

# DCWC Research Bulletin

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## Research Studies on Women and Children

### CHILD LABOUR

1. Drishti Stree Adhyayan Prabodhan Kendra, Pune. (2006).  
A Report on study of migrant girl domestic workers from tribal areas of Jharkhand, Chhattisgarh and Orissa. Pune : DSAPK. 145 p.

**Abstract :** Several men, women and children from tribal areas of Jharkhand, Chhattisgarh and Orissa migrate every year to other states in large numbers in search of employment as labourers. 9 districts, 3 each from the 3 states of Orissa (Sundergarh, Mayurbhanj), Jharkhand (Gumla, Ranchi, Simdega) and Chhattisgarh (Jashpur, Raigarh and Sarguja) were selected and 43 villages were covered during the survey. 3,171 families from these 43 villages were contacted for the survey. International Labour Organization (ILO) defines the domestic worker as “someone who carries out household work in private households in return for wages”. Domestic workers can be grouped into 3 types, Child Domestic Workers, Live-in Workers (full timers) and Part Time Domestic Workers. The women and girls migrating from Jharkhand, Chhattisgarh and Orissa to Delhi, fall in the category of live-in domestic workers or full timers. There are many types of trafficking, involving young and old women, and underage girls and boys (children). The purposes for which trafficking occurs are prostitution, child labour, child sex work, bonded labour, camel jockeying, commercial servile marriage, agricultural work, begging, trade in body parts and informal sector work. The reasons for migration are attraction of large cities, poverty, competition with friends who have migrated earlier, boredom with rural life, ambition for earning more money, and ambition for living a better life. About 78,000 females have migrated from rural tribal areas in search of jobs for livelihood. Proportion of these migrants from Gumla and Ranchi districts of Jharkhand and Raigarh of Chhattisgarh appears to be more. Among these female migrants, the number of those going for domestic work to Delhi, Mumbai, Goa, Bangalore, Chandigarh and Chennai works out to be about 20,000. The percentage of females migrating for other wage labour was highest (92%) in Raigarh district of Chhattisgarh. Female migrants (FM) usually accompany other members of their families who also migrate for this type of work. Female migrants from Ranchi district of Jharkhand were maximum (73%). Out of 604 migrants for domestic work surveyed, 418 i.e 69% were working in Delhi, 10% in

Mumbai, and the rest in distant places like Chennai and Bangalore. Employers contacted placement agencies who matched the needs of employers with the migrant worker. Female Domestic Workers (FDWs) surveyed were found to be engaged in household chores like cleaning/ sweeping (62%), entire household chores (56%), washing clothes (54%), help in cooking (51%), baby sitting (33%), cooking (21%), shopping (20%), looking after aged persons (13%), and taking children to schools (8%). These FDWs are paid wages on the basis of type and quantum of work done. Generally wages vary from Rs.1500 to Rs.3000 per month. Chetanalaya NGO carries out field work, takes care of FDWs, fights for their rights if injustice is done, rescues minor girls, searches for and investigates rape cases, investigates physical/ sexual harassment cases, and investigates cases of non payment of wages. Nirmala Niketan, an NGO, provides residential accommodation to FDWs who are not in a position to work. Bharatiya Kisan Sangh, Ranchi (NGO) rescues minor girls and rehabilitates them. Prerana (NGO) in Mumbai works for trafficked women and children. Vanawasi Kalyan Ashram, Vanabandhu Parishad and Vishwa Hindu Parishad are also concerned with the problems of FDWs. They point out the risks or danger involved in migration and discourage them from migrating to Delhi or elsewhere, and their main activity is to provide education in tribal areas and strive for removal of illiteracy and ignorance. Vikas Bharati, Bishanpur (NGO) works in the areas of education, health, employment, environment, agriculture, village industries and technological development, etc. It was recommended that an effective mechanism to discourage migration of minor girls (below 18 years), both tribal and non-tribal, for employment as FDWs should be established by law. There is need to bring in a law for domestic workers to define the quantum of work, hours of work, wages paid to them, and other facilities to be given. It is essential to curb unlawful activities, especially the exploitation of FDWs, both financial and physical by placement agencies. Registration of girls migrating from villages or towns for work in other states as FDWs should be made compulsory. Special training centres/ institutes were established in districts for upgrading the skills of FDWs. Special and independent cells should be opened in the public relation offices of NGOs in Delhi for solving the problems/ difficulties faced by FDWs, and a number of counselling centres should be opened for their benefit.

**Key Words** : 1.CHILD LABOUR 2.DOMESTIC WORKERS 3.MIGRANT GIRLS  
4.TRIBAL GIRLS 5.ORISSA 6.CHHATTISGARH 7.JHARKHAND.

## CHILD WELFARE

2. Das Gupta, Monica et al. (2010).  
Gendercide : what happened to 100 million baby girls ? : the worldwide war on baby girls. New Delhi : World Bank. 6 p.

**Abstract :** In India, the preference for sons is more over daughters. This could be because hard physical labour is still needed for the family to make a living. A daughter is deemed to join another family after marriage and parents want someone to care for them when they are old. Millions of couples abort the foetus if it is a daughter, and try for a son. In China and northern India more than 120 boys are being born for every 100 girls. In China, the imbalance between the sexes was 108 boys to 100 girls for the generation born in the late 1980s; for the generation of early 2000s, it was 124 boys to 100 girls. Gendercide exists on almost every continent. It affects the rich and poor; educated and illiterate; Hindu, Muslim, Confucian, and Christian alike. Within China and India the areas with the worst sex ratios are the richest and best educated ones. China's one child policy can only be part of the problem, given that so many other countries are affected. All countries need to raise the value of girls. They should encourage female education; abolish laws and customs that prevent daughters inheriting property; make examples of hospitals and clinics with impossible sex ratio; get women engaged in public life using all possible means to increase visibility (e.g. television, newsreaders, women traffic police, etc.) Parts of India also have skewed sex ratios. Boys are slightly more likely to die in infancy than girls. To compensate, more boys are born than girls so that there will be equal number of young men and women at puberty. Between 103 and 106 boys are normally born for every 100 girls. The north-western states of Punjab and Haryana have skewed sex ratios. (Haryana 116 boys to 100 girls, 2001). NFHS 2, 1999, found that 33% of women without children wanted a son, 66.7% had no preference, and only a negligible number wanted a daughter. Mothers in some developing countries say they want sons, not daughters, by margins of ten to one. Among Indian women with 2 children (of either sex), 60% wanted a son next time, almost twice the preference for first borns. This reflected the desire of those with 2 daughters for a son. The share rose to 75% for those with 3 children. Difference in parental attitudes between first-borns and subsequent children is large and significant. The use of sex selective abortion was banned in India in 1994, and in China in 1995. Over the next generation, many of the problems associated with sex selection will get worse. Social consequences will become evident because



the boys born in large numbers over the past decade will reach maturity and girls of marriageable age would not be there. Modernization changes people's values and undermines those norms which set a higher store on sons. Governments are doing more than ever to persuade people to treat girls equally and there seems to be an incipient turnaround in the phenomenon of 'missing girls' in Asia".

**Key Words** : 1.CHILD WELFARE 2.DECLINING SEX RATIO 3.SEX RATIO  
4.FEMALE FOETICIDE 5.SON PREFERENCE.

3. FORCES, Forum for Creche and Child Care Services, New Delhi. 2009.  
Undoing our future : a report on the status of the young child in India.  
New Delhi : FORCES. 165 p.

**Abstract** : This report focuses on the very young child, as that is the most crucial and formative stage in a child's life and needs special attention. According to the Human Development Report (HDR), India's Human Development Index ranking was 128 in 2007 and 126 in 2006. According to the Global Hunger Index, India ranked 94<sup>th</sup> in 2007, according to the International Food Policy Research Institute (IFPRI). According to the NFHS III report, 21.5% infants born in India are low birth weight (LBW) babies, even though HDR 2007 gives a figure of 30%. There are several causes of high infant mortality rate (IMR), and high IMR is related to maternal and infant malnutrition. According to WHO, only 50% cases of acute diarrhoea were treated with oral rehydration salt (ORS) packets which are available under National Rural Health Mission (NRHM). With 80% health care in private hands and poor quality of care in Government hospitals, diarrhoea deaths occur even after reaching health care facilities. Under 5 mortality rate (U5MR) in India has gone down to 74.3 per 1000 live births in 2005-06 compared to 94.9 per 1000 live births in 1998-99. Highest U5MR is in U.P. state (96.4 child deaths per 1000 live births, and lowest U5MR is in Kerala (16.3 child deaths per 1000 live births) (NFHS III, 2005-06). 79.2% children in the age group 6-35 months are anaemic and the increase in childhood anaemia is alarming (74.2% in 1998-99). Madhya Pradesh has the most malnourished children (55%) and Kerala has the fewest (27%). Only 23% babies are breastfed within the first hour of birth, and 46% are exclusively breastfed for the first 6 months. If all babies were exclusively breastfed up to 6 months of age, 13-15% of all under-five deaths could be prevented, i.e. the lives of 3.5 lakh children could be saved. The Janani Suraksha Yojana is meant to promote institutional deliveries for mothers from the BPL category where a monetary incentive of Rs 1000/- is given. The Rajiv Gandhi National Creche Scheme provides creche services to children in the age group of 0-6 years, which includes supplementary nutrition, emergency medicines and

contingencies. In India, a total of 31,737 creches have been sanctioned till September 2007. Child development programmes such as ICDS and Early Childhood Education (ECE) under Sarva Shiksha Abhiyan (SSA) also contribute to the requirements of children under 6 years. The new Government programme “National Programme for Education of Girls at Elementary Level (NPEGEL)”, provides additional components of education for girls at the elementary level, and also provides additional early childhood care (ECC) centres under the scheme to relieve girls from the burden of sibling care. ECE has not received the attention that it should have. Highest percentage of pre-primary enrollment in primary schools is in Karnataka (28.38%), Jammu and Kashmir (26.35%), Madhya Pradesh (18.79%), Chandigarh (17.24%), Maharashtra (15.39%) and Haryana (10.52%). Except for Mizoram (8.51%) and Tripura (1.24%) all other states from the North Eastern Region (NER) reported high enrollment in pre-primary sections. The under sixes have been given low priority, are a neglected age group in the policy framework, and are treated as a concern of women, belonging solely to the domain of the family. Poverty, illiteracy, and lack of awareness about many issues has resulted in the poor health and nutritional status of children, high mortality rates, poor readiness for school and retention within the education system. Children of the urban poor in Delhi are a group of particular concern. More than 52% of Delhi’s population lives in slums, with poor or no basic services. Population below poverty line (BPL) in Delhi has risen from 11% to 22% between 1999-2000 and 2004-05 according to DES 2007-08. NFHS III data shows that Delhi’s underweight child population (0-3 years) is 33%, and 63% children 0-3 years suffer from anaemia. ICDS covers 35% of Delhi’s child population and has yet to reach many children. IMR in Delhi is 40 infant deaths per 1000 live births; 63.2% children between 12-23 months are completely immunized, 92% for the whole of Delhi, 69% for notified slums and 48% for non-notified slums. Institutional deliveries were 60.7% for Delhi, but only 11.1% for the urban poor. Ante-natal support was availed by 74% women in Delhi, and 35.6% urban poor women. Only 23.5% children of the urban poor were fully immunized. Children who were fully vaccinated ranged from 21% in Nagaland to 69.6% in Sikkim; and some of the other north-eastern states like Arunachal Pradesh and Meghalaya have poor vaccination coverage. Colostrum was fed to 19.3% infants, 34.5% infants were exclusively breastfed and 59.8% infants were given complementary food. The incidence of low birth weight (LBW) (less than 2.5 kg) varies from 8% in Mizoram to 27.3% in Tripura. In Assam, 196 ICDS projects and 25,416 anganwadi centres (AWCs) were in operation as on 31<sup>st</sup> October 2005. The proportion of children receiving supplementary food from an AWC varied from 14.7% in Arunachal Pradesh to 54.7% in Mizoram. In India, only 15% mothers received all the required components of Antenatal Care (ANC). Kerala (64%) and Goa (56%) had best ANC services, while Uttar Pradesh (4%) and Nagaland (2%) had poor ANC services. In Arunachal Pradesh,

Meghalaya and Mizoram only 6-9% women received the recommended components of ANC.

**Key Words :** 1.CHILD WELFARE 2.SITUATION OF CHILDREN UNDER SIX  
3.BUDGET FOR CHILDREN 4.ICDS 5.EXPENDITURE ON SNP  
6.IMMUNIZATION 7.EARLY CHILDHOOD CARE AND EDUCATION SCHEMES  
8.SOCIAL SECTOR SCHEMES 9.GOVERNMENT SCHEMES  
10.ALTERNATIVE NGO REPORT CHILDREN UNDER SIX 11.CHILDREN UNDER SIX.

4. Mobile Creches, New Delhi. (2010).  
Situational analysis of children under six in Delhi. New Delhi : MC. 72 p.

**Abstract :** The United Nations Convention on the Rights of Children (UNCRC) marks an important milestone in the context of human rights by bringing the rights of children into the political agenda. The 54 articles of UNCRC articulate the social, political, economic and cultural rights of children along with the state's responsibility. Children under six years have been a low priority and are an age group neglected by the Government, because under-sixes are seen to belong to the domain of the family, and also due to limited understanding of the pace of human development during the first 6 years of life. This assumption has resulted in weak national policy and programmes and their poor outcomes for health, nutritional status and development of young children. Children under six years require food and nutritional supplements, health care, safety, protection, love, care and stimulation for their holistic development. India has an estimated 150 million children under the age of six years and Delhi alone has 19 lakh (1.9 million) young children in this age group. Both, the size of the population and the critical importance of this age group make it imperative that their development issues be addressed as a priority. Delhi has a low mortality rate compared to other states in the country. The rates of neonatal, infant (IMR) and under-five mortality (U5MR) are much lower than the national rate but much higher than those intended to be achieved under the Delhi Development Goals of 33 per 1,000 by 2003. 23.5% children among the urban poor are fully immunized and protected from the risk of dying from easily preventable diseases. The remaining 76.5% are denied the essential protection required for survival. Micro studies conducted by Mobile Creches reveals further evidence of limited immunization: in slum settlements (Shadipur) 44%, among migrant workers 35%, and in new resettlement colonies (Madanpur Khadar) 47%. 33.3% of the children are underweight and stunted. Almost 66.7% children under 6 years suffer from anaemia in Delhi. 67% children on construction sites in the NCR and 79% children in Shadipur slum were found to be malnourished, as compared with the

Delhi average of 33%. Experts feel if more than 5% children are stunted it is a serious issue. In Delhi, not only is the percentage of stunted children 3 times more than the limit, but it also has increased from 13% to 16% between NFHS II and NFHS III. Almost 50% women in the reproductive age group in Delhi are anaemic according to NFHS 3 and this percentage has increased from 40% to 43%. Micro studies found that 40% of the women in Shadipur slums and 69% of the women construction workers in the reproductive age are malnourished. There has been a decline in the timely initiation of breastfeeding (within an hour of birth) with the percentage dropping from 23.8% in 1999 to 19.3% in 2006. The Mobile Creches studies found achievements in slum communities on a number of indicators such as exclusive breastfeeding and complementary feeding at six months to be much worse than that reported in NFHS 3. The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (PNDT Act), 1994 was passed to prevent female foeticide and to protect the right to life of the female child to be born. Female foeticide, emerging from a traditional preference for sons, is steadily skewing the sex ratio in India and in Delhi. 4% of the population are pregnant women and around the same are lactating mothers. 4% of Delhi's population is 5.5 lakhs, which means that there are 5.5 lakh pregnant women and 5.5 lakh lactating women. Of them services have reached only 73,301 women, around 6.5% of the total pregnant and lactating women. 88% of these women had received tetanus immunization and IFA tablets through MCD dispensaries, and only 0.9% of them had been weighed. These gaps are a matter of concern as they compromise the health of the foetus. According to the Ministry of Women and Child Development, in 6,106 AWCs, 5.6 lakh children are registered. As per NFHS III, ICDS in Delhi covers 35% of the children under six. This data is contradicted by the Neenv Delhi Forces Study of 242 AWCs in 27 ICDS projects that found a large gap between those actually attending the AWCs and the numbers registered. The first one is a study that Mobile Creches carried out in 15 construction sites in NCR in 2007. This study is referred to as Study 1. Study 2 is a study by Delhi School of Social Work Society conducted in 2008 of 9,576 construction workers. The shelter available to construction workers is poor both on site and off the site. Study 2 showed that 58% of the workers who lived in bastis were found to be staying on rent, only 13.98% lived at the work sites and 14.69% lived in their own houses. Study 2 showed that more workers in slums had access to safe drinking water (59%) compared with only 53% on construction sites. However, with regard to toilets, the slum dwellers were better off with 84% having access to toilets whereas access to toilets and urinals on construction sites was considerably less - 23%. In Study I 82% of the respondents interviewed at a Mobile Creche site mentioned the existence of a creche. While assessing the health status of children at construction sites Study 2 found that 32% infants received exclusive breastfeeding; only 31% received complementary feeding at 6 months; and 35% received complete immunization in Mobile Crèches. Malnourishment among children in the sample was as high as

65% to 70%. This is much higher than the national average, which stands at 47% according to NFHS III. Data available from Census 2001 indicate that 2.2% of the population in India has various disabling conditions. The proportion of funds that are allocated to sectors that enhance child development and protect children directly, is about 20% (average) of total outlay. The issue of the adequacy and quality of health services needs to be addressed particularly for urban poor settlements, and universalizing provision of day care services for women, specially of the urban poor, is a closely related strategy required for improving the health, survival and nutritional status of young children. Government of Delhi needs to develop basic quality standards for ECE and an age appropriate curriculum for all pre-schools in Delhi across public, private and voluntary sectors. The birth registration system must be made pro-active, easily accessible and corruption free. The state needs to come up with a pro-active solution for children in unauthorized slums, street children, etc. There is need for a fresh assessment of the current urban resettlement policy and its implications for the health and livelihood of citizens; and definite allocation of land for AWCs, pre-schools and crèches is required. The Ministry needs to develop a system of tracking children with disability, and as this is a critical area needing intervention, clear guidelines must be issued, training organized and there must be accountability of health functionaries. The state needs to examine the status of children under six in Delhi.

**Key Words** : 1.CHILD WELFARE 2.SITUATION OF CHILDREN UNDER SIX DELHI 3.CHILDREN UNDER SIX 4.SLUM CHILDREN 5.SITUATION OF CHILDREN UNDER SIX 6.PRESCHOOL EDUCATION 7.EARLY CHILDHOOD DEVELOPMENT 8.ICDS DELHI 9.URBAN POOR 10.DELHI.

5. Paintal, Manjeet. (2010).  
Preference of male child : a case study of Punjab. Chandigarh : Punjab Univ., Dept. of Sociology. 14 p.

**Abstract** : Punjab constitutes about 1.5% of the country's area but has 2.37% of the country's population. Punjab's sex ratio (number of females per 1000 males) is one of the lowest in the country (874). Disparity in sex ratio in Punjab was consistently rising from 1911 to 1999. It showed a decline from 882 in 1991 to 874 in 2001. The historic preference for male child is now a matter of concern for the most prosperous state of the country. Techniques are being used for sex determination with the intention of aborting the foetus if it turns out to be female. In Punjab, technology is being exploited with wrong motives and it has become a money making business. In 2001, the child sex ratio (0-6 years) in India and

Punjab was 927 and 798 respectively, and sex ratio (above 6 years) in India and Punjab was 933 and 876. Sex ratio in Fatehgarh Sahib was the lowest (757), and it was highest in Ferozpur (822). In terms of female literacy Hoshiarpur tops the list (75.56%), while Mansa was at the bottom (45.07%). The infant mortality rate (IMR) in 2007 in rural and urban areas in Punjab was 45 and 33 respectively. The traditional means adopted to eliminate girl children are poisonous oleander berries, lacing feed with pesticides, stuffing poppy seeds/ rice husk to slit tender gullets, stuffing the mouth of a baby with black salt/ urea, poison rubbed on mother's breast, suffocation with a wet towel or bag of sand, asphyxiation by exposure to a strong current of air from a pedestal fan and starvation. Punjab shows maximum decline in sex ratio due to its conservative nature towards girls. Changes have to be brought about and education can play a pivotal role in changing the mindset of the people of Punjab. Education and literacy programme needs to be implemented through Sarva Shiksha Abhiyan (SSA), non-government organisations (NGOs), universities, Nehru Yuvak Kendras (NYK), District Institutes of Educational Technologies (DIET), District Research Units (DRU), and Jan Shikshan Sansthan (JSS). To raise awareness about the importance of saving girl children, Nawanshahr district administration has undertaken various measures. These are intensifying the enforcement measures in the district; updating records of pregnant mothers both by Child Development Department and Health Department independently; organizing college level competitions on female foeticide, observance of mourning for a dead foetus in case abortion takes place outside the house of the family and the clinic where abortion was done; and organizing *langars* (community meals) on main roads and making college girls appeal to the general public to save the girl child.

**Key Words** : 1.CHILD WELFARE 2.DECLINING SEX RATIO 3.FEMALE FOETICIDE 4.SON PREFERENCE 5.SEX DETERMINATION TESTS 6.PUNJAB.

6. USAID, New Delhi. (2008).  
Community based interventions to delay age of marriage : a review of evidence in India. New Delhi : USAID. 4 p.

**Abstract** : According to legal provisions, the minimum age of marriage is 18 years for women and 21 years for men, but the actual age is much less in most of north India. In Jharkhand, 71% women married before 18 years, and in Uttar Pradesh (UP) 61% women married before age 18 years (NFHS 3, 2007). Early marriage is linked with higher total fertility rates and is generally followed by early child birth, which poses increased risks of maternal and newborn mortality or

morbidity. The USAID funded Vistaar Project facilitated the review of evidence, which was assessed by national experts in this field. The main purpose was to analyze the available evidence and make recommendations to the Government about how to improve community based interventions to delay the age of marriage. Age at marriage is influenced by many complex economic, social and health factors. Accordingly, there are a number of possible “pathways” that can be employed to delay marriage. They are creation and enforcement of laws; implementation of existing policies; providing information about ill effects of early marriage; bringing behaviour change through effective communication to delay marriage and first birth; promoting education for girls; providing health services, education and counselling to youth; mobilizing and empowering community to provide financial incentives; building vocational skills and providing livelihood opportunities. All the above mentioned interventions documented the importance of addressing gender inequalities and gender based constraints that lead to young age of marriage. ICRW and the Vistaar Project Team found that limited information was available, and much of the information identified was not publicly accessible. Most of the interventions identified (almost 30) did not collect evaluation data at the outcome or impact level; most of the intervention studies used a simple pre-post evaluation or quasi experimental study design, and it was challenging to document causality between an intervention and outcome of delayed age of marriage. Four of the five interventions selected for the review relied heavily on NGOs for implementation. There were 4 priority recommendations. There is a need for evidence on the topic of delayed age of marriage, and due to the need for more evidence new Government programmes in this area should be piloted and evaluated first in a few districts to ensure their effectiveness, before being implemented on a large scale. The Government could implement some variations in their piloted approaches to compare and determine the effective ones, which could then be replicated. Programmes in this area should include a strong monitoring and evaluation component to guide decisions on what programmes to implement at scale. The Vistaar Project experience showed that this process is valuable when it is conducted in an open, inclusive and participatory manner, the focus is on learning lessons, not identifying the “best model”, the audience is clear and evidence is reviewed from their perspective.

**Key Words :** 1.CHILD WELFARE 2.CHILD MARRIAGE 3.AGE AT MARRIAGE  
4.INNOVATIVE PROJECTS 5.CHILD MARRIAGE PREVENTION.

## EDUCATION

7. Mehta, Arun C.

Elementary education in India - where do we stand ? : State report cards 2007-08. New Delhi: National University of Educational Planning and Administration. 71 p.

**Abstract :** The National University of Educational Planning and Administration (NUEPA) has created a comprehensive database on elementary education in India, known as the District Information System for Education (DISE), under one of its prestigious projects. It covers both the primary and upper primary schools/ sections of all the districts of the country, and the number of schools/ sections imparting elementary education under the DISE has increased from 8,53,601 schools in 2002-2003 to 12,50,775 schools in 2007-08. About 87.39% schools are located in rural areas. During the period 2002-03 to 2007-08, 1,27,984 primary schools have been opened which is 15.89% of the total primary schools in the country. About 92% such schools have been provided school buildings. There are about 7.83% and 16.57% schools which have enrolment between 1-25 students and 26-50 students respectively. The distribution of schools by type of building shows that 71.73% primary schools have *pucca* (permanent) buildings as compared to 7.50% partially pucca and another 3.51% having *kuchcha* (temporary) buildings. Percentage of single classroom schools during 2004-05 to 2007-08 declined from 10.39% to 8.49%. On an average about 37 students are sitting in 1 classroom in primary schools. Other facilities available in schools have also increased. Maharashtra has the highest number of schools with computers (31,845 schools; 36.49%). The percentage of schools with ramps increased significantly from 11.49% in 2004-05 to 34.43% in 2007-08, which may help in attracting more physically challenged children to schools, who can also receive nutrition. Enrollment at primary and upper primary levels of education has increased significantly. The enrollment increased from 101.16 million in 2002-03 to 131.85 million in 2006-07 and further to 134.13 million in 2007-08. There was consistent improvement both in Gender Parity Index (GPI) and girls share in enrollment. Average of 624 districts in 2007-08 indicates GPI of 0.93 in primary classes and 0.89 in upper primary classes. SC and ST enrollment with respect to total enrollment works out to 20.08% and 11.60% respectively. In 2007-08, about 1.55 million differently abled children were enrolled in elementary classes across the country, of whom 1.15 million were in primary and 0.40 million in upper primary classes. The dropout rate for cohort 2006-07 indicates an average rate of 9.40% in primary grades. Tamil Nadu with 1.70% dropout rate and Himachal Pradesh with 2.60% dropout rate have achieved the goal of universal retention at primary level. The cohort survival rate to Grade V, estimated to be 72% indicates



a good number of children dropping out in primary classes. To achieve Universal Elementary Education (UEE), high transition is required from primary level to upper primary level. Transition rate increased from 64.48% in 2002-03 to 83.72% in 2005-06, but declined slightly to 81.13% in 2006-07. About 48.67% boys and 48.80% girls passed Grade IV/ V with a score of 60% and above, compared to 43.02% boys and 44.05% girls scoring 60% and above marks in the previous year, thus showing impressive improvement. In 2007-08 about 5.63 million teachers were engaged in teaching in elementary schools. Schools had 42.72% female teachers. There were 0.69 million SC and 0.51 million ST teachers engaged in government schools comprising 12.25% and 9.14% of the total teachers. The top five ranking states in Educational Development Index (EDI) are Kerala (EDI, 0.791), Delhi (EDI, 0.780), Tamil Nadu (EDI, 0.771), Haryana (EDI, 0.753) and Gujarat (EDI, 0.748). There are a few concerns which need to be accorded top most priority in the following year. Rationalization of teachers is the one solution as a number of schools are single teacher schools. The possibility of providing additional classrooms in schools having high student classroom ratio may be explored. Dropout rate needs to be checked to achieve UEE. Quality of education may be improved through active participation of teachers.

**Key Words** : 1.EDUCATION 2.PRIMARY EDUCATION 3.ELEMENTARY EDUCATION 4.STATE REPORT CARDS 2007-08 5.SARVA SHIKSHA ABHIYAN 6.STATISTICS 7.STATISTICS EDUCATION.

8. Mistry, Sonia, Pandey, Ravi Kant and Rizzo, Valentina. (2006).  
Quality education package : strengthening schools, strengthening communities. Lucknow: Lucknow Univ., Deptt. of Education, New Delhi: UNICEF. 52 p.

**Abstract** : The Quality Education Package (QP) began in Uttar Pradesh as a joint initiative of UNICEF and the State Government to improve primary education in a holistic manner. The objectives of the study were to identify and record those aspects of the QP that have proved successful; to identify best practices in the implementation process; to observe systematic successes and challenges of the QP significant for implementation outside Lalitpur; and to spot potential hurdles to the long term sustainability of the QP. The research focussed on 11 primary schools distributed in 3 blocks of Lalitpur districts i.e. Jakhaura, Biradha and Talbehat. Based on successful models in other states (primarily Maharashtra, Kerala, Karnataka, West Bengal and Andhra Pradesh), teachers and government officials developed numerous inputs which were ultimately tested in all first and second grade classes in government primary schools of Lalitpur district. These inputs included workbooks (for math and language

exercises), *chowkis* (4x4x1 tables), sports kits, math kits, motivation campaigns for orienting teachers, trainings for para teachers, and mirrors. Based on the research, findings were segregated into two major categories: the school and the community. The programme inputs, in conjunction with government programmes such as the mid day meal, impacted significantly on the quality of education in the surveyed schools. The meal programme supplies approximately 300 calories and 12 gm of protein per child per day. Many interviewed children enjoyed their meals, but some parents complained that their children were receiving insufficient portions or fell ill due to unhygienic preparation practices. The teaching – learning materials, when used, were praised by both teachers and students as an enjoyable way to teach, learn and practice new concepts. When compared to the reading and writing abilities of their 5<sup>th</sup> grade counterparts, 3<sup>rd</sup> grade students who made use of the workbooks the previous year, displayed equal or greater competencies. Other materials such as *chowkis* and sports materials, helped improve the school environment and increase retention, as did the mid day meal, when administered appropriately. Additional inputs such as the motivation campaign and math kit trainings for para teachers have made a clear difference in promoting the adoption of the package. While the programme had numerous successes in improving learning levels and increasing retention, there remain multiple hurdles, which continue to hinder the quality of education. The insufficient number of teachers and classrooms, the excess of administrative and governmental work undertaken by teachers, sibling care, underage enrolment, and continued use of corporal punishment all stunt the full potential of the current QP programme. Only female teachers attend the school regularly in Bamaraula. The male para teacher had been absent for an extended period of time. Observation of the 11 communities revealed numerous hurdles which must be addressed to sustain improvements made in primary schools. In most communities, the systems for Village Education Committees (VEC); Mother/Teacher Associations and Parent/Teacher Associations were in place; but of these only a few members had a functional understanding of their roles and responsibilities. In the village surveyed, the VEC generally headed by the Pradhan, was one of the more organized committees. Mothers also added that their own literacy impedes their ability to facilitate their children's education. Increasing the number of qualified teachers remains the single greatest factor for improving and sustaining education. ICDS centres should have sufficient resources to attract small children and reduce cases in which children drop out of school in order to care for their siblings. Functionaries of community organisations need training to function optionally in supporting the school and ensure smooth service delivery.

**Key Words** : 1.EDUCATION 2.QUALITY EDUCATION 3.SCHOOL IMPROVEMENT 4.PARA TEACHERS 5.SIBLING CARE 6.MOBILIZING COMMUNITY.

9. Pratham, New Delhi. (2010).  
Annual status of education report (rural) 2009 : provisional : January 15,  
2010. New Delhi: Pratham. 271 p.

**Abstract :** Annual Status of Education Report (Rural) (ASER) started in October 2005 as a result of the UPA Government's 2% education cess on all central taxes. The purpose of ASER Rural 2009 was two fold : to get reliable estimates of the status of children's schooling and basic learning (reading, writing and math ability) at the district level; and to measure the change in these basic learning and school statistics from last year. In 2009, ASER recorded household and village characteristics, education of fathers, and also continued the process of strengthening and streamlining started in 2008. In each district 2-4 villages were re-visited after the survey in order to check how the survey was conducted. All analysis was based on data from 29 districts. Children aged 3-16 years were asked about their enrollment status, type of school, tuition status, preschool status, etc. Children aged 5-16 years were assessed on reading tasks, arithmetic tasks, English tasks, etc. It was observed that the overall percentage of children aged 6-14 years, who were out of school had dropped from 4.3% in 2008 to 4% in 2009. Out of school girls 11 to 14 years it had dropped from 7.2% in 2008 to 6.8% in 2009. This decrease was clearly visible in Chhattisgarh (3.8%), Bihar (2.8%), Rajasthan (2.6%), Orissa (2.16%), and Jammu and Kashmir (1.9%). Other than Meghalaya all other states in the North-East also showed a drop in the number of dropouts. Andhra Pradesh recorded an increase in the percentage of 11-14 year old girls out of school from 6.6% in 2008 to 10.8% in 2009; so did Punjab from 4.9% in 2008 to 6.3% in 2009. For 6-14 year olds, between 2008 and 2009 there has been a slight decline in the percentage of children enrolled in private schools (0.8%). However, five states namely Uttar Pradesh, Rajasthan, Maharashtra, Andhra Pradesh and Gujarat recorded an increase of more than 5 percentage points in private school enrollment. Over 50% of 5 year olds are enrolled in schools. 25% of all rural children in Standard 5 could read simple sentences. Of those who could read sentences, over 80% could understand the meaning of the sentence. By Standard 8, 60.2% of all children could read simple sentences. In all north eastern states (except Tripura), Goa, Himachal Pradesh and Kerala more than 80% of children in Standard 8 could not read simple sentences fluently, but they could understand the meaning. It was found that the percentage of children taking paid tuition increased for every class, in both private and government schools. Only Kerala and Karnataka showed a small but consistent decline in the incidence of tuition across government school children in most classes. The incidence of tuition in

Bihar and Orissa was high, with very large numbers of government school children taking tuitions, ranging from about 33% in Standard I to well over 50% in Standard 8. Water is available in 75% government primary schools and 81% upper primary schools. Usable toilets could be found in over 50% government schools. About 12-15% girls' toilets were locked and only about 30-40% were usable. As far as mother's reading ability was concerned, in 27 out of 31 states more than 50% mothers could read. In Bihar only 39.5% mothers could read, which was the lowest percentage, whereas in Kerala 97.5% mothers could read. In Standard I-II more than 70% children could read letters or words in all states except Tamil Nadu (62.4%) and Uttar Pradesh (68.0%). In Standard III-V more than 50% children could read level 1 (Standard I Text) or more except Uttar Pradesh (48.6%) and Jammu and Kashmir (48.6%). More than 70% children in Standard I-II could recognize numbers 1 to 9 or more in all states except Uttar Pradesh. More than 40% children in Standards III-IV could do subtraction or more in all states of India except Uttar Pradesh (35.7%) and Tamil Nadu (39.7%). More than 40% children in Standards I-II could read letters or more in English in all states of India except the children of Dadra and Nagar Haveli (38.4%) and Gujarat (31.8%). It was found that there is a considerable variation across states in the grants received in the last school year. In Nagaland close to 90% of schools visited had received all their annual grants, whereas the percentage of visited schools receiving their grants in the 2008-2009 school year was 60% or below in Jharkhand, Orissa and Madhya Pradesh.

**Key Words** : 1.EDUCATION 2.PRIMARY EDUCATION 3.RURAL SCHOOLS 4.RURAL INFRASTRUCTURE.

10. Shirali, Abhishek et al. (2005).

School sanitation and hygiene education. New Delhi : Society of Development Studies. 58 p.

**Abstract** : The Total Sanitation Campaign (TSC) as a demand driven and participatory programme was launched in 1999. An integral component of this programme is the School Sanitation and Hygiene Education (SSHE) programme. It focuses completely on school children and tries to inculcate in them better hygiene practices. The SSHE programme envisages the construction of toilets in all levels of Government schools, i.e. primary, upper primary, secondary and higher secondary. Field work was carried out in Karnataka for a duration of 6 days. A total of 9 villages in Tumkur and Mysore districts were visited for observation and data collection. 79 children, 26 households and 12 teachers responded to the questionnaires. These covered a range of issues to ascertain

the availability of toilets, their upkeep and utility; the knowledge of good hygiene practices; the availability of clean water; and the incidence of water borne diseases, etc. The ratio of toilet units to users was 1:184 in the case of Tumkur and 1:86 in the case of Mysore. One unit equals 1 toilet plus 2 urinals for girls and 1 toilet plus 2 urinals for boys. This translates into 2 toilets and 4 urinals per 250 children. Under the TSC, as part of the toilet complex design, a tap for hand washing was provided outside the toilets. In 22% of the sampled schools, there was no tap for hand washing outside the toilet, and in 11% of the schools, the taps were non-functional, requiring repair. 67% of the sampled schools did not have a garbage disposal pit. However, 22% of the schools visited were engaged in building compost pits to convert garbage into manure, which they used for the school garden. Protection walls in schools were seen to be partial in 22% of the schools that were visited of which 11% had barbed wire fencing and the other 11% were entirely open from behind. In 45% schools there was no evidence of water storage inside the toilet, and in 89% of the sampled schools there was no provision of mugs to pour water. In the absence of mugs it would be difficult for small children to pour water from large buckets and they would contaminate the water by immersing their hands in it. There was no safe drinking water in 45% of the sampled schools as they did not have hand pumps or these were not functional, and there was no other method employed to purify water. 33% of the respondents in Tumkur used soap to wash their hands after defecation, and this was higher in Mysore at 85%. It was recommended that teachers and headmasters should not be the only ones to be held responsible for the maintenance of facilities because they have no control over the flow of funds. Observation visits should be made on a regular basis, following which a record should be maintained which clearly states the purpose of the visit, duration of the visit, and observations, requirements of schools and follow up on the earlier problems of schools. School authorities should be given technical training on the operation and maintenance of hardware components which would make the school authorities more self-reliant to ensure success of the school sanitation programme. It is essential to establish an efficient Monitoring System, and a register should be maintained to monitor the number of meetings that have taken place, as well as a file of the minutes of the meetings. The monitoring system should keep a check on the flow of funds so that funds are not exhausted and used purposefully, and the school authorities and teachers should be briefed about the many sources from where they can acquire funds.

**Key Words :** 1.EDUCATION 2.SANITATION 3.SCHOOL SANITATION  
4.TOILETS 5.HYGIENE.

11. Singh, Suman Kumar et al. (2006).  
Impact of in-service training of teachers : the experience of BEP (DPEP III). New Delhi : UNICEF. 103 p.

**Abstract :** The Bihar Education Project (BEP) (1991) emerged as the first major response in the country to the challenges of Universalization of Primary Education (UPE) unfolded by the New Policy on Education (1986) and its subsequent Plan of Action. BEP began the process of empowering teachers with a 21 day training package, which was carefully appraised and replaced by a completely revamped 10 day training package, Ujala. The in-service training became a recurrent activity of the project with the development of new modules, Ujala I (1998) and Ujala II (1999). While Ujala remained limited to the seven original districts of the project, its subsequent versions were used to train over 90,000 teachers drawn from all 17 districts of undivided Bihar. The in-service teacher training programme (ITTP) offered three rounds of training to teachers using three indigenously developed training modules (Ujala, Ujala I and Ujala II). The study was designed to evaluate comprehensively of the cumulative impact of the three training programmes; to measure the fulfillment of expectations from teachers; and also assess the kind and quality of interventions and contextual factors contributing to their success or failure. The study revealed that teachers had been traditionally attributing poor salary structure and coercive administration as being at the root of the poor quality of education in the state. The quality of education went on declining as it neither figured in the supervisory design, nor could be addressed through any capacity building mechanism. Further, teachers in the state are a heterogeneous lot. The teacher, traditionally, has been the sole purveyor of knowledge and thus has commanded the entire process of learning. His/her own experience as a student and then as a teacher for so long has strengthened this thinking. It was observed that the practical aspect of training is getting weaker and weaker. On the whole, it has been reduced to a mere pre-requisite for a job, rather than preparation for a highly challenging assignment. The thinking that has prevailed in society for long is that teaching primary grades is no big deal. Primary education administration in the state has experienced innumerable experiments in respect of recruitment, training and posting of teachers. By the time a certain policy comes to be fully implemented, a new one stares them in the face. The implications for teacher training, be it pre-service or in-service, are yet to be fully realized by the makers of education policy. BEP, no doubt, succeeded in opening effective channels of communication with teachers, which hitherto had broken down. However, this did not mean that it would necessarily lead to the objectives of the project. That the resolve could not be sustained long enough to result in improved performance in the classrooms suggests that earning goodwill was not enough. The cascade model of training, which emerged in the course of implementation of programmes

like mass literacy in the country, had been found to serve short term and limited objectives. The 5 day training of Resource Persons (RP) does not contain inputs on Ujala training, the efficacy of the cascade model of training creates fresh waves of doubt. The quality of training across the Block Resource Centres (BRC) has not remained uniform. In quite a few places poor logistic support, untrained RPs and BRC coordinators, and the absence of close monitoring are to blame for the unsatisfactory state of affairs. Coordination with the mainstream Education Department vertically is missing in the arrangement. It was recommended that text books should be supplied to schools well in time and regularly. Regular recruitment policy of teachers should be implemented so that there would be no shortage of teachers in schools.

**Key Words** : 1.EDUCATION 2.TEACHER TRAINING 3.TRAINING OF TEACHERS 4.IN-SERVICE TRAINING TEACHERS 5.DPEP 6.DISTRICT PRIMARY EDUCATION PROGRAMME 7.PRIMARY EDUCATION 8.BIHAR EDUCATION PROJECT 9.QUALITY EDUCATION 10.BIHAR.

12. Sud, Anup and Sujata. (2006).  
Academic performance in relation to self-handicapping, test anxiety and study habits of high school children. Shimla : Himachal Pradesh Univ., Dept. of Education. 6 p.

**Abstract** : Self handicapping refers to placing obstacles in the way of one's task performance, so that one can furnish oneself with an external attribution when future success is uncertain. The present study investigated the relationship of academic performance with self handicapping, test anxiety, worry, emotionality and study habits of high school children (n=200) from 2 government senior secondary schools of Himachal Pradesh. Children were similar in age and socio-economic background. It was observed that academic performance was significantly and negatively correlated only with self handicapping for the total sample as well as for boys, and with worry for total sample as well as for girls but not with any other variables. It had also been observed that on self handicapping boys reported higher mean scores than girls, and with regard to study habit scores, boys reported poorer study habits than girls. Only worry turned out to be significantly and negatively related to academic performance. It was observed that males were more willing to make ability attributions and were less confident of their ability with regard to test anxiety and its worry and emotionality components. Only worry had been found to be negatively and significantly related to academic performance for total sample as well as for girls. It reflects that it was worry and not emotionality that strongly relates to academic

performance. It was found that females experience more worry than their male counterparts. Lack of relationship between academic performance and study habits (regardless of gender) highlights that perhaps negative striving factors have greater impact on academic performance. The study habits scores of children in the present study were found to be average and the mean score was 59 for boys and 63 for girls. It was recommended that much research is needed in future to reveal the causes of gender differences in academic achievement and self handicapping.

**Key Words** : 1.EDUCATION 2.STRESS 3.ANXIETY 4.SCHOOL STRESS  
4.MENTAL HEALTH 5.ACADEMIC PERFORMANCE 6.TEST ANXIETY  
7.FAILURE IN SCHOOL 8.SELF HANDICAPPING 9.HIGH SCHOOL  
STUDENTS 10.HIMACHAL PRADESH.

13. World Bank, New Delhi. (2009).  
Secondary education in India : universalizing opportunity. New Delhi :  
WB. ~125 p.

**Abstract** : Since Independence, India has invested huge resources into the expansion and improvement of education in the country, in an effort to extend access from the elites to the masses. The first ten years of schooling are expected to provide general education without differentiation into arts, science and vocational streams. Elementary education aims to develop literacy and numeracy, acquaintance with the social and physical environment, creative expression and healthy living. Secondary education aims to develop the intellectual, social and moral qualities essential for democratic citizenship and to prepare young people for entry into the world of work or for continuation of academic pursuits. Senior secondary education is mainly for university preparation and separates students into separate streams for arts, science and often commerce. The 4 types of schools are government schools established by central and state governments; local body schools established by local government (e.g. municipalities); private schools that receive government grants-in-aid (known as aided schools); and private unaided schools. The primary justification for investment in secondary education lies in its contribution to economic growth, poverty reduction and important contribution to democratic citizenship. India's gross enrollment rate (GER) at the secondary level of 40% is inferior to the GERs of its global competitors in East Asia (average 70%) and Latin America (average 82%). The attendance rate of the general population (55%) is nearly 80% higher than the average attendance rate for STs, SCs and Muslims (31%). Children with Special Needs (CWSN) are another vulnerable group where disability legislation commits GOI to free schooling for CWSN to age 18 years in environments which are best suited for their individual learning needs. But at the secondary level the number of seats depends on the role of



private aided and unaided schools. The current grant-in-aid does not provide incentives for aided schools to expand enrollment or operate in under-served areas. Public Private Partnership (PPP) can be structured through building construction maintenance, catering, etc., giving incentives to improve quality, and ensuring equity for disadvantaged groups. Transparent, competitive open public bidding processes would generate value for money. India has to develop an open learning system that allows for exit and multiple re-entries so that youths can upgrade their skills and qualifications at the time and place convenient to them. Distance education using information and communication technologies (ICTs) can extend opportunities to young people who have to work and want to continue schooling. The National Institute for Open Schooling (NIOS) was established in 1989 by Ministry of Human Resource Development (MHRD) to cater to the educational needs of school dropouts and socially and economically disadvantaged sections of the learner population. It also offers vocational courses. NIOS revises course materials, and using simple illustrations NIOS reaches women, SCs, STs and students from rural areas. The cost per student in NIOS is lower than that of Government schools. U.P. provides stipends to all SC, ST and OBC children in primary schools, while in some states SC/ST children receive incentives in the form of free text books, uniforms, stationery, scholarship, and transport allowances up to Rs. 250 per student per year. M.P. provides a cash grant of Rs. 500 for girls who enter secondary education. A.P. provides free bus passes to girls in secondary education. Rajasthan provides free bicycles to disadvantaged girls for entering secondary education. TN also provides bus passes or bicycles to those who are admitted for senior secondary education, and TN is planning to use capitation grants to help girls to enroll in private schools. The share of spending at each level in 2004-05 for elementary (Grades 1-8), secondary (Grades 9-12) and higher education were 52%, 30% and 18% respectively. The total public spending on secondary education amounted to US \$ 7.2 billion, equivalent to 1.11% of GDP. In 2006, combining both recurrent (non-plan) and investment (plan) spending, elementary education accounted for just over 50% of total public spending on education, secondary education for about 30%, tertiary education 12%, and technical education 4%. To improve the quality and effectiveness of teachers the scope of current problems calls for a central policy thrust focusing on pre-service and in-service professional development. Teachers Training Colleges (TTCs) need to improve their links with government departments of education, so that they can modify their intake of trainees and their subject matter expertise to respond to forecasts of the demand for teachers. Assessments of teachers' knowledge and skills should be done and tailored professional development programmes should be developed to address weaknesses.

**Key Words** : 1.EDUCATION 2.SECONDARY EDUCATION 3.LEARNING ACHIEVEMENT.

## HEALTH

14. Breakthrough, New Delhi. (2009).

Is this justice ? : multi-media campaign to reduce stigma against women living with HIV/AIDS: summary of campaign evaluation. New Delhi : Breakthrough. 4 p.

**Abstract** : In February 2007, Breakthrough launched India's first multimedia campaign to bring attention to the stigma and violence faced by women living with HIV/ AIDS (WLHA). The campaign demonstrated how HIV positive status, compounded by a husband's death, often leads to loss of rights and consequent eviction of women from marital and natal homes. Currently women form 31.2% of the estimated 2.47 million people living with HIV/ AIDS. It was experienced by WLHA in India that gender plays a key role in the nexus between HIV related stigma, shame and blame. WLHA often face limited access to care and treatment, denial of their rights to confidentiality, homelessness, job loss and no access to their children. 90% of WLHA are thrown out of their homes after their husbands die of AIDS. The campaign was released in seven Indian languages and reached more than 50 million people across India. The campaign focused on the states of Uttar Pradesh (Kanpur), Karnataka (Udupi) and Maharashtra (Aurangabad), which have a combined total population of 314 million. According to Television Audience Measurement (TAM) and the National Readership Survey, the campaign reached over 34 million people through television, 29 million through print media and 18 million through radio. The research and analysis survey included Baseline Research (pre-campaign) and Endline Research (post-campaign). The Baseline Research (BR) assessed the interplay between gender, HIV status and women's rights, to ascertain the magnitude of their vulnerability and identify stigma indicators. The Endline Research, conducted after the campaigns sought to assess the reach and impact of the Breakthrough Campaign and measure changes in knowledge and attitudes towards WLHA against the Baseline stigma indicators. The Endline Research (ER) included 1,125 people divided equally among males and females. It was found that there was 22% decrease in the number of people who felt that it is necessary for a woman to stay with her HIV positive husband. There was a 10% decrease in the number of people who blame a woman for not satisfying her husband sexually. It was revealed that women cannot negotiate safer sex, and there was 4% increase in the number of community members who realized this

from Baseline to Endline. Women are subjected to domestic violence and there was 8% increase among community members about this issue (Endline 33%). Women are treated unjustly after their husbands' deaths; 31% women suffer and are blamed for men's shortcomings; and 36% WLHA were thrown out of their homes. It was recommended that family support and right to shelter should be enforced to reduce the stigma and discrimination that WLHA face.

**Key Words** : 1.HEALTH 2.AIDS AFFECTED WOMEN 3.AIDS AWARENESS CAMPAIGN 4.AIDS CAMPAIGN 5.CAMPAIGN ON AIDS 6.DISCRIMINATION AGAINST AIDS AFFECTED WOMEN.

15. Diabetes Foundation of India, New Delhi. (2008).  
Childhood obesity in Asian Indians : a burgeoning cause of insulin resistance, diabetes and sub clinical inflammation. New Delhi : DFI. 4 p.

**Abstract** : There is a general misconception in parents in India and other developing countries that an obese child is a healthy child, and that if the child is fat, "baby fat" will go away with time. Obesity has reached epidemic proportions globally. More than 1 billion adults are overweight, and at least 300 million of them are clinically obese. The rising prevalence of obesity in developing countries is due to rapid urbanization and mechanization which has led to reduction in the energy expenditure along with an increase in energy intake. Obesity is associated with increased risk of the metabolic syndrome, type 2 diabetes mellitus (T2DM), hypertension, dyslipidemia, polycystic ovarian syndrome (PCOS), coronary heart disease (CHD) and some of these metabolic derangements start in childhood. Nearly 22 million children under the age of five years are estimated to be overweight. The calculated global prevalence of overweight (including obesity) in children aged 5-17 years is 10%, and the prevalence varies from over 30% in America to less than 2% in sub Saharan Africa. Almost 38-65% of adult urban Indians in Delhi fulfill the criteria for either overweight/ obesity or abdominal obesity. The prevalence of overweight/ obesity in urban children in Delhi has shown an increase from 16% in 2002 to about 24% in 2006. Prevalence among adolescent children 14-17 years was 29% in private schools and 11.3% in government funded schools in 2006-07. For any proposed value of body mass index (BMI), Asian Indians have a higher magnitude of adiposity, abdominal obesity and have a lower muscle mass than white Caucasians. The health consequences of childhood obesity with reference to Asian Indians is that about 33.3% of overweight or obese urban Asian Indian children have insulin resistance. Also, higher level of hyper insulinemia and related metabolic derangements have been recorded in Asian Indian neonates

and children as compared to white Caucasian neonates. Abdominal obesity is the strongest risk factor for T2DM. In children, T2DM has been increasingly reported globally. T2DM is higher in children and adolescents in North India. Risk factors for development of T2DM in Asian Indian adolescents and young adults were hypertriglyceridemia, high waist to hip ratio, and family history of diabetes. Obesity contributes to the development of vascular inflammation in Asian Indian adolescents, high C-Reactive Protein (CRP) levels were seen in 13% subjects overall, in 22% of overweight and in 25% of those with excess body fat. Obese adolescent girls are likely to suffer from Polycystic Ovarian Syndrome (PCOS), a syndrome of variable combinations of menstrual irregularity, hirsutism or acne, with obesity and insulin resistance. Childhood obesity in India is because of high burden of school work and academic competitiveness leading to decreased participation in sports and other forms of physical activity. Studies from India show that females have more obesity due to sedentary lifestyle as compared to males. Lack of appropriate play area and limited open space around homes makes it difficult for children to stay physically active. Parents are often overworked and find it easy to let children order “fast foods” as they hardly have any time to oversee balanced nutrition for children, children spend more time in front of TV and computers at the expense of sports and physical activity which leads to obesity. Community based interventions are aimed at providing a conducive environment for children to follow a healthy lifestyle. Community programmes have been initiated by CHETNA, MARG and Diabetes Foundation on a large scale for the first time in South Asia to cover 5,00,000 children in 15 cities of north India. Further, education was given regarding diet and physical activity to children, parents and teachers.

**Key Words :** 1.HEALTH 2.CHILDHOOD OBESITY 3.OBESITY

16. International Institute for Population Sciences, Mumbai. (2008).  
National Family Health Survey 3 : 2005-06 : Assam. Mumbai : IIPS.120 p.

**Abstract :** The 2005-06 National Family Health Survey (NFHS-3) is the 3<sup>rd</sup> in the NFHS series of surveys. The first NFHS was conducted in 1992-93, and the second (NFHS-2) was conducted in 1998-99. All three NFHS surveys were conducted under the stewardship of the Ministry of Health and Family Welfare (MOHFW), Government of India. The survey provides trend data on key indicators like HIV/ AIDS related behaviour, attitudes towards family life education for girls and boys, use of Integrated Child Development Services Scheme (ICDS), men’s involvement in maternal care and health insurance, information on married and unmarried men and women. In Assam, NFHS 3 was based on a sample of 3,437 households and 3,840 women aged 15-49 years and

1,394 men aged 15-54 years were interviewed. Percentage of children aged 6-17 years attending school was 77.2% for males (urban and rural); 74.7% for females (urban and rural); and 75.9% for the total population (urban and rural). Children's (0-18 years) living arrangements showed that 83.5% male children and 81.2% female children lived with both parents (total 82.3%) but only 4.3% male children and 6.1% female children did not live with either of the parents. 7.2% of children (0-18 years) had one or both parents dead. The number of registered children under age five years was 40.2% below 2 years of age, and 44.8% in 2-4 years age group. Hence, 42.6% male children and 43.4% female children were registered. 69% of currently married men either want no children, are themselves sterilized or have a spouse who is sterilized. Among those who do not want another child, 50% women and 47% men would like to wait at least 2 years. In Assam, 24% women and 18% men want more sons than daughters, but only 2-3% women and men want more daughters than sons. Total fertility rate (TFR) for urban women was 1.43 and rural women was 2.65. The TFR for 'No Education' group was 3.35 and '10 or more years education group' was just 1.29. The TFR for SCs was 2.45; STs 2.49, OBCs 1.61 and others was 2.73. Among young women aged 15-19 years, 16% had begun childbearing, a level similar to the national average. 3% women aged 15 years had started childbearing, but among women aged 19 years, almost 39% are already either mothers or pregnant. Young women in rural areas are more likely to have begun childbearing than young women in urban areas (17% and 13% respectively). Teenage pregnancy and motherhood were more prevalent among women with no or little education and among women in lower wealth quintiles than among other women. Female sterilization and the pill were the most widely known methods of contraception, known by 95% of currently married women and men (93% each). Only 40% of currently married men knew about the IUD, although 91% knew about condoms. 82.4% women were married at the exact age of 25 years while 18.5% women were married at the exact age of 15 years. 40.8% men were married at the exact age of 25 years and only 1.2% of the men were married at the exact age of 15 years. With 66 deaths before the age of 1 year per 1,000 live births in the 5 year period preceding the survey, the infant mortality rate (IMR) in Assam is the 5<sup>th</sup> highest in the country. Nonetheless, IMR in Assam has declined from its estimated level of 70 deaths per 1000 live births in NFHS-2. The under-five mortality rate (U5MR) is 85 deaths per 1,000 live births. Girls in Assam face a higher mortality risk than boys, and infant mortality is higher in rural areas (16%) than in urban areas. 26.7% women who availed ANC services had received information on where to go if they had pregnancy complications; 17.6% received information on prolonged labour; 17.3% received information on convulsions; and 16.7% received information on bleeding. Nearly 78% births in Assam take place at home; only 22% take place in a health facility. Institutional births exceeded home births for women from urban areas (58%), women with 10 or more years of education (68%), and women belonging to highest wealth quintiles (86%). About

31% births take place with assistance from a health professional and 25% babies are delivered by a traditional birth attendant (TBA). Only 31% children aged 12-23 months were fully vaccinated against the 6 major childhood illnesses, i.e. tuberculosis, diphtheria, pertussis, tetanus, polio and measles. 62% of the children aged 12-23 months received BCG vaccination and 59% received 3 doses of polio vaccine. Only 45% received 3 doses of DPT vaccine and 37% had been vaccinated against measles. 6.2% male children under age five years and 8.4% female children under 5 years had symptoms of ARI. 38.4% male and 31.4% female children sought help for ARI from a health provider, and 8.9% males and 8.3% females were given antibiotics. 8% children had diarrhoea in the 2 weeks preceding the survey, and 31% of them were taken to a health facility. 26% were treated with oral rehydration therapy (ORT), including 15% children who were treated with a solution prepared from oral rehydration salt (ORS) packets, and 13% were given gruel. 40% of the children with diarrhoea did not receive any type of treatment at all. 10% received antibiotics, which are not recommended for treating childhood diarrhoea. 47% children under age five years are stunted (short for their age), 14% are wasted (too thin for their height), which may result from inadequate food intake or a recent illness. 36% children were underweight, which takes into account both chronic and acute undernutrition. Even during the first 6 months of life, when most babies are breastfed, 30% are stunted, 22% are wasted and 30% are underweight. Children in rural areas are more stunted, but even in urban areas 36% of the children suffer from chronic undernutrition. The ICDS programme provides nutrition and health services for children under age 6 years and pregnant or breastfeeding women, as well as preschool activities for children aged 3-5 years. Among 89% of the children under 6 years in Assam who are in areas covered by an anganwadi centre (AWC), only 30% receive services from the centre. 28% of the children under 6 years receive supplementary food; 15% of the children aged 3-5 years receive early childhood care or preschool services; 7% children aged 0-71 months received immunization from a centre; and only 5% children each received health check ups and growth monitoring services. Children of mothers with 5 or more years of schooling are likely to receive ICDS services. Only 13% children under age 6 years had mothers who received any service from a centre during pregnancy and the same proportion had mothers who received any service when breastfeeding. In Assam breastfeeding is universal (96%) and 63% of children under 6 months are exclusively breastfed, as the World Health Organization (WHO) recommends. Eating foods rich in iron and taking iron supplements can prevent anaemia. Only 24% children aged 6-35 months ate iron rich foods during the day or night before the interview, and only 1% of the children aged 6-59 months were given iron supplements in the week before the interview. Highest percentage of children between 6-59 months given vitamin A in the last 6 months, iron supplements in the last 7 days, and given deworming medication in the last 6 months were 30.4%, 1.5% and 20% respectively, while the lowest percentage for the same in

children between 6-59 months was 2.5%, 0.0% and 0.0% respectively. 41.9% women aged 15-19 years were thin, i.e. body mass index (BMI) <18.5 kg/m<sup>2</sup>, while 0.2% women were obese, i.e. BMI ≥30 kg/m<sup>2</sup>. 49% men aged 15-19 years were thin having BMI <18.5 kg/m<sup>2</sup>, while none of the men were obese in the age group of 15-19 years. 70% of the women in Assam have anaemia, including 45% with mild anaemia, 21% with moderate anaemia, 23% with severe anaemia. 40% men in Assam are anaemic with men under 20 and over 40 years being more likely to be anaemic. 0.28% of the adults aged 15-49 years are infected with HIV, including 0.35% in urban areas and 0.25% in rural areas. 72% men and 23% women use some form of tobacco in Assam. More men (38%) than women (8%) drink alcohol. In Assam, 34% women aged 15-49 years have experienced physical violence and 12% have experienced sexual violence. In all, 37% women have experienced physical or sexual violence, including 42% ever married women. About 36% ever married women reported being slapped by their husbands; 15% ever married women had their arm twisted or hair pulled; 13% had been pushed, shaken or had something thrown at them by their husband; 13% had been punched with his fist or something. 8% reported that their husbands kicked them, dragged them or beat them up, and 2-3% said that their husband tried to choke or burn them. 14% reported that their husbands forced them physically to have sex, and 6% reported that their husband forced them to perform sexual acts that they did not want to do.

**Key Words** : 1.HEALTH 2.NFHS 3 ASSAM 3.NATIONAL FAMILY HEALTH SURVEY 3 4.INFANT MORTALITY 5.CHILD MORTALITY 6.EARLY MARRIAGE 7.IMMUNIZATION 8.CHILD NUTRITION 9.ANAEMIA 10.DOMESTIC VIOLENCE 11.ASSAM.

17. International Institute for Population Sciences, Mumbai. (2008). National Family Health Survey 3 : 2005-06 : Bihar. Mumbai : IIPS. 120 p.

**Abstract** : The National Family Health Survey (NFHS-3) 2005-06 is the third in the series, and provides trend data on key indicators and new topics such as HIV/ AIDS related behaviour, attitude towards family life education for girls and boys, use of the Integrated Child Development Services (ICDS) programme, men's involvement in maternal care, and health insurance. In Bihar, NFHS-3 was based on a sample of 3,016 households and covered 3,818 women aged 15-49 years and 1,214 men aged 15-54 years from a sub-sample of households. Information was obtained on population, health and nutrition. In Bihar, only 56% children aged 6-17 years attend school, and school attendance is higher in urban areas (67%) than rural areas (54%). 61% children aged 6-10 years attend

primary school (66% in urban areas; 60% in rural areas). Children aged 11-14 years attending school were 64%, which dropped to 34% for children aged 15-17 years. 70% children below 18 years lived with both parents, 4.1% were living with neither parent, and 5.1% had one or both parents dead. Total registered births of children under 2 years were 6.2%, and of children 2-4 years were 5.5%. Fertility in Bihar is the highest of any state in India (4) and women in Bihar have 1.3 children more in their lifetime than women in India as a whole (TFR of 2.7). Fertility in rural areas is 4.2 children per woman, and fertility in urban areas is 2.9 children per woman. Fertility rates are higher for women in disadvantaged groups (4.8 children per woman among the scheduled castes and 4 among other backward classes) than for women who are not in any of these groups (3.4). Among young women aged 15-19 years, 25% had begun childbearing. 7% women aged 16 years had begun child bearing, and 58% women aged 19 years were already mothers or pregnant. Young women in rural areas are almost three times as likely to have begun child bearing (28%) as young women in urban areas (10%). Government family planning programme promotes 3 temporary methods of contraception namely, the pill, IUD, and condoms. Of these 3 methods, married women are most likely to know about the pill (96%) and men are likely to know about condoms (91%). The median age at first marriage is 15 years among women aged 20-49 years and 20 years among men aged 25-49 years. 69% women aged 20-24 years got married before the legal minimum age of 18 years and 43% men aged 25-29 years got married before the legal minimum age of 21 years. The infant mortality rate (IMR) is 62 infant deaths per 1,000 live births. The under-five mortality rate (U5MR) is 85 deaths per 1,000 live births. 1 in 16 children die within the 1<sup>st</sup> year of life and 1 in 12 die before reaching age five years. Girls in Bihar face higher mortality risk than boys, and U5MR is 108 for girls and 83 for boys. Infant mortality was 84 per 1,000 live births for teenage mothers, compared with 57 for mothers aged 20-29 years. Women receiving ante-natal care (ANC) in Bihar were 32% which was less than the national average (74%), and was also the lowest of any state in India. During their last birth, 30% mothers received iron and folic acid supplements (IFA), but only 10% mothers consumed IFA for 90 days or more. 73% mothers received two or more doses of tetanus toxoid (TT) vaccine. Only 4% women took a deworming drug during pregnancy. Only 20% births in Bihar take place in a health facility, and this proportion is more than twice as high in urban areas compared to rural areas. Institutional births are common among women in the highest wealth quintile (74%); women who received four or more ANCs visits were 63%, and women with 10 or more years of schooling (59%). In Bihar, only 33.3% children aged 12-23 months are fully vaccinated against 6 major illnesses tuberculosis, diptheria, pertussis, tetanus, polio and measles. Only 7% children 12-23 months received no vaccinations at all. Only 65% children aged 12-23 months received BCG vaccination, 46% had received 3 doses of DPT vaccine, and 40% had received measles vaccine. 7% children under age five years had



symptoms of acute respiratory infection (ARI). Of these children, 70% were taken to a health facility and 14% received antibiotic drugs. Overall, 11% children under age five years had diarrhoea, 54% were taken to a health facility, 47% were treated with oral rehydration therapy (ORT) including 21% with oral rehydration salt (ORS) packets, and 26% were given gruel. More than 28% children with diarrhoea did not receive any type of treatment at all; 23% received antibiotics, which was not recommended for treating childhood diarrhoea. The ICDS programme, provides nutrition and health services for children under age six years and pregnant or breastfeeding women, and early childhood care or preschool activities for children aged 3-5 years. The most common services children received were immunization (8% of children under six years), early childhood care or preschool education (5% of children aged 3-5 years), and supplementary food (4% of children under six years). 56% children under five years are stunted, or too short for their age, which indicates that they have been undernourished. 27% children below 5 years are wasted, or too thin for their height. 56% are underweight which takes into account both chronic and acute undernutrition. Children in rural areas are more undernourished but even in urban areas, 48% of the children under age five years suffer from chronic undernutrition. Girls are more stunted and underweight but boys are more likely to be wasted than girls. Only 28% children under six months are exclusively breastfed, as the World Health Organization (WHO) recommends. Only 30% are put to the breast within the 1<sup>st</sup> day of life, including only 4% who started breastfeeding in the 1<sup>st</sup> hour of life. Mothers in Bihar breastfeed for an average of 25 months, which is one month longer than the minimum of 24 months recommended by WHO. Eating food rich in iron and taking iron supplements prevents anaemia. Only 6% children aged 6-35 months ate iron rich foods during the day or night before the interview, and only 3% children aged 6-59 months were given iron supplements in the week before the interview. 43% children aged 6-59 months had been given vitamin A supplements in the last 6 months and 25.2% children were given deworming medication in the last 6 months. 45% women and 35% men are thin. Undernutrition is serious among the young (in the age group 15-19 years), and among those belonging to the scheduled castes. Overweight and obesity is not a major problem in Bihar, and fewer than 5% adults suffer from this form of malnutrition. 67% women are anaemic in Bihar and 34% men are anaemic. 0.28% adults aged 15-49 years are infected with HIV, including 0.35% in urban areas and 0.25% in rural areas. 66.7% men and 8% women including 5% pregnant women use some form of tobacco. Men who use tobacco chew tobacco in the form of paan masala, gutka or other tobacco products, whereas among women who use tobacco, smoking cigarettes or bidis was more common. 35% men and 1% women drink alcohol. 54% married women reported having been slapped by their husband, about 25% reported having their arms twisted, hair pulled, being pushed, shaken or having something thrown at them. 20% reported having been punched with the fist or something

that could hurt and 17% reported being kicked, dragged or beaten up. 18% reported that their husbands had physically forced them to have sex and 20% reported emotional violence. 21% had sought help to end violence, but 66.7% women neither sought help nor told anyone about the violence. Only 3% women who faced sexual violence had sought help. Very few women sought institutional help from police (2%) or a social service organization (1%).

**Key Words** : 1.HEALTH 2.NFHS 3 BIHAR 3.NATIONAL FAMILY HEALTH SURVEY 3 4.INFANT MORTALITY 5.CHILD MORTALITY 6.EARLY MARRIAGE 7.IMMUNIZATION 8.CHILD NUTRITION 9.ANAEMIA 10.DOMESTIC VIOLENCE 11.BIHAR.

18. International Institute for Population Sciences, Mumbai. (2008).  
National Family Health Survey 3 : 2005-06 : Gujarat. Mumbai: IIPS.  
122 p.

**Abstract** : The National Family Health Survey (NFHS-3) 2005-06 is the third in the series of surveys. It provides trends data on key indicators and includes information on several new topics such as HIV/ AIDS related behaviour, attitudes toward family life education for girls and boys, use of the Integrated Child Development Services (ICDS) programme, men's involvement in maternal care and health insurance, and information on married and unmarried men and women. In Gujarat, NFHS-3 is based on a sample of 3,126 households. 3,729 women aged 15-49 years and 1,428 men aged 15-54 years from a sub-sample of households were interviewed to obtain information on population, health and nutrition. In Gujarat, only 71% children aged 6-17 years attend school. School attendance is somewhat higher in urban areas (74%) than rural areas (69%). 90% of primary school age children (6-10 years) attend school (92% in urban areas; 89% in rural areas); the percentage attending school drops to 74% for children aged 11-14 years and further to 32% for children aged 15-17 years. 66% girls aged 6-17 years attend school compared with 75% of boys in the same age group. 91% of the children below 18 years were living with both parents, 3.5% were not living with either parent, and 2.7% had one or both parents dead. 83.6% children less than 2 years of age and 86.8% children between 2-4 years of age are registered. A woman in Gujarat will have an average of 2.4 children in her lifetime. Between NFHS 2 and NFHS 3 fertility decreased by 0.3 children. Fertility in rural areas is 2.8 children per woman, while fertility in urban areas is 1.9 children per woman, which is lower than the replacement level. Fertility rates are higher for women in disadvantaged groups (2.5 children per woman among both the scheduled castes and scheduled tribes and 2.8 among other backward

classes), compared with women who are not in any of these groups (2.0). Among young women aged 15-19 years, 13% have already begun childbearing. Although few women aged 15-16 years have started childbearing, 28% women aged 19 years are already either mothers or pregnant. Young women in rural areas (16%) are more than twice as likely to be mothers as young women in urban areas (7%). Government family planning programme promotes 3 methods: pill, IUD and condoms. Married women are likely to know about the pill (90%) and men are likely to know about condoms (96%). The median age at first marriage is 18 years among women aged 20-49 years and 22 years among men aged 25-49 years. On an average, men get married more than 4 years later than women. Almost 39% women aged 20-24 years got married before the legal minimum age of 18 years. 31% men aged 25-29 years got married before the legal minimum age of 21 years. Infant Mortality Rate (IMR) in Gujarat has been decreasing. It is estimated at 50 deaths of infants before the age of 1 year per 1,000 live births. The under-five mortality rate (U5MR) is 61 deaths per 1,000 live births. These rates imply that despite decline in mortality 1 in 20 children still die within the first year of life, and 1 in 16 die before reaching the age of five years. The IMR in rural areas of Gujarat is 61% higher than that in urban areas. Children born to mothers under the age of 20 years are much more likely to die in infancy than children born to mothers in the prime childbearing ages. IMR is 90 per 1,000 live births for teenage mothers, compared with 55 for mothers aged 20-29 years. Among women who gave birth in the 5 years preceding the survey, 84% received antenatal care (ANC) from a health professional (63% from a doctor and 21% from other health personnel) for their last birth. 13% received no ANC, and 93% urban women received ANC from a health professional for their last birth, compared with 78% rural mothers. For their last birth, 82% mothers bought or received iron and folic acid supplements (IFA); but only 37% mothers consume IFA for the recommended 90 days or more. 80% mothers received 2 or more doses of tetanus toxoid (TT) vaccine. Only 7% took a deworming drug during pregnancy. 63% births during the past five years took place with assistance from a health professional and 32% babies were delivered by a traditional birth attended (TBA). Only 22% home births were assisted by health personnel. 45% children aged 12-23 months were fully vaccinated against the 6 major childhood illnesses, tuberculosis, diphtheria, pertussis, tetanus, polio and measles. Most children are partially vaccinated, and only 5% children received no vaccinations at all. 86% children received BCG vaccination; 61% received at least 3 doses of the DPT vaccine; 65% received 3 doses of polio vaccine; and 66% aged 12-23 months have been vaccinated against measles. 8% children under age five years had symptoms of ARI. Overall, 13% children had diarrhoea in the 2 weeks preceding the survey. 57% of them were taken to a health facility, 43% were treated with Oral Rehydration Therapy (ORT), and 22% were given gruel. 32% did not receive any kind of treatment. The ICDS programme provides nutrition and health services for children under age six years and pregnant or

breastfeeding women, as well as preschool activities for children aged 3-5 years. Among 84% of children under 6 years in Gujarat who are in areas covered by an AWC, 44% receive services of some kind from a centre, 37% children receive early childhood care, 34% receive immunization, 32% receive supplementary food and 25% receive health check ups. 52% children under age 5 years are stunted or under nourished; 19% are wasted or too thin for their height. Children in rural areas are more undernourished, but even in urban areas 47% children under age 5 years suffer from chronic undernutrition. 48% children under 6 months are exclusively breastfed as the World Health Organization (WHO) recommends. Only 58% are put to breast within the 1<sup>st</sup> day of life, including 28% who started breastfeeding in the first hour of life. Eating food rich in iron and taking iron supplements can prevent anaemia. Only 6% children aged 6-35 months ate iron rich foods during the day or night before the interview, and only 10% children aged 6-59 months were given iron supplements in the week before the interview. 28.5% children aged 6-59 months were given vitamin A supplements in the last 6 months, and 10.9% children aged 36-47 months were given deworming medication in the last 6 months. 36% both women and men aged 15-49 years are too thin, and 17% women and 11% men are overweight or obese. Only 47% women and 53% men have healthy weight for their height. More than 55% women have anaemia including 36% with mild anaemia, 17% with moderate anaemia, and 3% with severe anaemia. 74% ST women are anaemic. 22% men are anaemic, and more men under 20 and over 39 years are likely to be anaemic. 45% ST men are anaemic. Only 0.28% adults aged 15-49 years are infected with HIV in Gujarat, including 0.35% in urban areas and 0.25% in rural areas. 60% men and 8% women use tobacco, including 7% pregnant women. It was in the form of paan masala, gutka or other tobacco products. 16% men and 1% women drink alcohol. Among women aged 15-49 years, 26% experienced physical violence and 7% experienced sexual violence. In all 28% women aged 15-49 years experienced physical or sexual violence including 31% of ever married women. Only about 30% women who experienced violence sought help to end the violence. 58% women neither sought help nor told anyone about the violence.

**Key Words** : 1.HEALTH 2.NFHS 3 GUJARAT 3.NATIONAL FAMILY HEALTH SURVEY 3 4.INFANT MORTALITY 5.CHILD MORTALITY 6.EARLY MARRIAGE 7.IMMUNIZATION 8.CHILD NUTRITION 9.ANAEMIA 10.DOMESTIC VIOLENCE 11.GUJARAT

19. International Institute for Population Sciences, Mumbai. (2008).  
National Family Health Survey 3 : 2005-06 : Kerala. Mumbai : IIPS. 120 p.

**Abstract :** The National Family Health Survey (NFHS-3) 2005-06 is the third in the NFHS series of surveys. The survey provides trend data on key indicators and information on new topics such as HIV/ AIDS related behaviour, attitudes toward family life education for girls and boys, use of the Integrated Child Development Services (ICDS) programme, men's involvement in maternal care, and health insurance. In Kerala, the survey was based on a sample of 3,023 households. 3,566 women aged 15-49 years and 1,121 men aged 15-54 years from a sub-sample were interviewed. Almost all children aged 6-10 years attend school in Kerala (97% in urban areas and 99% in rural areas). At age 15-17 years, girls are more likely than boys to be attending school. Children below 18 years who live with both parents are 72.8%, children not living with either parent are 2.7%, and children who have one or both parents dead are 2.2%. Birth registration for children between 0-2 years was 88%, and birth registration for children between 2-4 years was 89.1%. A woman in Kerala will have an average of 1.9 children in her lifetime. Fertility in rural Kerala is 2.0 children, which is 0.3 children higher than that in urban Kerala, where the fertility is 1.7 children. Among young women aged 15-19 years only 6% have begun childbearing; which is much less than the national average of 16%. Government family planning programme promotes 3 temporary methods: the pill; IUDs, and condoms. Almost 90% currently married women know of these methods, and 97% married men know more about the condoms than the pill or IUD (84%-86%). The contraceptive prevalence rate among currently married women was 6.9%. The median age at first marriage among women aged 25-49 years in Kerala is 21 years; and the median age of marriage of men aged 30-49 years was 28-29 years. Almost 15% women aged 20-24 years got married before 18 years, and only 3% of men aged 25-29 years got married before 21 years. Infant mortality (IMR) is estimated at 15 deaths before the age of one year per 1,000 live births; under five mortality (U5MR) in Kerala is 16 deaths per 1,000 live births. All women received antenatal care (ANC) from a health professional, including 98% from a doctor and 1% from any other health personnel. 1% women received ANC from a traditional birth attendant (TBA) or ICDS worker. Among women with births in the last 3 years, the proportion who received 3 or more ANC visits decreased by almost 5% points between NFHS-2 and NFHS-3. 96% women received iron and folic acid (IFA) supplements during pregnancy but only 75% consumed IFA for the recommended 90 days or more. Almost 90% women

received two or more doses of tetanus toxoid vaccine, and 10% took a deworming drug during pregnancy. Almost 99% births in the preceding 5 years took place in a health facility, and only 1% took place at home. 64% births took place in a private health facility compared with 36% in a public health facility. 75% children aged 12-23 months in Kerala are fully vaccinated against 6 childhood illnesses: tuberculosis, diphtheria, pertussis, tetanus, polio and measles. Only 2% children have received no vaccination at all. 3% children under age five years had symptoms of acute respiratory infection (ARI). Of these children, 89% were taken to a health facility, and 33.3% received antibiotic drugs. Overall 7% children had diarrhoea in the past 2 weeks. Among these children, 63% were taken to a health care provider, 81% were treated with oral rehydration therapy (ORT), including 32% with a solution prepared from ORT, and 78% were fed gruel. The ICDS programme provides nutrition and health services to children under 6 years and pregnant or breastfeeding women, as well as preschool activities to children aged 3-5 years. Children aged 0-71 months in areas covered by an anganwadi centre (AWC) received supplementary food (25%); health check-ups (18%); and 31% children aged 36-71 months received early childhood care/ preschool services. 25% children under 5 years were stunted, 16% children under 5 years were wasted, and 23% were underweight. 14-16% infants 0-6 months were stunted or underweight, and 24% infants 0-6 months were wasted. Rural children 0-6 months are more likely to be undernourished, but even in urban areas 22% children suffer from chronic undernutrition. 56% children under 6 months of age are exclusively breastfed, 96% are put to the breast within the first day of life, and only 4% infants are deprived of the highly nutritious first milk. Among children between the ages of 6 and 59 months, 45% are anaemic, 24% are mildly anaemic, 21% are moderately anaemic, and 1% suffer from severe anaemia. 47% children aged 12-35 months were given Vitamin A supplement in the past 6 months. Only 6% children aged 6-59 months were given iron supplements in the week before the interview. Adults aged 15-49 years in Kerala suffer from a dual burden of malnutrition, about 20% adults are too thin (18% women and 22% men), and 28% women and 18% men are overweight. Only 54% women and 61% men have healthy weight. 33.3% women were anaemic, including 26% with mild anaemia, 7% with moderate anaemia, and 1% with severe anaemia. About 8% men aged 15-49 years were anaemic, and scheduled caste and OBC men were more anaemic than other men. Nationally 0.28% adults aged 15-49 years are infected with HIV, including 0.35% in urban areas and 0.25% in rural areas. If the 6 states considered by National Aids Control Organization (NACO) as having high HIV prevalence are excluded, the HIV prevalence for the remaining states, including Kerala, is estimated to be 0.08% for women and 0.16% for men aged 15-49 years respectively. More than 44% men and 2% women use tobacco. 45% men and 1% women in Kerala drink alcohol. 16% women 15-49 years experienced physical violence, and 5% women experienced sexual violence. In all, 17% women aged 15-49 years experienced

physical or sexual violence. 14.3% married women reported having been slapped by their husbands, 4-7% reported being pushed, shaken or having something thrown at them, having their arms twisted or hair pulled, kicked, dragged or beaten up. 4% married women reported that their husband had physically forced them to have sex, and 2% reported that their husbands forced them to perform sexual acts that they did not want to perform. 10% women experienced emotional violence committed by their husbands. Only 36% women sought help, and 46% neither sought help nor told anyone about the violence. Abused women seek help from their own families.

**Key Words** : 1.HEALTH 2.NFHS 3 KERALA 3.NATIONAL FAMILY HEALTH SURVEY 3 4.INFANT MORTALITY 5.CHILD MORTALITY 6.EARLY MARRIAGE 7.IMMUNIZATION 8.CHILD NUTRITION 9.ANAEMIA 10.DOMESTIC VIOLENCE 11.KERALA.

20. International Institute for Population Sciences, Mumbai. (2008).  
National Family Health Survey 3 : 2005-06 : Orissa. Mumbai : IIPS. 119 p.

**Abstract** : The National Family Health Survey (NFHS-3, 2005-06) is the third in the NFHS-series of surveys. It provides trend data on key indicators and includes information on new topics such as HIV/ AIDS-related behaviour, attitudes towards family life education for girls and boys, use of Integrated Child Development Services (ICDS) programme, men's involvement in maternal care and health insurance, information on men and unmarried women, HIV prevalence for India, etc. In Orissa, the survey covered 3,910 households, and 4,540 women aged 15-49 years and 1,592 men aged 15-54 years were interviewed. School attendance among 6-17 years children was higher in urban areas (75%) compared to rural areas (63%). 86% of primary school age children (6-10 years) attended school (96% in urban areas and 84% in rural areas). School attendance dropped to 66% for children aged 11-14 years and was only 24% for children aged 15-17 years. 82% children below 18 years lived with both parents, 5.2% children did not live with either parent, and 6.4% children had one or both parents dead. Birth registration of children below 2 years of age was 58.3% and 56.2% for children aged 2-4 years. A woman in Orissa will have on an average 2.4 children in her lifetime. Fertility in rural areas was 2.5 children per woman, and 1.9 children per woman in urban areas. Fertility rates are higher for scheduled tribe (ST) women (3.1 children per woman) than for women from scheduled castes, other backward classes (OBC) and those who are not in any of these groups (2.0-2.3). Among young women aged 15-19 years, 14% began child bearing (15% in rural areas and 10% in urban areas), which was a little

lower than the national average (16%). Government promotes 3 temporary methods for family planning: the pill, the IUD, and condoms. Of these 3 methods currently married women are most likely to know about the pill (89%), and currently married men are likely to know about the pill (87%) and condoms (84%). 98.2% women were married at the exact age of 25 years, and 24.2% women were married at the exact age of 15 years. 69.4% men were married at the exact age of 25 years, but 2.4% men were married at the exact age of 15 years. The infant mortality rate (IMR) was estimated at 65 deaths before the age of 1 year per 1,000 live births. The under-five mortality rate (U5MR) is 91 deaths per 1,000 live births. The higher rates of infant and child mortality in Orissa imply that despite declines in mortality, 1 in 15 children still die before reaching age five. Girls in Orissa have a lower mortality risk than boys. The infant and U5MR are 23-26% higher for boys than for girls. The infant mortality is 91 per 1,000 live births for teenage mothers compared with 60 for mothers aged 20-29 years. 75% women who gave birth in the last 5 years received antenatal care (ANC) from a health professional, 58% from a doctor, 17% from all other health personnel, and 12% from an anganwadi/ ICDS worker. 13% women received no ANC at all. 90% urban women received ANC from a health professional for their last birth, compared with 72% rural mothers. 83% mothers received iron and folic acid (IFA) supplements, and 34% mothers consumed IFA for the recommended 90 days or more. 83% mothers received two or more doses of tetanus toxoid (TT) vaccine during their pregnancy. Almost 67% births in Orissa take place at home. In 91% cases of home births, a clean blade was used to cut the cord, but only 50% of home births followed the recommendation that the baby be immediately wiped dry and then wrapped without being bathed first. During the past five years 44% births took place with assistance from a health professional, and 18% babies were delivered by a traditional birth attendant (TBA). 38% babies were delivered by a relative, other untrained person, or by no one. 13% of home births were assisted by health personnel. A disposable delivery kit (DDK) was used in only 44% home births. 52% children aged 12-23 months had been fully vaccinated against 6 major childhood illnesses, namely tuberculosis, diphtheria, pertussis, tetanus, polio and measles. However 12% children received no vaccinations at all. 84% children received BCG vaccination, and 65-68% received 3 doses of DPT, at least 3 doses of polio vaccine and measles vaccine. 3% male children and 2.6% female children under six years had ARI symptoms. Those who sought help from a health provider and received antibiotics were 81.7% for males (% not shown for females); and 13.6% for males (percentage not shown for females) respectively. Over all 12% children had diarrhoea in 2 weeks preceding the survey. Among these children, 59% were taken to a health facility. More than 55% children were treated with oral rehydration therapy (ORT), including 40% children who were treated with a solution from oral rehydration salt



(ORS) packets, and 15% were given gruel. 27% children with diarrhoea did not receive any treatment at all and 12% received antibiotics. Only 9% children received more liquids than normal, and 39% children with diarrhoea received less fluids to drink than normal or no liquids at all, which increases the risk of dehydration. Among the 80% children under 6 years who are in areas covered by an anganwadi centre (AWC), 66.6% received services of some kind from a centre. Children 0-59 months received growth monitoring (56% children); supplementary food (53% children); health check-ups and immunization (42-43% children); and 28% children aged 3-5 years received early childhood care and education (ECCE) or preschool services. 30% mothers of children who were weighed at AWCs received counselling from the anganwadi worker (AWW) after the child was weighed. Even during the first six months of life, when most babies are breastfed, 26% children were stunted, 28% were wasted, and 36% were underweight. Children in rural areas are undernourished, but even in urban areas more than 35% children suffer from chronic undernutrition. The majority of scheduled tribe children are stunted (57%) or underweight (54%). Girls and boys are about equally likely to be undernourished. 82% infants are put to the breast within the first day of life, including 55% who started breastfeeding in the first hour of life. Mothers in Orissa breastfeed for an average of 34 months, which is almost a year longer than the minimum of 24 months recommended by WHO. 30% of last born children aged 12-35 months were given a vitamin A supplement in the past six months, but 61% children aged 6-35 months ate vitamin A rich foods during 24 hours preceding the interview. 41.5% children aged 6-59 months were given micronutrients such as vitamin A supplements in the last 6 months, and deworming medication was given to 20.2% children in the last 6 months. 41% women and 36% men in Orissa are too thin for their height, and 6-7% adults are overweight or obese. Only 52-58% women and men are at a healthy weight for their height. Overweight and obesity are common among older adults, among those in urban areas, and among the more educated. Using iodized salt prevents iodine deficiency, which can lead to miscarriage, goitre, and mental retardation. 61% women had anaemia, with 45% having mild anaemia, 15% moderate anaemia, and 2% severe anaemia. 34% men were anaemic and men under age 20 and over age 39 were more anaemic. More than 50% scheduled tribe (ST) men and those with no education were anaemic. 0.28% adults aged 15-49 years were infected with HIV, (0.35% in urban areas and 0.25% in rural areas). 31% women and 69% men in Orissa use some form of tobacco, including 26% pregnant women. Women and men who use tobacco are most likely to chew tobacco in the form of paan masala, gutkha or other tobacco products. Among men, smoking cigarettes or bidis is quite common. 40% men and 7% women drank alcohol. 36% women aged 15-49 years had experienced physical or sexual violence, including 42% of ever married women. 32% married women reported having being slapped by their husband, 12-14% report having their arm twisted or their hair pulled. 12% reported that their husbands had physically forced them

to have sex. Over all, 38% ever married women had experienced spousal physical or sexual violence from their current husband, or if not married, their most recent husband. Only 19% women who experienced violence sought help to end the violence. 67% women neither sought help nor told anyone about the violence. Very few women sought help from any institutional source, such as the police, lawyers, religious leaders or social service organizations.

**Key Words :** 1.HEALTH 2.NFHS 3 ORISSA 3.NATIONAL FAMILY HEALTH SURVEY 3 4.INFANT MORTALITY 5.CHILD MORTALITY 6.EARLY MARRIAGE 7.IMMUNIZATION 8.CHILD NUTRITION 9.ANAEMIA 10.DOMESTIC VIOLENCE 11.ORISSA.

21. International Institute for Population Sciences, Mumbai. (2008).  
National Family Health Survey 3 : 2005-06 : Tamil Nadu. Mumbai : IIPS.  
130 p.

**Abstract :** The 2005-06 National Family Health Survey (NFHS-3) is the third in the NFHS series of surveys. The surveys provides trend data on key indicators and includes information on new topics such as HIV/ AIDS related behaviour, attitudes toward family life education for girls and boys, use of the Integrated Child Development Services (ICDS) programme, men's involvement in maternal care and health insurance, information on married men and women. In Tamil Nadu, the survey was based on a sample of 6,344 households. It interviewed 5,919 women aged 15-49 years and 5,696 men aged 15-54 years from all the selected households. Information was gathered on population, health and nutrition indicators. Almost all primary school age children (6-10 years) attend school (99% in urban areas and 98% in rural areas). School attendance dropped to 88% for children aged 11-14 years and was only 54% for children aged 15-17 years. Total number of slum children who attend school in Chennai in the 6-17 years age group were 80.7%, total non- slum children who attended school in the 6-17 years age group were 86.9%. Children under age 18 years who lived with both parents were 81.8%, children not living with either parent were 4.3%, and children with one or both parents dead were 4.5%. Total registered children between 0-2 years and 2-4 years were 85.3% and 86.1%. At current fertility levels, a woman in Tamil Nadu will have an average of 1.8 children in her lifetime. Fertility in rural areas (1.9 children per woman) is slightly higher than that in urban areas (1.7 children per woman). Among young women aged 15-19 years, 8% have begun child bearing. Young women in rural areas are almost twice as likely to have begun child bearing (10%) as young women in urban areas (5%). Government promotes 3 temporary methods of family planning: the

pill, IUDs and condoms. Of these 3 methods, women are slightly more likely to know about the IUD (78%) and pill (74%) than condoms (70%). Men are most likely to know about condoms (97%). The median age at first marriage among women aged 20-49 is 19.4 years. More than 50% of the men aged 25-49 years marry after age 25. More than 22% women aged 20-24 years got married before age 18 years. Infant mortality (IMR) is estimated at 30 deaths before the age of one year per 1,000 live births. The under-five mortality rate (U5MR) is 36 deaths per 1,000 live births. The U5MR for girls (48) is higher than the rate for boys (42). 98% women received antenatal care (ANC) from a health professional (84% from a doctor and 14% from an ANM/ nurse/ midwife/ LHV). 75% women received ANC during the first trimester of pregnancy. Almost all mothers (98% in urban areas and 94% in rural areas) had 3 or more ANC visits. More than 90% women who received ANC had their weight taken, blood tested, blood pressure taken, urine tested and their abdomen examined. Almost 90% children in TN who were born in the last five years were born in a health facility. The percentage of births delivered in a health facility increased from 64% in NFHS-1 to 90% in NFHS-3. Institutional births are common among younger women, urban women, women with more education and women having their first birth. 90% births took place with assistance from a health professional, 6% were delivered by a traditional birth attendant (TBA) and 3% by a relative, friend or other untrained person. 81% children aged 12-23 months in TN are fully vaccinated against 6 childhood illnesses: tuberculosis, diphtheria, pertussis, tetanus, polio and measles. All children have received BCG vaccination, 96% have received the recommended 3 doses of DPT, 88% have received the recommended 3 doses of polio vaccine, and 93% have been vaccinated against measles. 4% children had symptoms of acute respiratory infection (ARI). Of these, 75% were taken to a health facility or health provider and 7% received antibiotic drugs. 5% children had diarrhoea. Among them, 63% were taken to a health facility, 59% were treated with Oral Rehydration Therapy (ORT), including 32% who were treated with a solution from Oral Rehydration Salt (ORS) packets and 32% were given gruel. The ICDS programme provides nutrition and health services for children under 6 years. Of the 97% children under age six years who are in areas covered by anganwadi centres (AWCs), only 43% receive services from the centre. 34% children received immunization, 32% received supplementary food and growth monitoring (32%). Early childhood care and preschool services were received by 27% children aged 3-5 years. 31% children under age five years in Tamil Nadu are stunted, too short, 21% are wasted, too thin, and 30% are underweight. 34% children in Tamil Nadu are exclusively breastfed for the first six months, and 9% are put to the breast within the first day of life. Among children aged 6-59 months, 69% are anaemic, which includes 27% mildly anaemic, 35% moderately anaemic, and 3% severely anaemic. Children aged 6-59 months who were given vitamin A supplements in the last 6 months were 52.3%, children given iron supplements in the last 7 days were 18.4%, and children given deworming

medication in the last 6 months were 15.7%. 28% women and 27% men, and 21% women and 15% men were overweight or obese. Only 51% women and 58% men have healthy weight for their height. 53% women have anaemia in TN, including 37% with mild anaemia, 14% with moderate anaemia, and 2% with severe anaemia. 17% men are anaemic, and men under 20 and over 40 years more likely than men aged 20-39 years to suffer from anaemia. The HIV prevalence rate in TN is slightly higher than that of India as a whole. Nationally 0.28% adults aged 15-49 years are infected with HIV (0.35% in urban areas and 0.25% in rural areas). 40% men and 3% women use tobacco products. 2% pregnant women and 1% breastfeeding mothers use tobacco. 42% men and 0.1% women in TN drink alcohol. 39% women in Tamil Nadu experienced physical or sexual violence, including 45% of ever married women. 40% ever married women had been slapped by their husbands; 16-20% had their arm twisted or their hair pulled, they were pushed, shaken, kicked, dragged or beaten up. Overall 42% of ever married women have experienced physical or sexual violence from their husband. Only 37% of the women who experienced violence sought help to end the violence. 54% women neither sought help nor told anyone about the violence. Abused women seek help from their own families. Very few women seek help from the police.

**Key Words** : 1.HEALTH 2.NFHS 3 TAMIL NADU 3.NATIONAL FAMILY HEALTH SURVEY 3 4.INFANT MORTALITY 5.CHILD MORTALITY 6.EARLY MARRIAGE 7.IMMUNIZATION 8.CHILD NUTRITION 9.ANAEMIA 10.DOMESTIC VIOLENCE 11.TAMIL NADU.

22. International Institute for Population Sciences, Mumbai. (2008).  
National Family Health Survey 3 : 2005-06 : Uttar Pradesh. Mumbai : IIPS. 139 p.

**Abstract** : The 2005-06 National Family Health Survey (NFHS-3) is the third in the series of surveys. In Uttar Pradesh (UP) 12,183 women aged 15-49 years and 11,458 men aged 15-54 years were interviewed to obtain information on population, health and nutrition indicators. The survey covered 10,026 households representative of the state. Only 69% children aged 6-17 years attend school in UP, and this percentage is similar in urban and rural areas. 80% primary school age children (6-10 years) attend school (78% in urban areas and 81% in rural areas). In UP, 64% girls aged 6-17 years attend school compared to 74% boys. In rural areas 84% boys compared to 78% girls in the age group 6-10 years are attending school, and by age 15-17 years only 49% boys and 28% girls are attending school. 80.3% children below 18 years live with both parents, 3.2%

live with neither of their parents, and 5.3% children have one or both parents dead. 6.8% children below 2 years and 7.3% children in 2-4 years age group are registered. A woman in UP will have an average of 3.8 children in her lifetime. Fertility in rural areas is 4.1 children per woman, much higher than that in urban areas, where the fertility rate is 3 children per woman. Fertility rate for women in disadvantaged groups is higher (4.5 for scheduled castes and 3.8 for other backward classes) than that of women who are not in any of these groups (3.2). Total fertility rate for Muslims (4.3) is about half a child higher than the rate for Hindus (3.7). Among young women aged 15-19 years, 14% have begun child bearing, which is a little lower than the national average (16%). Young women in rural areas are twice as likely to be mothers as young women in urban areas (16% and 8% respectively). Government family planning programme promotes 3 temporary methods of contraception, namely the pill, the IUD, and condoms. Of these 3 methods, currently married women are most likely to know about the pill and condoms (94-95%), and currently married men are most likely to know about condoms (98%). The median age at first marriage is 16.2 years among women aged 20-49 years and 20.1 years among men aged 25-49 years. 59% women aged 20-24 years got married before the legal minimum age of 18 years and 51% men age 25-29 years got married before the legal minimum age of 21 years. The infant mortality rate (IMR) in UP is the highest of any state in the country, 73 infant deaths per 1000 live births. The under-five mortality rate (U5MR) at 96 deaths per 1,000 live births, is the highest in the country, i.e. 1 in 14 children still die within the first year of life and 1 in 10 die before reaching age five years. IMR in rural areas of UP is 17% higher than in urban areas of the state. IMR is 108 per 1,000 live births for teenage mothers compared with 75 for mothers aged 20-29 years. Children from the scheduled castes (SCs) and other backward classes (OBCs) are at greater risk of dying than children not belonging to vulnerable groups. Among women who gave births in the 5 years preceding the survey, 66.7% received antenatal care (ANC) from a health professional (23% from a doctor and 43% from other health personnel) for their last birth. 34% women received no ANC. 79% urban women received ANC from a health professional for their last birth compared with 62% rural mothers. Muslim women are less likely than Hindu women to receive ANC, as are scheduled tribe (ST) women compared to women of any other caste/ tribe. In 53% cases mothers received iron and folic acid (IFA) supplements during their last births, but only 9% mothers consumed IFA tablets for 90 days or more. 65% mothers received 2 or more doses of tetanus toxoid vaccine. Only 2% mothers took deworming drug during pregnancy. 27% of the births during the past five years took place with assistance from a health professional and 40% babies were delivered by a traditional birth attendant (TBA). The remaining 33% were delivered by relatives or untrained persons. 9% of home births were assisted by health personnel. 23% children aged 12-23 months were fully vaccinated against 6 major childhood illnesses: tuberculosis, diphtheria, pertussis, tetanus, polio and measles. Only 3%

children below 2 years received no vaccinations at all. Muslim children were less likely to be fully vaccinated than Hindu children, and boys were more likely than girls to be fully vaccinated (25% of boys compared with 21% of girls). 7% children under five years had symptoms of acute respiratory infection (ARI) (cough and short rapid breathing that was chest related and not due to blocked or runny nose). Of these children, 73% were taken to a health facility or health provider and 9% received antibiotic drugs. 8% children had diarrhoea, and among these children, 58% were taken to a health facility. 26% children who had diarrhoea were treated with some kind of oral rehydration therapy (ORT), including 13% children who were treated with a solution prepared from oral rehydration salt (ORS), and 12% with gruel. 28% children with diarrhoea did not receive any treatment and 9% received antibiotics. ICDS programme provides nutrition and health services for children under age six years and pregnant or breastfeeding women. 15% of the children under six years received supplementary food, 14% children under six received immunization, 13% of children aged 3-5 years received childhood care and 3% received health check ups. More than 25% age-eligible children from scheduled castes in areas covered by an anganwadi centre received some kind of service. 57% children under 5 years are stunted, or too short for their age, which indicates that they have been undernourished for some time. 15% children were wasted, or too thin for their height, which may result from recent inadequate food intake or a recent illness. Only 51% children under 6 months are exclusively breastfed as WHO recommends. In addition only 24% are put to breast within the first day of life, including only 7% who started breastfeeding in the first hour of life. Eating foods rich in iron and taking iron supplements can prevent anaemia. Only 7% children aged 6-35 months ate iron rich foods during the day and only 2% of children aged 6-59 months were given iron supplements in the week before the interview. 13.9% children 6-59 months were given vitamin A supplements in the last 6 months and 11.1% were given deworming medication in the last 6 months. More than 33.3% adults are too thin, and a little less than 10% are overweight or obese. About 55% women and men are at a healthy weight for their height. Undernutrition is high in the age group of 15-19 years. 50% women in UP have anaemia, including 35% with mild anaemia, 13% with moderate anaemia, and 2% with severe anaemia. 24% men are anaemic with men under 20 and over 39 years being more likely to suffer from anaemia than men in other age groups. In UP, only 0.07% adults aged 15-49 years are infected with HIV, including 0.10% in urban areas and 0.06% in rural areas. Prevalence is 0.05% among women compared with 0.10% among men. 64% men and 12% women use tobacco including 11% pregnant women. 25% men and 0.3% women drink alcohol. 41% married women reported having being slapped by their husband, 15-17% report having their arms twisted, being pushed, shaken, kicked, dragged or beaten up. 9% reported that their husbands had physically forced them to have sex. Overall 42% married women experienced spousal, physical or sexual violence from their current husband, or if

currently not married, their most recent husband. 38% women who reported sexual violence suffered from injuries as a result of spousal violence. 27% women who experienced violence sought help to end the violence. 2 out of 3 women neither sought help nor told anyone about the violence, and only 13% suffering from sexual violence sought help. Abused women seek help from their own families and very few women seek help from any institutional source such as the police.

**Key Words** : 1.HEALTH 2.NFHS 3 UTTAR PRADESH 3.NATIONAL FAMILY HEALTH SURVEY 3 4.INFANT MORTALITY 5.CHILD MORTALITY 6.EARLY MARRIAGE 7.IMMUNIZATION 8.CHILD NUTRITION 9.ANAEMIA 10.DOMESTIC VIOLENCE 11.UTTAR PRADESH.

23. National Institute of Health and Family Welfare, New Delhi (2009).  
Use of tobacco in India : challenge and interventions. New Delhi : NIHFV.  
3 p.

**Abstract** : Globally approximately 5.4 million people die each year as a result of diseases resulting from tobacco consumption. More than 80% of these deaths occur in developing countries. Tobacco is a risk factor for 6 of the 8 leading causes of death and also is the most common preventable cause of death in the world. More than 0.8 million people die due to tobacco consumption in India every year. Nearly 2200 Indians die each day due to tobacco related diseases. As per estimates, 10 million persons will die in India from smoking by 2010, and 70% of these will be in the age group of 30-69 years. It is consumed in many forms, both smoking and oral consumption e.g. bidi, gutka, khaini, paan masala, hukka, cigarettes, cigars, chillum, chutta, gul, mawa, misri, etc. In India, 57% males and 10.8% females consume tobacco in some form. The Global Youth Tobacco Survey (GYTS), 2006 for India indicates that 14.1% children in the age group 13-15 years consume tobacco in some form. About 40% of the disease burden in the country is related to diseases caused by tobacco, and 50% of all cancer deaths in the country are due to tobacco consumption, e.g. cancer of the oral cavity, lung, throat, esophagus, stomach and urinary bladder. Studies have indicated that incidence of impotence is 85% higher among smokers, and tobacco use by pregnant women leads to low birth weight babies and birth defects. More than 10 million farmers, farm workers, tendu leaf pluckers, bidi rollers, middle-men, agents, retailers constitute tobacco work force (ILO, 2002 estimates: 5.5 million bidi hand rollers, 85% of whom are women and children). Total economic cost of the 3 major diseases due to tobacco use (cancer, cardiovascular diseases and lung diseases) in India was Rs 30,833 crores, while

the revenue collected was approximately Rs 27,000 crores for the same year. To control the menace of tobacco, Government of India enacted "Cigarette and Other Tobacco Products Act" in 2003. The specific provisions under the Act are a ban on smoking in public places; ban on direct/ indirect advertisement and sponsorship of tobacco products; ban on sale of tobacco products to minors; ban on sale of tobacco products within 100 yards of educational institutions; and specified health warnings on tobacco products and packages. At present the National Tobacco Control Programme (NTCP) is under implementation in 42 districts in the country. The main components of the programme are mass media awareness campaigns; setting up of tobacco products testing laboratories; capacity building at the state/ district level to create infrastructure under the NRHM for implementation of provisions under the law and undertake tobacco control initiatives, e.g. school programmes, trainings, cessation facilities, etc. GATS - Global Adult Tobacco Survey (GATS-India) is being undertaken in the country to build a baseline database regarding prevalence of tobacco products use, related behaviour practices and other issues, and collaborate with concerned departments for projects on alternate crops and alternate livelihoods for tobacco farmers and bidi workers. Measures for implementation of NTCP and Tobacco Control Act are integration of components of tobacco control in NRHM and on-going national health programmes, e.g. National Cancer Control Programme, RNTCP, National Mental Health Programme, School Health Programme; inclusion of tobacco control component in UG and PG medical/ dental/ nursing curriculum; starting new courses on tobacco control; smoke free environments should be designated; expansion of cessation facilities in all medical/ dental colleges and health care institutions; development of training materials on tobacco control; and building capacity of states for initiating tobacco control measures.

**Key Words** : 1.HEALTH 2.TOBACCO 3.SUBSTANCE ABUSE 4.SMOKING  
5.PREVENTION SMOKING 6.TOBACCO CONTROL.

24. Shekhar, P. Satya et al. (2008).  
Baseline survey on Reproductive and Child Health - 2, Andhra Pradesh.  
Hyderabad : Indian Institute of Health and Family Welfare. 7 p.

**Abstract** : The main focus of various interventions being initiated under RCH-II (2005-2010) and NRHM (2005-2012) by GoAP is on reduction of IMR/ MMR; improving the access to integrated comprehensive primary health care and achieving population stabilization with gender and demographic balance. The objective of the survey was to provide district level data on key maternal and



child health indicators such as infant mortality rate (IMR), antenatal care (ANC) coverage, delivery care, postnatal care, breastfeeding practices, prevalence of diarrhoea and ARI, contraceptive prevalence and its future use, child immunization coverage, reproductive tract infections (RTIs), and awareness of selected health interventions under RCH-II. The survey covered all 23 districts of Andhra Pradesh (AP). A total of 1320 villages and 980 urban blocks were selected. The survey covered an overall sample of 59,117 households (where a woman gave a child birth, alive or dead) since January 2004 till the date of survey. Thus, the survey covered about 1200-1300 children in each district based on births. About 63% mothers received ANC in the first trimester of their pregnancy. Districts where fewer than 35% mothers received ANC in the first trimester were Mahabubnagar and Ranga Reddy districts. 54% mothers received or purchased IFA tablets during the ANC period. 89% mothers received services like weight measurement, blood pressure check-up, blood examination for haemoglobin estimation and abdominal check-up at least once during ANC. About 60% mothers were given information on expected date of delivery (EDD), need for institutional delivery and correct breastfeeding practices. About 76% mothers delivered their babies in a health facility (35% in public and 41% in private). The deliveries conducted in public health institutions increased by 8 points (9.7 points in rural and 3.8 points in urban areas) as compared to 4.3 points (3 in rural and 0.5% in urban) in private sector. More than quarter (27%) deliveries were either caesarean (C) type or involved other interventions. Highly developed districts in Telengana region reported higher proportion of C section deliveries as compared to West Godavari, Krishna and East Godavari districts of Coastal Andhra Region. The incidence of low birth weight (LBW) babies decreased to 17% from 23% reported earlier in the MICS (2000) study conducted by UNICEF. Immunization was 80% or more in coastal districts with the exception of Nellore (79%) and Prakasam (77%) districts. In the Rayalaseema region, Kurnool had 87% immunization, whereas Kadapa, Anantapur and Chittoor districts reached immunization coverage level of 71-80%. Children aged 0-6 months exclusively breastfed were 78.4% at state level (77% in rural and 80% in urban areas) based on the last 2 births in 3 years before the survey. In the case of breastfeeding practices, about 21% mothers were observed to squeeze out colostrum – the first milk from the breast – before they initiated breastfeeding their babies. 33% infants were breastfed within one hour of birth. Less than 20% infants were breastfed within one hour of birth in Ranga Reddy, Nalgonda, Kadapa, Medak and Mahabubnagar districts. Neonatal mortality rate (NMR) accounts for 70% of infant deaths that occurred between January 2004 and July 2005. IMR in AP was 52.2 deaths per 1000 live births in 2005. Districts that recorded high IMR (72-63) were Mahabubnagar, Medak, Adilabad, Nizamabad, Nalgonda and Khammam in Telengana region; Srikakulam and Vizianagaram in Coastal Andhra region and Ananthapur in Rayalaseema region. Rural IMR was found to be considerably higher (62.2) than urban IMR (39.1).

Indirect interventions like emergency health transport, free bus pass to pregnant women, JSY and ASHA scheme will be effective only if health care delivery system is strengthened as per the set norms of Indian Public Health Standards (IPHS).

**Key Words :** 1. HEALTH 2.REPRODUCTIVE CHILD HEALTH 3.RCH SURVEY 4.MATERNAL HEALTH 5.ANTEPARTURIENT CARE 6.INFANT MORTALITY 7.SAFE DELIVERY 8.IMMUNIZATION 9.BREASTFEEDING.

25. Uma Devi, V. et al. (2007).

A Study on healthy practices of reproductive health including menstrual hygiene of the adolescent girls of tribal welfare schools of Andhra Pradesh. Indian Institute of Health and Family Welfare, Hyderabad. Hyderabad : IIHFW. 7 p.

**Abstract :** Reproductive health has gained global recognition while shifting policy from population control approach to life cycle approach. It emphasizes the need for paying special attention to adolescents whose reproductive health needs have been either overlooked or ignored. Adolescents (10-19 years) in India constitute 22% of the country's population. The objectives were to assess the knowledge of adolescent girls (AGs) staying in tribal schools regarding reproductive health and menstrual hygiene; study the existing food beliefs and practices during menstruation; find out the socio-cultural factors hindering the adoption of healthy menstrual hygiene practices; design and develop suitable IEC tools and training methods based on their needs; and devise training programmes and IEC activities for inculcating hygienic practices during menstruation. The study was conducted in 9 Integrated Tribal Development (ITD) areas of Andhra Pradesh (AP). Out of a total of 248 schools, a sample of 29 schools were selected for the study, representing 11.7% of the universe. 8497 (84.3%) girls were included in the study. 87.7% girls did not even know that adolescent age period was between 10-19 years. Only 12.3% girls said that 10-19 years could be considered as adolescent age for both boys and girls. Nearly 42.7% subjects were not aware of physical changes that occur during adolescence. Adolescent girls' awareness about onset of menarche and menstruation was found to be low (2.3%). Only 64.4% of the girls claimed to be cognizant about menarche but this was not reflected in their knowledge scores. 58.9% respondents felt that menstruation is a natural phenomenon among girls wherein impure and contaminated blood is sent out of the body. 7.5% girls were not using any type of pad during menstruation. They were managing with inner clothes or 2 panties at a time. About 22.7% girls were throwing used pads in the

open space. Half of them also admitted that they did this despite having bins in the school/ hostel premises. Dysmenorrhea was the common reproductive health problem faced by 23.8% of the girls. Other symptoms like itching and rashes were reported by 14.5% and 12.1% girls respectively. During menstruation about 51.1% girls were avoiding protective foods like milk and milk products because it was believed that they increased while discharge and caused foul smell. Similarly, protective foods like egg, meat and tomato were also avoided by 51.7%, 33.6% and 29.4% girls respectively due to wrong notions/ apprehensions. Just over 25% of the subjects could tell the correct age at marriage for girls (18 years). Their awareness levels with regard to immunization for children and pregnant women was very low (1.8%) which calls for education on these aspects. 3.4% girls engaged in sex willingly or forcibly with their friend cum lover. 31.9% girls were aware of HIV/ AIDS. Out of 18 ANMS, 16 said that they discussed reproductive health related topics with girls at regular intervals, and dysmenorrhea was mentioned by 15 ANMs. There is a need for educating adolescent girls about reproductive health and hygienic practices to be followed during menstruation. Use of sanitary pads like clean sun dried cotton cloth during menstrual periods should be encouraged so that their economic condition does not pose a problem. Preparation of menstrual pad and its disposal should be stressed during training, knowledge regarding HIV/ AIDS and its modes of transmission should be included in training curriculum of AGs.

**Key Words** : 1.HEALTH 2.MENSTRUAL HYGIENE 3.ADOLESCENT GIRLS 4.TRIBAL GIRLS 5.ADOLESCENT TRIBAL GIRLS 6.REPRODUCTIVE HEALTH.

26. World Health Organization, Geneva. (2009).  
Diarrhoea : why children are still dying and what can be done. Geneva : WHO. 60 p.

**Abstract** : Diarrhoea remains the second leading cause of death among children under five globally. Nearly one in five child deaths - about 1.5 million each year - is due to diarrhoea. It has been estimated that 88% of diarrhoeal deaths world wide are attributable to unsafe water, inadequate sanitation and poor hygiene. The main purpose of this report was to raise the profile of the neglected disease, to focus attention on the prevention and management of diarrhoeal diseases as central to improving child survival. It was observed that nearly one in 4 people in developing countries were practicing indiscriminate or open defecation. It was estimated that globally 1.2 billion people practice open defecation, 83% of whom live in 13 countries. More than 80% of the developing world's population use an

improved drinking water source and more than 4 out of 5 children who are underweight for their age live in Africa or South Asia. Only 37% infants in developing countries are exclusively breastfed for the first six months of life. The proportion of children fully protected by vitamin A has increased fourfold since 1999. In developing countries, only 39% of children under five with diarrhoea receive the recommended treatment (ORT, oral rehydration therapy with continued feeding) to prevent dehydration and worsening nutritional status. Africa has the lowest levels of treatment coverage (35%), followed by South Asia (37%) and the Middle East and North Africa (39%). East Asia and the Pacific (excluding China) have the highest treatment coverage levels, at 55%. Children in urban areas (42%) are more likely to receive the recommended treatment than those living in rural areas (38%). Similarly, children from the wealthiest households (40%) are more likely to receive the recommended treatment than those from the poorest households (34%). Only 33% of the children with diarrhoea in developing countries receive ORS to treat their illness. Children in urban areas (39%) are more likely to receive ORS than those living in rural areas (31%). Similarly, children from the wealthiest families are 1.5 times as likely to receive ORS to treat diarrhoea as the poorest children. UNICEF alone has procured more than 350 million ORS packets since 2000. Procurement of low osmolarity ORS started in 2003 and over 80 countries have received the new formulation. It was observed that less than one quarter (22%) of children with diarrhoea in developing countries drink more fluids of any type during their illness. Nearly 33% children with diarrhoea in developing countries receive either much less food or none at all during their illness. UNICEF's procurement of zinc tablets started in 2006 and has increased significantly since then. In 2006, UNICEF procured 20.5 million zinc tablets, the figure rose to 73.7 million in 2007 and 157.9 million tablets in 2008. Despite this major progress, global zinc availability is still dismally low compared to the global need. This report puts forward a new 7 point plan for comprehensive diarrhoea control. The plan includes a treatment package to significantly reduce child deaths due to diarrhoea, and a prevention package to make a lasting reduction in the diarrhoea burden for years to come. It was found that in India in 2008 the under five mortality rate was 69 per 1,000 live births, there were 1,830,000 deaths of children under five years, there were 126,642,000 children under five years, 26% children had ORS packets, 20% children had recommended homemade fluids, 10% had increased fluids intake, and 70% had continued feeding during diarrhoea in 2005-2008. It was observed that in India in 2006, 89% of the population had improved drinking water sources and 28% had improved sanitation facilities. 70% one year old children were immunized against measles, 43% children aged 0-59 months were under weight, 48% were stunted, 46% infants aged 0-5 months were exclusively breastfed, 57% infants aged 6-9 months were breastfed with complementary foods, and 77% children aged 20-23 months were still breastfeeding during the years 2003-2008. In 2008, 53% children aged 6-59 months were given vitamin A

supplementation. In 2005-2006, 33% children under five years received oral rehydration therapy for diarrhoea. It was recommended that national and district health planners should include diarrhoea control in programmes targeting childhood, malaria, pneumonia and HIV; ensure that low osmolarity ORS and zinc are adopted as policy; accelerate the provision of basic water and sanitation services; induce change in behaviour through community involvement, education and health promotion activities; and monitor progress at all levels to make the result count.

**Key Words :** 1.HEALTH 2.INFANT MORTALITY DIARRHOEA 3.DIARRHOEAL DEATHS 4. ORAL REHYDRATION 5.IMMUNIZATION.

## RURAL DEVELOPMENT

27. UPVAN, Uttar Pradesh Voluntary Action Network, Lucknow. (2008). Poverty eradication programmes in Uttar Pradesh : review by civil society organizations : ICDS, NREGS, PDS : summary and conclusion of report. Lucknow: UPVAN. 16 p.

**Abstract :** In view of regular revealment of the drastic situation of “poor and poverty” through exposures by print and audio visual media, UPVAN Board decided that UP Social Watch Report 2008 to be prepared under United Nation Millennium Campaign, will highlight the ground realities of 3 schemes of the state which are meant to benefit rural people. The report was to be given to the concerned departments of the state for pro-people policy change. 3 schemes selected were Integrated Child Development Services Scheme (ICDS); National Rural Employment Guarantee Scheme (NREGA); and Public Distribution System Scheme (PDS). The sample for the study was 10 districts, 100 villages, 1000 respondents and 13 member organizations of the network. In UP, Government of India introduced ICDS on a pilot basis in 1975 in 3 blocks of the state. Presently 1.01 lakh anganwadi centres (AWCs) are functioning under 812 child development projects in rural areas. The objectives of this scheme are to provide all round development of children; check the health and nutritional standard of children up to 6 years of age; bring down the ‘drop out’ rates in primary classes, implement child development programme by coordinating various departments’ policies and strategies; and identify physical nutritional needs of children by capacity building of mothers through awareness generation and education. According to the population norm of 500-1500 beneficiaries per anganwadi centre, documents showed that there were 1.65 crore beneficiaries, which was

55 lakhs less than the expected 2.20 crores. Supreme Court raised the number of beneficiaries from 100 to 147 but still every girl child and pregnant mother was not benefited by the ICDS centre as 80-98% respondents were unaware of the benefits provided under the scheme. Anganwadi workers (AWWs) are required to register births and deaths in their village areas, but 72% respondents from east, 56% from west, 58% from south and 47% from central areas were unaware about it. The National Rural Employment Guarantee Act (NREGA, 2006) is the first law which relates employment to human rights. It was specially meant for the most backward and poor districts of the country. The objectives of this scheme are to guarantee 100 days of unskilled employment for rural households; create permanent assets for production in village; and minimize the rate of migration from rural to urban areas. On the basis of secondary information available, out of 104.1 lakh applicants, 30.13 lakh (29%) labourers were benefited with employment, of whom 11.24 lakh (about 33.3%) could open bank accounts in their names. Implementation of NREGA is meaningful only when it covers majority of BPL households at village level. All the registered village households were claimants of job cards under NREGA, but only 41% in the east, 21% in the west (Etah), and 38% in central regions could manage to get them. Public supply system of food grains in rural and urban areas of the state was controlled and implemented by the Department of Food and Civil Supplies. Later on the distribution of food grains in villages was handed over to local cooperative societies and was managed by them from January 1981. To remove corrupt practices in public distribution system (PDS) its responsibility has been assigned to "Uttar Pradesh State Food and Essential Goods Corporation". The 18 selected districts are located in Bareilly, Moradabad and Lucknow and Devipatan divisions of the state. The whole system made fair, and ration cards were introduced in 3 different colours with a photo of the head of the household and a hologram. Objectives of the system were to ascertain the continuity of supply; ensure availability of essential commodities on subscribed rates; maintain good quality of food grains; and bring transparency in the distribution system to check the black marketing of essential food grains, sugar and other goods. It was found that arrangements have been made to ensure distribution of 10kg wheat and 25kg rice in eastern region, and 15kg wheat and 20kg rice in the western region to satisfy the need of 41 lakh Antyodaya households and 66 lakh BPL households identified in the state. About 67-92% respondents from all 4 regions found food grains and other commodities to be less than their household needs in each month. About 77-84% respondents from Bundelkhand, east and central regions had no complaints. The remaining respondents (23-16%; 64% respondents from west) were of the opinion that the allotment of ration for BPL households is sold in the black market by leakage and pilferage due to illiteracy and ignorance of the common people. In Bundelkhand and eastern districts 58% and 45% respondents referred to the discriminatory behaviour of village pradhans, but they were reluctant to express their feelings and comments against the village

headman because they wanted to keep away from unpleasant situations. The Government needs to closely monitor the implementation of schemes in order to benefit the truly deserving recipients.

**Key Words :** 1.RURAL DEVELOPMENT 2.POVERTY ALLEVIATION PROGRAMMES 3.EVALUATION OF GOVERNMENT PROGRAMMES 4.ICDS 5.NATIONAL RURAL EMPLOYMENT GUARANTEE ACT 6.PUBLIC DISTRIBUTION SYSTEM.

## **SOCIAL DEFENCE**

28. Equations, Bangalore. (2008).  
Rights of the child in the context of tourism : a compilation. Bangalore :  
Equations. 191 p.

**Abstract :** Goa, a small state on the western coast of India, has become immensely popular the world over as a tourist destination. Today, 33% of Goa's population consists of 'migrants', people who have made Goa their home. The children of these workers are denied of an opportunity to enroll in formal schools; are denied basic health care, and along with their parents lead a marginalized existence that threatens their right to a safe, loving and secure environment. The present study identified groups of vulnerable children and brought out recommendations that could be used by the Government and the community to protect the rights of all children, especially those identified as "children at risk." It was revealed that a majority of child workers (both boys and girls) belonged to families that had migrated to the state in search of employment due to extreme poverty and displacement. A small percentage of children also consisted of those who were orphans or from broken homes and had run away from homes and come here in search of work. In addition to this, there were agents who brought children and women into the state to work as domestic labour. Children were mainly employed in the unorganized sector where they were engaged in selling plastic bags, fish, vegetables, fruit in the markets; rag picking; off – loading fish and vegetables from trucks that come to the main markets; as domestic workers; at construction sites; in garages; and in many other kinds of work in order to sustain themselves and their families. Most of the children did not consider schooling to be feasible as they found it very difficult to cope with the formal system of education. The enrolment of girl children in formal schools was much less than that of boys because of their domestic responsibilities, and families did

not consider it feasible to invest their limited resources in educating them. Safety concerns were also important in preventing girl children from accessing formal education. It was observed that children were vulnerable to abuse from their own family, police, tourists, paedophiles, and their employers due to their poor working and living conditions. A majority of the children had poor access to health care and a significant number were malnourished and were prone to alcoholism and substance abuse due to the fact they wanted to escape and be able to endure the problems they encountered. Most of the children were unaware of health facilities and were unsure about how to access these. It was recommended that the Government should review the implementation of the Goa Children's Act periodically and ensure that the limitations that were either real or perceived as barriers to its effective implementation are corrected. Government should also prepare a Plan of Action for the rescue and rehabilitation of child workers before implementing the notification to implement the ban on child labour in the domestic sector, hotels, *dhabas* (small eating places) and recreational centres that is to be effective from the 10<sup>th</sup> of October 2006.

**Key Words** : 1.SOCIAL DEFENCE 2.CHILD PROSTITUTION 3.SEX TOURISM 4.CHILD TRAFFICKING 5.CHILD LABOUR 6.CHILD SEXUAL ABUSE 7.PAEDOPHILIA. 8.GOA.

29. Equations, Bangalore. (2004).  
Towards strengthening rights of minors and adolescents in tourism.  
Bangalore : Equations. 80 p.

**Abstract** : The sexual exploitation of minors and adolescents in tourism is a global phenomenon that affects both tourist sending and tourist receiving nations. It has an impact on millions of minors and adolescents each year and constitutes a violation of the rights of the child. It occurs in many ways, including child labour, child pornography, trafficking and sexual exploitation. The present study "child victims of commercial sexual exploitation in tourism" was undertaken to find out the prevalence and trends of exploitation. 100 children aged 5-18 years of different backgrounds in four states (Kovalam in Kerala; Mahabalipuram in Tamil Nadu; Colva Beach side in Goa and Gokarna in Karnataka) were interviewed. A majority of the children were in the age group 10-14 years (49%), 24% were in the age group 14-16 years, and 23% were 16-18 years old. 20% of them had fathers engaged in agricultural work and 11% had mothers working in the agricultural sector. The other occupational backgrounds among the fathers of children were labour (9%), fishing (5%), and drivers (4%). Similarly, 24% of the mothers were housewives, 6% were working as labour, and 4% as domestic



helps. 80% children had attended school. The children were engaged in rag picking (25%), as tourist guides (29%), and restaurant or hotel workers (17%). 28% children had been working for more than five years, 28% for more than 2 years, and 31% for less than one year. Majority of the children were either not educated or had low education, and knew more than one language. They were well versed in Hindi and English. The main problems faced by children were finding work (28%), not having enough money (10%) and harassment (10%). Other problems they faced were injuries, health problems, and problems due to police harassment. 54% of the children said that they received some kind of help from tourists at least once. The help they received from tourists was in the form of food (80%), money (76%), clothes (61%), travelling (33%), etc. Some tourists also helped them in terms of health support (22%) and family support (11%). 69% of them responded that the help they got was in the form of friendship. Most of the children had gone to hotels (74%) and restaurants (63%) with the tourists. Trekking (23%) and swimming (33%) were other popular pastimes. 16% of the children said that they saw movies and went to the disco also. 21% of the children had been taken to lonely places. Most of the children said that they talked about personal matters (60%), including family problems and other issues they faced. 9% of the children said that they also discussed financial matters with tourists. Only 21% of the children responded that they were physically close with tourists. 7% of the total children said that they could escape from eventualities. Most of the children (95%) responded that the tourist had taken naked pictures of the children. 81% of the children experienced touching and being undressed by the tourist. 62% of the children had seen pornographic pictures with tourists. 62% were kissed by tourists. 48% of the children said that they had seen naked pictures of the tourists. Children said that did not share these incidents with any one because they felt shame (14%), they would not receive further help from tourists (12%), they felt it was their own mistake and feared punishment (4%), and also due to threats from tourists. As far as the economic status of tourists was concerned, 16% of the children said that these were rich tourists and 15% said that these tourists were back packers who did not have much money with them. 25% of the children reported that the tourists were Europeans, 21% said that they were Americans, 4% were South Asians and 7% were of Japanese/ Chinese/ South East Asian origin. It was recommended that offenders should be publicized by Interpol, and scanning of tourists on their arrival should be done as a part of the immigration process to deter paedophiles.

**Key Words :** 1.SOCIAL DEFENCE 2.CHILD PROSTITUTION 3.SEX TOURISM 4.CHILD TRAFFICKING 5.TOURISM 6.PAEDOPHILIA 7.CHILD SEX TOURISM.

30. Nair, P.M. (2010).  
Human trafficking : dimensions, challenges and responses. New Delhi :  
Konark Publishers. 302 p.

**Abstract :** Human trafficking is an organized crime involving the overt or covert participation of several criminals at various places at different points of time. The process of human trafficking involves recruitment or hiring or transfer, exploitation, and commercialization of human beings. It involves the displacement of a person from one community to another, commercial exploitation and commodification of the victim. Trafficking could be for sexual exploitation, labour or for other types of exploitation. It may be brothel based exploitation or non-brothel based exploitation which may include massage parlours, beer bars, friendship clubs, tourist circuit, beauty parlours, etc. Labour exploitation can be for industrial labour, agricultural labour, domestic labour, labour in entertainment industry like circus, camel racing, begging, alms collection, etc. Trafficking for other forms of exploitation includes activities like organ transplant/ organ trade, adoption, child soldiering, drug couriering, arms couriering and for employment in anti-establishment activities like militancy, terrorism, rebellion, riots, conflicts, etc. HIV and trafficking are inter-related as sexual exploitation by multiple persons makes the victims highly vulnerable to HIV. Victims of trafficking are generally poor, illiterate, school dropouts, lack parental care and attention, there is absence of community control over the activities of undesirable persons and predators, criminals move around freely without any control, violations against women and children are perceived as insignificant or trivial issues, a culture of silence prevails, a number of persons go missing, and socially sanctioned prejudices exist. Identification of victims is fundamental to response, both for preventing and combating trafficking. Identification also facilitates decisions regarding policy matters on anti-human trafficking, reorientation and revision of the legal systems, and brings the role of victims into the centrality of the anti-human trafficking process. The responder needs to be trained on various dimensions of human trafficking, and needs regular capacity building/ upgradation of knowledge, skills and resources. Sometimes victims are compelled to work as witnesses, which they may find to be intimidating. NGOs take steps to address the vulnerabilities of victims, and identify the dimensions of trafficking; and police officers have realize the linkages between 'missing persons' and 'human trafficking', and decide to attend to all the 'missing persons complaints' in a sustained manner, involving the law enforcement agencies and NGOs. Media has also decided to bring out pamphlets, write-ups and stories on human trafficking, and educate the public as to how children and women can be trafficked. Panchayati raj institutions (PRIs) have started empowerment programmes which have made a tremendous impact and have been appreciated as a good model in preventing human trafficking at

the grass roots level and source areas. To combat and prevent human trafficking the list of services to be provided by the police is long - intelligence collection about victims, rescue victims from exploitation, register crimes, conduct professional investigations, attend to the legal steps required to ensure that offenders do not cause any harm to the victim, ensure that human rights and gender rights are not violated, etc. The Prosecutor has to ensure an expeditious trial, ensure action, ensure victim-witness care and protection. The Judiciary has to fix priority for trial and other issues in the justice delivery process, schedule the dates/ days/ time of trial, etc. Medical Professionals have to provide services such as examination of victims with due respect to human rights and gender rights, give priority attention to a trafficked victim, etc. The Counsellor can support the victim, take the role of a mentor, have the right perspective and be positive. Media presentation, both audio and visual, should make the public aware of the dimensions of human trafficking with sensitivity. Teachers and parents should identify vulnerable children and given them special care.

**Key Words :** 1.SOCIAL DEFENCE 2.TRAFFICKING 3.TRAFFICKING PREVENTION 4.SITUATION OF TRAFFICKING 5.ENFORCEMENT MACHINERY 6.IMPLEMENTATION MACHINERY 7.PROBLEMS IN IMPLEMENTATION 8.CRIME PREVENTION 9.VICTIMOLOGY.

## **SOCIAL WELFARE**

31. Ram, F., Mohanty, S.K. and Ram, Usha. (2009).  
Progress and prospects of millennium development goals in India.  
Mumbai : International Institute for Population Sciences. 77 p.

**Abstract :** India is passing through the demographic, epidemiological and economic transition. The birth rate in India has declined from 37 in 1972 to 24 in 2006 and the death rate has declined from 15 to 8 per 1000 population during the same period. The life expectancy at birth for the country has increased from 52 years in 1978 to 64 years in 2004 indicating substantial improvement in longevity (RGI, 2006). However, the Infant Mortality Rate (IMR) has remained unacceptably high at 57 per 1000 live births in 2006 and there are evidences of increase in the male adult mortality. Using 1991-97 data, Acharya et al (2004) found that Gujarat and Maharashtra were the fastest growing states in the country and experienced growth rates comparable to the East Asian countries, while Assam experienced negative growth rate during the late nineties. The Millennium Development Goals (MDGs) have been widely accepted as a

yardstick for measuring the development progress across countries. It comprises 8 goals, 18 targets and 48 indicators. The year 1990 has been considered as the base year and the year 2015 as the end period for this purpose. India aims at achieving the MDG by 2015. The relative contribution of various factors like education, poverty and economic development in improving the health of the population and in reducing infant and child mortality is also examined. The indicators of MDG are: percentage of population living below poverty line; prevalence of underweight children; net enrolment ratio in primary education proportion of pupils starting Grade 1 who reach Grade 5, literacy rate of 15-24 year olds, ratio of girls to boys in primary, secondary and tertiary education, ratio of literate women to men 15-24 years old; under five mortality rate (U5MR), infant mortality rate, proportion of 1 year old children immunized against measles, maternal mortality ratio, proportion of births attended by skilled health professionals; proportion of population with sustainable access to an improved water sources, urban and rural. Based on the estimates of Mixed Recall Period (MRP), the percentage of population living below poverty line in India had declined from 36% in 1993-94 to 22% in 2004-05. The second indicator is for hunger, i.e. the percentage of children under age three years who were underweight for age had declined from 51.5% in 1992-93 to 45.9% in 2005-06. The literacy rate in the age group of 15-24 years has increased from 69.5% in 1992-93 to 80.8% in 2005-06 (NFHS). The gender disparity in enrolment in 6-17 years age group has improved during 1992-2005. The actual rate of annual progress is 3.62%, which is lower than the required rate of progress 4.35%. The under-five mortality rate has declined from 109 to 95 per 1000 live births during 1992-93 and 1998-99 and further to 74 in 2005-06. The current level of IMR is highest in the state of Orissa and lowest in the state of Kerala. The estimates until 2001 are taken from SRS while that of 2010 and 2015 are projected under the minimum infant mortality rate of 15 as observed for the state of Kerala in the recent past. The IMR of India has declined from 134 in 1971 to 66 in 2001, the projected IMR is 52 for the year 2010 and 46 for the year 2015. The IMR for rural India has declined from 144 in 1971 to 72 in 2001. The projected estimate of IMR is 56 in 2010 and 50 in 2015 under the assumption of a minimum IMR of 15. In case of urban India, the IMR has declined from 85 in 1971 to 52 in 1991 and 42 per 1000 live births by 2001. The estimated figure of U5MR is likely to be 67 by 2010 and 58 by 2015. In 1990, female child mortality was around 11% higher than male mortality, and female mortality has improved faster and by 2015 it will be 7% higher (if the same trend continues). None of the major states will be reaching IMR below 30 by 2015 except Kerala. UP, MP, Rajasthan, Bihar and Orissa are above 50, and the highest IMR of 77 is observed in Orissa. In 2001, states like Orissa, Rajasthan, MP and UP had IMR above 80, and the predicted values indicate that they were nowhere close to the target outlined in MDGs. Maharashtra, Punjab, Tamil Nadu and Gujarat attained the targets but for other states it is difficult to reach a level of below 50. Urban areas of states like Orissa,

Rajasthan, MP and UP have a long way to go in order to reach the desired goal. India's maternal mortality ratio (MMR), estimated at 400 to 570 per 100,000 live births, is 50 times higher than that of developed countries. The percentage of population living below the poverty line (BPL) for India has declined from 55% in 1973-74 to 22% by 2004-05 based on MRP. According to estimates for 1999-2000, based on the 30 days recall period, Orissa recorded the highest percentage of BPL population (over 47%), followed by Bihar (nearly 43%) and MP (over 37%), and the lowest was in Punjab (6%) and Haryana (9%). The projected levels reveal that the percentage of population living below the poverty line would come down to 16% or less for all states except Assam by the year 2014-15. The states of Orissa, MP and Bihar have higher levels of both poverty and hunger, whereas in Haryana, Punjab, Maharashtra and Gujarat the extent of hunger is high despite lower levels of poverty ratios. From this we can say that reduction in poverty levels alone would not yield a reduction in the incidence of hunger. Child mortality decreases with increasing levels of education of women (~1.3%) and standard of living (0.3%).

**Key Words :** 1.SOCIAL WELFARE 2.MILLENNIUM DEVELOPMENT GOALS 3.PROGRESS TOWARDS MILLENNIUM DEVELOPMENT GOALS 4.HEALTH INDICATORS 5.POVERTY 6.HUNGER 9.UNDER WEIGHT CHILDREN.

## **WOMEN WELFARE**

32. Cequin, Centre for Equity and Inclusion, New Delhi. (2009).  
Perception and experience of gendered violations in public places in Delhi.  
New Delhi : Cequin. 39 p.

**Abstract :** Violence against women (VAW), either in the private or public sphere, is a violation of women's human rights and a form of gender-based discrimination and must be treated as such. Sexual harassment and assaults on women are so common that they are condoned as minor acts of eve teasing and not a matter of grave concern. Women across all ages, classes and castes are subjected to various degrees of harassment in public spaces, and curbs are placed on women's freedom of mobility, speech and expression. They are unable to achieve their full capabilities due to social and cultural constraints which often create violent barriers, thus impeding their effective economic and political participation. Gender based violence in public spaces is addressed by the law enforcement agencies under 2 basic categories - rape and eve teasing - and Cequin has launched a campaign to 'Make Delhi Safe for Women'. It conducted

a survey in Delhi to understand the perception and experience of women and girls about the nature and frequency of violations against them. The survey was conducted in slums, schools, colleges, metro stations, bus stands, market places and residential colonies. The total sample comprised 630 women. Around 40% women felt that women are vulnerable because of their 'dependent' status, 19% felt that the physical structure of women made them vulnerable and only 2% felt that women did not have a voice to protest. Only 0.5% women thought that their way of dressing made them vulnerable. 33% respondents felt that there is no particular age or type of women who are more vulnerable to harassment. While the highest vulnerability was of women in the 17-25 years age group, nearly 26% felt that the younger age group of 11 to 16 years was vulnerable. More than 60% of the respondents felt that girls less than 10 years are the most vulnerable. Most women felt that men knowingly harass women and it did not make any difference whether the women were married or single. 25% women felt that being women was enough to be harassed. 12.7% women ranked parks and bus stops as the most unsafe places, followed by empty roads (12.1%), market places (11.8%) and subways (8.2%). 82% felt that buses were the most unsafe mode of transport and 12% felt that auto rickshaws were equally unsafe. 97% women felt that sexual harassment was quite common, and 88% mentioned that women rarely got any help from the public when they were harassed. 33% respondents perceived that men harassed women just for fun. 25% women felt that men asserted their masculinity, and less than 20% women said that eve teasing satisfied their biological urge. 15% women reported that they received comments, 13% reported getting offensive looks, 12% were physically touched or experienced body brushing, 10% were stalked, 8.4% were winked at, 8% were subjected to whistling and offensive sounds and songs, 6% reported that the abuser touched their body parts in public and 2.2% reported being exposed to flashing. 28% respondents experienced the incident in the afternoon and 25% mentioned late evening as the time of occurrence. While 40% women protested the incidents, 4% went to the police, and only 2% lodged an FIR with the police. Around 44% respondents reported that they never received any help from the people around when they were harassed by men in public places. More than 40% of the respondents felt that it was not necessary, and police would have embarrassed them more than helping and that they did not trust the police, while around 30% said they were afraid of the police and they managed to solve the problem on their own. 95% women restricted their mobility due to sheer fear of being harassed by men in public places. It was recommended that the police should be pro-active, honest and compassionate; and strict punitive action against the abuser would make men think twice before harassing women. Parents, family, teachers and media should play an active role in bringing down gendered violations in public places; girls and women should be encouraged to protest; women's confidence should be built up; and they should be taught self defense strategies. Preventive and redressal strategies should be put in place for

women using transport, visiting markets and public spaces; security and vigilance measures should be stepped up; punitive action should be taken against offenders; awareness campaigns should be launched on laws; support services should be provided; and the public sensitized to come forward to assist women facing harassment.

**Key Words** : 1.WOMEN WELFARE 2.VIOLENCE AGAINST WOMEN  
3.SEXUAL 4.HARASSMENT 5.SAFETY 6.WOMEN'S SAFETY 7.EVE  
TEASING 8.CRIME AGAINST WOMEN 9.GENDER VIOLATIONS 10.DELHI.

33. Kanglei Young Women's Socio-cultural Organization, Imphal. (2003).  
Khwairamband Keithel "IMA Market" : women's market of Imphal city of  
Manipur state. Imphal : KYWSCO. 20 p.

**Abstract** : Khwairamband Keithel, also known as the IMA Market, is considered as the biggest women's market in the world for open vendors. It is run and managed exclusively by women. They sell their products sitting in rows in open sheds. In the past men were not allowed to enter the market, but this tradition is now changed and men are allowed in the market to purchase items. This market Keithel, located in the capital of the state, started in pre-historic times. The modern market owes its origins to King Khagemba (1597-1652) who recognized and shifted the 9 existing markets in Kangla area into 3 markets at the present site. The 3 markets named as Awang, Sana and Kha, are now located around the areas of Rupmahal Hall, Johnston School and State Museum campuses. The market managed by women can be divided into 2 types according to the type of transaction of their businesses, the Athabis or collectors/ wholesalers and Lallonbis the retailers in the sheds. Strengths of the institution of IMA market are that it gave opportunity to any woman irrespective of caste or creed, marital status or age to come out of their home and earn a livelihood with dignity. Women were illiterate in the past but of late many educated women are also entering this profession. Women above 80 years of age and disabled women are also selling products and earning a living due to these markets. These businesses can be started with low investment in a small time frame. These markets are run with a spirit of cooperation and living together, and no cut throat competition had ever been thought of or tried. Women acted together as a catalyst and fought against violence due to alcohol use and against violation of human rights by the state. Women vendors dealing with clothes earn the highest in festival seasons like Holi, Ningol Chakkouka, Cheiraoba, Lai Haraoba, etc. Their daily profit goes up to Rs. 500-700 but in the rainy season there are no sales and their average income remained around Rs. 3000 per month. The IMA

market is suffering due to neglect of the community and is not growing or developing as other markets in the changing global scenario. If it is supported with a proper in-depth study and the needed credit, technology and management tools it can become a very sustainable business system benefiting thousands of women and families. There is also a need for financial institutions and banks to be pro-active and come forward to extend financial support. As proper attention and care of children suffers when the mother is at work, child care facilities are needed in the IMA market.

**Key Words** : 1.WOMEN WELFARE 2.WOMEN'S MARKETS 3.ECONOMIC EMPOWERMENT WOMEN 4.INCOME GENERATION 5.EMPLOYMENT GENERATION 6.SMALL BUSINESS 7.MANIPUR.

34. Rao, V.M. (2004).  
Evaluation of Women Dairy Project (Phase 2) in Rajasthan : STEP scheme of Ministry of Women and Child Development. Pune : Vaikunth Mehta National Institute of Cooperative Management. . 112 p.

**Abstract** : Role of women in the agricultural sector, especially as keepers of livestock, greatly improves world food security by enhancing health and livelihood of individual families (Sinn, et. al, 1999). 90% of the work on cattle care or dairying is done by women making it more or less a female domain (Veena et. al, 1986). Support to Training and Employment Programme for women (STEP) was launched in 1986 to ensure well being of women in traditional informal sectors. It aims at increasing self reliance and autonomy of women by enhancing their productivity and enabling them to take up income generation activities (animal husbandry, dairying, poultry, sericulture, fisheries, etc.). The current study evaluated Women Dairy Project (Phase 2) which was also implemented in the Phase 1 unions during 1993-95. It was proposed to organize 210 women dairy cooperative societies (WDCSs) with a membership of 8400 women during the project period. Estimated cost of the project was Rs 5.62 crores of which the contribution of unions and Rajasthan Cooperative Dairy Federation (RCDF) was Rs 2.33 crores (RCDF, 1991). The study also aimed to draw lessons for future policy exercises. Phase 2 of Women Dairy Project (WDP) was implemented in 7 milk unions of RCDF. Based on spread, membership, procurement, input supplies, and member participation, 6 WDCSs from each milk union were identified. 5 women members from each WDCS were drawn randomly (representing different sizes of land holdings, caste, milk supplied and income). Thus, 42 WDCSs and 210 women members formed the sample of the study. Average age of women was 37 years and 66.7% of the respondents were



illiterate. Most of them had little formal education. Nearly 45-50% of the women interviewed were economically vulnerable and their families suffered regularly from droughts and periods of food shortage. The total average annual income of respondents was Rs 54410 which varied between Rs 36320 in Ajmer to Rs 95341 in Jaipur. The per capita income at the aggregate level, was Rs 7773 which is below the poverty line. Also dairying has been a major source of income in all the districts covered. Ownership of animals (cows and buffaloes) increased from 2.7 units; pre-WDP implementation to 4.4 post WDP implementation, while maximum increase is noticed in Jaipur division. Average milk production of households increased from 6 litres to over 10 litres during the period under review, and consumption increased from 1.7 litres to 3 litres. Highest increase in milk production as also consumption was noticed in Bharatpur. The tasks women are associated with relate to cleaning, cutting, feeding green fodder, milking, preparation of milk products, and dung cakes, etc. Time devoted to off-farm activities was less than 7% of women's total workload, and no change was noticed in the time allocated to household activities. At the aggregate level, women spent 777 minutes during pre-WDP phase and 819 minutes during post-WDP phase. Officials of the union motivated about 31% of the women into joining cooperatives, followed by women themselves (28.6%), and about 12% of the husbands also helped in mobilizing women to take part in WDCS. WDCS provide a number of benefits such as subsidized cattle feed, vaccination to animals, and veterinary medicine to members of milk unions. Emergency visits and fodder seeds are also provided. Training is imparted under WDP and aimed at capacity building of women. Income generating projects include handicrafts, preparation of national flags, chinks, pickles, papad, detergents, printing press, bakery products, etc. It was recommended the project period should be extended to 5 years instead of 3 years, with repetition of training programmes for state women development corporations and ST/ SC/ BC corporations. DRDAs should support STEP by extending financial assistance for creation of infrastructure, organization of SHGs, and promote development of entrepreneurship. Preference should be given to women for recruitment of supervisors/ officers under STEP programme and NGOs should be involved in organizing the WDCs. Efforts should be made to identify marginalized, assetless and destitute women for providing support services, and society should create awareness among women on social issues like health, girls education, child marriage, family planning, nutrition, etc.

**Key Words** : 1.WOMEN WELFARE 2.STEP 3.STEP EVALUATION  
4.DAIRYING 5.INCOME GENERATION 6.RAJASTHAN.

35. Rao, V.M. (2006).

Evaluation of Women Dairy Project (Phase 6) in Rajasthan : STEP scheme of Ministry of Women and Child Development. Pune : Vaikunth Mehta National Institute of Cooperative Management. 115 p.

**Abstract** : Role of women in agricultural sector, especially as keepers of livestock, greatly improves world food security by enhancing health and livelihood of individual families (Sinn, et al 1999). 90% of the care of cattle was undertaken by rural women, making it more or less a female domain (Veena et al, 1986). Dairying is a sub-sector of agriculture, and it provides round the year rural employment. Therefore, marginal work force is comparatively lower in dairy sector and women play a predominant role. Cooperative development (CD) programme, women's dairy cooperative leadership development programme (WDCLP), and STEP are some of the programmes aimed at providing support to women. Support to Training and Employment Programme for women (STEP) was launched in 1986 was a measure to ensure well being of women in traditional informal sectors, and aimed at increasing self reliance and autonomy of women by enhancing their productivity and enabling them to take up income generation activities (animal husbandry, dairying, poultry, sericulture, fisheries, etc.). Women face challenges such as child marriage, dowry, death, *purda* (veil), *nata* (relationships), infanticide and foeticide, and their male counterparts frown on their public presence. Women, in general, get low and inferior quality food, have no control on their reproductive life, and have limited access to health services. Rajasthan has 9186 gram panchayats (GP) with 3056 women sarpanchas, and these panchayats have 1.05 lakh ward panchas among whom 35,408 are women (Bhatt and Kataria, 2000). Women head 11 zilla parishads as pramukhs. Thus, women of Rajasthan are undergoing a revolutionary change and are exercising their political rights. Objectives were to study the implementation of WDP (Phase 6) among selected WDCSs; evaluate the performance of selected WDCSs during project and post-project periods; observe changes in women covered under WDP programme; and to document life histories of selected dairy women. Phase 6 of WDP was implemented in Ajmer, Banswara, Bikaner, Jaipur, Jodhpur, Pali and Sriganganagar milk unions of RCDF. Percentage of literates was more in Jaipur (60%) followed by Sriganganagar (57%), while it was the lowest in Bikaner (23%). Average annual income was the lowest in Jodhpur (Rs. 29021) and highest in Jaipur (Rs. 90864), while it was Rs. 57,514 at the state level. Income from dairying constituted as much as 28% of the total income. Field experience revealed that hardly 20% of the members belonged to the target group. Respondents owned about 3 animals (buffaloes and cows) during pre-WDP phase which increased to 5.4 animal units) post WDP phase. Improved income enabled respondents to purchase cattlefeed, followed by food items and savings. Increased income also helped improve the

quality of food and education given to children. The lifestyle, standard of living, communication skills, and social status of the women beneficiaries improved substantially. On the whole the impact was more in Jaipur and Sriganganagar. It was recommended that unions should try to increase the percentage of target group members; there should be regular and effective supervision of WDCS; efforts should be made to involve women in the day-to-day management of the WDCSs; and concurrent evaluation of the project should be taken up in the second year and terminal evaluation latest by the fifth year.

**Key Words** : 1.WOMEN WELFARE 2.STEP 3.STEP EVALUATION  
4.DAIRYING 5.INCOME GENERATION 6.RAJASTHAN.

36. Vetivel, S. (2005).  
Economic versus social transformation in the Tamil Nadu women's self help movement. New Delhi: UNICEF. 23 p.

**Abstract** : The Tamil Nadu women's self help programme, called the Mahalir Thittam (women's programme), was formally initiated by the state government in 2 blocks of a district in the late 1980s in partnership with an NGO. In phases, the programme was extended to the entire state. The vision of the Mahalir Thittam is to reach out and empower poor women through self-reliant and sustainable self help groups (SHGs). In the Mahalir Thittam, there are more than 1.5 lakh SHGs with a total membership of about 30 lakhs. It is being implemented in partnership with more than 460 NGOs. The 4 stakeholders were: financial institutions, government institutions, NGOs, and women's self help groups. Rural families are constantly in need of money to meet 'social' expenses such as birth/ naming ceremony of a child, a girl coming of age, functions and formalities associated with the marriage of a daughter, medical expenses, expenses for house repairs, etc. Families often take loans at exorbitant rates of interest (120% p.a.) (kandhu vatty), mortgaging jewellery, house or farmland. When the family harvests a good crop, it retrieves the mortgaged property. If the monsoon fails, however, these families are caught in a debt trap. Thus, creating an alternative form of credit for them was a major challenge for the government, NGOs and development workers since Independence. Savings collected from the members of a "thrift group" were given back as credit to needy members of the group to meet any emergent expense at a reasonable interest rate of 24%. A form of credit union, named Cheetu, had existed among women in Tamil Nadu villages for decades and these groups ended due to frauds perpetrated by those who had taken credit, not repayed the person who had initiated the scheme, and ran away with the money borrowed. More importantly, a positive mindset for a micro credit

programme existed in rural families, and the programme met a felt need at the right time. Economic transformation took place in 3 phases: savings and internal lending; external credit linkages; and setting up of micro enterprises. An amount of Rs 10 per week or Rs 520 per year (about 10 euros), is the minimum any woman would be able to save. A 20 member group could save an amount ranging from Rs 10,400 to Rs 20,800 a year. This is a huge amount for a village group. At the end of the first year, a member would have Rs 1,165 to her credit; at the end of the second year, Rs 2,605; and at the end of third year, Rs 4,430. These are huge amounts for a village woman. The amount an SHG accumulates at the end of each year for 3 years, Rs 23,300, Rs 52,090 and Rs 88,590 respectively is also huge. Monthly repayment of loans are deposited in the group's bank account every week very regularly. This weekly deposit is a must for the success of an SHG. The noteworthy economic transitions of the savings and internal lending phase are decision making, financial management of the savings, and internal lending, which are under the control of SHGs. SHG women from being debtors, have made their families creditors. SHGs have grown into mini banks and their families have been able to retrieve their properties mortgaged under the kandhu vatti. Economic transformations of this phase are that the simple rural housewives have become entrepreneurs and have learnt to handle huge sums of money. The negatives are loans have become central to the SHGs from the time they were formed and continue to be the same; loan amounts are used to purchase clothes, celebrate festivals, etc; when no loans are expected then members start defaulting on both external credit and internal loans; and savings are distributed among the SHG members, after which it goes defunct until it is re-formed. Indicators of economic transformation impact assessed after 3 years were the amount to each member's credit; gross amount (savings and interest) with the group; the status of family debt before forming the SHG and 3 years after formation; and incomes earned. The process of social transformation of women commences in a village from the time an NGO Cluster Coordinator (CCO) enters a village and starts mobilizing women to set up the first SHG. Social transformation of women did not take place easily, women had to bear with and overcome men's resistance, suspicion, ridicule and beatings. Breaking gender-based restrictions on mobility was the first and fundamental social transformation that women themselves brought about. Women were able to bring home money and became more knowledgeable and capable. Economic transformation justified social transformation. The process of empowerment was through the formation of federations at the level of panchayat, block and district. NGOs need to realize that they cannot run elementary schools, and they need to equip themselves to ensure that SHGs do not deviate from the empowerment and rights path, and the micro enterprises started become successful. The movement needed to keep a balance until the focus shifted to micro enterprises and other economic development activities, including the opportunity to avail loans. Bankers and Government officials need to play central roles as failure of

micro enterprises could make the movement fail. Renewed efforts are required to put the movement back on the 'rights and empowerment rails' by enhancing the roles of women's self help group federations, and NGOs should be facilitated by a 'think tank'.

**Key Words** : 1.WOMEN WELFARE 2.SELF HELP GROUPS 3.ECONOMIC EMPOWERMENT 4.ECONOMIC TRANSFORMATION 5.MOBILIZING WOMEN 6.SOCIAL TRANSFORMATION 7.WOMEN'S MOVEMENTS 8.SITUATION OF WOMEN 9.TAMIL NADU.

## YOUTH WELFARE

37. Ram, F. et al (2009).  
Youth in India : situation and needs 2006-07 : Maharashtra. Mumbai : International Institute for Population Sciences. 271 p.

**Abstract** : This study, undertaken by the International Institute of Population Sciences, Mumbai and the Population Council, New Delhi, is the first sub-nationally representative study conducted to identify key transitions experienced by married and unmarried youth in India. Young people aged 10-24 years numbered almost 315 million and represented 31% of the Indian population in 2001. A total of 7,570 married and unmarried young women and men were interviewed. The sex ratio in Maharashtra was 947 females per 1,000 males, and the sex ratio of the child population aged 0-6 years was 862 females per 1,000 males. It was observed that there was a decline in the child sex ratio as compared to 2001. It was observed that about 66.7% young men and 40% young women had engaged in paid or unpaid work. Almost 20% youth (17-19%) reported initiating work as a child (before age 15 years). Majority of young men (98% of married and 62% of unmarried) and a substantial proportion of young women (36% and 29% respectively) had engaged in paid or unpaid work at some point in 12 months. 20% young men and 17% young women showed levels of unemployment, while 64% young men and 71% young women reported interest in vocational skills training. 40% young men and hardly any young women accessed pornographic or "blue" films and over 50% of those reported that they accessed these films sometimes or frequently. 25% young men read pornographic material and 40% had accessed such material on the internet. Less than 8% young men and women reported that their mothers or fathers would disapprove if they brought same sex friends to their home, nearly 66.7% young men and over 75% young women reported expecting parental disapproval if they

brought an opposite sex friend home. Sensitive topics such as romantic relationships, reproduction and contraception, and even issues of adolescent body changes were rarely discussed with either parent (reported by fewer than 7% of youth). In total, 16% young men and 3% young women reported the experience of pre-marital sex in romantic and other partnerships. Consistent condom use was limited to just 7% of sexually active young women and 22% of sexually active young men. Youth preferred to marry after 18 years of age, but 35% of the young women aged 20-24 years were married before the age of 18 years. In contrast, just 2% young men were married before 18 years. Almost all youth reported arranged marriages. Dowry characterized the marriages of almost 66.7% young men and 70% young women. Violence was reported by almost 25% young women and 20% young men. Sexual violence was also reported. Almost 25% young women reported being forced to engage in sex with their husbands, but just 9% young men reported forcing their wives to engage in sex. 3% young men reported an extra marital sexual encounter. In contrast, hardly any young women reported an extra marital sexual encounter. As some young men and women engaged in sex before marriage there is need to build reproductive health awareness among young people, develop their skills to negotiate safe sex, communicate with partners, make appropriate family planning choices and prevent infections. Parents must involve their children in marriage related discussions. Parents must be made aware of the physical and mental health dangers of early marriage its adverse consequences. Counselling and contraceptive services must be made available to unmarried young people in a non-threatening, non-judgmental and confidential environment. These findings call for the implementation of strategies outlined under the National Rural Health Mission's Reproductive and Child Health Programme. Efforts must also be made to address the mental concerns of youth.

**Key Words :** 1.YOUTH WELFARE 2.SITUATION OF YOUTH MAHARASHTRA 3.SITUATION OF ADOLESCENTS MAHARASHTRA 4.EARLY MARRIAGE 5.AIDS AWARENESS 6.REPRODUCTIVE HEALTH 7.PRE-MARITAL RELATIONS 8.MAHARASHTRA.

38. Ram, Usha et al. (2009).  
Youth in India : situation and needs 2006-07 : Bihar. Mumbai :  
International Institute for Population Sciences. 294 p.

**Abstract :** Youth in India: Situation and Needs Study, referred to as the Youth Study, is the first ever sub-nationally representative study conducted to identify key transition experiences of married and unmarried youth in India. There are around 315 million young people aged 10-24 years and they constitute 31% of

the Indian population. Numbers are projected to increase and peak at around 358 million in 2011 before stabilizing at around 336 million by 2026. While today youth are healthier, more urbanized and better educated, social vulnerabilities persist and transition to adulthood is marked by early entry into the labour force, abrupt and premature exit from school, early marriage, etc. In transition to adulthood, young people face significant risks related to reproductive health and many lack the knowledge and power to make informed choices. Bihar had population of 83 million in 2001, and ranked as the 3<sup>rd</sup> most populous state in India. The state's population is projected to have reached 93.6 million by 2008. The sex ratio in Bihar is 919 females per 1,000 males, and is lower than that of India (933). The state is mainly rural and just 11% of the state's population lives in urban areas. Young people aged 10-24 years are ~24 million, and account for 29% of the state's population. The population aged 15-24 years was 16% and it is projected to increase to 22% by 2011, before beginning to decline. 75% young men and 50% young women were engaged in paid or unpaid work. Almost all married young men and 67% unmarried young men, 50% married and 40% unmarried young women, were engaged in paid or unpaid work. 38% young men and 25% young women were engaged in unpaid work on the family farm or business. Over 33% young men and women started work as children (before 15 years). 22% young men and 36% young women were unemployed. Unemployment was high among young women in urban areas, particularly the married, and exceptionally high among the educated and economically better off. 25% young men and 4% young women had watched pornographic films, and of these, about 40% reported having viewed such films sometimes or frequently. 20% young men and 6% young women accessed pornographic books and magazines; of those exposed to the internet, 33% young men and 10% young women accessed pornographic material on the internet. 14% young men and 3% young women reported pre-marital sex with romantic or other partners. First pre-marital sex took place earlier among young rural men compared to young women and urban youth. Consistent condom use was reported by 6% young men and 2% young women in all pre-marital encounters reported. Most young men preferred to marry in young adulthood; almost 25% young women preferred to marry before 18 years, and 60% preferred to marry before age 20 years indicating adherence to social norms. 46% young women aged 20-24 years were married before age 15 years, 77% before age 18 years, and 87% before age 20 years. Even though early marriage was less prevalent among young men, 13% of those aged 20-24 years were married before age 18 years and 31% before age 20 years. Just 4-7% youth reported that they met and interacted with their spouse prior to marriage. 90% met their spouses only on the wedding day for the first time. 30% young women reported that they faced violence perpetrated by the husband and 30% young men reported perpetrating violence on their wives.

49% young women reported that their first sexual experience within marriage had been forced, and 54% reported ever being forced to engage in sex with their husbands. Recent sexual violence was reported by 25% young women and 10% young men. 4% young men reported an extra marital experience. In contrast, hardly any young women reported an extra marital encounter. It was recommended that efforts should be made to achieve universal school enrolment and ensure at least primary school completion; invest in promoting youth employment; promote youth agencies and gender equitable norms among youth; provide opportunities for savings, especially for young women; promote youth participation in civil society and political processes and reinforce secular attitudes; provide family life education in school and for out of school youth; intensify efforts to eliminate the practice of early marriage; enable married young women to exercise greater control over their lives and create a supportive family environment.

**Key Words** : 1.YOUTH WELFARE 2.SITUATION OF YOUTH BIHAR 3.SITUATION OF ADOLESCENTS BIHAR 4.EDUCATION 5.EMPLOYMENT 6.EARLY MARRIAGE 7.HEALTH SITUATION 8.PARTICIPATION OF YOUTH 9.AIDS AWARENESS 10.BIHAR.

39. Ram, Usha et al. (2009).  
Youth in India : situation and needs 2006-07 : Jharkhand. Mumbai :  
International Institute for Population Sciences. 289 p.

**Abstract** : This study is the first sub-national representative study conducted to identify key transitions experienced by married and unmarried youth in India. Young people aged 10-24 years number almost 315 million and represent 31% of the Indian population. Numbers are projected to increase and peak at around 358 million in 2011 before stabilizing at around 336 million by 2026. The youth study identified key transitions experienced by youth, including those pertaining to education, work force participation, sexual activity, marriage, health and civic participations; patterns of young people's reproductive practices in and outside of marriage, decision making and attitudes. Jharkhand was carved out of the state of Bihar in the year 2000, and is one of the smaller states of India in terms of geographical area. Jharkhand, with a population of 26.9 million in 2001, ranks 13<sup>th</sup> in terms of total population among states in India. The state's population is projected to have reached 30 million by 2008. With 941 females per 1,000 males in 2001, the state registered a slightly higher sex ratio than the national average (993). The state has a large rural population, and only 22% of the population lives in urban areas. Educational attainment levels among youth are lower in the



state than in India, and gender differences in enrollment are substantially wider. Among young people aged 10-24 years, only 78% men and 55% women were literate in 2001. Young men (27%) and women (33%) reported unpaid work on the family farm or business. 29% young men and 35% young women reported initiating work in childhood or in early adolescence (before 15 years). Majority of the young men (57% of the unmarried and 96% of the married) and young women (42% and 47% respectively) had engaged in paid or unpaid work at some point during the past 12 months. Unemployment was 22% among young men and 26% among women. It tended to be higher among unmarried than married young men; but among young women a reverse pattern was evident. It was exceptionally high among the educated and economically better off youth. About 33.3% young men and 4% young women watched pornographic films, and 20% young men and 5% young women accessed pornographic books and magazines. Between 40% and 66.7% young men and women acknowledged the influence that media had on youth behaviour. 17% young men and 7% young women reported the experience of pre-marital sex within romantic and other partnerships. 8% young men and 7% young women had initiated sexual activity before the age of 18 years. More youth in rural areas engaged in pre-marital sexual activity than their urban counterparts. Only 7% young men and 2% young women reported condom use in all pre-marital encounters. 25% young women aged 20-24 years were married before 15 years of age, 60% before 18 years, and 75% before age 20 years. Even though early marriage was less prevalent among young men, 10% young men aged 20-24 years were married before the age of 18 years and 25% before the age of 20 years. 2% young men reported an extra marital sexual encounter, while none of the young women reported an extra marital sexual encounter. It was recommended that efforts should be made to achieve universal school enrollment and increase levels of school completion; invest in promoting youth employment; youth agencies and gender equitable norms should be promoted among youth; opportunities should be provided for formal savings, especially for young women; family life education should be provided in school and for out of school children; efforts should be intensified to eliminate the practice of early marriage and create a supportive family environment.

**Key Words** : 1.YOUTH WELFARE 2.SITUATION OF YOUTH JHARKHAND 3.SITUATION OF ADOLESCENTS JHARKHAND 4.SITUATION OF ADOLESCENTS 5.PARENT CHILD RELATIONSHIP 6.REPRODUCTIVE HEALTH 7.PRE-MARITAL RELATIONS 8.FAMILY VIOLENCE 9.AIDS AWARENESS 10.JHARKHAND.

40. Ram, Usha et al. (2009).  
Youth in India : situation and needs 2006-07 : Tamil Nadu. Mumbai :  
International Institute for Population Sciences. 285 p.

**Abstract :** The present study was conducted to identify key transitions experienced by married and unmarried youth in India. Young people aged 10-24 years constituted almost 315 million and represented 31% of the Indian population in 2001. The survey, conducted in Tamil Nadu, covered 9,752 young people, of whom a total of 7,996 married and unmarried young women and men were successfully interviewed. The study collected information pertaining to key transitions experienced by youth including those related to education, work force participation, sexual activity, marriage, health and civic participation, the magnitude and patterns of young people's sexual and reproductive practices within and outside of marriage as well as related knowledge, decision-making and attitudes. 90% youth were hindu and 5% were muslim. It was found that the motivating reason behind school discontinuation in 47% cases of young men and 51% of young women was poor academic performance. Marriage was reported as a reason for school discontinuation at high school level by 10% of the married young women. The majority of young men (all the married men and 59% of the unmarried men) and a substantial proportion of young women (29% married and 37% unmarried women) had engaged in paid or unpaid work at some point in the 12 months preceding the survey. Unemployment rates ranged from 7% among young men to 15% among young women. 43% young men and 53% young women were interested in vocational skills training. It was revealed that 26% young men and 14% young women with five or more years of education had exposure to internet. Large proportions of youth were exposed to the media, typically newspapers, magazines or books (96% young men and 78% young women with five or more years of education) and television (96% of all young men and 92% of all young women). 62-68% young women compared with 43-48% young men reported that their father or mother would be angry if they talked to a person of the opposite sex from outside the home. 61-83% youth reported discussing school performance or friendships, two relatively general topics, with their mother or father, and only 9% or fewer youth rarely discussed sensitive topics such as romantic relationships, reproductive processes and contraception with either parent. Almost all youth reported having same sex peer networks. Opposite sex peer networks were less common, but were nonetheless reported by 29% young men and 27% young women. 52% young men reported independent decision making on all three issues, namely choice of friends,

spending money and purchase of clothes; just 22% of young women reported doing so. Although young women were more likely than young men to have saved money (31% and 19% respectively), they were somewhat less likely to own a bank or post office savings account (9% women and 13% men); and less likely than their male counterparts to operate these accounts themselves (75% to 85% respectively of those who had an account). 51% young men and 56% young women justified wife beating in at least one situation. Just 26% young men and 42% young women disagreed with the view that woman should obtain her husband's permission for most things. Many young women (22%) and 6% young men reported that they had never received information on sexual and reproductive matters (prior to marriage among the married). In pre-marital romantic relations, 74% young men had held hands with a romantic partner, about 25% had engaged in sexual relations with that partner; and among young women, while 60% had held hands with a romantic partner, 10% had engaged in sexual relations with this partner. In total, 9% young men and 2% young women reported the experience of pre-marital sex within romantic and or other partnerships. Findings indicated that Tamil Nadu is characterized by a relatively late age at marriage: hardly any young men and only 18% young women aged 20-24 years were married before age 18. The study revealed that 4% young men had an extra marital sexual encounter. 34% young men reported perpetrating physical violence on their wife. Dowry characterized the marriages of 84% young men and 88% young women. Contraceptive use at any time within marriage was reported by 18% young men and 21% young women. Just 16% young men and 17% young women reported the use of contraception. 23-25% young men reported the consumption of alcohol and tobacco. 13% young men and 10% young women reported mental health disorder. 10-13% of the married and 1-3% of the unmarried youth had undergone HIV testing, however, they were overwhelmingly in favour of pre-marital HIV testing. Regarding participation in civil society and political life, 91% married young men, 82% unmarried men and 67% young women, irrespective of marital status, had cast their vote in the most recent election. Majority of youth (64-73%) reported disillusionment with the commitment of political parties to work for change at the community level. 69% young men and 49% young women reported unemployment as the single most important problem. Additionally, 10% young men and 14% young women reported poverty as the major problem. It was recommended that interventions are needed to give married youth a second chance to continue their education. Multiple activities are needed to address barriers to education such as economic reasons, attitudes and perceptions, and school related reasons, notably poor

infrastructure, quality of education and academic failure. There is need to provide opportunities for youth employment; build upon youth's growing access to the internet; promote youth agencies and gender equitable norms among youth; provide opportunities for formal saving, especially for young women; promote youth participation in civil society and political processes; reinforce secular attitudes; provide family life education for those in school and those out of school; ensure that the transition to married life is safe and wanted; address power imbalances within marriage; create a supportive family environment; and reorient service provision to address the unique needs of unmarried and married young women and men.

**Key Words :** 1.YOUTH WELFARE 2.SITUATION OF YOUTH TAMIL NADU  
3.SITUATION OF ADOLESCENTS TAMIL NADU 4.REPRODUCTIVE HEALTH  
5.PRE-MARITAL RELATIONS 6.EDUCATION 7.EMPLOYMENT  
8.VOCATIONAL TRAINING 9.DOMESTIC CHORES 10.PROBLEMS OF  
YOUTH 11.AIDS AWARENESS 12.TAMIL NADU.

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