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Research Studies on Women and Children

CHILD WELFARE

1. Jay Prakash et al. (2008).

Kishori Shakti Yojana (KSY) under the ambit of ICDS in Uttar Pradesh and Rajasthan : final report. New Delhi : Formative Research and Development Services. ~80 p.

Abstract : This study seeks to document the details (approach, components, technicalities, community response and participation, etc.) of adolescent girls (AGs) scheme on ICDS projects in the state of Rajasthan (blocks of Abu Road and Revdar in Sirohi district and Jhadol and Khaiwara in Udaipur district) and in Uttar Pradesh (blocks of Jasrana and Khairagarh in Firozabad district and Babaganj and Patti in Pratapgarh district). In Rajasthan, 826 AG beneficiaries, 48 parents of AGs, 81 AWWs and 3 CDPOs were taken; and in Uttar Pradesh 622 AGs, 99 AWWs, 3 CDPOs and 48 parents of AGs were selected. It was found that 49.2% girls had dropped out from schools while 16.2% were illiterate. Around 73.5% girls were aware about the AGs scheme while the remaining were not. Awareness was found to be much better in Uttar Pradesh (94.5%) than in Rajasthan (57.6%). About 47.7% girls mentioned that they visited AWCs daily, followed by once in a week (31.6%) and once in a month (10.5%). Approximately 9% AGs mentioned that they went to the AWC when called by the AWW, and a very small percent (1.4%) girls mentioned that they never visited any AWC. The major activities under KSY in Rajasthan were stitching and weaving courses, while in Uttar Pradesh the major focus of the scheme was to provide knowledge related to health and hygiene to AGs. Around 38.7% girls mentioned that they came to know about the scheme from AWWs, 8% girls mentioned that they came to know about KSY from TV/ radio, family members, friends, newspapers, sector supervisors, etc. Around 90% girls were registered at AWCs. More girls were registered in Uttar Pradesh (96.8%) than in Rajasthan (83.5%). The remaining 10% were not aware. 73.9% girls mentioned that AWWs were the main motivator who encouraged them to join KSY. 87% girls said that their parents and family members did not oppose their joining the scheme. 43.1% girls mentioned that new learning had been in the area of health, followed by education (29.7%), reproductive health (10.5%), vocational training (6.2%), and art and painting (6.1%). Some girls also learnt about nutrition (1.8%) and were given environmental education. In Rajasthan, 40% girls mentioned that there had been

some skill development programme at the AWC. Around 80% girls were satisfied with the work of AWW. The satisfaction was much higher in Uttar Pradesh (98.7%) than in Rajasthan (65.9%). Around 70% girls were able to read newspapers and could write a letter. Reading and writing skills were found to be higher in Uttar Pradesh (85%) than in Rajasthan (60%). In Uttar Pradesh 94.9% girls mentioned that they learned about gender equality from KSY, only 56% girls in Rajasthan stated the same. 56.8% girls desired to learn about stitching followed by craft (23.2%), and to prepare home made items (20.2%) such as making *papad*, pickles, etc. In Rajasthan, the emphasis was on stitching courses; while in Uttar Pradesh, craft, and preparing home made items was given much emphasis. 50% girls were aware of diarrhoea. This awareness was much higher in Uttar Pradesh (59.2%) than in Rajasthan (45.3%). 40% girls were aware of anaemia. 15.6% girls were aware of the need to take IFA tablets to combat anaemia. Four out of five girls (81%) mentioned that child immunization was essential. In Uttar Pradesh around 97% girls were aware about immunization, and in Rajasthan only 70% stated this. 63% girls were aware of at least one method of delaying pregnancy. Awareness was more in Uttar Pradesh (68.8%) than in Rajasthan (59.3%). Only 3% girls in Rajasthan were aware of Reproductive Tract Infection (RTI) symptoms, 11% girls were aware of Sexually Transmitted Infection (STI). In Uttar Pradesh 22% girls were aware of STI, and 15% were aware of RTI. In 98% AWCs attendance register, immunization register, supplementary food register, birth register and stock register were maintained. About 53.4% AWCs had medicine kit and 66.7% AWCs had weighing machine. Only 41% AWWs had received training about KSY. 85% AWWs received training in Rajasthan while in Uttar Pradesh only 4% AWWs received training about KSY. AWWs mentioned that 55% AGs visited AWCs for IFA tablets. 47% AWWs said that girls visited AWCs daily, followed by a fixed day (29.4%), alternate day (19.4%) and no regularity (4.4%). AWWs mentioned that nutrition and hygiene were the most important issues girls came to learn at AWCs, followed by reproductive health issues (9.4%), and work related to households (8.3%). 71% AWWs mentioned that girls do not come to the centre, and if they come, they do not stay for long and do not pay attention to what AWWs tell them. AWWs mentioned that the training given was not sufficient for implementation of KSY. In Uttar Pradesh most of the AWWs were not aware about KSY. They felt they were overburdened with responsibilities, which made them inefficient in delivering the services. Parents were not allowing their daughters to come to AWCs as they were not able to perform household chores. 25% respondents desired that raw material for vocational training should be available at AWCs. While in Rajasthan the stress was on availability of raw materials, in Uttar Pradesh majority of the girls desired training in vocational courses. Raw material and necessary equipments should be made available at

AWCs. There should be master trainers in each project for effective implementation of the vocational training programme. Five days training is organized at the block level, which should be at the panchayat level, so that beneficiaries from 4-5 AWCs can be provided the training together. Timing for girls under KSY should be separate from the time for other activities at AWCs. The quality of training given to AWWs under KSY should be better and more extensive. Community should be sensitized on reproductive health issues for better coordination from the community.

Key Words: 1.CHILD WELFARE 2.ADOLESCENT GIRLS SCHEME 3.ADOLESCENT GIRLS IN ICDS 4.KISHORI SHAKTI YOJANA 5.KNOWLEDGE OF ADOLESCENT GIRLS 6.ICDS 7.ROLE OF ANGANWADI WORKERS 8.RAJASTHAN 9.UTTAR PRADESH.

2. John, Mary E. and Ravinder Kaur, et al. (2008).
Planning families, planning gender : the adverse child sex ratio in selected districts of Madhya Pradesh, Rajasthan, Himachal Pradesh, Haryana and Punjab. New Delhi : Action Aid India. 91 p.

Abstract : A major impetus for this study was the issue of the sex ratio and its decline, which has been recognized as a demographic and statistical fact. This micro level qualitative study sought to understand the behaviour, meaning and structure of society and social agents that lie behind the growing imbalance in the sex ratio. This study was undertaken in two stages. H.P., M.P. and Rajasthan were taken up at the first instance in 2003, and Haryana and Punjab were added later on, in 2005. The districts chosen were Morena (M.P.), Dholpur (Rajasthan), Kangra (H.P.), Rohtak (Haryana), and Fatehgarh Saheb (Punjab). Morena (M.P.) had the lowest child sex ratio in the state, and had the highest rates of child malnutrition and anaemia among women. Population decline had set in only recently in the age group 1-4 years in rural sites, and in the 5-9 age cohort in urban areas. Levels of literacy showed a large gap between men and women, averaging 85% among men and 62% among women (age 6 years and above). The gap between men and women was enormous in the realm of work. Among women, work participation was only 7% in rural areas and 9% in urban areas. Dholpur has the lowest gender development index of 0.27 as per Rajasthan's State Development Report of 2002, while Ganganagar had the highest. In Dholpur (Rajasthan) female literacy rates are the lowest of all the study sites, at 34% in rural and 58% in urban areas according to Census of India 2001. In

Kangra (H.P.), there were clear trends of population decline going back to two decades in the 10-14 years age group in rural sites and in the 15-19 years age group in urban sites. Literacy was extremely high and close to 100% in two of the urban sites among men, with roughly a 10% gender gap. Among women, 84% and 93% were the rural and urban literacy rates respectively. Work participation rates among men (in the population aged 15 years and above who reported work as their main activity) were unusual in Kangra. Rural rates (62%) were slightly lower than urban rates (69%). Rural men reported that no work was available for them and household work was their main activity. The gap between men and women in the realm of work was large. Proportionately, more urban women (23%) claimed to be employed than women in rural sites (16%). In Rohtak, Haryana, overall, the age pyramids were broadly congruent, indicative of a rural-urban convergence, with a fertility decline observable from the 10-14 years age group. The 15-19 years age group was particularly noteworthy, both for the drop in frequencies and for the small number of girls. Male literacy was high, both in urban and rural areas (94% and 93% respectively), whereas female literacy rate was 68% in rural and 84% in urban areas. 18% rural women reported themselves as primary workers compared to 13% women in the urban sites. Half of the rural workers were engaged in dairying followed by daily wage labour. 11% women in rural areas and 81% women in urban areas had no work. Fatehgarh Saheb has the lowest child sex ratio in Punjab, 754 as per the Census of India 2001. The gender development index, according the Punjab Development Report of 2004, placed Fatehgarh Saheb in the second last position with 0.56; Amritsar was last (0.54). In Fatehgarh Saheb the literacy rate of males was 82% and 88% in rural and urban areas respectively. The female literacy rate was 70% in rural areas and 77% in urban areas. Among women, the majority were housewives (80% rural and 76% urban), and 15% rural women and 19% urban women were engaged in work. Morena and Dholpur showed significant skewing against girl children, which was not the case in the other three sites. In Morena the figures for non surviving girls versus boys among first, second, and third order births were 51 girls/31 boys, 40/17 and 31/15 among women aged 34 years or less (among a cohort of 950 mothers). In Dholpur, the equivalent comparative numbers of dead girls/boys among the same age of women (cohort of 580 mothers) were 24 girls/49 boys among first borns, 33/26 among second borns, and 28/18 among third borns. Indeed it is among first borns that boys are twice as vulnerable, and severe skewing against girls is visible among third borns. The relatively better child sex ratio in urban Dholpur is partially due to severe poverty, resulting in high death rates of boys as well as girls. In Rohtak and Fatehgarh Saheb the fertility and sex determination decisions were contentious issues between husbands and wives. Wives are adamant on aborting female fetuses, and make superhuman efforts to have at least one male child. In all the five

districts, no government schemes of any kind were being implemented or were known about. Considering the fact that the study was conducted close to the districts centres of the worst child sex ratio districts of the region, this is in itself a major problem with the existing schemes. At the same time, the Government has been advertising various schemes and it is worth briefly reviewing them. Some schemes have been announced by the Government but do not figure on the website of the Government such as Ladli Scheme. One of these is the monitoring of pregnancies in select districts with very low child ratios. Women who become pregnant are to be monitored all the way to the completion of their pregnancy. This is particularly problematic, and is not just an invasion of privacy. There is the obvious problem that abortion decisions bearing no connection to sex selection are thereby curtailed. The arm of the state is now attempting to turn to a surveillance of populations, and mothers in particular, to enforce the birth of daughters. Ensuring the birth of girls or the supply of sufficient women to society treats women as a necessary stock of society required for its stable reproduction. There is an urgent need to reorient public schooling such that it no longer exacerbates inequalities in fundamental ways across class, caste, and gender. Attempts should be made to redress the causes of gender imbalance.

Key Words: 1.CHILD WELFARE 2.DECLINING SEX RATIO 3.SON PREFERENCE 4.SEX DISCRIMINATION 5.AGE AT MARRIAGE 6.FEMALE FOETICIDE 7.MADHYA PRADESH 8.RAJASTHAN 9.HIMACHAL PRADESH 10.HARYANA 11.PUNJAB.

3. NIPCCD, New Delhi. (2008).
A Socio-cultural study of the declining sex ratio in Delhi and Haryana. New Delhi : NIPCCD. 141 p.

Abstract : Declining sex ratio is an issue of grave concern in India. Family and social pressures to produce a son are immense. The present study was done to assess the various socio-cultural, economic, demographic, cultural and other factors that contributed to the declining sex ratio. The study was conducted in Delhi and Haryana and data was collected through interviews. In all, the sample of the study comprised 300 women, 300 men, 300 mothers-in-law, 13 *dais* (midwives), 107 women opinion leaders, and 94 ICDS and health functionaries. A majority (76.9%) of the *dais* in the sample were trained, and on an average 75% of the *dais* conduct 1-5 deliveries per month, and 25% reported getting an opportunity to conduct 6-10 deliveries in a month. Most of the respondents comprising women of Delhi (92%) and Haryana (99.3%) were aware of the

phenomena of declining sex ratio throughout the country. Most women perceived non-availability of brides (92.3%) as the major repercussion of missing girls, followed by an increased rate of crime against women (67%), and polyandry (20%). The *dais* of Haryana mentioned that crime against women would increase drastically (100%), and there would be no bride available (100%). The CDPOs of Delhi and Haryana mentioned that increased rate of declining sex ratio would lead to an increased rate of crimes against women. Almost all other ICDS functionaries (Supervisors and AWWs) and medical officers mentioned that an increased rate of crime against women, non-availability of brides and lack of female workforce would be major repercussions of the declining sex ratio in the country. The reasons for son preference from all respondents including Delhi were that a son is a support and provider in old age, brings in dowry instead of draining family resources, continues the family name, and performs the last rites of parents. The main reason given by women, men, *dais*, ICDS and health functionaries for not wanting daughters was 'dowry'. Other reasons were that investing in girls was seen as a waste, with no returns, the safety of girls was a matter of concern and fear of harm to the family honour if anything untowards happened to the girl. The ideal family composition, as perceived by the majority (67%) of mothers-in-law, included one boy and one girl. Around 26.7% of the women still believed that check-ups were not required during pregnancy, and 65% of the women in Delhi and 68.7% in Haryana still believed that deliveries should be conducted at home. Women's knowledge in Haryana regarding problems encountered during pregnancy and childbirth was better than that of women in Delhi. Approximately, 60% of the women in Delhi and 64.7% in Haryana responded that breastfeeding should be initiated with an hour of birth. About 60.7% of the women in Delhi and 99.3% in Haryana answered correctly about exclusive breastfeeding. All the women (100%) in Haryana and 79.3% in Delhi knew the ideal time for the introduction of complementary feeding. It was shocking to note that 97.3% women in Haryana and 87.3% in Delhi decreased the food intake of a child during illness. Abortions, whether spontaneous or induced, were less in Haryana as compared to Delhi. The study revealed that mothers-in-law were the major decision-makers on how money earned at home was to be spent, more than the women themselves. There is a need to organized sensitization programmes on prevention of female foeticide and infanticide for the functionaries of voluntary organizations and the community.

Key Words: 1.CHILD WELFARE 2.FEMALE FOETICIDE 3.DECLINING SEX RATIO 4.SEX RATIO 5.SON PREFERENCE 6.FAMILY SIZE 7.ABORTIONS 8.SEX DETERMINATION TESTS 9.DOWRY 10.DELHI 11.HARYANA.

4. NIPCCD, New Delhi. (2008).

A study on child marriage in India : situational analysis in three states.
New Delhi : NIPCCD. 218 p.

Abstract : Child marriage is a practice which is one of the most serious social maladies affecting the lives and future of India's youth. The study was done to assess the prevalence and incidence of child marriages and analyze the various socio-economic and cultural factors leading to child marriage. Data was collected from 2 selected districts each of the 3 states, namely Rajasthan (Tonk and Jaipur), Uttar Pradesh (Varanasi and Meerut), and Madhya Pradesh (Shajapur and Bhopal) where incidence of child marriage was high according to NFHS-2 data. Four villages were selected from each district. In-depth interviews were conducted with panchayat representatives, heads of families, couples who were married before attaining 18 years, NGO representatives working on this issue, police personnel and district magistrates. Findings revealed that in Uttar Pradesh 88% of the respondents, in Madhya Pradesh 62% and in Rajasthan 61.8% of the respondents believed that boys should get married at the legal age, i.e. 21 years and above. Regarding the right age of marriage for girls, in Uttar Pradesh 81.6% of the respondents, Rajasthan 62% and in Madhya Pradesh 61.6% of the respondents reported that girls should get married when they are 18 years of age or above. In Rajasthan, economic burden or poverty (60.2%) was the main cause for the practice of child marriage, in Uttar Pradesh family tradition (54%), and in Madhya Pradesh customs and beliefs (71.6%) was the reason for prevalence of child marriage. Other reasons were safety of girls, community pressure and bride price. In Uttar Pradesh, up to 66% of those married below 18 years mentioned that marriage meant 'celebrating festival'. In Rajasthan 83.3%, in Uttar Pradesh 50% and in Madhya Pradesh 83.3% respondents mentioned that they were not interested in getting married before 18 years. All the NGO representatives and District Magistrates of the three states stated that family traditions, poverty and customs and beliefs were the major reasons for child marriage. The level of awareness regarding registration of marriage was limited among the respondents in all the three states (Rajasthan 75.6%, Uttar Pradesh 83.6%, and Madhya Pradesh 68.4%). In Uttar Pradesh and Madhya Pradesh all the ten police personnel interviewed were aware that child marriages were illegal. In all the 3 states, District Magistrates were fully aware about Prohibition of Child Marriage Act 2006. In the present scenario, though several people interviewed were aware about the law against child marriages, due to lack of enforcement and political will, they continue to follow the practice. Only when the law is made strict

and strong action is taken against those who continue to practice child marriages, can the menace be tackled. Also, all stakeholders, community members, panchayat members, etc. should be sensitized and convinced about the negative impact of child marriage on children, and about protecting the sexual and reproductive health and rights of girls and young women through awareness generation programmes.

Key Words: 1.CHILD WELFARE 2.CHILD MARRIAGE 3.EARLY MARRIAGE
4.AGE AT MARRIAGE 5.MADHYA PRADESH 6.UTTAR PRADESH
7.RAJASTHAN.

5. Tejinder Kaur. (2008).
Studies on adolescent girls : an analytical review. New Delhi : NIPCCD.
231 p.

Abstract : Adolescents in India account for one-fifth of the total population, and are a significant human resource that needs to be given ample opportunity for holistic development towards achieving their full potential. The present study is a compilation by NIPCCD on various aspects of adolescents growth and development undertaken in the last five years to analyse the trends in development of adolescent girls in the country, their needs related to basic health and nutrition, psychological development, prevention of substance abuse and trafficking, gender differentials in development, problems related to adolescent pregnancy and poor reproductive health, as well as issues related to life skills education. It was found that recent studies have been taken up to evolve growth standards for Indian adolescents, and some studies have shown that girls have better nutritional status in terms of weight for age and body mass index (BMI) than boys, but there was slow growth of girls after 13-14 years of age. A statistically significant increase in height (from 2.5 to 3.5 cm) and weight (1.0 to 1.5 kg) indicates some improvement in overall growth and development of adolescent girls over the past two decades. Prevalence of anaemia was reported to be above 80% in various states of India. Obesity was reported to be higher in adolescent girls (5%) from higher socio-economic status than adolescent boys (2%). Studies showed that more than 55% adolescents were anaemic, and nearly 40% suffered from dental carries. In winters 70-75% girls reported cold

and cough and fever. In summer conjunctivitis (57.5%) and diarrhoea (23.7%) was reported, and rainy season saw a peak in skin infections (27.5%) among adolescent girls. More than 60% AGs also reported having suffered from malaria at sometime or the other. It was observed that adolescent girls were obsessed with their figures, and the desire to have a thin frame of body pushes them into anorexia nervosa. More than half the adolescent girls and young married women in rural areas and urban slums did not know about RTIs (Reproductive Tract Infections) and nearly 95% of them suffered from vaginal infections leading to watery/ curdy discharge. Home delivery posed a greater risk of RTIs as compared to institutional deliveries. 40% of these adolescents did not know the causative factors associated with HIV/ AIDS. As per research conducted during the last five years, adolescent mothers constituted a high percentage of women experiencing premature labour and delivering intrauterine growth retarded babies. Data showed that 'out of school' adolescents were 1.6 times more at risk of contracting RTIs. School going girls were 2.4 times more likely to adopt safe practices during menstruation. Research indicated that 80% of the rural and urban adolescent drug abusers reported their families to be less harmonious. Nearly half of the adolescents faced mental torture, and 20% faced sexual harassment. More than 60% of the married adolescents did not know about HIV/ AIDS, syphilis and gonorrhoea, and their level of knowledge and awareness regarding these topics improved with interventions like interpersonal communication, distribution of pamphlets, and video presentation. Research also confirmed the effectiveness of the strategy of Government – NGO partnership in development programmes. Distribution of audio-visual material coupled with interpersonal communication has emerged as a viable training methodology option. It was suggested that gender differentials at the household level in intra-family food distribution need to be removed through gender sensitization and improving availability of food within the family. Campaigns for small families and literacy need to be intensified for better adolescent health and nutrition, with special reference to the micronutrient status of girls. Also, there should be a slot for reproductive health education in schools. For 'out of school adolescents', nutrition and health education under Kishori Shakti Yojana, and reproductive health should be included in the modules for both the age groups.

Key Words: 1.CHILD WELFARE 2.ADOLESCENT GIRLS 3.SLUM GIRLS
4.TEENAGE PREGNANCY 5.RURAL ADOLESCENTS 6.ANAEMIA
ADOLESCENT GIRLS 7.NUTRITIONAL STATUS ADOLESCENT GIRLS
8.ADOLESCENT REPRODUCTIVE HEALTH.

DESTITUTE CHILD

6. Subhasis Ray. (2008).
Integrated programme for street children : an evaluation. New Delhi:
NIPCCD. 189 p.

Abstract : Street children are often subjected to harassment and eviction in India. The main objective of the present study was to identify the types of children that are covered under different projects run under the Street Children Scheme; the extent to which facilities are being provided to them, as envisaged in the scheme; the main occupations children are engaged in; the nature and extent of nutrition and food, health and shelter facilities given to them. About 50% of the 61 voluntary organizations (VOs) were studied. From each VO two centres (eg. 24 hour Drop-in Shelter and/ or Contact Point/ Club) were selected. From each centre 7 street children belonging to 3 different age groups (<8 years, between 8-14 years, >14 years) were selected. In all 762 schedules were administered. Other respondents were Chief Functionary (61), Supervisory Functionary (59), Opinion Leaders (61), Employers (175), and Government Functionaries (20). About 117 Centre Observation Schedules were also filled in, bringing the total responses to 1433. Study was initiated in June 2006 in 26 States/ UTs of India. VOs were selected proportionately from all States/ UTs. 4.4% VOs were established with the objectives of working in the area of counselling, rehabilitation, job placements, etc. 41% voluntary organizations were working in the area of education, more particularly non-formal education. In 12 states a majority of the organizations were working for welfare of the underprivileged sections of society. 51% VOs were working with women. 11% organizations were working with youth and adolescents. 15% organizations were also working with the aged population, whereas, 13% organizations were working with mentally challenged persons. 8 organizations (13.11%) were working with working children, 4 organizations (6.56%) were working with destitute children, 3 organizations (4.92%) were working with children of sex workers, and as many organizations were working with orphan children. It was found that most of the centres (73.58%) fell in the category of Contact Points/ Clubs/ Day Care Centres. About 19% employers mentioned that they provided shelter to the children working with them. 41.71% employers mentioned they provided free medical aid to children, 57% employers provided other amenities such as shoes (30.86%), free clothing (20.57%), meals (5.71%), festival gifts (3.43%), and umbrellas (0.57%). More than 70% employers allowed children to take leave on medical grounds. However, about 43% employers did not allow the children any weekly

holiday. 50% employers either encouraged the children to go to school or taught them at their own level. Amazingly, majority of the respondents reported that they extended entertainment facility to the children such as radio (38.29%), television (38.86%), indoor games (13.71%), magic shows (12%), movies (5.71%), and outside trips (1.14%). 72.82% children mentioned that lack of proper shelter was one of the major problems they encountered in life. 20.17% children aged 8-14 years and 22.80% children above 14 years of age mentioned that starvation was the major problem they faced in life. Police harassment (16.71% and 12.95% respectively); rape (0.58% and 0.52% respectively); sexual exploitation (3.17% and 3.63% respectively); commercial exploitation (12.39% and 9.33% respectively); a grave injury/ disability/ disease (20.75% and 20.21% respectively); substance abuse (3.75% and 7.77% respectively); drug peddling or smuggling (1.73% and 4.66% respectively), and other problems (8.07% and 16.58% respectively) were the traumas faced by children aged 8-14 years and above 14 years. Information was also gathered regarding the aspirations of beneficiaries. The most overwhelming response in this regard was to 'earn lots of money' (33.33% in below 8 years, 43.80% in 8-14 years, and 49.22% in above 14 years age group). The second highest response was to 'teach at a school' (28.38% below 8 years, 21.90% 8-14 years, 23.32% above 14 years). 85% Opinion Leaders confirmed their help and support to the Centres. They also motivated the community to cooperate with the Centre Staff (69.23%), participate in programmes/ activities of the Centre (69.23%), identified and enrolled children (61.54%), solved problem/ difficulties faced by the Centre (46.15%), helped in enrolling children in formal schools (42.30%), helped in ensuring cleanliness of the Centre and surroundings (36.54%), and provided financial and material help (23.08%). There were other activities/ work they would like to carry out. It was recommended that the ratio of Centre to Project Coordinator should not be more than 5:1 to facilitate close and regular supervision of the Centres. The size of the room/ space where the Centres are being run should be commensurate with the number of children attending. Periodic awareness generation campaigns should be launched. Provision of vocational training to children would enable them to earn a living with the skills learnt.

Key Words: 1.DESTITUTE CHILD 2.STREET CHILDREN 3.INTEGRATED PROGRAMME FOR STREET CHILDREN 4.STREET CHILDREN PROGRAMME 5.PROGRAMMES STREET CHILDREN 6.PROBLEMS OF STREET CHILDREN 7.PROBLEMS OF FUNCTIONARIES.

EDUCATION

7. Mehta, Arun C. (2008).
Elementary education in India : analytical report 2006-07 : progress towards UEE. National University of Educational Planning and Administration, New Delhi: NUEPA. 373 p.

Abstract : The National University of Educational Planning and Administration has created a comprehensive database on elementary education in India known as District Information System for Education (DISE). The project covers both primary and upper primary schools/ sections of all the districts of the country. A total of 11,96,663 schools were covered from 609 districts across 35 states and UTs in 2006-07. Of these nearly 87.15% schools were located in rural areas. More than 85% schools had drinking water facility available in 2006-07 compared to 83% in 2005-06. The percentage of single classroom schools during 2002-03 to 2006-07 declined from 12.08% to 9.7%. Despite decline in the percentage of single classroom schools, their number in absolute terms is significant, which needs intervention without delay. The percentage of schools with ramps increased significantly from 4.63% in 2002-03 to 26.61% in 2006-07; this development may help in attracting more physically challenged children to schools. Together with enrolment by nature of disability, DISE is the only source that provides comprehensive information about physically challenged children in schools on a regular basis. In 2006-07, about 1.42 million disabled children were enrolled in elementary classes across the country, of which 1.04 million were in primary and 0.38 million in upper primary classes. Providing nutritious food to all children under the mid-day meal scheme is one of the ambitious programmes of the Government. Availability of kitchen sheds in schools was added to DISE during 2006-07. It revealed that 29% schools managed by the Government and aided schools have kitchen sheds in school. The percentage of such schools is 30 and 23 respectively in rural and urban areas. The percentage of schools with kitchen sheds varies from 80 in Tamil Nadu to 3 in Jammu and Kashmir. More SC/ ST girls were enrolled in private schools also. The enrolment of SC and ST girls was 20.11% and 11.36% respectively. The SC and ST enrolment in Government run primary and upper primary schools combined was 78.50% and 84.55% respectively. The share of OBC enrolment in primary and upper primary classes was 42.18% and 41.23% respectively. During 2006-07 DISE collected

information on enrolment of Muslim children for the first time, which was 9.39% at primary level and 7.52% at upper primary level. The percentage of Muslim girls' enrolment was as high as 48.65 (Gender Parity Index (GPI) – 0.95) and 49.33 (GPI-0.97) at primary and upper primary levels. There was high dropout rate at primary level over a period of five years. Arunachal Pradesh had a high dropout rate of 16.85% compared to 13.67% in Rajasthan, 21.02% in Orissa, 11.94% in Haryana, 18.77% in Meghalaya, 20.21% in Manipur, 12.33% in Uttar Pradesh and 9.34% in Bihar. Except Arunachal Pradesh, Manipur and Meghalaya, all these other states are big and crucial to attain the state of universal retention at the primary level of education. Kerala with 1.80%, Tamil Nadu with 1.54% and Himachal Pradesh with 1.85% dropout rate have almost achieved the goal of universal retention at primary level. As many as 83.72% children across 35 states and union territories transited from primary to upper primary level of education compared to 82.24% in the previous year. Although TR showed improvement but still about 17% children drop out in transition. There were about 40 districts in the country which had 25% or more Muslim students in primary classes. Most of these districts were from the states of Assam, Bihar, Jammu and Kashmir, Karnataka, Uttar Pradesh and West Bengal. There were about 514,000 para-teachers constituting around 10% of the total number of teachers. About 70,338 schools had only para-teachers. The percentage of such schools was very high in Rajasthan (17.98%), Madhya Pradesh (30.71%), and Chhattisgarh (16.53%). About 53% male and 49% female para-teachers were graduates and above. About 15.40% male and 12.61% female para-teachers in primary schools had BEd. or equivalent degrees. The Educational Development Index (EDI) revealed that Sikkim out-performed the other six states in the north-eastern region which was true for primary and composite primary and upper primary levels of education. Seven states have been grouped under smaller states. These smaller states were doing much better than a number of bigger states. Bihar and Jharkhand were ranked 35 and 34 in case of composite primary and upper primary levels of education, with an EDI as low as 0.321 and 0.381 respectively. Amongst 21 major states, the top ranking states were Kerala (EDI 0.772), Delhi (EDI 0.757), Tamil Nadu (EDI 0.741), Himachal Pradesh (EDI 0.707) and Karnataka (EDI 0.680). These states were educationally advanced states. In West Bengal EDI was 0.458 and in Arunachal Pradesh EDI was 0.432 in the case of composite EDI at primary and upper primary level. States with high EDI values are better than those with low EDI values, but still they may not be well placed with regard to all the four sets of indicators used in computation of EDI. Even if a state is ranked first, it may still need further improvement, for which individual EDI values should be critically analyzed. There is also need to analyze each indicator separately and identify states that need improvement. Many schools are left to para teachers, who manage school affairs. Studies

should be initiated on the functioning of all such schools. The drop out rate was high at primary level; it needs to be checked, without which neither the goal of universal primary education nor retention can be achieved.

Key Words: 1.EDUCATION 2.PRIMARY EDUCATION 3.ELEMENTARY EDUCATION 4.ANALYTICAL REPORT 2006-07 5.UNIVERSALIZATION OF ELEMENTARY EDUCATION 6.INTEGRATED EDUCATION 7.INCLUSIVE EDUCATION 8.PRESCHOOL EDUCATION 9.FAILURE IN SCHOOL 10.REPEATERS SCHOOL 11.EDUCATION STATISTICS 12.PUPIL TEACHER RATIO 13.SCHOOL STATISTICS 14.STATISTICS EDUCATION 15.SCHOOL FACILITY.

8. Pratham, New Delhi. (2008).
Annual status of education report (rural) 2007 : provisional : January 16, 2008. New Delhi: Pratham. 252 p.

Abstract : The ASER (Annual Status Education Report) is published once a year. This is the third ASER study which was done to get reliable estimates of the status of children's schooling and basic learning (reading, writing and math ability) at the district level, and to measure the change in these basic learning and school statistics from last year. Data was collected from 567 districts all over India, and the age group that was selected was between 3 to 4 years. The study found that overall enrollment in private schools had increased from 18.7% in 2006 to 19.3% in 2007. Major increase in the proportion of children in preschools (anganwadis or balwadis) was in Himachal Pradesh, which showed an increase of 30% points. It was found that across the country, the proportion of children in Std. 1 who could not even recognize alphabets had dropped from 38.4% in 2006 to 31.9% in 2007. The proportion of children in Std. 1 and Std. 2 who could recognize letters, and read words has gone up nationally from 73.3% in 2006 to 78.3% in 2007. Many states showed improvement in reading levels for children in Std. 1 and Std. 2, particularly in Rajasthan, Arunachal Pradesh, Manipur and Assam, where there has been an improvement of more than 10% points. States in which there were significant improvements in the ability of children in Std. 3 to Std. 5 to read Std. 1 level textbooks, were Himachal Pradesh and Andhra Pradesh, where the improvements were over 10% points. ASER 2007 could not observe any change in math learning ability anywhere in India, except for a few nodes of improvement in Himachal Pradesh. The study showed that more than 50% children could read English words, out of them over 70% were in Std. 1 to

Std. 4, and over 80% children in Std. 5 to Std. 8 could tell the meaning of the sentences in their language. Of the children who were able to read a Std. 1 level book, 66% of children in the 6-10 years age group could answer questions from a Std. 1 level text book. Even though these children could not comfortably read a Std. 2 level text, 23% could answer questions based on a Std. 2 level text. Similar patterns were visible among the older children (11-14 years) as well. There is need to give proper education to rural Indian children.

Key Words: 1.EDUCATION 2.PRIMARY EDUCATION 3.SCHOOL EDUCATION 4.LEARNING ACHIEVEMENT 5.QUALITY EDUCATION 6.EDUCATION RURAL AREAS 7.OUT OF SCHOOL CHILDREN 8.EDUCATION STATISTICS 9.STATISTICS EDUCATION 10.RURAL EDUCATION 11.MOTHERS' EDUCATION.

HEALTH

9. Anderson, Mary Ann. (2006).
Reproductive and child health, nutrition and HIV/ AIDS program :
RACHNA : final evaluation. New Delhi: CARE. 120 p.

Abstract : The Reproductive and Child Health, Nutrition and HIV/ AIDS Programme (RACHNA) is CARE India's umbrella programme that consists of two projects. The first, the Integrated Nutrition and Health Project (INHP II) targets pregnant and lactating women and children less than 2 years to improve child survival and nutritional status. It works in 94,593 catchment areas in 747 blocks in 789 districts of 9 states namely Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. The second project is *Chayan*, a reproductive health and HIV/ AIDS prevention project. The rural component of *Chayan* also worked with ICDS and RCH to promote family planning for birth spacing, and prevention and management of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) in 36,300 communities in 300 blocks in 29 districts. The INHP II project was in operation for five years from October 2001 to September 2006, and *Chayan* started nearly an year later and was in operation from July 2002 to October 2006. Data was collected with the help of CARE district staff from ICDS projects, Reproductive and Child Health Programme (RCH), National AIDS Control Programme (NACP) and National AIDS Control Organization (NACO). It

was found that weight-for-age malnutrition reduced significantly from 61% to 53% across INHP-II programme areas. This reduction was nearly twice that seen in the all India rural figures. Impressive increases were found in the use of RCH services, including measles immunization, which nearly doubled, and tetanus toxoid immunization, micronutrient supplementation with Vitamin A, iron and folic acid, and contacts and home visits by Auxiliary Nurse Midwives (ANMs). Impact on increasing antenatal check-ups was mixed. The use of ICDS nutrition services also increased, including supplementary feeding for pregnant and lactating women and children 6-23 months, and contacts and home visits by AWWs. Most notable achievements were improved newborn care practices, including use of “5 cleans” at delivery, initiating breastfeeding within the first hour after birth and giving no prelacteal feeds, and drying and wrapping the baby. The percentage of mothers who gave at least half the recommended quantity of semi-solid foods to children 12-23 months showed no significant improvement. Under Rural *Chayan* Project, major improvement was observed in access to oral contraceptives and condoms in programme villages with 68% AWCs having a supply of free contraceptives. Women’s awareness of RTI/ STI symptoms increased significantly, but referral and treatment networks remained weak. There is a need to strengthen the key state level systems, initiate policy dialogue at State and Central Government levels, and enhance the nutritional focus of ICDS. The programme can be further strengthened by improving contraceptive counselling skills of AWWs, ANMs, RHCAs (Reproductive Health Change Agents), and CAs (Change Agents) by making optimal use of training material (flipcharts) about advantages and side effects of contraceptive methods, so that informed choice can be made, and by involving men.

Key Words: 1.HEALTH 2.REPRODUCTIVE HEALTH 3.NEWBORN CARE 4.RACHNA PROGRAMME 5.CHILD HEALTH 6.CHILD NUTRITION 7.REPRODUCTIVE AND CHILD HEALTH 8.CHILD SURVIVAL 9.MATERNAL AND CHILD HEALTH 10.CARE PROGRAM 11.AIDS AWARENESS 12.VISTAAR PROJECT.

10. Bang, Abhay T. et al. (2005).
Neonatal and infant mortality in the ten years (1993 to 2003) of the Gadchiroli field trial : effect of home-based neonatal care. Gadchiroli : SEARCH. 16 p.

Abstract : The current global estimates put the number of neonatal deaths each year at 4 million and of stillbirths at another 4 million. The present study was

done to evaluate the effect on neonatal and infant mortality during 10 years (1993-2003) in the field trial of home based neonatal care (HBNC) in Gadchiroli; and also to estimate the contribution of the individual components in the intervention package on the observed effect. The study was conducted in 39 intervention area villages and 47 control area villages, and measured the still birth rate (SBR), neonatal mortality rate (NMR), prenatal mortality rate (PMR), post neonatal mortality rate (PNMR) and the infant mortality rate (IMR) of the last ten years in Gadchiroli, Maharashtra. The study found that the total number of live births in 10 years (1993-2003) were 8811 and 9990. NMR in the control area showed an increase from 58 in 1993-1995 to 64 in 2001-2003. NMR in the intervention area declined from 62 to 25; the reduction in comparison to the control area was by 44 points. Early NMR decreased by 24 points (64%) and late NMR by 20 points (80%). It was found that SBR decreased by 16 points (49%) and the PMR by 38 points (56%). The PNMR did not change, and the IMR decreased by 43 points (57%). All reductions were highly significant except for SBR. The cause specific NMR for sepsis decreased by 90%, for asphyxia by 53%, and for prematurity by 38%. The total reduction in neonatal mortality during the intervention (1996-2003) was ascribed to sepsis management (36%), to supportive care of low birth weight (LBW) neonates (34%), asphyxia management (19%), primary prevention (7%) and management of other illnesses or unexplained (4%). There is a need for health education programmes for parents, specially for the management of asphyxia and sepsis, which, in turn, depend on supportive care, that is, breast feeding and thermal care for the survival of the treated neonates.

Key Words: 1.HEALTH 2.CHILD SURVIVAL 3.INFANT MORTALITY REDUCTION 4.NEWBORN CARE 5.INTERVENTION PROGRAMME 6.HOME BASED NEONATAL CARE 7.NEONATAL CARE 8.SEARCH PROGRAMME 9.IMNCI 10.GADCHIROLI 11.MAHARASHTRA 12.VISTAAR PROJECT.

11. CARE India, New Delhi. (2003).
Reproductive health in slums of Allahabad. New Delhi : CARE. 47 p.

Abstract : Slums are basic shelters for migrants that have insufficient living facilities. This study was carried out on the basis of the previous pilot project of CARE (1995-1998). The present study was a joint venture of CARE and ASRHA (Action for Slum Dwellers Reproductive Health in Allahabad), which was

operational during 1999-2004. The project targeted 30,000 women and men in the reproductive age group (15-44 years) and 40,000 adolescents in 143 slums of Allahabad. The study was carried out to mobilize women, men and adolescent groups around reproductive health, to sensitize service providers to ensure accessibility, availability and affordability of quality services; and thereby improve the reproductive health of slum dwellers. It was found that 59% women had more than 2 children. 6.7% women had correct knowledge about menstruation. 54.2% women reported that spouses could also be responsible for infertility. 19.6% women knew that males are responsible for the birth of a male or female child. Only 2.9% of the women had complete and correct knowledge about functioning of the reproductive system. In 49% cases, husbands helped pregnant women with household chores and reminded them to take medicine. During the baseline survey, 81% of the women knew that the child should be weighed within 2 hours of birth. 38% women knew that the child should be put to the breast within two hours of birth. 88% women had knowledge of 2 TT doses. 92% women knew about the number of antenatal check-ups (ANC) required. 78% women knew that delivery should be conducted at an institution. 73% women knew that 3+ ANC visits should be made during pregnancy, but only 31% had undergone them. 66% of the women knew about the check-up required during the first trimester, but only 39% had the check-up. At the time of final survey, 41% of the women knew that 2 TT shots were required during pregnancy, and an equal percentage of them had taken them. 12% of the women knew of IFA tablets and the quantity to be consumed, but only 5% of them did so. 72% of them knew of institutional deliveries yet only 33% of them availed this facility. 81% women who delivered during the final survey period said that the child should be weighed within two days of birth, but only 24% actually got their child weighed within the stipulated time. 35% knew that the child should be put to the breast within 2 hours of birth, but only 15% practiced it. ASRHA also organized vocational training for adolescent girls on the art of applying henna, beautician, tailoring, stitching, embroidery, making soft toys, painting, typing and computers. A minimal fee was charged for each course. It was found that girls had innumerable restrictions imposed on them and they spent most of their time doing all the household chores. 25.2% of the girls were dropouts from school, the major reasons being financial constraints and household chores. 36.4% of the girls did not discuss their problems with anybody. 8% of the girls had complete knowledge about reproduction. Only 2% AGs had complete knowledge about the reproductive function. Most of the boys spent time loitering with friends and watching T.V. Tobacco in the form of cigarettes, *beedis*, *gurkha*, betel leaf and liquor were the most common addictives among adolescent boys. 29% of the boys had discontinued education; monetary problem and a dislike for studies being the major reasons attributed to the cause. Only 9% of the boys had complete

knowledge about reproduction. Only 3% had complete knowledge about reproductive function of the body. ASRHA arranged typing and computer education training for boys. The study also found that there were 13 ARCs (Adolescent Resource Centres) in the study area. It was suggested that there should be an increase in the number of ARCs, and interesting games should be made available at ARCs to sustain the interest of adolescent boys so that they visit ARCs regularly. Some income generation programmes should be initiated in collaboration with other agencies for skill development of adolescents, which would also sustain the interest of adolescents.

Key Words: 1.HEALTH 2.ADOLESCENT REPRODUCTIVE HEALTH 3.REPRODUCTIVE HEALTH 4.SLUM DWELLERS 5.LIVELIHOOD 6.EMPOWERMENT ADOLESCENT GIRLS 7.ADOLESCENT GIRLS 8.MEN'S INVOLVEMENT 9.ALLAHABAD 10.UTTAR PRADESH 11.VISTAAR PROJECT.

12. Chhattisgarh, Dept. of Health, Raipur. (2006).
Mitanin programme : the State Health Resource Centre (SHRC),
Chhattisgarh. Raipur: CHH-DH. 148 p.

Abstract : The health status of a population reflects the set of prevailing social, economic and political conditions. The present study was carried out in May 2005 to evaluate the SHRC's role in strengthening key aspects of the public health system in Chhattisgarh. The study was carried out in seven districts namely Rajnandgaon, Durg, Rajgarh, Bastar, Dantewada, Kanker and Dhamtari. Discussions were held with health personnel, NGO team members, prashikshikas and Mitans. SHRC has been engaged in four major programme areas: 1. The Mitans Programme, 2. Health Sector Policy Reform, 3. Response to ongoing requests from the Department for data, reports and presentations, and 4. Designing and negotiating new projects with GOI's external donors. Mitans programme is the flagship programme of SHRC. SHRC staff are closely involved in designing and supervision of the multi-skills training. SHRC has contributed to publishing literature in the field and has pioneered several publications. The Essential Drugs List, Drug Formulary, Standard Treatment Guidelines, etc. have reached the peripheral health facilities in Chhattisgarh and have been appropriated for use in Jharkhand. SHRC team has provided timely and professional help with preparation of project proposals and reports besides participating in discussions. The financial systems within SHRC are well established and function well. There has been an under utilized of budget and

available funds. SHRC has developed its own institutional policies and procedures and sometimes adopted Action Aid Policies. SHRC has been part of the negotiation team along with GOI officials in negotiating with donors such as ECTA of the European Commission and others. Survey team found that the Mitanin Programme has covered all areas and there were Mitanins in almost all places. Supportive institutional mechanisms have been established at state level with the SHRC Advisory Committee, and at district and block level with District RCH Societies and a variety of arrangements. The evaluation team interacted with the group of AWWs, ANMs and AWHs. 65% of them mentioned that Mitanins helped them in their work. The primary role played by Mitanins was directed towards mobilizing community members for MCH clinics and immunization. The impact of processes (such as community involvement) were side lined, and some necessary inputs (like drug kits) were awaited in most areas. There was no hard data available on actual services provided by Mitanins, either with the Mitanin or with the health system, hence it was difficult to gauge the impact of the programme. But the SHRCs Director felt that malaria deaths in the State had halved due to Mitanin Programme. They treated fever cases with chloroquin tablets. This itself was a public health gain, and breastfeeding messages had reached even *paras* (hamlets) in backward areas. However, this positive note was not supported by the community, and the community was not quite aware of the programme. The knowledge level of Mitanins, their home visits, provision of primary medical care, referral, cooperation with ANMs and AWWs, Panchayat connection, awareness about gender rights, etc. were presently at low levels. Their training, follow up and support systems need considerable strengthening. It was suggested that thoughtful planning should be done, potential problems considered and options should be weighed. Despite the good efforts made on some fronts like preparation of good training booklets, separate support systems for Mitanins, pictures or symbols on tablet packs, *kala jathas* (mobile exhibitions) to generate enthusiasm and community awareness, and ensuring a Mitanin everywhere, the programme faces serious challenges. The following initiatives need to be given attention: inclusion of preventive/promotive health tasks, with necessary training and field support to functionaries, developing need based evolving programme content, introducing methods for assessment and performance appraisal for trainers at all levels and Mitanins, etc. Drug supply and replenishment should be through dual channels, Government and NGOs.

Key Words: 1.HEALTH 2.BEST PRACTICES 3.MITANIN PROGRAMME
4.BEST PRACTICES HEALTH 5.HEALTH SYSTEM 6.PUBLIC HEALTH
7.QUALITY IMPROVEMENT 8.PERFORMANCE IMPROVEMENT
9.CHHATTISGARH 10.VISTAAR PROJECT.

13. Chhattisgarh, Dept. of Health, Raipur. (2005).
Outcome evaluation of the Mitanin Programme : a critical assessment of the nation's largest ongoing Community Health Activist Programme. Raipur: CHH-DH. 38 p.

Abstract : Mitanin Programme is the latest in a long series of programmes using Community Health Volunteers (CHVs) to reach health services to every hamlet and village in Madhya Pradesh and Chhattisgarh. There were quite a few community health volunteer schemes started by civil society at micro level namely Jamkhed Programme, RUSHA (in Vellore), FRCH (in Maharashtra), SEWA (in Gujarat), and SEARCH (in Gadchiroli) that have played an important role in health care. The Mitanin Programme is essentially an attempt to scale up the community health worker experience to the macro scale of full state. The broad objective was to disseminate health information, provide health education, and improve public awareness of health issues. The Programme was expanded in 80 blocks in the first phase, and the last 66 blocks were taken up in the second phase. It was observed that Mitanin programme had reached its primary target of 54,000 trained Mitanins in three years since its announcement and two years since its inception in the field. 88.97% of the Mitanins selected were literate. The lowest literacy rates were for the six blocks of Bastar district – where of the 250 Mitanins 187 or 62.3% were literate, and Mahendragarh where 56.25% Mitanins were literate. Even within the six blocks of Bastar there was wide variation, with the figure being as low as 17.02% for Badekilipal and as high as 100% for Bastar. It was found that 1219 Mitanins were looking after approximately 55,560 households, and there were nearly 45.57 households per Mitanin (family size was assumed to be 5). The three blocks that had significantly larger number of Mitanins with low coverage (<20 houses per Mitanin) were Podiproda (88%), a tribal highly dispersed block under BGVs, and Mahendragarh, another dispersed tribal block (46%); Pithora in Mahasamund (36%); and Badekilipal in Bastar (32%). The rest had figures close to the total group average or less. Mitanins were to be selected by the hamlet after consultations with all stakeholders and the selection was to be approved by the Panchayat. Data revealed that 61.27% of the Mitanins had been selected after village level meetings had taken place – the single most sensitive indicator of a correct selection process. 72.33% of the surveyed Mitanins had completed up to Rounds 4 or 5 of training. 1.98% Mitanins had completed one round of training, 4.22% had completed two rounds, and 8.09% had completed three rounds. Training was on child health, women's health, malaria and gastroenteritis, drug kit, TB/ leprosy, etc. 82.36% of the Mitanins reported that they had made house visits for counselling in the previous

week. A majority of them (58.65%) had visited less than 10 households, while 14.77% had visited 11 to 20 households, and 8.94% had visited more than 20 households. Regarding consultation for illness in the previous week, 63.58% Mitanins had advised on illness management, and of these 23.22% had counselled for at least three different illness types, and 24.28% had counselled for two different illness types. 82.44% Mitanins maintained the Village Health Register but 17.86% did not maintained the Register. 52.17% Mitanins entered data regarding child weights, 68.09% regarding immunization, and 46.76% were regularly entering data on births and deaths. 66.57% Mitanins report that ANMs met them regularly during visits. 54.47% Mitanins had referred cases to ANMs/ health sub-centres, and 40.53% had referred cases to PHCs. A majority of the Mitanins were in Grade A (60.13%), 25.26% were in Grade B, 13.05% were in Grade C and 1.57% were in Grade D. 75.72% of the Mitanins reported that a hamlet level committee was in existence in their hamlet, which was linked to this programme and supported it. 63.66% Mitanins had a self help group in the hamlet which functioned as the committee, or was there in addition to the health committee. It was recommended that there is need for close and tight monitoring, with an alert leadership at every level for responding and troubleshooting whenever violations of the processes take place.

Key Words: 1.HEALTH 2.BEST PRACTICES 3.MITANIN PROGRAMME 4.BEST PRACTICES HEALTH 5.COMMUNITY INVOLVEMENT 6.ROLE OF VOLUNTARY ORGANIZATIONS HEALTH 7.PERFORMANCE IMPROVEMENT 8.CHHATTISGARH 9.VISTAAR PROJECT.

14. Fiedler, John L. and Jain, Meenakshi. (2006).
A Cost analysis of CARE India's reproductive and child health, nutrition and HIV/ AIDS (RACHNA) program : final report. New Delhi : CARE. 60 p.

Abstract : The Reproductive and Child Health, Nutrition and HIV/ AIDS (RACHNA) Programme is a USAID funded project designed to reduce infant mortality, child malnutrition, and HIV transmission, and to increase the rate of contraceptive prevalence among vulnerable section of the population in India. The RACHNA Programme consists two components, INHP-I (Integrated Nutrition and Health Project) which was started in October 1996 and ended in September 2001, and follow-on project, INHP-II, which was initiated in October 2001 and covered 95 million people, 95,000 Anganwadi Centres in 95,000 village located in 78 districts of nine of India's 29 states. The second component of RACHNA

was *Chayan* started in September 2002, and comprised two set of activities, reproductive health and HIV prevention. The study was conducted to know how much it would cost to replicate the RACHNA programme. Data was collected by CARE staff, and also by State Office staff, district teams, NGOs, CDPOs, ICDS Supervisors, AWWs, ANMs, Medical Officers, Lady Health Visitors, change agents (CAs), members of the community, mothers' committees, and mothers and children participating in the ICDS programme. The *Chayan* – Rural Programme was spread over 29 districts, with coverage at the block, sector, and AWC levels as per the proto typical state. It was found that the total estimated cost of INHP was Rs.57,487,788, total estimated cost of *Chayan* – Rural was Rs.25,235,602, and the total estimated cost of RACHNA programme was Rs.82,723,389, if one state was added to the RACHNA Programme. The composition of RACHNA's estimated total annual recurrent costs divided into different parts in percentage were 17% for capacity building, 21% for NGOs, 19% for district level, 8% for state level, 10% for behaviour change communication (BCC), 11% on CARE India head quarters (CIHQ), and 15% on other expenses. RACHNA Programme has addressed almost all the issues properly. RACHNA Programme is effective in impacting the nutritional status of the beneficiary ICDS children when they avail long term benefits from the ICDS programme. RACHNA should try to develop a system of tracing its children's participation rates, which can be used as a tool to monitor the programme. Still, there is need to restructure the Programme content in future, if any effort to scale up or replicate the Programme is required.

Key Words: 1.HEALTH 2.REPRODUCTIVE HEALTH 3.RACHNA PROGRAMME 4.CHILD HEALTH 5.CHILD NUTRITION 6.REPRODUCTIVE AND CHILD HEALTH 7.CARE PROGRAMME 8.AIDS AWARENESS 9.VISTAAR PROJECT.

15. Gururaj, G. (2008).
Injuries in India: a national perspective. Bangalore : National Institute of Mental Health and Neurosciences. 23 p.

Abstract : The rapid and unprecedented motorization in India combined with the lack of a safety environment has been a noticeable feature contributing to accidents and injuries. The number of vehicles had grown from a mere 306,000 in 1951 to 58,863,000 by 2002 (Ministry of Road Transport and Highways). Due to this large number of vehicles and lack of safety concerns, accidents and

injuries take place every year which contribute to a significant number of deaths, hospitalizations, emergency care, disabilities (physical, social and psychological), amputations, disfigurement, pain, suffering and agony. According to National Crime Records Bureau (NCRB) Report 2001, 2,710,019 accidental deaths, 108,506 suicidal deaths and 44,394 violence related deaths were reported in India. The injury mortality rate was 40 per 100,000 population during 2000. The number of deaths due to accidents increased by 47% during the period 1990-2000; 93% were due to unnatural causes and 7% (17,366) were due to natural causes. The study showed that nearly two-third deaths occurred among those 16-44 years of age, and the highest rate was among 30-44 year olds (35%). The 10 states recording the highest number of deaths caused by road accidents were Tamil Nadu (15.18%), Maharashtra (12.4%), Kerala (11.5%), Karnataka (10.1%), Andhra Pradesh (7.9%), Gujarat (7.2%), M.P. (7.1%), Rajasthan (6.5%), Tripura (4.3%), and U.P. (3.4%). Among cities, the highest number of deaths occurred in Delhi (1736), Mumbai (1362), Chennai (761), and Bangalore (659). It was found that the 23 metropolitan cities have an RTI (Road Traffic Injury) mortality rate of 1000 \pm 200/1,00,000 population which was higher than the national average of 800/lakh. Studies showed that the economic impact of RTIs was estimated to be Rs. 55,000 crore, nearly 3% of the GDP (Gross Domestic Product), which was much higher than the 2% in high income countries. The disability rate due to injuries in India was 1.9% of its population in 1991, which increased to 2.1% in 2001 (Census 2001). As per the NSSO Report (2003), the prevalence of mental retardation, mental illness, visual, hearing, speech and locomotor disabilities was 4%, 7%, 11%, 10%, 5%, and 53% respectively among the various types of disabilities. Data indicated that excessive speed, non-usage of helmets, driving under the influence of alcohol, poor road design and infrastructure related factors, poor visibility and crashworthiness of vehicles were some major risk factors for the increasing number of RTIs. Deficient emergency care, non-availability of physical and medical resources and lack of skilled staff lead to sub-standard care and unnecessary referrals which results in an increase in secondary injuries. There is need to develop a national policy and strategies for injury prevention and control with a major thrust on reduction of RTIs, suicides, burn injuries, work-related injuries and violence, which would be integrated, co-ordinated, cost effective and sustainable. Also, there is need to develop a comprehensive national policy on building an effective trauma care system, and to urgently facilitate mechanisms for capacity building, strengthening the knowledge base and promoting research across all related sectors.

Key Words: 1.HEALTH 2.INJURIES 3.ACCIDENTS 4.INJURIES INDIA
5.ROAD ACCIDENTS 6.DOMESTIC VIOLENCE 7.INJURY PREVENTION.

16. Paranjpe, Priya et al. (2006).
Report on the training for home based newborn care 2001-2005.
Gadchiroli : SEARCH. 81 p.

Abstract : Home-based Neonatal Care (HBNC) is an effective approach developed by SEARCH in which village women are trained as Community Health Workers (CHWs) and empowered to help mothers care for their newborns, and if necessary, to treat them when they are sick. This study was conducted in 39 villages in Gadchiroli district of Maharashtra, where this scheme reduced neonatal mortality rate by 70% and infant mortality rate by 57% over an 8 year period (1995-2003). Training was given to a large number of personnel (CHWs, TBAs, Supervisors) in different places to deliver HBNC of comparable quality. Further, a project named ANKUR was started in Gadchiroli in 2001 to implement a Home-based Neonatal Care Project on a wider scale. Local women were selected and trained as CHWs to provide home-based neonatal care. Ankur project was completed in 2005, with the promising result of achieving nearly 50% decline in neonatal mortality from baseline in 1998-2000. Ankur Project revealed that with proper intervention 50% reduction in NMR can be achieved, competence of CHWs and Supervisors can be improved with proper training and supervision, women living in communities can provide essential and emergency newborn care and make a difference. It was observed that 84 out of 92 CHWs evaluated were judged competent to deliver home-based neonatal care. Only 6 out of 92 CHWs scored less than 70% on a written test. Although CHWs performed well, it was found that they need continuing support to maintain and strengthen their skills, especially in providing health education, and in the management of asphyxia, sepsis and breastfeeding problems. The training manual and material developed and used in this training was highly effective in a variety of settings such as rural, tribal and urban areas, and subsequently in the ICMR trial, these were found to be effective in 5 different states of India. The entire training was done without hospitals, proving that it is possible to train CHWs in the classroom and in the community. The health education flipchart has been very well received by mothers, who find the information useful. The traditional birth attendant (TBA) was trained for 6 days under Ankur. TBA practices appear to be good, and old ideas are changing. While many of the TBAs have been trained (some as long as 15 years ago) under the Government programme, the fact that they have been re-trained under this Project, received a token stipend for identifying pregnant women, and are regularly visited by Supervisors seems to have been instrumental in the high level of cooperation. It was observed that most of the trainers and Supervisors performed well. The detailed training material and support from the master trainers were instrumental

in this success. It was suggested that CHWs need continuing support to maintain and strengthen their skills, especially in providing health education, and in the management of asphyxia, sepsis and breastfeeding problems. More training was needed on health education, ARI management and breastfeeding problem management.

Key Words: 1.HEALTH 2.CHILD SURVIVAL 3.NEWBORN CARE 4.CARE OF NEWBORN 5.HOME BASED NEONATAL CARE 6.TRAINING HEALTH WORKERS 7. MAHARASHTRA 8.VISTAAR PROJECT.

17. Sharma, Suresh. (2008).
Childhood mortality and health in India. Delhi : Institute of Economic Growth. 39 p.

Abstract : Childhood is a significant stage of life and deprivation during this period can have a long term adverse impact on the well-being of children. The present study was done to examine the determinants of childhood mortality and child health in India, and the factors explaining the differential performance of child immunization and treatment of childhood diseases. Data was taken from 3 rounds of the National Family Health Survey of India (NFHS) conducted in 1992-93, 1998-99 and 2005-06. Analysis revealed that on account of interventions for children, the infant mortality rate in India had gone down from 114 in 1980 to 58 in 2005. Data from NFHS indicated that under-five child mortality (U5MR) rate was 109.3 per 1000 live births in 1992-93, declined to 94.9 per 1000 live births in 1998-99, and 74.3 per 1000 live births in 2005-06. The neonatal mortality rate was 48.6 per 1000 live births in 1992-93, which decreases to 39 in the year 2005-06. It was found that mortality in India was lower for females (37) than for males (41). As children get older, females had higher mortality than males. The study found that females had 36% higher mortality than males in the post neonatal period, but a 61% higher mortality than males at age 1-4 years. It was found that infant mortality rate was lowest when mother's age was 20-29 years (50), and was substantially higher when mother's age was less than 20 years (77), and 40-49 years (72). Similar age differentials were found in neonatal mortality, post neonatal mortality and child mortality (at age 1-4 years). In India, it was found that STs have the highest infant mortality, followed by SCs. The situation regarding child immunization was not as clear. Only a small improvement was found in full vaccination coverage. Only 44% of the children aged 12-23 months were fully immunized in 2005-06, which was a slight improvement from 42% in 1998-99 and 36% in 1992-93. It is estimated that

under-nutrition and anaemia were contributory factors in over 50% of under-5 deaths in the country. The other major causes of infant mortality were premature births and low birth weight, poor intra-partum and newborn care, diarrhoea diseases, acute respiratory infections, and other infections. There is need to strengthen the health system, prioritize essential elements of child health and nutrition services, and develop and expand community participation for the prevention and treatment of childhood illness. Also, a multi-sectoral approach should be adopted which would include female education and nutrition, increasing the use of health services during pregnancy and delivery, eliminating gender gap in child health services, and improving nutrition throughout the life cycle.

Key Words: 1.HEALTH 2.CHILD MORTALITY 3.CHILD HEALTH 4.INFANT MORTALITY 5.U5MR 6.UNDER FIVE MORTALITY RATE.

18. Tamil Nadu, Dept. of Health, Chennai. (2008).
Arogya Iyakkam Tamil Nadu : February 2002 - March 2003. Chennai:
TN-DH. 45 p.

Abstract : The Arogya Iyakkam Community Health Programme, in 2003, reached out to 10 lakh people in 1000 villages in 23 blocks all over Tamil Nadu. The Programme aims to improve children's and women's health, organize and empower women around their health needs, improve public health services, bring about critical policy changes, and develop mechanisms for panchayat intervention in health. Health activists of most blocks are now well trained and are fully into the programme. Some of the state level coordination issues have also been addressed, and the focus now is on better training and material support. Once the initial problems of scale management were achieved, the state team began to look at quality improvement. If the citizens of the block took keen interest in the programme, the state team could visit and help the block in terms of training, material support and implementing the programme. But organizing the block team itself and building up motivation to undertake the programme are not things the state team can take up at this stage, particularly when there are many other blocks which need help. There are a few blocks like Karyapatti which no longer need financial support. They are able to generate their own funds for training and for block trainers. Their focus was on self help groups and they had very little energy and time left for the health programme. Although the savings programme is also an important programme, there is no need for the state team to spend so much energy on it, as they know what to do and can do it

themselves. Similarly, there are blocks like Anaicut, which even after repeated efforts to reorganize and motivate have not managed to pick-up. The district team has also not played a role in strengthening the block functionaries. Therefore it was felt that project functionaries should stop working in 3 blocks, namely Karyapatti, Anaicut, and Andipatti. It meant that the systematic health training programme would stop. Regular interaction, particularly with Andipatti and Karyapatti, would continue. Their functionaries could be invited to the state review and training sessions, and hopefully they could develop future programmes with them. Three other blocks namely Periyakulam, Tirumangalam and Watrap have been put on warning. This programme has had a lot of visitors to see the working of the programme. There is need now for visitors to regularly keep in touch with the blocks, provide moral support and to regularly encourage the block teams. This is a difficult programme which requires a lot of patient work and such encouragement by outsiders would improve the enthusiasm of the block functionaries and citizens and also improve efficiency. The focus of the programme should be on more house-to-house visits, talking to community members, and measuring the impact of this work. Monitoring of the Government Health System also needs a larger focus; particularly, follow-up strategies need to be planned at the district and state levels. The focus should be on preparing more creative material, improving training and quality of the programme, and addition of new components like women's health programme.

Key Words: 1.HEALTH 2.BEST PRACTICES 3.AROGYA IYAKKAM 4.BEST PRACTICES HEALTH 5.COMMUNITY INVOLVEMENT 6.QUALITY IMPROVEMENT 7.TAMIL NADU 8.VISTAAR PROJECT.

19. Visaria, Leela. (2008).
Assessment of the impact of SEWA's maternal health interventions.
Ahmedabad : Gujarat Institute of Development Research. 24 p.

Abstract : The Self Employed Women's Association (SEWA) in Ahmedabad, Gujarat state of India is a union of informal women workers, and is engaged primarily in organizing women in income generation activities and providing them banking services through women's bank. The present study was carried out to understand whether the training provided to health workers in antenatal care, delivery care and post natal care can improve maternal care outcomes. It also aimed to identify the practices that can be taken to scale in the existing government health system. SEWA has selected one PHC area from each of the three blocks for its health inputs and intervention. 12 treatment and 12 control villages were selected for the study, covering 480 women, 22 TBAs and 11

female health workers (FHWs) from 24 villages. It was found that between 52% and 55% women in both the areas were literate, but only around 15% to 18% of them had studied beyond Class 8. The age of marriage of girls in this region continues to be low, and the average age of marriage ranged between 16.5 and 17.1 years. Between 53% and 63% of the girls were married before the legal minimum age of 18 years. In spite of widespread use of media to encourage parents not to marry their daughter before the age of 18 years, the practice of early marriage continues. Nearly 25% of the women become pregnant within one year of marriage, and an additional 30% between one and two years of marriage. This was found in both experimental and control villages. Women living in villages where the 'Swasthya Sarthi' programme has been implemented with the TBAs having been trained and Health Supervisors providing support to them (treatment area) were compared with those living villages where TBAs had not been trained (control area). Television has made an inroad in the villages of Gujarat, and one in two households owns a TV set. In the four experimental villages, 10% of the women reported that they had become members of SEWA Union. However, this percentage was much smaller (3.5%) in the case of control villages. Between the two regions, this was the major difference. Women reporting a visit by TBA during their last pregnancy was significantly more in the experimental villages compared to the control villages. About 33% women reported that the TBA enquired about the status of their pregnancy in the villages where they had received training from SEWA, whereas in the control villages only about 13% of the women reported that TBAs visited them during the antenatal period. Also 92% of the women in the experimental villages registered their pregnancy as opposed to 77% of them in control villages. Taking two tetanus toxoid injections was quite common and accepted as a part of routine pregnancy care among pregnant women in both experimental and control villages, but taking iron and folic acid tablets to reduce anaemia during pregnancy was still a problem. Of the 100 tablets routinely given to pregnant women, only 33% them reported consuming more than 50 of them as per their own admission, in both the experimental and control villages. It was suggested that there is need to provide TBAs more comprehensive training and support in a way that they are able to take on a broader health promotive role, and not merely be trained to conduct aseptic deliveries. The public sector, in collaboration with NGOs, should take up a similar task of training the existing cadre of TBAs to serve the remote and backward areas within each state.

Key Words: 1.HEALTH 2.MATERNAL HEALTH 3.BEST PRACTICES
MATERNAL HEALTH 4.CARE OF MOTHER 5.SEWA PROGRAMME.

ICDS

20. Barman, Nibha Rani. (2001).
Functioning of anganwadi centre under ICDS scheme : an evaluative study. Jorhat, Assam: Assam Agricultural Univ., Faculty of Home Science, Dept. of Child Development and Family Relations. 87 p.

Abstract : This study was conducted to evaluate the impact of the ICDS programme on beneficiaries, and assess the performance of AWWs. The study was undertaken in Jorhat district of Assam. Out of 150 AWCs, 50 AWCs were covered, and a total of 150 beneficiary women were selected for the study. It was found that Community Survey was conducted very often by 86.67% AWWs. Activities based on community participation and maintaining liaison with other institutions were given medium level of priority by the AWWs. Formal sessions of NHE were conducted only in 26.67% AWCs, out of which in only 6.67% AWCs, NHE sessions were conducted once in 6 months, and in 13.33% AWCs, NHE sessions were conducted once in a year. 77.33% beneficiaries expressed dissatisfaction due to irregularity of NHE programme, 65.33% mentioned that teaching was not satisfactory, and 64% expressed that the content of classes and timing of classes was unsatisfactory. The immunization status of children below 1 year of age against BCG, measles, DPT and polio was 52.2%, 49.45%, 41.59% and 86.7% respectively. Immunization of children in the age group 1-3 years for DPT booster and polio drops was 52.16% and 80.40% respectively. DT was given only to 26.12% of the total children aged 3-6 years. Of the total pregnant mothers, only 54.25% received Tetanus Toxoid vaccine. 100% of the beneficiaries were aware of the health services provided, and about 60% were satisfied with the services. 60% AWWs mentioned that health check-up was carried out for both children and women at least once in 3 months. Medicine kit was available in all AWCs, which was replenished regularly. Only 26.67% beneficiaries were aware of referral services, and only 17.33% were satisfied with the service. Only 26.67% AWWs conducted referral services at their centre, but none of them filled in the referral slips with requisite details. Only 26.67% AWWs arranged meetings for imparting NHE to mothers, and only 6.67% used aids during meetings. All the AWWs weighed the children, but only 46.67% of them interpreted the growth trends. Only 33.33% AWCs had adequate indoor space. Outdoor space and storage space was available only in 40% and 13.33% of the AWCs respectively. All beneficiaries were aware that supplementary nutrition was provided by AWWs but none of them were satisfied with the services due to irregular supply of food, poor quality and insufficient quantity of food. 100% beneficiaries were aware of the PSE component, but only 26.67% of them were satisfied with PSE being imparted at AWCs. The reasons for

dissatisfaction were the informal character of PSE and unsatisfactory activities conducted under the preschool component. The training of ICDS functionaries should emphasize more on important functions like growth monitoring, health and nutrition education, NPE (Non-Formal Preschool Education) and referral services. The content of the training course for AWWs also needs thorough analysis.

Key Words: 1.ICDS 2.FUNCTIONING OF ANGANWADI CENTRES 3.ICDS SERVICES 4.JOB PERFORMANCE OF ANGANWADI WORKER.

21. Gangur, S.G. (2007).
Analysis of role effectiveness of ICDS supervisors of Gujarat. Indore :
NIPCCD, Regional Centre Indore. 105 p.

Abstract : The present study was carried out to assess what steps could be taken to further improve the job performance of ICDS Supervisors. The study analysed the tasks or jobs performed by them, and difficulties faced as perceived by Supervisors. The study was conducted in Ahmedabad, Vadodara, Surendranagar, Valsad and Dangs district of Gujarat. Data was collected through interviews with Supervisors, CDPOs and AWWs. It was found that majority of the Supervisors (67%) were graduates, postgraduates (23%) and matriculates (10%). In urban blocks, 30% of the Supervisors were post graduates, followed by 25% post graduates in rural areas and 15% in tribal blocks. Overall, 78% Supervisors had ten years and more experience whereas only 17% of them in urban blocks (NGO run) had job experience of six months and less. 45% of the Supervisors had to supervise more than 26 centres in the distance range of 5-20 km and more. The distance travelled by urban Supervisors was less compared to the distance travelled by Supervisors of tribal and rural areas. Prior to undertaking visits, many Supervisors had travelled up to 30 km from the place of their stay in tribal and rural blocks. Major job responsibilities undertaken and time spent on each activity during the visits to AWCs were supplementary nutrition, records and registers, growth monitoring, and community and official meetings, etc. 38.33% of the Supervisors had utilized a maximum of three hours and more for planning and conducting meetings. 51.66% Supervisors had spent half an hour for undertaking home visits, especially for at risk women, children and disabled children. 3.33% of them had spent maximum time ranging from three to four hours for home visits. 60% of the AWWs felt that during field visits Supervisors could have given them guidance on maintenance of growth monitoring registers, supply of food materials, sustaining

the quality of food to attract women beneficiaries, and also mobilizing panchayats and community support for delivery of services. 85% of the AWWs found that Supervisors were more helpful in managing AWCs. 80% AWWs felt that their Supervisors need to ensure solutions to the problems they faced such as timely payment of honorarium, monitoring of stationary requirements for AWCs, etc. 81% of the AWWs felt that Supervisors utilized more time in verifying records and registers mainly relating to supplementary nutrition, growth monitoring, food stock registers, and targets and achievements regarding health services. 81% AWWs agreed that a Supervisor was an important link to facilitate them in attending to building problems, organizing community building rapport with ANMs and community leaders. It was suggested that the number of NGOs managing one ICDS block needs to be reduced so that the monitoring mechanism could be streamlined. Government could develop training modules on management of ICDS for NGO executives. The present honorarium is insufficient. Honorarium needs to be enhanced in accordance with the standard norms of Government, rather than be based on number of AWCs fixed per year.

Key Words: 1.ICDS 2.SUPERVISORS 3.JOB PERFORMANCE OF SUPERVISORS 4.ROLE OF SUPERVISORS 5.SUPERVISION IN ICDS.

22. Joshi, Anita. (2001).
A Comparative study of urban, rural and tribal mothers regarding their knowledge, attitude and practices of nutrition. Indore : Bal Niketan Sangh, Indore. ~270 p.

Abstract : This study was conducted in three blocks of Madhya Pradesh namely Indore (urban), Sanwer (rural) and Nalcha (Dhar) (tribal) to assess the knowledge, attitude and practices regarding nutrition of rural, urban and tribal AWWs and beneficiary mothers. A total of 480 beneficiary mothers (BMs) and 60 AWWs were selected for the study. AWWs and BMs in urban areas had maximum awareness about the nutritional requirements of growing children, that was 100% and 87.5% respectively. Though AWWs of both rural and tribal areas were fairly well aware but the respective BMs were quite lacking in knowledge about the same. All groups were not very aware of the sources of energy rich foods (ERFs) in a child's diet. The correct knowledge about energy rich food in children's diet was found in 55% AWWs in urban areas; 35% AWWs in rural areas and 20% AWWs in tribal areas. Similarly, 51.8% BMs in urban areas; 36.3% BMs in rural areas and 45.6% BMs in tribal areas had correct knowledge about ERFs. 82.5%, 66.2% and 70.6% mothers and 95%, 80% and 95% AWWs

of urban, rural and tribal areas respectively take food supplying haemopoietic substances like pulses, green leafy vegetables and citrus fruits to prevent anaemia. 95% urban AWWs were giving and 94.3% BMs were taking iron tablets from AWCs. 95% AWWs of rural areas were giving iron tablets but only 31.9% mothers in rural areas were taking iron tablets. On the other hand in tribal areas, 35% AWWs were getting IFA tablets but 75.6% mothers of that area were getting iron tablets. Both, urban groups of AWWs and BMs and tribal AWWs were moderately good regarding practices of taking additional food during pregnancy, and the figures were 65%, 56.3% and 60% respectively. 14-27% mothers and 5-30% AWWs had partially right practices regarding the same. Regarding the practice of taking additional food during lactation, only 75% and 48% urban in comparison to 95% and 72% rural and 95% and 88% of tribal AWWs and BMs consumed extra food during lactation. Tribal lactating mothers had better practices, and they added milk, eggs, *dal* (pulses), *daliya* (porridge), ghee, etc. to their diet, in comparison to urban and rural mothers. All urban AWWs (100%) had right practice of breastfeeding within 6 hours of delivery in comparison to 85% rural and 65% tribal AWWs. Similarly, 90% urban mothers started breastfeeding within 6 hours of delivery in comparison to other groups of mothers. 95%, 80% and 80% of urban, rural and tribal AWWs and 88.7%, 68.7% and 70% of mothers respectively had right practices and were using *katori* (bowl) for feeding milk to their children. Urban group had the highest number of women adopting good practices among the three regions. 100% urban AWWs and 87.5% urban BMs had correct knowledge regarding nutrition in diarrhoea. 85% rural AWWs and 71.2% rural BMs, and 70% tribal AWWs and 82.5% tribal BMs had correct knowledge about nutrition in diarrhoea. 95% urban AWWs and 100% urban BMs had good practices regarding anganwadi food for children. They encouraged children to consume the food. 75% rural AWWs and 72.9% rural BMs, 80% tribal AWWs and 88.7% tribal BMs encouraged children to consume the food provided at AWCs. 96.3% urban BMs and 95% urban AWWs had right practices for washing grains. In rural areas 80% AWWs and 60% BMs, and 70% tribal AWWs and 58.7% tribal BMs had correct knowledge about the same. Urban AWWs had 100% knowledge of vaccination in childhood, but only 70% AWWs in rural group and 85% AWWs in tribal group were aware. Awareness of mothers regarding vaccination was found to be 86.6% in rural areas, 82.5% in urban areas and 76.2% in tribal areas. Urban AWWs were 100% aware that there should be a gap between child births, while 71.3% urban BMs were aware of the same. Rural and tribal groups of AWWs and BMs had moderate awareness about keeping the right gap between child births. To improve the overall quality of nutrition and health education (NHEd), and develop the skills of AWWs refresher training should be organized at the sector level so that AWWs can easily participate in the training. In tribal areas, self help groups of AGs could be initiated through

ICDS. Training AGs is very important to overcome the culture specific problems of the area.

Key Words: 1.ICDS 2.NUTRITION AND HEALTH EDUCATION 3.NUTRITION IN ICDS 4.KAP OF MOTHERS 5.KAP OF AWWs 6.KAP OF ANGANWADI WORKERS 7.MADHYA PRADESH.

23. Pandey, D.D. et al. (2008).
Time and work study of anganwadi workers. New Delhi: NIPCCD. ~275 p.

Abstract : This study was conducted to understand the time allocation pattern of AWWs and to apprehend its various dimensions in terms of workload. The study was conducted in 24 ICDS projects from 14 districts in 4 states namely Assam, Maharashtra, Tamil Nadu and Uttar Pradesh. All AWWs in tribal and urban projects had received some kind of training inputs. Untrained AWWs from rural projects were found only in Uttar Pradesh. 71% AWWs in Assam and 50% AWWs in Uttar Pradesh had received special training compared to 43% and 30% AWWs working in Tamil Nadu and Maharashtra. In Tamil Nadu 73% AWWs spent 7-8 hours per day at AWCs. The time spent was lowest in Assam where 96% AWWs spent up to 4 hours per day at AWCs. It was up to 4 hours in 60% AWCs in Uttar Pradesh and 4% AWCs in Maharashtra. In Assam, 30% AWWs were taking maximum time to reach AWCs compared to fewer AWWs (17%) in Tamil Nadu and Uttar Pradesh, and 2% in Maharashtra, who took a long time to reach AWCs. About 29.1% AWWs of Assam spent up to 1 hour for PSE activities and 70.8% AWWs spent 1-2 hours. In Maharashtra, 12.4% AWWs spent up to 1 hour, 70.8% devoted 1-2 hours, and 16.6% AWWs spent 2-3 hours on PSE. In Tamil Nadu 33.3% AWWs spent up to 1 hour, 64.5% spent 1-2 hours, and 2.06% AWWs spent 2-3 hours. In Uttar Pradesh, 6.2% AWWs spent up to 1 hour, 52.06% AWWs devoted 1-2 hours, 25% AWWs spent 2-3 hours, and 16.6% AWWs spent 3-4 hours on PSE. Overall, 20.2% AWWs devoted up to 1 hour, 65.1% devoted 1-2 hours, 10.9% AWWs devoted 2-3 hours, and 4.1% AWWs devoted 3-4 hours per day to PSE activities. Overall, 21.8% AWWs devoted 10-20 minutes for group activities, 22.8% AWWs devoted 20-30 minutes, 22.3% AWWs devoted 30-40 minutes, 8.3% AWWs devoted 40-50 minutes, and 16.1% AWWs devoted 50-60 minutes for group activities. About 57% AWWs were spending less than one hour for organizing SN services, which included preparation and distribution of SN to beneficiaries of ICDS. 22% AWWs from Maharashtra and 23% AWWs from Uttar Pradesh spent 1-2 hours daily in organizing SN services. 62% AWWs were involved in cleaning utensils and 44%

had to cook as a large number of posts of AWHs were lying vacant in all the four states. 62% AWWs spent 1-2 days on NHEd service. In Maharashtra, all the AWWs spent 1-2 days for organizing NHEd sessions compared to the state of Assam, where 90% AWWs spent 4-6 days for the same. Health camps were organized monthly in 41% AWCs and quarterly in 22% AWCs. In Assam, none of the AWWs organized health camps, 83% AWWs were organizing health camps on monthly basis in Uttar Pradesh compared to 39% AWWs who were organizing health camps on monthly basis in Maharashtra. In 63% AWCs, health camps were organized on quarterly basis in Maharashtra. Immunization camps in rural, tribal and urban projects in Assam and Maharashtra were organized on monthly basis. It was weekly in 23% AWCs in Tamil Nadu and 17% AWCs in Uttar Pradesh. Overall, in 87% AWCs the frequency of organizing immunization camps was monthly. Growth monitoring (GM) activities were organized on monthly basis in 77% AWCs, and quarterly basis in 15% AWCs. 47% AWCs spent 1-2 hours on undertaking GM activities, followed by 2-3 hours in 17% AWCs, and 3-4 hours in 15% AWCs. None of the AWWs from Assam had taken more than two hours for GM activities, while in Maharashtra more than 50% AWWs took 2-4 hours for undertaking such tasks. 100% AWWs in Assam and 92% in Maharashtra devoted less than one hour daily for completing records and registers. In Assam all the AWWs devoted up to one hour daily for maintaining registers. In Maharashtra 83.3% AWWs devoted between one hour, 14.5% AWWs devoted between 1-2 hours, and 2.06% AWWs devoted between 2-3 hours. In Tamil Nadu 60.3% AWWs devoted less than one hour, 29.1% AWWs devoted 1-2 hours, 6.2% AWWs devoted 2-3 hours, and 12.5% devoted between 3-4 hours in maintaining the daily records and registers. In Uttar Pradesh 91.6% AWWs devoted up to 1 hour and 2.06% AWWs devoted 1-2 hours for maintaining registers. Overall, 83.8% AWWs spent up to 1 hour, 11.4% AWWs devoted 1-2 hours, 2.06% AWWs devoted 2-3 hours, and 1.03% AWWs devoted 3-4 hours per day for this task. For home visits, 77.06% AWWs spent up to 1 hour and 22.9% AWWs spent 1-2 hours. In Maharashtra 79.1% AWWs spent up to 1 hour and 20.8% AWWs devoted 1-2 hours. In Tamil Nadu 70.8% AWWs spent up to 1 hour and 18.7% AWWs spent 1-2 hours. In Uttar Pradesh 85.4% AWWs spent up to 1 hour and 12.4% AWWs spent 1-2 hours for home visits. 60% AWWs were reportedly not engaged in any other activity or miscellaneous tasks. Average time spent by AWWs per day for miscellaneous work was as follows: in Assam 37.5% AWWs devoted 3-6 hours and 16.6% AWWs spent 6-9 hours; in Maharashtra 2.06% AWWs spent <1 hour, 8.3% AWWs spent 3-6 hours and 2.06% AWWs spent 6-9 hours; in Tamil Nadu 22.9% AWWs spent <1 hour and 2.06% AWWs spent 6-9 hours; in Uttar Pradesh 14.5% AWWs spent 1-3 hours, 20.8% spent 3-6 hours, 16.6% AWWs spent 6-9 hours and 4.1% AWWs spent >9 hours. In total 6.2% AWWs devoted less than one hour, 3.6% AWWs spent 1-3

hours, 16.6% AWWs spent 3-6 hours, 9.3% spent 6-9 hours and 1% spent more than 9 hours for miscellaneous work. 67% AWWs from Assam utilized the help of AGs in preparation and distribution of SN, while their help was being utilized to a minimum extent on this dimension (12.5%) in Tamil Nadu. Visits of community leaders were reported to be very often by 20% AWWs from Assam, 17% from Maharashtra, 20% from Tamil Nadu and 2% AWWs from Uttar Pradesh. Lack of involvement of community leaders and lack of role clarity among AWWs were also identified as possible reasons for work pressure on AWWs as mentioned by 45% and 16% CDPOs respectively. Low honorarium to AWWs was mentioned as a major concern by all CDPOs (100%) in Uttar Pradesh and many of them from Assam and Tamil Nadu (83%). CDPOs mentioned that maintaining too many records and registers, assigning too many job responsibilities, and undertaking too many tasks were other dimensions on which the opinion of CDPOs from Maharashtra differed considerably from their counterparts working in the remaining three states of Tamil Nadu, Assam and Uttar Pradesh. 70% Supervisors mentioned that due to work pressure on AWWs, it was difficult for them to discharge their duties properly. 62% Supervisors of Assam, 67% of Tamil Nadu, 68% of Uttar Pradesh and 61% from Maharashtra mentioned that AWWs faced difficulty in discharging their job responsibility. The concern for high work load among AWWs was expressed by maximum number of AWWs from Assam (96%), followed by AWWs from Tamil Nadu (90%); Uttar Pradesh (71%) and Maharashtra (63%). AWWs working in urban projects exhibited high concern for work load, compared to their counterparts working in rural (75%) and tribal (71%) ICDS blocks. The involvement of AWWs in holding elections and other miscellaneous tasks needs to be avoided. Categorical instructions are required to be issued by Government of India in this regard. The supportive help being provided by AWHs and AGs to run the day to day activities of AWCs needs to be considered while talking about work load and time management of AWWs. There is need to educate ICDS functionaries about the synergetic importance of deployment of AWWs tasks with those of various allied ministries/ departments. NIPCCD and MLTCs may like to take up this issue in job and refresher training of CDPOs and Supervisors. Skill training workshops are also required. There is need to appoint a committee for prescribing minimum records and registers to be maintained at the AWC to reduce the workload of AWWs.

Key Words: 1.ICDS 2.TIME MANAGEMENT IN ICDS 3.TIME ALLOCATION ANGANWADI WORKER 4.ANGANWADI WORKERS.

LEGISLATION

24. Wali Khanna, Charu. (2008).
Violence against women : Directory of Supreme Court judgments. New Delhi: Social Action Forum for Manav Adhikar. 299 p

Abstract : This directory is an attempt to familiarize ordinary women and non-legal people with their legal rights and entitlements. This directory reflects the sensitivity of courts in implementing the law and in interpreting statutory provisions. In this study the causes and consequences of violence against women and effective measures taken by courts in India are explored. In a survey conducted by Social Action Forum for Manav Adhikar (SAFMA) almost 30% respondents admitted to having abortions done after knowing that the foetus was a female. In 1986, the Foundation for Research in Community Health, Bombay found that in Bombay city 84% gynaecologists admitted to having performed amniocentesis tests for sex determination. A petition was filed for implementation of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 renamed after amendment as the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act to ban all advertisements including sex determination techniques, which can be abused. 2001 Census figures revealed a greater decline in sex ratio in the 0-6 years age group in states like Haryana, Punjab, Maharashtra and Gujarat. The National Family Health Survey (2005-06) revealed that almost 46% women got married before the age of 18 years, and infant mortality rate was 77 per 1,000 live births for teenage mothers. The Child Marriage Restraint Act, 1929 was enacted to prevent child marriages. According to United Nations Population Fund (UNFA) around 66% married women in India were victims of domestic violence. The National Family Health Survey 3 found that the experience of spousal violence ranges from a low of 6% in HP to a high of 59% in Bihar. Married women with no education (46%) were much more likely than other women to have suffered spousal violence. However, spousal violence extended to women who had 12 or more years of higher education also, with 12% reporting violence. The protection of women from Domestic Violence Act 2005 is a new legislation, which in addition to the existing criminal law, empowers courts to grant protection to victims of domestic violence and provides other relief. Despite legislation and a sensitive judiciary, dowry related crimes are on the increase. In 2006 National Crime Records Bureau estimated that there had been an estimated number of 63,128 cases of 'cruelty' by husband and relatives, out of which the conviction rate was 21.9%. 'Torture' cases in the country have

increased by 8.2% over the previous year (58,319). 14.5% of these were reported from Andhra Pradesh (9,164). The highest rate was in Tripura (13.7%) as compared to the National rate (5.6%). The maximum number of crimes related to 'Dowry' were in Bihar (20.2%) and Tripura (31%). In 2006 there were 7,618 incidences of 'Dowry deaths' (registered under Sections 302, 304B IPC), being 0.4% of the total crimes in India and the conviction rate was as low as 33.7%. These cases have increase by 12.2% over the previous year (6,787). The maximum number of dowry deaths were reported from UP (24%), Delhi (18.7%), and Bihar (15%). According to SAFMA almost half the marriages broke off as parents were unable to cough up sufficient dowry, and in 90% cases the reason was social pressure and honour of the family. Under Dowry Prohibition Act 1961, imprisonment was prescribed for offenders for a term which shall not be less than six months but which may extent to two years and with a fine which may extent to ten thousand rupees. National Crime Records Bureau (NCRB) found that rape is another serious and violent crime in India. NCRB data revealed the profile of the average rapist, and over 75% were known to the victims. In fact, nearly 10% were relations. Another disturbing aspect was that about a quarter of the rape victims were minors. Highest number of rapes reported during the year 2006 were in MP (2,900), followed by West Bengal (1,731) and Maharashtra (1,500). The lowest numbers of rapes were reported in Sikkim, followed by Goa. Rape is covered under Section 375 and Section 376 of the Indian Penal Code, and prescribes punishment as imprisonment which may extent up to ten years. In 2006 a total of 1,64,765 incidents of crime against women were reported showing an increase of 5.9% over 2005. Andhra Pradesh, having nearly 7.2% of the country's population, accounts for 13.0% of the total incidents (21,484 cases). UP having nearly 16.5% of India's population reported 9.9% cases of crime against women (16,375 cases). Figures often mislead since they under estimate the problem. Many cases are not reported because victims are afraid to tell the police, friends or family about the abuse, or may be the fear of being jeered at, ostracized or simply embarrassed, makes them remain silent. Victims may also keep quiet because they and their families have been threatened with further harm if they tell any one. SAFMA revealed that on an average, at least one in two women had been subjected to eve-teasing in the course of their life, while 43.6% had been subjected to criminal force. There is an escalation of reportage of sexual violence in media. It leads to awareness of the issue, but being a visual media, it can also lead to sensationalism. To convict an offender, criminal law requires proof 'beyond reasonable doubt'. Ignorance makes women file wrong FIRs. Indecent assaults are often magnified into attempts at rape, resulting in the offender being acquitted due to lack of evidence. The notification issued by the State Government granting exemption from payment of court fees to certain class of women who were subjected to

some forms of violence provided access to justice for redressing their grievances. A large numbers of children in our society do not have the basic rights to food, shelter, education and a good childhood, and the situation of girl children is even worse. Often, girls are subjected to violence on the basis of gender, depriving them of an appropriate social and cultural environment. There is need for medical professional bodies/ associations to create awareness against the practice of pre-natal determination of sex and female foeticide and to ensure proper implementation of the Act. The Supreme Court expressed regret that a law which aimed at preventing such illegal practices was not implemented and therefore, non-governmental organizations (NGOs) were required to approach the Courts for its implementation, which is normally the function of the executive.

Key Words: 1.LEGISLATION 2.VIOLENCE AGAINST WOMEN 3.SUPREME COURT JUDGEMENTS 4.HIGH COURT JUDGMENTS 5.LEGAL RIGHTS OF WOMEN 6.MAINTENANCE 7.DIVORCE 8.DOMESTIC VIOLENCE 9.JUDICIARY 10.IMPLEMENTATION MACHINERY.

NUTRITION

25. Sachdeva, H. P. S. (2008).
NFI Bulletin, 2008 Jul, 29(4): Role of Micronutrients Supplementation in Improving Child Health. New Delhi : Nutrition Foundation of India. 5 p.

Abstract : Micronutrients are essential for the maintenance of health, and children are particularly vulnerable to the effects of deficiency. On the basis of observational evidence it was found that prophylactic Vitamin A supplementation helps in preventing childhood mortality between 6 months and 6 years of age. Another important micronutrient is Iron and iron deficiency is believed to be the most important causal factor for anaemia. But all anaemia is not due to iron deficiency and also not all iron deficient individuals are anaemic. On the basis of a systematic review of the findings of 55 trials, it was concluded that iron supplementation increased haemoglobin levels in children significantly but modestly. The rise was greater with baseline anaemia, and lower in malarial hyperendemic areas. The study found that iron-fortified foods result in a significant improvement in haemoglobin, serum ferritin and serum transferrin receptor, and a reduced risk of remaining anaemic and iron deficient at the end of the intervention. Observational data indicated a strong association of iron deficiency with poor mental and motor development in children. Evidence

showed that iron supplementation improves mental development scores modestly. Some evidences from earlier reviews showed that iron administration slightly increases the risk of developing diarrhoea; in non-malarious regions iron supplementation has no apparent beneficial or harmful effects on the overall incidence of infectious illnesses. It was also found that in malaria endemic regions, particularly those with high transmission rates, iron supplementation may result in increased risk of malarial infections. Another study showed that in areas where iron deficiency was common and malaria absent, daily supplementation of young children with iron and folic acid has no effect on their risk of death, but might protect them against diarrhoea, dysentery, and acute respiratory illness. Another important micronutrient is Iodine. Several reviews suggested that with iodine fortification or supplementation, goitre prevalence decreased by 19-64% in children, and almost all programmes reported normal median urinary iodine excretion levels. It was estimated that iodized salt reduced the risk of iodine deficiency and the DALYs (disability adjusted life years) associated with iodine deficiency by 41% in children. Zinc is found to be another important micronutrient, and researchers found that zinc had a beneficial role in acute and persistent diarrhoea in children. It was found that zinc supplemented children had 16% faster recovery and had a 34% reduction in the odds of acute episodes lasting more than 7 days. Studies showed that deficiency of other micronutrients Vitamin B-complex and Vitamin D was quite prevalent in India and led to adverse child health consequences. There is an urgent need to control these micronutrient deficiencies by providing fortified food, supplementation to the children having micronutrient deficiencies, and also food programmes should be organized to cope with these resultant health problems.

Key Words: 1.NUTRITION 2.RESEARCH NUTRITION 3.NUTRITION SITUATION 4.NUTRITION INDIA 5.MALNUTRITION 6.MICRONUTRIENT DEFICIENCY.

26. Ramachandran, Prema. (2008).
NFI Bulletin, 2008 Jul, 29(3) : dietary intake, physical activity and nutritional status of Indian adults. New Delhi: Nutrition Foundation of India. 5 p.

Abstract : In this paper, the changing pattern of dietary intake and physical activity in adults, and the impact of these on nutritional status of adults is explored. Analysis is based on secondary data from NNMB (National Nutrition Monitoring Bureau – 1990), NFHS–2 (National Family Health Survey–1998-99) and INP (India Nutrition Profile – 1975-2005). Data from the NNMB and INP

surveys show that in mid 1990s, the average intake of cereals was near the recommended dietary allowance (RDA). The reported intake of foodstuffs was higher in INP states as compared to NNMB states; this is attributable to higher intake of cereals and pulses in the non-NNMB states, which were covered in the INP. Intake of pulses, vegetables and fruits were low among both men and women in all the states. NNMB data showed that over time there has been a reduction in the average intake of cereals, among both men and women, especially since the mid 1990s. Data from the NNMB surveys show that energy intake was high in the mid 1990s and subsequently there has been a small decline in energy intake. Data on time trends in total energy intake and percentage of energy intake from fat, carbohydrate and protein from all the major states from INP for adult men and women show that carbohydrates remain the major source of energy in the Indian diet. Data from NNMB surveys showed that dietary intake has not undergone any major shift towards increase in the consumption of fat/ oils, sugar and processed food. Since 1990s there has been an increase in percentage of energy from fat till 2001, but subsequently there was a reduction in percentage energy from fat. However, even in 2001, the percentage energy from fat was below 15% (WHO/ FAO/ UNO). NFHS-2 data showed that the prevalence of under nutrition in adults was higher in rural areas as compared to urban areas. Prevalence of over nutrition was higher in urban areas. Prevalence of both under nutrition and over nutrition was higher in women as compared to men. NFHS-3 data showed that the prevalence of over nutrition was four-fold higher in urban areas as compared to rural areas. All the states in India have entered the dual nutrition burden era. According to the Prospective Urban and Rural Epidemiological (PURE) India study, majority of the urban population is working in white or blue collar jobs, where occupation related physical activity levels are low. As a result even though urban men and women spend time in domestic and occupation related activities, their energy expenditure for these activities is low. Average intake of nutrients by men according to NNMB survey in 2004-05 were 54.8 g protein, 26.9 g fat, 2000 kcal energy, 511 mg calcium, 16.9 mg iron, 267 ug Vitamin A, 1.3 mg Thiamin, 0.7 mg Ribo, 16.1 mg Niacin, and 50 mg Vitamin C. The nutrient intake for women was 46.5 g protein, 21.8 g fat, 1738 kcal energy, 443 mg calcium, 13.8 mg iron, 254 ug Vitamin A, 1.1 mg Thiamin, 0.6 mg Ribo, 14.2 mg Niacin, and 47 mg Vitamin C. It was suggested that adults should eat a balanced diet with adequate energy intake, and lots of vegetables should be consumed. NHE messages should be communicated to all. If they follow this advice there will be improvement in under nutrition and micronutrient deficiencies.

Key Words: 1.NUTRITION 2.RESEARCH NUTRITION 3.NUTRITIONAL STATUS 4.BODY MASS INDEX 5.VITAMIN A DEFICIENCY.

RURAL DEVELOPMENT

27. Shukla, Saurabh and Gautam, J.N. (2008).

Impact of information communication technology in rural areas of Uttar Pradesh : bridging the divide. New Delhi: India, Ministry of Rural Development. 15 p.

Abstract : This study was carried out to assess the impact of both, newer ICTs (Information Communication Technology) (like cell phones, computer and Internet) and older ICTs (radio, TV and landline phones) in the day to day life of R-3 (Remote, Rural and Regional) communities in the rural areas of three districts of Uttar Pradesh, namely Mirzapur, Badaun and Muzaffarnagar. A total of 356 villages were covered, 101 villages from Mirzapur, 75 villages from Badaun and 180 villages from Muzaffarnagar. It was found that Library/ Community Information Centres/ Panchayat Offices were rare in Uttar Pradesh, there were 64.44% such centres in Muzaffarnagar; 48.51% in Mirzapur and 32% in Badaun. The presence of cinema/ video centres and stadium/ auditorium were rare in all the districts. In Mirzapur only 1% persons, in Badaun 1.33% persons, and in Muzaffarnagar only 2.22% villagers were familiar with the term ICTs, whereas a majority of the population surveyed in villages i.e. 99% in Mirzapur, 98.67% in Badaun and 97.78% in Muzaffarnagar were completely ignorant about ICTs. Cell phones were found with 17.82% people of Mirzapur, 9.3% people of Badaun, and 40% persons in Muzaffarnagar. Computer was observed with 1.98% persons in Mirzapur, 6.67% persons in Muzaffarnagar and 0% persons in Badaun. Internet was hardly present in Mirzapur (0.99%), Muzaffarnagar (2.22%) or Badaun (0%). According to CII (2007), 72% Indians live in rural areas/ villages, and ICTs can be a major driver of the economy and development. ICTs can play a major roll in environmentally sustainable rural development, and the establishment of telecentres in rural communities facilitates socio-economic empowerment. In all districts, whether NREGA or non-NREGA, the presence of newer ICTs (like cell phones, computer and Internet) was less compared to older ICTs (radio, television and landline phone), and the reference indicator 'electricity' was mostly available throughout the survey area, but its supply was very inconsistent in Uttar Pradesh. Face to face communication and letters were the most important communication mediums for specific information on issues such as education, health, agricultural business and transportation facilities. However, there had been a reduction in the number of social visits, face-to-face

communication and travel since the telephone became available. Modern ICTs like e-mail or Internet was hardly used by rural communities in communicating with people within or outside their environs. In all districts people did not have easy availability or access to different ICTs, and 95.02% persons in Mirzapur, 96% in Badaun and 95.56% in Muzaffarnagar did not have access. Majority of the villagers (95.04% in Mirzapur, 93.33% in Badaun and 85% in Muzaffarnagar) did not feel that ICT was necessary for living. Lack of training/ skills and illiteracy were other factors responsible for not having ICTs (81.19% in Mirzapur, 92% in Badaun and 90% in Muzaffarnagar). Cost factor/ affordability was another criteria for not using ICTs in Mirzapur (98.1%), Badaun (92%) and Muzaffarnagar (98.89%). Distance was an impeding factor in Mirzapur (62.38%), Badaun (85.33%), and Muzaffarnagar (85%). Lack of infrastructure was found to be an obstacle in 78.21% cases in Mirzapur; 93.33% cases in Badaun and 57.78% cases in Muzaffarnagar. Local availability was also a factor for non-use in Mirzapur (46.53%), Badaun (20%) and Muzaffarnagar (28.89%). Gender bias and cultural barriers were considered equally important in hindering the spread of ICT in all the districts. Libraries/ Community Information Centres (CICs) Panchayat Offices can be remolded into information hubs or kiosks, if equipped with proper ICT infrastructure facilities. It can be interpreted that wider coverage, enhancement and upgradation of ICT initiatives (either Government or private) are required, especially for those who can not afford it and do not have access to the information that is likely to improve their health, education, livelihood, and can protect them against vulnerable situations. They should be empowered to utilize opportunities for a more prosperous future.

Key Words: 1.RURAL DEVELOPMENT 2.INFORMATION COMMUNICATION TECHNOLOGY 3.ICT FOR RURAL DEVELOPMENT 4.INFORMATION TECHNOLOGY 5.ROLE OF INFORMATION TECHNOLOGY IN RURAL DEVELOPMENT.

SCHEDULED TRIBES

28. Nirwan, Raj Singh. (2006).
Status of women among tribals in Rajasthan. New Delhi : National Commission for Women. 202 p.

Abstract : The role of women in tribal society is more important than in other social groups because, more than women in any other social group, tribal women

work harder, and the family economy and management depends on them. This study was carried out to ascertain the status of tribal women in three districts of Rajasthan namely Udaipur, Sirohi and Baran and covered Bhil, Garasia and Saharia tribes respectively. The study investigated the status of women with special reference to their socio-economic life, taking into account various considerations affecting this role. Sample size of the study was 634 tribal women. Findings of the study indicated that almost all (185 out of 207 Saharia women, 179 out of 219 Garasia women and 172 out of 214 Bhil women) the respondents were illiterate. 206 men among the Saharias were wage labourers, while this number was 202 among Bhills, and 170 among Garasias. 66% had a feeling of financial exploitation. In Baran 40% had the communication facility of telephone or post offices. In Sirohi only 9 out of the 21 (43%) villages had communication facility, and in Udaipur region 11 out of 16 (68%) villages had this facility. Power supply was available in all the villages in Sirohi and in only 32% villages in Udaipur district. However, the power supply in villages was very erratic. IMR among the Saharias was 14% higher compared to other tribes. Overall, 3 out of every 4 women among Garasias (75%), and almost all (100%) of the Bhil women did not receive any antenatal check-up during their last pregnancy. 90% of the deliveries in tribal areas were conducted by rural professionals. All the health problems of women during pregnancy, such as constipation, urinary ailments, false labour pains, and sometimes even premature abortions were managed by *dais* (midwives). The reproductive age was found to be less than 14 years in 25% of Bhil women. It was seen that no bias was observed by the tribals in vaccination of their sons or daughters. Tribal women, in spite of the recent legislative provisions, did not take part in the electoral process. The migration from their hinterlands to the nearest urban city was seen to be lower among the Garasias (6%) compared to 41% among the Bhils. As their expenditure was more their income, many tribals were in debt. The expenditure pattern showed that 40% of the income was spent on household affairs, 20% was spent on payment of loans, 10% on travel, and the rest was spent on liquor. Almost all women gave birth to their first child before the age of 19 years. 92% Garasia women and 75% Bhil women did not show any expectation for a son at the time of birth of their first child. But 62% of the Saharias wanted a male child. The most popular programme about which respondents were aware was the Drought Relief Programme (81.1%), Child Development Schemes (64.2%), SGSY (52.4%), Mid Day Meal Scheme (70.8%), Pradhan Mantri Sadak Yojana (61.8%), health related programmes (75.7%) and women and child development programmes (65.1%). Under Antyodaya Anna Yojana tribals were being provided 35 kg of food grains a month, 25 kg of wheat at Rs.2/- per kg and 10 kg of rice at Rs.3/- per kg. Another scheme which was reported to have been successful was the Indira Awas Yojana and about 32 women among the Saharias and 6 women

among the Garasias had benefited from the scheme. 38.65% respondents assigned the first priority to provision of employment, followed by the availability of safe drinking water. About 9.36% respondents in villages assigned first priority to connectivity with roads. It was suggested that there is need for organizing large scale and focussed campaigns in tribal areas for women's rights such as land rights. Also, moderately qualified or even literate tribal women should be chosen as community workers to work in these areas. There is need to strengthen developmental programmes which can help tribal women. There are many tribal crafts and handicrafts, which if given suitable inputs, modernized, made attractive, and marketed through networks, could prove to be a regular and sustainable source of income and employment in tribal regions of the country.

Key Words: 1.SCHEDULED TRIBES 2.TRIBAL WOMEN 3.STATUS OF TRIBAL WOMEN 4.BHIL TRIBE 5.SAHARIYA TRIBE 6.GARASIA TRIBE 7.TRIBALS RAJASTHAN 8.TRIBAL CUSTOMS 9.GOVERNMENT PROGRAMMES 10.RAJASTHAN

SOCIAL DEFENCE

29. Uma, V. et al. (2002).
Commercial sex workers and their children in coastal A.P (Andhra Pradesh). Ongole, A.P: Help Ongole, Andhra Pradesh. 112 p.

Abstract : Prostitution is quite widespread in coastal Andhra Pradesh, but there are no estimates of the number of women engaged in the activity. This study attempts to provide details of the number and profile of commercial sex workers in six districts of coastal Andhra Pradesh. The main objectives were to identify the geographical pockets from where a large number of women join this profession; to enquire into the reasons why women enter into commercial sex work; and to generate a reliable database on different dimensions of sex work for the six districts of coastal Andhra Pradesh. A total sample of 8290 was selected from six coastal districts (East Godawari – 2000, West Godawari – 1518, Krishna – 1111, Prakasam – 907, Nellore – 1181, and Guntur – 1573). The study was conducted by HELP, an organization working with sex workers, in collaboration with Action Aid India. It was observed that, 41.8% CSWs (commercial sex workers) were in the age group of 18-25 years; 41.32% were in the age group

25-35 years; and 6.21% were less than 18 years. They remain in the business till the age of 35 years. 56.79% CSWs were illiterate, 21.85% were partially literate, and the rest had some school education. 33% of the sex workers from East Godawari, West Godawari and Krishna district were in the occupation with the knowledge of their family. This could be inferred from the fact that they were married and continued to be in the profession without their marital status being disturbed. Majority of the respondents (84.02%) entered the profession intentionally, and 15.98% of the respondents in the sample entered the profession unintentionally and unknowingly. Majority of the families, i.e. 40.51% were engaged in daily labour and a large number of them were from West and East Godawari districts, followed by Prakasam district. Further, 7.29% of the families were engaged in commercial sex work and a large number of them were from Guntur district. It was found that about 48.7% of the families had an income of Rs.5000/- and less per annum. Among them were the families of CSWs in East and West Godawari districts. 4.85% of the families were earning annual income between Rs.5000/- to Rs.10,000/-, and large number of these families were from Guntur and Prakasam district. 91.91% of the respondents entered the profession due to economic adversity. Further, 79.82% cited economic reasons as the primary cause for continuing in the profession. A large number of them belong to Guntur district. 58.09% of the respondents had no financial commitments towards agents; 24% of the respondents shared 50% of their earnings with agents; 10% of them parted with 25% of their earnings; and 5.14% of the respondents paid 75% of their earnings to agents. The average income of pimps and brokers would reportedly be two and half times the average income of CSWs. 42.31% of the CSWs earned Rs.25 to Rs.50 per client and the CSWs from West Godawari district featured in this category. 32.32% of the respondents earned Rs.10-25 per contact, and a large number of CSWs from Nellore district were in this category. 95.5% CSWs faced problems, and of them 81.43% faced problems from the police. 17.4% of the CSWs experienced violence and exploitation from customers. With regard to the means adopted by CSWs to overcome their problems, 48.13% ran away from the place, 36.23% made payments to the police, and 13.97% continued, irrespective of the problems. 53.8% of the CSWs did not receive any support during times of crisis; 12.8% received support from agents, 17.5% from the legal system, and 10.7% through payment of money. Further, 74.08% of the CSWs of West and East Godawari and Krishna districts wanted to come out of the profession. 41.15% CSWs experienced police violence, 26.51% feared contracting AIDS, and 10.26% suffered from ill health, 87.41% of the CSWs were not aware of government schemes. It was suggested that in the present context of market economy and the globalization process, intervention has to be made adopting an integrated approach, instead of a tubular mode. The network of organizations working in

this area firmly believes that an integrated effort has to be made at the entry point to stop further trafficking into sex work.

Key Words: 1.SOCIAL DEFENCE 2.PROSTITUTION 3.SEX WORKERS
4.COMMERCIAL SEX WORKERS 5.CHILDREN OF PROSTITUTES
6.COASTAL AREAS 7.COASTAL ANDHRA PRADESH 8.ANDHRA PRADESH

30. UNICEF, Innocenti Research Centre, Florence, Italy. (2008).
South Asia in action : preventing and responding to child trafficking : child rights based programme practices. Florence, Italy : UNICEF-IRC. 37 p.

Abstract : Unknown numbers of children are trafficked within and across the borders of South Asia. They are trafficked into situations of exploitation and abuse such as hazardous labour, commercial sexual exploitation, domestic servitude, begging and criminal activities. This study addresses programme practices that aim to combat child trafficking. It presents three case studies of child rights based initiatives: 1. Para-Legal Committees in Nepal, 2. Regional Anti-Trafficking Network in the Indian State of Andhra Pradesh, and 3. Bangladesh intervention for children previously involved in camel racing in the United Arab Emirates. The focus is on prevention, along with other components of right based programming. These case studies from South Asia provide practical examples and lessons learnt from implementing key components of a comprehensive right based approach to child trafficking. These interventions include awareness raising, community mobilization, political and social commitment, networking and cooperation, victim assistance and sustainability. The case study on Para-Legal Committees in Nepal shows how community members can also aid in early detection of cases, mediate between opposing parties and advocate for policy and legal reform. Reintegration is one of the greatest challenges facing those working with children who have been trafficked. Physical health challenges can be serious, as many children rescued from sexual exploitation were HIV positive. Rescued children had inadequate medical support, including access to antiretroviral medicine. In terms of mental health and social factors, many trafficked children have dealt with and perhaps not fully recovered from the trauma caused by the trafficking experience. Because of the weak structures to address exploitation and abuse, the Para-Legal Committees respond to individual children and women. A key success factor in all three projects was the active involvement of the Government, at local and central levels. The additional success factor in the Bangladesh Intervention was commitment by the Government of United Arab Emirates to address the demand

side of child trafficking by banning the use of children in camel racing, establishing follow-up mechanisms, and providing significant resources for repatriation and reintegration of the children. Further, community's voluntary contributions, combined with ongoing capacity building support, coaching from organizations such as UNICEF, non governmental organizations (NGOs) and respective Governments have proved to be valuable. Adopting and replicating a standardized approach to community mobilization and empowerment has proved successful. It was found that the participation of younger children has been weak in all three initiatives, as has the participation of youth in some cases. Women and adolescent girls were typically the focus of and are actively involved in initiatives aimed at preventing discrimination. Poverty remained a challenge throughout the region in India's Andhra Pradesh state, where 17 of 23 districts are reported to be affected by trafficking, whether as source, transit or destination areas. Districts of Cuddapah, Anantpur and Chittoor are major source areas from where girls and women are trafficked. The Andhra Pradesh activities for prevention of trafficking include formation of anti-trafficking committees/ community vigilance groups; school campaigns; *balika sanghas* (girls collectives); street theatre; law enforcement; community based teams; social mobilization; convergence of services; and sustainability and monitoring. It was recommended that National Child Protection Systems should be developed, guided by the UN Convention on Child Rights and mobilized at all levels. Financial National Plans of Action should be drawn up on child trafficking, or child trafficking could be considered within other national planning processes.

Key Words: 1. SOCIAL DEFENCE 2.CHILD TRAFFICKING 3.TRAFFICKING PREVENTION 4.PREVENTION CHILD TRAFFICKING 5.COMMUNITY INVOLVEMENT 6.WOMEN'S GROUPS 7.BEST PRACTICES TRAFFICKING 8.REINTEGRATION TRAFFICKED VICTIMS

SOCIAL WELFARE

31. Council for Social Development, New Delhi. (2008).
India : social development report 2008. New Delhi: Oxford. 311 p.

Abstract : In India development projects in the last 60 years are estimated to have displaced roughly 60 million people, most of whom have never been properly resettled. The present report examined the social impact of a number of current industrial projects in India in the context of massive unresolved displacement problems suffered by the people. It was found that in Andhra

Pradesh the proportion of landless rose from 10.9% to 36.5% in 2001 and in Assam from 15.56% to 24.38% in 2006. Official figures which were updated up to 2004 showed that the total number of displaced persons (DPs) or project affected persons (PAPs) in Jharkhand and Orissa went up to 3 million each, 5 million in Andhra Pradesh, 1 million in Kerala, 100,000 in Goa, 2 million in Assam, and 7.5 million in West Bengal. Even excluding the high displacement in states like Chhattisgarh and M.P., they account for 27 million DP/PAPs. Most displacement for dams and other projects was in administratively neglected 'backward' regions in which much of the livelihood lost was of tribal persons from CPRs (Common Property Resources). No compensation was paid for it. Also, they owned very little private land and they were paid low compensation for it because of the 'backwardness' of the region. The amount paid as compensation was so little that the land losers could not begin a new life with that amount. Displacement took many DPs/PAPs beyond impoverishment; led to deterioration of their economic status, marginalization, that led to deterioration of their social, cultural and psychological status. Their economy, culture and identity were linked to the land, forests and other resources that the project alienated them from. Due to displacement the whole family suffered the impact of joblessness, reduction in income, and women and children felt the ill effects of going below the poverty line more than men. In the absence of alternatives, 56% of the displaced families in Assam and 49% in West Bengal pulled their children out of school and made them child labourers so that they could earn an income. Because of forced displacement others had taken to crime. Also, domestic violence and drinking had increased after displacement. There was also a rise in malnutrition related diseases, dengue and water borne diseases such as hookworm, cholera, gastroenteritis, etc. because certain diseases were commonly associated with wetlands and locations around dam constructions. The report also showed SDI (Social Development Index) for rural and urban areas in 2005. Among the rural areas Kerala (72.57) had top rank during 2005 followed by Himachal Pradesh (62.90). The next high ranking states were Jammu and Kashmir (61.13), Tamil Nadu (58.27) and Punjab (57.41). Orissa (32.98), Rajasthan (31.87), Chhattisgarh (29.21), M.P. (27.84), U.P. (26.21), Jharkhand (18.83) and Bihar (18.29) had aggregate index value below the national average (33.97). In the case of urban areas, during 2005, Himachal Pradesh (72.90) was at the top followed by Kerala (67.49), Jammu and Kashmir (62.77), Punjab (56.36) and Tamil Nadu (53.26). There were significant differences in the aggregate index values of the 3 states at the bottom - M.P. (32.0), U.P. (26.1) and Bihar (16.0). In the smaller states, Mizoram (72.40) was top ranking and Arunachal Pradesh (33.64) was below the national average. There is need to adopt credible policies that minimize displacement, properly compensate those relocated to make

development possible, and give them a permanent stake in project benefits. This would help in improving the SDI of the states below the national average.

Key Words: 1.SOCIAL WELFARE 2.SOCIAL DEVELOPMENT INDIA 3.SOCIAL DEVELOPMENT INDEX 4.POVERTY 5.EDUCATION 6.HEALTH 7.WOMEN IN SOCIAL DEVELOPMENT 8.CHILD DEVELOPMENT 9.SOCIAL DEVELOPMENT REPORT 2008.

WOMEN WELFARE

32. India, Ministry of Panchayati Raj, New Delhi. (2008).
Study on elected women representatives in panchayati raj institutions.
New Delhi : I-MPR. 161 p.

Abstract : This study analyzed issues related to elected women representatives vis-à-vis their male counterparts. It investigated their socio-economic characteristics, tracked their political careers over the past three rounds of election, and examined the quality of their post-election participation in terms of performance of their roles. A total of 23 states, 114 districts, 228 blocks and 1368 gram panchayats were selected for the study. The responsibilities that accompany a higher position in panchayati raj institutions (PRIs) are reflected in the higher proportion of Pradhans, as compared to ward members, spending the greater part of their time in panchayats related works. In case of women representatives, prior association with any form of politics was low, and for most women the act of contesting the first election signalled their entry into active politics. Whatever prior association they had was of a limited nature. Overall, 93% male pradhans reported performing their primary role of organizing and attending gram sabha meetings. Though in smaller numbers than male pradhans, 86% female pradhans reported executing this important role of being a local panchayati raj functionary. However, the participation of women citizens of the village was quite low (less than 25%). The selection of beneficiaries for different schemes is usually done during gram sabha meetings (56%). But at least one-third (31%) of the time, these lists are prepared ahead of the meetings and are present for mere approval by the gram sabhas. Elected representatives (81%) mentioned that most of the time the programme guidelines related to drawing up the list of beneficiaries appear to be adhered to. However, the community's perception about beneficiary selection for different schemes and its implementation were not that high. Training in 'Rules and Regulations of

Panchayats' and in 'Roles and Responsibilities of Panchayats' are very critical for better performance, but these were attended by only 57% and 43% of the representatives respectively. Irrespective of gender and position, three-fifths apparently felt the need for training on 'Rules and Regulations of Panchayats'. It was found that overall elected women representatives were functioning within an enabling environment at the level of the village, community and the household. The positive impact of working as a panchayati raj functionary is evident from the fact that a sizeable proportion of women representatives perceive enhancement in their self-esteem (79%), confidence (81%) and decision making ability (74%). While no gender discrimination in panchayats was mentioned by 60% of the elected women representatives, acceptability in panchayat meetings and enabling them to raise issues freely was mentioned by 94% women members. The performance of women representatives who belonged to the younger age category (21-35 years) was better than those who were above 35 years. Educated women representatives showed a significant positive correlation with better performance than those who were illiterate. It was suggested that younger and educated women should be encouraged to join politics. 43% of the women elected did not receive any training. Hence training should not only be made mandatory for all elected representatives, but it should also be organized regularly. Women can become better performers by virtue of being politically more aware and experienced, thus effort should be made not only to maintain the representation of women in politics in terms of their percentage, but also their ability in politics.

Key Words: 1. WOMEN WELFARE 2.PANCHAYATI RAJ INSTITUTIONS
3.WOMEN IN PANCHAYATI RAJ 4.ELECTED WOMEN REPRESENTATIVES
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