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## Research Studies on Women and Children

### CHILD WELFARE

1. Centre for Development and Population Activities, New Delhi. (2001).  
Adolescent girls in India choose a better future : an impact assessment.  
New Delhi : CEDPA. 21 p.

**Abstract :** India has one of the fastest growing youth population in the world, with an estimated 190 million adolescents and girls below 19 years of age, comprising 25% of India's rapidly growing population. The present study was done to assess the impact of CEDPA's (The Centre for Development and Population Activities) Better Life Options Program (BLP) on the decision making and reproductive health behaviour of adolescent alumnae girls who graduated from the program in the peri-urban slums of Delhi (implemented by Prerana, Delhi), rural Madhya Pradesh (implemented by Bhartiya Grameen Mahila Sangh-BGMS) and rural Gujarat (implemented by Gujarat State Crime Prevention Trust-GSCPT). The study compared BLP alumnae who completed the program between 1996 and 1999 with a similar control group of young women (15-26 years old) who had not been exposed to the program. The study found significant differences between controls and BLP alumnae in terms of education, vocational skills, economic empowerment, autonomy and mobility, self-confidence, reproductive health and child survival behaviour, and health seeking behaviour. The study found that a higher percentage of BLP alumnae (37%), married after the legal age of marriage, 18 years, compared to the control group (26%). It was found that a significantly higher proportion of girls in the BLP group (55%) had exercised their choice to select their husbands compared to girls in the control group (34%). A significantly higher number of alumnae were literate compared to the controls. Around 99% of the BLP alumnae had learned a vocation skill compared to 22% in the controls. It was found that BLP alumnae were more in control of all major life decisions and their mobility (to use public transport) was also significantly higher than the control group. About 50% BLP girls felt that infertility was not usually the woman's fault. The study revealed that BLP alumnae used mass media to get information, participated in camps and were aware of the major issues in India, especially issues faced by girls/women. Married alumnae reported significantly more positive behaviour compared to married controls with respect to a host of indicators related to reproductive health and child survival. A significantly higher number of BLP alumnae reportedly used contraception. During pregnancy, alumnae had received

more antenatal and postnatal care as compared to controls. Regarding child survival practices BLP alumnae reported higher rates of complete primary vaccinations among children over one year old compared to controls. Awareness of HIV/AIDS was significantly higher among BLP alumnae as compared to control group. There is need to strengthen adolescent-friendly reproductive health programmes and services, and initiate a Better Life Options Program for boys as well.

**Key Words** : 1.CHILD WELFARE 2.ADOLESCENT GIRLS 3.ADOLESCENT EDUCATION 4.BETTER LIFE OPTIONS PROGRAMME (BLP) 5.INTERVENTION PROGRAMME 6.CHILD MARRIAGE 7.EARLY MARRIAGE 8.AGE AT MARRIAGE 9.VOCATIONAL TRAINING 10.PROGRAMME ADOLESCENT GIRLS 11.EMPOWERING ADOLESCENT GIRLS 12.VISTAAR PROJECT.

2. International Centre for Research on Women, New Delhi. (2006).  
The Early marriage trap in India : trading-in the childhood, health and life choices of girls. New Delhi : ICRW. 5 p.

**Abstract** : There are 51 million adolescent girls between 15-19 years in India who are married. South Asia is one region of the world where early marriage continues to be a widespread practice, with 48% women aged 15-24 years married off before the age of 18 years. ICRW (International Centre for Research on Women) conducted a baseline survey as part of an adolescent reproductive health programme called DISHA (Development Initiatives for Sexually Healthy Adolescents) on 1,750 boys and 1,767 girls between the ages of 14 and 24 years and 1,231 adults aged 30 years and above from six sites in Bihar and Jharkhand. DISHA survey highlights the fact that marriage for girls in these states takes place at very young ages, and is earlier than what most girls prefer. More than half (57%) of the girls aged between 14 and 24 years were married at the average age of 16 years, lower than both the legal age of marriage (18 years) and their ideal age of marriage (17 years). Evidence indicates that early marriage poses serious obstacles to the rights, health and well being of girls, and to their ability to access information and develop skills to ensure a healthy transition from adolescence to adulthood. In India, over 27% women currently aged 20-24 years have experienced at least one birth by age 18, and childbearing by women in the 15-19 years age group accounts for 19% of overall fertility. The DISHA Baseline Survey from Bihar and Jharkhand shows that 93% of married girls aged 14-24 years have at least one child, with the first child being born on an average 18-24 months after marriage. 46% of the girls could identify where at least one method of contraception was available, but they could not use the facility despite a desire to

delay and/ or space the first and second births. Only 22% girls knew of STDs and only 12% were using any method of family planning. Only 57% adolescent girls who had children received any check-ups during their first pregnancy. 80% of the young women gave birth outside a medical facility. Elders in the households of girls who marry early are less likely to take their wishes into account regarding schooling opportunities when compared to girls who marry later. Only 1.5% married girls between 14-24 years were currently enrolled in school, whereas 40% unmarried girls in the same age range were currently in school. 60% adults in the project area of Bihar and Jharkhand did not know that the legal age at marriage for girls in India is 18 years. 60% adults felt that the ideal age at marriage for girls is less than 17 years. 11% reported that young girls between 14 to 15 years should be married. Less than 30% girls in the sample reported that their wishes were taken into account when the decision to marry them off was made, reflecting the influence of household elders in making decisions related to timing of marriage. 4.4% adults supported the education of girls aged 14-15 years, but the majority (91.1%) said that access to schooling would depend on several other factors. ICRW is currently testing the effectiveness of an integrated approach to delay marriage for young girls, while also serving the reproductive health needs of young people - married and unmarried – through DISHA programme. The results of this programme, in terms of delaying marriage and improving the reproductive health outcomes of young people, will help identify the effectiveness of the integrated approach as well as the specific pathways through which active intervention can create social change to improve the lives of adolescent girls.

**Key Words** : 1.CHILD WELFARE 2.CHILD MARRIAGE 3.EARLY MARRIAGE 4.BIHAR 5.JHARKHAND 6.VISTAAR PROJECT.

3. Joshi, Kavita. (2004).  
Sexuality in India : teenager and teacher. Delhi : Lalita Devi Institute of Management and Sciences. 240 p.

**Abstract** : The foundation of any society rests on healthy sexual attitudes grounded in appropriate, adequate and accurate sexual information. The present study was carried out to provide authentic information and understanding regarding the process of growing up to students according to their age, so as to enable them to cope with adolescence related problems; promote among students a responsible behaviour towards the opposite sex; and to help them understand the responsibilities of parenthood. Adolescent students in the age group 15-18 years were taken for the study. 396 students and 144 teachers were selected for

the study from 4 Kendriya Vidyalayas, namely Kendriya Vidyalaya Tuglakabad, Kendriya Vidyalaya INA Market, Kendriya Vidyalaya Andrews Ganj and Kendriya Vidyalaya Sadiq Nagar, New Delhi, by simple random sampling method. For the components/ variables of sex and sexuality values and perceptions related to gender equality, peer group dependence, monogamy, social approval, and dating were covered. For the components need for sex education, homosexuality, virginity, role of media, deviant behaviour, role of religion and morality, sex crime, life style, myths, etc. the difference between students and teachers on these components has been found to be significant, either on 0.01 or 0.05 level. The three groups of adolescent students belonging to low, middle and high SES level were found to be insignificantly different on values and perceptions of the components peer group dependence, monogamy, role of media, deviant behaviour, role of religion and morality, sex crime, life style, dating and heterosexuality. On variables gender equality, virginity, peer group dependence, monogamy, role of media, deviant behaviour, social approval, role of religion and morality, sex crime, life style, myths and misconceptions, no significant difference was found between male and female adolescent students of low SES group. Male and female adolescent students of middle SES level have a significant difference in values and perceptions relating to the variables need for sex education and heterosexuality. Comparison of sex and sexuality related values and perceptions of male and female adolescent students of high SES showed the difference to be significant for gender equality variable and heterosexuality. Comparison of male students of different SES shows significant difference on the values and perceptions relating to gender equality, homosexuality, virginity, social approval and myths and misconceptions. High SES males agree more on gender equality and social approval than middle or low SES males. Comparison of female students of low, middle and high SES shows no significant difference among them on values and perceptions relating to all the variables except that of the variable deviant behaviour, where a significant difference was seen between middle and high SES groups. Middle class females agree more on these value components. There was significant difference between the TGT and PGT trained teachers on sex and sexuality related values and perceptions relating to the components of gender equality, role of religion and morality and heterosexuality. As SES has emerged as an important factor in acceptance of sex education, it was suggested that curriculum planners could take into consideration this finding while planning sex education/ adolescence education or reproductive health curriculum.

**Key Words** : 1.CHILD WELFARE 2.SEXUAL BEHAVIOUR 3.ADOLESCENTS 4.YOUTH 5.HIGH SCHOOL CHILDREN 6.SEXUALITY 7.SEX EDUCATION.

## EDUCATION

4. Zhang, Yanhong. (2008).  
A View inside primary schools : a world education indicators (WEI) cross national study. UNESCO. Paris : UNESCO. 290 p.

**Abstract :** The WEI (World Education Indicators) was founded in 1997 as a joint endeavour of the UNESCO Institute for Statistics (UIS) and the Organization for Economic Co-Operation and Development (OECD). The objective of the WEI-SPS study was to obtain cross-national data on how schools function, including the level of school resources and potential indicators of practices related to quality and equality issues in education. Eleven countries participated in the SPS study: Argentina, Brazil, Chile, India, Malaysia, Paraguay, Peru, the Philippines, Sri Lanka, Tunisia and Uruguay. In India only four states were included in the sample: Assam, Madhya Pradesh, Rajasthan and Tamil Nadu. In Sri Lanka, all the provinces were included but three had low response rates. The other countries had response rates of about 90% or more. Data was collected through questionnaires and interviews. It was found that about 10% pupils were in village schools in Argentina, Chile and Uruguay and more than 50% in India, the Philippines and Sri Lanka were in village schools. Chile had the highest share of private enrolment, where about 50% of primary pupils were in such schools, while India had about 35% pupils in private schools. In other Latin American countries, private enrolment ranged from 10 to 16%. Over 50% pupils in India were in schools without electricity. In Peru and Sri Lanka, more than 20% pupils were in schools without electricity. In Argentina, Brazil, India, Paraguay, Peru, the Philippines, and Sri Lanka, more than 10% pupils were in schools without running water. Only Chile and Malaysia had over 90% pupils in schools where sitting places were sufficient, and Brazil joined them for writing places. Schools in Peru, the Philippines and especially Sri Lanka were badly off in terms of equipping primary schools with toilets for boys and girls. Schools in India and Tunisia were not much better off. In all countries except Paraguay, Peru, the Philippines and Sri Lanka, there were more school libraries than classroom corner libraries. Only Malaysia had special science laboratories (79% of pupils), but fewer than 20% pupils were in such schools in Brazil, India, Paraguay, Tunisia and Uruguay. Chile was impressive with the number of schools equipped with computers for pupil use and with access to internet. In Argentina, Brazil, Chile, India, Malaysia and Uruguay, there were more than 70% schools where the heads deemed the school buildings to be in good condition, however in Peru, the Philippines and to some

extent in Sri Lanka, school heads considered the buildings to be in poor condition. The country with the highest percentage of specialist teachers was Malaysia (93%), followed by Argentina (39%), the Philippines (36%) and Tunisia (26%). School heads overall had very positive perceptions of their pupils' attitudes and behaviour at school. In most countries, with the exception of India, Malaysia and Sri Lanka, majority of the teachers expressed low levels of satisfaction with their salaries. Educators, parents, policy makers and the public need to work together in order to ensure that once young individuals enter schools they gain a fruitful learning experience.

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

## **GROWTH AND DEVELOPMENT**

5. Mary Jessai Rani, P. (2006).  
A Study on early child care alternatives adopted by mothers who work in shifts. Chennai : Loyola College, Dept. of Social Work. 183 p.

**Abstract** : Infancy and childhood are important and crucial stages in life, which have to be handled appropriately. The recent study was carried out in Chennai to understand the various child care alternatives adopted by mothers who work in shifts. Respondents were staff nurses of Government Institute of Child Health, Egmore and St. Thomas Multi-Speciality Hospital, St. Thomas Mount and Mugalivakkam (private hospitals). Data was collected from 100 respondents aged between 20-40 years, mainly between 25-40 years. 53% of the respondents used the public bus system to reach their place of work. 58% had done a diploma in nursing and about 42% had a bachelor's degree in nursing. 53% of the respondents had only one child and 47% had two children. 47% of the respondents had participated in some kind of training. 63% of the respondents chose the profession of nursing because of a role model either in their family or friends circle. 85% of the respondents chose this profession as a first option in their career, whereas 15% of the respondents chose the profession as second option. 27% of the respondents faced problems due to patients and their caretakers constantly questioning them, to which they have to respond aptly; 25% of the respondents expressed their inability to take care of the family as a problem; and 24% of the respondents said that the need to be very patient was a

big problem. 62% of the respondents said that they had servants to help them, but 38% of them did not have maids to help them in their daily chores. 38% of the respondents went back to work when their child was three to five months old, 34% returned back when their child was 5-10 months old, and 20% went back when the child was 3 months old. 97% nurses were having day shifts. 37% nurses left their child with their mother/ mother-in-law. 23% of the respondents employed baby sitters, 16% of them left their children in crèches. 13% left their children in the care of other relatives who lived close by, 11% left the children with friends, and 6% of the respondents' children were taken care of by their husbands. 62% said that their child sometimes cried when they had to leave for work. 30% respondents said that their child did not cry. 89% of the respondents felt that the caretaker was loving to the child and the child felt at home with the caretaker. 11% said that child was not attached to the caregiver. 59% said that their child had food satisfactorily when in others care. 99% of the respondents said that when it came to playing and talking with the caretaker, the children behaved well. 82% of the respondents said that their child fell sick very rarely. 55% said that they can work in peace knowing that their child was cared for. It was suggested that the organizations who offer crèche facilities should recruit baby sitters who have undergone training in early childhood care and development. Fathers and other members of the family who are involved in child care should be provided training in child rearing as they have a very crucial role to play in the absence of mothers. Government could introduce a policy to follow the pattern of flexi-time work for pregnant women and mothers with infants, so that they could strike a satisfactory balance between work and home.

**Key Words** : 1.GROWTH AND DEVELOPMENT 2.CHILD CARE 3.WORKING MOTHER 4.NIGHT SHIFT 5.PROBLEMS OF WORKING MOTHER 6.IMPACT ON CHILD DEVELOPMENT 7.CHENNAI 8.TAMIL NADU.

## HEALTH

6. Ghosh, Meenakshi and Goldar, Bishwanath. (2007).  
Safe water, safe waste disposal and health outcomes. Delhi : Institute of Economic Growth. 24 p.

**Abstract** : Despite the progressively increasing outlays under plans, universal provision of safe drinking water and improved sanitary facilities is still a distant

goal. Only 64% to 74% of the rural population of the country draws its drinking water from protected sources leaving the unserved population exposed to dangers emanating from consuming contaminated water. The corresponding figures for the urban population are relatively better; about 91% to 93% of the population enjoys access to drinking water from protected sources. Only six states have been able to ensure full coverage in rural areas, while on the urban front, only 77% of class I cities enjoy full water supply coverage. Regarding sanitation facilities coverage, data from various sources reveals that only 18% to 19% of all rural households, and 75% to 81% all urban households have access to toilets. It was found that the incidence of diarrhoea is relatively higher among households with low standard of living. While the incidence of diarrhoea is 23.09% among households with low standard of living, it is lower at 20.22% among households with medium standard of living, and still lower at 16.71% among households with high standard of living. Comparison of incidence of diarrhoea across states shows a wide variation in the rate. Some of the states for which the incidence is found to be relatively high include Jammu, Delhi, Madhya Pradesh, Orissa and Maharashtra. On the other hand, the incidence is found to be rather low in Assam, West Bengal, Punjab, Karnataka, Kerala and Haryana. The incidence rate is relatively lower for private tap water users and private hand pump users in a majority of states. In many cases, the incidence rate for public tap users is higher than that for private tap users. This may in part be due to the fact that in the process of collection of water from public taps contamination takes place. It was concluded that interventions resulting in better access to piped water and sanitation facilities can have significant health benefits. However, policies aiming at improving coverage may often be compromised by deteriorating distribution systems, contamination during storage post collection, or lack of hygienic practices, which may undermine the quality of the water at point of use. Universal provision of safe drinking water supply and sanitation in urban and rural India has emerged as major challenge, but the realization of this goal will still take some time.

**Key Words** : 1.HEALTH 2.HEALTH STATUS SLUM CHILDREN 3.HEALTH STATUS SLUM DWELLERS 4.SLUM CHILDREN 5.SANITATION 6.DIARRHOEA.

7. Gopalan, Saji Saraswathy. (2007).  
Microfinance and its contributions to health care access : a study of self help groups (SHGs) in Kerala. Bhubaneswar : Public Health Resource Network. 16 p.

**Abstract** : SHGs have become a movement in the state of Kerala, but their impact on society in general and poverty in particular is still unknown. Household health

expenditure in Kerala has increased over five times (517%) during the 10 year period 1987-1996. This increase was significantly higher (768%) among the poorest sections of society as compared to the richest (254%). Kerala spent on an average Rs. 2548 per capita per annum on health during 2004-2005. The present paper analyzed the possibility of micro finance as an alternative to finance health care. The study is based on the analysis of primary data. The rural area was selected because of its importance as the region of the inception of Credit Development Societies (CDS), the premier SHG in Kerala. The semi-urban area was selected because of its proximity to the capital city of Kerala. The study concentrated on women SHGs only. Questionnaires were separately needed for SHG beneficiaries and officials. 4 SHGs were selected. SHG 1 and SHG 2 were rural SHGs and SHG 3 and SHG 4 were semi-urban SHGs. The study found that nearly 50% women had no assets or very few assets. The success of SHGs in enhancing income appeared to be highly significant. The highest percentage of enhancement was found in rural areas. In the category of currently held up loans, the percentage of loans for health was significant (9%) in proportion to the loans for other purposes like employment, housing, debt, etc. Rural areas had the largest share of loans taken for health (7%). During the period 2003-05, 238 loans were disbursed by the four SHGs. Out of these, 22 (9.2%) were for health care purposes. 16.6% members of SHG 1 and 7.1% of SHG 2 took loans for health purposes. The total amount of loan disbursed for health was 3.6%. The average monthly expenditure was Rs. 26,630 for SHG member and Rs. 15,100 for spouse. A vast majority (77%) of SHG members utilized both government and non-government health facilities for treatment of their illness, whereas 23% relied only on government facilities. There was no significant difference in the exclusive access to government health facilities between rural and semi-urban areas. The participation of the elderly as well as women below 30 years of age was very small; which could be due to lack of autonomy of women, either financial or in decision making. Women had low capacity to meet their requirements, especially health care, and also felt the necessity for informal financial arrangements like micro finance to meet their emergencies and other felt needs. Majority of the respondents were without any personal income, had a very low standard of living, low health status and low health seeking behaviour, especially women. More than 40% of the families living below the poverty line were headed by females. Experiences with Grameen Bank in Bangladesh and SEWA in India show that micro credit linked health insurance schemes as well community financing schemes were the most effective way to save the poor from the cost of health care. The small amount of loans taken for health purposes reveals that people were not considering micro finance as an option for major health care expenditures. It was suggested that there should be more support from the local government system for the functioning of the micro finance mechanism in terms of

mobilization and management of resources, which could win the confidence of people and thereby add to their sense of security. Community financing and other risk pooling mechanisms for meeting emergency health care expenditures can be explored.

**Key Words** : 1.HEALTH 2.FINANCING HEALTH CARE 3.HEALTH CARE 4.ROLE OF SELF HELP GROUPS 5.SELF HELP GROUPS 6.LOANS FOR HEALTH CARE 7.KERALA

8. Gupta, Indrani. (2006).  
Health of the urban poor : progress and challenges. Delhi : Institute of Economic Growth. ~30 p.

**Abstract** : The present paper analyses the secondary data on issues pertaining to health of the urban population, with special emphasis on health of the urban poor. The report brings out the similarities between slums and rural areas with respect to health, education, employment and mortality issues. The study found that Neonatal Mortality Rate (NMR) is 31/1000 for urban India while it is nearly 40/1000 for the urban poor, and constitutes 40% of under 5 mortality among urban poor in India (Urban Health Research Centre). IMR was also about 1.3 times higher for the urban poor than the national average. More than 1 million babies are born every year in urban slums, indicating serious lack of awareness about family planning practices. The re-analysis of the NFHS data (by UHRC) also indicated that about 56.8% of children less than 3 years old (about 4.5 million) among the urban poor were malnourished. The situation is far worse in less developed states like Madhya Pradesh, where 72.4% urban poor children were reported to be malnourished. The symptoms of cold, cough, fever, and diarrhoea for children below 3 years of age in NHFS II survey was very similar for rural and urban areas. About 25.9% of children in urban Low Standard of Living Index group suffered from a diarrhoea episode in the 2 weeks preceding the survey as compared to 15.8% in urban High Standard of Living Index group. 45.7% urban and 53.9% rural women were anaemic. 32% urban and 36.1% rural women had mild anaemia. 12.2% urban and 15.8% rural women had moderate anaemia. 1.5% urban and 2% rural women had severe anaemia. 1,966 urban and 2,649 rural people per thousand were suffering from Asthma. 390 urban and 600 rural people per thousand were suffering from Tuberculosis. 307 urban and 476 rural people per thousand were dealing with medically treated tuberculosis. 1,225 urban and 1,410 rural people per thousand had Jaundice during the past 12 months. 2,156 urban and 4,254 rural people per thousand had suffered from Malaria during the

past 3 months (NFHS II 1998-99). The prevalence of newer diseases like HIV and AIDS was seen more in urban areas (76%). Most HIV/ AIDS infections were seen in socio-economically vulnerable and marginalized groups who reside in the poorer areas of urban cities – antenatal clinic attendees, STD patients, female sex workers, men who have sex with men (MSM) and injecting drug users. The 60<sup>th</sup> Round of the National Sample Survey (NSS) on morbidity and health care revealed that the number of persons per 1000 reporting ailments during a period of 15 days was 88 for rural areas and 99 for urban areas, which may mean either greater morbidity or greater reporting. The NSS report on the condition of urban slums indicates that the access to a nearest health facility for both notified as well as non-notified slums is extremely poor, though there is a lot of variation across states. The 60<sup>th</sup> Round of the NSS found that in 78% rural and 81% urban areas public health providers were available for treatment of illness. 13% of the total expenditure of the Ministry of Health and Family Welfare is spent on less than 0.3% of the work force via the CGHS scheme. It was recommended that for mapping of the urban poor local bodies should be involved. To reach the benefits of ICDS to all the urban poor, it is vital to update ICDS lists through proper identification of beneficiaries and mapping all listed and unlisted slums/ urban poor clusters.

**Key Words :** 1.HEALTH 2.HEALTH STATUS SLUM DWELLER 3.URBAN POOR 4.HEALTH SERVICES.

9. International Centre for Research on Women, New Delhi. (2004).  
Development Initiative on Supporting Healthy Adolescents (DISHA). New Delhi : ICRW. 5 p.

**Abstract :** The International Centre for Research on Women (ICRW) is leading a large scale collaborative initiative, DISHA (Development Initiative on Supporting Healthy Adolescents), to improve the reproductive health and well-being of young people in the states of Bihar and Jharkhand, India. The present study was done to improve the skills and capacity of youth regarding reproductive health and livelihood opportunities, ensure the provision of youth-friendly health services, and mobilize the community to support young people's access to reproductive health information and services. The study covered a sample of 1750 boys and 1767 girls between the ages of 14 and 24 years and adults (n=1231) who were 30 years and older. It was found that 57% girls and 27% boys aged 14-20 years were married. Around 93% married girls and 91% married boys in the sample had at least one child, and the first child was born 18-24 months after marriage. 59%

males and 38% females reported that household elders never took their opinion into account regarding childbearing matters. In the total sample of both states, 64% adolescents were aware of the pill and 60% were aware of the condom, compared to only 34% who knew of intrauterine devices (IUD), and 22% who knew about injectable contraceptive methods. Reproductive health knowledge was greater among boys than girls, a greater proportion of boys (78%) than girls (46%) could identify how to obtain at least one method of contraception. The baseline survey showed that youth access to reproductive health services in Bihar and Jharkhand was inadequate, and just over half (57%) of adolescent girls who had children received any check-ups during their first pregnancy. Only 12% married girls and 15% married boys used any method of family planning. Limited mobility and lack of parental support were the major barriers to youth access to reproductive health services, particularly for girls, and for unmarried youth. Boys and girls in Bihar reported higher levels of school enrollment and lower levels of paid economic activity than their peers in Jharkhand. Young people in both states express high self-esteem and self-confidence with regard to their qualities and roles in the household, despite their impoverished setting. While differences exist between girls and boys, particularly in Bihar, there was relative gender equality in terms of perceptions of self worth and abilities in Jharkhand. Interventions need to address the multiple spheres of young people's lives in order to improve the lives of youth in a sustainable way.

**Key Words :** 1.HEALTH 2.ADOLESCENT REPRODUCTIVE HEALTH 3.DISHA PROJECT 4.ADOLESCENT HEALTH 5.ADOLESCENTS 6.AGE AT MARRIAGE 7.CHILD MARRIAGE 8.EARLY MARRIAGE 9.REPRODUCTIVE HEALTH 10.FERTILITY 11.BIHAR 12.JHARKHAND 13.VISTAAR PROJECT.

10. Madhya Pradesh, Dept of Public Health and Family Welfare, New Delhi. (2006). Reproductive and child health RCH 2 : State programme implementation plan. Bhopal : MP-DPHFW. ~106 p.

**Abstract :** The Reproductive and Child Health Programme (RCH II) in Madhya Pradesh seeks to improve the health status of all women and children through improved access and quality Reproductive and Child Health Services with focused attention to the most vulnerable sections of society. The goals of RCH II are to reduce Maternal Mortality Rate (MMR) from 350 in 2007 to 220 by 2010, Infant Mortality Rate (IMR) from 75 (2007) to 60 by 2010 and Total Fertility Rate (TFR) from 3.2 (2007) to 2.1 by 2010. The achievement that took place during the year 2005-06 on Maternal Health were the appointment of 48 Post Graduate Medical

Officers (Obs., Gyanae. Paed. & Anesth.) in Comprehensive Emergency in Obstetric Neonatal Care [CEmONC] and 125 Medical Officers appointed in Basic Comprehensive Obstetric Neonatal Care [BEmONC] facilities on a contractual basis; Incentive scheme for motivating health worker; Janani Kalyan Insurance Scheme; promotion of institutional deliveries, and Deen Dayal Mobile Health Clinics were opened in 11 tribal blocks through NGOs. Standard treatment protocols were set for managing different Obstetric emergencies and new born care; minimum equipment requirements for EmONC and BEmONC facilities were decided; and to facilitate the process of labour provision of a birth companion had also been made. The State Government had planned to enhance availability of facilities for institutional deliveries; for emergency obstetric care; hiring of service providers; infrastructure strengthening; and training of Medical Officers, health officers, staff nurses, lab technicians, etc. The other implementation plans of the State Government regarding maternal health in Madhya Pradesh were strengthening Antenatal and Postnatal services, increased access for safe abortion services, involvement of NGOs and promotion of Public-Private Partnership, and prevention and management of RTI/STI. The achievements that had taken place in the year 2005-06 regarding Child Health were IMNCI (Integrated Management of Neonatal and Childhood Illness) was implemented in 8 districts of Madhya Pradesh namely Bhind, Morena, Datia, Sehore, Bhopal, Vidhisha, Shivpuri and Gauna; 23 state core trainers and 193 mid level trainers were trained; there was reduction in the number of severely malnourished children from 5.5% to 1.2% and reduction of malnourished children by 50% through Bal Sanjeevni Campaigns; State Task Force and State Core Group have been constituted and regular meetings were being convened for monitoring routine immunization activities, for transportation of vaccines and supervision of immunization sessions; and alternate vaccine delivery system had been started in all the districts. Population Stabilization was an other area of focus and the achievements that were found during 2005-06 were Quality Assurance Committee had been constituted at the State level, public-private partnership (PPP) for providing family welfare services to BPL families had been started; training of ANMs in IUD-CUT 380 A had been started; sterilization wards were being developed in all districts hospitals; hiring of counsellors for family welfare services at all CEmONC facilities was in process; 40 surgeons had been trained for NSV operations; and 28,417 cases have been attended to in 2005-06. The State Government had also planned strategies for Adolescent Health, general concerns in RCH/Sex ratio, Health Management Information System, behavioural change communication, urban health, tribal health, and strengthening of health programmes and infrastructure. There is a need for the Health Departments to become the repository of institutional leadership and support for the health system in the State, capable of rendering decentralized, pro-active and user friendly

health care services - preventive, promotive and curative to the people of the State, pursuing excellence in operation, expanding access to services and increasing the demand for services.

**Key Words** : 1.HEALTH 2.REPRODUCTIVE AND CHILD HEALTH (RCH) 2 MP 3.MATERNAL AND CHILD HEALTH 4.TRAINING HEALTH FUNCTIONARIES 5.MADHYA PRADESH 6.VISTAAR PROJECT.

11. Uttar Pradesh, Dept. of Planning, Lucknow. (2005).  
Note on health sector in Uttar Pradesh. Lucknow : UP-DP. 50 p.

**Abstract** : There is urgent need to invest in human capital in Uttar Pradesh if the state is to improve its ranking on Human Development Index and the country is to attain the Millennium Development Goals by 2015. This report focused on the Health Sector in Uttar Pradesh. A computation of HDI (Human Development Index) showed that Uttar Pradesh ranked 12 in 2000-01 whereas the top 3 ranking states were Kerala, Punjab and Tamil Nadu. Although Uttar Pradesh had a fairly large public sector health infrastructure comprising one Super Speciality Institution (SGPGI), 7 Government and 4 Private Medical Colleges and Hospitals, 53 District Hospitals, 13 combined hospitals, 388 Community Health Centres, 823 Block PHCs and 2187 Sub Block PHCs, apart from 20,521 sub centres, yet only 9% of the state's population actually make use of this facility for treatment of ordinary ailments, and people mostly have to depend on private health care. The Infant Mortality Rate (IMR) was 76 in Uttar Pradesh whereas it was 60 at the all India level, Child Mortality Rate (CMR) was 98 in Uttar Pradesh and 80 in India, Maternal Mortality Rate (MMR) was 707 for Uttar Pradesh and 407 for India, and the Total Fertility Rate (TFR) in Uttar Pradesh was 3.99 while it was 2.85 for India as a whole. Infant Mortality Rate (IMR) in the rural areas of Uttar Pradesh was nearly twice as high as that in urban areas. A World Bank study of the year 2000 showed that the estimates of DALYs (Disability Adjusted Life Years) had highest loss rate at 273.2 DALY in Uttar Pradesh among all the Indian states. The overwhelming cause of premature death and disability could be attributed to communicable diseases, malnutrition and perinatal conditions - a disease pattern common among poor populations. It was found that 92% of hospitalization cases in rural areas in Uttar Pradesh fell in the infectious and parasitic diseases category, more specifically within diarrhoea and gastroenteritis. In Uttar Pradesh, public health spending had increased from 0.91% of SDP in 2002-03 to 0.98% in 2003-04. It was found that every sixth malnourished child in India lives in Uttar Pradesh and Uttar Pradesh ranked second with respect to prevalence of

malnutrition among children under 3 years of age in India. The National Rural Health Mission (NRHM) was launched on 5<sup>th</sup> August 2005 in Uttar Pradesh with several health goals, but this can be achieved only if there is convergence of resources, strategy and efforts of Departments like Rural Development, Panchayati Raj; Women and Child Welfare; Health, Family Welfare and Medical Education, etc. According to an estimate, about 3.5 lakh additional nurses would be required in the country by 2015, and at least 15.20% are required in a big state like Uttar Pradesh alone. Of the 11 medical colleges in Uttar Pradesh, 7 are in the public sector and 4 are in the private sector. Based on the norm of one medical college for every 50 lakh population, there ought to be 35 medical colleges in the state. Thus there is a deficit of 24 medical colleges in the state. In Uttar Pradesh there were about 25000 registered Homeopaths and about 50000 registered Ayurveda and Unani practitioners, and all these are Registered Medical Practitioners (RMP). In general, RMPs operate from a single, rented room which serves as their clinic and they usually keep a patient's chair or bench, a stethoscope, a blood pressure gauge and syringes. Almost all RMPs have fewer resources for patients. There is urgent need to focus attention on the Health sector in the state as without qualitative improvement in this sector, it is almost impossible to improve the ranking of the state on Human Development index or achieve the Millennium Development Goals. Many provisions of the state population policy, 2000 still remain to be implemented.

**Key Words** : 1.HEALTH 2.HEALTH SYSTEM UTTAR PRADESH 3.UTTAR PRADESH 4.VISTAAR PROJECT.

## ICDS

12. Datta, Vrinda. (2001).  
Factors affecting job performance of anganwadi workers : a study of three districts of Maharashtra. Mumbai : Tata Institute of Social Sciences. 158 p.

**Abstract** : This study was conducted to understand the issues affecting job performance of AWWs by looking at various dimensions. 6 blocks from three districts of Maharashtra, namely Nagpur, Nasik and Amravati were covered. A total of 615 AWWs and 72 Supervisors were selected. It was found that the training centres were very old and there were no additional classes or laboratories for intensive work or doing practicals. There was no feed back taken from training

centres. The CDPO does not visit the AWCs to see how AWWs communicate with beneficiaries. 70% Supervisors were graduates or post graduates. Their training had been done long ago and there had been no refresher training courses for them. 70% Supervisors had more than 10 years experience. Out of 72 Supervisors, around 52 of them visited AWCs only once a month, while 17 of them visited twice a month, and only 3 Supervisors visited AWCs more than twice a month. 50% Supervisors looked into the many registers and records maintained like attendance, growth chart, food record, Mahila Mandal meetings, etc. They also looked at records of severely malnourished children. 97% AWWs mentioned that training helped them to measure a child's height and weight. 98% AWWs said training was essential for knowledge about immunization, distributing nutritious food, and providing parents with nutrition and health education. Only 74% AWWs mentioned that training was useful to create self help groups and conduct adult literacy classes for women. 46% AWWs mentioned they would try and take interest in children by telling them stories or singing songs, etc. Another 24% organized interesting activities like picnics or playing with toys. Some said that decorating the AWC well would induce the children to come, while others mentioned that parents need to be convinced first to send their children to the AWC. 36% children were neat, clean, hygienic and obedient, and 12% children looked physically dirty and suffered from coughs and colds. 89% Supervisors mentioned that attendance of the AWW was regular. 56% Supervisors said that AWWs participated in the block office work and 13% participated only if there was some important work. 81% AWWs were fully trained and had adequate information to measure height and weight of children. 43% AWWs were giving personal attention to each child. 58% taught according to the syllabus. AWWs mentioned that training prepared them for informal education, nutrition demonstration, home visits, plotting weight charts and health related issues. All AWWs could weigh children and interpret growth charts. 90% Supervisors agreed that AWWs got average co-operation from villagers in their work. There is need to improve the quality of training, improve board and lodging facilities. There is need for Mobile Training Units. Basic text books should be available in regional language.

**Key Words** : 1.ICDS 2.UDISHA TRAINING 3.TRAINING OF ANGANWADI WORKER 4.ANGANWADI WORKER 5.JOB PERFORMANCE 6.PRESCHOOL EDUCATION IN ICDS 7.COMMUNITY PARTICIPATION IN ICDS 8.PARENTS PARTICIPATION.

13. India, Ministry of Women and Child Development, New Delhi. (2007).  
Implementation completion report of World Bank assisted ICDS III/ WCD  
Project : Borrower's [Government of India] evaluation report. New Delhi :  
I-MWCD. 15 p.

**Abstract :** The ICDS-III Project was made effective for a period of five years originally in five states covering Uttar Pradesh and Rajasthan in the northern part, Maharashtra in the western part, and Kerala and Tamil Nadu in the southern part of India. The Project envisaged introduction of ICDS services in 318 new (uncovered) blocks and strengthening and improving service quality and management in 685 existing (old) blocks in these states. The distinctive feature of the coverage of the Project was the inclusion of 69 tribal blocks (in Rajasthan, Maharashtra and Kerala), 51 coastal blocks (in Kerala), 804 rural disadvantaged blocks (in five states), and 79 urban blocks with poor outreach of basic services (in Rajasthan, Maharashtra and Kerala) in the Project. The National Training Component of ICDS-III Project, Udisa, aimed at improving the quality of ICDS services by providing for improved training of ICDS functionaries all over the country; strengthening/ establishing training centres, developing training materials, etc. 'UDISHA' focussed on eliminating the heavy backlogs in jobs and refresher training of all functionaries. Capacities of existing AWTCs and MLTCs (Middle Level Training Centres) have been further strengthened to take up increased responsibility and new AWTCs and MLTCs have also been established for the purpose. The Project has achieved overall its main objective of clearing the backlog of job training. A total of about 928,000 ICDS functionaries, out of which 366,000 AWWs and 759,000 other persons have been imparted on the job and refresher training under the Project through a countrywide network of about 600 AWTCs, 40 MLTCS and the National Institute of Public Cooperation and Child Development and its Regional Centres. The overall performance under job training for the different categories of functionaries was 115% of the PIP target, while such performance under refresher training was 129%. The performance as per revised targets are 84% for all categories of functionaries under job training and 68% under refresher training. Information, Education and Communication (IEC) had been one of the major interventions in the Project, which laid special emphasis on IEC by focusing on communication for behaviour change (BCC) for appropriate child caring and rearing practices in households. Free Expression for Quality Improvement (FREQI) provided an opportunity for the formation of quality circles to encourage better interaction among AWCs, they could exchange notes freely, bring them to the notice of the supervisory staff, and with their support achieve higher quality of service delivery. Kerala had conducted the maximum number of FREQI meetings and used up the entire allocation, followed by Tamil

Nadu with 98% utilization, Uttar Pradesh with 97%, Rajasthan with 88%, Maharashtra with 74% utilization and the overall achievement was 88%. Some of the major problems identified due to FREQI meetings were that there were absence of growth monitoring charts and weighing scales, dislike of the supplementary food by the community, operational problems regarding shifting of AWCs to primary schools, and absence of referral slips, etc. There were some new initiatives taken during the implementation of Project Udisha, like training through Mobile Training Teams, which was provide at the project level/ block level by key trainers. This training has been in full operation in Tamil Nadu, and partly in the states of Uttar Pradesh, Rajasthan, Madhya Pradesh, Nagaland, Sikkim and Jharkhand. Significant progress was achieved in antenatal care, immunization, de-worming and treatment of diarrhoea. Monthly growth monitoring of under 3 children also improved overall, as was mentioned by AWWs (from 67% in Base Line Survey (BLS) to 82% in End Line Survey (ELS)). Practice of weighing infants at birth showed overall improvement from 40% in BLS to 46% in ELS. Impact of Information, Education and Communication (IEC) was increased awareness of infant breast feeding practices among the AWWs. But knowledge transfer from AWWs to AGs and women remains a matter of concern. In Uttar Pradesh, a team of talented AWWs formed '*Anganwadi Kala Jattha*' to spread awareness and social mobilization campaigns through rallies, door to door contact, wall writings, folk songs, group discussions, *Nukkad Nataks* (street plays) and quiz. By performing live in front of a large audience, AWWs have gained immense confidence, which reflected in a positive improvement in their routine work of running AWCs. AGs clubs were constituted under each AWC in the state which was an innovative initiative under the ICDS-III Project, considering the importance of adolescence period in a life cycle. There is urgent need to establish a Nutritional Surveillance System up to the block level to monitor the nutritional status of severely and moderately malnourished children and take appropriate actions for their management. Establishment of State Project Management Unit in the project states and central project unit at the central level, along with all necessary project approval processes, should be completed before the launch of the Project for an effective taking off of the Project.

**Key Words** : 1.ICDS 2.WORLD BANK ASSISTED ICDS PROJECTS 3.BEST PRACTICES 4.IMPACT EVALUATION 5.VISTAAR PROJECT.

14. Pandey, D.D. (2004).  
Integrated child development services scheme : presenting innovative  
panorama. New Delhi : NIPCCD. 17 p.

**Abstract :** This study was conducted to evaluate the causes which adversely affect implementation of ICDS. A total of 109 participants, 76 CDPOs/ ACDPOs and 33 trainers of ICDS functionaries were covered in the study. Slow career progression of functionaries, lack of motivation among Supervisors, and AWWs wish to become regular Class III employees were identified as most important factors adversely affecting the implementation of ICDS. Community participation is essential for the programme to be successful. Two factors affect the implementation of ICDS. Firstly, community leaders stand away from the programme due to their non-involvement in the initial stages of the programme. Secondly, service providers mentioned their frustration with criticism of the ICDS programme management. Poorly equipped AWCs were found to be the most important factor. Functionaries failed to take advantage of the richness of the local surroundings to the full extent due to inflexible nature and rigidity in making use of locally available rich sources. They were always eager to use early childhood education aids supplied by State owned agencies. This deep rooted habit of dependence of the public negates the basic challenge emanating from the community. The ICDS manual envisages on the spot feeding of vulnerable children and pregnant or lactating mothers. But sometimes the beneficiaries are unable to get ration due to inaccessible AWCs and traditions or superstitions prevailing in the community. A large number of posts are lying vacant. It is difficult for ICDS functionaries to elude the pressure exerted by local politicians. Due to inefficient work culture in the government system, new ideas and practices are never welcomed. As a consequence of this, a large amount of budgetary allocations are surrendered or remain unutilized. Proper budgetary allocations and effective utilization of financial resources could improve the quality of ICDS services. There is need to avoid high cost model of ICDS, and the system should prefer to work with a model promoting the provision of necessities. There is an urgent need to fill up the large number of vacancies. Policy designers and decision makers should take the view of beneficiaries, and before taking any decision, views of the community may also be solicited.

**Key Words :** 1.ICDS 2.FUNCTIONING OF ANGANWADI CENTRES 3.FACTORS AFFECTING ICDS 4.QUALITY OF SERVICES 5.DELIVERY OF SERVICES 6.IMPROVING QUALITY.

15. Pandey, D.D. et al. (2008).  
Quality of pre-schooling under different programmes including ICDS : a study. New Delhi : NIPCCD. ~200 p.

**Abstract :** This study was conducted to assess the qualitative inputs being provided under different public initiatives of preschool in India. A total of eight districts were selected from 4 states namely Haryana, Himachal Pradesh, Uttar Pradesh and Punjab, and two clusters (one each from rural and urban areas) were selected, bringing the number of clusters up to 16. Total 96 PSE centres were studied. It was found that PSE kits were available in 65.62% ICDS centres, 62.5% SSA/ NPEGEL (National Programme of Education of Girls at Elementary Level) centres and 40.62% RGNCS (Rajeev Gandhi National Creche Scheme) centres. In Himachal Pradesh PSE kits were available in 87.5% ICDS centres, in Uttar Pradesh 75% centres, and 50% centres each in Haryana and Punjab. Overall, very few RGNCS centres had the PSE kit; among states, Haryana had the lead with 50% centres having kits. In more than 50% ICDS and RGNCS centres, the PSE kit was complete whereas under SSA/ NPEGEL only 40.62% centres had complete kits. Higher number of ICDS centres in Himachal Pradesh (87.5%) had complete kits, while the lowest number was found in Haryana and Uttar Pradesh, 37.5% each. 62.5% of *Bachpanshalas* in Haryana had complete kits, while SSA/ NPEGEL initiatives in other states were lagging behind. Punjab and Himachal Pradesh had 25% complete kits each and Uttar Pradesh had 50%. Teaching learning material was present in only 46.8% SSA/ NPEGEL centres, 32.5% ICDS centres, and 31.2% crèche centres. The utilization of blocks for organizing various activities was higher in ICDS centres (40.62%), followed by SSA/ NPEGEL (28.1%), and crèches (18.7%). Around 87.5% AWWs, 70% SSA functionaries and 43.75% crèche workers were trained. The highest number of trained AWWs were in Himachal Pradesh (100%) while the lowest were in Uttar Pradesh (75%). PSE activities were organized for 3-4 hours a day in almost half of all the PSE centres. It was highest in SSA (56.25%), and the lowest in ICDS (46.87%). In around 34.37% SSA centres and 31.25% centres under RGNCS (Rajeev Gandhi National Creche Scheme) PSE activities were organized for 1-2 hours a day. In 6.25% SSA centres, 3.12% centres under ICDS, and 15.62% RGNCS centres, crèche workers organized PSE activities for more than four hours. Overall, children's participation in PSE activities was good in ICDS and SSA/ NPEGEL centres against average in RGNCS. Children's participation in RGNCS of Haryana and Himachal Pradesh was average, good in Punjab and poor in Uttar Pradesh. Maintenance of records was very good in RGNCS and SSA/ NPEGEL centres, while it was good in ICDS. In Haryana and Punjab records were in very good condition, and in Uttar Pradesh they were in good condition. The attendance of all

children enrolled was highest in RGNCS centres (90.62%), followed by ICDS (81.25%) and SSA (75%) centres. Average attendance was 100% in all three public PSE settings in Punjab, it was 87.5% in Uttar Pradesh and 75% in Himachal Pradesh. In Uttar Pradesh only 37.5% centres had full attendance in comparison to ICDS in Himachal Pradesh and Punjab (100%), and Haryana (87.5%). About 50% of SSA centres in Himachal Pradesh and ICDS centres in Uttar Pradesh had half attendance. 12.5% ICDS centres each in Haryana and Uttar Pradesh had less than half attendance. The transition rate was above 80% in most of the PSE centres. Highest transition rate was among ICDS centres (75%), followed by SSA centres (56.25%), and RGNCS centres (50%). 6.25% RGNCS centres had 0% transition rate, followed by 3.12% in ICDS and SSA centres. 0% transition rate was found in Uttar Pradesh only, and in 25% SSA centres in Himachal Pradesh. It was suggested that decentralized mode of training initiatives have to be strengthened through respective BRCs (Block Resource Centres) and CRCs (Cluster Resource Centres). NCERT may be assigned the task of doing work in pedagogical aspect for ECE initiatives under SSA/ NPEGL, while NIPCCD may be given the responsibility of continuing with training, research and resource material availability for ECE (Early Childhood Education) under ICDS and RGNCS.

**Key Words :** 1.ICDS 2.PRESCHOOL EDUCATION IN ICDS 3.EARLY CHILDHOOD EDUCATION 4.PRESCHOOL ACTIVITIES 5.LEARNING ACHIEVEMENT.

16. Pasupuleti, Usha Rani et al. (2004).  
Integrated Child Development Services. New Delhi : Discovery. 183 p.

**Abstract :** This study was conducted in the state of Andhra Pradesh to evaluate the job performance and job expectations of Supervisors working in urban, rural and tribal ICDS projects. Three districts, namely Hyderabad (urban), Anantpur (rural) and Visakhapatnam (tribal) were covered. A total of 72 Supervisors, 28 CDPOs and 144 AWWs were selected. Majority of Supervisors (46.8 to 81.2%) in all projects had average knowledge about activities and programmes of ICDS. Around 81.2% of the urban Supervisors had average knowledge, while 6.2% and 12.6% had low and high knowledge. The knowledge level of 9.4%, 75% and 15.6% Supervisors who worked in rural projects was low, average and high respectively. In tribal projects, 41.7%, 45.8% and 12.5% Supervisors had low, average and high knowledge levels. On the whole 19.4% Supervisors had low

knowledge levels, while 66.7% and 13.9% Supervisors had average and high knowledge levels. Overall job performance of Supervisors was found to be low, medium and high in 20.8%, 65.3% and 13.9% cases respectively. In urban areas, 6.2% Supervisors had low job performance, 87.6% had medium job performance and 6.2% Supervisors had high job performance. In rural areas low job performance was observed in the case of 12.5% Supervisors, medium job performance was observed in the case of 71.9% Supervisors, and 15.6% Supervisors showed high job performance. In tribal areas, low and medium job performance was 41.7% each, and high job performance was observed in the case of 16.5% Supervisors. Majority of AWWs in Hyderabad urban projects were Muslims who could not write in Telugu language and they were not able to fill up records and registers. In rural projects there were many vacant posts of Supervisors, and the Supervisors in position were supervising about 30 AWWs or even more. In tribal projects all the Supervisors mentioned that their major concern was the selection of uneducated women as AWWs who were not able to fill up the records and registers. There is an urgent need to select educated women as AWWs. AWWs in urban projects need to be trained intensively in filling up the records and registers. Urban Supervisors also mentioned that there was no crèche facility available where they could leave their children and they were not getting loans for owning vehicles. They suggested that these facilities should be extended to them. Necessary training may be imparted to Supervisors and AWWs to utilize the locally available material for preparation of toys, because in tribal projects AWWs were unable to attract and hold the attention of children during PSE due to lack of proper play material and teaching aids, and the children just took their food and ran away. Provision of the required facilities can divert Supervisors and AWWs efforts towards the effective management of ICDS scheme activities.

**Key Words** : 1. ICDS 2.JOB PERFORMANCE 3.SUPERVISORS 4.JOB PERFORMANCE SUPERVISORS.

17. Sampath, T. (2006).  
A Study on community participation in integrated child development scheme (ICDS) in Chennai. Chennai : Loyola College, Dept. of Social Work. 160 p.

**Abstract** : This study was conducted to evaluate the status and obstacles to community participation, and offer suggestions to enhance community participation in the ICDS programme. A total of 180 respondents including 40 AWWs, 26 AWHs, 36 mothers, 24 self help group members, and 26 AGs were selected for the study. It was found that ICDS staff had inadequate knowledge

about the basic concept of community participation. 26% mothers, 16% SHG members, 14% youth, 36% AGs and 10% councillors participated in the range of 20-40% in the ICDS programme. 30% of the community participated in the range of 40-60% and helped in the day to day activities and functioning of ICDS. 22% of the community participated in the range of 40-60% in the form of material contribution. 34% of the community participated in the range of 40-60% in the special programmes of ICDS. 24% community participated in the range of 40-60% in monitoring ICDS centres and its functioning. Around 48% respondents mentioned that community participation was satisfactory. 60% AWWs were satisfied; 20% had low satisfaction; 10% had very low satisfaction; 6% were very highly satisfied, and 4% were highly satisfied with their job performance. Majority of the ICDS buildings were in poor condition without basic facilities. They were not located within community areas, and mothers had difficulty in sending and bringing back their children from ICDS centres. Parents were interested to send their children to private crèches and schools because they thought 'private' meant quality and was a status symbol. Sometimes the quality of supplementary nutrition was poor, and it led to a poor image and negative attitude among mothers towards ICDS and its services. AWWs were maintaining 20-26 or more number of registers. Some AWWs had clubbed the contents and maintained a single register. There was lack of co-ordination and co-operation between Government departments while implementing the ICDS programme in Chennai city. In a few places the Corporation was running pre-primary schools, and this created confusion among the community about where they could send their children. Parents were sending their children to ICDS centres due to their rapport with AWWs and Helpers and services provided at AWCs. These two kinds of preschools created unnecessary internal conflict between AWWs and Corporation teachers, and created confusion among community members. The State Government should motivate all local body representatives to spend 15% of their area welfare allotment fund for the ICDS programme, including infrastructure development and maintenance of the AWCs. State Government could recognize ICDS and give ICDS functionaries the power to issue certificates to preschool children, and make it as an official procedure to get a preschool certificate from ICDS to enroll the children in first standard in all government schools, and government aided schools. The State Government should pass a resolution to separate "Dr. MGR Sathu Unavu Scheme" for preschool and school children, and give the name "Dr. MGR Upgraded Preschool or Nursery School ICDS" for all preschools for the benefit of the administration as well as to enhance community participation.

**Key Words** : 1.ICDS 2.COMMUNITY PARTICIPATION IN ICDS 3.ICDS SERVICES 4.URBAN ICDS 5.CHENNAI 6.TAMIL NADU.

18. Sharma, Adarsh and Pandey, D.D. (2005).  
Impact of ICDS training on service delivery by anganwadi workers : a study.  
New Delhi : NIPCCD. 86 p.

**Abstract** : This study was conducted to evaluate the impact of Job Training Course (JTC) on job responsibilities of AWWs. Two districts of Uttar Pradesh, namely Muzaffarnagar and Saharanpur were covered, and 100 AWWs, 50 from Saharanpur AWTC and 50 from Muzaffarnagar AWTC were selected. AWWs' ability regarding composite skills concerning PSE sessions, namely story telling, narrating children's song, organizing outdoor games, organizing creative activities, organizing number games, organizing word games, etc. was evaluated. It was found that the AWWs who had undergone the JTC were equipped in a better way with five skills namely story telling, narrating children's song, organizing creative activities, organizing number and word games. The AWWs who attended JTC had better composite skills for selection of proper teaching aids, conducting innovative activities, maintaining teaching aids and preparation of teaching aids to conduct PSE. AWWs who had attended the training had significantly better composite skills for communicating with children than those AWWs who had not attended JTC. In the new syllabus of JTC, the practice of STTD (Simultaneous Training Technology Design) has been adopted, in which the trainees not only use their skills in role play, but also practice these skills in institutional settings. There has been a special session on skills for interacting with preschoolers, thus JTC had a significant impact in developing the skills of AWWs to communicate with children more effectively. But there was insignificant difference on the skills of softness in voice and appropriateness of communication at children's level in the field. Most of the time AWWs prepare various teaching aids without keeping in mind that they are to be used for children. The ICDS functionaries lacked the basic directional philosophy of the scheme. They always seemed to need early childhood education aids supplied by state owned agencies. This habit of AWWs negates the basic challenge emanating from the Non-Formal Pre-School Education component of the ICDS Scheme. AWWs of both the groups were able to keep children happy and allowed children to play with toys/play material. The AWWs who underwent JTC did not exhibit significant gain on the composite skill of delivery of supplementary nutrition and its constituent set of two skills, namely maintaining hygiene and distributing supplementary nutrition as per norms under the schematic pattern of the scheme compared to their counterparts who did not attend JTC. After training AWWs had learnt the skill to prepare a variety of foods because there were enough number of sessions during JTC on this. They

could use locally available food stuff and ready to eat food. AWWs who had attended JTC had better composite skills for eliciting community participation than those who had not attended JTC. Both the groups of AWWs had a similar attitude towards running the AWC efficiently but the inner willingness of AWWs to go through the reading material was much more in the case of AWWs who had attended JTC. The syllabus of JTC should be developed according to the educational and professional background of AWWs, trainers of AWTCs and infrastructure and process based facilities available at AWTCs. Intensive research is required (by NIPCCD) to ensure that the concepts introduced are compatible with the understanding of trainers as well as trainees of AWTCs. Training strategies should be designed in such a way that the trainees are adequately prepared to handle the revised syllabus. Trainers guides or handbooks should be made available to all the trainees .

**Key Words** : 1.ICDS 2.TRAINING OF ANGANWADI WORKERS 3.IMPACT OF TRAINING 4.SERVICES DELIVERY 5.DELIVERY OF SERVICES 6.QUALITY OF SERVICES 7.ICDS SERVICES 8.ANGANWADI WORKERS.

19. Vinnarasan, A. (2007).

A Study on factors influencing non enrollment of children in the ICDS anganwadi centres at Chennai Corporation. Chennai : Loyola College, Dept. of Social Work. 170 p.

**Abstract** : This study evaluated the factors influencing non-enrollment of children in ICDS AWCs run by Chennai Corporation. 88 AWCs situated in Adayar, Besant Nagar, Mandaiveli, Santhome, Kotturpuram and Pattinapakkam were covered. Total 150 non-enrolled children aged 2 1/2 to 5 years residing in ICDS area were selected for the study and information was gathered from their mothers. It was found that 47.3% respondents believed that the purpose of existence of the AWC was to look after young children. Respondents mentioned that providing nutrition in the AWC was for the growth of children (47.3%) and to provide nutrition (32.7%) to children. They were aware of the provision of supplementary nutrition, but not aware of the special care given to malnourished children under the supplementary nutrition component of ICDS. 40% respondents mentioned that they were not aware that ECE (Early Childhood Education) contributed to the child's holistic development. 77.3% respondents were approached by either the anganwadi worker or helper for enrollment in the ICDS centre. Only 17.3% respondents had made any attempt to enroll in ICDS. Except 11.3% of the respondents, the others

were not convinced that ICDS had been offering good quality services to the beneficiaries. 29.3% respondents said that poor physical infrastructure was the reason for their child's non-enrollment in the AWC. Every second respondent (50.7%) mentioned that the AWC in their habitation was not friendly. 100% respondents mentioned that providing PSE in the mother tongue was good for the child, and an overwhelming majority (91.3%) felt that teaching in English was also mandatory for the child's future. 34% respondents felt pride in sending their children to English medium preschools. More than half the respondents (60%) had attributed medium of instruction, which was Tamil in AWCs, to be the reason for their child's non-enrollment. 25.3% mothers felt that AWCs attitude was also the reason for not sending their children to the AWC. Nearly 22.7% respondents mentioned that community participation in children's enrollment was high in their habitation. Adequate funds should be allotted to improve the physical infrastructure of AWCs and provide them with basic facilities. Training for the staff should emphasize the value of their work, impart skills to mobilize community support, and also sensitize them about the Right to Participation of children in AWCs. Government should emphasize and strongly enforce the convergence of services to children through different departments. The focus of ICDS should shift to providing quality PSE as the main task, with nutrition and health services playing roles similar to the Mid Day Meals in schools.

**Key Words :** 1.ICDS 2.ENROLMENT OF CHILDREN ICDS 3.NON ENROLMENT ICDS 4.REASONS FOR NON ENROLMENT 5.CHENNAI 6.TAMIL NADU

## LABOUR

20. Singh, C.S.K. (2002).  
Cash and in-kind modes of wage payment in Maharashtra. NOIDA : V. V. Giri National Labour Institute. 26 p.

**Abstract :** Wages, as defined under the Act, means all remuneration capable of being expressed in terms of money. The present study explores the prevalent modes of payment, the workers' preference, and the preference determinants. The study covered five districts of Maharashtra namely, Sangli, Kolhapur, Ratnagiri, Pune and Nagpur. It was found that for the purpose of minimum wages, the State Government has classified workers into three categories: daily rated, *mahinedar* or monthly rated, and *saldar* or *salkari* or working on yearly basis. It

was also observed that the mode of wage payment, cash or in-kind is district neutral, taluk neutral and even village neutral. It is, instead, employment relation specific and crop specific. Cash payment as a principle mode of payment is supplemented by kind component (tea, wheat, chilli, onion, coconut and clothes, etc.) as a subsidiary mode. It was found that in Kalamba village of Kolhapur district a large number of agricultural workers were migrants, both inter district and intra-district. They have been engaged as yearly workers for the last 10-12 years. The workers contracted debts from the employers and became permanent farm servants, getting a monthly wage of Rs.1500/- plus breakfast on paper. The actual cash wage was however Rs.20/- per day only. In Basarage village of Gandhingaj taluk, Pune, the situation was identical. The *Saldar* workers were indebted to employers. Here the wage on paper was Rs.12,000/- per year. In addition a worker gets the following articles in kind: wheat 50 kg, chilli 5 kg, onion 10 kg, and clothes 1 pair. In Karnal village of Sangli district workers receive their share of wage payment in cash. There were instances of labour attachment system in cash crops as well. The farmers of Shankarpur village of Nagpur district employed *saldar* workers who were engaged in the cultivation of guava, chiku (sapota) and papaya. Monthly wage was Rs.1200/- to Rs.1500/- inclusive of deduction by the farm owner for adjusting the debt amount. In Narbe village of Ratnagiri district mango cultivation provides employment for six to seven months per year. The workers were generally yearly workers and some of them were monthly workers also. The cash payment per month was Rs.180/-. The meal component was 0.5 kg rice, 50 gm *dal*, and 50 gm bajra. Workers of Bhatyle in Ratnagiri who climbed the trees were paid Rs. 41/- per day, and the others got Rs. 37/- per day. As an incentive, the worker gets Rs. 4.50 per day. Further, in Kaseli of Rajapur there were seasonal agriculture workers earning Rs. 65/- for making compounds, Rs. 70/- for applying insecticides and Rs. 70/- for plucking. The male workers of Ganjar Dhak Pala of Dahanoo taluk, Nagpur got Rs. 30/- and female workers got Rs. 25/- per day. In Sangwi village of Bhor taluk women workers were paid Rs. 25/- and male workers were paid Rs. 30/- for paddy harvesting. Similarly in Asawe, Dahanoo, daily wage of paddy harvesting was Rs. 30/- in cash. So the workers did not really have a free choice between two alternatives, the choice was conditioned. It was suggested that in a non-barter and highly monetized economy cash payment to workers would not only grant them the freedom to sell their labour power in the labour market, it would also strengthen the wage goods market, which would be beneficial for the economy as a whole.

**Key Words** : 1.LABOUR 2.WAGES 3.MINIMUM WAGES 4.CASH PAYMENT  
5.NON CASH PAYMENT 6.PAYMENT IN KIND 7.PIECE RATE WORK  
8.AGRICULTURAL LABOUR 9.MAHARASHTRA

## NUTRITION

21. Anima Rani and Sharma, Naresh Kumar. (2008).  
An Empirical study of the mid day meal programme in Khurda, Orissa.  
Hyderabad : Hyderabad Univ. Dept. of Economics. 10 p.

**Abstract** : This study aimed to investigate some aspects of the mid day meal (MDM) scheme in Khurda district of Orissa. Secondary data was obtained from district and state level authorities including reports of the Department of Women and Child Development, Government of Orissa. 150 students and their households from 10 schools were selected for the study. Apart from these, information was collected from non-governmental organizations (NGOs) and Government officials. It was reported that MDM was completely implemented as a cooked meal scheme in all the tribal districts and underdeveloped areas like Koraput, Bolangir, Nawarangpur, Sonapur, Malkangiri, Nuapada, Rayagada and Kalahandi. The other districts covered by MDM scheme were Mayurbanj, Sundargarh and Keonjhar. All the 10 block of Khurda district were distributing dry rations from 2001. The distribution rate was 3 kg of rice per child per month. The eligibility criteria for a student to obtain ration in a month was that the student should have 80% attendance in the previous month. The Government of India provides rice free of cost, while the State Government provides the funds to meet the other expenditure like cost of *dal* (15 gms : 35 paisa), vegetable, salt and condiments (10 paisa), oil (30 paisa) and transportation (10 paisa). Total expenditure was 85 paisa per child per day. For fuel and stationary, Rs.1.30 per child per month was spent. It was found that poor infrastructural facilities created disturbance in the smooth functioning of the cooked meal scheme. This was the main reason for shifting over to the dry rations scheme in 2001. The main reasons were no separate space for cooking; no separate place for serving meals; no storage facilities for grains; no proper storage facilities for drinking water; uncertainty about quality of rice; irregular inspection by Government officials; and disruption in the teaching process. It was found that the rate of growth of school enrolment during the cooked meal scheme (1995-96 to 2001) was 3.8% per annum, which was much higher compared to the rate of growth of enrolment of 1.5% per annum, when dry ration scheme was in operation (2000-01 to 2003-04). There was a large increase in the enrolment among boy students (17%) in contrast to the girl students (11%) in the second period over the first period. It was observed that when the cooked meal scheme was in operation, there was a

marginal decline in the gender gap (from 14% to 13% in terms of the girl enrolment as a proportion of boy enrolment); this gap however widened to 16% after the switch was made to dry rations. During the household survey, it was reported by 150 households that enrolment had certainly increased when cooked meals were served. Parents were happy that their children got nutritious meals. 5 schools reported an increase in attendance, four schools reported that there was constant attendance, and in 1 school attendance was reduced. 5 schools reported decrease in the number of dropouts after the introduction of the cooked meal scheme, and four schools talked about consistency in the dropout rate. After dry rations were introduced, four schools reported an decrease in dropouts, and six schools said that dropout rates have remained constant. All schools reported an increase in nutritional status of the children after the introduction of cooked meal in their diet. 8 schools reported that the change in nutritional status of children was positive in the case of dry ration, and two schools reported consistency in the nutritional status. 102 housewives and 11 working mothers welcomed the cooked meal scheme. Only 10 working mothers and 11 housewives supported dry ration scheme. Further, 145 households feel that children had been motivated to go to school due to the cooked meal scheme. In contrast, only 19 households found that dry scheme had a motivating effect on students. 132 households (88%) felt that the cooked meal scheme should be re-started, and only 18 households (12%) were against this view. On the other hand only 30 (20%) households hold the view that dry ration should continue to be distributed. It was suggested that inadequacy of staff should be rectified. The menu of the food should be changed from time to time to break the monotony.

**Key Words :** 1.NUTRITION 2.MID DAY MEAL 3.COOKED MEALS 4.READY TO EAT MEALS 5.SCHOOL LUNCH 6.ORISSA.

22. Bhandari, Nita et al. (2003).  
Effect of community based promotion of exclusive breastfeeding on diarrhoeal illnesses and growth : a cluster randomised controlled trial. New Delhi : AIIMS, Dept. of Pediatrics. 6 p.

**Abstract :** In developing countries, breastfeeding is common but exclusive breastfeeding is not. The present study was carried out to assess the feasibility and effectiveness of an educational intervention to promote exclusive breastfeeding in India. The study was conducted in Haryana during 1998-2002. In the Intervention Project, health and nutrition workers were trained to counsel

mothers for exclusive breastfeeding at multiple opportunities. Traditional birth attendants (TBAs), local village based workers namely Anganwadi workers (AWWs) of the ICDS Scheme, auxiliary nurse midwives (ANMs), and other health care providers were trained to counsel mothers/ caregivers. 1115 infants, born in the 9 months after the functionaries were trained, were taken for the study, 552 in the intervention and 473 in the control communities. Feeding at the age of 3 months, anthropometry and diarrhoea prevalence at age 3 months and 6 months were assessed. It was found that exclusive breastfeeding rate at the age of 3 months was 381 (79%) in intervention and 197 (48%) in control groups. About 22% children in the intervention group and 30% children in the control group had suffered from diarrhoea in the 7 days preceding the study. 50% women and 15% men have never been to school. Maternal under nutrition was high, and 26% married women have body mass index (BMI) less than 18.5 kg/ m<sup>2</sup>. Health care is provided through primary health centres, each of which serves a population of about 30,000 through two or three medical officers, auxiliary nurse midwives and other ancillary staff. There were six sub-centres attached to each primary health centre. Exclusive breastfeeding rates in infants aged 4-6 months were 5% (78) and 8% (74) in the intervention and control communities, respectively. Similarly, 13% (195) infants younger than six months in the intervention group had diarrhoea in the previous 7 days compared with 15% (196) in the control areas. By age 3 months more infants and mothers in the intervention than in the control communities had been visited at home by Anganwadi Workers (254 (53%) vs. 110 (27%)), had attended weighing sessions (202 (42%) vs. 22 (5%)) and immunization sessions (414 (86%) vs. 330 (80%)), had visited a primary health centre (80 (17%) vs. 28 (7%)), and had met with an auxiliary nurse midwife at the monthly meeting (71 (15%) vs. none). The intervention had a small effect on the proportion of infants delivered by traditional birth attendants (384 (70%) vs. 305 (66%)). The proportion of health worker to mother interactions in which mothers spontaneously recalled being counselled on exclusive breastfeeding was 49% (218) vs. 1% (3) in immunization sessions, 61% (155) vs. 2% (2) during home visits and 61% (123) vs. none at weighing sessions. Information obtained during home visits when infants were aged 3 months showed that pre-lacteal foods of honey, tea and diluted milk were fed to 31% neonates in the intervention group compared to 75% in the control communities, and many more children were exclusively breastfed in the intervention group. At the 3 month and 6 month visits, fewer mothers in the intervention areas than in control areas reported infants with diarrhoea in the previous 7 days. It was recommended that infants should be breastfed exclusively till 6 months of age.

**Key Words** : 1.NUTRITION 2.BREASTFEEDING 3.IMPACT OF BREASTFEEDING 4.DIARRHOEA 5.INFANT GROWTH 6.VISTAAR PROJECT.

23. Bhandari, Nita et al. (2004).

An Educational intervention to promote appropriate complementary feeding practices and physical growth in infants and young children in rural Haryana, India. New Delhi : AIIMS, Dept. of Pediatrics. 7 p.

**Abstract** : More than 60% of the children living in South Asia are malnourished. Complementary feeding practices are often inadequate in developing countries, resulting in a significant nutritional decline between 6 and 18 months of age. Primary Health Centres (PHCs) provide health care; each serves a population of ~30,000 through 2 or 3 Medical Officers, auxiliary nurse midwives, and other ancilliary staff. There were 6 Sub-Centres (SCs), serving a population of ~5000, attached to each PHC. The study was conducted in the state of Haryana in India. Training was given to health and nutrition workers including ICDS Anganwadi workers regarding detection of feeding problems, negotiation with mother on possible solutions, starting complementary feeding at 6 months of age, the specific foods, meal frequencies, food density, inclusion of locally accepted foods, etc. The effect of the intervention was measured on child feeding practices and growth between 6 and 18 months of age. A total of 1115 infants were identified from 8 communities. Of these 1025 were available at the baseline visit, 552 in the intervention and 473 in the control communities. The children available in the intervention and control groups for the measurement of outcomes at the age of 6, 9 and 18 months of age were 468 (84.8%) and 412 (87.1%), 451 (81.7%) and 403 (85.2%), and 435 (78.8%) and 394 (83.3%) respectively. Intervention exposures were reported for the previous 3 months interval as elicited through interviews at infant ages 9 and 18 months. At the 9 months visit, a higher proportion of infants in the intervention group compared with those in the control communities had one or more of the following contacts in the last 3 months: home visits by Anganwadi workers (67% vs. 31%), attendance at weighing sessions (47% vs. 1%), immunization sessions (77% vs. 85%) and visits to primary health centres or private practitioners (77.8% vs. 80.4%). Over a fourth of caretakers in the intervention communities had attended one or more meetings conducted by auxiliary nurse midwives (27% vs. 0.2%). Caretakers in the intervention communities reported being counselled more frequently at these contacts; the proportion who spontaneously recalled being counselled on optimal complementary feeding practices was 34% vs. 0.2% at the immunization sessions, 43% vs. 0.5% at home visits, and 36% vs. 0% at weighing sessions, in the intervention and control communities respectively. The intervention group children attained higher length at 12 months and had higher increment in length between 6 and 12 months of age. The proportion of children with height for age Z

scores less than – 2SD did not differ between the 2 groups. Among males, the intervention resulted in a 0.37 cm higher attained length at 18 months (95% CI, 0.08, 0.66). The 24 hour breastfeeding frequency in the control group children at 9 months was  $6.6 \pm 3.0$  and it was  $7.8 \pm 3.0$  in the intervention group. The breastfeeding frequency was similar in the 2 groups at 18 months of age. The proportion of children breastfed at 9 months was 90.8% in the control communities and 94.7% in the intervention communities. The proportion of children breastfed was similar at 18 months of age (72.2% vs. 70.8%). At 9 months, 34.8% mothers in the intervention group reported that they actively encouraged their child to eat more compared with 7.7% in the control group. It was suggested that educational interventions can improve feeding practices, but the effect of such interventions on physical growth varies in different settings.

**Key Words** : 1.NUTRITION 2.INFANT AND YOUNG CHILD FEEDING 3.COMPLEMENTARY FEEDING 4.NUTRITION EDUCATION 5.CHILD GROWTH 6.INFANT GROWTH 7.INFANT FEEDING PRACTICES 8.VISTAAR PROJECT.

24. Bhandari, Nita et al.(2005).

Use of multiple opportunities for improving feeding practices in under twos within child health programmes. New Delhi : AIIMS, Dept. of Pediatrics. 9 p.

**Abstract** : Under-nutrition is associated with over half of the 11 million childhood deaths that occur annually all over the world. The present study was carried out to promote exclusive breastfeeding and appropriate complementary feeding practices in under twos to ascertain the feasibility of using available channels for nutrition counseling, their relative performance, and the relationship between intensity of counseling and behaviour change. A community based controlled, effectiveness trial was carried out in rural Haryana. Following channels were used for the intervention: 1. traditional birth attendants to counsel on immediate and exclusive breastfeeding at birth; 2. local village based workers (anganwadi workers) belonging to ICDS scheme to counsel mothers of children under two; 3. auxiliary nurse midwives to counsel mothers at immunization clinics; and 4. primary health centre physicians and private practitioners to counsel caregivers. A total of 1025 newborns were enrolled in the cohort, 552 in the intervention and 473 in the control group. In the cross sectional survey, a total of 2350 interviews were conducted (1173 in the intervention and 1177 in the control communities). The majority of births were assisted by traditional birth attendants (TBA); 72.5% in the

intervention communities and 67.7% in the control areas. Immunization contacts were the most common opportunities for counselling during the first 9 months of life. Beyond 9 months, health care provider visits were the most common opportunity. Mothers of over 95% of the children aged 3-18 months were exposed to at least one of the channels of counselling, 26% to 34% were exposed to at least 2 channels, and 29% to 34% were exposed to three or more channels. Monthly meetings conducted by auxiliary nurse midwives (ANMs) with community representatives, and neighbourhood meetings held by community representatives were additional opportunities that generated awareness about the intervention. The highest attendance of caregivers of infants in the cohort at monthly meetings was 28.4% at the 12 months assessment; for neighbourhood meetings it was 20.2% at 18 months. Rates of counselling by dais for the intervention group were 32% for immediate breastfeeding, 14.3% for advice on not giving any water, and 18% for advice against administering *ghuttis*, a herbal product. There was a significant increase in the proportion of caregivers counselled during home visits at 6 months. Between 6-9 months of age, home visits were the most reported source of counselling (42.6%), followed by immunization and weighing sessions; these rates were similar for the 9 to 12 months period. Counselling during home visits and weighing sessions continued to be important, but counselling and immunization sessions declined as expected, because fewer children were brought for immunization at this age. Between 30% and 47% mothers were not counselled by any channel, 25% by 2 to 3 channels; and counselling by all 4 channels was rarely reported between birth and 18 months. Among the 155 mothers who reported being counselled through only one channel at the 3 month assessment, immunization clinics (56.7%) were the common source of counselling, followed by home visits (28.4%), weighing sessions (11.6%), and sick child contacts (3.2%). At the 9<sup>th</sup> month assessment, in those who reported being counselled only once, home visits (48.6%) were the most common source of counselling, followed by weighing sessions (31.3%), and immunization sessions (27.1%). Mobilizing anganwadi workers and mothers was more rewarding in terms of counselling than training health workers. Moreover, it was feasible to use multiple opportunities available within existing programmes, without affecting routine services, and some of these are substantially enhanced by the approach.

**Key Words** : 1.NUTRITION 2.INFANT AND YOUNG CHILD FEEDING 3.COMPLEMENTARY FEEDING 4.INFANT FEEDING 5.YOUNG CHILD FEEDING 6.UNDER TWOS 7.NUTRITION COUNSELLING 8.NUTRITION EDUCATION 9.HARYANA 10.VISTAAR PROJECT.

25. Gopalan, C. (2008).

NFI Bulletin, 2008 Jul, 29(3) : Vitamin A deficiency - overkill. New Delhi Nutrition Foundation of India. 8 p.

**Abstract** : The nutrient that has been occupying centre stage in the international nutrition scene, for over 3 decades, has been Vitamin A. Vitamin A is an important essential nutrient involved in quite a wide range of metabolic functions. Data from National Nutrition Monitoring Bureau (NNMB) and Indian Council of Medical Research (ICMR) micronutrient surveys indicates that over decades there had been a reduction in the prevalence of Bitot's spots which is caused due to the deficiency of Vitamin A. Vitamin A administration was associated with a reduction in childhood mortality and was taken up in 72 blocks in Uttar Pradesh, India between 1999-2004. In this study, children from different areas were given six monthly massive dose of Vitamin A, six monthly de-worming or both or neither. About 1 million children were followed longitudinally and mortality rates in 1-6 years old children were recorded. There was no significant difference in the death rates between children who received the massive dose of Vitamin A and those who did not. It was well known that massive doses of Vitamin A could lead to acute toxicity symptoms in a certain proportion of cases. These toxic symptoms consisted of signs of increased intracranial tension. It was found by a study in Assam that several children died as a result of massive dose of Vitamin A which attracted severe censure and condemnation from the judiciary. It was found that currently 38% of Indian children were stunted with linear growth levels below 2 SD of the international standard. The prevalence of stunting in India is higher than that in Sub-Saharan Africa. Detailed studies have shown that in children of poor communities, the downward deviation from normal growth sets in during the third and fourth months of infancy and progresses till the fifth year of age. According to available survey reports of the NNMB (National Nutrition Monitoring Bureau) Bitot's spots, the mild form of Vitamin A deficiency, was seen in just 0.7% of children under 5 years of age in India. There were reports to showed that 90% of children suffered from anaemia. The emergence of the dual nutrition burden should therefore be considered as an opportunity to improve nutritional status of the population by combating both Vitamin A deficiency and excess of Vitamin A through nutrition and health education.

**Key Words** : 1.NUTRITION 2.RESEARCH NUTRITION 3.VITAMIN A DEFICIENCY 4.DIETARY INTAKE 5.FOOD CONSUMPTION 6.NUTRITIONAL STATUS WOMEN.

26. Institute of Health Management Pachod, Pune. (~2005).  
Reducing iron deficiency anaemia and changing dietary behaviours among adolescent girls in Maharashtra, Pune : IHMP. 2 p.

**Abstract** : India has the highest prevalence of iron deficiency anaemia among women in the world. The present study was carried out on 1142 adolescent girls residing in 16 slums of Pune from 2000-2003. The main objective was to increase the number of daily meals adolescent girls eat from 2 meals to 3-4 meals, and to encourage girls to consume iron rich foods on a daily basis. Weekly iron and folic acid tablets were given in the first 3 months; ongoing nutrition education through home visits and meetings was done by community health workers, participatory activities were undertaken such as food fairs, community projects were undertaken through IHMP's life skills programme; audiovisual materials such as flash cards and posters were developed by the adolescent participants. Blood samples were collected at baseline and end of the study, and haemoglobin was estimated. Findings showed that anaemia is significantly more likely among girls who eat two or fewer meals in a day, have been sick in the past year, and consume few iron rich foods. It was also found that intervention has influenced dietary behaviour with a significant increase in the intervention site compared to the control site in the percentage of girls who eat more than 3 meals a day, eat lemon with their meals, as well as in the frequency of eating fruits. Blood testing showed that mean Hb levels increased from 5.8 to 9.5 gm/ dl for severely anaemic girls, and from 8.9 to 11.2 gm/ dl for moderately anaemic girls. It was suggested that Government's Anaemia Prevention and Control Programme should focus on adolescents. Participatory nutrition education can influence adolescent girls' anaemia status and dietary behaviour. Iron supplementation programmes need to include nutrition education programmes to be effective. Key dietary behaviour messages for girls include: eating more than 3 meals a day, eating with family so as to eat enough, eating green vegetables daily, and eating lemon or *amla* with meals. More effective methods need to be devised for community based Hb testing.

**Key Words** : 1.NUTRITION 2.ANAEMIA ADOLESCENT GIRLS 3.BEST PRACTICES 4.ADOLESCENT GIRLS ANAEMIA 5.GOOD PRACTICES 6.INTERVENTION PROGRAMME 7.INSTITUTE OF HEALTH MANAGEMENT PACHOD 8.VISTAAR PROJECT.

27. Kotecha, Prakash V., Karkar, Purvi and Nirupam, Siddharth. (~2005). Adolescent girls anaemia control program. Ahmedabad : Medical College Vadodara, Dept. of Preventive and Social Medicine. 31 p.

**Abstract** : Anaemia is widely prevalent among adolescent girls (AGs). The present study was initiated by Government of Gujarat with the main aim to ensure that 90% of the adolescent girls (13-19 years) in schools and 70% of out of school girls participate in weekly consumption of IFA tablets under supervision. The Anaemia Control Programme is operational in 410 schools covering 65,000 adolescent schoolgirls as beneficiaries. 30 schools were taken at baseline from urban (10), rural (10), and tribal (10) areas. To measure anaemia prevalence, haemoglobin (Hb) level and serum ferritin levels were measured at baseline and endline, and the difference was seen. A total of 2766 AGs were available for final analysis. Anaemia prevalence (Hb<120 gm/ l) was recorded as 53.2% at endline compared to baseline anaemia prevalence of 74.7%. There was a reduction of 21.5% in anaemia prevalence after initiation of the programme. The reduction achieved was maximum in rural areas followed by urban areas, both showing a net reduction of over 23%, while tribal areas showed a reduction of about 16%. Mean rise of haemoglobin was seen to the extent of 6.4 gm/ dl with regional differences, and maximum rise was seen in rural areas, followed by urban areas. Severe anaemia prevalence reduced from 1.6% at baseline to 0.5% at endline. Reduction values for moderate and mild anemia were 51% and 22% points. A total of 804 samples were studied for serum ferritin in the present study. The proportion of girls having serum ferritin less than 12 µg/ ml, indicative of poor iron storage, declined from 49.7% to 39.4%, and the decline was consistent in all the areas. The median ferritin of the group increased from 12 mg/ ml to 16.5 mg/ ml, and the improvement was recorded across all ages. Results revealed that 34.9% of the anaemic girls became non-anaemic. About 19.8% non-anaemic girls, that is 5.1% of the total girls (52/1016), became anaemic. Net reduction of anaemia prevalence was 20.8% (74.2% to 53.4%). Maximum reduction of anaemia prevalence (25.2%) was observed in urban areas, followed by rural areas (22.8%), and tribal areas (12.7%). Out of 2766 girls, 72.4% mentioned that they received the brochure; more rural and tribal girls reported this as compared to urban girls. 87.2% of the girls had read the brochure, either by themselves (57.2%), or with their friends (55.1%), or with their teachers and friends (23.1%). 99% respondents recalled at least one correct message. 37.8% of the girls had actually seen posters related to the Anemia Programme in their schools. Majority of those who responded (90%) were able to give correctly the name of the condition of pale

blood, anaemia or *pandurog* (anaemia). 66.6% of the girls could not correctly reply when asked to name the nutrient which leads to pale blood. Only 12.1% answered iron or '*Loahtatva*'. 7.5% mentioned 3 or more correct signs or symptoms of anaemia. IEC material had been received and read by most of the girls. However, the understanding of messages and retention of information was not fully satisfactory. It is still to be explored, how best IEC can be used adequately. This may mean more motivation, systematic monitoring of IEC uses, and enhanced emphasis on IEC during training.

**Key Words** : 1.NUTRITION 2.ANAEMIA ADOLESCENT GIRLS  
3.ADOLESCENT GIRLS ANAEMIA 4.INTERVENTION PROGRAMME ANAEMIA  
5.GUJARAT 6.VISTAAR PROJECT.

28. Mishra, Rudra Narayan. (2007).  
Nutritional deprivation among Indian pre-school children : does rural-urban disparity matter?. Ahmedabad : Gujarat Institute of Development Research. 34 p.

**Abstract** : India is one of the few countries in the world where there is poor nutritional status among many young children, which is detrimental to their health outcome. The present study was done to evaluate the achievement of Indian states on 3 anthropometric indicators (Height-for-age, Weight-for-age and Weight-for-height), to measure the prevalence of child nutrition. Data collected from all 28 states of India through NFHS-2 (1998-99) and NFHS-3 (2005-2006) was analysed. The rural-urban difference for states in NFHS-3 showed that Rajasthan had the highest difference of 13.5% points in child stunting, followed by Punjab (12.5%) among states of northern India. In the western region in Maharashtra, the rural-urban difference was 10.9% in 1998-99 which came down to 5.5% in 2005-06. The prevalence of stunting in Gujarat was nearly stagnant in all the 3 rounds, 42.4% in 2005-06, 43.6% in 1998-99 and 43.6% in 1992-93. The rural-urban difference was also stagnant at around 8%. In Kerala, southern India, the prevalence of child stunting was minimum and the rural-urban difference was also very nominal (-0.2%). And Tamil Nadu was the next best state where aggregate prevalence of stunting was about 25%. At all India level, the prevalence of stunting showed gradual decline from NFHS-1 (52% in 1992-93) to NFHS-3 (38.4% in 2005-06). Using weight-for-age of children as an indicator, Punjab had the lowest prevalence of underweight (27%) children among all other counterparts of northern India. The situation in Madhya Pradesh had worsened as prevalence of

underweight among pre-school children had increased from 57.4% in 1992-93 to 60.3% in 2005-06. In eastern India the concentration of under-weight among young children was very high in West Bengal, Bihar, and Chhattisgarh. For Bihar and Jharkhand the prevalence of underweight had increased from 54.3% each in 1998-99 to 58.4% and 59.2% in 2005-06. Among North-Eastern states, Meghalaya (46.3%) had the highest prevalence of underweight. Maharashtra had highest decline in prevalence of underweight in all the 3 rounds at State level, (12.9%), as well as in rural areas (14%). In south India, Kerala continues to be the best performer in the region, in all the 3 rounds (28.8% in 2005-06, 26.9% in 1998-99 and 28.5% in 1992-93). At all India level, the prevalence of underweight had come down marginally between NFHS-2 and NFHS-3 (from 47% to 45.9%). For northern India, it was found that wasting increased over the period of time at aggregate level, especially in the last phase, for all states in the region. The situation worsened in Madhya Pradesh, where the aggregate prevalence of wasting increased from 20.2% in NFHS-2 (1998-99) to 33.3% in NFHS-3 (2005-06). In eastern India the prevalence of wasting had come down in Chhattisgarh and Orissa in the NFHS-2, whereas for Bihar, Jharkhand and West Bengal, prevalence of wasting among young children has shown an increase in all the 3 rounds. Among the North-Eastern states, Meghalaya had the highest prevalence of wasting. The prevalence of wasting among young children had come down in the second phase among Western states, specially in Goa and Maharashtra. The prevalence of wasting among all the Southern states except Karnataka (where it has come down from 20% to 17.9%) has gone up between the last two rounds of NFHS. Future intervention programmes aiming at reducing undernourishment among Indian children should be more focussed.

**Key Words :** 1.NUTRITION 2.NUTRITIONAL STATUS PRESCHOOL CHILDREN 3.PRESCHOOL CHILDREN 4.UNDERNUTRITION 5.MALNUTRITION 6.PERFORMANCE OF STATES.

29. Moretti, Diego, et al. (2006).  
Extruded rice fortified with micronized ground ferric pyrophosphate reduces iron deficiency in Indian school children : a double-blind randomized controlled trial. Bangalore : St. John's National Academy of Health Sciences. 8 p.

**Abstract :** Iron fortification of rice could be an effective strategy for reducing iron deficiency anaemia in South Asia. The study aimed to determine whether

extruded rice grains fortified with micronized ground ferric pyrophosphate (MGFP) would increase body iron stores in children. The study was carried out in Franciscan School of Bangalore on 970 students, of 4-14 years. It was found that mean ( $\pm$ SD) daily iron intakes in 6-13 years old children were  $5.0\pm 2.2$  mg (boys) and  $4.7\pm 2.2$  mg (girls). Only 6% was heme iron. Estimated dietary iron bioavailability ranged between  $4.5\pm 2.3\%$  and  $6.5\pm 2.9\%$  (boys) and between  $4.6\pm 2.0\%$  and  $7.1\pm 8.2\%$  (girls) depending on the model used to assess iron bioavailability. The sensory study showed that at both 3 and 5 mgFe/ 100 g rice, fortified and unfortified uncooked rice were indistinguishable. Similarly, in all the cooked recipes – plain white rice, vegetable rice, lemon rice, tomato rice and tamarind rice – the meals containing rice fortified at 3 mgFe/ 100 g were indistinguishable from the meals containing unfortified rice. The mean ( $\pm$ SD) iron content of the lunch meals served to the iron fortified and control groups were  $19.2\pm 2.5$  and  $1.2\pm 0.6$  mg Fe/ meal, respectively. For specific meals, the mean ( $\pm$ SD) iron content per daily serving of the unfortified tomato rice, lemon rice and vegetable *pulao* meals was  $1.0\pm 0.2$ ,  $1.6\pm 0.2$  and  $1.4\pm 0.6$  mg respectively. The mean ( $\pm$ SD) phytate content of the tomato rice, lemon rice and vegetable *pulao* was  $95\pm 20$ ,  $120\pm 30$  and  $175\pm 15$  mg, respectively. No detectable ascorbic acid was present in any of the cooked samples received. It was observed that the prevalence of Iron deficiency (ID) decreased from 78% to 25% in the iron fortified group and from 79% to 49% in the control group. By logistic regression, there was significant time X treatment interaction for ID, whereas IDA was not significantly affected by treatment ( $p=0.161$ ) or time ( $p=0.453$ ). However, the prevalence of IDA decreased from 30% to 15% in the iron fortified group and remained virtually unchanged in the control group (28% and 27%). There was no significant difference in mean C-reactive proteins (CRP) or the prevalence of elevated CRP values between the 2 groups from baseline to the midpoint of the study, with the prevalence increasing from 7.6% to 20% in the iron fortified group and from 9% to 17% in the control group. There was no significant evidence of an effect of treatment on the frequency or severity of infectious disease, as measured by the questionnaire. At baseline, mean Z scores in the entire sample were as follows – height for age,  $Z=1.36$  ( $SD=1.17$ ); weight for age,  $Z= -2.09$  ( $SD=1.11$ ); and weight for height,  $Z= -1.77$  ( $SD=1.12$ ). Findings indicated that providing iron-fortified extruded rice grains in a school feeding programme is an effective iron fortification strategy. Whether applied more generally or targeted to school feeding programmes, extruded – iron fortified rice could help reduce the large burden of ID and IDA in the rapidly growing urban populations of South and Southeast Asia.

**Key Words** : 1.NUTRITION 2.ANAEMIA 3.FOOD FORTIFICATION 4.SCHOOL LUNCH 5.SCHOOL FEEDING PROGRAMME 6.MICRONUTRIENT DEFICIENCY 7.VISTAAR PROJECT.

30. Ramachandran, Prema. (2008).  
NFI Bulletin, 2008 Jul, 29(2) : changing food consumption patterns in India.  
New Delhi : Nutrition Foundation of India. 8 p.

**Abstract :** The NSSO has been carrying out Consumer Expenditure Survey at roughly at 5 year intervals for assessing the impact of economic, agricultural and food distribution related interventions on food consumption over time in different states in urban and rural areas and in different income groups. Data from the 27,32,38,43,50,55 and 61<sup>st</sup> Rounds of NSSO on consumption expenditure on food and non-food items show that there has been a decline in the proportion of expenditure on food items in the last three decades in both urban and rural areas. The decline is mainly due to low cost of cereals which are the major source of energy in Indian dietaries, and it was seen in all income groups. The share of cereals in household expenditure has fallen from 41% to 18% in rural India and from 23% to 10% in urban India over the same period. Over this period, the expenditure on pulses has remained more or less the same in all the income groups. However, because of the soaring cost of pulses, there has been a decline in pulses consumption in all the income groups. Among the upper income groups, there has been a greater dietary diversification with increase in consumption of milk and animal products; as a result, in these income groups there has not been any decline in protein intake in spite of reduction in pulse intake. However, among the poorer segments of the population, pulses remain the major source of protein and lower pulse consumption can result in further reduction in already low protein consumption. NSSO Survey data showed that there has been an increase in the per capita consumption of edible oil. There has been a rise in oil consumption both in rural and urban areas. Vegetable oils such as groundnut, mustard oil, soya oil, sunflower oil are the major oils used. The growing consumption of empty calories from oils, fats, sugars and beverages is a matter of concern, because they contribute to the increasing prevalence of over-nutrition in all age groups, especially among the urban affluent segments of the population. NSSO Consumer Expenditure Data shows that there has been a slow but steady decline in energy intake in rural areas. In urban areas there has been a very small reduction in energy intake between mid seventies and mid nineties. There was a small rise in 1999-2000 but in 2004-05 the energy intake was lower than in all the previous years. There has been a small but steady decline in protein consumption in rural areas between 1973 and 2004-05; this is mainly attributable to the decline in cereal and pulse consumption. The protein consumption in urban areas has remained unaltered perhaps because of the increasing consumption of milk and animal products. However, in 2004-05 average fat intake contributed to less than 15% of the total energy intake. There were relatively large inter state differences in

protein consumption. Intake is relatively low in states like Tamil Nadu, Karnataka, Orissa and West Bengal where rice is the major cereal consumed and pulse consumption is low. India is currently undergoing rapid socio-economic demographic, health and nutritional transition; and NSSO Surveys can help nutrition scientists to monitor the on-going transition in household food consumption, identify beneficial and adverse trends, and initiate appropriate interventions.

**Key Words** : 1.NUTRITION 2.RESEARCH NUTRITION 3.DIETARY INTAKE 4.FOOD CONSUMPTION 5.EXPENDITURE ON FOOD 6.GROWTH 7.GROWTH RETARDATION 8.ANTHROPOMETRIC INDEX.

31. Right to Food Campaign Madhya Pradesh Support Group, Bhopal. (2006).  
Malnutrition disaster in Madhya Pradesh : a sad picture of chronic hunger and un-accountable system. Bhopal : RFCMPSG. ~30 p.

**Abstract** : Malnutrition is one of the most sensitive and burning issues in Madhya Pradesh. Data provided by the Government of Madhya Pradesh shows that about 5.7 million children were malnourished. The study showed that in the state of Madhya Pradesh alone there were 10.6 million children in the age group 0-6 years and out of these only 2.33 million have been brought into the realm of the Integrated Child Development Services Scheme, which aims to providing a reasonable level of nutrition to poor children. Data collected by Kuposhan Niwaran Abhiyan (Malnutrition Elimination Campaign), which was carried out in 5 phases, showed that the percentage of malnourished children in the first round was 57.57% and it was 55.24% in the fifth phase. In the year 2001, in a study conducted by CEHAT, it was found that 80% children of Bhil tribal community were severely malnourished. The inadequate allocation of funds was also a major issue which proved the negligence of the State towards the problem of malnutrition. According to the Planning Commission's assessment of fund requirements, funds needed for SNP (Supplementary Nutrition Programme) for children (0-4 years old) and mothers in Madhya Pradesh were Rs.211 crores (Rs.2110 million), but instead of that only Rs.59 crores (Rs.590 million) were made available by the State Government. Some regions of Madhya Pradesh were the worst affected. These were Chhattarpur where 8 children died due to malnourishment and measles within a period of 12 days, Damoh where 7 children died due to malnutrition within 2 months, Khandwa, Shivpuri, Morena and Sheopur where 13 children died within 3 weeks. There is urgent need to improve the health and nutritional status of children aged 0-6 years by expanding the supplementary

nutrition programme (SNP) and bringing more children under its ambit, and by improving coordination within State Health Department to ensure delivery of required health inputs in remote areas.

**Key Words :** 1.NUTRITION 2.MALNUTRITION MADHYA PRADESH 3.HUNGER 4.RIGHT TO FOOD 5.CHRONIC HUNGER 6.COMBATING MALNUTRITION 7.MADHYA PRADESH.

32. Verma, Jessica L. et al.(2007).

Community level micronutrient fortification of a food supplement in India : a controlled trial in preschool children aged 36-66 months. Child in Need Institute. Kolkata : CINI. 7 p.

**Abstract :** Children participating in the ICDS in India have high rates of iron and Vitamin A deficiency. This study was conducted in 30 AWCs of Mahestala block in South 24 Parganas, West Bengal to assess the efficacy of a premix fortified with iron and Vitamin A added at the community level to prepared *khichdi*, a rice and *dal* mixture. All attending children received a single 200 gm portion of the *khichdi* treatment assigned to their AWC 6 times a week for 24 weeks. For each 200 gm serving of *khichdi*, the premix provided 14 mg encapsulated ferrous fumarate, 500 International Unit (IU) Vitamin A (retinyle acetate: particle size of 250; cold water soluble) and 0.05 mg folic acid. The placebo premix contained only dextrose anhydrous. Both premixes were packed in resealable polyethylene bags in 500 gm increments. Each selected AWC received 500 gm premix at baseline and after 3 months of the intervention. After 2 weeks of the intervention, 85% AWWs had minor problems with the packaging of the premix, including breakage of the polyethylene bag and failure of the bag to properly seal. Total 684 children were screened and enrolled, 168 (24.5%) were lost to follow-up (dropped out) before the 24 week assessment; thus 516 completed the 24 week trial. Reasons for loss to follow-up were refusal of further venipuncture (n=161), change of location (n=5), and low attendance at the AWC (n=2). Most of the characteristics of the children who dropped out of the study did not differ significantly from those of the children who completed the trial, including the age, sex, iron status, and mean haemoglobin concentration. However, the prevalence of anaemia was significantly greater in the children lost to follow-up (35.1%) than in those who completed the trial (26.2%) ( $p < 0.05$ ). Prevalence of anaemia in fortified group was 19.1% at 0 week; 9.8% at 12 weeks; and came down to 4.1% at 24 weeks. Similarly in non-fortified group it was 32.6% at 0 week; 13.3% at 12 weeks and 20.7% at 24

weeks. Iron deficiency in fortified group was 22.5% at 0 week; 10.2% at 24 weeks; and in non-fortified group it was 20.7% at 0 week and 30.4% at 24 weeks. Prevalence of Vitamin A deficiency of fortified group was 17.5% at 0 week; and 8.1% at 24 weeks; and in non-fortified group it was 13% at 0 week; and 6.3% at 24 weeks. Low Vitamin A status in fortified group was 47.9% at 0 week and came down to 21.5% at 24 weeks. Similarly, in non-fortified group, low Vitamin A prevalence was 40.8% at 0 week, and it came down to 20.4% at 24 weeks. The failure of the fortified *khichdi* to increase serum retinol concentrations or to reduce the prevalence of Vitamin A deficiency and low vitamin status might have resulted because of the deterioration of Vitamin A in the fortified premix. The addition of a fortified premix to *khichdi* in ICDS AWCs provides an excellent opportunity to provide the needed micronutrients to children with or at risk of micronutrient deficiencies through out India. It also would be an effective means of meeting the micronutrient malnutrition needs of pregnant and lactating women and of younger children who are consuming solid foods.

**Key Words** : 1.NUTRITION 2.ANAEMIA PRESCHOOL CHILDREN 3.FOOD FORTIFICATION 4.IRON SUPPLEMENT 5.VITAMIN A 6.NUTRITION AND ICDS 7.ICDS AND NUTRITION 8.MICRONUTRIENT DEFICIENCY 9.VISTAAR PROJECT.

## **SOCIAL DEFENCE**

33. Malhotra, Charu. (2007). Internally displaced people from Kashmir : some observations. New Delhi : JNU, Centre for the Study of Social Systems. 11 p.

**Abstract** : In the Indian context, there was conflict-induced displacement in Kashmir. Large scale internal displacement of Kashmiri Pandits took place from the Kashmir valley during 1980-90. The Kashmiri Internally Displaced Persons (IDPs) exist as a heterogeneous group. The present study defines how Kashmiri people could be identified as 'Internally displaced persons'. The study was carried out among IDPs in camps in Jammu region and in apartments in Noida. In Noida there were 600-700 families who were Kashmiri IDPs. According to the data gathered from Relief Commissioner's Office in Jammu there were around 34,131 registered displaced families living in Jammu region, 5889 families were living in camps around Jammu region, 19,338 families were living in Delhi, and the rest

were living in other parts of country. The informants in camps in Jammu reported to have come in a crowd, as they were familiar with the place. The presence of friends or relatives provided support, and for economic reasons the informants could not move beyond Jammu. Some of the displaced people (DPs) moved to Noida because it was in the National Capital Region (NCR) which has an abundance of job opportunities. Another added advantage for moving to Noida was the availability of cheap apartments. In Jammu, apart from rented accommodation and private houses, the Kashmiri IDPs lived in various camp areas. Most of interviewees in camps in Jammu region had land in the form of poultry farms, dairy farms, orchards or were engaged in agri-business. The study showed that government officials were not entitled to any relief or cash payment, only basic pay, while the non-government family heads were entitled to relief in the form of ration and cash payments of Rs. 3000 per family per month. Most of the people interviewed in Noida were from Srinagar city and they were government officials. They reported that they moved because of economic security of jobs. Initially, for a few months, people in camps in Jammu lived in cloth tents, which would get soaked in the rains or get blown away due to winds. Although there was provision of electricity, water had to be fetched from a distance. The Government had provided ORTs (One Room Tenements) for displaced people after much persuasion. The ORTs had tinned roofs and were small structures about 10 feet by 15 feet. Informants reported that it was suffocating for entire families comprising about 4-5 persons to be cooped up, and they termed these ORTs as *kabutarkhanas* (pigeon cages). Informants reported that relations between neighbours were quite good and helpful. Respondents in Noida mentioned that the bonding was weaker between neighbours in Noida as compared to the bonding in Kashmir. Displacement had also led to corresponding changes in the form of the family. Respondents mentioned that certain festivals had lost their significance after displacement and their cognitive life/ world had been altered. Internally displaced children faced challenges to their inheritance, culture and linguistic rights and the elder generation in Noida apartments lamented that their children have lost touch with Kashmiri culture as the community had been scattered. Displacements had impacted gender relations, in Noida and Jammu women reported feeling unsafe in comparison to Kashmir. Displacement had adversely affected the people and the respondents suffered both personal and political losses and gains. Displaced Kashmiri people need to be recognized as citizens not simply as victims, and agencies working for their welfare need to be acknowledged.

**Key Words :** 1.SOCIAL DEFENCE 2.TERRORIST VIOLENCE VICTIMS 3.KASHMIRI MIGRANTS 4.DISPLACED PERSONS 5.INTERNALLY DISPLACED PERSONS 6.KASHMIR 7.JAMMU AND KASHMIR.

34. Mohinder Singh, et al. (2008).  
Mapping of the informal justice system in Haryana. Kurukshetra :  
Kurukshetra Univ., Dept. of Public Administration. 168 p.

**Abstract** : Sometimes remedies for justice are not adequate or sufficient to bring to people the sense of justice they demand. The present study was carried out to study the concept, evolution, nature and components of the Informal Justice System (IJS) in Haryana, and critically examine the need and relevance of the Informal Justice System for the redressal of grievances of the people. 2 blocks of each district were selected, and 2 municipalities were selected from each district. A total sample of 3250 persons (2,500 rural and 750 urban) were selected for the study. It was found that 54.2% of the users said that they first contacted members of the immediate family to resolve conflicts/ issues on their own. Users also gave preference to different IJSIs (Informal Justice Systems Institutions). 88.5% gave preference to Bhaichara Panchayat (Brotherhood Group); 65.2% gave 2<sup>nd</sup> preference to Biradari Panchayat (Community Group), followed by Caste Panchayats; and 29.6% gave third preference to Sarvajatiya panchayat (All Caste Group), followed by Khap Panchayat (a Group of Villages) and Religious Panchayats. IJSIs have a deep rooted historical perspective. 72.5% representatives of IJSIs said that these community based institutions have been in existence from ancient times. Proper representation to women, disadvantaged groups, minorities and SCs is not given in IJSIs: 96.1%, 69.6%, 50.8% and 43.5% of the users admitted this, respectively. 69% of all IJSI representatives were nominated/ elected more than five times; 11.5% 4 times; and 70% were nominated/ elected more than 3 times. 56% representatives said that these institutions have constituted committees and sub-committees and 83% respondents said that the findings of the committees were made public. 53.5% representatives of IJSIs did not possess the requisite knowledge of legal provisions, and 46.5% said they possessed this knowledge. 62% representatives said all types of cases came before IJSIs; 36% representatives reported cases related to property, land, water, drains, street brawls, children, family matters, money and theft related cases; and 2.0 of them reported marriage related disputes. 92.7% of the users accepted the date, time and agenda set by the panchayat, and publicly informed the community. 67.2% of the users said it was informed through personal contact; 18.6% said through watchman; 13.1% said through public announcements, and 1.1% mentioned other means. 58.4% of the users admitted dominance in these meetings, 44.4% of these users mentioned dominance by key persons, 24% mentioned Sarpanch, 23% mentioned

Chairpersons, and 8.7% mentioned Tholedar (area in-charge). 67% women could not get the opportunity to express their views, about 38% of the users also could not get the same. 58.6% of the users, 95% of the representatives of LSGs (Local Self Governments), 96.9% of CSOs, 99% representatives of IJSIs; and 81.6% official respondents perceived that IJSIs were able to significantly reduce the workload of FJSIs (Formal Justice System Institutions). As women have been deprived of their legitimate rights, it was recommended that special attention should be paid to disseminate functional knowledge and information on both formal and informal justice rendering institutions to women. Women should be helped to understand the supplementary role of their IJS and FJSs. A district IJS Advisory Council (DIAC) should be established. Justice should be speedy and easily available. Government should issue necessary instructions to officials to keep proper records of settlement of disputes and ensure transparency in the working of IJSs. Government should make funds available to villagers to develop their own villages and make them self-reliant.

**Key Words** : 1.SOCIAL DEFENCE 2.INFORMAL JUSTICE SYSTEM 3.JUSTICE SYSTEM 4.PANCHAYAT JUSTICE 5.BHAICHARA PANCHAYAT 6.BIRADARI PANCHAYAT 7.KHAP PANCHAYAT 8.PUNISHMENT 9.REDRESSAL MECHANISM 10.HARYANA.

35. Save the Children, Kolkata. (2008).  
Study on missing children West Bengal. Kolkata : SC. 48 p.

**Abstract** : Many children go missing in India, and some of them are never found. The present study was carried to understand the dynamics of trafficking and migration of children (missing) in selected endemic blocks of West Bengal, to collect reliable information on the number of children trafficked, and among them the number of missing children. Sandeshkhali I and II, and Pathar Pratima blocks under the jurisdiction of Sandeshkhali Police Station in North 24 Parganas and Pathar Pratima Police Station in South 24 Parganas were selected for the study. Based on village level information, a total of 3,429 children were found to have gone out/ sent out to work in urban centres. Out of these, 271 households were identified where parents did not have any information on the whereabouts of their child. Another key finding of the study was that the NCRB website displayed information about 149 children missing from Sandeshkhali and Pathar Pratima (142 and 7 respectively), while data revealed that 71 children had been reported missing since 2005 in Pathar Pratima for which a GD/ FIR had been filed. Also, 28

missing children were traced during this period, but the GD/ FIR for most of them had been filed much earlier than 2005. Similarly data received from Sandeshkhali Police Station revealed that from 2004 to 2006, as many as 302 children were reported missing, and only 30 children were traced during this period. 66.67% of the missing children were girls, while the remaining 33.33% were boys. 49.06% of the missing children were between the age of 15 and 18 years, 29.96% were between 13 and 14 years, and 20.97% were below 12 years of age. 15.04% of the missing children had never attended school, while 76.69% children had studied up to the 5<sup>th</sup> Standard. Among girls, 64.61% had attended school up to the 3<sup>rd</sup> Standard, while 14.61% had never attended school. Only 16.18% of the cases were reported to the police or Panchayats. In 83.82% of the cases, parents either tried to get information on the child themselves or through other contacts. 82.92% children left their homes for work, while 11.67% had been taken out of their homes for marriage or had been given assurances of marriage. Almost half (48.36%) of these children had been taken out of the village by contractors or agents. About 49.54% children were reported missing for over 2 years. 72.77% of the respondents attributed absence of communication as the reason to think that the child was missing, while in 17.41% cases the child just left home and did not return. It was suggested that as mandated under Section 63 of the Juvenile Justice Act 2000, all police stations should have an officer designated as Child Welfare Officer. At the state level, an officer of the rank of DIG should be designated as the Nodal Officer in charge of missing children. All stakeholders, including police administration and community representatives, should be sensitized on the issue of missing children.

**Key Words :** 1.SOCIAL DEFENCE 2.MISSING CHILDREN 3.WEST BENGAL.

## **SOCIAL WELFARE**

36. Goldar, Bishwananth et al. (2007).  
Well being of the urban poor : assessment and policy issues : a study of slum clusters in Jaipur, Ludhiana, Mathura and Ujjain : final report. Delhi : Institute of Economic Growth. 170 p.

**Abstract :** Rural to urban migration has been an important contributing factor towards increasing urbanization. Many of these migrants are engaged in low paid informal jobs and stay in slums and slums squatter colonies. The present study

investigated the link between migration and urban poverty, inter-linkages between employment and poverty, and the role of networks in accessing jobs and subsequent upward mobility. Also, urban poverty is characterized by inadequacy of basic services such as water, sanitation and health. 500 households were selected from each of the four cities Jaipur, Ludhiana, Mathura and Ujjain. Survey work was carried out for six months during the year 2006-07. The slums considered in this study were only of a particular type i.e., *jhuggi-jhopdi* clusters, *kachha* (non-permanent structures) *basti* or *gandi / malin* (low caste) *basti*. It was observed that slums had a higher proportion of child population (14.26%) than cities (13.05%) at the all India level. Majority of the slums in Jaipur (88%) had *pucca* (permanent) or semi-*pucca* structures. 90% of the slums were very close to *pucca* (metalled) roads. The width of the road ranged from 1.5 feet to 20 feet. More than 80% of the slums had both street lighting and household electricity connection. 92% of the slums of Jaipur reportedly had water supply. 80% of the slum dwellers had their own toilets, 28% had covered drains, and 44% had *pucca* drains. Majority of the children of Jaipur slums were going to school. ICDS centres, NGOs and post offices were present in some of the slums of Jaipur. In Ludhiana, central part of the city has only 4% of the slums. Eastern part of the city has 73% of the slum population. More than 80% of the slums had more than 6 feet wide roads. Only three out of 25 slums had narrow streets (less than 3 feet). Most of the residents had their own toilets. 72% slums had covered drains. No garbage disposal system was found. Domestic violence and child labour was prevalent. Some of the slum dwellers also reported atrocities by the mafia. Only 1/3 of the slums had ICDS centres. In Mathura, the slums were not uniformly distributed in the city. Vrindawan town had the maximum concentration of slums. 32% had *kachha* streets inside the slums. More than 6 feet wide streets had been reported in 12 out of 25 slums of Mathura. 80% slums reported water logging in the rainy season. 84% slum dwellers had their own toilets. 33% had *kachha* drains. 44% had garbage disposal system. Children were going to school regularly. Drug abuse and alcoholism was found in 24% slums. In 24% slums child marriage was prevalent. In 60% slums women were found to be participating in economic activities. Mathura was deprived of day care centres, welfare institutions and ICDS centres. Ujjain has a high concentration of slums. 84% were located in the main city. Serviceable *kachha* streets were observed in 40% slums. Only 13% slums had both street lighting and household electricity connection. Children were seen working in household activities like incense stick rolling, toy making, *papad* making, etc. Child marriage, domestic violence, small crimes and alcoholism was also observed. ICDS centres were there in the majority of slums. The incidence of diarrhoea was prevalent in all the four cities (6.6%). 30% of the diarrhoea cases in the last 15 days prior to the survey occurred among children below 5 years of age. Another 20% occurred among children between five to fifteen years of age. On an

average, respondents had 2 episodes of diarrhoea every year. The average cost of illness was Rs.123 per household per month. Overall 70% of slum dwellers had access to piped water or deep bore well or tube well, the remaining 30% used other sources. Large proportion of women had home deliveries, pointing again to the failure of RCH programme in slums. Majority of women visited private clinics for antenatal check-ups. Poor infrastructure and lack of basic amenities like sanitation, garbage disposal, potable water are important determinants of ill health. It was suggested that Government should take serious note of its continued lapses in health services, and evaluate why the various schemes for slum development, as well as specific health infrastructure improvements have not worked well so far.

**Key Words** : 1.SOCIAL WELFARE 2.SLUM DWELLERS 3.URBAN POOR 4.SLUM CHILDREN 5.HEALTH STATUS SLUM CHILDREN 6.TOILETS 7.DRINKING WATER 8.SANITATION.

37. Mukhopadhyay, Sudesh et al. (2006).  
United States Agency for International Development (USAID) assisted Development Assistance Programme II : Final evaluation July 2006. New Delhi : Catholic Relief Services. 73 p.

**Abstract** : Operating in India since 1946, Catholic Relief Services (CRS) has been in the forefront of combating hunger and providing food support to its local partners in the implementation of education, health and agriculture programmes. CRS India's Title II supported Development Assistance Programme (DAP) for 2002-2006 targets annually 970,000 persons belonging to India's most marginalized communities located in the most food insecure tribal belts of Central India and North Eastern states. The present study was done to assess improvement in the health of lactating/ pregnant women and children aged 0-3 years, increase agricultural productivity of 200 farming communities/ families' conditions during the five year DAP period, increase opportunities for and participation of disadvantaged children and provide a safety net to victims of calamities – the destitute, orphaned, sick and dying, especially children. DAP II agricultural activities targeted 45,000 families most in need in areas with a high percentage of rural, SC and ST population. These areas were Jharkhand, centered around Ranchi; Chhattisgarh, centered around Raipur; Bundelkhand, centered around Jhansi in Madhya Pradesh; Rajasthan, centered around Udaipur; and Gujarat. These areas were characterized by low levels of per capita income

and human development. Literacy levels were poor especially among women and infant mortality was relatively high. Throughout most of the year residents experienced acute shortage of water. Through this programme, farmers learned about improved farming techniques. It was found that overall, production was very successful after this programme, and farmers practiced rain-fed agriculture in dry areas, without irrigation, by using water harvested through watershed management techniques. The study revealed that project activities had contributed greatly in increasing on farm production and income at the household level, as well as providing opportunities for income earning at the village level. Farmers stated that as a result of the project, they have more food secure months, with grain available for 5-10 months now compared with 2-3 months at the baseline. Under the Education Programme, CRS supports 4,894 educational institutions and partners and served 306,281 children in Fiscal Year 2005. As part of the programme, Title II, Food Support was distributed to Early Childhood Development Centres (E CDC), School Feeding Programmes in primary schools (SF) and Boarding Institutions. Over the life of the project, CRS had greatly increased access to primary education for children from low income groups, excellent strides have been made to increase school attendance, dropout rates have reduced, etc. Overall improvement could be contributed to many factors: reasonable size of schools leading to availability of adequate number of teachers, private management ensuring regularity in teaching, and food support for poor children on a regular basis. It was found that parents sent their children not only for a nutritious hot meal, but they also came to know about the value of other aspects of the education programme such as quality of schooling and additional support for enhancing achievements. Mothers seemed to be very motivated to send their children to schools especially girls. Health was another area of DAP II which aimed to strengthen the delivery of health services. DAP II placed emphasis on improving access to SMCS (Safe Motherhood and Child Survival) services such as antenatal care, postnatal care, safe delivery and immunization services. In 2005, CRS served 222,096 participants under the Health Programme and distributed 6,331 metric tonnes (MTs) of food. One of the most consistent improvements seen across all areas of care was the preference of women to seek care/ consultation for themselves or for their child at a health facility as opposed to seeking services from non-medical professionals outside the hospital or health centre. There was a remarkable increase in the number of women delivering in a health facility. In addition, CRS increased immunization coverage in the target area by 13% among all children 12 months of age, and reduced malnutrition by 10%, a noteworthy achievement. There was notable improvement in mother's knowledge for almost all danger signs during pregnancy, child nutrition, and advantages and benefits of immunization and Vitamin A. CRS should focus on expanding best practices, help community structure to continue programme

activities, and have/ make formal linkages with local governments for technical support.

**Key Words** : 1.SOCIAL WELFARE 2.USAID ASSISTED PROGRAMMES 3.SOCIAL WELFARE PROGRAMMES 4.CATHOLIC RELIEF SERVICES 5.CHILD SURVIVAL 6.SAFE MOTHERHOOD 7.EARLY CHILDHOOD DEVELOPMENT 8.CRECHES 9.EDUCATION 10.NUTRITION 11.CHILD NUTRITION 12.MID DAY MEALS 13.NEWBORN CARE 14.CARE OF NEWBORN 15.ICDS 16.MATERNAL AND CHILD HEALTH 17.INNOVATIVE PROJECTS 18.OUTREACH 19.VISTAAR PROJECT.

38. Shah, Amita. (2007).  
Patterns, processes of reproduction, and policy imperatives for poverty in remote rural areas : a case study of southern Orissa in India. Ahmedabad : Gujarat Institute of Development Research, Ahmedabad. 30 p.

**Abstract** : Incidence of poverty is generally higher in areas with low agronomic potential. The present study was carried out to identify areas with high incidence of poverty over a long period of time, and examine the important features associated with poverty scenarios. The study is based on 4 villages, Hanumal, Kamel, Balel and Sindhigudha in Lamtaput block in undivided Koraput district. A total of 159 households were selected for the study. It was found that about 17% of the sampled households did not own any land. It was observed that agriculture was the major contributor, accounting for 42.5% of the estimated income of households. This was followed by wage income, contributing 25.2%; forest resources 15.1%; and other activities 17.2%. Highest per capita income from all sources was found in Kamel. Overall income of households ranged between Rs. 9,147 to Rs. 13,854 per annum. About 38% households reported partially shifting from eating rice to *ragi*. 30% of households reported net reduction in cereal consumption in order to cope with internal shock. It is likely that most of these households belonged to the category of severely poor. About 21% households reported borrowing money from moneylenders in order to cope with the difficult situation. 16% households reported borrowing from shop keepers/ traders. According to community based ranking, as many as 98% of the households were considered as poor. Of the total households, about 50% were categorized as extremely and highly poor, and another 28% as average poor. An important observation was that the proportion of severely poor was significantly higher among more remote villages (36.3%) as compared to less remote villages (25.3%). Conversely, the proportion of non-poor was higher in the less remote

villages compared to the more remote villages. Poverty was highest among the SCs (93.4%), followed by STs (90.3%), and then by other communities (75%). Similar pattern was observed in the case of the severely poor. 45.7% of the SC households belonged to severely poor category, as compared to 26.9% in the case of STs, and 15% in the case of others. Physical remoteness at regional/district level emerges as the most important factor explaining the level of poverty in Koraput, which is significantly higher in comparison to other forest-based districts in northern Orissa. The various schemes for employment generation and other developmental programmes initiated in the 150 most backward districts is a testimony of the recognition of sustained concentration of poverty in certain pockets of the country. While wage employment or other subsidies are crucial for making a dent on chronic poverty, the long term solution lies in addressing structural problems, and integration of forest management into the larger framework of development. The thrust should be on participatory forest management.

**Key Words** : 1.SOCIAL WELFARE 2.POVERTY 3.POVERTY ALLEVIATION 4.DEVELOPMENT 5.TRIBALS 6.LIVELIHOOD 7.KORAPUT 8.ORISSA.

## **WOMEN LABOUR**

39. V. V. Giri National Labour Institute, NOIDA. (2002).  
Women weavers of Sualkuchi, the silk town of Assam. NOIDA : VVG NLI.  
50 p.

**Abstract** : Handlooms provide a utilization of leisure to the women folk of rural Assam who work for a few hours a day to produce hand-woven cotton fabrics, mostly for personal use. 247 women wage weavers were randomly selected for the study. In addition, 50 male wage weavers and 168 master weavers (of whom 27 were women) and 32 entrepreneurs were also selected. The study was carried out through field visits in Sualkuchi area of Assam. It was found that there were 1,122 looms of 200 weavers, giving an average of 5.6 looms per weaver. Of the 200 weavers, 82 (41%) were financing their activities from their own sources, altogether 49 weavers also took the help of their friends and relatives. 50 weavers had taken loans from financial institutions under different schemes of the Government. Most of the sampled weavers (54.5%) were selling their products in

the local market. 19% Sualkuchi workers sold their products locally as well as in Guwahati. Sualkuchi produced 15 million square metres of silk and 15,000 square metres of muga fabrics. Out of the 200 firms, on an average, 68 had unused looms and 2 were lying idle. 52 of them reported shortage of labour. A few weavers were selling their products directly to consumers (9% only). 91% weavers do not sell their products directly to the ultimate consumers. 49% of the master/entrepreneur weavers belonged to the scheduled caste community. Master/entrepreneur weavers from OBCs constituted 27% of the sample. In 109 master/entrepreneur weaver households at least one illiterate member was found. 5% entrepreneurs/weavers were earning less than Rs. 20,000 in an year, which was below the poverty line. 60% earned more than Rs. 48,000 per year. Most of the women wage weavers (80.6%) were unmarried, whereas the situation was reverse in the case of male wage weavers and 52% of them were married. 45 women wage weavers, out of the total women wage weavers, had a family income of less than Rs.19,650 per annum. 55% workers reported that they got free accommodation and tea and snacks during work hours from their employers. 32 women wage weavers (12.9%) reported that they got tea and festival advance from their employers. 76.9% women and 44% male weavers remitted home a part of their earnings after meeting their own expenditure. Only 39 women weavers (15.8%) and six male weavers (12%) reported that their income was just sufficient to meet their own consumption needs. 65.2% women and 84% male wage weavers had taken advance from their employers prior to joining their jobs. 9.7% women and 14% male wage weavers reported that they had their own bank accounts. Most of the weavers appeared to be happy with their jobs and only 42 wage weavers were found to be unhappy. It was suggested that the handloom weavers of Sualkuchi need the administration to play a supportive role in the form of improving infrastructural facilities, the most common request being uninterrupted supply of electricity, at a reasonable price. An institutional arrangement for regular supply of silk yarn at competitive prices is also required.

**Key Words** : 1.WOMEN LABOUR 2.WEAVERS 3.SILK INDUSTRY  
4.SUALKUCHI 5.ASSAM.

## WOMEN WELFARE

40. Voluntary Association for People Services, Virudhunagar. (2008).  
Enhancing women's empowerment through information and communication  
technology : a report. Virudhunagar : VAPS. ~125 p.

**Abstract** : Women are equal beneficiaries to the advantages offered by technology and the products and processes, which are by products of technology use. The present study was carried out to assess ICT infrastructure in rural areas vis-à-vis that in urban areas for women's empowerment, and to assess the status of ICT in education in terms of policies regarding scholarships, reservations, business development programmes, etc. for self-employment opportunities for women. The study was conducted in all five major corporations in the state of Tamil Nadu, i.e. Chennai, Thiruchirappalli, Madurai, Coimbatore, and Thirunelveli. The total sample size was 500 women/ girls. Out of 500 respondents, the highest number of women/ girls interviewed were in the age group of 32 years, followed by girls below 17 years. Majority of the respondents were college educated (374), followed by school educated (57), technically educated (44), and just literate or those who had no schooling. It was found that ICT introduction has made life easier for 284 respondents, followed by 169 who somewhat agreed. Only 24 and 19 respondents said that they did not know, or could not say respectively, whereas only 3 respondents said that they did not agree with the idea. 224 respondents said that ICTs were easily available, 23 respondents disagreed, and 52 said that they did not know. Only 30 respondents said that they used information technology, 12 for booking tickets, 27 to get information about different aspects of life, and 5 persons said they used IT for banking and insurance. Out of the 500 respondents, 111 said they got information from the Internet, which showed that Internet facility was available in their locality. 90 respondents said communication was through print media, and 33 mentioned radio as a source of information. Of the respondents who said there was easy availability of the Internet, the highest number (170) said they preferred cyber cafes. 116 said they used IT in the office, both for official purposes and personal work. Respondents used Internet according to their need, but only 103 said that they used it almost regularly. 118 respondents used Internet once a week, 88 used it when they felt it necessary, 66 used it very rarely and also said that it was not necessary for them

to use Internet daily or for unnecessary purposes. 48 said that they never used the Internet. 234 respondents strongly agreed that ICT had enabled women to know what is happening across the globe more easily. 376 respondents said that it was essential in their job. Regarding the facility of working from home, 215 respondents said they were to some extent provided this facility of working from home. Also, 132 strongly agreed that ICT enabled people to work from home. About 204 respondents said it took away women's relaxation time. Majority (258) of the respondents wanted to make use of ICT for the next generation. It was concluded that the use of ICT helps to bridge the gap between people's opportunities for self-employment in the informal economy and the high growth sectors of the world's economy. SEWA has started using telecommunication as a tool for capacity building among the rural population. It was suggested that Government departments and others should come together to make poverty alleviation programmes successful through women centric initiatives in which poor women are organized to circumvent the problems of liberal development processes. Women need to be encouraged and trained to become producers on all ICTs. Clearly, engendered ICT policy needs to be developed.

**Key Words :** 1.WOMEN WELFARE 2.INFORMATION AND COMMUNICATION TECHNOLOGY 3.EMPOWERMENT WOMEN 4.SELF HELP GROUPS 5.STATUS OF WOMEN 6.INFORMATION KIOSK 7.TAMIL NADU.

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