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CONTENTS

RESEARCH STUDIES ON WOMEN & CHILDREN

CHILD LABOUR

1. Satapathy, D.M, et. al (2005).
Socio-clinical profile of child labourers in Berhampur Town of Orissa. *Health and Population Perspectives and Issues*, Apr-Jun, 28(2) : 89-98.

Abstract : Child labour is a major social problem. In 2002, the International Labour Organization (ILO) had estimated that about 246 million children aged 5-17 years were employed worldwide and 98% of these were in developing countries. With more than 10.4 million child labourers in the 1991 Census, India has the largest number of child labourers in the world. These children mostly live in urban slums and are exposed to the risk of infectious diseases, malnutrition and impaired cognitive development. The present study investigated the socio-clinical profile of 335 working children (5-15 years), engaged in different sectors, in Berhampur town of Orissa. The study was conducted by the Department of Community Medicine, MKCG Medical College, Berhampur during October-December 2003. Data was collected through observational technique, interviews, questionnaires and physical examinations. It was observed that 55% of the children were between 13-15 years, 44% were from rural areas and 61% were from large families (parents with more than 2 children). In 41.7% cases, more than one sibling had joined the labour force. It was also found that 35% of the children did not attend any school while 51% had primary and 14% had secondary level education respectively. The various reasons given for joining the labour force were to support or supplement the family income (62%), less or no interest in studies (18%), being beaten or scolded by the teacher (11%) and out of self interest (9%). The study also revealed that many children had to work beyond their physical capabilities, the working hours varied from 3.5 hours per day to 12 hours and 75% children were not given any food during working hours. The wages were exploitatively low, i.e. Rs 297.90 per boy and Rs. 306 per girl per month for an average 8 hours working day. Different grades of malnutrition were observed among 85% boys and 73% girls. The common diseases among these children included anaemia (51.34%), respiratory tract infections (22.08%), helminthic infestations (21.49%), scabies and skin infections (16.41%) and minor injuries (5.67%). One girl had goitre. More than two thirds of the children (68.4%) were addicted to betel nut or chewing tobacco products like *khaini* or *zarda*, 23.4%

were *bidi* smokers and 7.7% consumed alcohol. Thus, immediate action by Government and NGOs is required for alleviating the plight of working children, by establishing more vocational and educational institutions, creating awareness among the public about the hazards of forced labour, providing nutritional benefits and compulsory primary education for children, and placement services for children who had undergone vocational training in schools.

Key Words : 1.CHILD LABOUR 2.WORKING CONDITION 3.EXPLOITATION CHILD LABOUR 4.HEALTH STATUS 5.HEALTH STATUS CHILD LABOUR

CHILD WELFARE

2. Association for Development, New Delhi. (2005).
A Study report on needs of adolescent girls in Trilokpuri. New Delhi : AFD. 35 p.

Abstract : Adolescence comes from the Latin word adolescere, which means to grow into adulthood. Association for Development (AFD), an NGO of trained social workers, conducted sessions on reproductive health issues and various related problems with adolescent girls and women of the community. During direct interaction with the girls it was realized that adolescent girls in the Trilokpuri community had little exposure to the outside world. With this background in mind, awareness sessions were taken with these girls on issues of sexuality, interpersonal relationships, legal rights and provisions for women in distress, self concept, and negotiation skills. This intervention has been going on for around five years. The major objective of this study was to assess sexual health needs of adolescent girls and to develop an effective community based intervention programme. The study was conducted in Trilokpuri resettlement colony, Delhi. In the first stage, adolescent girls in the age group of 16-22 years, five married and five unmarried, formed the sample. Data was collected using in-depth interviews. The major findings were that 80% girls did not have any information about menstruation before its onset. Around 90% girls had only heard about HIV/AIDS but did not have any more information on it. Around 90% girls were aware of the disadvantages of early pregnancy but their awareness about contraceptive techniques was limited to the use of condoms or Mala D only. 9 girls felt that these programmes should be conducted regularly using a fixed curriculum; 8 girls felt that their mothers should also be included in such programmes. Though most girls admitted that they were eve-teased at one point of time or the other, but they did

not see it as sexual abuse. Married girls talked about their anxieties about sexual life after marriage. Married girls strongly recommended prior information sessions on family life education before marriage so that they are able to take on new roles and expectations in a positive manner. It was recommended that the topic of sexual health needs of adolescents, being a very sensitive issue, needed to be taken up in a structured manner, providing all information in stages as per the age. While addressing the issue, it is essential to take into consideration "gatekeepers" of society and strategies need to be planned to involve them in the programme, while saving the interests and free expression of adolescent girls. The second objective of the study was to find out the impact of on-going awareness programmes on adolescent girls in the community. AFD is working on prevention of crime through awareness campaigns with adolescent girls groups in the Trilokpuri community. 150 girls between 16-22 years of age were the direct beneficiaries of the agency. Information on crime, nutritious diet, health and hygiene, self concept, etc. was new to almost all the girls, and clarified their concepts regarding these topics. Information about legal matters and police station procedures was complex but of concern to almost all the girls. The respondents felt themselves to be better informed than other age mates who had never attended such meetings. The concrete impact of these sessions on girls was mainly increased confidence and making their parents and peers realize their worth. The third objective was to strengthen the existing legal empowerment intervention programme for adolescents in the community. Out of 40 girls, 31 girls had a negative opinion about the police whereas only 9 had a good impression about the police. Almost all girls were of the view that "*Sarkari* (government) *Vakeel* (lawyer) takes less money than a private *Vakeel"*. Legal empowerment of adolescent girls in the community was almost negligible. There is a need to involve "gatekeepers" of the community also in the programme to ensure its implementation at the community level. Emphasis on exposure visits to police stations, information about crime against women cells and other legal bodies to help girls grow out of their cocoons needs to be imparted. New strategies should be developed to reach out to the male members of the community.

Key Words : 1.CHILD WELFARE 2.ADOLESCENT GIRL 3.ADOLESCENT GIRL NEED 4.REPRODUCTIVE HEALTH 5.AWARENESS GENERATION PROGRAMME 6.LEGAL AWARENESS 7.EMPOWERMENT ADOLESCENT GIRL 8.INTERVENTION PROGRAMME 9.CRIME 10.VIOLENCE 11.COMMUNITY PARTICIPATION 12.DOMESTIC VIOLENCE 13.LEGAL RIGHTS 14.REPRODUCTIVE HEALTH ISSUES.

3. Ganguly Thukral, Enakshi et al. (2005).
Status of children in India Inc. New Delhi : HAQ Centre for Child Rights. 200 p.

Abstract : The most important factor for continued marginalization of children today is the process of globalization. Although several child specific interventions directly concerning children, such as National Charter for Children (2003), National Commission for the Protection of Child Rights, etc. have been initiated, many gaps still remain. ICDS was also started to cater to the needs of young children in the 0-6 years age group to address ECCE concerns. However, the services under ICDS covered only 22% of the children in the 0-6 years age group. Despite the supplementary nutrition component, 47% of the children were found to be undernourished. State-wise disparities were also reported. AWCs were functioning extremely well in Maharashtra and Tamil Nadu, as opposed to Uttar Pradesh. More than 30% of the children under 5 years were severely stunted and 20% were severely underweight. National Rural Health Mission (NRHM) was being implemented in 18 states that had weak public health indicators, and aimed at integrating different vertical programmes. Poverty was the major cause of deteriorating health situation in India. India had the highest percentage of anaemic pregnant women and neonatal deaths in the world. Childhood malnutrition was found to be a serious problem, and the major factors responsible were low birth weight, poor infant feeding practices, infections due to poor sanitation, etc. About 13.1% of the substance abusers were below 20 years of age. *Sarva Shiksha Abhiyan* (2001-2002) had been started to achieve universalisation of elementary education. However, Education Guarantee Scheme employed less qualified, under paid local teachers and replaced trained professional teachers. The Gross Enrollment Ratio (GER) increased from 32.1% in 1950-51 to 82.4% in 2001-2002. Increase in GER had been higher for girls than boys. However, several gaps still existed, as children of manual scavengers were expected to clean toilets, Dalit children were made to sit separately and drink from separate containers. Girl children were discouraged to go to schools which had male teachers, yet only 35% of the teachers in schools were females. About 11 million children were on the streets as a result of trafficking, or forced eviction due to development projects, or they had escaped from abusive homes. Lack of adequate space led to increased vulnerability for gender based violence. There had been an 11.1% increase in crimes against children in 2003 compared to 2002. Many crimes went unreported. The alarming rise in buying and selling of girls was a consequence of the new market economy in India. In the 0-5 years age group, the sex ratio had dropped to an all time low of 927 females for every 1000 males. Globalised India also

witnessed a rise in child marriages, even in the socially progressive states such as West Bengal and Karnataka. Juvenile delinquency was also on the rise, due to low education and poor economic set up. The Union Government's allocation towards child protection was only 0.03% of its total budget allocation (BE 2005-06). Children also bore the brunt in situations of armed conflict and natural disasters. Children were often enticed by promises of food, shelter and security and used as a weapon during conflict situations. Natural disasters also rendered children homeless. Due to lack of psycho-social rehabilitation after Orissa cyclone, many girls even committed suicide. In 2003, the victim was below 18 years of age in 41% cases of incest. Madhya Pradesh had the highest number of rape cases. There had been a 16.5% increase in cases of child rape. Globalisation has added many more sectors and industries in which children are employed. In cotton seed production, 90% of the workforce comprised children who were enrolled in schools. National Crime Records Bureau (2003) revealed that there were 2571 cases of trafficking of children for purposes such as domestic labour, marriage, adoption, entertainment in circus industry, etc. Heavy investments need to be made in dealing with non-communicable diseases. Increased participation of NGOs in disseminating information about good health practices is required. Policy makers should take into account the special needs of children while preparing resettlement sites for evicted children. Union Government should allocate greater amount of its budget for child protection.

Key Words : 1. CHILD WELFARE 2.SITUATION OF CHILDREN INDIA 2005 3.RIGHTS OF THE CHILD 4.DISABLED CHILDREN 5.MALNUTRITION AMONG CHILDREN 6.CHILD NUTRITION 7.EDUCATION FOR ALL 8.RIGHT TO EDUCATION 9.CHILD SEXUAL ABUSE 10.TRIBAL CHILDREN 11.JUVENILE JUSTICE 12.INSTITUTIONAL CARE 13.ARMED CONFLICT.

4. Kurz, Kathleen M. (2006).
Delaying age of marriage and meeting reproductive health needs of married adolescent women. Washington, DC : International Centre for Research on Women. 6 p.

Abstract : Marriage among adolescent girls younger than 18 years often has significant negative consequences for them and their newborns. Early marriage often leads to high risk of health and nutrition deficiency, maternal mortality, school dropouts, domestic violence, sexual abuse and malnourished children. Child marriage is prevalent in many developing countries. In Africa, 77% women 20-24 years old were married before the age of 18; and among women aged 20-24 years

old in South Asia, 65% women in Bangladesh and 48% women in India were married before the age of 18 years. Results were drawn from descriptive and intervention research in India carried out by Christian Medical College (CMC), Vellore; Foundation for Research in Health Systems (FRHS), Ahmedabad; Institute for Health Management, Pachod (IHMP); King Edward Memorial (KEM) Hospital and Medical Center, Pune; and Swasthya, New Delhi along with International Center for Research on Women (ICRW), Washington, DC. Each group carried out 3 interventions between 2002 and 2005 on life skills course, health education, nutrition behavioural change, etc. In rural Maharashtra, median age at marriage was as low as 14.5 years. After the life skills course, girls age at marriage showed significant increase from 16 years in 1997-2000 to 17 years in 2001. About 17% girls in rural Maharashtra used contraceptives for delaying pregnancy in the first year of their marriage. Young women in India suffered silently with regard to RTIs, a cause of infertility; chronic poor health; premature deliveries and low birth weight of their newborns. Husbands made decisions about seeking care, mothers-in-law had influence over these decisions, and girls had neither decision-making power nor influence. In Tamil Nadu, 53% women reported gynaecological symptoms. According to laboratory diagnoses, 15% had STIs and 28% had endogenous infections. From FRHS intervention study in rural Maharashtra, majority of almost 1000 husbands were knowledgeable about prenatal, delivery and postnatal care. The community considered maternal care to be exclusively women's domain. It is crucial to get husbands involved in the programme, since they are often the decision-makers, they accompany the young women to the clinic, and are the ones who pay for care. Interventions aimed at delaying age at marriage to beyond adolescence and improving the reproductive health of young married women are likely to improve the nutritional status of young women, young mothers and their infants.

Key Words : 1. CHILD WELFARE 2.ADOLESCENT 3.ADOLESCENT HEALTH 4.ADOLESCENT REPRODUCTIVE HEALTH 5.AGE AT MARRIAGE 6.CHILD MARRIAGE.

5. Srivastava, Arti. (2005).
Attitude towards girl child and the declining sex ratio in Bhopal : a pilot study. Bhopal : Sarojini Nadu Govt. Girls Post Graduate College, Centre for Women's Studies. 43 p.

Abstract : Female foeticide is the intentional abortion of female foetus due to preference for male babies and the low value associated to females. In patriarchal

Indian society, it is the son who takes care of parents in their old age. The main objectives of this study were to investigate the attitude of parents towards the birth of a girl child; analyse gender discrimination at birth and during socialization of a child; evaluate awareness and attitude towards Pre-Natal Diagnostic Techniques (PNDT) Act 1994; and create awareness about the dangers of female foeticide. The study surveyed only one ward of Bhopal municipal area. A sample of 200 households was selected for field survey, and they all belonged to different socio-economic classes. A man or woman who had been married for 5-10 years was interviewed. Of the total respondents, 164 (82%) were women and 36 (18%) were men. The sample had 13.5% Muslims and the remaining were Hindus. About 69% of the study population was educated upto high school level. Of the 164 females, only 26 had higher education. Almost 39.5% respondents were either in business or in government service, and 25.5% respondents were earning their livelihood through petty labour. About 15% females wished to give birth to sons; 10% of the sample wanted daughters and 75% did not show any preference. For 12% respondents, the birth of a daughter was not regarded as a happy moment in the family; but when asked about their own reaction at the birth of a girl, only 7 husbands responded negatively. More than 90% families welcomed female births when the father of the child welcomed the girl child. Around 85.5% informants performed some socio-religious rites at the birth of a newborn; 14.5% answered negatively. Some parents said raising a girl child was quite a costly affair. Out of 200 respondents, 145 (72.5%) perceived that bringing up a son was also difficult in some way or the other way. According to religion and economic status, gender discrimination was observed, but respondents from highly educated families denied making any discrimination between son and daughter. Almost 50% of the study population considered two children to be ideal for a family. One post-graduate and almost half the under graduate respondents felt one child was ideal for a family. Out of 134 respondents who knew about the PNDT Act, only 18% were in favour of sex determination test. In 1991, there were 889 women per 1000 men in Bhopal, but PNDT Act helped in raising the sex ratio though by only 6 females per 1000 men in a decade's time. People should be made aware that reducing the number of girls increases physical and social threat to their childhood, marriage and future life. It is high time to realize that decreasing sex ratio would disempower women. Therefore, discrimination against the girl child poses a threat, not only to daughters, but also to the family and society as a whole.

Key Words : 1. CHILD WELFARE 2.GIRL CHILD 3.DECLINING SEX RATIO 4.FEMALE FOETICIDE 5.ATTITUDE TOWARDS GIRL CHILD 6.SEX RATIO.

GROWTH AND DEVELOPMENT

6. Kale, Giteshwari and Bhargava, Shruti. (2006).
Sounds to sentences : pathway of language development in 14-28 months infants. *Journal of the National Academy of Psychology*, 51(1) : 12-18.

Abstract : The present study examined the pathway of language development of 14-28 months old infants in terms of expression, comprehension and vocabulary. Data was collected from Hindu Gujarati, middle class families (n=36) of Baroda, through an observation guideline and an interview guideline for infants and mothers respectively. Results showed that infants of age 14-16 months used a mixture of verbal as well as non-verbal gestures to communicate. Pointing gestures were found to peak at 16-18 months and were established in subsequent ages. The 18-20 months period emerged as a transition period for language and development. It was found that the use of gestures decreased considerably at 20-24 months and communication was mostly verbal. Infants at the age of 24-28 months were found to be using adult like language with extensive vocabulary. Most mothers (33) reported that they started labeling objects before or when the child was one year old. Majority of the mothers (28) mentioned that they talked to their infants in adult language and substituted some words with simple words. Data showed that as infants grew older more mothers started showing things, books, telling stories and rhymes. Some mothers mentioned that they taught their babies specifically after 18 months. The teaching methods used by mothers to reinforce language development of their infants were repetition (21), verbal encouragement (6) and intonation to make infants speak correctly (2). In the present study, it was felt that there is a need to investigate the influence of variety of languages that an infant is exposed to even before starting school.

Key Words : 1.GROWTH AND DEVELOPMENT 2.LANGUAGE DEVELOPMENT 3.INFANT DEVELOPMENT 4.CHILD DEVELOPMENT 5.MOTHER CHILD INTERACTION.

7. Pandey, D D. (2005).
Public financing of early childhood care and development. New Delhi : National Institute of Public Cooperation and Child Development. 17 p.

Abstract : The present study aimed to obtain a contemporary perspective of investment in selected areas of Early Childhood Care and Development (ECCD) initiatives. The design of the study involved the analysis of time series data. Descriptive statistics were used for the analysis. Also, the total budget, the inter and intra allocation of funds and external inflow of resources were analyzed. Within the Union Ministry of Human Resource Development (MHRD), the Department of Women and Child Development was the nodal agency which took care of and financed ECCD programmes such as supplementary nourishment, health care and early educational aspects of child development. However, much work needs to be done in the area of implementation of ECCD. Also, though the ECCD programme had received highest priority within the state supported documents, little importance had been given to it in terms of budgetary allocations. The budgetary allocation of the Central Government showed an upward trend towards ICDS, however, the funding of state owned ICDS increased by 4.15% only. The total budget allocation of Project *Udisha,* a World Bank assisted nationwide training project of ICDS, showed a declining trend of 16.6%. The central scheme of crèches/ day care centres was introduced in 1975 all over the country and the Government of India (GOI) had set up a corpus of Rs.19.90 crore under the National Creche Fund with a view to meet the growing need for more crèches. However, the growth of crèches has not been proportionate to the growth of the population. Within the Department of Education, there had been a steady jump in the allocation of funds in the area of providing early educational opportunities for children. The Ministry of Health and Family Welfare (MHFW) had given due consideration to the twin issues of Child Survival and Safe Motherhood (CSSM) with the introduction of this programme in 1996 to achieve the multiple objectives of reproductive health, child survival and fertility regulation. There was a steady increase in the allocation of funds in the health sector from Rs.989.74 crores (RE) in 2002-2003 to Rs.1266.96 crores (RE) in 2003-2004. The highest allocation of funds was in the case of Immunization and Polio Eradication Programme. In the budget allocated for children, education sector has been given the highest priority, followed by child development, (CD), and then health initiatives (2002-2003 and 2003-2004). External agencies were also funding CD programmes. However, these agencies provided financial assistance only to some selected states, excluding others without any criteria. Kerala, despite being well developed in various aspects of CD, had been selected for external aid under ICDS. Union Government should direct various departments concerned with ECCD to incorporate budget for children as an inbuilt component under the main budget. The State Women and Child Development Departments should network at the

district level with NGOs, so that the schemes in operation reach the grass roots level. Measures should be taken to strengthen pre-school education programmes. To enhance funds for ECCD, the Government may explore the possibility of taking contributions from the corporate world and NRIs and give them tax benefits in return. The funds so generated should be used for enriching pre-school education. Decisive measures for proper and effective utilization of financial resources need to be taken up.

Key Words : 1.GROWTH AND DEVELOPMENT 2.EARLY CHILDHOOD CARE AND EDUCATION 3.EARLY CHILDHOOD EDUCATION 4.ECCE 5.EARLY CHILDHOOD DEVELOPMENT 6.COST OF ECE 7.COST OF ECCE 8.COST OF PRESCHOOL EDUCATION 9.PRESCHOOL EDUCATION 10.ICDS MODEL 11.PRESCHOOL EDUCATION IN ICDS.

8. Shanmugavelayutham, K. (2006).
The Grants for scheme of assistance for creches for children of working and ailing mothers: a process document of advocacy for revising. Chennai : Forum for Creches and Child Care Services Tamil Nadu. 70 p.

Abstract : The Tamil Nadu Forum for Creches and Childcare Services (TN-FORCES) was initiated in 1992. The objective of TN-FORCES was to advocate the cause of effective early childhood care and development services to children below 6 years, especially the children of those mothers who were employed in the unorganized sectors. TN-FORCES used a variety of strategies namely advocacy, lobbying, information sharing, capacity building, strategizing and carrying out joint activities. The first major advocacy activity was the presentation of a memorandum to the Minister for Social Welfare, Government of Tamil Nadu in 1992 on the need to enhance grants for the creche scheme. A public hearing programme on child services was organized by TN-FORCES on 2nd June 1998 at Chennai. The purpose of the programme was to highlight the need for childcare services and the problems faced by women due to lack of these services. A workshop on the status of childcare workers in the voluntary sectors was jointly organized by MSSRF and TN-FORCES on 22nd April 1999. Other strategies were organizing a rally of about 500 creche workers and anganwadi workers on 22nd October 1999 projecting various demands. TN-FORCES also organized a meeting to finalize suggestions to the Government regarding the scheme. The great outcome of advocacy activities was the enhancement of grant for 212 Creches run by the Tamil Nadu Social Welfare Board from Rs.25,410/- per center per annum to Rs.70,800/-. Around 12,470 Creches for about 3.11 lakh beneficiaries were run by the Central Social

Welfare Board through selected voluntary organizations. The grant for these crèches was increased from Rs.18,480/- per centre per annum to Rs.42,800. Ceiling for eligibility was raised from Rs.1,800/- p.m to 12,000/- p.m for a family. The most significant outcome was spontaneous and self-directed decision to strengthen and sustain TN-FORCES through the participants own efforts. For TN-FORCES and other network organizations, a pro-active stand has to be taken, not only to revise the scheme regularly, but also demand increased allocation of resources for young child related programmes.

Key Words : 1.GROWTH AND DEVELOPMENT 2.CRECHE SCHEME 3.EVALUATION OF CRECHE SCHEME 4.CHILDREN OF WORKING MOTHERS.

9. Shastri, Jigisha and Mendiratta, Ankita. (2006).
Children attributes : what parents like and dislike in their young children ?. *Journal of the National Academy of Psychology*, 51 (1) : 45-48.

Abstract : Parental ideas regarding a child's development operate within a border, a cultural belief system, particularly of shared beliefs, values and practices. The present study explored the attributes parents like and dislike in their 3-3.5 years old children in Baroda. A sample of 74 parents of 33 girls and 41 boys participated in the study. Results showed that parents listed 158 attributes describing their children, which were categorized into four groups that were attributes of relatedness, personality attributes, the attributes of achievement and ability, and attributes of socially acceptable behavior and habits possessed by the children. Of those 158 attributes, 46.2% attributes were positive description of children and 53.79% were negative descriptions. Of the 73 (46.20%) positive attributes which were liked by the parents, maximum attributes described relatedness (36.9%) like child being social, interactive, affectionate, friendly, kind hearted, respectful, expressive and responsible; 31.5% mentioned personality attributes that is child being disciplined, independent, intelligent, curious, and punctual; 26.78% described attributes of ability and achievement, that is child being creative, competent, good in academics, inclined towards school, etc; and a small percentage (27.8%) of the attributes described were related to socially acceptable behavior and good habits. Of the 85 (53.79%) negative attributes that parents disliked in their children, maximum were personality attributes (50.58%) such as the child being selfish, stubborn, ego-centric, disobedient, demanding, etc; 34.11% parents described attributes of social misbehavior and bad habits in their child; 11.76% mentioned attributes of lack of ability and achievement, that the child refused to attend school,

disliked school and had poor writing skills; and a small percentage (3.52%) mentioned attributes of relatedness like not sharing, fighting, harassing others, etc. The attributes of children described by parents helped researchers to understand what parents value in their children. This in turn will reflect in their child rearing practices and the goals they will set for their children.

Key Words : 1.GROWTH AND DEVELOPMENT 2.CHILDREN'S ATTRIBUTES 3.ACHIEVEMENT 4.CHILD PARENT RELATIONSHIP 5.PARENT CHILD RELATIONSHIP.

HEALTH

10. Behura, B.K and Mohanty, R.P. (2003).
Adoption of family welfare measures among four communities in fringe villages of Bhubaneswar city. Bhubaneswar : Nabakrushna Choudhary Centre for Development Studies. 154 p.

Abstract : In India, marriage is considered as a social and religious rite without which an individual cannot be considered as a full-fledged person. The present study covered 200 eligible couples of four communities to analyze the field reality on different aspects of family planning, i.e. sex preference, birth control measures and awareness level regarding the Government schemes on family planning. These communities were Brahman, Chasa, Bauri and Santals, who were settled in different slums of Bhubaneswar city, Orissa. Data was collected through primary and secondary sources. Results showed that in these communities the socio-cultural and economic importance of men was more than that of women. As far as the preferred number of children was concerned, 70% Santals, 48% Brahman and 28% Bauri opted for two children, but 38% Chasa felt that one should have a maximum of three children. Of the total 200 eligible couples, 77.5% male spouses and 58.5% female spouses were of the opinion that the family size should be limited or small. It was found that 94% Bauris, 86% Santals, 84% Chasa and 76% Brahmans wanted male/boy child because they considered them as an economic asset. A total of 40% Brahman, 32% Chasa, 42% Bauri and 16% Santal couples had adopted a modern family planning measure, namely sterilization. Of the total sterilization cases, 79% were women. Of the couples who adopted family planning 67% had gone in for tubectomy, 7.6% for vasectomy, 7.69% were using copper-T or other Intra-Uterine Devices, 10.7% took oral pills, and only 6.15% were using condoms. Regarding the knowledge of all couples on family planning methods, it

was found that every male and female spouse of the study communities had knowledge about at least one modern family planning measure, whereas all the male and female spouses had knowledge about sterilization method. The major sources of information about methods of family planning for couples were ANMs / doctors (44.6%), radio (44.62%) and television (43.06%). The couples who had adopted family planning methods (59% females and 33.3% males) suffered from several health problems such as abdominal pain, waist pain, headaches, chest pain, gastric problems, etc. It was suggested that Government and non-government agencies should focus on motivating the community about the need for reducing family size, importance of family planning and there should be provisions for cash payment or other incentives for family planning adopters.

Key Words : 1.HEALTH 2.FAMILY PLANNING 3.SEX RATIO ORISSA 4.FERTILITY RATE 5.DECADAL GROWTH RATE 6.FAMILY WELFARE PROGRAMME 7.POPULATION PROFILE 8.ORISSA.

11. CARE, New Delhi. (2002).
Final evaluation of CARE's Integrated Nutrition and Health Programme. New Delhi : AIMS. ~100 p.

Abstract : CARE India's Integrated and Nutrition Health Program (INHP), launched on October 1 1996, is a 10 year program which strives to achieve improved coverage rates of healthy practices associated with health status, survival and mortality reduction and nutritional status of mothers with children under 2 years. This report was the final evaluation of the INHP Programme which covered 7 Indian states, namely Andhra Pradesh, Bihar, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. The project reached over 7 million women and children in approximately 100,000 villages. Final evaluation of INHP was done on the basis of Baseline Survey and Mid-term Evaluation Quantitative Survey. The key indicators which were selected for the assessment included Antenatal Care (ANC), receipt of supplementary food from Anganwadi Centres (AWCs), immunization of children and infant feeding practices. Almost all the respondents were living in '*kuchha'* (temporary) houses, with only 6% having electricity and 24% with access to safe drinking water. The illiteracy rate was found to be very high, that is 66% of the respondents had never been to school. The level of 3 antenatal check-ups was only 62% during baseline which increased to 82% in the final evaluation survey. The coverage by 2 or more doses of TT of pregnant woman was reported to be between 82% and 92% in all areas. Around 32% of the respondents received Iron Folic Acid (IFA) tablets during pregnancy, which increased to 67% in the final

evaluation. The receipt of supplementary food from AWCs by pregnant women, which was 61% at baseline, was reported to be universalized in the final survey. The coverage of children by all immunization increased from 28% to 50% in the final survey, which was even higher than found in NFHS-2 for Orissa (44%). There was slight increase (15% to 19%) in the number of infants put on breast milk within first hour of birth. In case of breast feeding in first 8 hours, the increase was substantial, from 40% to 70% and 78% in the whole project area. Complementary feeding practices of children between the ages of 6-9 months were 56% in the whole survey. The knowledge levels of AWWs (anganwadi workers) and ANMs, and the supply of food in AWCs was found to be quite satisfactory. Enhancing the awareness of women regarding health and nutritional status during pregnancy and safe delivery is required, the working condition of equipment in Health Centres should be checked, and provisions should be made for giving some incentives to AWWs.

Key Words : 1.HEALTH 2.INTEGRATED NUTRITION AND HEALTH PROGRAMME 3.CARE PROGRAMME 4.HEALTH PROGRAMME 5.NUTRITION PROGRAMME 6.INTEGRATED DEVELOPMENT 7.ICDS 8.ORISSA.

12. Das, N.P and Shah, Urvi. (2005).
Stalling of infant mortality in India during the recent period : a state level analysis. Vadodara : Baroda Univ., Population Research Centre. 4 p.

Abstract : The level of infant mortality rate (IMR) of India was around 225 at the time of Independence which declined to 175 by 1961 and 80 by 1990-1992. But the pace of decline slowed down after that and reduced to about 74 during 1993-95 and 68 during 1999-2001, but after 1996 the IMR was stagnant in most states of India. The study attempted to examine the accessibility, effectiveness, and utilization of the Mother and Child Health (MCH) care services in states like Orissa, Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar which were more or less stagnating with high IMR and account for more than 60% of the infant deaths. Data was also collected by the National Family Health Survey which was based on two rounds. More than 60% of the infant mortality occurs in the neonatal stage in almost all the states, and this proportion was as much as 85% for low infant mortality states and as high as 72-73% for moderately high IMR states. Results indicated that in the states with low and moderate level of infant mortality, post-neonatal mortality had been largely controlled and hence neonatal mortality was increasingly becoming a significant component of infant mortality rate. Most of the

immediate causes of neonatal deaths were biological in nature. Several socio-economic factors such as per capita income, households with electricity, women's exposure to mass media and place of residence had a significant effect on infant mortality rate. Maternal and child nutrition was the strongest determinant of IMR. Women's education was also strongly associated with IMR. Findings suggested that the policy of strengthening MCH and reproductive health component under the family welfare programme is a right step towards reducing infant and child mortality. Addressing the component of mother and child nutrition through supplementation and IEC should get priority under the programme. Finally, establishment of links between health and developmental programmes, particularly those which seek to promote female education and literacy, cannot be overlooked in sustaining the reduction of IMR in the country.

Key Words : 1.HEALTH 2.INFANT MORTALITY RATE 3.STALLING OF IMR 4.LEVEL OF IMR 5.NEONATAL MORTALITY 6.POST-NEONATAL MORTALITY 7.RCH SERVICES 8.MCH SERVICES 9.CAUSES OF IMR.

13. Dubey, Viraj and Verma, Pooja Chandran. (2005).
A Study on reproductive and child health care of women aged between 18 to 35 years in different strata of society. Bhopal : Sarojini Nadu Govt. Girls Post Graduate College, Centre for Women's Studies. 30 p.

Abstract : The health of mothers has been a subject of national interest in India since Independence. According to WHO's definition, "health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity". It also includes reproductive health, and functions and systems at all stages of life. In India, the life time risk of a women dying from pregnancy or child birth is about 1 in 37, and any risk more than 1 in 100 is considered high risk. The study was based on a health survey of 240 married women aged 18-35 years of Bhopal municipal area and covered all socio-economic classes. In Madhya Pradesh, 88% women were involved in decision making; and 37% were involved in making decisions about their own health care. The socio-cultural norms and practices associated with menstruation in India have made it an unwelcome and often disgusting experience for women. Majority of respondents in lower strata were illiterate. A good percentage of the lower class was taking green vegetables, milk and milk products because of its easy availability at lower price, while intake of junk food was high in higher class. Awareness and maintenance of general hygiene was there in almost all classes, but awareness regarding safe drinking water was found to be low in lower class. In lower class and middle class,

females used indigenous signs like stoppage of menstrual cycle and nausea as indicators of pregnancy, but high class women confirmed this by undergoing urine test. About 63% females of lower strata went for ante-natal visit. Majority of high class and middle class women took calcium and iron supplements and vaccination against tetanus during pregnancy. Deliveries were normal mostly in all strata. In lower strata girls were married off before 18 years; in medium income group girls were married between 18-25 years, and age at marriage rose to 25 years in higher income section. In lower class, early age at marriage of respondents and early child bearing, within the first year of marriage, was common. Majority of women in higher and middle class had knowledge about family planning, but only a few females in the lower class were aware about it because of lack of education about contraceptive methods. To end unwanted pregnancies, abortion was found to be the easiest method to get rid of the foetus. Abortion is on the rise due to unsafe sex practices. Media was a prominent source in providing awareness about family planning practices for women in all 3 strata. Among the 3 strata of society, tubectomy was preferred as a method of family planning. Government, Family Planning Organizations and NGOs were actively participating in strengthening the safe motherhood programme. Non-availability of counselling services by Government and NGOs pertaining to nutritional intake, and family life education hampers the reproductive health of women. Delay in age of marriage should be encouraged. More awareness should be created regarding nutritional requirements of women. Government should organize health camps for detecting and taking corrective action for malnourished and anaemic girls and women right from the adolescent age.

Key Words : 1. HEALTH 2.REPRODUCTIVE AND CHILD HEALTH 3.RCH SERVICES

14. Gujarat Institute of Development Research, Ahmedabad. (2006).
Trends in religious differentials in fertility, Kerala : an analysis of birth intervals. Ahmedabad : GIDR. 19 p.

Abstract : Fertility differentials by religion and other cultural factors have been observed in developing as well as in developed countries. NFHS-2 reported Total Fertility Rate (TFR) for Muslims to be 3.59; Hindus 2.78; Christians 2.44, and Sikhs 2.26. Fertility changes and variations can be meaningfully studied through an analysis of the family building process. This study had two principal objectives: firstly, to examine the magnitude of the religion effect and net effect of other socio-economic factors, and secondly, to assess trends whether the religion effect has

changed in recent years. The sample covered a fairly large number of ever married women belonging to each of the three major religions, 2346 Hindus, 1147 Muslims and 824 Christians. Data comprised the fertility histories of women interviewed in the survey, who were in the 13-49 years age group during 1992-93. The level of education was higher among Hindus and Christians compared to Muslims. Standard of living was better among Christians than others. Work participation was much lower among Muslim women compared to Hindu and Christian women. The analysis was carried out for three birth intervals, second, third and fourth and three time periods, 1972-76, 1977-81 and 1982-86. There was a steady decline in mean second birth interval for Christians. The mean third birth interval declined for Hindus and Christians, but was stable for Muslims. The median among Muslims has been shorter than Hindus and Christians in all the periods, clearly showing a greater tendency to have higher order births early among Muslims. During 1982-86, the risk was lower for Muslims and higher for Christians. For second birth, Muslims do not have higher propensity than others. The risk of having the second birth was higher in urban areas during 1977-81 and 1982-86, working women had higher risk in 1982-86 period. Sex of first child did not seem to influence the chances of having the second birth. As expected, at higher levels of education the risk of the third birth was lower and the effect was clear from high school level onwards. Death of the second child during infancy increases chances for the third birth. During 1972-76 and 1982-86, the relative risk of having the third birth was higher if the second birth was a female. Working women had lower risk of having the third birth during the recent period (1982-86). A greater proportion of Muslim women had an additional birth after the second and third births, as compared to Hindu and Christian women. Finally, the results clearly showed that though fertility in Kerala has fallen below the replacement level, the differentials by religion have widened.

Key Words : 1. HEALTH 2.FERTILITY 3.RELIGIOUS DIFFERENTIALS 4.BIRTH INTERVALS 5.PROPORTIONAL HAZARD 6.RELIGIONWISE DATA 7.KERALA.

15. Gupta, Anita. (2005).
A Study of the relative efficacy : self controlled procedures on improving mental health and performance of high school children. Delhi : Delhi Univ., Deptt. Of Psychology. 85 p.

Abstract : Mental health professionals are interested in the mental health of adolescents and youth, as these individuals are in a tremendously stressful and competitive society. In the present study, the aim was on improving the

performance of the school students in relation to examination anxiety. Examinations are stressful for most students and test anxiety is a pervasive problem on college and school campuses. The primary purpose of the present investigation was to study the effectiveness of three therapeutic techniques in reducing test anxiety and improving the mental health of high school students who had poor study habits. The objectives of the study were to investigate the nature of study habits of high test anxious students as compared to their low test anxious counterparts; study relative efficacy of systematic restructuring, relaxation and study skill counselling in the reduction of worry state rather than the emotionality state of high test anxious students as compared to their low anxious counterparts. A sample of about 300 high school girls from Grade IX onwards had been taken from 5 selected government schools of Delhi. It was important to establish that all the 3 treatment conditions helped the subjects to improve their mental health. Worry and emotionality did not differ significantly, showing that relaxation therapy has influenced both the components equally. The high score indicates poor study habits and poor attitudes towards study habits. In cognitive therapy group, many subjects said “they were worrying less”. Further, for cognitive therapy and study skill training, homework assignments should be followed up. High test anxious students have generally poor study habits as compared to their low test anxiety counterparts who also have poor study habits. High test anxious students perform more poorly than low test anxious students in a variety of contests. All the therapeutic techniques resulted in similar amount of anxiety reduction. Both, emotionality and worry components were equally influenced by relaxation therapy and study skills counselling. This study will be a pioneering attempt in India to initiate research efforts in this area.

Key Words : 1. HEALTH 2.ADOLESCENT MENTAL HEALTH 3.COGNITIVE THERAPY 4.RELAXATION THERAPY 5.STUDY SKILL 6.TEST ANXIETY 7.ADOLESCENT ANXIETY 8.MENTAL HEALTH 9.MENTAL HEALTH OF ADOLESCENT 10.STRESS ADOLESCENT 11.ANXIETY ADOLESCENT.

16. Jain, S K et al. (2006).
Child survival and safe motherhood program in Rajasthan. *The Indian Journal of Pediatrics*, Jan, 73(1) : 43-47.

Abstract : This study was planned to evaluate the Mother and Child Health (MCH) services, particularly immunization in rural areas of the poorly performing state of Rajasthan. A survey was conducted in rural areas of Alwar District among 210 children aged 12-23 months and 210 mothers of children aged 0-11 months. Less

than one third (28.95%) of the children aged 12-35 months were fully immunized with BCG, 3 doses of DPT, 3 doses of OPV and measles vaccines. Around a quarter (26.5%) had not received even a single vaccine (not immunized), and little less than half (44.5%) were found to be partially immunized. Around half of the eligible children were vaccinated for BCG (55.9%) and measles (43.6%). Though nearly two-thirds (66.8%) were covered with first dose of DPT and OPV, about one-third of these children dropped out of the third dose of DPT and OPV for various reasons. The main reasons for dropout or non-immunization were "lack of information about the immunization programme" (41.3%). Three-fourths (74%) of the mothers of infants (0-11 months) were found fully immunized with tetanus toxoid. Though nearly all (more than 96%) of the children were immunized through Government established centres, but immunization cards/ documents were made available to only 27.6% children. The problem of low coverage and high dropout rate of immunization could be overcome by creating awareness about its importance. Increasing community participation through intensive and extensive health education campaigns should also be undertaken. Since most of the deliveries took place at home under the supervision of untrained midwives, training programme as well as involving them in IEC activities should be contemplated.

Key Words : 1. HEALTH 2.CHILD SURVIVAL AND SAFE MOTHERHOOD 3.IMMUNIZATION 4.DELIVERY OF SERVICES 5.RURAL AREA 6.RAJASTHAN

17. Ladusingh, L, Minita Devi, N and Singh, Jitenkumar. (2006). Sex preference and contraceptive use in Manipur. *Sociological Bulletin,* Jan-Apr, 55(1) : 67-77.

Abstract : Preference for sons is pervasive in traditional and patriarchal societies. The present study analyzed sex preference for children in Manipur under the assumption that couples satisfied with sex composition of their children resort to contraceptive practice to discontinue child bearing. Data was collected from sampled representative areas of all eight districts of Manipur of which 3 were in the valley and 5 in the hilly region. The distribution of currently married women in rural and urban areas of Manipur was 541 and 356 respectively. The study showed that the number of women who used contraceptives in rural and urban areas were 113 and 152; the prevalence rate of using contraceptives was 20.9% in rural areas and 42.4% in urban areas. It was found that in rural areas, 25.5% of the women with one boy and one girl used contraceptives, compared with 12.5% of those with two daughters. The contraceptive prevalence rates in the valley and the hill districts

were 31.3% and 54.2% respectively and these figures were more for women with children of one sex only. The usage of contraceptives was 47% among literate and 24.1% among illiterate women. Contraceptive use increased by 22.1% in the case of women above 30 years of age. The contraceptive usage of women who were satisfied with the sex composition of their children was 19.9% in hill districts, 16.7% for non-working women and 15.9% for women in the valley. Contraceptive use among women who were below 30 years of age and residing either in rural or urban areas, was below 10%. The study revealed that son preference was stronger in rural and hill areas and also among illiterate women, possibly because of the nature of livelihood in these residence backgrounds. So, the study suggested that strategies must be devised to educate illiterate women and community people about contraceptive use, gender equity and also about reproductive health.

Key Words : 1. HEALTH 2.SEX PREFERENCE 3.CONTRACEPTIVE USE 4.SEX COMPOSITION 5.SON PREFERENCE 6.MANIPUR.

18. Niranjan, S, Singh, K.S and Rao, G. (2006).
Evaluation of AIDS intervention projects in Maharashtra, India : key facilitating factors and barriers in the control of HIV/AIDS. *Indian Journal of Social Development*, June, 6(1) : 15-36.

Abstract : This study presents 32 intervention programs evaluated during 2002-2004 that contained substantial HIV/AIDS prevention efforts in Maharashtra. Data obtained from in-depth interviews, participant observation, structured interview schedule, field notes and other sources of information had been put together and was analyzed. Of the total 32 intervention projects evaluated across Maharashtra, 10 are truck driver / cleaner intervention projects, 7 were migrant / industrial worker projects, 5 were commercial sex worker projects and 10 were programmes with other groups of high risk populations such as men having sex with men (MSM), people living with HIV/AIDS (PLWH/A), street children, eunuchs, bar girls and drug users. Analysis of data identified 12 key factors which facilitated AIDS prevention programmes and these were accessible project office, culturally appropriate and language specific IEC materials, repeated delivery of essential AIDS prevention messages through outreach workers/ peers, condom promotion through depots or outreach workers, recruitment of staff from the community, capacity building of staff, promoting integration into and acceptance within the community, creating a forum for open discussion, dispelling misconceptions, requesting for participatory involvement of community residents and local celebrities, a strong clinical component including early detection of STDs through syndrome management, and

strengthening referral services. The analysis suggested that almost all 12 factors were consistently identified in 60% of the sex worker projects, 40% of the trucker projects, and 10% of the migrant worker projects. Outreach to high risk populations had been identified as the primary strategy. Although the STD diagnosis and treatment strategy was implemented in only 67% of the projects, it had been found to be more effective than any other strategy in the reduction of HIV/AIDS and risk behaviour among high risk populations in Maharashtra. Besides this, there were several other factors that characterized the implementation and impact of the intervention such as health education, treatment and referral services, focus on the need for consistent use of condoms, etc. Implementation level plans should focus on improving health infrastructure of the project, and training staff to achieve desired objectives. There must be recommendations to guide the development and implementation of future targeted community based AIDS prevention projects in India.

Key Words : 1. HEALTH 2.AIDS 3.AIDS PREVENTION 4.AIDS INTERVENTION PROJECTS 5.BARRIERS AIDS CONTROL 6.EVALUATION OF AIDS INTERVENTION PROJECTS 7.FACILITATING FACTORS 8.INNOVATIVE PROJECTS AIDS 9.MAHARASHTRA.

19 Patro, B K et al. (2005).
Contraceptive practices among married women in a resettlement colony of Delhi. *Health and Population Perspective and Issues.*, Jan-Mar, 28(1) : 9-16.

Abstract : India was the first country in the world to launch Family Planning in 1951, but the birth rate still continues to be high. A cross-sectional community based study was conducted in a resettlement colony of Delhi. The objective of the study was to find out the contraceptive usage among currently married women aged 15-49 years, and the factors influencing the use of such contraceptive practices. Findings revealed that about two-thirds (63.3%) of the eligible couples were using a contraceptive method, and the effective Couple Protection Rate (CPR) was 56.1%. A number of these women (37%) had undergone tubectomy. Among the users of temporary methods of contraception, condom (56%) was the most preferred method. Permanent methods of contraception were mainly availed from public sector hospitals. Decision regarding contraceptive use in the family was mostly taken jointly by the husband and wife (65.7%). Number of living children at the time of first contraceptive use was found to be more than two in 74% cases. Socio-Economic Status (SES) of the family was seen to be significantly associated

with the use of contraceptive methods. The reasons for non-acceptance were either expectation of a male child (44%) or fear of side effects (29%). Despite their knowledge about different methods, one-third of the women were not using any contraception because it was not available free of cost. Findings support the contention that there is still a need to intensify IEC activities, motivate the population to practice contraception, and remove the myths and beliefs associated with their usage.

Key Words : 1.HEALTH 2.CONTRACEPTIVE PRACTICES 3.RESETTLEMENT COLONY 4.MARRIED WOMEN 5.SOCIO-ECONOMIC STATUS 6.CONTRACEPTIVE USE 7.DELHI.

20. Ram, F, Sinha, R K and Mohanty, S K. (2006).
Marriage and motherhood : an exploratory study of the social and reproductive health status of married young women in Gujarat and West Bengal, India. New Delhi : Population Council. 51 p.

Abstract : In India, sexual activity and child bearing among young women takes place overwhelmingly within the context of marriage. Despite the high prevalence of early marriage, little is known about the lives of married young women including the nature of the early years of marriage or the pressures they face. The objectives of the baseline survey were to examine married young women's knowledge of key reproductive health issues; understanding their reproductive health behaviour and practices. The survey was conducted in two rural settings in India – Vadodara Block in Vadodara district, Gujarat and Diamond Harbour Block in South 24 Parganas district, West Bengal. Respondents included young women who were newly married, first time pregnant or first time mothers, regardless of age. In Vadodara, out of 1,711 eligible women 1,079 respondents were interviewed. In Diamond Harbour, out of 1,395 eligible women, 1,036 respondents were interviewed. In Vadodara, 99% respondents were Hindus and in Diamond Harbour, 55% were Muslims. Work participation among women declined after marriage, particularly in Diamond Harbour from 39% to 17%, and in Vadodara from 27% to 5%. Over 80% women in Vadodara and 48% in Diamond Harbour, handed over all their earnings to family members. In both sites, majority of the young married women did not have a say in decisions related to the purchase of various household items. In both sites, married women's mobility was extremely limited. Only 30% women reported that they could go alone to visit a friend or relative. Majority of married women in both sites maintained regular connection with members of their natal family. Only 31% women in Vadodara and 13% in Diamond

Harbour felt that wife beating was not justified for any reason. In Vadodara (7.4%) and in Diamond Harbour (12.3%) married young women experienced physical harm in the year prior to the survey. 92% women in Vadodara and 86% women in Diamond Harbour were abused by their husbands. The median age at marriage for all respondents was 19 years in both sites. Majority of women (49% in Vadodara and 62% in Diamond Harbour) were aware about the concept of fertile period, while 12% and 13% could accurately identify a woman's fertile period. 15% women in Vadodara and 8% in Diamond Harbour did not have any knowledge about STDs. In both sites, Vadodara (22%) and Diamond Harbour (31%) women had heard about HIV/AIDS. In Vadodara, (14.6%) practised 'safe period' method or condoms (13.2%), while in Diamond Harbour oral contraceptive pills (31.8%) were frequently used. Joint decision-making of the first pregnancy was twice as high in Vadodara as in Diamond Harbour (56% versus 24%). Majority of deliveries (83% in Vadodara and 67% in Diamond Harbour) were attended by trained traditional birth attendants. It was customary in both study sites, to keep a woman in 'isolation' after the delivery in her natal home. Only 35% mothers in Vadodara and 53% in Diamond Harbour reported feeding colostrum to their babies. In Vadodara (27.6%) and Diamond Harbour (42.6%), immediate breastfeeding after delivery was prevalent. 85% mothers in Vadodara and 89% in Diamond Harbour reported some immunization of their babies. In Vadodara and Diamond Harbour, pregnant women received help in doing household chores (83% and 78%) respectively; and in accessing health services (85% and 91%), as well as getting emotional support (97% and 92%) during pregnancy. Programmes need to constructively prevent misinformation and harmful practices, and address the considerable gaps that remain in maternal and child care and prevention of infection. It is critical to directly address and ameliorate women's social and economic disadvantage and isolation, as well as engage husbands, mothers and mothers-in-law in programmes for married young women.

Key Words : 1. HEALTH 2.REPRODUCTIVE HEALTH 3.DOMESTIC VIOLENCE 4.MARRIED YOUNG WOMEN 5.YOUNG WOMEN 6.DECISION MAKING 7.MARRIAGE 8.MOTHERHOOD 9.EARLY MARRIAGE.

21. Rasania, S.K, et al. (2005).
Knowledge and attitude of mothers about oral rehydration solution in few urban slums of Delhi. *Health and Population Perspectives and Issues*, Apr-Jun, 28(2) : 100-106.

Abstract : Diarrhoea is one of the major causes of morbidity and mortality among young children and about 60-70% of diarrhoea related deaths are caused by

dehydration. Scientific basis of Oral Rehydration Therapy (ORT) has revolutionised the concept and management of diarrhoea. Since the use of oral rehydration solution (ORS) largely depends on the level of knowledge and attitude of mothers, the study was undertaken to determine the same in women living in the slum areas adjoining Lady Hardinge Medical College, New Delhi. Also, an attempt was made to correlate the literacy level of mothers with the use of ORS. Out of the 457 families surveyed, 579 children were found to be below 5 years of age. A diarrhoeal episode was considered to have occurred if any child had loose/watery stools thrice or more during the last 24 hours preceding the study. The prevalence rate of diarrhoea was found to be 10.1% at the time of the study and 16.01 % in the month preceding the study. Out of the total 457 mothers interviewed, 210 (46%) used ORS packets when the children had diarrhoea. The common sources of ORS packets were hospitals (44.8%), dispensaries (21.01%), private practitioners (21.1%) and chemist shops (13.3%). Only 38.7% mothers were able to tell the correct method of preparation of ORS solution, 41.6% had knowledge about the exact quantity of ORS to be given to the child, 13.3% of the mothers knew the harmful effects of giving too much ORS at a time, and 28.4% knew about the danger of keeping ORS for a longer period. The findings also revealed that many mothers (29.3%) had misconceptions about the use of ORS and it was significantly high among the ORS non-users and less literate mothers. Though 69.8% mothers had knowledge regarding the role of ORS during diarrhoea but only 46% had ever used ORS. Among the ORS users, most of them (89.5%) had correct knowledge regarding the role of ORS during diarrhoea and 67.6 % knew how to prepare ORS. Hence, there is a need for extensive IEC activities to raise the level of knowledge among communities regarding the use of ORS and its preparation, as poor literacy status and lack of awareness limits the ability of mothers to utilize ORS properly for preventing diarrhoeal deaths due to dehydration.

Key Words : 1. HEALTH 2.ORAL REHYDRATION THERAPY 3.ORAL REHYDRATION SOLUTION 4.DIARRHOEA MANAGEMENT 5.URBAN SLUM 6.MOTHERS 7.KNOWLEDGE OF MOTHER 8.HEALTH EDUCATION 9.DELHI.

22. Visaria, Leela, Barua, Alka and Mistry, Ramkrishna. (2006).
Medical abortion : some exploratory findings from Gujarat. Ahmedabad : Gujarat Institute of Development Research. 28 p.

Abstract : A medical abortion is brought about by taking a drug or a combination of drugs orally, intramuscularly and/ or vaginally to terminate a pregnancy. It is an

alternative to surgical procedures. To induce medical abortion, a combination of Mice pristone along with Misoprostol were used. The present study was an exploratory qualitative study, carried out in Ahmedabad urban area. The study aimed to understand the perspective of the service providers in making medical abortion available to the client. As a part of the study, a few chemists were interviewed to understand the marketing strategies followed by the drug industry. Using snowball sampling technique, 13 chemists and 10 service providers were interviewed. Pharmaceutical companies provided the drugs for medical abortion directly to gynaecologists as well as chemists to stock. Getting information about availability of drugs was a sensitive issue, as chemists feared they might get into trouble with law enforcing agencies. On an average, there was a demand between one to four customers asking for abortion pills in a month. Some chemists also give abortion pills to their “regular or known” clients without prescription. 69% chemists did not advise the customer to consult a doctor before taking the pill, and 85% did not inform customers about the possible side effects. Chemists themselves had little knowledge or understanding of when to take which drugs and did not provide much information to the client. Chemists received limited feedback from the client, and hence were not sure about the efficacy of the drug. Service providers came to know about abortion drugs through medical representatives of pharmaceutical companies. The cost of medical abortion was quite high if the service providers followed recommended protocol, thus they did away with either the ultrasound examination or the clinic visit. Most service providers informed their clients of various options available for abortion, and did not insist on using any one method. Service providers claimed that they prescribed medical abortion largely because it was the client’s preference. Service providers said that religious beliefs of clients also determined the choice of methods. Almost all service providers reported that they counselled their client, and said that counselling for medical abortion took much more time than counselling for surgical abortion. All the service providers rated the efficacy of the drug regimen, if properly adhered to, to be above 90%. Only in 5% cases, abortion was not complete and required surgical intervention, which rarely posed any problem. Since, the medical abortion technique was non-invasive, therefore much less fraught with risk. Also, medical abortion was patient friendly and the woman did not have to be admitted to hospital. In addition, women could use this method without informing their family. However, there was no training for medical abortion, and providers had to rely on satisfied customers word of mouth that they provided medical abortion. Service providers were not clear whether MTP Act applied to medical information. Service providers should be provided with technical knowledge about dosage, side effects and their benefits.

Key Words : 1. HEALTH 2.ABORTION 3.REPRODUCTIVE HEALTH 4.WOMEN'S HEALTH

NUTRITION

23. Chiddarwar, Sonali S. (2000).
Assessment of nutritional status of children below five years of age. Nagpur : Indira Gandhi Medical College, Dept of Preventive and Social Medicine. ~150 p.

Abstract : The objectives of the present study were to study the various factors influencing the nutritional status of children below 5 years of age and to make suitable recommendations based on findings. Data was collected through household survey in Nagpur. 384 children in the age group of 0-5 years were included in the study. After obtaining information through a pre-tested proforma, all the subjects underwent clinical examination and anthropometric measurements. It was found that subjects in upper social classes had better health and nutritional status than those in lower socio-economic classes. Immunization status was found to be good. 99.18% of the children were vaccinated with BCG, 96.7% with DPT-I/OPV-I, and 90.11% were given measles vaccine. 34.62% children were given pre-lacteals in the form of honey or jaggery water. 32 mothers in the survey did not feed colostrum to their children. 39.84% children were normal, whereas 60.16% children were suffering from various grades of undernutrition. 27.47% children suffered from Grade I undernutrition, 22.53% suffered from Grade II undernutrition, and 9.34% and 0.82% were in the category of Grade III and Grade IV undernutrition respectively. The prevalence of undernutrition was highest in 36-48 months group (67.16%), followed by 48-60 months (65.38%). Increased prevalence of under nutrition in these 2 age groups reflected the cumulative effect of food deprivation, repeated bouts of acute infection, extensive parasitism, emotional deprivation, etc. The prevalence of undernutrition was higher among females (59.36%) than males (40.64%). The reason for this was that males were given priority over female children as they would be future breadwinners. Also, females were considered a liability. Even immunization coverage was significantly less among females as compared to males. There was an association between birth order and undernutrition. Undernutrition was found to be lowest in children of first birth order (49.65%) and highest (100%) in children of fifth or more birth order. A significant association between birth order and undernutrition could be due to the fact that with higher birth order the family size increases, leading to shortage of food. Undernutrition was higher in children of illiterate mothers (88.46%) as compared to children of mothers who were educated up to higher secondary level or above (29.87%). Reasons cited for this were that an educated mother was more aware of the importance of hygiene, sanitation, immunization, and need for health check-ups, etc. Even children of educated fathers had lower prevalence of undernutrition.

The prevalence of undernutrition was lower among children of housewives (58.05%), as compared to mothers engaged in services (62.5%) or labour (88%). This could be because working mothers spent less time with their children. Children having birth weight less than 2 kgs were more undernourished (80%) as compared to children having birth weight more than 3 kgs (33.33%). Lower birth weight made the child more vulnerable to repeated infections, such as respiratory infections. Undernutrition was lowest when weaning started between 4-6 months of age (49.42%) and highest when weaning started at 12 months of age (85.71%). After the age of 6 months, breast milk was not sufficient to fulfil the caloric requirement of the child. Due to economic and cultural reasons, children were often deprived of additional foods, thus they became apathetic, reacted less to social and psychological stimuli, and were susceptible to infections. Infants with past history of illness were more likely to be undernourished than those without any history of illness. General literacy level of the community should be improved with special emphasis on mothers' education. Families should be given information about the importance of regular check-ups, antenatal and post-natal care, immunization, etc. Knowledge should be given to caregivers about breast feeding and weaning practices.

Key Words : 1. NUTRITION 2.NUTRITIONAL STATUS PRESCHOOL CHILDREN 3.ANAEMIA PRESCHOOL CHILDREN 4.PRESCHOOL CHILDREN 5.UNDER FIVES 6.MALNUTRITION CHILDREN.

24. Khan, Q. H and Singh, M.P (2005).
Status of Iodine Deficiency Disorders (IDDs) in Amreli District of Gujarat. *Health and Population Perspectives*, Apr-Jun, 28(2) : 71-78.

Abstract : Iodine deficiency is the most common cause of preventable mental retardation and brain damage. It causes goitre and decreases the production of hormones vital to growth and development. In India it is estimated that about 200 million people are at risk for iodine deficiency disorders. A re-survey was conducted in Amreli district of Gujarat in March 2000, by the Department of Community Medicine, Medical College Bhavnagar, to find out the existing status of iodine deficiency disorders (IDDs) and to compare the data with the survey conducted earlier (1988). For data collection, 10 villages were selected from the total of 10 talukas of the district by simple random sampling so as to cover at least 1% of the village population and 5% of the primary school children. A total of 9,652 primary school children and 12,052 village population was surveyed. Information from all individuals was collected on a standard proforma and cases of goitre were

identified and classified (Grade O, I and II) as per the classification by WHO. A population was considered to be endemic for goitre when the prevalence of goitre in the community exceeded 5%. Findings revealed that the overall prevalence rate of goitre among primary school children in the entire district was 10.67% with almost equal prevalence among boys and girls. Goitre in 4 school children was accompanied by other manifestations of IDDs such as mental retardation, deafness and mutism (overall 0.04%). Goitre prevalence in the entire district community was (2.65%), which included cases of both Grade I (2.55%) and Grade II goitre (0.1%). The prevalence was slightly higher in females (3.26%) than males (2.05%). The entire district had 10 cases of mental retardation, 1 case of deafness and mutism and 2 cases of cretinism. Also, comparative figures showed that the percentage of goitre cases among primary school children declined from 17.1% in 1988 to 10.67% in 2000. The decline in goitre cases may be due to increased awareness among the community. When the criteria of endemicity was applied, Amreli district of Gujarat was reported as a non-endemic district for IDDs.

Key Words : 1. NUTRITION 2.IODINE DEFICIENCY DISORDERS (IDD) 3.GOITRE 4.ENDEMIC GOITRE 5.MENTAL RETARDATION 6.DEAF 7.MUTISM 8.CRETINISM.

25 Kumari, K . (2005).
Health and nutritional status of school going children in Patna. *Health and Population Perspectives and Issues*, Jan-Mar, 28(1) : 17-25.

Abstract : Health and nutrition in early stages of human life determine, to a great extent, the physical and mental well being of a person. The present study was undertaken to determine the nutritional status of 700 school going children (444 boys and 256 girls) in the age group of 6-11 years. The subjects belonged to families with varying socio-economic status and were drawn from different schools of Patna by random sampling method. The growth status of children was evaluated by applying anthroprometric parameters and was compared with standards adopted by National Centre for Health Statistics (NCHS). A 24-hour recall method of diet survey was adopted to assess food intake of the children and from the data, the total intake of protein, iron, Vitamin A and overall calories was calculated. The dietary intake of nutrients was compared with the recommended dietary allowance (RDA) given by the Indian Council of Medical Research (ICMR). Results showed that regardless of the income group to which the children belonged, there was a marked deficiency in the intake of different nutrient categories. However, out of 700 children, the distribution for various nutrient groups where the children fulfilled or

exceeded the RDA (100%) was in the category of calories with respect to 26 children (5 males and 21 females), protein with respect to 34 children (28 males, 6 females), Vitamin A with respect to 174 children (109 males, 65 females), and iron with respect to 244 children (83 males, 161 females). The survey revealed that children belonging to the low income group were the most affected in all the categories of nutrients. It was observed that as the income level of parents increased, so did the calorie intake in children. The income level was very well correlated with the intake of RDA of Vitamin A as well, and 41.67 % females and 38.0 % males in higher income group (HIG) qualified for > 100 % RDA category. Both, higher awareness about vitamin supplements and affordability seemed to be responsible for this situation. In all income groups, 50 % of the females consumed more than the RDA for iron, which was very essential for their health. The average height for boys and girls was 118.67 cm and 113.67 cm respectively, at the age of 6 years and 135.57 cm and 137.55 cm respectively at the age of 11years. The findings were slightly less than the standards recommended by NCHS. The average weight for boys and girls was 20 kg and 18.33 kg respectively, at the age of 6 years, and 28.88 kg and 29 kg respectively, at the age of 11 years. The girls weighed slightly more than the boys in the 11th year. The findings were slightly higher in comparison to NCHS standards, probably due to the altered food habits among children. The mean value of arm circumference of the children of both sexes increased with age. The findings for male children were in accordance with the standards recommended by NCHS, whereas, it differed for females in the age group of 6-10 years. However, no significant variation from standards was noted in the arm circumference in case of female children of 11 years. Nutritional deficiencies in children of HIG families indicated that there was lack of awareness about balanced and nutritious diet, independent of the economic factor among families.

Key Words : 1. NUTRITION 2.NUTRITIONAL STATUS CHILDREN 3.HEALTH STATUS 4.RECOMMENDED DIETARY ALLOWANCE (RDA) 5.DEFICIENCY DISEASES 6.SCHOOL CHILDREN 7.BIHAR

26. Nutrition Foundation of India, New Delhi. (2005).
NFI Bulletin, 2005 Oct., 26(4) : Integrated Child Development Services : Body composition and BMI criterion for Indians. New Delhi : NFI. 8 p.

Abstract : Integrated Child Development Services (ICDS) aims at improving growth and development during the critical intrauterine period, infancy and early childhood by providing an integrated package of nutrition, health and education

services right in the vicinity of both, urban and rural population. The study evaluated the impact of the nutrition component of various Government programmes dealing with nutrition. Data from National Family Health Survey-2 1998-99 (NFHS-2) indicated that exclusive breastfeeding among infants in the age group of 0-3 months was only 55.2%, and 33.5% infants in the age group 6-9 months received breast milk and semi-solid food. In an attempt to improve appropriate complementary feeding, a nationwide programme Pradhan Mantri Gramodaya Yojana (PMGY) (Prime Minister's Rural Development Programme) for providing take-home weaning foods for one week to below poverty line (BPL) families with infants between 7-12 months of age, was initiated in 2002-03. Experience gain in the last three years indicates that merely making financial provisions does not result in increase in the number of under-three children getting food supplements, and improvement in timely introduction of complementary feeds. Surveys carried out by the National Nutrition Monitoring Bureau 1999 (NNMB) had shown that over the last three decades there was no increase in the dietary intake of pre-school children. Lack of knowledge on child feeding, rearing and caring practices were major factors responsible for the low dietary intake in pre-school children. Time trends in nutritional status of pre-school children from NNMB and NFHS (2001) surveys showed that over 45% of the pre-school children were under nourished. Budget of the Department of Women and Child Development for the year 2005-06 was Rs. 35000 million for ICDS. But increase in the number of children in the 6-36 months age group or 3-6 years age group receiving food supplements through ICDS during the nineties was not commensurate with increase in the number of ICDS blocks. Drought surveys carried out by NIN have shown that ICDS programme was fully utilized by the population to bridge the gap in food supply, prevent reduction in dietary intake, and prevent deterioration in nutritional status of pre-school children. It appears that the nutrition component is well accepted by the population, but it is functioning more as a social welfare programme rather than a nutrition programme. The norms for funding ICDS programmes are uniform. Currently it is envisaged that 102 individuals per anganwadi should receive food supplements. But, as there is great difference in the percentage of BPL families and birth rates between states and districts, the number of persons who require food supplements in the anganwadi would also vary. Often the most needy persons are not identified and food supplements are not given according to their need. The most needy segments, that is children aged 6-36 months and women who are not able to come to the anganwadi, do not receive the food. To bring about change in the nutritional status of children, screening of all pre-school children should be done at least once in 3 months for early detection of undernutrition. Therefore, the focus should be on strengthening the nutrition and health education programme, enhancing the quality and impact of ICDS, and improving community ownership of the programme. It will be possible to cover a large number of children with the same fund allocation if take home food grains are

provided to the family, and coupled with appropriate nutrition education, this will enable the under nourished child to consume all the food, that is about 600 kcal spread over 2 or more meals.

Key Words : 1. NUTRITION 2.RESEARCH NUTRITION 3.BODY MASS INDEX 4.BMI INDIANS 5.ICDS NUTRITION 6.CHILD NUTRITION 7.NUTRITION IN ICDS 8.ICDS.

SOCIAL DEFENCE

27. Association for Development, New Delhi. (2004)
Rape victims seeking justice - unending ordeal : a study report. New Delhi : AFD. 30 p.

Abstract : Rape victims and their families need emotional support and legal guidance. The objective of the present study was to identify the concrete problems faced by victims of sexual abuse at police level, hospital level and community level, once the case is reported. The study covered east, north-east, north-west and central districts of Delhi. The sample consisted of 150 cases of sexual abuse referred to Pratidhi or AFD-Umeed in the year 2002. Questionnaire technique was used for data collection. 89% families reported that policemen visited their homes in uniform. 16% families reported paying for transport while going for MLC. This was a problem for daily wage earners who already had a meagre income. 31% families complained that policemen passed undue remarks on the character of the victim and her family members when they went to register a complaint. 17% accused the police of favouring the accused and neglecting the victim's problems and in 15% cases, police forced the victim's families to compromise with the accused person's family. 27% families had problems in accessing the status of their case, and 22% families faced the problem of being called to the police station frequently, due to which their jobs suffered. This was especially true for daily wage earners. Other problems mentioned were unnecessary delay in filing FIRs (8%), giving money at police stations to get a copy (6%), and demand for bribe (2%). 16% families were very upset at the way they were treated at the hospital. They complained of being kept waiting for more than 4-5 hours for getting MLC done. 5% families also faced the problem of undesirable remarks or queries made by the doctor. In 33% cases, neighbours and people from the victim's village were a source of stress for the victim's family. If the victim was above 13 years old, the community pressurized the family to compromise with the accused person's family, and abused and boycotted

the victim's family. 36% victims were blamed by their own family and 37% withdrawn from school or vocation. Victims were also isolated (27%) or married early (25%). In 25% cases, the complete family withdrew from the neighbourhood due to shame or fear from the accused person's family. The major problem faced by almost all families was the long delay in starting of the case. Families had to suffer postponement of hearing dates at least 4-5 times. In 88% cases, the accused was known to the family and belonged to lower socio-economic group. 95% accused were school dropouts. 50% of the accused had no regular jobs, and their jobs were seasonal like labourer, white washer, rickshawpuller, etc. They had excess time on their hands, along with exposure to sexual issues through mass media. This could be seen as one of the precipitating factors for occurrence of sexual offences. Most of the families were legally ignorant, and apprehensive in approaching police to know about the status of their case. To help the victim, interaction with her should be done by a female police officer. Provisions should be made to check the policemen who are guilty of probing into the character of the victim, or her family. Police should visit the victim's home in plain clothes and show their identity proof to the victim before questioning her. Fast track courts for rape cases are required. Victim should be provided with police protection if there is any threat to her life.

Key Words : 1. SOCIAL DEFENCE 2.RAPE VICTIMS 3.SEXUAL ABUSE 4.REHABILITATION PROGRAMME 5.COUNSELLING SERVICES 6.LEGAL GUIDANCE 7.REHABILITATION RAPE VICTIMS 8.LEGAL AWARENESS.

28. Datar, Chhaya. (2003).
Reform ? Or new form of patriarchy ? Devadasis in the border region of Maharashtra and Karnataka. Mumbai : Tata Institute of Social Sciences, Unit for Women's Studies. 66 p.

Abstract : *Devadasis* are the 'Wives of God'. The custom of *devadasi* is prevalent in South India where young girls are dedicated to goddess *Yellamma*. These girls cannot marry, and to earn a livelihood become mistresses or adopt prostitution. The objectives of the present study were to study the socio-cultural aspects of *devadasi* custom and to understand the rehabilitation measures for them. Data was collected from *devadasis* of Nipani village (border of Maharashtra and Karnataka) and villages around it where the influence of *Yellamma* cult was strong. *Devadasis* in the age group 17-70 years were selected, and data was gathered through interviews and questionnaires. Reasons cited for dedication were mental retardation, hunchback and a need to continue the tradition. The presence of '*jata'*

or matted hair was a significant factor in the dedication of girls. Often, mother and daughter got possessed, went into a trance and were told to dedicate their daughters. Illiteracy was a common factor among *devadasis,* and about 85% of the *devadasis* were illiterate. Deserted women who had no other source of income were found to be adopting prostitution under the garb of becoming a *devadasi*. Lower caste women also took up prostitution after migration to cities, as these untouchable *devadasis* were not preferred by men in the villages. Most of the *devadasis* were employed as workers in *bidi* (cigarette) and tobacco processing factories. Only very young or old *devadasis* were unemployed. *Devadasis* also earned a sizable amount from performing rituals such as *jagran* (whole night prayers), etc. 12% women in *devadasi* households contributed upto 75-100% of the total family income. *Devadasis* were given higher status in some villages and were not seen as prostitutes. 67% women voted for the *devadasi* system to continue. 42.9% upper caste men saw them as incarnation of Goddesses. Even their family members said that *devadasis* were highly respected. Only in towns were they considered as prostitutes. However, the younger *devadasis* felt that they were looked at as prostitutes. 15% *devadasis* reported that they had a choice in selecting their life partner, 10% had a choice in how to spend their income, and 20% had a choice about breaking up a relationship. 33% *devadasis* had a relationship with men, and it was discovered that these were cases of bigamy. *Devadasis* went to PHCs or municipal hospitals to have babies. Not even 10% had babies while they were below 18 years of age. It is essential to remove superstitions and motivate *devadasis* to give up this practice. One group advocated that financial assistance and incentives should be given to the man who marries a *devadasi*. However, another group cautioned against this incentive and felt that men would marry them for monetary gains and later abandon them. *Devadasis* should be informed about the benefits of self-employment.

Key Words : 1. SOCIAL DEFENCE 2.DEVADASIS 3.REHABILITATION OF DEVADASIS 4.GOVERNMENT PROGRAMMES DEVADASIS 5.KARNATAKA 6.MAHARASHTRA.

29. Joshi, A, Singh, Y.P and Garia, P.S. (2000).
Evaluation of institutions caring for children of prostitutes. Lucknow : Giri Institute of Development Studies. 107 p.

Abstract : This study evaluated the functioning of NGOs working for the children of prostitutes that were being funded by the Ministry of Social Justice and Empowerment (MSJE), New Delhi. Children of prostitutes are looked down upon by

society for no fault of theirs. The Government has the added responsibility to rehabilitate these children, if they are to lead a peaceful life. 16 NGOs were spread over 8 districts of Uttar Pradesh. The MSJE gave grants-in-aid to these NGOs for providing vocational training to these children with the objective of rehabilitating them, and special emphasis was given to the girl child. Each NGO had to select 25 children from prostitute households. In 7 cases the place of registration and the place where vocational training was imparted were in two separate districts. Only 6 agencies were actually running training centres. 7 institutions which did not have any beneficiaries, had closed down their centres. In 2 institutions, no children were found despite fixing a date for inspection in advance. The agencies felt that their centres should be residential in nature for effective rehabilitation. They also feel that Government should provide financial assistance to children to start their own work after training had been completed. There was a divide among the agencies regarding location of the training centres. One group advocated that training centres should be located within residential areas of prostitutes to avoid nuisance created by outsiders, whereas the other group wanted centres to be located elsewhere to keep the children away from the unhealthy environment. It was found that 33.3% of the children in the centres were 10 years old or below, thus it was difficult for these children to learn properly. The main focus was on girl children. However, in some families the number of male children was quite high and this explained why mothers were so keen to find a suitable vocational training programme for them as well. The agencies allowed children to repeat the training for a second year and this was approved by the Ministry. The most common course was tailoring (76%), painting, and in a few centres embroidery and music were also taught. However, prostitutes were not interested in teaching music to their children, as they considered music to be an integral part of the dancing profession. One agency had also introduced beauticians course from the year 2000. Mothers advocated that new courses such as shorthand, typing, computer programming and carpentry should be introduced. 40% and 46% of the children were highly satisfied with the training and teachers respectively. Less than 40% of the children were happy with quality of refreshments provided to them, confirming the fact that Rs.5/- that was allocated per child for refreshments was insufficient. The children had been motivated to join the programme by their teachers, family members, or by children who had undergone the training programme prior to them. 45% of the children failed to identify the usefulness of the programme. 50% of the children felt that they should be provided financial assistance by the Ministry for them to become self-sufficient. Some children felt that they should be provided with scholarships. Around 80% of the children in the survey were engaged in some activity. Some of the children desired to become social workers and help those who were in the same predicament as their own. In case the training centres were made residential, over 95% of the children were willing to avail this facility. Ministry should instruct all agencies to provide the address of the place of their registration as well

as the location of their training centres, to facilitate monitoring of their programmes. Vocational training should be provided to children who have a minimum age of 13 years, and children below 13 years of age should be given non-formal education. Surprise checks by the Ministry should be conducted to ensure that centres are working properly. Awareness programmes should be undertaken to motivate the prostitutes to send their children to training centres.

Key Words : 1. SOCIAL DEFENCE 2.CHILDREN OF PROSTITUTES 3.EVALUATION STUDY 4.INSTITUTIONAL CARE 5.HOMES FOR CHILDREN OF PROSTITUTES.

30. Joshi, A and Singh, Y.P. (2001).
The Problem of beggary and measures undertaken by the state : a case study of Lucknow. Lucknow : Giri Institute of Development Studies. 28 p.

Abstract : Beggary is defined as an act of soliciting or receiving cash or kind, in a public or private place, without doing any work in exchange for money received. Poverty, deprivation, physical disability or deformity and neglect were some of the primary reasons responsible for propagating beggary. The state of Uttar Pradesh passed the Anti-Beggary Act on August 14, 1975. The Act comprehensively defines begging, the penalties which a beggar can be subjected to, the institutions in which he/she can be placed for correction, and the exact procedure to be adopted through which a beggar can be convicted and placed in a corrective home. Under this Act, an individual found begging can be caught by the police, placed before a judicial magistrate and sentenced to serve a term in a certified institution known as Beggars Home. Little effort had been made to correct the shortcomings of the Prohibition of Beggary Act, and it was found that rounding up of beggars was restricted to 8 districts which had a Beggar Home, though the Act was applicable all over the state. Also, there was only one place which had separate Beggars Homes for males and females. The duration of stay in a home ranged from 1 year upto 2 years. A meagre amount of Rs. 8/- per day was sanctioned per inmate and this was supposed to be spent on their food, clothing and other requirement such as soap, etc. This price structure made it impossible to provide inmates with 3 meals a day. Beggars Homes aimed to provide vocational rehabilitation to inmates, and thus provided training in tailoring, carpentry, etc. There was also provision to provide financial assistance of Rs.1500 to inmates in accordance with the vocational training. Barely 3.24% expenditure had been on inmates during 2000-01, despite an increase in grants for Beggar Homes from 1992-93 to 1996-97. Beggar Homes were in a dilapidated condition with inadequate staff, and consequently most

homes did not have any inmates or had inmates below their capacity. Raids were restricted to railway stations. At other public places, the police and Beggar Home authorities did not conduct raids as they faced resistance from the general public. Also, majority of the beggars left after the remand period, which stretched from 14 days to 3 months, and went back to beggary. In such a short period it was difficult to impart them with any training, and beggars were also not interested in changing their profession. A survey of 50 beggars from different parts of the city was conducted at railway and bus stations, market centres and temples. The survey included child beggars (5), female beggars (15), able-bodied beggars (15) and disabled or aged beggars (15). 74% beggars belonged to SC/ST or OBC category, 12% belonged to higher caste and 14% were Muslims. Family size of the beggars was low, and for children it was 3.6 persons per household. For female and able bodied beggars the number was 2.73 and 2.01 persons per household respectively. In the case of disabled or aged beggars the average family size was only 1.40. Around 80% of the family members were illiterate and 78% were employed. From the 78% employed family members, 88.5% were beggars. 14% households were concentrated in the income group of Rs. 501 to Rs. 750 per month. Disabled and aged beggars had a low income of Rs. 717 per month. 48% lived in *kuchha* (temporary) houses and 52% had no shelter and stayed in and around railway stations, temples and other places. 70% of the income was spent on food items, 9.8% expenditure was on recreation and 6.8% on other items. 33% households had such low incomes that they were unable to save anything. The meagre savings met occasional demands for additional household expenditure, for medical commitments and to honour social commitments. 7% people in the sample were migrants and highest number of migrants were from Bihar. The reasons reported for begging were poverty (42%), inability to procure jobs (30%), being forced to take up beggary due to illness or disability, or it was the traditional occupation. The average earnings per day were lowest among child beggars (Rs. 14.60) and highest for disabled (Rs. 18.27). 88% beggars did not beg at a fixed location. There were some periods of the year (festivals and special functions held by the temple) when their earnings increased by 50%. All beggars had lost hope of doing anything other than begging, and 88% had never thought of changing their profession. Those who made efforts to seek employment could not find jobs or raise requisite funds to be self employed. Only 12% respondents had knowledge about Anti-Beggary Act, and children and females were totally unaware of it. 90% beggars reported that they faced no threat from the police. Immediate repair work needed to be done at the Beggars Home Lucknow.

Key Words : 1.SOCIAL DEFENCE 2.BEGGARY 3.BEGGAR HOMES 4.INSTITUTIONAL CARE 5.CHILD BEGGARS 6.INSTITUTIONS FOR BEGGARS.

SOCIAL WELFARE

31. Chhattisgarh, Chief Minister's Office, Raipur. (2005).
Human Development Report Chhattisgarh 2005. New Delhi : New Concept Information Systems. 274 p.

Abstract : Chhattisgarh, one of the youngest States of the Indian nation, was constituted on 1st November 2000. The main objective of the Human Development Report (HDR) was to provide a platform and trigger a debate to evolve the human development blueprint for the State of Chhattisgarh. The report focused on the Human Development Index (HDI) of 16 districts of Chhattisgarh. Data was collected through various sources, from Census of India 2001, education department, Sample Registration System (SRS), from '*Jan Rapat*' (people's views/report) and from other secondary sources. Important indicators used in the report were health, education, income and Infant Mortality Rates (IMR). Out of 16 districts, 6 districts had higher HDI values than the State average. These 6 high ranking districts were Korba, Durg, Mahasamund, Raipur, Janjgir Champa and Dhamtari. Out of these 6 districts, Korba ranked first on the HDI values (0.625), whereas the lowest ranked district was Bastar (0.264). On health indicators, Mahasamund ranked at first place (0.697) and Rajnandgaon showed lowest health values (0.063). Korba ranked at number one in the income index (0.980) and Kabirdham was lowest with income index value (0.104) and ranked at number 16. On the education index values, Rajnandgaon ranked at first place (0.838) while Dakshin Bastar Dantewada ranked at number 16 with lowest values (0.413). The data on IMR was not available for all districts so it was calculated for seven mother districts using fertility tables from the Census figures for 1991. Mahasamund ranked highest on IMR with 36 infants death per 1000 live births, whereas Rajnandgaon was at the bottom with 112 infants death per 1000 live births. There were still some districts of Chhattisgarh which lagged far behind on all the important indicators of Human Development Index. The Government should formulate strategies for improvement in the education system, health system and areas related to human development.

Key Words : 1. SOCIAL WELFARE 2.HUMAN DEVELOPMENT REPORT 2005 3.CHHATTISGARH 4.HUMAN DEVELOPMENT REPORT CHHATTISGARH 5.HUMAN DEVELOPMENT INDICATOR 6.CHHATTISGARH.

32. Dhar, Hiranmay. (2003).
Evaluation of programmes for improvement in the quality of life in rural areas of Uttar Pradesh. Lucknow : Giri Institute of Development Studies. Lucknow. 131 p.

Abstract : Many social group specific programmes were started by the Government in the 1960s as a part of the anti-poverty drive. The present study is an evaluation of such programmes in 2 villages in Hardoi district of Uttar Pradesh. A field survey was conducted in 2 villages namely, Lacchipur and Kalyanpur. Information was elicited from 62 households in Lacchipur and 63 households in Kalyanpur using a questionnaire. Dominant land holders were mostly upper castes. The OBC and SC/ST worked as agricultural labourers and construction workers. Ration shops under Public Distribution System (PDS) were not opened regularly or were opened at a time when most villagers had no money. There were malpractices in the distribution process. Kerosene was the only commodity which was purchased by everyone. Other commodities were sold occasionally and were of poor quality. The upper castes were educated and were keen to provide education to their children, including girl children. Even the SCs/STs and OBCs wanted to send their children to school despite financial constraints. Both the villages had primary, junior and high schools. There were private schools as well, where the relatively resourceful sent their children. At the junior and high school level the dropout rate was high, especially from SC/ST families. The dropout rate was higher for girls than for boys. Villagers wanted to provide education to the girl child for better marriage prospects, however the reason reported was that girls should also work and thus should study. There was not much enthusiasm for adult education programmes. The general source of medical treatment in both villages were quacks. Despite availability of primary health centres, villagers went to private doctors during emergencies. People were hesitant to give information about the functioning of Jawahar Rozgar Yojana (JRY), as contracts were mostly controlled by the village elite. People lacked information about the various types of work under this scheme. Even in the case of Integrated Rural Development Programme (IRDP), the rural poor were dependent on the village gentry for project details. The latter often withheld information for their own benefits. There were many malpractices and often the applicants did not receive the entire money. The OBCs benefited most from these schemes as they were well informed. Cooperation between banks, dealers and beneficiaries is important for schemes to be successful. The Block Development Officer should ensure efficient dissemination of

information. Also, the *Panchayat* (village council) system needs to be strengthened for alleviation of poverty.

Key Words : 1.SOCIAL WELFARE 2.QUALITY OF LIFE 3.RURAL AREAS 4.RURAL DEVELOPMENT 5.RURAL INFRASTRUCTURE 6.POVERTY ALLEVIATION 7.UTTAR PRADESH.

33. Gujarat Institute of Development Research, Ahmedabad. (2005). Infrastructure and growth in a regional context : Indian states since the 1980s. Ahmedabad : GIDR. 21 p.

Abstract : Over half a century now, in the post World War II scenario, the crucial role of infrastructure in promoting regional development has been identified and eminently articulated in the literature on development economics. Numerous studies, largely concerned with developed nations, have established that a stronger infrastructure base contributed directly or indirectly to the generation of income and employment in a given region. This study exclusively considers certain important physical infrastructure, namely transportation, power, telecommunications, irrigation, drinking water and sanitation. Advanced and proactive states, namely Maharashtra, Gujarat, Haryana and Kerala have been in the forefront of development promoting this crucial component - infrastructure. The states with least progress were Madhya Pradesh, Assam, Bihar and Orissa; and the level of development reflects the inability of these states to mobilize resources for financing state highways. In terms of per capita electricity consumption, Gujarat, Punjab, Goa, Maharashtra and Tamil Nadu are far ahead of low consuming states as Assam, Bihar, Uttar Pradesh, West Bengal and Madhya Pradesh. Even during the period of reforms, the poorer states have failed to catch up with the much acclaimed communications revolution. Since the early 1990s, national highways continued to be an important infrastructure resource. From 1980-2001, all the four selected infrastructure variables, namely density of national highways (NH), density of rail routes (Rail), irrigation intensity (Irr), per capita consumption of electricity (Ele), and teledensity (Tel) had grown in importance in impacting state per capita income. The strong linkage between electricity and rural development is evident. The increased coverage of rural electrification has been very low in states such as Bihar, Orissa, Uttar Pradesh and West Bengal, ranging between just 5% and 20%. Absence or inadequacy of basic infrastructure continues to plague the progress of numerous villages and habitations. One of the most neglected aspects of infrastructure in rural India is the availability of sanitation facilities. In poorer states such as Orissa, Madhya Pradesh and Bihar, the coverage of this facility is

abysmally low. Investing in infrastructure continues to be a Central Government activity. The private sector has preferred investing in the information and communications sector, but in relatively better-off states. Detailed studies examining the dynamics of processes underlying lopsided growth and endowment of infrastructure across Indian states are essential for understanding the actual context within which development decisions are taken.

Key Words : 1.SOCIAL WELFARE 2.DEVELOPMENT 3.REGIONAL DISPARITY 4.INFRASTRUCTURE 5.PHYSICAL INFRASTRUCTURE 6.INVESTMENT DECISIONS 7.INDIAN FEDERATION.

34. Habitat International Coalition, Housing and Land Rights Network, New Delhi. (2003)

The Impact of the 2002 submergence on housing and land rights in the Narmada valley : report of a Fact Finding Mission to Sardar Sarovar and Man Dam projects. New Delhi : HIC-HLRN. 52 p.

Abstract : The Housing and Land Rights Network of Habitat International Coalition (HLRN-HIC) despatched a Fact Finding Team (FFT) to the Narmada Valley from 18-24 September 2002 to investigate the resettlement and rehabilitation issues arising from the Sardar Sarovar and Man Dam projects. The FFT visited affected villages and rehabilitation sites, and met with officials of the Grievance Redressal Authority (GRA) and the Narmada Valley Development Authority (NVDA) in Madhya Pradesh and Gujarat, and the Narmada Bachao Andolan activists. It was found that submergence due to the 2002 monsoons and raising the dam's height in May 2002 had destroyed the crops and homes of Sardar Sarovar Project (SSP) affected villages in Maharashtra and Madhya Pradesh. The rehabilitation sites (Dhar District, Madhya Pradesh) visited by FFT were not fit for habitation and rejected by the villagers because there were some rocky, uneven plots for housing and also no provision for agricultural land. The residents of the Chikhald village, Madhya Pradesh were not resettled at all because the rehabilitation site chosen for them was itself subject to being submerged. The state Government had issued *ex-parte* house and agricultural land allotments to "non-responsive families", i.e. families that had not accepted any rehabilitation offer of the state. The Government sent notices to the oustees informing them of the allotment of a house or land often in another state. Once this notice was sent, the people were counted as rehabilitated on Government records, even while living in their original villages. The

Chairman of Madhya Pradesh GRA admitted that he had no infrastructure to verify claims of the NVDA. But the affected people told FFT that the NVDA official that had falsely included families in the rehabilitated list was himself sent to investigate the matter. The affected people in Alirajpur, Jhabua district in Madhya Pradesh complained that they were offered only cash compensation for their submerged lands from Government, and though they had cultivated the land for generations their names did not figure in land records. There was evidence that the Madhya Pradesh Government misapplied the Narmada Water Dispute Tribunal (NWDT) Award, as the Government was unable to rehabilitate affected persons according to the Award's provisions. The Supreme Court had directed that raising the height would be *pari passu* (construction and rehabilitation should make equal progress and should be related) for each stage before they continued to raise the height. In July 2002, police forcibly evicted the residents of Khedi Balwadi (Man Dam Project, Madhya Pradesh), dragged them into trucks and moved them to 2 locations 45-70 km away. Due to this, approximately 25 children, including infants, were separated from their parents and abandoned in the village. Due to heavy rains following the closure of the dam's sluice gates, the homes and crops in several villages were completely inundated by the new reservoir and people had been forced to live in squalid conditions in tin sheds. The project-displaced tribals were not given access to full information about entitlements under the Madhya Pradesh Rehabilitation and Resettlement Policy. Villagers stated that 10 years ago they were forced to accept cash compensation for partial loss of cropland, and they were told that their homes would not be affected by the dam. HLRN requests the NHRC to investigate and monitor the displacement and rehabilitation of the project-affected persons to ensure protection of rights guaranteed under India's Constitution and human rights treaty obligations; and also requests the Government to impose an immediate moratorium on any increase in the height of the SSP until all affected families have been fully rehabilitated in accordance with all applicable laws and policies.

Key Words : 1. SOCIAL WELFARE 2.DISPLACED PERSONS 3.HOUSING RIGHTS 4.LAND RIGHTS 5.HUMAN RIGHTS 6.RESETTLEMENT POLICY 7.TRIBAL AREAS 8.NARMADA DAM PROJECT 9.SARDAR SAROVAR PROJECT 10.REHABILITATION DISPLACED PERSONS 11.MADHYA PRADESH

35. Lim, Ai Li and Anand, Rita. (2006).
Confronting discrimination nomadic communities in Rajasthan and their human rights to land and adequate housing. Habitat International Coalition, Housing and Land Rights Network. New Delhi : HIC-HLRN. 45 p.

Abstract : Since 2001, Habitat International Coalition, Housing and Land Rights Network (HIC-HLRN) conducted a study concerning the ongoing struggle for land and housing rights of 6 nomadic communities namely Bhopas (traditional Hindu religious story performers), Gadhiar Lohars (blacksmiths), Kalbelias (practitioners of black magic and snake charmers), Nats (acrobats and jugglers who perform in fairs and carnivals), Banjaras (traders of salt and cattle) and Bawarias (hunters, trappers and trekkers) of Alwar district, Rajasthan. The primary objective of the study was to identify the substantive concerns of the communities and to articulate these concerns within the paradigm of fundamental human rights, and in particular, the right to land and adequate housing. Data was collected through HIC-HLRN and Muktidhara Sansthan, a community based organization in Rajasthan. It was found that settlement efforts were hindered by public antipathy towards nomadic communities. Government housing policies also do not address the obstacles that nomadic communities face regarding settlement. It was found that applications for title deeds filed by nomadic families were not processed, reportedly due to pressure exerted by members of settled communities on local land allotment authorities. Civic amenities such as piped water, sanitation facilities and electricity were non-existent. One hand pump was commonly installed for each settlement and overuse had affected the quality of water pressure. Types of shelter varied according to the lifestyles of the tribes, ranging from make-shift tent to thatched huts. Access to health care, schools and public distribution shops was severely limited by poor road connections. District land allotment authorities allegedly refuse to provide information related to the status of their title deed application. A vast majority of nomadic communities subsist below the poverty line but ration cards were not distributed in each settlement. Incidents of harassment, intimidation or violence due to caste hostility were under-reported because law enforcement authorities exhibited caste based bias. Inadequate access to schools contributed to high illiteracy rates amongst nomadic communities. Many families were unable to register their children in schools without permanent addresses or identity cards. The Government should establish constitutional safeguards for de-notified tribes that have been excluded from constitutional schedules, and promote public awareness and re-education by advocating against caste segregation.

Key Words : 1.SOCIAL WELFARE 2.HOUSING RIGHTS 3.HUMAN RIGHTS 4.RIGHT TO HOUSING 5.ADEQUATE HOUSING 6.NOMADS 7.NOMADIC TRIBES 8.RIGHT TO LAND 9.DENOTIFIED TRIBES 10.BAWARIA TRIBE 11.PROBLEMS OF NOMADIC TRIBES 12. RAJASTHAN.

36. Samal, Kishor C. and Mohanty, Srikanta. (2003).
Coping strategy of weaker sections (dalits and women) in post super cyclone Orissa. Bhubaneswar : Nabakrushna Choudhary Centre for Development Studies. 173 p.

Abstract : The present study examined the consequences of the Super-Cyclone 1999 that hit 12 districts on the coast of Orissa. The Cyclone affected 97 community blocks, 28 urban bodies, 1827 Gram Panchayats and 15,676 villages covering a total population of 13 million. The main objectives of the study were to assess the loss incurred by weaker sections, measure the benefits received from relief provided by Government and other agencies, and find out the coping strategy in post Super Cyclone Orissa. The study covered 9 villages of the most affected Erasma block of Jagatsinghpur district where more than 8000 people were killed. Data was collected through primary and secondary sources. The samples taken were women-headed households (38.96%), male-headed households (61.03%), dalits (54.69%) and non-dalits (45.39%). Cultivation was the main income earning occupation of the sample households. Study found that when warning about oncoming cyclone came, only 17% of the sample households took precautionary measures, while the remaining 83% did not take any action. Findings revealed that the Super-Cyclone affected the people of Erasma block so badly that all the sample villages remained marooned and isolated for days together. All the basic necessities as well as household articles, food stocks, clothes, and income generating assets were swept away. There was no electricity and telephone connection and roads were blocked by fallen trees and other debris. The Indian Air Force air-dropped food and other relief materials 3-4 days after the cyclone stopped. Major relief operation was started by the Government on an average gap of 8 days after the cyclone. Food items, clothes, polythene rolls, tarpaulins, blankets, candles, match boxes, bleaching powder, oil, baby food, drinking water, water purifying tablets, and fodder were some of the relief materials distributed by the Government. Several relief operations i.e. reconstruction of damaged infrastructure, digging new tube wells, ex-gratia payments to next of kin, revival of agriculture and horticulture, supply of nets and boats to fishermen, revival of plantation and Food for Work Programmes were carried out by several NGOs, Gram Panchayats and Government. Government of Orissa paid an amount of Rs.75,000 to next of kin (legal heir of each person who died during 1999 Super Cyclone). Provision of safer houses is the first requirement of affected people who face the sudden impact of natural disasters like cyclones, floods, etc. Also, community participation and involvement of local level agencies is necessary, not

only in rescue and relief operations, but in the contingency plans for disaster management of all states.

Key Words : 1.SOCIAL WELFARE 2.CYCLONE 3.DISASTER MANAGEMENT 4.SUPER CYCLONE 5.WOMEN AND CHILDREN 6.COPING STRATEGY 7.COPING MECHANISM 8.SC WOMEN 9.DISASTER RELIEF 10.ORISSA.

WOMEN WELFARE

37. Bhandan, Mala. (2004).
Women in two work roles and the quality of their life. *Journal of the Indian Sociological Society*, Jan-Apr, 53(1) : 94-103.

Abstract : The presence of women in paid employment outside the home is not a new phenomenon. Dual earner households have become a salient feature of contemporary life. The present study adopts a different approach and examines the two roles in terms of their independence as well as joint contributions to the Quality of Life of working women. It focuses on women's lives at home and in the office, and attempts to understand the possible linkages, compatibilities and conflicts between these two spheres. For a working individual, Quality of Life cannot be separated from the quality of work. A preliminary survey of women clerks in Delhi City, showed that they faced many problems in their daily lives including transportation, long working hours, worry about children, etc. A stratified random sample of 100 married women clerks working in Central Government departments in Delhi was chosen for the study. Women clerks in the sample belonged to Haryana, Punjab and Uttar Pradesh. Interview methods were used for collecting data. Data showed that 64% respondents had to part with their entire salary for the family. In most cases, women were given a specific amount of money to manage kitchen expenses and all other household income rested with their husbands. The study did not support the view that working women control the income earned by them and in turn it enhanced their participation in financial decision making of the household. About 50% respondents served food to other family members and they ate last. A nutritional analysis of the women sampled showed that protein and calorie intakes of respondents were not very significantly different from the Recommended Dietary Allowances (RDA). About 90% respondents availed institutionalised medical care for minor ailments and the remaining took recourse to self-medication at home. At office, respondents were seated in small, overcrowded

and ill-maintained rooms with very little space to move around. Holding a job had a positive effect on other aspects like age at marriage, as getting a permanent Central Government job enabled them to get married easily. Recreational and social life of respondents showed that social aspects of their well being were taken care of more in the office than at home. They found office tasks monotonous and boring. Respondents had adopted the 'easy going' and 'relaxed' work culture which is characteristic of Government offices all over the country. Respondents' routines showed the existence of a considerable amount of drudgery in their lives. Most of them reported that running between office and home, traveling by irregular and crowded city transport, and endless household chores caused them physical and mental fatigue. The husband's participation in household tasks was seen to be very marginal. The fact that women, like men, held full time office jobs, in no way helped to change the traditional pattern of sharing the intra-household tasks among males and females. The study showed insignificant impact on the social and economic position of these women within the family. Women's needs arising from their dual domestic and occupational roles require serious attention of the household and society.

Key Words : 1.WOMEN WELFARE 2.WORKING WOMEN 3.WORK ROLES 4.ECONOMIC AUTONOMY 5.ROLE CONFLICT 6.ECONOMIC INDEPENDENCE 7.WOMEN CLERKS 8.DELHI.

38. Bokil, Milind. (2005).
Ending domestic violence : self help groups can help. Pune : Development Support Team. 32 p.

Abstract : The issue of domestic violence or violence within the family exists in all forms and is related to two institutions namely marriage and family which cannot be intruded upon by the state or judiciary beyond a limit. At present, self help groups (SHGs) have emerged as the most widespread women's organization at the grassroots level. The present study explored the usefulness of SHGs to tackle the issue of domestic violence. The study encompassed the metropolitan, urban, rural and tribal areas of Maharashtra, and gathered first hand information from 42 victims of domestic violence. Findings revealed that domestic violence was mostly committed against young women. The main reasons behind marital problems and subsequent domestic violence were the practice of early marriage, unequal power relationships in the matrimonial family, poverty, husband's alcohol addiction, greedy in-laws, lack of education and access to resources. Domestic violence was reported across all communities and almost all the cases belonged to poor

households, however, it was relatively higher in Muslim families. In most cases, initially women suffered violence patiently and reported it to their parents or neighbours only when it became unbearable. Only in extreme cases were marriages dissolved, or the incidents reported to the police, as the affected women did not want to break the marriage due to its traumatic impact on the children and their subsequent separation from parents. The first and foremost resort of the affected women was their parent's place, followed by sister's or brother's homes. The incidence of using women's shelter homes was nil. Some community based organizations, such as SHGs were also observed to be wielding considerable influence. The various tasks undertaken by SHGs included arbitration in domestic quarrels and disputes, pressurizing the perpetrators to stop violence, counseling, assistance in seeking police support, facilitation of legal action and providing moral and motivational support to the victim. Although SHGs were best placed to address the issues of domestic violence, but their potential was not fully realized as the members were not equipped with knowledge about women's rights and legal provisions, were unable to provide shelter and security to the victim, and the promoting NGOs did not necessarily build their capacity in this regard. Hence, in order to make SHGs competent to handle the issues of domestic violence, it is essential that the promoting NGOs impart proper education and build their capacity. Also, a special fund for helping women in distress is necessary and shelter facilities are warranted at the community level. Campaigns to end domestic violence need to keep SHGs at the forefront of action and the SHG leaders can be trained as 'Community Counsellors' and 'Barefoot Lawyers'.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE 3.SELF HELP GROUPS 4.ROLE OF SELF HELP GROUPS.

39. Lakdawala, Hanif and Surendradas, Sandhya. (2001).
Angst theirs and ours : domestic violence : an epidemic on the upsurge. Ahmedabad : Sanchetana Community Health and Research Centre. 36 p.

Abstract : Domestic violence is defined as all actions against the wife (victim) by her present husband (perpetrator) that threaten the life, body, psychological integrity and restrict her liberty. The present study aimed to identify the health consequences of domestic violence (DV) on the victims, and identify appropriate strategies to reduce occurrence of DV. All married women in the reproductive age group of 15-45 years staying with their husbands in one of the slum areas of Ahmedabad formed the universe of the study. The total number of respondents was 400 and the number of survivors were 268 or 67%. Nearly 34.70% survivors

suffered from verbal and physical abuse. Nearly 70.59% survivors were from joint families and 65.77% survivors were from nuclear families, suggesting that DV cuts across all family types. There was no major difference in the abuse pattern amongst Hindus (68.78% victimization) and Muslims (66.03% victimization). The percentage of survivors were found to be high in lower age groups (71.90% among 18 to 27 years) than the older age groups (58.33% in 38 to 45 years). The reasons given were that men mellow down with age, and children grow up so men find it embarassing to beat their wives. 72.51% wife abusers were in the age-group of 30 to 39 years, and most non-victim husbands were in the later age group of 50+. 70.94% survivors were illiterate, wheras non-victims were better educated. Illiteracy was a major hindrance which crippled survivors, as they believed that whatever happened to them was fate. Even husbands who did not abuse their wives were comparatively better educated. 71.26% husbands of survivors were illiterate. Daily wagers showed highest victimization rate of 78.05%. 66.13% survivors were home makers. Husbands of home makers believed that they enjoyed themselves at home by taking rest. Self-employed women had least victimization (53.57%). They were mostly engaged in home-based activities like kite-making, quilt-making, etc. Unemployed men showed lesser abuse rate (58.82%) as women earned and managed the family. Women living in nuclear families enjoyed more decision making power than in joint families. Neither could women say no to physical relations with husband, nor could they decide on adoption of family planning methods. DV resulted in traumatic physical and mental consequences. Severely battered women had typical injury patterns which included cut on the scalp, on the palm and on the hands. Few even complained of partial loss of hearing and vision after being hit on sensory organs. Minor lacerations and bruises, blood clotting, swelling, blue body, dark circles around eyes were spotted among those who were battered. Women who were sexually harassed suffered from vaginal infections and menstrual problems. Abuse led to a host of psychological problems. Women complained of restlessness and uneasiness which persisted even if their husbands were not around. Violence resulted in mood disorders (80.22% suffered from depression), eating and sleeping disorders. Only 12.13% of the victims went to the doctor in the aftermath of violence. Gender sensitivity training programmes need to be started to change the attitude of men. Counselling centres should be started to address the mental health needs of victims of DV. Self employment programmes need to be started for women.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE 3.VIOLENCE AGAINST WOMEN.

40. Lakdawala, Hanif, Sen Balasaria, Rini and Rajput, Payal. (2003). Why some men batter their wives : a report about perpetrators of domestic violence 2003. Ahmedabad : Sanchetana Community Health and Research Centre. 40 p.

Abstract : Violence against women occurs in several forms including intimate partner violence, sexual harassment, sexual assault, forced prostitution and rape. The most pervasive form of violence against women is abuse by husband or intimate male partner. Out of 130 households in one of the slums of Ahmedabad, 120 households were surveyed. A detailed questionnaire was used to elicit the responses of men and women perpetrators and non-perpetrators. The survey revealed 27 perpetrators and 93 non-perpetrators of DV. Most men respondents hardly ever thought of what their wives did for their family. Even though 45% women worked, 44.20% husbands saw no change in the role that the wife played on the home front. Husbands of home makers were unwilling to let their wives work, as they felt threatened with the idea of their wives working. 35% men whose wives worked, said that wives took decisions about household matters, followed by matters of child rearing and the children's education. Only 8% men said that their wives took financial decisions too. 92% wives had no say in money matters, even though 45% wives earned. 44.20% male respondents admitted that they did not believe in gender equality. Even most perpetrators did not consider men and women equal. 7.5% respondents approved of wife beating. Nearly 33% perpetrators disapproved of wife beating, but at the same time indulged in it. Those who did not approve of spousal violence said that a wife performs multiple roles that need to be appreciated. Wife beating would indirectly affect other family members, and could also result in heavy medical expenses, if she got injured in the process. Humiliation of battered women was never provided as a reason or consequence for disapproving of this form of violence. Nearly 74.20% respondents were aware of the physical impact of battering like injury, body pain and weakness. 89% of the perpetrators were also aware that wife beating is illegal and severely punishable. 66.70% respondents seemed aware that the prevalence of domestic violence (DV) adversely affected children in the family. 91 men in the study held alcohol addiction as the main culprit for DV. 37.10% men blamed alcohol addiction followed by economic stress (24.20%) as a reason for abuse. 66.70% respondents disapproved of wives turning to the justice system for help. Most respondents said that they had to raise their hand on the wife as they did not fulfil the duties of being a good housewife. Some respondents felt that the wife's attitude towards the husband was annoying such as her rudeness, denial of sex and her suspicious nature. Most respondents felt that help was always available for DV, primarily through relatives and neighbours. 14% respondents reported that if the matter turned serious it was taken to the *Panch* (village elders) for a solution. 3.30% men

said that police was approached in some cases, but they played no preventive role. 81.50% perpetrators felt the need to stop DV. A multi-pronged approach involving family members, community, police, health care centres and education system needs to be adopted to make a difference. Gender sensitization training through broad-based campaigns seems to be an urgent need. Women's groups need to be organised to combat DV. Standardized interviewing procedures in health and hospital settings could help in better identification of abuse cases. To prevent abuse, counselling centres for couples are needed.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE 3.VIOLENCE AGAINST WOMEN 4.FAMILY VIOLENCE 5.MEN'S PERSPECTIVE 6.OPINION OF MEN.

41. Meher, Shibalal. (2003).
Self-help groups and poverty in Orissa. Bhubaneswar : Nabakrushna Choudhary Centre for Development Studies. 142 p.

Abstract : Orissa is one of the poorest states in India, where people die of starvation. According to latest estimates of the Planning Commission, it has the highest percentage of people below the poverty line, which indicates that the performance of Orissa in eradication of poverty is unsatisfactory. Poverty alleviation has been the central objective of development planning, and micro credit programmes operated through Self Help Groups (SHGs) have been instrumental in elimination of poverty. The present study was carried out in Koraput district. The study investigated the link between micro credit and alleviation of poverty and also examined the sustainability of SHGs. The sample was collected through multi-stage sampling method. In the first stage, five Self Help Group Promoting Institutions (SHGPIs) were selected from state and district level organizations. In the second stage, one successful SHG was selected based on its performance as judged by the promoting institutions. The selected SHGs included Abhilipsa Swasahayak Sangha (ASSS), Noorjahan Swasahayak Dal (NSD), Champa Gulapi Mahila Sangha (CGMS), Budhima Mahila Sanchaya Samiti (BMSS), and Maa Sidheswari (MS). In the third stage, 77 beneficiaries were selected from SHGs, out of whom 6 members were non borrowers, and were taken as control group. Information was collected through questionnaires, discussions and interviews. Among the different SHGs, NSD had the largest poverty impact, followed by CGMS and MS. The

poverty gap impact of ASSS and BMSS was lower compared to the other three SHGs. No strong correlation was found between income impact and asset creation, which indicated that an increase in income had not led to any increase in assets. However, the highest positive asset impact was observed in the case of ASSS and lowest in the case of MS. The study rejects the hypotheses that poorest borrowers may tend to have lower levels of asset accumulation. It was found that members got access to loans after formation of SHGs. There was high repayment ratio of the SHG members suggesting that the poor were bankable, and the groups were functioning well. It was observed that the level of empowerment was low except in the case of BMSS which showed moderate impact. Only social empowerment showed moderate improvement while both economic and political empowerment showed low improvement even after women joined SHGs. The long run sustainability of SHGs was assessed on the basis of the strength / quality of social capital. The study showed that though SHG based micro finance had better outreach and positive impact, however, there is a need to improve the process of empowerment and the strength of social capital formation of SHGs so as to make them sustainable in the long run.

Key Words : 1.WOMEN WELFARE 2.SELF HELP GROUPS 3.POVERTY RATIO RURAL 4.STATUS OF EDUCATION 5.POOR WOMEN 6.POVERTY ORISSA 7.CREDIT FOR WOMEN 8.IMPACT OF SELF HELP GROUPS ON POVERTY 9.ORISSA.

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