

# DCWC Research Bulletin

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## Research Studies on Women and Children

### CHILD LABOUR

1. Prayas Institute of Juvenile Justice, New Delhi. (2007).  
Child labour : Prayas' perspectives and responses. New Delhi : Prayas.  
12 p.

**Abstract** : Despite being considered the 'supreme asset' of our country, a large number of children in India have remained deprived of their right to health, physical and psychological development. Child labour is defined as paid or unpaid work of children below the age of 14 years. There is no definite or even an approximate estimate of the number of children at work in India because of various reasons like differences in definitions, typology of the work involved, guess estimates and varying perceptions of the different agencies working for curbing this problem. As per 1991 census, the total number of children between 5-14 years in India was 203.3 million of which 11.28 million were working children (6.18 million boys and 5.10 girls). This number rose to 12.59 million in Census 2001. The 55<sup>th</sup> Round of the NSSO Survey conducted in 1999-2000 estimated the child labour population to be 10.4 million. These estimates are far less compared to the NGO estimates of 100 million child labour in India possibly because it considers every out of school child to be either engaged as child labour or as potential child labour. The reasons behind child labour are complex and vast. At the macro level, lopsided developmental efforts in rural areas, unemployment and underemployment, stark poverty affecting millions, globalization creating an unsupervised employment hierarchy often misused by local level employers, and poor infrastructure development comprise the most common reasons. The incidence of child labour is high wherever access to primary education is low. The educational scenario in India continues to be bleak despite programmes launched under Directive Principles of State Policy, 93<sup>rd</sup> Amendment reiterating universalization of free and compulsory education for children 6-14 years and the Sarva Shiksha Abhiyan (SSA). Inadequate vocational skills and training opportunities in the existing educational system are major contributory factors to the problem of child labour. The proportion of formally vocationally trained youth (20-24 yrs) in the labour force constitutes only 5.06% which is much below the international standards. In spite of all legal and policy commitments and recent notification banning domestic child labour all over India, curbing the problem of child labour remains a complex issue and a matter of grave concern. Delhi itself has an estimated 0.5 million child labourers. Delhi has a large number of street and working children engaged in vending, shoe polishing, working in *dhabas* (roadside eating places), etc. To curb the

problem of child labour, the Labour Department, NCT of Delhi conducted several rescue operations with the support of NGOs to rescue these children from exploitative situations. But, in the absence of an adequate rehabilitation plan and programme linking the rescue operation at the destination point with effective rehabilitation facilities at the source has often made these exercises futile and meaningless. Prayas advocates the total elimination of child labour and believes that this objective can be achieved by adopting needs and rights based approach, and that legislation alone cannot be a solution to the problem. The target group of vulnerable children is those out of school (child labour or potential child labour), street and working children, slum children, children with disabilities, beggars and children, especially girls, engaged in households and working outside their homes. In their free time, these children could attend school and learn skills that would provide them stability in future. Prayas concept of Alternative Education (AE) is a planned structured programme with options are suited to meet the needs of every out of school child between 6-14 years. The main focus of AE programme is to prepare children for entry into the formal school system and to provide vocational skills training. Further, Prayas has created several mechanisms and institutions like the Child Helpline (1098), Crisis Intervention Centre (CIC), Shelter Homes for Boys and Girls, and Railway Assistance Booths. All these institutions cater to the rehabilitative needs of children in difficult situations. Further more, Prayas got an opportunity to participate in the Indo Norwegian Development Cooperation Programme in 1997 and established the Institute of Juvenile Justice as a National Resource Centre for Child Labour and Child Protection. The organization also works in close coordination with the Labour Department, Government of NCT-Delhi in its rescue and rehabilitation programmes for curbing the problem of child labour. The task involves preventive, promotive, ameliorative, curative, rehabilitative and reformatory measures. Prayas has adopted model innovative practices of child protection to promote child rights by promoting social mobilization, sensitizing the community, and building its capacity to encourage community owned initiatives to deal with child labour. Capacity building of the judiciary, the police, and NGOs is undertaken through training and sensitization programmes; and networking with the media is done to bring about social awareness and create a positive environment.

**Key Words :** 1.CHILD LABOUR 2.INNOVATIVE PROJECT 3.INNOVATIVE PROGRAMME 4.TRAFFICKING CHILD LABOUR 5.CHILD TRAFFICKING LABOUR 6.REHABILITATION CHILD LABOUR 7.STREET CHILDREN 8.VOCATIONAL TRAINING 9.GIRLS HOSTELS 10.TRAFFICKING LABOUR 11.OUT OF SCHOOL CHILDREN.

2. Save the Children, New Delhi. (2007).  
Child domestic work : a study on the lives of child domestic workers in Leh and Kargil. New Delhi : SC. 28 p.

**Abstract** : Child Domestic Worker (CDW) refers to a child engaged in domestic chores in a home outside their families for a wage, in cash or kind. The present study assessed the issue of CDW and its prevalence in Leh and Kargil, factors responsible for leading children into domestic work, and the community's perception about CDWs. The study was conducted with a wider group of stakeholders in Leh and Kargil, and data was collected from CDWs, their parents and community people (school teachers, labour officers, police officers, anganwadi workers, etc.). The study covered 103 children below 18 years who were engaged as CDWs in Leh and Kargil, and 21 families of these CDWs. Around 53.4% CDWs were girls compared to 46.6% boys. Almost 73% CDWs lacked economic self-sufficiency and were from BPL families. The remaining 33% were above the poverty line (APL) and could manage their household; these families preferred to send their children to work outside their towns. In 80% cases, the head of CDW family was illiterate. The education of their mothers was even worse; around 101 out of 103 CDWs' mothers were illiterate. Around 72.8% CDWs were school dropouts, and 13.59% had never been to school. It was found that around 45.6% CDWs came from families with more than 8 members. About 67.9% fathers and 88.3% mothers earned their living from small businesses and by working as agricultural labourers respectively. Many families (56%) had some amount of cultivable land. Around 69% respondents mentioned that poverty was the main factor responsible for children to be working as CDWs. Around 61% CDWs did not want to go back home as they had no alternative. About 51% of the CDWs managed to go to school with their employer's permission. Around 63% children were happy with their working conditions. More than 50% children did not have any idea about their mode of payment, 10% got their wages directly. Around 27% CDWs mentioned that their income was taken directly by their parents, and in 3% cases middlemen who arranged the placement took it. About 33% did not get any wages or received less than Rs.200 per month. Only around 11% of them got Rs.1000/- or more in a month. Only 67% children managed to get health care support when they fell sick. About 5% got treatment only in case of serious sickness, and 9% never got any such support. A majority (72.5%) of the respondents/community people mentioned parental ignorance and illiteracy as reasons for children not attending schools. Trafficking in children was found to be a prevalent practice in the source area. About 38% people knew about child trafficking. Among them 11% knew persons engaged in child trafficking. Local self government and the community should play a proactive role to stop child abuse. Strong conviction about the problem can be considered central to preventing children from becoming CDWs.

**Key Words** : 1. CHILD LABOUR 2.DOMESTIC WORKER 3.CHILD DOMESTIC WORKER 4.LEH 5.LADAKH 6.KARGIL 7.JAMMU AND KASHMIR.

3. Sekar, Helen R. (2007).  
Impact of technological change on the demand for child labour in brassware industry of Moradabad. NOIDA : V.V. Giri National Labour Institute. 206 p.

**Abstract** : The demand for child labour, related to technological change in today's developing economies, has not received much attention in contemporary debates on child labour. The present study was done to assess the effects of technological change and industry restructuring on the existence of child labour. The study was conducted in Moradabad city, Uttar Pradesh, and covered 150 production units out of which artisan units constituted 65.3% (98), *kharkhanedar* units or multi-process units constituted 28% (42), and exporters or fully mechanized units constituted 6.67% (10). Of the total artisan units studied, 68.37% had *pucca* (permanent) structure and the remaining 31.63% were housed in semi-*pucca* structure. Space to carry out various manufacturing processes was adequate in 91.84% of the artisans units and grossly inadequate in 95.24% of the *kharkhanedar*s units. All the exporters were satisfied with the space availability. A total of 1105 workers were selected as the sample for the study. In artisan units, 382 workers were employed out of which 311 were adult males, 2 were adult females, 64 were male children and 5 were female children. Almost all the workers in artisan units were on contract basis. In *karkhanedar* units, the total number of adult workers were 295 (male 293 and female 2) and child workers were 32 (male 30 and female 2). In *karkhanedar* units also all workers were on contract basis. In the exporter units, the status of 63.6% of the total work force was contractual, 17% had permanent status and the remaining were temporary workers. Women constituted 10.3% of the total permanent workers, which included the administrative staff. Export units did not employ any child labour. Around 76% *karkhanedar* units and 67% artisan units imparted training/knowledge to its workers. Only 10% export units had this facility and inclination. Not even a single unit owner was aware of the various kinds of training that could be imparted regarding the various skills related to brassware manufacturing. The mode of payment to workers was based on time rate/piece rate, and pocket expenses were also given. Workers who were paid in both time rate and piece rate constituted 42.2% of the total, those who were paid in time rate, piece rate and given pocket expenses constituted 47.4%, and the remaining 10.4% of the workers were paid only in time rate. Children were put to work mostly because they were out of school. Their early entry into the workforce was a natural trap due to their reduced working capacity after 30 years. Highest productive capacity of an artisan was at the age of 18 and started declining after 30 years. Reduced physical capacity, declining income, low longevity and ill health were the

reasons for pushing children into work at an early age. The two most hazardous processes in the brassware industry were moulding and polishing. The child was employed to do two types of jobs. He rotated the wheel, which was called *pankha* (hand wheel) to keep the furnace fire burning and the temperature in the furnace was about 1100° C. The child also checked the molten metal by opening the top of the underground furnace. In these processes there was not only danger of getting badly burnt, but he also inhaled the fumes and hazardous gases. Lead and Zinc poisoning were the most prevalent health hazards in Moradabad brassware industry. Dangerous machinery, sharp tools and toxic substances in the working environment of children affected them adversely. Unhygienic living and working conditions make children vulnerable to communicable diseases. Child labour was anyway often casual and poorly paid. Severe malnutrition, anaemia, hard labour, fatigue and inadequate sleep made children more susceptible to accidents. In most units, the machines used in the polishing process neither had any exhaust system, any provision of screens or enclaves to prevent flying metal dust affecting the workers, due to which many injuries could happen. Around 30% of the units' owners felt that there was risk in adopting new technologies. According to them, lack of finance, lack of knowledge of new technology, lack of skilled manpower, slackness in the demand for products, erratic power supply, etc. were some of the major barriers in adopting new technologies. Overall, the city of Moradabad lacked infrastructural facilities for promoting brassware industry. Introduction of technology had resulted both in the influx of workers and displacement of workers, both adults and children. A vast proportion of *karkhanedar* and export unit owners and around 62% artisan unit owners strongly believed that the existing practice of employing child labour could be stopped by introducing technology. Interaction with various sections of society indicated that child labour was not a necessity for anyone, but a compulsion for the poor family. Literacy level of the population had a strong correlation with the incidence of child labour, and a substantial proportion of the population above 5 years was found illiterate. The reasons for leaving school and joining work related to supplementing family income, absence of adequate number of government schools, and bad quality of teaching. It was suggested that policies should be made to eliminate child labour; education should be provided to children of poor families; and there is a need to improve the general economic condition of states, so that working conditions in industries are improved and they absorb modern technologies.

**Key Words** : 1.CHILD LABOUR 2.BRASS INDUSTRY 3.LABOUR 4.WOMEN LABOUR 5.MORADABAD 6.EXPORT UNITS 7.UTTAR PRADESH.

## CHILD WELFARE

4. Gopalan, C. and Ramachandran, Prema. (2007).  
Report of evaluation of National Programme for Adolescent Girls. New  
Delhi : Nutrition Foundation of India. 313 p.

**Abstract :** The National Programme for Adolescent Girls (NPAG) aims to improve the nutritional status of AGs. NPAG was being implemented in 51 districts of 35 states. Ten districts were selected to assess the performance of NPAG. These were Banswara (Rajasthan), North West Delhi, Haridwar (Uttaranchal), Kalahandi (Orissa), Lunglei (Mizoram), Palakkad (Kerala), Panchmahal (Gujarat), Surguja (Chhattisgarh), Sonbhadra (Uttar Pradesh) and Thiruvannamalai (Tamil Nadu). The sample size in each district was 1000 complete residential households from 40 selected Primary Sampling Units (PSUs). The villagers, beneficiaries, social activists and health functionaries mentioned that this scheme was very popular and they wanted it to be continued by maintaining a streamlined supply of food grains throughout the year. In 2006-07, around 92,908 AGs benefited from the scheme. 10 kg food grains were distributed to every undernourished girl. The food grains given to the beneficiary AG were shared by other members of the family. Thus the food given did not impact adequately on the AGs under nutrition status. In all districts all AWWs received training to weigh AGs and provided NHE. Chits were distributed to AGs and they collected ration from ration shops. In Kalahandi urban (Orissa) and North West Delhi (Urban) chits were not distributed and no rations were given to AGs. In most districts only one or two AWWs maintained records of NPAG, and in Sonbhadra (Uttar Pradesh) none of the AWWs had records of this programme. In Panchmahal (Gujarat) AWWs mentioned that very little ration went to undernourished girls. Joint families disagreed with this; but if a daughter of one family got free ration, all family members wanted to share it. Ration shopkeepers mentioned that free ration improved household food security, but did not improve dietary intake or nutritional status of undernourished girls. In Surguja there were no AWCs in urban areas, therefore urban poor families were not benefited by this scheme. The budget provided for NPAG is not sufficient and the supply of food grains was not timely and regular. If there was more than one AG in the family, then the 2<sup>nd</sup> and other AGs were not given benefits under the scheme. All AWWs received support from PRIs, ANMs and families of the AGs. Ration shopkeepers were interested to provide food grains. The Project Director mentioned that the selection of AGs was not always accurate. Adolescent daughters-in-law were generally not thought of as beneficiaries of the programme. Many AWWs depended on friends / a male relative for record keeping, which led to inaccuracies. Due to long procedures of financial and administrative sanctions, there was delay in reaching the programme to the beneficiaries. Sufficient and timely release of

central budget is needed to ensure continuous supply of food grains throughout the year. All eligible AGs of a family should get benefits, unlike only one, as is currently the practice.

**Key Words** : 1.CHILD WELFARE 2.ADOLESCENT GIRL SCHEME  
3.EVALUATION ADOLESCENT GIRL SCHEME 4.ROLE OF ANGANWADI  
WORKERS 5.NUTRITION EDUCATION 6.NUTRITION PROGRAMME  
ADOLESCENT GIRLS 7.ICDS.

5. Haq Centre for Child Rights, New Delhi. (2007).  
Budget 2007-08 and children : a first glance. New Delhi : HCCR. 17 p.

**Abstract** : Nineteen percent of the world's children live in India and they comprise 42% of the country's population. This report presents the Union Budget of GOI for the year 2007-08, and the allocations for children. The total Union Budget of the Government of India was Rs. 6,805, 205.1 million for the year 2007-08 and the share of children in the Union Budget was Rs. 329,583.3 million (4.8466%). Within the Child Budget (2007-08), the share for Child Development was Rs. 54894.4 million, budget for Child Health was Rs. 33010.3 million, budget for Child Protection was Rs. 3048.6 million, and budget for School Education was Rs. 23863.00 million. According to Global Hunger Index, 47.5% children were under-weight in India. India was home to nearly 40% of all low birth weight babies in the developing world. The report revealed that in India around 44% children aged 12-23 months had received all recommended vaccines. Around 46% children continued to be under-weight. India had the highest number of births and neonatal deaths in the world. Data showed that prevalence of anemia in India was over 90% in pre-school children, adolescent girls and pregnant women. Around 79.2% children in the age group 6-35 months were anemic in India and 81.2% were anemic in rural areas. Only 40.7% were institutional births in India. During 2004-05, a total of 2.60 lakh new leprosy cases were detected of whom 13.3% were children. According to the Reproductive Child Health (RCH) Survey (2002-04), 21% boys got married before 21 years and 28% girls got married below the age of 18 years. According to Census of India 2001, among all persons living with disability, 35.9% were children and young adults aged 0-19 years. Data collected by National Crime Records Bureau 2002-05 showed that there had been an average increase of 12.97% in crime against children. India is home to the highest number of child labourers in the world. There were 89,347 disabled children in the age group 5-14 years in the total working population of India. The school education scenario was unsatisfactory as around 13.4 million children aged 6-14 years were out of school. The drop out rate from Classes I to X was 62.68%. Of every 100 children dropping out of school, 66 were girls. In 2005, there were 30,048 primary

schools all over India running without a building and none of the states have provided a *pucca* (permanent) building to all its primary schools. Around 10.39% of the total schools in India had only a single classroom. The Union Budget that is sanctioned for children should be used properly for child welfare and to ensure the proper growth and development of each and every child.

**Key Words :** 1.CHILD WELFARE 2.BUDGET FOR CHILDREN 2007-2008  
3.CHILD BUDGET 4.SOCIAL SECTOR SPENDING.

6. Sen, Juthika et al. (2004).  
Report on survey and evaluation of the adolescent girls scheme. New Delhi :  
Voluntary Health Association of India. 77 p.

**Abstract :** Universalization of the ICDS programme drew the attention of all concerned to undertake a quick appraisal / evaluation of the Adolescent Girls (AGs) scheme, and take follow-up measures in order to extend it further. This study identified the factors which would help or hinder the success of the programme. Three blocks of Delhi were selected for the study, namely Mehrauli, Kanjhawala, and Alipur. The 872 respondents included 200 AGs, 200 mothers of AGs, 200 non-beneficiaries (AGs), 200 mothers of non-beneficiaries, and 15 local leaders, 40 AWWs, 14 Supervisors and 3 CDPOs. According to project level functionaries and beneficiaries, growth monitoring was one of the activities, which had been greatly strengthened due to the involvement of AGs. 10.5% beneficiaries (AGs) came to the AWC only for SN. The timing of schools and AWCs were the same so they had little time to spend. The attendance of children in the AWC had increased along with the participation of mothers in Nutrition and Health Education (NHE) activities. Mothers of beneficiaries mentioned that the food provided in these blocks was of the ready to eat variety. 75% of them were satisfied with the food, while 24% were not. 57% AWWs mentioned that the place and time of imparting NHE by them was convenient for AGs. 25% AWWs conducted NHE prior to the arrival of children in the AWC. Only 5% AWWs conducted NHE at the time when AGs came to collect SN. The maximum emphasis of NHE was on breastfeeding (100%), followed by immunization (97.5%), diet during pregnancy and lactation (92.5%), diarrhoea management (93%), nutrition during adolescence (62%), growth monitoring (62.5%), and health services (60%). The coverage on kitchen gardening (17.5%) and conservation of nutrients (15%) remained poor. 37% AWWs mentioned that NHE sessions were conducted on a fortnightly basis and four days a week, while 12% of them conducted it once a week. According to Supervisors and the CDPO, AGs had gained adequate knowledge and had acquired information related to various important aspects from

the NHE sessions. The awareness levels of both beneficiaries and non-beneficiaries were almost at par. AWCs were open to all for nutrition and health education sessions. According to AWWs, non-beneficiaries also attended the sessions as and when they wished. They were utilizing the knowledge gained from NHE sessions in their daily life. The not applicable respondents' category was the school going adolescent girls (non-beneficiaries) who did not attend the NHE sessions. 9% AWWs mentioned that the scheme was useful in promoting better motherhood and better child care practices, and generated awareness about health and hygiene. 62% AWWs said that the scheme also helped in enhancing the status of AGs in their families. Non-beneficiaries mentioned that immunization helped in improving the health status of AGs, and services like referral services, providing deworming tablets and health check-ups were also useful services. All the local leaders, Supervisors, CDPOs and 95% of the AWWs mentioned that these services are subject to the availability of stocks at the AWC, as the supply at present was very irregular. 82% AWWs felt that there were some gaps in the scheme. The scheme did not recognize the work of AGs, which made the scheme less attractive to AGs. If some incentive and recognition was given to the work of AGs, their attendance would increase further and the scheme would receive a more positive response from the people. The duration of involvement of AGs, which at present was only six months, should be increased. Project level functionaries lacked training about the AG scheme. There should be emphasis during training on AG scheme. Some incentive should be given – may be a credit certificate or preference in job appointment for AWW should be given to AGs. Quality of food supplied should be improved and quantity should be increased.

**Key Words** : 1.CHILD WELFARE            2.ADOLESCENT GIRL SCHEME  
3.EVALUATION ADOLESCENT GIRL SCHEME    4.ROLE OF ANGANWADI  
WORKERS    5.NUTRITION EDUCATION    6.NUTRITION PROGRAMME  
ADOLESCENT GIRLS    7.ICDS    8.KISHORI SHAKTI YOJANA    9.STATUS OF  
ADOLESCENT GIRLS.

7. Solidarity Among Women, Thiruvananthapuram, Kerala. (2002).  
Adolescent girls scheme - an evaluation in Kerala. Thiruvananthapuram,  
Kerala : SAW. 94 p.

**Abstract** : Adolescent Girls (AGs) Scheme aims to increase awareness about maternal and child care practices among out of school adolescent girls. This study reviewed the efficacy of the AGs scheme in four less developed Northern districts of Kerala namely Palakkad, Malappuram, Wayanad, and Kasagode. A total of 1530 respondents were selected, of whom 500 were AG beneficiaries, 500 were mothers

of beneficiaries, 150 were non-beneficiaries, and there were 150 local leaders, 150 AWWs, 50 Supervisors and 30 CDPOs. It was found that 30.20% of the girls were 14-15 years of age, followed by 29.20% and 28.60% in the 11-13 and 14-15 years age group. 12% girls were in the 18 years category. Nearly 16% of the girls were married at age 18 years and less. Mostly tribal girls were married off early, before 18 years and had one or two children also. 46.34% had studied less than SSLC and 3.57% were illiterate. Nearly 69.64% girls knew about the scheme from the AWC or AWW. 92% of the girls felt that the scheme had helped them to want to return to studies, however only 25% to 30% had done so, that also not to regular formal studies, but to local parallel schools or private tuition or had enrolled in correspondence studies. Training was found to be satisfactory by 88% AGs. AGs clubs were as effective as self help groups (SHGs) in Kerala, which have done much to empower women economically and build their self confidence. 42% of the AGs shared an equal status with the men folk in their family; 55% gave a negative response. The greatest problems were lack of support from parents and the timings of the scheme. Nearly 58% of the girls wanted to study more health related issues like growing up, AIDS, pregnancy, etc. 40% girls wanted to know more about job oriented programmes. The mothers of AGs were not aware of the programme. Even if their daughter was a beneficiary, the mother had not taken any interest to understand the scheme. Those mothers who were aware of the scheme felt that the scheme was good. 68% mothers mentioned that the time spent by their daughters on Anganwadi work was taking them away from doing households chores. 38% of the mothers who were part of SHGs were more accommodative and were conscious that the AGs scheme could help their daughter prepare for a life in future. 38% of the mothers wanted job oriented training; they were unaware that the scheme would not give a certificate for a job. Local leaders mentioned that the health and nutrition education given to mothers should be ranked first because mothers have the greatest responsibility in forming the girl child's character. Almost all local leaders did not know anything about the scheme, nor did they ever participate in any activities of the scheme. The AWC in Kalpetta was outstanding in many aspects and ICDS was functioning best there. Attappady block in Palakkad was found to be lacking in many indicators of performance, due to problems in networking with other agencies. Tribal girls were not active in the scheme; they were hesitant to participate and the workers were not very keen on their participation. Non-beneficiaries had little idea about the scheme. All AWWs mentioned that they were facing shortage of funds and of trained resource persons. They were over burdened with work. Resource persons should conduct trainings. Awareness training should be conducted for officials and local leaders ensure their cooperation and participation. The timing of classes should be decided by AGs, their parents and the implementing staff. Training team should consist of at least one female to help girls overcome their anxiety to raise questions on personal issues. 'High risk' AGs require extra attention. Tribal girls should be induced to join the scheme by reinforcing the benefits to be gained. Cultural

programmes, art and sports competitions must also be held to encourage the talent of AGs and also to attract them to the scheme.

**Key Words** : 1.CHILD WELFARE 2.ADOLESCENT GIRLS SCHEME  
3.EVALUATION ADOLESCENT GIRLS SCHEME 4.ICDS 5.NUTRITION  
PROGRAMME ADOLESCENT GIRLS 6.ROLE OF ANGANWADI WORKER  
7.KERALA.

## DESTITUTE CHILD

8. Joshi, Harish, Visaria, Leela and Bhat, Rajesh. (2006).  
Children without childhood. Ahmedabad : Ahmedabad Study Action Group.  
63 p.

**Abstract** : Street Children is a global urban phenomenon and their number is increasing. Among them, the children who have runaway from their homes and are struggling for survival on their own, and those who have no families are the most vulnerable. This study was conducted in response to a need expressed at a large GO-NGO meeting in Ahmedabad to discuss child rights. This study endeavours to bring to light some details of the lives of these vulnerable street children so that those working with them get clues to devise their strategies for operation. The study was conducted at the main Kalupur Railway Station and under the nearby Sarangpur bridge. 153 street children were interviewed to find out the reasons for leaving home, place of stay, duration of stay, occupations followed, earning and expenditure, harassment, treatment of sickness, willingness to study and feelings about being away from homes and family members. For the in depth study 34 street children were interviewed. NGO officials, hotel owners where street children went for meals, owners of food stalls at Kalupur Railway Station, and traders who were contact with these children cast insight on this issue. Out of 153 street children, three were girls (2%) and these were also not on the street but interviewed at the Observation Home for Girls situated in Odhav where they were kept. More than 50% of the street children were 15 to 17 years or older, children aged 8-10 years were about 8%, and the rest were between 11-14 years. Nearly 33% of the children were literate and 58% had received some primary education ranging between Classes 1-7. Nearly 10% had studied beyond Class 7. As nearly 66% of the street children had some schooling, re-entry into the school system and resumption of their education could be done with the help of 'bridge courses', and connecting them with the National Open School System to help in their rehabilitation. However, children's lack of will, attractiveness of street life and sense of independence, fear of formal schools and punishment

meted to children by teachers, language barriers, paper work, delays/ hurdles, absence of good bridge courses, and most importantly, the main stream school system's insensitivity to the special needs of such children were hurdles. Most of the children could communicate in Hindi and Gujarati languages. Only 5 of the 34 children interviewed in-depth were unable to write in any language. 40% children were from Gujarat, and the rest were from Uttar Pradesh (13%), Bihar (12%), Madhya Pradesh (7%), Maharashtra and Rajasthan (13%). 14% came from Delhi, Tamil Nadu, Punjab and West Bengal, and also Nepal from where three children came. About 16% of the children had come with their relatives or friends, but could not specify whom they met first after coming to Ahmedabad. To survive street children (SC) undertook a variety of occupations – bottle picking (22.9%), cleaning train compartments and begging (5.9%), plying pedal rickshaws (10.5%), helping as cooks (9.2%), selling items (8.5%), working at tea/ snack stalls (9.8%), rag picking (12.4%), and other occupations (14.4%). On an average SC worked 7.7 hours a day; younger children spent 7.5 hours a day working, and older children spent 7.8 hours a day. 45% SC had stayed in Ahmedabad for more than 2 years, 26 children had been there for less than a month, and of them 8 had not yet found any gainful work. SC woke up early in the morning, 12.4% children between 3 and 4 a.m., 34.6% children between 5 and 6 a.m., 26.8% at 7 a.m., and 26.1% had no fixed time. SC spent their money on food (78.4%), *gutkha*/ smoking (55.6%), cinema (17.0%), gambling (14.4%), drugs (13.1%), and other things (20.9%). Children who saved money were bottle picking (Rs. 32/ day), rag picking (Rs. 22/ day), pedal rickshaw pullers (Rs.48/ day), helping cooks (Rs. 54/ day), selling items (Rs.64/ day), working at tea/ snack stalls (Rs.25/ day), cleaning train compartment (Rs.51/ day) and in other occupations (Rs. 50/ day). Among the reasons for leaving home were harassment by family members (38.6%), being orphans (15.7%), for earning (13.7%), fight with friend/ teacher/ family (7.8%), did not want to study (8.5%), family disintegration (3.3%), other reasons (12.4%). When SC fell sick they generally went to a medical store for self medication (27.5%), Government hospital (23.5%), private clinic (13.7%), NGO centre at station (13.7%), and 33 (21.6%) children had never fallen sick after leaving home. 85% of the children were addicted to drugs. The most essential services required by street children were night shelter (61.8%), clothes (38.2%), medical treatment (26.5%), toilet and bathroom (23.5%), education (20.6%), food (11.8%) regular employment (5.9%), financial assistance (2.9%) and other services (20.6%). SC should be rehabilitated by Government and NGOs. For legislation to be effective, measures encompassing education, employment and income generation, and child welfare must accompany it. The phenomenon of street children cannot be eliminated in a short spell of time. The focus also has to be on improving the living conditions of SC and protecting them from exploitation for which well coordinated and committed efforts are required.

**Key Words** : 1.DESTITUTE CHILD 2.STREET CHILDREN 3.AHMEDABAD  
4.PROBLEMS OF STREET CHILDREN 5.GUJARAT.

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Children on the wheels : issues of child protection and the situational assessment exercise of the railway children in New Delhi Railway Station : a Prayas Sathi joint report. New Delhi : Prayas. 23 p.

**Abstract** : A large number of platform, street and working children use railway platforms for their survival. Prayas Juvenile Aid Centre recognized the need for carrying out an intervention study at the railway platform. Therefore a survey was conducted by a joint team of volunteers and coordinators with the cooperation of Northern Railways, Railway Protection Force, Infosys Foundation, Saga Charitable Trust and Railway Children (UK). The study assessed the number of children who leave home; where they come from; the problems faced by them when they actually land up on New Delhi Railway Platform; and recommend child protection strategies which could be undertaken in partnership. The study involved professional researchers, porters, higher level authorities and groups of street and working children. During the study period, it was observed that approximately 150 children came to the railway station on a daily basis. 795 children were selected for interview. The children working on platforms were between 6-18 years. Among them 1% were around 6 years old, 12% were between 8-11 years old, 50% were between 12-15 years, and 37% were between 16-18 years. 42.27% children had been staying on the platform for between 1 day to 2 months, 28.18% children had been staying at the platform for between 3 months to 13 years. Children who had been staying on the platform for more than 1 year were very much addicted to living on the platforms and they were not willing to go back home. About 24.66% children had a single parent, 7.16% children were orphans, 5.91% children did not know whether their parents were alive or not. Most of these children's parents were very poor and daily wage earners. About 13% children were found begging on the platforms, 8% children swept the platforms, 32% children worked in the shops/ kiosks/ *dhabas*, railway luggage office, etc, 10% children were rag pickers and 37% children were not doing any work but were just idlers. 52% children were happy staying on the platform, 6% were angry, and 27% children felt scared/ fearful staying on the platform. 15% children were confused as to whether they were happy or fearful. 46.03% children were addicted to consuming drugs, solutions, alcohol, smoking, etc. 47.93% of the children were not addicted to any substance. Information about 6.04% children could not exactly be ascertained. Daily earnings of the children were between Rs. 50-300. 26.66% children earned between Rs. 50-100 per day; 58.49% children earned between Rs. 100-200 rupees / day; and 14.85% children earned between Rs. 200-300 per day. The usual working hours of these children were between 5-12 hours a day. 26.67% children worked between 5-7 hours; 61.38% children worked between 7-10 hours; and 11.95% children worked 10-12 hours a day. The main reason for children to run away from home were fights with their parents/ siblings, etc., for education, for repaying a loan, for freedom, due to abject poverty, etc. 11.95% spent most of their money on cigarettes or alcohol, 47.79%

gambled, and 16.35% children spent their money on movies, travelling, etc. 23.90% children spent their income on their home. It was recommended that there is a definite need for NGOs like Prayas, Sathi, Government departments and other concerned NGOs to be available constantly on railway stations with a variety of child protection services. NGOs should concentrate more on providing direct support to these children and make them understand that their life is more comfortable and safe at their home rather than on the platform. A special centre for drug de-addiction and counselling should be established. There should be good shelter home facilities for these children. There is a definite need to create a database of children who are placed at homes and missing children, and develop child tracking system with the cooperation of Police and National Crime Records Bureau (NCRB).

**Key Words :** 1.DESTITUTE CHILD 2.STREET CHILDREN 3.RAILWAY PLATFORM 4.RAILWAY STATION 5.CHILDREN IN NEED 6.EXPLOITATION CHILDREN 7.STREET AND WORKING CHILDREN 8.PLATFORM CHILDREN 9.NEW DELHI RAILWAY STATION 10.DELHI.

## HEALTH

10. HNB Garhwal Univ., Dept. of Anthropology, Srinagar, Uttarakhand. (~2006).  
Care of neonate, pregnant and lactating women in Uttarakhand : a study of Jaunsari, Tharu and Bhotia tribes : study report. Srinagar : HNBGU-DA.  
71 p.

**Abstract :** Tribal and remote communities are more susceptible to health and nutrition related problems largely due to ignorance, poor socio-economic conditions, inaccessibility to modern health facilities and deep-rooted traditional beliefs and taboos. This study was designed to investigate the nutritional profile of neonates, pregnant and lactating women and traditional child care practices. The study was conducted in the tribal inhabited blocks located in Dehradun, Chamoli and Udham Singh Nagar districts of Uttaranchal state of India, and the three major tribes selected were the *Jaunsaris*, *Bhotias* and *Tharus*. Data was collected through a house to house survey and a sample of 137 infants, including 53 neonates and 84 suckling infants, and 187 women including 53 pregnant and 81 lactating mothers were selected. The mean age of marriage was found to be highest among *Bhotias* (21.45 years) compared to *Tharus* (18.69 years) and *Jaunsari* women (16.03 years). Highest illiteracy was among *Jaunsari* women (67.7%), followed by *Tharu* women (42.3%), whereas in the *Bhotia* tribe around 41.15% women had attained above 10+2 level of education. The mean age at first delivery among *Bhotia*, *Tharu* and *Jaunsari* women

was 23.16, 20.52, and 18.86 years respectively. A vast majority of women among all tribal groups were housewives. Regarding suckling pattern of infants, *Tharu* neonates showed the highest suckling episodes (7–9 per day); among the *Bhotias* majority of them (58.8%) had between 4–6 suckling episodes per day, and the rest (41.2%) had 7–9 episodes. In the case of *Jaunsaris*, majority of neonates (61.1%) suckled between 7–9 times a day, followed by 33.3% of them who suckled 4–6 times a day. The study showed that *Jaunsari* lactating mothers of infants were shortest, lightest but fattest of the 3 groups, whereas pregnant women of *Tharu* were the leanest among all the groups. The mothers of new born babies in *Jaunsari* and *Bhotia* tribes were taller as compared to pregnant women, whereas the *Tharu* women with nursing infants were shortest. The study found that the intake of various nutrients (Protein, Fats, Energy, Carbohydrates, Calcium and Iron) by pregnant, neonate's mothers and lactating mothers of *Jaunsari*, *Bhotia* and *Tharu* tribal women was much below the level recommended by ICMR, 2002 (Indian Council of Medical Research). The daily calorie intake of the sampled infants of all the tribes was less than the level recommended by ICMR, and ranged between 43 kcal/ day to 280 kcal / day. Due to this, the majority of infants had slightly low weight-for-age and low weight-for-stature (height). The percentage of stunted neonates in all three tribes was very high, as revealed by height or length for age; the percentage of short infants was less among suckling infants compared to neonates. Majority of all the three tribes were only mildly malnourished as per their weight-for-age indicator. It was suggested that Public Awareness Programmes should be launched in tribal areas to inform about the benefits of a balanced diet, and to dispel doubts about food items. Public health authorities of the state should get together and explore various health aspects of the tribal population. A state level policy, with proper monitoring system for tribal welfare, would help in integrating the ongoing development activities with special emphasis on women and child development.

**Key Words** : 1.HEALTH 2.TRIBAL MATERNAL CARE 3.TRIBAL HEALTH  
4.HEALTH TRIBALS 5.MATERNAL CARE TRIBALS 6.CARE OF NEW BORN  
7.TRIBALS 8.CUSTOMS TRIBALS 9.BELIEFS TRIBALS 10.JAUNSARI TRIBE  
11.THARU TRIBE 12.BHOTIA TRIBE 13.UTTARAKHAND.

11. International Institute for Population Sciences, Mumbai. (2007).  
National Family Health Survey (NFHS-3) 2005-06 : India : Vol.I. Mumbai :  
IIPS. 540 p.

**Abstract** : The National Family Health Survey (NFHS), initiated in the early 1990s, has emerged as a nationally important source of data on population, health and nutrition for India and its states. The National Family Health Survey – 3 (NFHS-3)

was designed to provide estimates of important indicators on family welfare, maternal and child health and nutrition. NFHS-3 also provides information on several new and emerging issues, including family life education, perinatal mortality, adolescent reproductive health, high risk sexual behaviour, tuberculosis and malaria, and domestic violence. NFHS-3 collected information from a nationally representative sample of 109,041 households, 124,385 women aged 15-49 years, and 74,369 men aged 15-54 years. The NFHS-3 sample covered 99% of India's population living in all 29 states. From among all the women and men interviewed nationwide, 102,946 were tested for HIV. It was found around 35% of the population was below 15 years of age (37% in rural areas and 30% in urban areas), 56% were between 15-59 years, and 9% of the population was above the age of 59 years. Only 55% women in the age group 15-49 years were literate, whereas 78% men were found to be literate. More than 50% women were married before the legal minimum age of 18 years and 58% men were married by the age of 25 years. Around 70% of urban total fertility and 63% of rural total fertility was concentrated in the prime childbearing age of 20-29 years. Around 98% women and 99% men (15-49 years) knew one or more methods of contraception. Over 94% women and men knew about female sterilization whereas male sterilization was known to only 79% women and 97% men. Knowledge of contraception was widespread among adolescents (96%). Contraception prevalence rate varied from 73% in Himachal Pradesh and 71% in West Bengal, to 30% in Nagaland and 24% in Meghalaya. NFHS-3 estimated that infant mortality was 57 deaths per 1000 live births. In 2001-05, the infant mortality rate was 50% higher in rural areas (62 deaths per 1000 births) compared to urban areas (42 deaths per 1000 births). Infant mortality was highest in U.P. (73%) and lowest in Goa (15%). The perinatal mortality rate, which included still births and very early infant deaths, was estimated at 49 deaths per 1000 pregnancies that lasted 7 months or more for the 2001-05 period. The perinatal mortality rate was highest in rural mothers due to less education and also mothers in the lowest wealth quintile. Only 44% pregnant women started antenatal care during the first trimester of pregnancy; 22% had their first visited during the 4<sup>th</sup> and 5<sup>th</sup> month of pregnancy; and just over half of mothers (52%) had 3 or more antenatal care visits. Fewer mothers received IFA (Iron Folic Acid) tablets in rural areas (61%) compared to urban areas (76%). Tetanus Toxoid coverage increased with the educational level of women, and was considerably higher in urban areas (86%) compared to rural areas (73%). Around 39% births in the 5 years preceding the survey took place in health facilities, more than 50% took place in the woman's home, and 9% took place in their parents' home. Urban residence, education and wealth were all strongly and positively associated with the likelihood of an institutional delivery. Several states from North Region (U.P.), Central Region (Chhattisgarh, M.P., and Rajasthan), East Region (Bihar and Jharkhand) and Northeast Region (Arunachal, Assam, Meghalaya and Nagaland) performed poorly on safe motherhood indicators. By contrast, Mizoram performed above the national average on delivery care indicator and postnatal care indicator, but poorly on the antenatal care indicator. Nationally, 72% of the NFHS-3

sample enumeration areas were found to be covered by an AWC and 62% were covered by an AWC that had, by the time of the survey, existed for at least 5 years. It was found that only 28% of the children had received any service from an AWC in the year preceding the survey. Around one in five mothers received any service from an AWC during pregnancy and lactating period. Only 25% of last born children who were ever breastfed started breastfeeding within one day of birth and almost 45% did not start breastfeeding within one day of birth. Almost 69% children under 2 months of age were exclusively breastfed. NFHS-3 found that only 25% of children aged 12-35 months received vitamin A supplements in the 6 months before the survey. Almost 48% children under 5 years of age were stunted and 43% were underweight. Around 24% under fives were severely underweight. The prevalence of anemia was considerably higher in rural areas, among children of women with no education, among scheduled castes (SCs) and scheduled tribes (STs), and among children in households in the lower wealth quintiles. Almost 7 in 10 children aged 6-59 months were anemic, included 40% who were moderately anemic and 3% who were severely anemic. Only 44% children aged 12-23 months were fully vaccinated, (BCG, DPT and Polio) and 5% had not received any vaccinations. Nationally, 36% women and 34% men in the 15-49 years age group had BMI (Body Mass Index) below 18.5 which indicated chronic nutritional deficiency. Regarding knowledge of HIV / AIDS it was found that overall, approximately 4 in 10 women and 7 in 10 men knew each of the 3 ABC methods of prevention – abstinence, being faithful, and using condoms. Nationwide, the HIV prevalence rate for population aged 15-49 years was 0.28%. Women's participation in decision making was highest in all the Northeastern states except Tripura, as well as in Delhi, Tamil Nadu, Kerala and Goa. Overall, 35% women aged 15-49 years in India experienced physical and sexual violence. The study will provide policy makers and programme managers with up to date estimates of indicators that can be used for effective management of health and family welfare programmes with an emphasis on both, the reproductive and nutritional health aspects.

**Key Words :** 1.HEALTH 2.NATIONAL FAMILY HEALTH SURVEY 2006  
3.NATIONAL FAMILY HEALTH SURVEY 3 4.CHILD HEALTH  
5.IMMUNIZATION 6.INFANT MORTALITY 7.CHILD MORTALITY  
8.MATERNAL HEALTH 9.NUTRITIONAL STATUS 10.MICRONUTRIENT  
DEFICIENCY 11.ANAEMIA 12.BREASTFEEDING 13.WOMEN AND  
CHILDREN 14.TEENAGE PREGNANCY 15.CHILD MARRIAGE  
16.DOMESTIC VIOLENCE 17.ICDS 18.AIDS PATIENTS 19.FAMILY  
PLANNING.

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Verification of last doses of vaccines for various vaccination programmes and verification of third pre-natal checkup of pregnant women and third post natal check up of women after delivery. Guwahati : Gauhati Univ., Population Research Centre. 40 p.

**Abstract** : Women in the reproductive age group and children under the age of 15 years constitute two-thirds of India's population. Their health status represents to a great extent the health of the nation. The present study examined the accuracy of records with that of immunizational status of children who received last doses of different types of vaccines, mothers who got third check-up at the time of pregnancy, and also check-up after delivery. The study was conducted in 10 wards of Halakura and Golokgonj in Dhubri district of Assam and covered 31 sub-centres, 2 state dispensaries, 1 community health centre (CHC) and 1 mini Primary Health Centres (PHCs). The study surveyed 1471 households, 1096 children who received last doses of vaccines, 686 expectant mothers who received 3<sup>rd</sup> pre-natal check-up during pregnancy and only 15 mothers who received third postnatal check-up after delivery. Data was collected through interviews and field surveys. It was found that most households were dependent on agriculture; and around 34% of the families had annual income between Rs.10,000 – 20,000/-, which indicated that the households were not economically sound. Almost 19% husbands and 29% wives were illiterate. Comparison of statistics obtained from PHC/ SCs records and information obtained through personal interviews revealed that there was no discrepancy in the number of immunization cases (children who had received last dose of vaccines). Among males last dose vaccination decreased from 34% for 2<sup>nd</sup> birth order to 8% for birth order 5 and above. In the case of females also, last dose vaccination decreased from 35% for 2<sup>nd</sup> order birth to 7% for birth order of 5 and above. It was found that 77% male and 80% female children had their immunization cards at the time of interview. Most of the mothers of children who had no immunization card were illiterate and were housewives. The percentage of children not having immunization cards increased with increase of birth order. The recording of pre-natal check-up cases was accurate. About 96% mothers had registered their names after 16 weeks of their pregnancy. Only 2% pregnant mothers were not provided Iron and Folic Acid tablets. Haemoglobin test was not done for 72% pregnant mothers, and blood pressure was not checked for 46% pregnant mothers. Other examinations like foetal heart sound were not done for more than 80% pregnant mothers. Most deliveries took place at home (80%), followed by 13% deliveries in PHCs and 7% deliveries at CHCs. Home delivery were more common among illiterate mothers (50%) and those who had illiterate husbands (42%). Deliveries assisted by nurse/ midwife were found to be higher (33%) than the deliveries assisted by others. Normal deliveries were higher (92%) among those that took place at home. Around 60% mothers reported that their babies were not weighed at birth. However, majority of the mothers (87%) reported

that their babies were of average size at birth. About 69% mothers reported that they came to know about post-natal care from ANMs. 42% mothers had received advice on proper breastfeeding and 36% received advice that the baby should be kept warm after birth. However, only 8% mothers received advice on "ARI" and "Diarrhoea". It was suggested that some measures may be taken by higher authorities to identify the drawbacks of the immunization programme for children, pre-natal care for pregnant mothers and post-natal care of women after delivery, and policies should be made to make the health, immunization and nutrition programme successful.

**Key Words :** 1.HEALTH 2.IMMUNIZATION 3.IMMUNIZATION CHILDREN  
4.CHILD IMMUNIZATION 5.IMMUNIZATION PREGNANT WOMEN 6.POST  
NATAL CHECK UP 7.DHUBRI DISTRICT 8.NORTH EAST INDIA 9.ASSAM.

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Morbidity pattern and its association with malnutrition in preschool children in desert areas of Rajasthan, India. Jodhpur : Desert Medicine Research Centre. 8 p.

**Abstract :** Malnourished populations are more susceptible to most infections and the severity of illness and mortality rates are worse. The present study was done to examine the morbidity pattern of preschool children and find out the diseases prevalent in desert areas of Rajasthan. The study was conducted in the desert districts that were Barmer, Jaisalmer, Nagaur, Bikaner, Churu, Jodhpur, Sirohi, Jalore, Sikar, Pali and Jhunjhunu. A total of 538 households were covered and 834 preschool children were examined. The average family size was 6.34. Out of 834 preschool children, around 16.4% were found to be sick at the time of the survey. About 10.7% children suffered from skin morbidities, 8.9% from eye morbidities and 7.2% from fever. The study found that skin morbidity increased according to age and was maximum at the age of 2 years and then showed a decline. In most age groups, skin and eye morbidities were higher among females as compared to male preschool children, which could be due to the fact that girls were not given proper care as compared to boys in the desert areas. Another cause was typical to desert climatic conditions such as scarcity of water, extremes of temperature with high intensity of ultra violet rays, low rainfall and high density of silica particles in the environment. The overall prevalence of clinical Marasmus as judged by muscle wasting was 4.8% and the peak prevalence was observed between 12 and 24 months of age. Prevalence of the various signs related to protein calorie malnutrition (PCM) were depigmentation of hair (21.6%), dryness of hair (8.5%), sparseness of hair (3.2%) and moon face (0.5%). Regarding Vitamin A deficiency signs, the overall prevalence of Bitot's spots and Conjunctivitis Xerosis was

observed to be 1.6% and 2.8%. Angular Stomatitis, the major deficiency sign of B-complex vitamin, was observed to be 2.2%. Around 11.8% preschool children were anaemic. Other deficiency signs such as bleeding of gums (1%) were also observed. The study showed that morbidity was found to be higher in the low income group (up to Rs.600/ pm) i.e. 52.6%, and it was low in the high income group. Morbidity decreased as the level of education increased, i.e. from 44.5% to 15.6%. Regarding the type of family, nuclear families had higher morbidity (16.6%) as compared to joint families (15.9%). Poor housing conditions correlated with high morbidity (20.3%) compared to good housing conditions (11.9%). It was suggested that a strong need exists for planning and programming intervention activities for nutrition and health education in the desert area so that the percentage of morbidity among preschool children can be reduced.

**Key Words** : 1.HEALTH 2.CHILDHOOD ILLNESSES 3.CHILDHOOD DISEASES 4.MORBIDITY PATTERN 5.MALNUTRITION 6.PRESCHOOL CHILDREN 7.DESERT AREA 8.MALNUTRITION PRESCHOOL CHILDREN 9.RAJASTHAN.

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Study of prevalent maternal beliefs regarding diet during common childhood illness in Thar Desert, Rajasthan. Jodhpur : Desert Medicine Research Centre, Jodhpur. 4 p.

**Abstract** : Malnutrition is a major health problem in developing countries where poverty and lack of education are also prevalent. The study was carried out in rural households of Thar Desert and the target population was young women having preschool children. 17 villages were selected, from three ecological sub-regions, i.e., Marusthali, Shekhawati and Luni basin. The sample size was 434 rural households calculated on the assumption that 12% to 15% of the total population was preschool children. Information on maternal beliefs regarding diet during common childhood illness, demography and other socio-economic aspects was collected through interviews from 434 rural young mothers who represented the entire caste groups present. About 94% of the women were illiterate, 48% belonged to lower and upper middle income groups, 98.6% were Hindus and 79% had nuclear families. The young mothers categorized food according to seasons. Nice food according to them was *mung* (green) bean and *arhar* (red gram) pulses (96.2%), onion (58.7%), *kair* (59.1%), *sangri* - dry pods of *prosopis cineraria* (54.6%), *kumathia* - seeds of *acacia senegal* (29.11%), spinach (57.7%), tomato, *desi* ghee, butter milk and oil (11.7%). Pearl millet (79.8), milk (58.2%), jaggery and water melon were considered as hot food. Wheat (79.9%) and *chhachh* - butter

milk (69.5%), rice, *rab* (wheat flour cooked in curd), and Bengal gram are considered as windy food. Millet was considered as heavy food by 96.2% women. During diarrhoea, 37% to 42% women preferred to give rice, curd, *zeera* and turmeric as they considered these as cold and light foods, which help in reducing the frequency of diarrhoea and dysentery. Restricted food included pearl millet *roti* (*bread*) (37.4%), vegetables (37.1%), ghee (38.8%), oil, jaggery, chillies and pulses. It was observed that during attack of measles and typhoid most women gave only *lehta* (slush) of pearl millet with sugar (33 to 40%), *khichri* (rice and pulses), milk and tea, roasted gram, and raisins with *jaiphal* (nutmeg) considering these items as hot and helping in early appearance of rashes. Results revealed that 80% to 90% women avoided *roti*, vegetables, ghee, oil and *khatai* (sour food). Restrictions on food were followed by majority of mothers, which is no longer a part of modern system of treatment. Human body requires more nutrients during illness due to increased metabolic demands of the body. Restriction of food due to prevalent beliefs in rural population reduces the nutrient intake and may lead to protein calorie malnutrition. The study recommends that while planning a nutritional and health education programme for desert areas, culturally accepted food should be given due consideration, by encouraging useful practices and discouraging harmful ones.

**Key Words** : 1.HEALTH 2.CHILDHOOD ILLNESSES 3.MATERNAL BELIEFS  
4.FOOD BELIEFS 5.FOOD TABOOS 6.DIET DURING ILLNESS 7.DESERT  
AREA 8.THAR DESERT 9.RAJASTHAN.

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Childhood illnesses and malnutrition in under five children in drought  
affected desert area of western Rajasthan, India. Jodhpur : Desert Medicine  
Research Centre. 9 p.

**Abstract** : In desert areas of western Rajasthan, drought occurs frequently. The present study was undertaken to assess the impact of drought on childhood illness and nutrition in under five children of the rural population. The study was carried out in 24 villages belonging to 6 *tehsils* of Jodhpur district which was a drought affected desert district of Western Rajasthan. A total of 914 under 5 children (0-5 years) could be examined for their childhood illness history, malnutrition, dietary intake and clinical signs of nutritional deficiency. The main childhood illnesses observed during drought were respiratory (7.5%), gastroenterological (7.5%), and fevers (viral, malaria and jaundice) (5.6%). Male children were reported to have significantly higher illnesses (28.5%) than females (18.7%). Other illness observed were ear disease (2.1%), skin problems (0.5%) and eye disease (0.2%). All childhood illnesses showed increasing

trend with age, i.e. 13% in infants to 26.0% among children in 4-5 years age group. Recent malnutrition (weight for age) was observed to be 39%. Highest level of recent malnutrition was observed in 1-2 years age group. Girls were found to be more malnourished (40.8%) as compared to boys (36.1%). Overall 25.8% children suffered from chronic malnutrition, i.e. long term malnutrition. Chronic malnutrition was also higher in girls (31.2%) than in boys (20.4%), particularly among children aged 1-2 years. The overall prevalence of Anaemia was observed to be 30.5%. Prevalence of various signs related to Protein Calorie Malnutrition (PCM) was observed to be high, i.e. discoloration (20.2%), dryness of hair (21.6%), and others which accounted for 2.6% only. Prevalence of Marasmus was 1.7%. All signs associated with PCM were observed to be higher among girls (46.3%) than boys (42.8%). Vitamin A deficiency sign (*Bitot Spot*) was observed in just 0.2% children, and no night blindness was observed. The overall prevalence of Vitamin B complex deficiency was seen in 3% children, and Vitamin C deficiency was observed in 0.1% children. The study suggested that firstly, gender differences should be removed by giving proper education to community people; also, effective measures to make adequate calories and proteins available to all age groups, especially to under 5 children through the ongoing nutrition programmes, needs to be ensured.

**Key Words** : 1. HEALTH 2.CHILDHOOD ILLNESSES 3.CHILDHOOD DISEASES 4.MALNUTRITION 5.DROUGHT AREAS 6.PRESCHOOL CHILDREN 7.UNDER FIVE CHILDREN 8.MALNUTRITION PRESCHOOL CHILDREN 9.RAJASTHAN.

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Migration and vulnerability to HIV/AIDS : towards evolving viable intervention strategies. NOIDA, UP : V.V. Giri National Labour Institute. 83 p.

**Abstract** : Labour migration has long been viewed as an important concomitant of economic development. The present study was done to analyze the macro patterns of internal labour mobility; investigate the profile of migrant workers and households in the areas of social, economic, health and behavioral characteristics; and identify the general factors of vulnerability to HIV/ AIDS. Through various sources, it was found that major destination centres for a large number of migrant workers and sites of high incidence of HIV/ AIDS were the metropolitan centres in India. Therefore, Delhi including Noida (Uttar Pradesh), was chosen as a destination centre and primary survey was conducted there. Research also revealed that Bihar was one of the regions from where a large quantum of seasonal / circular migration originates so Bihar was also chosen for primary survey in terms of the originating centre. A total of 500 male migrants, and 100 female migrant workers between 15-40 years were

selected from Delhi, and a total of 300 migrant households were selected from Bihar. Data was collected by interviewing migrants and through secondary sources. 58% male migrants and 93% female migrants were married, whereas only 7% female migrants and 42% male migrants were unmarried. Around 62% male migrants were educated up to primary level, whereas 65% female migrants were illiterate. Almost all migrant workers were born in rural areas and had migrated to urban areas in search of employment. Majority of the male migrants were from Bihar (55%) and Uttar Pradesh (35.8%). Majority of the female migrants were from Uttar Pradesh (43%) and Bihar (33%). Lack of sufficient earning was the major reason for migrant workers to leave their previous place of stay. The average monthly earning of males was Rs. 1265.24/- and females was between Rs. 600-1200/-. Majority of the migrant workers worked all days in a week. One important variable related to HIV / AIDS among males was the frequent visits to their hometown. Around 50% males reported that they went home twice a year, 25.6% went annually, and 12.4% went quarterly; whereas 44% female migrants reported that they rarely visited their hometowns. About 76% male respondents consumed liquor along with their friends, and as they have no other entertainment, it also became a habit with them. The study showed that almost all females stayed with their husbands, parents or siblings. Around 8% males were affected by physical ailments such as body pain, vomiting, loose motions, fever, etc and about 18% reported that they suffered from T.B., jaundice, high blood pressure, etc, either in the past or present. Females reported that they were affected by ailments only occasionally. Less than 18% of the male respondents had contracted STDs, and the initial response of majority of the infected persons, (60.2%) was to ignore it. Among females only 5% suffered from STDs. The non-reaction to STDs treatment was due to their lack of disposable income, and also due to fear that they would be looked down upon by society. About 46% married male migrants reported that they had or continued to have sexual relations outside their wedlock. Among unmarried migrants, 45% stated that they already had sexual relations, whereas none of the female migrants had extra marital relations. About 89% male migrants were aware about condoms and their benefits, however only 57% knew how to use it. 30% female migrants knew about condoms, but only 22% knew how to use them. About 61% migrant households had information about condoms but only 33% of them knew how to use them; and 43% of them had some idea about HIV / AIDS but the rest of them had never heard of it. Around 75% male migrant labourers became aware of HIV / AIDS through T.V., radio and advertisements. Only 21% female respondents had heard about HIV / AIDS, and 19% reported that sex was the medium of HIV / AIDS transmission. Majority of male respondents (55%) knew that multiple sex partners were a cause of HIV / AIDS and condom use could eliminate the risk of infection. About 72% migrant households reported that they were economically poor, and 70% households lived below the poverty line. Around 58% were extended families, and about 40% heads of households were illiterate. It was suggested that migrants should be provided better health facilities, and extended health education on issues such as HIV / AIDS, STDs,

etc. Also, there is need for advocacy to remove stereo types and misapprehensions about migrants.

**Key Words** : 1.HEALTH 2.AIDS MIGRANT WORKER 3.MIGRANT WORKER  
4.HIGH RISK GROUP 5.PROBLEM OF MIGRANT WORKER 6.SLUM  
DWELLERS 7.HEALTH SLUM DWELLERS 8.SEXUAL BEHAVIOUR.

## ICDS

17. Banerjee, Sangita. (1999).  
A Study on community participation in ICDS at North Calcutta. Kolkata :  
Vidyasagar School of Social Work. 72 p.

**Abstract** : Community participation increases the effectiveness of any programme including ICDS. This study investigated how better community participation can be ensured. It covered a total population of 854, among whom were 15 mothers and 15 fathers of beneficiary children, 10 were non beneficiary parents, representatives of local organisations and 5 were functionaries of different centres. Fathers of beneficiary children mentioned that they could not earn money if they did not go outside the home and the adult family members looked after their children. Only 7 out of 15 mothers reported correctly about the programme services for children rendered by ICDS. Mothers of the beneficiary children were encouraged by family members to send their child to the centre. 3 respondent mothers reported that slum children did not get adequate food, proper education, etc. Most respondent mothers knew about the reasons for starting ICDS in their area. 9 mothers mentioned that AWWs visited their homes once or twice every three months, while 4 said they visited every month, and 2 were not happy with the AWW because they had no fixed time and they were not delivering services satisfactorily. Out of 15 respondents, 13 were involved in Jeevandeep programme to promote savings habit among the mothers of beneficiary children. Respondents were not aware about the facilities provided to pregnant women from the centre. They said they would be more interested if the AWW could visit them more often, twice in a week, and more people would get involved in the programme. The non-beneficiary respondents mentioned that there was no relation or co-ordination between the local clubs, youth organisations, and Mahila Mandals with the AWC. Out of 10 non-beneficiary respondents, 9 had not played any important role for the betterment of the centre; only one father had helped in searching space for the AWC in their locality. It showed that AWWs had no links with people who were not getting benefits from their centre. 3 non-beneficiary respondents mentioned that the behaviour of AWW was not good; they favoured healthy, good looking and well-dressed children. 2 mentioned that the quality of food distributed at the centre caused stomach trouble, therefore they were not sending

their children to the AWC. Beneficiary respondents requested that uniforms should be provided for beneficiary children like in other schools, there should be a programme for them, and more effort should be on motivational work. There is need to have a short duration preparation phase to raise awareness of the community about benefits of ICDS before launching the scheme in that area. Self help should be encouraged as per the capabilities status of the community. Authorities should provide uniforms to beneficiary children and supply good quality food grains and adequate medicine. ICDS functionaries should not have any bias or show partiality to any child, and supervisors should see that AWWs carry out their responsibilities effectively.

**Key Words** : 1.ICDS 2.COMMUNITY PARTICIPATION IN ICDS 3.ICDS WEST BENGAL 4.CALCUTTA 5.WEST BENGAL.

18. Centre for North East Studies and Policy Research, Guwahati. (2006).  
Final report on functioning of anganwadi centres in Assam and Meghalaya.  
Guwahati : CNESPR. 230 p.

**Abstract** : The Centre for North East Studies and Policy Research (CNESPR) conducted a study to assess the functioning of ICDS in the AWCs of Assam and Meghalaya. In Assam, Kamrup, Dhubri and Dibrugarh, and in Meghalaya, East Khasi Hills and West Garo Hills were selected. In Kamrup, about 35 (87.5%) centres out of 40 had 70-89 beneficiaries. On an average every centre had a total of 25.60 children in the age group of 0-3 years, and every centre provided services to nearly 6.33 pregnant mothers and 6.41 lactating mothers. The average number of live births were 6.10 per centre per year. Only 22.5% centres recorded the total deaths. On an average 1.22 deaths occurred per year. Out of the total 40 centres, 34 centres accounting for 85% provided immunization to the beneficiaries and 6 of the centres did not keep records of immunization. Only 31 centres provided PHC services to the beneficiaries, but 9 centres did not provide immunization services, and did not keep any record. On an average the centres provided immunization services to nearly 13.23 people, indicating a very low performance of the PHCs. In Dibrugarh, nearly 68% of the centres provided services to 5-9 pregnant mothers and 8 lactating mothers. Around 66% centres did not keep any record of the nutritional status of children. The average numbers of live births of children in all 40 centres were 7.36 and nearly 1.10 deaths took place yearly. In Dhubri district, on an average every centre had 97.16 beneficiaries and 42.63 children in the age group of 0-3 years. Only 37 centres maintained records and every centre had 5 pregnant and 5 lactating mothers. Only Dhubri district provided services to adolescent girls, and no other district had any AG beneficiaries which took advantage of the AWC. Most of the

centres (82.5%) had 5 AG, whereas 15% of them did not maintain any records. On an average, the centres had 4.91 AGs as beneficiaries. The average enrollment of children per centre was 40.26. 65% of the male children and 52.5% of the female children were among the 20-24 enrolled children. On an average there were 6.4 live births in every centre per year. Most centres had not recorded live births (62.5%). 2.5% of the centres had recorded more than 10 live births. Every centre had 1.33 deaths. 85% of the centres had not recorded any death. In East Khasi Hills every centre had nearly 96 beneficiaries. Every centre provided services to nearly 8.06 pregnant women and 7 lactating mothers. The average enrollment per centre was 34.63 children. In 14 centres majority of the children had normal nutritional status i.e. 35% of the children had average diet. On an average every centre had 9.94 live births yearly. In West Garo Hills, 7 centres catered to the needs of nearly 60-69 child beneficiaries. Every centre averaged 85.13 beneficiaries. 53% of the total centres provided services to 5-9 pregnant women and 8 lactating mothers. 41.10 children were enrolled per centre. In 35% of the centres children had average growth (52.18). The number of children who had normal growth was between 50-59. In 15 centres the growth of children was below normal, whereas the children of 11 centres had better nutritional status. Most of the centres did not maintain proper records of the nutritional status of children. The average number of live births were 10.31 annually. Only 27 centres maintained death records, while 13 centres did not maintained them. The number of deaths per year was 2.07. AWCs provided immunization services to nearly 28.77 beneficiaries. Only 32 centres provided immunization services through PHCs, but 8 of the centres did not keep the record or they did not provide immunization services. In all districts, 5% centres did not keep any record of the services related to pregnant and lactating mothers. Either they did not provide any services or they were not aware of this service. More than 85% women in rural areas and 98% in remote areas gave birth at home. Only about 42% women in Meghalaya and 58% in Assam had access to safe delivery facilities. Most of the centres in West Garo Hills and East Khasi Hills were in interior villages and were inaccessible. There were no transport facilities. There were many complaints against the RTE packets as these were half opened and damaged. In several villages, pregnant women also refused immunization. Many parents did not allow their children to be weighed because of superstition. Community must be made aware of the benefits provided by AWCs. Services of ICDS should be available for every child under 6 years, not only for those from BPL families. Take-home rations (THR) for children should be provided on a regular basis. There is urgent need to revamp the training capsule and improve supervision and monitoring arrangements.

**Key Words :** 1.ICDS 2.FUNCTIONING OF ANGANWADIS 3.ANGANWADI CENTRES 4.ANGANWADI WORKER 5.PRESCHOOL EDUCATION 6.SUPPLEMENTARY NUTRITION 7.CASE STUDIES 8.NUTRITION IN ICDS 9.NORTH EAST INDIA 10.ASSAM 11.MEGHALAYA.

19. Indian Institute of Development Management, Bhopal. (2003).  
Presentation of Nutrition survey : endline survey of World Bank assisted  
ICDS-II projects in Chhattisgarh. Bhopal : IIDM. 40 p.

**Abstract** : World Bank assists ICDS projects so that qualitative improvement is achieved in services provided. The present study explored the functioning of World Bank assisted ICDS – II projects in Chhattisgarh, and assessed the existing level of ante- and postnatal care; breastfeeding and child care practices; awareness about Anganwadi centres; nutritional status of children and growth monitoring; their perception of the causes of under nutrition, i.e. health and other specific reasons; understand the resource base of beneficiary groups; and the manner in which they met their nutritional needs. The information related with this study has been collected from heads of households, mothers of children aged 0-3 years and 3-6 years, pregnant women, lactating women, adolescent girls and Anganwadi workers. The World Bank assisted 152 blocks in 16 districts, of which 61 were rural, 85 were tribal and 6 were urban blocks. The study covered 66 AWCs. 314 pregnant women were interviewed, 78% were in the age group 19-29 years; mean age was 23.8 years; 47% were illiterate, 18% had studied up to middle school, 4% in urban (new) and 4% in tribal (old) were graduates. It was found that T.T. injections were administered to 69% pregnant women (PW), out of them 64% had 2 injections. ANC check up was done by doctors in 45% cases and 89% PW were aware of the existence of AWC in the village. 71% PW were registered in AWCs, and of them 77% registered within 4 months. Weight of 14% PW was recorded every month. Advice on breastfeeding, child care and nutrition was given by elderly women (64%) and ANMs / AWWs (10%). Lactating Women (LW) interviewed were 321, their mean age was 24.6 years, and 53% were in the age group 19-24 years. Total illiterate women were 51% (tribal projects 67%; rural projects 55%; urban projects 30%). 11% LW took 100 IFA tablets and 54% took any number of IFA tablets; 89% were administered TT injections, and out of them 85% took 2 injections when they were pregnant. During delivery 87% LW had no complications. 86% women had home deliveries (rural projects 97%; tribal projects 94%; urban projects 59%). 24% newborns were weighed at birth, and the weight records of 58% infants were available in AWCs. 17% were low birth weight babies. Breastfeeding was initiated within 2 hours of birth in 45% cases, and 51% currently lactating women squeezed their first milk. During the last 2 weeks prior to the interview, 16% children were reported sick. Out of them 73% had fever, 29% had diarrhoea, and 22% had cough. Deworming tablets were given to 6% children. 52% LW collected supplementary food from AWCs. 77 adolescent girls (AGs) were interviewed in the study. Intake of vitamins, IFA tablets and supplementary nutrition was 31%, 4%, and 3% respectively. 11% AGs took IFA tablets for more than 3 months. 64% AGs were unaware of anaemia, and 80% had never undergone blood tests. 25% AGs had access to health / nutrition and family life education. 4616 mothers of children aged 0-6 years were interviewed. In 44% cases breastfeeding

was initiated within 2 hours of birth; and 54% mothers squeezed out their first milk. Average breastfeeding rate was 8 times a day. The mean age for starting semi-solid food was 7 months. Within 2 weeks preceding the survey, 21% children were sick. Of these, 77% had cough, 27% had fever, and 29% had diarrhoea. 76% of the 59 AWWs interviewed had both the trainings. Pre-school education was conducted for 5.7 days on an average. Family planning measures were available in 44% AWCs. Mahila Mandals were formed in all AWCs where health and nutrition education was imparted to women. Mothers were not aware of the causes of malnutrition in urban areas, and in tribal areas they believed malnutrition was a curse of God and Goddesses. In rural areas they believed ghee and milk would cure malnutrition. Efforts should be made to make the community aware about malnutrition and remove misconceptions about food through proper nutrition education.

**Key Words** : 1.ICDS 2.WORLD BANK ASSISTED ICDS PROJECTS  
3.NUTRITION IN ICDS 4.FUNCTIONING OF ANGANWADIS 5.ENDLINE  
SURVEY 6.SUPPLEMENTARY NUTRITION.

20. Kariyil, Antony and Sunny, Celine. (2001).  
A Study on redesigning the anganwadis in Kerala. Kalamassery, Kerala :  
Rajagiri College of Social Sciences, Research Institute. 142 p.

**Abstract** : This study attempted to make a realistic assessment of the time utilization by AWWs in relation to their multifarious tasks, and evolve appropriate strategies for improving the functioning of AWCs in Kerala. 400 AWCs and 10,470 respondents were selected. More than 90% of the workers were matric and 92% had undergone refresher training. 60% of the AWWs spent less than 150 minutes per day on PSE as against the stipulated time of 180 minutes; and in some centres less than 60 minutes were spent on PSE. In 88% centres majority of the AWWs (55.3%) spent less than 15 minutes on introductory activities. Checking the hygiene of children took below 10 minutes. In 13.3% centres hygiene was neglected. AWWs in tribal areas spent 20-30 minutes on informal talks. In 76.7% centres less than 20 minutes were assigned for motor activities, which should have been 30 minutes daily. AWWs in 25.3% never attended to this aspect. AWWs in 43% centres did not assign time for creative activities but more AWWs in tribal areas undertook creative activities than AWWs in rural areas. In 37% centres, AWWs spent less than the expected time for supplementary nutrition (SN). Urban areas had highest number of centres where AWWs allocated 90 minutes on SN. The average time spent for each house visit was to be 19-20 minutes, but AWWs in majority of the centres (69.8%) spent below 20 minutes for this. For maintaining records 27-30 minutes were spent daily, which was equivalent to the expected time. However, in certain centres more time was spent on

maintaining records. Almost 100% centres had weighing scales, and children were weighed regularly. More than 75% centres utilized morning hours for weighing children. Immunization camps were organized at the AWC in 66.8% cases, the rest were organized at the primary health centres. 80.5% of the AWCs held immunization camps monthly. AWWs spent one day each for project level and sectoral meetings. Time was spent for informing the community, making arrangements, taking sessions and reporting. The average time spent was 30 minutes each, but more than 90% of the AWWs spent below 30 minutes. There was no perfect referral in the centres. However, most centres provided referral services either partially or for namesake. AWWs mentioned that inadequate public cooperation hindered the smooth functioning of centres. Exhaustive tasks and lack of time stagnated their creativity for discharging their duties in a better way. Helper mentioned that absence of AWWs normally doubled their workload. Beneficiaries were satisfied with the on going services of the centre but they complained about the poor infrastructure in a majority of the AWCs. Majority of the key personnel appreciated the activities carried out by AWWs, but they also expressed the need to discontinue certain tasks like health services, surveys, number of meetings, number of registers to be maintained, house visits and panchayat related tasks. Efforts should be made, at the policy level, to exclude the AWW from undertaking health services. AWWs should only be entrusted with the task of supplying IFA tablets and other medicines in the kit. The number of registers and records to be maintained by AWWs should be reduced. The number of sectoral/ project level meetings should be reduced. A time frame should be fixed for specific activities/ services of the pre-school component. Indicators for monitoring allocation of time for various activities should be incorporated in the training module of the Supervisors and Child Development Project Officers (CDPOs). Strict measures should be taken by the authorities to minimize interruptions during pre-school activities.

**Key Words** : 1.ICDS 2.TIME MANAGEMENT 3.TIME ALLOCATION  
4.ANGANWADI WORKER 4.REDESIGNING ANGANWADIS 5.TIME  
MANAGEMENT ANGANWADI WORKERS 6.PRESCHOOL EDUCATION IN  
ICDS 7.JOB RESPONSIBILITIES OF ANGANWADI WORKER 8.HOME VISITS  
9.ICDS BENEFICIARIES 10.SCHOOL ENROLMENT.

21. Uttarakhand, Dept. of Women and Child Development,  
ICDS Unit, Dehradun. (2007).  
Community based monitoring system. Dehradun : ICDS Unit. ~30 p.

**Abstract** : Community based interventions aim at community development, and development projects like ICDS cannot be carried out efficiently unless all people in

the community participate actively. Community based monitoring system (CBMS) aims to induce behavioural change among community members to make the programme sustainable and feasible. This project seeks to induce change so that the community shares equal responsibility in the delivery of services. The study was conducted in 65 AWCs from 3 blocks of Uttaranchal and covered Thatyur (tribal block), Chamba and Bhilangana (non-tribal blocks). Focus Group Discussions (FGDs) were organized in each of the 20 villages, and the participants were Gram Pradhan, influential persons like PRI members, SHG members, teachers, and the Anganwadi worker. It was found that the respondents were generally satisfied with the frequency of distribution of supplementary nutrition. In two villages, Bangoli in Chamba and Indrola in Bhilangana, supplementary nutrition was given weekly. In Titrana, Dauni, and Maiti villages of Bhilangana, SN was supplied irregularly. The community was hardly aware about this fact and it emerged that registration with AWC was being done primarily to distribute SN. In almost 33% villages, pregnant women did not get themselves registered at the AWC. The importance of health check-up was least understood and it was advocated by all that a strong awareness drive must be launched to strengthen this component. Even though village Khaseti in Bhilangana block of Tehri district was very close to a health facility, only a few persons were visiting the health facility. Thus, it became clear that awareness and orientation were the basic needs in the villages visited to bring about behavioural change. Availability of ANM, lack of information about her outreach schedule, and busy schedule of the women in villages were also closely linked to the poor status of health check-ups in blocks. Overall, only in 33% villages was the status of T.T. vaccination to pregnant women satisfactory, and these villages were close to a health facility. Beneficiaries were reportedly getting IFA tablets but consumption pattern of IFA was seen to be a major bottleneck. Most pregnant women were not following the prescribed course of IFA tablets and discontinued after consuming a few tablets (20-30). Barring one village in Chamba block, there is no awareness about T.T. vaccination to adolescent girls. In 40% villages, colostrum was not being fed. About 50% children were exclusively breastfed for six months. In all villages, the mother and newborn child are kept isolated for a period of 11 to 21 days. The study probed the community for the prevailing local customs, traditions, and folk art that could be used to develop a community based self-monitoring tool. The study recommended that the active involvement of PRIs and Mahila Mandals should be sought. AWW should attend the village Panchayat meetings and report the progress on various services during the meeting, and the Panchayat Committee should also help her in sorting out the problems with health department and the community.

**Key Words :** 1.ICDS      2.MONITORING ICDS      3.COMMUNITY BASED  
MONITORING      4.CUSTOMS      5.BELIEFS      6.CUSTOMS NEWBORN  
7.UTTARAKHAND.

22. Uttarakhand, Dept. of Women and Child Development,  
ICDS Unit, Dehradun. (2007).  
Infant death audit. Dehradun : ICDS Unit. 100 p.

**Abstract** : In India, infant mortality constitutes more than 70% of all under-five child deaths in the country, highlighting the importance of focusing on infant deaths to bring about reduction in infant and child mortality, which is the ultimate goal of the ICDS programme. The Directorate of ICDS in Uttaranchal decided to probe into the causes of infant deaths so as to formulate appropriate remedial interventions. Accordingly, AMS was commissioned to conduct an Infant Death Audit in the rural areas of Uttarkashi and Pithoragarh districts to identify the various causes of infant mortality in the project area, and suggest suitable interventions at various levels to bring about behavioural changes to reduce infant mortality. Block-wise details were gathered about the number of infant deaths in the year April 2004 to March 2005 based on the Monthly Reports of the ICDS and health department functionaries. The sample size for conducting infant death audits was fixed at 70 which was more than 50% of the total reported infant deaths in the area. 3 districts from Pithoragarh and 2 from Uttarkashi were selected for the study. 'Verbal Autopsy' method was used for determining the cause of death. Findings of the study indicated that ARI/ pneumonia and diarrhoea were the two major killers, accounting for nearly half (47%) of the total infant deaths. In 14% cases, the deceased baby was reported to have an inborn abnormality or malformation. The outbreak of measles accounted for 10% of the infant deaths in the area. In around 12% cases, the infant was assessed to have died due to asphyxia, hypothermia or tetanus. Other causes accounted for 14% of the cases. The overall incidence of low birth weight babies (LBW) in the study area was found to be around 41%. District-wise analysis revealed the incidence of LBW to be higher in Uttarkashi (45%) as compared to Pithoragarh (36%). During the interaction, parents and caretakers were asked whether the infant was ill at the time of his/ her death. In 66 cases, parents had recognized that the infant was ill. Out of these 66, in 33% cases, the parents had not sought any medical treatment, even after recognizing that the infant was ill. At one place, in 28 out of 38 (75%) cases of infant deaths, ANMs reported that they had come to know about the infant's illness only after his/ her death. Thus in only 20% of the infant death cases (8 out of 38) had the ANM played some role during the infant's illness. About 30% of the mothers reported that they had not been registered at all for maternal care services when they were pregnant with the deceased infant. Overall, 71% of the mothers reported to have received at least one dose of T.T. vaccination. Out of these 54% reported to have received 2 doses, while the remaining 17% had received only one dose of TT vaccination. In 7 (20%) cases mothers had been weighed during pregnancy. Out of the 70 cases of infant deaths covered under the study, in 12 the baby was not breastfed at all due to one reason or the other. Out of the remaining 58 cases, in only 40% cases breastfeeding had been initiated within one hour. In another 48% cases,

breastfeeding had been initiated on the same day, mostly within 2-3 hours. Colostrum was given to the deceased infant in 39% cases in Pithoragarh and 29% cases in Uttarkashi. The proportion of exclusively breastfed among deceased infants was just 17%. In an overwhelming majority (87%) of infant death cases, the newborn had been given bath immediately after cutting the umbilical cord, which in most cases was within 1 hour of birth. Warning signals were identified as an area of intervention to prevent infant deaths. AWWs capacity should be built to identify the signs and symptoms of ARI/ Pneumonia and she should properly counsel parents on home based care in such cases and in making referrals. Mother's knowledge regarding diarrhoea management should be enhanced. Dehydration should be controlled by giving WHO-ORS and feeding more than the normal quantity of fluids during diarrhoea. Pregnant women should be weighed for weight gain during pregnancy which was virtually non-existent, but which was an important indicator of the pregnancy outcome. There was need to strengthen the referral mechanism for closer coordination between ANM and AWW. AWWs should be trained to use referral slips and health functionaries should give due cognizance to the referrals made by AWWs.

**Key Words** : 1.ICDS 2.INFANT MORTALITY 3.INFANT DEATH 4.CAUSES OF INFANT DEATHS 5.LOW BIRTH WEIGHT 6.HIGH RISK INFANT 7.HIGH RISK BABIES 8.UTTARAKHAND

23. Uttarakhand, Dept. of Women and Child Development, ICDS Unit, Dehradun. (~2007).  
Prevention of low birth weight babies in the state. Dehradun : ICDS Unit.  
~50 p.

**Abstract** : The birth weight of an infant is the single most important determinant of its chances of survival, healthy growth and development. This study investigated the incidence of low birth weight (LBW) babies in three distinct geographical regions of Uttaranchal namely Garhwal, Kumaun and foothills. A sample size of 50 infants was taken, and ICDS and Non-ICDS villages were compared. It was found that even in most of the institutional deliveries, family members were unable to tell the weight of the infant at birth. Parents' perception was that about 43% of the babies born in Uttarkashi were much smaller than normal, while in Pithoragarh none was much smaller than usual as per parents' perception. In Pithoragarh, 20% of the LBW babies were found to be pre-term. However, in Uttarkashi, 27% LBW babies were observed to be pre-term. 32% of all LBW babies were pre-term. The other factors influencing LBW of the baby are maternal malnutrition and anaemia, intrauterine

environment, socio-economic causes such as hard physical labour during pregnancy and illness specially infections, short maternal stature, very young age, high parity, smoking, close birth intervals, etc. The study observed that in majority (86%) of the LBW cases, mothers were found to be anaemic. In only 24% cases mothers of LBW babies received 100 or more IFA tablets. Majority of the mothers (70%) stated that they had actually consumed less food during pregnancy as compared to their non-pregnancy intake. More than 28% mothers reported that they had not been registered for maternal care services when they were pregnant with the LBW baby being studied. Early registration of mothers was found in only 42% of the LBW cases. Out of 36 registered cases, maximum (64%) reported to have registered at PHC/sub-centre or at the Army hospital, while 28% had been registered at the Anganwadi Centre (AWC). The remaining 8% had registered with private doctors. 70% of the mothers had received at least one dose of TT vaccination. Of these, 58% had received 2 doses, while the remaining had received only one dose. As regards IFA supplementation, almost 64% mothers of LBW infants received IFA tablets during pregnancy. In ICDS villages, 72% of the mothers received TT vaccination, 20% of the mothers were weighed during pregnancy, and 24% mothers reported that the AWW had advised them to take extra diet during pregnancy. In 3 cases out of 50, the baby was not breastfed at all due to one reason or the other. Out of the remaining 47 cases, in only 38% cases, was breastfeeding initiated within one hour. In 45% cases, breastfeeding was initiated on the same day, mostly within 2 to 3 hours. In the remaining 17% cases, breastfeeding was initiated after a considerable gap, ranging between 2 to 11 days. Further, among LBW babies, the practice of giving colostrum was observed in little less than 57% cases. It was observed that 1 out of 7 (14%) LBW babies had received both BCG and OPV drops. It was recommended that if predisposing factors associated with pre-term birth like maternal malnutrition, pregnancy, high BP, diabetes, etc. are identified well in advance and properly managed, the problem of LBW may be reduced to a great extent. There is a need to orient AWWs on pre-term milk, essence of pre-term milk for a LBW baby, and on breastfeeding a LBW baby. AWWs may be asked to submit monthly details of the weight at birth of the newborns in her village to keep a check on them. There is need to launch an awareness drive in the community to create awareness about the necessity and importance of registration. There is a need to provide training to AWWs on the use of referral slips and sensitizing health functionaries to give due cognizance to the referrals made by AWWs.

**Key Words :** 1.ICDS 2.LOW BIRTH WEIGHT 3.AGE AT MARRIAGE  
4.MATERNAL CARE 5.INFANT NUTRITION 6.PREVENTION LOW BIRTH WEIGHT.

## LABOUR

24. Rehman, M. M. (2007).  
Operation of welfare fund for beedi workers in Madhya Pradesh : profile, problems and prospect. NOIDA :V. V. Giri National Labour Institute. 88 p.

**Abstract :** *Beedi* workers constitute one of the most vulnerable segments of the country's labour force. The present study was done to assess the organizational set up of welfare schemes; study the cess collection process in the industry and the mechanism for administration and disbursement of funds; evaluate the impact of welfare measures on beneficiaries of the Welfare Fund; and study the working conditions and employment pattern of *beedi* workers. The study covered 2 districts of Madhya Pradesh, namely Sagar and Jabalpur, and a total of 194 beneficiaries were selected (97 Sagar and 97 Jabalpur). Data was collected through interview and survey method. It was study found that the highest concentration of *beedi* workers was found in districts Sagar (2.92 lakhs), followed by Damodh (1.37 lakhs), Jabalpur (1.03 lakhs) and Satna (75,000) which accounted for more than 80% of the total *beedi* workers of the state. Most respondent households had more than one member engaged in *beedi* rolling and were well conversant with *beedi* rolling skills. Almost all respondents stated that *beedi* making was their regular job. The level of awareness about various schemes among respondents was higher in Jabalpur than in Sagar. The overwhelming majority of respondents were not at all aware about some important laws. In Jabalpur, majority of the sample respondents obtained application forms from the Dispensary, while an overwhelming majority in Sagar obtained them from other sources. In Jabalpur more than 80% of the total education expenditure of households was met from assistance provided under the Education Schemes of the Welfare Fund. In Sagar, about 14.58% households received benefits from educational schemes which constituted less than 20% of the total expenditure incurred for their children. For 41.66% households, the proportion of education expenditure constituted between 21 - 40% of their children's annual education expenditure, for 20.83% households it amounted to 41 - 60% of the annual expenditure, and for the remaining households the proportion of assistance to the total annual expenditure, varied between 61 – 80% and above. In Jabalpur, *beedi* workers were granted Rs.10,000/- as subsidy amount for constructing one room dwelling units under the Housing Scheme. But due to lack of housing sites and the cumbersome process to avail the Fund, majority of the *beedi* workers did not encourage many needy workers to venture for the scheme. In Sagar, among those workers who benefited from the Housing Scheme, almost 50% of the amount was accounted for by the subsidy given by the Labour Welfare Organisation, Jabalpur. Under the Heart, Cancer and T.B. Treatment Scheme in Jabalpur, the amount of assistance received for the treatment of heart and cancer, varied

between 36% and 40% of the total amount spent by them. In the case of cancer patients, the amount was about 17.37% of the total expenditure incurred. In the case of T.B. patients, none of the patients received any benefit with the exception of one beneficiary, who received 88% of the total money spent. In Sagar almost all patients benefited from the T.B. Treatment Scheme. For Cancer treatment the amount they received from the Welfare Fund constituted between 26% and 65% of the total expenditure they incurred respectively. For Heart treatment beneficiaries received between 3.06% and 6.0% of the total amount covered. In Jabalpur the 5 respondents who received financial assistance under Maternity Benefit Scheme, received between Rs.250 and Rs.500, whereas in Sagar each beneficiary received Rs.500. In both Sagar and Jabalpur districts, under Group Insurance Scheme, the amount received by the beneficiaries varied from Rs.3000/- to Rs.10,000/-. In Jabalpur the amount of assistance received for spectacles varied between 42% and 60% of the total expenditure incurred by them. Regarding the performance level of dispensaries, the highest number of out patients per staff per day attended was found in Jabalpur (1:22.90), followed by Sagar (1:18.09). It was suggested that there is a need to make people aware about the welfare schemes through massive awareness generation programmes, and special measures should also be taken to improve the health status of *beedi* workers and make their future bright.

**Key Words** : 1.LABOUR 2.BEEDI WORKERS 3.WELFARE FUND 4.CHILD LABOUR BEEDI INDUSTRY 5.MADHYA PRADESH.

## NUTRITION

25. NIPCCD, Regional Centre Indore, Indore. (2007).  
Mid day meal scheme in Madhya Pradesh : a study. Indore : NIPCCD-RCI.  
215 p.

**Abstract** : The Mid-Day Meal scheme (MDM) was started to improve the nutritional status and school enrolment of children. This study assessed the performance of the scheme and its impact in Madhya Pradesh. A total of 120 schools were selected from 30 blocks in 15 districts spread over seven divisions of Madhya Pradesh. The sample constituted 2300 children, 240 members of Parent-Teacher Association (PTA), 233 school teachers, 60 PRI members, 600 parents and 107 office bearers of Mid- Day Meal implementing agencies like self help groups, Parent Teacher Association, and Non Governmental Organizations (NGOs). The state has developed guidelines for conversion of grains to hot cooked meals, delineated the activities, and also suggested the unit cost. The provision of 'hot cooked meal' for primary school

children started in the year 2004. Presently the scheme covers 94,905 primary schools including government/ government aided primary schools, EGS, AIE, Madarasas and Ashram Shalas. The three viable models suggested for implementation of the scheme are school run kitchens managed by Parent Teacher Association, Government and NGO Partnered Central Kitchen; and Government and Women self help groups partnered initiatives. Voluntary organizations in the state have emerged as viable institutions to serve as a catalyst for social activities. Naandi Foundation is identified as a key NGO for implementing MDM scheme through centralized kitchen in the city of Indore, Bhopal and Jabalpur, which presently covers 791 schools in the state. The scheme has opened up a channel and created employment opportunities for needy women through Self Help Groups (SHG). SHG members deliver services in the form of cooking, serving, cleaning wheat and pounding *masalas* (condiments) and receive wages for their services. The state has created assets by constructing 20,869 kitchen sheds in the school premises, and nearly 46% of the sampled schools have created such assets. Only 16% kitchens were well lit and ventilated. The approved monthly requirement of food grain is supplied periodically to schools through transportation arranged by the District Collector in coordination with State Civil Supplies Department. During the rainy season, especially in tribal areas, transportation of food grains was quoted as one of the major hinderances. The stakeholders' participation in the programme was minimal, as by and large, the programme was perceived to be a government programme. There were hardly any community innovations for quality optimization worth documenting. Traditional *chulha* was widely used as a cooking device in majority of the schools (72.5%) especially in tribal and rural areas. The drinking water facility was available in 67% of the schools surveyed. Dry type of toilet was found in 60% of the sampled schools, which is a cause for concern. Mostly the assistance for mid day meal infrastructure was drawn either from central assistance or through other schemes like SGRY, PMGSY, SSA. The scheme was operational all through the year (200 days) in 89% of the schools surveyed. This information was derived from the 'operational school days' in a year. The quantity of meal, as perceived by all respondents, was found to be adequate. It was found that all children enrolled were utilizing the services of mid day meal. The enrollment of children had increased (18%) consequent to the provision of cooked meals in school. School attendance (11%) also increased in almost all districts after initiation of the scheme. The nutritional profile of children receiving mid day meal serves as a useful back drop for planning any intervention. The median height of boys was in the range of 115-137 cms and girls were 109-137 cms. The median weight of boys was in the range of 18-28 kg and the weight of girls was in the range of 15-27 kg. The overall prevalence of under weight (<median-2SD) was about 58%, of whom 17% were severely underweight (<median-3SD), and 41% were moderately under weight (median-3SD to median-2SD). About 42% of the children were stunted. The present study recommended extension of mid day meal to higher age groups, as prevalence of under nutrition was found to be high among older children, which is a hindrance to

their over all development, specifically affecting their learning abilities. Further, this would also minimize dropout cases among children attending upper primary classes. The quantity of cereals and pulses should be enhanced to match one-third requirement of the child per day to bridge the calorie and protein gap.

**Key Words** : 1.NUTRITION 2.MID DAY MEAL SCHEME 3.EVALUATION MID DAY MEAL SCHEME 4.SCHOOL LUNCH PROGRAMME 5.NOON MEAL SCHEME 6.SCHOOL ENROLMENT 7.MADHYA PRADESH.

26. Singh, Madhu, B., Fotedar, Ranjana and Lakshminarayana, J. (2004).  
Nutritional status along with micronutrient deficiency disorders and morbidity in pregnant and lactating women in desert areas of Rajasthan. Jodhpur : Desert Medicine Research Centre. 5 p.

**Abstract** : The nutritional status of people residing in desert areas is generally poor due to harsh environmental conditions. This study was conducted in Jodhpur to assess the nutritional status of pregnant and lactating women; study the morbidity profile of diseases among rural pregnant and lactating women of desert areas of Rajasthan; and develop a nutrition package for pregnant (384) and lactating women (400) based on the findings of the study. A total of 1193 households were covered. Pregnant and non-pregnant women were examined for nutritional deficiency signs, dietary pattern was observed and morbidity survey was undertaken. Haemoglobin level and IDD was assessed by clinical examination. Anaemia was observed to be maximum among pregnant and lactating women and least in control group. Severe anaemica was 3 times higher in pregnant and lactating women (10.5 to 14%). Consumption of iron folic acid tablets by pregnant and lactating women was observed to be low (39.0 to 48.0%). Abortions, child deaths, still births and premature births were observed to be higher in anaemic pregnant and lactating women. The analysis of 1049 urine samples revealed that the median urinary iodine values were less in lactating women (85 mcg/l) according to WHO cut off points (100 mcg/l), whereas pregnant women and control group were observed to be just on the marginal values. Nearly 34% to 42% pregnant and lactating women suffered from mild to moderate iodine deficiency disorders, whereas among control group it was 34.6%. Severe iodine deficiency disorders were higher in lactating women (14.2%) compared to control group (7.3%). Iodine deficiency disorder (UIE Level) showed increasing trend with decline of income and educational status. Iodine content of 719 salt samples was estimated using standard iodometric titration method. A high proportion of women (80.8%) consumed salt having inadequate iodine content, i.e. less than 15 PPM. Consumption of salt deficient in iodine content was higher in low income group (38.9 to 44.9%) and among illiterate women (nearly 80%). Sickness at the time of survey was highest in lactating women

(9.2%) followed by pregnant women (6.5%). Main morbidities observed were aches (3.8%) and gastroenterological complaints (2.8%). Vitamin A deficiency based on Night Blindness was higher in pregnant women (8.8%). Analysis of dietary intake revealed that consumption of cereals and fats was low of pregnant and lactating women i.e. 76-84% and 80% of RDA, (ICMR norms). Consumption of pulses and legumes was very low (47 to 65% of RDA), and consumption of leafy vegetables was also low, i.e. 12 and 7% of RDA of pregnant and lactating women; but the consumption of milk and milk foods was found to be adequate. The average intake of nutrients showed high deficiency of protein and calories in pregnant and lactating women, along with high deficiency of Iron and Folic acid and Vitamin A. These results helped in developing the database for micronutrient deficiency disorders, nutritional deficiencies, and morbidity in pregnant and lactating women in desert areas. Nutritional intervention packages for this region can be developed by introducing the adequacy, i.e. bioavailability of iron and vitamin A, etc. in usual diets, which can be improved by altering meal patterns to favour promotive practices. Iron and Vitamin A supplementation are the most common strategies to control these deficiencies in developing countries for the time being, until either significant improvements are made in the diets of entire populations or food fortification is achieved.

**Key Words :** 1.NUTRITION 2.NUTRITIONAL STATUS PREGNANT WOMEN 3.PREGNANT WOMEN 4.LACTATING WOMEN 5.MICRONUTRIENT DEFICIENCY 6.ANAEMIA 7.IODINE DEFICIENCY 8.VITAMIN A DEFICIENCY 9.DESERT AREAS 10.RAJASTHAN.

27. Singh, Madhu, B., Fotedar, Ranjana and Lakshminarayana, J. (2007).  
Studies on the nutritional status of rural population in desert area of Rajasthan. Jodhpur : Desert Medicine Research Centre. 7 p.

**Abstract :** The nutritional status of people in desert area requires special attention. This study was undertaken (in 2005-06), to assess the nutritional status and dietary habits of the rural population in a desert area of Rajasthan. The study covered 560 households in 28 villages belonging to 6 tehsils of Jodhpur district. A total of 3301 individuals (1731 males and 1570 females) were examined for anthropometry, dietary intake and nutritional deficiency signs. Anthropometric measurements were expressed as a percentage of the standards available from NCHS for a given age and sex. 59.5% respondents belonged to nuclear families, and 24.4% belonged to joint families. The weights of preschool children were expressed as percent of NCHS standards and categorized into different nutritional grades, based on Gomez classification. The overall prevalence of under nutrition was very high, 81.0%, and it was higher among scheduled caste and scheduled tribe communities (85.7% to

88.0%) in comparison to other communities (74.7%). Severe under nutrition was very high, 34.4%, which needed attention. Under nutrition was higher in nuclear families (82.0%) compared to joint families (79.2%), and was observed to be maximum in semi-*pucca* (permanent) houses (36.7%) followed by *pucca* houses. The distribution of adults according to BMI grades showed that 44.5% had normal BMI (18.5-25.0) while 55.5% had chronic energy deficiency. Severe chronic energy deficiency was highest in scheduled caste (23.7%) and scheduled tribe (18.4%) communities followed by backward classes and other communities. Severe chronic energy deficiency was higher in extended nuclear families (18.2%) compared to nuclear and joint families (14.5%), and maximum in families residing in semi-*pucca* houses. Regarding nutritional deficiency signs, it was observed that discoloration and sparseness of hair, a sign of protein calorie malnutrition was observed to be high (7.1%) and was higher in females than males. Marasmus was observed only in females (0.2%). Angular stomatitis, cheilosis and glossitis ranged between 0.2 to 1.8%. Vitamin A deficiency (Bitot Spot) was 0.3% and it was higher in males than females. Dental caries (30.4%) and dental flurosis (25.1%) were high in this area. Females suffered more from dental caries and dental flurosis than males. Thyroids, palpable and visible, were 0.6%, Koilinichia, a sign of Anaemia, was observed to be higher in females (0.2%). Dietary analysis revealed that consumption of food stuffs per day was marginally low in Cereals (97% of RDA), very low in Fats and Oils (50% of RDA), Pulses and Legumes (47.5% of RDA), Leafy Vegetables (4.1% of RDA ) and other vegetables (65% of RDA). It was recommended that there is a need to develop continuous monitoring service to study the nutritional status, dietary habits, food availability and the effect of the changing social and environmental factors on the health status of the population. The results of such a study in desert areas would provide information and useful guidelines not only for food policies, but also assess impact of the nutritional programme currently in progress and for future planning in Rajasthan.

**Key Words** : 1. NUTRITION 2.NUTRITIONAL STATUS RURAL  
3.MALNUTRITION 4.RURAL AREA 5.DESERT AREA 6.RAJASTHAN.

28. Singh, Madhu, B. et al. (2006).  
Studies on the nutritional status of children aged 0-5 years, in a drought-affected desert area of western Rajasthan, India. Jodhpur : Desert Medicine Research Centre. 7 p.

**Abstract** : Drought condition occurs quite frequently in the Thar Desert, which lies mostly in the Indian state of Rajasthan. The present study was undertaken to assess the impact of drought on the nutritional status of preschool children aged 0-5 years in

a desert area in Rajasthan which faces drought conditions very frequently. The study was carried out in 24 villages in 6 *tehsils* of Jodhpur district, Rajasthan. A total of 914 children were examined at household level, and their nutritional status was assessed using anthropometry, dietary intake, and clinical signs of nutritional deficiency. The mean weight and height of children were compared with NCHS (National Centre for Health Statistics) standards. It was found that about 60% of the children were underweight (weight for age) while the prevalence of severe underweight was found to be about 31%. The overall prevalence of stunting (height for age) was about 53%, with the extent of severe stunting being about 34%. Analysis by age revealed that children in the age group 1-2 years suffered more from stunting. Severe stunting was higher among girls (36.7%) than boys (31.0%). It was found that prevalence of wasting was about 28% with the extent of severe wasting being 10%. Again, children in the age group 1-2 years suffered more from wasting. About 36.4% of the preschool children in this study suffered from mild to moderate deficit in fat deposits, and 36.9% suffered from severe deficit of fat deposits. Around 30.5% children suffered from *anaemia* on the basis of *conjunctival pallor*, *platyonychia* and *koilonychia*. Prevalence of *marasmus* was 1.7% among boys and girls. Vitamin A deficiency was indicated by the overall prevalence of *Bitot's spots* among 0.2% children. The incidence of Vitamin B complex deficiency or angular *stomatitis* was observed to be 0.5%, *cheilosis* 0.9%, and *glossitis* 1.6%. Vitamin C deficiency was observed in 0.1% cases (bleeding gums), caries and mottling of tooth enamel were observed in 2.7% and 3.9% of the children respectively. The energy deficit observed among preschool children was very high, 76%. Efforts should be made to incorporate measures, such as ensuring the supply of adequate energy and protein to all age groups, especially preschool children, into ongoing nutrition programmes in order to improve food security. Furthermore, there is a strong need to develop nutritional packages based on the locally available diet and feeding habits of preschool children, which would provide them adequate energy, protein and nutrients.

**Key Words :** 1.NUTRITION 2.MALNUTRITION PRESCHOOL CHILDREN  
3.MALNUTRITION 4.NUTRITIONAL STATUS PRESCHOOL CHILD  
5.STUNTING 6.UNDER WEIGHT 7.DROUGHT PRONE AREA 8.DESERT  
AREA 9.RAJASTHAN.

29. Soman, C.R. (2007).  
NFI Bulletin, 2007 Oct, 28(4) : fifty years of primary health care : the Kerala  
experience. New Delhi : Nutrition Foundation of India. 8 p.

**Abstract :** During the last 50 years, the health infrastructure in Kerala has shown significant growth in terms of manpower, beds and institutions. When Primary

Health Centres (PHCs) were considered the number had increased from 369 in 1960 to 1356 in 2004. A major development in Kerala's health scene was the virtual domination of the private sector. It was found that more than 70% beds and institutions were in the private sector, and over 70% professionals served in the private sector. According to Human Development Report Kerala 2005, the highest infant mortality rate was found in 2 districts of Kerala, Wayanad (22 deaths per 1000 live births) and Idukki (20 deaths per 1000 live births), whereas lowest IMR was found in 3 districts Kollam, Pathanamthitta and Alappuzha (8 deaths per 1000 live births) in each district. Complete immunization was found to be highest in Alappuzha (97.4%), whereas lowest was in Malappuram district (59.8%). There were 93 Anganwadi Centres (AWCs) in 2 districts of Kerala, 92 ANCs (Ante-Natal Care) centres in Kottayam district, 90 ANCs in 4 districts of Kerala namely Kollam, Ernakulam, Wayanad and Kannur, whereas the lowest number of Anganwadi centres were found in Trivandrum (72). The percentage of low birth weight was found to be highest in Wayanad (30%) and lowest in Trivandrum (11%). The report on vital statistics for Kerala estimated that there were over 49,000 deaths from heart attacks during the year 2004. Prevalence of Type-2 diabetes and hypertension was found to be high in both men and women in both rural and urban areas. Incidence of over weight and obesity emerged as significant health problems in Kerala. The risk factors related to cardio-vascular diseases was 48.3% in rural females and 42.9% in urban females, and 33.6% in rural males and 32.1% in urban males on the BMI $\geq$ 25 scale. The mean serum cholesterol in Kerala population (both rural and urban areas) exceeded 230 mg/dl and was much higher than reported levels from the rest of India. Data showed that nearly 37% males in rural Kerala and 31% in urban areas were smokers. It was probable that the distorted profile of dietary fat, loaded heavily in favour of saturated fats, almost exclusively provided by fresh coconuts and coconut oil, was the principal reason for the observed cardio-vascular diseases in Kerala. The study of Kerala has not yet taken note of the magnitude or developmental consequences of the burden of non-communicable diseases. Simple dietary and lifestyle interventions like exercise, increased consumption of fruits and vegetables, and abstinence from tobacco and alcohol can make a substantial dent in the problem of non-communicable diseases in Kerala.

**Key Words** : 1.NUTRITION 2.RESEARCH NUTRITION 3.PRIMARY HEALTH CARE KERALA 4.HEALTH SITUATION KERALA 5.ADOLESCENT EDUCATION 6.ADOLESCENT HEALTH 7.ADOLESCENT GIRL 8.HEALTH AND NUTRITION EDUCATION 9.KERALA.

## SOCIAL DEFENCE

30. Bawa, Manorama. (2004).  
A Report on assessment of custodial establishments for women. New Delhi  
: All India Women Conference. 59 p.

**Abstract** : The criminal justice system as a whole, including prisons and prisoners, has come under critical review in recent years. The present study focused on the infrastructure in jails, medical care available to prisoners, food and clothing, educational activities, recreational facilities, rehabilitation and several other issues. Data was collected on women prisoners from custodial institutions in Kerala (169), Bihar (389), Jharkhand (379), and West Bengal (538). The women prisoners were divided into 3 categories – convicts, under trials and detenues. Inmates in custodial institutions were mainly in the age group 31-50 years and mostly, they were mothers-in-law/ sisters-in-law accused of murder/ torture/ harassment. It was also observed that in many cases, women had not committed the crime, but they owned responsibility for the same to save the guilty men folk of their families. Other cases in which women prisoners were involved were kidnapping, drug peddling, theft, quarrel and immoral trafficking. The women prisoners (detenues) in all the 4 states were largely from poor and disadvantaged sections of society, with little or no educational background. Most of these prisoners were married, divorcees, neglected by their husbands, or were living with alcoholic husbands. The surveyed jails had separate cells earmarked for women prisoners. However, most jail buildings were very old and decrepit. In certain jails, women inmates had to pass through the enclosure for men for accessing the bathroom or toilets. This was inconvenient to women inmates as they were subjected to teasing by the male prisoners. There were also women detainees who stayed in the jail along with their children and most of the children were between 0-3 years. Jails did not offer a conducive atmosphere for bringing up these small children. They were often found loitering around without any care and attention. Prison rules did not permit children above 5 years of age being kept in detention. However, in West Bengal, 10 children above 5 years of age, 7 boys and 3 girls were being kept under detention. Overcrowding and sanitation and hygiene were common problems. The prisoners lived under dehumanizing conditions. The number of female staff in prison was insufficient, and service conditions of the staff were also not satisfactory. Although the general health condition of the inmates was found to be satisfactory, many of them seemed to suffer from mental problems. Some women prisoners also had various kinds of handicaps – locomotor, mental, visual and hearing, but there were no specific amenities provided to handicapped prisoners. In prisons, there was no resident lady doctor available. Sick rooms were not assigned separately in any of the jails. Diet provided was as per the prescribed norms, and extra nutritious diet was also provided to expectant and nursing mothers.

Post natal care such as immunization of children was given at the nearby hospitals. Convict prisoners were provided clothes by the prison authorities and they were usually given about 3-4 sets in a year. All other prisoners were permitted to use their own clothing. Bedding was provided by the authorities only to convicts and not under trials. In almost all the jails, no adult education programmes were conducted. Vocational training on cutting, tailoring, embroidery, glass painting was given to women prisoners in some jails of Jharkhand and West Bengal. Library facilities were made available to the prisoners in almost all prisons, but as the inmates were not educated they could not use the library. There was no emphasis on health education, physical education, exercises, etc. Television and radio sets were provided in jails, and also indoor games like chess, ludo, playing cards, carom boards, etc. The Government, NGOs and National Commission for Women should put in efforts to educate women prisoners about their legal rights, health, etc. Jails should facilitate as rehabilitation centres; and income generation activities should also be carried out in jails, which would engage the inmates in a productive way and thereby improve their mental well-being.

**Key Words** : 1.SOCIAL DEFENCE 2.CUSTODIAL INSTITUTIONS  
3.INSTITUTIONAL CARE WOMEN 4.PRISONERS 5.JAILS 6.AFTER CARE  
HOME 7.JUVENILE HOME FOR GIRLS 8.SHORT STAY HOMES 9.POLICE  
LOCK UPS 10.NARI NIKETANS 11.WOMEN LOCK UPS 12.BIHAR  
13.JHARKHAND 14.WEST BENGAL 15.KERALA.

## **SOCIAL WELFARE**

31. Family Health International, New Delhi. (2007).  
Mapping and size estimation of injecting drug users in five north eastern  
states of India. New Delhi : ICMR. 41 p.

**Abstract** : HIV infection related to injecting drug use (IDU) is becoming a public health problem in states like Assam and Mizoram. A need was felt to assess the problem in this region. The study was carried out in five north-eastern states of India, viz Manipur, Nagaland, Mizoram, Meghalaya and Assam with funding support from USAID. Rapid Field Assessment (RFA) was done in Assam at Guwahati (14), Tezpur (1), Jorhat (1), Dibrugarh (1) and Tinsukia (1) centre(s). Heroin, brown sugar, cannabis, opium, SP, synthetic and psychotropic drugs were the most commonly used drugs in Assam. The size of IDU population as reported by SACS and NGOs was estimated to be around 300 in Assam. However, Drug De-addiction Centres (DDC) reported the number of IDUs to be between 250 and 300, and PLHA reported that there were 400 IDUs in Guwahati alone. Drug use in the state was showing an

upward trend, and as a result, so was HIV among IDUs. According to one DDC about 70% of IDUs were HIV positive. IDUs preferred to inject in isolated and deserted places. In Manipur, 30 interviews were conducted. Out of 9 districts, the most drug prone areas were East and West Imphal, Thoubal and Bishenpur. Key Informants (KIs) generally agreed that most IDUs were young males. However, there is an increase in the abuse of adhesives and dendrite by young school children. Some KIs believe that 6000 – 17,000 IDUs are HIV infected. In Meghalaya, 20 in-depth interviews were conducted, and discussions with stakeholders from SACs, DDCs and NGOs were held. The total IDU population of Meghalaya was estimated to be 1462. In Assam and Meghalaya, either private or government HCPs (Health Care Providers) were present in the vicinity of almost all the sites. In Manipur, no HCPs were available in the vicinity of 424 (31.7%) sites. In Nagaland, there were about 173 sites, but no HCPs were available. However, NGOs were present in most areas in Manipur and Nagaland. About 5-6 NGOs associated with drugs and HIV / AIDS looked into the needs of the target groups in Meghalaya. In half of Manipur's IDU sites, the users were both youngsters and old people. Nearly 33% of the IDUs comprised adults and 20% were young (18-25 years). Male IDUs were also many more than females. IDU population appeared to be relatively small in some states, however the problem is spreading in all districts of these states. Due to the associated health risk of injecting drugs to the individual and the community, the public health response needs to be strengthened to tackle the drug use issue in north – east India. Inadequacy of the current program interventions to reach out to the target population was reflected in the study. High rate of risk taking behaviours like sharing injection equipment was positively correlated with availability of risk reduction activities like Needle and Syringe Exchange Programme (NSEP) in the area. It is necessary to expand and strengthen the already existing activities in all the states to deal with the IDU and HIV / AIDS issue in north–east India.

**Key Words :** 1.SOCIAL WELFARE 2.DRUG ABUSE NORTH EAST INDIA  
3.INJECTING DRUG ABUSERS 4.AIDS PREVENTION 5.HIGH RISK GROUP  
6.NORTH EAST INDIA.

## **WOMEN LABOUR**

32. Bhatt, Aparna and Sen, Aatreyee. (2005).  
Report on domestic workers. New Delhi : National Commission for Women.  
98 p.

**Abstract :** The International Labour Organization (ILO) defines a domestic worker as “someone who carries out household work in private households in return for wages”. The report focused on the findings of two public hearings in Mumbai and Delhi. The

hearings investigated cases of gross human rights violations against domestic labourers/ workers by both state and private parties, and aimed to report, campaign and litigate for the same. A gathering was organized of 140 domestic workers in Mumbai and 200 domestic workers in Delhi. These hearings had a multi-disciplinary panel consisting of professionals ranging from lawyers, journalists, activists to academicians, etc. Domestic workers were categorized into 3 groups namely child domestic workers (CDWs), live in workers (full timers), and part time domestic workers. The problem of each type of worker was not very different from the other but the intensity of exploitation increased with lower age groups (children). The report showed that poverty was the main factor responsible for the plight of domestic workers. Several other problems faced by domestic workers were strenuous working hours, low wages, no job security, physical assault if the work was not done, frequent scolding for minor things like breaking a cup, and most of the times salary was deducted for any breakage or minor accidental damage while at work. One major problem faced by live in workers/ full timers was trafficking. They were trafficked from villages and brought to Bombay or Delhi by giving them high expectations of better lives and most of the time false hopes. All the full timers and part time domestic workers complained that no yearly increment, holidays, bonus, medical allowances and maternity leave benefits were given to them. Suggestions given/ made by panelists were that CDWs should be treated like children not as slaves or bonded labour by their employers; compulsory registration of domestic workers should be done to avoid the problem of very young children working in homes; awareness and sensitization programmes should be launched for both politicians and government servants on the plight of domestic workers; all domestic workers throughout the country should be guaranteed minimum wages, paid work off, adequate and free medical treatment; and the Labour Commissioner of the states should register all CDWs under the provisions of Child Labour Act.

**Key Words** : 1.WOMEN LABOUR 2.DOMESTIC WORKERS 3.PROBLEMS OF DOMESTIC WORKERS 4.LEGISLATION FOR WOMEN 5.LEGISLATION FOR WOMEN LABOUR 6.CASE STUDIES DOMESTIC WORKER

## **WOMEN WELFARE**

33. Andhra Pradesh Industrial and Technical Consultancy Organization, Hyderabad. (2004).  
Pilot study on impact evaluation of STEP in Andhra Pradesh, Karnataka, Kerala, Maharashtra and Orissa. Hyderabad : APITCO. 244 p.

**Abstract** : Women, in Indian society, are traditionally expected to confine themselves to domestic environs and play a passive role as daughters, daughters-in-law, wives

and mothers. The present study was commissioned by Department of Women and Child Welfare (DWCD) through APITCO to evaluate the impact of STEP projects in the states of Andhra Pradesh, Karnataka, Kerala, Maharashtra and Orissa. STEP aims at empowering poor women and promoting sustainable livelihoods for them in 10 traditional sectors (agriculture, small animal husbandry, dairying, fisheries, handlooms, handicrafts, *khadi* and village industries, sericulture, social forestry, and wasteland development) through mobilizing them into cohesive and active groups and upgrading their skills. The study focuses on understanding the incremental incomes of the beneficiaries, sustainability of activities during post-programme phase, entrepreneurial competencies of the beneficiaries, enabling role played by implementing agencies, and major constraints in the process of implementation. Information was gathered from beneficiaries, control units, implementing agencies, trainers, support providers and end users. In all, 4789 beneficiaries and 753 control units, spread over 380 villages across 81 districts in the five states were contacted. The results revealed that 27 projects were approved under STEP with an aggregate outlay of Rs. 890.1 million, and project inputs aimed at developing vocational skills of the beneficiaries. It was observed that 66.8% beneficiaries were either landless or owned not more than two acres of agricultural land. All implementing agencies, except Karnataka State Handloom Development Cooperation (KSHDC), mobilized the beneficiaries either into women's development cooperation or self help groups. Dairying was the single largest income generating activity pursued by beneficiaries. Selection of the income generating activities was based predominantly on the implementing agency's experience and convenience. Infrastructure available for training was rated 'very good' in respect of all the four apex dairy development cooperatives implementing STEP projects in Karnataka, Orissa, Maharashtra and Andhra Pradesh. The trainer base for vocational skill development of all the implementing agencies was regarded as good. Training inputs in terms of coverage and quality varied widely between implementing agencies. Coverage and quality were better of agencies involved in dairy development projects. Handloom and mushroom cultivation were also regarded to be better. STEP projects were well conceived and clearly delineated only with respect to Karnataka Milk Federation (KMF) and Orissa Milk Federation (OMFED) the two major partners of DWCD in STEP implementation. Maharashtra Rajya Sahakari Dudh Mahasangh Maryadit and Andhra Pradesh Dairy Development Cooperative Federation (APDDCF) organizational structures for STEP implementation were considered to be inadequate and weak given the magnitude of the job involved. Among others, Rashtriya Sewa Samiti (RASS) and Kagal Education Society (KES) had fairly well defined organization structures. Concurrent evaluation of STEP projects periodically was not in vogue at the time. Such evaluations were carried out only when DWCD required them. STEP made a definite impact on the socio-economic empowerment of poor women in Andhra Pradesh, Karnataka, Kerala, Maharashtra and Orissa. The vocational base skills of the beneficiaries across the activities improved considerably. Women's Development Cooperatives contribute close to 30% of the milk

procurement by implementing agencies in Andhra Pradesh, Karnataka, Maharashtra and Orissa. The programme sustained the livelihoods of 0.169 million poor women in rural areas. 76.9% of the beneficiaries assisted earned incremental incomes up to Rs. 1,000 per month. Lifestyles of the beneficiaries improved as a sequel to STEP. 38.4% beneficiaries felt that the programme has had a positive impact on their children's education. 42.6% of the beneficiaries felt that the programme had made them health conscious. The study recommended that implementing agencies should be exposed to the techniques of systematic selection of income generation activities. The training infrastructure should provide access to better and contemporary equipment. Periodic training and re-training of trainers is necessary to enhance their capabilities. DWCD should release funds only when the required MIS is in place with the implementing agencies. STEP project proposals should be sanctioned only after a thorough project appraisal is done by a competent agency. DWCD should indicate the period of operation of STEP at any given point of time.

**Key Words** : 1.WOMEN WELFARE 2.STEP 3.SUPPORT TO TRAINING AND EMPLOYMENT PROGRAMME 4.ECONOMIC EMPOWERMENT 5.INCOME GENERATION 6.TRAINING-CUM-PRODUCTION CENTRES 7.LIST OF TRADES 8.SELF EMPLOYMENT 9.LIST OF INCOME GENERATION ACTIVITIES 10.ANDRHA PRADESH 11.KARNATAKA 12.KERALA 13.MAHARASHTRA 14.ORISSA.

34. Brara, N. Vijaylakshmi. (2006).  
A Situational analysis of women and girls in Manipur. New Delhi : National Commission for Women. 179 p.

**Abstract** : Majority of the women in Manipur are the bread earners of their families, many of them the only bread earners. This study was carried out by the team of National Commission for Women at Manipur in 2004 as women in Manipur had been victims of mental, physical and sexual violence. It was estimated that 3-4 out of ten rape cases went unreported. Even the present NGOs who claimed to be fighting for the dignity of women failed to form a pressure group. Issues of domestic violence and gender discrimination were being obscured, sidelined and marginalized for the greater cause of nationhood and self-determination. Being main earners, women had no time to concentrate on their own plight. The Commission visited Manipur from 19<sup>th</sup> to 21<sup>st</sup> September 2004, and the NCW Team held an interactive session with NGOs, women activists, lawyers and elected representatives. There were about 150 participants in the interactive meeting. The Team found that Manipur is economically far below on the ladder. There is no major industry. Agriculture is at subsistence level. There is land scarcity due to tremendous rise in the population. There are also long term insurgency

problems, and ethnic conflicts are coming to the fore. By the end of 2002, 414,800 had registered themselves in the employment exchange; of these 108,000 were women and 306,700 were men. There are no official statistics available on sex workers. Since women have traditionally taken upon themselves to feed their family, it is difficult for them to meet their needs with their meagre earnings and rising costs. Women at Ima Keithel are losing their land due to population pressures and are not able to get sufficient produce. There are no cold storage facilities and no schemes like Mahila Kosh for women to get low interest bank loans. The Team observed that women in Manipur seemed to be healthier than their counterparts in the rest of India. Girls seemed to survive more than boys, as expectation of life at birth was 60.40 years and 62.30 years for rural and urban girls respectively, while it was 56.70 years and 60.60 years for boys in rural and urban areas. The social neglect of women and girls is a matter of concern. They are subjected to heavy work both within and outside the home from an early age. They are less likely to receive medical help when they are sick. Further, by the age of five years, female mortality exceeds that of males by 20% in Manipur. HIV / AIDS has emerged as a major public health problem. There are more than 50 NGOs working in this field. Prominent among them are MACS (Manipur AIDS Control Society) and SASO (an organisation of ex-drug addicts). In the age group of 21-30 years people with HIV numbered 320, while there were 193 women. In the age group of 31-40 years, there were 344 men and 99 women. In the hills, much of the work is done by women and there is "iron like grip" rigidity in the division of labour. The women bear, on an average, 6 children, with no health centres near by, and their health deteriorates with every delivery. In the hills of Manipur, which constitute five districts, the health care system is dismal. PHCs are every where, but only on government records. The concerned doctors hardly ever attend their assigned PHCs. The problem gets further compounded because of the inaccessible and difficult hilly terrain. Therefore, women's health suffers the most. They work quietly and are invisible in any decision making bodies. It was recommended that there should be an exclusive government policy to improve women's health. Women are susceptible to illnesses and diseases of the reproductive system such as cancers of breast, uterus, cervix, ovaries, apart from other diseases which are common to both the sexes. There was repeated demand from all the women's NGOs to open separate women's hospitals and have exclusive women's PHCs. But with even the already existing PHCs not functioning, their demand would probably take a very long time to be fulfilled.

**Key Words :** 1.WOMEN WELFARE 2.SITUATION OF WOMEN MANIPUR  
3.SITUATION OF WOMEN 4.DOMESTIC VIOLENCE 5.FEMALE FOETICIDE  
6.EDUCATION 7.LITERACY RATE 8.POLITICAL EMPOWERMENT OF  
WOMEN 9.HEALTH AND FAMILY WELFARE 10.FAMILY COUNSELLING  
CENTRE 11.SGRY 12.SWARNJAYANTI GRAMEEN ROZGAR YOJANA  
13.CRIME AGAINST WOMEN 14.TRAFFICKING OF WOMEN AND GIRLS  
15.MANIPUR.

35. Chakravarti, Tapati. (2006).  
A Situational analysis of women and girls in Tripura. New Delhi : National Commission for Women. 143 p.

**Abstract** : This study, undertaken by Economic Science Society of Tripura, assessed the situation of women in Tripura in the light of changes that have taken place over the years. Women's access to available health care facilities, existing education system, employment and training for skill formation and political participation were examined on the basis of secondary data. Only 1.05% girls in the 10-14 years age group were married as against 0.06% boys in the same age group. The incidence of child marriage was low in Tripura compared to many states in north India. Medical and Public Health Services started late in Tripura. The State Government provides health care services through government hospitals, dispensaries, community health centres (CHCs), sub-centres (SCs), and other health facilities. Tertiary medical care is provided by the newly created Super Speciality Block of G.B. Pant Hospital at Agartala in collaboration with Care Foundation, Hyderabad. Medical services are generally provided free of cost to patients including indoor patients. The patient to doctor ratio was 4693:1 in 1999, which needs to be improved. Expenditure on rural health increased over the years Rs. 205 lakh in 1999-2000; Rs. 310 lakh in 2000-01; Rs. 510 lakh in 2001-02. Under Rural Health Mission expenditure on rural health scheme would be increased. Birth rate appears to be lower in Tripura (16.5) due to decline in fertility rate (2.1). Death rate has also been declining (5.4) in Tripura. The couple protection rate was 55.5% in Tripura. The prevalence of Asthma was higher among males (5488) than females (4474) in the year 1999-2000. The prevalence of Tuberculosis was also higher in males (1356) than in females (957). Further, Jaundice was also found to be higher in males (9368) than females (7034). It was observed that infant mortality in Tripura was higher for males (63.7) than females (60.4, NFHS-2). 55% of married women currently use family planning in Tripura. 19% of births in Tripura occurred within 24 months of the earlier birth. The study reveals that only 33% deliveries are assisted by a doctor and 13% deliveries are assisted by a nurse or midwife. 54% babies are still delivered at home. It was found that 70% pregnant women received antenatal care in the state. AIDS is a killer disease. 49.0% females were aware of this disease. The study reveals that pulses (52.7%) and green leafy vegetables (58.1%) were consumed on daily basis. It was also found from the Survey that milk and curd (32.9%) was an important part of the daily diet of most women in Tripura. The study reveals that in Tripura more children are undernourished due to illiteracy or low level of literacy among their mothers. According to NFHS-2, children from low income households

were found to be undernourished. The study revealed that 58.8% male children and 64.9% female children aged 6-35 months were anaemic. More than 60% children have anaemia in Tripura which is a matter of great concern. Among ever-married women aged 15-49 years, 43.5% had mild anaemia, 14.0% had moderate anaemia, and 1.4% had severe anaemia. 66% mothers in Tripura received at least two tetanus toxoid injections during pregnancy. According to NFHS-2, 63.0% women received Iron and Folic Acid tablets or syrup. In all, 80% women received IFA tablets for more than 3 months. 69.9% women consumed all the tablets. About 41% children were fully vaccinated. The work participation rate of total workers was lower for women in Tripura in 1991 (13.76%) and it increased in 2001 to 21.1%. The work participation rate for main workers was 10.14% in 1991 and 10.9% in 2001. The work participation rate of marginal workers was very low in 1991 (3.62%) and it increased in 2001 to 10.1%. The proportion of agricultural labourers was much higher for females (34.6%) than males (19.6%). The numbers of both male (2061) and female workers (790) has declined in *bidi* manufacturing. According to the Labour Department, about 4000 women were engaged in sericulture projects in Tripura. Of these women workers, 15% were scheduled castes and 60% were scheduled tribe women. For economic empowerment of women, 8733 SHGs (66%) have been formed in the state and training is being imparted to them for accessing micro-credit. 202 SHGs have taken up economic activities in the field of Animal Resources (139), Business sector (12), Agriculture (6), Cane and Bamboo (15), Tailoring (2), Fisheries (16), Handloom (6), and Horticulture (6) sectors. 51,000 women have been participating in economic activities through cooperation among themselves. In the three tier Panchayat election held in 2004, the percentage of elected women representatives out of women contestants at the Gram Panchayat level were 91% for SCs, 85% for STs and 98% for General category. The number of women representatives in the Legislative Assembly of Tripura has been microscopic and it has declined from 2 in 1988 to 1 in 2003. Crime against women was also found to be rising. According to Office of the Superintendent of Police, Government of Tripura, women continue to be victims of various types of crimes (Rape 22.94%, Molestation 20.05%, Kidnapping and abduction 8.08%, Dowry death 3.03%, Torture of Women 44.01%, and Other crimes 1.87%). It was recommended that the reproductive and child health programme needs to focus on informing pregnant mothers about the necessity for consuming IFA tablets. The unmet need for family planning is still substantial. Community participation should be enhanced by giving functional responsibilities and powers to Panchayati Raj Institutions. Emergency services in rural hospitals should be started by putting doctors on rotation duty, and ensuring ambulance services and transport facilities to needy patients. Micro level studies should be undertaken to assess the impact of different development policies and programmes on women and girl child, such as the impact of 'Mid Day Meals' on the

school attendance of children in the age group 6-14 years. A Women's Study Centre should be opened in Tripura University under UGC guidelines for facilitating research on women related issues.

**Key Words :** 1.WOMEN WELFARE 2.SITUATION OF WOMEN TRIPURA  
3.SITUATION OF WOMEN 4.DOMESTIC VIOLENCE 5.FEMALE FOETICIDE  
6.EDUCATION 7.LITERACY RATE 8.HEALTH AND FAMILY WELFARE  
9.FAMILY COUNSELLING CENTRE 10.SELF HELP GROUPS 11.SGSY  
12.SWARNJAYANTI GRAMEEN SWAROZGAR YOJANA 13.POLITICAL  
PARTICIPATION OF WOMEN 14.CRIME AGAINST WOMEN 15.TRAFFICKING  
OF WOMEN AND GIRLS 16.TRIPURA

36. Damodarani, Sumangala and Menon, Krishna. (2007).  
Migrant women and wage employment : exploring issues of work and  
identity among health care professionals. NOIDA : V.V. Giri National Labour  
Institute. 50 p.

**Abstract :** Women's movements world over have been concerned with questions of women's participation or non-participation in paid work and employment. The present study looks at the lives, work and struggles of women from Kerala working in Delhi as health care professionals, more specifically as nurses. A large proportion of nurses in Delhi are migrant Malayalee women. The migration of nurses from Kerala and a preponderance of Malayalees among nurses in most parts of the country are a phenomena that raise interesting issues on the relationship between gender, work and migration. The first set of issues relate to demand and supply factors. This study was carried out in two major public hospitals, AIIMS and Safdarjung in South Delhi, one major private hospital (Mool Chand), and one small hospital, Red Cross. 70 nurses and 10 private nurses were selected for the study. 25 nurses were in the age group of 20-25 years, 35 nurses were between 25-40 years and 10 nurses were between 40-60 years. Many Malayalee women have joined the nursing profession and constitute trained health manpower, which has resulted in continuous employment opportunities for nurses from Kerala in different parts of Delhi and the world. The demand for nursing personnel is on the rise, commensurate with the growth in health care institutions. However, even though trained nurses number around 700,000 or so in the late nineties, hospitals function with nurse – patient ratios of 1:70, or even more, which is considered grossly insufficient by international standards, which prescribe the nurse – patient ratio to be 1:5. Further, state governments and private hospitals are faced with perpetual shortages and are unable to fill vacant positions for nurses. The severe shortage of nursing personnel in advanced countries is due to a variety of reasons. One, the culture of nursing has becoming less appealing to the local population; and

secondly, increasing demands on nurses, partially as a result of the shortage of nurses, has led to early career burnout. Thirdly, the nursing staff shortage is accompanied by high and rising costs of health care in all advanced countries, making the recruitment of local nurses an expensive affair. A major trend observed in India was that nurses apply for positions in advanced countries from a very early stage in their careers. Out of 25 nurses interviewed, 8 had been educated in Kerala, 4 in other states of India, and the remaining 13 in Delhi. Nurses usually stayed together in groups in available rented accommodation. When they lived with relatives, including families of siblings, they moved out with their friends after they got used to the city. Women who had been in the city for more than five years were the primary breadwinners of their family. The nurses who migrated from Kerala reported low salaries, low nurse – patient ratios, and more difficult working conditions as the reasons for moving away from Kerala. Those who got government jobs in Delhi, found conditions of employment highly satisfactory in terms of remuneration. All the respondents felt their situation was good compared to the private sector, but were on the look out to migrate to western countries. The nurses interviewed distinguished themselves from non-Malayalee nurses on one hand, and from non-nurses on the other. Nurses had fairly strong perceptions of their identity, both as women and as migrants. Even in the case of long term migration, the migrants' sense of identification with the city was minimal. The study found that migrant communities tend to reinforce and reconstitute family and gender relations through a relatively greater emphasis on ethnic identities. Their identity as Malayalees appeared to dominate their identity as women, and the need to emphasise the former tended to circumscribe the possibilities of introspection regarding the latter.

**Key Words** : 1.WOMEN WELFARE 2.NURSES HEALTH CARE PROFESSIONAL 3.WORKING WOMEN 4.HEALTH PROFESSIONALS.

37. Lathansangi. (2004).

A Situational analysis of women and girls in Mizoram. New Delhi : National Commission for Women. 69 p.

**Abstract** : Mizoram is one of the youngest, smallest and isolated states in India. It has a population of 891,058 (2001 Census) and the population is estimated to be 926,640 by the year 2003. It has a variegated hilly terrain where internal communication is still difficult in most rural areas. The study undertaken by National Commission for Women in 2004 revealed that due to its proximity with Myanmar, the state is host to a large number of Myanmari migrants, many of whom are long term settlers. They are involved in the trade of goods from other Asian Countries and providers of unskilled labour and services. Migrants from other Indian states are

largely involved in road construction, trade and other unskilled labour. The state has eight districts, of which five were created in 1997 from a larger erstwhile Aizawl district. The combined population of erstwhile Aizawl district is 620,030 with urbanization being 37.5%. The sex ratio is 944 to 1000 as compared to 938 for the state and 933 for the country. Mizo society is deeply community oriented in nature, social life is care-free, and men and women mix together freely. Thus there is no rigid distinction between males and females in work areas, which makes outside observers believe that the status of women is in no way inferior to that of men, and hence women do not suffer derogatory or discriminatory treatment. But women in Mizoram, have their own unique problems, and the situation is not satisfactory. Women shoulder most of the family's burden of work. The status of Mizo women in the past, especially in the pre-Christian days was very low both in the family and society. A wife was fully engaged with household duties, but her status was insignificant and always subordinate to men. In case of divorce, Mizo women did not have any legal claim on the family property except a small share decided at the time of marriage, which they carried with them as a sort of dowry. In the absence of a male child, a daughter could not claim, as a matter of right, the family property, but it would normally go to the nearest male relative. The whole management of household affairs was left to women. They had to do everything at home except build a house and repair the tools used for jhumming, etc. In some cases, women also helped their husband in cutting, jhumming, etc. Recognition is not given to women's hard labour. Mizo women today continue to be the main work force, breadwinners and work in various capacities as government employees, in business and commercial sectors and in religious life. Despite their hard labour, they have no rights of inheritance or ownership, either in their parents' home or after their marriage. They have no right over their own income, over their children or over their properties. Mizo women are excluded in all decision-making bodies in social, religious and political fields. In social organizations such as YMA (Young Mizo Association) and VDP (Village Defence Party), women are active and important members, and their contribution makes these social organizations successful. But they are seldom given any decision making opportunities. In church activities they are excluded from decision making bodies, ordination and other responsible positions. Women are seldom given membership in the village council or bodies like Legislative Assembly. Although the status of Mizo women has improved significantly, especially after the propagation of Christianity, the stage of gender equality is yet to be reached. It was recommended that the State Government has an important role to play in empowering the developed women of the state. Public opinion should be mobilized to enlighten the state authority. Family institutions have to be changed and re-created so as to create awareness among the women themselves. The monetary value of the work done by women in domestic chores must be worked out, so that the women themselves would be aware of their contribution to the family income. Cooperation among

various women's organizations such as MHIP and women's wing of various churches is necessary so that all work together to uplift the status of Mizo women. Mizo women are economically empowered, but they should strive more to achieve economic independence. Creating opportunities for women would be a prudent policy, not only for equity but also for economic growth.

**Key Words :** 1.WOMEN WELFARE 2.SITUATION OF WOMEN MIZORAM  
3.SITUATION OF WOMEN 4.DOMESTIC VIOLENCE 5.FEMALE FOETICIDE  
6.EDUCATION 7.LITERACY RATE 8.HEALTH AND FAMILY WELFARE  
9.CRIME AGAINST WOMEN 10.TRAFFICKING OF WOMEN AND GIRLS  
11.MIZORAM.

38. Mathur, Kanchan et al. (2006).

Local customs and practices in Rajasthan and their impact on women : an in-depth study of *dakan/ dayan* (witches). Jaipur : Institute of Development Studies. 79 p.

**Abstract :** In Rajasthan, violence against women constitutes a legitimized and routinised aspect of prevailing cultural definitions of gender. It is also used as a tool to ensure that women remain within socially defined boundaries of behaviour and space. The present study was done to understand the phenomena of naming/ labeling women as witches (*dakan/ dayan*), and also analyzed the cause, nature and forms of violence meted out to women. The study was conducted in 6 districts of Rajasthan namely Tonk, Bhilwara, Ajmer, and Kota (plains region), Jodhpur (desert region) and Udaipur (tribal region). Data was collected through field visits, interviews and from secondary sources. The study covered 63 women aged 25 years to 70 years of whom 8 women were no longer alive, 7 had been victims of violence (murder), and only one had a natural death. A large majority of women (55.6%) were dependent on agriculture and animal husbandry and this dependence declined to 41.3% after they were labelled as *dayans* by the community people. This was because either people grabbed their land or they were not being allowed to cultivate their fields on account of being labeled as *dayans*. The second largest category (28.6%) were women engaged in traditional occupations such as sweeping and petty trade; making pots and lamps for festivals; performing certain rituals on death, birth and marriage functions; selling flowers, fruits and vegetables; selling bangles; conducting prayers and other religious ceremonies at the village temples, etc. The percentage of these women engaged in traditional occupations had declined from

28.6% to 4.8% as a result of labelling. The study found that widows or separated women alone were more likely to be labelled as *dayans* and a large majority (44.4%) of the women were married. More than 50% of the women stated that they had been suffering physical and mental violence for 20 years or more. Superstition was a prime reason for accusing women as *dayan/ dakan*. Besides superstition, other reasons behind branding/ naming women were land/ property disputes, infertility and childlessness, deformities and challenges (low intelligence levels), fear of ignominy or disgrace, personal and caste rivalry, and often the assertive nature of women. Women once labelled were subjected to various forms of mental and physical violence including immolation, hair being cut off, heads shaved, branded with iron rods, raped, and made to eat animal excreta, hurting genitals, murdered or even forced to commit suicide. As a consequence of this, labelled women lost their reputation in their families and community. Apart from creating feelings of helplessness, fear and powerlessness, labelling and consequent violence impacts their lives in several ways. These women often experienced severe depression and low self-esteem. The state machinery such as police, judiciary, PRIs, NGOs, media and caste panchayat had been largely ineffective in preventing this practice, the prime reason being the absence of an Anti-Witchcraft Act in the state. Women did not have easy accessibility to these institutions as these were patriarchal in nature and approaching them required a lot of courage on the part of women. Most women were illiterate also. Interventions have to be planned, both in terms of countering the violence meted out to women survivors and also towards preventing it from happening in the future. One main step that needs to be taken is changing the mindsets of people to remove myths, beliefs and superstitions.

**Key Words** : 1.WOMEN WELFARE 2.WITCHES 3.CUSTOMS 4.CUSTOMARY PRACTICES 5.BELIEFS 6.DAKAN 7.DAYAN 8.VIOLENCE AGAINST WOMEN 9.STATUS OF WOMEN 10.RAJASTHAN

39. Ranbir Singh. (2006).

A Situational analysis of women and girls in the union territory of Dadra and Nagar Haveli. New Delhi : National Commission for Women. 97 p.

**Abstract** : Independent India proclaimed equality of the sexes as a Fundamental Right under the Constitution and directed state policy towards removing the various

disabilities that prevent women from realizing their potential. The present study was a situational analysis of women and girls in the Union Territory of Dadra and Nagar Haveli which focused on socio-economic conditions, education and literacy, health, crime against women, traditional practices and Panchayati Raj indicators. Data was collected through field surveys and from secondary sources. Dadra and Nagar Haveli was a tribal dominant small Union Territory, and as per 2001 Census the total population was 220,451 (males 121,737; females 98,720). The tribal population of DNH was 1,37,208 and was divided into 3 major groups namely Varlis, Dhodias and Kokanas. Literacy rate was 40.70% in 1991 which had risen to 60.03% as per survey of 2001. Female literacy rate was 42.9%. There were 17,235 families below the poverty line (BPL), and a Survey by Planning Commission (2001) had estimated that 6000 more families were BPL. It was found that beneficiaries covered under various agricultural schemes were about 12,000 every year, out of whom 3500 to 4000 were women, which was 30% approximately. In 2000, the sterilization method was used by 704 people, which increased to 785 in 2004; c-c (condom) users increased from 1245 in 2000 to 3604 in 2004, and oral pill users increased from 1171 to 4188 in 2004. The number of pregnant women receiving Tetanus injections was 6775 in 2001 which increased to 7682 in 2004. Vaccines received by children were DPT (7080 in 2001 and 7582 in 2004), and B.C.G. (6998 in 2001 and 7904 in 2004). According to the Census of India 2001, total number of disabled persons was 2018 in the total population (1257 males and 761 females). Several schemes were implemented by the Department of Rural Development and these were Swarna Jayanti Gram Swarozgar Yojna (SGSY), Swayamsidha, Indira Awas Yojana, Indira Mahila Yojana, Balika Samridhi Yojana, National Family Benefit Scheme (NFBS), and Total Literacy Campaign. Under the SGSY scheme, 40% beneficiaries were women, and 18 women's Self Help Groups (SHGs) were formed during 2003-04. Under the Swayamsidha scheme, 90 SHGs were formed and 246 benefited from the scheme. The girl child covered under Balika Samridhi Yojana (BSY) was entitled to post-birth grant of Rs. 500/- annually when the girl started attending school. She became entitled to the annual scholarship and there were 32 girl beneficiaries during 2003-04. Under National Family Benefit Scheme there were 1132 persons in 2003-04, of whom 789 were female beneficiaries. Under the Total Literacy Campaign Scheme, special emphasis was given to girls' education. The U.T. administration had one tribal ICDS block under which 138 Anganwadi Centres and 40 wheat based centres were functioning. The total number of women beneficiaries who received supplementary nutrition and wheat based nutrition were 3099 in 2004-05. Of these, 1123 were pregnant mothers, 1535 were nursing mothers and 441 were adolescent girls. The total number of crimes against women reported in 1999 was 19 which decreased to 11 in the year 2004 and constituted 4.5% of the total crimes. Crime rate in the U.T. was much lower than the over all crime rate of India. In 1995-96, there were 4 female inmates lodged in the Sub Jail of the U.T., in 2002-03 there were

only 2 female inmates, and in 2003-04 there was no female inmate lodged in the Sub Jail. The study suggested that various schemes related to education, health, nutrition, personal laws, etc. should be implementing by the Government of India to address women's problems in Dadra and Nagar Haveli.

**Key Words :** 1.WOMEN WELFARE 2.SITUATION OF WOMEN DADRA AND NAGAR HAVELI 3.SITUATION OF WOMEN 4.DOMESTIC VIOLENCE 5.FEMALE FOETICIDE 6.EDUCATION 7.LITERACY RATE 8.DISABILITY 9.HEALTH AND FAMILY WELFARE 10.FAMILY COUNSELLING CENTRE 11.PANCHAYATI RAJ 12.SELF HELP GROUPS 13.SGSY 14.CRIME AGAINST WOMEN 15.TRAFFICKING OF WOMEN AND GIRLS 16.DADRA AND NAGAR HAVELI.

40. Sujaya, C.P. (2001).  
Climbing a long road : women in agriculture in India : ten years after Beijing.  
Chennai : M.S. Swaminathan Research Foundation. 132 p.

**Abstract :** From the earliest days of agriculture, women have played a key role in the selection of plants for cultivation, animals for domestication and in conservation. Yet women's efforts and achievements have been little recognized or rewarded. Involvement of women in agriculture is due to out migration of males from low paid agriculture to higher paid industry. Incidence of work-related migration for less than a year is as low as 3.6% for rural women as compared to a high 33.7% for rural men. Women's work participation is mostly related to available local work or family enterprises, which restricts their upward mobility. Women's remuneration is lower and working conditions are worse. Women's employment in the informal sector is increasing due to factors connected with globalization such as export-oriented industrialization and relocation of industries in developing countries. According to Census 2001, more than 110 million women are engaged as workers; in rural areas, 36.5% of them are cultivators and 43% work as agricultural labourers. Female agricultural workers are subject to the worst ill effects of poverty. In rural India, agriculture and allied sectors employ 89.5% of the total female labour. Women work extensively in livestock maintenance, forest resource use and fish processing. Women provide 50% of the labour in rice cultivation. In the plantation sector, women are the crucial labourers. The study found that in livestock management, indoor jobs are done by women in 90% of the families. In animal husbandry women account for 93% of the total employment. Women have a role in land use (providing fertilizer to the soil) and

in supplying inputs from the forests (fodder for the cattle). In Mizoram, women have knowledge about animal ecology that male hunters acquire. In overall farm production, women's average contribution is estimated at 55 – 66% of the total labour, and is much higher in certain regions. In the Himalayan region, a pair of bullocks works 1064 hours, a man 1212 hours and a woman 3485 hours in a year, on a one hectare farm. These figures illustrate women's significant contribution to agricultural production. BPF (Beijing Platform for Action) mandates that women should be enabled to benefit from ongoing acquisition of knowledge and skills beyond those acquired in youth. About 50,000 women receive training in Industrial Training Institutes (ITIs) and women's wings in general and private ITIs. The existing facilities for training in agriculture available at college / university level respond to a very different kind of demand. There is a basic mismatch between the kind of work that women in farming and allied sectors actually perform in their day to day lives in primary sectors such as agriculture, fisheries and dairying, and the training offered. Training is offered in simple agricultural skills and technologies, such as soil testing and preparation, seed selection and testing, preparing compost, vermi-composting, bio-pesticides and bio pest control. The study found 600 trained women as link workers in Tamil Nadu with communication skills training, who then trained other farming women in agricultural techniques. The Information Age with its transformational potential raises the question whether the ICT revolution can become a powerful vehicle for gender equality. The National Research Centre for Women in Agriculture (NRCWA) has initiated projects on almost all aspects of the roles of women in agriculture. Women's issues in 2005 claim just a little more political space than they did a decade ago. Governments need to link macro-economic policies and development strategies to meet the needs of women in poverty, with their full involvement and equal participation. They should be provided safety nets to enable women living in poverty withstand adverse conditions and preserve their livelihoods in times of crisis.

**Key Words** : 1.WOMEN WELFARE      2.AGRICULTURE AND WOMEN  
3.SITUATIONAL ANALYSIS    4.SELF HELP GROUPS    5.FISHER WOMEN  
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