

EFFICIENCY BUILDING STRATEGIES FOR INCLUSIVE GROWTH USING MICROFINANCE LENDING MODELS

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ABSTRACT: Inclusive growth is the buzz and the need of the hour for a growing economy like India. The main objective of financial inclusion of extending outreach to a growing share of poor households and to the approximately 80% of the population is yet to be reached directly by the banks. The larger of the two main models, the self Help Group Bank Linkage Programme and the Microfinance lending model has contributed largely towards achieving this objective. It is generally believed that microfinance reduces poverty significantly by giving credit to the poor who in turn invests in income generation activities. The poor would thus graduate out of poverty. This exploratory article discusses about the micro finance concepts and its contributions as a creative financial tool for managing inclusive growth. It also enumerates the evolution of microfinance as a fit activities of NABARD and the different linkage models of the Microfinance Institutions. The current setup for regulating the microfinance Institutions in India and the retrospective effect of the Andhra Pradesh crisis is also deeply analyzed. The myth that Microfinance for inclusive growth of the country is discussed through the Self-Help groups. The contribution of microfinance as a standalone tool contributes for Capacity Building, poverty reduction and empowerment of women is tested for its reality. Also the risks involved in micro-lending models in Micro finance lending practices and through channelized regulations from the centre and through transparent operations, the MFIs should protect the interests of the clients and should help them in getting relieved from their existing debt traps.

Index Terms

Micro finance, Micro Credit, NABARD, Self-Help groups, NGOs, Per capita Income, Inclusive growth, Joint Liability Groups(JLGs)

Introduction to Microfinance

It is a universally accepted fact that the power of financial services to the customer, particularly low-income households is realized only through the availability of a broad range of services, and not just through small loans or opening bank accounts. Microfinance is one of the financial services offered to rural and poor as a part of the financial inclusion programme.

Microfinance is the provision of financial services to low-income clients or solidarity lending groups including consumers and the self-employed, who traditionally lack access to banking and related services.

More broadly, it is a movement whose object is "a world in which as many poor and near-poor households as possible have permanent access to an appropriate range of high quality financial services, including not just credit but also savings, insurance, and fund transfers. Those who promote microfinance

Evolution of Microfinance

The history of micro-finance in India is much longer and more complex than other developing nations. For many other countries the experience of extending credit on a systematic basis and on a large scale to the rural population is new, which gives them

generally believe that such access will help poor people out of poverty.

Microfinance is a broad category of services, which includes microcredit. Microcredit is provision of credit services to poor clients. Although microcredit is one of the aspects of microfinance, conflation of the two terms is endemic in public discourse. Critics often attack microcredit while referring to it indiscriminately as either 'microcredit' or 'microfinance'. Due to the broad range of microfinance services, it is difficult to assess impact, and very few studies have tried to assess its full impact.

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The means, standard deviations and the F ratio were calculated to find out if the difference in the level of stress between the parents of Mentally Challenged and Normal Children was significant. Table 1 shows that there was significant difference in the stress level between the parents of mentally challenged and the normal children. Therefore, the hypothesis "There will be no significant difference in stress between the parents of Mentally Challenged and the Normal Children" is rejected.

Depression among Parents of Mentally Challenged and Normal Children N=50

Depression	Parents		Standard Deviation	F
	Mean	Standard Deviation		
Mentally Challenged	20.84	8.13	5.81	70.89*
Normal Children	8.94	5.81		

* = Significant at 0.01 level

Table 2 shows the F ratio in one-way analysis of variance. Results showed there was significant difference in depression between the Parents of Mentally Challenged and the Normal Children. Therefore, the hypothesis "There will be no significant difference in depression between the Parents of Mentally Challenged and the Normal Children" is rejected.

Physiological Symptoms among Parents of Mentally Challenged and Normal Children N=50

Physiological Symptoms	Parents		Standard Deviation	F
	Mean	Standard Deviation		
Mentally Challenged	3.64	1.37	1.34	55.29*
Normal Children	1.74	1.34		

* = Significant at 0.01 level

Table 3 shows the F ratio in one-way analysis of variance. It was used to test the significance of difference between mean scores obtained by Parents of Mentally Challenged and Normal Children in the area of physiological symptoms among the parents of Mentally Challenged and the Normal Children. Therefore, the hypothesis "There will be no significant difference in the physiological symptoms among the parents of Mentally Challenged and the Normal Children" is rejected.

Emotional Symptoms among Parents of Mentally Challenged and Normal Children N=50

Emotional Symptoms	Parents		Standard Deviation	F
	Mean	Standard Deviation		
Mentally Challenged	5.32	1.98	1.87	36.14*
Normal Children	3.00	1.87		

* = Significant at 0.01 level

Table 4 shows the values of mean, standard deviation and the F ratio, which reveals a significant difference in the area of Emotional Symptoms of Stress among the Parents of Mentally Challenged and Normal Children. Therefore, the hypothesis "There will be no significant difference in the Emotional Symptoms among the Parents of Mentally Challenged and the Normal Children" is rejected.

Cognitive Symptoms among Parents of Mentally Challenged and Normal Children N=50

Cognitive Symptoms	Parents		Standard Deviation	F
	Mean	Standard Deviation		
Mentally Challenged	3.84	1.50	1.49	40.98*
Normal Children	1.92	1.49		

* = Significant at 0.01 level

Table 5 shows the F ratio in one-way analysis of variance. Results showed there was significant difference in the cognitive symptoms among the parents of mentally challenged and normal children. Therefore, the hypothesis "There will be no significant difference in the cognitive symptoms among the parents of mentally challenged and the normal children" is rejected.

Behavioural Symptoms among Parents of Mentally Challenged and Normal Children N=50

Behavioural Symptoms	Parents		Standard Deviation	F
	Mean	Standard Deviation		
Mentally Challenged	3.82	1.84	1.56	24.87*
Normal Children	2.12	1.56		

* = Significant at 0.01 level

Table 6 shows the F ratio in one-way analysis of variance. Results showed there was significant difference in the behavioural symptoms among the parents of mentally challenged and normal children. The behaviour of the parents of mentally challenged parents changed with the type of behaviour of their child. Therefore, the hypothesis "There will be no significant difference in the behavioural symptoms among the parents of mentally challenged and the normal children" is rejected.

The above study reveals that the parents of mentally challenged experience higher level of stress and depression compared to that of parents of normal children. Because raising a child with a disability can cause more daily stress and long-range health problems than parenting a child without disabilities. Parents of mentally challenged work fewer hours, feel more stress. The majority of parents who care for children with disabilities report feeling stressed coping with the responsibilities. These parents must deal with the "death" of the perfect child who existed in their minds and learn to love and accept the child they have.

CONCLUSION

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Challenged and Normal Children.
 There will be no significant differences in Depression between the Parents of Mentally Challenged and Normal Children.

- There will be no significant differences in the Physiological (part-1) Symptoms of Stress between the Parents of Mentally Challenged and Normal Children.
- There will be no significant differences in the Emotional (part-2) Symptoms of Stress between the Parents of Mentally Challenged and Normal Children.
- There will be no significant differences in the Cognitive (part-3) Symptoms of Stress between the Parents of Mentally Challenged and Normal Children.
- There will be no significant differences in the Behavioural (part-4) Symptoms of Stress between the Parents of Mentally Challenged and Normal Children.

MATERIALS AND METHODS

SAMPLE

The sample consisted of 100 parents, out of which, 50 were Parents of Mentally Challenged and 50 were of Normal Children. These parents were randomly selected from the population of various special schools and from the surrounding area of Mangalore, Karnataka.

TOOLS

Selection of the methods and tools is a very important aspect of the study, since it is key to gaining information. The needed information from the sample is collected through:

Stress Inventory (Revised 2005)
 Hemalatha and Nandini constructed the inventory. Stress inventory consists of fifty items.

Table 1
 Stress among Parents of Mentally Challenged and Normal Children

Stress	Parents		Mean	Standard Deviation	F
	Mentally Challenged	Normal Children			
			15.76	5.29	46.89*
			8.78	4.89	

* = Significant at 0.01 level

thoughts of suicide, with or without a specific plan.

The mentally challenged show behavioural problems and deficits in their adaptive behaviour in various areas, such as communication skills, self-help skills, socialization, application of basic academic skills to daily life activities, social skills, vocational and social performance and responsibilities, which lead to lot of stress and depression in their parents. All these, in turn, will affect their well-being. While parenthood brings immense amounts of joy, pride, personal growth and other good things to those with children, it can also bring a lot of challenges, and researchers are finding that these challenges can take a toll. A parenting stress study by Florida State University professor Robin Simon and Vanderbilt University's Ranae Evenson (2005) found that parents have significantly higher levels of depression than adults who do not have children. Parenting can be a pleasurable experience despite its inherent anxieties, worries, frustrations and physical stress. Raising a child who is mentally challenged requires emotional strength and flexibility. The child has special needs in addition to the regular needs of all children and parents can find themselves overwhelmed by various medical, care giving and educational responsibilities. Whether the special needs of the child are minimal or complex, the parents are inevitably affected. Support from family, friends, the community or paid caregivers is critical to maintaining balance in the home.

Depressed Mood: A person may report feeling "sad" or "empty" or may cry frequently. Children and adolescents may exhibit irritability.

Decreased Interest or Pleasure: A person may show markedly diminished interest or pleasure in all, or almost all, daily activities.

Weight Changes: Significant changes in weight when not attempting to gain or lose (a gain or loss of 5% or more in a month) may be indicative of depression. In children, this may also present as a failure to make expected weight gain.

Sleep Disturbances: Insomnia or sleeping too much may be a symptom of depression.

Psychomotor Agitation or Retardation: The person may be observed to be either agitated or restless or physically slowed down in their movements.

Fatigue: Deep fatigue or a loss of energy is a symptom of depression.

Feelings of Worthlessness or Guilt: A depressed person may feel that they have no value or they may feel inappropriately guilty about things they have no control over.

"Brain Fog": A depressed person may have a diminished ability to think, concentrate or make decisions.

Thoughts of death: A depressed person may have recurring thoughts of death, especially

OBJECTIVES

- To identify the level of Stress between the Parents of Mentally Challenged and Normal Children
- To assess the level of Depression between the Parents of Mentally Challenged and Normal Children
- To find out the mean differences in the level of Stress and Depression between the Parents of Mentally Challenged and Normal Children

NULL HYPOTHESES

The hypotheses are stated as null hypotheses so that they can be either accepted or rejected based on the results.

- There will be no significant difference in Stress between the Parents of Mentally

DEPRESSION

Depression is a common disorder affecting at least 10% of the population directly at some stage or other in their lives. In addition to the marked impact it may have on many facets of the patient's life and that of the family, mood disorders have had a major influence on the artistic, political, religious and financial spheres of most cultures. The forecast is that by 2020, depression would be the single leading cause of death (Murray & Lopez, 1996). It has also been estimated that depression would be the second largest illness by 2010 keeping in mind its pace by which it is affecting people world over (Kohli, 2004).

If one has experienced five or more of these depression symptoms within the same two week period - especially if a depressed mood or loss of interest or pleasure is among symptoms - this could be indicative of an episode of depression. The symptoms should not be accounted for by another illness, drugs of abuse or prescription medications.

1. Depressed Mood: A person may report feeling "sad" or "empty" or may cry frequently. Children and adolescents may exhibit irritability.
2. Decreased Interest or Pleasure: A person may show markedly diminished interest or pleasure in all, or almost all, daily activities.
3. Weight Changes: Significant changes in weight when not attempting to gain or lose (a gain or loss of 5% or more in a month) may be indicative of depression. In children, this may also present as a failure to make expected weight gain.
4. Sleep Disturbances: Insomnia or sleeping too much may be a symptom of depression.
5. Psychomotor Agitation or Retardation: The person may be observed to be either agitated or restless or physically slowed down in their movements.
6. Fatigue: Deep fatigue or a loss of energy is a symptom of depression.
7. Feelings of Worthlessness or Guilt: A depressed person may feel that they have no value or they may feel inappropriately guilty about things they have no control over.
8. "Brain Fog": A depressed person may have a diminished ability to think, concentrate or make decisions.
9. Thoughts of death: A depressed person may have recurring thoughts of death, especially

under four parts namely Physiological, Emotional, Cognitive and Behavioural. There are two possible responses to each item namely 'Yes' or 'No'. The Samples were asked to tick (✓) any one, which applies to them most. There was no time limit. But the samples were asked to respond as quickly as possible.

Beck's Depression Inventory (Beck, 1971)

Beck's Depression Inventory consists of 21 items and there are four possible responses to each item namely Always, Often, Sometimes and Never. The Samples were asked to tick (✓) any one, which applies to them most. There was no time limit. But the samples were asked to respond as quickly as possible.

PROCEDURE

The Stress Inventory and Beck's Depression Inventory were administered to the subjects (n=100) to assess their level of stress and depression. These inventories consists of few statements with alternative answers which the subjects have to read carefully and have to indicate their answer by putting a tick (✓) to any one, which applies to them most.

STATISTICAL ANALYSIS

Statistical analysis was done with the help of Statistical Package for Social Sciences (SPSS). The mean, standard deviation, and ANOVA were used to find whether there were significant differences in stress and depression between the parents of Mentally Challenged and Normal Children.

RESULTS AND DISCUSSION

The mean scores and standard deviations with regard to stress and depression were calculated for the parents of Mentally Challenged and Normal Children. One way Analysis of Variance (ANOVA) was used to test the significance of the difference between the mean scores obtained by the parents in the areas of stress and depression. The results were:

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ABSTRACT: Parenting can be a pleasurable experience despite its inherent anxieties, worries, frustrations and physical stress. Raising a child who is mentally challenged requires emotional strength and flexibility. The child has special needs in addition to the regular needs of all children and parents can find themselves overwhelmed by various medical, care-giving and educational responsibilities. Whether the special needs of the child are minimal or complex, the parents are inevitably affected. The mentally challenged show behavioural problems and deficits in their adaptive behaviour in various areas, such as communication skills, self-help skills, socialization, application of basic academic skills to daily life activities, social skills, vocational and social performance and responsibilities, which lead to lot of stress and depression in their parents.

Aim: To identify and compare the level of stress and depression among the parents of mentally challenged and normal children. Materials and methods: The sample comprised of two groups such as the parents of mentally challenged group (N=50) and the parents of normal children group (N=50). The tools used were Stress Inventory (SI) and Beck's Depression Inventory (BDI). Statistical Analysis: Means, Standard Deviations and ANOVA were used to analyze the data. Conclusion: Results revealed that the majority of the parents in the present study brings the awareness of the stress and depression faced by the parents and especially those of mentally challenged children.

INTRODUCTION

Stress as a physical, mental, or emotional response to events that causes bodily or mental tension. Stress is any outside force or event that has an effect on our body or mind. Most of the people experience stress at one time or another. Without stress, there would be no life. However, excessive or prolonged stress can be harmful. Stress is unique and personal. A situation may be stressful for someone but the same situation may be challenging for others. People feel little stress when they have the time, experience and resources to manage a situation. They feel great stress when they think they can't handle the demands put upon them. Stress is therefore a negative experience. And it is not an inevitable consequence of an event. It depends a lot on people's perceptions of a situation and their real ability to cope with it.

Parenting is the process of promoting and supporting the physical, emotional, social, and intellectual development of a child from infancy to adulthood. Parenting refers to the activity of raising a child rather than the biological relationship. There is no single or definitive model of parenting. What may be right for one family or one child may not be suitable for another. With authoritative and permissive (indulgent) parenting on opposite sides of

the spectrum, most conventional and modern models of parenting fall somewhere in between.

According to Ron Huxley LMFT: "Nothing describes parenting better than stress!" Stress is defined as any physical or emotional demand that one feels unable to handle. These demands encompass all of the little hassles one experiences every day, from the moment one tries to get children up for school to the moment they finally get them to bed at night. Even though these daily hassles are often considered trivial, over time, these hassles add up, building in pressure, until they are ready to burst out with anger and frustration. Taking care of a normal child is an easy task for the parents when compared to that of the child with disability. Parents of children with disabilities have a greater number of stressors and a higher number of days during which they have at least one stressor. They also report to experience a greater number of physical health problems. Parents with disabled children experience stress sometimes or always' while trying to balance the responsibility of caring for their children and other obligations. Parents with children with mild to moderate disabilities report their child's condition is the main source of stress.

Mental retardation is a particular state of functioning that begins in childhood and is characterized by limitation in both intelligence and skills. Mental retardation reflects the "fit" between the capabilities of individuals and the structure and expectations of their environment. THE AAMR DEFINITION OF MENTAL RETARDATION

Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18 (American Association on Mental Retardation, 2002). Mental retardation varies in severity. There are four different degrees of mental retardation: mild, moderate, severe and profound. These categories are based on the functioning level of the individual.

TYPES OF MENTAL RETARDATION

The different types of mental retardations are Down's Syndrome (Mongolism) Phenylketonuria (PKU) Cretinism (Thyroid Deficiency) Cranial Anomalies Microcephaly Hydrocephalus

CAUSES OF MENTAL RETARDATION

Risk factors are related to the causes. Causes of mental retardation can be roughly broken down into several categories:

1. Infections (present at birth or occurring after birth)
 - Congenital CMV, Congenital rubella, Congenital toxoplasmosis, Encephalitis, HIV infection, Listeria, Meningitis.
2. Chromosomal abnormality: Chromosome deletions (Cri du chat syndrome), Chromosomal translocations (a gene is located in an unusual spot on a chromosome, or located on a different chromosome than usual), Defects in the chromosome or chromosomal inheritance (for example, fragile X Syndrome, Angelman Syndrome, Prader-Willi Syndrome), Errors of chromosome numbers (Down Syndrome).
3. Genetic abnormalities and inherited metabolic disorders: Adrenoleukodystrophy, Galactosemia, Hunter Syndrome, Hunter Syndrome, Lesch-Nyhan Syndrome, Phenylketonuria, Rett Syndrome, Sanfilippo Syndrome, Tay-Sachs Disease, Tuberculous Sclerosis.

Congenital hypothyroidism (poorly regulated diabetes), Reye syndrome, Hyperbilirubinemia (very high bilirubin levels in babies), Nutritional Malnutrition, Toxic Intrauterine exposure to Alcohol, Cocaine, Amphetamines and other drugs, Lead Poisoning, Methylmercury Poisoning.

5. Trauma (before and after birth): Intracranial haemorrhage before or after birth, Lack of oxygen to the brain before, during or after birth, severe head injury.

TREATMENT

Behavioural, Social and Educational Treatment Modalities Although mental retardation is often initially caused by a medical problem, medical treatments alone are quite inadequate for treating the intellectual and social deficits associated with mental retardation as an ongoing condition. The majority of mental retardation treatment is therefore behavioural, social, and educational in nature, rather than primarily medical.

The treatment programme for addressing the needs of the mentally retarded population suggests that a coordinated interdisciplinary effort can produce the best results. Accordingly, behaviour therapists, speech and occupational therapists, special education specialists, case managers and social workers work together to create and implement mental retardation care programmes in most communities. These professionals collaborate with the individual's family and community services to develop individualized treatment plans specific to each affected individual's strengths and needs. Early intervention is crucial in order to ensure optimal development of mentally retarded children. Intervention programmes are offered beginning as young as birth through two years of age. These programmes serve multiple functions: They inform parents and primary caretakers about early development; they provide interventions designed to help children grow and learn; and they collaborate with families to design treatment plans to help children function to the best of their abilities. Settings for these programmes include home, school and community.