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RESEARCH STUDIES ON WOMEN & CHILDREN

CHILD WELFARE

1. Barse, Sheela. (1998).
   Our children are gone an 'expose' of the continuing extinction of tribals' rights and interpretation of the Indian constitution and international law to protect their children's rights. Mumbai : Neergaurav Research and Development Foundation. 182 p.

Abstract : The present study was conducted to investigate the situation of tribal children in Kokru village in Melghat hilly region of Maharashtra. Nearly 18% of all Kokru children under the age of six years have died in the preceding four years. The Kokru mainly live in Melghat. This hill range is one of the best areas of Maharashtra. The Kokru are scattered in about 300 out of the 311 hamlets in two tehsils. Soon after the British "discovered" Melghat in 1855 as a gigantic reserve for commercial exploitation of high quality wood, they forcibly shifted the Kokru whom they described as "great axe wielders" to labour colonies, euphemistically called "Forest Villages". The latest records of Women and Child Welfare Department, Government of Maharashtra, show that 18,96,000 children under the age of 5 years in the State are under-nourished. The pied pipers of death in Melghat are Government policies and failures, specifically discrimination against indigenous projects, bondage of adult members of the tribe to their creditor employers, the lowest daily minimum wage approved by the Government of Maharashtra, devastatingly deprivational market control by the Government under a Tribal Farm Produce Monopoly Procurement Scheme; land grabbing by usurious creditors; loss of nutritional and medicinal/ herbal resources as a consequence of faulty forest protection policy; and the non-implementation of health care services through the Integrated Child Development Services Scheme (ICDS). The ICDS administrators assumed that additional calories are a panacea for malnourishment. Specific malnutritions, namely iron, calcium, Vitamin A, B, C, D, etc. deficiencies, immune system dysfunctioning; distortions in the metabolic processes and disease-related damage / depletion is ignored. The ICDS Grade I ranges from 80% to 71% weight for age, unlike the international Gomez Grade I which has a cut-off percentage of 76. This 5% difference at age one in actual terms translates into 0.63 kg. A child needs nearly four months to gain that much weight. A result of the 5% differential is that many babies who ought to be in Grade II are placed in Grade I. Fifty percent of deaths were therefore of children who were not in the crisis grades of ICDS. The evidence of child under-nutrition recorded in the ICDS weight card books that some children had slipped into Grade II (less than 70% of normal weight) and Grade III (less than 60% of normal weight) remained on paper. It did not provoke the ICDS and medical personnel to give even rudimentary care to these children, despite the fact that one primary function of the anganwadi is referral services. Nutritional

support to children was not only illogical, but in some cases is likely to be damaging. No specific services have been set up to reach out to the youngest children, in the age group of 0-3 years. Anganwadi workers are not professionally equipped to assess causes of deaths. Medical records show that all signs of under-nourishment and epidemics in Melghat were ignored until the shocking death toll was published in newspapers in August 1993. The disturbing fact that 15.7% of the Melghat population was suffering from tuberculosis was revealed when in response to the request to High Court, mobile hospitals were arranged. The sex ratio in Melghat village is less than 90 females for 100 males. Setting up of forest villages amounted to a continuous rights deprivation of the tribals by manipulated dislocation. The employment in Melghat is exploitative, enslaving and gender discriminatory. The total emoluments of a bonded labourer is approximately Rs. 120/- for 30 days of work. Deprivation of traditional nutrition and medicines as a result of faulty forest policy, and non-respect for local bio-diversity was one of the causes of child deaths in Melghat. The Government of Maharashtra should not establish separate '*Prakalp Adhikaris'* as that would only aggravate the administrations' hegemony over indigenous people. The Government must ensure to tribals of Melghat access to safe drinking water and water for horticulture and agricultural purposes. The Tribal Department Chief must ensure continuity of the ethnic identity. The Secretary must ensure enforcement of the Maharashtra Restoration of Land to Scheduled Tribes Act, 1974.

Key Words : 1.CHILD WELFARE 2.RIGHTS OF TRIBAL CHILDREN 3.RIGHTS OF THE CHILD 4.CONSTITUTIONAL LAW CHILDREN 5.CHILD HEALTH 6.ICDS 7.UNICEF 8.CHILD HEALTH PROGRAMME 9.CHILD NUTRITION 10.NUTRITION IN ICDS 11.CHILD SURVIVAL 12.TRIBAL CHILDREN 13.RIGHT TO LIFE 14.SCHEDULED TRIBES 15.MELGHAT FOREST DWELLER 15.SHEELA BARSE VS GOVERNMENT OF MAHARASHTRA.

2. Ghosh, Esther Anupama. (2003).
   Attitude and knowledge of rural couples regarding female foeticides : abstract. Hisar : Chaudhury Charan Singh Haryana Agricultural Univ., College of Home Science, Dept. of Extension Education. 2 p.

Abstract : The study was conducted in Allahabad, Uttar Pradesh. Palpur and Ravanika villages from Chaka and Karchana blocks were randomly selected. Total sample size from both the villages was 100 married couples. These 100 couples were assessed for their existing knowledge and attitude towards female foeticide. A print media package was prepared which was tested for effectiveness and impact. The impact was tested by introducing the package to 30 couples and then assessing the post – exposure knowledge gain. It was found that the existing knowledge level about female foeticide was low for almost all couples, while the attitude of most couples was highly unfavourable towards female foeticide. Factors

found to be significantly associated with the attitude of couples were number of daughters, distance from sex determination clinic, monthly income and mass media contact, and those significantly associated with knowledge were monthly income, mass media contact, education and number of sons. The impact of the package was found to be significant on knowledge but not on attitude.

Key Words : 1.CHILD WELFARE 2.FEMALE FOETICIDE 3.RURAL PARENTS 4.RURAL AREAS 5.PARENTS 6.ATTITUDE OF PARENTS.

3. Prasad, Shweta. (2001).
   Female foeticide : a study of Varanasi. Varanasi : Banaras Hindu Univ., Centre for Women's Studies and Development. 33 p.

Abstract : The primary objective of the study was to gauge the prevalence of sex determination (SD) tests and impact of the Pre-Natal Diagnostic Techniques Act, 1994 in Varanasi district, Uttar Pradesh. Ten diagnostic centres were randomly chosen for the survey. Number of women who agreed to be interviewed was 20. During the survey, 80% of the diagnostic centres were found to conduct sex determination tests. On an average, the numbers of tests conducted per day by these diagnostic centres were 15 to 20. Not all diagnostic centres were secretive about these tests. Doctors replied that it was "the pressure from clients" which compelled them to perform SD tests. Money was also an important factor behind SD tests for doctors. The Pre-Natal Diagnostic Techniques Act, 1994 remained on paper only. All the patients interviewed had a college degree. They were all from middle class families except a few who belonged to very well-to-do families. The average age of patients was 28 years. Most of them were members of high caste Hindu society. The reasons given by most patients for undergoing the SD test were that they wanted to avoid the problems of dowry, finding a suitable and good match for a daughter, the world was not a safe place for a girl to live in, to have a balanced family, giving birth to a male child was essential for "*moksha*" (liberation from the cycle of birth and death), and male child was necessary for "*vansha*" (continuation of their lineage). The number of couples going in for the test during the second and third pregnancy was found to be quite high. In the case of all the respondents, it was a family decision to undergo the SD test. In some cases, doctors referred the patients to other clinics conducting these tests. The administration was not ready to penalize doctors unless it received a complaint. The real issue involved in SD tests was not that of sex – determination, but of sex discrimination and sex selective abortions which was rooted in the attitudes and values of the patriarchal social structure. Therefore, passing laws was not enough to prevent people from adopting such practices. In order to prevent SD tests, we would have to concentrate on eliminating gender disparity by changing those practices, attitudes and values which devalue a daughter. A comprehensive in – depth study is needed to delineate all the causes of SD tests which would pave the

way for obtaining suitable solutions. It was suggested that Government hospitals should be authorized to perform pre-natal diagnostic tests to ensure strict accountability. Sex pre-selection techniques are out of the purview of the Central Act, therefore the Act should be amended to cover these techniques. Creating awareness among parents against this practice of aborting females is imperative.

Key Words : 1.CHILD WELFARE 2.FEMALE FOETICIDE 3.DECLINING SEX RATIO 4.SEX SELECTIVE ABORTION 5.ABORTION 6.SEX DETERMINATION TEST 7.GIRL CHILD 8.DISCRIMINATION AGAINST WOMEN 9.VARANASI 10.UTTAR PRADESH 11.PNDT ACT 12.PRE-NATAL DIAGNOSTIC TECHNIQUES ACT.

4. TINNARI, Third World Centre for Comparative Studies, New Delhi. (2002). Missing girls : a case study of Delhi. New Delhi : TINNARI. 160 p.

Abstract : The present study covered all five zones of Delhi, namely Central, North, South, West and East zones. Interviews, focus group discussions, observation and records were used to gather data. The Poverty Ratio for Delhi in 1999-2000 was 8.23% compared to All India average of 26.10%. The population of Delhi increased from 0.4 million in 1901 to 13.8 million in 2001. Sex ratio for all ages declined from 827 in 1991 to 821 in 2001 compared to 933 for India. Sex ratio in the age group 0-6 years declined from 915 in 1991 to 865 in 2001. Birth rate has come down from 33.10 in 1951 to 19.4 in 1999, and Infant Mortality Rate (IMR) has also declined from 84.00 in 1951 to 31 in 1999. According to 2001 Census, urban female literacy was 75.49% and rural female literacy was 68.23%. Delhi was the "crime capital" of the country. National Crime Records Bureau (NCRB) report 2000, reported that there were 56,249 cases of crime in Delhi. Delhi's share was 18.2% in the murders committed in 23 large cities of India, though the number of kidnapping and abductions dropped from 3,046 in 1999 to 2,935 in 2000. In 2002, out of 233 rape cases registered, 152 victims were below 18 years of age. 88% persons in the higher income group, 73% in the lower income group, and 64% in the middle income group showed no preference for a male for the first born child. Whereas 25% in the lower income group, 32% in the middle income group and 8% in the higher income group preferred the first born to be a male. Reasons given for son preference were sons carry on the family name (67%); provide support during old age (46%); and 39% said that they are required to perform last rites. 60% did not want daughters because of dowry and wedding expenses. Close to 67% respondents celebrated the birth of a son by performing all rituals compared to 18% who celebrated the birth of a daughter. 82% distributed sweets at a son's birth and 43% distributed sweets at a girl's birth. In the lower income group, 50% males were married before the legal age of 21 years, and 57% females were married before 18 years of age; in the middle income group, 31% males got married before the legal age, and 35% females were married before 18 years; while in higher income group

3% males and 4% females were married before the legal age. The incidence of teenage pregnancies was 55% in lower income, 23% in middle income and 1.13% in higher income group. 36% of lower income respondents reported incomplete or no immunization, whereas it was universal in middle and higher income groups. Respondents suggested that Government should have pro-girl child policies, programmes and projects, and carry out mass campaigns using media, T.V., posters, street plays, rallies and marches to create awareness about the value of the girl child. It was clear from the study that strong son preference continues to exist, to the extent of being an obsession. A well planned 'Save the Girl Child Campaign' should be launched, with a role for all, children, adults, media, government and voluntary groups, whose involvement is important.

Key Words : 1.CHILD WELFARE 2.GIRL CHILD 3.SEX RATIO 4.INFANT MORTALITY RATE (IMR) 5.INCIDENCE OF CRIMES 6.INFANTICIDE 7.FOETICIDE 8.FEMICIDE 9.TEENAGE PREGNANCY 10.DECLINING SEX RATIO 11.GENDER DISCRIMINATION 12.DELHI.

COMMUNICATION

5. Purayidathil, Joy and Shejwal, B.R. (2005).
   Impact of television viewing on adolescent lives, cognitive processes and adjustment. *Psychological Studies* , 50(1) : 90-97.

Abstract : The study, conducted in Maharashtra, examined the differences in the cognitive processes and adjustment of 654 higher secondary 11th grade students based on their TV viewing habits. There were 409 light viewers versus 245 heavy viewers, and 286 girls versus 368 boys. The schools were selected from districts and talukas avoiding the metros and villages. A background information form was prepared to gather the demographic details of participants and information on their TV viewing habits. All those who viewed TV upto two hours per day were grouped as light viewers and those who viewed more than two hours were grouped as heavy viewers. Results of the study indicated that heavy viewers were poor compared to light viewers in the areas of analytical thinking, figure evaluation, similarity exploration and verbal facility. However, heavy viewers were found to be more inquisitive than light viewers. The heavy viewing adolescents imitated not only behaviours but also the attitudes and ideologies from TV. Such imitation tendencies could render heavy viewing adolescents poor in their adjustment. The heavy viewers of TV are likely to hold and nurture values and lifestyles that are imbibed from the TV portrayed stereotypes. Such values and lifestyles are likely to differ and come in conflict with the accepted and normative value system and lifestyles in the family and society. Findings also indicated that as more time was spent on TV viewing, less time was spent on interaction with the environment

outside. Moreover, the arrival of TV has remarkably affected the very atmosphere of interpersonal communication in families. Gender differences were found in adjustment, where girls were found to be better adjusted than boys, which may be due to stricter parental control and discipline of girls. Thus, the younger generation should be guided properly about regulating their TV viewing habits.

Key Words : 1.COMMUNICATION 2.TELEVISION VIEWING 3.MEDIA 4.ADOLESCENT 5.COGNITIVE PROCESSES 6.ADJUSTMENT ADOLESCENTS .

6. Sophia Centre for Women's Studies and Development , Mumbai. (2005). Misrepresentation of women in advertising : a study : women and environment. Mumbai : SCWSD. 49 p.

Abstract : The roles and portrayal of women in media over the years have not transcended gender stereotypes. Mulvey stated that the woman displayed in a film or an advertisement, functioned on two levels, as an erotic object for the characters, and as an erotic object for the spectator. People are often unaware of the powerful effects that cultural stereotypes have on them. 80 people were interviewed, 20 men and 20 women each from Upper Middle Class (UMC) and Lower Income Group (LIG) respectively. One of the most valuable assets of advertising was the Indian woman. Women have always been represented through the eyes of men. Photographers and advertisers started pushing boundaries and utilized more nudity on their images. Women were displayed in provocative poses in order to appeal to consumers. The custom of '*Pati Vrataa*' is still followed through the Whirlpool mom as a supermom. The Sony ad for audio system signified that if a man bought this piece of equipment, chances were that he might have the woman as well. A man's presence was a promise of power, whereas a woman's presence implied self-conscious display. Apart from being used as sex objects, a woman being used in relation to negative products such as alcohol and drugs has become accepted by our culture. What do they sell at the end of the day? Is it women, sex or sexuality? Women are placed in such provocative and alluring positions, that society is forced to see them as objects of sexual desire. Sexuality was the focal point in Axe deodorant commercial. Stereotypes ranged from believing that if a woman is fairer, she is more intelligent, beautiful and able to snag a good looking husband. 85% men from the upper middle class were not subjected to any kind of discrimination on the basis of their looks. 55% men did believe that a woman with fair skin was more privileged. 55% women felt that fair women were not more beautiful but definitely more privileged than darker women. 75% men from LIG believed that social stereotypes have to be imitated by the media for consumers to identify with the product. 100% women from LIG argued that fairness craze was because people perceived them in a different light. Logically, an advertisement should showcase the product describing its features and price, but other publicity gimmicks are used. Society as a whole needs to

overcome the normalizing power of cultural images, and the continuing social realities of dominance and subordination.

Key Words : 1.COMMUNICATION 2.PORTRAYAL OF WOMEN IN MEDIA 3.GREEK GODDESS 4.ADVERTISING AND WOMEN.

CRIME AGAINST WOMEN

7. Walikhanna, Charu. (2004).
   Women silent victims in armed conflict: an area study of Jammu & Kashmir. New Delhi : Serials Publication. 149 p.

Abstract : The silent victims of war are women who are most vulnerable in situations of armed conflict. Women are often singled out for human rights violations which are not inflicted on men, and assault on a woman's body is used as a weapon of war. Women are victims of gender discrimination and violence. It was very difficult to collect data in Kashmir. The following study was conducted with the help of documented cases, interviews with the victims or relatives of victims like parents, etc., interviews with medical specialists and others. Women are viewed as commodities and subject to a schism that divides them into the categories of usefulness and exchange value, to be exploited in conditions of conflict and considered the spoils of war. Jammu and Kashmir is no exception to the situation. The generation of Kashmir women found themselves sandwiched between the violence of militants and the atrocities of security personnel. It has been observed that in situations of armed conflict often the security forces are violators of the law, becoming perpetrators of sexual violence against women. It has been observed that security forces have perpetrated crimes of gender violence, and the courts in India have time and again taken cognizance of the same. Rape is used as a means of targeting women whom the security forces accuse of being militant sympathizers. Often gender violence remains hidden behind the veil, and the family of the victim never makes a complaint. Courts observed that crime against women in general, and rape in particular, is on the increase. In Kashmir, medical specialists in hospitals in Srinagar claim that the number of neurological disorders among women is on the rise. The number of abortions has also increased. Women gangraped by militants or security forces were severely traumatized. The militants also took away young girls, married them, raped them, and when they were tired of the girls, they abandoned them. A new phenomena emerging in Kashmir is the problem of half widows, women who do not know whether their husbands are alive or their whereabouts. In the early years of insurgency, reports of rape by militant groups were rare, but since 1991 their number has increased. Official sources say that women militants have become more active and dangerous, particularly with the induction of the women *fidayeen* squads (suicide squads). Rape as a gender

specific form of abuse in Kashmir must be understood in the context of the subordinate status of women generally in South Asia. Even within the rules protecting civilians, there is no equality in the treatment of men and women. There is requirement for a new protocol, and the protocol should include the many other aspects of women's experiences of sexual violence in armed conflict situations on which the present law is silent. Every state should implement the UNHCR guidelines on the protection of refugee women, and every state should recognize the critical role Non Government Organizations (NGOs) and domestic groups can play in challenging human rights abuses in their countries.

Key Words : 1.WOMEN WELFARE 2.CRIME AGAINST WOMEN 3.WOMEN IN ARMED CONFLICT 4.TERRORIST VIOLENCE 5.ARMED CONFLICT 6.WOMEN IN DIFFICULT CIRCUMSTANCES 7.VICTIMS OF VIOLENCE 8.JAMMU AND KASHMIR.

EDUCATION

8. TINNARI, Third World Centre for Comparative Studies, New Delhi. (2002).
   Impact study of education incentives to school going girls in Haryana IWEDP. New Delhi : TINNARI. 102 p.

Abstract : A study was carried out to investigate whether government initiatives had an impact on girls education in Haryana. Haryana's population was 21.0 million in 2001. Children in the age group 0-6 years numbered 3.2 million. Sex ratio decreased from 871 in 1951 to 861 in 2001. The sex ratio for all ages was highest in Mahendragarh and improved from 910 in 1991 to 919 in 2001. The range of district-wise female literacy increase was highest in Hisar (19.97%) and lowest in Ambala (11.83%). The present study investigated the education component of the IWEDP under which some incentives were given to encourage parents to send their girls to primary schools, and to help them continue up to higher secondary level. This project also gave incentives to women to become regular members of the *Jagriti Mandalis* (women's empowerment groups). *Kishori Balika Yojana* is a very good programme, and this programme is popular as *Didi* (Elder Sister) Programme in the villages. A remarkable aspect of the project was the horizontal integration of women of all castes and classes. The study covered 40 villages, four each in ten C.D. Blocks of districts Mahendragarh and Rewari. In all 371 girl beneficiaries were interviewed in groups. In Mahendragarh district, child sex ratio (0-6 years) has fallen steeply from 892 in 1991 to 814 in 2001. Female literacy rate has gone up from 36.5% to 54.61% during 1991-2001. In Rewari district, women constituted 47.38% of the total population of the district. The sex ratio has fallen steeply from 927 in 1991 to 901 in 2001. The child sex ratio (0-6 years) has fallen from 894 in 1991 to 814 in 2001. Female literacy rate has gone up from 46.3% to

61.45% during 1991-2001. In Rewari district, educational incentives were given to the girls in the form of money. The incentives encouraged mothers to attend JMs meetings and send their daughters to school. The number of primary schools in Mahendragarh district has gone up from 347 to 705, and from 277 to 517 in Rewari district during 1994-2000. Female enrolment has gone up in both the districts. In all, 78 girl beneficiaries in district Mahendragarh and 66 in district Rewari were interviewed. In the IWEDP districts, education of girls has made substantial progress. In Rewari, girls form 50.48% of the students at the primary level; 55.25% at middle stage; and 42.81% at the high school/ higher secondary stage in 1999-2000. In Mahendragarh, girls form 49.59% of the student population at primary level; 45.29% at the middle level and 42% at the high and senior secondary level. Majority of them were going to government schools. Primary schools were available in every village. For middle and secondary education, 63% girls in Mahendragarh travelled a distance of 0.5 - 1 km; 19% travelled 2 - 5 km, and 18% travelled more than 5 km. In Rewari, 65% girls travelled 0.5 - 1 km.; 21% travelled 2 - 5 km and only 13% traveled more than 5 km. The impact of incentive based education on attitudes to self in terms of self image and self esteem of girls has been positive. There should be more Jagriti Mandalis, so that more village women can benefit from the programme. Income generating skills should be taught and special emphasis should be given to women's empowerment. To motivate girls for higher education more senior secondary schools should be opened in villages.

Key Words : 1.EDUCATION 2.GIRLS EDUCATION 3.INCENTIVES 4.EMPOWERMENT WOMEN 5.FEMALE LITERACY 6.JAGRITI MANDALIS 7.GIRL BENEFICIARIES 8. REPRODUCTIVE HEALTH 9.ADOLESCENT GIRLS 10.DROPOUT 11.DISCRIMINATION AGAINST GIRL CHILD 12.INCENTIVES EDUCATION 13.INTEGRATED WOMEN'S EMPOWERMENT AND DEVELOPMENT PROJECT (IWEDP) 14.AWARENESS GENERATION PROJECT 15.HARYANA .

HEALTH

9. Nanda, Satyajeet. (2005).
   Micro determinants of human fertility : study of selected physiological and behavioural variables in SC and ST population. Ahmedabad : Gujarat Institute of Development Research. 34 p.

Abstract : This paper is an attempt to study plausible casual relationship of women's physiology and behaviour components with fertility in more or less non-industrial rural populations in Orissa. A total of 600 women, 300 each from Schedule Castes (SCs) and Schedule Tribes (STs) were interviewed. The sample consisted of 12% married teenagers, 60% were in the middle age group of 20-34

years, and 27% were in the age group of 35 years and above. Around 56% women had given birth to a child less than 2 years ago. Distribution of women by age at last delivery showed that 21% women delivered during their teenage, 6% delivered below 17 years of age, 22% had their last pregnancy at 30 years, and 7% delivered at more than 36 years of age. Another risk factor was that 64% expectant mothers did not receive any antenatal care (ANC), no tetanus toxoid (TT) vaccine or iron folic acid (IFA) tablets during their last pregnancy. Family planning use was reported by 19% of all women. About 15% of all women and a higher proportion of SC women reported to have mental strain in their marital life. Around 27% of all women felt that 4 or more children were an ideal family size while 10% did not report any specific number. 28% of ST women as compared to 26% of SC women perceived 4 or more children to be ideal. 60% of the sample women perceived an interval of 2-3 years between births to be ideal. 65% SC and 55% ST women perceived an interval of more than one year between marriage and the first birth to be an ideal condition. 44% of all women perceived two sons to be the ideal composition of the family, 11% wanted more than 3 sons. Overall 40% women and more ST women desired 2 or more sons at the beginning of the family building process. 77% of all women and a higher proportion of ST women reported taking part in deciding the family size. 84% women had some knowledge about contraceptives. The verbatim and incidents presented in the paper gave an impression that on the one hand child survival was demanded and on the other, there was a need for access to controlled and intended fertility.

Key Words : 1.HEALTH 2.FERTILITY 3.WOMEN'S FERTILITY BEHAVIOUR 4.FERTILITY BEHAVIOUR 5.WOMEN'S HEALTH 6.SC/ST WOMEN 7.IDEAL FAMILY SIZE 8.FAMILY SIZE 9.ORISSA.

10. Srivastava, Alok. (2005).
    Eliminating leprosy : so near...yet so far. New Delhi : Centre for Media Studies. 17 p.

Abstract : Centre for Media Studies (CMS) conducted a survey on a cross-sectional population of Delhi in March 2005, to understand people's perception and opinion on various issues related to leprosy. Delhi was selected for two reasons, firstly being the capital, it is the hub of all awareness activities, and secondly for its cosmopolitan profile. A day long consultation on leprosy with print and electronic media professionals was also conducted by CMS in association with International Leprosy Union (ILU) to build a network of media people so that they could play an important role towards leprosy elimination. Study was conducted with a sample of 200 males and females. Around 60% of the respondents were in the age group 21 to 40 years, 58% were graduates, and 10% were less than secondary school (Class 10) qualified. Most males and females were employed. Among males, 30% were traders or shopkeepers and around 25% of the females were students or

housewives. 60% of the sample was married. All of them were familiar with leprosy and most of them knew that 2005 had been declared the Year for Eliminating Leprosy. Regarding awareness about the symptoms of leprosy, 90% males and 84% females associated ‘white patches’ with leprosy. Only 33% males and 14% females could recall correctly ‘pale patches without sensation’ as a symptom. Deformation of body parts like fingers, nose, ears and eyes seems to be a more recognized symptom. Eight out of ten respondents were aware that ‘anyone’ could get infected and 30% agreed that bacillus of leprosy is present in every individual’s body. About 90% males and females were aware that leprosy is curable. But most of them disagreed with doctor’s views that 95% cases are not infectious. Majority were of the opinion that if detected and treated early, a person could lead a normal life. Good diet and hygiene can prevent its occurrence. Non-acceptance of a leprosy infected person in society could be the reason behind such people not revealing their disease. Most people were of the opinion that beggary was the main source by which leprosy patients earned their livelihood. It was recommended that timely action by various organizations and Government to sensitize the community to have a more positive attitude towards leprosy patients only would lead to elimination of this disease.

Key Words : 1.HEALTH 2. LEPROSY 3.LEPROSY ELIMINATION.

11. Visaria, Leela and Nanda, Satyajeet. (2003).
    Assessment of training of traditional birth attendants in rural areas of Gujarat. Ahmedabad : Gujarat Institute of Development Research. 37 p.

Abstract : According to the NFHS II conducted during 1998-99, close to 75% of poor rural women belonging to disadvantaged groups in India were reported to depend on traditional birth attendants (TBAs), generally known as *dais* to deliver their babies. At macro level, in societies where TBAs were the major providers of delivery services, maternal mortality has not been able to come down below 100 per 100,000 live births. The Gujarat Institute of Development Research at the request of SEWA, Ahmedabad undertook a study of the *dais* in Gujarat. Three categories of *dais* were selected for the study – those trained by SEWA, Government or other NGOs, and those who received no training at all. 269 *dais* had undergone the 3 month training from the year 2000 to 2003. Eight batches of dais were trained. The *dais* was distributed into three groups: 76 *dais* were trained for 3 months and given refresher training, 20 were given PHC training, and 22 were untrained. More than 90% *dais* belonged to backward communities and scheduled castes. The average age of *dais* was 53 years and 70% were widows. The average number of live births that the *dais* attended per month was more than 4. Nearly two thirds of the *dais*, besides conducting deliveries, provided other services to women such as pregnancy check up before the delivery, advising women about taking enough rest, tetanus toxoid injections, nutritious food, etc. Nearly 20 % *dais*

provided delivery care as a social service; nearly 50% of them received payment partly in cash, and 20% were paid only in cash. Nearly 70% *dais* reported that they were not paid immediately. 62% of the *dais* reported that the payment did not vary based on the sex of the child. Nearly 75% of them had to travel for more than an hour to reach the training location. Almost 90% of SEWA trained *dais* indicated that they applied mild pressure on the stomach of the woman when the placenta did not come out on its own. More than 50% *dais* did not apply anything to the stump, and less than 10% used ghee or something similar on the umbilical stump. 40% of the *dais* knew that first cry of the child was of prime importance. Two fifths also reported wrapping the baby in a clean cloth. Nearly 60% *dais* gave prelacteal feed to the newborn. Two-thirds of the *dais* reported that they visited pregnant women more than five times before conducting the delivery. In Focus Group Discussions (FGDs), women unanimously indicated that they called *dais* only when labour pains begin. 15% *dais* reported no maternal death in the villages in the past one year, while 25% reported maternal deaths. 79% of SEWA trained *dais* did not wash their hands before the training but more than 80% did wash after the training. 58.1% *dais* under SEWA training did not boil instruments earlier, but after training 41.9% boiled all instruments. More than 80% of the *dais* had cordial or reasonable relationship with the public health functionaries such as ANMs. *Mamta dai* kit was provided to all the PHC trained *dais* and 71% of the SEWA trained *dais*. Nearly 30% of SEWA trained *dais* received supply of iron tablets from SEWA health worker in their area, and 70% of the SEWA trained *dais* accompanied women to the referred centers, if the need arose. The emphasis during the training should be that *dais* should be able to recognize abnormal position of the foetus and complications during pregnancy, and instead of trying to manage these they should seek the assistance of better trained staff. Trained *dais* were more suitable to take on these responsibilities as they live in the villages, and can be called at any time. Duplication of training efforts should be minimized.

Key Words : 1.HEALTH 2.TRAINING OF TRADITIONAL BIRTH ATTENDANTS 3.REPRODUCTIVE HEALTH 4.TRADITIONAL BIRTH ATTENDANTS (TBA) 5.CURRICULUM 6.TRAINING OF DAIS 7.DAIS 8.SAFE DELIVERY 9.REFERRAL SERVICES 10.TRAINING OF HEALTH FUNCTIONARIES 11.COORDINATION 12.SEWA PROGRAMME 13.GUJARAT.

NUTRITION

12. Administrative Staff College of India, Hyderabad. (1997).
    National strategy to reduce childhood malnutrition : investment plan final report. Hyderabad : ASCI. 164 p.

Abstract : The study was conducted to assess the impact of the national strategy to reduce childhood malnutrition. India, with a population growth rate of 1.97%, is

annually adding about 18 million people. Birth and death rates have considerably declined in both rural and urban areas. The study was carried out in 24 states and in the Capital Territory of Delhi during 1992-93. Nearly 33% of the female children covered did not receive any primary vaccine but the figure was around 28% among males. Lowest coverage was reported for measles (males 44%; females 41%). The NFHS survey results indicated that more children residing in rural areas were underweight compared to their counterparts in urban areas (55.9% vs 45.2%). Around 88.9% respondents felt that maternal health and nutritional status was an important determinant for child's nutritional status while 79.4% felt that hygienic practices were important. The major direct food interventions were supplementary feeding programmes such as ICDS, Mid Day Meal Programme, Tamil Nadu Integration Nutrition Project (TINP), Nutritional Anaemia and Nutritional Blindness Prophylaxis Programmes, and Universal Salt Iodization Programme. Foods safety nets such as Public Distribution System (PDS) is the major food subsidy programme in the country. Poverty alleviation programmes were Integrated Rural Development Programme (IRDP) and National Rural Employment Programme (NREP). The states with significant share of cereal subsidy were Andhra Pradesh (12.91%), Tamil Nadu (10.99%), Kerala (10.1%) and Maharashtra (5.81%). Poverty has been declining from the mid seventies from 56.4% to 35% during 1990-91. National literacy rate has gone up from 52.2% in 1991 to 63.38% in 2001. Children aged 3-6 years who under went non-formal preschool education were found to have better developmental scores and their school performance was also better than their counterparts who did not participate in ICDS. Literacy rates ranged from 74.3% in Kerala to 31.8% in Rajasthan. Approximately 30% of all babies in India were born with low birth weight, which is less than 2.5 kg. About 70% Indians used iodized salt, and 30 out of 33 States / Union Territories in the country have banned the use of non-iodized salt for edible purposes. A larger percentage of children 1-3 years suffered from severe growth deficits. The case studies on Panchayat Raj and NGOs are limited to a few states/ areas where these institutions/ organizations have successfully demonstrated their capabilities. Attention needs to be given to some of the national priorities at the local level. PRIs should therefore, prepare a time bound action programme to tackle social issues like girls education, health and nutrition, abolition of child labour, enforcement of minimum wages, limiting the size of families, etc. Improved access to basic health care and educational opportunities should be provided at village level for younger adolescents (11-14 years) and school dropouts through bridge courses. Much more needs to be done to combat child malnutrition.

Key Words : 1.NUTRITION 2.CHILD NUTRITION 3.MALNUTRITION 4.MALNUTRITION CHILDREN 5.CHILD MALNUTRITION 6.COMBATING MALNUTRITION 7.FOOD FORTIFICATION 8.STRATEGY MALNUTRITION 9.STRATEGY CHILD MALNUTRITION 10.MID DAY MEAL 11.NNMB SURVEYS 12.TINP 13.SUPPORT SERVICES WORKING WOMEN 14.WORKING WOMEN 15.INFANT NUTRITION.

13. Kilaru, A, et al. (2005).
Community-based nutrition education for improving infant growth in rural Karnataka. *Indian Pediatrics*, 42(5) : 425-32.

Abstract : The objective of the study was to evaluate a nutrition education intervention designed to improve infant growth and feeding practices in rural Karnataka. Infants below six months were enrolled between 1997-1999 from 13 villages, 11 selected randomly and two selected purposively. Infants and recent births were identified by field workers through a combination of house visits, the snowball technique and by the Auxiliary Nurse Midwife (ANM). Respondent were mostly illiterate, and monthly questionnaires were used to document feeding practices, including a 24-hour recall of foods and fluids consumed, weight of the infants, morbidity experiences in the previous month, and height was measured every three months. Visits were made till the infant completed 2 years of age. Infants enrolled in the study in early 1997 that were already a year old and without nutrition education were considered the non-intervention (NI) group. Other infants who were not older than 5 months of age when the counseling began were considered to be the intervention group. Girl infants enrolled in the intervention had a weight velocity that was 77 gm per month greater than non-intervention girls between 6-10 months of age. Significant differences were observed in the feeding of bananas, with intervention infants being more likely to eat these (33%) compared to non-intervention infants (4%). Intervention infants were also significantly more likely to be fed at least four times in 24 hours in addition to breast milk. One of the most significant findings was the increase in weight velocity among the intervention girls compared to NI girls. Girls in the intervention group were more likely to have at least 4 positive feeding behaviours compared to NI girls. The study limitations include the non-randomized allocation of the intervention and non-intervention groups. Data was collected but was not so reliable due to difficulties involved in collecting such data in the field. It was recommended that women and their families should be counseled during antenatal visits. Addressing groups of families through the anganwadi could be a better way of reducing the cost of nutrition education interventions. Teaching families to increase feeding frequency, increase dietary diversity, modify household food as well as raising awareness on existing food taboos for young children (e.g. bananas and eggs), could reduce the incidence of growth faltering and subsequent malnutrition.

Key Words : 1.NUTRITION 2.NUTRITION EDUCATION 3.NUTRITION INTERVENTION 4.INFANT NUTRITION 5.MALNUTRITION 6.INFANT FEEDING 7.INFANT GROWTH 8.GROWTH INFANT 9.COMMUNITY EDUCATION.

14. National Institute of Nutrition, Hyderabad. (2004).
Food colours in ready to eat foods in unorganized sector : a case study. Hyderabad : NIN. 6 p.

Abstract : Data on usage of permitted synthetic food colours and the levels to which they can be used was evaluated in a variety of Ready-to-Eat (RTE) food samples collected from outlets in Hyderabad City. Tests for the quality, quantity and extent of use of colours in such foods produced by the unorganized sector were also conducted. A random sampling technique was followed. A total of 145 outlets, viz. supermarkets (23), sweetmeat stalls (45), wholesale markets (15), retail outlets selling only confectioneries and other coloured RTE foods such as deep-fried snack foods, sugar toys, coloured synthetic powders, etc. (10), bakeries (21), fast food centres (6) and small vendors (25) were surveyed. A total of 545 samples of coloured food items were purchased from these 145 outlets. Out of the 545 coloured RTE foods analyzed, 32% were sweetmeats, 40% were hard boiled sugar confectioneries, 21% were miscellaneous foods and 7% were non-alcoholic beverages. The analysis showed that 90% of these foods contained permitted colours, while 8% used non-permitted colours and 2% had a combination of permitted and non-permitted colours. Findings indicated that permitted colours tartrazine along with brilliant blue F.C.F is the mostly widely used colour. The study showed that permitted colours were used in a majority of RTE foods. However, the quantities of colours detected ranged from 101 ppm to 18,767 ppm. The highest concentrations were found in sweetmeats (18767 ppm), non-alcoholic beverages (9450 ppm), miscellaneous foods (6106 ppm) and hard-boiled sugar confectioneries (3811 ppm). However, the use of non-permitted colours was found to be considerably low. It was also observed that some RTE foods which were not supposed to contain any added colours as per the PFA Act, contained colours. The Prevention of Food Adulteration (PFA) Act (1995) permitted eight colours to be added to specific foods but only six colours were being used. The usage of synthetic food colours is on the rise because of increased demand of ready-to-eat (RTE) foods. Excessive intake of synthetic colours may lead to toxic manifestations in humans. This observation necessitates the need for large scale multi-centric studies in the country to assess the usage of food colours in various RTE foods and help in effecting necessary modifications with regard to both, numbers and levels of permitted colours in foods to be allowed as per the PFA Act. There is also a need for strict vigilance and enforcement by the Food Health Authorities as per the PFA Act. Consumer education should be given due priority so that consumers could be vigilant and avoid the adverse effects on their health due to excessive intake of permitted as well as non-permitted food colours.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.FOOD SAFETY 4.FOOD COLOUR 5.FOOD ADULTERATION 6.COLOUR FOODS 7.STREET FOOD 8.MALNUTRITION ORISSA 9.WASTING ORISSA 10.ORISSA 11.CHILDREN 1-5 YEARS.

15. Sahu, T., et. al. (2005).
Prevalence of goitre in 6-12 years children of Kandhamal District in Orissa. *Indian Journal of Community Medicine*, 30(2) : 51-52.

Abstract : The objective of the study was to assess goitre problem and its severity as public health problem at the district and sub district level. Thirty cluster villages and schools in 3 blocks of Khandhamal district of Orissa were randomly selected. The study was conducted from October 2003 to March 2004. 1448 children were clinically examined for presence or absence of goitre, of whom 843 children were examined during community survey and 605 during school survey. Out of 1448 children examined, 437 (30.18%) had goitre. All three blocks were found endemic for goitre; severity of goitre was moderate in one block and severe in the other two blocks. Prevalence of goitre among boys was 27.38% and girls was 33.14% in the same age group. The higher prevalence of goitre among girls may be due to puberty related iodine metabolism in this age. School survey was able to detect more cases of goitre as compared to community survey. Goitre in 6-12 years children of Kandhamal district of Orissa with overall prevalence among 30.18% amounted to a severe public health problem. Iodine deficiency needs further epidemiological evaluation in tribal settings. School surveys should be adopted to assess the goitre problem in the community.

Key Words : 1.NUTRITION 2.IODINE DEFICIENCY DISORDERS (IDD) 3.GOITRE SURVEY 4.GOITRE 5.GOITRE CHILDREN.

SOCIAL DEFENCE

16. Advani, Poornima and Gonsalves, Lina. (2000).
Rape a legal study. New Delhi : National Commission for Women. 159 p.

Abstract : Women have suffered discrimination and been the victims of atrocities for long. A conscious and compassionate vision was needed to evaluate and assess the mental condition of women subjected to gender – based violence. In 1983, a few measures, including more stringent laws were introduced, but they did not meet the demands of the situation. Sometimes, in the eyes of the judiciary, consideration of the young age of the rapist outweighs compassion for the victim. Feeling of terror, mistrust, depression, rage and guilt seem to engulf the victim. NCW renewed its efforts towards amendment of the law concerning rape. There are three types of rapists, those who commit rape due to (i) pent up sexual impulses, (2) sadistic character and (3) aggressive criminal tendencies. In 1983, Section 376 A was incorporated in the Indian Penal Code, where sexual act with legally separated unwilling wife was recognized as a criminal offence. The

Supreme Court observed that even a prostitute has a right to privacy in the ruling in Maharashtra Vs Madhikar Narain Mardika case. In India, the rule of corroboration of the prosecutrix has undergone a change through statutory amendments and decisions of the apex court. Under Section 376 A, where the wife was below 12 years, the penalty was severe; it was the same as provided for the offence of rape. Three workshops were conducted by NCW to elicit the comments of experts in the field and they recommended that if an accused who had knowledge that he was a carrier of HIV infection, infected another as a result of rape, the law should award life imprisonment to the rapist along with monetary compensation to the victim. All participants expressed the view that as human rights activists worldwide are working towards abolishing capital punishment which is considered to be barbaric, capital punishment for victims of rape need not be recommended. Most states made compensation to rape victims mandatory. NCW took a fresh look at the law on rapes so that the laws could be revamped in order to adequately address the various types of sexual assault in the light of the experience gained during the last decade. The law on rape needs to be amended.

Key Words : 1.SOCIAL DEFENCE 2.RAPE 3.LEGISLATION FOR WOMEN 4.LEGAL AMENDMENTS 5.DATE RAPE 6.DEFINITION OF RAPE 7.RAPE LAW 8.CASE STUDIES.

17. Committed Communities Development Trust, Mumbai. (1999).
Survey, mapping and needs assessment of sex worker settlements in Mumbai city, its suburbs and in Navi Mumbai. Mumbai : CCDT. 40 p.

Abstract : The study aimed to identify and map sex workers settlements in Mumbai city and its suburbs. Snow balling technique was used for collecting data. The selected women were multi-lingual and spoke Hindi, Marathi and Kannada. Every place had settlement areas, and these were located very close to some industries and textile mills. About 3-4 women lived in each home, and elder children attended the municipal school in the vicinity, but there was no provision of a balwadi or crèche. Women had sufficient information on HIV/AIDS and visited private practitioners for health problems. In Gaiwadi, girls came from various parts of Mumbai and their husbands and children were not aware of their profession. Each building housed 25-30 women and rooms measured approximately 8 feet by 8 feet. The reasons for entering these professions are financial need, desertion by the spouse, alcoholism and unemployment. Gaiwadi women looked healthier than Kamatipura women. In Sewri, there was no facility of a hospital or a school. In Ghatkopar, most of the women were from Maharashtra and Karnataka. There was poor drinking water facility. The women expressed that during the rains, the condition of the road worsened and had the problem of water stagnation. Bhandup was largely populated by eunuchs and *goondas* (hooligans) who came mainly from Karnataka. Here, eunuchs were engaged in sex work, dancing, beggary and

extortion. In Mahim, the sex workers were largely eunuchs. The clients were young college students and men, mostly from the middle class. In Malavni, several beauty parlours operated where sex work took place under cover. Girls generally came from Dahisar, Mira Road, Kandivali, etc. In Chembur, blue films were screened which were seen by young and older men. At Reay Road, girls and women were observed soliciting clients on the main road. According to the prostitutes there were no education facilities for children. They mentioned the lack of medical facilities as their major need especially with regard to STDs. The children in most of the settlements were suffering from malnourishment and from skin ailments. In Juhu, sex work was carried out in lodges, and call girls catered to the rich clientele. In Turbhe, there were 75-80 brothels and the population was mainly Nepali. There was a private Hindi medium school till Class VIII in the adjoining area. The average age of women was 25-26 years but girls from 16 years to women of 40 years worked in this profession. Awareness about HIV/AIDS was present among women in these areas. The rationale for conducting the survey was to help and increase the outreach of welfare and development programmes of the Government and NGOs to these newer areas. One of the main interventions required in a sex worker settlement, particularly for children would be to empower and expose them to opportunities in mainstream society. Planned, well coordinated and regular rescue operations would be more effective in arresting trafficking. There is a need to sensitize the police force to the issue of trafficking.

Key Words : 1.SOCIAL DEFENCE 2.PROSTITUTION 3.SEX WORKER 4.NEEDS ASSESSMENT 5.RED LIGHT AREA 6.SETTLEMENT COLONY 7.AIDS.

18. Khot, Seema. (2005).

Needs assessment of bar girls in Navi Mumbai for planning appropriate interventions to ameliorate their conditions : a study conducted by Save the Children, India and VEDH. Pune : Baif Development Research Foundation. 46 p.

Abstract : Girls who work in bars which serve alcohol and entertain clients by live dance performances are known as bar girls. The study was conducted by Vedh in August – September 2001 to study the situation of bar girls in Navi Mumbai who were trafficked into this profession from all over the country. The study was carried out in 28 villages around Navi Mumbai. A series of data collection methods were used, namely focus group discussions, observations and interviews of bar girls and their families, bar owners and agents. It was found that there were a total of 164 bars in Navi Mumbai, of which 150 were dance bars. The estimated number of bar girls was above 5000. 75% of the girls interviewed were less than 25 years of age, and of the 50 girls interviewed, 64% were married. The children of bar girls were affected the most, as their health, food and schooling were at stake. The factors

which made young girls leave their families were poverty, rural/ farming family background, lack of education, male member's decision, luring by agents, etc. The agent's network with politicians and mafia was also one of the major coercive causes for girls getting into dance bars or the sex trade. Even women relatives were used by agents to assist in getting girls into bars or the sex trade. Some of the bar girls in Navi Mumbai were from Bangladesh and some were from Nepal. Bar girls usually stayed in rented houses of 1-2 rooms, without basic amenities or proper ventilation. Bar girls were subjected to physical, social, sexual and economic exploitation by family members, agents, bar owners and clients. All these factors had an adverse impact on their health. An in-depth study of the problem of bar girls was recommended, as this was a rapid study and the investigators had to rely on information provided by bar owners. The process of prevention should start from families. To control trafficking, awareness generation among village women, formal education of girls, sex education of girls and boys, and vocational training to potential bar girls is needed. Vigilance in bars, preparing and displaying a code of conduct for clients and customers in bars, better 'employee benefits' to bar girls, basic amenities in residential colonies, and crèches for children were also needed. Rescue operations would require political will, deputation of Government machinery, legislative back up, as well as community based rehabilitation. Sensitization of bar owners, agents and bar girls was necessary for successful rehabilitative intervention. The intervention activities should include counseling, vocational training, micro credit group formation, medical facilities, promotion of the use of condoms, sex education, crèches for the children of bar girls, and their marriage.

Key Words : 1.SOCIAL DEFENCE 2.BAR GIRLS 3.DANCE BAR GIRLS 4.DANCE BARS 5.PROSTITUTION 6.TRAFFICKING 7.NEEDS ASSESSMENT 8.NEEDS OF BAR GIRLS 9.MUMBAI 10.NAVI MUMBAI.

19. Raut, D.K, Pal, D. and Das, A. (2003).
    A Study of HIV/STD infections amongst commercial sex workers in Kolkata (India), part-II sexual behaviour, knowledge and attitude towards STD/HIV infections. *Journal of Communicable Diseases*, 35(3) : 182-87.

Abstract : A community based study of Human Immunodeficiency Virus (HIV) and sexually transmitted diseases (STDs) was carried out among 867 commercial sex workers (CSWs) of different red light areas in Kolkata. 22.26% sex workers were in the age group of 16-20 years, 33.45% between 21-25 years, and the majority (74.28%) under thirty years of age. The commonest sexual practice was normal peno-vaginal practiced by 94.1% sex workers, 32.5% practiced peno-oral sex, and around 13.96% sex workers participated in group sex activities. The most common habits of sex workers were betel nut chewing (67.59%) and alcohol consumption (61.1%), but drug abuse was not practiced. Around 78.09% workers were in the

trade since the last ten years, and 21.91% for more than ten years. Sex workers on an average remained in the trade for 6.71 years. The knowledge of CSWs about STDs and HIV / AIDS infections was quite low. About 49.48% CSWs had heard about STD / HIV / AIDS, and 49.6% knew that STD / HIV could be prevented by condom use. Prevention and control strategies should not only target sex workers but also clients and youth, which constitute the major high risk groups.

Key Words : 1.SOCIAL DEFENCE 2.PROSTITUTION 3.SEXUAL BEHAVIOUR 4.DRUG ABUSE 5.PROSTITUTE 6.KNOWLEDGE 7.ATTITUDE 8.AIDS AWARENESS.

20. Raut, D.K, Pal, D. and Das, A. (2003).
A Study of HIV/STD infections amongst commercial sex workers in Kolkata (India), part-III, clinical features of sexually transmitted diseases. *Journal of Communicable Diseases*, 35(4) : 244-48.

Abstract : In India, the HIV/AIDS epidemic is now more than a decade old. Increasing sex trade, use of illicit drugs, and rates of sexually transmitted infection contributed to an increased vulnerability of people to HIV/AIDS. Around 84% of HIV infections in India were attributed to hetero sexual transmission. Blood sampling of the sex workers was done. About 44.98% had history of burning sensation, 45.9% had abdominal pain, 25.03% had sores, and 1.7% had swollen inguinal lymph glands. On clinical examination, 80.16% had STDs, 28.48% had more than one STD infection, 49.6% had vaginal discharge with duration varying from a few days to months, genital ulcers were seen in 25.03% workers, scabies was observed in 12.1% cases, inguinal bubo in 1.7% cases, 13.73% had chronic weight loss, and only 32% had taken medical treatment for their genital tract ailments. Genital warts were found in 13.7% sex workers in Kolkata, which were less compared to 32% observed in Mumbai. The study reflected the grim health situation of commercial sex workers and scenario of STD infections prevalent among sex workers and also in the community.

Key Words : 1.SOCIAL DEFENCE 2.PROSTITUTION 3.COMMERCIAL SEX WORKER 4.SEXUALLY TRANSMITTED DISEASE (STD) 5.HIGH RISK GROUP 6.AIDS.

21. Sanlaap, Calcutta. (~1998).
Fallen women or fallen society : coining experiences from red light areas in India. Calcutta : Sanlaap. 17 p.

Abstract : Children of prostitutes are in a terrible situation all over the world. Many prostitutes understood the importance of education and felt sorry that their children were thrown out of school. The situation was worse for girl children and they dropped out from school as other children knew about their mother's profession. A woman deserted by her husband tried several quick trades but failed to feed her four children and thus took up prostitution which brought her the much needed money. In Maharashtra, Andhra Pradesh and West Bengal, children of prostitutes were denied admission. Prostitutes in Calcutta were forming organizations to demand "reservation" for their children in education, jobs, shelter, etc. These children grow up and become drivers, garage mechanics, private tutors, office club actresses, *jatra* actresses, cooks, housemaids and some even become anti-social elements. In Andhra Pradesh, a girl's birth in the Domari Caste was celebrated as the girl child would join prostitution and be a breadwinner. In West Bengal, girls aged one month to ten years or even older girls were brought by agents to join this profession and finally work as prostitutes. In the Bedia Community in U.P., women became the breadwinner and jackpot for the agents who set them up, brought clients and used them till they provided them with money. In Calcutta brothels, girls were kept under strict vigilance, and children born to them were kept with the mother in very early childhood. Mothers wanted that their children should be rescued from this environment and profession. There were debates that prostitution should be legalized but even if it was legalized, prostitutes would keep on being used because the whole society does not miss a chance to use a woman. Even if women earn their own living and support their families, they are exploited by the men in society, mentally, physically and financially. License to these women will not change the exploitation by men, who pose as their protectors, lovers, clients or providers. Trafficking was rampant in the Indian situation, and women and girls were brought and bought from Nepal and Bangladesh. Every year girls are sold by parents in the name of marriage, and girls are also kidnapped by agents. In early times in Calcutta, rich men used to come from villages and stayed with women who took care of them. Nepal is poorer compared to India, and girls and women were brought in large numbers. Women suffered cuts, thrashings, even attempts to murder but survived. There is no planned programme of reporting this to police stations. Demands of cheap labour from Bangladesh to work as domestic servants, labour in the carpet industry, dry fish and *churi* industry or plastic factories in India, leads to trafficking of women. Prostitution in India and Pakistan is on the rise. Rehabilitation programmes are required to deal with the problem, and pressure points on respective country Governments. Regional and country networks, and information networking would help in combating trafficking.

Key Words : 1.SOCIAL DEFENCE 2.PROSTITUTION 3.TRAFFICKING WOMEN.

22. Vijaya Kumar, S. (2002).
Devadasis vulnerable among vulnerable. Hyderabad : Council for Social Development. 55 p.

Abstract : History has evidence of the Devadasi system existing in many parts of the world in some form or the other. Devadasi girls are dedicated to God and also known as sacred prostitutes. Devadasi system is a form of "exploitation of lower caste girls by upper caste feudalistic lords under religious faith". This system was mainly followed by scheduled castes and backward communities where it was customary to dedicate young girls as Devadasis and to perpetuate the patrilineal lineage. A Devadasi who lives as a concubine gets a weekly or monthly sum towards her livelihood. Furthermore, a Devadasi was believed to be immune from widowhood and called "*akhanda saubhagyavati*" one who can never be a widow, since she is wedded to a divine deity. To eliminate this social evil, National Commission for Women (NCW) formulated an agenda to streamline the process of rehabilitation of devadasis; protect their girl child from the system; and educate all their children. NCW focused its attention on analyzing the situation of Devadasis in Andhra Pradesh, Karnataka and Maharashtra. Devadasis covered under the rehabilitation program were 14,339 in Andhra Pradesh and 16,560 in Karnataka. During public hearings in Andhra Pradesh, it became evident that the devadasi system had deep roots in village level traditions, and more particularly for girls from vulnerable communities. In Karnataka, devadasis requested the Government to make a provision for old age pension and food security in the rehabilitation program. Quite often, girls from Andhra Pradesh were brought to Karnataka and initiated into the devadasi system. Most devadasis were aware of the rehabilitation program. Awareness programs were given much importance in the action program and carried out in all villages during fairs at Yellamma temples. With increased awareness, devadasis were not forcing their daughters to follow the system. Devadasis strongly argued that prostitution was not at all a part of devadasi system. Very few children of devadasis utilized the facilities available under education program. Karnataka State Women's Development Corporation (KSWDC) organized health camps twice in a year for Devadasis in which a few HIV cases were identified. Devadasis have requested for a special scheme through which the educational cost of their children can be taken care of. Since there was no proper coordination and cooperation between the stakeholder departments, the program itself was suffering to a large extent. Without assessing the capabilities of devadasis, programs were implemented, but they failed to achieve their goals. Social awareness may help in eradicating this system.

Key Words : 1.SOCIAL DEFENCE 2.DEVADASIS 3.REHABILITATION OF DEVADASIS 4.PROSTITUTES 5.PROSTITUTION 6.PREVENTION PROSTITUTION 7.SOCIALLY SANCTIONED PROSTITUTION.

SOCIAL WELFARE

23. Mahatma Gandhi Labour Institute, Ahmedabad. (2005).
Gujarat Human Development Report 2004. Ahmedabad : MGLI. 353 p.

Abstract : The study assessed the present level of development of Gujarat State. According to Gujarat Human Development Report 2004, the population of Gujarat increased from 9.1 million in 1901 to 50.65 million in 2001. The total Crude Birth Rate (CBR) declined from 39.2 in 1971 to 24.9 in 2001. According to 2001 Census, the overall sex ratio of Gujarat was 919. Crude Death Rate in 2001 was 7.8. The State per capita income in 2000-01 was Rs. 12,975 (at 1993-94 prices). According to the Census of India 2001, there are 21.247 million workers in the state in a population of 50.656 million. Unemployment rate in Gujarat is lower than that in the country. Unemployment was 4.63% (current daily status) in 1990-2000 compared to 7.29% for the country. The female work participation rate (WPR) in Gujarat was 39% in 2001. According to most experts like Dreze and Deaton (2003) and Dev and Ravi (2003), the incidence of rural poverty is higher than the incidence of urban poverty in the state. According to the Population Census 2001, the literacy rate in the state increased by a mere 8.38%. Enrolment rate in the age group of 6-14 years in Gujarat is 96% and retention rate upto Class V is 54%. Maternal Mortality Rate in the year 1992-93 was 389. According to SRS, infant mortality rate was 60 in 2001. Life expectancy rate at birth of males was 61.53 years and of females was 62.77 years (2001). Child mortality rate was found to be 85.1 per 1000 live births in 1998. Total Fertility Rate (TFR) was 3.0. In Gujarat, the mean BMI (Body Mass Index) for women was 20.7 and 37% women have a BMI below 18.5, which is called a situation of chronic energy deficiency. There were 32613 Self Help Groups (SHGs) functioning in Gujarat. According to police records, in 2002 the number of registered dowry deaths was 41. It would be useful to conduct primary studies to fill in critical gaps in information and have in-depth understanding of Human Development. This first Human Development Report needs to be followed up by periodic Human Development Reports. The value of the reports would increase if new monitoring indicators other than those already covered are evolved for monitoring the process of human development.

Key Words : 1.SOCIAL WELFARE 2.HUMAN DEVELOPMENT REPORT GUJARAT 2004 3.INFANT MORTALITY 4.POVERTY 5.SELF EMPLOYMENT PROGRAMMES 6.WATER 7.RIGHT TO HEALTH 8.SOCIAL SECURITY 9.HEALTH SITUATION GUJARAT 10.NUTRITION SITUATION GUJARAT 11.EDUCATION GUJARAT 12.CHILD LABOUR GUJARAT 13.SEX RATIO 14.FEMALE HEADED HOUSEHOLDS 15.VIOLENCE AGAINST WOMEN 16.EARLY MARRIAGE 17.EMPOWERMENT WOMEN 18.GUJARAT.

WOMEN WELFARE

24. Athalye, Naina Rao. (2004).
    Stress and health implications of domestic violence. Mumbai : Sophia Centre for Women's Studies and Development. 57 p.

Abstract : The concepts studied in the present research on domestic violence were stress measured as daily hassles, and health. Domestic violence ranged in frequency and intensity. The British Medical Association further categorized domestic violence into physical violence, sexual abuse, psychological abuse and emotional abuse. In 1993, the World Bank estimated that domestic violence accounted for at least 5% of the health problems of women in the developed countries and 20% in developing nations. 280 women with mean age of 38.5 years were given inventories. Nearly 50% women were unaware of the laws protecting women from violence. 100% women agreed that they had been a victim of domestic violence. 60% were verbally abused by husbands in the presence of others for not following his instructions. 67.5% women cried and prayed when their husbands were violent. 65.5% women worried about their children when their husbands became abusive. 52.5% reported that financial independence would reduce the violence. 42% reported that they stayed in the marriage for the sake of their children. Women victims reported more stress as compared to the non-victimized group. Women reported more stress along with more health symptoms. A significant relation was found between daily hassles and health of the victimized and the non-victimized group. A victim of domestic violence would experience even routine tasks such as daily chores and child care as insurmountable mainly because of fatigue, chronic headaches, infections or depression. Men should overcome patriarchal beliefs and get involved in the process of establishing gender equity. The research design was too simplistic, other variables could be included. Future research could examine traditional gender role beliefs from different economic, social and religious strata of society.

Key Words : 1.WOMEN WELFARE 2.VIOLENCE AGAINST WOMEN 3.DOMESTIC VIOLENCE 4.HEALTH 5.STRESS 6.PHYSICAL HEALTH 7.MENTAL HEALTH 8.CRIME AGAINST WOMEN CELLS 9.POLICE CELLS FOR WOMEN 10.IMPACT OF DOMESTIC VIOLENCE.

25. Centre for Social Research, New Delhi. (2005).

A Study on special arrangements to combat violence and crime against women in the States of Punjab and Haryana. New Delhi : CSR. ~200 p.

Abstract : Domestic violence is one of the most poignant forms of betrayal. Dowry still remains a major cause for violence within the private domain. The study assessed the effectiveness of Crime Against Women Cells (CAWC) in addressing domestic violence with the major objectives to examine the nature of assistance and support services to victims; the role of Crime Against Women Cells and other agencies in redressal of domestic violence; assess the effectiveness of CAWCs; and suggest ways and means to strengthen CAWCs for the effective combating and redressal of domestic violence. The study was conducted in Amritsar, Patiala, Moga and Mohali districts of Punjab and Ambala, Karnal, Gurgaon and Jhind districts of Haryana. According to the functionaries of the Cell, 20% cases were solved by Community Resource Policing Centre (CRPC). CRPC in Amritsar was found to be particularly effective in cases where families belonged to low economic background. It was observed by an NGO 'Shakti' that cases can be settled in CPRC only if a person has political or high bureaucratic connections. The Cell worked in close relationship with Nari Niketan, a shelter home for women. CPRC are extremely, important as they deal with not only incidents of violence, but they save the Courts time in dealing the cases, and are convenient for people. The police along with the community have tried to reform traditional institutions in dealing with domestic violence as in Community Policing Resource Centres in which Women Cell is a part. About 50% respondents were satisfied with the functioning of the Cell, while 26.9% could not say anything. Hindus form an overwhelming majority of about 90% of the state population in Haryana. The responses revealed that despite its positive intentions, the Cell in Gurgaon had limitations. In Jhind, of the solved cases, 10% were divorce cases and the rest 10% cases were referred to the Court. In Jhind, the victims were not vociferous regarding the functioning of the Cell. Some respondents stated that Cell officials were corrupt and they tried to extract money. The number of cases of this nature which used to come to Courts earlier came down, as 25% cases were solved by the Cell. There existed a sharp difference in the opinion and experiences of victims and the accused. In Karnal, CAW Cell was established in 1995. It was found that 70% cases were fake and the rest 30% cases were registered under the Dowry Act. However in both the states and both the institutions under study, the respondents were appreciative of the fact that these institutions had friendly and cooperative environment, and reassured victims rather than being hostile and cold.

Key Words : 1.WOMEN WELFARE 2.VIOLENCE AGAINST WOMEN 3.CRIME AGAINST WOMEN 4.COMBATING VIOLENCE 5.CRIME AGAINST WOMEN CELL 6.WOMEN POLICE STATIONS 7.PUNJAB 8.HARYANA.

26. Gunthey, Ravi. (1999).
Influence of environmental stress, work environment and family environment on working women of public and private sectors in relation to their mental health. Jodhpur : Jai Narain Vyas Univ., Dept. of Psychology. ~20 p.

Abstract : The study was conducted by Department of Psychology, Jai Narain Vyas University, Jodhpur to know the unique environmental stress attributes of working women in the public sector as compared to private sector and non-working women; to know the effect of family environment dimensions on the mental health of working women in both the sectors vis-à-vis non-working women; to know what are the changes in mental health status as a result of work environment factors affecting working women in public and private sector and non-working women; and to understand the level of insecurity among women in the private sector. Incidental purposive sampling technique was used to select the sample. In the present study, 386 working and 193 non-working women were taken as the sample. Findings indicated that the feeling of insecurity, unsafety and lack of self-confidence was more among working women. Family members of working women in the public sector and non-working women were concerned and committed to family affairs, and were found supportive to each other. The family members of private working women encouraged them to be assertive, self-sufficient and to make decisions on their own. They also preferred an achievement oriented or competitive framework than their counterparts. The order and organization level was higher in the families of private working women in terms of structuring family activities, financial planning and explicitness and clarity with regard to family rules and responsibilities than the families of women working under public sector and non-working group. Feelings of personal development and growth and the desire to be self sufficient was higher among working women in the public sector. Working environment of the private sector emphasized good planning, efficiency and encouraged the worker to "get that work done", which was different from their counterparts. Private sector working women perceive direct stresses like insecurity of jobs, excess work and less freedom due to which their emotional balance, adjustment process and tolerance level was under great threat which influenced their mental health as compared to women working in public sector and non-working women respectively. The problems faced by private and public sector working women in India are not at all insurmountable. Perceptible changes can definitely be brought about with sincere efforts and proper attention from all concerned. The actual situation must be brought out in the open by conducting more fact oriented studies, and researcher's efforts can create social awareness about their problems among all. Social scientists must realize their responsibilities and work in a more coherent, practical and result oriented manner.

Key Words : 1.WOMEN WELFARE 2.MENTAL HEALTH 3.WORKING WOMEN 4.STRESS 5.WORK ENVIRONMENT 6.FAMILY ENVIRONMENT.

27. International Centre for Research on Women, New Delhi. (2002).
Innovative, women-initiated community level responses to domestic violence : a study of Nari Adalat. New Delhi : ICRW. 114 p.

Abstract : In India, politicization of domestic violence as a public issue gained strength largely through the Indian women's movement. There was a difference in the nature of mobilization by women's groups in rural and urban areas. Gujarat ranked sixth among the low poverty states in India, with only 18% of the population below the poverty line in 1987-88. The age at marriage was high (20 years), and a fairly high percentage of girls (68%) aged 6-14 years were attending school. The sex ratio in Gujarat declined over the last decade from 934 to 921. The child sex ratio 0-6 years has fallen sharply from 928 to 878 in the last decade. Female literacy rate was 58.6%. Female work participation rates in urban Gujarat are far lower compared to rural areas. In 2000, studies show that anywhere from 40% to 75% of married women have reported partner violence, and 24% to 64% women seek help from women's groups. Registered crimes against women (CAW) have shown an increase of 8.4% between 1997 and 1998 and 3.3% between 1998 and 1999. The Crime in India report 1999 showed that presently 2 out of every 10 crimes committed were crimes against women. The International Center for Research on Women (ICRW) and Mahila Samakhya (MS) program in Gujarat decided to initiate the documentation and impact assessment of innovative community level responses to domestic violence. Women did try to raise issues of domestic violence and sexual harassment in *sangha* (group) meetings, but there was fear and hesitation about discussing these issues openly. Women said that our men will not even allow us to come to this forum if we call ourselves the *Nari Adalat* (Women's Court). Reported cases of dowry have risen from 63 in 1993 to 94 in 1999. *Nari Adalat* and *Mahila Panch* are community level responses to violence against women. The police formed a more significant constituency, as threat of police action is a major strategy used to pressurize perpetrators.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE 3.VIOLENCE AGAINST WOMEN 4.LOK ADALATS 5.NARI ADALAT 6.MAHILA PANCHAYAT 7.MAHILA SAMAKHYA PROGRAMME 8.BARODA 9.GUJARAT.

28. Mukherjee, Mukul. (2004).
A Situational analysis of women and girls in West Bengal. New Delhi : National Commission for Women. 144 p.

Abstract : A study on situational analysis of women and girls in West Bengal (WB) was conducted. The population of West Bengal increased from 68 million in 1991 to 80.2 million in 2001, comprising 41.5 million males and 38.7 million females. The

mean age of marriage for women in West Bengal went up from 18 to 19.7 years, while for men it increased from 24.6 to 25.9 years. 45.3% women had at least one reproductive health problem. Mean number of children ever born to women aged 40-49 years were 4.2. About 48.8% children below 3 months were exclusively breast-fed. 41.5% children were under nourished. About 43.8% children had received all vaccinations. HIV/AIDS cases increased from 670 in 2000 to 1131 in 2002-2003. Maternal Mortality Rate was 264. The Infant Mortality Rate (IMR) was 49 in 2002 (SRS Bulletin). Literacy rate for rural men went up from 62% to 74% between 1991 and 2001, while for rural women it rose from 38% to 54%. Urban women's literacy rate was higher than all India figures of 73%. Dropout rate for girls was 57% as against 46% for boys in Class I-V in 2000-01. Rural and urban female work participation rates in West Bengal were 16.8% and 19.1% in 2001. In 1991, 2.7% girls and 5.6% boys in the age group 5-14 years were child workers. Torture/ cruelty by husband/ relatives increased from 111 in 1995 to 222 in 2003. Kidnapping and abduction cases were 86 in 2003. Sexual harassment / eve teasing increased from 46 in 2000 to 57 in 2003. There were 36 rape cases in West Bengal in 2003. Introducing target based schemes for promoting literacy and education among children of ST families, especially girl children; and building all weather roads for connecting schools to relatively inaccessible rural pockets are required. NGOs can play a major role in the fight against violence inflicted on women. By imparting awareness, raising self-confidence and providing requisite support, NGOs can make an important contribution to women's quest for security and justice.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN WEST BENGAL 3.SITUATION OF WOMEN 4.HEALTH 5.LITERACY 6.EDUCATION 7.VIOLENCE AGAINST WOMEN 8.EMPOWERMENT WOMEN 9.INFANT MORTALITY 10.AIDS 11.WEST BENGAL.

29. National Commission for Women, New Delhi. (2004).
    National Consultation on Gender Budgeting : proceedings, outcome and follow-up. New Delhi : NCW. 112 p.

Abstract : Even today, there are villages that are 10 km away from a *pucca* (proper) road, do not have electricity, or a school. Despite the Five Year Plans and major and minor changes in development policy and poverty alleviation strategies adopted since Independence, poverty and hunger still persist. The Economic Survey 2002-03 and the Tenth Plan document emphasized the Millennium Development Goals (MDGs) and set monitorable targets for eradicating poverty and achieving development. The incidence of poverty has declined from 54.9% in 1973 – 74 to 26.1% in 1999-2000. The rate of growth of employment on current daily status declined from 2.7% per annum in 1983-94 to 1.07% per annum in 1994-2000. A Nationwide survey showed that over 43.5 million people living in 1.42

lakhs habitations were at health risk due to problems of drinking water quality like excess fluoride, arsenic, salinity, iron and pesticides. The World Bank and WHO have estimated that in India, 21% of all communicable diseases (11.5% of all diseases) were water related. It was estimated, India has 20% of the global child population but accounts for 40% of the world's malnourished children. 4.2% of rural and 1.1% of urban households reported getting two square meals a day only during some months of the year. The Report on the State of Food Insecurity in the World, 1999 estimated that in the developing world, 790 million people did not have enough to eat. 204 million people were identified as undernourished in India. Sex ratio in the 0 – 6 age group declined steeply from 945 in 1991 to 927 in 2001, implying that millions of girls went missing in just a decade. The incidence of anaemia among pregnant women was estimated to be as high as 88%. A WHO study in six states in India revealed that 40% women reported physical abuse by their partners, and 14% faced severe abuse. Budgetary allocations (2003-04) for women were working women's hostels (Rs. 44.8 million), labour and social securities (Rs. 300 million), maternity benefits (Rs. 220 million), RCH (Rs. 1229.6 million), and tuberculosis and malaria (Rs. 100 million). The share of women's component of composite public expenditure of Central Government showed a decline from 3.89% in 1995-96 to 2.02% in 2001-02. Women constitute around 50% of the population and they must be part of the budget formulation process. Employment creation programmes must be strengthened. Domestic violence must be treated as a crime and adequate allocations must be made for shelters for women. Access to work, drinking water, drainage and toilets, public infrastructure such as roads, transport facilities, medical facilities, shelter and social security should be given much greater priority in the budget.

Key Words : 1.WOMEN WELFARE 2.GENDER BUDGET 3.BUDGET FOR WOMEN 4.POVERTY 5.UNEMPLOYMENT WOMEN 6.SEX RATIO 7.VIOLENCE AGAINST WOMEN 8.POOR WOMEN 9.POVERTY ALLEVIATION 10.PROGRAMMES FOR WOMEN 11.GOVERNMENT INITIATIVES 12.LACUNAE.

30. National Commission for Women, New Delhi. (2004).
    Report of the National Task Force on Technological Empowerment of Women in Agriculture. New Delhi : NCW. 107 p.

Abstract : This study was undertaken to assess the status of women who are involved in agriculture. The population of females increased from 117 million to 407 million between 1901 and 1991. A sectoral profile of the female work force indicated that more than 80% of female workers are engaged in the agriculture sector in rural India. High percentage of independent participation of women (43%-

81%) was observed in all homestead activities like cooking, cleaning, collection of fuel, fetching water, care of children, etc. Independent participation of women was found to be very marginal in major crop production (1%), post harvest activity (2%), livestock management (6%), and entrepreneurial activities (0%). This indicated the involvement of men in skilled agricultural work, and limiting the role of women to drudgery prone, unskilled activities like weeding, transplanting, harvest cleaning, grading, etc. Nearly 80% women are engaged in agriculture, while the figure for men is 60%. While the number of women engaged in agriculture and allied activities (primary sector) has increased in absolute terms, their participation rate has come down from about 90% to 85%. The National Policy for Empowerment of Women, 2001 aims to help women by providing appropriate technologies suiting their needs. The Technology Mission in the Department of Agriculture and Cooperation is implementing the scheme "National Perspective Plan for Women Farmers". Under the Oil Seeds Production Programme and the National Pulse Development Programme preference is given to women farmers. Efforts have also been made to involve farm women groups under both the programmes to perform activities involved in maize production in the country. The Indian Council for Agricultural Research has established a National Research Centre for Women in Agriculture (NRCWA) at Bhubaneswar for undertaking women specific research studies in the field of agriculture. The Central Sector Scheme for Women in Agriculture was approved for implementation in one district each of 15 states of the country during the Ninth Five Year Plan. The project entitled "Training and Extension of Women, Orissa" in its second phase is being implemented in eight districts of Orissa. The drudgery involved in household and agricultural work is tremendous and leads to several health problems. It has been seen that the most common occupational health hazard of women is overwork. Careful studies on the impact of new technologies should be undertaken in selected farm areas. Specific steps must be taken to provide women with managerial and organizational skills. Only concerted action of the agricultural research system and policy makers can lead to meaningful research on issues concerning women. In order to have effective implementation of programmes, there should be integrated women's development programme.

Key Words : 1.WOMEN WELFARE 2.AGRICULTURE AND WOMEN 3.WOMEN IN AGRICULTURE 4.POLICIES AND PROGRAMMES FOR WOMEN 5.NATIONAL TASK FORCE 6.NATIONAL TASK FORCE ON WOMEN IN AGRICULTURE 7.WOMEN LABOUR 8.WOMEN AGRICULTURAL LABOUR 9.AGRICULTURAL LABOUR 10.CHILD LABOUR 11.LEGISLATION FOR WOMEN 12.LEGISLATION FOR CHILDREN.

31. National Commission for Women, New Delhi. (2004).
A Study of the implementation of current policies, programmes and schemes for women and girls in India : a comparative study : Vol. one. New Delhi : NCW. 292 p.

Abstract : The present study is an empirical investigation into the status of women in India as it obtains today after five decades of planned development. The study had the following objectives : firstly, to observe the implementation of the national and state policies and programmes specifically designed for advancement of women; and secondly, to make suggestions for cohesive and better implementation of development policies and programmes within the framework of gender equality and equity. India's population in 2001 stood at 1,027 million comprising 531.3 million males and 495.7 million females. The highest proportion of rural population was in Himachal Pradesh (90.2%), Bihar (89.53%), Sikkim (88.90%), Assam (87.28%), Orissa (85.03%), Tripura (82.98%), Nagaland (82.26%), and Meghalaya (80.37%). Six states were studied namely Uttar Pradesh, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, and Mizoram. Uttar Pradesh had the highest population of 166.1 million followed by Maharashtra 96.8 million. Orissa had highest proportion of population below the poverty line (BPL) (47.18%). Tamil Nadu registered Human Development Index (HDI) of 0.531 (3rd rank), Maharashtra 0.523 (4th rank), Mizoram registered 0.548 (7th rank), Orissa 0.404, Madhya Pradesh 0.394, and Uttar Pradesh 0.388. Life expectancy has gone up from 36.7 years in 1951 to 64.6 in 2000, birth rate has gone down from 40.8 to 25.8 per 1,00,000 population. Birth rate was highest in Uttar Pradesh (32.1) and lowest in Kerala (18.0). Infant Mortality Rate was highest in Orissa (97) and lowest in Kerala (14). Death rate was highest in Orissa (10.6) and lowest in Kerala (6.4). The rural Maternal Mortality Rate (MMR) was higher 619 compared to 267 in urban areas. Female work participation rate (FWPR) in 2001 was highest in Mizoram (47.63%) and lowest in Uttar Pradesh (16.28%). Three of the six states studied have their own state policies, namely, Maharashtra, Madhya Pradesh and Tamil Nadu. Legal awareness is limited to educated urban women especially those who were currently attending higher education institutions and/ or are employed. Awareness about all programmes and schemes meant for women's development is fairly high in Tamil Nadu and Maharashtra, namely Bal Vivah Virodh Abhiyan, SHG Groups in Ujjain, Panchayati Raj which is transforming lives, and Bairani Kuldi - a microcredit initiative. Mahila Vikas Samabaya Nigam (Women's Development Corporation), Orissa, the principle agency for economic empowerment programmes for women, is doing tremendous work and implementing several Central Government Schemes in this area. The Tamil Nadu Women's Development Corporation is doing remarkable work for the economic and social empowerment of women. Uttar Pradesh Women Development Corporation, established in 1999, is attempting to rejuvenate local crafts and provide monetary benefits to local craftswomen. The Population Policy of Maharashtra holds both incentives and disincentives. Kishori Shakti scheme needs to be universalized for out of school adolescent girls with much more stringent inputs. All forms of discrimination against the girl child and

violation of her rights should be eliminated by undertaking strong measures, both preventive and punitive, within and outside the family.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN INDIA 3.SITUATION OF WOMEN 4.STATUS OF WOMEN 5.EMPOWERMENT WOMEN 6.GENDER 7.FEMALE LITERACY 8.EXPLOITATION OF WOMEN 9.CRIME AGAINST WOMEN 10.PROGRAMMES FOR WOMEN 11.INDIA.

32. National Commission for Women, New Delhi. (2004).
A Study of the implementation of current policies, programmes and schemes for women and girls in India : a comparative study : Vol. two. New Delhi : NCW. 385 p.

Abstract : A study was undertaken to assess the implementation of various programmes and policies in the northern, western, central and eastern regions of India. Field visits were made to six states namely, Madhya Pradesh (MP), Maharashtra, Mizoram, Orissa, Tamil Nadu (TN) and Uttar Pradesh (UP). **Madhya Pradesh** constituted 9.38% of the country's total area, and 34.43% of the total population was below the poverty line. The Government of MP formulated a comprehensive Policy for Women in consultation with various concerned departments for the safety and protection of women, women's autonomy, dignity, empowerment and participation. The state schemes for women and children were *Ayushmati Scheme* for providing free treatment to landless rural women and girls who fell ill; *Vaishyavrati Unmulan ke liye Jabali Yojana* for elimination of prostitution; grant-in-aid to orphanages; and legal aid centres for women and children. Some notable state initiatives of MP were decentralization through *Gram Swarajya*; Panchayati Raj transforming lives through initiatives of women members; and *Bal Vivah Virodh Abhiyan* (child marriage prevention campaign). Gender and poverty need to be addressed more directly, especially among the non *Suvarna Jaatis* the Dalits, and the minorities. **Maharashtra** is the second largest Indian state in terms of population and the third largest in terms of area. The New Women's Policy 2001 was a charter for women's empowerment, which emphasised women focused planning, women's participation in decision making, health package for women, etc. to further government initiatives. Several NGOs are working collaboratively with the Government to further the cause of women. Annapurna Mahila Mandal (AMM), an NGO in Pune City, works with poor self employed women and men in urban slums. Human development approach is recommended as it offers a comprehensive framework that goes beyond a mere sectional or departmental mode of action. **Mizoram** does not have a separate Department for Women's Development. The two schemes for girls were *Balika Samridhi Yojana and Kishori Shakti Yojana,* and Mizoram has set up State Commission for Women. Position of women in the traditional Mizo family was one of complete subordination and subservience. Government programmes for women and child development are

trying to bring a change in the situation. The Women and Child Development Department, **Orissa** launched “Mission Shakti” in 2001. Centrally sponsored schemes like Operation Blackboard Scheme, Programme for Massive Orientation of School Teachers (PMOST), Education Television (ETV) Programme, Mid-Day Meal and State Government Programmes for improving School Education were Teachers Training on MLL; competency based, child centered joyful teaching learning; Orientation of Supervising Officers, etc. Awareness about all programmes and schemes meant for women’s development was very low. The **Tamil Nadu** government implements schemes for the overall development of women and girls like Girl Child Protection Scheme, which provides enhanced benefits to girls belonging to poor families; and Cradle Baby Scheme to counter female infanticide. In 2002, Tamil Nadu has formulated a Gender Policy on Women as a follow up of the National Policy on Women’s Empowerment 2001. Crimes against women and girls are on the increase. Foeticide and female infanticide continue to plague certain pockets and other crimes against women are also not letting up, despite the establishment of *Mahila Thanas* (Women Police Stations). In **Uttar Pradesh,** the programmes under Women’s Welfare Directorate were Working Women’s Hostels; Swadhar Scheme for Women in Distress; National Social Assistance Programme and other programmes for specific needs of women. The State Department of Women and Child Development does not have its counterparts at the district or at the block level, and all schemes and programmes for women and girls are riding on the back of the ICDS structure, which is detrimental to both.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN 3.HUMAN DEVELOPMENT INDICATORS (HDI) 4.GENDER DISPARITIES 5.LITERACY 6.SELF HELP GROUPS 7.REPRODUCTIVE HEALTH 8.WORK PARTICIPATION RATES 9.STATE PROFILE 10.INDIA 11.MADHYA PRADESH 12.MAHARASHTRA 13.MIZORAM 14.ORISSA 15.TAMIL NADU 16.PROGRAMMES FOR WOMEN AND GIRLS 17.PROGRAMMES OF GOVERNMENT 18.GOVERNMENT INITIATIVES 19.FEMALE WORK PARTICIPATION 20.UTTAR PRADESH.

33. Pandey, Balaji and Rout, Binaya Kumar. (2004).
    Development induced displacement in India : impact on women. New Delhi : National Commission for Women. 47 p.

Abstract : The study was conducted by National Commission for Women to find out the adverse effects of displacement of people from their original place of habitation due to large-scale land acquisition; to find out the economic, social and environmental problems faced by displaced people; and to know the severity of problems due to multipurpose dam projects. India’s development programmes have caused the displacement of approximately 20 million people over roughly four decades, but as many as 75% of these people have not been rehabilitated. A

significant number among the displaced people are tribals and other economically marginalized rural people, who depended on the natural resource base for their livelihood. The tenancy land owners whose lands are being acquired by development projects are entitled to cash compensation at market prices as per the legal instruments such as Land Acquisition Act, 1984 and Coal Mining Bearing Act, 1957. Different State governments and Central ministries have followed different policies on resettlement and rehabilitation in the absence of a National Resettlement and Rehabilitation Policy. Only recently have the links between gender, poverty and development induced displacement come to be recognized. In the policy revision process, the World Bank took no proactive steps to address the issues of gender, or try to improve the status or rights of displaced women. Whenever there is unemployment arising out of displacement and jobs are scarce, women are the first ones to lose. This is not only because they lack skills, but more so because they have to make way for men. It has been observed that most tribal communities are patriarchal, but compared to mainstream society, they allow greater freedom to women. In the eligibility for R and R (resettlement and rehabilitation) benefits, women should be treated at par with their male counterparts. House and land should be allotted and registered in joint names. Ministries or Departments of the Central or State Governments undertaking projects that displace people should amend their existing R and R policies to ensure payment of R and R benefits in the form of cash in the joint names of female and male heads of households. Sanitation facilities in resettlement colonies must be provided, and better educational facilities should be given to the children of disabled persons.

Key Words : 1.WOMEN WELFARE 2.DISPLACED WOMEN 3.REHABILITATION OF DISPLACED WOMEN 4.PARTICIPATION OF WOMEN 5.VIOLENCE AGAINST WOMEN 6.COMMUNITY INVOLVEMENT 7.MOVEMENTS 8.WOMEN'S MOVEMENTS.

34. Prasad, Shweta. (2000).

    Wife-battering : a study of domestic violence in the slums of Varanasi : project report. Varanasi : Banaras Hindu Univ., Faculty of Social Sciences, Centre for Women's Studies and Development. 25 p.

Abstract : Wife abuse is not a recent phenomenon. Its roots can be traced to the remote past. The National Family Health Survey (NFHS) II of India (1998-99) reported that 50% of women in India accepted at least one reason for wife-beating. About 40% women justified beating for neglecting the house or children; 7% for not paying the expected dowry; and 25-37% for some other reason. Out of 209 slums in Varanasi only one slum was selected for the present study. The total population of the *basti* was 1,188 and from the total number of women, 20 cases were taken up randomly for an in – depth study. 80% women experienced the first incidence of

violence within 2 years of their marriage, 10% experienced between 4-5 years of marriage, while 10% did not experience any kind of physical violence. 70% reported that alcoholism was the major reason for wife battering. About 90% respondents believed that poverty was the reason behind their husband's aggressive behaviour, while 10% of them were uncertain about the reason for battering. Only 20% women reported sexual jealousy to be the cause of violence. Almost all the women claimed that their husbands took good care of them during pregnancy. Dowry was reported to be a cause of marital violence in 40% cases. 30% respondents faced violent behaviour on other issues. 69% women sustained severe injuries due to beating. It was found that women suffered varying degrees of physical as well as psychological violence by their husbands. The process of sensitizing men on the issue of domestic violence should start from early childhood itself. There should be at least one shelter home in every city. Indigenous arbitration bodies like mahila mandals, self help groups, etc. should be formed in each locality to combat the problem of domestic violence locally.

Key Words : 1.WOMEN WELFARE 2.WIFE BATTERING 3.DOMESTIC VIOLENCE 4.FAMILY VIOLENCE 5.SLUMS VARANASI 6.CAUSES OF WIFE BATTERING 7.NATURE OF VIOLENCE 8.SLUMS 9.DOMESTIC WORKERS 10.SLUM WOMEN 11.VARANASI

35. Rajgopal, Pratibha. (2005).
A Situational analysis of women and girls in Madhya Pradesh. New Delhi : National Commission for Women. 497 p.

Abstract : A situational analysis of women and girls in Madhya Pradesh, undertaken by National Commission for Women, found that about 6% of the country's total population resided in Madhya Pradesh. According to 2001 Census, the population of Madhya Pradesh has grown by 24.34%. During 1991-2001 the female population growth rate was 1.97% as compared to 1.90% growth rate of the male population, and 1.93% for combined growth rate. The sex ratio in Madhya Pradesh according to 2001 Census was 920 females for 1000 males which reflected the poor status of females as compared to males. Madhya Pradesh had 10,600,796 children in the age group 0 to 7 years. According to district statistics for 2002, percentage of female live births to total births was 45.35% in rural areas and percentage of female deaths to total deaths was 42.54% in rural areas. The birth rate was 30.8 for the year 2001. The death rate in the State is estimated to have come down to 10.1 in 2001 according to the Sample Registration System. According to the 1991 Census, the female mean age at marriage was 16.6 years in undivided Madhya Pradesh which was well below the female legal minimum age at marriage of 18 years, and a recent rapid household survey NFHS II, 1998-99 suggested that more than 51% females were married before 18 years. Female life expectancy between 1961-70 and 1993-97 increased by more than 10 years, while

the corresponding gain for males was about 9 years. Female literacy rate rose from 29.35% in 1991 to 50.55% in 2001. Gross Enrolment Ratio (GER) rose from 76.5% in 1996 to 96.2% in 2000-01 and 101.7 in 2002-03. Total Fertility Rate (TFR) according to SRS 1999 was 3.3. Mean birth weight of babies born to poor women was 2.7 kg as against 3.2 kg for children born to women from higher income group. Women's role in decision making was limited. About 81.7% women decided what to cook in the household, while only 44.3% women decided about purchasing jewellery, etc. The occupation of women contestants in politics indicates that contestants were mainly from agriculture backgrounds (27.64%), housewives (22.64%) and social or political activists (14.57%). The remaining 35.18% were in service, teachers, business, contractors or lawyers. During 1998, torture (41375) and molestation (30959) topped the list of crimes against women, contributing to about 31.09% and 23.26% of all crimes respectively.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN MADHYA PRADESH 3.SITUATION OF WOMEN 4.POPULATION 5.SEX RATIO 6.BIRTH RATE 7.LIFE EXPECTANCY 8.EDUCATION WOMEN 9.LITERACY 10.HEALTH STATUS OF WOMEN 11.CRIME AGAINST WOMEN 12.WOMEN PRISONER 13.POLICY FOR WOMEN MADHYA PRADESH 14.EMPLOYMENT WOMEN 15.MADHYA PRADESH.

36. Regional Centre for Urban and Environmental Studies, Lucknow. (2005).
Role conflict among women representatives in urban local government : a case study of Uttar Pradesh. Lucknow : RCUES. ~120 p.

Abstract : The case study of Uttar Pradesh was conducted by Indian Council of Social Science Research to trace the background of women entering into politics and their role; to highlight the change that occurs in the status and position of women representatives; to examine the nature and degree of conflict between various roles; to assess the various forces involved; to assess the long term consequences on family and children; and measure the social benefits to society. Primary data was collected through personal interviews and mailed questionnaires, while secondary data was collected through books, reports and journals. Five Municipal Corporations, 37 Municipal Councils and 45 Nagar Panchayats were selected for the study. About 20% elected women were just literate. The highest number of women representatives were found to be housewives followed by 15% who were full time politicians. A negligible number of women were professionals. About 66% elected women were working for earning additional income for the family, and an equal number wanted to utilize their education. 80% elected women representatives were earning a monthly income of less than Rs. 10,000. About 20% were found to be adding more than Rs. 10,000/- per month to their family income. The traditional system of male dominance prevails even after women earn an independent income and perform a political

role. Income of the husband was also an important determinant of the status of the family as well as extent of conflict in role performance of women representatives. With regard to spending of family income, it was observed that husbands spent the maximum part of the family income. A women representative had to meet the expectations and obligations corresponding to her various roles within the family, whether nuclear or joint. The political role compelled the wife to step out of the limited sphere of the house and thereby made her over burdened with work load. Majority of the elected women managed day to day household chores on their own. The major reasons for disputes with husbands were found to be freedom due to new roles (36.25%), modernity (33.75%), social liaisons (26.25%), conflict with family traditions and decorum (12.50%), and their negligence of family (48.75%). Around 35% women joined politics because they wanted a career in politics, and a large number of women (40%) joined politics because of the force imposed by family. It was encouraging to note that women representatives were always encouraged to putting forth their views by female colleagues (62%), male colleagues (56%), President/Mayor (65%), and family members (62.50%). Most of the times female colleagues were found to be cooperative and supportive (79%). They always encouraged (77%) and appreciated (75%) one another, and never passed teasing comments (93%). The relationship between male members and female members are not at all good. Women in general, were found to be enjoying their role despite having a lot of conflicts. Male dominated society needs to change its mindset in tune with the change in times and circumstances.

Key Words : 1.WOMEN WELFARE 2.URBAN LOCAL GOVERNANCE 3.WOMEN COUNCILLORS 4.PANCHAYATI RAJ 5.POLITICAL PARTICIPATION OF WOMEN 6.ROLE CONFLICT 7.MUNICIPAL CORPORATIONS 8.UTTAR PRADESH

37. Sophia Centre for Women's Studies and Development, Dept of Psychology and Education, Sophia College, Mumbai. (2003).

    Women and health : A study of the cognitive and attitudinal impact of an AIDS awareness educational intervention on college students. Mumbai : SCWSD. 38 p.

Abstract : The aim of the study was to explore the changes in knowledge and attitudes of Sophia College undergraduate students, after they attended a formal discussion on “Women and AIDS”. To study the cognitive and attitudinal impact of exposure to relevant programmes, the Department of Education and Psychology of Sophia College organized a Panel Discussion on the social, psychological, medical and legal aspects of “Women and AIDS” and its implications. The “MDACS Knowledge Test” was used to measure information and understanding about modes of HIV transmission, clinical testing and prevention. The “MDACS Attitudinal Scale” measured the individual’s attitudes towards those infected with HIV/AIDS,

peer pressures, HIV/AIDS intervention strategies, employment rights, and marital and reproductive health issues. The sample consisted of 136 female undergraduate students in the age group 19-20 years. 72.8% students were from nuclear families, 14% from extended nuclear, and 13.2% were from joint families. The students were from Arts, Science and Vocational Studies. The panel discussion was effective in bringing about changes in both knowledge and attitudes. The Panel Discussion had a large impact on increase in knowledge (d = 0.87), but the impact on the attitude was moderate (d = 0.50). 43% of the variance limitations of the study were that a one-group pre-test / post-test design was used. The intervention was brief, limited by space and time, and the post-test evaluation was also immediate. Intentions and behaviour should also be included in future research. A multi-component model for HIV/AIDS prevention and education on college campuses, based on surveys of students and faculty members prior knowledge and attitudes about HIV/AIDS, seems to be necessary. Women's issues in HIV/AIDS prevention and sexual health promotion with regard to biological and social conditions and constraints in women's lives should also be explored. In addition to group contact programs, mass media can be used to reduce high risk drug or sexual behaviour. Misinformation, feelings of invulnerability, and perceptions about sexually and personal freedom, continued to be major barriers to the effort to prevent AIDS.

Key Words : 1.WOMEN WELFARE 2.AIDS AWARENESS 3.AIDS/HIV 4.AIDS EPIDEMIC 4.HIV INFECTION 5.STRATEGIES 6.PREVENTION OF AIDS 7.INFORMATION, EDUCATION AND COMMUNICATION (IEC).

38. Sophia Centre for Women's Studies and Development, Dept of Sociology, Sophia College, Mumbai. (2003).
    Women and health : sexual harassment of women at the workplace : a study. Mumbai : SCWSD. 20 p.

Abstract : Sexual harassment at the workplace is an issue that has slowly came out of the closet. The study was conducted with a sample of 76 working women, of whom 47 were unmarried, while 39 respondents were married. All were of different ages, levels and designations. Most of the respondents (61%) identified 'physical misbehaviour' as sexual harassment. 16% of the women felt that any form of gender discrimination meant sexual harassment, 14% felt non-verbal and physical gestures with sexual overtones was sexual harassment, and about 8% identified demands for sexual favours as sexual harassment. 67% described physical forms of sexual harassment such as physical touch, abuse, molesting, pinching, poking, etc. About 57% respondents identified verbal harassment as verbal abuse, dirty remarks, talks related to sex, slang language; 18% identified demands for sexual favours including blackmailing, sexual favours in exchange for the promise of a permanent job; 41% mentioned non-verbal gestures and actions such as staring,

touching or showing one's private parts. 25% said sexual harassment occurred frequently at the workplace, 36% said it occurred sometimes, 30% felt it occurred rarely and 7% said it did not occur. The nature of harassment experienced by 31% women was verbal harassment such as references to sexual intercourse, comments on dress and figure, etc.; 29% mentioned unwanted physical contacts; 20% had faced demands for sexual favours; 11% non-verbal harassment such as staring, and around 11% found it difficult to share the nature of sexual harassment they experienced. 42% said that the harasser was a senior; in 20% cases it was the immediate boss; and 5% were colleagues. 42% said that they confronted the harasser; 25% complained to the authority; and 22% chose to confide in a colleague. 71% respondents felt angry, 37% experienced embarrassment, 29% had feelings of helplessness, and 11% were frightened. 3% felt bad about the entire episode, 3% lost respect for their boss, and 11% were not affected. 51% women ignored the situation, 34% avoided the harasser, 26% lodged a complaint, and 8% said they would leave the job. 12% respondents said that employees should create awareness about this problem, while 14% felt that severe punishment should be given to the harasser. The study revealed the widespread prevalence of sexual harassment. There is a need for greater awareness and gender sensitization among women. Awareness and implementation of the Supreme Court Guidelines on Sexual Harassment is very low, and in a few cases vague and inadequate.

Key Words : 1.WOMEN WELFARE 2.SEXUAL HARASSMENT 3.GUIDELINES ON SEXUAL HARASSMENT 4.EMOTIONAL EFFECT ON WOMEN 5.WORKPLACE 6.SEXUAL HARASSMENT AT WORKPLACE.

39. Sophia Centre for Women's Studies and Development, Mumbai. (2005).
    Women in Panchayat Jasai : A case study : women and environment. Mumbai : SCWSD. 31 p.

Abstract : In the past, women in Maharashtra have participated in political movements including the freedom struggle and later various protest movements. The percentage of women MLAs in Maharashtra fell from 12.87% in 1957-62 to 2.81% in 1995-2000. To study the performance of women's participation in panchayats, Jasai village in Raigad district of Maharashtra was studied. The advantage of an all women panchayat was the absence of corruption. The Panchayat constructed a road for Buddha Wada. Certain aspects of development were neglected and those did not seem as urgent to the Sarpanch. There was no female doctor in the village. The female Sarpanch was fearful of talking in front of men who were strangers, but later on her fear disappeared. She got the nominal allowance of Rs. 400 that the Government gave her as a Sarpanch. She expressed a lot of faith in the *Gram Sevak* (rural development functionary). The questionnaire

was administered in Marathi. The total number of responses received back were 62 but only 56 were valid. Very few of the 56 respondents had studied beyond the 7th Standard. 50% of the respondents were married. 44 were unemployed. Almost 90% respondents exercised their right to vote. 15 women said that they did not have time to attend *gram sabha* (village meetings). The majority were of the opinion that the Sarpanch had not done anything. 14 women were willing to stand for elections. Women in the age group 25-30 years were willing to support females who stood for elections. Government and certain NGOs have developed training programmes for newly elected women representatives to make them aware of their role and responsibilities. Awareness should be created among the electorate at the local level of the aims and objectives of the 73rd Amendment to the Constitution enabling the participation of women in local governance.

Key Words : 1.WOMEN WELFARE 2.PANCHAYATI RAJ 3.GRAM PANCHAYAT 4.WOMEN SARPANCH 5.GRAM SEVAK 6.PANCHAYATI RAJ INSTITUTION (PRI) 7.JAWAHAR ROZGAR YOJANA (JRY) 8.GOOD PRACTICE.

40. Vaidya, Vijay. (2004).
A Situational analysis of women and girls in Himachal Pradesh. New Delhi : National Commission for Women. 89 p.

Abstract : A situational analysis of women and girls in Himachal Pradesh (HP) was undertaken by National Commission for Women (NCW). It was found that HP has no state policy for women. According to 2001 Census, population of Himachal Pradesh is 6,077,248 comprising 3,085,256 males and 2,991,992 females. About 90% population of Himachal Pradesh lives in rural areas. There was a slight decrease in sex ratio from 856 in 1991 to 851 in 2001. The total fertility rate for Himachal declined sharply from 1991 to 1999 compared to the declined in the TFR of India, and the decline was more in rural areas than urban areas. According to SRS estimates for the year 2002, the crude birth rate was 20.7, while that of India was 25.0. According to SRS 2002, infant mortality rate (IMR) was 52 in HP, being 28 in urban areas and 53 in rural areas. According to the study, major causes for premature mortality are diarrhoeal diseases, lower respiratory tract infections, other maternal conditions, infectious diseases and perinatal conditions, which account for almost 48% of all premature mortality. Iron deficiency anaemia was prevalent among women. In rural areas, median age for marriage for the age group 25-29 was recorded to be 19.6 years, while for women in 45-49 years age group it was 20.4 years. NFHS-II survey found that contraceptive prevalence rate in Himachal Pradesh was quite high, with 68% married women using some form of contraception against the national figure of 48%. Despite having a high proportion of women receiving antenatal care (87.2%), institutional deliveries were low at

31.7%. Himachal Pradesh has a higher female literacy rate compared to the rest of the country, as per the 2001 Census, but the sex ratio in the 0-6 years age group is extremely low. Literacy increased to 84.57% in 2001. Between 1981 and 1998, the enrolment level in schools increased by three times in Himachal Pradesh. There has been gradual increase in the proportion of women to the total work force, and gender disparity has reduced over the decades. Work Participation Rate (WPR) for women in 2001 was 43.66%. Presently out of 68 seats in the State assembly, only 4 are held by women. In 2003, there were 126 rapes, 250 molestations, 96 kidnappings, 31 cases of murder, and a few dowry deaths. Females constitute 0.07% of the total police workforce, a number almost negligible. There is need for a state policy for women with the framework in place. Himachal Pradesh State Commission for Women should have a wider and proactive role. Gender sensitization is also required. Active dissemination of the findings of the studies carried out by the State, research scholars, NGOs and research institutions is needed for creating awareness about issues, avoiding duplication, and bringing evidence based advocacy into the picture. Gender budgeting is required to create gender responsive governance. There should be proper documentation of records and creation of central databases. Most of the times it is not absence of information, but unavailability of information which impedes empowerment of women.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN HIMACHAL PRADESH 3.SITUATION OF WOMEN 4.SEX RATIO 5.EDUCATION 6.PUBLIC HEALTH 7.WORK PARTICIPATION RATE 8.CRIME AGAINST WOMEN 9.POVERTY 10.STATUS OF WOMEN 11.GENDER 12.GIRL CHILD 13.WOMEN'S HEALTH 14.HIMACHAL PRADESH.

41. Vijayanthi, K.N. (2004).
    Power to the women - a new strategy for poverty reduction in a urban community development programme. *Social Action*, 54(1) : 1-17.

Abstract : During the course of the UN Decade for Women, the fact that “70% of the world’s poor were women” was widely stated. Chennai is one of the major metropolitan cities in India. Yet, there are 1500 slum areas in Chennai city. Approximately one third (15 lakh) of the city’s population live in slums. Tamil Nadu Slum Clearance Board, a quasi Government Organization, has implemented a demonstration project called ‘Control of Diarrhoeal Diseases through Water Supply and Sanitation’ in five slum areas in association with UNICEF and financial assistance of British Airways. The main objective was to control diarrhoeal diseases adopting CDD WATSAN strategy through an organized community structure. The duration of the project was for three years. In 2000, 48.50% of rural

SC/ST households and 56.30% of urban households lived below the poverty line. 80% families with children under five benefited from the interventions. Out of 1698 high risk households, 1543 did not have toilets. Women and girls were forced to wait until dark due to inadequate toilet facilities, and thus became prone to urinary infections and other health related complications. 746 high risk families were falling under the category of households having food insecurity. There were 1002 alcoholic members among 1698 high risk households. In 1698 high risk households, there were 443 child labourers, of whom 250 (56%) child labourers were streamlined into regular school through transit schools. By being women centered, the CDS (Community Development Society) has generated a remarkable level of enthusiasm and motivation. There are various models of urban poverty alleviation and reduction programmes but there is no comprehensive community based approach to reduce or alleviate poverty in the real sense. Poverty reduction schemes should be closely monitored by various stakeholders to reduce shortcomings and achieve the set goals. Consequently, many National Governments initiated measures to improve the situation of women, by starting several new initiatives.

Key Words : 1.WOMEN WELFARE 2.POVERTY 3.POVERTY ALLEVIATION 4.COMMUNITY DEVELOPMENT PROGRAMME 5.SANITATION, 6.ILLITERACY 7.SAFE DRINKING WATER 8.DRINKING WATER 9.CHILD LABOUR 10.DRUG ADDICTION 11.POVERTY INDEX 12.HIGH RISK FAMILY 13.URBAN POOR.

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