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RESEARCH STUDIES ON WOMEN & CHILDREN

CHILD WELFARE

1. National Institute of Public Cooperation and Child Development, New Delhi. (2005).
   Born to die : a case study on female infanticide in Usilampatti.
   New Delhi : NIPCCD. 32 p.

Abstract : Female infanticide is the deliberate killing of female infants soon after birth for the purpose of eliminating the female child. The phenomenon of female infanticide is as old as many cultures, and has likely accounted for millions of gender-selective deaths throughout history. A Plan of Action for the SAARC Decade of Girl Child 1991-2000 and National Plan of Action for Children was formulated in 1992 for the "Survival, Protection and Development of Children", including the girl child. Balika Samriddhi Yojana 1997 was a major initiative of the Government to raise the overall status of the girl child. According to Human Development in South Asia 2000, in India, 18% more girls than boys die before their fifth birthday. In Bombay, 84% gynaecologists admitted that they performed sex-determination tests. Nation - wide, the sex ratio continues to fall, and the sex ratio 0-6 years fell from 945 in 1991 to 927 females per 1000 males in 2001. Around 150 female infants were put to death each year in a cluster of 12 villages of Rajasthan. The Bhati community in Jaisalmer has the lowest sex ratio of 550 in the world. In Tamil Nadu, the vice of female infanticide involves the cruelest methods of putting the child to death by smothering, poisoning and the use of violent means. People tolerate a first born female baby but not a second girl baby. In Tamil Nadu, gender imbalance increased over the years as there were 972 females per 1000 males in 1901, which has reduced to 929 females per 1000 males in 2001. In Jaipur, Rajasthan, pre-natal sex determination tests resulted in an estimated 3,500 abortions of female foetuses annually. In Bihar, a girl child is stuffed in a clay pot. The objectives of this study were to evaluate the Mother and Child Welfare Project of ICCW Tamil Nadu; identify reasons for success or failures of the Project; and understand the ways and means adopted to promote the survival, growth and development of the girl child from conception to birth, and at subsequent stages of life. The staff of the Project visited the houses of pregnant women and counselled them and their family members against killing female babies. Illiteracy was the root cause for all problems, and the female literacy rate in Usilampatti Taluk was 23%. Many programmes for women's development like Rashtriya Mahila Kosh; Reception Centre for Female Babies; sponsorship for girl students; area intensive programme at Kalluthu; adolescent girls training; health care programme; vocational training centre for women and girls, etc. are in operation. There were 18 Day Care Centres for children of working mothers in 18 different villages. To raise the status of women and girls, income generation projects were started. Female

infanticide, a highly prevalent practice observed at the start of the Project, declined over the years. With the credit-worthiness of women increasing, their decision making in the family had increased tremendously. These partially empowered women have been able to raise personal as well as community issues that affect their lives, like the alcoholism of their spouses, water problem in villages, and found permanent solutions through their single-minded and collective participatory efforts. In future, efforts can be to sustain and enhance positive gains achieved by this Project. ICCW Tamil Nadu Project is a replicable model towards curbing the practice of female infanticide, and it is also a concurrent attempt to empower women. This study is more relevant and meaningful for States like Gujarat, Haryana, Himachal Pradesh and Punjab where there are less than 800 female children for 1000 male children. Depressing socio-economic, cultural and demographic practices also have led to reduction in enrolment and retention of girls in schools, extracting excessive work from them, and providing them least recreational and rest facilities. As educated citizens, girls would be able to intervene more forcefully and positively on social issues to bring in a chain of social change. There is a need to take up focused programmes like education and health in each and every nook and corner of India with the help and support of civil society groups. District level committees on violence against women need to monitor the clinics and activities of radiologists scrupulously. Students in schools and colleges need to be sensitized on this issue, and made aware of the far reaching impact of sex selective abortions at both micro and macro level.

Key Words : 1.CHILD WELFARE 2.FEMALE INFANTICIDE 3.CASE STUDIES 4.USILAMPATTI 5.TAMIL NADU.

2. National Institute of Public Cooperation and Child Development, New Delhi. (2004).

A Case study on female infanticide in Usilampatti district, Tamil Nadu. New Delhi : NIPCCD. 38 p.

Abstract : In India, there are less than 93 women for every 100 men in the population (2001). For a poor family, the birth of a girl child can signal the beginning of financial ruin and extreme hardship. During 1800, the British Government found that there were no daughters in a village in Eastern Uttar Pradesh. The Tenth Plan recognized the rights of the girl child to equal opportunity, to be free from hunger, illiteracy, ignorance and exploitation. In the National Policy for the Empowerment of Women 2001, a policy framework has been laid down for Elimination of Discrimination Against and Violation of the Rights of the Girl Child. Studies have revealed that female foeticide and infanticide are practiced specifically among certain communities. The main objectives were to study Mother and Child Welfare Project (MCWP) run by ICCW, Tamil Nadu with a view to collect first hand experience and information about the Project on Female Infanticide;

identify reasons for success or failures of the activities of the Project; document the activities as a case study for use in training programmes; and to understand the ways and means adopted to promote the survival, growth and development of the girl child from conception to birth and at subsequent stages of life. Usilampatti Taluka of Madurai District, Tamil Nadu was studied. A study of Tamil Nadu by Guild of Service, Chennai found that "female infanticide is rampant" in the State but only among Hindu families. Of the 1,250 families covered, 740 (59.2%) had only one girl child and 249 (19.9%) agreed directly that they did away with the unwanted girl child. In Bihar, holding the baby from the waist and shaking it back and forth snaps the spinal chord. In certain blocks in Katihar district, Bihar 35 *dais* accepted having killed three to four babies a month, making the total number of female babies who were killed approximately 560 per month. The four major causes for this problem were women were considered as an economic liability to the family; women were neglected in the process of decision making in the family and in the community as a whole; very low female literacy rate and lack of job knowledge and earning capacity; and prevalence of dowry and other customary practices that are specifically related to women. To combat these issues, various programmes are being implemented under the Mother and Child Welfare Project (MCWP) in Usilampatti. These are mother and child care counselling programme, women's development project, sponsorship for girl students, area intensive programme – Kalluthu, adolescent girls training programme, health care project, vocational training programme for women and girls, day care centres for children and reception centre for female babies. SIDA, Sweden also undertook a project covering Usilampatti taluka. The major objectives of this Project were to abolish the practice of female infanticide in Usilampatti Taluk; improve the status of women in the community; and bring about a change in gender attitudes in the community. The ultimate goal of the Project being the protection of the girl child, it was necessary to assess to what extent this has been achieved in the past 12 years. Groups of women, making purposeful strides towards the bank or for their meetings have become a common sight in these villages. The grassroots movement initiated by ICCW, Tamil Nadu towards economic, social, political and cultural development of the girl child and society as a whole has accomplished a creditable task. Efforts in future to sustain and enhance positive gains and the attempt made by the Council (ICCW) prove that social change can be brought about against unhealthy practices. The recommendations were that all girls must go to school. Their education would make the whole family educated. The need of the hour is to change the "mind set" prevailing in primitive society. There is need to take up programmes like education and health in each and every nook and corner of India with the help and support of civil society organizations. District Level Committees to combat Violence Against Women need to be set up to monitor the clinics conducting sex determination tests and activities of radiologists scrupulously.

Key Words : 1.CHILD WELFARE 2.FEMALE INFANTICIDE 3.USILAMPATTI 4.ICCW TAMIL NADU PROJECT 5.CASE STUDY 6.INTERVENTION PROGRAMME.

HEALTH

3. Goyal, R.S and Khanna, Anoop. (2005).
Reproductive health of adolescents in Rajasthan : a situational analysis. Indian Institute of Health Management Research, Jaipur. Jaipur : IIHMR. 35 p.

Abstract : Adolescence is a crucial period in the life of an individual. Policy interest in adolescents began to grow only when ICPD (International Conference on Population and Development) held in 1994 in Cairo emphasized the need to focus on adolescents. India has nearly 200 million boys and girls in the adolescent age group of 10-19 years (NFHS-II: 1998-99). In India, not all adolescents are able to seek education. In the 10-19 years age group, 2 out of 3 boys and 2 out of 5 girls are literate. Rajasthan has a population of 56 million (Census 2001). A large proportion of the population suffers from deprivation in matters of health, safe water supply and housing. 31% rural and 11% urban families live below the poverty line. There are nearly 13 million adolescents in Rajasthan. The sex ratio of this age group is 927 females per thousand males. In Rajasthan, nearly 70% children in the age group of 11-14 years and 46% children aged 15-17 years attended schools in 1998-99. The schooling of children 11-14 years old showed improvement between 1992-93 and 1998-99. The study also revealed that 70% teenage married women did not have regular access to any media. To get information on sex and related issues, many times adolescents refer to sex magazines, pornographic photo albums, adult movies and such other means. A girl in Kerala waits for marriage for almost five years after attaining menarche, whereas a Rajasthani girl gets married before she attains menarche. Rajasthan is the only state in India where the age at marriage is lower than the age at menarche, and more than 61% girls in Rajasthan got married before 18 years of age. Teenage fertility increased from 112 in 1992-93 to 126 in 1998-99. Nearly 70% of them did not receive iron and folic acid supplementation. More than 75% adolescents were aware of AIDS. The level of awareness was significantly higher among literate girls than illiterate girls. In a study conducted in Madras, 71% teachers felt that sex education would negatively influence the morality of adolescents; and in Rajasthan, 59.3% teachers said that education on sexual and reproductive health issues should be provided through teachers. The study by IIHMR (ICMR) found that 65.8% girls had information about the onset of menses and a UNICEF study found that 38% girls were unaware of menstruation at the time of their first period. More than 15% adolescents had sexual intercourse. Rajasthan does not have any state specific education policy, but the State Government has prepared action plans to implement the National Policy on Education. Low nutritional status of adolescent girls has emerged as a serious cause for concern. Nearly half of the teenage girls suffer from some degree of malnutrition. This situational analysis clearly indicates that there is no

appropriate fit between the current programmes and the needs of adolescents. The following guidelines may help design and strengthen the programme interventions for adolescents, namely to provide fundamental skills; address social norms and practices; exploit peer pressure to promote desirable behaviour; impart necessary skills to teachers and health providers; build an environment of family and parent support; develop community based programmes; promote programmes for boys also, and implement these in a phased manner.

Key Words : 1.HEALTH 2.ADOLESCENT REPRODUCTIVE HEALTH 3.ADOLESCENT HEALTH 4.ADOLESCENT SEXUALITY 5.REPRODUCTIVE HEALTH 6.EARLY MARRIAGE 7.TEENAGE PREGNANCY.

4. India, Ministry of Health and Family Welfare, New Delhi. (2005).
National Commission on Macroeconomics and Health : Financing and delivery of health care services in India : background papers : Vol. III. New Delhi : MHFW. 318 p.

Abstract : The importance of economic growth, measured by increases in Gross Domestic Product (GDP) and GDP per capita, for policy purposes can hardly be over emphasized. The role of health in influencing economic outcomes has been well understood at the micro level. This study is confined to the major Indian states excluding Jammu & Kashmir; Goa and Himachal Pradesh. The range of variation in growth rates is from a low of about 0.9% and 1% respectively in Madhya Pradesh and Bihar to a high of 3.8% in Maharashtra. Kerala stands out as an exception; though it does not have very high per capita income, it has the lowest IMR of 14 infants deaths per 1000 live births. A strong positive association is observed between initial per capita income and long run economic growth and growth in per capita income across the states. States that have experienced higher (lower) levels of growth over the thirty year period witnessed a lower (higher) level of poverty, the exceptions being Kerala and West Bengal. Analysis shows that a thousand rupee increase in per capita health expenditure would lead to a 1.3% increase in Life Expectancy at Birth (LEB), while a 10% increase in per capita income is required to increase the LEB by about 2%. A survey conducted in 6 states to assess the technical capacity of these states to implement maternal health (MH) programmes showed that except one Deputy Director in Kerala, there was not even one officer in the other 5 states namely Tamil Nadu, Maharashtra, Rajasthan, Gujarat and Chhattisgarh who were exclusively earmarked for monitoring the maternal health programme. In the surveyed districts, there are a total of 9457 health facilities run by qualified providers, and of these, 61% are private. The 52nd Round of the National Sample Survey (NSS) showed that 35% of those hospitalized in Bihar got pushed below the poverty line on account of meeting the cost of medical treatment. VHAI is one of the major national networks of more than 4000 NGOs spread across the country. Questionnaires were sent to the 27 State Voluntary Health

Associations to provide names of the organizations in their network that provide medical care. The responses received were brought out in volume two of the series titled “The Study on Macro Economics and Health”. This study was undertaken to understand the financing patterns of health care. It showed that it is not possible to put the not-for-profit sector into one typology because of its heterogeneity in terms of organizational structure, pattern of funding, ownership, nature of services and its changing character. Other than these, many organizations were directly contacted and questionnaires were sent to them and also to those organizations/ individuals who could give any further leads in the form of names of not - for - profit health providers. As the processes of globalization and liberalization are intensifying in India, controls and regulations on a lifeline industry such as the pharmaceutical industry are being lifted. Financing of disease control programmes are affected through societies, created for the specific programmes at State and district levels. It is clear that a substantial amount of health expenditure (presumably curative care), in India is not covered by insurance schemes, and thus have the potential of leaving people who incur such expenditures worse off. Education is a key factor for human resource development. The quality of education depends on the quality of the educators. This study analyses the resource requirements for meeting certain targets of the health sector and analyses the gap between the required and the actual expenditure in 15 major states in India. Improving the health status of the population is a critical component of human development, and the States will have to re-assign their priorities in favour of the health sector in the interest of development.

Key Words : 1. HEALTH 2.COST OF HEALTH CARE 3.HEALTH CARE SERVICES 4.HEALTH SERVICES 5.POVERTY 6.ECONOMIC GROWTH 7.FINANCING OF HEALTH CARE 8.PUBLIC HEALTH INFRASTRUCTURE 9.DELIVERY OF HEALTH SERVICES 10.MACROECONOMICS HEALTH 11.HEALTH SYSTEM.

5. India, Ministry of Health and Family Welfare. (2004).
State of India's newborns. New Delhi : MHFW. 173 p.

Abstract : The new born health challenge faced by India is bigger than that experienced by any other country. Each year, 20% of the world’s infants are born in this vast and diverse country. The current neonatal mortality rate (NMR) of 44 per 1,000 live births accounts for nearly two-thirds of all infant mortality and half of under-five child mortality. Infections (52%), birth asphyxia (20%), and prematurity (15%) are the leading causes of neonatal deaths. The highest burden of neonatal deaths occurs in Uttar Pradesh (26.1%), Madhya Pradesh (13.0%), and Bihar (11.8%). The SRS country estimates of still birth rate (SBR) and perinatal mortality rate (PMR), 2000 were 8 and 40 per 1,000 births. Over 80% of Low Birth Weight (LBW) neonates weigh between 2,000 and 2,499 gm. Maternal malnutrition and ill

health, high fertility rate, teenage pregnancy, and maternal infections are the possible major risk factors. The LBW rate was 34% in control and 22.8% in intervention villages. Free hospital care and transportation were made available for infants aged 0-2 months in two urban slums of Delhi. In India, it was estimated that about 7,000 voluntary agencies were involved in health related activities. Training and education to improve the effectiveness of nursing care in various medical specialties, including neonatology, have not been given the importance they deserve. In Madhya Pradesh, the NMR for the urban poor was 69.7 per 1000 live births compared to the urban average of 44. The National Neonatology Forum (NNF) has a program of accrediting newborns units in India. It has developed technical guidelines on neonatal monitoring, equipment, ventilation, and nursing, among others. The activities supported by WHO, India with respect to maternal mortality were developing “Life Saving Anaesthetic Skills for Emergency Obstetric Care”; expanding safe abortion services; and developing community level skilled birth attendants (CLSBAs). UNFPA supports quality reproductive health services on the basis of individual choice. DFID recognizes the critical importance of improving neonatal health in order to achieve the child mortality Millenium Development Goals (MDG). The Integrated Nutrition and Health Project – II (INHP II) is the second phase of a ten-year project (1996-2006) being implemented by CARE India with the goal of achieving “sustainable improvement in the nutrition and health status of women and children”. Population Council aims to improve the well being and reproductive health of current and future generations around the world. WHO estimates showed that India tops the list of nations burdened by Neonatal Tetanus disease, with 48,600 neonatal deaths annually due to this preventable disease. Kangaroo Mother Care (KMC) is an evidence based modality for care of LBW neonates in resource poor settings. The vision for newborn health in India is ambitious yet achievable. It is time to orchestrate a national effort to accomplish the Newborn Health Mission. This Mission will be equity-driven, will strive to remove gender disparity in perinatal-neonatal care, and by 2015 AD this Mission will help place India in the category of proud nations with low newborn and child mortality.

Key Words : 1.HEALTH 2.CHILD SURVIVAL 3.NEONATAL MORTALITY 4.NEWBORN 5.CARE OF NEWBORN 6.CHILD HEALTH.

6. Indira Gandhi Medical College, Dept of Preventive and Social Medicine, Nagpur. (1998).

A Study of maternal factors influencing low birth weight. Nagpur : IGMC-DPSM.~120 p.

Abstract : The high purpose of investment in obstetrics is to ensure that every newborn is physically sound in mind and body. Low birth is one of the most serious challenges facing maternal and child health programme planners in both developed

and developing countries. More than 25 million low birth weight (LBW) babies are born every year throughout the world of which 19 million were born in developing countries. This study was carried out at Indira Gandhi Medical College and Hospital, Nagpur, Maharashtra. The aims and objectives were to study the association of low birth weight with maternal constitutional, socio-economic and obstetric factors; to study the association of low birth weight with maternal morbidity and environment factors; and to suggest suitable recommendations based on study findings. About 60% birth weight variations can be attributed to the environment in which the foetus grows. The pilot study was carried out using a pre-designed proforma on a sample of 40 cases with equal number of controls. The sample size was estimated to be 251 cases with equal number of controls, which was confirmed from epi-info statistical software. Mothers were interviewed within 24 hours of delivery. It was observed that mothers in 22 cases and 21 controls were illiterate. 19.1% cases and 14.7% controls were educated upto middle standard. 5.6% cases and 2.4% controls had height less than or equal to 140 cm; 29.5% controls had height 146-150 cm; 26.7% cases and 42.2% controls had height 151-155 cm. Percentage of LBW was highest (56.1%) when birth interval was 12 -< 24 months and it decreased to 25.2% when birth interval was 24 -< 36 months. About 8.0% cases and 4.0% controls had urinary tract infections (UTI) during antenatal period. Mothers with weight < 40 kg had 2.92 times higher risk of delivering LBW babies. Risk of delivering LBW babies is 4.43 times higher among mothers who have anaemia (Hb < 10 gm %) than mothers who do not have anaemia (Hb > 10 gm %). It was observed that 54.6% case mothers were exposed to biomass fuel during antenatal period, while 31.9% control mothers were exposed to biomass fuel during antenatal period. There were more cases i.e. 4.4% who were engaged in laborious work during pregnancy. The risk of delivering LBW babies was 3 times higher in mothers who had the habit of chewing tobacco than mothers who did not chew tobacco. The utility of ANC visits in delivery of a healthy baby is of utmost importance. Therefore, health check up of mother during antenatal period is a must and should be followed scrupulously. Laborious work should not be undertaken by pregnant mothers. The methods of birth spacing must be stressed during the antenatal advice given to mothers, especially in the age group of 20-30 years.

Key Words : 1.HEALTH 2.LOW BIRTH WEIGHT 3.MATERNAL FACTORS.

7. Indira Gandhi Medical College, Dept. of Preventive and Social Medicine, Nagpur. (2001).
Study of health problems of adolescents in urban field practice area, Sadar, Nagpur. Nagpur : IGMC-DPSM. 110 p.

Abstract : Adolescence is the period of transition from childhood to adulthood. Adolescents constitute 21.8% of the population of India numbering around 207 million. The present study was carried out in field practice area of the Medical

College at Sadar, Nagpur to study the various health problems among adolescents and factors influencing these problems. 575 families were residing in this area, constituting a population of 3498 as per the survey data of November 1999. A total of 700 study subjects were examined of whom 336 (48%) were males and 364 (52%) were females. The maximum number of adolescents were educated upto high school (39.43%); 9.5% had primary education; 31.43% had education upto middle school; and 19.57% had education above high school. All male adolescents were unmarried (336) but 6 female adolescents were married. About 50.28% adolescents belonged to low socio-economic status. About 384 (54.85%) adolescents had the habit of chewing tobacco and *gutka*, and of them 197 (58.63%) were males. Of these 197 male adolescents, 31 (9.22%) were in the habit of smoking and 11 (3.27%) had the habit of alcohol consumption. Even females (51.38%) were habituated to chewing tobacco and *gutka*. It was observed that majority of fathers (78.85%) and mothers (37.15%) also had the habit of chewing tobacco and *gutka*. About 45% fathers smoked bidis and cigarettes, and 50.28% were habituated to alcohol consumption. The habit of chewing tobacco and *gutka* was higher in nuclear families (60.47% males and 53.03% females) as compared to joint families (45% males, 41.17% females). Habit of chewing tobacco and *gutka* was higher among adolescents belonging to upper and upper middle socio-economic status groups (83.67% males, 80.77% females). This habit was higher among employed adolescents (95.45% males, 93.75% females). The age of menarche in females ranged from 10 to 17 years. Around 25.27% adolescent girls had attained menarche at the age of 13 years. It was observed that 62.71% adolescents were suffering from acute nasopharyngitis (common cold) and acute tonsillitis; 57.28% adolescents were having anaemia; 35.58% had chronic energy deficiency; and 43% had low weight. Prevalence of anaemia among adolescents was higher among females (60.16%) as compared to males (54.16%); 37% adolescents had dental caries; 34.28% deposit of nicotine stain on teeth; 3.42% dyspepsia (APD); 5.57% multiple boils; 7.57% urticaria and 54.14% acne. About 84% adolescents were going to school and 16% had left school. Prophylaxis Programme against Nutritional Anaemia among children should be extended to male adolescents also as it was extended to female adolescents under the RCH Programme. As most of the morbid conditions were related to environmental sanitation and personal hygiene, health education should be imparted regarding the improvement of environmental sanitation and importance of maintaining good personal hygiene. Parents should be given health education about the complications arising due to tobacco and *gutka* chewing, as they act as role models for adolescents.

Key Words : 1.HEALTH 2.ADOLESCENT HEALTH 3.HEALTH PROBLEM 4.PROBLEMS OF ADOLESCENT 5.TOBACCO CONSUMPTION 6.ANAEMIA ADOLESCENT.

8. Jhingan, A. K. (2005).
Increase in incidence of childhood obesity in school children : A study of schools in Delhi. New Delhi : Delhi Diabetes Research Centre. 5 p.

Abstract : The incidence of childhood obesity among school going children is on the rise. Diseases normally seen in adults because of obesity are now being seen with increasing frequency in children, particularly Type 2 diabetes. Sedentary activities like watching television, computer games and eating junk food are considered to be the main cause of increasing prevalence of obesity in children. The main objective of the study was to determine the seriousness of the problem of obesity in school going children. Over 3800 school children were contacted through this research. Children over 85th percentile as per BMI charts were considered overweight. Questionnaires were given to children to assess their lifestyle habits. Analysis of the data collected revealed that over 17% children were found to be overweight. Some even had high blood pressure and a family history of diabetes. At least 11% children preferred eating lunch from the school canteen; and over 81% children claimed that they went out to a fast food joint at least once a week. 62% children liked eating junk food like burgers, pizzas, etc; and 47% children took at least 1 cold drink daily. 26% children reported either their mother or father being overweight and 10% children had a mother or father with diabetes. 26% children did not exercise at school, and 13% children do not play outdoors at home. 35% children spend more time watching TV and playing on computer. Immediate intervention is suggested to prevent the epidemic of obesity impacting more and more children. Overweight children have 70% chance of becoming overweight or obese adults. Recommendations to schools and parents are to encourage physical activity on daily basis; work on incentive based plans to encourage children to indulge in sports and other physical activities in school; and discourage eating at fast food joints, and give children a healthy nutritive diet that limits calorie and fat intake.

Key Words : 1. HEALTH 2.OBESITY 3.DIABETES 4.OBESITY CHILDREN 5.OVER WEIGHT 6.JUNK FOOD.

ICDS

9. FORCES, New Delhi. (2005).
The Micro Status of ICDS in Hayathnagar (A.P.) : a study by FORCES. New Delhi : FORCES.16 p.

Abstract : Support services to provide day care to children have had a rather chequered history in India. It was estimated that there were 23 crore children belonging to approximately 17 crore women below the poverty line. FORCES undertook this study to ascertain the status of ICDS services in Hayathnagar,

Ranga Reddy District. AWWs and beneficiaries were covered in Peddambarpet village, and the AWC at Thorroor village, Andhra Pradesh was studied. The interaction with stakeholders, beneficiaries, administrators and workers was the source of primary data. The AWCs aimed to cover 40% eligible beneficiaries with SNP and PSE services. The monthly progress report of Hayathnagar in June 2005 showed that 183 children received DPT; 207 received Polio drops; and 230, 241, and 207 children received DPT first, second and third doses respectively. Almost 100% of the children were going to pre-schools that are private and 95% of them were helped with their studies by relatives. Sex selective abortions were found to be frequent among Reddys and Choudharys. 154 AWCs in Hayathnagar were catering to 17073 children below the age of six years, and 2983 pregnant and lactating mothers. 148 AWCs had supplied SNP for 21 days in a month. Malnutrition was not an important issue here as 50% children belonged to normal category, 49% belonged to Grade 1 and Grade 2, and only 1% were in the Grade 3 or Grade 4 category. Deliveries were carried out mainly by *dais* and PHCs had permanent *dais.* In Peddambarpet village, mothers attending meetings had birth registration certificates for their children. The distribution of SNP and immunization was taking place regularly as described by the CDPO. Private Doctors were preferred over PHCs as they provided better care. For deliveries, the mothers depended on *dais*. In Thorroor village, the Centre was neat and clean and looked fit for children to enjoy their time with pictures, drawings, etc. Only 12 beneficiaries below three years received ready mix supplementary nutrition, which was highly appreciated by the beneficiaries. The number of beneficiaries should be increased from 12 to 40 so that more children benefit from this scheme. Pregnant women and lactating mothers should be encouraged to take food at the Centre instead of taking bimonthly ration. As the AWCs were running from 9 a.m. to 3.30 p.m., they could easily be upgraded and made into anganwadis - cum - crèches by adding another human resource for taking care of children below 3 years. This would be really beneficial for mothers working in the unorganized sector.

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3. NUTRITION IN ICDS 4.ADOLESCENT GIRLS 5.PRE-SCHOOL EDUCATION IN ICDS 6.GIRL CHILD 7.GIRL CHILD PROTECTION SCHEMES 8.RANGA REDDY DISTRICT 9.IMMUNIZATION 10.COVERAGE OF ICDS 11.AIDS AWARENESS CLASSES 12.MALNUTRITION 13.CANDIES 14.NUTRITIOUS CANDIES 15.FORTIFIED CANDIES 16.ANDHRA PRADESH.

10. FORCES, New Delhi. (2005).
A Micro study of the status of the young child - a block level study in Chandauli district of UP : by FORCES. New Delhi : FORCES. 20 p.

Abstract : Chandauli was chosen as one of the districts for a micro level study of the status of child care services at block level. The study was carried out in Kamalpur and Hetampur villages of Dhanapur Block in Sakaldeeha *Tehsil* of Uttar

Pradesh. Data was gathered through field visits. In Chandauli, 90% of the Anganwadi Centres were catering to a population size of more than 1000 people as the district was densely populated. At the block level, 80 beneficiaries were interviewed in 20 Anganwadi centres. All the Anganwadi centres had *pucca* (permanent buildings), infrastructure and 9 out of 10 centres were located in primary schools. Chandauli had the best record of all the districts in this regard as all the Anganwadi Centres had drinking water and sanitation facility. Only 45% centres had toilet facilities. In Hetampur village, there were 186, 165 and 170 children below six years under three AWCs, and 28, 25 and 26 adolescent girls each. Teaching aids in the form of charts and posters were available at the AWCs but the condition of these aids was bad. The AWWs were highly educated and 80% of them were graduates. The block seemed to have low rate of malnutrition. Awareness about malnutrition and its gradation was not clear to most of the AWWs. Children suffering from Grade I and Grade II malnutrition were not receiving any intervention at all. Disability was one area which was neglected in this region. In Kori village, every alternate house of the village had a physically challenged member. In Hetampur village, all deliveries were conducted by the ANM. A large percentage of adolescent girls (80%) had not received any immunization. The immunization record of the children was quite impressive but Vitamin A distribution was not satisfactory. The linkage between primary schools and AWC was quite strong. All the AWCs used pre-school kits for teaching. The concept of creche was not very evident. The children of working mothers were taken care of by elderly relatives at home. Stronger linkages between ICDS and the community could bring in socially desirable changes. This block which is rich in human resources, should be sensitized so that they demand access to the services to which they are entitled, and ensure that the rights of the young child are respected.

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3.PRE-SCHOOL EDUCATION 4.PRESCHOOL EDUCATION IN ICDS 5.COMMUNITY HEALTH CENTRE 6.MATERNAL MORTALITY RATE 7.AWW UP 8.IMMUNIZATION STATUS 9.NUTRITION AND HEALTH EDUCATION IN ICDS 10.GIRL CHILD 11.DISTRICT CHANDAULI (UP) 12.UTTAR PRADESH.

11. FORCES, New Delhi. (2005).
A Social audit of ICDS in the state of Bihar : a study by FORCES. New Delhi : FORCES. 44 p.

Abstract : The integrated child development services, launched as a centrally sponsored scheme in 1975, is the largest early childhood care programme in the country currently. This programme was taken to rural areas in the Fourth Five Year Plan period to foster all round development of the pre-school child. The objectives of the study were to assess the financial and physical performance of ICDS in the

state of Bihar and identity the gaps; to assess the training methodology and quality of training of Anganwadi workers and identity existing gaps; assess the extent of transition of children from anganwadis to primary schools, and recommend strategies to bridge the gaps in implementing the programme with full effectiveness. 12 districts of Bihar were surveyed; one block was studied in-depth; and 1 CDPO, 2 supervisors, 10 Anganwadi workers each, and mothers of children in the age group of 3-6 years were chosen for data collection. The state of Bihar suffers from not only economic backwardness, but also from under utilization of facilities available in the state. Thirty five million of Bihar's population is illiterate, of whom 21 million are women. As per Government data, Bihar has the second highest number of children in India after Uttar Pradesh. ICDS covered 50% of the eligible population. Around 26% children of Bihar suffered from malnutrition. Though the overall coverage of the programme was very low (31%), the programme covers BPL families (71% of the children below six years of age and 67% pregnant and lactating mothers) and SC/ST/OBC population as well. The survey shows a wide coverage of SCs, OBCs and minorities (78% for children below six years and 74% for pregnant and lactating mothers). 42% AWCs had *pucca* (permanent) infrastructure; 22% AWCs were operational from the AWWs residence; 8% AWCs had their own infrastructure; 10% AWCs had toilet facilities; and 75% centres recorded supply constraints. Percentage of children below three years of age with anaemia was 81.3% in Bihar. In 1991, 1.9% of the population was disabled. About 75% of the disabled population lives in rural India. Kishori Shakti Yojana was in a desolate state. Both urban and rural Bihar record the most number of births without any health professional in attendance. 17% children die due to prenatal conditions. Analysis of the coverage of the districts as well as the states clearly shows that AWC are able to cover only 30% of the target group. There is a dire need to prioritize the effort to functionalize the sanctioned projects under general category. The 68% AWCs with *kuccha* (non-permanent) infrastructure should be provided with proper *pucca* (permanent) infrastructure with adequate space for activities and storage. Beneficiaries should be made aware of the requirements for nutritious food through nutrition and health education (NHE).

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3.EARLY CHILDHOOD CARE AND DEVELOPMENT 4.EARLY CHILDHOOD CARE AND EDUCATION 5.ECCD IN ICDS 6.PRE-SCHOOL EDUCATION 7.NUTRITION IN ICDS 8.SEX RATIO 9.WORLD BANK ASSISTED ICDS 10.FOOD STORAGE 11.ADOLESCENT GIRLS 12.SCHOOL ENROLMENT 13.IMPACT OF ICDS 14.SCHOOL ENROLMENT 15.TENTH FIVE YEAR PLAN ICDS 16.MALNOURISHED CHILDREN IN BIHAR 17.DAY CARE CENTRES 18.CRECHES 19.NUTRITIONAL STATUS BIHAR 20.BIHAR.

12. FORCES, New Delhi. (2005).
A Social audit of ICDS in the state of Uttar Pradesh : a study by FORCES. New Delhi : FORCES. 51 p.

Abstract : The ICDS programme aims at giving a head start to young children by providing an integrated programme in health, nutrition and pre-school education. The objectives of the study were to assess the financial and physical performance of ICDS in the State of Uttar Pradesh and identify the gaps; to assess the quality of monitoring of the programme and recommend improvements in the delivery of ICDS and the resources of the Government; to assess the practicality of merging anganwadi centres and crèches as suggested by the Government; and to assess the extent of transition of children from anganwadis to primary schools and their readiness for primary school. Use of secondary data from concerned Government Departments was made to facilitate comparisons. The survey on ICDS was carried out in 12 districts of Uttar Pradesh. Uttar Pradesh has the highest number of children (157,863,145) in 0-6 years of age in India and is also the highest receiver of funds for ICDS. Majority of the beneficiaries were Below the Poverty Line (BPL) category. Coverage of Scheduled Castes and OBC category was 35% to 39% for child and adolescent beneficiaries, while it was 48% for pregnant and lactating women. 64% anganwadis surveyed were operating from the premises of primary schools. Out of 120 anganwadis surveyed in 12 districts, 96 Anganwadi Centres had drinking water facilities. Dry ration was distributed once a week to the functionaries. In Uttar Pradesh, 6.5% women started breast feeding within one hour of birth, and 13.4% within one day. Uttar Pradesh has a very high prevalence rate of anaemia among children below 3 years of age (73%). Only 14% AWCs recorded children with disabilities, and only 6% of them have availed of referral services. About 17% children died due to prenatal conditions. The role of community representatives was found to be mixed. In villages where the community representative plays a proactive role, the AWC was found to be operating on a more successful note. 80% AWC used kits for teaching. 50% AWWs complained of supply constraints in food and medicine. 90% AWWs received their salary irregularly. There is need to spread awareness among the community about pre-school education, so that children start attending pre-school at the early age of three years. Kishori Shakti Yojana should be made mandatory for all adolescent girls and the duration of receiving services from the AWC should not be only for six months. FORCES proposes separate infrastructure and manpower for day care centres as the AWW is already burdened with a number of activities.

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3.EARLY CHILDHOOD CARE AND DEVELOPMENT 4.SOCIAL AUDIT ON ICDS 5.NATIONAL NUTRITION POLICY 6.PRESCHOOL EDUCATION IN ICDS 7.DAY CARE CENTRES 8.FAMILY HEALTH SURVEY 9.NUTRITION ADOLESCENT GIRL 10.ADOLESCENT GIRL 11.UTTAR PRADESH.

13. FORCES, New Delhi. (2005).
The Status of the young child in Rajasthan : a study by FORCES. New Delhi : FORCES. 64 p.

Abstract : The principal objectives of the study on the status of the young child in Rajasthan was to gauge the extent, depth and outreach of ECCD services in the state in the context of CRC; to frame Macro and Micro recommendations to bridge the gap in implementation of ECCD services; to ensure survival rights of the girl child with special focus on declining sex ratio in Rajasthan; and to appraise the Government's role in protecting the young child in difficult circumstances. Primary data was collected from twelve districts of the state through questionnaires given to stakeholders involved directly or indirectly with ECCD services. Out of the 12 districts studied by FORCES, Jaisalmer, Karauli and Ganganagar did not have an urban AWC. A total of 10,600 beneficiaries were taken care of in 348 creches run under Central Government's Day Care Scheme and 76 creches functioned under National Creche Fund Scheme. 68% population of the state had access to drinking water, but 25% of the population was exposed to high levels of fluorides, nitrates and salinity in drinking water. IMR has remained almost static at 79 since 2001. Observations by UNICEF were only 24.2% children were fully immunized before 12 months, and 73.8% deliveries were conducted at home. In rural areas health staff attended only 29.7% deliveries, resulting in poor newborn care. Rajasthan is a low HIV/AIDS prevalent state in India, with only 1135 reported cases. Around 3% AWC beneficiaries received immunization from private doctors. *Neem Hakims* (traditional system doctors) were found to be popular as they were available throughout the day and were easily accessible. Malnutrition among children was evenly prevalent all over Rajasthan. In fact, there was not one district that had less than 30% prevalence of malnutrition. Malnutrition among children in districts ranged from 30% to 59.4%. Anaemia among adolescent girls and women results in an increased risk of premature delivery and low birth weight. Vitamin A deficiency persists to be a major public health problem. Successive droughts over the years have aggravated the problem further. Rajasthan has over one crore children but only 26% were covered by supplementary nutrition programme (SNP) of AWCs. UNICEF collaborates with DWCD for Child Development and Nutrition Program support in the form of capacity building of ICDS and health functionaries; improving nutritional status and overall development of children by promoting early child care practices at the family level; programming for elimination of Iodine Deficiency Disorders (IDD); and supplying materials and equipment to improve quality of ICDS centres. As per the study, 55% children received breast-feeding within two hours of birth and 37% within a day. About 60% to 70% working women were leaving their children in the care of elderly relatives, usually grand parents. AWCs are providing pre-school education to children in the age group of 3-6 years. Education of children below six years or before the child starts schooling is getting more attention now. In Rajasthan, females are at a disadvantage, and the female literacy rate was only 44.3%. There is need to control premature births through control of anaemia and other effects of malnutrition on mothers; ensuring sufficient supply of

ORS at the centre; maximizing institutionalized deliveries; and implementation of the merger of AWCs with crèches, which should happen right away. To make ECD centres operational, necessary functionaries should also be appointed. Preschools should be provided to the children in remote/ tribal areas belonging to nomadic or disadvantaged groups. Initiatives should be taken to make the illiterate AWWs literate through Sarva Shiksha Abhiyan (SSA). All unregistered ultrasound machines should be registered, and *dais* (midwives) should be sensitized so that they restrain themselves from practices like doing away with the girl child.

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3.EARLY CHILDHOOD EDUCATION 4.EARLY CHILDHOOD CARE AND EDUCATION 5.ECCE 6.MALNUTRITION 7.CHILD MALNUTRITION 8.NUTRITION IN ICDS 9.PRESCHOOL EDUCATION IN ICDS 10.CHILD CARE RAJASTHAN 11.RAJASTHAN.

14. National Institute of Public Cooperation and Child Development, New Delhi. (2005).

Report of pre-test study : mother and child protection card. New Delhi : NIPCCD. 121 p.

Abstract : Infant mortality and maternal mortality are the two most crucial indicators to determine the quality of maternal and child health of a country. The common causes of perinatal deaths that relate to maternal factors include pregnancies under 18 years and over 35 years of age, high parity, birth spacing of less than two years, poor nutrition particularly anaemia, toxemia and diabetes. About 12.4 million children under the age of 5 years die every year in developing countries. India also has the unfortunate distinction of having 75 million (63%) of children under- five who are malnourished. The objectives of the Pre-Test Study were to determine the format and content acceptability of Mother and Child Protection Card; determine the feasibility of usage of Mother and Child Protection Card; and study the advantage of the Family Growth Card over the existing Growth Monitoring Cards in used ICDS and health systems. Data for the Pre-Test Study was collected from all over India including the NCT of Delhi. In all, 280 mothers/women beneficiaries, including expectant mothers and nursing mothers were selected randomly from Mehrauli and Najafgarh ICDS blocks, who could comprehend either Hindi/ English (read and write) for eliciting their views on the Mother and Child Protection Card. Data was also collected from ICDS and health functionaries. A total of 280 mothers/women beneficiaries, including 90 expectant mothers and 90 nursing mothers were selected purposively after ascertaining that the mother/ caregiver had used the card in the past two months. The basic purpose of this exercise was to assess the knowledge gain of mothers after using the card and consultation of the guidebook in case of doubt. The percentage of mothers (both pregnant and lactating mothers) on clarity and comprehension of illustrations

and messages on developmental milestones, increased considerably. All pregnant and lactating mothers had gone through the card and guidebook out of interest. After two months of usage of the card, about 91% pregnant mothers and 92% lactating mothers expressed that the card should be in the custody of mothers as it has very valuable information about their child. 95% pregnant and lactating mothers felt that the card should be priced. The findings revealed that the gain in knowledge of pregnant mothers was considerably higher than that of lactating mothers. About 80% mothers, both pregnant and lactating, learnt about important aspects of child care, maternal care and developmental milestones and care behaviour after reviewing the card. The functionaries seemed fairly satisfied with the information and illustrations on developmental milestones and care behaviour. About 90% doctors, 81% functionaries and 88% mothers found that the card would be very useful to mothers. Exclusive breastfeeding, including early initiation of breastfeeding, is good for child health and is known to all health and ICDS functionaries and mothers. According to the law, a man can only marry after he attains the age of 21 years and a woman after completing the age of 18 years. The NFHS data has highlighted the fact that IMR and incidence of low birth weight of babies has a direct correlation with age of mothers. The illustrated portion of antenatal care in the card has comprehensively included all essential components of obstetric care. All existing cards in the health and ICDS sectors should be immediately replaced with the Mother and Child Protection Card, in order to avoid any confusion in the minds of health and ICDS functionaries.

Key Words : 1.ICDS 2.MOTHER AND CHILD PROTECTION CARD 3.CHILD DEVELOPMENT 4.MONITORING CHILD DEVELOPMENT

15. Operation Research Group, Centre for Social Research, New Delhi. (2005).

Evaluation of Project Udisha : the national training component of World Bank assisted Women and Child Development Project : 2 vols. New Delhi: ORG. ~400 p.

Abstract : Integrated Child Development Services (ICDS) programme is the world's largest child care programme reaching out to 35.4 million children below six years of age and 6.4 million expectant and nursing mothers. Udisha, the nation wide training component of ICDS programme, implemented since 1999, is the crucial foundation of the new Women and Child Development Project. The highlights of Udisha are revision of the syllabus, revised financial norms, training based on area/ region specific needs, integration and coordination of training, clearing backlog for job and refresher training for AWWs by training teams, technical support and institution building, and monitoring. Both, secondary and primary sources were utilized to study the progress of Udisha; training needs of ICDS functionaries; and impact of training on quality of service delivery. The

achievement of CDPO/ ACDPOS training was 42%. Chhattisgarh, Maharashtra, Assam, Meghalaya, Bihar and Tamil Nadu did organize a variety of innovative training programmes. Out of 571 sanctioned AWTCs only 445 (80%) were operational. Shortage of training infrastructure in Madhya Pradesh, Bihar, Orissa, Andhra Pradesh, Rajasthan and Gujarat was relatively very high. The syllabus has been revised by shifting the focus on child centered development revolving around the six services of ICDS. Officials at the Central and State level had positive opinion with regard to improvement in the skills of various functionaries. Overall 91% supervisors said that training has helped the system in improving service delivery in the field. Over 50% supervisors contacted felt that there has been a change in the way pre-school activities were organized post Udisha training. Various constraints faced by AWCs do not allow the AWWs to perform at their best. In case of supervisors refresher training, Punjab has achieved 66% of the target, while Himachal Pradesh has achieved only 1.4% of the target. A few reasons for non-achievement of the desired target was delay in creation of training infrastructure, frequent transfers or deputation of trained CDPOs to other departments, low attendance, non-availability and non-accessibility of training infrastructure and aids, etc. In U.P., after the launch of UDISHA, one innovative training programme was organized in the year 2001-2002. Assam has undertaken 12 innovative trainings for the AWWs and supervisors. CDPOs reported that there were several constraints faced by the supervisors and AWWs at the grassroots level. The excess workload on AWWs and their low remuneration were also revealed as major constraints. To enable the AWWs to work in line with the objectives of the training, it is essential that ground realities are understood and addressed, and problems related to infrastructure and supplementary nutrition are tackled effectively.

Key Words : 1.ICDS 2.UDISHA TRAINING 3.TRAINING OF ICDS FUNCTIONARIES 4.ICDS TRAINING 5.TRAINING OF FUNCTIONARIES 6.WORLD BANK ASSISTED ICDS TRAINING 7.EVALUATION OF UDISHA 8.TRAINING OF MANPOWER IN ICDS.

LEGISLATION

16. Council for Social Research, New Delhi. (2005).
IPC section 498 A : used or misused.-- New Delhi : CSR. 106 p.

Abstract : Violence against women (VAW) is a phenomenon that cuts across boundaries of culture, class, education, ethnicity and age. The most important amendment came in the form of the introduction of Section 498A in the Indian Penal Code (IPC), which deals with domestic violence against women. Section 498A of the Indian Penal Code, is a criminal offence. It is a cognizable,

non-bailable, and compoundable offence. The key objectives of the study were to analyse the prevalence, patterns and trends of domestic violence (DV) related cases filed under Section 498A and to assess the need for this provision; to serve as a base for conducting further detailed studies pertaining to the legal effectiveness of the current statutes, and the need for new statutes to combat domestic violence. NGOs and the community were selected to understand the developments at every stage in the process and also to analyse their perception of the processes involved. 30 case studies were taken up covering all the states, five cases were taken from each centre, and only five cases were taken up from Karnataka. Out of 46 victims, 36 approached other sources of help such as family friends, NGOs, lawyers and Police before filing cases under IPC Section 498A. A chargesheet was filed in the rest of the 40 cases and these cases were sent for judicial trial. Of the 40 cases which went for trial in Court, 28 cases are still pending. In Karnataka, out of three cases, two of the victims suffered physical and mental torture for over three and a half years before approaching the police. Out of the total cases that reached the court, 16% cases have either been compounded or withdrawn. According to NFHS-2 study conducted in 1998-99, a sample of 90,000 married women aged 15-49 years were interviewed, and of them 18.9% experienced domestic (physical) violence at the hands of their spouses. One in five women experienced at least some form of violence. UNFPA reported that 40% women in India suffer some form of domestic violence. The National Crime Records Bureau (NCRB) data for 2003 also showed that approximately 50,000 cases of domestic violence were reported in India during the year. There has been a 67% decadal growth rate in Crime Against Women (CAW) between 1993 and 2003. Cruelty by husband and relatives has a major share in CAW. According to NCRB data, 2003, 36.1% of CAW was due to cruelty at home, followed by cases of molestation and rape. In four study areas namely Delhi, Karnataka, Rajasthan and West Bengal, cruelty by husbands and relatives was lowest compared to other crimes. Incidences of cruelty have increased sharply from 2000-2001 except for Delhi, where the increase was marginal. A majority of women (80%) reported the incidence of violence only when physical torture was inflicted on them. According to 46 victims who were studied in depth, it was difficult for them to prove mental cruelty and at times physical cruelty too. In Karnataka, 8 out of 10 victims rated community response as supportive. Except in Rajasthan (6 out of 10 victims) and a few in West Bengal (2 out of 10 victims), most women reported that the police had been uncooperative in providing support. Of the 18 NGOs contacted, 11 NGOs recognized the need for a Domestic Violence Bill. A majority of lawyers (62%) and all the seven Public Prosecutors felt that there was no need for a separate law since the Indian Penal Code had sufficient tools to take care of DV. On the basis of interviews conducted, victims found Section 498A of IPC to be somewhat useful and felt the need for further strengthening it.

Key Words : 1.LEGISLATION 2.DOMESTIC VIOLENCE 3.DOMESTIC VIOLENCE LEGISLATION 4.FAMILY VIOLENCE 5.CRIME AGAINST WOMEN 6.IPC SECTION 498 A 7.LEGISLATION FOR WOMEN 8.MISUSE OF LAW.

17. Reddy, Ramakrishna. (2004).
Prevalence of iron deficiency anaemia and malnutrition in India. Bangalore : Institute for Social and Economic Change. 116 p.

Abstract : Prosperity of a nation is reflected in the strength of its human resources, and welfare states all over the world aim to ensure the well-being of their populations in order to remain in the forefront of development at all times. This study is basically an in-depth analysis of the secondary data available on the prevalence of iron deficiency anaemia and malnutrition. Iron deficiency anaemia is the leading cause of morbidity among vast sections of people, especially in developing countries. In 1998-99, data on iron deficiency anaemia and malnutrition among 90,000 ever married women in the reproductive age group of 15-49 years and their children aged below 3 years were collected by directly measuring haemoglobin levels. A total of 92,466 households were surveyed of which two-thirds were in rural areas (NFHS-2 data). Prevalence of moderate anaemia was higher among teenage women being 18%, followed by 17% among women in the age group 20-24 years. Assam had the highest prevalence of iron deficiency anaemia in the country (70%), followed by Bihar (63%) and Tripura (59%); and the lowest prevalence rate was in Kerala (23%), followed by Manipur (29%). About 72% infants aged 6-11 months had anaemia, with 27% having mild anaemia, 42% moderate anaemia and the rest had severe anaemia. Anaemia increased in the second year of life, and 78% children aged 12-23 months had anaemia. The pattern of prevalence of anaemia among children was highest in the eastern region of the country, namely the states of Bihar, Orissa and West Bengal among children aged 6-35 months at 77%; followed by North Indian States like Delhi, Haryana, Himachal Pradesh with 76% prevalence; and north eastern states namely Arunachal Pradesh, Assam, Manipur which had lowest prevalence of iron deficiency anaemia at 59%. About 13% currently married women had height below 145 cm. As fertility became lower in the age group 30-34 and 35-49 years the prevalence of malnutrition reduced by about 8-9%. Malnutrition was widely prevalent in the north eastern region of the country. The percentage of women with BMI below 18.5 was significantly lower among women with high standards of living (17%) compared to women with low standards of living (48%). The percentage of women with height less than 145 cm was highest in Meghalaya (21%); followed by Bihar (20%). The nutritional status of 24,600 children was assessed using anthropometric measurements, and 57% children were underweight or undernourished, 59% were stunted and 17% were wasted. Maharashtra had the highest prevalence of iron deficiency anaemia (46%) and malnutrition (38%) in the Western region. The prevalence of malnutrition was higher, among children of illiterate mothers; with 79% children being underweight and 78% suffering from iron deficiency anaemia. The NFHS-2 data has brought out the fact that a large section of women in their reproductive phase in India face the greatest disadvantage of the

risks involved in reproduction. There is a need for repeating haemoglobin tests and anthropometric measurements at specified intervals to monitor the situation. The period specified as early childhood should be increased from 0-35 months to 0-59 months so that more children come within the ambit of Government programmes. Unmarried adolescents should be treated as a prime segment of the female population. Targeted nutritional supplementation programmes must be introduced from infancy and early childhood, for preschool children, pregnant women and lactating mothers. Food security is another aspect that needs to be given priority by planners considering the widespread prevalence of malnutrition in the country.

Key Words : 1.NUTRITION 2.ANAEMIA 3.MALNUTRITION 4.WOMEN AND CHILDREN 5.NFHS 2 DATA.

18. Sophia Centre for Women's Studies and Development, Dept of Chemistry, Sophia College, Mumbai. (2003).

Women and health : survey on food and nutrition : a study. Mumbai : SCWSD. 16 p.

Abstract : This project was initiated under the theme Women and Health undertaken by Sophia College for Women. Information was elicited from students through questionnaires. The questions pertained to their eating habits and daily diet. The survey also tried to find out whether they were happy with their present way of life as well as the items purchased by the family towards their food for the month. After statistical observation, information was obtained that 59% students rarely skipped their meals, but 9% of the girls missed their meal on a daily basis. Some students (28.71%) skipped meals as they did not feel hungry; and 40.26% skipped meals due to lack of time. 11% students skipped meals in an attempt to lose weight. About 44% students skipped meals due to their busy schedule. Ideally, the time gap between meals should not be more than 4 hours, but a majority of the respondents had their meals at an interval of 4 hours or more. About 58% students (48 out of 75) had a time gap of 6 hours or more between meals, which was not healthy. Around 60% of the student population consumed 5.8 glasses of water. The most preferred drink by the students during meals was buttermilk, which was consumed by 164 students out of 590. About 44% respondents rarely ate out, but 15% respondents ate out at least twice a week. Biscuits and chocolates seemed to be a daily habit with the students, and sandwiches and potato wafers were also popular. Nearly 55% students rarely or did not take soft drinks, while 45% students did have an ice cream either regularly or once in a while. About 75% consumed non-vegetarian foods on alternate days, or at times less frequently in the month. About 35% students believed that they were overweight. 34% were already avoiding sweets and oily foods in an attempt to reduce weight, and outdoor games came second in this effort to reduce weight, with 32% students choosing this form of exercise. Jogging, swimming and yoga were other modes of exercise preferred

by the students. Approximately 18% students came up with the correct answer for the proper order of the mode of cooking which would least affect the nutritional value of food. Almost 80% of the students had not heard about organic farming, and 60% had not heard about genetically modified food products. Majority of the population believed that they were consuming adequate amounts of all nutrients, 23% students believed that their intake of calcium and iron was insufficient, while 23% believed they were consuming excess amount of carbohydrates, and 28% believed that their consumption of fatty foods was above the average permissible limit. This survey indicated that a majority of the students believed that they were overweight. Though students have access to information about their nutritional needs; this information is not applied in their daily life. There is a great need for creating awareness regarding the nutritional needs of college-going adolescent girls. Through competitions and public education programmes on radio and television channels, girl students and boys can be made aware of tasty, aesthetically appealing and nutritious diets.

Key Words : 1.NUTRITION 2.WOMEN AND NUTRITION 3.DIETARY HABITS 4.EATING HABITS 5.MEALS 6.BEVERAGES 7.HEALTH FOODS 8.NUTRITION AND WOMEN 9.COLLEGE STUDENTS 10.ADOLESCENT GIRLS.

SOCIAL DEFENCE

19. Bureau of Police Research and Development, New Delhi. (2004).
Procurement by kidnapping of women and children for prostitution at metropolitan centres : a study of Kolkata, Hyderabad and Bangalore. New Delhi : BPRD. ~53 p.

Abstract : There have been a number of cases where girls/ women have been taken away from their homes by force or deceit and gradually intimidated into joining the flesh trade, and to lead the life of a prostitute. Criminals involved in this type of trafficking normally target such persons and adopt such *modus operandi* that the developments leading to the crime do not appear to or amount to any offence at any particular place at the time of its commission. The objective of the study was to elicit information from prostitutes who have come to the metropolitan sex market in the last 10 years, in order to identify the modes of kidnapping and routes of procurement of women and children for prostitution. A total of 349 interviews were taken of prostitutes in Bangalore (146), Kolkata (153), and Hyderabad (50). Most of the prostitutes belonged to India, 12 belonged to Bangladesh and only 2 were from Nepal. Out of 348 women, who disclosed their religion, 254 (72.98%) were Hindus, 76 (21.83%) were Muslims and 18 (5.17%) were Christians. The number of married prostitutes (187) was higher than that of unmarried ones (162). Maximum number of prostitutes interviewed were illiterate or

had primary education only. Persons instrumental in inducting the prostitute into flesh trade were husbands in the case of Bangalore, while the kidnapper played a major role in Kolkata. Majority of respondents indicated the presence of one to three members in most of the gangs, while gangs having a larger number of members were very few. It is clear that more women were working in these gangs than men. According to the information revealed about places of operation of the gangs they appear to have large areas of operation. Further strategy can be drawn up to tackle this issue of preventing as well as rescuing helpless girls and women from being forced into prostitution.

Key Words : 1.SOCIAL DEFENCE 2.KIDNAPPING 3.PROSTITUTION 4.TRAFFICKING 5.TRAFFICKING PREVENTION 6.GANGS 7.PROCUREMENT 8.WOMEN AND CHILDREN 9.METROPOLITAN CITIES 10.KOLKATA 11.HYDERABAD 12.BANGALORE.

20. Council for Social Development, Hyderabad. (1990).
National seminar on the rehabilitation of jogins, bonded labour and persons engaged in uclean occupations : Transactions of the seminar. Hyderabad : CSD. ~365 p.

Abstract : The system of dedicating girls in the name of religion is prevalent all over the world. Girls are dedicated to be the brides of Christ or *Devdasis,* and *Jogins* are dedicated to Goddess Renuka. They are denied normal married life and are expected to serve the deity. Objectives of the NGO, Asha Jyoti were to raise the status of destitute women and rehabilitate them socially, economically and emotionally; to educate them about preventive health care and immunization of children and mothers; to admit their children in schools; and to impart functional literacy skills. The obsession to make girls as *jogins* was so prevalent that even for petty causes a girl is made a *jogin*. Unlike prostitution, there was no involvement of middlemen or pimps here, nor do the women go out of their way to entice customers. *Jogins* are one step above the prostitutes and one step below the *Devadasis* for a number of reasons. The reason for the perpetuation of the system is when a *jogin* becomes the collective property of the village, she cannot displease anybody. It has been estimated that there are as many as 25000 *jogins* in Andhra Pradesh alone. Rehabilitation of *jogins* was taken up both by the Government and voluntary agencies. The State Government enacted a comprehensive bill in 1988 prohibiting the *jogin* system. This bill made the children of *jogins* as legitimate children. Chelli Nilayam is a voluntary organization and its main activities included counseling, spreading awareness of laws related to j*ogins* and helping them in their rehabilitation; Society for Awareness through Learning and Training (SALT), Hyderabad conducts periodical surveys on the status of the j*ogins* in the slums of twin cities. Nearly 22-30 children of *jogins* were identified by SALT and were sent to social welfare hostels and 'Child Heaven Centre' at Hyderabad. Bonded labour is

prevalent in Karnataka, Gujarat, Kerala, Bihar, Madhya Pradesh, Maharashtra, etc. Nearly 62% of bonded labourers were freed from bondage. In 1988, 35,465 bonded labourers were released from bondage, and out of them 23,956 were rehabilitated. There was a wide gap between the number of bonded labourers released and rehabilitated. In Andhra Pradesh, the system of bonded labour is prevalent in the Scheduled Areas. In Anantapur District, 98 bonded labourer households were freed immediately after the legislation on Bonded Labour was passed. The other State Governments and Union Territories are also taking necessary action. It is relatively easy to release a bonded labourer but their rehabilitation is difficult. The Yanadi Tribals were illiterate and hence they did not know about the amount that was being written as accounts due against their needs. The bonded labourer rehabilitation scheme, started in 1978-79, is centrally sponsored and the assistance available for each bonded labour was Rs. 4,000/- which was raised to Rs. 6,250/- in 1986. Socio-economic condition of rehabilitated scavengers in Municipal Corporation of Hyderabad was studied. A total of 402 scavengers were rehabilitated. 53% males and 40% females were interested in vocational training. Though there are various vocational trades like carpentry, fitter, welder, electrical, etc. taught in Government training institutions like ITIs, it was observed that nearly 95% respondents opted for other trades. Voluntary organizations can play an important role in planning and development and their collaboration should be considered essential in view of physical and financial constraints. The outlay provided by the Government in the sectoral programmes formulated for the upliftment of scavengers was not sufficient and would have to be increased.

Key Words : 1.SOCIAL DEFENCE 2.JOGINS 3.PROSTITUTION 4.DEVADASIS 5.REHABILITATION OF PROSTITUTES 6.SOCIALLY SANCTIONED PROSTITUTION 7.BONDED LABOUR 8.SCAVENGERS 9.UNCLEAN OCCUPATIONS 10.SCHEDULED CASTES.

21. National Commission for Women Delhi, New Delhi. (1999).
Rape victims : networking for a supportive infrastructure New Delhi : NCW. 22 p.

Abstract : Violence against women is a matter of serious concern. Rape particularly, is one of the most brutal forms of aggression against women and shakes the foundation of the life of the victim. In Delhi, there appears to be relatively higher incidence of rape in the age group 0-15 years. In 1998, the 0-15 years age group comprised 51% of total rape victims. Out of 449 accused arrested, 308 had committed single rape, 69 double rape and 64 were arrested as accused in multiple (gang rape) cases. The Delhi Comission for Women has also been able to hand over cases of victims to other NGOs like Sewa Bharti, Nehru Bal Samiti, etc and follow up action taken up by them is being monitored. Out of 50 cases taken up, 47 could be located. About 60-70% rape victims just vanish from the

scene/locality of occurrence. More than social ostracism, the cause might be threats and further insecurity from the rapist. In the absence of security of conviction, the victims insecurity increases and they feel unsafe. The interrogation of minor victims should not be held in the *thana* (police station) premises. There is no separate cell for questioning of rape victims though they should be dealt with sympathetically. The cases relating to rape and molestation of women should be investigated by women police officers. Death penalty is advisable only in extreme cases. The punishment for custodial rape should be severe. Establishment of Day Care Centres and Non Formal Education Centres for minor and adolescent girls in these slum areas is very important.

Key Words : 1.SOCIAL DEFENCE 2.RAPE VICTIM 3.RAPE 4.REHABILITATION OF RAPE VICTIM 5.NETWORKING 6.CRIME AGAINST WOMEN 7.SUPPORT SYSTEM.

22. UNICEF, New Delhi. (2005).
Rescue and rehabilitation of child victims trafficked for commercial sexual exploitation : report. New Delhi : UNICEF. 165 p.

Abstract : The past few years have seen a growing awareness and concern from Government of India (GOI), NGOs and the International Community about the increasing prevalence of trafficking for the purpose of commercial sexual exploitation of children (CSEC) in India. The commercial sexual exploitation of children is a major global industry and researchers suggest that it generates upto US $ 5 billion world wide. The income earned by this industry through trafficking tourism and pornography is second only to that generated by the smuggling of drugs and arms. The study aims to build upon the current state of knowledge on this issue. The states studied were Andhra Pradesh, Goa, Karnataka, Maharashtra, Tamil Nadu and West Bengal. Information was collected from 14 NGOs, 2 forums of commercial sex workers, 7 State Government Homes, 2 policemen, 1 Government official, 1 girl in after care programme and 2 individual rescuers. A total of 25 girls from the State Homes and NGO Homes were interviewed. Additionally, children rescued from commercial sexual exploitation were interviewed, when possible. The objectives of the study were to obtain a better understanding of the rescue and rehabilitation processes; to gain a more complete understanding of the involvement of the State; and to make recommendation on the need for developing guidelines for rescue and rehabilitation. There are an estimated two million children aged between 5 years and 15 years forced into CSE around the world. Girls between the ages of 10 and 14 years are more vulnerable; 15% commercial sex workers in India; and 5,00,000 children worldwide are forced into this profession every year. Other studies conducted prior to 2000 revealed that approximately 20% women in prostitution in Mumbai were under 18 years of age. In Mumbai, street boys often sell sexual services as it is more profitable and

demands less physical labour. In Bangalore, boys having sex with a man was a practice identified as one form of CSE. Goa is one of the prime destinations as here children are trafficked from Andhra Pradesh. Peer trafficking was also encountered, where victims themselves were used to force or entice other children. Mumbai is supplied with women in prostitution from 40 districts across 11 States, while in Delhi prostitutes came from 70 districts across 14 States in India. The girls are examined for their complexion, health, age and possible deformities. They are often asked to undress so that they can be examined closely. From time to time, raids were carried out in red light areas, and the children rescued were placed in Homes run by the Government or NGOs. NGOs working for the welfare of trafficked children include Bharatiya Patita Uddhar Sangh (Delhi), Prerna (Mumbai), Sanlaap (West Bengal), Gram Niyojan Kendra (Uttar Pradesh), ICCW (Tamil Nadu), Odanadi (Karnataka), etc. Some rescued children were found to be addicted to drugs and alcohol. Recreational facilities provided by the Homes were physical activities that included outdoor games, yoga, sports, Karate sessions. In all the State Homes, counselling is provided by NGOs visiting or networking with that Home. All Short Stay Homes (SSH) primarily focused on repatriating the children to their families as did many Long Stay Homes. Six organizations helped children to become economically independent by enabling them to start stalls and shops. Information collected from the girls rescued revealed that the first signs of a Police raid and rescue operation often led to confusion and chaos in the brothels. The negative outcomes include runaways, attempts at suicide and refusal to participate in programmes. The data indicates that there must be a balance in terms of the components of the rehabilitation programme. Health, education, vocational training and counseling are all important aspects of the rehabilitation process. There is a need to arrest trafficking at the source areas. Raids are not the answer to solving the problems of trafficking, and Governments need to work more seriously on this issue. One rescued child said that the Police should rescue all the children in prostitution.

Key Words : 1.SOCIAL DEFENCE 2.CHILD TRAFFICKING 3.TRAFFICKING 4.CHILD PROSTITUTION 5.TRAFFICKING PREVENTION 6.CHILD SEXUAL ABUSE 7.EXPLOITATION OF CHILDREN 8.REHABILITATION OF PROSTITUTES 9.PROSTITUTION

SOCIAL WELFARE

23. George, Annie. (1997).
Sexual behaviour and sexual negotiation among poor women and men in Mumbai : an exploratory study. Vadodara : Sahaj Society for Health Alternatives. 136 p.

Abstract : This study examined aspects of sexual behaviour and sexual negotiation of an urban slum population with a view to gaining insights into the

sexual lives of people that would be useful in understanding the social context and conditions for the spread of HIV/AIDS in Mumbai. This study was conducted between October 1995 and September 1997 in Brihan Mumbai, having a population of 9.9 millions (Census of India, 1991), adopting qualitative research methodology, and using a semi-structured interview format. Of the 87 women contacted, 65 participated in the study and they were mostly from Kaamgar Nagar; 37 men were also contacted but only 23 participated in the study. Fifteen men were in the age range 26 to 35 years, the youngest man interviewed was 26 years and the oldest was 42 years. The average age of women was 29.9 years. Forty-seven women were literate having five years of schooling. The average age at first marriage was 16.2 years. The personal and family situation of the men and women respondents indicated early marriages, early child bearing, and child care responsibilities that were shouldered in small homes in poor conditions, where even basic facilities were available only on payment of exorbitant rates. In marriages where men provided for the family regularly (42 of 65 women respondents, and 22 of 23 male respondents), their wage was perceived to be adequate for the family. Thirty-two women reported being beaten by their husbands at least sometimes. Women were beaten on the arms, back and thighs. Sticks, hands, cooking vessels, etc. were the instruments used for beating. The consequences of such violence as expressed by the women were aches and pains, cuts and bruises with bleeding, damage of vision and hearing, and problems during pregnancy. But four women mentioned that they beat their husbands. Alcohol abuse was the major reason for wife beating. All women respondents counted on their parents and siblings as their main source of support, whether they were in harmonious or in conflicting marital relationships. A few women shared a compatible relationship with their husbands, but women felt compelled to live up to the belief of male right to sex in marriage. There were some men who said they used force all the time, some who used it some of the time, and some who did not use it at all. Men's views about their wives sexuality appeared to be that it is a force which exists primarily to please the husband or fulfill his sexual needs. For men, the risk of unwanted pregnancies existed only within the context of marriage. For most men and their wives, female sterilization was the preferred method of contraception. The possibility of contracting sexually transmitted diseases, including HIV/AIDS, through sex with sex workers and other outside women was well known to men, and some of them used condoms only with sex workers. One of them had between 100 to125 sexual partners in his lifetime. Women who were poor, who provided sex for money, or who were otherwise marginalized, did not consider their risk of acquiring AIDS to be high, because they had always faced some kind of risk on the other. The availability of condoms and its increased marketing increased its appeal across all sectors. Reforms in the health sector along with greater focus on HIV/AIDS prevention strategies will go a long way in controlling the AIDS epidemic. There should be more clinics and qualified and

sensitive doctors to provide high quality treatment for sexual transmitted diseases. Short term improvements in men's and women's access to education, health care and economic opportunities may improve their health status.

Key Words : 1.SOCIAL WELFARE 2.SEXUAL BEHAVIOUR 3.AIDS 4.HIV/AIDS 5.SEX INDUSTRY 6.LOCAL SEX INDUSTRY 7.HEALTH FACILITIES 8.SEXUAL NEGOTIATIONS 9.GENDER ISSUES 10.PATRIARCHY 11.VIOLENCE AGAINST WOMEN 12.SEXUAL UNHAPPINESS 13.SEXUALITY 14.MUMBAI.

WOMEN LABOUR

24. Krishna, Sangeeta. (2001).
Women vendors : a study of Varanasi. Varanasi : Banaras Hindu Univ., Faculty of Social Sciences, Centre for Women's Studies and Development. 45 p.

Abstract : Working women in the informal sector is an important segment of the labour force. The economic and social conditions of those working in this sector are dismal. It was estimated that about 15% urban informal sectors workforce are street vendors. Participation rate of female workforce in the informal sector is as high as 49% as against 15% to 17% in the case of males. The objectives of the study were to ascertain the motivational factors for choosing the trade/ business; ascertain the impact of women's economic activities; understand the gendered nature of the activities and roles performed by women. In all 21 women were interviewed. Purposive sampling method was used for interview because it is difficult to ascertain the exact number of women vendors. Majority of them were illiterate and only a few were literate upto primary and middle levels. Nearly 29% women sellers under study had large families (5 to 6 children). Majority of the respondents came from families which have an income of even less than Rs. 50 per day. Only 2 had a daily earning of between Rs. 81-100. Majority of them worked for at least 8 to 10 hours and a few worked 14 to 16 hours. The most frightening experience for these women sellers is the regular eviction carried out by the district or municipal administration. Although these poor women have been selling seasonal fruits, vegetables, etc. for the last 15-20 years, yet they do not have a secure a place to sit and vend. Majority of them reported that their activity gives them a ready source of money everyday; it also releases them from the monotony and drudgery of household work. Most of the times, in the absence of any knowledge about calculations, they are cheated by customers. Working women generally bear double burden as worker, homemaker and mother. Majority of the women sellers had no aspirations or expectations, but left their destiny on fate. They faced economic uncertainties due to police harassment, eviction drive by the

municipality, frequent clashes with local shopkeepers, as well as hostilities of the urban middle class people. Town planning must take into consideration vending lanes on the road so that traffic need not be obstructed. The police and the municipality must take an attitude of helping these women rather than harassing them. The periodic 'encroachment' clearance should be done only after providing some alternatives.

Key Words : 1.WOMEN LABOUR 2.VENDOR 3.STREET VENDOR 4.WOMEN VENDORS 5.WORKING HOURS 6.SUPPORT STRUCTURE 7.ROLE CONFLICT 8.MUNICIPALITY 9.CASE STUDY 10.PROBLEM OF WORKING WOMEN 11.FEMALE HEADED HOUSEHOLD.

25. Rani, Uma. (2005).
Income, risks and vulnerabilities among women informal workers : case study of Surat City. Ahmedabad : Gujarat Institute of Development Research. 45 p.

Abstract : The structure of employment is changing across the world with manufacturing and servicing processes being relocated from high income countries to low income countries. An attempt was made to understand what risks and vulnerabilities influence the livelihood outcomes of workers in the informal sector in Surat city in Gujarat. The basic needs relate to food, shelter, health, education and income. Surat city has a population of two million people and the female population is about 48%. The working age population in the city was about 69 percent, which was similar across gender. The total labour force in the city was about 935,000, comprising 35% females and 65% males. The employment status was 99% of women in the working age group were employed; about 95% of men were gainfully employed. About 65% of the workers in the informal sector were casual wage labourers, 16% were self-employed, 6% were unpaid family helpers and 9% were engaged in home-based work. The average days of work available to the workers were 302 days, with women having slightly higher number of days of employment. The most vulnerable were the piece rate and casual workers in terms of number of days of work. On an average, these workers reported 82 and 67 days of unemployment respectively. The migrant population in the city was about 70%. Across gender, men's annual earnings were much higher than women, in all the activities. The average household income of Rs. 52058 was much above the poverty line, but about 15.4% households obtained incomes below the poverty line. About 70% women perceived that there was likelihood of losing either their present job or the economic activity they were pursuing. About 27% women had the privilege of working in a job of their choice, but about 37% had no choice. About 48% households had small children below the age of ten years. The literacy rate among the sample respondents was 76% and there was a wide disparity across gender. About 12% households did not send their girl child to school, while only 8%

did not send their boy child to school. About 64% self-employed women operated from within their homes, and 35% of them were operating on streets, without any legal status. About 37% households did not own the house they lived in, and they lived in rented or other premises. A high proportion of women workers (53%) had very little or no work for four months in a year, and another 30% had a slack season for about 3 months. About 54% households did not have access to public health care facilities, and of those who had government health facilities, about 21% did not avail the public health facility. The risks that informal workers faced were that of the death of an earning member in the household, loss of job due to illness, loss of job or assets, loss of work, etc. About 13.1% of all households and 30% poor households faced this crisis. About 41% households reported expenditure on illness as a major crisis, especially among poor households; 17% experienced the birth of a child as a vulnerable situation, and 24% households had large outstanding debts, in both female and male headed households. Women, with their dual burden, had to deal with provision of both basic and economic needs of the households. There is a need to address the economic insecurities of these women. Economic policies must be developed in conjunction with policies concerning reproduction and child care. A mechanism through which the insecurities of the women could be addressed is organization of these women into groups or unions, as hardly 2% of them were part of unions at the time of the study.

Key Words : 1.WOMEN LABOUR 2.WOMEN LABOUR UNORGANIZED SECTOR 3.UNORGANIZED SECTOR 4.INFORMAL WORKERS 5.LABOUR FORCE 6.FOOD 7.HEALTH 8.WOMEN WORKER 9.VULNERABLE GROUP 10.SURAT 11.GUJARAT.

WOMEN WELFARE

26. Balodi, Arti. (2004).
Impact study on training program : Swa-Shakti. Dehradun : Uttaranchal, Dept. of Women and Child Development, Swa-Shakti Project. 25 p.

Abstract : Swa-Shakti Project creates opportunities for achieving more stability in women's lives through various training programs in fields such as women's empowerment and self reliance. The Swa-Shakti Project commenced from April 2002 and was implemented in 14 blocks of three districts of Almora, Pithoragarh and Tehri Garhwal in Uttaranchal. The specific objectives were to establish women's Self Help Groups (SHGs), which build self-reliance and self confidence and provide them greater access to and control over resources; sensitize and strengthen the institutional capacity of support agencies, Government, NGOs and banks to proactively address women's needs; increase the incomes of poor women through their involvement in income generating activities; to develop linkages

between SHGs and lending institutions to ensure women's access to credit financing; and to improve access to better health care, education and drudgery reduction facilities. To conduct this study, 10 SHGs with 106 respondents were randomly selected in 3 blocks of the project area of Almora District. Concept and promotion of SHGs brought a positive change in social dynamics of the group members. A few SHG members expressed the view that SHGs were a platform for women to interact and led to empowerment. Empowerment of women was observed in the form of participation in making financial decisions for the family. The groups were also found to be influential in the community with some women becoming members of Panchayati Raj Institutions (PRIs). Swa-Shakti Project emphasized on formation and strengthening of women SHGs in its project area. The main two or three Income Generating Activities (IGA) were seen in sample SHGs, and they were using these activities as a source of income. Promotion of SHGs under Swa-Shakti has influenced the political scenario in the sampled villages. SHG members have become more aware about the role and responsibilities of various Government departments. SHG members in some study villages have become aware of reservation for women in panchayats, participated in Gram Sabha Meetings and tried to solve community problems regarding basic amenities, irrigation, drinking water, sanitation, etc.

Key Words : 1.WOMEN WELFARE 2.TRAINING IMPACT 3.EMPOWERMENT WOMEN 4.SELF HELP GROUPS 5.IMPACT OF TRAINING 6.KNOWLEDGE LEVEL.

27. Banatwala, Qudsiya. (2005).
Bangles of fire : women and environment : a study. Mumbai : Sophia Centre for Women's Studies and Development. 54 p.

Abstract : A widespread belief is that men are more aggressive than women. This study investigated the involvement of women in riots and incidents of communal violence in Gujarat and Maharashtra. In 95% cases, women murdered strangers, and in 60% cases women slayed relatives and friends. In a study of 460 female murderers, it was found that women were becoming more stereotypically male in their reasons for murdering. The differences in physical aggression of Hindu and Muslim women were significant. The Rashtriya Swayamsevak Sangh (RSS), the most effective organizer and bearer of the political ideology feels that India has been a Hindu rashtra since many millenniums, and the interests of Hindus should not be compromised in India. The wide range of data collected by fact finding teams of the People's Union for Civil Liberties, Vadodara and Vadodara Shanti Abhiyan (May 31, 2002) revealed that women from communities were affected by the fear and terror promoted by hooligans, the State and the police. One of the most disturbing features of the Mumbai riots in 1992-93 was the large scale participation of women and young girls in acts of violence. In the domain of public violence, a large number of women have been extremely active and visible in

attacks against each others' castes. The Gujarat Genocide 2002 also saw wide scale participation of women. The insecurity of Hindu women is, in many ways, a product of Hindutva ideology that set them up as being vulnerable to sexual attacks by Muslim men. Generally women did not applaud rape, but during and after the carnage, many Hindu women were openly justifying the rape of Muslim women. Some organizations are organizing training camps in places like Rajasthan, Uttar Pradesh (Lucknow), Ayodhya, etc. and after attending one such camp, women trained in these skills stated that they 'felt empowered'. Women who engaged in violence were often in violent relationships themselves. They lived in such unbearable tension that when they abused others, it gave them a sense of control and power. Hope lies in the fact that Hindutva is not a general tendency in India. Hindutva women need to be provided a platform to come together and interact with other Hindu and non-Hindu women. The need of the hour is for women to unite and fight this move to divide Indian people along lines of religion and caste.

Key Words : 1.WOMEN WELFARE 2.VIOLENCE AGAINST WOMEN 3.AGGRESSION IN WOMEN 4.GUJARAT RIOTS 5.MUMBAI RIOTS 6.PSYCHOLOGICAL PERSPECTIVE OF WOMEN 7.RASHTRIYA SWAYAM SEVIKA SAMITI (RSS) 8.RIOT VICTIMS 9.AGGRESSIVE WOMEN 10.RIOT AFFECTED WOMEN.

28. Centre for Development Research, New Delhi. (1999).
Widows in pilgrimage centres : an anthropological perspective : executive summary. New Delhi : CDR. 16 p.

Abstract : Reasons for the influx of widows to pilgrimage centres cannot be classified as the reasons were sundry. The study was conducted during May to December 1999 in four pilgrimage centres of Uttar Pradesh, namely Vrindavan, Mathura, Varanasi and Haridwar. 1030 widows were interviewed and in-depth discussions were held with 40 widows. In Vrindavan, downtrodden ladies were given Rs. 2.00, 250 gm of rice and 50 gm of *dal (*lentils) for singing bhajans during mornings and evenings. Two rehabilitation centres were built for aged women. In one old age home, a television was installed in the centre of the courtyard for the entertainment of widows. Bhajan Ashrams existed in many places including Mathura. Widows did not get any pension, but they also did not pay any rent for their accommodation. In Haridwar, throughout the day widows lined up on the many steps of the river. Indra Basti Colony in Haridwar was populated by Bengalis, but in other colonies mostly women from Bihar and Uttar Pradesh lived. Widows from Bihar sustained themselves by begging. There was no organization to cater to their needs. Varanasi was heavily populated with Bengali widows from the upper castes. In Kashi (Varanasi), widows/ old couples could rent a room and stay there till their death. Rama Krishna Hospital provided board and lodging to Bengali widows, who came from Belur Math of Calcutta. The overall scenario in Varanasi,

compared to other pilgrimage cities, seemed much better. Three fourths of the widows in the four pilgrimage cities were Bengalis, in Mathura (87%), Vrindavan (82%), Varanasi (65%) and Haridwar (43%). 81% were illiterate and 11% had studied up to primary school. Illiteracy was highest among widows of Haridwar (94%). Marwadi Seva Sangh Ashram had around 300 rooms for *yatris* (tourists). Few other places for widows were Moksha Bhawan, Rajkiya Vridh Graha, Rama Krishna Seva Ashram, Mother Teresa Hospital, and Leper Home. There was uniformity in the life styles of widows irrespective of the place. 17% lost their husbands at a very young age, i.e. below 25 years, 19% between 25 and 35 years, and 28% lost their husbands when they were 50 years or above. In 88% cases, remarriage of widows was not customary in their castes. 69% widows had children to look after, but still they left them for pilgrimage places. 15% widows had dependent children living with them. 30% widows left their homes as there was nobody to look after them. In Haridwar and Mathura, the major source of awareness was information gathered from other widows. 84% stated that they did not get enough money to save. 44% widows in Mathura, 42% in Varanasi, 18% in Vrindavan and 17% in Haridwar were getting pension regularly. 23% widows reported that their last rites were performed by fellow widows. Some basic education should be imparted to make widows less vulnerable to exploitation by unscrupulous people. They should be made aware of their rights. The Government should provide hostels with basic amenities for widows, and a minimum sum of Rs. 500 p.m. for their sustenance. Widows should be taught certain crafts, and these items should be marketed by NGOs.

Key Words : 1.WOMEN WELFARE 2.WIDOWS 3.OLD AGE HOME 4.PILGRIMAGE CENTRE 5.NEEDS OF WIDOWS. 6.MATHURA 7.HARIDWAR 8.VARANASI 9.VRINDAVAN

29. Centre for Development Studies and Action, New Delhi. (2001).
Status of women and children in displacement : summary. New Delhi : CDSA. 37 p.

Abstract : Displacement has different implications for men, women and children. It has different consequences for the various classes and sections of the displaced community. The vital concern of this study was to examine and understand the problem of gender inequality that added to the plight of women and girls as refugees. A total of 500 people including 391 women and 109 girl children were contacted in their places of location – camps/ tents, homes of relatives, short stay homes and orphanages. Women were particularly affected as many of their problems were because of their gender. Women respondents also considered that the present system of aid assessment and assistance was rather discriminatory against women due to the existing differences in providing monthly allowance. Another major problem specific to displaced women was sanitation. Lack of toilet

facilities was inconvenient and made women physically unhealthy and uncomfortable; it also made them more vulnerable to physical and sexual harassment. Almost all women faced problems in the upbringing of their children due to lack of financial resources. Most women had cordial relationships with their husband/ in-laws. They felt that the Government should have a special policy for displaced women and children, so that they could become economically independent. Recreational facilities like library, reading room, playground or parks have not been provided by the authorities in resettlement areas. Most of the girls never reacted against the discrimination within families. While distributing agricultural land, plots for houses, and cash, the same should be done in the form of a joint *patta* in the names of both, the husband and wife. At the policy or programme level, there should be more stability and similarity in the rehabilitation process. The measures towards self-reliance can be encouraged cautiously after a careful assessment of programme evaluation. Only 15.3% women accepted that after displacement their personal life had improved; 18% believed that family life had improved. Both, women and girls have repeatedly complained against the presence of liquor shops in their areas. There is need to provide more transport and medical clinics with regular medical staff in the area. In the rehabilitation programme, loan facility or financial support for establishing new businesses and house construction for the oustee families at minimal rates of interest should be provided. There is a need to explore the means of establishing self-sufficient health care units which are administered by the refugee community itself.

Key Words : 1.WOMEN WELFARE 2.DISPLACED WOMEN AND CHILDREN 3.DISPLACED WOMEN 4.DISPLACED CHILDREN 5.MIGRANT 6.KASHMIRI MIGRANT 7.BURMESE MIGRANT 8.TERRORIST VIOLENCE 9.DEVELOPMENT PROJECTS 10.REHABILITATION 11.CYCLONE 12.EARTHQUAKE

30. Gangopadhyay, Maushumi. (2001).
A Study on the psychosocial circumstances in the family life and environment of married women victims in the reported cases of family violence in Delhi and Kolkata Metropolis. New Delhi :National Institute of Criminology and Forensic Science. 158 p.

Abstract : The term ‘domestic violence’ refers to a self contradictory incident in civilized, modern social life. The venue of domestic violence is the victim’s family environment, where a powerful family member expresses atrocity on a helpless, dependent and powerless family member. The aim of the present study was to understand why family violence takes place and affects mainly married women, and whether the causes are universal. Purposive sampling method was used to identify the respondents. A homogenous group of victims belonging to two sub-groups of two different sub-cultures were selected. Out of them in Delhi only 20 and

in Kolkata 30 cases were excluded on technical grounds applicable to undisposed cases. Around 180 victimised daughters-in-law from Delhi and Kolkata were divided into two sub-groups city-wise comprising 90 victimised daughters-in-laws from each metropolis. The victims belonged to higher middle economic class and lower middle economic class. In the Indian context, the family sub-culture had a parochial attitude and the daughter-in-law was expected to fulfill certain obligations and duties. Altogether, there were 79 cases where married women were maltreated and victimised for non-payment of promised dowry and other gifts, and subjected to physical and mental torture. Data was gathered using Family Violence Data Recording Inventory Scoring Schedule (FVDR) which had two modes. Around 130 victims perceived and described their in-law families as middle economic class, greedy, boastful and highly prejudiced, while another 50 victims perceived and described the status of their in-law families as hazy and unstable income class, greedy, pressurizing for gifts, ill-reputed, highly prejudiced, boastful, ill-tempered and having women oppressors. 80 victims experienced ill-treatment by their in-laws before marriage, while 108 victims experienced ill-treatment after their marriage. In both modes boastfulness was found common with ill-temper or bad manners, while notoriety for women's oppression was found present in one of the modes. In 50 cases in Delhi and 40 cases in Kolkata, socio-cultural influences were different in their pre- and post-marital family environment. All victims, who were respondents, were not allowed to spend money for personal requirements from the family fund. Negotiations during marriage and conventional dowry payment was still present in 105 families, and of them 40 families failed to meet their commitments, while the rest 65 fulfilled the requirements. Significant differences were observed between the informants who were brought up and spent their married life in Delhi and Kolkata. Lack of economic self-sufficiency, devaluation of the self-esteem of daughters-in-law, no guarantee to get an oppression-free social life, fear of sexual exploitation, and other social insecurities were mentioned in Delhi. Education of women, with competence-based vocational training for them, must be made compulsory. Each and every adolescent girl student must be made aware of the essential ethics of conjugal life and cohabitation. For the criminal part of domestic violence, legal support for the victim and help for punishing the abuser are essentially required.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE 3.SOCIAL PROBLEM 4.VIOLENT BEHAVIOUR 5.FAMILY VIOLENCE 6.PSYCHOSOCIAL FACTORS 7.FAMILY CIRCUMSTANCES 8.WOMEN'S STATUS 9.STATUS OF WOMEN 10.MARITAL PROBLEM 11.DELHI 12.KOLKATA.

31. Institute of Social Studies Trust, Bangalore. (2000).
Redesigning from the roots : critical review of training initiatives : towards empowerment of women and redesigning policy. Bangalore : ISST. 18 p.

Abstract : The Department of Women and Child Development organized a consultation workshop on 19th June 2000 for the preparation of a Policy Document

for Women's Empowerment. In this workshop, the views and experiences of NGOs were solicited. They shared their field and research experiences. ISST had undertaken a research project and the objectives of the study were to conduct a review of training initiatives for women in Karnataka with particular focus on capacity building initiatives for political and economic empowerment; to assess gaps from the vantage point of women's empowerment; and to provide relevant input for designing a policy for women's empowerment in Karnataka. Very basic and fundamental aspects/ components of training/ capacity building emerged as areas of prime concern in the study. Women at the grassroots are already familiar with the term 'training' and for them 'what goes into it, their experience of it and what comes out of it' is of prime concern. Data was insufficient. There were hardly any in-service on-going trainings/ capacity building for Government officials either to prepare them as trainers or to serve as gender sensitive officers. No provision has been made in the Panchayati Raj Act to make training an obligatory function of the State and Panchayats, or to appropriately remunerate elected representatives. There exist no terms of reference to facilitate constructive and consistent collaborations between NGOs and the Government. It was felt that most often collaboration with Government was not worked out on equal terms. State capacity building initiatives do not address and arrange for practical gender needs like crèches, etc. State initiatives to prioritize Training/Capacity Building for women must get reflected in budget allocation to the concerned department. It is important to develop Monitoring – Evaluation indicators based on gender perspective for attitude and behaviour impact; knowledge and skill impact; ripple effect in society, and move on from the present priority of pedagogy impact. The study highlights the need for such on-going exercises, not only with an objective of redesigning policy, but also with a view to review 'policy performance'. There is need to pay special attention to basic components of training like the objectives, perspective and philosophy of Training/ Capacity Building for empowerment of women.

Key Words : 1.WOMEN WELFARE 2.TRAINING WOMEN 3.EMPOWERMENT WOMEN 4.EVALUATION OF TRAINING 5.POLICY IMPLICATIONS 6.EVALUATION OF TRAINING WOMEN.

32. Institute of Social Studies Trust, Bangalore. (1997).
Study of initiatives for increasing community involvement in Karnataka and Tamil Nadu. Bangalore : ISST. 83 p.

Abstract : Health of a woman has a profound implication for the development and well being of a nation. Poverty, health and development are closely interlinked. The number of women who receive antenatal and post partum care through family welfare programme is still relatively low. A variety of socio-economic factors are responsible for women's lower educational attainment, the need for female labour at home, low expected returns of girls education, and social restrictions. The objectives of the study were to review the experiences of one district from each state in community involvement initiatives; to formulate operationally useful

guidelines for effective training of panchayat functionaries; and prepare a communication strategy and communication package for training. One district in each state was selected for the study, Bijapur in Karnataka and Madurai in Tamil Nadu. The persons interviewed in Bijapur district were 28 and data collected was over two months. Tamil Nadu has a weak tradition of Panchayati Raj and is one of the last states to conduct elections to the 3-tier system, which were finally held in October 1996. In Karnataka, the fertility rate was 2.9 for women (15-49 years) which was about 15% lower than the national average. Most women knew about family planning methods but their knowledge was limited to sterilization. Their main source of Family Planning messages has been the electronic mass media, namely radio (52%) and television (22%). The IMR was 42% higher and the CMR was 78% higher in rural areas compared to urban areas. In Tamil Nadu, family welfare services are extended through a network of 1222 Primary Health Centres and 118 Post Partum Centres. Madurai has 41 primary health centres, 314 sub-centres and 87 NGOs are providing health care facilities. The sex ratio was 974. 24% ever married women married a first cousin and 22% married a second cousin, uncle or other blood relative. Overall 90% illiterate women approved of family planning. Breastfeeding was nearly universal in Tamil Nadu. Common illnessess found in Bijapur were diarrhoea, under nutrition and anaemia. Training programs were insufficient, and no training programs had been conducted for panchayat members. In the *taluk* (block) there were no drinking water facilities. Common health problems were known to most of the people. Mass media has played a very important part in propagating health messages. On the whole, girls lacked knowledge about pregnancy and child care. There is a growing necessity to have training programs organized for panchayat members in both the districts, and to motivate and initiate them to articulate and demand health services. Increased educational status is associated with better bargaining power, control over resources, knowledge of skills, and informed choices for decision making. The IEC program should go beyond selective media methods to interpersonal communication. Panchayats can mobilize people to demand for services including health services.

Key Words : 1.WOMEN WELFARE 2.COMMUNITY INVOLVEMENT 3.COMMUNITY PARTICIPATION 4.COMMUNITY DEVELOPMENT 5.ROLE OF NGOS 6.VOLUNTARY ORGANIZATION 7.PRIMARY HEALTH CENTRES 8.ANGANWADI WORKERS 9.HEALTH SYSTEM 10.KARNATAKA 11.TAMIL NADU.

33. Jamwal, Vijay. (2004).
Study on drudgery reduction and time utility : Swa-Shakti. Dehradun : Uttaranchal, Dept. of Women and Child Development, Swa-Shakti Project, ~30 p.

Abstract : India has witnessed a three-fold increase in population over the last half century without corresponding growth in opportunities, especially in rural areas. Women constitute 50% of the population and are the backbone of the family. Swa-

Shakti Project planners felt that formation of women's groups would lead to leadership development among women, enable the group to take up problems related to women, inculcate saving habit, build their capacities to develop micro enterprises and generate income, establish a networking of SHGs, initiate community development and impose a high moral standard. Some of the entry point activities were distribution of improved stoves and pressure cookers, construction and repair of local water resources and meeting place, and attending to the health problems of women in the project area. The objectives of the study were to assess the time saved by women as a result of inputs provided to them; alternative usage of the time saved by women; and utilization of community assets mobilized by the project. In all 20 beneficiaries were selected. The sample consisted of 19 groups, 6 in Pithoragarh, 6 in Almora and 7 in Tehri Garwal. In Almora, community assets for drinking water were created and the training and implementation related to grading were promoted in Tehri Garhwal and Pithoragarh. As a result of the introduction of gas and improved stoves the time required for cooking was reduced. There were some external factors also that helped in the reduction of drudgery like opening of primary schools in the vicinity; drinking water schemes of Government, etc. Women were using most of their saved time by relaxing and participating in meetings and trainings, which showed their increased awareness. Swa-Shakti promoted the development of community assets, but the community also contributed in its construction, as well as mobilized resources from other sources. The major part of the investment in Almora was mobilized from other sources, whereas in Pithoragarh the Project was the major contributor, and the situation was more or less the same in the case of Tehri Garhwal, where three quarters of the contribution was made by the Project. Benefits enumerated by the beneficiaries were availability of clean drinking water and knowledge of sanitation; availability of water for irrigation; availability of a meeting place; saving in costs and a well laid down path that reduced the inconvenience of commuting.

Key Words : 1.WOMEN WELFARE 2.DRUDGERY 3.DRUDGERY REDUCTION 4.SWA-SHAKTI PROJECT.

34. Krishna, Sangeeta. (2002).
Changing perceptions of marriage, education and career among single women : a study of Varanasi. Varanasi : Banaras Hindu Univ., Faculty of Social Sciences, Centre for Women's Studies and Development. 89 p.

Abstract : Marriage choices are very much linked up with economic, demographic and cultural conditions. Today, the increasing incidence of singlehood among middle class women is explained by their economic independence. The objectives of the study were to ascertain the changing status of single women in urban areas and to examine how far they have been integrated into modern Indian society; what

sort of change has come into the lives of single women in the present social context; what is the nature and extent of change in their informal social relations; and what is the pattern and accommodation of acceptance in the social milieu, family, community and workplace. This inter-generational study includes the never-married single women between the age group 30 and above. For the present study, a small sample of 30 single working women from different colleges and departments of Banaras Hindu University have been taken. A study of changing attitudes towards these issues is very significant in finding out the changing social behaviour. The collected data reveals that out of 26 Hindu respondents most of them (86.7%) were from upper castes, 42.3% (11) belonged to Brahmin, 26.9% (7) from Kayastha, 11.5% (3) from Rajput, and 3.8% (1) were from Bhumihar and Kurmi caste each. About 23.2% women were found to be living in their own house, 26.6% in parental house, 13.3% in rented accommodation and 36.6% in allotted quarters. About 40% respondents were living in nuclear families, 20% in joint families, 3.3% in extended families, whereas 36.6% of them had no specific family pattern, and were either living all alone, or living with one of their parents. Education for single women was very important because it was only after acquiring education that they could get a job. Their minimum qualification was a post graduate degree, with 80% having doctorate degrees. Mothers of the respondents above 45 years were less educated than the mothers of respondents in the age group 30-45 years. In some cases, girls were unwilling to marry in the absence of a suitable partner of their choice, academic calibre and understanding, etc. Only 3.3% respondents from the older age group reported that she remained unmarried out of her choice. 6.6% respondents from older age group and 3.3% from the younger age group wanted to serve society. 3.3% respondents in the younger age group were sports persons and felt that they were misfits in society. These days girls do not consider marriage as the “major goal” or “end” of their life and they are finding many more options. About 30% young respondents remained unmarried because of their unwillingness to get married. Respondents approved the idea of compulsory education for women, and the reasons cited were to become economically independent and financially secure (99%), to make them aware and assertive about their rights (85%), to help in establishing self identity (77%), etc. Only 19.9%, 6.6% from 30-45 age group and 13.3% from above 45 age group approved of adoption. There is a need to treat single persons as part of the “mainstream or aggregates” and not as a “category” or “others”. Increments should be given to those working single women who have adopted children. Majority of single women suggested the opening of Old Age Homes for Single Women by voluntary organizations or the State. Media can play a significant role in negating the misconceptions, prejudices and bias against single women. Police needs to be reoriented in their thinking and provide security to single women. Above all, the most important aspect is the attitudinal change of society. These women expect society to be sensible, have good human values, and think in a far sighted way.

Key Words : 1.WOMEN WELFARE 2.SINGLE WOMEN 3.MARRIAGE 4.PERCEPTION OF MARRIAGE 5.CAREER 6.CAREER CONSCIOUS 7.WORKING WOMEN 8.VARANASI 9.UTTAR PRADESH.

35. Nirantar, New Delhi. (2005).
How has the Gujarat massacre affected minority women ? The survivors speak. New Delhi : Nirantar. 60 p.

Abstract : A six member team of women from Delhi, Bangalore, Tamil Nadu and Ahmedabad undertook a five day fact-finding mission from March 27 – March 31, 2002, to assess the impact of the continuing violence on minority women in Gujarat. The objectives of the fact-finding mission was to determine the nature and extent of the crimes against women; and find evidence of the role played by the police and other state institutions in protecting women. The team visited seven relief camps in both rural and urban areas (Ahmedabad, Kheda, Vadodara, Sabarkantha and Panchmahals districts). The fact finding team found compelling evidence of the most extreme form of sexual violence against women during the first few days of the carnage in Ahmedabad on February 28 and March 1, 2002. In the beginning there were 625 residents in the camp. About 35 attempted to return home but most of them came back to the camp. With the entire community under threat, women in particular were paying the price with their freedom and mobility being restricted. Mothers feared for the safety of their daughters. In many cases entire families have been killed. Women testified to having witnessed several members of their family dying. They were dealing not only with the trauma of this loss, but facing a future with their life's savings and livelihood sources destroyed. Adivasis who were involved in the violence were only misguided youth. Usually young boys were members of these groups. However, even in its worst moment, there remained in Gujarat isolated pockets of calm where the police and the administration stood firm, giving lie to the theory that the post-Godhra carnage was an unstoppable case of spontaneous communal combustion. The fact finding team found that the state had failed in its foremost responsibility of implementing International Human Rights norms and instruments. The pattern of violence did not indicate "spontaneous" action. There was pre-planning, organization, and precision in the targeting. There was compelling evidence of sexual violence against women. Among the women surviving in relief camps, some had suffered the most bestial forms of sexual violence – including rape, gang rape, mass rape, stripping, stuffing of objects into their body, and molestations. There was evidence of State and Police complicity in perpetuating crimes against women. The impact on women had been physical, economic and psychological. On all three fronts there was no evidence of State efforts to help them. Rural women in Gujarat have been affected by communal violence on this scale for the first time. One of the strategies proposed by the State Government to deal with the aftermath of violence in rural areas, is to set up Peace Committees that will engage in confidence building measures. Counselling should be provided immediately, even before registering the case. A comprehensive rehabilitation policy for rape victims and for their families needs to be announced urgently. Wherever necessary, the help of human

rights groups, women's rights groups and relevant UN Special Rapporteurs should be sought to examine the extent of violation of rights.

Key Words : 1.WOMEN WELFARE 2.RIOT AFFECTED WOMEN 3.GUJARAT RIOTS 4.MUSLIM WOMEN 5.VIOLENCE AGAINST WOMEN.

36. Rajasekhar, D. (2004).
Micro finance poverty alleviation and empowerment of women : a study of two NGOs from Andhra Pradesh and Karnataka. Bangalore : Institute for Social and Economic Change. 152 p.

Abstract : Micro- finance aims at providing the rural and urban poor, especially women, with savings, credit and insurance and aims to improve household income security. This study examined the economic and social benefits of micro- finance programmes implemented by two NGOs in Karnataka and Andhra Pradesh. In 1991, about 38% of the total population were workers in Kolar district, Karnataka. The proportion of workers in the total male population was 47.79%, while the proportion of females was 26.94%. Of the 881,514 workers; 48.71% were cultivators and 26.02% were agricultural labourers. The illiteracy level was high especially among women. The total credit flow from institutional agencies increased from Rs.102.18 crores in 1995-96 to Rs.147.18 crores in 1998-99. The achievement exceeded 100% in the case of crop loans and 200%-300% in case of horticulture and plantation during 1995-1997. Targets could not be achieved in the case of sericulture and animal husbandry. In 1972, under the World Bank Aided Project, Dairy Development Corporation was instrumental in initiating White Revolution in Southern Karnataka. In Andhra Pradesh, Krishna is one of the most prominent coastal districts. The total population of the district was 42.18 lakhs comprising 21.51 lakh males and 20.67 lakh females. The literacy rate for the district as a whole was 53.2%, excluding population in the 0-4 years age group. In 1991, 43.29% population was of workers and rest was of non - workers. These 'non-workers' in the age group of less than 15 years and more than 60 years have been shown as a separate category of others as the work participation tends to be low in these two age groups. Non-workers formed nearly 21% of the population while others formed 35.99%. The work force participation rate was low in the district in general. About 70% agricultural families maintained one or two milch animals for additional income. Similarities between the two districts were the geographical proximity and size. The dissimilarities were rainfall, which was more uneven and uncertain in Kokar district; irrigation facilities; occupational distribution; and banking network. Gram Vikas, an NGO working in Kolar district, has a goal of "empowering marginalized rural women" with special emphasis on children, natural resource management and networking with rural women's associations to accomplish sustainable development through food security. For children, important activities were providing nutritious food, non formal education, support towards

education and health care activities. Credit was available to women from savings fund, federation loans and credit from banks. In Krishna district, Sanghamitra, an NGO, has been working since 1985 in the area of poverty alleviation and empowerment of women. The contribution was by way of giving loans from the revolving credit fund built with the help of donor assistance. Under its Savings Programme, Lending Programme and Credit from Savings Fund were the activities undertaken. The rule formulated by Grama Vikas that households sending children to school would be accorded priority in the loan sanction was an attempt to translate the strategy of micro-finance as an instrument of poverty reduction into practice. The savings programme of Grama Vikas was larger than that of Sanghamitra. The micro-finance programmes undertaken by NGOs do provide access to credit for the poor, enable them to undertake income generation programmes, and contribute to higher recovery rates. Responsibilities such as development of economic infrastructure and providing bank finance to micro-finance groups must be undertaken by the Government, as only micro-finance programmes cannot alleviate poverty.

Key Words : 1.WOMEN WELFARE 2.MICRO-CREDIT 3.MICRO-FINANCE 4.POVERTY 5.POVERTY ALLEVIATION 6.SELF HELP GROUPS.

37. Singh, Manisha. (2002).
Mental health status of working middle-aged women : a study of school teachers of Varanasi City. Varanasi : Banaras Hindu Univ., Faculty of Social Sciences, Centre for Women's Studies and Development. 68 p.

Abstract : In Indian society, women are the nucleus of a family around which the members live their family life tied with forces of love, affection, and emotion. This study relates to working women who are in their middle age of life. The objectives of the present work were to assess the mental health of working middle aged women; to find out the psychosocial stress in this age group; to know about the general physical problems of women; evaluate the reasons of family tension of these lady teachers; compare the mental health status of women who were in menopausal phase with those who were in post-menopausal phase; and to study whether being a woman these teachers are satisfied with their life or lead a so called “happy life”. Data was collected on a sample of middle-aged lady school teachers of Varanasi City through interview schedules and questionnaires. About 94% subjects were Hindu and the remaining 4% were Muslims and 2% were Christians. Percentage of married subjects was 82% while 8% were unmarried. During middle age, 38% women reported fat gain; 32% tiredness and 22% weak eye sight as the major physical changes experienced. The reasons given for their mental problems were family (36%); and children’s education, employment, demands, marriage, etc (14%). Family income of 46% women was more than Rs. 20,000 p.m., whereas 32% had an income of nearly Rs. 10,000 per month. 82%

women were living in nuclear families. 50% women reported their family environment as good; 36% had average family environment, and 14% had bad family environment. It is natural to expect some change in physical beauty with increasing age, and it was seen that 86% subjects had a complex about their physical beauty in middle age, while 14% had no complex about it. 84% of the women studied had mental tension at their work place, while 16% felt no mental tension. 62% subjects were underestimated by the family as well as society. Comparison between coping styles and reasons for family tension revealed that 60% subjects adopted avoidance pattern of coping against family tension; 26% had approach coping, and 14% had cognitive behavioural coping. Nearly 46% teachers did not find any change in their husband's behaviour whereas 30% reported negative change in the behaviour and attitude of their husbands. 66% and 46% women had reported adjustment and insecure feelings at the time of their marriage. About 54% of the women were of the opinion that menopause caused physical problems, but only 24% actually faced any physical problem during menopause. It was interesting to note that 64% of these women were not satisfied being a woman; and only 36% were satisfied as a wife, mother or daughter. Psychosocial Stress Scale showed moderate to high level of stress in 54% subjects, 18% cases had low scores. Anxiety level was found to be low in 64% cases and moderate in 32% cases. Programmed interventions like meditation, relaxation and other sensitization programs, aiming at lifestyle changes and emphasis on wellness as personal choices, will change their attitudes, behaviour, quality of life, etc. Such programme interventions will provide enhancement of positive healthy habits, reduce stress and will add quality of life to their greying years. Essential care and some preventive steps, if not taken in middle age, may result in serious problems with the onset of old age.

Key Words : 1.WOMEN WELFARE 2.MENTAL HEALTH 3.WORKING WOMEN 4.STRESS 5.MENTAL STRESS 6.WOMEN'S HEALTH 7.GENERAL HEALTH QUESTIONNAIRE (GHQ) 8.PSYCHO-SOCIAL STRESS SCALE 9.ROLE CONFLICT 10.COPING BEHAVIOUR 11.SCALE STRESS 12.SCHOOL TEACHERS 13.STATUS OF WOMEN 14.TEACHERS 15.VARANASI 16.UTTAR PRADESH.

38. Tandon, Jannavi, Mishra, R. N. and Saxena, H C. (1997).
Impact study of Rashtriya Mahila Kosh credit facilities to poor women through non-governmental organisations. Varanasi : Banaras Hindu Univ., Faculty of Social Sciences, Centre for Women's Studies and Development. 100 p.

Abstract : Non-availability of credit has been a critical constraint in the efforts of poor women of our country to achieve economic self reliance. The major objective of the Kosh was to promote or undertake provision of credit as an instrument of socio-economic change for the development of women. The objectives of this study

were to see the working of NGOs in relation to credit loans and their respective policies and procedures; to study the socio-economic and demographic profile of women applying for loans; to study the repayment schedules; and to solicit their views regarding the entire loan system. The study investigated the total impact of the loan distributed from two NGO centres. The work area of the NGOs was scattered and covered almost the entire state. Adithi, Patna, Bihar covered Muzzaffarpur, Vaishali and Sitamarhi, while Shramik Bharti at Kanpur covered the whole of Kanpur. Adithi took up credit based activity since 1989. At first the activity was only for empowerement of women and dissemination of information. But later Adithi started the empowerment of women below the poverty line through livelihood and income generation programmes by forming self sustainable groups. Loans were given by Adithi only for productive purposes and not for consumable items. After disbursement of loans, meetings were conducted to assess the scheduled programmes, and calculate the marginal loss or profit likely to accrue. The NGO instituted monthly meetings as a rule, which were followed very consciously by majority of the groups. It was observed that most of the women members did not need to be called repeatedly for meetings. In Bihar, 80% of the total groups have collected and deposited cash in their group accounts in banks. More women in U.P. (28.8%) compared to Bihar (15.5%) were of the age group 45 years and above. 48.8% women in U.P. compared to 41.41% in Bihar were illiterate. Significantly, more women (64.8%) in U.P. compared to 39.7% in Bihar were without any land owned by their families. Housing condition of around 50% women was not satisfactory in both the states. Majority of the women in Bihar (60.4%) as against 7.0% in U.P. took loans for starting cottage industries. Women in Bihar (91.4%) were more knowledgeable about RMK than women in U.P. (56.8%). About 62.4% women in U.P. compared to 37.9% women in Bihar felt that the amount of loan sanctioned was insufficient for the purpose. For marketing their goods, 98.4% women of U.P compared to 56.9% women of Bihar did not receive assistance from NGOs. Utilization of loan by self in the agriculture sector was 66.7% for women of U.P as against none in Bihar. Minor conflicts within the groups regarding conflicting personal views and interests were solved smoothly. Women felt that the loan amount should be increased and they should be assisted in marketing their goods.

Key Words : 1.WOMEN WELFARE 2.RASHTRIYA MAHILA KOSH 3.GROUP LEADERS 4.CREDIT FOR WOMEN 5.LOANS FOR WOMEN 6.NGO 7.ROLE OF VOLUNTARY ORGANIZATION 8.GROUP FORMATION 9.UTTAR PRADESH 10.BIHAR.

39. Vasudevan, Sulochana and Sahai, Ragini. (2005).
On wings of change taking women upward : an Indian experiment. New Delhi : India, Ministry of Human Resource Development, Department of Women and Child Development, Swa-Shakti Project. 89 p.

Abstract : Demand for micro credit in India has grown phenomenally, and India is the largest emerging market for micro credit in the world. Approximately 75 million households are estimated to require micro finance. Of these nearly 60 million

households are in rural India and the remaining 15 million are urban slum dwellers. The Swa-Shakti Project was launched by DWCD, Government of India in April 1999. The overall objective of the Project was to bring about socio-economic advancement among rural poor women in the Project areas and strengthen processes that promote economic development of women and enable an environment for social change. The activities undertaken by the project were capacity building of women's groups and implementing agencies, both government and NGOs; access to credit and inputs for starting feasible on farm and off farm income generating activities; access to information on health and nutrition; awareness generation regarding legal rights; drudgery reduction and creation of community assets; and promoting sustainable SHG clusters and federations. More than 6,000 Self Help Groups (SHGs) were promoted even before the Mid-Term Review. The SHGs were able to leverage community as well as government support, and gain recognition from informal groups and opinion makers as a village level institution in their own right. One of the innovations introduced by Swa-Shakti in 2002 was the business counseling centres (BCC), which provide assistance to rural women entrepreneurs. In Madhya Pradesh, a collaboration with the private sector industry generated substantial benefits to the SHGs in Tikamgarh and other districts. The States of Uttaranchal, Jharkhand and Chattisgarh, which were new states formed while the Swa-Shakti Project was already underway, also formed SHG clusters. The benefits received under the various schemes have been sanitation, drinking water, smokeless chulahs, electricity, biogas, dwelling units, etc. The women in a Swa-Shakti Project in Haryana wanted to set up a centre, a multipurpose hall where they could hold regular meetings and conduct their training sessions. A child care centre for children of weaker sections was established in Sardulla village in Ranchi district, in which 35 children were enrolled, with preference being given to children of SHG members. In UP, two schools have been repaired benefiting two villages and 14 SHGs; 35 hand pumps and platforms have been constructed. In Jaunpur district of UP, anti-dowry campaign was launched; and a *safai abhiyan* (cleanliness campaign) was undertaken in Mainpuri, U.P. The project was regularly supervised by World Bank members consisting of Task Leader and subject specialists. In the seven years that Swa-Shakti has been implemented, it has covered a wide spectrum of processes to fulfill its objective of empowering women. The special initiatives under the project were tele-conferencing, a collage of joyful learning activities, *Haat* (local bazaar), interventions in tribal areas, campaigns against witch craft, *Kishori Panchayat* fostering leaders for tomorrow, action research on Musahar Community, etc. Swa-Shakti experience was the recognition of the importance and usefulness of diverse specialist partners with clearly focused roles and responsibilities, formal and informal networks that facilitated communication and accumulation of capacities. Unless such specialists are involved, the sustainability of SHGs as a viable entity would remain a question mark.

Key Words : 1.WOMEN WELFARE 2.SWA-SHAKTI 3.SWA-SHAKTI PROJECT 4.EVALUATION OF SWA-SHAKTI 5.EMPOWERMENT WOMEN 6.SELF HELP GROUPS.

40. Vijaya Kumar, S. (1995).
Widows in countryside : problems and prospects, Andhra Pradesh. Hyderabad : Council for Social Development, Hyderabad. 160 p.

Abstract : An overwhelming majority of women in rural areas are engage in the unorganized sector. Among women, the incidence of widowhood is much higher compared to that of men (widowers). In this study, special attention was focussed on the issue of social security available to widows from Government Schemes, familial and other informal sources. The primary aim of this study was to examine the socio-psychological, economic and social network aspects. Education is an important factor determining the status of women in society. The study was conducted in rural areas of Andhra Pradesh. About 56.4% respondents were illiterates and 16% could read and write. Present study indicates that almost all women had left their parental home, and even after they lost their husbands, a majority still lived in their husband's home. About 26.2% households were headed by widows themselves. Majority of respondents (82.7%) got married at the age of 20-39 years. 52.9% widows were of the opinion that widows should not remarry and in this category, majority (53.7%) were from the upper castes. About 32% were sending their children to school before their husband's demise, and only 22.7% reported that their children's education was not disturbed. Nearly 32.9% were engaged as wage labourers in agricultural work, and 20.4% in waged non-agricultural work; 10.2% were self employed and only 4% were working as domestic help. Out of the total sample, 66.6% had an income below Rs. 3,000 per year and 6.2% were earning more than Rs. 3000 per year. About 27.2% were not having any income. Only 38.9% widows said that they got their deceased husband's share of assets. About 70.7% settled the issue of sharing assets with the help of Caste Council or elders of the village, and the remaining 25.9% approached the Courts to get their entitlement. Around 92.9% widows encountered economic problems; 24% were getting help in the form of kind; 2.7% received cash, and 15.1% received both, kind and cash. Only 18.2% widows were getting regular help. Though a majority of the widows were aware of development programmes, only 34.7% applied for aid under the different programmes. 30.2% widows were having a ration card in their name. About 92% widows were aware of Widow Pension Scheme and 65.7% had applied for it. In some cases, money lenders started harassing the widows to either repay the loan immediately or to handover the land they possessed. As a social security measure, the State must take necessary steps to protect the 'living standards' of widows. A separate legal cell should be established with certain constitutional privileges to look into the specific issues related to widows. To start their own business, financial and technical assistance must be routed to widows through rural banks. All widows should be educated so that they can think critically and fight for their rights. Involvement of women in Panchayati Raj system will help in improving their socio-economic status. While implementing welfare measures and social security packages for widows, it is better to adopt a decentralized system by identifying the local conditions.

Key Words : 1.WOMEN WELFARE 2.WIDOWS 3.RURAL AREAS 4.WIDOWS RURAL AREAS.