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CONTENTS

RESEARCH STUDIES ON WOMEN & CHILDREN

AGED WELFARE

1. Sinha, Debotosh. (2005).
Problem of elderly abuse : some reflections and implications for social work practice. *Perspectives in Social Work*. 20(3) : 31-37.

Abstract : Worldwide there are 600 million people aged 60 years, and the number is expected to reach 2 billion by 2050. In India, life expectancy increased from 40 years in 1951 to 64 years in 2005. Thus, there are 77 million older persons in India in 2005. Old age has never been perceived as a problem in India. But in urban areas, older persons feel isolated and insecure. Modernization and industrialization have created a rupture in the traditional Indian society. Usually the family members or other caregivers are themselves the abusers. The objectives of the study were to investigate the problem of elderly abuse; formulate an appropriate response; and see how social work interventions could be effective in dealing with such problems. There is no single pattern of elderly abuse. It can take different forms such as emotional abuse, physical abuse, neglect, sexual abuse, financial exploitation and many other forms of abuse. About 80% of the elderly population in India lives in rural areas, and 30% elderly are below the poverty line. When the elderly are isolated from society or from social networks, they are not permitted to come into the mainstream society. Elderly people with severe physical or mental impairments tend to become more dependent or vulnerable. It was found that abuse was cyclic in nature. The present generation felt that older people were unproductive and treated them as a burden. The physical abuses observed among elderly people were repeated unexplained injuries; bruises or grip marks around the arms or neck and inconsistent explanations of the injuries. Emotional/ psychological abuses were verbal assaults, humiliation, threats, harassment or abusive behavior. When the elderly were neglected they had sunken eyes, extreme thirst, bedsores, signs of malnourishment, etc. When the elderly were sexually abused, they showed bruised breasts, torn or bloody underwear, unexplained vaginal or anal bleeding, etc. At times caregivers withheld even the basic rights. Studies have found that individuals in poor health were more likely to be abused than relatively healthy individuals. Some caregivers may be abusing elders by using them as a scapegoat or as an outlet for their own difficulties and frustrations. This abuse could be due to marital stress between an older couple, family stress, emotional and psychological problems of caregivers, certain societal attitudes, etc. Social workers in India need to develop the skills for working with elderly. At the community level, planning for long term care must focus on four themes: developing priorities to reflect values;

setting up human services organizations governed by a set of rules and procedures, choosing objectives to which participants and organizations are committed; and mobilizing the various resources. WHO has developed awareness materials to assist professionals with screening tools to identify abusive and potentially abusive situations, protocols for referral and intervention, and training resource kits for service providers. People and caregivers should be sensitized about the security of elderly persons; elderly individuals should not be left alone for long periods of time; family members should have close ties with their ageing relatives or friends; and communities should consider providing direct assistance to care giving families.

Key Words : 1.AGED WELFARE 2.AGED ABUSE 3.ELDERLY ABUSE 4.PHYSICAL ABUSE 5.EMOTIONAL ABUSE 6.PSYCHOLOGICAL ABUSE 7.NEGLECTED 8.SEXUAL ABUSE 9.CULTURAL FACTORS 10.ABUSE OF AGED.

CHILD LABOUR

2. Mishra, G.P and Bajpai, B.K. (1999).
An Evaluation Study on National Child Labour Project in Ferozabad. Lucknow : Giri Institute of Development Studies. 171 p.

Abstract : National Child Labour Projects (NCLP) were conceptualized and put into operation from financial year 1995-96 by the Ministry of Labour. The purpose of the study was to evaluate the content, process and impact of National Child Labour Project (NCLP) on special schools for rehabilitation of child labour and the affected families in Ferozabad. Data was collected from 40 centres/schools by interviewing students and their parents. Out of 40 centres, 27 centres were located in urban areas and 13 were in rural areas, which were run by two agencies namely Child Labour Welfare Society (CLWS) and District Council for Child Labour (DCCL). There were 3165 students studying in these centres of whom 2665 (84%) were enrolled in the schools run by CLWS and 500 (16%) children were enrolled in DCCL. In the schools run by DCCL, 200 students were getting vocational training, but in the schools run by CLWS there was no provision for vocational training. The proportion of female students was below 50% in special schools. The facility of nutritional food, books and stationery were available to 100% students in rural and urban areas. But students and parents were not satisfied with these facilities. Medical check-up was done of only 17.49% students. About 68% students were found to be working while getting education. More than 65% children worked because of their low household income. Out of 362 working children, 56 suffered as

they became handicapped, and developed chronic diseases. More than 93% child workers were not provided facilities like drinking water, light and sanitary conditions at the place of work. 57.3% children had started working below the age of 14 years. In urban areas, a large proportion of households (84%) were satisfied with rehabilitation programmes as compared to households in rural areas (74.6%). Only 40% people were aware about anti-poverty programmes. The problem of child labour still persists. It was suggested that there should be proper implementation of NCLP to create awareness among people about anti-poverty and welfare programmes, and awareness campaigns for parents so that they should not permit their children to work as child labour. Also, there should be more trained staff and improved facilities for imparting vocational training in these centres.

Key Words: 1.CHILD LABOUR 2.NATIONAL CHILD LABOUR PROJECT 3.FEROZABAD 4.NATIONAL CHILD LABOUR PROJECT FEROZABAD 5.CHILD LABOUR REHABILITATION 6.REHABILITATION CHILD LABOUR.

3. Nagda, B.L. (2005).
Socio-Demographic parameters of health of working children. *Indian Journal of Population Education*, Sep (30) : 12-25.

Abstract : Working children can be broadly defined as that segment of the child population which participate in work either paid or unpaid. World Bank (2002) revealed that there are 6 crore working children in India including one and a half crore bonded working children. Working children are engaged in agrarian, industrial and service sectors. UNICEF has classified working children into three categories namely, within the family, within the family but outside home, and outside the family. The main objectives of the study were to investigate the socio-demographic and economic background of working children and their families and assess the type of work done by them along with its impact on their health. Five towns in the urban areas of Udaipur district, including district headquarters, were selected for the study. A total of 200 children were selected who were engaged in different types of economic activities in the unorganized sector. Interview schedules and observation methods were used to collect data. It was found that about 89% of the children belonged to scheduled castes and scheduled tribes. The mean family size was 5.9 and the mean monthly income of working children was Rs. 578 per month. About 71% of the parents and 75% working children were illiterate. More than half of the working children were in the age group 10-12 years. They worked at construction sites of buildings and roads. Some of them worked in factories and also as domestic servants. Mean working hours of male and female children were 8.1 and 7.6 respectively. The length of working hours varied from 6 to 12 hours per day. The children strongly agreed that it was poverty, disinterest in studies,

motivation by friends to take up a job, death of parents, and the need to supplement family income that compelled them to take up jobs. The children worked in un-congenial conditions which deteriorated their health. About 66.67% of the working children were suffering from various diseases such as fever, cold and cough (18% females), tuberculosis (2.3% males), respiratory infections (15%), and diarrhoea (13%). A majority of them did not know the symptoms of diseases, availability of treatment and sources of immunization, etc. For the physical and mental development of working children, some special safeguards are needed such as the existing child labour laws need to be enforced more effectively; the Government should appreciate those villages and panchayats where there are no working children; and all the Government departments should work together in order to eliminate the evil of child labour. The Government should make sincere efforts to promote the small family norm which would help to reduce fertility and the number of family members who have to be fed within the limited resources available.

Key Words : 1.CHILD LABOUR 2.HEALTH 3.WORKING CHILDREN 4.SOCIO-DEMOGRAPHIC FACTORS 5.SOCIO-ECONOMIC FACTORS 6.HEALTH STATUS CHILD LABOUR 7.OUT OF SCHOOL CHILDREN.

CHILD WELFARE

4. Bhargava, Pradeep, Mathur, Kanchan. and Rajagopal, Shobhita. (2005). Understanding childhood poverty in Rajasthan. London : Childhood Poverty Research and Policy Centre. 70 p.

Abstract : The present study examined childhood poverty and the mechanisms that led to transmission of poverty over a life course, and between generations. The study was carried out in 4 villages in 2 districts of Rajasthan, namely Banswara and Tonk. A total of 1,281 children in 3 age groups (454 children in 0-5 age group; 394 in 6-10 age group; and 433 in 11-17 age group) were covered. Assessment involved both qualitative and quantitative methods. Total household incomes were low, and the proportion of households below Rs.4,000 per capita income per annum (the official consumption poverty line) was 91% and 79% in Banswara and Tonk respectively. The depth of poverty was also high with more than 50% households in Banswara and more than 33% in Tonk below a per capita per annum level of Rs.2000. Around 45% of households in both districts consumed less than 33% of the basic norm of 450 grams of food per day (which is the poverty line norm per capita per day). Many families were forced to migrate because they were unable to meet their livelihood needs in the village. The mean annual income of

children who migrated without families was around Rs.4000/- in Banswara and Rs.2400/- in Tonk. Children in Rajasthan contributed in various activities of their households and in earning a livelihood, by participating in agriculture, cattle grazing, wage labour, etc. Parents wanted their children to start work at an early age due to poor living conditions. The most deprived children were those who worked for wages in the construction industry, and in the harvesting of soya crops. Girls spent 33-50% more time than boys in various activities, thus they were more deprived of educational opportunities. 84% households in Banswara and 93% in Tonk were indebted. The loans taken were used for social ceremonies such as marriage and death feasts. Most parents desired education for their boys, but girls' education was not a priority. There was high incidence of early marriage and early pregnancy among girls which propagated inter-generational transmission of poverty. Gender discrimination exacerbated the impact of poverty on women due to unequal access to food, health, wages and inheritance rights. There is a need to improve the availability of employment through the extension of employment guarantee programmes, so that the stress of earning livelihoods which is passed on to the children when adults are unemployed, is reduced. Formal credit and micro-finance institutions should be set up to prevent the spiral of indebtedness. Preventive programmes to deal with underlying social and economic causes of poor mother and child health (weak, under nourished girls being pushed into motherhood) are necessary.

Key Words : 1.CHILD WELFARE 2.SITUATION OF CHILDREN RAJASTHAN 3.POOR CHILDREN 4.POOR CHILDREN RAJASTHAN 5.CHILDHOOD POVERTY 6.CHILDHOOD POVERTY RAJASTHAN 7.POVERTY RAJASTHAN 8.SCHOOL DROPOUT 9.DROPOUT RAJASTHAN 10.POVERTY 11.CHILD LABOUR RAJASTHAN 12.MIGRATION RAJASTHAN 13.GIRL CHILD 14.RAJASTHAN.

DESTITUTE CHILD

5. Wankhede, Nilkantha S. (2003).
Study of medico social problems of inmates of Government Observation Home for Boys, Nagpur. Nagpur : Indira Gandhi Medical College, Dept. of Preventive and Social Medicine. ~120 p.

Abstract : Family is a crucial guiding influence in the child's personality development. Any faulty familial, environmental, socio-cultural conditions could maladjust the child. In the past five decades, a large majority of Indian children continue to remain in distress and turmoil despite hectic planning of welfare

programmes, legislation and administrative actions. According to Juvenile Justice Act 2000, Juvenile is defined as “a person who has not completed 18 years of age”. The problem of juvenile vagrancy is more acute in urban communities and especially in industrial areas. This study was carried out at Government Observation Home for Boys, Nagpur. The study design was comparative cross-sectional study. 5000 subjects were included in this study of whom 250 study subjects were inmates of Government Observation Home. It was observed that the maximum number of subjects (25.2%) were in the 10-16 years age group and a few 7.6% were below 10 years of age. Majority of the delinquents (75.71%) were above 14 years of age and a few (73.6%) were below 14 years of age. It was observed from the study that 6.4% parents of study subjects were skilled workers as compared to 19.2% of comparison subjects, and 13.2% parents were unemployed as compared to 2.8% of comparison subjects. It was found that 80.7% delinquents belonged to urban areas as compared to 73.6% neglected children in urban areas. When delinquents and neglected juveniles were compared with each other, it was observed that 72.14% delinquents belonged to nuclear families compared to 64.55% neglected children. About 5.6% study subjects belonged to upper middle socio-economic class, 18.0% study subjects to lower middle socio-economic class and 20.2% belonged to upper lower socio-economic class. It was observed that stealing was the commonest reason for their apprehension in all ages (36.8%), followed by vagrancy (29.2%), begging (12.4%), fighting and quarrelling (9.2%), murder (3.2%), etc. 56% study subjects were apprehended for various serious criminal acts, and 44% were admitted due to child neglect and abuse by parents and relatives. About 31.2% parents of study subjects were illiterate as compared to 7.2% of comparison subjects. Around 30.8% study subjects were illiterate as compared to 3.2% comparison subjects. School dropout rate was higher after 5th Standard. 3.2% parents of study subjects had an over protective attitude compared to 4.8% parents of comparison subjects. Haemoglobin level of 4.8% study subjects was normal, 24.4% had mild anaemia, 38% had moderate anaemia, and 16.8% had severe anaemia. Overcrowding was observed in institutions and cleanliness was not maintained. Immunization status of study subjects was significantly lower as compared to comparison subjects in respect of BCG immunization. At every Observation Home there should be a full time qualified physician. Facilities like toilets, and washing and cleaning facilities should be provided to maintain cleanliness within the premises. Institutions should have facilities for recreation and education. Health education and counselling aimed at reducing the behavioural problems among inmates of juvenile correction centres should be imparted.

Key Words : 1.DESTITUTE CHILD 2.INSTITUTIONAL CARE 3.OBSERVATION HOMES 4.INSTITUTIONALIZED CHILD 5.JUVENILE DELINQUENT 6.NUTRITIONAL STATUS JUVENILES 7.HEALTH STATUS JUVENILES.

EDUCATION

6. Joshi, A. and Singh, V.P. (2000).
Navodaya vidyalayas of Uttar Pradesh and Himachal Pradesh : a comparative analysis. Lucknow : Giri Institute of Development Studies. 164 p.

Abstract : Education plays a pivotal role in laying a proper foundation for the overall socio economic development of any region. In order to ensure that there is full representation of all categories of children, it was decided to have many Navodaya Vidyalayas (NV) per district, and to give admission on a blockwise basis while keeping in mind the proportion of population per block. Planning Commission, New Delhi decided to look into the functioning of the Navodaya Vidyalayas and to make an inter-state comparison of the Vidyalayas functioning in different states. Giri Institute of Development Studies (GIDS), Lucknow undertook the study in the states of Uttar Pradesh and Himachal Pradesh. Objectives of the study were to find out the extent to which Navodaya Vidyalayas have been successful in selecting intelligent and meritorious students from the SC/ST population; find out how far Navodaya Vidyalaya have ensured the intelligence level of their students; and in case if there is a difference in intelligence whether this is due to administrative, managerial or financial reasons and what measures can be adopted so that the inadequacies of implementation failures can be removed. For the purpose of the study it was decided to select three Navodaya Vidyalayas from each state. From each Navodaya Vidyalaya 24 students were interviewed and the total sample comprised 144 students. Unfair means were being used in admission tests which was proved by the fact that in Class VI there were some very poor children who did not know even the Hindi alphabets. Every Navodaya Vidyalaya has the science stream. Over 50% of children in Lucknow region secured 60% marks whereas percentages were low in Himachal Pradesh during 1995-96, but it has been improving since then. In Chandigarh, children could achieve 51% marks in 1997 and 1999. Every school was given a 10 KV generator set to be used during power failure. In old school buildings and hostels, construction and state of the buildings was rather poor and needed repair. The actual number of non-teaching staff was less than the sanctioned number of posts in all the schools except in Shimla. Every Navodaya Vidyalaya had a PT teacher and all sorts of games and sports were played but places like Mandi, Shimla did not have any play fields. In the case of 3 Navodaya Vidyalayas of Himachal Pradesh, 25% children in Shimla, 12.5% in Mandi and 41.7% in Una felt that the quality of food was not good. The condition of bathrooms and toilets was so bad that it could not even be described. Each Navodaya Vidyalaya had a number of very talented children and this talent could blossom if suitable opportunities were provided. The main problem besides homesickness was the busy schedule which children had to follow. From the

students point of view the educational standards maintained by the Navodaya Vidyalaya were very satisfactory and shows the caliber of the teaching staff. Two states have not accepted the scheme due to political reasons and as a result meritorious children of these states have been the unfortunate sufferers. The Samiti should think of asking parents to contribute at least partly towards the education of their children. Children from really poor families should be provided totally free education.

Key Words : 1.EDUCATION 2.NAVODAYA VIDYALAYAS 3.RURAL CHILDREN 4.RURAL EDUCATION 5.UTTAR PRADESH 6.HIMACHAL PRADESH

7. Pratham, New Delhi. (2006).
Annual status of education report : January 17, 2006 : provisional : ASER 2005 rural. New Delhi : Pratham. 130 p.

Abstract : The present study (ASER) was conducted to investigate the status of education in rural India. The objective of the study was to analyse learning level of children, enrollment and dropout trends in school, gender differences and school functioning. Data was collected through household level interviews, testing of children to assess their ability to read and do simple arithmetic at Class 2 level, and assess the status of government schools. Information related to children attending school was collected from National Sample Survey and National Family Health Survey 1998-99. 509 rural districts were covered in ASER 2005; and data from 485 districts was used in preparing this report. More than 9521 villages were visited. A total of 33,2971 children in the age group of 6-14 years were examined out of whom 18,2671 were boys and 15,0261 were girls. ASER recorded that 93.4% children in the 6-14 years age group were enrolled, out of whom 75.1% were in government schools, 16.4% in private schools, and a very small proportion around 1% were enrolled in Madrasas, EGS and alternate schools. 6.6% children were not in school. 60% of the students in private schools were boys, and 52.8% of the out-of-school children were girls. Some basic reading and arithmetic tasks were given to children to check their learning levels. 35% of all children could not read simple paragraphs and close to 50% could not read a simple short story. 65.3% in government schools and 52.4% in private schools could not read short texts. The proportion of children unable to read was substantially higher in Uttar Pradesh, Tamil Nadu, Gujarat, Karnataka and Madhya Pradesh, whereas Bihar featured in the top five states when ranked by Standard V children's ability to read. Arithmetic learning records showed that 41% children were unable to do either two digit subtraction or division problems. 24.4% children could do subtraction problems but could not correctly do division problems. About 25% children aged 11-14 years could not do either subtraction or division, and about 50% children could not do

division. In private schools, 33.4% children of Standard VI-VIII could not do division and in government schools the percentage was 40%. The big surprises were found in southern states where Tamil Nadu and Karnataka recorded high percentages of children who could not do the division problem that was given to them. On an average, over 75% teachers were found to be attending school on the day school visits were made. Approximately 71% enrolled children in primary schools and 73% children in schools up to Standard VIII were present on the day of school visit. Pupil Teacher Ratio, based on attendance of children actually present and number of teachers who attended on the day of visit, was well below 1:40, with the exception of Uttar Pradesh, where the ratio was 1:49. At the national level, on an average, there was one teacher in a school with enrollment of 50 or less children, and 2 teachers in a school of 51 to 75 children. 78% of the primary schools visited had either a hand pump or a tap, and of these, 85% had water supply. 60% of the schools visited had toilet facilities, but only 70% of these were usable. 83% schools up to Standard VIII had hand-pumps or taps, but only 87% of those had water supply. 77% had toilets of which 72% were working. More than 80% children in Standard V had textbooks in the 8886 schools observed. Availability of textbooks was low in primary schools of Bihar (52.4%), Jharkhand (35.1%) and Orissa (32.3%). 70% of the schools visited were preparing or serving mid-day meals. ASER 2005 showed that enrollment levels in schools were very high in almost all states, however basic reading and arithmetic skills needed to be improved. A solid foundation in elementary classes was essential to build up a base for learning.

Key Words : 1.EDUCATION 2.PRIMARY EDUCATION 3.SCHOOL EDUCATION 4.LEARNING ACHIEVEMENT 5.QUALITY EDUCATION 6.EDUCATION RURAL AREAS 7.OUT OF SCHOOL CHILDREN 8.EDUCATION STATISTICS 9.STATISTICS EDUCATION 10.RURAL EDUCATION.

8. Singh, Y.P, Joshi, A. and Garia, P.S. (2003).
Social acceptability of parishadiya primary schools in comparison with other type of schools functioning in the same area. Lucknow : Giri Institute of Development Studies. 195 p.

Abstract : Primary education provides the base on which an individual proceeds to acquire higher education. The study highlighted the social acceptability of Parishad Primary Schools of Uttar Pradesh (Faizabad and Agra) in terms of enrolment, quality of education and teachers, infrastructure of schools, parents' views, and compared Parishadiya Schools with private schools functioning in the same area. Data was collected by interviewing parents, members of the Village Education Committee (VEC), from schools and other secondary sources. It was found that

60% of the students of both the districts came from poorer sections of society because of incentives such as free books, free monthly ration and free education. Many students leave Parishad Schools because they do not provide regular and good quality education. 49% parents in Faizabad and 47% parents in Agra have expressed satisfaction over the quality of education, but they were not very satisfied with the general atmosphere prevalent in Parishad schools. The percentage of trained teachers in Faizabad and Agra was 99% and 97% which was good but the number of teachers was less. Many schools do not have maths and science kits provided by District Institute of Education and Training (DIET), and in schools that have such kits, teachers do not use them while teaching. As far as infrastructure was concerned a high percentage of Parishad Schools were located within the village. 95% schools had water, but toilet facilities were inadequate, particularly in Faizabad. These schools were also deficient in teaching and playing materials, and also did not have boundary walls and play fields. There were 65 private schools spread over the two districts. In Faizabad, the average number of teachers per school was 6 while in Agra it was 5. The infrastructure facilities in private schools were in better condition compared to Parishad schools with respect to availability of playgrounds and play material and all were in *pucca* (permanent) buildings. But children have to pay high fees in private schools. Parents were impressed with the quality of education and proper management in private schools. It was suggested that the quality of education of Parishad schools must be improved by giving training to teachers, providing learning and teaching materials, filing the vacant posts of teachers, and paying teachers a good salary.

Key Words : 1.EDUCATION 2.PRIMARY SCHOOL 3.PARISHAD SCHOOLS 4.PRIVATE SCHOOLS 5.PRIMARY SCHOOLS UTTAR PRADESH 6.ACCEPTABILITY OF PARISHAD SCHOOLS 7.UTTAR PRADESH.

GROWTH AND DEVELOPMENT

9. Pandey, D. D. (2005).
Contrary currents in early childhood education. New Delhi : National Institute of Public Cooperation and Child Development. 37 p.

Abstract : The study assessed the situation of pre-school education in India. As per the analytical report on primary education during 2003 carried out by National Institute of Educational Planning and Administration (NIEPA), only 14.27% primary schools had attached pre-primary sections in India. Except for West Bengal, the percentage of pre-primary sections attached to primary schools in all other states

was above 3%. West Bengal had only 0.12% such primary schools. The states of Maharashtra (36.47%), Madhya Pradesh (35.33%), Andhra Pradesh (22.95%), Chhattisgarh (16.80%), Assam (15.90%), and Tamil Nadu (11.65%), etc. had a large number of preschool centres (PSCs) attached to primary schools. Pre-primary sections were also attached to a large number of elementary (23.21%) and integrated higher secondary schools (39.84%). In Andhra Pradesh and Madhya Pradesh, pre-primary sections were attached to a large number of elementary (23.21%) and integrated higher secondary schools (39.84%). In Andhra Pradesh and Madhya Pradesh, pre-primary section was attached to 36.79% and 45.30% of the total elementary schools. In Karnataka and Tamil Nadu, pre-primary section was attached to as many as 78.43% and 66.50% of the total integrated higher secondary schools. The percentage of enrollment in pre-primary classes was only 2.66% in PSCs attached to primary schools, and 1.45% and 0.56% respectively in PSCs attached to the elementary and higher secondary schools. The highest percentage of pre-primary enrollment in PSCs in attached primary schools was found in Madhya Pradesh (9.78%), and the lowest in Himachal Pradesh (0.89%). Madhya Pradesh also had the highest percentage (4.44%) of pre-primary enrollment in PSCs attached to elementary schools. The lowest pre-primary enrollment (0.07%) was found in Uttar Pradesh. The Early Childhood Education Scheme was implemented in 9 educationally backward states namely Andhra Pradesh, Assam, Bihar, Jammu and Kashmir, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal to reduce dropout rates and to improve the rate of retention of children in primary schools. The National Crèche Fund (NCF) was setup in 1994 to meet the growing needs for more crèches, and only the children of parents whose family monthly income did not exceed Rs.1,800 were eligible for enrollment. The Central Sector Scheme of Assistance to Voluntary Organizations for running Day Care Centres for Children of Working/ Ailing Mothers was started to provide help to migrant, agricultural and construction labourers. The Early Childhood Care and Education (ECCE) schemes were run by NGOs to provide education to children of socially and economically backward sections. The NGOs primarily worked with children of tribal people, migrant labourers and rural inhabitants. However, urban slums were not covered adequately under the pre-school education schemes. Children often found the transition from pre-school to primary school to be difficult, as a wide gap existed between the education techniques of the two systems. This led to increased dropout rates at the primary schooling level. Uneven geographical distribution by teacher education training centres existed, and no centres were found in the North-East region. Under utilization of ICDS training centres was reported. Reasons for this were non-deputation of sufficient number of trainees and non-reporting of trainees at training centres. No well defined monitoring system for evaluating the training programmes was present. There is need for a strong alliance between Government and voluntary organizations to upgrade the early education centres. The Union Government should ensure that each state's Women and Child Development

Department should network with NGOs at the district level. Government should allocate more funds for ECCE.

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

HEALTH

10. Balasubramanian, P. (2005).
Health needs of poor unmarried adolescent girls : a community based study in rural Tamil Nadu. Indian Journal of Population Education, March-June (28-29) : 18-33.

Abstract : Adolescent girls constitute one fifth of the female population in the world. In countries like India, adolescent girls face serious health problems due to socio-economic, environmental conditions and gender discrimination which makes them more vulnerable to health risks. A vast majority of girls in India are suffering from either general or reproductive morbidities. The main objective of this study was to explore health needs of 391 adolescent girls in the age group 11-18 years. A complete house to house survey of unmarried adolescent girls was done in 13 villages of Chunampet panchayat, Tamil Nadu, not only to assess their general and reproductive health status, but also to assess their care seeking behaviour for their illness and to document their menstrual practices and patterns. Findings showed that the mean age of girls was 14.56% years and a majority of them (89%) had attended school. All except 5 were Hindus and belonged to the 'Dalit' community. About 67.26% of the girls interviewed had reached menarche, and two-fifths of these girls felt tense, anxious and angry during their periods. It was also observed that prevalence of reproductive morbidity was very high, and 82% of girls who had attained puberty had one or more gynaecological problems. The mean age of menarche was 13.48 years. A negative association was observed between age at menarche and morbidity i.e. prevalence of morbidity increased with age at menarche. Dysmenorrhoea and menstrual irregularities were highly prevalent. There was a close relationship observed between menstrual hygiene and reproductive morbidity. Girls who bathed in rivers, lakes and ponds reported higher morbidities. About 130 girls (33.25%) were working. The prevalence of reproductive morbidity was higher among working girls. The prevalence of general morbidity increased with age and it was higher among illiterates than literates and was

slightly higher among girls who did not work. An overwhelming majority (87%) of adolescent girls in the survey had any one of the morbidities, reproductive (46%), general (5%) or both (37%) at the time of the survey. The treatment seeking behaviour for reproductive illness was very low, however it was comparatively good for general illnesses like cold, cough, headache, fever, etc. Around 50% of the girls had undergone treatment for these illnesses. It was apparent that adolescent girls had some reservations in seeking treatment for reproductive illnesses even though they had these for a long time. Findings indicated that girls suffered the health consequences of their socio-economic status, poor personal hygiene and lack of nutrition. Improving awareness about self care practices and care seeking behaviour may prevent the reproductive morbidities that were an outcome of poor personal hygiene. Also, there is an urgent need for accessible health services for adolescent girls in rural areas in all dimensions including reproductive health.

Key Words : 1.HEALTH 2.ADOLESCENT HEALTH 3.ADOLESCENT GIRLS 4.UNMARRIED GIRLS 5.RURAL POOR.

11. Gulati, S.C and Sharma, Suresh. (2002).
Fertility and RCH status in Uttaranchal and Uttar Pradesh : a district level analysis. Delhi : Institute of Economic Growth, Population Research Centre. 15 p.

Abstract : The study attempted to highlight the linkages between fertility and other crucial Reproductive and Child Health (RCH) components viz. antenatal care, safe deliveries and children's immunization; and other socio-economic demographic indicators at the district level in Uttar Pradesh (UP) and Uttaranchal. Data was collected from district level surveys conducted under RCH programme during 1998 and 1999, Censuses, Planning Commission documents, and Center for Monitoring Indian Economy (CMIE). Demographic Factors and Reproductive Health Care was found to be good in most of the hill districts of Uttaranchal compared to the districts of Uttar Pradesh. Dehradun was placed at the top with RCH status (2.4%) compared to the other districts. Districts which were found to be demographically backward with low status of RCH were Firozabad, Bareilly, Moradabad, Allahabad, Aligarh and Mirzapur in Uttar Pradesh. Fertility levels were found to be much lower in hill districts compared to districts in the plains of Uttar Pradesh. Western Uttar Pradesh had higher levels of fertility compared to eastern UP. However, the districts of Ballia (55.57%) and Mirzapur (55.7%) of eastern parts showed high levels of fertility. Safe deliveries and children's immunization were associated with significant and inhibitive impact on fertility. Women's empowerment and enabling factors like female education and work participation also depicted a significant and inhibitive impact on fertility. Muslim dominated districts showed higher levels of

fertility compared with other districts. Results suggested that there was a need for proper implementation of health and family welfare programme and focusing attention on Muslim dominated districts, so that there is better utilization of RCH care to control fertility.

Key Words : 1.HEALTH 2.REPRODUCTIVE AND CHILD HEALTH 3.FERTILITY 4.UTTARANCHAL 5.UTTAR PRADESH.

12. Gulati, S.C and Sharma, Suresh. (2001).
Reproductive and child health status in India : district level analysis. Delhi : Institute of Economic Growth, Population Research Centre. 41 p.

Abstract : The objective of the study was to analyse the reproductive and child health status (RCH) in India. The survey was conducted in 504 districts of India, which were covered under RHS-RCH project sponsored by Ministry of Health and Family Welfare. Data collected by the 1991 Census of India was used for analysis. RCH indicators and 12 socio-economic and demographic variables were selected. 97 out of 504 districts depicted low status of RCH, and 81 of these 97 districts were in Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan, while the remaining 16 districts were from North-Eastern region i.e. Assam, Meghalaya, Nagaland and Arunachal Pradesh. Furthermore, within the 4 states Bihar was found to be (39/43) lagging far behind in terms of RCH utilization and demographic backwardness, where 39 out of 43 districts had low RCH status. Next most backward was Uttar Pradesh (29/68) with low RCH status. High RCH status was found in four southern states namely Andhra Pradesh (10/23), Karnataka (10/20), Kerala (13/14) and Tamil Nadu (21/22), and among the smaller states Himachal Pradesh showed good performance (8/12) and came under high RCH status. Leh in Jammu and Kashmir was one of the best performing district in India. Women's empowerment and enabling factors like female literacy and female employment were found to be an important determinant of RCH status and demographic development at district level. Infrastructure variables like number of ANMs, and road connectivity of villages showed a significant and positive impact on the RCH status of the districts. Furthermore, extent of urbanization and economic development also depicted a significant and promotive impact on RCH status. Muslim dominated districts were associated with a significant and negative impact on RCH status. The study suggested that special measures should be adopted for the districts falling in lower categories of RCH status. Provision of quality health care services, improved health infrastructure, and trained health personnel were essential for fertility control and population stabilization.

Key Words : 1.HEALTH 2.REPRODUCTIVE AND CHILD HEALTH 3.RCH SERVICES 4.DISTRICT WISE ANALYSIS

13. Gulati, S.C and Sharma, Suresh. (2003).
Women's reproductive tract infections in Uttar Pradesh and Uttaranchal. New Delhi : Institute of Economic Growth, Population Research Centre. 11 p.

Abstract : Population policy document for Uttar Pradesh (2000) envisages substantial reduction in the proportion of women having RTI (Reproductive Tract Infection) and STI (Sexually Transmitted Infection) symptoms from 32% in 1997 to 10% in 2011 and 5% in 2016. A similar vision was set for the state of Uttaranchal. The present study purports to highlight the crucial factors influencing the incidence of RTIs/STIs and other inter-linkages between the incidence of RTIs/ STIs and other RCH (Reproductive and Child Health) components viz. utilization of antenatal and delivery care, children's immunization, contraceptive usage, socio-economic and cultural factors, and infrastructure variables through factorial investigations. The study also intends to prioritize the implications that facilitate control of the incidence of RTIs/ STIs in Uttar Pradesh and Uttaranchal. District-wise database for RTIs/ STIs amongst women in these states has been drawn from the Rapid Household Survey under the RCH Project conducted during 1998-99. The district level survey elicited information from selected currently married women aged 15-44 and men aged 20-54 years about reproductive health. Some specific information was also collected 3 months preceding the survey to classify men and women suffering from RTI/ STI. The study revealed interstate variations in the incidence of RTIs/ STIs among males which was found to be 3 % in Himachal Pradesh and 21% in Uttar Pradesh. In general, the incidence was much higher in the Western districts of Uttar Pradesh and some hilly districts like Tehri-Garhwal (56.5%) of Uttaranchal. The eastern parts of Uttar Pradesh except Barabanki (52%) have evinced lower levels of the incidence as compared to the Western parts. Muslim dominated districts in Western Uttar Pradesh like Rampur (59%), Moradabad (58%), Pilibhit (56%), Shahjahanpur (48%), etc. depict relatively much higher incidence of women's RTIs. It was found that in most of the districts the prevalence rate was higher for females as compared to males, which could be due to frequent child bearing making women more vulnerable to RTIs. The incidence rates have been classified into three categories viz. low, medium and high, and women's incidence rate of RTIs/ STDs ranges between 19-31%, 32-39% and 40-59% respectively. The factorial analysis highlighted strong and inverse linkages between incidence of women's RTIs/ STIs and utilization of RCH care. The important socio-economic characteristics depicting strong linkages with the incidence of RTIs turned out to be infrastructural characteristics like housing conditions, including *pucca* (permanent) to *kaccha* (temporary) house ratio, proportion of houses with basic amenities like toilet, kitchen and safe drinking water. The sectoral aspects of economic development like agricultural, industrial and overall urbanization level depicted strong linkages with the incidence of RTIs/ STIs. Institutional deliveries depicted

significant and inhibitive effect on the incidence of RTIs/ STIs, and so did women's empowerment indices like women's literacy and participation. Districts with predominance of Muslim population depicted higher incidence of RTIs/ STIs. The study also found that higher fertility was associated with higher incidence of RTIs/ STIs. Hence, it is suggested that proper focus on components like RTI and infertility control would generate more credibility of the package of RCH services amongst people. The positive paradigm shift towards the RCH care package now is most appropriate and desirable towards control of RTI/ STDs and thereby fertility too.

Key Words : 1.HEALTH 2.REPRODUCTIVE TRACT INFECTIONS (RTIs) 3.REPRODUCTIVE HEALTH 4.UTTAR PRADESH 5.UTTARANCHAL.

14. James, K.S. and Subramaniam, S.V. (2004).
Neonatal mortality in India : the role of maternal factors. *Demography India*, 33(2) : 157-71.

Abstract : The objective of the study was to develop a framework within which to understand the determinants of neonatal mortality in India. To collect the data National Family Health Survey (NFHS) 1998-99 was analysed. The study was conducted in all the major states of India. Variables used in the survey were demographic (age of the mother at birth, birth order, birth interval), nutrition (body mass index), mother's education level, work status of women, standard of living, place of residence, health behaviour, genetic factors, hospital care and injury (prenatal and postnatal complications). Among the demographic variables, birth interval was found to be significant. Children with previous birth interval less than 18-24 months had significantly lower chances of survival as compared to children with more than 24 months birth interval. Mothers giving birth in the age group 25-30 and birth order 3-6 had lower neonatal deaths than those giving birth during 18-24 years. Nutritional status of mother assessed through Body Mass Index was found to be insignificant. Neonatal Mortality was less among highly educated mothers compared to mothers with low education. The incidence of neonatal mortality was higher among working mothers compared to non-working mothers. High neonatal mortality among children of working mothers confirmed that it was merely the poverty factor and not the lack of sufficient attention paid to the child due to work. Standard of living and urban residence were not significantly associated with neonatal mortality. Genetic factors measured in terms of previous experience of still birth or spontaneous abortion was found to be highly significant in explaining neonatal mortality. The health behavior of mother in terms of smoking, drinking alcohol and chewing tobacco, and injury variables was found to be insignificant. Health seeking behaviour of the mother was significantly associated with neonatal mortality, as also a proper medical check-up and immunization which showed

positive relationship with neonatal mortality. The available trends and patterns on infant mortality in India suggest that effective reduction in IMR will depend primarily on controlling neonatal deaths. However, delivery under medical supervision showed a positive significant relationship with neonatal mortality. The study indicated an urgent need to provide standard hospital care to save the lives of neonates

Key Words : 1.HEALTH 2.NEONATAL MORTALITY 3.INFANT MORTALITY 4.MATERNAL MORTALITY.

15. Kanitkar, Tara and Radkar, Anjali. (2004).
Self-reported symptoms of reproductive health problems of women in India. *Demography India*, 33(2) : 231-248.

Abstract : Reproductive health has been till recently a neglected area in the public health domain of several developing countries including India. This study focused on some aspects related to prevalence rate of Reproductive Tract Infections (RTIs) among married woman aged 15-49 and factors associated with RTIs in urban and rural India. Data was collected through National Family Health Survey-2 (1998-99) on some common symptoms of RTIs namely, abnormal vaginal discharge, urinary tract infections and intercourse related pains. Demographic, social, behavioural and economic factors were considered. The prevalence rate of RTIs in urban areas was 37% and in rural areas 40%. Abnormal vaginal discharge and severe abdominal pain was found to be 45% in urban and 49% in rural areas. 42% reported pain or burning while urinating and 31% mentioned pain during intercourse in urban areas. On an average, women reported more than two symptoms of RTIs which were 2.32% in urban and 2.50% in rural areas. Highest prevalence rate of RTI symptoms were noted in the north-eastern states and Jammu and Kashmir. Northeastern states show prevalence rates within the range of 67% for Meghalaya and 42% for Arunachal Pradesh, whereas 61% women reported at least one symptom of RTI in Jammu and Kashmir. It was observed that woman having no children had the highest prevalence rate of RTIs (42% in urban and 43% in rural areas). Muslim women reported the highest RTI prevalence. Illiterate women reported high prevalence rate of RTIs as compared to literate women. Among the iatrogenic factors, induced abortions, spontaneous abortions and sterilizations were significantly associated with RTI prevalence in both areas. One important factor associated with RTI symptoms was the place of delivery. Home delivery was the greatest risk factor associated with RTI symptoms, and delivery in private hospitals had minimum risk. Highest RTI prevalence rate was observed for women who married at age 15 years and lowest for women married at 19 years or above. Those who were exposed to mass media reported fewer symptoms of RTI. Women who

had experienced beating were more likely to have RTI symptoms than those who had not. It was found that women having a high standard of living had fewer symptoms of RTIs than those with a low standard of living. It was suggested that there is urgent need for improving the implementation of reproductive health programmes and strengthening health education for mothers.

Key Words : 1.HEALTH 2.REPRODUCTIVE HEALTH 3.MATERNAL HEALTH.

16. Pandey, Arvind, et al. (2004).
Are too early, too quickly and too many births the high risk ? an analysis of infant mortality in India using National Family Health Survey. *Demography India*, 33(2) : 127-57.

Abstract : The National Population Policy has emphasized the need to reduce Infant Mortality Rate (IMR) and minimize the risk of death of mother and child. The present study examined the level of Neonatal, Post-neonatal, and Infant Mortality Rate in the context of high-risk birth, along with various causative factors and variations that exist across states. Field surveys and interviews were conducted, and information / data collected through National Family Health Survey 1998-99 (NFHS) was analysed. The survey covered 99% of India's population living in all 26 states. Birth records of all those children (of eligible women) who were ever exposed to the risk of death, and were between 1-12 months of age during the ten year period preceding the reference date were analysed. Maternal factors such as age, birth orders, birth intervals, socio-economic variables (place of residence, mother's education, caste, mother's exposure to mass media, standard of living index, and sex of child) were investigated. Antenatal care (ANC), health check-ups, number of tetanus injections received by mother and consumption of iron folic acid tablets or syrups were the health factors considered. Neonatal, post-neonatal and infant mortality was found to be much higher in rural areas compared to urban areas in all the major states of India. Higher educational level of mothers was associated with lower level of neonatal and post neonatal mortality in all the states of India. Neonatal Mortality was higher among children of Schedule Caste and Schedule Tribe mothers compared to OBC mothers. Mass media had a positive effect on reducing neonatal mortality. It was found that children belonging to low standard of living were more likely to have higher neonatal, post-neonatal and infant mortality in almost all states of India. The neonatal mortality was higher among males than females for some states except Haryana, Punjab, Andhra Pradesh and Tamil Nadu, whereas female mortality was found to be higher in post-neonatal stage in the states of Haryana, Punjab, Rajasthan, Madhya Pradesh, Uttar Pradesh, Bihar and Orissa. Mothers below 20 years and above 35 years have experienced higher neonatal mortality than those giving birth at age 20-34 years.

Higher neonatal mortality was found when the birth interval was less than 24 months in almost all states. Average sized babies at birth tend to have lower neonatal mortality than babies with smaller or larger size. Mothers who had undergone three and above antenatal check-ups had lowest neonatal mortality, which was found to be lower in all the states except Haryana, Maharashtra and Punjab. Place of delivery did not seem to have an impact on neonatal mortality as was seen in states like Rajasthan, Madhya Pradesh, Uttar Pradesh, Bihar, Haryana, Tamil Nadu and Karnataka. Results indicated that strategies need to be built into IEC system to create awareness among mothers about child care and child survival

Key Words : 1.HEALTH 2.INFANT MORTALITY 3.CHILD MORTALITY 4.NEONATAL MORTALITY.

17. Paul, Dinesh et al. (2005).
Psycho-social morbidities among adolescents going to schools of South West Delhi. New Delhi : NIPCCD. 90 p.

Abstract : In India, adolescents constitute 20% of the total population, but none of the existing health policies or programmes are specifically targeted at this group. The objectives of the present study were to identify needs and problems of school going adolescents, to identify the correlates affecting adolescent mental health and to identify adolescents with problem behaviours. Data was collected from schools of South West Delhi through purposive sampling. In all 1302 adolescents in the age range of 12-19 years were selected randomly for the study. The tools employed were personal data sheets (for adolescents and teachers), Youth Self Report (YSR) by T. M. Achenback and identification of sources of daily stress. Only about 35.41% adolescents had secured marks above 50%. About 76% adolescents girls were found to be undernourished. Factors associated with this were gender discrimination, nutrient deficient diets and media influence for encouraging slim physiques. Eight core problem behaviours identified were withdrawn, somatic complaints, social problems, thought problems, attention problems, delinquent behaviours, aggressive behaviours and anxiety/ depression. These were further classified as Internalising Syndrome (withdrawn, somatic and anxious/ depressed), Externalising Syndrome (delinquent behaviour and aggressive behaviour) and Neither Internalising Nor Externalising Syndrome (Social problems, thought problems and attention problems). About 630 students were identified as having psycho-social morbidity, and among these 422 were categorised as high risk cases. Social problems (34.41%) was the leading cause of morbid conditions, followed by anxiety/ depression (19.74%), somatic complaints (19.12%), thought problems (14.13%), delinquent behaviour (10.75%), attention behaviour (10.52%),

aggressive behaviour (8.92%) and withdrawn behaviour (6.91%). Ten common concerns which were sources of stress were too many things to do, concern about weight or physical appearance, doing home work, frequent nagging and scolding, meeting deadlines at work, taking many decisions, attending tuitions, meeting responsibilities outside home, and arguments with friends and family. Also, a significant positive correlation (Karl Pearson's Coefficient of Correlation) was found between the class in which adolescent was studying and the problem behaviour. It was suggested that once the problem is diagnosed, therapies should be planned and administered keeping in view individual needs for not only the problem behaviour but also to bring about holistic development of adolescents. Also, other than school curriculum, emphasis should be laid on other components of development, particularly life skills, problem solving, developing competence and dealing with psycho-social difficulties. With this purpose, outreach programmes should be organized by specialist organizations, NGOs and expert teams for group counseling. Appointment of qualified counselors in higher secondary schools and intermediate colleges is the need of the hour.

Key Words : 1.HEALTH 2.ADOLESCENT MENTAL HEALTH 3.MENTAL HEALTH 4.MENTAL HEALTH ADOLESCENT 5.STRESS ADOLESCENT 6.BEHAVIOUR PROBLEM 7.JUVENILE DELINQUENT 8.MORBIDITY ADOLESCENT.

ICDS

18. Operations Research Group, Centre for Social Research, Mumbai. (2005). Consultancy for continuous social assessment (CSA): final report. Mumbai : ORG. 168 p.

Abstract : The objective of Continuous Social Assessment (CSA) was to provide necessary inputs for evaluation of the performance of Integrated Child Development Services Scheme (ICDS). A participatory approach was employed, wherein beneficiaries, functionaries and intermediaries (NGOs, Panchayats, etc.) involved in ICDS were contacted for the study. Techniques used were Desk Research, Rapid Field Reconnaissance Survey, Participatory Interviews, Observation of Anganwadi Centres (AWCs), Facility Mapping and Stakeholders Analysis. Urban, rural and tribal areas in Maharashtra were selected for the study. Anaemia appeared to be the most prevalent illness among women in urban, tribal and rural areas, whereas diarrhoea was the most common illness found among children. Poor socio-economic conditions and contaminated water respectively, accounted for these illnesses. Key reasons for malnutrition among women and

children were found to be poverty, lack of nutrition, early marriages and frequent pregnancies with strenuous labour, and unhygienic living conditions. Awareness about AWCs was low in urban areas as opposed to rural and tribal areas where awareness was high. Nearly 80% of the pregnant women interviewed had registered with AWCs within 4 months of conceiving. The services people were most aware of were provision of supplementary nutrition to expectant mothers and children and the immunization programmes. Lactating mothers provided with supplementary nutrition reported to be maintaining good health. Children coming to AWCs also had appropriate weight. In rural and tribal areas, children did not avail of the pre-school education programmes at AWCs due to distance and illnesses. The problems encountered at AWCs were under utilization of services and sparse funds. Under utilization of resources was due to lack of knowledge and superstitions of the respondents. There is a need to improve awareness about the services provided at AWCs so that the beneficiaries can avail of them. ICDS should work towards educating people about the ill effects of early marriages to prevent health problems in mothers and children. Parents should be made aware about the benefits of pre-school education. Community members should contribute money to meet the unforeseen expenses of AWCs.

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3.HEALTH STATUS CHILDREN 4.HEALTH STATUS ICDS CHILDREN 5.NUTRITION IN ICDS 6.COMMUNITY PARTICIPATION IN ICDS 7.PARTICIPATORY EVALUATION 8.SOCIAL ASSESSMENT 9.IMPACT OF ICDS 10.ADOLESCENT GIRL 11.OPINION OF ANGANWADI WORKERS.

19. World Bank, New Delhi. (2003).
World Bank Economic Restructuring Project (APERP) (Credit 3103-IN) Nutrition/Integrated Child Development Services (ICDS) component : supervision mission.-- New Delhi : WB. 15 p.

Abstract : The World Bank assisted Andhra Pradesh Economic Restructuring Project (APERP) under which strengthening the Integrated Child Development Services (ICDS) component was the major initiative. Under APER Project, the ICDS component covered 251 blocks, 108 old ICDS projects for service quality improvement inputs, and 143 new blocks in which ICDS services were initiated in 21 districts. Baseline data from Mehboobnagar district showed that 79% adolescent girls were anaemic, a large number of children were moderately malnourished, and the prevalence of stunting among children was wide spread in the state. Objectives of the project were universalization of ICDS which has now been achieved in terms of block outreach; but to target the deserving poor households will be the real challenge during the remaining project period. Service Quality Improvement has

been good where all 101 new blocks have received equipment and supplies; and Women's Empowerment Mothers' Committees were constituted in the newly expanded 101 blocks. Reduction of adolescent girls' anaemia (79%) is the single most important outcome indicator the Project needs to focus on in order to address inter-generational malnutrition. There was sustained progress under Civil Works. "Mother and Child Health Protection Cards", known as *"Sanjeevini Cards"*, that were launched in 61 projects in Phase I of the programme have now been expanded to cover 150 plus 101 blocks. Model Early Childhood Development (ECD) Centres along with ICDS were instrumental in ensuring that 0.2 million children were enrolled in Class I. There was sustained progress in implementing joint activities between the ICDS and the Andhra Pradesh State AIDS Control Society (APSACS). Under UDISHA, more than 30,000 AWWs and Helpers will require training. A visit to AWC, Rachapalem, Chittoor District revealed that the Adolescent Girls Programme of the center had 15 enthusiastic participants. The Primary Health Centre (PHC) appeared to be well maintained with no cases of infant deaths or maternal deaths during the last one year. Under Nayudupeta Project in Nellore District, buildings were constructed in 41 centres under the Project. There were 15 cases of severe malnutrition among children in the age group 0-3 years, and 5 cases in the age group 3-6 years. Most of the women were actively participating in the management of the ICDS programme, such as village mapping, and addressing advocacy issues like age at marriage. It was recommended that a rapid assessment of tribal blocks should be undertaken. In order to clear the backlog of training of ICDS functionaries, there is need for constituting non-institutional mobile training under the scheme. It was also recommended that provisions should be made for visits by doctors to tribal blocks, and incentive schemes taken up for functionaries should be reviewed. A systematic effort is required to involve women in core issues of ICDS such as reduction of child malnutrition through improved home based care and feeding. A pilot project is recommended with some committees to be established on the line of the Community Interest Fund (CIF) based on the concept of the District Poverty Initiative Project (DPIP). The innovative activity funds under the project may be utilized to set up anganwadi funds as revolving funds to be used for improving health referrals, emergency care of children and women at risk, and for any other purpose that the Committee finds useful.

Key Words : 1.ICDS 2.WORLD BANK ASSISTED ICDS PROJECTS 3.APER PROJECT 4.ICDS IN ANDHRA PRADESH 5.ANDHRA PRADESH ECONOMIC RESTRUCTURING PROJECT 6.EVALUATION OF ICDS 7.ANAEMIA IN ADOLESCENT GIRLS 8.ANDHRA PRADESH.

LABOUR

20. Anand, Ruth. (2000).
Study of street hawkers/ vendors in Bangalore city. Bangalore : Singamma Srinivasan Foundation, Bangalore. ~100 p.

Abstract : This study has attempted to understand the nature, size, characteristics, and issues of hawkers and vendors in Bangalore City. Large scale migration to urban centres in search of employment, natural disasters, and closure of existing industries are among the many factors that compel people to seek self employment in street hawking. Data was collected through three questionnaires (household questionnaire, time use questionnaire and questionnaire for currently married persons) in three districts (Bangalore urban, Bangalore rural and Tumkur). The meeting was held in Bangalore City where NGOs were working with hawkers/ vendors and shared their ideas and the problems faced by hawkers. Firstly, they do not have a common platform to fight for their rights. Vendors/ hawkers in all cities face continuous harassment from the police and Municipal Authorities. Hawking and non-hawking zones were a serious issue in Bangalore. The objective of the study was to know the status and socio-economic conditions of hawkers/ vendors in the city. A sample of 162 individuals from five areas namely Majestic, City Market, Ganganagar, Singapur and Gowripalya were selected for the interviews. In Bangalore, hawking is considered to be illegal. Of the total sample, 36% were males and the rest 64% were females. About 50% respondents were from middle income group, 43% from low income group and only 7% were from higher income group. Around 85% respondents felt that they were not a nuisance and only 15% of them said they did create a nuisance sometimes by following people and shouting. 55% respondents said they do obstruct the path, 35% said they weigh less and only 10% said they spread dirt around. When asked about the kind of measures they needed, 83% respondents said that vendors should be provided with space, 52% said they should be given licenses, and 60% of them felt they should be treated as respectable citizens. The problems of hawkers/ vendors needs to be solved jointly and it should be solved in a macro perspective. It was revealed that vendors/ hawkers need adequate representation in various local/ Government bodies since they do not have adequate support.

Key Words : 1.LABOUR 2.STREET HAWKERS 3.STREET VENDORS 4.URBAN POOR 5.BANGALORE.

NUTRITION

21. Acharya, Rajib, et al. (2004).
Nutritional and health impact on children breastfed beyond infancy : evidence from India. *Demography India*, 33(2) : 205-229.

Abstract : Breastfeeding is the physiological norm for both mothers and children. The study was carried out to examine the beneficial effect of breastfeeding on common childhood morbidities and its positive impact on child growth related to height and weight of children in the age group 0-35 months. Data about children was collected from mothers covered by National Family Health Survey-2, 1998-99, and a questionnaire was used to collect information related to weaning status and duration of breastfeeding. Results showed that 15% children suffered from diarrhoea who were completely weaned (no breastfeeding), 25% who were not weaned (only breastfed) and 20% who were partially weaned. The prevalence of Acute Respiratory Infection (ARI) increased drastically from 15% for completely weaned children to 26% for children not weaned at all, and 21% among children who continued to be breastfed along with supplementary food. Household conditions, hygiene, economic conditions, general health of baby and mother, and age of mother were some of the reasons associated with the prevalence of ARI and diarrhoea. 46% to 63% children who were not weaned at all and breastfed even after 18 months suffered from childhood diseases. It was found that 63% children who were partially weaned were underweight and 27% were severely underweight. 50% children in the age group 12-35 months who were completely weaned were stunted and 25% of them were severely stunted. Those children who were given weaning foods as per schedule and breastfed for 18-23 months tended to be less underweight than those who were breastfed for less than a year. It was found that prolonged breastfeeding had a positive effect on weight and growth of babies but it was also important that proper supplementary diet was given to the child along with breast milk.

Key Words : 1.NUTRITION 2.BREASTFEEDING 3.CHILD FEEDING 4.INFANT FEEDING 5.BREASTFEEDING PRACTICES 6.CHILD HEALTH 7.WEANING FOODS.

22. Giri Institute of Development Studies, Lucknow. (2000).
National Programme of Nutritional Support to Primary Education : Mid-Day Meals : a comparative lessons of experience in Uttar Pradesh and Himachal Pradesh. Lucknow : GIDS. 184 p.

Abstract : The National Programme of Nutritional Support to Primary Education (Mid-Day Meals Scheme) is intend to give a boost to universalisation of primary education by increasing enrollment, retention and attendance, and simultaneously aims at improving the nutritional level of students. The study focused on the impact of Mid-Day Meals Scheme (MMS) on enrolment growth, retention at primary level, school attendance, profile and perception of beneficiaries in primary schools of Uttar Pradesh in comparison with Himachal Pradesh, by comparing the pre Mid-Day Meal Scheme period (pre-MMS 1989-90 to 1993-94) and post Mid-Day Meal Scheme period (post-MMS 1994-95 to1998-99). Data was collected by interviewing parents and children of the selected primary schools as well as through secondary sources. The average annual growth rate of enrollment of boys, girls and total students in Uttar Pradesh was found to be 2.73%, 3.61% and 3.03% which was high compared to pre- and post MMS level. In Himachal Pradesh, the annual growth rates of enrollment of boys, girls and total students were calculated to be 3.65%, 3.65% and 3.53% during the scheme year, which was not significant. The enrolment growth in Uttar Pradesh was relatively slower than Himachal Pradesh. The retention rates in Uttar Pradesh during MMS increased by 77% for boys, 66% for girls and 75% of total students, which was quite significant compared to pre- and post MMS levels. Retention rates in Himachal Pradesh increased by 1.40% for boys, 4.90% for girls and 3.08% for total students during the scheme period over the base of non-scheme period. Retention rates were found to be high in Himachal Pradesh compared to Uttar Pradesh. The attendance rates in Uttar Pradesh of boys, girls and total students in Classes I-V was 77.43%, 75.64% and 76.86% in 1994-95, which increased to 79.78%, 78.06% and 79.19% in 1998-99, when MMS was implemented. In Himachal Pradesh, the attendance rate increased to 92.9% in 1998-99. The attendance rates in Uttar Pradesh were lower than of Himachal Pradesh. Most beneficiaries who availed the benefits of MMS were from poor socio-economic background in Uttar Pradesh, and 50% of the total beneficiaries belonged to upper castes in Himachal Pradesh. Proportion of total school-aged children not going to school was much higher (nearly 17%) in Uttar Pradesh as compared to only 5% in Himachal Pradesh. The educational level of beneficiary parents was low in Uttar Pradesh compared to Himachal Pradesh. As far as quality of education was concerned, 41% parents in Uttar Pradesh and 32% parents in Himachal Pradesh were satisfied with the increasing enrolment, retention level and attendance of students at primary level. It was suggested that the delivery system of the scheme and its management should be restructured, and awareness

generated about the need and importance of basic education among the community.

Key Words : 1.NUTRITION 2.MID DAY MEAL 3.PRIMARY EDUCATION 4.NUTRITION SUPPORT TO PRIMARY EDUCATION 5.SCHOOL LUNCH 6.GIRLS EDUCATION 7.GIRLS ENROLMENT 8.UTTAR PRADESH 9.HIMACHAL PRADESH.

23. Kanani, Shubhada, et al. (2005).
Are recommended infant and young child feeding practices being followed in our region? Assessment methods and research evidence. Vadodara : M S Univ., Faculty of Home Science., Dept of Foods and Nutrition. 108 p.

Abstract : Childhood undernutrition is a major public health problem throughout the developing world and is one of the main causes of death of many children. In this study, data was collected at household level in rural areas and urban slums of Vadodara. The tools used were Semi-Structured Interviews (SSI), Direct Observations Method and 24-hour diet recall of children under 2 years of age. Malnutrition was present due to inadequate dietary intake that resulted from poor household food security, poor health services, and poor care of women and children, especially the girl child. Poor nutrition during formative years (0-2 years) led to significant morbidity, mortality, delayed mental and motor development, impairments in intellectual performance, unfavourable reproductive outcomes, and overall poor health during adolescence and adulthood. There was high prevalence of malnutrition among under threes, especially during the period 6-24 months when transition from breastfeeding to complementary feeding (BF-CF) took place. The contributory factors were lack of awareness of desirable BF-CF practices and inadequate care-giving. 40% - 67% of the newborns were given prelacteals, mainly water and honey. The main reasons for this were that “it inculcates s*anskar* (values) in the newborn”, “it clears the dirt from the baby’s stomach”, and “initially no breast milk is produced and the child is hungry”. Some families fed colostrum (first milk) to the child, which has anti-infective properties. Nearly two-thirds (63%) of the women squeezed out the first milk before they began breastfeeding. Complementary foods were stored, prepared and fed in an unhygienic manner, which resulted in an increased risk of illness to the child. Mothers did not pay attention to whether their child had enough to eat, and to other psychosocial aspects of care during feeding, which were important for adequate food and nutrient intake. Nursing mothers should be educated by nutritionist about healthy BF-CF practices. Mothers should be encouraged to practice responsive feeding that involves sitting with the child while feeding, encouraging the child to eat, etc.

Good hygiene practices should be used for storage, preparation and feeding of complementary foods.

Key Words : 1.NUTRITION 2.INFANT AND YOUNG CHILD FEEDING 3.INFANT FEEDING 4.COMPLEMENTARY FEEDING 5.CHILD NUTRITION 6.WEANING FOODS 7.RESEARCH TOOL.

RURAL DEVELOPMENT

24. Khadi and Village Industries, Mumbai. (2005).
Report on evaluation study of rural employment generation programme. Mumbai : VMRCDI. 384 p.

Abstract : The Khadi and Village Industries Programmes (KVIP) have a unique capacity for generation of large scale employment in rural areas with less capital cost. The Rural Employment Generation Programme (REGP) is not a poverty alleviation programme but a compendium of all other such schemes under Khadi and Village Industries (KVI) sector which were merged into REGP when they were streamlined and approved by the Government of India. The principal objective of the study was to study the impact on rural employment of the magnitude, nature, quality and linkages developed by the enterprises for ensuring sustainability, and to study the optimal level of investments required. Basic data collected for the study revealed that 1,18,466 projects were sanctioned under REGP as on March 31, 2001 in 34 States and U.Ts of the country. The mandate was to cover a sample of 10% of projects by selecting samples State-wise on probability proportional to the total number stratified into three. A State-wise analysis indicated that Gujarat led other States in creating employment with 17 persons employed per enterprise. State-wise, Agro and Food based industry were highly preferred in Punjab (71.8%); Andhra Pradesh; (63%); Tamil Nadu (55.6%); Uttar Pradesh (46.5%); Meghalaya (44%), and West Bengal (35%). Projects receiving direct assistance from banks were mostly working satisfactorily, with 359 service projects comprising 80.13% of the total, followed by mineral based industries with a total of 353 projects comprising 74.47% of the total. In Andhra Pradesh, out of 23 districts where projects were assisted, Mahabubnagar had the highest number of projects assisted (9.69%). In Rajasthan, districts where enterprises were concentrated were Jaipur (10.9%), Banswara (10%), Tonk (8.6%) and Ajmer (8.6%), etc. The percentage of enterprises assisted by banks that were working satisfactorily was highest in Andhra Pradesh (97.3%), and Madhya Pradesh (94%), while the projects not working satisfactorily were in Gujarat (28.5%), and West Bengal (27.9%). The local sale of bank assisted enterprises was higher in Andhra Pradesh (95.5%) and West

Bengal (93.7%), and lowest in Maharashtra (40%). Rajasthan had the most number of enterprises (15.5%). In the General Category, the State Board assisted 45.3% enterprises or 23.2% started by entrepreneurs. The appraisal aspect of the project should be left to the prerogative of the Branch Manager, who finances the proposal. Bankers were happy in prompt release of margin money but requested for post-sanction follow up by the KVIC/ KVIB. REGP has, in a majority of the cases, encouraged cementing the relationship between financial institutions and entrepreneurs. The overall additional employment generated under the projects was 10 persons per enterprise on an average. The annual average income of Rs.43,000 was not uniform over the different levels of investment per enterprise. There may be adequate and improved technologies available, but knowledge about them and their application requires innovate entrepreneurial skills. REGP also needs to be reoriented to promote upward social mobility by focusing on certain down trodden social groups in society.

Key Words : 1.RURAL DEVELOPMENT 2.EMPLOYMENT GENERATION 3.RURAL EMPLOYMENT 4.ENTREPRENEURS 5.RURAL ENTREPRENEURS.

25. Khadi and Village Industries, Mumbai. (2004).
Status of village industries in India : Report of an all India Survey 2004. Mumbai : KVI. 383 p.

Abstract : In the Indian context, rural industrialization assumes great significance as 72.22% (Census 2001) of its population lives in rural areas. The present study aimed to understand the trends and size of village industries in India. A stratified 3-stage sample design (districts, blocks, villages) had been adopted. An all India survey was conducted in 29 States (including Delhi), zone-wise. A total of 100 districts were chosen through sampling and 2 blocks were selected from each district; from each block 5 villages were selected and from each village 10 units were chosen for data collection. The largest group of industries was tailoring and preparation of readymade garments (9.81%), followed by carpentry (7.62%), auto garage/ cycle repair (6.78%), beauty parlour (6.10%) power *atta chakki* (5.79%) and village pottery industry (5.79%). Nearly all units were proprietary in nature (97.4%). Over two-thirds of the owners belonged to backward classes (scheduled castes, scheduled tribes, etc.). Nearly 15% owners had no technical training, and 86.3% of the units were not registered with any agency. Nearly 86% of the units were not maintaining books of accounts. Majority of the units were receiving no power supply. 95% of the units were not covered under any insurance scheme. Nearly 25% units in the sample were found to be loss making, and 84% of these loss making units were own account enterprises (OAEs). 86% of the units marketed their own products. The percentage share of rural village industries in GDP was

found to be 5.2%. However, the formal financial system was not well suited to meet the credit needs of the informal sector. Inadequate access to credit, high interest rates and lack of tax benefits made expansion difficult. This further led to curtailing employment and income opportunities. Most entrepreneurs in the North – East (N-E) were first generation entrepreneurs. To support their venture they needed continued support from banks and financial institutions. Female participation in N-E village industries was higher than the all India level. Also only 10% of the owners of N-E units were illiterate, indicating that village industries provided employment avenues to educated persons. The major problems encountered by village industries all over India were procurement of raw material, competition from larger units, etc. Two-thirds of the respondents expressed lack of awareness about schemes that could rehabilitate or revive their business. An important aspect of rural industrialization is empowerment of the vulnerable, but barring north-eastern and south – eastern states, the percentage of female proprietary units were low. Credit policies for this sector need to be suitably framed to have greater outreach. Quality standardization should be enforced in village industries. Adequate training facilities need to be provided and multi- tasking should be a part of the training process.

Key Words : 1.RURAL DEVELOPMENT 2.VILLAGE INDUSTRIES 3.INDUSTRY 4.INDUSTRY RURAL AREAS 5.KHADI AND VILLAGE INDUSTRIES 6.RURAL EMPLOYMENT 7.EMPLOYMENT RURAL AREAS 8.MARKETING 9.LIST OF INDUSTRIES.

SCHEDULE TRIBES

26. Kumar, B.L. (2004).
Schools and schooling in tribal Gujarat : the quality dimension. Ahmedabad : Gujarat Institute of Development Research. 33 p.

Abstract : Gujarat state has a sizeable population of tribals and a majority of them live in the eastern border areas which are socio-economically backward. Realizing that education is important for social transformation and economic development of tribals, the Government of Gujarat has been providing sustained support to improve literacy and education among tribals through Tribal Area Sub Plan by providing them a large number of educational facilities. This study looks into issues related to access, enrolment, retention and quality of education in tribal areas of Gujarat. It is based on the survey carried out in 40 villages of 4 tribal talukas, one each from four Integrated Tribal Development Project Areas, between August to December 2000. Ten villages in each taluka were selected randomly on the basis of size of the

village population. A detailed inquiry in each village was done, both at household level and school level, to collect information about the schooling facilities available and the quality of education imparted in these schools. An indepth inquiry was also done in randomly selected 16 Ashram schools operating in the four talukas. Ashram schools play an important role in tribal education. Discussions were also held with district officials and taluka and village panchayat heads to gain more understanding about the functioning of schools and problems related to schooling in tribal areas. The study revealed that nearly 84% of predominantly tribal habitations had the facility of primary schools and 11% of such habitations had a school within a distance of 1km, but still a large number of children continued to remain out of school, and dropout rates were quite high among tribal children due to poverty, migration, indifferent attitude and lack of interest of parents in educating their children. Besides these, lack of access to upper primary and secondary level schools, uninspiring school environment, low level of learning achievement and failure were reported as major school related reasons for low school retention rates. Also the implementation of the incentives provided under the tribal area sub plan was poor, both in terms of coverage and quality. The school survey results showed that single or two teacher schools were most prevalent. The functioning of schools was poor due to absence and irregular attendance of teachers. Moreover, many schools lacked minimum facilities such as drinking water, toilets, library, etc. Multi-grade teaching was a common feature and teacher's academic skills were rarely raised through special training in handling multi-class schools, leading to poor quality of teaching. Also ashram schools, which were envisaged to be an ideal alternative for sparsely populated tribal populations, failed to deliver the goods. Thus universalization of elementary education is the real challenge for tribals who are socially, economically and educationally the most disadvantaged group. Hence, effective implementation of incentive schemes and community participation in the governance of primary schooling system can yield better results.

Key Words : 1.SCHEDULE TRIBES 2.EDUCATION TRIBALS 3.SCHOOLS TRIBAL AREAS 4.TRIBAL AREAS 5.QUALITY OF EDUCATION 6.SCHOOLING 7.ASHRAM SCHOOLS 8.GUJARAT.

SOCIAL DEFENCE

27. Kadrekar, Ujwala and Sawant, Chitra (2004).
Report on jail inspection (March 2001 - August 2002). Mumbai : National Commission for Women Maharashtra. 16 p.

Abstract : Women prisoners face many hardships in India. The present study is a report of jail inspections carried out in Maharashtra, covering 27 jails in all. A questionnaire was used to assess the quality of living conditions in these jails. 18

jails were inspected as per the questionnaire, whereas remaining 9 were inspected generally. 33% jails reported the problem of overcrowding. One of the jails had the capacity for 4 women prisoners but 15 prisoners were housed in it. 18.51% jails failed to provide adequate food to the inmates. Even pregnant women and the children of inmates were not given supplementary nutrition. The toilets in these jails were in a very bad condition and 14.81% jails had inadequate toilet facilities. Unhygienic conditions resulted from inadequate water supply, which further led to skin diseases, like scabies among the prisoners. Adequate medical help was not available in 11% of the jails. Anaemia was a common condition found among the prisoners. Children of inmates also lacked many facilities such as pre-school education, clothing, proper bedding, medical help, etc. 23.22% jails failed to provide the facility of bail to its women prisoners. The reasons cited for this were unavailability of escorts to accompany them to court and non-availability of financially sound sureties. No legal aid was available to these prisoners, despite this being a mandatory right. Much work needed to be done in the area of providing employment facilities to the inmates. Undertrials were not provided with any vocational training, and age old vocational courses were run for convicts that provided them with fewer future job prospects. Construction of new jails with adequate facilities is needed and conditions in the presently existing jails should be improved. Adequate food, water and toilet facilities in existing jails is essential. Inmates should be trained in vocational courses that provide them with opportunities for future employment. Efforts should be made so that prisoners can obtain bail quickly, and free legal aid should be provided to inmates who cannot afford it. Children of inmates should be provided with basic necessities, and facilities like education, recreation, etc.

Key Words : 1.SOCIAL DEFENCE 2.WOMEN PRISONER 3.JAIL INSPECTION REPORT 4.PROGRAMMES WOMEN PRISONER.

28. Malhotra, Seema. (2005).
Women in Tihar Jail : a report on the training programme in skill development. New Delhi :Delhi Univ., Women's Studies and Development Centre. 40 p.

Abstract : The study was undertaken to assess the impact of a training programme in skill development among women in Tihar Jail. Three specific groups were targeted and each had a different role to play in the Training Programme in Skill Development. The first was workers (undertrials in Tihar Jail), second the volunteers (people working in the NGO Scope Plus), and third was Tihar Jail Employees' Wives who have a separate production unit that allows them to earn a small amount to supplement their husband's meagre wage. It was believed that the programme has a beneficial effect on the volunteers who participate. The objective

of the study was to find out whether beneficiaries were gaining from the programme on these fronts, namely acquiring new skills in life, enhancing self esteem, learning productive ways to pass the long hours in jail, earning pocket money, etc. The NGO Scope Plus has direct access to all three targeted groups. A questionnaire was used to gather information. More than half the people interviewed were undertrials in Jail and most of the production work is done by them. Around 20% volunteers and police wives enjoyed spending their free time with their children while another 20% completed pending work in their free time. Almost 75% respondents preferred working in groups rather than individually. Respondents were given some sort of training before involving them in the training programme. 96% believed that taking part in the programme raised their self esteem, and only 4% believed that their self esteem had not increased at all. Most of them felt that their self worth and self esteem has risen substantially. More than 66.7% respondents said that their self confidence had increased as a result of their involvement with the skills programme. Nearly 66.7% respondents stated that their patience had increased since starting the skills programme. Around 50% thought that their involvement in the skills programme increased their communication skills. The activities carried out inside Tihar Jail were making paper products like stationary items, folder sets, paper bags, etc. Volunteers and prison employees' wives felt that their participation in the skills programme was a wholly positive experience. Some of the good innovations in Tihar Jail are improvements in the lodging facilities of prisoners, food, clothing and bedding, medical care of prisoners, providing communication facilities to prisoners, educational activities, vocational training, future programmes, rehabilitative activities, etc.

Key Words : 1.SOCIAL DEFENCE 2.WOMEN PRISONER 3.TIHAR JAIL 4.MENTAL TENSION 5.DEPRESSION 6.SKILL TRAINING PROGRAMME 7.SELF CONFIDENCE 8.EDUCATION WOMEN PRISONER 9.TRAINING PROGRAMME 10.SKILL DEVELOPMENT 11.VOCATION TRAINING 12.INCOME GENERATION.

29. Ramesh, Asha. (1993).
Impact of legislative prohibition of the devadasi practice in Karnataka : a study. New Delhi : Multiple Action Research Group. 65 p.

Abstract : The *devadasi* system led to exploitation of women belonging to lower castes by men belonging to upper castes in accordance with religious sanctions. The Karnataka Government passed a legislation in 1982 prohibiting the *devadasi* practice, and the present study attempted to examine the effectiveness of this legislation in 2 districts of Karnataka namely, Belgaum and Bijapur. 100 *devadasis* were selected randomly (50 from each district) and interviewed. The Karnataka Devadasi Act (1982) declared the dedication of girls as *devadasis* to be illegal and provided legal status to the marriage of a *devadasi*. Under this Act, the people performing or abetting a *devadasi* ceremony would face imprisonment and fines.

However, the Act failed to provide a definition for the dedication ceremony, thus people performed these ceremonies under the guise of religious ceremonies. The Government had not framed any detailed rules under this Act, making it difficult to implement it. The main reasons for dedication of the girls were absence of a male child, poverty and superstitions (presence of matted hair and skin problems in the girl child, etc). Most *devadasis* reported that they were aware of the ban imposed on the *devadasi* system and they also knew about the rehabilitation programmes that existed for them. Training programmes were started for skill generation among *devadasis* and even financial help was provided to them to buy cattle, etc. However, the loans for rearing cattle and dairy farming were not useful for *devadasis*. They were able to earn Rs.250/- per month during the skills training programme, but later were unable to sell their products and earn a regular income. In Belgaum, the rehabilitation programme had failed to reach the beneficiaries. Most *devadasis* experienced a change in their social standing, for the better, after they discontinued their profession. Most of them desired to educate their children and were against the dedication of their girl child. In Belgaum, several *devadasis* were active in stopping dedications. Some even registered complaints with the local police to stop the practice. Voluntary organizations also motivated *devadasis* to take advantage of the schemes that had been introduced for them. Several awareness programmes such as songs, street plays, etc. had been taken up by them. It was seen that most *devadasis* ended up in red light areas of Mumbai. More avenues of self-employment should be opened up for *devadasis*. There is a need to market the products produced by them. Integrated programmes to empower these women socially should be started so that they can themselves put a stop to the *devadasi* system. Special Schools for the children of *devadasis* should be started.

Key Words : 1.SOCIAL DEFENCE 2.DEVADASI 3.PROSTITUTION 4.REHABILITATION OF DEVADASI 5.LEGISLATION FOR WOMEN 6.LAW AND WOMEN 7.GOVERNMENT INITIATIVE.

SOCIAL WELFARE

30. Jafri, S.S.A. (2001).
Evaluation of Swarn Jayanti Shahri Rozgar Yojana (SJSRY) and National Slums Development Programme (NSDP), 1999-2000 in Lucknow division of Uttar Pradesh. Lucknow :Giri Institute of Development Studies. 195 p.

Abstract : Under the Swarn Jayanti Shahri Rozgar Yojna (SJSRY), besides self employment programme, wage employment is to be provided for unemployed, and casually employed poor are to be benefited. Employment generation scheme is being implemented in all towns/cities of India where people living below the poverty line are identified. Women, SCs and STs are given special attention. The study surveyed 1581 beneficiaries or 20% of all programme beneficiaries of SJSRY, National Slums Development Programme (NSDP) and other programmes

operational in Lucknow division. Household related socio-economic condition was also investigated. The survey revealed that the overall literacy for males was 76.37% and 59.54% for females. The highest proportion of literates were in Sitapur city, where 90.14% males and 78.10% females were literates, and next was Unnao city having 88.46% literate males and 62.20% literate females. In technical education, diploma holders were very rare, being only 17% among males, while among females there were none recorded in Lucknow division. In Lucknow division, overall male and female labourers were 21.94% and 12.41% respectively. There were places where more than 30% employees were labourers. Lucknow division had 11.68% male artisans and 27.59% female artisans. Most of the artisans were *mistries* or masons engaged in building construction. Other artisans were welders, carpenters, mechanics, embroidery workers, etc. Average income of the workers among males and females of Lucknow division was Rs.2216.00 and Rs.945.00 per month respectively. There were 66.98% p*ucca* (permanent) houses, 22.39% *semi-pucca* (semi-permanent) and 10.63% *kutcha* (non-permanent) houses. Overall, 81.97% of the surveyed houses of 1581 beneficiaries were electrified. Around 66.22% houses belonging to beneficiaries had a drinking water source within their premises. Around 66.12% beneficiaries of Lucknow got fewer amounts under Urban Self Employment Programme (USEP) than 66.81% beneficiaries in 61 towns, who got a larger amount. Under USETP Training Programme, poor women were given training in groups either in chiken embroidery, other embroidery, tailoring, manufacture of readymade clothes and other related trades. Out of 168 USETP beneficiaries surveyed, 45.24% were trained in chiken embroidery, 25.59% were trained in manufacture of readymade garments and 2.98% in embroidery. Urban Wage Employment Programme (UWEP) provided Rozgar Card to local labourers and *mistries* (masons), but all the beneficiaries complained of getting low wages. Development of Women and Children in Urban Areas (DWACUA) encouraged poor women to form and register a society so that they could start an economic activity. In real terms, DWACUAs were run only in Nakhas and Indranagar zones and Hardoi town. Under Balika Samridhi Yojana (BSY), poor mothers of female children were either given cash of Rs.500.00 or Kisan Vikas Patra for the welfare of female children. NSDP is one of the most important programmes in operation, and since the very beginning a huge amount is spent on it. It is high time that other cities and towns where slums/ *bastis* exist also take up these programmes in order to encourage balanced development. The percentage attendance of Balbari Shiksha (preschool education) students was quite impressive, but in the case of receiving reading and writing material and *Pushtahar* (nutritious meals), respondents expressed their dissatisfaction, and these aspects require attention.

Key Words : 1.SOCIAL WELFARE 2.SLUM DEVELOPMENT 3.URBAN DEVELOPMENT 4.SHAHARI ROZGAR YOJANA 5.EMPLOYMENT SCHEME 6.SWARN JAYANTI SHAHARI ROZGAR YOJANA 7.EMPLOYMENT 8.UTTAR PRADESH.

31. Verghese, Bindu P. (2004).
Human development in Kerala : disparities and distortions. Thrissur, Kerala : Calicult Univ., Dept of Economics, Dr. John Matthai Centre. ~200 p.

Abstract : Human development is concerned with a whole spectrum of human activities from production processes to institutional changes and policy dialogues. A purposive sample of 440 households from 6 different districts of Kerala was taken, inclusive of marginalized groups like fishing community, SC/STs and slums dwellers. Secondary data was also collected from Department of Economics and Statistics and other departments. Kerala remained in 1st position in Human Development Index (HDI) in 1981, 1991 and 2001. Human deprivation expressed in terms of Human Poverty Index (HPI) was least in Kerala. Public policies of State Government had played an important role to achieve high human development. North Kerala performed poorly on HDI in comparison to South Kerala. However, these northern districts had better Gender Development Index (GDI) than the southern districts. This was due to women's contribution to total income and their high work participation rate 24.3%. Women's development was limited to positive health and education attainments, but their participation in decision making bodies such as local level bodies, legislative assembly and parliament was dismal. Increased rate of crime against women and high suicide rates among them were observed. 30% of women respondents who travelled regularly reported suffering sexual harassment while traveling. Deprivations in terms of educational and employment status, health and nutritional attainments, and in terms of political and social attainments existed among Scheduled Tribes, Scheduled Castes, marine fishing community and slum dwellers in Kerala. Caste wise disparity of HDI was high. Regional differences in human development existed among these groups as well. Housing facilities index was also low - 96% of the houses in one of the districts got housing facility index below 3 (maximum value 12). The level of living of tribals was associated with the amount of land they possessed, but not a single SC household possessed land above 25 cents. Also, price crash of tropical crops and closures of tea estates due to globalization worsened conditions of tribals. Educated unemployment and unemployment among females was high in Kerala. Regional disparity in human development, in terms of north-south divide needs to be addressed through appropriate policies. Protective measures for agricultural labourers and plantation workers need to be taken up to protect them from the impact of globalization.

Key Words : 1. SOCIAL WELFARE 2.HUMAN DEVELOPMENT KERALA 2004 3.HUMAN DEVELOPMENT REPORT 4.GENDER DISPARITY 5.GENDER DISPARITY KERALA 6.TRIBAL DEVELOPMENT 7.TRIBAL KERALA 8.KERALA.

WOMEN LABOUR

32. Vanker, Purushottam. (2005).
At the Kadiyanaka : challenges faced by construction workers in Ahmedabad. Ahmedabad : Self Employed Women's Association. 31 p.

Abstract : The present study was undertaken to assess the challenges faced by construction workers, due to mechanization, wage structure, etc. The sample consisted of 250 workers (150 females and 100 males) in the construction sector. For every 3 females 2 male respondents were picked up at random from each of the 50 *kadiyanakas* (labour points) of Ahmedabad. Due to rampant unemployment, many educated people and unemployed factory workers had joined construction work. Increased competition led workers to work for lower wages and sometimes they failed to find work. Also, migrant labourers worked for very low wages and further harmed prospects of the regular workforce. Respondents said that communal violence also affected their work as they were scared to move to another area in search of work. Mechanization had also led to a decreased demand for these workers. More than 30% of the total workers reported that they had met with an accident or had experienced an episode of sickness related to work. This led to declined work efficiency in addition to medical expenses. More than 23.2% of the workers met with accidents. 16.4% of the female workers faced sexual harassment, while 9.2% of the workers faced mental harassment due to abusive language and low wages. It is necessary to provide workers with skill training to enable them to adapt to the rapidly changing construction industry. Construction Workers Welfare Board should compensate workers for accidents. Also, it is important to identify the safety measures and equipment that is required and to ensure the implementation of safety norms and measures.

Key Words : 1.WOMEN LABOUR 2.CONSTRUCTION WORKER 3.INFORMAL SECTOR 4.UNORGANISED SECTOR 5.MULTIPLE JOBS 6.LABOUR CONSTRUCTION WORKER 7.CASUAL LABOUR.

WOMEN WELFARE

33. Fazl, Fareha, et al. (2004).
Gender : what difference does it make? A psychosocial exploration of harassment, sense of safety, discrimination and prejudice. New Delhi : Delhi Univ., Dep of Psychology. 40 p.

Abstract : Sexual harassment can be unwanted and uninvited behaviour, words, gestures, threats or physical contact on a sexual basis that results in physical harm

or causes the recipient to feel uncomfortable or threatened. The present study was undertaken at Zakir Husain College as a pilot project. The total sample consisted of 83 students chosen through the process of random sampling. There were 25 males and 58 females in the study. A questionnaire that assessed the prevalence of safety and harassment in Zakir Husain College was given to each respondent. 29% of the girls reported that gender discrimination was present as opposed to 36% of the boys who reported the same. Girls also reported that boys were given more privileges and support as opposed to them. Girls had less decision-making powers about their personal and professional life. 79% of the girls reported presence of harassment in college, but only 48% of the boys believed this to be true. Female respondents cited the effect of media, vacant surroundings, lack of security and lack of sex education as the main reasons for their feelings of fear and unsafety in college. The students feared outsiders the most, followed by non-teaching staff, fellow students and the teaching staff. All kinds of suggestive gestures, verbal attacks, staring and actual physical abuse were seen at the college campus, and more so outside the campus area. 26% girls said that they had confidantes with whom they could share their harassment episodes and 43% gave justified reasons for not reporting such incidents to anyone. Reasons for non-reporting were lack of adequate social support system, non-immediacy of action and humiliation. It has been suggested that media should avoid depicting hot and bold scenes with revealing attitudes. Also, sex education can be included as an integral part of the curriculum to increase awareness. Adequate security arrangements should be made on the campus especially for women.

Key Words : 1.WOMEN WELFARE 2.SEXUAL HARASSMENT 3.GENDER DISCRIMINATION 4.HARASSMENT 5.PREJUDICE 6.DISCRIMINATION 7.COLLEGE SETTING 8.OPINION OF STUDENTS 9.SAFETY 10.MEDIA 11.TELEVISION 12.ZAKIR HUSSAIN COLLEGE.

34. National Commission for Women, New Delhi. (2002).
Life after death : a journey into the lives of war widows. New Delhi : NCW. 85 p.

Abstract : The transition from being a married woman to a state of widowhood is often tumultous and painful. 5 northern states of India, namely Delhi, Haryana, Punjab, Rajasthan and Western Uttar Pradesh were selected for the study. A total of 40 respondents (8 respondents from each state) were covered from the 1971 war and the Kargil War (1999). Interview schedule and observation technique were used for the study. Majority of the war widows were illiterate. Only 7% of the entire sample were graduates. The number of widows in the age-group of 15- 20 years was highest in Delhi. The age of marriage was closely related to the literacy level

and thus the independence of a woman. Most of the widows who were married before 18 years of age were either illiterate or had studied up to primary level. These widows were largely dependent on their in-laws and were often not respected by them. Only 29% of the respondents had remarried. Most of them had married their brothers-in-law and the decision was taken by their parents-in-law. There was discrepancy in the compensation received by a 1971 war widow and a Kargil war widow. The benefits offered to widows were allotment of petrol pumps/gas agency or agricultural land. In addition, counselling on running petrol pumps or gas agency, concessions for telephone facilities, air and rail travel, and free medical facilities in army hospitals were provided. In many cases, benefits provided to widows were utilized by in-laws on the pretext of being their well wishers. Many widows also declined the offer for employment, as they did not want to work outside their houses. The other reasons for refusing employment were widow's illiteracy, pressure from in-laws, responsibility of young children, etc. Education of women and prevention of child marriages would lead to empowerment of women. It should be ensured that the benefits reserved for war widows are utilized exclusively by them or their children, to prevent in-laws from misusing these schemes.

Key Words : 1.WOMEN WELFARE 2.WIDOWS 3.WAR WIDOWS 4.ECONOMIC DEPRIVATION 5.EMOTIONAL DEPRIVATION 6.KARGIL WAR 7.PROBLEMS OF WIDOWS.

35. National Commission for Women, New Delhi. (2005).
Violence against women in North East India : an enquiry. New Delhi : NCW. 50 p.

Abstract : The ongoing armed conflict situation prevalent in North-East India has led to violence against women in the form of sexual, mental and physical abuse. Even domestic violence has been on the rise in the region. The study was conducted in the states of Assam and Manipur and data was collected through verbal interviews and questionnaires. Both primary and secondary data were collected. Police records revealed an increase in the cases of domestic violence. Most women felt that it was legitimate for their husbands to beat them, and to reprimand their husbands for the same would be a sin. Many dowry deaths were also reported in predominantly Bengali areas. 19.83% of the parents had taken loans to bear the intense pressure of giving dowry. Women were also forced out of their marital homes for dowry. Women were most vulnerable to armed conflict due to their restricted mobility, limited access to health care, and the lack of opportunities for education, employment, and even leisure. Many women's groups had not been able to fight violence and articulate their rights because they did not

know their rights. These women who lived under conflict situations suffered from acute mental health problems. Their psychological trauma was associated with sexual rights violation and with disappearance of their family members. Conflict in north-eastern region has resulted in increase in the number of female headed households. No avenues of employment were made available to these women. These women had to resort to selling liquor and drugs or have entered prostitution to run their households. Sexual violence has been used as a means of spreading terror in the north-east region. If an unmarried girl was raped, there was even more pressure on the family to keep quiet. However, the mental health needs of the rape victims were not even recognized. In some cases the rape victims were so traumatized that they would not leave their home for months. Witch-hunting was also prevalent in Assam. Women who were branded as witches were physically and mentally tortured, and even buried or burnt alive. Factors responsible for witch-hunting were personal enmity, control over resources and superstitious beliefs. Armed conflict also resulted in displacement of families, who were forced to live in refugee camps. Health risks were highest to pregnant women and children in these camps. There is a need to provide women with skills that would generate self-employment. Women's groups need to obtain more information on legal safeguards, rights and support services, and then disseminate this information to the local women. Couselling centres need to be set up to combat the rising mental health problems among these women.

Key Words : 1.WOMEN WELFARE 2.VIOLENCE AGAINST WOMEN 3.DOMESTIC VIOLENCE 4.SINGLE WOMEN 5.WITCH HUNTING 6.AIDS 7.MANIPUR 8.ASSAM 9.NORTH EAST INDIA.

36. National Commission for Women, New Delhi.
Report on study of war widows. New Delhi : NCW. 85 p.

Abstract : The present study aimed to understand the status and resettlement needs of war widows. A total of 596 families of martyrs and 500 war widows were covered through survey method for the study. 6 States, namely, Uttar Pradesh with Uttranchal, Punjab, Bihar, West-Bengal, Rajasthan and Karnataka were selected and all 27 wars or conflicts fought between 1947 to 2000 were a criterion for selection of the sample. Nearly 33% of the war widows were solely dependent on the family pension. The average monthly income of each war widow from the family pension was Rs.4514. There was also disparity in the pension amounts received by widows based on the time period of death of the soldiers and the orders prevailing then. Also, the family pension was not adequate to make both ends meet. A lot of physical efforts needed to be put in to actually draw the amount of pension, especially by the war widows staying in far away hilly areas who travelled for 2

days to reach the places where pension was paid. Many of the war widows were uneducated and could not conduct any transactions required to obtain the pensions. Some widows were also ignorant about the financial assistance they should receive, thus head of the families such as father-in-law, etc. conducted all the transactions. 85% of the widows who remarried, were forced to marry their younger brothers-in-law as a compromise. It was difficult for them to mentally accept this change of roles from 'sister' to wives. Widows were ill-treated by their in-laws and the root cause for this was the money that they received from the Government. Only 64% war widows actually received the benefits of schemes, such as allotment of petrol pumps that were supposed to help them earn their living. It is imperative to update the details of families of martyrs and the schemes meant for their benefit by the Sainik Welfare Boards. This would ensure that these families received the benefits meant for them. Families should be provided with guidance as to how to invest the money they received, for maximum gains. The performance of Sainik Welfare Boards needs to be evaluated regularly to make them more responsive to the needs of the target population.

Key Words : 1.WOMEN WELFARE 2.WIDOW 3.WAR WIDOWS 4.SAINIK WELFARE BOARDS 5.WOMEN IN DIFFICULT CIRCUMSTANCES.

37. Saha, Surashree. (2003).
Problems while organising : drawn from the meeting with co-operative members. Ahmedabad : Self Employed Women's Association. 17 p.

Abstract : Most co-operative movements failed to reach the economically poor in the informal economy. The present study involved 60 cooperatives with a view to understand the problems faced by members while operating a cooperative. The cooperatives faced problems while registration. As per Cooperative Society of Gujarat State Act, if a Primary Milk Cooperative of a village had to register themselves, they would have to collect 80 to 100 litres of milk everyday continuously for 6 to 12 months or else they would be disqualified. Many cooperatives from Rann of Kachh (Gujarat) failed to collect requisite quantity of milk due to consecutive droughts (1999-2003) and migration of live stock herders. Some cooperatives remained defunct even after registration due to lack of proper income and thus were unable to submit lease money to the State Cooperatives Federation. Cooperatives producing goods in rural areas were required to pay octroi tax during transportation of raw material and finished goods (even for National and State level exhibitions) leading to increased cost of production and restrictions in competing with market prices. The cooperatives were unable to obtain Government contracts due to the high tender fees charged while submission of the tenders. Many new acts were added or reformed without prior discussion or intimation to the related

cooperatives. These societies were operating from rented rooms and needed more space to build their own centres. Even *dais'* (midwives) cooperatives needed rooms, as they found delivery rooms in patients' houses to be unhygienic. Health cooperatives were not involved in Government's Revised National Tuberculosis Control Programme (RNTCP) and Aids Awareness Programme. These health cooperatives had a good rapport with villagers, thus could convince them easily. With the advent of globalization and resultant mechanization men were monopolizing all the jobs in the construction industry and women were rendered jobless due to lack of skill training. It was mandatory that all governing bodies of Boards/*Nigam* of Directorates (Gujarat) should recruit a woman representative. However, most seats reserved for female candidates had been kept vacant. Reliable market information such as colour schemes and designs were not available to handicraft cooperatives, thus they were unable to sustain in competitive markets. Government Departments should be directed to buy goods and services from women's cooperatives. Women Cooperative members should be given mandatory appointments on the Boards of Cooperatives. Also, cooperatives should be exempted from octroi tax, and lease money should not be charged while cooperatives are non-operational. Women workers should be provided with training for up gradation of their skills. Health programmes should be implemented through the existing health cooperatives. Market information such as latest trends about colours and designs should be made available to handicraft workers, so that their products are saleable.

Key Words : 1.WOMEN WELFARE 2.COOPERATIVES; 3.WOMEN'S COOPERATIVES; 4.ORGANISING WOMEN 5.ORGANISING RURAL WOMEN 6.SEWA PROGRAMME

38. Sethi, Namita. (2005).
A Report on violence against women. New Delhi : Delhi Univ., Womens' Studies and Development Centre. 300 p.

Abstract : The objective of the present study was to locate Violence Against Women (VAW) in various spheres of the society and to devise effective strategies to ensure a peaceful existence for women. Statistics on VAW have been collected from various sources. Recent statistics were collected from 8 newspapers (4 English, 4 Hindi) of Delhi by a research team at *Jagori,* an NGO working for women. These statistics were broad indicators of the cases reported and were not the actual cases. A rape occurred every 36 minutes. The conviction rate of the offenders was dismally low in proportion to the number of cases that were reported. Mostly, the victims were too scared to report the cases due to loss of honour/reputation, fear of reprisal, depression, etc. At Government hospitals, the

victims were treated with great insensitivity. They were not given information about the prolonged and intensive examination that occurred during the Forensic Medical Examination (FME). Most women were subjected to long waits and they withdrew their complaints at this stage only. These women had to undergo repeated tests at the hospital to rule out the possibility of pregnancies or HIV infections. HIV brought additional stigma and trauma for some women. Also, the victims had to tell their stories many times and were made to recall every gruesome detail. In 84% of the cases the offenders were known to the victims. The offenders were either neighbours (32%) or relatives (6.3%). The rapists who were arrested could be released on bail and it took up to 7 years for the sentence to be passed. Meanwhile, the perpetrators intimidated the victims and pressurized them to withdraw their cases. Gang rapes were used to humiliate *dalits* (scheduled castes), tribal women and minority communities. About 1000 cases of rapes were annually reported by the women of disadvantaged communities (*dalits,* tribal women) and these were only the official figures. Apart from caste and communal violence, the security forces in Jammu and Kashmir and police were also implicated in some cases. In prostitution, some groups advocated abolition whereas some commercial sex workers (CSWs) were fighting for their rights. Most prostitutes distrusted regulations and licensing as it gave excessive powers to the police. All prostitution was not forced and all CSWs did not wish to quit. Most CSWs were not able to use condoms or advice given by NGO activists, as the clients demanded unprotected sex. Domestic violence (DV) constituted about 32.3% of the total crime against women. There were no distinctions vis-à-vis DV between joint - nuclear, working class - business class, love -arranged marriages, etc. Women asked for help only when violence went on for many years (usually the 8th year), or when violence threatened their or their children's safety, or when confronted with loss of children's custody. Rate of convictions in cases of DV were low due to delayed investigations, lack of sufficient evidence, etc. Moreover there was always pressure on the women to reconcile. Active networking between prosecution, police and NGOs along with greater protection for victims is called for. Counselling centres are needed to help victims recover from their traumas. Alternative legal structures like '*Nari Adalats'* (women's courts) and '*Mahila Panch*' (women village leaders) should be set up to deal with violence against women.

Key Words : 1.WOMEN WELFARE 2.VIOLENCE AGAINST WOMEN 3.RAPE LAWS 4.DOMESTIC VIOLENCE 5.SARC (SEXUAL ASSAULT REFERRAL CENTRE) 6.SEXUAL HARASSMENT 7.PROSTITUTION 8.TRAFFICKING 9.FORCED PROSTITUTION 10.FOETICIDE 11.INFANTICIDE 12.CHILD ABUSE 13.CHILD SEXUAL ABUSE.

39. Sheena, P. (2004).
Employment of women in the organised sector of Kerala : a case study of Kozhikode district. Thrissur, Kerala : Calicut Univ., Dept of Economics, Dr. John Matthai Centre. ~270 p.

Abstract : The present study examined the trends of female employment in the organized sector of Kerala and assessed the working conditions in this sector. Primary data was collected from 495 women (292 from rural areas and 203 from urban areas) employees in the organized (Public and Private) sector through a questionnaire. Secondary data was collected from publications of the Department of Economics and Statistics, State and District Planning Boards, Department of Census and Reports of National Sample Survey Records. Female employment was highest in schools and in the Health Departments, and their lowest participation was in the Police Departments. In the health profession, female nurses superceded males, but there were very few female doctors. Female participation was high in clerical and last grade jobs in the banking sector. No female was employed in a high cadre job in the Police Department. Socio-economic conditions of women in the public sector were better than those in the private sector. 42% public sector employees earned between Rs. 5000- 7000 per month, whereas 39.3% private sector employees earned below Rs. 1000 per month. A majority of women in the private sector spent their income mainly on food followed by clothing, medicines, etc. Most of the college lecturers spent their income on purchase of gold and clothing. 75% of the public sector employees had the habit of saving, whereas 50% of the private sector respondents did not save owing to low level of income and number of family dependents. Due to increase in cost of living and inflation, both public (66.8%) and private sector (69.6%) respondents preferred nuclear families. However, there was greater need for women to work in the nuclear family set-up, in order to meet the family expenses. Employment also gave women more decision-making powers and an improved status at home. However, public sector women had more decision-making powers than private sector women. 73.2% private sector employees were from OBC and SC/ST category, and a significant chi-square value proved the association between caste and occupational status. Most of the organized sector employees were from rural background, but more urban respondents were found in high category posts (managers, lecturers, etc.) owing to better educational backgrounds. Most respondents were married, and as marriage entailed greater financial burden respondents had to work. Parental education influenced the education as well as occupational career of their children. The fathers of employees in high cadre jobs were better educated than the fathers of lower cadre employees. Mother's education and parents' occupation had a positive impact on female employment. Most employees with high cadre jobs worked for professional growth, whereas school teachers, nurses, clerical workers worked for economic necessity. In the private sector, promotions in administrative posts were based on gender-based favouritism and influence. Industrial workers (52%) and

last grade employees (23.3%) lacked maternity benefit schemes at their workplace. In the public sector, women in police, nursing profession and managerial posts had to work for longer hours than others, whereas in the private sector nurses, clerks, mangers and last grade employees had to work for more than 8 hours a day. Also, salaries of private sector employees were not in tune with their qualifications and working hours, and a majority of industrial workers (private) did not get any benefit for their overtime work. 1.4% of the organized sector employees faced verbal sexual harassment at their work place from their colleagues and employers. Some lower category employees (private sector) were reluctant to respond about harassment due to fear of losing their jobs. Separate and adequate basic facilities were not provided at work in both sectors. Care should be taken to provide employees with basic facilities and maternity benefits. Promotions should be based on seniority and merit. Steps should be taken to prevent sexual harassment at work. Employee work hours should either be reduced or they should be duly compensated for the same.

Key Words : 1.WOMEN WELFARE 2.WORKING WOMEN 3.EMPLOYMENT WOMEN 4.ORGANIZED SECTOR 5.WORKING MOTHER.

40. Singamma Sreenivasan Foundation, Women's Information and Resource Centre, Bangalore. (2001).

The Gender audit : holding development accountable. Bangalore : SSF-KWIRC. 163 p.

Abstract : The National Policy for Women's Empowerment mandates gender audits as an important method of monitoring women's empowerment. The main objective of the present study was to develop gender audits at the district level. 5000 households were surveyed from 2 districts, namely, Bangalore (urban) and Tumkur (rural) with 2,500 households from each district. Quantitative data was collected through household surveys and secondary data sources. Qualitative data was collected through Focus Group Discussions. Sex ratio was unfavourable to females in both the districts. Sex ratio in the 0-6 age group observed in the survey was much lower than the census figures (1991) and it was lower in Bangalore than in Tumkur. The reason for this was female foeticide following sex determination tests that were done. Work Participation Rate (WPR) for females (main and marginal workers) was less than that for males especially in Bangalore (16% females: 57% males). Agricultural wage rates per day were higher for males than for females. In Tumkur, the wage rates for males and females were Rs.31/- and Rs.22/- respectively. Also, 40% of the females worked as unpaid family workers as opposed to 16% males. In Tumkur, girl children spent more time than male children in domestic services such as, fetching water, fuel, cleaning, etc. Most girls were not

able to go to schools due to this. More than two-thirds of the time spent on economic activities by women was unpaid. Literacy rates were higher for males than females in both the districts. However, there had been an increase in the literacy rates from 1991 to 1999 and the increase in literacy rate was greater for females than for males. Also, the male and female students who appeared for 10th Board Examination were equal in numbers. Not even 1% of the married men (20-49 years) had undergone sterilization, whereas nearly half the number of married women (15-44 years) had been sterilized, despite the fact that male sterilization was simpler and safer. 54% of the women in Tumkur were sterilized as opposed to 45% in Bangalore. Morbidity rates were higher for females than for males in both the districts. In Bangalore, morbidity rate for females were 37% higher than that for males. Only a small percentage of women owned assets (agricultural land, flat, livestock, etc.). In Tumkur men owned ten times more agricultural land and five times more flats than females. Urban women in Bangalore had greater control over their earnings and savings as compared to rural women in Tumkur. However, very few women had any savings (6 in the entire survey). Only 17% of the women in Tumkur and 33% of the women in Bangalore had no restrictions placed on their mobility. Restrictions were placed when women wanted to go shopping or wanted to go to a hotel/cinema, etc. All women conformed to gender relation that permitted them to go out, and permission was given by men in the family. Also, decisions about property, loans, number of children were taken by men, whereas women were confined to making decisions about rearing of children. 63% of the women were not involved in decision making in the family. Women also reported facing violence in the initial stages of marriage and were harassed by in-laws on the issue of having girl children. Harassment was faced about the issue of not earning enough money (working women) or not managing money properly (housewives), or mischief by the children. Men also picked up quarrels when under the influence of alcohol or when they were suspicious of their wives' character. Non-death crimes (rapes, physical assaults, etc.) against women were more in Bangalore than in Tumkur. Participation of women in elections was nil and it was seen that all contestants to the *Lok Sabha* elections were males. There is a need to sensitize various government agencies in the ways of handling gender differences. Professional empowerment should go beyond administrative and technical positions and should include participation in cooperatives and self help groups. Bringing about women's ownership or control over assets is extremely important.

Key Words : 1.WOMEN WELFARE 2.GENDER AUDIT 3.GENDER PLANNING 4.GENDER 5.GENDER EMPOWERMENT MEASURE 6.FEMALE WORK PARTICIPATION RATE 7.WORK PARTICIPATION RATE 8.EMPOWERMENT WOMEN.

41. Swabhiman, Bhubaneswar. (2005).
Abuse and activity limitation : study on domestic violence against disabled women in Orissa. Bhubaneswar : Swabhiman. 33 p.

Abstract : Women with disabilities are more vulnerable to sexual, physical and emotional abuse. The present study covered 729 disabled women from 12 districts of Orissa. Both quantitative and qualitative data were used. Women with disability (WWD) neglected their personal hygiene. Only 42% reported taking bath on a daily basis and 43% changed their clothes daily. Only 27% of the physically disabled (PD) women and 31% of the mentally challenged (MC) women got access to medical and health care. Both, PD (22.6%) and MC (48.5%) women were beaten at home. Rape was also reported by 12.6% of the PD and 19% of the MC women. Some of these women reported that they were raped by their family members (20% PD and 22% MC). The reason for higher incidence of rape and beatings of MC women was that they did not understand the concept of shame, thus they reported freely. Also, their families did not hesitate in reporting rapes as it could be used as an excuse for forced sterilization of these women. The sexuality of WWD was not recognized. According to society, sex was needed only for procreation, thus a denial of reproductive role meant a denial of their sexual life. Only 44.2% PD women and 21.6% MC women expressed the desire to have children. PD women (6%) and MC women (8%) were forcibly sterilized. Domestic violence against disabled women led to depression, post-traumatic stress disorder, etc. among them. Community workers and service providers need to be trained adequately on the issue of violence against disabled women. Skill Development programs and Self Help Groups should be organized for WWD. Society needs to be oriented about the needs of WWD so that they are not abused.

Key Words : 1.WOMEN WELFARE 2.VIOLENCE AGAINST DISABLED WOMEN 3.ABUSE 4.FAMILY VIOLENCE 5.WOMEN ABUSE 6.DISABLED WOMEN 7.ORISSA.

42. Vasantha Kumari, P. and Lakshumma, G. Venkata. (2005).
Impact of women's education on health and family welfare. *Indian Journal of Population Education,* Sep(30) : 26-32.

Abstract : It is estimated that about 850 million people in the world are illiterate, and of them about 50% are in India alone. But if we take the illiteracy rate among women, the situation becomes more alarming. High morbidity and high mortality,

particularly among infants and children, are an index not only of a community's low health level but also of inadequate health education. This study was undertaken to assess the impact of women's education on health and family welfare aspects. The sample comprised 100 mothers (50 illiterate and 50 literate) of school going children. Random sampling method was used in selecting the sample from Gyampalli village of K.V. Palle Mandal of Chittoor District. A questionnaire prepared for the purpose of data collection, contained thirty questions and was broadly divided into 3 categories namely physical health, child care and sanitation, and nutrition and diet. Results of the study indicated that a large percentage of women were caught up in old beliefs and faiths due to lack of knowledge which can be provided only through education on hygiene, sanitation, etc. which helps in reducing child mortality by taking care of diseases like diarrhoea. There were not many differences among responses of literate and illiterate mothers regarding knowledge. However, significant differences existed among some statements such as 'Our traditional habit of eating more rice and less vegetables and lentil makes a proper nutritional meal' which recorded 57% positive responses by illiterate mothers as compare to nil response by literate mothers. Illiterate mothers lacked knowledge about nutrition and the effect of surroundings on the child's health. Hence, to fill up the gaps in knowledge, it is essential that nutrition and health education is imparted to them, as a great number of diseases can be prevented with little or no medical intervention if the adult members of the community were adequately informed about them and were encouraged to take necessary precautions in time. So the education of adult women, who constitute an important and sizeable portion of the country's population, is the need of the hour.

Key Words : 1.WOMEN WELFARE 2.HEALTH STATUS 3.WOMEN'S EDUCATION 4.FAMILY WELFARE 5.LITERACY 6.IMPACT OF WOMEN'S EDUCATION.

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