.7	96.1	100.0
Total	**228**	**80.9**	**100.0**	
Urban respondents	54	19.1		
Total	**282**	**100.0**		

Table 10: Distribution of respondents by job card holder

Is respondent a job card holder	No. of respondents	Percent	Valid Percent	Cumulative Percent
No	62	27.2	27.2	27.2
Yes	166	72.8	72.8	100.0
Total	**228**	**100.0**	**100.0**	

On the day of interview the respondents who are job card holders are asked the number of days on which they were engaged to work during the last month and last three months. The Act allows a job card holder to get employment for 100 days a year. During the last month 47% of the respondents that is 107 respondents did not get any work despite the fact that they are job card holders. Another 33 respondents got less than 10 days to work during the last month. Fifteen respondents reported that they got exactly 10 days to work in the last month. Only 10 respondents work at least 10 days to work during the last month under NRRGS.

Further analysis shows that there are still 37 respondents who did not engaged any day to work during the last three months. 39 respondents got less than 10 days to work during the last three months under the scheme and 72 respondents got 10 – 19 days to work in

the same period. The rest of respondents who had a job card got at least 20 days to work during the three months period preceding the interview.

Under the NREGS any job card holder who are engaged to work is entitled to get Rs. 100/- per day. On the average the beneficiaries of the scheme in the present study also get Rs. 100/- per day even though some of the respondents reported the amount they got are Rs 80 – 95 per day. Some of them also reported more than Rs. 100/- per day. One of the notable findings in this section shows that about 37% of the benefitted respondents are not satisfied with the amount paid by the scheme.

Almost 90% (148) of the respondents who are benefitted from the NREGS have opened a bank account as the ACT allows them to do so but still the remaining 10% did not open their own bank account. However, out of these respondents who have opened bank accounts only 92 of them keep those bank passbooks with themselves.

Table 11: Have bank account for NREGS

Have a bank account	Respondents	Valid Percent	Cumulative Percent
No	17	10.3	10.3
Yes	148	89.7	100.0
Total	**228**		

5.4 Access to Health Care

In this section we attempt to investigate the awareness and feasibility of the respondent and family members in accessing the health care facilities available in the area. The basic health care for the family is being assesses by asking questions on the awareness and accessibility of the family with regards to immunization of children and visits to health professionals at times of common diseases like fever, diahorrea cold and cough, stomach pain etc. Quite impressive is that about 60% of the respondents have currently accessed any sort of health facilities at least for immunization of their children during the last three months from date of interview. The remaining 40% reported either they do not have access or don't know which do not mean they these respondents are absolutely unaware of the present health facilities.

Table 12: Access to health care services

Accessed	Respondents	Percent	Valid Percent	Cumulative Percent
No	102	36.2	36.2	36.2
Yes	168	59.6	59.6	95.7
Don't know	12	4.3	4.3	100.0
Total	**282**	**100.0**	**100.0**	

All the interviewed respondents are asked whether they have visited a health professional during the last three month from the date of interview. Also they are asked if any of the family members have visited a health professional during the same period. Approximately 46% of the respondents reported that they visited a health professional at least once during the last three months. Eighty six (31%) respondents visited 1 – 2 times, thirty one respondents (11%) visited 3 – 4 times and fourteen respondents (5%) visited more than three times during the period. About 53% or 150 respondents did not visit any health professional during the last three months. However, about 74% of the respondent's family members visited a health professional at least once during the last three months. The following **Tables 13 and 14** shows the exact distribution of respondents and family members by number of visits to a health professionals during the last three months.

Table 13: Respondent's visit to a health professional in last 3 month

No. of Visits	Respondents	Percent	Valid Percent	Cumulative Percent
None	150	53.2	53.2	53.2
1 to 2 times	86	30.5	30.5	83.7
3 to 4 times	31	11.0	11.0	94.7
More than 4 times	14	5.0	5.0	99.6
Don't know	1	.4	.4	100.0

Total	**282**	**100.0**	**100.0**	

Table 14: Respondent's family visits to a health Professional in the last 3 months

Visits of Family members	Family Members	Percent	Valid Percent	Cumulative Percent
None	102	36.2	36.2	36.2
1 to 2 times	101	35.8	35.8	72.0
3 to 4 times	60	21.3	21.3	93.3
More than 4 times	15	5.3	5.3	98.6
Don't know	4	1.4	1.4	100.0
Total	**282**	**100.0**	**100.0**	

Most of the health facilities accessed by the respondents during the last three months are of the type Primary health centers or sub centers in the rural areas. About 49% of the respondents visited either a PHC or a PHSC for their health problems. Also 40% of the respondents visited a hospital for health related problems during the last three months. 9.2% of the respondents went to a private clinic to see a health professional. We also investigate the proximity of the health facilities from their homes by asking the time taken to reach their nearest health centers. Most of the respondents can reach their nearest health facilities within half an hour. Few respondents that is about 10% reported that they require at least one hour or two to reach their nearest health center.

Table 15: Distance of nearest health care facility

Time	Frequency	Percent	Valid Percent	Cumulative Percent
About 5 minutes	27	9.6	9.6	9.6
About 10 minutes	112	39.7	39.7	49.3
About 30 minutes	113	40.1	40.1	89.4
One to two hours	26	9.2	9.2	98.6

More than two hours	4	1.4	1.4	100.0
Total	**282**	**100.0**	**100.0**	

Table 16: Type of health facility

Type of Facility	Frequency	Percent	Valid Percent	Cumulative Percent
Hospital	113	40.1	40.1	40.1
Pvt. Clinic	26	9.2	9.2	49.3
PHC/PHSC/CHC	137	48.6	48.6	97.9
Traditional Healer/Quacks	1	.4	.4	98.2
Other	5	1.8	1.8	100.0
Total	**282**	**100.0**	**100.0**	

The most common type of sickness in the respondent's family are investigated by enquiring the type of sickness complain that have occurred to these respondents during the last three months prior to the date of interview. Psychological or mental problems are the most commonly reported complain that have occurred in these families. Next is the joint pain which is generally coupled with that of mental illness. Nearly 36% of the respondents reported either a joint pain or a mental problem. General weakness which might have resulted from insufficient nutritional food intake and other related diseases are also among the frequently reported complains. Some other sickness that have been reported are cold and fever (7.4%), Diahorrea (1.4%), skin infection (0.9%) and others (20%). Nearly 20% of the respondents did not have any health complain during the period.

Table 17: Type of sickness

Type of sickness	Frequency	Percent	Cumulative Percent
Cold and fever	21	7.4	9.3
Diarrhea	4	1.4	11.0
Joint pain	52	18.4	33.9
Weakness	40	14.2	51.5
Skin infection	2	0.7	52.4
Mental problem	51	18.1	74.9
Other	57	20.2	100.0
Total	**227**	**80.5**	
No Complain	55	19.5	
Total	**282**	**100.0**	

The Chart below shows the most common type of sickness that have been reported during the last one year prior to the survey date. Among those who have reported a complain of sickness during the period of study, we also investigated whether these respondents have consulted a health professional such as a doctor, a nurse, for their sickness. There are only 224 respondents having a health complain and the objective is to assess the level of awareness about these common ailments and their level of consciousness on health problems occurring in their household members. Almost 46% of the complained respondents consulted their illness with a doctor or nurse in government hospitals that is either a Hospital or primary Health Centers or sub-centers. Another 25% consulted a private doctor which is more expensive as compared to government hospitals. 5% of them consulted other health professionals which include mostly homeopathy clinics, ayurvedic and quacks. It is quite embarrassing finding that nearly 23% of the respondents did not consult any health professional despite their illness complains. They reported one or the other reason for not having consulted a health professional which include **Not seriousness, lack of money, Lack**

of assistance to access a health setup etc. Table 18 shows the distribution of sick respondents as they consulted a health professional during the last one year.

Chart 5: Common sickness reported during the last three months

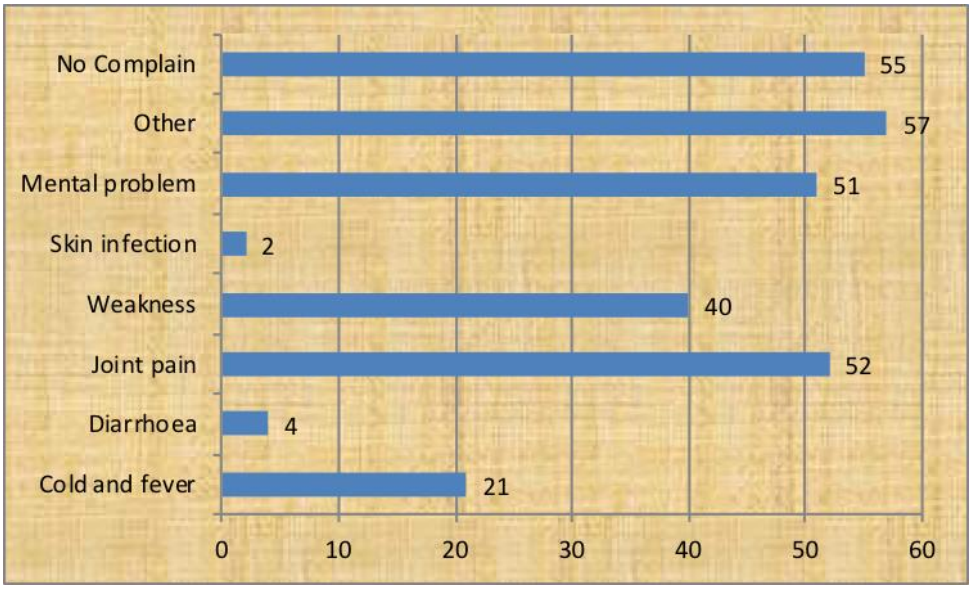


Table 18: Consult a health professional

Consulted	Frequency	Percent	Valid Percent	Cumulative Percent
Doctor in Govt. Hospital	87	38.8	38.8	38.8
Doctor / nurse in PHC/PHSC	17	7.6	7.6	46.4
Private Doctors	57	25.4	25.4	71.9
Others(Homeo, Ayur, Dai etc.)	11	4.9	4.9	76.8
Not consulted	52	23.2	23.2	100.0
Total	**224**	**100.0**	**100.0**	

Chart 6: No. of families who consulted a health professional

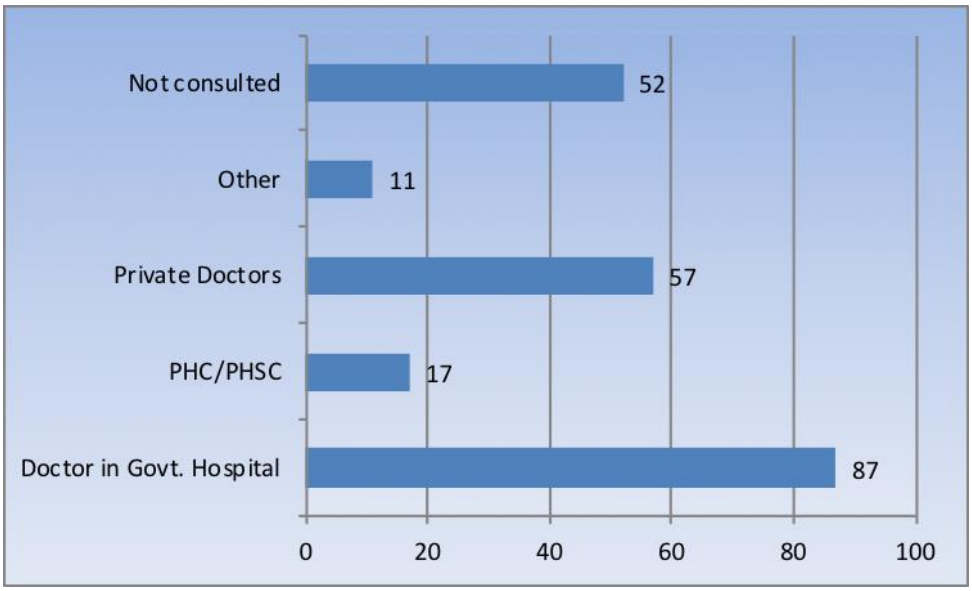


Table 19: Medicine prescribed

Medicine prescribed	Frequency	Valid Percent	Cumulative Percent
No	1	.6	.6
Yes	171	99.4	100.0
Total	172	100.0	

Table 20: Source of Medicine

Source of Medicine	Frequency	Valid Percent	Cumulative Percent
Medical store	168	98.3	98.3
Govt hospital	3	1.7	100.0
Total	**172**	**100.0**	

Table 21: Any surgical operation during the time of sickness

Surgical Operation?	Frequency	Valid Percent	Cumulative Percent
No	156	88.0	88.0
Yes	19	11.4	99.4
Total	**175**	**100.0**	

Table 22: Place of Operation

Place of operation	No. of Respondents	Valid Percent	Cumulative Percent
Govt. hospital	10	52.6	52.6
Private hospital	9	47.4	100.0
Total	**19**	**100.0**	

5.5 National Rural Health Mission (NRHM)

In this section we discuss about the services delivered by the health workers in the society and more particularly to those families who are victims of the armed conflict situation in the State of Manipur. The primary objective here is investigated through the services delivered by health system during delivery cases that occurred in the victim families during the three years period prior to the date of survey. There were only 48 families out of 282 families interviewed in which there was a woman who gave birth to a new baby during the said period. Approximately 58% of the all deliveries in these families took place in Government hospitals and nearly 10% of them the deliveries took place in private hospitals which indicates that some of the families can afford the higher price of these private hospitals. However nearly 21% of delivery cases took place at home only, where no medical

professionals are not assisting the deliveries. This is quite an embarrassing situation in this modernized concept of living.

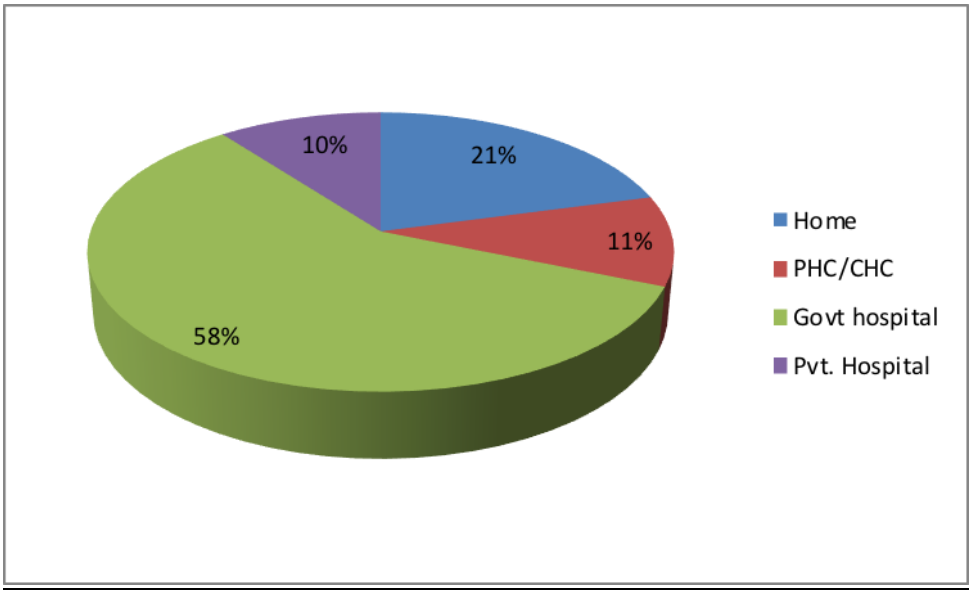
Table 23: Delivery case during the last three years

Delivery	Frequency	Percent
No	234	83.0
Yes	48	17.0
Total	**282**	**100.0**

Table 24: Place of delivery

Place of delivery	Frequency	Valid Percent	Cumulative Percent
Home	10	20.8	20.8
PHC/CHC	5	10.4	31.3
Govt hospital	28	58.3	89.6
Pvt. Hospital	5	10.4	100.0
Total	**48**	**100.0**	

Chart 7: Place of Delivery (Percentage)



Most of the delivery cases that took place in the hospitals or PHCs and PHSCs are assisted by Doctors and nurses, whereas those cases that was done at homes were assisted by local dais (Maibis). Table 25 shows the numbers of delivery cases and assistance at the time of delivery. Almost 81% out of 48 delivery cases, were assisted by doctors only and 8.3% were assisted by nurses whereas 10.4% cases were assisted by local dais only.

Table 25: Who assisted the delivery?

Assisted by	Frequency	Valid Percent	Cumulative Percent
Local Dai	5	10.4	10.4
Nurse	4	8.3	18.8
Doctor	39	81.3	100.0
Total	**48**	**100.0**	

Under the National Rural Health Mission that is implemented in the state of Manipur by the state and Central Government scheme, there is a provision for the so called Accredited Social Health Activists (ASHA) to visit the families and provide assistance and related awareness on health schemes and benefits to localities concerned. Among the 48 victim

families where a delivery case took place during the last three years the ASHA worker visited in 31 families which is about 65% and in the remaining 35% the none of the ASHA did not visit them.

Table 26:
During pregnancy did any ASHA visited the women?

Visited by ASHA	No. of Families	Valid Percent	Cumulative Percent
No	17	35.4	35.4
Yes	31	64.6	100.0
Total	**48**	**100.0**	

In Table 28 we present the related activities and help of the ASHA workers in the 31 victim families as they visited them. Advice for health check-up, bringing them to a doctor, explanation about the janani Suraksha Yojna (JSY) are the main activities of ASHA workers.

Table 27: What type of help ASHA provided?

ASHA Help	No. of Families	Percent	Valid Percent	Cumulative Percent
Tell about JSY	3	1.1	9.7	9.7
Advice to check-up	5	1.8	16.1	25.8
Bring or assist to a doctor	1	.4	3.2	29.0
Multiple response	22	7.8	71.0	100.0
Total	**31**	**11.0**	**100.0**	

Some of the families reported that the assistance of ASHAs are not satisfied to them. That is about 39% did not get satisfaction from the ASHAs activities with them and the remaining 61% reported that they are satisfied. Out of 48 delivery cases that took place in the victim families during the last three years 16 families were benefitted financially from the Janani Suraksha Yojna (JSY), a scheme under the central government which provides financial help to pregnant women.

Table 27: Did you satisfied with the ASHA?

Satisfied?	No. of Families	Valid Percent	Cumulative Percent
No	12	38.7	38.7
Yes	19	61.3	100.0
Total	**31**	**100.0**	

Table 29: Did you get any financial help under JSY

Financial Benefit	No. of Families	Valid Percent	Cumulative Percent
No	32	66.6	69.6
Yes	16	33.3	100.0
Total	**48**	**100.0**	

Table 30: Child immunization

Immunized?	Frequency	Valid Percent	Cumulative Percent
No	2	2.1	2.1
Yes	46	97.9	100.0
Total	**48**	**100.0**	

Immunization of children at the time of delivery and during the period of five years after birth have become quite a necessary medical awareness in this new age health infrastructure. In this regard we enquire about immunization of the newborns to those women who have given birth to a bay during the three years prior to survey. It is quite impressive that 98% of the babies are immunized.

5.6 Education of Children

Those children who are below eighteen years of age in victim families are of primary importance under the objective of the study. The education and health of these

children are very much related with the socio economic conditions of the families to which they belong. There are 430 children in the total of 282 victim families who are 18 years or below and currently schooling. Table 30 shows the distribution of families by the number of children who are currently schooling. One of the interesting finding in this study shows that most of the families in this study did prefer to educate their children in government or government aided schools. That is shown in Table 30 which reveals that nearly 68% of the families prefer to educate their children in private schools.

Table 31: No. of Children currently in education

Number of Children	No. of Families	Percent	Cumulative Percent
None	55	19.5	18.9
1	97	34.4	53.6
2	77	27.3	81.1
3	37	13.1	94.3
4	12	4.3	98.6
5	4	1.4	100.0
Total	**282**	**100.0**	

Table 32: How many of them are in Govt./ Govt. aided school

No. of Children	Frequency	Percent	Valid Percent	Cumulative Percent
None	191	67.7	83.0	83.0
1	18	6.4	7.8	90.9
2	10	3.5	4.3	95.2
3	8	2.8	3.5	98.7
4	2	.7	.9	99.6
5	1	.4	.4	100.0
Total	**230**	**81.6**	**100.0**	

For those families whose children are currently studying in government or government aided schools, the respondents are asked whether they got the benefit of government educational schemes such as the Surva Shiksha Avyan (SSA). The Central government though invested considerably in the primary education under the Right to Education for all, the actual mass did not get the benefit at the right time for the right

families. Therefore in this section we investigate the beneficiaries whether or not the benefits are satisfactory to them and also sought suggestions for improvement. Among 39 families who enroll their children to government schools, only 32 families got benefitted from SSA and the remaining seven families either did not aware of it or did not get the benefits. The benefitted families got books and materials under the scheme and also got free admission of their children. The mid day meal scheme is also another provision for the SSA and most of the families though got such benefits reported complain in terms of the quality and quantity being provided. Tables 32 and 33 tells the pictures of educational benefits availed by the families under the SSA.

Table 33:
Any benefit from govt. related educational scheme such as S.S.A?

Benefitted	Frequency	Valid Percent	Cumulative Percent
No	7	18.4	18.4
Yes	32	81.6	100.0
Total	**39**	**100.0**	

Table 34: If yes, what are the benefits?

Type of benefit	No. of respondents	Valid Percent	Cumulative Percent
Books and learning material	2	6.5	6.5
Free admission	2	6.5	12.9
Multiple response	28	87.1	100.0
Total	**32**	**100.0**	

Under the Surva Shiksha Avyan that is implemented in Manipur the Mid day meal scheme is another component wherein the students enrolled in Governemnt schools are provided at least one meal during the school hours. In this regard the respondents were asked whether they availed the mid day meals to their children. Out of 32 families whose children are in government schools or government aided schools 5 of them reported that they are not availed of these mid day meals. Remaining 27 families got the benefit of mid day meal

scheme to their children. To investigate the consistency of the mid day meal scheme we asked question on the number of days on which no meals were provided during the last three months. In Table 35, three respondents reported that there was not a single day without the mid day meal and six respondents said there were one or two days without meals. However, it is to be noted that most of respondents that 23 respondents (70%) claimed that there were many days without the mid day meals. Further investigation shows that the school authorities provide raw materials for food such rice, dals, oils instead of cooked food at school. However the quality of these foods are not at a satisfactory level to the families.

Table 35: Mid day meal during the last three months

No. of Meals	No. of respondents	Percent	Valid Percent	Cumulative Percent
0	5	2.1	18.2	18.2
1	22	7.8	66.7	84.8
2	5	1.8	15.2	100.0
Total	**32**	**11.7**	**100.0**	
Not Applicable	250	88.3		
Total	**282**	**100.0**		

Table 36: Days with no Mid day meal

Days no meal	Frequency	Valid Percent	Cumulative Percent
No	3	10.3	10.3
One or two days	6	20.7	31.0
More than 2 days	23	69.0	100.0
Total	**32**	**100.0**	

When asked about the quantity of food provided to the children of the victim families, only four respondents answered as plenty (14.3%) and 32% of them suggested that quantity is just enough. However, many of the families reported that the quantity of food is either not nearly enough or not quite enough. Table 36 shows the distribution of families by their suggestions on the quantity of food provided for their children under the Mid-day meal scheme of the SSA. In terms of the quality of food provided only one respondent satisfied and the remaining twenty seven respondents are either not satisfied or just satisfied.

Table 37: Quantity of food provided

Quantity of food	Frequency	Valid Percent	Cumulative Percent
Plenty	4	14.3	14.3
Just enough	9	32.1	46.4
Not nearly enough	11	39.3	85.7
Not quite enough	4	14.3	100.0
Total	**28**	**100.0**	

Table 38: Can you tell us the quality of food provided?

Quality of food	No. of Respondents	Valid Percent	Cumulative Percent
Not satisfactory	12	42.9	42.9
Just satisfactory	15	53.6	96.4
Highly satisfactory	1	3.6	100.0
Total	**28**	**100.0**	

5.7 School Drop out for children

In this section we investigate the school drop out cases of children of the victim families. In general due to poverty coupled with unhopeful ending these children do not complete primary or secondary education. Also these children are overlooked by their parents for their basic education because of the parents busy in earning their day to day livelihood. Thus the children are deprived of their right to education. Some of the families who reported that they are not interested in their children education, the main reason for not attending schools regularly are lack of financial assistance. Consequently those children are also engaged in work or are sick. One family reported that the child is facing discrimination in the school and did not attend school regularly.

One of the impressive finding this section is that the school drop out rate for children is not so high. Nearly 92% of the families reported no drop – out of school for their children during the last three years. In 8% of the families there was a school drop out cases. Table 39

shows the school drop out rates of the 237 families wherein they have at least one child who is currently in school education.

Table 39: Reasons for not attending School regularly

Reason	No. of families	Valid Percent	Cumulative Percent
Not interested	7	33.3	33.3
Discrimination	1	4.8	38.1
Lack of financial means	7	33.3	71.4
Illness of child	3	14.3	85.7
Engaged in work	1	4.8	90.5
Others (specify)	2	9.5	100.0
Total	**21**	**100.0**	

Table 40: How many children have dropped out of school?

Dropped out	No. of families	Valid Percent	Cumulative Percent
0 (no cases)	219	92.4	92.4
1	12	5.1	97.5
2	4	1.7	99.2
3	1	.4	99.6
5	1	.4	100.0
Total	**237**	**100.0**	

5.8 Public Distribution System Availed by the families

It has been observed in almost all the parts of the state that the Public distribution system in Manipur is systematically and effectively performed. Due to lack political commitments on the part of the enforcing agencies and lack of sincerity of the local bodies

has resulted in the unsmooth functioning of the public distribution system in the state. Those who are below the poverty line as defined by the government itself and who could be the real beneficiaries of the public distribution system have become so ignorant about their rights due to such a corrupt system. The victim families in the present studies are also target families for PDS and thus been enquired about the benefits they got out of the PDS in Manipur.

Out of 282 families include in the present study, only 116 are either a BPL card holder or AAY card holder which entitled them to avail the benefit of Public distribution system for families below the poverty line. The remaining 166 families are either unaware of these benefits or are not eligible for it. Most the card holders are provided Rice, Kerosene (SK oil) and Sugar at a lower rate. Only one family got only SK oil and thirty four families got only rice. The rest got all the three items being distributed by the local bodies selected from time to time.

Table 41: Distribution of families by BPL/AAY card

BPL/AAY Card	Frequency	Percent	Cumulative Percent
No	166	58.9	58.9
Yes	116	41.1	100.0
Total	**282**	**100.0**	

Table 42:
What are the food items distributed/sold under BPL/AAY

Consumer Items	No. of families	Valid Percent	Cumulative Percent
Rice	34	29.3	29.3
Kerosene (Sk oil)	1	.9	30.2
Multiple response	81	69.8	100.0
Total	**116**	**100.0**	

The quantity of rice distributed to the families varies from half kg as the minimum to 28 kg. as maximum. This is being recorded for the last three months preceding the survey. The maximum number families reported that they got eighteen or twenty kg of rice per

month. The table 42 shows the exact distribution of families by the amount of rice they got per month.

Table 43: Quantity of rice per month under BPL/AAY?

Amt. in Kg.	No. of families	Percent	Cumulative Percent
.50	2	1.8	1.8
1.00	18	16.1	17.9
2.00	10	8.9	26.8
3.00	8	7.1	33.9
4.00	3	2.7	36.6
5.00	13	11.6	48.2
6.00	2	1.8	50.0
7.00	1	.9	50.9
8.00	4	3.6	54.5
10.00	12	10.7	65.2
12.00	2	1.8	67.0
14.00	1	.9	67.9
15.00	6	5.4	73.2
20.00	19	17.0	90.2
22.00	1	.9	91.1
25.00	8	7.1	98.2
28.00	2	1.8	100.0
Total	**112**	**100.0**	

Table 44: Charge of rice per kg.?

Price (Rs.)	No. of families	Valid Percent	Cumulative Percent
4.00	1	.9	.9
5.00	6	5.4	6.3
6.00	7	6.3	12.5
7.00	3	2.7	15.2
8.00	24	21.4	36.6
8.50	3	2.7	39.3
9.00	4	3.6	42.9
9.50	1	.9	43.8
10.00	54	48.2	92.0
11.00	5	4.5	96.4
12.00	3	2.7	99.1
13.00	1	.9	100.0

Total	**112**	**100.0**	

Table 45: Quality of rice?

Quality of rice	Frequency	Valid Percent	Cumulative Percent
Not satisfied	29	26.1	26.1
Satisfied	81	72.1	98.2
Highly satisfied	2	1.8	100.0
Total	**112**	**100.0**	

Table 44 shows the quantity of kerosene oil distributed to the families during the last three months. Some of the families did not get any Sk oil during the period though they received it before some time that is before three months. Most of the families got 1 to 2 liters of SK oil per month. However 34 families never receive any Sk oil before or later even though they are BPL card holders.

Table 46: Quantity of Sk oil per Month

Quantity (in litres)	No. of families	Percent	Valid Percent	Cumulative Percent
.000	9	7.8	11.0	11.0
.500	4	3.4	4.9	15.9
1.000	45	38.8	54.9	70.7
2.000	19	16.4	23.2	93.9
3.000	2	1.7	2.4	96.3
5.000	1	.9	1.2	97.6
7.000	1	.9	1.2	98.8
8.000	1	.9	1.2	100.0
Total	**82**	**70.7**	**100.0**	
Never	34	29.3		

received				
Total	**116**	**100.0**		

The price of SK oil that is being distributed to BPL card holders among the families are not uniform. It ranges from rupees 14 as minimum to rupees 30 as maximum. However majority of the families buy the SK oil at rupees 20/- per litre and Rs. 25/- per litre.

Table 47: Charge of Sk oil per litre

Price per litre	No. of families	Valid Percent	Cumulative Percent
14	5	6.6	9.2
15	3	3.9	13.2
16	1	1.3	14.5
18	2	2.6	17.1
19	1	1.3	18.4
20	34	44.7	63.2
22	4	5.3	68.4
24	1	1.3	69.7
25	22	28.9	98.7
30	1	1.3	100.0
Total	**76**	**100.0**	

Sugar is the third main item distributed to the beneficiary families under the public distribution system (PDS). We enquire about the quantity and price per kilogram of sugar that is being distributed to the families during the three months to one year period prior to survey. Surprisingly, Most of the families did not get any amount of sugar which means that that this item is not distributed during the period. This indicates that the public distribution system in the state is not functioning properly though in the past the conditions are not enquired and so uncertain. Very few families that is about 5% of them reported that they buy sugar at Rs. 15 to 25 per kilogram.

Table 48: Quantity of sugar per month distributed under BPL/AAY?

Quantity of Sugar	No. of Respondents	Valid Percent	Cumulative Percent
0	76	93.8	93.8
1	1	1.2	95.1
2	2	2.5	97.5
5	2	2.5	100.0
Total	**81**	**100.0**	

Table 49: Cost of the sugar per kg.

Price in Rs. Per Kg.	No. of Respondents	**Valid Percent**	**Cumulative Percent**
15	1	20.0	20.0
20	1	20.0	40.0
25	3	60.0	100.0
Total	**5**	**100.0**	

6. Discussion and Conclusion

6.1 Discussion

The first and foremost question to be answered in the present study as mentioned in the objective of the study is the assessment of the present needs of the children of victim families in terms of their socio-economic, health and education in the four valley districts of Manipur. The socio-economic and health status of those children are indirectly addressed through the same status of the families to which they belong and consequently the information extracted from the respondents who are care givers of the children or main bread earner of the family are discussed as follows.

Most of respondents interviewed are females and widows who are fortunately in the middle age groups of 18 – 60 years, with the exception of some very old respondents who at least answers the questions. One of the spouses expired either by the armed conflict situation or is permanently disabled. Though some of the respondents are illiterate, the rest of them are able to read and write. However, most of them do not reach higher educational qualifications which indicate that they are unsuitable for government jobs which are otherwise paid better than private jobs in Manipur, (Ref to Table 4). Consequently, the economic conditions of the victim families are very poor and so immediate attention is recommended in order to cope up with their problems on health and education of children. Many of the families source of income is what they called self employed which gives a mere day to day livelihood for surviving their children, (Ref to Table 5, 6**). Only 21% of the families reported that they have a monthly income of at least Rs 4000/- per month**.

Access to basic health care in the victim families still needs some more attention. Despite the bigger efforts of government and non-government organization to avail and acquire the basic health cares for all families, nearly 40% of the studied families do

not access to these basic health care system in the state. These families are either unaware of the information or not serious enough to avail the facilities, (Ref. Table 12, 13). The non-governmental organization who are working in the related fields of health are suggested to work further in this regard. **Regarding nature of sickness occurred during the last three months to one year, that the respondents have reported the most common type if the mental or psychological problems and the next is Joint pain and general weakness**. Because the victim families are once traumatized due to the present conflict situation and consequently the mental health are generally not good. Joint pains and weakness in general are also result of the same cause. While working with the health of these victim families, the organizations are recommended to prioritize in these types of sickness of these respondents. It is of quite important and necessary for the members of the victim families to consult health professionals like a doctor in government hospital at times of serious illness. However, some of families are not serious or could not afford the medical fees required and they did not consult a health professionals (Ref Table 18).

Education of children for victim families not only helps to produce a good human resource to the society but it also gives a ray of hope to their parents and family members. There are 430 children in the total of 282 victim families who are 18 years or below and currently schooling (Ref Table 30). Fifty-five families do not have any child currently in education. The present study also reveals the marked difference between Government schools and private schools in the state as most of the families despite their low income prefer to educate their children in private schools only, (Ref. Table 31). **Only 17% of the families send their children to Government or government aided school** and these families got benefitted from the Surva Shiksha Avyan (SSA) scheme in terms of their books, materials, free admission and mid day meals. The quantity and quality of the meals provided however needs to be redefined and checked through competent authority as the families have complains on compromising the quantity and quality of the foods.

Checking for the school drop-out rate of children as well as the irregular attendance at school have become a means to identify the interest of the parents to educate their children and also the financial capability of family members for children education. There are some drop cases and poor attendance of children of victim families. When asked about the irregular attendance of children to school the primary reasons are lack of financial involvement, sickness of children and lack of interest to study.

To assess the adequacy and effectiveness of the public distribution system (PDS) and their delivery system to the victim families is also one of the primary objectives of the present study. The present political chaos and social norms coupled with irregular law and order situation have greatly affected the smooth functioning of the Public Distribution System in the state. The victim families who are mostly below the poverty line and deprived of the basic amenities could not be improved their livelihood by the PDS in the state. More than 58% of the families do not have a BPL/AAY card which entitled them to avail the items distributed under PDS. The rest of the families despite having issued a BPL card could not avail the items regularly. **The only item which they got to some extent is rice though it is also not in a regular manner**. Items like kerosene and sugar are not distributed at all. Very few families reported that they got these items once in six months or one year at a variable rate ranging from Rs. 14 to 30 per litre of Kerosene and Rs. 15 to 25 per kilogram of sugar. In this regard the government and non government organizations working for these families needs attentions to improve the public distribution system for all and particularly for these victim families.

The National Rural Employee Guarantee Scheme implemented by the State and Central government aims at improving the financial conditions of the rural poor by giving at least 100 days employment to the rural areas of the country. The minimum wages as prescribed the authority is Rs 100/- per day of work. Most of the victim families under study are resided in rural areas of the four districts, (Ref Table 1) and approximately 73% of the families have a job card holder in their families. The objective of the scheme to give employment to the families at least 100 days in a year is still to be fulfilled.

The National rural Health Mission (NRHM) which is also implemented by the state and the central government under the banner of Health for all has given some benefits to the victim families. The Janani Suraksha Yojna (JSY) under which the pregnant women are availed some financial aid and other benefits has also benefitted the families under study. The ASHA workers visited the families during pregnancy and also counseled them and brought them to doctors for health check up. The new babies are immunized with few exceptions and during the time of health complains most of the families are aware to consult health professionals. However, in order to achieve the 100% goal it is still some more activities yet to be done.

6.2 Conclusion and Recommendations

The wounds inflicted by armed conflict on children - physical injury, gender-based violence, psychosocial distress, are affronts to every impulse that inspired the United Nations Convention on the Rights of the Child. Armed conflict affects all aspects of child development - physical, mental and emotional. Such effects accumulate and interact with each other. To be effective, assistance must take account of each. The impact of armed conflict cannot be fully understood without looking at the related effects on women, families and the community support systems that provide protection and a secure environment for development. Children's well-being is best ensured through family and community-based solutions that draw on local culture and an understanding of child development.

The disruption of food supplies, the destruction of crops and agricultural infrastructures, the disintegration of families and communities, the displacement of populations and the destruction of educational and health services and of water and sanitation systems, all take a heavy toll on children.

6.2.1 HEALTH AND NUTRITION

In the state of Manipur, people have started witnessing deaths of men, women and children killed in bomb blast planted in public places by insurgent groups for their own reasons, cross firing between the state/central forces and the insurgents. Many others have also become handicapped due to these reasons that simply ignored the victims. All the victims and their families are traumatized at least once which have caused serious mental and psychological health problems and the authorities have escaped from being concerned to what they have involved. The situation will become worsen day by day if there is a sincere intervention by all sections of the society in general and by the concerned government and non government organizations working with these victim families in particular.

6.2.2 Disrupted health services and food supplies

The health care system in most part of the remote areas of the state are not so impressive due to lack of adequate infrastructure, men-power and most importantly due to the lack of seriousness of personnel who are directly involved in the system. The health delivery

needs further strengthening and the system needs further streamlining so that the targeted goals are achieved in time. The insurgent groups needs to understand not to disrupt the health related supplies and the delivery system. The frequent bandhs and economic blockades in the national highways should not hamper the supply lines for health food items.

Restrictions on travel also hamper the distribution of drugs and other medical supplies, causing health systems' referral services and logistic support to break down. Many of the health services of a country are diverted to the needs of military casualties. Hospitals are forced to neglect the regular care of patients or to shift them to health centres. A concentration on military needs also means that children injured in a conflict may not get effective treatment or rehabilitation. Children living with disabilities get little, if any, support. For children, a dangerous implication of the breakdown of a country's health facilities during conflicts is the disruption of vaccination programmes.

6.2.3 Some recommendations for action (Health and Nutrition)

- All parties involved including insurgents to a conflict should be obliged to maintain basic health systems and services and water supplies.
- Special attention should be paid to primary health care and the care of children with chronic or acute conditions. Adequate rehabilitative care should be ensured to facilitate the fullest possible social integration.
- Child-focused health needs assessments involving local professionals, young people and communities should be speedily carried out by organizations working in conflict situations.
- During conflicts, Governments and non-State entities should be encouraged to facilitate "days of tranquility" or "corridors of peace" to ensure continuity of basic child health measures and delivery of humanitarian relief.
- Emergency relief should give attention to the rehabilitation of agriculture, livestock and fisheries and to employment or income-generating programmes, to enhance local capacities to improve household security on a self-reliant and sustainable basis.
- Health professionals must be advocates of the rights of the child. WHO, in collaboration with professional, humanitarian and human rights organizations, should encourage pediatricians and all other doctors and health workers to disseminate child

rights information and to report rights violations encountered in the course of their work.

6.2.4 Empowering families and communities in the healing process

The family is essential to children's care and protection and is an important social, economic and cultural factor in child development. But often, families are worn down by conflicts, both physically and emotionally, and face increased impoverishment.

The most effective and sustainable approach to recovery is to mobilize the existing social care system. This could involve mobilizing a refugee community to support suitable foster families or extended family systems for the care of unaccompanied children. Another alternative is to provide care through peer-group living arrangements that are strongly integrated into communities. Institutional approaches can contribute to isolation and stigmatization and have proven ineffective.

Education has a crucial preventive and rehabilitative part to play in fulfilling the needs and rights of children in conflict and post-conflict situations. Education also serves much broader functions. It gives shape and structure to children's lives and can instil community values, promote justice and respect for human rights and enhance peace, stability and interdependence.

Unfortunately, not even schools are safe from attack during times of armed conflict. In rural areas the school building may be the only substantial permanent structure, making it highly susceptible to shelling, closure or looting. Often, local teachers are prime targets because they are important community members or because they may hold strong political views. The destruction of education networks represents one of the greatest developmental setbacks for countries affected by armed conflict. Lost education and vocational skills take years to replace, making the overall task of post-war recovery even more difficult.

During armed conflicts, fear and disruption make it difficult to create an atmosphere conducive to learning, and the morale of both teachers and pupils is likely to be low. As conflicts drag on for months or even years, economic and social conditions suffer and educational opportunities become more limited or even cease to exist altogether. Sometimes, even when educational opportunities exist in war-torn areas, parents may be reluctant to send

their children to school. They may be afraid that the children will not be safe while they are on their way to and from school, or during classes. Mothers and fathers may need their children to work in the fields, in shops or at home caring for the youngest children.

Educational activity must be established as a priority component of all humanitarian assistance. When children have been forced to leave their homes and are crowded into displaced persons camps, establishing schooling systems as soon as possible reassures everyone by signalling a degree of stability and a return to normal roles and relationships within the family and community. Refugee children can sometimes attend regular schools in host countries, as provided for in international law, though very few get the opportunity to do so. Some host Governments refuse to provide -- or to allow international agencies to provide -- educational activity for refugee children. The efforts of United Nations agencies and other organizations to meet the educational service needs of children affected by conflict require significantly increased support.

6.2.5 Creative ways to maintain education

Even in situations of armed conflict, it is important to carry on educating children and young people, no matter how difficult the circumstances are. Education promotes their psychosocial and physical well-being. Teachers can recognize signs of stress in children as well as impart vital survival information on issues such as personal safety and health. They can also promote tolerance and respect for human rights. When schools become camp sites for security personnel, alternative sites for classrooms can be established, as was done in In Manipur It has been observed that some schools and old government offices have been converted to military camps for temporary arrangements.

6.2.6 Some recommendations for action (Education)

- All phases of emergency and reconstruction assistance programmes should take psychosocial considerations into account. They should also give priority to preventing further traumatic experiences.
- While focusing on a child's emotional wounds, programmes should aim to support healing processes and re-establish a sense of normalcy.

- Programmes to support psychosocial well-being should include local culture, perceptions of child development, and an understanding of political and social realities and children's rights. They should mobilize the community care network around children.
- Those Government and Non-Governments, organizations should prevent the institutionalization of children which means that these victim children should not be admitted to any institute for any cause, rather it should be done with the full cooperation of the community so as to ensure their long-term reintegration.
- All possible efforts should be made to maintain education systems during conflicts. The international community must insist that Government or non-State entities involved in conflicts not target educational facilities, and indeed promote active protection of such services.
- Donors should extend the boundaries of emergency funding to include support for education. The establishment of educational activity, including the provision of teaching aids and basic education materials, should be accepted as a priority component of humanitarian assistance.
- Support for the re-establishment and continuity of education must be a priority strategy for donors and NGOs in conflict and post-conflict situations. Teachers should be trained to understand the ways in which conflict affects children as well as to impart vital survival information on issues such as landmines, health and promoting respect for human rights.

The present study which is entirely based on the information collected from the victim families may be considered as a baseline study to the assessment of their socio-economic needs. Further study on the implementation of delivery systems such as of their health, education and other amenities will be required for strengthening of the systems.

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Appendix 1

A Study on the Socio-economic and Health Status of Children of Victim Families by Armed Conflict Situation in four Valley Districts of Manipur

(A component of "Promoting organized Initiative of Victims and Civil Society Institutions for Ending Violence against Children" Project funded by EU)

Wide Angle Social Development Organization
Sagolband Moirang Hanuba Leirak, Imphal

Interview Questionnaire

**The respondent in this questionnaire should be the Head of Household/Main earner/care giver in the victim family not below the age of 18 years on the date of interview.*

Identification

Serial no of Questionnaire:

Name of the interviewer:

Name of respondent:

Address:

Locality:

Landmark (if any):

District:

Rural – 1 Urban – 2

Date of interview:

Status of interview: complete – 1 deferred -2

Approximate duration of interview: ..... mins.

Signature of interviewer:

Section 1: Demography of Respondent

Q.No.	Questions and Filters	Coding Categories	Skip to
1.	How old are you?	Age in years.....	
2.	Sex of respondent	Male – 1 Female – 2	
3.	Have you ever attended school?	No – 0 Yes – 1	>Q5

4.	What is your highest educational level?	Literate – 1 Up to primary – 2 Middle – 3 Secondary – 4 Higher – 5	
5.	What is your marital status?	Currently married – 1 Single – 2 Divorced /Separated – 3 Widow(er) – 4	
6.	How many members are there in your family (same kitchen)?	Male ..... Total ..... Female	
7.	What is your primary occupation?	Do not have one – 1 Household duties – 2 Business – 3 Private employee – 4 Govt. Employee – 5 Self employed – 6	
8.	Do any other member(s) of your family have some source of income?	No – 0 Yes – 1	
9.	What was the total gross income of your family for the last month?	Up to 1000 - 1 1000 - 2000 - 2 2000 - 3000 - 3 3000 - 4000 - 4 4000 - 5000 - 4 Above 5000 - 5	
10.	Have you ever got the benefit of ex-gratia?	No – 0 Yes – 1	
11.	How many children live in your family (below 17 years of age)?	NO.	
12.	Of these how many have been orphaned (at least one parent died)?	No.	
13.	What is the nature of orphan- hood?	Father expired – 1 Mother expired – 2 Both expired – 3 Both alive – 4	>Q16
14.	When did father died? (no. Of months from date of expiry till date)	Time in months.....	
15.	When did mother died? (no. Of months from date of expiry till date)	(Asks if both expired) Time in months.....	
16.	How many adults live in your family (Above 18 years)?	No.	
17.	Of these how many are above 65 years of age?	No.	

Section 2: National rural employment guarantee scheme

18.	Have you heard about the NREGS/Job card?	No – 0 Yes – 1	
19	Are you being a job card holder?	No – 0 Yes – 1	>Q27
20.	During the last month how many days you are engaged for work under this scheme (NREGS)?	..... Days	
21.	During the last three months how many days you are engaged for work under this scheme (NREGS)?	..... Days	
22.	How much amount do you get from this scheme per day?	Rs.	
23.	Do you satisfy the amount?	No – 0 Yes – 1	
24.	Do you know the amount given by the govt. for card holders per day?	No -0 Yes – 1	
25.	Do you have any bank account?	No - 0 Yes - 1	>Q27
26.	Do you keep your bank pass book with you?	No - 0 Yes - 1	

Section 3: HEALTH [GENERAL]

27.	Do you currently have access to health care services? E.g. vaccination of children, care for fever, diarrhoea, etc.	No – 0 Yes – 1 Don't know – 2	
28.	In the past three months how many times did you see a health professional?	None - 1 1 to 2 times - 2 3 to 4 times - 3 More than 4 times – 4 Don't know - 5	
29.	In the past three month how many times did your family go to see a health professional?	None - 1 1 to 2 times - 2 3 to 4 times - 3 More than 4 times - 4 Don't know - 5	
30.	How long does it take you to travel to your nearest health care facility?	About 5 minute -1 About 10 minute -2 About 30 minute - 3 One to two hours – 4 More than two hours – 5 Don't know - 6	
31.	What type of health facility is this?	Hospital - 1 Pvt. Clinic - 2	

		PHC/PHSC/CHC – 3 Traditional Healer/Quacks - 4 Other - 5	
32.	Did you have any complain about your health during the last one year?	No - 0 Yes - 1	>Q39
33.	What type of sickness? (if yes in Q29)	Cold and fever - 1 Diarrhoea - 2 Joint pain - 3 Weakness -4 Skin infection – 5 Mantel problem - 6 Other - 7	
34.	Did you consult any health professional?	Doctor in Govt. Hospital - 1 PHC/PHSC -2 Private Doctors - 3 Other - 4 Not consulted - 5	 >Q40
35.	Whether medicines were prescribed?	No – 0 Yes - 1	>Q41
36.	Whether medicine was taken as prescribed?	No – 0 Yes - 1	
37.	Where is the source of medicine?	Medical store -1 Govt hospital - 2	
38.	Was there any surgical operation during the time of sickness?	No - 0 Yes - 1	>Q41
39.	Where was it done?	Govt. hospital - 1 Private hospital - 2	
40.	Reason for not consulted?	Lack of money – 1 Lack of a man to assist - 2 Distance is so far – 3 No time to go – 4 Not serious - 5 Other (specify) - 6	

Section 4: National rural health mission (NRHM)

41.	Did any women in your family given birth to a new born during the last three years?	No – 0 Yes - 1	>Q49
42.	Where the delivery taken place?	Home -1 PHC/CHC -2 Govt hospital – 3 Pvt. Hospital – 4 Others - 5	
43.	Who assisted the delivery?	Local Dai -1	

		Nurse – 2 Doctor – 3 Others - 4	
44.	During pregnancy did any ASHA visited the women?	No – 0 Yes – 1	>Q47
45.	What type of help ASHA provided?	Tell about JSY -1 Advice to check-up – 2 Give medicines – 3 Bring or assist to a doctor – 4 Others - 5	
46.	Did you satisfied with the ASHA?	No – 0 Yes -1	
47.	Was the child immunized?	No – 0 Yes – 1	>Q49
48.	Did you get any financial help under JSY (Janani Suraksha Yojna)	No - 0 Yes - 1	

Section 5: EDUCATION and SUPPORT

49.	How many children of your family are currently attending school?	No.	
50.	How many of them are in Govt./ Govt. aided school	(If the no. is 0 skip to next section) No.	
51.	Have you got any benefit from govt. related educational scheme such as S.S.A?	No – 0 Yes - 1	
52.	If yes, what are the benefits?	School Uniform – 1 Book and learning material– 2 Free admission - 3 Others – 4 Multiple response -5	
53.	For the last three months, how many meals are provided to your children by the school authority during the school hours?	...../days D.K - 1	
54.	For the past three months, was there ever a day on which the school did not provide any meal?	No – 0 Yes for one or two days – 1 Yes many days - 2	
55.	Would you say that the quantity of food provided from the school has been.....?	Plenty - 1 Just enough - 2 Not nearly enough – 3 Not quite enough - 4	
56.	Can you tell us the quality of food provided?	Not satisfactory – 1 Just satisfactory – 2 Highly satisfactory -3	
57.	If any of your children do not attend school	Not interested – 1	

	on regular basis, what are the reasons for not attending?	Discrimination – 2 Lack of financial means – 3 Illness of child – 4 Engaged in work -5 Others (specify) - 6	
58.	How many children have dropped out of school?	No	

SECTION 6: PUBLIC DISTRIBUTION SYSTEM (PDS)

59.	Do your family have a BPL/AAY card?	No -0 Yes - 1	>stop
60.	What are the food items distributed/sold under BPL/AAY?	Rice - 1 Sk oil - 2 Sugar - 3 Others - 4	
61.	During the last year, how many kg. of rice **per month** do you get under BPL/AAY?	.....kg.	If 0 Kg GT Q64
62.	Charge of rice per kg.?	Rs.	
63.	Quality of rice?	Not satisfied – 1 Satisfied – 2 Highly satisfied – 3 Other – 4	
64.	During the last year how many litres of Sk oil (kerosene) **per month** do you get under BPL/AAY?	.....litre.	If 0 Lit. GT Q66
65.	Charge of Sk oil per litre?	Rs.	
66.	During the last year how many kg of sugar **per month** do you get under BPL/AAY?	.....kg	If 0 kg STOP.
67.	Charge of the sugar per kg.?	Rs.	