# A CRITICAL EVALUATION OF SOCIAL WELFARE POLICIES IN JAMMU AND KASHMIR : WITH SPEACIAL REFRENCE TO CHILD AND WOMEN'S DEVELOPMENT PROGRAMME

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*By*
**GH. NABI ITOO**

CENTER FOR THE STUDY OF SOCIAL SYSTEMS
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067
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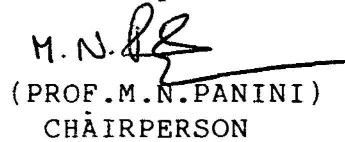
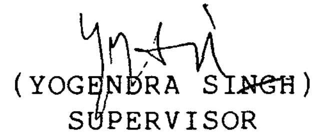
जवाहरलाल नेहरू विश्वविद्यालय
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110067

CENTRE FOR THE STUDY OF SOCIAL SYSTEMS
SCHOOL OF SOCIAL SCIENCES

## CERTIFICATE

Certified that the dissertation entitled, "A Critical Evaluation of Social Welfare Policies in Jammu and Kashmir : With Special Reference to Child and Women's Development Programme", which is being submitted by Gh.Nabi Itoo for the award of Degree of Master of Philosophy is his original work and may be placed before the examiner for evaluation. This dissertation has not been submitted for the award of any other degree of this university or of any other university.





(PROF.M.N.PANINI)
CHAIRPERSON

(YOGENDRA SINGH)
SUPERVISOR

GRAM : JAYENU TEL. : 667676, 667557 TELEX : 031-73167 JNU IN

"**DEDICATED**
TO
THE
MEMORY
OF
MY
DECEASED
PARENTS;

ESPECIALLY

TO

***MY BELOVED MOTHER***

WHO LEFT ME DURING THE INFANCY OF MY CAREER

AND WHO HAD A HIGH DREAM OF MY SCHOLARLY LIFE.

ALAS! ...LIFE DID NOT FAVOUR HER

TO SHARE THIS DREAM WITH ME."

**Dedicated** To

***Mr. SHER ALI BODHA***

Who persuaded my quest for higher studies and enlightened me from time to time with thought provoking ideas, which acted as a beacon-light in my career-building.

**Dedicated** To

***All My Family Members***

Who left no stone unturned to satisfy me in every respect and sacrificed both financially and sentimentally for the attainment of my present position. Lack of Words leave me handicapped to express how much I missed them during my stay outside the home.

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# Chapter-I

# INTRODUCTION

The concept of social welfare has undergone a tremendous change over a considerable period of time and has come to cover the total grant of social and developmental activities and has no longer restricted its scope and extent for providing succour to some specific segments of society. The concept of social welfare is dynamic. The social welfare activities are therefore integrated into our developmental thinking and now cover the whole spectrum of services and institutions which are engaged and involved in the provision of services for the total upliftment of the community and for the welfare of the society. In this backdrop it is of utmost importance to ensure a proper awareness among the masses about the concept of the social welfare, its changing connotations, its widening dimensions and immense and supreme importance in building up a balanced social structure in which all sections of society can equally partake of the benefits of general developmental programmes and measures. As a matter of fact, social welfare constitutes an integral component of all national developmental programmes envisaged in the Directive Principles of State Policy enshrined in the Constitution with a view to provide a welfare state.

**Definition**

Having touched upon the idea behind social welfare measures, it is essential now to define the concept of social welfare:

i) According to the Dictionary of Social Sciences, "on the utilization point of view individual welfare, is in principle measurable and social welfare is simply the sum of the welfare of all individuals."

ii) According to K.S. Shukla,[1] "Social welfare refers to those services which are designed for those weaker and vulnerable sections of community, who due to some handicap -- social, economic, physical, mental etc. are unable to make use of these services."

The operational part of this definition can be seen as the services relating to children, youth, women, aged and infirm handicapped persons, Scheduled Castes and Scheduled Tribes, community welfare services, social defence, social welfare measures and social welfare services for other weaker sections of the society.

iii) According to M.N. Zald,[2] "Social welfare institutions are the patterned collection of positions and organizations whose primary manifest purpose is to restore and/or maintain members of the community at a minimum level of personal and

social functioning."

In view of the prevailing trend of social welfare services in India, the definition of Shankar Pathak,[3] is more useful, "Social welfare may be defined as the organized provisions of resources and services by the society to deal with the social problems. These services may be provided by the state or voluntary organizations, with a view to ameliorating the conditions of the people affected by the problems as well as to protect others who are likely to be affected in the future."

In the light of above definitions, it can be argued that the social welfare refers to the helping of individuals or groups who, for one reason or another, are needy that is those who are unable to attain a defined minimum level of functioning by their own efforts or the efforts of their family or friends. "In nutshell, social welfare can be said to be the exploitation of organized resources and measures, for the benefit of weaker sections of the society." These measures include all economic, social and even political which promote the welfare of the society, particularly the weaker sections.

The emergence of the modern system of social welfare has been rife with controversy. Competitive philosophies of the nature of man and the good society have offered

alternative approaches to welfare organization and welfare services.

## Social Welfare Models

Let us now turn to the models of social welfare, evolved in different societies. Richard Titmuss[4] has advanced three models of social policy which summarize the pre-dominant items of contents and approaches of social policy in the free world. These are:

**(a) Residual Welfare Model**

In this model, the individual is viewed as the most important unit and instrument of his own welfare. It assumes that there are ample opportunities available to each individual which he can utilize for achieving his potential. The cause for any failure, therefore, lies with the individual himself and not with the opportunity structure or the institutions monitoring the social and economic process in society. According to this model, in order to make the distressed individuals self-reliant, a temporary help is needed. This leads us to argue that most of the western countries and especially United States, have adopted this model of social policy.

**(b) Achievement Performance Model**

This model considers the social needs to be met on the basis of merit, achieved status differentials, work performance and productivity. Consequently, the community should consider the larger financial and technical resources, and should promote social and welfare services. However, the beneficiaries should pay for these services like any other services in the market. Thus the availability of the services depends upon the position of payment. Those with ample resources can use these services to the maximum limit. There are many mechanisms through which one's ability to pay is enhanced. The important, as Titmuss points out, are occupational and fiscal welfare schemes available particularly to those who are favourably located in job structure and in respect to the ownership of their sources.

**(c) Institutional Redistribution Model**

This model is based on idea of social justice and confirms the right of an individual to obtain the basic social and welfare services, without any consideration of payment. Thus the important aspect of this model is that services under this model are universally provided, irrespective of income, education, and caste status of the beneficiaries. The provision of these services to the citizenry is considered an essential function of the state. Under this model, services are also provided on a selective

basis, particularly to the groups which need special care. Since these services are provided without any social or economic criteria defining eligibility, they do not carry any stigma against the recipients. Further, since these services are also available to the weaker or disadvantaged sections of the population, they tend to work as counter-measures against disruptive forces of change and thus tend to contribute towards stability and equilibrium in the social system.

In the backdrop of above models, we see that both at all India level and at the level of the State of Jammu & Kashmir, the Institutional Redistributional Model of Social Welfare has been followed.

## Social Welfare in India

In India, state participation in social welfre has a long and continuous history extending over hundreds of years. The right of the indigent to receive succour is recognized in society dating back to the Vedic period. The responsibility of society towards individuals in distress and the groups in need was shared equally by the community and the rulers. The giving of alms and the feeding and care of destitutes were acts of religious merit. The kings and chiefs were enjoined to provide free kitchens during fam-

ines.

Besides this religious emphasis leading to individual actions of charity, the social institutions like joint family, caste provided for mechanisms which would help to meet the needs of the old, the sick and the otherwise helpless sections of the community.

The source of state sponsored welfare activity was mainly religious. This can be illustrated by the fact that the Muslim rulers who were dominant in the 13th and 14th centuries onwards were inspired by the same spirit and established the services in the field of religion and education. This is born out of the existence of `*zakat*' (payment of 2.5% of one's income for charitable purposes), building of mosques with schools and the classical example of Ferozeshah Tuglak who established Dewani-Khairat for the performance of marriages of the poor and hospitals for the relief of the sick and affiliated. In addition to this there were destitute homes connected with temples, rendering the same services.

Under the British rule (17th and 18th centuries), no substantial efforts seem to have been made for looking after the social needs of the community at large. But the penetration of new thinking to bring social reforms in the Hindu social structure cannot be undermined. The Christian

missionaries attacked child marriage, polygamy and female infanticide and worked for the abolition of *sati*. They argued in favour of widow re-marriage and agitated against practices of human torture in worship.

India in the 20th century has been actually passing through a transition from social reforms to social welfare. The dawn of independence in 1947 witnessed the beginning of an era of intensive developmental activity in India. The aim was to improve the economic and social conditions of the masses and to secure a social and economic order based upon the values of freedom and democracy in which "Justice" - social, economic and political - shall inform all the institutions of national life. The idea of a welfare state is fully defined in Art.41 of the Constitution of India, which propagates: "The State shall, within the limits of its economic capacity, strive to promote the welfare by securing and protecting as effectively as possible a social order in which there will be justice - social, economic and political." It gave special protection to children, youth, women etc. and made provisions for securing human conditions of work, maternity relief and special care of weaker sections of the society. With a view to provide opportunities of development of countryside a scheme of community development was launched in 1952. This was followed by another scheme of Welfare Extension projects sponsored by the Central

Social Welfare Board (CSWB) through which welfare services were provided to women and children in rural areas by non-official committee.

Eversince the inception of First Five Year Plan, the welfare services in India have improved vastly. These vast improvements may be attributed to the special organization, namely the Central Social Welfare Board which was set up during August 1953 to assist in the improvement and the development of social welfare activities in the country.

One of the most significant trends in social welfare during the past forty years has been the increasing responsibility the State has assumed in promoting the well-being of the weaker sections of the community. This can be understood from the increasing allocations for social services in the successive five year plans. The provision made for social services was Rs.531 crores (about 14% of the total outlay), Rs.850 crores (18%) and about Rs.1,300 crores (19%) respectively. Similarly, the provision made for social welfare in the three five year plans was Rs.5 crores (1% of the total outlay for social services), Rs.19 crores (2.2%) and Rs.31 crores (2.3%) respectively. The amount for social services kept on increasing and reached to Rs.2,052.62 crores for 1989-90 only. This, however, does not include the provision made by the state governments outside the plan for development of social welfare activi-

ties in their respective regions.

## Social Welfare in Jammu & Kashmir

While the central government set up a Central Social Welfare Board fairly early during this period, most state governments established social welfare departments or directorates, as also Social Welfare Advisory Boards, and entrusted to them increasing functions. Side by side, the State evolved a substantial grant in aid to voluntary organizations. In Jammu & Kashmir this provision came into force during July 1970 and since then various voluntary non-official organizations, who are engaged in social welfare, are getting grant in aid.

The central government executes it through the agency of the Central Social Welfare Board and the J&K government through the State Social Welfare Advisory Board. This programme has brought into the fold 6,000 institutions, and has proved a useful instrument for the promotion of social welfare activities by the voluntary organizations on a systematic basis. The J&K State government has also gone far beyond what they ever attempted before in this respect.

Another significant development in J&K is the recognition of the role of voluntary organizations and voluntary workers and the partial encouragement afforded to

them yet another feature was the planned development of welfare services in rural areas which released great deal of potential energy and created feeling of hopeful participation.

## Social Legislation and Social Welfare

With the social welfare programmes coming increasingly within the purview of the state, the central government has facilitated their successful implementation by enacting appropriate legislations. The important ones are Immoral Traffic in Women & Girls Act (1956), the Probation of Offenders Act (1958), the Orphanage and other Charitable Institutions (Suppression & Control) Act 1960 and the Children's Act 1960. These Acts not only aim at tackling some of the existing social evils and problems, but are also designed to ensure uniformity in the various remedial measures. At the same time, in view of the fact that conditions differ from state to state, rule-making power under these Acts have been vested in the state governments. The J&K did in past adopt such legislations, but the laws often remained unforced. There is now growing emphasis on their effective implementation, and care is taken to provide adequate administrative machinery for this purpose. How far these measures have produced the fruitful results, will be assessed in the coming discussions.

Thus the above discussion leads us to argue that both at all India level and at the level of the State of J&K the Institutional Redistributional model of social welfare has been followed. This is obvious from the fact that the provision of these services is included in the Directive Principles and as an integrated part of the developmental plans. There has been increasing allocations in successive plans for social services regarding the welfare of masses, in order to establish an egalitarian social system. Besides this, the services have been institutionalized on selective basis for the vulnerable groups like children, women, Scheduled Castes, Scheduled Tribes and the handicapped. The government has established a guild of official and non-official organizations to take these services to the doors of the weaker sections. While providing social services there is no consideration of religion, caste, class etc. otherwise the services are provided on a universal basis. The government feels imperative on its part to provide such services in order to protect these sections of the society against the customary denial and exploitation. Welfare is considered as an investment in order to make the all round development - social, economic and political - a surety.

## Role of International Agencies

Surveying the scene of welfare services in India, one comes across several international welfare agencies working in different fields of welfare in different parts.

Some of the more important of international welfare organizations to take up work in India have been the Red Cross, the Y.M.C.A. and the Y.W.C.A., but these organizations are now working in India through their national organizations, which are autonomous in all important matters.

After the first World War, the League of Nations had initiated certain international organizations, which also found their way in India. The most important of these is the International Labour Organization (I.L.O.), which has steadfastly continued to serve the cause of labourers in India through the vicissitudes of the two world wars. Today I.L.O. is one of the specialized agencies of the United Nations organizations. This status it has acquired by a special treaty with U.N.O.

This brings us to another category of international organizations that have initiated, sponsored or aided valuable welfare programmes in India. Chief amongst those which have contributed to the welfare programmes in India at

national level and state level in J&K, are the United Nations International Children's Emergency Fund (UNICEF), the World Health Organization (WHO), The United Nations Educational Scientific and Cultural Organization (UNESCO), and the Food and Agriculture Organization (F.A.O.).

Amongst these organizations mention must be made of UNICEF, which has played a pre-dominant role in India.

UNICEF completed 43 years of its services in India since its inception in 1949 with the distribution of milk powder among the children. During the years 1949-92, the role of UNICEF has undergone several changes. At the initial stages there was programme for supplementing nutrition for children upto 5 years of age, pregnant women and tactant mothers. In 1959 an agreement was signed by the Government of India, UNICEF, FAO and WHO in regard to its implmentation of extended Nutrition programmes. According to this programme, food was distributed among the target groups through Mahila Mandals. In February 1963, the Government of India, UNICEF and WHO formulated a bigger nutrition programme known as 'Applied Nutrition Programme (ANP)'. In this programme, besides the earlier provisions, there was a provision of training to impart knowledge about applied nutrition and health services to the children and pregnant mothers.

Now, it is essential here to discuss about the role of UNICEF in recent years (1974-92) UNICEF's priority target group in India, i.e. children under six years of age totals upto more than 120 million (1980). The common objectives of the organization and India's current national development plans are the psychological, physical and social development of these pre-school children in the disadvantaged areas -- backward rural towns to help to achieve these goals UNICEF in 1974 projected five years of assistance in the form of 'single integrated country programme' closely linked to India's Five Year Plan 1974-79 with a commitment of $ 61,405,000.

UNICEF in collaboration with UNESCO is going to launch a programme about education in nine developing countries including, India and Pakistan. This will be a future trend of the role of U.N. in India. A new scheme is being co-sponsored by UNICEF that would support and strengthen voluntary organizations, already engaged in welfare, and development of street children, to enable them to reach out a large number of such children in 13 metripolitan cities of India. 90% of the cost of the project would be provided by the central government and UNICEF and remaining 10% borne by the non-governmental organizations. The scheme will be implemented with the help of a city level task force.[5]

## Scope of the Study

In the preceding introductory discussions, we have briefly dealt with the conceptual issues (definition, models) concerning the problem of social welfare. In addition, we have given historical background of the social welfare programmes in India at the national level and at the J&K State level. The role of international agencies is also considered in this connection.

After the above discussion it is essential now to focus on the issues this study stands for. One of the significant developments in J&K since independence is the recognition of a planned development of welfare services in the state, which released great deal of potential energy and created a feeling of hopeful participation, but only to a limited circle. This is due to the fact that when the government initiated and sponsored the welfare schemes in the state, the weakers sections of the community did not become active participants and did not adopt them, as it was hoped. This can be attributed to two factors. Firstly, the models of welfare schemes were new and alien to them and adopted without any modifications according to the local social structure. Secondly, before introducing these schemes, no effort was launched to generate a new consciousness about the perception and benefits of the schemes. This created a visible gap between targets and achievement.

In the light of above facts, the present study will try to answer the questions:

(a) How far are the alien models of welfare responsible for limited success and what is the maximum possibility of success, if these are modified according to the local social structure?

(b) Second, the organization of welfare activities and their nature in relation to the local conditions?

(c) The most important issue is to find out that to what extent is the nature of the social structure responsible for the limited success and the necessary conditions to be created for the success of these welfare programmes in a traditional society like Kashmir.

Having done this, we feel it necessary, now to make our study more focussed. Consequently, we turn our attention to the State of J&K to which we have dealt briefly in the introduction. This study would be useful as no systematic and organized study has been conducted on the social welfare programmes in Jammu & Kashmir. More particularly, the approach adopted in this study has been to study the social welfare programmes in relation to the social structure both at macro and micro level. Some specific aspects of the J&K situation have been discussed in the following chapters.

Different chapters in this study deal with a variety of issues concerning the welfare policies in J&K. Chapter II attempts to characterize the nature and the organization of social welfare services in J&K. From the delineation of roles (played by official and non-official organizations) it would be clear that the roles are only complementary and are not substitutes to one another.

Chapter III on the problems of women in J&K and welfare policies will look into the status of women from ancient to the modern times. Besides we shall attempt to study the customary practices that have gradually come into society and their role in determining the status of women. An attempt will be made to study the impact of the welfare policies to improve the lot of womenfolk in the State.

Chapter IV will continue the analytical, critical and descriptive survey of various welfare programmes employed for children in J&K and their relative success or otherwise in dealing with various problems that the children have been facing from time to time. It would also refer to some of the serious problems that emerged as a result of local social structure, leading to the unsatisfactory performance and coverage of welfare policies.

Chapter V will sum up the main conclusions of the study. In this chapter an attempt will be made to compare

positive and negative aspects of the welfare policies and a critical evaluation vis-a-vis the social structure. But one fact to be noted remains, that from the nature of welfare policies about children and women, it would be difficult to make a sharp distinction between social welfare programmes and those for economic development. They subserve the same identical purpose of improving the quality of life. Any marked lag between the two creates new stresses and problems.

## Method of the Study

In the preparation of this study an attempt has been made to make use of both primary as well as secondary sources that could be available. These include published and unpublished documents and other material like reports, resolutions, declarations, speeches and information brochures etc. about social welfare schemes regarding women and children and their subsidiary organs and other affiliated bodies, information gathered from interviews with concerned officials and other informed persons from inside or outside the Social Welfare Deptt. of Jammu & Kashmir and other bodies, government documents, official statements and reports, books, newspaper reports, articles and reference material.

**Notes & References**


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2. M.N. Zald, Social Welfare Institutions, New York: Willey Press, 1965, Introduction, p.3.

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## Chapter II

## ORGANIZATION AND NATURE OF SOCIAL WELFARE PROGRAMMES

Mankind has now reached a stage of political development when it has become the manifest concern of every State to proclaim that it stands for achieving the welfare of the citizens irrespective of creed, colour, sex or religion. Keeping in view this fact, planning for social work and welfare thus becomes a continuous process and has, at each stage, to take into consideration the current ideational climate of the people and the time spirit of the era or generation to which it must closely be related.[1]

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With the increasing professionalism and specialism, the concept and dimensions of welfare, which appeared to have been enmeshed with traditional social systems, also got affected. Consequently, the sentiments of personalized welfare started sliding back in the human mind and this paved way for new rationalizations, structures and functionings of social welfare.

### Social Welfare Administration at National Level

In a traditional society like India, welfarism appeared to be a part of overall social dynamics. In the contemporary era, the process and pace of development seems to have

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had an impact on the welfare dimensions. As a consequence, social welfare which continued to be an informal and voluntary process is gradually getting transformed more into a formal system official and voluntary. As a result of the continued decades of planned development, social welfare as a plain component has acquired great significance. This can be assessed by the evidence of its widening interface with government and increasing participation by voluntary agencies. Therefore forming a joint guild to carry on welfare services indifferent parts of India.

After the above discussions, let us now turn to what the social welfare administration stands for. Different people define it differently but some sort of generality is found as it refers to the process of applying professional standards competence and resources to ensure successful implementation of the targetted programmes of social welfare through various social agencies, i.e. official and voluntary -- for the fulfilment of the ideals, goals and aspirations.[2]

The subject of welfare is under the State list in the Constitution of India. Accordingly there are organizations for welfare at the union level as well as at the State levels. The initial organized effort towards the creation of organization for welfare was the establishment of Department of Social security which was recommended by the Renka

Ray Committee which submitted its report in 1960. The department was redesigned as Department of Social Welfare in the year 1966 which constituted a Ministry in 1971 and known as Ministry of Education and Social Welfare which was reconstituted in the year 1979 and became as the Ministry of Social and Women Welfare in the year 1989.

Over the years, the creation of the Ministry of Welfare has focussed attention on the issues relating to the welfare of various sectors, e.g. Scheduled Castes and Scheduled Tribes (SC/ST), Handicapped and more particularly women and children are being handled by the Ministry of Welfare (Department of Women and Child Welfare was part of the Ministry of Human Resources Development between 1985-1990 and was transferred to the Ministry of Welfare in the year 1990 with an independent secretary). The Ministry of Welfare is the *nodal* Ministry of overall policy planning and co-ordination of programmes of development for various sectors requiring development inputs.

The department has two broader divisions: (a) one headed by the Secretary, Welfare; (b) The other headed by the Secretary, Women and Child Welfare. The Department has seven wings catering to various aspects of welfare and department of the various sectors of society.

The Secretary, Departmeent of Women and Child Welfare

is assisted by the two joint secretaries to the Government of India. In each wing there are Directors, Deputy Secretaries, Under Secretaries, Joint Directors and other officials to handle the task relating to the specified wing of the Ministry.

**Nature of Welfare Services at National level**

It is now imperative on our part to deal with the nature of welfare services at national level. Traditionally the area of social welfare concerned itself with the protective, curative and rehabilitative services upto the close of Fourth Five Year Plan, most of the programmes were curative and rehabilitative in nature. But from the Fifth Five Year Plan onwards, the development dimensions of vulnerable sections assumed importance. Programmes of welfare as envisaged in each plan, are designed eventually to supplement the longer effort of human resources development. The emphasis is on the development of those sections of the society who were suffering from one or the other kind of handicap. Each five year plan has been designed to improve the quality of life and to cater special needs of the vulnerable sections, particularly, that of women and children, through organized and sustained development activities. Besides, the due consideration from the government, called upon the increasing allocation in successive five year plans. This can be very well understood by the following

discussions.

Due to the variety of social pressures, the aftermath of independence and interaction of the planning process from 1950 onwards, formal departments of social welfare have started appearing on the Indian Social scene. Each five year plan had a separate allocation of budget for social welfare. This can be seen in the light of figures available in the Table 1. According to this table ever since from the First Five Year Plan there have been increase in the outlay and expenditure in both centre and state levels, e.g. while as the outlay (under central sector) during 1951-52 to 1955-56 was Rs.4.00 crores as outlay and 1.60 crores expenditure. This has raised to Rs.799.97 crores and state outlay as Rs.191.8 crores during 1985-86, 1989-90. Thus these figures show an increasing trend in the outlay and expenditure in social welfare sector.

## Table 1

### Outlays & Expenditure in Social Welfare Sector in Five Year Plans

| Plan | Centre | | States | | Union Territories | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Outlay | Expenditure | Outlay | Expenditure | Outlay | Expenditure | Outlay | Expenditure |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| I Plan 1951-52 to 1955-56 | 4.00 | 1.60 | - | - | - | - | 4.00 | 1.60 |
| II Plan 1956-61 | 12.00 | 8.49 | 7.00[a] | 4.95[a] | a | a | 19.00 | 13.44 |
| III Plan 1961-66 | 19.00 | 12.84 | 11.05 | 5.63 | 1.21 | 0.93 | 31.26 | 19.40 |
| Annual Plans 1966-67-1968-69 | 8.51 | 7.76 | 4.18 | 3.20 | 0.79 | 0.60 | 13.48 | 11.56 |
| IV Plan 1969-74 | 80.96 | 65.71 | 11.07 | 9.36 | 0.91 | 1.43 | 92.94 | 76.50 |
| V Plan 1974-79[a] | 63.53 | 43.55 | 19.50 | 13.63 | 3.14 | 1.71 | 86.17 | 58.89 |
| VI Plan 1980-85 | 150.00 | 225.91 | 109.78 | 138.44[c] | 12.19 | 16.14[c] | 271.97[c] | 410.49 |

Note: An outlay of only Rs.29.43 crores was initially provided in fourth plan for central and centrally sponsored schemes under social welfare sector. In 1970-71, the special nutrition programme was introduced in non-plan with a budget provision of Rs.4.00 crores. Since this is a development programme, from 1971-72 it was included in the plan and an outlay of Rs.10.00 crores was provided in1971-72, Rs.20.00 crores for 1972-73 and Rs.17.53 crores in 1973-74. Therefore all allocations of Rs.4.00 crores for the special nutrition programme in 1970-71 has been also shown in the above figures.

(a) Cols (4) & (5) includes figures for Union Territories.
(b) The V Plan was terminated in 1977-78, i.e. one year before its normal term of 5 years.
(c) Includes anticipated expenditure of 1983-84 and outlay of 1984-85 in the state sector.

Source: (i) VII Five Year Plan, 1985-90, Vol.II, Planning Commission, Govt. of India, 1985, pp.317-318.
(ii) Ministry of Social & Weomen's Welfare, Govt. of India, Data Publishedin A Handbook of Social Welfare Statistics, 1986, New Delhi.

## Social Welfare Programmes & their Nature in Jammu & Kashmir

Before I come to the social welfare organization in J&K, it is essential to have a general understanding of social welfare administration at the state level. Like the Ministry of Welfare in the union governmeent, the Departments of Women and Child, Backward Classes are operating in the States which function as nodal departments in regard to the development of various sectors of the weaker sections. In addition the Ministries having a sectoral concern for the weaker sections have a cell which oversee the developmental work relating to various weaker sections.

**Organizational Structure at State level**

In J&K, the functioning of the social welfare sector could broadly be divided into two areas: (a) The creation of Secretariat of Social Welfare; (b) Establishment of Directorate of Social Welfare.

In J&K the Secretary, Welfare holds concurrent charge of another Ministry (Education). There is one Secretary for SC, ST, Backward Classes, women and child development. The Secretariat holds the responsibility of formulating the policy for the welfare and development of concerned weaker sections. The Secretary who is assisted by Joint Secretaries, Deputy Secretary and Under Secretaries in additon to other technical staff.

While as Children's Board in India was established on 3 December 1974, with Prime Minister as Chairman, consequently, in J&K the Board constituted under the Chairmanship of Chief Minister. This Board was reconstituted on 7th December 1983 and presently consists of 13 members and the Chief Minister as the Chairman. The State Social Welfare Advisory Board comprised of 18 non-officials and 3 officials.[3]

There is a Director of Social Welfare in general for SC, ST, and Backward Classes and women and child development. Besides, there are Additional Directors, Joint Directors, Deputy Directors and Assistant Directors, to assist the Director.

**CHART I**

**Social Welfare Organization in Jammu & Kashmir**

Secretary (Concurrent Charge)

Incharge of the policy formulation for SC, ST, Backward Classes, Women & Child Development

Directorate Level

Director Social Welfare (at State level)

Incharge for the implementation of welfare policies for SC, ST, Backward Classes, Women & Children

Regional Level

Social Welfare Deputy Director Incharge

Welfare for SC, ST, Backward Classes, Women & Children (General Welfare)

ICDS, Deputy Director Incharge

Women and Children (Especially Nutrition, Maternity and Immunization

District Level

Incharge, District Social Welfare officer & Development Commissioner (Honorary) Supervision

Chairman, Assistant Commissioner Development

Incharge Programme Officer Supervision

Block Level

Incharge, Tehsil Social Welfare Officer, Field implementation of general social welfare including women and children

Incharge, ICDS Project Officer, Field implementation of ICDS services through various Departments; especially for expectant and nursing mother and children (0-6)

Local Centre Level

Through a guild of block level trained personnel

Nutrition services through local Anganwadi centres

Maternity services through through Health Centre

Immunization through local Health Centres

**Organizational structure at Regional Level**

In J&K, there are regional offices of the Directorates under the charge of an officer of the level of Joint Director/Deputy Director. Since there are separate regional offices for all the three regions, i.e. Jammu, Kashmir and Ladakh. The Directorates function through regional headquarters, where there is an officer known as Regional Director.

**Organizational Structure at District Level**

At the district and field level, the organizational structure varies from state to state, on the one hand and from department to department, on the other. *In case of J&K in certain cases the same scheme is operated by various departmental agencies. This sometimes results in overlapping and duplication of effort and complicates the administration of a specific programme.* For example, as many as eight departments deal with social welfare.

The district level officers are primarily concerned with co-ordination and to monitor the social welfare schemes. The district level committee is constituted to get these schemes implemented through various related departments. This committee comprises of District Commissioner, District Social Welfare officer, and the Assistant Social Welfare Officer.

The bulk of the social welfare programmes in rural areas for women and children are handled by the project implementing committees set up by the Social Welfare Board in co-ordination with the block organizations.

## Nature of Welfare Services in J&K

*So far as the nature of welfare services for women and children, is concerned, it would be difficult to make a sharp distinction between social welfare programmes and those for economic development. They subserve the same identical purpose of improving the quality of life. Any marked lag between the two creates new stresses and problems.*

There are separate offices at regional, district and block level to render the social welfare services for children and women. Their function is separate as well as co-ordinating in nature, i.e. in case of women's welfare, the social welfare department at the district level supervise the implementation of schemes and programmes. Besides, there are Integrated Child Development Services (ICDS) district officers for the welfare services to children. These offices are known as 'programme office', where the progress reports are prepared on the basis of information collected from different projects, and send them to the

directorate office. This office performs the supervisory function also.

**Block Level Organization and Nature of Welfare Services**

Let us now turn to the block level. As at district level, so, at block level there are separate offices for the welfare of women and children. The block level office is under the charge of a tehsil level committee, comprising of concerned Tehsildar, Tehsil Social Welfare Officer and Block Officer (B.D.O.). Besides, these offices have technical staff to implement the welfare schemes. Following services are provided to women and children in these centres:

**Training-cum-Production Services:**

The training-cum-production scheme was started in 1978. A particular block is divided into various social welfare centres (commonly known as `*Silai*' centres) where the recruited female candidates are given training in different craft skills, so that after receiving training they can become economically independent. The trainees are encouraged to set up their own small production units and for which the government provide some subsidy to them. The number of trainees in each centre is 25 candidates and a scholarship of Rs.100 (per month) is provided to each candidate during the 11 months period of training. Each

centre has two trained teachers, who impart them training in tailoring, doll-making, paper machie , knitting, hand embroidery etc. At present there are around 68 such centres only in Kashmir.[4]

**Financial Assistance Services:**

Another scheme started during 1977, is meant to provide financial assistance to the handicapped, widows and handicapped children. Besides this the old age pension scheme was started during August 1976. Another scheme started during 1978, August is mainly concerned with providing scholarships and uniform to the needy school going children at primary level classes. Under this scheme books, uniform and financial assistance are provided to the needy students. There is a committee at district level to monitor the proper distribution. This committee comprises of District Commissioner, District Education Officer and District Social Welfare Officer.

**Subsidy and Equipment Services to Women:**

A particular scheme was started during 1977, whereby sewing machines to the poor and destitute women are provided in order to help them in their economic life. In 1989 one more scheme `Ladies Vocational Centres´ (LVC), was started, whereby needy qualified women are given training in stenography, typing etc. The social welfare Department is

running cottage industry centres since 1960. These centres impart training in carpet making weaving etc. Every year 25 female (in each centre) are given training in carpets, papier machie etc. At present there are 9 such centres working in Kashmir only. Besides this the Department is running five destitute homes. This scheme was started in 1960 and since then each home provides shelter and rehabilitation to 25 women, each home.[5]

## Integrated Child Development Services

In 1975 the scheme of ICDS was started and since then most of the services for the welfare of children are provided through this scheme, in co-ordination with other departments. A particular ICDS block is under the charge of a ICDS project officer, who is assisted by technical staff. Each block is divided into several zones and each zone has a number of ICDS centres. The department provide supervisory staff to the project officer and each project has four to five supervisors, who occasionally visit the centres in order to watch the proper implementation of the services. Each supervisor is assigned to visit some centres and collect progress report from the centre.

**ICDS Centre (Anganwadi Centre) and its Service:**

ICDS centres are commonly known as `Anganwadi centres" and a lady teacher is incharge of the centre. She is assisted by a helper (male/female). After the appointment, she has to go under a training period, before she joins the actual field. She is paid Rs.250 per month. She has to go to the area where the centre is located and register the children (0-6). Each centre is provided nutritional food supply for raising the health status of these children. Nursing mothers are provided nutritional food in the name of her baby, till the baby reaches to the age of three years.

Programme of Nutrition and Child Development Bureau was established with the main function to provide services to children through integrated child development services, which is a centrally sponsored scheme. It was launched in 1975 with the purpose to provide such services to children covering their physical, mental, health and social apects.

Welfare extension projects provide basic, minimum services to women and children in the rural and urban areas. They are rendering vital services in J&K. The idea is two-fold, on the one hand to concentrate on the health and development of children, and on the other hand to create a new awareness among the rural women about child health care, maternity services and social education. At present there

are 34 ICDS projects in Jammu and 32 projects in Kashmir. During 1992 year only an amount of Rs.1 crore and 60 lakh was spent on the welfare of children. An amount of Rs.1 crore and 95 lakh was spent on women's welfare.[6]

**Immunization and Maternity Services:**

Another welfare service for women and children is the immunization with the Health Department of J&K is rendering to expectant mothers. The department organize medical camps in project areas. The idea is to improve the health status of women and children. The department has a particular district level medical officer and block medical officer (B.M.O.), at block level. Within each block there are several primary health centres at the distance of one or two kilometres. In each primary health centre (PHC) there is a doctor, a *Dai* and some more staff. The B.M.O. appoint a team consisting of trained personnel and they visit farflung and rural areas to provide B.C.G., anti-tetanus and anti-polio vaccine to the children below 6 years of age. The maternity services are provided to expectant mothers. Sometimes special camps are organized at district level where *dais* and lady doctors render these services to women. This type of services play a vital role in lessening the rate of pre-natal deaths. Since the *dai* is always available and at the time of delivery either the woman visits the health centre or the *dai* is called to the house, where she

conducts the delivery. The health department of the state started a new scheme, 'Rehbare Sehat', under which camps are organized to train the local voluntary women in conducting a safe delivery at homes. This scheme has proved a remarkable initiative in the light of the fact that around 66% deliveries are conducted by these local *dais*. But still the coverage of the scheme is very low.

**Functional Literacy Services**

So far as the functional literacy programme is concerned, this is dealt with by the State Education Department in collaboration with the University of Kashmir and Jammu University. The state education department has set up district level offices under the charge of a person who is from the education department itself. He is assisted by the instructors in supervising the proper implementation of the programme. This is a part time scheme, with strength of 25 in each centre and one instructor preferably a lady. The idea behind the scheme is to make the women aware about the child care, maternity services and social education. The books are provided by the State Education Department, written in the local language in all the three regions, i.e. Kashmir (Urdu), Jammu (Hindi) and Ladakh (Ladakhi).[7]

Finally, the above discussion brings us to conclude that no doubt the welfare of women and children is dealt with by various departments and it is this factor which contributes to some complications in the implementation of some specific programmes. But to ensure the smooth and steady progress, there is a timely need for co-ordination among the various agencies operating in J&K. But the recent trend (1980s onwards), shows that there has been a movement towards greater co-ordination. In J&K, periodical co-ordination meetings are held under the auspices of the planning and development departments. Periodical conferences of secretaries and heads of departments are also held to review the progress of expenditure on various welfare schemes, the implementation and allied matters.

As at the centre, State Social Welfare Advisory Board co-operate with the state government in the implementation of welfare services for specific groups like women, children and the handicapped. The Central Social Welfare Board along with the state government has been making contributions towards the expenditure of the state Board as also to the expenditure on Welfare Extension projects. The government realize the advantages of the Board's initiative not only in the context of the programme for these groups, but also in the context of developmental schemes in general. The activities of the Social Welfare Department and the State

Social Welfare Advisory Board have been well integrated and they function as a single agency in promoting Social Welfare programmes in J&K.

## Critical Appreciation

Though, progress has been made as a result of different welfare programmes, it leaves much to be desired. Particularly, there is a need for special attention to monitoring and a critical evaluation of the implemented policies so far.

Whatever are the achievements, too much failures in this regard dominate the scene. This fact can be due to the nature of the social structure partly and more important than this is the lack of proper organization of welfare policies. Due to the prevailing political considerations, or because of diffused outlook of public regarding social welfare, there are variety of gaps, missing points and inconsistencies in the existing social welfare organization in J&K.

**I. Late Initiation of Welfare Service:**

Among these the first point to be highlighted is the late implementation of social welfare services. Although at the national level the vast organization of welfare services

started as early as during 1951, but in case of J&K no serious initiative was taken in this regard. No doubt, the plan outlay was very much present every year, but in actual practice no serious and large scale network of social welfare services took place at gross root level. The late initiative of social welfare programmes resulted in the fact that the authorities could not understand the roots and incidence of social problems of vast weaker sections and more particularly, the problems confronting the development of women and children. This has contributed to the seriousness of social problems in J&K.

### II. Lack of Sufficient Funds:

Lack of sufficient allocations along with the gap between money released and spent on social welfare, has been the important factor contributing to the seriousness of the problems. But again we can argue that in the absence of proper organizational network, it was not possible to make proper use of the funds. But now the organization of welfare services has improved a lot and it has established a network of trained personnel in most of the areas of the state.

### III. Concentration of Welfare Services in Urban Areas

The third point to be discussed is the lack of proper organization of welfare activities and particularly their

concentration in urban areas than in rural and backward areas. Since, J&K has most of its population (90%) in rural areas, where both women and children suffer badly from the social problems and these areas need some serious attention.

The State has vast areas which are farflung and where the access is very difficult. These areas need to be reach out and try to understand the specific problems of children and women there. One of the developments in this regard is that during last few decades there has been a total shift from specific areas to the community welfare approach. One of the essential decisions in this regard should be to make the organization and administration of welfare policies flexible. This will lead to the easy modifications according to the varying situations. There should be a provision to encourage the participation of local people in the administration of welfare programmes. Finally, the success depends upon the sincere, dedicated, morally motivated and well trained personnel. The Department of Social Welfare will have to consider the training and research aspect sincerely.

**IV. Lack of Voluntary Participation**

Lack of voluntary organizations is one of the decisive factors contributing to the poor performance of welfare policies in J&K. Since the provision to aid voluntary organization was made as late as during 1978. This late

action in this regard can be very well understood by the fact that at present there are only 21 institutions run by the voluntary organizations in the whole state. The number of beneficiaries is as low as 107 (residential) and 2,001 (non-residential).[8] Hence the above discussion leads us to argue that it is now high time to encourage the voluntary organizations and particularly women's organizations, with sufficient government aid to carry on welfare activities in most remote areas. They can play more effective role than the governmental departments and government agencies. Another point to be highlighted is the establishment of tribal welfare Boards, headed by a local trained person along with the people of concerned area.

**Notes & References:**


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3. _Social Welfare Statistics 1981_, Central Social Welfare Board, New Delhi.

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6. Announcement made on Radio, News by Govt. of J&K, Oct. 1992.

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# Chapter III

## PROBLEMS OF WOMEN IN JAMMU AND KASHMIR AND WELFARE POLICIES

Kashmiri Society (J&K) consists of Hindus, Muslims, Christians, Buddhists and Sikhs, each professing different religion, tradition and customs. Family and marriage laws are the two basic concepts that determine the status of women in a society. The study of any development legal system requires a critical and analytical examination of its fundamental elements and conceptions which go to make the contents or body of that law. It also required consideration of the line of development it has pursued. Not to speak of the different status assigned to women among Muslims, Christians and Sikhs, even amongst the Hindu it is not the same every where. There is a wide divergence between castes and tribals and even between the various regions of J&K.

Women in J&K have almost always been regulated to a secondary role vis-a-vis men. Many stern religious and social customs left women weak and fragile and dependent on men, from the time of birth to death, till the turn of the century when many of the mal-practices were abolished. But the initiative in this regard was taken during medieval period when Muslim rulers abolished *sati* and encouraged

widow-remarriage and gave women inheritance right.[1] After independence further reforms were carried out to improve the lot of women. In this regard social welfare measures have done a commendable job.

## Women and their Problems during Ancient, Medieval and Modern Period

Women constitute the half of the population of J&K. From the ancient period till now the status of women has undergone several changes. Though majority of them have been subject to various social and legal disabilities in the past, yet they have played a vital role in the family and the community. Perhaps it is this historical fact that led the Late Prime Minister of India, Jawaharlal Nehru to remark, "women in Kashmir have played a notable part in its history. Broadly speaking woman has greater rights there than in other parts of India."[2]

Because of the low status given to women in the past and the lower educational standards, women have always been treated as a weaker and vulnerable section of society. No doubt during the Muslim rule in Kashmir certain reforms were introduced, e.g. eradication of *sati*, but new social problems eroded in the society to which women became an easy prey. In the following discussions an attempt will be made to analyze the status of women in J&K and the various social

problems prevalent during ancient, medieval and the modern period. This will be helpful to assess the impact of social welfare measures to improve the status of women in a traditional society like Kashmir.

## Position of Women During Ancient Period

A striking feature of the socio-cultural history of J&K during the ancient Hindu period is the important and sometimes decisive role played by women in the affairs of the State. Be it as queens or as ordinary inmates of the *harem* (separate residential quarter for women) or as courtesans, women come frequently into picture.

This position of importance implies that women of at least the upper class received education of not only general nature but in diplomacy and statecraft too. No wonder we find the women of J&K as active as men in the discharge of public duties. There is no indication of women being in seclusion or relegated to the background. The use of the veil was non-existent. We find for instance women seated along with other officials and ministers in the court of Harsha.[3]

## Child Marriage

The women in that sense enjoyed equal rights with men is amply proved by the appointment of queens along with

their husbands at the time of coronation. That women owned private property, is illustrated by another reference of Kalhana (author of Rajtarangni). Women had thus emerged from the domestic into the political stage, were free, owned immovable property, managed their own estates and even fought as the head of their troops.[4] Regarding the age of marriage, however, we are in the dark. But a reading of Rajtarangni gives the impression that child marriage was probably not in vogue.

**Polygamy Marriage**

Although polyandry marriage was not prevalent in Kashmir, polygamy marriage was prevalent, at least among the rich. The joint family was common and we find mother in-laws wielding their well known rod of authority and strictness over their daughter-in-laws. Widow re-marriage was not allowed and they were expected to live a pure life, devoid of all luxury. The ornaments or gorgeous dress were forbidden to them.[5]

***Sati* Custom**

The custom of *sati* (burning of a widow on the funeral pyre of her husband) was also prevalent from early times. When the dead body of her husband was available, the wife burnt herself along with it, but when it was not, she ascended a separate pyre, even some days after his death.

The custom seems to have been in general vogue long after the end of Hindu rule, when Sultan Skinder considering it contrary to the law of Islam, stopped it forthwith.[6]

**Prostitution Problem and Devadasi**

Prostitution was popular in society during Hindu period. Kalhana also testifies to the gross immorality and laxity of character among the ladies of the palace and court. A life free from the maxims and morals naturally gave rise to a number of evil practices in the society. One of these was the institution of `Devadasi´ or the dedication of girls to the temple deities. It seems to have existed in J&K and several parts of India from ancient times. These Devadasis could be taken away by the ruler for his personal enjoyment.[7]

## Position of Women During Medieval Period

The advent of Muslim rule towards the middle of the 14th century did not produce any immediate change in the position of women in the society, rather a new institution of *purdha* came into existence. Since for a considerable time there was nothing to distinguish a Hindu from a Muslim in dress, manners and customs where from the *purdha* entered into Kashmir is difficult to say. It is generally believed that seclusion of women was practised at least among Hindu —

kings and nobles in the Middle Ages. The Sultans, besides marrying within the families of Chaks, Magreys and Baihaqi. Sayyids also entered into matrimonial relations with the families of the Rajas of Jammu, Kishtwar and Rȧjouri, who being Rajputs had already adopted the institution of *purdha* among their womenfolk.[8]

**Restriction on the Movement of Women**

By and by with growing influence of the Sayyids from Persia and Central Asia, the *purdha* (ideally identity mark) became common not only among the upper class Muslims but of Hindus as well. Women's right place was considered to be her home and her most sacred duty was obedience to her other family members. This naturally led to the institution of '*Harem*' in the case of more prosperous and respectable classes of the society.[9]

The above facts should not be taken for granted for the promotion of polygamy. The polygamy was practised only by a privileged few (because of heavy conditions). But women belonging to the lower classes, especially in the rural areas could not afford to be shut up in their houses. They moved about freely without a veil and helped their menfolk in almost every walk of life, in the fields, the gardens and on the rivers.

## Education and related Problems

Education seems to have been limited to the women of well-to-do families only. Those belonging to the lower classes could neither afford nor had the leisure to receive it. But this should not lead us to argue that *purdha* became a hurdle in their way to receive education. The life of Haba Khatun, Sultan Yusuf Shah's (1578-79), (1580-86) queen, however, shows that opportunity did exist even for the peasant girls to acquire knowledge. Parents generally preferred their daughters to receive religious knowledge and this was done in their own homes.

## Marriage and Related Matters

Marriage was generally a family affair. Arranged marriages were commonly prevalent. The custom of child marriage among both Muslims and Hindus came into vogue during the rule of the Afghans. Prostitution seems to have been prevalent throughout the medieval period.

## Practice of *Sati*

The practice of *sati* which was common under Hindu rule was stopped by Sultan Skinder who considered it un-Islamic, and because of these restrictions the practice seems to have lost its importance. Even among the Muslims of Rajouri Jammu, the widows were burried alive with their dead hus-

bands and it was during Jahangir's time that the practice was stopped.

Though, with the introduction of *purdha*, women lost some of the privileges during the Muslim rule, yet Islam conferred on her the rights denied to her by Hindus. A Hindu widow could neither remarry nor inherit. The Muslim widow could on the other hand, remarry and got right of inheritance. Divorce, though permitted among the Muslims was rarely restored

## Position of Women During British Period

### Institution of *Purdha*

The position of women did not undergo any appreciable change during the British rule. Even during the period of Maharaja of J&K (Dogra Rule), *purdha* existed among the upper class Muslim and Hindu women. But vulnerable majority from lower class women worked with their men in carrying out the economic activities. But for the women of upper classes home continued to be the proper place and household activities marked the ultimate boundary of her role in the society.

### Child Marriage Practice

Child marriage was prevalent everywhere and the most victims were the female issues in the family. Since the

joint family prevailed commonly, it became a hindrance in the way to raise the status of women. The in-laws and husband generally had a crude attitude towards the daughter-in-laws. During this period, woman was restricted to the four walls of house and her world was reduced to the services to her family member and considered mainly for child bearing and raring.

**Family Conservatism and Modern Education**

British during their rule started modern secular education and it created a family tension. Parents preferred their daughters to receive religious education which was not possible in modern British established educational system. That way it gave rise to the family tension by awakening women about their rights. Again, only the women from upper classes could avail this facility and the lot of majority of lower class women could not change because they were always busy with their long hour works and hardly could get time to receive formal education.

**Biased Attitude of Parents**

From the early period till the mid of this century, parents had a biased attitude towards the female issues. Whether it is education, treatment, marriage etc., parents always had a preference for the male issues. The best role

for women was considered to be household activities only.

## Position of Women during post-Independence Period: A National Scene

As soon as India achieved her independence and consequently the independence of J&K, things begin to change, although at a very slow pace. This can be attributed to the fact that no serious attention was paid to the eradication of social problems and it was only during last thirty years that thought provoking initiation took place. Before going into the details about the welfare programmes organized and their impact on the status of women, it is essential here to discuss about the situation at national level. This will lead us to a broader understanding about the fact that the efforts at national level swept the State of J&K in its swing for developing a new awareness among women through social welfare schemes and programmes.

The stirring of conscience among thinking men in the 19th century led to an improvement in the position of women and their gradual emergence from a status of social and political (with which the name of Raja Ram Mohan Roy will ever be associated) ushered in a period of steady advancement and opened up new avenues for self-expression. It was then that a fresh chapter in the history of India's womanhood began. Besides Roy, Kesab Chandra Sen, Swami Dayanand

Sarswati, Sir Syed Ahmad Khan and Mahatama Gandhi, fought for higher social status and educational facilities for women. Their reforms include abolition of *sati*, child marriage and Devadasi besides removal of restrictions on widow re-marriage etc.

As a result of these social reforms, many government and voluntary organizations in the 19th century took up various services for the welfare of women. Except setting maternity services and family planning programmes for women, the government did not do much in developing other activities for the welfare of women. Bulk of welfare programmes for women, were, therefore run by voluntary organizations with the aid from government. There are of course several hundreds of smaller organizations that have worked towards the solution of local problems and the promotion of local betterment schemes.

## Role of Voluntary Women's Organizations at National Level

The earliest women's organizations working at national level include the Women's Indian Association, founded in Madras in 1917, under the inspiration of Dr. Annie Besant and Mrs. Margaret's cousins. These two Foreign women were the vanguard of the fight for women's welfare. In 1925, the National Council of Women was established as an active agency in the cause of women. It has thirteen state branch-

es and is affiliated to the international Council of women. Another all India body of repute has been the Young Women's Christian Association. It has well planned hostels, employment bureaux and commercial schools for working girls in most of India's principle cities. The Indian Federation of University Women has watched over and safeguarded the academic interests of women and their right of entry into the widening stream of vocations and professions, on equal terms with men.

Another attempt in this regard took place when the Kasturba Gandhi National Memorial Trust was founded in 1944. Its vast funds are devoted almost exclusively to the well-being of women and children in the rural areas, and its programme of training *grahama sevikas* holds out rich promises of a much needed welfare services in India. The All India Women's Food Council completes the list of women's associations. The literature and recipes published by the Council have been of great assistance to housewives vexed with the problem of providing adequate needs for the family.

Viewed against the above background, the women's movement and the consequent attempts by the government and voluntary organizations brought about a social and political revolution in the world of status of women in India. These efforts contributed to a greater extent to the prestige of

women. Here a brief touch will be given to the social problems and customs attacked so far.

**Attack on Early Marriage:**

The serious problems of early marriage, with its concomitant evil of early motherhood, engaged the attention of the reformers and the legislators. In 1929, the Child marriage Restraint Act was adopted in an attempt to correct the position. *Purdha*, which kept women secluded and segregated, has yielded to the knock of enlightened propaganda. Mere traces of it only now remain.[10]

**Abolition of Devadasi:**

The problem of devadasi girls dedicated to the temples and the Hindu widows was an additional challenge to the social conscience of the people. Before suitable legislation could be introduced to illegalize the devadasi system and to permit widow remarriage, the social work of the pioneers centred largely around the establishment of `Seva Sandans' and widow homes. These offered training facilities and sheltered occupations, which enabled women to rehabilitate themselves.

**Restraint on Prostitution:**

Another blot on the social status of women has been prostitution. Admittedly the strange "profession", as it is

sometimes called, is common to all countries. The Association of Moral and Social Hygiene in India has, for some decades now, agitated for the control of prostitution, and formulated schemes and frame Bills, which if accepted shall considerably mitigate this evil. There are some enactments in force -- *Suppression of Immoral Traffic Acts* in the major states of India, but they are defective in content and ineffectual in operation.

## Social Welfare Measures and Their Impact on the Status of Women in J&K

The impact of British rule was felt in various areas of society. British rule began to act as a catalytic agent in custom bound Indian society, and old values and traditions began to be questioned by the intellectual elite of India. The various reform movements that grew up in the different parts of India addressed themselves to constructive efforts calculated to uplift the women.

It is essential here to argue that before independence, in a backward State like J&K, there were virtually no voluntary organizations in the field of social welfare. A few bold women ventured forth in the welfare field in the teenth of great opposition against the emancipation of women. They persuaded their sisters to come out and encouraged them to learn and earn. In the mountainous terrain state where most

parts are difficult of access and totally cut off from rest of the world during the winter months, it was impossible for a handful of dedicated workers to make much of an impact.

After independence, things began to change. There was a new awakening of interest in bring about social change and in particular, the emancipation of women.

## Emergence of J&K Social Welfare Advisory Board

The emergence of Central Social Welfare Board (1951), and the subsequent setting up of the State Social Welfare Advisory Boards put J&K on the social welfare map of India. Another bold measure was the setting up of the State Advisory Committee under Remuneration Act on 7th September, 1976.

Progress in social welfare is difficult to measure. Its true tests are the extent of participation by voluntary workers and no less important is the response from the local community. Various government departments in co-operation with the J&K Social Welfare Board have done credible work in sponsoring and sustaining various welfare policies in the state. Voluntary organizations have been encouraged through financial assistance to promote welfare services in the backward areas and to initiate new types of welfare activities.

With the best effors of State Social Welfare Department and Social Welfare Advisory Board, various welfare schemes that emerged in different spheres of welfare addressed themselves to constructive efforts meant to encourage the status of women. Looking at the intensity of problems, till now the performance is not satisfactory. Thus it leaves much to be done in future. Let us now turn to the welfare schemes and relate them with the upliftment of women, in order to reach an analytical understanding about the success of these welfare programmes.

### (a) Socio-Economic Programmes:

With the economic development under the successive five year plans, it should be possible for women to be able to obtain employment still there will be many who because of various disabilities and handicaps, may not be able to do so, unless a number of training centres and workshops are not set up under sheltered conditions, where the women could be taught certain skills and absorbed into industrial and commercial employment.

The socio-economic programme of J&K aims at schemes of giving training and work to needy women in social welfare institutions. Great emphasis has been laid in Board's activities on the ultimate rehabilitation of needy women either through education or through involvement in economic

activities. The effort has been to provide economically backward women with the opportunity to work by affording them facilities to work on full time or part time basis either in the homes or in the training-cum-production centres.

**Training-cum-Production Scheme:**

This scheme was started with the aim at helping the needy women to be economically independent. The effort has been to provide economically backward women with the opportunities and by affording them facilities to work on a full time or part time basis either in homes or in training-cum-production centres (commonly known as Silai centres) which give them reasonable wages in a State where people are traditionally skilled in handicrafts. The programme has been steadily gaining strength and popularity. At present there are 68 such centres in Kashmir only, where training is given in different crafts like tailoring, paper machixe, doll making etc. Each centre has a strength of 25 women and hence every year about 1,700 women are benefitted. Besides this, a scholarship of Rs.100 is given to them per month.

Upto 1985 there were 65 production units in J&K, set up with the financial assistance of Rs.2 lakh from the Social Welfare Board. Six handloom, 10 handicrafts units and 34

agro-based units which were getting assistance from the Board. One such unit which is providing employment to over 200 women has not only been its products. There are some units which have made their mark by producing fashion garments which have caught the export market. Many more production units are in pipeline - among them is a soap making unit.

**Equipment Subsidy Scheme:**

In 1975 the J&K Social Welfare Department started a scheme, whereby sewing machines are provided to the poor, widow and the needy women. The idea is to raise their income, so that they can be economically independent. According to the information just in 1990-1991 about 500 such sewing machines were distributed among the needy women.[11] Another scheme of the same nature is known as 'cottage industry centres'. This scheme was started in 1960, where in the training is given to women in different carpets. These carpets have also the export touch. The idea is again, to train the women, so that after receiving training they can start their own units and for this they are provided financial subsidy by the social welfare department.

**Animal Husbandry Scheme for Tribal Women:**

For women who are not able for one reason or the other to participate in production units, the State Board has been

trying to develop animal husbandry. Buffaloes have been provided to the needy women, particularly in tribal areas and the needy women of Jammu division to supplement the meagre income of their families. During 1979 one such sheep unit was set up in the Kangan area of Kashmir division. Needy Gujjar women are provided with the five sheeps each. The idea is that the women should look after the sheep and multiply them, and also earn profits through the wool that they get branch out in to other activities like hand spinning, hand weaving and hand knitting. This has proved very popular among the tribals and many more such units are under contemplation. The State Social Welfare Board has set up Wool Bandars at different places and they provide women, wool for spinning and for that reasonable payment is made. This is also contributing to their income.

**Ladies Vocational Training Scheme:**

During the recent past there have been serious attempts at shift from the training in handicrafts to training in technical expertise. The idea is that after receiving training a woman can become sure of some job because either she can seek government job or start her own unit. For this purpose the Social Welfare Department started a 'Ladies Vocation Centre' (LVC) scheme during 1989. The minimum qualification for the admission to these centres is matric and above.

The adult education centres provide condensed course of education to the women after passing 10th class. They become eligible for this training in technical professions like typing, stenography etc. In nutshell, the idea behind all the above schemes is to raise the socio-economic status of women. As a matter of fact, once a woman is an earning hand she can contribute to her family income and look after the future of her children in a better way.

## Critical Appreciation of Socio-economic Schemes

No doubt that the above mentioned socio-economic schemes have helped women to become economically independent, but most of them have been concentraed in urban and semi-urban areas while as there is a bulk of women living the farflung and tribal areas. Most of these areas are out of access. So what is needed is to take these services to rural areas in order to help the women in backward areas to raise their socio-economic status.

This goal can be achieved by arranging special teams to visit the farflung areas, where the women are most backward and economically dependent. These services can be more fruitful if the locally trained people are encouraged to participate in the welfare activities.

**Lack of Sufficient funds:**

Several factors contribute to the poor performance of the welfare programmes. Most important among them is the lack of sufficient funds. This can be illustrated from, that the Scholarship of Rs.100 provided to women in training centres is a very little amount. It needs to be raised to minimum Rs.250. This is essential in the light of the fact that women equally participate in the economic activities with men. These women belong to the lower class families. And when they join the centre, this adversely affects the economic condition of their families.

**Less Benefit to the actual producer**

Those women who run their own units do not get much benefit and it is the middleman who purchase the products from them and buy them at very cheap rates from the actual producer. There is a need to set up co-operatives where the government can directly purchase the products from these women. In this way the chunk of middleman will go to the pocket of actual producer. Besides, the assistance provided to tribal women in the form of five sheeps each, is very less and there is a need to raise this number and locate the really deserving cases for the assistance.

**Trainees Lack Proper Eqipments**

Another problem is that most of women after receiving training are not in a position to buy the equipments needed for the production of things. As mentioned earlier that the State Social Welfare Department, through a scheme is providing sewing machines to the needy women, but only a limited number of the women get benefit of these schemes. The women in rural areas are still out of coverage.

**Trained Women unable to get Government Jobs**

After receiving training most of the women are in search of some government jobs and very few of them get such a chance and so to speak only those who have some access. Thus, majority of the trained expertise is marred. This problem can be overcome by the Social Welfare Department itself. Since the Department provides uniforms to the students at different levels and the State government is also providing uniforms to the servicemen in police, forest and fire services. It is here that the services of these women can be utilized and this will definitely provide a chance to these women to raise their income.

**Lack of Part-time Training Courses**

Under most of these schemes women are given full day training course. Being an agricultural society, women in

J&K are always busy with their economic and household activities and they hardly get an opportunitty to spend full day in the training cenre. Therefore, some of these schemes should give training on part time basis in which rural women can participate without much pressure. Since Kashmiri society has a mixed family system, i.e. neither purely joint nor nuclear and a woman cannot ignore her other activitties and spend whole day in the centre.

### (b) Condensed Adult Education Courses

Many women need to earn their own livelihood but not all are qualified to do so. On the other hand various programmes of development under education, health and welfare particularly, for women and children require mature women workers with a background of general education upto a level but they are not available. This is due to the fact that overall low female literacy rate in J&K. As per figures whereas the total literacy rate at all India level was 52.17% during 1991 and out of this male literacy was 63.83% and female literacy was as low as 39.42% only. While as this was 36.2% during 1981 and out of this 46.9% for males and 24.8% for females. The overall literacy in J&K was as low as 26.67% out of this the male literacy was 22.17% and female literacy as low as 9.28% only. These figures were in rural areas as low as 4.98% for female and 28.38% in urban

areas. Out of the vast majority of illiterate women, for those large number of comparatively older women, who have not completed even primary school education required for work in the rural areas, arrangements to bring them up to prescribed minimum standards of education are necessary.

**Objective of the Scheme**

To meet the above needs, a condensed course of training was sponsored by the State Social Welfare Advisory Board in 1958 for the women of the age group of 15 to 35 years. The idea is to prepare and enable women to attain within a period of about two years a minimum qualification of 8th class or vernacular final or school final. While the Board's assistance is available for the training of any suitable women of this age group, preference is given to destitute or deserted women and widows. These women after attaining a minimum level of qualifications, are recruited for the posts like primary school teachers, midwives, Anganwadi/Balwadi teachers, Adult Education workers, craft instructors, family welfare workers. The scope of this programme was widened in 1975-76 with the addition of two components, namely vocational training course and one year course for failed candidates.

## Education and its Role in Proper Socialization of Children

Besides the above needs, it helps a woman to maintain her family well and definitely such women pay serious attention to socialize their children in a proper manner. At the same time she can encourage the proper education of her children. This is more fruitful in case of the women in rural areas. What happens in the rural areas generally the female literacy is very low, this is due to the reason that parents (particularly mother when illiterate), do not worry about the good future of their children. At the same time parents prefer that their children should help them in economic activities. This is more acute in case of a female baby, if her mother is illiterate she also prefers that her daughter should help her in household activities rather than going to school. This is not case with an educated mother. That is why always stress has been laid on that if we educate a male, it means educating an individual, but if we educate a woman, it means educating a family. Mother's role in the socialization of child and immediate interaction with the child, vests the vital significance of mother being literate or illiterate.

The scheme is called a condensed course of training, because the syllabus which is ordinarily covered in normal school in three to five years is condensed and covered in a

period of 2 to 3 years. The J&K Social Welfare Advisory Board, has so far conducted 14 such courses about different spheres. It has helped more than 400 adult women to pass the matriculation examination till 1979 and thus became eligible for admission to the different institutions.

**Part-time Adult Education Centres**

Each unit consists of around 25 to 30 women who are all admitted at the same time so that they can be given training for the full two years. Women between 15 to 35 years of age are admitted generally. These women must be totally illiterate before they are admitted. The important thing is that only such women are admitted who are needy and dependent and want to take up a job as a career. In this regard preference is given to rural women. These centres are provided with one instructor each who is paid an amount of Rs.100 per month. Black-boards, maps, and charts are sometimes provided. But in most of the cases this is not found. Each trainee is provided a set of books, written in their own language, i.e. Urdu (Kashmir Division), Hindi (Jammu). The location of the centre is preferred in such areas where there is no government or private school facility.

**Role of Semi-Government Institutes**

From the date of its inception in J&K, no serious efforts were made to start this programme in all corners of

the State. But during the last one or two decades, with the best efforts of the Board in collaboration with other State departments, the programme has got a new momentum. State Institute of Education and Adult and Continuing Education Centre (Kashmir University/Jammu University) are putting in their best efforts in this regard. In order to meet the expenses of the programme during 1984-85 an amount of Rs.0.14 lakh was sanctioned for one year course, Rs.0.34 lakh for two years course and Rs.0.05 lakh for vocational courses was released for this purpose. As compared to this during 1983-84 Rs.0.16 lakh and 0.36 lakh for one year course and two years course respectively. During the same period an amount of Rs.0.24 lakh was sanctioned and this amount was Rs.0.90 lakh during 1982.[13]

No doubt that with the best efforts of State Board in collaboration with other government departments, have done a good job in this regard and the programme is becoming more and more popular. The contributions of this programme in raising the status of women cannot be ignored. This programme has played a vital role in urban as well as in the rural areas to help the women to attain a minimum level of qualification and this helps them in getting some kind of job or getting admission in the technical Institutes. Notwithstanding the limited achievements, there are several drawbacks with the organization and implementation of the

programme. Some of the important ones can be discussed as:

**I. Lack of Sufficient Staff:**

Each centre is provided one instructor for the batch of 25 women. As a matter of fact one instructor is not sufficient for this number. There should be three lady teachers exclusively for one batch of 25 trainees. One of the teachers should have an overall charge. She should be a full time worker and should reside on the premises in the case of residential institutions. She should be graduate trained teacher or with an experience of at least 5 years. The other two teachers may be part time. They should have passed at least high school. The teachers with additional qualificaions for physical instructions, and craft training should be given preference.

II.

Since the incharge supervisor for a particular area is not provided any kind of transport facility. In order to cover a large number of centres and frequent visits to the centres, proper transport facility and travelling allowances must be provided to the supervisors. This will help them to reach the difficult places and definitely motivate the supervisor to reach the farflung places, where access is very difficult. Besides this the low salary of instructor

needs to be raised. The other related problem is that no rent is paid to building owner, where the centre is opened. This is again creating problems in the success of this programme.

**III. Low Profile of the Masses:**

Even trainees themselves face a lot of problems. Firstly, no incentive is given to the women who come to these centres. Therefore the people do not find it beneficial from that point of view. There is one more factor in this way that due to poor economic background, women are always busy with their work side by side their men. It is therefore essential to provide some sort of scholarship so that this will act as a motivating force. At the same time the syllabus included should not be very heavy for the beginners. *Being a traditional society, people in Kashmir prefer their women to get religious education. Therefore religious education should be made as a part of the syllabus. Emphasis should be on functional literacy and family welfare.* There is a need to go to the people and convey them the benefits of such schemes, before a particular centre is started. This will help the people to perceive the usefulness of such schemes. The timing of the training should be at the convenience of the participants.

**IV. Caste as a Barrier:**

*In case of Jammu, the upper caste people do not go to that centre where the low caste women are admitted or if the instructor is of a particular caste, the women from other castes do not come to the centre.* Therefore, separate centres with local instructors should be preferred.

**V.**

In case of Ladakh no instructor is provided or is not available from the local population. And it is difficult to motivate a person from outside to work on very low salary of Rs.100. One of the general problems is that in most of the centres there is lack of equipments. This is mainly due to the lack of sufficient funds.

## (c) Hostels for Working Women

With an increasing number of employment opportunities mostly in big cities and industrial towns, more and more women have to live away from their homes and families in such places. They need suitable and cheap residential accommodation. The data available reveals that out of a total work force of 315 million at all India level, 90 million are women. This means around 30% workers are women and out of this 87% come from rural areas mostly engaged in agriculture labour and household industry. Out of this

total of 30% only 10% are scientists and technicians, while as 9% are civil servants and only 2% judges or lawyers.[14] This 87% of the total working force need cheaper accommodation with adequate supervision.

**Role of Central Social Welfare Board**

In February 1956, the Central Social Welfare Board decided that the provision of hostel facilities for working women of lower income groups in towns should come within the purview of objects for which financial assistance could be extended to the voluntary welfare organizations. Accordingly the Board started giving assistance for the provision or expansion of hostel facilities for working women of groups whose earnings ranged from Rs.50 to Rs.300 per month. Under the scheme the Ministry of Social & Women's Welfare gives financial assistance to voluntary organizations since 1972 for construction/expansion of hostels for working women in cities. The organization should be in possession of land for construction to be eligible for the grant in aid from the central government which earlier did not exceeded 60% of the total cost of the construction.

**Role of National Level Organization**

Some of the organizations like Y.W.C.A., All India Women's Conference, etc. run hostels for the working women in the higher income groups; and the girls of lower income groups who are unable to take advantage of such hostels, are

left without any suitable alternative. The scheme sponsored in 1972 by the Ministry of Social Welfare and CSWB was meant for this purpose. During 1983-84, around 46 hostels were sanctioned for different states and an amount of Rs.2,750 lakh was also sanctioned. While as during 1984-85 the number of hostels, sanctioned came down to 19 and an amount of Rs.1,258 lakh was sanctioned. This amount includes the amount released during these years for hostels sanctioned in earlier years.[16] Besides this, during last few decades some of the voluntary organizations working in the field of women's welfare have already under taken hostels for the working women in lower income groups. Most of these institutions are run in rented buildings, except that are run by the Y.W.C.A. in their own buildings.

**Zonewise Women Participation in Workforce**

With the increasing trend of women participation in both public and private sector, the problem has become acute once more. As the figures available about the North Zone of India in the Tables 2 and 3 reveal that while as the total number of working women upto 1983 at all India level was 240.03 lakh both in public sector and private sector. Out of this 12.6% were the women workers and of them 10.4% were in public sector and 17.6% were in private sector. As per the figures in Table 3 reveal that the number of total workforce rose to 246.22 lakhs during 1984-85. Out of this

12.9% were women workers and 173.00 lakh (10%) in public sector and 78.32 lakh (17.8%) in private sector. As the data of 1992 reveals out of a total work force of 315 million, female participation rose to 90 million which means that the female participation increased from 12.9% during 1984-85 to 30% during 1991-92.

## Jammu and Kashmir Situation

As a consequence and like other States of North Zone India, in J&K also the problem became far acute because no serious efforts were made in this regard and very few efforts were stated later on. As the data in the Table 2 reveals that there was a total of 34.00 lakh work force during 1983 in North Zone and of this 10.7% were women, In this total figure J&K had a number of 1.73 lakh and out of this total the women participation was 8.6%. This includes 8.3% in public and 14.0% in private sector. In other words there was a total number of 13.5 thousand women in public sector and 1.4 thousand in private sector. These figures rose to 1.79 lakh total work force during 1984-85 and the women participation reached to 8.8% of the total workers. Out of this 14.2 thousand in public sector and 1.5 thousand in private sector. While as the number for North Zone rose to 35.01 lakh, with 11.0% women participation.

## Table 2

### North Zone: Employment in Organized Sector as on 30.6.1983[a]

| Sl. No. | State | Total in Lakhs Sector | | | Women in Thousands Sector | | | %age of Women to Total Sector | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Public | Private | Total | Public | Private | Total | Public | Private | Total |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| | North Zone | 26.19 | 7.18 | 34.00 | 275.1 | 89.5 | 364.5 | 10.5 | 11.5 | 10.7 |
| 1. | Haryana | 3.40 | 1.91 | 5.32 | 35.7 | 12.1 | 47.8 | 10.5 | 6.5 | 9.0 |
| 2. | Punjab | 4.99 | 1.76 | 6.75 | 70.4 | 15.5 | 85.9 | 14.1 | 8.8 | 12.7 |
| 3. | Himachal Pradesh | 2.37 | 0.13 | 2.50 | 19.3 | 2.2 | 21.9 | 8.9 | 16.9 | 8.8 |
| 4. | Chandigarh | 0.47 | 0.15 | 0.63 | 6.9 | 2.0 | 8.9 | 14.7 | 13.3 | 14.1 |
| 5. | Delhi | 5.81 | 1.94 | 7.75 | 71.2 | 20.8 | 91.9 | 12.3 | 10.7 | 11.9 |
| 6. | Rajasthan | 7.51 | 1.81 | 9.33 | 57.7 | 35.5 | 93.2 | 7.7 | 19.6 | 10.0 |
| 7. | Jammu & Kashmir | 1.63 | 0.10 | 1.73 | 13.5 | 1.4 | 14.9 | 8.3 | 14.0 | 8.6 |
| 8. | All India | 165.37 | 74.66 | 240.03 | 1718.1 | 1317.3 | 3035.5 | 10.4 | 17.6 | 12.6 |

a - Provisional.

Sources: Director General of Employment & Training, Ministry of Labour, New Delhi, published by Ministry of Family Welfare, Govt. of India.

## Table 3

### Employment in the Organized Sector in North Zone States as on 31.3.1985[a]

| Sl. No. | State | Total in Lakhs Sector | | | Women in Thousands Sector | | | %age of Women to Total Sector | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Public | Private | Total | Public | Private | Total | Public | Private | Total |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 1. | All India | 173.00 | 70.22 | 246.22 | 1868.3 | 1301.2 | 3169.5 | 10.8 | 17.8 | 12.9 |
| 2. | North Zone | 26.87 | 8.14 | 35.01 | 289.6 | 96.8 | 386.4 | 10.8 | 11.9 | 11.0 |
| 3. | Haryana | 3.60 | 1.93 | 5.53 | 41.5 | 13.1 | 54.6 | 11.5 | 6.8 | 9.9 |
| 4. | Punjab | 5.19 | 1.85 | 7.05 | 74.6 | 17.6 | 92.2 | 14.4 | 9.5 | 13.1 |
| 5. | Himachal Pradesh | 2.36 | 0.19 | 2.51 | 21.4 | 2.3 | 23.7 | 9.1 | 12.5 | 9.3 |
| 6. | Chandigarh | 0.50 | 0.16 | 0.66 | 6.7 | 2.2 | 8.9 | 13.4 | 14.3 | 13.6 |
| 7. | Delhi | 5.62 | 1.99 | 7.61 | 63.2 | 21.4 | 84.5 | 11.2 | 10.7 | 11.1 |
| 8. | Rajasthan | 7.90 | 1.93 | 9.83 | 68.0 | 38.7 | 106.7 | 8.6 | 20.1 | 10.9 |
| 9. | Jammu & Kashmir | 1.70 | 0.09 | 1.79 | 14.2 | 1.5 | 15.7 | 8.4 | 15.4 | 8.8 |

a - Provisional

Source: Director General of Employment & Training, Ministry of Labour, New Delhi. Published by Ministry of Family Welfare, Govt. of India.

**Acute Shortage of Hostels and amount released:**

Keeping in view the increasing trend, the Ministry of Welfare and CSWB has been providing funds to J&K, like other States of India. The amount of grant has not been permanent, but varies from year to year. During 1983-84 the Ministry of Social Welfare provided to the State Social Welfare Board an amount of Rs.4.24 lakh for this purpose. While as this amount was Rs.3.65 lakh during 1974-75. At present there is only one such hostel in Srinagar and it has the capacity of 50 only. While as at all India level there are only 195 hostels constructed so far, out of 360 sanctioned upto 1985. The capacity of all the hostels runs into 23,081 women only.

It is note-worthy that even during recent decades, with clear understanding and knowledge of the problems working women face in cities, till 1985 only one hostel was sanctioned for J&K and with a low capacity of 50 only. This again is contributing to the problems of working women. Besides, in these hostels no proper facilities are available and lack proper supervision.

**Need for proper Supervision and good Sanitation:**

A majority of 87% residents in these hostels come from orthodox rural culture where they are subject to rigorous discipline. This creates difficulties in the adjustment

with the people after the girl leaves her family. Economy in a village is quite different from the economy of town or city which is money economy and where everything is judged in terms of the money and not on the cultural traditions. A girl with this type of background is little confused when she faces new situations. Therefore, any organization running a hostel for working women has to keep in mind that most of these girls are in a transition period from one type of life to another and, therefore they may take sometime in adjusting themselves to the changed circumstances. They miss the customs of protection of the family and find themselves in a new environment with considerable freedom from both social restrictions and economic dependence. A hostel should, therefore, not only be a place living like a hostel but it must also be a place of continuous education in adjusting to the new type of life. In these hostels there is a very low participation of residents in day-to-day affairs. This has to be changed. In order to overcome the personal problems, the residents must be provided proper counselling services in a family atmosphere. The working women with children must also be admitted in the hostel.

### (d) Family Welfare Services for Women

During past times very strong family ties existed. The only source of security to the members was joint family.

Family used to provide all the services to its members in the time of need. In due course of time the increasing urbanization and industrialization has weakened the family to a great extent and it is no more possible for joint family to look after its members. Changing needs and particular problems require the services of trained personnel. So far, the tendency has been to place women and children, who were victims of broken families, material adjustments and economic difficulties, in these institutions.

In the West, where due to various factors, the family ties have broken, new institutions have come into existence as an alternative. The emergence of `Family Welfare Agency', to help people to solve their family problems can be mentioned in this regard. But in our own societies we do not have many such agencies and looking to the future trends in social and economic life, the necessity of having such services is greatly felt, the joint family no longer can handle adequately, all the problems, particularly when some of the problems of relationship cannot be dealt with satisfactorily without some assistance.

**Health Situation at National level:**

As against the above mentioned background, the significance of this truth is being increasingly realized by the governmental and voluntary agencies, and health services

have begun to figure prominently in every scheme of planned development. As a result of intensified efforts in recent years the medical services for women and children in Jammu and Kashmir have expanded greatly and governmental departments have stepped more and more into this field of work, which was once the concern mainly of private organizations. Unfortunately, due to the past neglect, there is still a lamentable lack of trained personnel and institutions to impart trainings to such personnel. This absence of adequate and insufficient services leaves infant mortality rate at the high figure of 71 per thousand and live births and of maternal morbidity at a figure several times as much.

Looking to the health position during 1959, it was all distressing. At all India level there were approximately 1,750 maternity and child welfare centres, 15,000 midwives, 1,000 health visitors and 100 public health nurses for a population of 360 million people. This information reveals that the number of personnel and institutions is too less and since then every year has marked enormous population growth in India with 843.39 million population in 1991 with decreasing female ratio from 972 in 1901 per thousand males to 929 per thousand males during 1991. Similarly the population of J&K which was around 60 lakh with 25.77 (rural) and 46.86 (urban) during 1971-81 and this has raised to a

population of 77 lakh, with combined growth rate 28.02 for 1991.[17] The above figures show the pressure of population and it can be well understood how it is affecting the limited resources. The Government of India recognizing the legacy of previous regime, and recognized the urgency for all round development in this regard. Each State is assisted by the funds provided under the five year plans, has, therefore, undertaken vast betterment schemes both in rural and urban areas to raise the health status of women. The per capita public sector expenditure on health (medical and public) and famly welfare can be understood by the figures in Table 4. As per these figures at all India level and in all states the trend has been increase in health expenditure every year. At present there are 130,000 (subcentres), 2,000 (community health centres), over 6 lakh trained birth attendents and 4 lakh community health guides.

**J&K Situation**

The Jammu & Kashmir government also realized the enormous trend of the social problems arising out of all this situation. Welfare Extension projects to provide basic minimum services to women and children in the rural areas came into existence during 1961. Their scope and activities have been greatly enlarged in recent years in the rural areas of the State. The whole State has been divided into

several projects, each serving a group of 25 villages and providing maternity and child health services, craft classes, as well as social education for women and children through Anganwadis/Balwadis. The projects have created a new awareeness among rural women in respect of child health care, maternity services and social education.

**Special Medical Projects:**

In order that these facilities may extend to the outlying areas of the State, the Advisory Board has set up 11 special projects during 1985 and around 55 centres are working Leh, Baramullah, Poonch, Akhnoor and Gurez areas. An amount of Rs.15.06 lakh was sanctioned for this purpose by the State Advisory Board. Under each project there are five centres which make available these services to other farflung areas of J&K.

**Special Medical Teams:**

Another activity organizing medical camps in project are as was started during 1980-81. These are occasions when social and health workers from urban areas take various measures to motivate and improve the health of women and children. The CSWB during 1981 sanctioned an amount of Rs.40 lakh for this purpose. This amount was raised to 300 lakh during 1984-85.

## Table 4

### Per Capita Public Sector Expenditure on Health and Family Welfare from 1980-81 to 1982-83

(amount in Rs.)

| Sl. No. | State/Union Territory | 1980-81 Health | 1980-81 Family Welfare | 1981-82 Health | 1981-82 Family Welfare | 1982-83 Health | 1982-83 Family Welfare |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| | India | 23.53 | 2.14 | 27.86 | 2.77 | 32.85 | 4.30 |
| | States: | | | | | | |
| 1. | Andhra Pradesh | 20.5 | 2.33 | 22.51 | 2.94 | 25.38 | 3.88 |
| 2. | Assam | 18.79 | 1.13 | 19.88 | 1.39 | 24.69 | 2.50 |
| 3. | Bihar | 13.29 | 1.36 | 14.49 | 1.98 | 15.60 | 2.86 |
| 4. | Gujarat | 22.84 | 2.97 | 26.71 | 4.50 | 31.58 | 5.84 |
| 5. | Haryana | 28.45 | 2.18 | 37.10 | 2.21 | 40.12 | 4.63 |
| 6. | Himachal Pradesh | 79.37 | 4.71 | 101.29 | 5.88 | 103.47 | 16.98 |
| 7. | J&K | 82.95 | 1.94 | 94.72 | 2.14 | 105.74 | 2.04 |
| 8. | Karnataka | 17.00 | 2.22 | 21.00 | 2.56 | 26.71 | 2.94 |
| 9. | Kerala | 29.76 | 2.40 | 35.61 | 2.67 | 36.81 | 3.22 |
| 10. | Madhya Pradesh | 21.14 | 1.97 | 23.05 | 2.58 | 27.21 | 3.61 |
| 11. | Maharashtra | 25.14 | 2.05 | 33.26 | 3.10 | 39.39 | 5.39 |
| 12. | Manipur | 90.14 | 4.62 | 83.04 | 5.69 | 95.39 | 5.16 |
| 13. | Meghalaya | 120.10 | 3.24 | 131.65 | 4.59 | 148.22 | 6.75 |
| 14. | Nagaland | 201.67 | 1.37 | 208.38 | 1.67 | 313.86 | 8.93 |
| 15. | Orissa | 19.84 | 2.43 | 22.18 | 3.09 | 28.12 | 4.96 |
| 16. | Punjab | 29.60 | 2.15 | 32.55 | 3.08 | 32.66 | 5.40 |
| 17. | Rajasthan | 31.12 | 2.24 | 37.22 | 2.86 | 51.44 | 3.83 |
| 18. | Sikkim | 76.12 | 3.10 | 84.08 | 3.19 | 95.10 | 7.53 |
| 19. | Tamil Nadu | 20.99 | 1.88 | 30.10 | 2.25 | 37.18 | 3.08 |
| 20. | Tripura | 30.87 | 0.96 | 39.04 | 1.36 | 43.33 | 2.46 |
| 21. | Uttar Pradesh | 12.50 | 1.68 | 14.38 | 2.42 | 17.38 | 4.80 |
| 22. | West Bengal | 24.25 | 1.56 | 27.78 | 1.77 | 31.08 | 2.79 |
| 23. | Arunachal Pradesh | 99.85 | 6.88 | 158.05 | 1.50 | 170.05 | 1.30 |
| 24. | Goa, Daman, Diu | 95.71 | 1.88 | 122.94 | 2.02 | 144.16 | 2.58 |
| 25. | Mizoram | 141.95 | 4.37 | 138.88 | 5.27 | 178.06 | 7.20 |
| 26. | Pondicherry | 75.11 | 2.69 | 94.11 | 3.38 | 106.28 | 4.24 |

Source: Health Statistics of India 1985, Central Bureau of Health, Director General of Health Services, Ministry of Health & Family Welfare, 1986, p.79.

As mentioned earlier the idea behind these family welfare services is to focus its attention on the family as a unit and try to help the members either individually or collectively and in helping the family, utilize the existing resources of the family and the community. This is more a preventive rather than a treatment in some cases and helps in meeting the situation, before it goes out of hand and becomes a problem.

**Family Planning Services:**

Family planning was the first scheme to be adopted during the very first Five Year Plan. This programme has played a vital role in improving the health status of women. The idea behind this scheme is to bring about better social and personal adjustment among its clients. This programme has done a commendable job in developing a consciousness among the women in rural areas to care timely for the welfare of their family. During 1980-81, the Government of J&K spent Rs.1.94 lakh on family welfare, out of total expenditure of Rs.82.95 lakh. This amount increased to Rs.2.14 lakh out of a total Rs.94.72 lakh, during 1981-82. And this amount was raised to Rs.2.04 lakh out of total expenditure of Rs.105.74 lakh[18] for 1982-83. This scheme mainly emphasized on birth control. But besides this the couples are advised and educated about their health and the health of

their children. Efforts are made to educate women about the intervals between births and its impact on the health of women. The scope of the scheme goes to the lengths to advise the couples who do not have children. Even the unmarried women are educated about motherhood.

It is neither nor desirable for any agency like this to provide direct social services to a family. This will mean duplication of services and multiplicity of agencies in a community. Therefore, the Family Welfare Agency in J&K make use of the services rendered by other agencies like health departments, ICDS etc. Women, particularly in rural areas, need medical aid, ante-natal and neo-natal and post-natal care, placement in a social or medical institution, vocational rehabilitation etc., for this purpose the existing services in the community should be utilized.

**Health a co-ordinated Effort in J&K**

To provide the above services various agencies co-ordinate and mention may be made of the Health Department is playing a vital role to take these services to the farflung areas where the access is very difficult. The State Health Department has developed a guild of trained personnel in different projects of J&K. The government is also providing funds to construct and start the new primary health centres at the nearest posible distance. While as the number of

family welfare centre and subcentres was 273 during 1975-76. There were 176 medical blocks functioning for this purpose. The number of family welfare centres reached to 243 during 1983 and this number is in addition to the large number of subcentres functioning in different parts of J&K. Out of this number 79 were functioning in rural areas covering a population of 3,758 thousand and 107 were functioning in urban areas covering a population of 858,000. These figures reveal that the number of health centres is far less than the increasing population figures.

**Rehbare Sehat (Training) Scheme**

During 1984 the government of J&K started a new scheme `Rehbare Sehat', covering 29 blocks. Upto 1985, 13 such blocks were covered which include 2 blocks of Leh and Kargil also. The idea behind the new scheme is to make sure the large coverage of rural women. For this purpose around 6,000 trained volunteers were required and out of this 1,000 personnel were trained only during 1980-85.[19] The staff position upto 1977-78 was not satisfactory because of the variations between requirement and the personnel available. During 1977 there was only one Health & Family Welfare training institute. There was a requirement of 57 Medical Officers (M.O.) and only 51 were in position. During the the same period there were 60 Extension Educators (E.E.) and only 7 lady health visitors (L.H.V.) were in position,

against the requirement of 57. Out of 228 required family health assistants only 63 were in position. Besides this out of 142 required auxiliary nurse midwife, only 107 were available. Even out of these figures, the majority of them were working in urban and semi-urban areas and it was only during next decade that attention was shifted to rural areas. From 1977 to 1984 the number of family welfare centres was raised from 57 to 243 during 1983-84. Under the training scheme there was also an increase in this respect. As against 82 required medical officers there were 82 in position and there were 82 extension educators. Besides there were 82 lady health visitors. But even during this period out of 188 required health and family workers, only 77 were available and out of 186 required midwives only 107 were available. There were 23 new family welfare centres under construction in farflung rural areas during 1983-84. During 1984-85 there were two district training institutes in J&K. During the same period there was again an increase in trained personnel and it reached to 224 (M.O.), 190 (B.E.E.), 440 (H.A. female), 67 (H.A. male), 364 M.P.W. (male) and 210 M.P.W. (female).[20]

## Maternity Services

Let us now turn to discuss the nature of the services provided in the family welfare centres, to raise the health

status of women and the child.

Maternity and child welfare form an integral part of the health services, but as mother form the web of a nation's coming generation, a special service supplements the health services for women in addition to the health services available to the general populaion. These services are:

i. Ante-natal care,

ii. Domicilary and institutional mid-wifery services,

iii. Post-natal care IV, well baby clinics,

iv. Health Education,

v. Maintenance of records.

In J&K, maternity and child welfare centre, whether as an independent unit or as a part of the primary health centre, is the focal point from which the health care of mothers and children reaches out into homes of people. During 1975 there were 273 rural family welfare centres functioning under different schemes. Out of this 57 centres were independent and 188 under Public Health Care (P.H.C.), 85 under Family Planning. For the same period there was a requirement of 376 such centres, hence there was a gap of 103 centres, but with the greatest emphasis after years this gap has lessened. During 1983-84 the number of independent units rose to 79 located at different places. Besides this, under P.H.C. scheme 90 centres were functioning. In addi-

tion to this there were 398 sub-centres and 32[21] subsidy centres with less gap between requirement and the availability. The following services are usually provided in these centres.

**Ante-natal Care**

The expected mothers are ushered into a waiting room where their attendance is registered and they get their cards. From there, they go to weighing room to be weighed and are then seen by the Public Health Nurse (P.H.N.) or Health Visitor. The PHN chart down her history if it is her first visit, advise her when necessary and help her to solve any problems that arise. She (PHNs) also carry out certain routine tests and examinations and refer selected women to the doctor. In every case, the expectant mother has to see the doctor on her first visit and at least once in a week during the remaining period of pregnancy. She is seen by the doctor more often, if as the case may be.

**Maternity Camps (Multi-purpose Scheme)**

To render these services in an efficient and safe manner special camps are organized where the personnel are provided proper training in this regard. The scheme was started during 1974-75. During 1971 in J&K there was one state level institute, besides special camps to provide particular kind of training. During 1977 there were 63

trained family welfare health assistants and 7 lady health visitors. During the same period there were 8 district public health nurses. Another scheme known as 'Multi-purpose Scheme', was started to make the staff position more wide and during 1984 out of total 10 districts of J&K two were covered under this scheme. But only in one district this scheme is implemented. During the same period under this scheme 440 female health assistants and 210 female multipurpose workers (FMW) were trained upto January 1984. During the 6th plan (1980-85) out of 774 required trained ANM/HW(F) and LHW/HA(F), 381 were in position and out of 193 required 67 were in position, respectively. The fact that the above figures reveal a gap between the required and available personnel to deliver these services, but from the time of the inception of the scheme every year there is a very slow increase of trained personnel. The late initiation has contributed to the low achievements as compared to other states of India. But the fact remains that these services have developed a new awareness, among the rural women folk and the trend shows that more and more women are coming to avail these services. More success will require dedicated workers and hard motivating forces.

**Midwifery Services**

The hospitals and maternity homes, in towns and cities institutional midwifery services are provided. In rural

areas a few maternity beds are provided in primary health centre. A woman who is expected to have a normal delivery is encouraged to have her baby at home provided the conditions in the home permit of doing so. To obtain the conditions in the home, Primary Health centre staff for a home delivery, the woman should have attended the ante-natal clinic regularly. Home deliveries are conducted by midwives and/or *Dais* employed in the centre. Local *Dais*, who also conduct deliveries in homes, are given training by the M.C.H. centre staff to obtain a more safe service. Post-natal care in the lying period is given by the midwife who delivers the woman. General supervision is exercised by the P.H.N. from the centre. The doctor incharge of the M.C.H. centre is called in, if medical attention becomes necessary.

**Post-natal Care**

A post-natal clinic usually conducted on the same day as the clinic for infants. About six weeks after delivery, the mother is seen by the doctor who examine her to ascertain that she has returned to normal health. The mother is advised about diet, exercise etc. On this occasion advice is given on the space of future pregnancies.

To provide these services in an efficient manner and to make a safe delivery, special camps are organized for the training of midwives and *Dais* at district or sub-district

level. During 1974-75 a new scheme for training was started whereby the new targets are set for future. Besides this during 1980s a new scheme 'Rehbare Sehat' was started to impart training at district level. During 1983 there were 3,424 trained *Dais* and 3,424 were in 1984. The target set included 1,000 for 1983-84 and 5,000 for 1984-85. During 1984 there were 83 such centres functioning in villages and the number of blocks covered was 13. Out of targetted 6,000 required voluntary health guides, only 24.50% of the target was achieved till 1984.

**Maternity Services and Infant Mortality**

Although there has been a steady progress in the trained personnel availability and its low profile in rural and hilly areas, this cannot be denied that the progress has got a tremendous momentum to motivate and develop awareness about this type of services. These services have played a vital role in reducing the birth rates. By reducing the infant mortality (both neo-natal and pre-natal) and morbidity people have become to a greater extent of surity of the survival of their children. This can be clearly understood from the Tables 5 and 6. The estimated births by medical attention for 1987 have been around 1.5% and 20.6% deliveries conducted under the maternity service schemes. While as 66.5 are conducted by the local untrained *dais*.

Thus it can be emphasized that more emphasis should be given on the training of local voluntary *dais*. As against this 55% deaths take place in homes who have not visited the hospital, health centre or any other such institution. While as only 8.3% deaths occurred in hospitals. Besides, the family welfare workers have developed a new awareness about the space of births and its effect upon the health of women. But one of the drawbacks has been the concentration of these personnel in urban areas than in rural areas, whereas women in urban areas are comparatively more literate and aware about the benefits of such services. On the other hand women in rural areas are mostly illiterate and the medical or maternity facilities are rare. Therefore if this scheme is to become a big success, a strong campaign will have to be launched to encourage the participation of local voluntary women workers.

## Table 5

### Percent Distribution of Sample Births by type of Medical Attention at Birth 1987

| Sector | Type of Medical attention at birth | | | | |
|---|---|---|---|---|---|
| | I | T | U | O | J&K |
| 1 | 2 | 3 | 4 | 5 | |
| Rural | 6.9 | 15.9 | 76.1 | 1.1 | |
| Urban | 27.0 | 37.2 | 32.8 | 2.4 | |
| Combined | 11.5 | 20.6 | 66.5 | 1.4 | |

I - Institutions like hospitals, maternity/nursing homes, health centres.
T - Delivery conducted at home by doctor, trained *dai*, trained midwife, trained nurses etc.
U - Delivery conducted at home by untrained village *dai* or other untrained professional functionary.
O - Delivery conductred at home by relations and other excluding the above.

Source: Sample Registration System 1987, Registrar General of India, Ministry of Home Affairs.

## Table 6

### Percent Distribution of Sample deaths by type of Medical Attention received before death 1987

| Sector | Type of Medical attention at death | | | | |
|---|---|---|---|---|---|
| | I | M | U | N | J&K |
| 1 | 2 | 3 | 4 | 5 | |
| Rural | 5.9 | 52.0 | 28.0 | 14.1 | |
| Urban | 16.7 | 67.9 | 10.3 | 5.1 | |
| Combined | 8.3 | 55.6 | 24.0 | 12.1 | |

I - If the death occurred in a hospital dispensary, health centre, other medical institutions etc.
M - If the death occurred at home but was not attended by a qualified practitioner.
U - If the death occurred at home and was attended by an unqualified practitioner.
N - No professional doctor/Hakim/Vaidya attended.

Source: Sample Registration System 1987, Registrar General of India, Ministry of Home Affairs.

## Maternity Service projects: a critical appreciation

i) The Government of J&K during 1974-75 started the scheme `Rehabare Sehat' and under this schemee local voluntary *dais* were encouraged to receive training about safe delivery. But this programme could not continue very long. This is because of the reason that these voluntary women are not paid any honorarium and at the same time this type of camps are not organized at local level. They are organized either at district level or sub-district level. As the data in Table 5 reveals that about 66.5% births are conducted by local women, therefore, to give training to such women is a must for the real success of the programme. One note worthy thing is that most of these family welfare centres lack lady doctors, because most of them after completing training period prefer to settle in the cities, where they get ample of facilities and earn huge amounts through private practice. It is desirous to make it encouraging trend to admit more and more female students for medical profession from the rural areas. *At the same time it should be made compulsory that after they complete their training they must be bound to serve in rural and backward areas of J&K for at least 5 years of their career private practice should be banned for these years.*

ii) *Another most unfortunate problem is that in the rural areas once a lady doctor or a trained midwife or a dai conduct the delivery, they demand huge amounts from these people and if some one fails to do so, she becomes a handicapped in receiving better treatment. This has created a lot of distress among the rural and backward masses of J&K.*

iii) Thirdly, the J&K has a considerable portion of its population living in hilly and tribal areas. There are places, which remain cut-off for most of the period. In order to make the safe delivery a sure, it is essential that local women should be encouraged to receive training by organizing special camps for this purpose, some kind of incentive must be provided to them during training period. Obviously these women can always be available and can serve the community at the time of need.

iv) One more problem is that the women in rural areas generally do not pay visit to maternity centre for post-natal services. This aspect has to be emphasized during pre-delivery period and motivate the women by informing her about its benefits. Rural women must be provided proper and energetic medicine free of cost, for their safe recovery.

## (e) Rehabilitation & Old age Pension Scheme

Social institutions like the Joint Family, Caste System and Panchayat have been providing help to the needy, destitute and aged since old times. Since due to several factors these institutions have weakened and it is no more possible to expect such services from these traditional institutions. The problem of old persons in J&K is not as serious as else where, but there are few problems which need immediate attention

**Old Age Pension Scheme:**

In order to provide social security by way of grant of financial assistance to destitute, old and disabled women who have none to support them and have no source of livelihood, the government of J&K started 'Old Age Pension' scheme during 1976. This scheme is administered by the J&K Social Welfare Department. A woman is deemed to be destitute if she has no income or source of income to maintain herself or having one or more dependent members, but her total income does not on average exceed Rs.25 p.m. She must be a widow and of 65 years or more in age. Provided that in the case of a woman incapacitated to earn a living due to blindness, leprosy, insanity, paralysis or loss of one or more limbs or is disabled due to any other ailment, the age restriction does not apply. An amount of Rs.50 is monthly paid to each

case. During 1980-81, the Ministry of Social & Women's Welfare released an amount of Rs.0.25 lakh, and this amount was raised to 0.93 lakh during 1984-85. The total number of beneficiaries (both male and female) during 1984-85 was 5,464. The total amount disbursed during 1983-84 was Rs.45 lakh.[21]

**Markazi Falahi Mastoorat/Nari Niketan**

Another scheme meant for the rehabilitation of destitute women is known as `Markazi Falahi Mastoorat/Nari Niketan'. Under the centrally sponsored scheme of training for rehabilitation of women in distress, started in 1977-78, Government of India extended 90% assistance subject to ceiling of Rs.1,09,350 to voluntary organizations for imparting training in marketable skills to destitute women. From 1979-80, 90% expenditure of the scheme is shared equally by the J&K Government and the Central Government. The following categories of women are admitted to these destitute homes:

(a) Who are deserted and have none to look after them.

(b) Who are widows and have no means of livelihood.

(c) Who are between the age of 60 and 65 years with no means of livelihood and suffering for want of shelter. After the age of 65 they shall be brought under the fold of old age pension scheme.

(d) Who are not in receipt of old age pension.

(e) Who are orphan/destitute having no source of income.

(f) Destitute women with female babies are also admitted.

These inmates remain in the institution till they are rehabilitated properly or till they get married. As far as possible an endeavour is made to rehabilitate the inmates. If an inmate cannot get a job due to age bar or any other reason she is covered under any of the schemes for employment or self-employment. If an inmate of marriageable age is willing to get married, she is provided with financial assistance by the competent authority and discharged from the institution after the solemnization of her marriage. The inmates are provided all facilities for continuation of their studies, course or training, as the case may be. Besides this they are provided with free bedding and clothing.

Each destitute home has a capacity of 25 inmates. At present (Decmeber 1992) there were five such homes working in Kashmir. Thus benefiting a number of 125 such women.

**Job Reservation Scheme:**

*Besides the above schemes, a particular quota of jobs is reserved for women* in different state departments, institutions. The Government of J&K in 1976 issued an order in this regard which reads:

"Whereas the Government is of the opinion that women in the State are socially and educationally backward and are not adequately represented in the services under the State. Now, therefore, the Governor hereby directs that recruitment vacancies shall be reserved in favour of women candidates subject to their minimum suitability for various services/posts in the services under the State."

This quota includes 5% direct recruitment in the junior wing of Kashmir Administrative Services, 5% in Engineering. Besides this the quota is 10% in non-professional courses.

## Legal aid to women

In addition to the above welfare schemes, several legal Acts have been passed for the welfare of women. Some of the central Acts which are directly applicable to J&K include:

(a) Hindu Widow Remarriage Act and Property Act, 1963.

(b) Buddhist Polyandrous Marriage Prohibition Act, 1941.

(c) Dowry Prohibition Act, 1961.

The Acts passed by the J&K Government include:

(a) Immoral Traffic Act, May 1928.

(b) Infant Marriage Prohibition Act, 1985.

(c) Probation of Offenders Act, 1966

(d) Children's Act, 1970.[23]

The fact that the statute book is full of different social legislation, and every years new social legislations and Acts are passed, but the experience reveals that most of these social legislation are ineffective to produce any concrete result. This is particularly due to lack of public awareness about these laws.

## Conclusion

Thus the above discussions lead us to conclude that the position of women in Kashmiri society has become a victim of destructive customary practices, social and ritualistic. Furthermore, this unwholesome situation tended to encourage rigidity in both Hindu society and Muslim society. The degradation of women's position can be seen in her inferior status, the prevalence of early marriage and imposition of social barriers on women in general and on widows in particular. Thanks to the early social reforms and latter efforts of government and voluntary organizations, that the scene has changed to a new direction.

Considering the magnitude of the problems in J&K, the results achieved so far cannot be said to be spectacular. But considering the limited financial resources, the

difficulties of transport and access to areas where even a jeep cannot reach, the level of backwardness and poverty, it can be claimed that results are encouraging. It shows we could achieve more through the dedication and leaderlship of voluntary agencies duly backed by the government.

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## Chapter IV

## PROBLEMS OF CHILDREN IN JAMMU & KASHMIR AND THE WELFARE POLICIES

"Nation marches on the feet of children. We have a vulnerable section of population under six years of age. After going in to the backdoor corners, we should put our selves in the web of a heavy question that how well are we preparing our children to be the architects of our nation."

The quality of Human Resources of any country is largely determined by the quality of its child development services. Therefore, the sole purpose of children's welfare rests on all round development -- physical, mental and social - of a country, since the children are the key to development and future of mankind in general, and of a nation in particular.

The above discussions are not merely to underline the importance of the child in the scheme of things, for it is universally accepted, but to put ourselves the question whether we are really serious about the welfare of children in relation to the various disabilities, they suffer, inspite of drastic developments both in developed and developing countries. The forthcoming discussions will concentrate on various problems of children and the impact of social welfare policies adopted so far to improve the lot of chil-

dren in India at national level in J&K at state level.

## New Challenge to the Traditional Role of Joint Family in Child Welfare

In India in general and in J&K in particular, the Joint Family System still prevails on a considerable scale. One notices, however, that changes have overtaken in the wake of rapid urbanization and the attendant social forces.

The Joint Family System with the changes that over took it with the progressive in roads in to the economy of self sufficiency in rural areas and with its divergence in to cellular units extended to urban areas, increasingly failed in giving adequate material and emotional protection to the child. Life which became complicated kept on making heavy demands on the individual. The education given in the family and at the local level proved increasingly inadequate to meet the challenges thrown up by modern life. In facing new problems the younger generation could not depend much on the advice of old who were supposed to be repositories of wisdom and authority.

All these factors led to the collapse of old order. The social institutions and individuals lagged behind. The safeguards which were there in the order ceased to be effective. The new ways of life made unknown and heavy demands

on individuals. This situation gave rise to series of complicated problems. The dumb, the deaf, the blind, the physically handicapped, and the mentally ill who were formerly cared in the family were now being exposed to new dangers.

**Incidence and Nature of Emerging Problems:**

Before the state effort had become sizable and effective the familyWas incapacitated to take care of the problematic persons. This led to the more serious problems which had social roots and to which children became an easy prey. The crumbling of the old order, absence of new healthy substitutes, and confusion in transition made the situation extremely complicated. The absence of a definite comprehensive plan behind the welfare of children contributed the problems to become more grim.

Against the above background some knowledge of the needs of the child, availability of funds and desire to do something for suffering children seemed to be important considerations that prompt promotion of child welfare institutions. Although at national level this aspect was attended during the early period of independence, but in case of J&K this aspect remained neglected for a considerable period of time. Although in the absence of trained personnel and a scientific approach, some voluntary institutions and

organisations carried on welfare programmes, but at a small level. The voluntary effort, however was largely isolated and mostly unsustained.

The past four decades especially have seen Indian society and J&K virtually saturated with crime, sensationalism, sadism and brutality. Broken homes, conflicts and unhappy intra-familial relations, widening of spheres of occupational and social activities have inadvertently contributed to the present sad state of affairs. The problems both at national level and in J&K mark their dawn from social, economic, mal-nutrition and various disabilities to the victimization of the children.

## Specific Problems of Children in J&K

The world at present has about 4500 million inhabitants of whom 1500 million are aged below 15 years of age. Each year about 120 million infants are born, the great majority of whom are living in developing countries. In comparison to it the population of J&K is 7,718,700 and out of the total population the estimates percentage for 1987 was 13.8% males and 14.2% females.

**(a) Infant Mortality:**

Children constitute around 40% of the J&K population. Out of this the population of children in 0 - 4 age group is

13.8% males and 14.2% females. Under the age group 5 - 9, it is 17.4% for males and 11.8% for females. While as this is 13.0% for 10 - 14 (male/female) children. Around 10% of these die before they reach one year of age. Those who survive are either impaired, disabled or handicapped. The causes responsible for disability differ among industrialised and third world countries. In the former the disabilities are primarily linked with the ageing processes and to occupational diseases, in the latter they are the result of infectious diseases and malnutrition.[1]

**Low age at marriage and its impact on the child:**

As mentioned above children constitute 40% of J&K's population, a proportion which remained constant through the past 20 years (UNICEF census report 1984). The age distribution of the population according to UNICEF is the combination of high fertility and steady decline in mortality. State differences in fertility in terms of the level of education leads to the one visible factor i.e. a definite relationships between education and fertility. Looking from this point of view the female literacy in J&K is as low as 26% (1981) which leads to the early marriage of girls.

One of the crucial factors contributing to high fertility is the age at which girls get married. As at national level the average age of girls at marriage is as a whole

according to Registrar General's data of 1981, 16.7 years. It is thus obvious that a good part of pregnancies in India today are teen-age pregnancies. While as in case of J&K the data in the table 7 for 1987 reveal that the estimated fertility rate among the rural women was 61.4% in the age group of 15-19 years. For the same period it was 40.8% for urban women. The combined fertility rate among young women is 219.1 in the age group of 20-24. So as the age group at marriage goes high, the reproductive period is less and the child born can be healthy one than the child born in a teenage group of 15 to 19 years, as the mother during teenage is under developed and hence a greater chance of morbidity and infant mortality.

**Specific Age Groups and infant mortality:**

Though the general mortality seems to show figures almost half 47% of the total, deaths which occur in the first age 0-4 years seem to be more compared to the mortality in the other age groups. About one third of all deaths occur in the first year of life only. The proportion of infant deaths varies from region to region and is linked to a number of factors viz ante-natal care of expectant mothers, institutional care during delivery, infant care after birth, socio-economic support of the family and awareness or educational level. The figures in the tables 8,9 and 10

show the infant mortality rates linked with the factors like age at marriage of women level of education and most important the income level of the household. But all these factors are inter-related and dependent on each other. As age group is higher so the less infant mortality, higher education, less infant mortality, and as the higher income so the less infant mortality.

Table: 7

ESTIMATED AGE SPECIFIC FERTILITY RATES AND OTHER FERTILITY INDICATORS - 1987

( J&K )

| Age Group | Rural | Urban | Combined |
|---|---|---|---|
| 1 | 2 | 3 | 4 |
| 15-19 | 61.4 | 40.8 | 57.0 |
| 20-24 | 233.3 | 175.4 | 219.1 |
| 25-29 | 277.9 | 184.2 | 217.6 |
| 30-34 | 190.7 | 112.2 | 173.1 |
| 35-39 | 101.7 | 45.7 | 89.9 |
| 40-44 | 51.2 | 16.9 | 43.6 |
| 45-49 | 28.6 | 12.4 | 24.7 |
| Crude birth rate | 32.6 | 25.1 | 31.0 |
| General fertility rate | 4.5 | 2.9 | 4.1 |
| Gross reproduction rate | 2.1 | 1.3 | 2.0 |

Source: Sample Registration System 1987. Published by Registrar General of India, Ministry of Home Affairs, Govt. of India.

**(b) Problem of Disability:**

There are several causes of disability which can be classified as:-

(a) Diseases

(b) Mal-nutrition and low birth Infants

(c) Congenital Anomalies and socio-economics Status.

**(a) Diseases as a cause of Disability:**

Cotran in his study conducted in 1973 reveals that certain diseases of early infancy constituted the leading cause for deaths in United States, the mortality rate being 10 times greater in the first week of the infants life. He further points out that children are not merely variants of the disease of adult life. Most of the conditions are unique to or atleast take destructive forms in this period of life.

Table : 8

Infant mortality rate by age at marriage of women in J&K - 1984

| Age at Marriage (years) | Infant Mortality | | |
|---|---|---|---|
| | Rural | Urban | Combined |
| Below 12 | 205.7 | - | 164.5 |
| 12-14 | 85.2 | 48.3 | 78.3 |
| 15-17 | 79.7 | 63.2 | 77.4 |
| 18-20 | 82.5 | 55.6 | 77.9 |
| 21-23 | 73.9 | 19.7 | 63.4 |
| 24 + | 90.1 | 91.8 | 79.5 |

Source: Ministry of Social Welfare, Govt. of India, 1986.

## Table : 9

### Infant Mortality Rate by level of education of Women -- J&K 1984

| Level of Education | Infant Mortality | | |
|---|---|---|---|
| | Rural | Urban | Combined |
| Illiterates | 88.4 | 57.8 | 84.3 |
| Literate but below primary | 42.7 | 47.2 | 43.7 |
| Primary but below matric | 37.7 | - | - |
| Matriculation and above | 40.6 | - | - |

Inadequate Sample: Source:- Ministry of Social Welfare, Govt. of India, published in Hand Book on Social Welfare Statistics 1986.

## Table : 10

### Infant Mortality Rate by total annual income of the household -- J&K 1984

| Annual Income(Rs.) of the household | Infant Mortality Rate | | |
|---|---|---|---|
| | Rural | Urban | Combined |
| 5,000 and below | 84.4 | 88.2 | 84.5 |
| 5,001 - 10,000 | 81.3 | 80.4 | 81.2 |
| 10,001 and above | 81.5 | 28.2 | 68.5 |

Source: Ministry of Social Welfare, Govt. of India Published in Hand Book on social Welfare statistics 1986.

**Incidence of disability as a result of specific diseases**

The most hazardous period in life is during neo-natal period, and it is evident that apart from congenital anomalies the major cause for disability is attributed to the complications during pregnancy, especially the respiratory distress syndrome. Apart from this, diseases also are the main contributing factor to disability and death during the first year of life (Saunders 1979) poliomyelities or infantile paralysis as it is called, is one of the common causes of disability in children. Polio has in varying stages been affecting the lives of children below the age of 14 years.

The 1979 data reveal that while at national level 480 persons died because of Cholera, in J&K this figure was as high as 82 persons. The Dysentery and Diarrhea figures were 564 persons and fever death figures ran as high as 10,021. Besides this, the plague figures were about 12 persons and other causes tolled 11,157 lives. It is definite that the children are the easy prey to all these diseases which take a heavy toll of these children. Even out of these children, the kids of 0-4 age are more prone to these diseases. The data available show that the number of infant deaths due to various diseases is 20 for 0-4 age group, while as it is 1.2 for 5-9 age group and 0.9 for 9-14 age group. Respiratory disease tolled the death of 4,634 persons.

**(b) Malnutrition and low birth weight infants:**

According to a UNICEF Report (1979) there are about 60 million mal-nourished children in India. Statistics show that approximately 80% to 90% of children in India as well as in J&K, do not receive adequate amounts of key vitamins and minerals. Children in the age group 0-6 years suffer from nutritional anemia and protein calorie malnutrition in one form or the other where most of them have low body weights with a figure of 75% as compared to those of the standard weight of correspondingly well nourished children.

Nutritional blindness resulting from the deficiency ocular diseases, xeropthalmia and keratomalacia have been estimated to be the greatest cause of blindness in pre-School children. World Health Organization (WHO) data reveals that there are an estimated 42 million blind in the world at present. Xeropthalmia or nutritional blindness is one example which accounts to an estimated number of 250,000 children in Asia alone (Pettis, 1981).

Studies indicate that infants who are underweight or are born with low birth weight are a direct result of mal-nutrition and poor health status of their mothers, who during pregnancy have not balanced their diet with addition-al intake of iron and vitamins. Pre-natal and post natal care is therefore given much importance even from the nutri-

tional point of view. But in J&K the social education has not covered majority of women to develop an awareness among the rural illiterate women about the proper diets, child care etc. This is again proved by the data that highest infant mortality occur during 0-4 years of age. According to the data around 23.4% males and 16.6% female infants (0-4) die during this period.

**Socio-Economic Status and Disability:**

Several studies indicate a close relationship between socio-economic status and the disability among infants.

UNICEF report (1984) states that infant mortality which was 125 per thousand infants in the year 1978 was found to be higher in rural (136 per thousand) than in the urban areas (70 per thousand) and more higher among the Scheduled Castes, 159 for rural and 90 per thousand for urban areas. A study done by National institute of Public Cooperation and child Development (NIPCCD) in 1983, emphasised that mal-nutrition is a sure indicator to poor socio-economic status. Its report reveals that the number of children who die every month is approximately one lakh and every year 15 thousand become blind as a result of mal-nutrition (Vitamin A deficiency). This is either directly or indirectly the highest contributor to morbidity and infant mortality.

It is generally agreed that the income levels of a substantial section of the population at national level in India and in J&K at state level are too low to permit them access to the food consumption of adequate quantity and quality. The average food consumption in the households covered in NNMB reports apparently do not indicate major deficiencies (except for Vitamin A), but the average values may not tell us the whole story. The NNMB - NSSO (National Sample Survey Organization) linked surveys of 1983-84 showed that an average food expenditure of the families surveyed ranged from Rs.73 to Rs.80 per month, representing 60 to 70 percent of their total household expenditure. As against this, the NNMB data of 1988-89 show that in 34% of the households surveyed the monthly per capita income was less than Rs.60.[2]

After discussing the situation at national level, let us now turn to the situation in J&K. When we look in to the case of J&K the lower incomes also contribute to the problems of women and children directly. This can be understood from the figures in table 10, for 1984. The infant mortality among the households with annual income of Rs.5000, is 81.2 per thousand. This rate is 81.2 per thousand for those households with the annual income of Rs.5001 to 10,000. The infant mortality is lowest among those households which have an annual income of Rs.1,0001 and

above it. For them it is 68.5[3] per thousand.

**Decreasing trend of breast feeding and Infant mortality**

The importance of breast feeding for the survival of children has been underlined by the WHO - they say that infants breast fed for less than six months are five times more likely to die in the second six months of life than those who have been breastfed for longer. This will require the healthy mother and when she will take rich diets only then she can breast feed her child for a longer period. Here we can argue that women in J&K work for longer hours and particularly the women in rural areas do not get proper diet. Hence are not in a position to breast feed their children for a longer period. Similarly the weather condition they live in is again harmful for their health. During winter the women in rural and tribal areas get a very poor diet. All these factors along with the short intervals between births increases the risk of death of a newly born baby.

**(c) Problem of victimization and exploitation:**

Be it in the match making industry of the South or in the carpet industry of the North, Smiles have become alien to children. Man's blatant quest for economic and industrial progress makes the child crippled.

The exploitation of children is the outcome of inter play of several factors, which are both internal and external. Inside home they may include parental attitudes, poverty, poor housing etc. due to which the child seeks solace outside his home, comes in contact with undesirable elements and becomes a victim.

**Child Labour and Exploitation:**

One form of the child exploitation out side home is the child labour. Child labourers are those who are deprived of their right to grow as a healthy child; who are forced by the socio-economic handicaps to work for a living either to feed themselves or to support their families, and whose work affects their health and deprives them of their right to education.

There are record number of 16.5 million child labourers in India, while in J&K there are around 3 lakh children working in carpet industry only. Due to several socio-economic reasons, these children, mostly under the age of 14 years, are forced to work under the conditions which are in disharmony with their age and health. They are recruited mostly from the illiterates, small and middle class peasants. In Jammu region, the child workers mostly come from the Scheduled Castes and it is this group to which most bonded labourers belong.

Most studies into child labour point to a linkage between illiteracy, poverty, caste, class, bondage and child labour. This can be very well understood by the figures available in the table 11. To begin with, Kerala with the highest literacy has the lowest rate of child labour, whereas states like Andhra Pradesh having low rate of literacy have the high rate of child labour. In J&K, literacy rate being 26.67% (1981 census) child labour is 3.5%. Only 41.1% children belonging to untouchables and tribals were going to schools during 1978 (Govt. of India, 1985.).

**Exploitation of Female Infants:**

The internal factor of exploitation is the biased attitude of parents towards girl children. Working girl children are subjected to three fold discrimination. First of all, they belong to the weaker sections of society. Secondly, tradition and curstom diseriminate against them in case of education. Thirdly, they are allowed only into role-specific occupations, which in most cases ensure that education and benefits of the world outside their home evade them. The data shows that the literacy for female is 23.03% as against 36.87% in urban areas. While as this is 11.16 (females) and 20.34 (males) for rural areas. There are a dozen of laws prescribing minimum wage, age and other conditions for various categories of labour in both organized

and unorganized sector. As early as 1938, Indian Govt. passed children's Act to arrest the menace of child labour. In J&K, children's Act was enacted in 1970, but of no avail. These laws did little for the rehabilitation of child workers.

Table : 11

Literacy (1981) and child labour participation rate (CLPR) (1971) in India (States Graded According to literacy in 1981

| Literacy Ranking | States | Literacy 1981 | CLPR 1971 |
|---|---|---|---|
| 1 | Kerala | 70.42 | 1.30 |
| 2 | Mizoram | 50.88 | N.A. |
| 3 | Maharashtra | 47.18 | 4.74 |
| 4 | Tamil Nadu | 46.76 | 4.58 |
| 5 | Gujarat | 43.70 | 4.51 |
| 6 | Nagaland | 42.57 | 7.02 |
| 7 | Himachal Pradesh | 42.48 | 5.01 |
| 8 | Tripura | 42.12 | 2.54 |
| 9 | Manipur | 41.35 | 3.59 |
| 10 | West Bengal | 40.94 | 2.69 |
| 11 | Punjab | 40.86 | 4.16 |
| 12 | Karnataka | 38.46 | 6.50 |
| 13 | Haryana | 36.14 | 2.97 |
| 14 | Orissa | 34.23 | 5.30 |
| 15 | Meghalaya | 34.08 | 6.91 |
| 16 | Andhra Pradesh | 29.94 | 9.24 |
| 17 | Uttar Pradesh | 27.16 | 3.59 |
| 18 | Jammu & Kashmir | 26.67 | 3.56 |
| 19 | Bihar | 26.20 | 4.42 |
| 20 | Rajasthan | 24.38 | 5.16 |
| 21 | Arunachal Pradesh | 20.79 | N.A. |
| | National Average | 36.2 | N.A. |

N.A.: No information

Source: Govt. of India 1985: 460-461

The detailed analysis of various problems and their nature faced by the children in developed and developing countries, leads us to argue that the genesis of the problems lies in the social, economic and political factors. These factors and the dimension of these problems changed according to the time and space. One of the facts to be noted is that inspite of acute prevalence of these problems, no serious attention was paid in this direction. This is particularly true in case of developing countries which lacked an integrated approach to tackle the problems of children. It was only during the early decades of this century that positive steps were taken at international level and which became the guide-lines for child welfare to the individual countries.

## Child Welfare and Development in India

Before we go in to the details about the welfare measures and their impact on children, it is essential to deal with the conceptual issue of what is child welfare. This is important for us to know because only then we can reach a clear understanding. According to the U.N. guidelines, child welfare refers to the well-being of the child. It includes all services needed to ensure the physical, intellectual, emotional and social needs of the child. It should include all measures economic, educational, social and

health intended to give to each individual an equality of opportunity for growth and development. These welfare measures are indeed a part of investment, rather than expenditure.

The rights of the child (0-16 years) have been specified in the General Assembly Resolution of the U.N. in 1950 underlying the need for special protection and scope of opportunity and facilities to enable him to develop in a healthy and normal manner. The contribution of international agencies in the development and welfare of children in India can not be ignored. Particularly, the UNICEF's role has been of crucial importance. India has been receiving assistance from this organization and to run the different schemes and projects intended for the welfare of children. According to figures in table 12, during 1981 an amount of 33,242 (US$) were provided to India and this was raised to 40,011 (US$) during 1985.

## Child Welfare Measures at National Level:

There were no specific programmes for children at the central level prior to 1950, except those undertaken by a few ministries which organised certain welfare services for the children of their employees. Although the employment of children prohibition Act was passed in 1938, but it came into force of late.

Table : 12

UNICEF Assistance to India from 1981 to 1985 in (US$)

| Programme<br>1 | 1981<br>2 | 1982<br>3 | 1983<br>4 | 1984<br>5 | 1985<br>6 |
|---|---|---|---|---|---|
| (A) Funded by General Resources | 28,885 | 30,635 | 28,894 | 25,607 | 32,000 |
| I. Convergent Services | | | | | |
| a. Integrated Child Development | 1,107 | 7,489 | 7,994 | 6,175 | |
| b. Social inputs in Area Development | 1,377 | 1,284 | 2,434 | 2,826 | |
| c. Development of womens children in rural areas | 2,828 | 1,281 | 1,068 | 1,043 | |
| d. Urban Development | 427 | 1,186 | 1,707 | 1,220 | |
| II. Technical Services | | | | | |
| a. Water & Environmental Sanitation | 10,134 | 8,894 | 4,340 | 4,554 | |
| b. Health & Family Welfare | 6,609 | 6,514 | 6,153 | 5,120 | |
| c. Childhood education, disability & destitution | 2,682 | 1,667 | 3,467 | 2,561 | |
| d. Education in food & Nutrition in agriculture universities | 387 | 306 | 168 | 208 | |
| e. Food & Village technology & bigas | 438 | 548 | 198 | 218 | |
| III. Awareness & Capacity building | | | | | |
| a. National institute of public cooperation & child development | 123 | 132 | 86 | 98 | |
| b. Indian council of Medical research/research monitoring, evaluation | 538 | 653 | 514 | 431 | |
| c. Information/programme support communication | 194 | 248 | 276 | 416 | |
| IV. Others | | | | | |
| Emergency relief, rehabilitation etc. | 2,041 | 433 | 489 | 728 | |
| B. Funded by special purpose contributions for noted projects | 4,357 | 4,977 | 4,319 | 5,395 | 8,011 |
| Total | 33,242 | 35,312 | 33,213 | 31,002 | 40,011 |

1 liable to change, as it depends upon the availability of funds including supported donors.

Source: Department of Women's welfare, Ministry of Human Resources Development, Govt. of India.

## Role of Central Social Welfare Board:

A planned approach to child welfare was made in the first five year plan, when the planning commission decided to give priority to the needs of the child. Out of the Central Social Welfare Board's (CSWB) provision of Rs. 4 crores for grant in aid to voluntary organization. The largest part was given for child welfare services. As many as 992 grants, amounting to Rs. 29.90 lakhs were sanctioned under the first plan to about 592 organizations all over India. During the second plan period, upto Oct. 1960, the CSWB had made 3,561 grants amounting to Rs. 108.06 lakhs. The total number of grants sanctioned by the Board from August 1953 to Feb. 1961 was 6,853. They amounted in all to Rs.157.67 lakhs and were disbursed among 4,707 institutions.

## Role of National Children's Board:

The National children's Board in India was created in 1974 to ensure continuous planning and co-ordination of welfare services. A specific fund, National Children's Fund was created for this purpose in 1979. The National Children Board was re-constituted on April 4, 1984, which has 29 members and is headed by the Prime Minister.

## Social Welfare Measures and their Impact on Children in J&K

Setting up the Central Social Welfare Board in 1952, and the consequent establishment of State Social Welfare Boards, put J&K on the map of social welfare. The state social welfare department in collaboration with the State Advisory Board, initiated the welfare services for children in the different parts of the state. Besides this, the National Children Fund was created during 1979.

**Role of Voluntary Organizations:**

The voluntary organizations which are involved in the services for children can be listed as, Nehru Yuvak Kendras, Kasturba Gandhi National Memorial Trust, Bhartiya Adam Jati Sevak Sangh and Harijan Sevak Sangh. These organizations are provided grants in aid after the J&K government passed a legislation in July 1970 which provides for grant-in-aid to the voluntary organizations involved in the welfare activities.

Since 1974 different voluntary organizations have been getting grant in aid. During 1981-82, a sum of Rs. 0.24 lakh was sanctioned by the Ministry of Social and Women's Welfare, under the scheme of 'Children in need of care and protection', to these voluntary organizations. This amount was raised to 170.02 lakh for 1985, to render such services

all over India. Besides this, the Central Social Welfare Board released an amount of Rs.9,500 to voluntary organizations during 1984-85.[4] The granted funds were utilised for founding homes, orphanages, creches for the children of needy families, Balwadis, infant centres, cultural and recreational activities, holiday camps etc.

## Social Welfare Services for Children and the Role of Government Agencies

The Children's population (0-14), according to the census, constituted around 40% of the total population of J&K. The dependency ratio was more than 854 in 1981. By dint of this huge population the problems of children are bound to be enormous. Consistent efforts, as a part of Five Year Plans of the state have been made to improve the lot of children. These efforts came out in the form of different welfare schemes. But this should not lead us to assume that the performance is satisfactory. But still a lot is left to be done in the future. In the following discussions an attempt will be made to analyse the nature of these welfare schemes and their achievements and failures.

The welfare schemes for children can be divided under the following heads:-

## (A) Integrated Child Development Services

Off all the social welfare schemes, outstanding activity is that of the Integrated Child Development Services (ICDS), having extensive coverage in respect of beneficiaries and geographical spread. The centrally sponsored and UNICEF aided scheme envisages to provide an integrated package of services, including immunization and supplementary nutrition to children below 6 years of age, and to expectant and nursing mothers in backward rural areas, urban slums and tribal areas of J&K.

**Supplementary Nutritional Services of ICDS:**

With a view to provide every child up to the age of 0-6 years with an opportunity to grow into a healthy and useful citizen through a well planned and integrated programme for its development, the government of J&K started ICDS scheme during 1975. The ICDS project aim at co-ordinating and consolidating the existing child welfare services in a selected area preferably a community development Block, and also supplement such of those additional services as are required from out of the project.

Since 1975 the child health/nutrition programmes directed to pre-school children have received considerable attention. The ICDS, the universal immunization programme, the Diarrhoea control programme are all directed to the protection of this group. There has been a significant

decline in the incidence of severe malnutrition including nutritional blindness during the last few years. However there is still a great deal of work to be done. The prevalence of grade 1 and grade 2 malnutrition in the pre-school children is indeed some what higher than it was a decade ago. This can be understood from the figures for all India available in the Table 13. This is perhaps to be expected because while we had vigorously pushed strategies for control of child mortality, these had not always gone hand in hand with strategies for the promotion of child nutrition.[5]

Now let us turn to the present situation in J&K. At present there are around 70 ICDS projects functioning. The nutritional services are provided through Anganwadi centres in each project. Upto 1985, there were about 387 anganwadi centres operating in the state sector. Out of this number 378 were providing supplementary nutrition. The coverage was 5.64 thousand in the age group 0-3 years and this means there are 14.92 children per anganwadi centre. The number of beneficiaries in age group 3-6, was 8.47 per thousand in a total number of 14.11 thousand children (0-6). Thus the number of children each anganwadi centre reached to 37.33 children. During the period 1985, 2.90 thousand expected and nursing mothers were benefited.[6]

At present there are 34 ICDS projects functioning in the Jammu division of J&K. The total number of Anganwadi centres is 2334, with a coverage of 59000 children (1992). The number of projects in Kashmir division is 32. During 1992 an amount of Rs.1 crore and 60 lakh was spent on the welfare of children and an amount of Rs.1 crore and 95 lakh was spent on the welfare of women.

Table : 13

Percentage distribution of pre-school children according to standard deviation (SD) classification, India

| S.D. Classification according to | Period | -3SD | -3SD to -2SD | -2SD to -1SD |
|---|---|---|---|---|
| Weight/Age (under weight) | 1975-79 | 38.0 | 39.5 | 18.3 |
| | 1988-90 | 26.6 | 42.0 | 24.2 |
| Height/Age (Stunting) | 1975-79 | 53.3 | 25.3 | 14.6 |
| | 1988-90 | 36.8 | 28.3 | 21.0 |

Source: National Nutrition Monitoring Bureau, Report of Repeat Surveys (1988-90), National Institute of Nutrition, Hyderabad (1991).

**Sample ICDS Project:**

One of the fully operationalised projects is the Kangan project of Kashmir Division. The analysis of this particular project will give us the insights about the trend of achievement in J&K. Upto Nov. 1992 this project had set a target of 8008 and out of this 6633 were children and 1375 pregnant and nursing mothers. Out of this target the

achievement for the same period was 4984 children and 984 women were benefited. These figures show that the gap between set target and the achievement was 2040[7] in a single project. This leads us to argue that this state of non seriousness will contribute the problems to become more grave and out of control in the long run.

**Achievement of ICDS Projects under Central Sector and State Sector:**

Under the Central Sector the total number of Anganwadis was 1,074 (1985). Indicators of child development in ICDS projects reveal that up to 1985, 62.2% Anganwadi centres were reporting (functioning) and out of this 14% children were found malnourished. the Diarrhoea rate per thousand was 12.1%. Out of these 94.4% were advised oral dehydration treatment. Not only this 4.5% were found still births and the total infant mortality rate was as low as 31.3 per thousand in ICDS projects. Out of these figures the infant mortality for age group 1-3, was 17.5. This figure for 3-6, was 16.4 per thousand children. While the infant mortality for 1-6 years was 16.9 per thousand.

As compared to the above figures under the state sector 57.0% Anganwadis were reporting for 1985. As per data around 48.7% children were found malnourished, while the infant mortality was 130.4 per thousand during the same period in these centres. This was reduced to 71 per thou-

sand as compared to 31.3 per thousand children under the central sector. Again the figures show that the performance of central sector is better than the state sector ICDS projects of J&K.

**Achievement of ICDS in Central and State Sector in Supplementary Nutritional Programme:**

Under the supplementary nutritional programme in ICDS (Central Sector) the achievement data reveal that upto 1985 a total number of 1,074 Anganwadis were reporting and out of these 928 were providing the nutrition diets to the children upto 6 years of age. The total number of beneficiaries was 23.78 thousand children under the age group of 0-3 years. This means 25.63 children for each anganwadi centre, while the number of beneficiaries under the age group 3-6 years was 29.30 thousand with an average of 31.57 for each anganwadi centre.

As compared to the above figures, the data for state sector reveal that the total number of beneficiaries was 14.11 thousand children of 0-6 years of age, while it was 53.08 thousand in the central sector for the same period (1985). During 1985 the coverage of nursing and expectant mothers was 2.90 thousand in the state sector, while as it was 9.32 thousand in the central sector with an average of 10.04 to each centre. Again the figures show the poor

performance of state sector of ICDS projects to provide supplementary nutritional diets to the children (0-6yrs) and to expectant and nursing mothers.

### (B) Special Nutrition Programme (Balwadi Centres)

The another important scheme is the special nutrition programme launched during 1970-71 with the objective of providing supplementary food to children (0-6 age) and expectant mothers in urban slums, tribal areas and backward rural areas. This scheme is run by the All India voluntary organizations as a non plan programme. The voluntary organizations involved, include Nehru Yuvak Kendras, Kasturba Gandhi National Memorial Trust, Bharatiya Adim Jati Sevak Sangh and Harijan Sevak Sangh.

Mention may also be made of the Integrated pre-school project (urban neighbourhood) started in 1960-61 and is centrally sponsored scheme. The idea is to cater to the requirements of pre-school children and woman in low income groups in urban areas covering, inter alia, nutrition. Upto 1985 there were 1,074 such centres functioning and out of this 908 provided pre-school education. The achievement for the period 1985 was 27.24 thousand children under the central sector. But the performance of the state sector is not satisfactory as compared to central sector. Under the state sector there were 387 anganwadi centres and out of this 360

centres provided pre-school education benefiting 6.50 thousand children.[8]

### (C) Creches Scheme for the children of Working Women

Another scheme for creches organization is an important service that has made a considerable headway in J&K. The factory Act passed in India during 1948, made the provision of creches obligatory on factories employing 250 or more women. In J&K some creches have been set up in various industrial corners under this act. Besides this, the state board has started its own creches in the rural areas of the state. These centres provide recreational and nutritional services to the children of working women. According to the data available there were 138 such centres during 1981-82. This number reached to 165 during 1984-85.[9] In addition to this there were 18 day care centres for the period of 1980-81 and the number of beneficiaries was 577 children. The amount of Rs.0.22 lakh was the expenditure to provide recreational and nutritional services to children. This is note worthy that the number of such centres decreased in the coming years and reached to only 6 during 1984-85, with a poor coverage of 387 children.

## (D) Recreational Services to Children:

Recreational activities mentioned here relate to other services than those which are ordinarily provided under normal educational and municipal schemes for children. From 1956 on words, the J&K Social Welfare Board in co-ordination with other voluntary organizations started sponsoring the scheme of Holiday Homes for children from different destitute homes in the state. The idea is to provide them with opportunities of enjoying healthy surroundings, nutritious food and recreation for a part of the year and also enable them to acquire experience in group living.

With the help of CSWB during 1980-81, around 19 such camps were sanctioned and an amount of Rs. 0.95 lakh was sanctioned. But for the later years there was a decrease in such activities and during 1985 only 11 such camps were organised. Even there was a decrease in fund allocations and it was 0.73 lakh during 1984-85.[10] As a matter of fact this decreasing trend has contributed to the poor performance and at present hardly any such camp is organised. There is a doubt that the scheme will vanish if this trend and lack of funds continue in future.

### (E) Functional Literacy Programme

It is generally accepted that linking literacy with health, food and nutrition, maternal and child care, health and hygiene would produce desired successful results -- motivating the rural illiterate women to be literate. As one of the hindering facts to the success of health, nutrition, family planning and other developmental programme has been the low literacy of women. However functional literacy scheme of ICDS could not succeed in yielding desired results due to administrative obstacles and in co-ordination, tailor made programmes which were not suited to the local needs.

The alarming low percentage of literacy amongst the rural women in J&K required special efforts to reduce the prevailing illiteracy.

Emphasising the special importance of literacy as a component of educational programme for rural women in J&K, provisions were made in the Fifth Five Year Plan for programme of functional literacy for adult women which would endow them with necessary knowledge and skills to perform functions of a housewife such as child care, better nutrition, health care, home management etc. more effectively, the scheme of functional literacy for adult women has been formulated to be implemented as a programme of the educational component in ICDS project ares through the Anganwadi

worker in every village with the specific objectives:

(a) to enable illiterate women to acquire the skills of literacy, through functional literacy classes and participate in development efforts of the community, and

(b) to promote a better awareness among women about the modern methods of health and hygiene and about the importance of nutrition and protein rich food.

Under the central sector in J&K during the period of 1980-81, there were 300 Anganwadis providing functional literacy and around 2.38 thousand women were attending the Functional Literacy of Adult Women (FLAW). This number rose to 388 during 1982-83, with 5.18 thousand women attending classes. This number increased to 550 centres during 1984-85, with 7.22 thousand beneficiaries.[11] As compared to this under the state sector upto 1984-85, there were 13 projects sanction under FLAW programme of ICDS. But only 7 out of 13 were reporting and functionally operating. The number of the Anganwadis was 555 and out of this in 550 centres FLAW was operating. The number of women attending classes was 7.22 thousand.

*No doubt the achievement, what ever it may be, is important in this direction. But still much has not been achieved and this is mainly due to:*

(a) *The benefits of literacy are not perceived by the Adult women.*

(b) *Young Adults (15-30) took more advantage than others.*

(c) *Functional numerary is considered to be more important by the learners as opposed to traditional alphabetical literacy.*

(d) *Fourthly the chores of daily survival make class room attendance intensive.*

(e) *Fifthly it can be due to lack of women instructors.*[12]

## (F) Child Health Services

The health of the child along with that of the mother needs to be guarded. Ante-natal and post-natal services are, therefore, of vital significance. They will in the long run reduce the infant mortality rate, which was 127 during 1959 and has been reduced to 76 per thousand, and save the deterioration of the health of the mother and the child of today and tomorrow. Since 70% of the doctors are in the urban areas and therefore, the growth of maternity and child welfare work has been mainly through voluntary efforts, and government and local authorities have taken it up only recently.

It is true in J&K while formulating health planning, top priority has been given to maternity and child health

programmes. But today the conditions leave much to be desired. The medical services in rural and tribal areas are not so adequate as to ensure prompt curative treatment in the case of the sick child.

For want of these services children when in ill health continue to suffer with out hope of any treatment and if they suffer a physically handicap, due to malnourishing and improper diet, they become a life long burden to their family and society. In the backdrop of above facts ICDS was launched (1975) to provide a package of service including immunization against various diseases which make the children disabled for whole life. Each ICDS project has a medical team with specialists to check the health of these children. Besides, the Health Department of the State is also actively rendering the immunization services to the children in rural and backward areas. Services for treatment of children suffering from T.B. and those needing orthopedic treatment are very poor. B.C.G. vaccination and Diphtheria immunization are actively being carried out in urban areas and in rural areas still the coverage is very low because of unawareness about the benefits of these services among women. This is mainly due to two factors: (a) lack of sufficient staff and dedicated workers, and (b) more important is the lack of a considerable budget provision. It is note worthy, that the campaign against polio

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was launched recently and still the far flung and backward areas are out of its range.

Let us now turn to the medical supply in these ICDS projects. Under the state sector upto 1985 two projects were providing immunizational services and only 1.0% Anganwadis were visited by the medical officer. Out of two projects only one had the adequacy of Vitamin A supply, same is the case in the supply of BCG, DPT, DT and T.T., Vaccination and this supply was adequate only in one project and in case of Polio no vaccine was available in any project. Under the central sector there were 6 such projects functioning upto 1985 and T.T. Dose Second Vaccination coverage was 37.4% at district level and 38.1% at project level. While B.C.G. coverage was 34.0% at district level and 30.2% at project level, under D.P.T. dose III coverage was 27.8% and 12.6% at district and project level respectively. The polio dose III coverage was 19.2% and 5.1% at district and project level. And D.T. Dose II coverage was 8.8% at project level.[13]

The above figures show the poor performance and achievement of immunizational programme in J&K. This is the reason why a good number of children, already malnourished become easy prey to the disabilities in the absence of curative facilities. *It is essential here to highlight that if the facilities are available in some areas, but they lack*

*trained personnel. These vaccine are to be highly preserved carefully in medically safe machines or fringes or thermos-pholosic, but in most of the cases these vaccines become ineffective due to non availability of preservation arrangements.*

### (G) Welfare of the Handicapped & Destitute Children

The number of the destitute and handicapped children must be in thousands. In the absence of compulsory primary education and adequately organised health services, the problems of the socially physically and mentally handicapped children can not be eradicated properly. Due to the lack of reliable data the number of such persons is not known so far.

The National Association for the Blind in India is active since 1952 and since then various schools and homes for handicapped children have been started. The training of personnel for various positions in these institutions and equipping them effectively are two questions that need to be taken up and addressed properly. In J&K various legislations have been passed for the welfare of handicapped children. In 1979, the government of J&K passed a legislation for building the homes for blind. Besides, another scheme 'Janak Prosthetic Aid' was started in 1976 to provide grants

to the physically handicapped for specialised treatment out side the state for fitting up or repairing of artificial limbs. The labour and social welfare department of the state started a scheme in 1976 to provide scholarships to the physically handicapped children, studying in primary classes. An amount of Rs. 10 per month is provided to each child and obviously this amount is very less and can be hardly of sufficient use to the child. During 1977 a scheme for special assistance to crippled children was started in order to provide social security by way of grant to assist them for rehabilitation and treatment. In 1978 another scheme of grant of special stipend was started under this scheme. The students studying with in the state upto 10th class and suffering from T.B., Cancer or any other disability are provided special financial grant for the treatment and maintenance.

(H) **Rehabilitation of Destitute Children** ***(Falahi Itfab)***

The number of destitute children must be in thousands. To this may be added the number of children who are virtually destitute in view of the fact that they are without effective guardianship. The institutions that function under the children Acts in J&K work for the destitute children. In Jammu these are known as 'Bal Ashram' and in Kashmir as 'Falahi-Itfal'. These homes were started during

1979 in the state to provide shelter to the orphan, neglected, destitute children. The children under the age group of 6-16 are admitted in these destitute homes. As per the ideas of the scheme, free boarding and lodging, free bedding and clothing, books and fee is to be provided to these children.

Besides the above schemes, the children of those women who are admitted to the Markazi Falahi Mastoorat/Nari Nikatan, are also looked after in these homes. The children accompanying the mothers are entitled to admission subject to the condition that the male children after they attain the age of 6 years shall be transferred to Markazi Falahi Itfal/Bal Ashram. But the female children are allowed to stay with their mothers till they are rehabilitated properly or till they get married. They are provided financial assistance for managing the expenses of their marriage. They are also helped in continuing their studies, course or training as the case may be.

### (I) Social Legislation and Child Welfare

In addition to the above welfare schemes, the J&K Government passed certain laws for the welfare of children. Mention may be made of children Act, October 1970 which provides for the care, protection, maintenance, welfare, training, education and rehabilitation of neglected and

delinquent children. The probation offender's Act was passed in 1966 to provide for the release of offenders on probation after due admonition and for matters connected there with. Besides these the Infant marriage prevention Act was passed in 1985, regarding the prohibition of the marriage of a girl below 14 years and boy below 18 years of age. To enforce it effectively one who is found guilty can be punished for one year or with a fine of Rs.1000 or both.

## Critical Appreciation

In the above discussions we have tried to discuss the various social welfare programmes for children sponsored by the different Ministries of the government. Relevant social legislations in the field have also been discussed. As the data figures show the progress has been made in this regard, but it leaves much to be done in future.

### I. Gap Between Targets and Achievements

There is a pressing need for special attention to monitoring evaluation of these welfare schemes. One of the major problems is the lack of reliable sufficient data which contributes more to the failure of the welfare programmes. Inspite so many welfare schemes implemented so far at national level and in J&K at the state level, we are left in a

direct front with the reality that most of these schemes lack sufficient funds, trained staff to deliver these services and lack of motivation and awareness among the general masses. These are the factors which have led to the increasing gap between the targets and the achievements.

**II. Gap between different strategies for child welfare:**

From the fore going discussions we come to conclude that during recent past, child nutrition and health programmes directed to pre-school children have received considerable attention. But in spite of so much efforts there is still a great deal of growth retardation. The prevalence of grade 1 and grade 2 malnutrition in the pre-school is indeed some what higher than it was a decade ago (table 13). This can be particularly attributed to the gap between strategies for child mortality control and the promotion of child nutrition.

**III. Inadequate staff and material shortage in ICDS projects**

One of the note worthy facts is that most of the ICDS project officers are found inadequately equipped with trained personnel there by hampering the project activities. One more related problem is that of procedural cumbersomeness involved in the supply of materials, maintenance and repairs. This needs drastic change. This can be done by decentralising the authority from state level circles to the

project level. Besides this, local resources and materials must be encouraged and preferred for supply to these centres.

**IV. Immunization as a narrow vertical programme:**

The universal immunization programme has been implemented with considerable success in some parts of India. However, the major flaw with respect to its implementation has been that the programme was pushed not as part of integrated child-health care but as a narrow vertical programme (Gopalan, C. 1993). In the anxiety to achieve immunization targets the programme was not availed of to offer a package of health care services to mothers and children.

**V. Immunization vaccine offering less protection:**

Second problem with immunizational aspect of ICDS is that most of these vaccines loose effectiveness due to the lack of certain facilities and the vaccines offering less protection to the children than desired. It may be noted that 'Sabin Oral" vaccine, which gave protection in more than 95% cases in developed countries, at the best gives protection only to 30% children here. This is due to the reason that to be effective, the vaccine has to be kept in deep freeze. But in most of the ICDS projects such a facility is non-existent.

**VI. Ineffective Legal Aid:**

Whether it is at the national level or at the J&K level the law statute books are full of Acts passed for the welfare of children. Some of these have been passed before independence and most of them after independence. But one fact remains that most of these have proved to be ineffective. Whether it is the child labour prohibition Act or the child marriage prohibition Act, the reality confronts that at present there are 11.1 million child labourers in India, and in case of J&K around 92,221 children working in the carpet industry alone (1986). Still the child marriage is a rampant problem in some parts of India like Rajasthan. The grave trend can be assessed very well by the incident that took place on 28th September 1992, when a social activist (35 years age) was raped on the grounds that she was motivating people to fight against the child marriage in Rajasthan.[14] The most unfortunate thing to be highlighted is that no drastic measures were taken to prevent such incidents. This is again an indication of the low profile trend of people's awareness and handicap of legal legislations.

The ineffectiveness of laws can be attributed to the two factors. One in the absence of advice from social scientists, legal experts pass the laws from a legal point of view only e.g. "if we have to change the society, laws must be changed and enforced". But this is only half truth.

More important is to consider the public awareness as an important factor. Secondly, no enormous campaign has been launched to develop an awareness among the rural masses to perceive the benefits and importance of such legislations.

Finally it can be argued that to eradicate the problems of children will require not only the government action but voluntary efforts can be more effective. Equally the governments, the employers, social welfare organizations, social workers, implementors of legal provision and finally mass media can contribute to check these social problems.

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## Chapter V

## A CRITICAL EVALUATION

From whatever we have studied in the previous chapters one thing has been obviously clear that the social welfare programmes play a vital role in the over all development of a society particularly in terms of all issues and problems of special groups like women and children, it has been dealing with. so a thorough study of this kind in order to understand the phenomenon with all its important dimensions and facets -- mainly related to the organizational structure of welfare activities, role, achievements and short comings was legitimately called for. This is particularly so because the contemporary world community operates welfare activities through a huge network of international organizations like W.H.O., UNICEF, UNESCO, I.L.O. etc.

Besides, the above facts the importance lies in the point that developing countries have been borrowing models from the developed countries. In this regard an analytical study is required to find out whether borrowed models serve our purpose or not. And if we borrow models, they must be modified according to our own social structure. Unless and untill we do not formulate policies and programmes according to the nature of our own social problems and social values, spending of huge amounts of money will hardly bring satis-

factory results. *Henceforth, what is needed is that in accordance with the broader understanding of the targetted groups in the background of their cultural practices, reflexes and responses, the programmes for them need to be planned and executed.*

With the declaration of India as a 'welfare state' in a socialistic pattern of society, attempts were made on behalf of the state to provide welfare services to the needy and the destitute groups of the society. The main objective is the alround development -- physical, mental and social of these groups.

The preceeding discussions made it clear that there has been a gradual increase in the plan allocations for social welfare services. Diversification in programme contents has also been brought about. Until the Fifth Five Year Plan the services rendered, were mainly curative. A beginning was made for the introduction of preventive and developmental activities in the two subsequent plans. In order to make a dent in the intensity of the problems more time should elapse for the new approach to strike roots. There should be a preliminary compaign to prepare our system for this new initiation, if it is really to be successful. Although each one of the social welfare schemes has limited clientele, it satisfies a felt need in consonance with the basic philosophy of the social welfare. However, it should be conceded

that the creation of a wide spread awareness of the problems facing women and children in the society is more important to elicit co-operation and involvement of the community.

In the previous discussions various social welfare programmes for women and children sponsored by the different ministries and voluntary organizations have been discussed. Relevant social legislations in this field have also been mentioned. Though, it seems that a limited progress has been made as a result of these programmes, it leaves much to be desired. The need for special attention to monitoring, evaluation and sufficient reliable statistical data base has been expressed.

Child and women's welfare are itself a nebulous concepts covering both normal and special groups of women and children. The conclusions drawn from the previous discussions reveal that the services offered so far are only at the micro level without involving the community. This can be evaluated at two levels i.e. administrative level and at the organizational level of the social welfare services.

## A performance based evaluation of welfare schemes

### I. Concentration of welfare schemes only on (4-6) years children

Since the child and women's development is related in most of the ways and particularly the welfare of the chil-

dren, has got its bearing upon the welfare and well-being of women in the society. Therefore what is essential is that the child being a part of the larger unit of the family, all developmental programmes should have been directed to families instead of being directed towards individual children. There are indications that the children between 0-3 years are not covered in most of the schemes. At the same time in most of the schemes children of school age 6 years on words are also left in most of the nutritional schemes. Although it is true that the worst forms of malnutrition afflict the pre-school child, but it is also true that there is a great deal of morbidity and learning disabilities among children of school age because of which heavy investments in the primary eduation programme have not had the desired impact.

**II. High Infant Mortality as a result of ineffectiveness of Health Measures**

As it is obvious from the data used in previous discussions that most of the infant deaths occur during the years (0-3) and this has an adverse effect on the population growth which has touched enormous proportions. Co-relation and co-efficient between infant mortality rates and birth rates for 15 major states of India was 789 (Census 1991). This underlines the fact that high infant mortality rates induced couples, more especially among the poor, to have

larger family size. Consequently, birth rates are higher in the states which have higher infant mortality rates.

In case of J&K the infant mortality during 1976 was as high as 68 per thousand and out of this 73 in rural areas and 26 in urban areas. These figures show the concentration of health services in urban areas and their poor performance in rural areas where 90% population of the state lives in. The infant mortality reached to 76 per thousand during 1979 and during 1980 there was a slight decrease and it was 72 per thousand during this period. But again during the period of 1987 the estimated figures reached to 71 per thousand. Out of this 77 infant mortality was in rural areas and 47 in the urban areas. Till 1987 there was an increase in the rural infant mortality from 73 to 77 and in urban areas from 26 to 47 per thousand. Therefore this is a clear indication that health measures like immunization and maternity services have not arrested the infant mortality in any way. When we analyse infant mortality sex wise, it is 74 for males and 69 per thousand females. The estimated infant deaths to the total deaths during 1987 was 31.09% in rural areas and 18.3% in urban areas.

### III. Ineffectiveness of maternity Services

The neo-natal and post neo-natal deaths to the total infant deaths for 1987 was estimated as 58.23% and 41.77%

respectively. This is the indication fo the ineffectiveness and insatisfactory impact of maternity services in J&K. Out of the figures available the estimated pre-natal and still births for 1987 was shown as 50.1 per thousand and 12.9 per thousand respectively. Out of this 57.8% was pre-natal and 32.3% still births. Besides this out of these figures the pre-natal mortality was 54.4 per thousand for rural areas and 32.4 was for urban areas. Again the interesting figures reveal that out of total 72 per thousand and infant deaths for 1987, the highest rate was in the age group of 0-4 years and it was 36.61%. As mentioned earlier that in most of the welfare schemes the children of this age group are not covered. Even they are not covered under the nutritional facilities. This is contributing to the constant high infant mortality.

**IV. Failure of welfare policies to reduce the incidence of child marriage**

**(a) Late Anti-natal care to be ineffective**

On the basis of data gathered by the National Nutrition Monitoring Bureau it was earlier estimatd 15% to 29% of Indian women between 20-30 years of age in 10 states of India had body weights less than 38 Kgs, and 12% to 25%, heights less than 145cms. These women are thus poor obstetric risks due to the chronic ill health and under-nutrition. In almost all the welfare schemes antenatal care is confined

to the late stages of pregnancy and surely at this stage such a help can not correct the situation.

**(b) Younger age at marriage leading to high risk for the survival of mother and child**

The average age of girls at marriage at the national level as a whole according to the Registrar General's data of 1981 was 16.7 years. On the other hand the recent study of ICMR (1990) showed that the average age at marriage of rural girls in 6 states where the study was carried out was 13.8 years and their age at consummation of marriage was 15.3 years.

It is thus obvious that in spite of so much efforts, the welfare schemes have proved a failure to reduce the infant marriages. The above data is a clear indication of the fact that a good part of pregnencies in India today are teen age pregnencies. Indeed teenage pregnancy appears to be the rule rather than the exception.

The data available on J&K shows that upto 1984 the highest infant mortality has been in the age group of 15-19 and it is 109.6 per thousand. While as this is lowest during 45-49 age group and it is 56.8 per thousand. Therefore we can very well understand the survival chances of a child during the two age groups. Those born during 15-19 have a less chance of survival. As mentioned above the

average age at marriage is 16.7 years and it means majority of the children born to these teenage girls are at the greater risks of survival.

**V. Lack of the objective of child health and good motherhood**

Thus the above discussions lead us to argue that one of the major draw backs of social welfare policies has been the focus on what C. Gopalan calls 'child survival' and not the "child health and nutrition" and for women just a "safe" one and not "good motherhood". There is a need to shift the focus of welfare policies from individual members to the family as a unit. This is going to call for an integrated package of services to both women and children. Again it is hightime to concentrate these welfare programmes in rural and tribal areas where 90% of the population of J&K inhabits.

**VI.4 Unsatisfactory performance of Adult Education Scheme**

It may be pertinent to note that the welfare schemes implemented have not improved the lot of women to the extent as was desired. This can be understood from the figures available in the 1991 census, which shows the situation to be quite dismal. In absolute terms illiteracy has risen dramatically, indicating that the compaign for adult literacy has really not made a significant dent. The data shows that while as in India the literacy rate has moved

upto 52.11% (1991) from 43.56% in 1981. For men it moved from 56.37% (1981) to 63.86% during 1991. For women it moved from 29.75% (1981) to 39.42% during 1991. These figures for J&K were for 1971 as 26.75% (males) and moved to 36.29% during 1981. But the female literacy was as low as 9.28% (1971) and 15.88% for the year 1981. This low female literacy rate along with other indicators, reiterate the low status of women.

## A Policy Lapses based Evaluation

**I. Gap between population growth and health services**

Another related matter is that the health facilities have not kept pace with the populatin growth and consequently pressing demands on the part of governmental and voluntary agencies. The medical budget has never kept pace with population growth and our public hospitals and primary health centres are not properly equipped. According to data at present there are over 2000 PHC, 130000 sub-centres, 2000 community health centres. The data on J&K shows that upto 1978 there were 193 established health centres and out of this only 80 centres were functioning. For the same period there were around 85 family welfare centres to serve a vast majority of women and children. These centres were insufficient and mainly located in the urban areas. While as the immunization programme may have been partially effective,

the other aspects of the health services are still neglected. The primary cause of death is related to mal-nutrition, inadequate nutrition and the lack of potable water. There are indications that in spite of so many schemes and programmes to combat these causes, the children in rural areas are still most sufferers with out much hopes of proper care.

From the above discussions we can conclude that the basic health needs are related to drinking water, sewage and food. Health services are secondary to this, one is in need of them only when he is sick. Therefore, the basic concentration of the welfare policies should be to raise the alround status of women and to protect the children from the sufferings and disabilities.

**II. Status of rural women unchanged:**

To improve the status of women, by the government and voluntary organizations in J&K, the rural women continue to be more or less custom bound and are struggling to discover their own abilities and potentialities. To most Kashmiri women in rural areas, the home continues to be the focal point of their concern and interest. While the household interest has to be maintained, attempts should be made to draw them out more into the civic activities of the community. How far the Community Development projects and National Extension services are able to achieve this goal, has already been discussed in Chapter III and IV.

**III. Lack of Monitoring and Research:**

So far the social welfare policies for women are concerned, they lack proper monitoring and evaluation. This is the most neglected areas in almost all the welfare policies. Secondly, the research aspect has been neglected from the very beginning and this has led to the fact that the welfare policies have not been modified according to the changing social structure. It is this aspect which can search out the roots and the magnitude of the problems so that new trends and new policies can be implemented accordingly.

**III. Lack of Women's Voluntary Organizations:**

These programmes have not fully succeeded in developing an awareness among the rural women. This is due to the fact that voluntary women's organizations have not been encouraged in J&K. Secondly, the social education has not been a compulsory component of all the welfare policies. Therefore, it is the pressing demand of the hour that women's voluntary organizations, their participation in the administration of welfare services should be encouraged. These voluntary organizations can serve in the backward and tribal areas of J&K.

**IV. Masses do not perceive the Benefits of Welfare Services:**

Most of the welfare schemes lack sincere and sufficient personnel to implement them in an effective manner. One of the important causes of low profile from the masses towards these welfare schemes is that they do not perceive the benefits of these services. Therefore, the important point is that the welfare policies should have a programme to launch a campaign for developing an awareness among the masses about the importance and objectives of these welfare programmes. Unless they perceive the benefits of these welfare policies, their participation in these programmes is very difficult.

Let us now turn to the nature and organization of welfare services. It is note worthy that the welfare policies and programme have not been modified according to the local social structure. This has resulted in the indifferent attitude shown by the masses towards these welfare policies.

### (c) Broader area based Evaluation of welfare policies

**Literacy Aspect of the Welfare Schemes**

So far as the condensed course of education has been successful in developing awareness among the women in urban areas and majority of the women in rural areas are still out of its coverage. At the same time, this part time scheme is

carried out in different areas of J&K, but the problem is that in most of the cases, the instructors fix the time according to their own convenience. As a matter of fact, women are always busy in the economic activities with men, they are not in a position to attend these centres on arbitrary timing fixed by the instructor. Therefore it is essential that the instructors should pay a preliminary visit to the area and fix the timing at the convenience of the women in that area.

In case of Jammu region, caste becomes a hurdle in most of the centres. For example, if the instructor is from low caste, the upper caste women do not attend the centres. This is to be taken into consideration and separate centres should be established for them. One more note worthy point is that in Kashmiri society as a whole and particularly in rural areas, people prefer their women to get religious education rather than the formal type of education. Therefore, it is important that if this programme is to be made a success, the religious education should also be made a part of the syllabus. This will benefit in the way that people will allow their women to attend these centres.

One more problem is that of language and it is better to encourage local language as a medium of instruction in these centres. Research findings show that women in these

centres like better to be given functional education than aliphabatical literacy. Therefore, education about the welfare policies and child care should be made an important part of the course.

**II. Health and Family Welfare Aspect of Welfare Schemes:**

So far as the family welfare services are concerned, there are problems both in terms of sufficient trained staff and lack of sophisticated equipments. This can be very well understood from some cases where operation for birth control was conducted through machine, it proved to be failure because women who had gone under this kind of operation, were found to be pregnant. This creates doubts in the minds of the people about such services.

In case of maternity services, the doctors do not have proper training according to the community health needs. They offer no training in health management and the kind of training that is given is more appropriate for developed countries. Much more emphasis should be given to the community medicine while as a training period of residence in the community, would help the students to understand the community needs and participate in appropriate projects. Family planning should be integrated with teaching about maternal and child health.

The maternity services have remained restricted to the urban areas only and the majority of the rural women do not perceive the far reaching benefits of such services. Therefore what is needed is dedicated and sufficient number of female workers to develop such an awareness among the women in rural areas. One more related matter is that most of these doctors after completing training prefer to settle in urban areas due to ample of facilities and extra income from private practice. In such a situation most of the health centres in rural areas are found without a doctor. Therefore what is needed is that there should be a provision for more admissions of female candidates from rural areas to the medical training and it should be made compulsory for them to serve the first five years of their career in a rural or tribal area, after completing the training period.

As mentioned earlier that around 66% of the deliveries in J&K are conducted by the local *dais* and it is a fact that a woman prefers her delivery to be conducted at home rather than in a hospital. Thus it is most essential that particular training camps should be organized where the training should be imparted to these local women in order to make a safe delivery sure. Some financial assistance must be provided to them so that they will be attracted to participate in such training camps. These women can serve better in hilly and tribal areas which often remain cut off.

Finally the location of public health centre should be related to the population they serve, keeping in view the density of population, distance, topography and transport connections. The separation in many areas between the provisions for ante-natal care and for delivery care must be ovecome by fusing these two elements of maternity provision. This will definitely contribute to reduce the morbidity and infections and injuries which the child receives at the time of delivery. This calls upon,the role of mid-wives must be promoted to a much greater extent.

**III.Health and Nutritional Aspect of Child Welfare Services**

Let us now turn to the welfare of children and health. There are socio-economic and political reasons for the poor health of the children. Inappropriate health planning is also partly to blame, for which health professionals are also accountable.

**Need for New Approaches: Child Health and Nutrition and Not only just Child Survival**

The child can be best helped in the family. And, therefore it shall have to be our constant endeavour to strengthen the family in the services of the child. Unless better standards of life are available in the family it would be very difficult to expect a minimum standard of care

and attention for children. The basic objective should to provide food, clothing and housing. The struggle for these shall have to be continued and in course of time when we achieve certain minimum standards of living most of the families, conditions for children would gradually become better. Meanwhile the need is to find out ways and means to meet the needs of the child, as the distress on account of shortages of material goods is acute. This leads to ill healt and stunned growth. In order to avoid such a situation two kinds of measures can bring fruitful results. These are as follows.

**(a) Reaching Women and Child through family (maintaining balanced Nutritional status of Mothers)**

By maintaining proper health and nutrition during pregnancy, mother can make sure that the child has the correct and proper amount of nutrition to ensure that it grows up in normal health. All children should be immunized and protected against tuberculosis, diphtheria, whooping cough, tetanus and polio as well as typhoid. A healthy child can remain healthy in an environment which is hygienic. And finally, healthy child can be happy only if the family is happy. Therefore our welfare programmes should be based on this very idea.

It is most notable to discuss here that the late initiation of immunization in general and women's low socio-economic status in particular contributed to grave problems. In the rural areas joint families are prevalent and women in these families do not get much attention for their physical, mental and social upliftment. The situation of tribal women and scheduled caste women is more worse because of the fact that they have to strive hard for livelihood and survival. Keeping in view this fact there is a great need to encourage these women to become economically independent. For them proper arrangements of training in crafts etc. should be made. They should be provided more than 50% subsidy to purchase equipments and loans should be provided to those women who want to start their own units. It will be fruitful to establish government co-operatives who can purchase the products of these women directly from them. This will benefit them in the way that the profit of middleman will go to their pockets.

**(b) Harnessing Local Resources for the Supply in the ICDS Centres**

Supplementary feeding of infants must get top priority in all the feeding programmes due to the declining trend of breast feeding since women in rural areas are always busy in economic activities and loose a lot of energy. At the same time they do not get a proper balanced diet. In such a

situation they are not able to breastfeed their babies for longer periods. This is more interesting to note that the kind of food that tribal women get, is maize flour, which is nutritionally a poor diet and contains no significant vitamins. Low income does not allow them access to food of adequate quality and quantity. The ICDS and tribal extension projects have a very low coverage in these areas. Therefore special tribal ICDS blocks should be created and the participation of the local people be encouraged.

In the wake of the limited resources, it can be suggested that harnessing local resources for Anganwadi materials can be more useful. Since in J&K there are problems like, transportation, and most of the ICDS centres lack sufficient and timely availability of nutritious materials to be served to the children. In some cases, the Social Welfare Department is not able to reach a contract for the suply of food materials in a limited period. Thus sometimes the centres remain without supply for months and months. In order to overcome this problem, it is wise to train the Anganwadi teachers in how to use the locally available materials. For the success of this new approach, the local authorities i.e. projuect officers must be invested with more authority to take the decisions.

### (c) Need for an alternative to Formal Pre-School Education

Late initiation of ICDS projects in J&K, and due to several other factors, the Anganwadi centres are not working properly and co-ordinated efforts have not been made to offer health services and improve the nutritional status of the children. Pre-school education is conducted through the formal method and have failed to lay the foundations for physical, cognitive and social development of the children. This type of pre-schooling creates psychological problems among children. "Early schooling can lead to stress related problems in children (3-6) and also causes behavioral problems."[1] Therefore the pre-schooling of children in ICDS projects should be given in a non-formal tune.

## Some General Suggestions for the Organization and Implementation of Welfare Schemes:

After discussion the suggestions relating to the specific social welfare services, it is now imperative to put forward some suggestions relating to the broader understandings and successful implementation of various social welfare schemes:

(i) The first and the foremost suggestion would be the recognition of the context in which the welfare oriented programmes are planned and implemented usually changes

during the course of the programmes, thus making it difficult to plan many years in advance. Instead, planning, implementation and monitoring should be processes with the builtin flexibility to accommodate and facilitate modifications. Government commitment regarding personnel, resources and advocacy should be long terms.

Improved management at all levels, particularly at the block level. Flexibility mentioned above means continuous replanning, which needs the efficient use of information. This does not necessarily mean more information, but rather more appropriate and timely information. Therefore instead of adopting and trying to implement `pre-package´ technical interventions, the most appropriate actions should emerge from the assessment and analysis of the particular context. Regular monitoring at all levels will serve as a mechanism to assess the impact of welfare services rendered.

(ii) Early establishment of a community based monitoring system should be encouraged. Every project should have a plan to prepare the people about three months before it is launched. This emphasis should be given on educating masses about the benefits of these welfare services. Even if the planning process is delayed, it should be tolerated and even if some expenditure has to be incurred on the preparatory project phase - which involves community preparation and planning for the programmes.

(iii) There is a pressing need to use an explicitly formulated conceptual framework that reflects the biological and social causes of the nutrition problem, as well as importance of these causes at both macro and micro levels. Such a framework should reflect the multi-sectoral nature of the problem accommodating a number of potential causes in a particular context.

(iv) The major flaw with respect to the implementation of immunization has been that the programme was pushed not as part of integrated child health care but as a narrow vertical programme (Gopalan 1993). Secondly, the immunization has a setback of time factor as in some projects it is started earlier and in some later. To be effective the vaccines need to be kept in deep freeze in order to preserve their effectiveness. In most of the cases the freezing facility is not available and when the application of vaccine takes place, it proves ineffective. This can be very well understood from the fact that only `sabin oral´ vaccine which gave protection in more than 95% cases in developed countries, at best gives protection only to 30% of the children here. Therefore much funds and serious attention should be paid to provide such vaccine preservation facilities and should be given top priority.

After the detailed discussions about various social welfare policies, their nature and achievement, I feel it imperative on my part to conclude with the argument that considering the magnitude of the problems, the results achieved so far cannot be said to be spectacular. Considering the limited financial resources, the difficulties of transport and access to areas where even a jeep cannot reach, the level of backwardness and poverty, it can be said that the results are encouraging. Further success will depend on the dedication and sincerity of the government and voluntary agencies.

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