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Contents

Research Studies on Women and Children

AGED WELFARE

1. Hegdewar Samajothan and Kalyan Samiti, Munger, Bihar. (2004).
Problems and issues of elderly women in India: a comparative family study in state of Delhi and Bihar with executive summary. Munger, Bihar : HSKS. 89 p.

Abstract : The present study focused on personal, family and social aspects of elderly women, and attempted to identify their problems in the states of Bihar and Delhi. A sample of 800 women was selected from two districts of Bihar (Munger, Bhagalpur) and Delhi (South Delhi, East Delhi). In the sample there were 3.45% single women respondents, 51.5% widows, 3.94% divorcees and 0.69% separated women. About 41.4% of the respondents had living husbands. Most of the respondents were illiterate (68.52%), 8.8% were educated up to primary level, 4.51% up to middle level and 3.82% were educated up to high school level. 1.04% women were self employed, 2.31% had businesses, 0.81% were professionals, 0.69% were skilled labourers, 23.73% were labourers and 66.09% did not work. About 71.18% of the respondents received their food from their own sons; 6.25% respondents were getting food from their daughters; 18% reported that their nephews/ nieces were meeting their food requirements; 5% respondents were dependent on their brothers for food; and about 10.42% did not specify for certain personal reasons. 41.78% respondents reported that they were not able to walk properly due to osteoporosis, injuries, arthritis, muscular strain, etc; 41.55% respondents had weak eye sight, 48.95% had sleep disorders; 8.44% were suffering from T.B; and 2% respondents had cancer. 39.58% respondents had access to TV, 25% radio, 7.75% to newspapers, but 27.66% were unable to answer. Only 18.52% respondents had control over their children, 6.37% has some control over their children, while 50.46% did not have any control. 46% of the respondents in Bihar and about 67% in Delhi reported that their family's attitude towards them was affectionate, but in 18.28% cases the attitude was dominating. Over-protective behaviour was reported by 11% of the respondents. 4.62% respondents had 'nagging' families and about 14.23% had 'anxious' families. 23% respondents' families had an attitude of indifference towards the respondents. 10.64% respondents' families were observed to be quarrel-some; in Bihar about 11.49% and in Delhi about 9.54% respondents were observed to be quarrelsome. About 17.12% respondents were jealous/ peevish in both states. About 24.53% respondents were assessed to be ego-centric. About 40% respondents were not able to manage tension and anxiety. About 13.65% respondents in Delhi and Bihar were found to be interested in music. It

was recommended that there is a need for counselling and referral services for elderly women in view of their material and psychological problems. The traditional knowledge and skills of capable aged women should be utilized to provide services for women and children under various Government programmes. Recreation centres, exclusively for elderly women, should be set up at the village level and in each neighbourhood in urban areas. Local bodies should earmark specific allocations/ funds for providing relief to aged women, especially widows and neglected women.

Key Words : 1.AGED WELFARE 2.AGED WOMEN 3.PROBLEMS OF AGED WOMEN 4.DELHI 5.BIHAR.

EDUCATION

2. Nayar, Usha et al. (2007).
An analytical study of education of muslim women and girls in India (with summary & recommendations). New Delhi : Tinnari, Third World Centre for Comparative Studies. ~300 p.

Abstract : Muslim girls and women lag behind their male counterparts. The study was designed keeping vital factors in mind that affect Muslim women's education, such as regional imbalances, socio-economic condition, family background, etc. Muslims account for 13.4% of the total population of India, and they constitute 97% of the population in Jammu and Kashmir. Sex ratio in the Muslim community is 936, and the average household size was 6.2. The average work participation rate of Muslim women was very low (14.1%). Muslims record the highest incidence of poverty with 31% people being poor. The average literacy rate was 50.1% for Muslim women and 53.7% for all communities. Gender disparity in literacy rates among the Muslim population is about 9.67% points in rural and 13.11% points in urban areas. Muslim female literacy rate is significantly lower in 15 Indian states/ union territories – 0.6% in Bihar, 4.8% in Uttar Pradesh, 3.1% in Rajasthan and 2.2% in Kerala. Muslims had the highest number of literates without regular education and education below primary level (36.4%). Only 3.6% Muslims were graduates compared to the national average of 6.7%. Mean years of schooling (MYS) estimated for 7-16 years age group of population in 2001 was 3.9 years. The MYS of Muslims was 3.26 years, and it was 2.7 years for Muslim girls. However, percentage of girls in total population at primary school has gone up from 28.1% to 46.7% during 1950-51 to 2003-04. The dropout rate has also gone down from 71% to 29% for girls during 1960-61

to 2003-04 at the primary level, 85% to 53% at the middle level, and from 87% to 65% at higher secondary level. Girls Enrolment Ratio (GER) and participation in technical education is still low. Only 12.5% parents wanted to send their daughters to co-educational schools. Divide was also seen because of socio-economic status (SES). Only 16.1% Muslim girls from poor families attended schools compared to 70% of Muslim girls from good SES families. 98% of them attended government schools and only 2% went to madarasas. Kerala is spending 6.3% of GDP on education and ranks at number one position. 40% of the population of Hyderabad is Muslim, and 84% of the sampled Muslim women were illiterate. Being a vulnerable minority, they felt that their identity and lives were under threat, which enhances influence of the orthodox and conservative *ulema*, known for their lack of enthusiasm for 'modern' education. The study revealed that 54.45% people preferred regular schools to madarasas. The study found that only 23% girls in *maktabs* (small schools for girls) in villages were literate, i.e. could read and write their name. States like Uttar Pradesh, Bihar, Jharkhand, and Uttaranchal have very low (less than 70%) enrolment rates. As per National Sample Survey Organisation more than 25% of Muslim children in 6-14 years age group had never attended schools or were dropouts. Findings of the study revealed the educational backwardness of Muslims, and confirmed the unequal status of all women. Education is an economical empowerment tool for the girl child. Madarasa teachers stressed on religious education for Muslim girls, parents preferred both secular and religious education. It was recommended that Sarva Shiksha Abhiyan should have a strong pro girl child programme, with added emphasis on Muslim girls; encourage and equip a continuous and comprehensive database; collect educational data through village education registers as is done in the Madhya Pradesh Model; provide cost free quality education for all children from BPL households; provide girls hostels in regular middle and secondary schools so that more girls can enroll, specially Muslim girls; open schools in states should waive off examination fees for girls; SYNERGY Model for holistic development should be adopted; early marriages should be stopped; self help groups should be encouraged; and higher percentage of GDP should be allocated for education.

Key Words : 1.EDUCATION 2.MUSLIM GIRLS 3.MUSLIM WOMEN 4.EDUCATION MUSLIM GIRLS 5.MADARASA 6.MINORITY EDUCATION 7.STATUS OF WOMEN 8.STATUS OF MUSLIM WOMEN 9.FIVE YEAR PLANS 10.EDUCATION PROGRAMMES 11.LITERACY RATES 12.RELIGIOUS DATA 13.GIRLS EDUCATION 14.RIGHTS OF MUSLIM WOMEN

HEALTH

3. ARTH, Action Research and Training for Health, Udaipur. (2005). Census of health facilities in Udaipur district, Rajasthan. Udaipur : ARTH. 40 p.

Abstract : Udaipur is pre-dominantly a rural district of Southern Rajasthan, with a population of 26, 33,312 (Census 2001). The present study was done to map the availability and distribution of all health facilities in the district and to assess the potential for participation of private providers in public health care programmes. Data was collected from the clinics and hospitals of urban and rural areas of Udaipur city. Udaipur district comprised 10 tehsils and 498 gram panchayats. In the district as a whole, 44% of the facilities were operated by Government and the rest (56%) by the private sector. However, 65% of all private facilities were concentrated in urban areas, mostly in Udaipur city, whereas 84% of government facilities were located in rural areas. In urban and peri-urban areas, there were more health facilities. In contrast, remote, interior and tribal areas like Kotra, Jhadol and Dhariyawad lacked health facilities, and the private sector was poorly developed. Around 60% of the private sector facilities provided in-patient care, and of these 81% facilities were in Udaipur city. The major medical services provided in both private and government sector were related to RCH (ANCs, delivery), child care (diarrhoea, ARI, immunization), treatment of tuberculosis, malaria, eye problems, STDs, hypertension, asthma, dental extraction, accidents and injuries. Private facilities provided a range of medical and surgical services (chemotherapy, radiotherapy, ENT surgery, caesarean section, sterilization methods, orthopedic surgery, neurology, HIV testing, leprosy treatment, etc.). In Udaipur district only 16% PHCs (Primary Health Centres) had an indoor facility. The rest offered consultations and dispensed drugs. All the CHCs (Community Health Centres) have an indoor facility. They did not have facilities for blood transfusion, since a blood bank was available only at Udaipur, and there were no formal arrangements for blood storage in CHCs. Focus should be given to improve the health facilities of both sectors, and the district should be well connected with proper roads to rural areas and remote areas, so that people can receive timely medical aid.

Key Words : 1.HEALTH 2.HEALTH FACILITIES RAJASTHAN 3.HEALTH SYSTEM 4.HEALTH PRIVATE SECTOR 5.GOVERNMENT HOSPITALS 6.UDAIPUR 7.RAJASTHAN 8.VISTAAR PROJECT.

4. ARTH, Action Research and Training for Health, Udaipur. (2005). Nurse midwives for maternal health : experience in Southern Rajasthan. Udaipur : ARTH. 33 p.

Abstract : India has a high maternal mortality ratio (MMR) between 420-570 maternal deaths per 1000 live births, translating into an unacceptably high lifetime risk of one in 55 maternal deaths (WHO). The report focused on the experiences of nurse-midwives trained by ARTH (Action Research and Training for Health), who were a part of the pilot project 'Nurse Midwives for Safe Motherhood' that was launched in April 1999. The activities of this project were dovetailed with the existing Reproductive and Child Health (RCH) clinic that had been operational in village Kuncholi, Kumbhalgarh block, Udaipur district, Rajasthan since October 1997, along with community level educational activities. The nurse-midwives gained experience and confidence about conducting deliveries, over time. The first six months of this service saw a total of only 8 deliveries being conducted. The nurse-midwives attended 311 deliveries in 2004-05, and of them 48 women needed referral for maternal or fetal complications. Of all the women who attended for delivery, 97.9% had vaginal delivery (including 3% with vaginal breech delivery and 1.1% with a twin delivery), and caesarean section was needed for 2.1% women. Out of 1002 women who sought care from ARTH for delivery between Oct. 1999 and March 2005, referral was advised for 163 women. Of these 142 (14.2% of all women, and 87% of those advised referral) complied with the advice. Among 860 women whose deliveries were conducted by ARTH nurses, there were 7 stillbirths and 21 neonatal deaths. On the other hand, there were 22 stillbirths and 15 neonatal deaths among women who were referred. This could be because referred women constituted a high-risk group with maternal or fetal complications. The proportion of deliveries by skilled attendants almost doubled from 1999 to 2000, from 12% to 24%. Most of this increase was due to deliveries conducted by ARTH and government nurses. The deliveries conducted by nurse-midwives increased from baseline levels of 1.6% to 16% between the two surveys. The institutional delivery rate increased from 12% to 22% during this period. Most of this increase was due to deliveries at the ARTH clinic. Survey carried out in 1999 and 2002 in Kuncholi field area showed that the proportion of those receiving at least one check-up improved from 53% to 67%. It was found that ARTH field clinics or its health centres became the most common sites for ANC (Antenatal Care) between 1999-2002 – their use increasing from 2.5% in 1999 to 50% in 2002. In the first year, the average outpatient attendance (OPD) was 60 visits per month. During the 6 year period between July 1999 and March 2005, a total of 1377 Copper Ts were inserted in the ARTH clinic. Nurse-midwives managed, to a great extent, all clinic services,

including dispensing drugs, supplies, making their rosters for field clinics and managing them, taking decisions about home visits, providing care in cases of obstetric and neonatal emergencies, arranging transport, taking decisions about subsidy for a referral, maintaining records and registers, etc. In government PHCs, where doctors are not available at night, it is necessary to explore the possibility of upgrading the roles of locally resident lady health visitors and auxiliary nurse midwives into leadership roles. An immediate next step is to orient and sensitize doctors to the importance of a greater role of nurse-midwives in public health, and to foster a genuine desire to empower them.

Key Words : 1.HEALTH 2.MATERNAL HEALTH 3.NURSE 4.MIDWIFE 5.ATTENDED BIRTHS 6.SAFE DELIVERY 7.OBSTETRIC EMERGENCY 8.FOETAL DISTRESS 9.TRIBAL WOMEN 10.MATERNAL HEALTH TRIBALS 11.RURAL ROADS 12.RAJASTHAN 13.VISTAAR PROJECT.

5. ARTH, Action Research and Training for Health, Udaipur. (2005). Qualitative study on community values and perceptions on teenage pregnancy. Udaipur : ARTH. 27 p.

Abstract : The present study was undertaken to understand community values related to teenage sexuality and teenage motherhood; and to develop a communication strategy for preventing teenage motherhood. 15 villages, belonging to 4 panchayats of Udaipur and Rajsamand districts of Rajasthan, were selected for the study. 16 in-depth interviews were conducted with young mothers (16-22 years) who had experienced adolescent pregnancy, and married males (between 18-25 years) who had at least one child. 80 respondents, 40 women and 40 men, comprised the sample. Child marriage is very common in rural communities. There is no fixed age for engagement of boys and girls. Sometimes the child is barely 2-3 years old when engagements take place. Engagements are carried out in cradles also. It is believed that after a certain age it is hard to find a suitable match and this fear acts as one of the motivating factors for marrying off their children at an early age. Sometimes, even after a boy or girl attains maturity, marriage is not possible due to financial problems. In such cases, people practice *'Aata – Satta'* which means that they marry their daughter into one family and get their daughter–in–law from the same family. Marriages of adolescent boys and girls take place on the basis of accurate estimates of age made by their parents. In tribal castes people with low socio-economic backgrounds marry their girls at an early age (around 14-16 years). Boys are also married off early, between 13-20 years. These facts were affirmed on the basis of in-depth interviews conducted with 16 young men and women who confirmed that their own marriage was at 17.1 years (for men) and 12.4

years (for women). Parents try to marry off their daughters early so that their periods start only in their husband's home. They fear that if a girls' menstrual period starts in her parent's home, questions might be raised about her virginity and sexual morality. This belief therefore encourages the practice of early marriage and co-habitation. During Focus Group Discussions (FGDs) it was found that if there were 2 to 3 girls of varying ages in a close range, they were all married off at one time to save expenses on marriages. Among all communities, newly wed couples are expected to produce a child within two to three years after the 'Aana' ceremony/ living together. 45% participants said that it was an occasion of joy for their family if a 17 year old girl conceived. Most young men did not know anything about the process of pregnancy. Most of the adolescent boys, during FGDs, admitted to having some knowledge of family planning methods, but most females were completely ignorant of the subject. 50% women, during in-depth interviews, admitted to have some knowledge of contraceptive methods. It was found that the older generation had their own inhibitions regarding the use of contraceptives. They believed that family planning methods harmed the body and retarded the chances of future conception and should be kept at bay. Copper T and Mala D pills were the favourite contraceptives. It was suggested that adolescent girls need to be made aware of the various physical changes accompanying maturity such as the onset of menstrual cycle, etc. They should be informed about the process of conception; pregnancy and childbirth; family planning methods, their benefits and limitations, side affects; information regarding health services available in the region; and the importance of pre-natal, post-natal and delivery care.

Key Words : 1.HEALTH 2.TEENAGE PREGNANCY 3.EARLY MARRIAGE 4.ADOLESCENT REPRODUCTIVE HEALTH 5.COMMUNITY PERCEPTION 6.RAJASTHAN 7.VISTAAR PROJECT.

6. ARTH, Action Research and Training for Health, Udaipur. (2000).
Reproductive health on the ground : meeting women's needs in southern Rajasthan : report of 3 year experience of understanding change in health seeking behaviour. Udaipur : ARTH. 130 p.

Abstract : The present survey was conducted to record baseline data about socio-demographic profile of 10 project villages of Kumbhalgarh Tehsil. Further, the availability of Trained Birth Attendants (TBAs), Anganwadi Workers, literacy volunteers, women's groups, and health providers in project villages were also

mapped. The study covered 1058 women aged 15-49 years, and included ever married women with 1 to 2 living children, adolescent girls aged 15 to 19 years, childless women (married women with no living children), and women who had delivered within the past 2 years. The sex ratio in the area was 927 females per 1000 males. More than half the population was in the reproductive age group. About 66% adolescent boys aged 13-19 years were currently married, and the median age of marriage of husbands of recently delivered women was 16 years. More than 90% respondents were married before the age of 21 years. The median interval between marriage and cohabitation (*gauna*) was 2 years. Approximately 14% women and 16.2% men had gone through customary marriage (*nata*). Women of the area had high fertility. Findings revealed that 38% women had unmet need for family planning. These include 25% women who did not want any more children and 13% who wanted to have the next child after 2 or more years, or were uncertain about whether or when to have the next child. Only 2.5% women used contraception before at least one living child had been born. 55% adolescent girls were not aware of any reversible contraceptive method. Knowledge of sterilization was universal. Contraceptive pills were not readily available in villages. Some respondents also felt that using pills might adversely affect subsequent childbearing. The Maternal Mortality Ratio in Rajasthan was 670/1000 live births (Sample Registration System (SRS) 1998). More than 40% of the women suffered at least one problem during pregnancy. About 25% women had breathlessness, and 11% women had night-blindness, which is indicative of Vitamin A deficiency. Pre-eclampsia was found in nearly 5% women. Convulsions were reported by 4% women. 21% did not consider any kind of work as being heavy. 38.1% men had borrowed money for their wife's last delivery. The median amount borrowed in such cases was Rs. 1500 (range Rs. 200-12000). Money was borrowed from village moneylender (43%), friends or neighbours (16%), and family members. About 40% women reported having had at least one problem (burning urination, abdominal pain, vaginal discharge, and pelvic infection). In 2000, 15.7% and 2.4% currently married women said that they had heard of STDs and AIDS respectively. 24% women resorted to faith healing, while 27% made use of medical services. The median cost of treatment among women who could remember the cost was Rs. 500. 12.4% women felt that gynecological problems were not serious. 30.1% women felt that they would recover on their own, 16.3% didn't have enough money, 17.6% felt shy, 2% felt problems were due to spiritual forces, 7.8% did not understand them, and 5.2% were afraid of treatment. The study found that 53% of the childless respondents were suffering from primary infertility and 47% with secondary infertility. The mean duration of childlessness was 8.1 years. It was suggested that there should be regular availability of good quality and confidential reproductive health services, which could rapidly change this situation. An outreach programme must approach both men and women. There is need to promote long term reversible methods of family planning if unmet need for limiting family size is to be met. A

differential approach to deliver health services within heterogeneous communities, with greater focus on underserved groups, is required.

Key Words : 1.HEALTH 2.REPRODUCTIVE HEALTH 3.ABORTION 4.HEALTH BEHAVIOUR 5.UDAIPUR 6.RAJASTHAN 7.VISTAAR PROJECT

7. ARTH, Action Research and Training for Health, Udaipur. (2005). Situational analysis of abortion services in Rajasthan. Udaipur : ARTH. 84 p.

Abstract : Despite legalization of elective abortion through the Medical Termination of Pregnancy (MTP) Act in 1971, the availability of abortion services particularly in rural areas remains limited. The present study was done to assess the availability and adequacy of abortion services in districts of the state, and to assess institutional readiness for delivery of quality MTP services in the state. The study was conducted in 2 districts of Rajasthan, Jalore and Kota. Data was collected through interviews, secondary data was collected from the Directorate of Family Welfare, and a qualitative assessment was done of 5 training institutions. The total sample was of 618 informal service providers. Out of these 355 (57%) admitted to treating delayed periods. Providers who treated delayed periods included female paramedics (40%), male paramedics (17%), male unqualified practitioners (34%) and female untrained practitioners (8%). The most common method used for treating delayed periods was tablets (89%), followed by injections (58%). Invasive or surgical methods were tried out by a minority (7%) of providers. The commonest instrument used was the curette and occasionally a syringe, catheter or copper – T. The cost of such procedures was high, ranging from Rs.315 to Rs.516 per procedure. Out of 618 respondents, 90% gave injections for common ailments, 84% provided IV fluids, 61% applied stitches for injuries, 52% conduct deliveries, 61% treated incomplete abortions, and 64% treated menstrual problems. The study also enumerated 63 providers of Indian Systems of Medicine in the two districts, most of whom were male. Their practices and methods used to treat delayed periods were similar to those of informal providers. Eighteen of them were in government service, while the rest worked through private clinics. These 2 districts covered 42 government health centres all of which were mandated to provide abortion services. However, only 22 government facilities were actually providing abortion services. In the private sector there were 40 facilities providing abortion services, and only half of these were certified to do so. Around 19 uncertified facilities did not report any abortions, 30% certified private facilities and 23% government facilities also did not report all MTPs. At government facilities, the average minimum and

maximum cost of abortion were Rs.195 and Rs.457 for a first trimester abortion and Rs.317 to Rs.575 for second trimester abortion. At private facilities, the average minimum and maximum costs were Rs.540 and Rs.724 for first trimester abortion, and Rs.1144 and Rs.1681 for second trimester abortion. Data from State Directorate of Family Welfare revealed that 338 private facilities had been certified to provide MTP services in Rajasthan as of 2003. There were 8 MTP centres in Rajasthan. At the time of study they included 6 medical colleges. The total number of doctors trained from 1971 to April 2002 was 1056, of whom 786 had been trained after 1980. Enhancing access to safe abortion in Rajasthan would therefore require measures that allowed more legal facilities to be approved in a smoother way; use of modern, simpler and safer technology; and widespread dissemination of information about the MTP Act and technologies available.

Key Words : 1.HEALTH 2.ABORTION SERVICES 3.ABORTION 4.MEDICAL TERMINATION OF PREGNANCY 5.RAJASTHAN 6.VISTAAR PROJECT

8. ARTH, Action Research and Training for Health, Udaipur. (2003).
Situational analysis of health status and health system in Kotra tehsil, District Udaipur, Rajasthan. Udaipur : ARTH. 22 p.

Abstract : The present study was carried out to perform a rapid appraisal of the health problems affecting rural communities, especially women and children in Kotra tehsil of Udaipur district in Rajasthan. Through in-depth interviews, information was gathered from women and men of the community, primary health care providers, anganwadi workers, panchayat members, and representatives of NGOs that operated in Kotra. It was observed that median maternal height was 149 cms in Kotra. The occurrence of any illness in the last 2 weeks among children 0-35 months was 46%, 23.1% children had fever, 17% were wasted, 75% were stunted and 73% were underweight. Health care was provided by government physicians (9), male paramedics (26), ayurvedic doctors (8), ANMs (64), private unqualified providers (23) and NGO workers (21). Fully immunized children in rural Rajasthan were 13%. The community considers about 4 children as the ideal number of children for a couple to have. Most women and their families appeared to be against tubectomies for limiting their families. Many women felt that they would not be able to perform heavy work for several days after the operation. Discussions with women revealed that they were familiar with common methods of contraception, i.e. tubectomy; oral pills, condoms and

copper - T. Panchayat members felt that ANMs were responsible for poor use of non-terminal methods of contraception. 1.6% deliveries took place at health centres. Most deliveries were conducted at home by traditional birth attendants. Alchoholism was common among men. *Purdah* (veiling) was not followed among the tribals in Kotra. Kotra is the only block in the state that has sex ratio favourable to women. A few NGOs have been working in Kotra for several years, notable ones among them being Seva Mandir, Aastha and Vanvasi Kalyan Parishad. Seva Mandir provides health education to families. Aastha has been organizing communities and also strengthening Panchayati Raj Institutions (PRIs). Vanvasi Kalyan Parishad was undertaking the Tuberculosis Control Programme in the area. Well trained and well supported paramedics can provide primary curative care in rural areas. ANMs are expected to provide some basic management for childhood illnesses, treat malaria, etc., but are not officially allowed to do much else as far as curative care is concerned. They can be trained to perform tasks related to integrated management of childhood illnesses, and provide treatment for several gynecological conditions. There is need for a flexible and quick special management structure to implement the recommendations so that rural communities can have better health care.

Key Words : 1.HEALTH 2.HEALTH STATUS TRIBALS 3.HEALTH SYSTEM 4.TRIBAL HEALTH 5.MATERNAL HEALTH 6.MATERNAL HEALTH TRIBALS 7.TRIBES RAJASTHAN 8.NUTRITIONAL STATUS TRIBAL CHILDREN 9.HEALTH STATUS TRIBAL CHILDREN 10.KOTRA 11.UDAIPUR 12.RAJASTHAN 13.VISTAAR PROJECT

9. Catholic Relief Services, Lucknow. (2005).
Process documentation of the activity in Shivgarh block : behaviour change communication : 3 parts. Lucknow : CRS. ~60 p.

Abstract : Linkages and Catholic Relief Services (CRS) proposed to conduct a process evaluation of its Behavioural Change Communication Programme to improve infant feeding and maternal nutrition practices in the Safe Motherhood and Child Survival Programme (SMCS) project implemented in Rai Bareli district in Uttar Pradesh. The primary objective of the process evaluation was to improve understanding of how programme strategies contributed to achieve the objectives of the project. CRS and Gramin Vikas Sansthan (GVS) launched SMCS in 6 Gram Sabhas of Shivgarh block in Rai Bareli district. It was extended to 15 and 39 Gram Sabhas in 1999 and 2002 respectively. Rai Bareli is an under-developed district of Uttar Pradesh. Sex ratio in the district is 931 women for every 1000 men and female literacy rate is 17%. Two villages named Guriya

Garhi and Goorha were selected and focus group discussions (FGD) were conducted. The FGD points provided to the research team were very helpful in getting the perception of different groups. Personal or group counselling as well as awareness activities were well received by the communities, but the same level of acceptance was not reflected as far as adoption of practices was concerned. In spite of addressing target groups and making continued efforts in the adopted villages, community initiatives were not observed to the expected levels. The activities were effectively operational but the initiative of GVS/ CRS could not mobilize adequate support and resources from other groups or institutions working on similar issues. Based on experiences, felt constraints and feedback from CRS and communities, the Project Team identified a few strategies to be adopted while implementing further activities of the project. It was realized that programme activities should be owned by communities; hence their involvement at every level of project implementation vis-à-vis planning, operationalization, monitoring and evaluation is important. Messages should be designed and communicated to target groups in a more specific manner on a one-to-one basis, according to local, agro-climate and cultural situations. To achieve effective results and obtain maximum output from the efforts put in, it is necessary that resources and activities of different actors should be converged. Such coordination is required to be forged at institutional levels. It was found that non target groups were also important and should be involved so that a chain process is triggered and the whole community plays an active role. To enhance the impact of SMCS activities, CRS and LINKAGES developed a systematic Behaviour Change Communication (BCC) strategy as a Pilot Project in the area. It was expected that communications related to behaviour change would facilitate acceptance and adoption of good practices related to better infant feeding and maternal nutrition and lead to better long term effects. In the BCC phase, message clarity was ensured and messages were also developed. It was observed that messages from fellow community members, based on their own experiences, were very effective and well received. Efforts had been made to involve the community at every level during implementation of SMCS programme. This helped develop an environment of trust and ownership. Communities came forward to help in the project and contributed their time and resources. The community provided rooms, chairs, mobility, help in wall writing, awareness campaigns and other such support. Identity of the programme and organization shifted from food providers to social change organization. Collaboration showed results and the success of events like Health *Melas* (fairs), health campaigns, polio immunization drives, etc. were a few examples of such collaboration. Although efforts were made to influence practices on all the identified behaviours, the impacts have been more pronounced on some behaviours than others. Significant changes have been made within a limited

time, and the adopted communication strategies were effective; however, there are still challenge areas where more efforts are required.

Key Words : 1.HEALTH 2.CHILD SURVIVAL SAFE MOTHERHOOD 3.INFANT MORTALITY REDUCTION 4.CHILD HEALTH 5.MATERNAL HEALTH 6.BEHAVIOUR CHANGE COMMUNICATION 7.COMMUNICATION FOR BEHAVIOUR CHANGE 8.STREET PLAYS 9.HEALTH EDUCATION 10.NUTRITION EDUCATION 11.NUTRITION AND HEALTH EDUCATION 12.UTTAR PRADESH 12.VISTAAR PROJECT

10. Mavalankar, Dileep and Raman, Parvathy. (2006).
ANKUR Project : a case study of replication of home based newborn care : case study. SEARCH, Society for Education Action and Research in Community Health, Gadchiroli, Maharashtra. Ahmedabad : IIMA. 23 p.

Abstract : The global burden of neonatal deaths is estimated to be 4 million of which about 3 million occur during the first week of life. About 99% of neonatal deaths occur in developing countries and of these 50% occur at home. Global estimates show that 23% of neonatal deaths are due to complications of asphyxia; 36% due to infections (including 26% due to sepsis/ pneumonia); and of the remaining 41% neonatal deaths, 27% were preterm babies and 7% had congenital abnormalities. India contributes about 1 million neonatal deaths to the global burden, and its neonatal mortality rate (NMR) is 43/1000 live births. 67% of deliveries in India take place at home. Due to the high mortality rate, Society for Education Action and Research (SEARCH) initiated a Home Based Newborn Care (HBNC) project in Gadchiroli district of Maharashtra, due to which NMR was brought down to 62% in intervention areas, and there was 30% reduction in neonatal morbidity. The endeavour to replicate HBNC project in other districts of Maharashtra led to the inception of Ankur project. This involved 7 NGOs, 7 districts and covered a total population of 87,827 persons in tribal, rural and urban areas. The project was managed by project coordinators, Auxiliary Nurse Midwife (ANM) or Ayurvedic doctor as Neonatal Care Supervisor (NCS), and Vital Statistics Supervisor (VSS). Community consent was obtained from village panchayats and local governing bodies. Traditional Birth Attendants (TBAs) were also included and trained in HBNC. The entire Ankur project was divided in 3 phases: i. Intervention, which included registration of pregnant women, ii. Training, which included newborn assessment with other care support, and iii Follow up, which was done in the post natal period and comprised history, examination and other vital assessments of newborn. The training guidelines had 17 modules, and they were made highly practical due to the low literacy level of Village Health Workers (VHWs). Training included 3-5 days of residential training

segments. The coverage of HBNC increased from 70% to 90% by the end of the third year. Each worker was given basic instruments such as a weighing scale, ambubag (for giving artificial respiration to babies), disposable syringes and needles, drugs and medicines with kit bags, and a trunk to keep equipments and record books. The project had 2 levels of supervision, NCS and VSS. Due to health education and follow up in the post natal period, the practice of exclusive breastfeeding increased from 30-40% to 90% in 3 years. The main aim of the project was to reduce NMR by 30%, it actually reduced it by 51%. Other significant reductions were seen in Crude Birth Rate (CBR) 4%; Still Birth Rate (SBR) 38%; Early Neonatal Mortality Rate (ENMR) 44%; Peri Natal Mortality Rate (PNMR) 41%; Late Neonatal Mortality Rate (LNMR) 72%; Neonatal Mortality Rate (NMR) 51%; Post Natal Mortality Rate (PNMR) 38%; Infant Mortality Rate (IMR) 47%; 1-4 Mortality Rate (1-4 MR) 56%; and Child Mortality Rate (CMR) 49%. The policy suggestions to the Government for HBNC were scaling up efforts in other states via National Rural Health Mission (NRHM) and Ankur could be taken up as pilot projects; technical support from SEARCH can be used to facilitate RCH; lessons from this project can be used to improve basic newborn care; Government should also develop a plan like Ankur to ensure 100% registration of neonatal, infant and maternal deaths; and the new ASHA volunteer could be used to try out HBNC in selected pilot areas.

Key Words : 1.HEALTH 2.NEWBORN CARE 3.INFANT MORTALITY REDUCTION 4.ANKUR PROJECT 5.CASE STUDY 6.CHILD HEALTH 7.GADCHIROLI 8.MAHARASHTRA 9.VISTAAR PROJECT.

11. Mohan, Pavitra et al. (2003).
Daily up down : why would an Auxiliary Nurse Midwife (ANM) of Rajasthan prefer to reside within her work area ?. Udaipur : ARTH, Action Research and Training for Health. 24 p.

Abstract : Rural communities in India receive primary health care from a range of formal and informal providers. The present study was done to understand the underlying factors that affect ANMs' (Auxiliary Nurse Midwives) decision on where to reside - a decision that was critical in determining their availability to serve communities. The study was conducted in four blocks of Udaipur district, Rajasthan. Data was collected through interviews from 294 sub-centres of 4 selected bocks. Almost 231 ANMs were assessed in the study. Only 38% lived in a village of the sub-centre area, and the remaining 62% lived either in a town or a distant village. Almost all the ANMs were married and had children. A large proportion of ANMs (39%), irrespective of their place of residence, lived alone –

they managed their homes without family support. In almost all sub-centre areas, at least one village was connected by a metalled road. In spite of this, it was not easy to commute to the town in times of need. Most sub-centre areas had primary schools, but less than 24% had a middle or secondary school. While 81% sub-centres had their own building, 46% lacked residential accommodation. Almost 99% sub-centre villages had electricity and 25% had piped water. Most ANMs, irrespective of residential status, referred to difficult living conditions such as poor quality of sub-centre accommodation, and non-availability of essential items and amenities. Around 67% ANMs perceived their sub-centres to be unsafe for living. Some ANMs, both resident and non-resident, reported that they themselves had been harassed or intimidated at least once during their professional life. Most ANMs reported that supervisors did not attempt to solve problems related to their working conditions or place of stay. Despite all difficulties, staying within the sub-centre area did offer the ANM some advantages. They mentioned time and money saved on travel, lower living costs in the village, and the benefit of better rapport with the community as some advantages. It was found that a network of 27 ANM training schools provided pre-service training to ANMs in Rajasthan, and their annual capacity was 1620. Any girl who had completed higher secondary school was eligible for admission. Active effort by non-government and government organizations would enable ANMs to improve their living and working conditions, as also empower communities to hold them accountable for delivering reproductive and child health care services.

Key Words : 1.HEALTH 2.AUXILIARY NURSE MIDWIFE 3.LOCAL RESIDENCE 4.RESIDENCE OF ANM 5.VISTAAR PROJECT

12. Nakkeeran, N. and Yesudian, C.A.K. (2006).
Transfer of home-based newborn care from SEARCH to other organizations : process documentation of the ANKUR project (2001-2005). Mumbai : Tata Institute of Social Sciences. 76 p.

Abstract : Child health is an important area, which cannot be neglected. Society for Education, Action and Research in Community Health (SEARCH) started a project on Home Based Newborn Care (HBNC) with an aim to reduce IMR. HBNC thus conducted a 5 year phased study between April 1993 to March 1998 in Gadchiroli district of Maharashtra, which later on led to the inception of Ankur project in Maharashtra to reduce child mortality and morbidity. In the first year, which was the intervention phase, data collection and identification of pregnant ladies was done by Village Health Workers (VHWs); in the second year VHWs

were trained for HBNC – illness and neonatal sepsis; in the 3rd year VHWs gave health education to pregnant and other women. The study at Gadchiroli district revealed that 48% neonates suffered from high health risks, 93% received HBNC, Neonatal Mortality Rate (NMR) decreased from 62 to 25.5 in the intervention area, Neonatal sepsis also decreased from 16.6% to 2.8%. On the basis of these facts and study, SEARCH initiated Ankur project – a study of child mortality with 13 NGOs which covered a population of 226, 904 in 231 villages and 6 slums in Maharashtra. Ankur's study confirmed that NMR is still 75% of the Infant Mortality Rate (IMR). This process documentation study aimed at documenting the process of HBNC and Ankur's development. The study was done by Amhi Amachya Arigyasathi (AAA) for tribal areas, Indian Social Service Unit of Education (ISSUE) for urban areas and Sahyog Nirmitee (SN) for rural areas. Hence transferring HBNC expertise to Ankur's NGOs involved planning, project manual, micro planning, training material, curriculum, method, pattern and evaluation. In the implementation of Ankur project, delivery of HBNC was very important. It included health education, involvement of trained Traditional Birth Attendants (TBAs), VHWs, Project Coordinators and monitoring villagers to increase their participation in HBNC. The VHWs of HBNC were divided into 3 categories – medical, non-medical and communicators (persons with good interpersonal skills). Ankur covered 98.2% of total population taken. The VHWs performed following activities in relation to Mother and Neonatal care: a) preparation of list of eligible women, b) registration of these women; c) attending and recording deliveries; d) examining babies in 30 seconds/ 5 minutes/ within 6 hours; e) making home visits; f) recording still births, births and deaths within the neonatal period; g) giving injections of Vitamin K to newborns; and h) treatment of fever, aches and pains in community members. The impact was seen on Maternal and Child Health (MCH) after the project started. It recorded and highlighted the best Antenatal care (ANC) practices, diet and post natal care, which could be replicated elsewhere. 64% deliveries took place in hospitals in areas where ISSUE worked. VHWs were trained in neonatal care, cord care, eye care, best practices and breast feeding. HBNC also introduced management of pneumonia in children. It also dealt with myths and facts related to this disease. Other clinical conditions which HBNC catered to were – neonatal sepsis, hypothermia and high risk babies. It was recommended that HBNC can be extended to poor, tribal, rural and urban communities; HBNC can be included in public health systems; VHWs can be equipped with medical skills' at primary level; and community participation in HBNC can be strengthened.

Key Words : 1.HEALTH 2.NEWBORN CARE 3.INFANT MORTALITY REDUCTION 4.ANKUR PROJECT 5.TRAINING FIELD FUNCTIONARIES 6.VISTAAR PROJECT.

13. Paranjpe, Priya et al.(2006).
Training for home based newborn care (2001-2005) : a report on the contents and processes of training development for the replication projects. Gadhiroli, Maharashtra : SEARCH, Society for Education Action and Research in Community Health. 54 p.

Abstract : The Newborn Mortality Rate (NMR) of India has not shown significant drop. Home Based Newborn Care (HBNC) is an effective approach developed by SEARCH (Society for Education, Action and Research in Community Health) Gadchiroli, which included 39 villages of Gadchiroli district, Maharashtra, that brought down MMR by 70% and IMR by 57% from 1995-2003. The research design included 39 intervention villages and 47 control villages. The 3 year study was divided in 3 phases; 1st phase – registration phase, 2nd phase – training phase, 3rd phase – implementation phase. The successful implementation of this project led to the inception of ANKUR project with collaboration of 7 NGOs in Maharashtra, and ICMR is also replicating the HBNC approach in 5 Indian states – Rajasthan, Uttar Pradesh, Bihar, Maharashtra and Orissa. SEARCH master trainers trained the ICMR trainers, who in turn trained Traditional Birth Attendants (TBAs), 251 Shishu Rakshaks (new recruits) and 266 AWWs; a total of 517 health workers are now providing services to mothers and newborns. Training was based on practical experience and with standardized methods like newborn checklists, newborn illnesses, giving injections, etc. Community Health Worker (CHW) played an important role in networking, and 101 CHWs were recruited. The job of trainers was to develop curriculum, flip charts and health education film 'Tahula' in Marathi and 'Nanhi si Jaan' in Hindi. Training was for a 12 month period, covering 17 learning modules. The total duration of training was 31 days spread over a period of 1 year. Under Ankur project, Neonatal Care Supervisor (NCS), a health professional, and a Vital Statistics Supervisor (VSS) were responsible for hiring trainers. Another important aspect of the HBNC training method was Training Of Trainers (TOT), preparing competent trainers, and introducing them to the concepts of supervision, use of data, etc. To check the competency level, Ankur's training evaluation (early 2003) was conducted with a written exam, basic skill tests, quality of work, and field evaluation. 84 out of 92 CHWs who were evaluated were found to be competent, the average NCS score was 85% and VSS score was 68%. Major findings on CHW performance highlighted that CHWs performed at very high levels, 77.4% successfully evaluated antenatal delivery, and 77.5% were successful in post delivery evaluations. To maintain the sustained high level of knowledge and skills continued/ refresher training was given, the entire training so far has gone through 3 cycles, and it was tested at 12 different sites. HBNC programme also improved the self esteem of TBAs, and CHWs which also helped in women's empowerment. However, they were not confident about performing skilled tasks

like giving injections and carrying out neonatal assessments. The entire HBNC Project was designed such that site specific innovations could be incorporated as and when required. The model developed by SEARCH can be replicated to bring down IMR and MMR in other regions as well.

Key Words : 1.HEALTH 2.NEWBORN CARE 3.INFANT MORTALITY REDUCTION 4.INFANT MORTALITY 5.ANKUR PROJECT 6.TRAINING ANKUR PROJECT 7.GADCHIROLI 8.MAHARASHTRA 9.VISTAAR PROJECT.

14. Save the Children, Westport, USA. (2008).
State of the world's mothers 2008 : closing the survival gap for children under 5. Westport, Connecticut, USA : SC. 48 p.

Abstract : More than 200 million children in the world under 5 years do not get the basic health care they require, and the poorest children are the most vulnerable. This report covered 173 countries reaching children with basic health care, and outlined the best low cost health care practices adopted. In India 67,127,000 (53%) children do not get basic health care, and a poor child is three times more likely to die than a rich child because of greater exposure to unsafe water, poor sanitation, indoor pollution and inadequate housing conditions. They are more likely to be born with low birth weight, and become malnourished. The study also found that the poor parents often lack of knowledge of healthy practices and life saving services available. Also, staffing pattern, supervision and supply logistics are more difficult to reach in remote, impoverished and hilly areas. It was observed that national average of under 5 mortality rate per thousand live births was 76 in India in 2006, and the annual number of births was 27,195,000 in 2006. It was also observed that even with better infrastructure, disadvantaged ethnic groups sometimes faced unsympathetic or hostile providers, which in turn deters them from seeking prompt health care. The biggest killers of children worldwide are complications among newborns, pneumonia, diarrhoea and malaria. Child survival is one of the most long standing challenges facing the world, but “Child Survival Revolution” prompted the use of low cost basic health care interventions to prevent the major causes of infant and child mortality, and the number of child deaths are steadily declining. Now it is below 10 million for the first time. The study reported that India has the world’s largest child survival gaps between boys and girls. 61% of the children who die between the ages of 1 and 5 years are girls, which means that for every 5 boys who die, 8 girls die. While India has cut its overall child mortality rate by 34% since 1990, the survival gap between girls and boys has widened. The study also found progress in child survival and reduction in female mortality, but this was counterbalanced by female infanticide and sex-selective abortions. It

was estimated that 500,000 girls are missing each year in India due to sex selective abortions and infanticide. It was observed that 60 million mothers in the developing world gave birth at home with no professional care, and only some of the mothers and babies in high mortality settings receive postnatal care in the first few hours, days and weeks. In India, community health workers have been trained to treat infections, resuscitate asphyxiated newborns and care for low birth weight babies. As a result, newborn mortality rates in targeted areas declined by 50-60 percent. The Government of India now plans to replicate home-based newborn care throughout the country. It was suggested that health outreach strategies and funding allocations must target the hardest to reach mothers and children who are most in need. More funding is needed for staffing, transport, equipment, medicines and health workers training. More health workers should be trained and equipped to deliver basic health care services.

Key Words : 1.HEALTH 2.MATERNAL MORTALITY 3.INFANT MORTALITY 4.CHILD MORTALITY 5.CHILD SURVIVAL 6.MATERNAL AND CHILD HEALTH 7.SAFE MOTHERHOOD 8.CHILD HEALTH 9.HEALTH SERVICES 10.NEW BORN CARE.

ICDS

15. Anitha, C. and Begum, Khyrunissa. (2008).
Nutritional status of beneficiaries of ICDS in Mysore district : a situational analysis. Mysore : Karnataka State Open University, Department of Studies in Foods and Nutrition. 9 p.

Abstract : This study was conducted in Mysore district of Karnataka to assess the nutritional status of child beneficiaries. Ten per cent (281) of all the functioning AWCs from 12 taluks were selected, and 3425 child beneficiaries from 281 AWC were assessed for nutritional status. It was found that the children were considerably shorter and lighter than their American counterparts (50^{th} centile of NCHS data), and were nearer to 3^{rd} centile of NCHS standard. The percentages of normal grade children were 6.4% to 31.4% among males and 14.0% to 36.0% among females according to Gomez classification. Percentage of children in Grade III (severe malnutrition) ranged from 0.7% to 6.5% in both males and females. Comparison of the observed and recorded data (by AWW) for classification into grades of malnutrition found an exaggeration in the number of normal and Grade I children according to AWW. Hence it raises doubts regarding the competence of the AWW in performing nutrition surveillance.

Further, use of Indian Association of Pediatrics (IAP) classification was found to carry an in-built lacuna for exhibiting normal and Grade I at an exaggerated rate, and a concomitant decrease in Grade II and Grade III states of malnutrition. Use of 80% as the cut off level for classification of normal nutritional status according to IAP is not feasible, as it gives way to poor functional development in children. Hence it fails to project the actual state of nutrition. Deficiency symptoms of nutrition observed were flat nails (0.8-15%), night blindness (1.4-4.4%) and conjunctival xerosis (1.5-6.7%). Prevalence of anaemia in mild, moderate and severe conditions was 21%, 37% and 23% respectively, while 17.5% had normal haemoglobin level. It can be mentioned that the nutritional status of child beneficiaries has not improved to an appreciable level since the per cent of children in mild and moderate under nutrition is still high. Competence of AWWs for nutritional surveillance is doubtful, indicating the need for an intensive training programme to improve their performance.

Key Words : 1.ICDS 2.NUTRITIONAL STATUS ICDS BENEFICIARIES 3.ICDS BENEFICIARIES 4.PRESCHOOL CHILDREN 5.NUTRITIONAL STATUS PRESCHOOL CHILDREN 6.MALNUTRITION 7.MYSORE 8.KARNATAKA.

16. Dash, N.C. et al. (2006).
Impact assessment/ evaluation of ICDS programme in the state of Orissa. Bhubaneswar : Centre for Rural Development. ~170 p.

Abstract : This study was conducted in Orissa to evaluate the ICDS programme. A total of 250 villages/ AWCs were covered. 12,621 children under 3 years, 12,468 children 3-6 years, 2221 pregnant women, 2686 lactating mothers and 13908 AGs comprised the sample. It was found that supplementary feeding was usually given for 25 days in a month and was considered adequate by over 96% of the mothers of beneficiary children. 92% mothers mentioned that the quality of food was good. 60% mothers of non-beneficiary children considered supplementary feeding to be useful for the better health and nutritional status of children. Over 92% of the beneficiary children received 3 doses of immunization against DPT/ Polio. The immunization coverage for measles was 96%, and over 96% of them had received BCG immunization. Around 26.32% children of 9-12 months had received complete immunization. Almost 9 out of 10 mothers of beneficiary children mentioned that their children had been administered Vitamin A supplement against 77% of non-beneficiary children. 80% mothers mentioned that AWWs were capable of treating minor diseases. Nearly 73% mothers of

beneficiary children had received treatment/ health services from AWWs. Nearly 60% mothers of non-beneficiary children mentioned that they had been visited at home by the AWW within 1-3 months. Over 99% mothers of beneficiary children aged 3-6 years mentioned that they were sending their children for Preschool education (PSE). Among pre-school children, the proportion of female children (53%) was more than that of the males (47%). It was found that 8 out of every 10 lactating mothers mentioned that they did not receive any IFA tablets from the AWCs. 93% of the pregnant women mentioned that they had received at least 1 antenatal checkup, but only 22% of the pregnant women received 3 health checkups. Around 76% of the pregnant women mentioned that they received supplementary food. The Take Home Ration (THR) was usually shared with other members of the family (49%) and children (29%). About 90% pregnant women received IFA tablets supplied mostly by AWWs (75%), followed by ANMs (14%). It was found that home (58%) was the common place of delivery, followed by hospital (39%), and family members (21%). Traditional Birth Attendants (22%) and ANMs (7%) had been the birth attendants at home. 57% of the women faced obstetric complications during delivery and they were referred to First Referral Unit (FRUs) such as PHC (34%), District Hospital (30%) and Sub-Centre (7%). 99% of the AGs mentioned that vocational training was hardly addressed by AWWs. 88% of them said there was no Balika Mandal in their village. About 70% AGs were familiar with the symptoms of anaemia. About 60% of the children were found to be malnourished, 40% children had mild, 18% moderate and 0.6% had severe malnutrition. Female children (64%) were more malnourished than male children (54%). The nutritional status of beneficiary children was better than that of non-beneficiary children. 59% of the beneficiary children were malnourished compared to 69.9% of the non-beneficiary children. 92% AWWs could take the weight of children correctly and 90% were capable of maintaining growth charts. 96% AWWs provided HNE to target groups. They faced problems of irregular supply of food (12%), irregular supply of drugs (12%), and extraneous work assignments such as formation and grading of SHGs, survey works, preparation and distribution of emergency feeding, etc. Referral units were found to be suffering due to non availability of funds. The amount earmarked for the purpose, Rs. 10,000 per annum, was considered too small an amount and was found largely unspent. The medicine kit was hardly replenished on a regular basis. The lady village level workers, particularly in Balasore district, were deputed to the post of sector Supervisors, and they were neither conversant with the programme nor motivated. Maintenance of Records and Registers, updating and compiling them for monitoring progress was an uphill task for low educated AWWs, mostly in tribal areas. Health workers were not properly oriented to the concepts of ICDS scheme. Joint orientation of Health and ICDS workers would ensure mutual reciprocity and accountability. The funds earmarked should be enhanced. The medicine kits provided to AWWs need to be regularly replenished. A special campaign to enroll children with disability for PSE should

be launched. The convergence for antenatal and post-natal care and referral should be strengthened.

Key Words : 1.ICDS 2.EVALUATION OF ICDS ORISSA 3.TRIBAL ICDS PROJECTS 4.NUTRITIONAL STATUS PRESCHOOL CHILDREN 5.MALNUTRITION ORISSA 6.ICDS SERVICES 7.ORISSA.

17. Iyengar, Sharad D. and Mohan, Pavitra. (2000).
Nutritional status of rural preschool children in southern Rajasthan. Udaipur : ARTH, Action Research and Training for Health. 59 p.

Abstract : This study was conducted in five blocks of southern Rajasthan namely Salumber, Malvi, Kotra, Abu Road and Reodar to assess the nutritional status of children younger than three years, and to compare the nutritional status of children who were beneficiaries of the ICDS programme with those who were not. It was found that 89.1% of mothers had received no formal education. In poor rural areas, women were known to endure heavy work burden while getting far less to eat. 35.1% women did not know where the AWC of their village was located. A total of 1061 (23.1%) women had received Supplementary Nutrition (SN) from the AWC during pregnancy, but most of them shared it with the family. 44.8% children would have been listed as beneficiaries had the ICDS guidelines been followed, but only 6.8% were in fact listed as beneficiaries, and the targeted beneficiaries list was only about 15.1%. Salumber block had the highest programme effectiveness and Kotra district had the lowest having inadequacy of both, targeting and the quality of record keeping by AWWs. 76% of the infants were breast-fed during the first six months, and 13% infants received plain water in addition to breast milk. Almost 19.8% infants were not being given any weaning food at the end of 11 months of age. Only 49% had received any top feeds over the past 24 hours preceding the survey. Among children aged 6-11 months milk products were the most commonly consumed complementary foods. However, 64% of these children had received milk diluted with water. Cereals were consumed by less than 25% infants aged 6-11 months. 16.3% children had received supplement nutrition from the AWC in the past month. There was high morbidity among the children of these five blocks. 48% children had suffered from fever, cough or diarrhoea. The prevalence of illness was higher in children 6 to 24 months, after which it reduced. 65.4% children sought treatment for their illness, generally from locally available private or government sources. Immunization levels were found to be very low in all five blocks. Only 6.8% children in the age group 12 to 23 months had received all vaccines. Coverage for three doses of DPT and measles was very low. 26% children had not

received three doses of OPV, despite the on-going pulse polio campaign. Complete immunization was rare, and immunization cards were not given out to the beneficiaries. Around 48.1% (49.4% boys and 46.5% girls) from birth to three years of age, suffered from stunting, and 19.4% children (21.4% boys and 17% girls) suffered from wasting. There was no significant difference in the prevalence of wasting or stunting between beneficiaries and non-beneficiaries as the numbers were too small for comparison. There was high prevalence of illness, particularly among children between 6-23 months. Those who additionally received top feeds were poorly nourished compared to those who were on near exclusive breast feeding. After around twelve months mothers offered solid foods prepared for adults to their children, in addition to diluted drinks. Children did not consume these foods. Mothers invested far less time in actually feeding complementary foods as compared to breast feeding. As many as 40% of all mothers ate less food than usual during the index pregnancy. Contact with the primary health care system was limited if one went by the levels of complete immunization. A low level of routine contact with health care providers made it less likely that early malnutrition could be detected and treated by them.

Key Words : 1.ICDS 2.NUTRITIONAL STATUS PRESCHOOL CHILDREN 3.MALNUTRITION PRESCHOOL CHILDREN 4.BREASTFEEDING 5.COMPLEMENTARY FEEDING 6.INFANT AND YOUNG CHILD FEEDING 7.WASTING 8.RURAL PRESCHOOL CHILDREN 9.RAJASTHAN 10.VISTAAR PROJECT.

18. Right to Food Campaign Madhya Pradesh Support Group, Bhopal. (2006). Sheopur disaster : An alert note on death of children in Patalgarh. Bhopal : RFCMPSG. 12 p.

Abstract : This study was conducted in Patalgarh village situated in Sheopur, a Saharia tribe dominated district of Madhya Pradesh. It is an isolated interior village lacking even basic infrastructure facilities. Media reported that a large number of children were malnourished in Patalgarh, and some children had passed away due to malnutrition and illness. There were 120 Sahariya children aged 2-10 years in the village, of whom 13 died and 80 children developed post measles complications. Parents mentioned that the children did not have enough food to eat during the course of their illness. There was no AWC in Patalgarh village and the nearest AWC was situated 17 kms away in Hirapur village. Total population of the village was 580 and only 70 Antyodaya Anna Yojana cards were issued. Those who had cards had to travel a distance of 17 kms to bring ration, and when they went to the Fair Price shop, they either found the shop

closed or the shop owner said that their share of ration had not arrived. They got 20-25 kg of their share of ration instead of 35 kg. None of the social security schemes had been implemented in the village. They had not received any help from the Government. None of the widows in the village had received Widow Pension. According to Regional Medical Research Institute of Tribals in Jabalpur, 93% of the Sahariya children were malnourished and 15% were almost on the verge of death. The Malnutrition Elimination Campaign was conducted in 5 phases. In the first, second, third, fourth and fifth phases the number of malnourished children were 63.72%, 58.28%, 61.30%, 61.36% and 60.54% respectively. In Madhya Pradesh, out of the 10,618,323 children aged 0-6 years, only 2,334,789 were enrolled under the SNP - a mere 22%. While the norm for the average number of children to be enrolled per AWC was 80, only 57 were actually enrolled. Similarly, while the norm set for pregnant mothers was 20 per AWC, only 15 were actually enrolled. State officials mentioned that inadequate allocation of funds was a major issue for the persistence of malnutrition. The Annual Report 2002-03 of the Planning Commission showed that funds needed for the SN programme for children aged 0-4 years and mothers in Madhya Pradesh was Rs. 211 crore. However, only Rs. 59 crores had been made available by the State Government. The Centre had also set a norm of Rs. 1 per beneficiary per day, but the State spent only 49 paise (Rs. 0.49) on each child daily. After immunization children started vomiting and had diarrhoea because their resistance was so weak. There is need to improve the quality of immunization. Sick children should be segregated from healthy children.

Vitamin A should be administered and good antibiotic medicines should be given to sick children. The Government should accept the reality of malnutrition deaths with seriousness, and make sincere efforts to force the various departments and administration to work with the people, which in turn would pressurize them.

Key Words : 1.ICDS 2.MALNUTRITION DEATHS 3.CHILD DEATHS 4.CHILD MORTALITY 5.LACUNAE IN ICDS 6.HEALTH SERVICES.

LABOUR

19. Sekar, Helen R. (2008).
Vulnerabilities and insecurities of informal sector workers : a study of street vendors. Noida : V.V. Giri National Labour Institute. 156 p.

Abstract : Street vendors have an important role in the informal economy and their contribution is significant. Globally, over 25% of the workers operate in the

informal sector. There are over 1 crore vendors in India contributing to over 50% of the country's savings, and 63% of the GDP comes from vendors. Despite their contribution, vendors are seen as 'encroachers' and as a 'public nuisance' who obstruct traffic. The study on street vendors was conducted in Noida and was limited to informal vendors who do not have any fixed premises. They were broadly classified into three categories a) vending in fixed locations; b) vending in weekly bazaars, where location changes every day; and c) mobile and door to door vending. The sample size was 518, constituting 77% males and 23% females, and included child vendors. There were fewer female vendors and many of them earned less than their male counterparts because their vending hours were restricted due to domestic work and cultural reasons. The objective of the study was to understand and unravel the status and special vulnerabilities and insecurities of vendors. It was observed that vendors faced several problems because many of them were illiterate, ignorant and poor; no specific areas/ zones have been allotted for the purpose of vending which reflects the attitude of Noida Authority towards them; and the Government has no scheme for those who try to earn their livelihood through vending in the absence of employment. It was observed that in the case of 98% vendors vending was the only or primary source of household income. 67% of the vendors were from more disadvantaged socio-economic groups. The study identified various problems that were affecting street vendors such as police and local government harassment; confiscation and impoundment of goods; legal illiteracy among vendors (authorities take advantage); too small vending sites; availability of space is inversely proportional to the number of vendors; problems with allocation systems of vending sites, problems with permit system in limited vending areas; lack of facilities (e.g. shelters, storage); power struggles among market pradhans and their false promises; lack of unity among vendors, etc. It was suggested that laws on street vending should be enacted and existing laws should be reviewed in the light of Constitutional Rights to earn one's livelihood. Skill training should be imparted to vendors who want to move out of street vending into higher income earning economic activities. Efforts should be made to organize vendors to form a National Alliance of Street Vendors so that they can unite and speak in one voice to the municipalities and National Government. In order to deal with the problem of inaccessibility to credit, self help groups of women vendors should be constituted so that they could raise bank loans and also be targeted for group insurance schemes.

Key Words : 1.LABOUR 2.STREET VENDORS 3.FOOD HAWKERS 4.FOOD SAFETY 5.VENDORS 6.STREET FOOD 7.UNORGANIZED SECTOR 8.MIGRANT WORKERS 9.CHILD LABOUR VENDORS 10.NOIDA 11.UTTAR PRADESH.

20. Upadhyay, Vandana. (2007).
Employment and earnings in urban informal sector : a study on Arunachal Pradesh. Noida : V.V. Giri National Labour Institute. 92 p.

Abstract : The present study was carried out to know the nature and quality of employment in the urban informal sector in Arunachal Pradesh. Both primary and secondary data sources were used. Primary data was gathered from 150 selected enterprises in three urban localities of Itanagar, Nirjuli and Naharlagun. The variety of enterprises covered in the survey were auto repairing services (16%), hotels and restaurants (9.3%), petty trading in vegetables (6.7%), fabrication units (10%) and furniture shops (10%), etc. 12.7% of the enterprises were less than one year old, 38% enterprises were 2-5 years old, 30% enterprises were 6-10 years old, and the remaining 19.3% were more than 10 years old. 39.3% were Own Account Enterprises (OAEs), while the remaining 60.7% were establishments, employing at least one hired labourer. In the retail trade and hotels and restaurants group 58.3% were OAEs, 75% enterprises in transport and communication were OAEs, and 20% of the enterprises in manufacturing and processing were OAEs. 18% of the enterprises were operating without premises and these were mainly involved in transport, petty trading in textiles and vegetables. Of the total enterprises surveyed, 19.3% operated without any electricity and the rest had access to electricity. 32.0% of the enterprises operated with only one worker, 24% employed between 2 to 3 workers, 26.7% employed 4 to 5 workers, and 17.3% employed 6 to 9 workers. 18% of the enterprises were managed by female entrepreneurs. 42% of all enterprises in the category retail trade, hotels and restaurants were owned and operated by females; 21% of the total were owned by scheduled castes, and the rest by others. 9.3% of the entrepreneurs were illiterate, 5.3% had studied up to Class 11 or 12, and 1.3% had studied beyond that. 79.3% of the entrepreneurs did not want to expand their operations. 32.3% of the total workers in this study were females. Migrants constituted 86.2% of the total workers. The mean working hours per day in different occupation categories were Construction 8.10, Rickshaw pulling 9.70, Auto repair 8.85, Hotel and Restaurants 8.65, Petty trading 6.90, Domestic service 7.60, IT and Communication 8.33, Handicrafts 7.86. 98.5% of the informal sector workers did not have any paid leave. 68% received their wages in cash and 32% got their wages partly in cash and partly in kind. 60% received their wages on monthly basis, 19.4% received daily wages, 16.3% got weekly salaries, while 4% workers received irregular payments. 50% of the recruitments were done on the basis of personal contacts, and 45% of the contacts were made through relatives and friends. Only 4% of the recruitments were through agents or *sardars*. 55% of the workers have not changed their employers during the past one year, but 19.4% changed employers very frequently. Female workers, on an average, earned Rs. 2242 per month, while

male workers earned Rs. 2685 per month. Self employed workers in the informal sector earned Rs. 2837.50 per month, while hired workers earned Rs. 2445 per month. It was suggested that credit facilities should be available to entrepreneurs in the informal sector on the same terms as is given for modern enterprises. There is an urgent need to make provisions for their welfare through awareness building as well as meaningful state support. There is a special need for safeguarding the rights of migrant workers.

Key Words : 1.LABOUR 2.INFORMAL SECTOR 3.URBAN INFORMAL SECTOR 4.INCOME 5.URBAN AREAS 6.MICRO ENTERPRISES 7.ARUNACHAL PRADESH.

LEGISLATION

21. Jaisingh, Indira, Sathyamala, C. and Basu, Asmita. (2007).
From the abnormal to the normal : preventing sex selective abortions through the law. New Delhi : Lawyer's Collective, Women's Rights Initiative. 184 p.

Abstract : Sex pre-selection and sex selective abortions pose challenges to the legal system which call for the harmonization of the right to abortion with the prohibition against abortions based on sex of the foetus alone. The overall objective of the study was to critically examine provisions of the law and to provide recommendations for its enhanced effectiveness. The study was conducted in Delhi. Of the 1071 questionnaires sent to the verified registered units, there were 112 (10.5%) responses. Except for the districts of South West (6.6%), Central (4.3%) and New Delhi (which had only 12 units registered), the units responding to the Owners' Questionnaire were proportionately distributed over the districts. About 80% of the units were reportedly owned by men and a little more than 20% were owned by women. 12 of the 112 owners did not have any medical degree; and three Trusts did not respond to the questionnaire as it did not apply to them. 9% of the owners with medical qualifications had a non-allopathic degree (BUM, BAMS, BHMS, etc.); and the rest (91%) had a basic MBBS degree; 13% had a diploma in gynaecology/ radio diagnosis/ child health, etc. and 59% had post-graduate Masters qualification (MD/MS). Only a small proportion (5.2%) of the units had registered themselves under the Act, and the bulk of the registration (47.3%) took place only in 2002. 26% did not know the date of registration. Owners of 93 units (83.8%) affirmed that their units provided pre-natal diagnostic tests. The dominant practice appeared to be a single clinic, with 32 (60%) of the respondents functioning from one clinic only. 8 respondents

visited 2 clinics, 12 (23%) attended to patients from 3 or more than 3 clinics. Thus 52 gynaecologists practiced in 90 or more units. 70% of the respondents claimed that 100% of their patients were self-referred and 14% claimed that half of their patients were self-referred. 60% of the respondents stated that 50% of the pregnant women they attended were from the same locality. 70% women who enquired about the sex of the unborn child were women themselves, followed by other family members (50%), and in 20% of the cases it was the husband who enquired. All the 51 gynaecologists in the survey, who responded to the question on the law, stated that they had read the PCPNDT Act, but 14% of them were not aware of the Supreme Court judgment. 28% radiologists stated that they conducted the sex determination test, and 12% vigorously objected to the question itself. Almost all radiologists (95%) were found to be correctly maintaining Form F while conducting pregnancy related tests in consonance with the Act and Rules. 37% radiologists enquired about the number and sex composition of the children. 60% of the women respondents stated that there was no expectation to bear a male child. 70% did not name any person who had such expectations. The single reason for son preference (26%) was that sons would carry on the family name. 78% of the women were aware of the law against finding out the sex of the foetus. 67% of the respondents were of the opinion that a women should have the right to abort a foetus. It was recommended that ultrasound is not indicated/ advised/ performed to determine the sex of the foetus except for diagnosis of sex-linked diseases such as Dudhenne Muscular Dystrophy, Haemophilia A and B, etc. Both sonologists and radiologists should be allowed to conduct ultrasound tests under the Act. The Act and Rules should provide for the individual registration of doctors/ medical professionals in addition to the registration of units as a whole.

Key Words : 1.LEGISLATION 2.FEMALE FOETICIDE 3.SEX SELECTIVE ABORTION 4.SON PREFERENCE 5.ABORTION 6.GIRL CHILD.

NUTRITION

22. Sharma, Anshu, Prasad, Kanti and Visweswara Rao, K. (2000).
Identification of an appropriate strategy to control anaemia in adolescent girls of poor communities. New Delhi : Nutrition Foundation of India. 7 p.

Abstract : Even today nearly 1.5 billion people all over the world are affected by iron deficiency anaemia (IDA). In India alone, depending on age and sex, IDA has been reported to range from 38-72%, majority of them being women and

children. The IDA prevalence rate beyond the age of 6 years increases in girls. This could be due to certain factors like menstruation, gender discrimination in intra household food allocation and early marriage leading to early pregnancy. Adolescent girls form 22% of the total population and estimates suggest that about 25-50% girls become anaemic by the time they reach menarche. Absorption from a single dose of iron supplementation reduces from 30-40% on the first day to as low as 3-6% after a few days of continuous daily administration of iron supplements. The present study was therefore conducted to obtain baseline data on haemoglobin (Hb) levels of adolescent girls belonging to low socio-economic groups; investigate the comparative efficacy of once 'weekly' and 'daily' administration of iron-folate tablets with respect to impact on the Hb levels; and find out the effect of added ascorbic acid supplementation. The subjects were divided into the following three treatment groups: Group 1: 1 tablet of iron folate (100 mg elemental iron + 500 mg folate) once weekly; Group 2: 1 tablet of iron folate Vitamin C (100 mg elemental iron + 500 mg folate + 25 mg Vitamin C) once weekly; Group 3: 1 tablet of iron folate (100 mg elemental iron + 500 mg folte) daily. Children were administered tablets after lunch. The Hb level of a total of 520 urban girls and 185 rural girls was tested and the Hb status of urban girls was found to be better than that of rural girls. The percentage of girls with Hb less than 12g/dl in the urban sample was 61.9% as against 85.4% in the rural sample. Only 38.1% urban girls and 14.6% rural girls had Hb levels more than 12.0 g/dl. Prevalence of anaemia was lower in taller and heavier subjects. Weekly iron/ folate supplementation improved Hb by 0.62 g/ dl at 3 months and 0.79 g/ dl at 6 months. Iron/ folate/ Vitamin C supplementation increased Hb by 1.05 g/ dl at 3 months and 1.17 g/ dl at 6 months. However, daily iron/ folate supplementation was more effective than once weekly with an increase by 0.99 g/ dl at 3 months and 1.57 g/ dl at 6 months. Important findings that emerged from the study were children who were severely malnourished showed better absorption; to combat anaemia locally available GLVs (green leafy vegetables) could be used; and consumption of low cost sources of iron and Vitamin C rich fruits and vegetables needs to be advocated. Inclusion of Vitamin C in iron/ folate as part of a Public Health Operation may be recommended as it enhances the absorption of iron significantly, even weekly iron/ folate supplementation may be used in ICDS programme for less fatigue, better productivity, improved immune function, and reduced risk of reproductive failure and maternal mortality.

Key Words : 1.NUTRITION 2.ANAEMIA ADOLESCENT GIRLS 3.ADOLESCENT GIRLS 4.COMBATING ANAEMIA 5.INTERVENTION PROGRAMME ANAEMIA 6.VISTAAR PROJECT.

RURAL DEVELOPMENT

23. India, Ministry of Rural Development, New Delhi. (2007).
Monitoring and evaluation of rural development programmes. New Delhi : I-MRD. 167 p.

Abstract : The Tenth Five Year Plan adopted a set of quantifiable and monitorable targets which would enable us to focus on accelerating growth, not only as an end in itself, but also as the means to achieve success on other dimensions such as poverty reduction, employment creation and improvement in the quality of life. The Ministry of Rural Development implements various schemes for employment generation and alleviation of rural poverty and infrastructure development in rural areas. The Ministry has 3 Departments dealing with rural development, drinking water supply and land resources. The budget allocation for the year 2007-08 was Rs. 41,060 crores. The Government of India has brought in the National Rural Employment Guarantee Act (NREGA) to provide for the enhancement of livelihood security to poor households by providing at least 100 days of guaranteed wage employment in a year. The other major schemes under the Ministry are Swarnjayanti Gram Swarozgar Yojana (SGSY), National Food for Work Programme (NFWP), Sampoorna Grameen Rozgar Yojana (SGRY), Indira Awaas Yojana (IAY), Pradhan Mantri Gram Sadak Yojana (PMGSY), Watershed Development Programmes (WDP), Accelerated Rural Water Supply Programme (ARWSP), and Central Rural Sanitation Programme (CRSP)/ Total Sanitation Campaign (TSC). These programmes are for poverty alleviation, employment generation, area development and infrastructure development in rural areas. In 2007-08, the budget of the Ministry has been increased by 30.58%. Wage Employment in lakh person-days in the year 2006-07 under the major rural development schemes was 4,241 under SGRY/ NFWP/ NREGP; the number of beneficiaries assisted were 1,683,005; number of SHGs formed were 245,090; number of schools covered under ARWSP were 71,498; number of school toilets constructed were 132,124; and number of balwadi toilets constructed were 53,254. For proper monitoring and evaluation, Ministry of Rural Development has adopted a five pronged strategy of (i) awareness generation, (ii) people's participation, (iii) transparency, (iv) accountability and (v) strict vigilance. The Ministry has evolved a comprehensive multi-level and multi-tool system for monitoring and evaluation of its programmes at various levels. Findings indicate that during the quarter 114,030 works executed under SGRY were verified. 50.56% of the total works verified were found to be road connectivity, 12.38% related to socio-economic infrastructure, 10.16% were drainage works, 7.64% were soil and moisture conservation projects, 4.60% were drinking water projects, and 9.52% were classified as other

type projects. 91.55% of the verified works were found to be approved by Gram Sabhas, which was part of the annual action plan. Quality of the construction of 40.63% of the works was found to be 'good'. Only in 7.58% of the works was the quality found to be 'poor'. Only 1.09% of the works were abandoned due to various reasons such as shortage of funds, rejection of designs, disputes, etc. Under the Indira Awaas Yojana, till December 2006, 99322 houses were verified. 88.80% were new constructions and 11.20% were upgradations. 36.67% houses were allotted to male members of the household, 54.40% were allotted in the name of the female member of the household, and 7.93% were allotted jointly in the name of husband and wife. 77.55% of the beneficiaries were provided only cash for construction while in 21.07% cases cash and material benefits were given. The quality of construction was found to be average in 43.53% houses, good in 39.52% and poor in 7.16% houses. 65.10% houses had adequate ventilation, 58.70% houses had access to safe drinking water, and 46.22% houses had sanitary toilets. Only 16.49% had smokeless *chulhas* (stoves) and 32.89% IAY houses had electricity connection. Under the Swarnajayanti Gram Swarozgar Yojana 43282 SHGs were verified, with total membership of 452857 (62.85% females and 37.15% males). 34.71% SHGs had taken up economic activities, 8.55% had passed Grade II, 12.52% had passed Grade I and 44.22% groups were just formed. During monitoring it was found that 67.80% SHGs required training and 44.60% had been trained. 87.24% SHGs had found the training to be useful. 66.77% maintained Minute Books, 69.58% maintained Attendance Registers, 71.95% SHGs maintained Bank Pass Books, 59.23% SHGs maintained the Cash Book, and 59.66% SHGs maintained the Loan Register. 42.06% SHGs also maintained payment particulars. 62.68% Swarozgaris were involved in economic activities in the primary sector, 21.46% in the secondary sector, and 15.86% in the tertiary sector. It was also revealed that the Sarpanch/ village panchayat president played a significant role in the selection of individual Swarozgaris for assistance under SGSY. 42.98% individual Swarozgaris required training, however only 27.84% were given training and only 22.84% Swarozgaris found the training useful. It was suggested that the process of selection of beneficiaries should be transparent and unbiased. Bank credit facilities should be easily available for members. Long term strategies should be formulated to sustain the training, production and marketing initiatives. There is need to adopt an integrated approach to facilitate access to raw materials at reasonable prices for the development of a market.

Key Words : 1.RURAL DEVELOPMENT 2.PROGRAMMES RURAL DEVELOPMENT 3.RURAL DEVELOPMENT PROGRAMMES 4.EMPLOYMENT 5.RURAL EMPLOYMENT 6.HOUSING 7.WATER 8.SANITATION 9.TOILETS 10.EVALUATION RURAL DEVELOPMENT 11.MONITORING AND EVALUATION.

SOCIAL DEFENCE

24. Sachdeva, Suresh et al.(2007).
Birth of women dacoits : a case study of U.P. and M.P. : research proposal (with summary of research). Gwalior, Madhya Pradesh : Krestar Educational and Welfare Society. ~200 p.

Abstract : A study of women dacoits of the Chambal valley was undertaken to determine what special circumstances exist which pressurize women to take up dacoity. The purpose of the investigation was to see what special factors or circumstances made them choose this particular career in comparison to normal and other criminals of the same region. 5 districts of Madhya Pradesh and 3 districts of Uttar Pradesh were selected. Several sections of society, including young girls of Bhind, Morena, Sheopur, Gwalior, Shivpuri, Etawah, Kanpur and Orai were selected. The universe also included women dacoits imprisoned in the recent past who have been associates of Seema Parihar, Lovely Pandey, Sulekha Parbati, Babli, etc. 100 respondents were selected from each of the above mentioned districts for study. The first and foremost reason for the spread of dacoity in India is the population and fight for food, shelter, clothing, etc. Population increase has led to unemployment and this has forced people to take up dacoity and other crimes. Women are not given due respect and consideration as in the past, and males view women just as an object to satisfy their social, psychological and physical needs. All this has caused aggrieved women to break the chain of exploitation and take up arms. Financial imbalance could be another significant cause of dacoity as a majority of dacoits come from poor families. Rich people have ruled over poor people by taking away their lands, in lieu of loans, which the poor have to repay all their life without any delay or failure. Women were not allowed to take education above the primary level; in fact primary level education was also a dream for many women. Due to lack of education women did not get a platform to represent themselves in society. Unemployment in rural areas is rampant as there is no industrial or commercial set up, hence they take up some illegal activities for earning. Misbehaviour with women of rural areas by dacoits is another prominent cause of the birth of women dacoits. Often, when dacoits come to loot villages, they take away women for sexual assault. Subsequently, these women are not taken back by their families, so they have no option but to remain in the gang and act as dacoits. The study also reveals that many times women have to take up arms in order to take revenge for a wrong done to their family members, either by society or by dacoits. The study also revealed that sometimes women fell in love and eloped with dacoits. If a women has left home, she needs shelter, food, money for her needs, livelihood, etc. for which she starts doing small loots, robbery, etc.,

which ultimately leads to dacoity, and these women come to be known as *dasyu sundari* or women dacoits (like Kusma Main, Sarla Jatav, etc.). Further dacoits have no earnings other than collection of ransom from kidnapping. Sometimes money is also given by others to kidnap someone, with whom they have a grudge. This is known as *Supari* or contract job. The dowry system can also be traced as one of the foremost reasons for aggressive roles played by women. If the bride's father fails to pay the desired amount, the bride is tortured for her whole life by her in-laws. Dacoity and terrorism are two sides of the same coin. Terrorists also take help from dacoits, as revealed by the recent case of Gadariyas of Shivpuri region. Study also reveals that dacoits, after surrender and release from jail, take up politics as a career. Even politicians help dacoits indirectly in many ways. In turn, politicians are also helped by dacoits. Due to these kinds of crime, the younger generation is developing a negative image in their minds. To reduce crime and dacoity, it was recommended that first and foremost equality should be wide spread in our country. Education is the single most important input to reduce crime, dacoity, and the birth of bandits. Police system should be strong enough to protect civilians. A number of laws have also been promulgated for the protection of women; they should be implemented rigorously.

Key Words : 1.SOCIAL DEFENCE 2.WOMEN DACOITS 3.DACOITS 4.WOMEN CRIMINALS 5.FEMALE CRIMINALITY 6.UTTAR PRADESH 7.MADHYA PRADESH.

SOCIAL WELFARE

25. Ashok Kumar, et al. (2007).
Database on voluntary organizations : a compilation. New Delhi : NIPCCD. 476 p.

Abstract : The present study on voluntary organizations (VOs) was undertaken to evolve a mechanism for interacting regularly with voluntary organizations; identify their capacity building needs; and assess the requirements of voluntary organizations. Data was collected from 330 voluntary organizations from all states of India. The areas of information sought from these organizations were basic information, areas of interest, broad thematic areas in which they are functioning, capacity building initiatives, training needs, annual budget, nature of community support, availability of infrastructure facilities, types of publications bought out and areas of professional expertise. Out of 330 voluntary

organizations, maximum number of organizations were from Tamil Nadu (19.39%), Andhra Pradesh (14.85%), Uttar Pradesh (9.39%), West Bengal (8.79%), Orissa (6.39%), Delhi (5.15%) and Rajasthan (4.85%). The responses from the remaining States/ Union Territories were quite meagre. Maximum number of organizations (50%) were established during 1986-95. Around 312 voluntary organizations (94.5%) were registered under one Act or another, and as many as 18 voluntary organizations (5.45%) did not indicate their registration status. Over half of the organizations (50.32%) reported that they were carrying out health related activities such as community health services, health education, health check-up, health camps, RCH, HIV/ AIDS, etc. As many as 146 voluntary organisations (46.5%) mentioned that they were engaged in carrying out vocational training, skill development and employment generation programme. Around 42% organizations were involved in implementing educational programmes like non-formal education, formal education, adult education and computer education. It was gathered from 114 voluntary organizations that they were carrying out activities related to women's rights, women's empowerment, mother and child care and various women related issues. It was found that 93.64% voluntary organizations were engaged in providing training. Around 76.97% voluntary organizations were engaged in advocacy work, 65.15% in developing networks, 44.85% in fund raising, and 41.82% provided assistance to others. About 77% voluntary organizations were working with women as their target group, 60% were working with children, the target group of 14% voluntary organizations was girls/ adolescents, and 7% were working with child labour/ street children/ orphan children. Around 90% voluntary organizations mentioned that their area of interest was women's empowerment, 72% mentioned child health and nutrition their area of interest, and 78.48% expressed that vocational training/ skill development was the most important area for them. About 91.2% voluntary organizations considered training to be the most used initiative for capacity building of their staff. Maximum number of VOs (17.88%) had a budget of Rs. 1 lakh and 5 lakhs (1 lakhs = 0.1 million) 12% had a budget between 5 to 10 lakhs, 10.91% had a budget between 10 – 15 lakhs, and only 2.12% had a budget between Rs. 5 crore and more (1 crore = 10 million). Around 215 VOs mentioned that they received community support mainly in the form of labour, cash and kind. Several techniques were used for fund raising such as mailers, appeals, sponsorship, donation boxes, etc. Funds were also gathered through loans/ rent/ bank interest/ *hundi* (temple donation boxes) collection/ corpus fund, etc. Majority of the VOs (56.36%) had their own building and around 46.3% reported that they hired a building for the purpose. Most of the organizations (71.52%) had classroom facility, 68.7% had a lecture hall, 70.9% had a conference hall, 23.3% had hostel facility and 35.15% had guest room facilities. In most of the states handicraft and handloom products were manufactured. Only 12% VOs reported that they were involved in growing medicinal plants. More than 50% of the VOs mentioned that they brought out publications in the form of

leaflets. Only 5% VOs reported that they brought out Annual Reports. The information collected by all these VOs has been authenticated and certified. Further, these VOs would be required to update the information sent by them after every 3 years.

Key Words : 1.SOCIAL WELFARE 2.VOLUNTARY ORGANIZATIONS 3.ACTIVITIES OF VOLUNTARY ORGANIZATIONS 4.PROGRAMMES OF VOLUNTARY ORGANIZATIONS 5.NGOS 6.DIRECTORY OF VOLUNTARY ORGANIZATIONS

26. Shah, Amita and Yagnik, Jignasu.(2007).
Estimates of BPL-households in rural Gujarat : measurement, spatial pattern and policy imperatives. Ahmedabad : Gujarat Institute of Development Research. 30 p.

Abstract : The poverty scenario in Gujarat is marked by two important features – low incidence and spatial concentration. The present study was carried out to examine the extent and spatial concentration of BPL ratio across talukas in Gujarat and compare that with official poverty estimates across NSSO regions in the state. Data was gathered from secondary sources of information. Government of Gujarat had undertaken a socio-economic survey of 6.86 million households in rural areas (2003). Deprivation was assessed with respect to critical indicators such as food security, clothing, reasons for migration, and type of indebtedness among the BPL and APL (Above Poverty Line) households. It was found that 34.2% of households in Gujarat were below poverty line (BPL). Of the total of 2.35 million BPL households, 1.09 million were in the category of very poor and the rest were in the category of poor. These constitute 15.9% and 18.3% of the rural thresholds. The BPL ratio varied significantly across districts ranging from 11.26% in Junagarh to 71.47% in Narmada. The BPL ratio has declined from 39.5% to 34.2% during 1997 to 2003. The top 60 talukas with high BPL ratios were spread over 19 out of 25 districts in Gujarat. However, more than 70% of these 60 talukas are in 8 districts, viz Panchamahals, Dahod, Surat, Banaskantha, Jamnagar, Sabarkantha and Bharuch – Narmada combined. The 43 tribal talukas in Gujarat are among the 60 talukas where poverty ratios were highest. According to Planning Commission (Government of India, 2007), urban poverty was significantly higher than rural poverty till 1993-94, but the pattern has reversed in the subsequent two rounds. Rural poverty has declined from 27.9% in 1983 to 19.1% during 2004-05. Regional estimates of rural poverty in Gujarat bring out some important findings. There is only a marginal decline in rural poverty since the early nineties (i.e. 22.8% in 1993-94 to 19.1% during 2004-05).

Secondly, two out of the five regions have experienced increase though, marginal, in poverty ratio over the past decade; these regions are Dry Areas and Eastern Regions. Saurashtra and Eastern Regions have retained the lowest and the highest ranks with respect to poverty/ BPL ratios respectively, as also observed in the case of poverty estimates for 1993-94 and 1999-2000. There is higher incidence of poverty in drought prone areas. BPL estimates were found to be consistent with the expected scenario in terms of a positive association with degradation of natural resources, and also other determinants like land productivity and irrigation, urbanization, industrialization, educational infrastructure, etc. 44% of rural households had reported food scarcity, this was higher than BPL ratio (i.e. 34.2%) for the state. It was suggested that there should be a supplementary survey to estimate food security situation for verification of the actual magnitude of deprivation. It is also essential to develop spatial profiles and understand relative scenarios before putting up the information about individual households and resorting to modifications on a case-by-case basis. Lastly, it is imperative that the database helps trigger an informed debate on causes of poverty and the solutions there of.

Key Words : 1.SOCIAL WELFARE 2.POVERTY 3.BPL FAMILIES 4.RURAL POOR 5.BELOW POVERY LINE 6.SAURASHTRA 7.GUJARAT.

27. Singamma Sreenivasan Foundation, Bangalore. (2008).
Impact of state excise policy on arrack sales and consumption : final project report. Bangalore : SSF. 54 p.

Abstract : Alcohol has habit-forming and potentially addictive properties besides being hazardous to health. It also has detrimental effects on family and children. “Arrack” is diluted rectified spirit, readily used in place of alcohol in Karnataka. This study was undertaken before the ban on the sale of arrack in Karnataka. It is important to know that State excise on liquor contributed around 15% the State’s tax revenue. More than 50% of the revenue from liquor came from arrack sales. It contributed around Rs. 1565.40 crore out of Rs. 3414.94 crore in year 2005-06. However, the sale of arrack faced major protests by women and Stree Shakti self help groups. Therefore, the major objectives of the study were to study the impact on liquor consumption with respect to its geographical proximity, and to study the impact on the nutritional status of children (< 6 years) where liquor is consumed. A total of 1200 households were selected as sample from 120 villages, from 3 districts of Karnataka namely Chamarajanagar, Bijapur and Bellary. From each district 40 villages and from each village 10 households were selected. Out of 1194 households, 402 reported liquor consumption sometimes,

whereas 230 households reported liquor consumption on daily basis. 84% village households had access to liquor vending in close proximity. The correlation matrix suggested that people from SC, ST communities were frequent consumers of arrack. This was directly corrected to their lower socio-economic status and negatively correlated with the level of education. This was proven by the fact that Bellary's Hadgali taluk had maximum illiterates 66%, and 60% households consumed liquor, which was the highest in all 3 districts and taluks. To check the impact on nutritional status of children coming from Arrack consuming households their height, weight and Mid Upper Arm Circumference (MUAC) were noted. Out of 108 male children studied, 57 were from Arrack consuming households and 51 were from Non Arrack consuming households. Children from Non-Arrack consuming households were found to be nutritionally better off. Also Non Arrack consuming households had more female children, 53 out of 99, as compared to Arrack consuming households. The problem of arrack consumption has subsided after its ban. Stree Shakti self help groups have helped the Government in implementing the ban. The recommendations given were to impose a total ban on sale of arrack, or alternatively to limit its access. After the ban, the Government provided Indian made liquor (IML) as an alternative, with limited access, to curb the crunch of Rs. 2000 crore in revenue.

Key Words : 1.SOCIAL WELFARE 2.ALCOHOLISM 3.DRUG ABUSE ALCOHOLISM 4.IMPACT ON FAMILY 5.ILLICIT LIQUOR 6.ARRACK 7.NUTRITIONAL STATUS CHILDREN 8.KARNATAKA

STATISTICS

28. Jammu and Kashmir, Dept. of Economics and Statistics, Jammu. (2008). Economic survey 2007-08 : Jammu and Kashmir. Jammu : JK-DES. ~400 p.

Abstract : Economic Survey 2007 – 08 of Jammu and Kashmir (J&K) focuses on transformation of the economy over the planning period and the growth perspective in the changing economic scenario. J&K has a number of characteristics that pose special development challenges. The 10th Five Year Plan of J&K had targeted a growth rate of 6.10% of Gross State Domestic Product (GSDP) at constant prices. The GSDP of J&K state has been constantly increasing over the years. GSDP at constant prices for the year 2006 – 07 is estimated at Rs. 21556.82 crore as against Rs. 20336.50 crore for the year 2005 – 06, registering an increase of 6% over the previous year. The GSDP at

constant (1999-2000) prices is showing 5.45% average annual growth rate during the 10th Five Year Plan. This suggests that the state is growing at an average growth rate of 5.45% per annum, while inflationary growth is 4.61% points, making an aggregate growth of 10.06% at current prices during the same period. The outlay for the 11th Five Year Plan stands at Rs. 25834 crore which is 78.16% higher over the original 10th FYP outlay of Rs. 14500 crore. J&K state has passed Fiscal Responsibility and Budget Management (FRBM) legislation to discipline revenue expenditure portfolio on one hand and on the other earning benefit of about Rs. 500 crore by way of debt relief and debt waiver during the Twelfth Finance Commission period. There has been considerable improvement in health standards. Major issues of concern which need to be addressed during the 11th Plan are: 1. Very low couple protection rate (CPR) (15.9% as against 46.6% national level); 2. Low coverage of Vitamin A (22%) and Salt iodization (28.7%, 15 ppm and above); 3. Shortage of manpower and infrastructure in health institutions; and 4. Low awareness of HIV/ AIDS. Only 75% primary school teachers in the state are trained. The literacy rate of women was 43% (2001 Census) as compared to 53.67% for the country. Life expectancy at birth of females is 64.5 years. 54.3% of the deliveries take place in institutions. Infant mortality rate is 55/1000 live births in case of female children. There were 142 ICDS projects with 18,556 anganwadi centres providing services to 3.44 lakh beneficiaries, comprising 2.79 lakh children and 0.7 lakh pregnant and lactating mothers. Work participation ratio of females was 26.7% for rural females and 11.2% for urban females (NSSO, 61st Round). Unemployment rate among the educated was 8.3% in rural areas and 9.0% in urban areas of the state, whereas among youth it was 6.8% in rural and 14.7% in urban areas (NSSO 61st Round). The percentage of people living below the poverty line has been assessed to be 5.4%. The 11th Five Year Plan envisages addressing the following critical issues: unemployment needs to be reduced by developing skills through training; and there is need to make optimum use of the centrally sponsored scheme 'Upgradation of ITIs to Centres of Excellence'. 73.6 lakh families are covered under BPL component of the population getting ration and are provided 35 kg of food grains per family per month on subsidy rate, i.e. rice @ Rs. 6.25/kg and wheat @ Rs. 4.80/kg. Out 7.36 lakh BPL families, 2.56 lakh families are covered under AAY (Antyodaya Anna Yojana) category (poorest of the poor) and provided 35 kg of food grains per month on highly subsidized rate viz rice @ Rs. 3 per kg and wheat @ Rs. 2 per kg. The report mentioned that women were significant contributors to the growing economy. The total work force in 2001 was 37.54 lakh workers, consisting of 26.09 lakh main workers and 11.45 lakh marginal workers of whom 10.74 lakh were females. Work participation rate among females was 22.45% in 2001. 6% women were cultivators, 5% were agricultural labourers, and 10% were workers in household industries. There are 150 social welfare centres engaged in imparting training to women. The inmates are being provided training for 11 months and get a stipend of Rs. 100/- per

month. The Mid Day Meal Scheme was revised and universalized in Sept. 2004, and central assistance was provided @ Rs. 1.00/child/school for children of Classes I to V. Funding under the scheme was further revised in 2006 to Rs. 2/child/school to provide 450 calories and 12 grams of protein. Under ICDS, National Programme for Adolescent Girls (NPAG) was initiated. To achieve the goals of the Eleventh Five Year Plan, it was suggested that tourism potential available in the state should be tapped. Health, education and other infrastructure at the grass roots level needs to be strengthened.

Key Words : 1.STATISTICS 2.ECONOMIC SURVEY J & K 3.PROGRAMMES FOR WOMEN AND CHILDREN 4.SOCIAL WELFARE PROGRAMMES 5.WOMEN AND CHILDREN 6.JAMMU AND KASHMIR.

WOMEN LABOUR

29. Kumar, Hajira et al. (2004).
Victims of social injustice : landless labourer women in the states of Delhi, Haryana and Uttar Pradesh : a study (executive summary). New Delhi : Sarojini Naidu Centre for Women's Studies. 236 p.

Abstract : Landless unorganized female labour force is probably one of the most vulnerable sections of society. In India, 97% of the labour force works in the unorganized sector. NSSO Survey 53rd Round (1997) showed that 57% of the women in rural areas are self employed, 2.1% are regular employees and 40.9% are casual labourers. The purpose of the study was to address the issue of landless unorganized female labour force in India. The sample for the study consisted of 750 Land Less Labourer Women (LLLW), 250 each from Delhi, Haryana and Uttar Pradesh. The main objective was to suggest measures that could bring about improvement in LLLW's lifestyle, profile and socio-economic status. LLLWs are victims of social injustice as 85% were illiterate and only 15% had reached primary level of education. Among the 108 LLLWs who were above 50 years, 67 were widows. 90% of the LLLWs belonged to the backward (OBC) or schedule castes (SCs) and scheduled tribes (STs). Majority of respondents were from Uttar Pradesh as landlessness is more common there. Only 7% of the respondents had their own land and over 90% were landless. Gender disparity can be judged by the fact that literacy level of LLLWs' husbands was 50%, while theirs was 15%. 90% of the households were headed by men. Out of 80 households headed by women, 76 were widows. Nearly 40% of the respondents wished to educate their boys for alternate occupations. Barely 17% wished their daughters to study and only 3% discussed about the career of their girls. 60% of

LLLWs had monthly income between Rs. 2000 to Rs. 4000; 30% had income less than Rs. 2000 and only 10% had more than Rs. 4000. Apart from seasonal agricultural work, 97.61% worked as domestic help/ workers. About 84% of the LLLWs income was spent on food and less than 1% on education. LLLWs faced multifarious problems such as sexual harassment, wage differential and indebtedness. Only 2% could say 'no' to the work place harassment (WPH) and only 7% had good work atmosphere. As many as 37.6% preferred to remain silent about the events of Work Place Harassment (WPH). Only 2% to 3% were ready to complain against the assailant. 12.39% were of the opinion that Government should appoint inspectors to keep a check on WPH. Regarding wage differences, 37.6% LLLWs were unaware about the difference in wages between men and women. 15.9% women received equal wages. Only 26% of LLLWs were clearly aware that they received lower wages. The illiterate landless labourer women (LLLW) were found to be ignorant about various Government efforts to emancipate them. 70% of the LLLWs were in favour of reservation for women in various sectors of work; 5.9% respondents preferred welfare schemes; and only 3 respondents had heard about any NGOs working for them. To improve the status of LLLWs suggestions offered to Government were: creating cells to check work place harassment (WPH); providing subsidies to LLLWs; vocational training programmes; gender sensitization; reservation for women in Class I and Class II Government jobs; making education free and compulsory for children; and empowering village panchayats to develop various schemes for LLLWs.

Key Words : 1.WOMEN LABOUR 2.LANDLESS LABOUR 3.SOCIAL INJUSTICE 4.WOMEN LANDLESS LABOURERS 5.AGRICULTURAL LABOURERS 6.POOR WOMEN 7.VULNERABLE GROUPS 8.VULNERABLE WOMEN 9.DELHI 10.HARYANA 11.UTTAR PRADESH.

WOMEN WELFARE

30. Bakshi, J.D.(~2003).
Impact evaluation of women and girl beneficiary oriented programmes and schemes on their socio-economic status in Himachal Pradesh with executive summary. Andheri Village, Sirmour Dist, Himachal Pradesh : People's Action for People in Need. 122 p

Abstract : The Government has been undertaking several programmes to improve the socio-economic situation of women/ girls in Himachal Pradesh. The present study is an attempt to assess the outreach and impact of various

programmes in certain focal panchayats. In this study, the beneficiaries under 10 schemes for women/ girls were covered in 12 districts of Himachal Pradesh taking two development blocks – one comparatively developed and the other backward. A total of 1000 respondents from 125 House Holds (HH) were taken. The 10 specific schemes taken up were 1. Scheme of Widow Pension, 2. Balika Samridhi Yojana, 3. Vocational Training for Destitute Girls/ Women, 4. Working Women's Hostels, 5. ICDS, 6. Old Age Pension, 7. Grant for Construction of House (SC/ ST), 8. Assistance to Women Victims of Atrocities (SC/ ST), 9. Incentive for Inter-Caste Marriages, and 10. Hostels for SC/ ST Girls. The maximum number of women respondents (42.32%) were in the age group of 34-41 years, followed by the age group 26-33 years (17.23%), and 18-25 years (16.33%). Thus, maximum respondents were in the age group of 18-41 years (76%). Of the total respondents 39.53% were just literate, 11.23% were educated up to primary level, 10.22% up to middle standard, 9.24% up to high school level and about 2.33% up to college level. 27.42% were illiterate. 38.42% were SCs, 14.73% were STs, 7% were BCs, and 40% belong to general communities. 47.13% women were engaged in agriculture, 4.19% were self employed, 1.77% were in service and 34.12% were housewives. Awareness regarding development schemes was highest about ICDS (72.27%), Mahila Mandal Programme (71.21%), Safe delivery kits (70.57%), and the Widow Pension Scheme (60.59%). Schemes about which there was 40-60% awareness were Old Age Pension Scheme (57.75%), Girls Education Incentive Scheme (54.56%), BSY (48.35%), and Health Education (43.30%). The study reported that 54.27% awareness was generated by Anganwadis. About 37.94% respondents gained awareness from Mahila Mandals and about 17.10% were made aware of schemes by their husbands. 8.27% of the respondents received information from village Pradhans, 4.98% from media, 19% from school teachers and 4.38% from village Patwaris. 240 respondents benefited under the Widow Pension Scheme. Under Balika Samridhi Yojana there were 116 beneficiaries. The ICDS was covering 240 respondent families. Under the Scheme of Stipend to SC/ ST Girls for Technical Education in ITI, the daughters of 163 respondents were benefiting and 77 respondents had already gained from the scheme. Only 36 persons had benefited from the Inter-Caste Marriage Scheme. Of these, 19 respondents had already availed the benefits and 17 were in the process of availing inter-caste marriage grants. Under the scheme of Training for Self Employment, 86 were availing and 60 had availed benefits; under Swarnajayanti Gram Swarozgar Yojana 179 were availing and 61 had availed services; under National Maternity Benefit Scheme 90 were availing and 75 had availed services; under the Scheme of Safe Delivery Kit 20 were availing and 220 had availed benefits; under Health Education 29 were availing and 211 had availed benefits; and under Girls Education Incentive Scheme 213 girls were availing benefits and 27 had already availed benefits. The problems faced by beneficiaries at different levels were 'completion of formalities at different levels' (5.70%), and distance of programme

implementing agency from home (61%). It was suggested that the in-built difficulties in implementing different schemes for women should be reduced. Financial norms should be revised to enhance the amount of assistance extended to women beneficiaries. Provisions should be made for a single window system to reach the benefits, and mainstreaming of gender perspective should be introduced in different schemes.

Key Words : 1.WOMEN WELFARE 2.PROGRAMMES FOR WOMEN AND GIRLS 3.BENEFICIARY ORIENTED PROGRAMMES 4.EMPLOYMENT PROGRAMMES 5.ECONOMIC DEVELOPMENT 6.IMPACT ON WOMEN 7.EVALUATION OF PROGRAMMES 8.GIRLS EDUCATION 9.EDUCATION 10.STATUS OF WOMEN AND GIRLS 11.HIMACHAL PRADESH.

31. Benni, Basavaraj S. (2004).
Socio-economic impact of role conflict of working women in urban western Maharashtra (with summary). Kolhapur : Chh. Shahu Central Institute of Business Education and Research. ~240 p.

Abstract : India is progressing and so are the women of India. With more and more women working today, role conflict has emerged as the new age working women's problem. The study aimed to find out the socio-economic impact of role conflict of working women. 300 women working in government, semi-government and private institutions were selected from district headquarters of Western Maharashtra namely Ahmednagar, Kolhapur, Pune, Sangli, Satara and Solapur. 85% of the sampled working women (SWW) had higher qualifications in general and technical education. More than half of the SWW were in age group of 20-35 years. The survey revealed that the number of married working women was 6 times higher than that of unmarried women. 65% respondents had taken up jobs to fulfill family needs, 23% took jobs to prove their talent, and 8% joined service for personal freedom. Among 300 respondents 10% were bread earners and home makers, and 90% SWW were secondary bread earners. 5% of the total respondents felt role conflict (RC). Respondents above 45 years of age managed the two different roles successfully. Role conflict (RC) was more common among women in younger age groups and 76% SWW suffered from RC. There were different reasons for role conflicts among women. 23% worked for more than 9 hours a day and 100% of them suffered from RC. RC was also high in 80% SWW who had night duties. 59% SWW faced difficulty in getting leave, which increased RC tremendously in 37% respondents, and 41% suffered from partial RC. About 29% SWW were reaching home late, which increased RC in them. 61% SWW had both male and female co-workers. 72.26% had a good

relationship with their male colleagues, but 21% experienced inappropriate behaviour from their male counterparts. 76% respondents felt no discrimination between male and female workers. 49% of respondents were doing all the domestic work, 31% were only preparing meals, and only 14% were taking full help of servants. 45% respondents expressed that their job was affecting the health of their children, hence 40% were in full RC and 41% had RC to some extent. 47% SWW felt that they were unable to give proper attention to their children's education. Other trivial issues that came forward as RC situations were special occasions and dual roles. 81% found it difficult to be present on special occasions. Due to dual roles (job and home) 52% SWW found a change in their temperament. More than 50% SWW felt that they had higher status among relatives. Also 72% believed that the extra income helped them in becoming economically well off. It was suggested that special leave should be given to young working women, girl child education should be encouraged, salary in the private sector should be supervised by government bodies, the joint family system should be encouraged, flexible working hours and campus housing facilities should be given specially for those working in night shifts, and separate and better transportation system should be provided for women. Improving security of women in offices, providing good community child care centres and nurseries, awareness about legal rights, provision of good quality food for school lunch, health care facilities at school for children, and employment after break are the other measures suggested to reduce stress among working women.

Key Words : 1.WOMEN WELFARE 2.WORKING WOMEN 3.ROLE CONFLICT 4.WORKING MOTHER 5.CHANGING FAMILY 6.PROBLEMS OF WORKING WOMEN 7.FAMILY RELATIONSHIP 8.HOUSE WORK 9.MAHARASHTRA

32. Biswal, D.N. et al. (2005).
Gender discrimination and social status of women : a comparative study between tribals and caste Hindus of Orissa. Rourkela, Orissa : Centre for Developmental Activities. 219 p.

Abstract : Men of Indian society have been discriminating against women and considering them as a lesser sex since remote times. The aim of the study was to compare the gender discrimination and social status of women between the tribals (16 tribes) and caste Hindus (23 communities) of two districts namely Sundargarh (50.19% tribal population) and Khurdha (94.82% non-tribals) of Orissa. 500 households, 250 belonging to different tribal communities and 250 belonging to different caste Hindu communities constituted the sample. Samples were drawn from Begunia, Bhubaneswar, Khurdha, Bolagad and Jatni from

Khurdha district and Rajgangpur, Balisankara, Lephripara, Tangarpali and Sundargarh from Sundargarh district. The women of these tribal communities enjoy better social status than those of Hindu communities because of their higher involvement in the household economy. However, illiteracy among the ST men of Khurdha district was 36.90% and 64.23% for females. The corresponding illiteracy figures for scheduled tribes of Sundargarh district were 36.90% and 53.36% for males and females respectively. There were 22.85% illiterate Hindu males and 23.11% females in Khurdha. The corresponding illiteracy figures for Hindu communities in Sundargarh were 23.96% for males and 31.01% females. Hindus were engaged in 18 primary occupations, and scheduled tribes were engaged in 14 primary occupations. Occupations were agriculture, carpentry, painting, rickshaw pulling, fishing, weaving cloth, shop keeping, cattle rearing, etc. Most tribal women (37.6%) were also wage earners. They also collect minor forest produce (16.4%), prepare wine and sell it (8.8%), do petty business including shop keeping (6%), provide services (4.4%), practice swidden cultivation (4.4%) and agriculture (1.2%), and herd cattle (0.8%). The rest (19.6%) were housewives. 88% Hindu parents and 75.60% tribal parents desired to have sons. 93.18% Hindus and 80.95% tribals wanted to have a male child for economic reasons. 71% Hindu parents wanted male issues to continue their lineage/ generation/ *vamsa*; 30% of tribals have also highlighted this. A son (*putra*) is believed to rescue parents from hell 'narka' after death. Most Hindu parents (48%) felt that a married couple should procreate at least two children, ST parents (50.60%) also believed that a couple should procreate 3 children. 83.75% Hindus and 75% tribal parents said that both the children should be sons, and there was not a single parent who said that both the issues should be female. 46.96% Hindu parents wanted all the three progenies to be males, followed by 52.17% who wanted at least 2 sons and the rest could be girl children. A reverse trend is observed in the case of ST parents since 65.61% of them say that of the 3 children, 2 should be males and rest (one) could be a girl child. There were 46 caste Hindus and 25 tribal parents who were in favour of 4 children and majority of them preferred sons. About 20.40% Hindu and 2.80% tribal couples had medically determined the sex of their children before birth. 93.8% Hindu and 87.25% tribal families were patrilocal in nature. 30.93% Hindu and 74.50% tribal parents did not give much importance to the education of their female children. 91.60% Hindu and 73.20% tribal family members did not sit together for meals. 48.05% Hindu and 37.50% tribal women were scolded and beaten by their husbands. 64.94% Hindu and 32.64% tribal women gave all their earnings to their husband. 22% Hindu and 31.94% scheduled tribe husbands forcefully took the earnings from their wives. Women's participation in cooking food was maximum (86.3%). On the basis of the findings it was recommended that female education was the most vital instrument for development. Initiatives should be undertaken to popularize the laws and legal provisions meant for the

welfare of women, such as equal wages for equal work, etc. The legal provisions regarding conditions of women workers must be displayed in all offices/ factories.

Key Words : 1.WOMEN WELFARE 2.STATUS OF WOMEN ORISSA 3.GENDER BIAS 4.GENDER DISCRIMINATION 5.SON PREFERENCE 6.DISCRIMINATION AGAINST WOMEN 7.DIVORCE 8.TRIBAL WOMEN 9.TRIBAL WOMEN ORISSA 10.STATUS OF TRIBAL WOMEN 11.INHERITANCE 12.DISEASES 13.ORISSA.

33. Centre for Organization Development, Hyderabad. (2004).
Women in information technology : final report. Hyderabad : COD. 155 p.

Abstract : The status of women has changed considerably. Women have made significant strides in all fields, although their number remains insignificant. The present study was carried out to understand the role and contribution of women in the Information Technology (IT) field. 229 women and 104 men across 20 companies were selected for the study. A group of respondents assembled in a discussion room for about 45 to 60 minutes and were asked to fill up the questionnaire. An analysis showed that the percentage of women employees to the total employee strength was on an average 15%. The age profile of women respondents ranged from 21 to 53 years, with a median age of 27 years, and 87.4% women were below 35 years. 70% women were below 30 years compared to 43% men. Out of 229 women respondents, 52% were at junior level and 47.6% were at the middle level. 86% of the women professionals had less than 10 years of work experience, and 55% of the women had up to five years experience. 41.04% of the women were engineers, an equal percentage of them were graduates, and four women were Ph.Ds. In comparison, 62.5% men were engineers and one was Ph.D. Reason for getting attracted to the IT industry were challenging profession (78% women); compensation and benefits (46.7%); work climate (45.4%); and freedom of action (38.9%). The IT industry also gives immense satisfaction, a sense of achievement, tremendous opportunity for creative freedom, and independence for women (38.9%). When asked about their aspiration for ten years, some of them were not sure of themselves (17%). 33 women positioned themselves at the business head level, 38 of them at senior levels of management, 34 of them aspired to become entrepreneurs, and 35 women planned to retire, stay at home, and look after their children. An overwhelming majority of women (98.7%) listed family, health and maternity aspects as the most important reasons why women did not advance in careers at the same rate as men. 90.4% women and 81% men agreed that women work beyond office hours. 91% male respondents were of the opinion that women got

opportunities to travel for on-site assignments, but only 37.5% of the women respondents replied positively to this question. 62.5% women mentioned that they did not travel. Long hours of work topped the list of constraints in the organization for effective job performance. IT policy must take gender into account to provide an enabling environment for women, and gender policy must take into account the opportunities that IT can bring to women. Flexible working hours, especially during child bearing and rearing years may be allowed to meet the family needs, whenever it is possible to do so, without compromising the organisation's goals. A compressed work week allows full time employees to work longer days for the week or pay period. With the upsurge of IT, working from home is an accepted practice in many countries, although in India, it is in practice in a few organizations only. Creches should be provided for small children.

Key Words : 1.WOMEN WELFARE 2.WORKING WOMEN 3.INFORMATION TECHNOLOGY 4.PROBLEMS OF WORKING WOMEN 5.WOMEN IN INFORMATION TECHNOLOGY 6.ROLE CONFLICT 7.WORKING MOTHERS.

34. Integrated Rural Technology Centre, Mundur, Palakkad, Kerala. (2004). Gender profile in Kerala : final report. Mundur, Palakkad, Kerala : IRTC. ~100 p.

Abstract : Gender profile studies have a very short history in Kerala. The present study was conducted taking into account the experience of the earlier studies. The areas covered in the study were demographic factors, educational status, health status and employment details. The available information was compiled from 14 Blocks and comprised 90 *Gram Panchayats* (10% of the total). The study was carried out in 14 districts of Kerala namely Vanantha Puram, Kollam, Pathanamthitta, Alappuzha, Kottayam, Idukki, Ernakulam, Thrissur, Palakkad, Malappuram, Kozhikode, Wayanad, Kannur, and Kasaragode. The sex ratio of women in Kerala was 1058 females for 1000 males. Kerala has experienced the sharpest fertility decline in India in recent years. There were 14.8 lakh women in Kerala during 1999; 7.32% were 60+, 3.71% were 70+, 1.08% were 80+. Kerala has the lowest infant mortality rate of 15.3 compared to 70.8 in India. Kerala has an exceptionally advanced health care system in the country, and it has one hospital bed for every 382 persons. There are 3,421 medical officers and 7,800 junior and senior nurses. Also, there is one doctor for every 1806 population. Kerala is the most literate state in the country with a literacy rate of 90.92% as

against India's rate of 65.38% in 2001. Kerala's female literacy rate is 87.86% while the male literacy rate is 94.20%. The study also mentioned that there were 12,331 schools. There was 18.18% growth in the cases of crime against women. The crimes reported in 2001 were molestation (2,033), rape (550), kidnapping (125), eve teasing (86), marital torture (2,579), etc. Divorce rates are also high in Kerala. Trivandrum district stands first with 1850 divorces during the year 2002. 2,923 females committed suicide in 2001. The total workers in Kerala were 2,500,736 (main workers 1,757,391; marginal workers 743,345). The Work Participation Rate (WPR) of females in Kerala was 15.3% in 2001 compared to 25.7% in India. The WPR of males was 50.4% in Kerala compared to 51.9% for males in India. Although women are educated, have fewer children and live long, their labour in any form, has not been socially used. The profile of women in the Science and Technology sector is very poor. Majority of the students at the post graduate and research level were girls. Girls who had done research were either underemployed or unemployed. Very few women were appointed as teachers/ faculty in departments. There was 1 female teacher in Kannur University, 36 in Kerala University, 17 in Calicut University, and 4 in Mahatma Gandhi University. It was concluded that although empowerment programmes like 'Kudumbasree' and other poverty alleviation programmes have been initiated recently, the impact on women is yet to be reflected in society. Efforts should be made to do the same.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN KERALA 3.GENDER PROFILE WOMEN KERALA 4.FEMALE WORK PARTICIPATION RATE 5.KERALA.

35. Loyola College of Social Sciences, Loyola Extension Services, Thiruvananthapuram.(2004).

A Comparative study of self help groups (SHGs) organized and promoted by non-governmental organizations and Kudumbasree : a government organized non-governmental organization (GONGO) in Kerala, towards empowerment of poor women : final report (with executive summary). Thiruvananthapuram, Kerala : LCSS-LES. 114 p.

Abstract : Self Help Groups (SHGs) are becoming one of the important means for the empowerment of poor women in almost all developing countries, including India. This study was carried out to examine the functioning of SHGs organized and nurtured by NGOs and Kudumbasree, a Government sponsored NGO run under Poverty Eradication Mission (PEM) of the Local Administration in Kerala. 80 SHGs and a sample of 400 women members were selected for the study.

Wide variation was observed among the SHGs managed by NGOs and the SHGs managed by Kudumbasree regarding the constitution and functioning of SHGs. Majority of the respondents (43.3%) were in the age group 31-40 years. 79.5% of the respondents were married, and 12.8% were either widows or separated women. The average family size of the respondents was 5.12. This was mainly due to the joint family system still found in Northern Kerala. 84.25% of the respondents had their own houses, 8.25% lived in joint family houses, and the rest (7.5%) lived in rented accommodation. 16.8% of the families of respondents were women headed, and there was no significant difference between respondents from NGOs and Kudumbasree. For a majority of the respondents (39%) the motivating factor for joining SHGs was economic, which included inculcating savings habit and getting easy loans at reduced rate of interest. Only 6% of the respondents agreed that there were sub-groups in their SHG system. There were more alcoholics and drug addicts among the family members of respondents from NGOs (36%) than among family members of respondents from the SHGs of Kudumbasree (19.5%). A majority of the respondents (85.2%) had a monthly income of less than Rs. 2000. Most respondents (63.7%) did not have any deposits except the thrift savings. Insurance (24.3%) and chit funds (7.5%) were two methods used by the respondents to create assets and savings. Many respondents (79.88%) had awareness regarding the legal rights of women and children. 12.5% of the knowledge came to women through the SHG system. Majority of the respondents did not have savings account in any bank or post office, and only 20% of the respondents from NGOs and 23% respondents from Kudumbasree SHGs could not save any amount every month. 49% of the respondents still depended on moneylenders, even after they became members of SHGs, as they could not get sufficient money from the SHG for their needs. More women members of Kudumbasree (29%) attended Gram Sabha meetings than those of NGO assisted SHGs (16%). Apart from these, 33.5% respondents from NGOs and 40.5% from Kudumbasree had active membership in one or the other political parties. 82.5% of the respondents participated freely and frankly in SHG meetings. Self esteem, self confidence and fearlessness increased among members of SHGs, and they were seen going to government offices and police stations (64.3%), and talking to officials and policemen (65.5%). Programmes organized by NGOs such as NIDS (Neyyattinkara Integral Development Society) and KAIROS (Kannur Association for Integrated Rural Organisation and Support) were Vocational Training; Awareness Generation regarding health, literacy, management, micro credit, etc.; rallies against liquor and drugs; rallies for reservation for minorities; training on animal husbandry, etc. As women were still not able to influence men in sharing their daily household work, it was suggested that there is need to sensitize men about this aspect. NGOs as well as Kudumbasree should take greater interest in organizing awareness classes

regarding Government schemes so that all members of the group, particularly those from poor families, would benefit from these programmes.

Key Words : 1.WOMEN WELFARE 2.SELF HELP GROUPS 3.KUDUMBASREE 4.GOVERNMENT SUPPORTED SELF HELP GROUPS 5.NGO SUPPORTED SELF HELP GROUPS 6.EMPOWERMENT WOMEN 7.KERALA.

36. Mass Rehabilitation Society, Imphal. (~2003).
Evaluation study of various specific women related schemes during the Eighth Five year Plan in Manipur : research project. Imphal : MRS. ~135 p.

Abstract : This study was undertaken in Manipur to assess the performance and impact of women related development programmes on the status of women. Information was collected from 1000 women residing in two districts namely Imphal East and Imphal West. The State Government continued to implement development programmes during the Eighth Plan period, and women beneficiaries were also covered under poverty alleviation programmes like Integrated Rural Development Programme (IRDP), Training Rural Youth for Self Employment (TRYSEM), Jawahar Rozgar Yojana (JRY), Indira Awas Yojana (IAY) and Development of Women and Children in Rural Areas (DWCRA). The women specific programmes implemented during 8th Plan by the Social Welfare Department were 1. Support to Training – cum – Employment Programme for Women (STEP); 2. Construction of Working Women's Hostels; 3. Border Areas Welfare Extension Projects; 4. Vocational Training Courses; 5. Socio-Economic Programme; 6. Voluntary Action Bureau; 7. Orientation Training Programme; 8. Self-Employment Scheme; 9. Creche Programme; 10. Nutritional Programme; 11. DWCRA; 12. Grant – in – Aid to Destitute Widows; and 13. Family Counselling Centres. Only 16.72% of the respondents were illiterate, 24% respondents could read and write; 2.25% were educated up to primary level; 10.69% and 21.20% respondents were educated up to middle and high school level respectively; and 27% respondents were educated up to matric. Of the 640 families of respondents, the head of the families were engaged in self-employment in 163 (25.47%) cases; agriculture 128 (20%); service sector 210 (32.81%); and domestic work 212 (33.13%). Activities under the Self Employment Scheme were dress making, wool knitting and embroidery. Between 9-29% women were aware about Self Employment Schemes. In Imphal West, 117 (36.56%) women were aware of embroidery training. Only 11.25-34% respondents were aware of the Vocational Training Courses Scheme. 50 (15.62%) respondents of Imphal East, 63 (19.68%) of Imphal West and 65 (13.40%) respondents of fully surveyed villages were aware of the Creche Programme. 55 (17.18%) respondents of Imphal East, 81 (25.31%) of Imphal

West, and 79 (16.28%) respondents of fully surveyed villages were aware of the Nutrition Programme. 96 (19.79%) respondents of fully surveyed villages were aware of Chulah Programme. 115 (35.95%) respondents of Imphal East, 121 out of 320 respondents in Imphal West, and 189 (38.96%) respondents of fully surveyed villages were aware of the Socio-Economic Programmes. 26 (32.5%) respondents of Imphal West, 64 (20%) of Imphal East, and 109 (22.47%) of fully surveyed villages were aware of the Condensed Courses Programme. 47 (14.6%) respondents of Imphal East, 50 (15.62%) of Imphal West, and 71 (14.63%) of fully surveyed villages participated in the Craft Programme. 54 (14.86%) respondents of Imphal East, 55 (17.18%) of Imphal West, and 76 (15.67%) respondents of fully surveyed villages participated in Women's Education Programme. 98 (38.62%) respondents of Imphal East, 105 (32.81%) of Imphal West, and 94 (19.38%) respondents of fully surveyed villages participated in the Self Employment Scheme. 124 (38.75%) women respondents of Imphal East, 105 (32.81%) of Imphal West, and 97 (28%) respondents of fully surveyed villages participated in the Mahila Mandal Programme. 76 (23.75%) respondents of Imphal East, 71 (22.18%) of Imphal West, and 83 (17.11%) of fully surveyed villages participated in the ICDS Programme (anganwadi centres). 41 (12.81%) respondents of Imphal East, 37 (11.56%) of Imphal West, and 55 (11.34%) of fully surveyed villages participated in the Programme of Women in Panchayati Raj. It was recommended that Government should take up mass adult education/ informal education programmes in rural areas. Mass media and information technology should be utilized for creating awareness and benefiting people residing in rural areas. Voluntary organizations should be fully involved in implementing women related/ women specific schemes. They should be involved from the initial stages and help in monitoring the schemes so that the schemes can be run more effectively and successfully.

Key Words : 1.WOMEN WELFARE 2.PROGRAMMES FOR WOMEN 3.EMPLOYMENT WOMEN 4.ICDS MANIPUR 5.MANIPUR.

37. Nahar, U.R. et al. (2003).
Women and panchayati raj (with abstract). Jodhpur : Jai Narain Vyas Univ., Dept. of Sociology, Jodhpur. 262 p.

Abstract : Indian Women's life encompasses various dimensions of personal, domestic and community life. One of the most crucial aspects of women's emancipation is their political empowerment. Therefore, the present study investigated the social background of women in PRIs, awareness about the structure and functions of PRIs and the socio-cultural constraints faced by women. For the study, six districts of Jodhpur division of Rajasthan were covered namely Barmer, Jalore, Jaisalmer, Jodhpur, Pali and Sirohi. Rural population in

the area ranged between 65% to 92.72%, and the study included 1579 sarpanchs, 42 pradhans and 6 zila pramukhs. In all 234 women sarpanchs, 14 women pradhans, 2 zila pramukhs were selected as women respondents. 231 men respondents (MR), basically chairpersons, of panchayats and panchayat samitis, were also included. The average age of women respondents was between 43-46 years; 31% respondents were literate and 45% were illiterate; and 32% women respondents were from upper castes. The per capita income ranged between Rs. 501 to Rs. 1,100 in 51% cases, 23% had income between Rs. 1,101 to Rs. 1,500 and the remaining 26% had per capita income of more than Rs. 1,500. The socio- economic background of women respondents has significant bearing on their functioning as village sarpanchs. The awareness level of structure and composition of panchayat samiti was satisfactory among both men and women respondents. But only 50% knew about the provision of reservation of seats for special categories. The study revealed that activities of male respondents extended to almost all areas like village development, budget, education, etc., but women respondents were still confined to the roles assigned to them through PRIs. Women respondents were of the opinion that if national demands get top priority, there can be no local development. They also felt that there should be consensus in all matters. Men respondents felt that programmes of economic development should be pursued even if it meant hardship to people; this was disapproved of by women respondents. 49% women respondents said that the State should intervene in the sphere of religion. Also 85% women respondents felt that local leaders should chalk out their developmental programmes as per local needs. In terms of freedom of expression, 70% women respondents were of the opinion that they have more freedom as compared to yester years. However, 75% women respondents still observed the custom of *purdah* (veiling). This showed that Indian women live with several socio-cultural constraints, which have a direct bearing on their status and power. 33% women respondents considered themselves equal to men, but 56% male respondents considered women to be inferior to them. Still 55% male respondents favoured reservation for women in PRIs. They were confident that their participation would contribute to women's development. Panchayati raj represents political power at grass roots level. In the light of findings it was suggested that PRIs should be empowered; Gram Sabhas strengthened by women's participation; men and women should be educated for better understanding of problems and their resolution; free and frank participation of women should be encouraged; and PRI workshops, awareness camps, and counselling camps should be organized.

Key Words : 1.WOMEN WELFARE 2.PANCHAYATI RAJ 3.POLITICAL PARTICIPATION OF WOMEN 4.LOCAL GOVERNANCE 5.STATUS OF WOMEN 6.RAJASTHAN

38. Noble Social and Education Society, Tirupati, Andhra Pradesh.(2007). Perception of muslim women of their rights and status in the state of Andhra Pradesh (with research summary). Tirupati : NSES. ~230 p.

Abstract : According to 2001 Census, Muslim population in India is 138,188,240 constituting 13.40% of the total population of the country. The present study was done to examine the status of muslim women in terms of impact of education and employment as well as income generating activities, on the direction of change among Muslim Women in Andhra Pradesh. The study was conducted in 3 districts of Andhra Pradesh, i.e. Nizamabad, Kurnool and Guntur. Data was collected through interviews with 825 women. Three categories of women were taken, 1. illiterate Muslim Women (300 respondents), 2. beneficiary Muslim Women (300 respondents), those who had accessed Micro Credit, and 3. educated employed women (225 respondents). It was a comparative study of the status of the above mentioned three groups of women, as perceived by the women themselves. It was observed that girl child marriage in the Muslim community was prevalent in the case of uneducated and other women. The rate of illiteracy among the husbands of educated employed was only 9.73%, while the same for illiterate and beneficiary groups was 38.38% and 40.30% respectively. Educated employed women had fewer numbers of children than the other two groups. In the educated group, though payment of dowry was less, the practice was still prevalent. More than 50% married respondents indicated that the opinion against payment of dowry had not yet taken roots or crystallized among the Muslim community. Awareness about 'triple talaq' was very high in all the three groups, but the percentage of disapproval of 'tripal talaq' was high among educated employed women, while no response was received from more than 50% women among the illiterate. Probably there was fear in this group to respond to the question. As per Muslim Islamic tradition, a divorced women is entitled to maintenance only for 3 months after divorce, but it was found that among all the 3 groups, more than 70% of the respondents felt that maintenance allowance should be given to divorced women till their next marriage, or otherwise till her death. With regard to polygamous marriages, there was high rate of disapproval among the respondents of all the 3 groups. Majority of the respondents used *'purdah'* (veils) when they went out of the house, and the usage was higher among illiterate women. All 100% respondents from all the 3 groups did not visit mosques because Islam did not permit it, but all the respondents expressed the opinion that they would like to visit the mosque if permitted. With regard to inheritance of property rights, 73.67% respondents reported that they did not inherit any property from their fathers, and all the 300 sample beneficiaries had no idea what Islamic rules say about Muslim women inheriting property from their fathers. 19.33% beneficiaries accessed micro credit from Andhra Pradesh State Minorities Finance Development Corporation.

Majority of the beneficiaries (55.33%) accessed credit from District Rural Development Agencies (DRDAs) of their respective district. DRDAs seem to be acting as major facilitators of micro credit among Muslim women. 83% of the total beneficiaries took loans for starting petty business like selling clothes, starting small provision shops, selling eatables, etc. Muslim men's perception seems to be changing, like that of educated women. Majority of the muslim men in the sample exhibited modern attitude towards education of their daughters, considered 'triple *talaq'* as a bad tradition, and opposed the payment of dowry. It was suggested that though there was some change in the status of Muslim women, still, even among the educated women, the aspect of critical consciousness, a necessary requirement to achieve gender equality was only partially present. Gender equality requires attention, which should be taken up by Muslim women's organizations and other organizations dealing with women's rights. Micro-credit activities among them should be promoted and rural muslim women should be encouraged to become members of self help groups, in order to develop their managerial skills, self confidence, and increase their monthly and annual incomes.

Key Words : 1.WOMEN WELFARE 2.MUSLIM WOMEN 3.STATUS OF MUSLIM WOMEN 4.RIGHTS OF MUSLIM WOMEN 5.MUSLIM WOMEN ANDHRA PRADESH 6.ANDHRA PRADESH

39. SEDEM, Society for Economic Development and Environment Management, New Delhi. (2004).

Women's self help groups and managing convergence in Himachal Pradesh (with executive brief). New Delhi : SEDEM. 146 p.

Abstract : Women Self Help Groups (SHGs) have come a long way from its period of inception. SHGs are working well for women, not only in meeting emergency cash needs, but also in women's empowerment. The major objectives of this study were to understand the working environment of SHGs, performance of SHGs, analyse policies and programmes, and offer policy recommendations. About 200 SHGs having 237 males and 1,997 females were selected from 5 districts of Himachal Pradesh namely Kullu, Kinnaur, Solan and Sirmour. 37 *panchayats* in 8 blocks were surveyed. Key factors for the success of SHGs depended on endogenous and exogenous factors. Shared goals, common concerns, perseverance, and timely release of funds are some of them. The average membership in SHGs was 11.17 persons. 55.82% SHGs were linked to banks. Also, the average bank loan given was Rs. 17,015 per SHG or Rs. 1,523 for each member. This is an excellent performance, given the fact that banks are cautious with unsecured lending. 46% respondents believed that the major objective of SHGs is to improve the socio-economic status (SES) of members. However, 59% SHGs had no plans to add or diversify themselves into

income generation activities. But 50% SHGs believed that they could manage diverse activities, including Government programmes. SHGs are working well for women. However, a few ICDS – SHGs were not doing well because of (i) lack of knowledge, (ii) illiteracy (iii) poor leadership, etc. This could be due to the fact that 31% SHGs had members who had no prior experience. 61% SHG members still believed that they were stuck up and were not moving ahead. ICDS – SHGs had no male members. Even in non-ICDS-SHGs, female members were more - they had 295 men and 831 women. 52% SHG members mentioned economic growth as a benefit of joining SHGs. 32% mentioned loan as the other benefit of joining SHGs. However, in ICDS – SHGs 22% and in non-ICDS-SHGs 39% believed was too early to say anything regarding benefits. But 57% respondents in both groups said that there was an impact on their monthly income. About 96% of the total respondents approached AWWs, but only 35% respondents volunteered to help Anganwadi Workers (AWW). The major recommendations for SHGs working in Himachal Pradesh were that they should be formed through participative consultative process; there should be administrative continuity and continuous supervision for about 1 year; it should be a sustainable enterprise; and cross sectoral coordination, like organic farming with rain water harvesting, should be encouraged. SHGs should be given a transit time of say 24 to 36 months so that SHGs can become a sustainable enterprise from a group setting. Core competency should be developed to improve the standards of working of both, ICDS – SHGs and non-ICDS-SHGs in Himachal Pradesh.

Key Words : 1.WOMEN WELFARE 2.SELF HELP GROUPS 3.SELF HELP GROUPS HIMACHAL PRADESH 4.WOMEN'S WORK 5.ICDS AND SELF HELP GROUPS 6.INCOME GENERATION ACTIVITIES 7.SON PREFERENCE 8.GIRL CHILD 9.MICRONUTRIENTS 10.KNOWLEDGE OF MICRONUTRIENTS 11.HIMACHAL PRADESH.

40. Talwar, Sabanna et al. (2006).
Women education, employment and gender discrimination : a socio-economic study of Hyderabad-Karnataka state (in comparison with Mysore, Telengana and Marathwada regions). Belgaum, Karnataka : Karnataka Univ., Dept. of Studies and Research in Economics. 31 p.

Abstract : The present study was conducted to find out the socio-economic factors responsible for gender discrimination in the field of education and employment in a backward region like Hyderabad-Karnataka in comparison with Mysore, Telangana and Marathwada regions. 800 rural and 800 urban females were selected. 34% women in rural areas and 38% women in urban areas were from upper castes. 25.25% rural and 21.25% urban women were SC/ ST; 24.25% rural and 21.63% urban women belonged to backward classes; and 16.50% and 18.25% women belonged to minority community in rural and urban

areas. It was found that 30.69% women were self-employed, followed by Government employees (24.25%), private employees employed in various private business agencies or were entrepreneurs (23.37%); and agricultural workers (21.69%). 576 (72%) women in rural areas and 567 (70.87%) in urban areas were married. The mean age at marriage is high in urban areas; it was 20.20 years in rural and 21.00 years in urban areas. The mean number of children of rural respondents was 2.29, while the mean number of children of urban women was 2.31. The mean number of male children was nominally higher in rural areas (1.60) than urban (1.56) areas. The mean size of the family was 5.85 in rural and 5.38 in urban areas. The mean distance between school and home of women respondents while studying was 1.71 kms in rural areas and 1.62 kms in urban areas. In urban areas, 5.75% women respondents and in rural areas 6.00% respondents used bicycles and bus services respectively. 455 (56.88%) women in rural areas and 376 (47.00%) in urban areas experienced gender discrimination while at school. About 44.84% women respondents faced discrimination in household activities, followed by facilities for study (20.22%), availability of time for school (16.70%), play (13.41%), and regularity of school (4.83%). 23.63% women had permanent jobs, 34.63% had temporary jobs, and 41.75% women had daily wage jobs in rural areas of the study region. In urban areas, 32.75% women were in permanent, 43.25% were in temporary, and 24% were in daily wage jobs. About 17.13% women in rural areas stated lack of skills/ training and 12.88% women respondents stated 'competition with women' to be two important constraints they faced at the time of entry into the work force. In urban areas, 20.5% women respondents stated competition with men, 15.63% women stated lack of education, 14.25% women stated lack of help in the household, and 12.63% women respondents stated lack of training as the important constraints faced. 36.87% spent their own money but 43.13% women handed their money over to the husband in rural areas. In urban areas 44.75% women spend money on their own and 39.62% handed it over to their husband. The following suggestions were made to overcome this discrimination. Educational programmes for girls should be initiated in different fields. The number of government girls schools should be increased for easy accessibility of basic education to girls. Women must be facilitated to gain higher education, especially technical education, to obtain economic benefits from modern occupations. Organizational capacity should be built among women, and formation of groups/ professional organizations like SHGs, Credit Societies, etc. should be encouraged.

Key Words : 1.WOMEN WELFARE 2.DISCRIMINATION AGAINST WOMEN 3.INCOME WOMEN 4.GENDER DISCRIMINATION 5.EDUCATION WOMEN 6.EMPLOYMENT WOMEN 7.WAGE DIFFERENCES 8.ANDHRA PRADESH 9.KARNATAKA.

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