DCWC Research Bulletin

Vol. XXII **Issue 3** **July-September 2018**

2018

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DCWC Research Bulletin

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CHILD WELFARE

1. Davey, S., et al. (2018).
Predictors and Consequences of “Phubbing” among Adolescents and Youth in India: An Impact Evaluation Study. *Journal of Family and Community Medicine, Vol. 25(1): 35-42.*
G21231

Introduction: With the growing usage of addiction towards Internet and Smart Phones on the youth and adolescents. There is a growing unease that smart phones may actually create a form of misuse or overuse resulting in problematic Internet usage, generating a new problem known as “Phubbing” rather than a means of enhancing social interactions. The term “Phubbing” has been defined in various waysas modern communication in which a person snubs another in a social setting by concentrating on their phone instead of having a conversation. This phubbingphenomenon elucidates the real negative consequences of the lack of communication that detrimentally affects relationships and feelings of personal wellbeing.

Objectives: To assess the role of predictors and their consequent impact on adolescents and youth.

Methodology: Out of the 36 Colleges in Muzzaffarnagar, a total sample size of 400 students from 5 Colleges were randomly selected in the age group of 15–29 years which covers both adolescents (10–19 years – WHO definition) and youth(15–29 years – as per the National Youth Policy [2014]of India).

Results: The majority of college students in the present study were in the late adolescent to early youth age group (38.2%), male (51%), Hindus (47.8%), belonging to general caste (81.3%), above Class I of socioeconomic class (38.8%), and majority were medical students (24.7%).However, amongst one-fifth (20%) of non-respondents, majority were from engineering colleges (31%) and the smallest number from medical colleges (20%). The non-responses were from the group that they did not liked their privacy invaded (41%), they did not want to discuss this issue further (33%) without any reason, and the rest (26%) were afraid of being ordered by the college to stop using their smart phone in class.The prevalence of phubbing was majorly (49.3%) affected among the respondents. Expensive smartphones were frequently used device for phubbing (45.1%), in which Whats App was the main attraction (33.5%) for phubbing. The characteristics were also dominated by <½ hr of phubbing (42.6%) withfrequency <½ day (48.7%). However, college students were themselves phubbed at least 3–5 times/day (48.8%)and they also reported home family phubbing to be even higher (65.9%). On the Phubbing Questionnaire Scale, the most common response was “I feel incomplete without my mobilephone” (49.3%) and the least common was “I’m not busy with my mobile phone when

I’m with friends” (5.7%).On Adapted Mobile Phone Use Habits Scale, the most common response was “I am always preoccupied with my mobile phone (49.2%) and the least common was “Inever committed illegal acts (theft) to finance the use of my cell phone” (5.9%). On the Internet Addiction Scale, the most common response was “The people around me say that I spend too much time on the Internet” (49.1%)and the least common was “I prefer to spend time on the Internet rather than go out with others” (40%). On Brief Self-control Scale, the most common response was “I am unable to resist temptation if I see mysmartphone” (46.9%).The most important consequence of phubbing was “depression and distress” (55.5%), with the highest (RR = 1.28,OR = 1.74) of phubbing and self flourishing as a least consequence (36.6%, RR = 0.4, OR = 0.3)

Conclusion: Adolescents and youth of India need special guidance from government adolescent clinics or colleges or even families to control this habit in order to promote better physical, mental, and social health.

KEYWORDS: *1.CHILD WELFARE 2.ADOLESCENT GUIDANCE 3.YOUTH GUIDANCE 4.INTERNET ADDICTION 5.PHUBBING 6.ROLE OF PREDICTORS 7.PERSONALWELL-BEING 8.SMARTPHONES AND INTERNET ADDICTION SCALE 9.PHUBBING PREVALENCE QUESTIONNAIRE 10.SELF?CONTROL SCALE 11.PHUBBING CONSEQUENCES SCALES*

2. Kaur, R. et al. (2018).
A Descriptive Study on Behavioral and Emotional Problems in Orphans and Other Vulnerable Children Staying in Institutional Homes.*Indian Journal of Psychological Medicine, Vol. 40 (2): 161-168.*
G21232

Introduction: The issue of Psychological health and well-being is mostly not taken a good care of, and in a country like India, the subject has been lethargically treated as one of the welfare programmes in the society. The Children in the categories of being orphans and the other vulnerable children and adolescents (OVCA) living in institutional homes are more prone to behavioral and emotional problems than others as they are deprived of family's love and care.

Objectives:1.To study the prevalence and the types of behavioral and emotional problems in orphans and OVCA living in institutional homes; 2. To study the association between socio-demographic parameters and behavioral and emotional problems in these children; 3.To study the impact of behavioral and emotional problems on the child's life.

Methodology:A cross sectional, observational, descriptive study. The sample was drawn from 292 OVCA from six institutional homes in Visakhapatnam.

Results: The findings revealed that the total sample consisted of292 orphans and OVCA. Of these, 109 (37.3%)belonged to the age group 4–11 years and 183 (62.7%)belonged to the age group 12–17 years. The number of boys (n = 175) in the sample was more than the girls (n = 117). The reason for being in the institute for majority of the children was that they were abandoned by family (54.8%), followed by orphans (29.4%) and runaways (15.8%). Most of the children in institutional homes had been staying there from 1 to 5 years (50.3%). The age of admission to the institutional home for majority of the children (53.3%)was between 5 and 10 years; the academic performance was reported "average" for majority (46.2%) of children. Based on the Strengths and difficulties questionnaire(SDQ), a total of 49 (16.78%)children and adolescents of a study sample of 292 had scores more than the cutoff score of 16, thus marked positive for emotional and behavioral problems. Among the orphans and OVCA reared in institutional homes, age, sex, reason for being in the institute, age of admission, and years of stay in the home were all seen to be significantly associated ($P < 0.01$), with having emotional and behavioral problems. It further revealed that the orphan children and adolescents in institutional homes had a conduct problems (34.9%), peer problems (15.8%),emotional problems (14.7%), hyperactivity (8.60%), and had low pro social behavior (3.4%). In this study, the subscales of the SDQ were also scored separately and studied for association with sociodemographic factors by doing the Chisquare test and Fisher's exact test. Emotional problems were found to be significantly associated with age ($P < 0.01$) and gender ($P < 0.01$), reason for being in the home($P < 0.05$), and age at the time of admission in to the home ($P < 0.01$). Conduct problems were found to be significantly

associated with age (P < 0.01),gender (P < 0.01), reason for being in the institute(P < 0.01), duration of stay (P < 0.05), and age at the time of admission into the home (P < 0.01).Hyperactivity was also significantly associated with all the factors, except sex and academic performance. While peer problems were seen to be significantly associated with only gender, poor pro social behaviorwas the only one to be significantly associated with academic performance. Of the 49 children having emotional and behavioral problems, 45 were reported as having a negative impact on their overall lives. The results showed that home life (97.7%) was the most commonly affected domain, followed by classroom learning (88.8%), leisure activities (82.2%),and friendships (64.4%).

Conclusion: It was found that conduct problems are the most common in this group followed by peer problems and emotional problems. Hyperactivity and low pro social behaviors were less common. Being an adolescent, a boy, being abandoned, or having a shorter duration of stay in the institutional home increased the risk of having psychological morbidity.

KEYWORDS: *1.CHILD WELFARE 2.CHILD CARE INSTITUTES (CCIS) 3.ORPHANS AND OVCA 4.OTHER VULNERABLE CHILDREN AND ADOLESCENTS 5.BEHAVIOUR PROBLEMS 6.HYPERACTIVITY 7.EMOTIONAL PROBLEMS 8.PEER PROBLEMS 9.PSYCHOLOGICAL WELL BEING 10.PROSOCIAL BEHAVIOR 11.PSYCHOLOGICAL MORBIDITY.*

EDUCATION

3. Anand,P., Sachdeva, A., and Vipin Kumar. (2018).
Pathway to Care and Clinical Profile of Children with AttentionDeficit Hyperactivity Disorder in New Delhi, India.*Journal of Family and Community Medicine. Vol. 25 (2): 114-119.*
G21233

Introduction: One of the most complex neurological behavior disorder, Attention deficit hyperactivity disorder (ADHD) affects about 5 percent of the school-going children. Some of the prevalent traits found in this kind of disorder ranges from hyperactivity, inattention and impulsivity in various combinations, with onset before 7 years of age.

Objectives: To provide a quantitative description of the factors affecting the helpseeking pathway.

Methodology: A total of 50 children were enrolled for the study. Tools as Conners' Parent Rating Scale Revised (CPRSR: S) and behavioral observation were used in the study.

Results: The majority of patients were in the age group of 5–10 years (n = 44, 88%). Only 6 were aged 10–15 years. Majority of them were male children (n = 35, 70%) than females (n = 15). Most of these children belong to urban areas (n = 42, 84%). Children living in nuclear families formed the major subgroup (n = 35, 70%). A majority of the children were classified as ADHD combined type (n = 33, 66%) followed by ADHD hyperactive type (n = 12, 24%). The delay in seeking treatment for ADHD was assessed. The mean delay from the first onset of the illness to first consultation with a qualified health professional, in our subset of patients, was 2.32 ± 1.9 years. The children in the age group 5–10 years presented with a mean delay of 2.3 years, while the mean delay in those aged 10–15 years was 2.7 years (P = 0.601). Similarly, there was no significant difference in the mean delay of male and female children (P = 0.253) and type of school they attended (government or private school) (P = 0.076). Children from urban backgrounds presented significantly earlier than those from rural areas (P = 0.015). Higher maternal education, living in a nuclear family, and higher family income tended toward seeking earlier consultation for ADHD (P < 0.01). Children with combined and hyperactive type of ADHD presented significantly earlier than children with inattentive type of ADHD (P = 0.002). Children referred by the school teachers presented significantly earlier than the referrals from the health practitioners (1.8 years vs. 2.2 years). Most of the children had pediatricians (n = 26, 52%) as the first level of contact with a qualified health professional, followed by general medical practitioners (GMP) (n = 14, 28%). Only 4 children had contacted a psychiatrist at the first level. The

majority of patients were referred by school teachers (n = 14, 28%) followed by GMP (n = 12, 24%). Six children were sent by relatives or family members, four from social workers and two by the faith healers.
Pediatricians also referred six children to the tertiary center for management. The most common reason for the delay was that they thought the children were “just naughty” not that they had any disorder (n = 42, 84%), followed by belief that “hyperactivity was part of normal growth” (n = 32, 64%) and that the children would improve with time (n = 28, 56%). Lack of awareness of treatment options and associated stigma also contributed significantly to the delay.

Conclusion: Parents’ helpseeking behavior is affected by different sociocultural beliefs. Such factors as the lack of recognition and awareness of ADHD, resulting in the delay in seeking treatment should be addressed through health promotion programs.

KEYWORDS: *1.EDUCATION 2.ATTENTION?DEFICITHYPERACTIVITY DISORDER 3.BEHAVIOURAL DISORDER 4.ADHD, CONNERS' PARENT RATING SCALE?REVISED (CPRS?R: S) 5.DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 6.INTERVENTIONS 7.HYPERACTIVITY 8.NORMALGROWTH 9.GENERAL MEDICAL PRACTITIONERS (GMP) 10.INATTENTIVE BEHAVIOUR.*

4. Malhi, P., et al. (2018).
Cognitive Development of Toddlers: Does Parental Stimulation Matter?*Indian Journal of Pediatrics, Vol. 85 (7): 498-503.*
G21234

Introduction: Recent studies have shown that adverse childhood factors have a cumulative impact and as risks accumulate, the likelihood of having one or more delay in development also increases exponentially. Identifying the environmental determinants of children's cognitive abilities remain crucial for remediating the increasing achievement gaps between children from disadvantaged and economically well-off families.

Objectives: To examine the impact of quality of early stimulation on cognitive functioning of toddlers living in a developing country.

Methodology: A total of 150 toddlers in the age range of 12-30 months were taken for the sample from Child Care Centres and Play Schools in North India. StimQ Questionnaire (toddler version) and Developmental Assessment Scales for Indian Infants (DASII).

Results: It was found out that mean MDI (Mental Development Index) score was 91.5 (SD = 13.41); about a fifth (17.3%) toddlers showed cognitive delay (CD, scores less than 80). Some toddlers were found to own any art materials such as coloring books (30%), chalkboards (27%), colorful clay (18%) and just half of them got access to crayons. To enhance their language skills, toy letters (28%), toy numbers (21%) and shape sorters (13%) were missing in majority of the homes. Limited access to manipulative toys as colorful plastic rings (28%), nesting toys (25%), blocks (14%), beads (11%), and wood puzzles (6%). Regardless of the overall scarceness of the learning materials available to toddlers, typically developing toddlers (TD, MDI scores>=80) were significantly more likely to have access to symbolic toys (P=0.004), art materials (P=0.032), adaptive / fine motor toys (P=0.018), and life size toys (P=0.036). Just half (50%) toddlers had children's books and even among homes with book ownership, less than two-thirds (61%) parents read out aloud stories to their children on a regular basis. Homes of TD children were that of 3.7 times more likely to own children's book as compared to children with CD ($\chi 2 = 15.07$, P = 0.0001). Parents of typically developing toddlers were more involved in their development and were significantly more likely. Despite the overall paucity of learning materials available to toddlers, typical developing toddlers were significantly more likely to have access to symbolic toys ($P = 0.004$), art materials ($P = 0.032$), adaptive/fine motor toys ($P = 0.018$), and life size toys ($P = 0.036$). Multivariate regression analysis results indicated that controlling for confounding socio-economic status variables, higher parental involvement in developmental activities (PIDA score) and higher parental verbal responsively (PVR score) emerged as significant predictors of higher MDI scores and explained 34 percent of variance in MDI scores ($F = 23.66$, $P = 0.001$).

Conclusion: The study has indicated that there are lot of disparities in the early child development and had shown that they are not linked to economic disparities. A need to develop evidence-based parenting interventions for primary prevention of developmental problems, especially in minimal resource based countries is highly needed.

KEYWORDS:*1.EDUCATION 2.EARLY CHILDHOOD CARE ANDEDUCATION 3.ECCE 4.EARLY STIMULATION 5.COGNITIVE FUNCTIONING 6.TODDLERS 7.PARENTAL VERBAL RESPONSIVELY (PVR SCORE) 8.PARENTAL INVOLVEMENT IN DEVELOPMENTAL ACTIVITIES (PIDA SCORE) 9.TYPICALLY DEVELOPING TODDLERS 10.DEVELOPMENTAL ASSESSMENT SCALES FOR INDIAN INFANTS (DASII).*

5. Vashist, A. (2018).
School Absenteeism during Menstruation Amongst Adolescent Girls in Delhi, India. *Journal of Family and Community Medicine. Vol. 25 (3): 164-168.*
G21235

Introduction: Girls' health and education form the cornerstone of development and the gateway to full participation as women in political, economic, and cultural life of a country. Poor menstrual hygiene management has been shown to result in a sense of shame, anxiety, and embarrassment that contributes to absenteeism and poor performance at school.

Objectives: To determine the percentage of girls absent from school during menstruation, to evaluate the various factors associated with school absenteeism during menstruation, and to assess the practices regarding menstrual hygiene.

Methodology:A mixed method research of combined cross-sectional study and qualitative research was conducted in six government schools of Delhi. The sample size was 600 adolescent girls.

Results: Out of a total of 600 girls,464 (77.3%) girls were between 12 and 14 years and104 (17.3%) were aged 14–16 years. Only 32 (5.3%) girls were aged 16–18 years. Most of the adolescent girls (63%)included in the study came from middleclass families, one third (34%) girls were from lower middleclass families and from upper middle class (3.3%). The number of girls that had attained menarche at age < 11 years were 2 (0.3%), at age11 were 25 (4.2%), aged 12 were 179 (29.8%), aged 13 were311 (51.8%), aged 14 years were 77 (12.8%), and aged 15were 6 (1%). Hence, the mean age at menarche of the study population was 13 years. The majority of students had some information on menstruation and the major source was from school in sessions (85%) followed by school teachers (18%).Out of 600 girls, 245 (40.8%) were absent from school during menstruation while 355 (59.2%) attended. Of the 245 students, 168 (68.6%)took 1 day off, 59 (24%) took 3–4 days off, and 18 (7.4%)took 5-7 days off. The reasons for being absent were diverse; 187 (76.3%) complained of pain (dysmenorrhea),78 (31.8%) had excessive bleeding, 69 (28%) were absent because they were anxious about getting their clothes soiled, 53 (21.6%) do not attend school because they were embarrassed, and 9 (3.7%) were barred from attending school during their periods by their parents. About a third(34.5%) of the students indicated that they were not affected by menstruation, most of the students (65.5%) were of the view that it affected their

daily activities in school. Some (12%) of the adolescent girls missed class tests or examinations during menstruation and more than half (58.5%) were unable to participate insports. Another half (49.6%) complained of lack of concentration and some (1.8%) could not answer questions in class, a few (5.6%) were unable to write on the board, and least (2.5%) avoided sitting in a group.

Conclusion: From the findings of the cross-sectional survey, FGD sand the attendance records, it was observed that nearly half of the surveyed adolescent schoolgirls reported that they had been absent during their menstrual period.

Keywords: *1.HEALTH 2.CHILD HEALTH 3.SCHOOL ABSENTEEISM 4.MENSTRUATION 5.ADOLESCENT GIRLS 6.LOWER MIDDLE?CLASS FAMILIES 7.EXCESSIVE BLEEDING 8.AGE-AT- MENARCHE 9.HEALTH EDUCATION.*

6. Srinivasulu, K., Rao. K.V.P, and Kumar, K. P. (2018).
Urine Analysis as a Screening Tool in Early Detection of Renal Abnormalities in Asymptomatic School Children.*World Journal of Nephrol Urology Vol. 7 (1): 17-24*
G21236

Introduction: Early identification of kidney diseases in children and adolescents is an important initial step in prevention of chronic kidney diseases (CKD).UTI is very common in children with severe consequences on the kidney function leading to chronic kidney disease (CKD) and hypertension if left untreated.

Objectives: To screen asymptomatic school children in Nellore, Andhra Pradesh, and to detect the prevalence of renal disorders using urine dipstick method and associated risk factors.

Methodology:A cross sectional observational study. In total 1,626 school student from rural and urban area of Nellore were enrolled. Multistage random sampling method was adopted for selection of schools of rural and urban Nellore district of Andhra Pradesh, India for a duration of 2 years.

Results: Out of total 1,626 children, 883 (54.3%) were male children and remaining 743 (45.7%) were female students. The male to female ratio was 1.19. Out of total, 889 (54.7%) were from urban area and remaining 737 (45.33%) were from rural area. During the first screening by urine dipstick method, 45 (2.8%) children were found to having urinary abnormalities which were further investigated by confirmatory complete urine analysis. Finally 37were diagnosed having urinary abnormalities. So the prevalence rate of renal abnormalities in asymptomatic children was found to be (2.28%). The prevalence rate of isolated hematuria (IH) was (0.62%); isolated proteinuria (IP) was (0.18%); combined hematuria and proteinuria (CHP) was (0.18%) and UTI was (1.23%). Out of 10 confirmed cases of hematuria, majority (60%) were diagnosed to be due to UTI. Renal stone was the cause in some (20%) cases while post-infectious glomerulonephritis (PIGN) and IgA nephropathy (IgAN) were the causes of hematuria in (10%) cases each. Out of three confirmed cases of proteinuria, two cases (66.7%) were diagnosed to be due to nephrotic syndrome and one was due to orthostatic proteinuria. Out of three cases of CHP, two (66.7%) cases were due to PIGN and one was due to membranoproliferativeglomerulonephritis(MPGN). Total 26 cases were confirmed having UTI. Out of these 26 cases, gram-negative bacilli were detected in 11 (42.31%) cases and gram-positive were detected in 5 (19.23%) cases. In two cases mixed growth was isolated. In remaining eight (30.77%) cases bacterial count < 105 was found. Biopsy was done in all three confirmed cases of CHP. Among the three cases biopsied two were found to have PIGN and one was MPGN. Out of 10 confirmed IH cases biopsy was done in two cases. One of the cases had persistent hematuria for more than 6 months and the other had mild renal dysfunction at confirmation of hematuria. The former

case was found to have IgA nephropathy and the other was PIGN. Out of 883 male students, 13 were having confirmed renal abnormalities indicating that the prevalence of renal problem in asymptomatic male student was (1.5%). Out of 743 female students, 24 were having confirmed renal abnormalities indicating that the prevalence of renal problem in asymptomatic female student was (3.23%). Out of 889 urban students, 19 were having confirmed renal abnormalities indicating that the prevalence of renal problem in asymptomatic urban student was (2.14%). Out of 737 rural students, 18 were having confirmed renal abnormalities indicating that the prevalence of renal problem in asymptomatic rural student was (2.44%). Prevalence of hematuria in male was (0.23), (1.08) in female, and the difference was statistically significant ($P < 0.05$) indicating that the prevalence of hematuria was significantly more in female asymptomatic students compared to male asymptomatic students. Age wise prevalence of hematuria ranged from (0.52%) in 6-7 years age group to (0.73%) in 8-9 years age group. The difference was not statistically significant ($P> 0.05$) indicating that the prevalence of hematuria was not associated with age of the students. Prevalence of hematuria in urban students was (0.67) and in rural students was (0.54), and the difference was not statistically significant ($P> 0.05$) indicating that the prevalence of hematuria was not associated with area of residence of the students. The prevalence of IP in male was (0.23) and (0.13) in female, and the difference was not statistically significant ($P> 0.05$) indicating that the prevalence.

Conclusion: Asymptomatic urinary abnormalities might be detected by urine screening program at school age. Urinary abnormalities including IH and UTIs were significantly higher among female students compared to male students. The urine dipstick is a simple, feasible and cost effective technique for early identification of urinary abnormalities in asymptomatic school children.

KEYWORDS: *1.HEALTH 2.CHILD HEALTH 3.CHRONIC KIDNEY DISEASES (CKD) 4.NEPHROTIC SYNDROME 5.PIGN AND IGAN 6.URINARY ABNORMALITIES 7.URINE ANALYSIS 8.RENAL STONE 9.ORTHOSTATIC PROTEINURIA.*

7. Bali, S., Singh, A.R. and Nayak, P.R. (2018).
Iodine Deficiency and Toxicity among School Children in Damoh District, Madhya Pradesh, India.*Indian Pediatrics, Vol. 55 (7): 579-581.*
G21247

Introduction: In order to control the iodine deficiency disorders (IDDs), National Iodine Deficiency Disorder Control Programme (NIDDCP) emphasizes five-yearly district level surveys for the estimation of the IDDs. The monitoring and evaluation of Iodine level in population is essential, not only to estimate the prevalence of IDDs but also the potential toxic effects of excess Iodine intake.

Objectives: To estimate the prevalence of Iodine Deficiency Disorders, and household consumption of adequately iodized salt in Damoh district, Madhya Pradesh in 2016.

Methodology: It was conducted at Damoh district of MP from May to June 2016 among school-going children aged 6-12years. Thirty schools were selected from Damoh district by cluster sampling technique, using the method of Probability proportionate to size sampling in each school.

Results:A total of 2700 primary school children (aged 6-12 years)were examined for Total Goiter Rate (TGR). The overall prevalence was found to be 2.08 percent with Grade I (1.67%) followed by Grade II (0.41%). It was found that about one-fourth (27.6%) households were consuming inadequately iodized salt. Out of 270 urine samples, median Urine Iodine Excretion (UIE) level was 175 µg/L, and a fourth (25.9%) children had insufficient UIE in their samples. The frequency of insufficient UIE was more in older children(age 10-12 years, 42.9%), children of Hindu religion (92.9%), Other Backward Classes (70%) and Schedule Castes (18.6%).All the households 150 (100%)interviewed were found to be using packed salt. Majority of families [117 (78%)] and shopkeepers [20(66.7%)] were aware about iodized salt.On the basis of UIE level, the proportion of children with mild, moderate and severe iodine deficiency were45 (17%), 23 (8%) and 2 (0.7%), respectively. Total 76(28%) children were found to be 'Adequate' in Iodine Nutrition. The proportion of children with more than adequate Iodine intake was 27 (10%), and 97 (36%) of children had toxic levels of iodine in urine.

Conclusion: Under the revised guidelines of NIDDCP, the district of Damoh had been categorized under fourteen endemic districts for goiter in Madhya Pradesh in the year 2006. However, the study reveals a major fact that the district is no more an endemic area for iodine deficiency. A continuous monitoring to assess IDDs as well Iodine-induced toxicity in future.

Keywords:*1.HEALTH 2.CHILD HEALTH 3.IODINE DEFICIENCY 4.IODINE DEFICIENCY DISORDERS (IDDS) 5.NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAMME (NIDDCP) 6.TOTAL GOITER RATE (TGR) 7.URINE IODINE EXCRETION (UIE) LEVEL 8.IODINENUTRITION.*

8. Sankar, H. V., Anjukrishna, K. and Riaz, I. (2018).
Thyroid Stimulating Hormone Level at Diagnosis as a Predictor of Persistent Subclinical Hypothyroidism in Children with Down Syndrome. *Indian Pediatrics,Vol. 55 (7): 576-578.*
G21248

Introduction: Children affected with the Down Syndrome have been witnessed to develop thyroid dysfunction. The prevalence of congenital overt hypothyroidism and subclinical hypothyroidism (SCH)in children with Down syndrome is higher than that in the general pediatric population.

Objectives: To evaluate subclinical hypothyroidism in a cohort of children with Downsyndrome and identify a TSH level at the time of diagnosis to predict persistent hypothyroidism.

Methodology:192 children (age <3 years) with Down syndrome, registered inthe Genetic Clinic of a referral tertiary care Hospital from 2010 to 2015 were evaluated. All cytogenetically proven childrenwith Down syndrome, diagnosed before 3 years of age.

Results: Of the 192 children with Down syndrome, 145 (75.5%)had normal TSH and 47 (24.5%) (27 males) had increased TSH. The initial diagnosis was made during infancy in 35 children, and mean (SD) age of initial diagnosis was 11.5 (4) months. Mean (SD) TSH value at the time of diagnosis was 13.2 (15.1) mU/L. The TSHlevel was 5-10 mU/L in 26 children, 10.1-20 mU/L in 17children and more than 20 mU/L in 4 children. A history of maternal hypothyroidism was present in 2 children. Among 47 hypothyroid children, 4 (8.5%) had ove rhypothyroidism and 43 (91.5%) had subclinical hypothyroidism. Mean (SD) TSH level in children with overt hypothyroidism was significantly higher than that in subclinical hypothyroidism [46.5 (41.0) vs. 10.5 (3.8)mU/L; P<0.001]. Out of34 cases with subclinical hypothyroidism, 25 (73.5%)were transient with normalization of TSH level. In 9(26.5%) children, TSH at 3 years was high suggestive of persistent hypothyroidism. TSH level at the time of diagnosis was significantly higher in persistent hypothyroidism group 25.1 (25.6)mU/L as compared to those with transient hypothyroidism 8.9 (1.8) mU/L (P=0.003). ROC curve suggested a TSH cut-off value of 11.6 mU/L to predict persistent hypothyroidism with a specificity of 92 percent and sensitivity of 77 percent.Only 1 out of 4 patients with overt hypothyroidism showed agenesis of the thyroid gland on ultrasound examination.

Conclusion:A subclinical hypothyroidism is more common in children with Down syndrome and majority of these were transient in nature. An elevated initial TSHlevel of more than 11.6 mU/L will help predict the future possibility of persistence of hypothyroidism.

Keywords:*1.HEALTH 2.CHILD HEALTH 3.DOWN SYNDROME 4.TSH 5.THYROID FUNCTION TESTS 6.HYPOTHYROIDISM 7.ANTI-THYROID PEROXIDASE (TPO) 8.ANTI-THYROGLOBULIN (TG).*

ICDS

9. Dandotiya, D., et. al. (2018).
A Study onUtilization and Satisfaction of ICDS Services in Aanganwadis of Urban Bhopal.*Indian Journal of Youth & Adolescent Health, Vol.5(1) : 30-33.*
G21216

Introduction: With an objectives of improving the nutritional and health status of beneficiaries ranging from preschool children, expectant and nursing mothers and women in the age group of 15–44 years and to reduce the prevalence of under-nutrition and related morbidities and mortalities the Integrated Child Development Scheme (ICDS) providing services through an Anganwadi Centre (AWC) was universalized during the 10th Five Year Plan to whole of India. Knowingly, the utilization of ICDS services depends on various factors like infrastructure, availability of resources and the client's satisfaction.

Objectives: To determine the extent of utilization of AWC services by beneficiaries of 40 anganwadis of Bhopal; to determine the satisfaction level of beneficiaries of 40 anganwadis of Bhopal; and to explore the reasons for non-satisfaction of beneficiaries.

Methodology: Across-sectional study done in 40 anganwadi centers of Bhopal city in a period of three months. The total sample size was 240 registered beneficiaries.

Results: Out of 240 beneficiaries, 35 (14.5%) were pregnant women, 40 (16.7%) were lactating females, 81 (33.8%) were mothers of children of age greater than 0–3 years, 49 (20.4%) were mothers of children aged 3–6 years, 32 (13.3%) were adolescent girls (10–19 years) and 03 (01.3%) were women of reproductive age. Extent of utilization of different services revealed that most of the beneficiaries i.e. 164 (99.4%) out of 165 used the immunization services, 201 (83.7%) utilized the services for supplementary nutrition, while 39 (16.2%) did not take that service, 210 (87.5%) attended the health education services. Most of the beneficiaries i.e.160 (96.9%) out of 165 beneficiaries came for health check-ups regularly, 121 (93.1%) came for preschool education and 170 (70.8%) beneficiaries took iron and folic acid regularly. Out of 240 beneficiaries, 166 (69.16%) were satisfied with the services while the rest 74 (30.84%) were not satisfied with the services. Out of the Unsatisfied beneficiaries, 5 (6.8%) were pregnant mothers, 8 (10.8%) were lactating mothers, 18 (24.3%) were mothers of children aged 0–3 years, 23 (31.1%) were mothers of children aged 3–6 years, 19 (25.7%) were adolescent girls and 1 (1.4%) was a woman of reproductive age group. Reasons given by the beneficiaries for non-satisfaction with anganwadi services were less space at the center 07 (9.4%), poor quality of food 39 (52%), irregular preschool education 05 (6.7%), unavailability of school services 01 (1.3%) and others like unavailability of medicines were given by 22 (29.7%).

Conclusion: The satisfaction and utilization of the ICDS was found in higher precedence in the urban Anganwadi centres of Bhopal. A constant effort to improve the quality of services is the need of the hour. The commendable efforts of the frontline workers need to be acknowledged and rewarded for their endeavours.

KEYWORDS: *1.ICDS 2.UTILIZATION OF ICDS 3.AANGANWADI 4.ANGANWADI SERVICES SCHEME 5.ASS 6.ANGANWADI CENTRES 7.AWC 8.AWW 9.AWH 10.ANGANWADI WORKERS 11.ANGANWADI HELPERS 12.PREGNANT MOTHERS 13.LACTATING MOTHERS 14.ECCE 15.ANGANWADI KARYAKARTI BIMA YOJANA 16.AKBY 17.BHOPAL.*

10. Dixit, P. et al. (2018).
Impact Evaluation of Integrated Child Development Services in Rural India: Propensity Score Matching Analysis. *SAGE Open, Apr-Jun, 2018: 1-7*
G21215

Introduction: Nearlyhalf of all under-5 child mortality in India is attributable tounder nutrition (UNICEF, 2017). According to National Family Health Survey 4 (NFHS-4), the prevalence of stunting, wasting, and underweight among under-3 children in India is 38 percent, 21percent, and 36percent, respectively (IIPS & Macro International, 2015-2016).

Objectives: To estimate the impact of Integrated Child Development Services (ICDS) on the institutional delivery and on the nutritional status of children in rural India.

Methodology:A two-stage sample design yielded a representative sample of 32,072 women in the age group of 15 to 49 years.

Results: The findings revealed that the balancing property for both institutional delivery and undernutrition, was satisfied at 1 percent significance level. For institutional delivery, before matching analysis, higher chance (7.7%) were found for those women who received any nutrition and health education ICDS during pregnancy to go for institutional delivery as compared with those who did not. After matching, the figure escalated dramatically (12.3%). This indicates a positive impact of the ICDS services on institutional delivery; not to control for the background variables, then we clearly underestimate its impact. In case of undernutrition, the unmatched sample estimate highlighted that children who received the benefits had higher chance of being stunted (1.4%), higher chances ofbeing underweight (6.7%), and higher chance of being wasted (4.5%) as compared with children who did not get the services. After matching, we see that those children who received the benefits had higher chance of being stunted (0.1%), higher chances of being underweight (5.3%), and chance of being wasted (4%) as compared with children who did not get the services. For male children, the unmatched sample estimate revealed that those children who received the benefits had higher chance of being stunted (3.2%), underweight (7.7%), and wasted (4.7%) as compared with children who did not get the services. After matching, those who received the benefits had higher chance of being stunted (1.6%), underweight (5.4%), and wasted (3.2%) as compared with children who did not get the services. Similarly, among female children, the unmatched sample estimate shows that those children who received the benefits had higher chance of being underweight (5.7%) and wasted(4.3%) as compared with children who did not get the services. However, the unmatched sample also revealed that children who did not receive ICDS services were higher chance of being stunted (0.3%).After matching, those who received the benefits had higher chance of being underweight (6%) and wasted (2.7%) as compared with children who did not get the services. In the case of

stunting after matching result shows that children who do not receive ICDS services had higher chance of being stunted (0.2%)compared with children who get the services. In the study, the pseudo R2 provided an estimation of the predictors and explains the probability of the outcome, either maternal outcome(institutional delivery) or child health outcomes (stunting, underweight, and wasting).In all the cases, this value decreases after matching. Also, after matching, the p value of the likelihood ratio test of all the predictors becomes insignificant.

Conclusion: The matching result estimate overestimate indicates that the ICDS services have a negative impact on overall children's nutritional status. Supplementary feeding should be more focused toward the most vulnerable group of children below 3 years of age. The program should also put emphasis onfamily-based feeding and caring behavior, improving childcare behavior and educating parents about improving child health and nutrition.

KEYWORDS: *1.ICDS 2.INSTITUTIONAL DELIVERY3.MALNUTRITION 4.MATERNAL AND CHILD HEALTH 5.PROPENSITY SCORE MATCHING 6.SELECTION BIAS 7.ASS, ANGANWADI SERVICES SCHEME 8.NFHS 9.UNICEF 10.CHILD MALNUTRITION 11.NUTRITION AND HEALTH EDUCATION 12.NHED 13.UNDERWEIGHT 14.WASTING 15.STUNTING 16.SUPPLEMENTARY FEEDING.*

11. Garg, C. C.et. al. (2018).
Costing of three Feeding Regimens for Home-Based Management of Children with Uncomplicated Severe Acute Malnutrition from a Randomised Trial in India.*BMJ Global Health Care Journal; Vol.3(2): 1-10.*
G21237

INTRODUCTION: To a major known fact, of late India has accounted for over half of the global burden of Severe Acute Malnutrition (SAM) in the world. While WHO recommended a facility-based management for all the children with SAM getting treatment in the hospital, to be fed on milk based diets (F75 followed by F100). However, most of these children are left out in this whole SAM management. Subsequently since 2007, WHO has recommended Ready-To-Use Therapeutic Food (RUTF) for home-based management of uncomplicated SAM.

OBJECTIVES: To find out the cost estimates of three feeding regimens for Home-Based Management of Children with uncomplicated Severely Acute Malnutrition.

METHODOLOGY: Costing of the906 children were enrolled in the age-group of 6-59 months with uncomplicated SAM. Three feeding regimens—centrally produced ready-to-use therapeutic food, locally produced ready-to-use therapeutic food, and augmented, energy-dense,home-prepared food—were provided in a community setting for children for a period of 33 months.

RESULTS: Forthe entire period of 33 months over which the research activity was conducted, 48634 children were covered and 371 children were treated, with 124 under each ofthe Centrally produced Ready-To-Use Therapeutic Food (RUTF-C) and Locally produced Ready-To-Use Therapeutic Food (RUTF-L) regimens, and under the Augmented, energy-dense, Home-Prepared Food (A-HPF regimen). For each activity, the costs of consumables were added to the human resources costs to determine the total costs per week per child for staff and consumables. It was found that the cost per week per covered child was lowest for RUTF-C (Rs. 2.1) and highest for A-HPF (Rs. 1.5) under the government programme. Under the research activity, during the first week A-HPF (Rs. 3.3) costs were higher than RUTF-L (Rs. 2.9) and RUTF-C (Rs. 2.1), as more time was spent on demonstration of recipes, providing the feed and setting up the system of milk and egg vouchers with local persons. During weeks2–16, the RUTF-L (Rs. 3.9) cost per week was higher under the research activity, as the cost of RUTF-L (Rs. 3.5) preparation was higher. Around US$66

(Rs. 4100) was spent during week 1 per treated child under research activity, and between US$9 (Rs. 550) and US$10 (Rs. 600)under the government programme.The total costs for covered and treated children were derived based on the average number of weeks that a given regimen was required for the treatment. These were estimated at 10.3, 9.6 and 11 weeks for RUTF-C,RUTF-L and A-HPF, respectively. An equal number of covered children (48 634/3) was assumed to be covered across the three regimens for administrative costs. The average costs per treated child per episode under research were estimated between US$227 and US$238 (Rs.14 063–14 775) for each of the three regimens. Out of the total costs per treated child, about 30 percent of the costs were for administration under research activity. For the government programme, the costs per treated child were between US$53 and US$61 (Rs. 3307–3797)for each of the three regimens, with administrative costs at about 20 percent of the total costs. The total costs for treating 371 children were estimated at US$85 876 (Rs. 5324 000) for research programme and US$20 892 (Rs. 1295000) for the government programme.

CONCLUSION: The study provides evidence that home-based management of SAM with an RUTF-L is feasible, acceptable, affordable and efficacious. The average costs per treated child in the government setting were estimated at US$56 (~3500 rupees), which can be considered very cost-effective in terms of the DALY saved and GNI per capita of the country.

KEYWORDS*:1.NUTRITION 2.CHILD NUTRITION 3.SAM 4.WEIGHT FOR HEIGHT 5.HOME BASED MANAGEMENT 6.UNCOMPLICATED SAM 7.CENTRALLY PRODUCED READY-TO-USE THERAPEUTIC FOOD (RUTF-C) 8.LOCALLY PRODUCED READY-TO-USE THERAPEUTIC FOOD (RUTF-L) 9.AUGMENTED, ENERGY-DENSE, HOME PREPARED FOOD (A-HPF) 10.GOVERNMENT PROGRAMME 11.HUMAN RESOURCES COSTS.*

12. Chaudhary, S.R. (2018).
Infant and Young Child Feeding Index and its association with nutritional status: A crosssectional study of urban slums of Ahmedabad. *Journal of Family and Community Medicine, Vol. 25 (2): 88– 94.*
G21238

Introduction: For the healthy growth and development of the child, the Infant and Young Child Feeding (IYCF) are imperative for the infants and young children. IYCF practices are multidimensional and change rapidly in short intervals in the 1st year of life, asking for simultaneous assessment of various feeding dimensions in children of 6 months and older.

Objectives: To assess IYCF practices for children aged 6–36 months in terms of ICFI and some sociodemographic factors and to find out their association with nutritional status.

Methodology:A community based crosssectional study. Two staged cluster sampling methodology was adopted listing 43 Anganwadi Centres. The mother and child pair was included in the study, with a total sample of 210.

Results: Of the 210 mothers, some (40%) were illiterate and most were homemakers (77%); a few were skilled workers (12.9%)and the rest labourers (10%). The mean age of the mothers at first birth was 21.96 + 1.04 years. Of the children, majority (52.4%) were males than females (47.6%) and the majority were full term at birth (92.8%). The largest proportion of children in birth order was second (42.4%)followed by first (31%), third (24.3%), and fourth (2.4%).According to modified Prasad's classification of socioeconomic class (SEC),the majority of the mother–child pair interviewed belonged to middle and lower SEC, namely, fourth (42.4%), third (27.1%), fifth (22.9%),and very few belonged to the higher SEC, namely, second (6.7%) and first (1%).Almost all of the children were breastfed at some point in life (98.1%). Of these, breastfeeding had been initiated within 1 hour in some (38.3%) cases, followed by within 24 hours (28.6%), and after 24 hours (33%). More than half children were given colostrum (54.8%) and pre-lacteal feeds (60.5%) respectively. Only a fifth (19.1%) of the children were breastfed for 2 years and beyond, some (35.6%) were breastfed for 6–12 months, another (30.4%) for12–23 months, a fourth (26.2%) of the children were found to have been bottlefed, while rest (14.3%)only up to 6 months or less. Meal frequency was adequate in majority (64.3%) of the children. Dietary diversity of >4 food groups was given to certain (15.7%) children. Nutritional status assessment of the children revealed that majority (65.2%) of the children were stunted (height forage, i.e., HAZ score < −2SD), another (43.3%) children were underweight (i.e., WAZ score < −2SD), and rest (11.9%) children were found wasted (weight for height, i.e., weightforheightscores [WHZ] < −2SD). The mean HAZ, WAZ, and WHZ scores of the study population were (−1.63 ± 0.48), (1.42 ± 0.49), and (−1.11 ± 0.32), respectively. The mean HAZ,WAZ, and WHZ scores for the children aged 6–9 months were (1.18 + 1.3), (−0.4 + 1.3), and (− 2.14 + 0.8), respectively; for

children aged 10–12 months were (− 0.21 + 1.7), (−1.4 + 2.0), and (−2.32 + 1.8), respectively, and for those aged 13–36 months were (− 0.48 + 1.4), (−1.8 + 1.1),and (−2.70 + 1.3), respectively. Assessment of nutritional status further revealed that a statistically significant higher proportion of wasted children had illiterate mothers as compared to mothers who were literate. Higher proportions of underweight children were male. Stunting was prevalent in all socioeconomic groups.

Conclusion: The present study attempted to measure IYCF practices in a single index by using ICFI and determine its association with the nutritional status. The study depicts a significant association of ICFI with WHZ, WAZ, and HAZ scores.

KEYWORDS:*1.NUTRITION 2.CHILD NUTRITION 3.IYCF 4.NUTRITIONAL STATUS 5.INFANT AND CHILD FEEDING INDEX 6.WAZ 7.WEIGHT FOR AGE Z?SCORE 8.HAZ 9.HEIGHT FOR AGE SCORES 10.WHZ=WEIGHTFORHEIGHT SCORES.*

B. Research Abstracts on Child Protection

HEALTH

13. Chatterjee, S. et. al. (2018).
Variation in Cost and Performance of Routine Immunisation Service Delivery in India.*BMJ Global Health Journal; May, 2018: 1-10.*
G21240

Introduction: Under the largest Immunization Programme of India, Universal Immunization Programme (UIP) it includes BCG, hepatitis B, OPV, DPT, measles, Haemophilusinfluenzae type B (HIB) containing Pentavalent (DPT + Hepatitis B + HIB), Inactivated Polio Vaccine (IPV), Japanese Encephalitis (JE in endemic districts) and tetanus toxoid (TT) vaccines. Rotavirus vaccine and pneumococcal vaccine has recently been introduced in some states also.

Objectives: To estimate the costs of these delivery mechanisms.

Methodology: Stratified Random Sampling was used to collect data in 7 states with a total sample consisting of 99 Sub Centres (SCs), 89 Primary Health Centres (PHCs), 44 Community Health Centres (CHCs) and 23 Post-Partum Units in 24 districts of India, viz. Bihar, Gujarat, Kerala, Meghalaya, Punjab, Uttar Pradesh and West Bengal.

Results: The target population and the number of vaccinated children less than 1 year of age varied widely across locations. While average target children per vaccinator at Kerala SC was 76, the same in Bihar Sub Centre (SC) was 279. The average DPT1to DPT3 dropout rate also varied widely across facilities: at SCs (3%–12%), at Public Health Centre PHCs (4%–17%) and at CHCs (3%–13%). Personnel costs represented the largest share of total immunization costs for all types of facilities in all states in the study except for Gujarat SCs and PP units, where vaccines and supplies had the largest share because of use of Pentavalentvaccine. Personnel costs increased from (30%–64%) SCs, (31%–75%) in PP units, (38%–77%) in CHCs,(49%–74%) PHCs, and. Next major cost components were vaccines and supplies (about 18%) and ASHA incentives (about 10%). Capital cost was insignificant compared with recurrent expenses for all types of facilities; however, cost components under capital cost had varied contribution across facilities. While cold chain equipment was a major cost component for PHCs and CHCs, building cost dominated in PP units because of semi-urban and urban locations. Unit costs were highest in Banaskantha district in Gujarat probably because of low immunization coverage rate (39%) in this district as per the data used for district stratification. Cost per target child in Meghalaya and Punjab were higher than the national average, cost per FIC (Fully Immunized Children) in Meghalaya was higher than the national average and cost per dose delivered in Gujarat was higher than the

national average. Total estimated cost of delivering routine immunisation services at the national level was US$737 million at 2017 prices.

Conclusion: This study of immunization costing represents one of the most comprehensive exercises done in India at the facility level. This study calculated the actual cost of delivering immunization services at both fixed and outreach sessions.

KEYWORDS: *1.HEALTH 2.VACCINATION 3.CHILD PROTECTION 4.PRIMARY HEALTH CENTRES (PHC) 5.COST PER DOSE 6.IMMUNIZATION COST 7.COMMUNITY HEALTH CENTRES (CHCS) 8.POST-PARTUM (PP) UNITS 9.DROPOUT RATES 10.COST COMPONENT 11.IMMUNIZATION COVERAGE 12.COST PER TARGET CHILD 13.SUB CENTRES (SCS) 14.FIC (FULLY IMMUNIZED CHILDREN) 15.OPV 16.DPT.*

14. Dutta, N. (2018).
Street Children in India: A Study on their Access to Health and Education**.** *International Journal of Child, Youth and Family Studies*, Vol.9(1): 69-82.
G21239

Introduction: Child rights form an integral part of human rights and therefore every child is entitled to civil, economic, social, and cultural rights. The kind of intervention required by working street children living with their parents is much different from the degree of intervention lone street children would need or desire. However, in contemporary times, interventionists have changed from a charitable to a rights-based approach, working with children rather than for them, thus giving prime importance to child participation.

Aims: The study also aimed to assess the role and the effectiveness of social work interventions (which are among the protective factors) in ensuring the rights of vulnerable children.

Methodology: Both quantitative and qualitative methods were employed in this exploratory study. Two categories of street children took part in the study: those who lived with or without their parents in either Kolkata or Mumbai (comprising a total of 80 participants), and those who lived in a night shelter in Mumbai (20 girls).

Findings: For most of the children and their parents, poverty (83%) was the major reason they were living on the streets. Another cited the search of occupation (6%) for their living on the streets. While for some desertion or separation of parents (5%) was the reason for their living on the streets. Only one respondent (1%) reported having become a street child following the demise of both parents. The study revealed that a majority of children, especially females, had no access to educational facilities in the pre-intervention period. The majority of the children (91%) were found to belong to a street family, staying under parental guidance. As a daily wage earners in the case of fathers and domestic workers in the case of mothers, these children also corresponded to other works as wage workers (1%), rag pickers (3%), domestic help (1%), and other works (4%) etc. The majority of children in this study faced physical abuse, mostly from parental beatings. Almost all of the children, irrespective of gender, said that they were afraid of their parents, because their parents beat them when they were being naughty. Almost a quarter of the

children (21%) aspired to become doctors, and other hoped to be teachers (18%). Some children (16%) had not decided on a career path, while other (12%) hoped to join the police force, and a few aspired to become pilots (5%). The remainder (28%) had an assortment of ambitions, with the boys aspiring to be army officials, engineers, or sportsmen such as football players and cricketers, while the girls aspired to become fashion designers, artists, and actors.

Conclusion: It is evident from the study that the hardships of life as a street child could take away the innocence of childhood and lead one to become mature beyond one's years. Poverty is seen to be the leading cause for their being on the streets. While most of the children lived under parental guidance, receiving some care and security, all nevertheless faced hardships and challenges every day. The study led to a holistic understanding of the socioeconomic profile of street children, underlining the areas of deprivation and the necessity to overcome them in order to promote a better future for these children.

KEYWORDS: *1.DESTITUTE 2.CHILD PROTECTION 3.STREET CHILDREN 4.CHILD RIGHTS 5.SOCIOECONOMIC CONDITIONS 6.PARENTAL GUIDANCE 7.CHILD LABOUR 8.ABJECT POVERTY 9.NATIONAL CHILD LABOUR PROGRAMME 10.PENCIL PORTAL 11.SOCIAL INTERVENTIONS 12.CHILDREN IN NEED OF CARE AND PROTECTION 13.JUVENILE JUSTICE ACT.*

C. Women and Gender Issues

HEALTH

15. Nandi, S. et. al. (2016)
Evaluation of the JananiShishuSurakshaKaryakram: Findings on Inequity in Access from Chhattisgarh, India. *BMJ Global Health Journal, July, 2016: 2-43p.*
G21241

INTRODUCTION: Chhattisgarh is one of the poorer states in India, having a large tribal population, with infant mortality rate of 48 and maternal mortality ratio of 230. The JananiShishuSurakshaKaryakram (JSSK) initiated in 2011 by the Government of India aims to provide free maternal and neonatal services in all public health institutions in order to encourage institutional deliveries, and thereby reduce infant and maternal mortality.

OBJECTIVES: To understand the functioning of JSSK in Chhattisgarh and to what extent it has been able to fulfil its objective in the state, specifically with respect to coverage of vulnerable groups.

METHODOLOGY: A mix of quantitative and qualitative research with a total of 511 women in selected villages of two tribal (Sarguja and Bastar) and one non-tribal district (Mahasamund).

RESULTS: Coverage of antenatal care services was quite high with most (84%) of the women having attended at least three antenatal care visits. However, the quality of antenatal care services was better in the non-tribal district compared to the two tribal districts. Most of the antenatal care visits occurred in public services, with higher proportions in the tribal districts. Institutional delivery was 72 percent. Half of women who delivered at home wanted to go for institutional delivery but could not do so due to several barriers. The proportion of institutional deliveries was lowest among the tribal (62%) and non-literate respondents (60%). Of the institutional deliveries, majority (85%) were conducted in public facilities with higher proportions (93% and 96%) in the tribal districts. Availability of free transport to the facility was found to be high for people who called for it while return transport was provided to 60 percent of women who delivered at a public facility. Free food was provided to 55 percent of women. Referral transport to a higher public facility was not ensured in all cases. Though most of the facilities surveyed are undertaking deliveries, huge gaps were identified in preparedness for dealing with both basic deliveries and emergencies. These gaps include non-availability of essential medicines and/or blood bank/storage facility in most of the community health centres. None of the community health centres surveyed had a gynecologistnor adequate facilities for C-section. Out-of-pocket expenditure was incurred by most of women (98%)

who went to a private facility and by 56 percent of women going to a public facility. In private facilities, median out-of-pocket expenditure (INR 6,400) was ten times higher than in public facilities (INR 640). Even though half of the women had insurance cards under RashtriyaSwasthyaBimaYojana or MukhyamantriSwasthyaBimaYojana, only 16 women made use of these schemes. Out of these 16 women, 12 still incurred out-of-pocket expenditure.

CONCLUSION: The public health system has to an extent been made more accessible to the community, including vulnerable groups, for delivery services in Chhattisgarh. However, gaps still remain, especially with respect to quality of services, out-of-pocket expenditures and functionality of RashtriyaSwasthyaBimaYojana and MukhyamantriSwasthyaBimaYojana.

KEYWORDS: *1.HEALTH 2.WOMEN HEALTH 3.JANANI SHISHU SURAKSHA KARYAKRAM (JSSK) 4.MATERNAL MORTALITY RATIO 5.INFANT MORTALITY RATE 6.NEONATAL SERVICES 7.PUBLIC HEALTH INSTITUTIONS 8.ANTENATAL CARE 9.INSTITUTIONAL DELIVERIES 10.INSURANCE CARDS 11.RASHTRIYA SWASTHYA BIMA YOJANA 12.MUKHYAMANTRI SWASTHYA BIMA YOJANA 13.OUT-OF-POCKET EXPENDITURE 14.COMMUNITY HEALTH CENTRES.*

16. Caruso, B.A., et.al. (2017).

Understanding and Defining Sanitation Insecurity: Women's Gendered Experiences of Urination, Defecation and Menstruation in Rural Odisha, India.

G21242

Introduction: Globally, approximately 2.3 billion people lack access to basic sanitation, unshared household facilities that hygienically separate human excreta from human contact. The trial evaluated the impact of a rural sanitation intervention within the context of India's Total Sanitation Campaign. Research that further elucidates women's sanitation experiences and needs may help explain sanitation behaviour and reveal additional health impacts.

Objectives: To document the full range of voiced urination, defecation and menstruation concerns of women in rural Odisha, India, and to use findings to (2) develop a definition and (3)conceptual model of sanitation insecurity that shows the factors that contribute to sanitation insecurity and the impacts it may have on behaviour and health.

Methodology: Cluster randomised trial. The trial evaluated the impact of a rural sanitationintervention within the context of India's Total Sanitation Campaign.

Results: Sixty-nine women aged 18–75 years (16 UMW, 12 RMW,22 MW,19 OW) participated in interviews and 46 women aged 18–70 years participated in 8 FGDs (5–7 participants each; 23 unmarried and 23 married women).For interview participants, all (100%) were Hindu, a fourth (26%) had at least some primary education, two-third (66%) were general caste, followed by (62%) had children and partial (54%) had a toilet within their household compound. For FGD participants, most (98%) were Hindus, some (28%) had at least some primary education, mostly (65%) were general caste, partial (50%) had children and others (59%) had a toilet within their household compound. No recently married women participated in FGDs; family members did not give them permission. Nearly all women in interviews indicated concerns abouturination (91%), defecation (94%) and menstruation(97%). Three-quarters of women worried about where they urinated. While most participants who owned toilets reported having used them to defecate (FLI: 95%; FGD:100%), far fewer participants reported ever having used them to urinate (FLI: 14%; FGD 41%). Women considered toilets unfit for urination.

Conclusion: This research revealed that women at different life stages in rural Odisha, India have a multitude of unaddressed urination,defecation and menstruation concerns, and informed a definition and conceptual model for sanitation insecurity.

KEYWORDS: *1.HEALTH 2.WOMEN HEALTH 3.RURAL WOMEN4.SANITATION AND HYGIENE 5.OPEN DEFECATION 6.TOTAL SANITATION CAMPAIGN 7.RURAL SANITATION INTERVENTION 8.URINATION AND MENSTRUATION 9.WASTE MANAGEMENT 10.WASH (WATER, SANITATION AND HYGIENE) SECTOR 11.SANITATION INSECURITY.*

17. Shaikh, M. (2018).

Sex Differences in Utilisation of Hospital Care in a State-Sponsored Health Insurance Programme Providing Access to Free Services in South India.*BMJ Global Health Journal; Jun, 2018: 1-7*
G21243

Introduction: Universal Health Care (UHC) coverage provides healthcare and financial protection to all citizens and also helps to facilitate gender equity in care.UHC is included in the United Nations Sustainable Development Goals, to be achieved by 2030, and is expected to provide full coverage of essential health services to everyone, and to lay the foundation for making progress towards several other Sustainable Development Goals, including ending poverty and improving gender equality. Women are the majority of the world's poor andmight be major beneficiaries from UHC.

Objectives: To assess the utilisation of hospital care services among women and men in a large underprivileged population with access to free hospital care in India.

Methodology: Data were used from the RACHIS for hospitalizations between 2008 and 2012. The largest state-funded health insurance scheme in India, provides access to hospital care for households with an annual income below INR 60,000.

Results: Between 2008 and 2012, a total of 961,442 individuals (43% women) accessed hospital care under the RACHIS, accounting for 1 223 723 hospitalizations (48% by women), 7.7 million bed-days (47% by women) and a hospital expenditure of US$579.3 million (42% by women). The five leading causes of hospital care utilization for women were genitourinary diseases (i.e., diseases of the reproductive organs and the urinary system) (18%),neoplasms (i.e., benign (not cancer) or malignant (cancer)tumours) (16%), injuries (14%), digestive diseases (12%)and circulatory diseases (10%). However, neoplasms accounted for the largest number of hospitalizations (38%) and bed-daysused (38%), with the highest hospital expenditures for both neoplasms (20%) and circulatory diseases (20%).By comparison, the five leading causes of hospital careutilization by men were injuries (22%), circulatory diseases (16%), genitourinary diseases (16%), digestive diseases (12%) and musculoskeletal conditions (12%). Injuries were also the leading cause of hospitalizations (20%) and bed-days(25%), but the highest hospital costs were associated with circulatory diseases (29%). Sex-specific conditions accounted for 27 percent of hospitalizations,12 percent of bed-days and 15 percent of hospital expenditure in women. Chemotherapy for breast cancer(9%), cervical cancer (6%), ovarian cancer (2%) and hysterectomy (5%) were the most frequent sex-specific indications for hospitalization in women. The five leading causes of hospital care utilization for women for sex-neutral conditions were injuries (16%),neoplasms (14%), digestive diseases (14%), circulatory diseases (12%) and diseases of the genitourinary system(9%). However, neoplasms accounted for the largest

number of hospitalizations (25%) and bed-days used (38%), with circulatory diseases (20%) accounting for the highest hospital costs (23%). Women had a lower share of hospitalization events(42%), bed-days (44%) and hospital costs (39%) than men. In particular, less than athird of hospitalizations, bed-days and hospital costs for injuries, circulatory diseases and genitourinary diseases were for care provided to women. In contrast, about(55%–60%) of care for neoplasms was for women and over(80%) of the care for endocrine-related disorders was for women, largely driven by care related to thyroid disorders.The women-to-men ratio of sex-neutral hospitalizations,bed-days and hospital costs was below unity across all age groups, except for bed-day utilization in those aged 40–50 years, which may be explained by hospitalizations for neoplasms in women.

Conclusion: Women had a greater share of hospital care for sex-specific conditions than men. The study suggests that equal health coverage alone does not necessarily ensure equal access to essential health services. Unless explicit attention is given to women and their barriers to accessing healthcare, movement towards UHC alone may be insufficient to achieve gender equity in healthcare.

KEYWORDS: *1.HEALTH 2.WOMEN HEALTH 3.UNIVERSAL HEALTH CARE 4.UHC 5.GENDER EQUITY 6.FREEHOSPITAL CARE 7.SEX-SPECIFIC CONDITION 8.SEX-NEUTRAL CONDITION 9.EQUAL ACCESS 10.ESSENTIAL HEALTH SERVICES 11.NEOPLASMS*

NUTRITION

18. Momspresso and Medella. (2018).
Breastfeeding Challenges of Indian Moms.
Source: https://s3.amazonaws.com/mycity4kids-image/survey-results/Breastfeeding+Challenges+of+Indian+Moms+-+Momspresso+and+Medela+Survey.pdf
G21244

Introduction: Indian culture views that Indian mothers had been into breastfeeding and there are least chances of any support services for these mothers, particularly the ones experiencing motherhood for the very first time. Moreover, the working mothers are facing far more challenges and health concerns too.

Objectives: To understand the common issues and coping techniques with challenges related to their immediate environment - at home, at work, in public and so on; Glean insights in to what issues they face - medical or behavioural, and importantly, what support they received while breastfeeding; Start a conversation leading to action on how to make the breastfeeding journey easier for mothers.

Methodology: Online survey amongst 510 Mothers in Metro and Non-metro cities in the age groups of 25 – 45 years.

Results: The findings highlighted the respondents profile with majority (69%) of the women in 25-35 years age-group, followed by 36-45 years (26%).Most of the women were homemakers (40%) while a fourth (25%) were full time employees, and another (16%) were freelancer. These mothers belong to city of Delhi (31%), Mumbai (15%), Bangalore (11%), and equally participated from Pune, Hyderabad and Kolkata (5% each), respectively. Some other non-metro cities accumulated to a decent share (26%) while least participated from Chennai (3%). Majority of the mothers (74%) agreed on fully breastfeeding their children, while rest (26%) had partially breastfed. Out of the total, three-fifth (60%) mothers had only a single child (38%) had two children and a few (2%) had three children. On their experience about breastfeeding, majority (73%) of mothers opined that breastfeeding was a challenging experience, In contrast to this, however some (8%) strongly disagreed on this assertion. Almost two-fifth (42%) mothers had breastfed their kids for up to 2 years or more and 68 percent had exclusively breastfed for the first 6 months. According to most (98.6%) health benefits for the baby, while three-fourth (73.4%) opined to form a close bond with a baby were the main reasons to breastfeed the baby. More than half (57.5%) cited their own health benefits to the main reason to breastfeed, while for a two-fifth (39.7%) breastfeeding helps in post pregnancy weight loss. Majority of mothers rated sore and cracked nipples (22.3%) and feeding the baby while in NICU accounted (21.7%) as the top 2 medical challenges while

Engorged Breasts (20.7%) was considered another bigger challenge. Almost 38 percent mothers found the initial days after birth, in hospital to be the most challenging time of their breastfeeding journey. A third of working mothers (33%) found lack of nursing facilities to feed or express milk the biggest challenge in their workplace. For some (34.7%) sore and cracked nipples, latching problem, engorged breasts were some of the early days challenges. Waking up in the middle of the night and feeling exhausted were another major breastfeeding challenges (31.6%). According to some (17.8%) lack of proper feeding place in public was challenging. And another (17.4%) found post-partum depression as a major breastfeeding challenge. Further, 64 percent mothers received this support during their breastfeeding journey.

Conclusion: The journey from pre-partum to post-partum has been very challenging for any woman. To neglect the support and guidance required during pregnancy and after delivery makes the situation all the more complicated. Therefore awareness and proper guidance along with a broad societal approach is the need of the hour.

***KEYWORDS**: 1.NUTRITION 2.WOMEN NUTRITION 3.IYCF 4.BREASTFEEDING 5.POSTPARTUM DEPRESSION 6.ENGORGED BREASTS 7.BREASTFEEDING JOURNEY 8.NURSING FACILITY 9.LATCHING PROBLEM 10.EXCLUSIVE BREASTFEEDING 11.NICU.*

19. Sarthak and NCW (~2017)
Socio-Economic Status of Women of Denotified& Nomadic Communities in Delhi. 130p.
G21246

Introduction:A nomad is a person with no settled home, who moves from place to place as a way of obtaining food, finding pasture for livestock, or otherwise making a living. The denotified& nomadic communities are the most neglected and marginalized sections of Indian society. They are victims of stigma, social neglect and exploitation for centuries. Even after so many decades of Independence, they lack even the most basic amenities of life. Women among them suffer the most. Their literacy rate is very low. Most of them don't have access to health care facilities. They suffer from a number of atrocities not only by people of other communities but within their own families.

Objectives: To develop deep insight into the socio-economic factors responsible for the problem of women of Denotified& Nomadic Communities in Delhi; to assesses their socio-economic status and evolving new scopes and challenges; to appraise the effectiveness of various government schemes and interventions targeting the prevention of various atrocities and their rehabilitation; to evaluate coordination among various government agencies dealing with their problems; to assess the role of voluntary organizations working at grass root level and engaged in creating awareness, providing counseling and rehabilitative services; and; to give suggestions and recommendations to the govt. about new methods and approaches to tackle their problems.

Methodology: An exploratory – cum – descriptive design. The sample size of the study was 1600 women respondents between the age group of 18 to 65. 200 respondents from 8 denotified and nomadic communities as Qalandar, GadiaLohar, Sapera, Nat, Bhat, Sanshi, RaiSikh and Kanjar were covered.

Results: Most of the respondents were in the age-group of 26 – 45 years (47%) and least in the age-group above 75 years (4.7%). Of the communities surveyed, Qalanders, KanjarsandNats lived in slums. Sansis on the other hand live in Resettlement Colonies. RaiSikhs reside in the village at the outskirts of the city. GadiaLohars, who refuse to bea part of the slum and want to maintain their distinct cultural identity have their settlements in open space alongside the roads. Toilet facilities for the respondents was found to be amongst some (18%) households at home. 28 percent households use public toilets while maximum (54%) had no choice but to defecate in open. It was revealed that majority (62%) of the respondents were illiterate. Only 13 percent had educated upto the level of primary school. The percentage of girls in the category of graduate or above was found to be as low as5 percent. Low age at marriage was a major health concern for girls and women. It was found to be lowest among Qalandar community (average = 16 years) who belong to Muslims by religion.The

involvement of the Women in Income Generating Activities revealed that the majority of the respondents (38%) were working as house maids, then begging (34%), and the least were running small shops (9%) or were performing as folk artists (8%). Majority (73%) of the respondents registered their preference for boys for childbirth, while a few (9%) had no gender preference. The survey found that the respondents had several complaints against domestic violence as facing verbal abuse (85%), followed by beating, physical violence(56%), mental torture (45%), and denial of basic needs (36%). Cases of Sexual Harassment were registered with most cases of eve teasing (85%), followed by molestation (42%), stalking (32%), rape (10%). It was evident that majority cases (81%)of sexual harassment were not reported. The majority of the respondents did not reported, and kept mum (81%), while some reported to other family members (11%), others reported to cast panchayats(5%) and a few approached Police (3%).

Conclusion: They undertake the maximum burden of the household. They go long distance to collect water and firewood. The health departments of state governments should launch mobile health care units for providing pre and post natal care for pregnant women of nomadic communities and Special Residential Schools should be setup to provide free and quality education to girls of these communities. Awareness campaigns in order to protect these women and girls against sexual abuse and trafficking in the name of tradition can also be carried out.

KEYWORDS: *1.SOCIAL WELFARE 2.WOMEN SOCIAL WELFARE3.WOMEN PROTECTION 4.NOMADIC COMMUNITIES 5.SEXUAL HARASSMENT 6.DOMESTIC VIOLENCE 7.GENDER PREFERENCE AT BIRTH 8.MOLESTATION 9.EVE TEASING 10.OPEN DEFECATION 11.MATERNAL MORTALITY.*

WOMEN WELFARE

20. India, Ministry of Women and Child Development. (~2016).
Property Rights of Women in Tamil Nadu.
G21245

Introduction: The inheritance system in Indian society has been to preserve property, especially land property. Women's right to property has been recognized as an important development issue. Property rights for women can have an impact on decision making, income pooling, acquisition, and women's overall role and position in the community.

Objectives:1.To study the property rights of women in Tamil Nadu.
2. To highlight the discrimination of property rights of women belonging to various religious groups in Tamil Nadu.
3. To interview the Government Officials in the various districts of Tamil Nadu.
i. To find out the measures taken by them to eradicate the discrimination against women and its implementation process.
ii. To know the institutional mechanism which monitors and evaluates the implementation of laws related to inheritance of property of women.
4. To interview Lawyers in order to know their opinion on the laws related to the property rights of women.
5. To find the awareness of general Public Women with regard to the legislations on property rights of women in the selected districts chosen for the study.
6. To interact with the Tribal Women of the Nilgiris district of Tamil Nadu in order tofind out their awareness on the legal status of Tribal women.
7. To identify the types of barriers related to women's economic and property rights in relations to National and Regional policies and laws.
8. To identify issues for advocacy towards the promotion of community-based grassroot level efforts for women's property right entitlement.
9. To suggest for amendments of Acts wherever necessary to eradicate gender bias in the inheritance of property rights by women.
10. To provide recommendations for effective policy formulations and implementation in order to bring gender equality.

Methodology:A stratified sampling and simple random samplings were used in two districts from each region of north, south, east, west were selected. Government Officials, Lawyers, general women and Tribal women were the sample groups.

Results: About 53 percent of the lawyers were females and rest male lawyers. Majority (55%) of the lawyers specialized in civil law andathird(35%) took both civil and criminal law as their specialization. Almost all the lawyers (91%) have attended on cases related to property disputes and all of them agree that

women do approach them for cases regarding property matters. It was found that majority (86%) of the women were discriminated with regard to property rights and half (50%) of the lawyers agreed that women were discriminated by Parents, Male siblings, Husband and Sons. About 45 percent of them felt that the majority of discrimination was between married and unmarried daughters and some (17%) of them opined that the discrimination was between daughter and wife in the same family. Lawyers were of the opinion that women were not fully aware of their property rights and 46 percent of them believed that there needs to be a revision in the Property Rights Act. Majority (55%) of the lawyers felt that women were discriminated indirectly while some (40%) of them felt that the discrimination was donedirectly. Nearly half (53%) of the lawyers opined that Muslim religion discriminates women in the rights to property and a third (34%) of them felt that Hindureligion discriminated women. About 21 percent of the Lawyers felt that all the religions discriminated against women. A small percentage of the respondents felt that Christianity discriminated women and 10 percent of them said that Tribal women were alsodiscriminated.27 percent of the respondents felt that there were no laws to check with regard to religious groups, 18 percent felt that there was no law to check on discrimination against disabled indigenous women. About 36 percent of them had no sufficient information on laws for Minorities. About 23 percent of the respondents favoured laws regarding Migrant women and girls. Most of the women (93.8%) reported that their parents had given gifts and dowry as promised at the time of marriage. Majority of lawyers (65%) opined that there were no legal provisions to protect women and men equally on division of property in the event of Divorce. About 78 percent of the women said that their property was earned by their husbands.About23 percent of the respondents felt that Tribal women approached the Courts to solve their property disputes and were successful in getting justice. About 69 percent of the Lawyers felt that the Modern land laws conflict with traditional and religious land laws and 66 percent of them felt thatthe cultural norms and practices, exclude women in land allocation. Nearly a third (34%) of lawyers expressed that the existing laws, policiesand measures adopted are not adequate to ensure equitable distribution of land withemphasis on the gender equality. Almost all the Lawyers suggest that women need tobe made aware on women rights to property by Public Awareness Program (57%),educating the women (63%), through Media Advertisements (39%) and NGO's and Women's Groups (24%). Most of lawyers (72%) expressed that the existing women's Acts adequately protect the women's rights and if men were sensitized to women rights to property it may reduce discrimination against women. It was surprising to know that almost all the women (96%) disagree with the marriageable age fixed for girls. Most of them suggested that the marriageable age should be increased from 21-25 for girls and for boys 24-28 years of age. Almost 89 percent of the tribal women do not practice Polyandry/Polygamy. About 88 percent of the tribal women had ancestral property.

All of them inherited property from their fathers. Only 33 percent of the women possessed Assets, and 66 percent of them said it was earned by their husband.

Around 40 percent of women were aware of the Self Help Groups (SHGs) in their area and only 25 percent of them involved themselves in the SHGs.

Conclusion: The Lawyers expressed that the Hindu Succession Act Tamil Nadu Amendment,1989 and the Prevention of Domestic Violence Act, 2005 is more effective. A majority of women who had their right over their earnings stated quite emphatically that their spending was oriented towards family welfare. A similar gender positive approach was displayed by tribal women too, with regard to their understanding of married women, career and family life.

KEYWORDS: *1.WOMEN WELFARE 2.PROPERTY RIGHTS 3.HINDU SUCCESSION ACT 4.DOMESTIC VIOLENCE 5.FAMILY WELFARE 6.POLYGAMY 7.CHILD MARRIAGE 8.SELF HELP GROUPS (SHGS) 9.TRIBAL WOMAN.*

21. Haryali Centre for Rural Development. (2017).
An Evaluation of Working Women's Hostels that Received Grant-in-Aid Under the Scheme to Provide Safe and Affordable Accommodation to Working Women. 176p.
G21136

Introduction: In order to empower and sustain the capacity of a working women, the Government of India launched a Working Women's Hostel Scheme in 1972- 73. The major concern of the scheme was to enable a safe and suitably located accommodation for these working women, whether they work in an urban or semi-urban setting or in a rural area of their employment. These hostels also have the provision of daycare facility for their children.

Objectives: The study has the following objectives:

1. To identify the key achievements, short comings in the implementation of the scheme and suggest corrective measures to make the scheme more effective.
2. To assess the specific requirements of Hostels in Metropolitan cities and understand views of implementing agencies for improving the functioning of the Hostels.
3. To assess the capability and effectiveness of the organizations receiving grant-in-Aid from the Ministry and compare the functioning of the hostels run by the different organizations such as State Government/NGOs/other organizations.
4. To understand the housing needs of working women**,** reasons for staying in the hostel**,** satisfaction with hostel facilities and suggested improvements.
5. To study the socio-economic profile of beneficiaries such as age, education, employability, Salary, family background.

Methodology: Total 2223 respondents from 126 hostels across 11 cities all over the country were covered in this evaluation study.

Results: It was found that 68 hostels were fully functional while 14 hostels were not functional. 44 hostels were not found existing on the ground due to some specific reasons as non-availability of grant-in-aid funds, or duplication in the list. Of the 68 functional hostels, 86 percent hostels were healthy as these implementing agency was a Civil society organization (including Trust) met the prescribed conditions with a proven track record of working in the fields of women's welfare, sound financial position and Day-care Centre for pre-school children on a no- profit basis. Of the 68 functional hostels covered under the study, 20 (29%) were established in the decade from 1986-95,18 hostels were established between 1976-86.Another (20%) hostels were established from the inception of the scheme to 1976.Thus majority (82%) of the hostels were constructed between mid 1970's to mid 1990's.Only 12 hostels have been constructed in the last two decades. Three-fourth (76%) of the sanctioned grant-in-aid from the MoWCD was received in 68 fully functional hostels across India. Two- fifth (41%) faced no problem in receiving timely installments of the grants

from the Ministry. One-fourth (26%) of the 68 fully functional hostels were constructed with the sole support of the MoWCD. One-fifth (21%) of the hostels have also received funds for the construction from sources other than the MoWCD.About three-fourth (74%) of the hostel buildings have been constructed by the implementing agencies with MoWCD support exclusively for the purposes of the working women's hostels scheme. Only 1 percent of the hostels are working out of government buildings, namely one hostel in Bhopal, one in Lucknow and one in Bangalore. About a fourth (25%) of the hostels had 2 floors, some (10%)working women's hostels had a single floor and (9%) hostels had 4 floors. An exception was Mumbai where 15 working women's hostels (85%) had a large number of floors. The Working Women's Hostels in some cities like Chennai (156%), Bhopal (147%), Mumbai (117%) and Hyderabad (108%) occupancy exceeded sanctioned capacity leading to the problem of overcrowding. While hostels in cities like Surat (52%) and Lucknow (58%) were underutilized. The working women comprised majority (75%) of the occupants while rest (25%) were students. Field survey revealed that only (32%) of the hostels had the provision for reservation for differently abled women.

Majority (66%) of the working women's hostels have double beds. Most (85%) of hostels were equipped with a table, chairs (87%) and storage space (91%) such as almirah. Majority (90%) of the hostels had kitchens where food was cooked for the residents. Most of the respondents (91%) of the sample functional hostels had water coolers or filters installed. Almost all the hostels (97%) had a functioning Hostel Management Committees. Out of the total hostels, day-care centre facility was available in merely two hostels only. Majority (64%) of the respondents stated they chose to stay in working women's hostels on account of the services provided.

Recommendations: Stringent monitoring by the hostel management committee to ensure provision f reservation and facilities for the differently abled. In and Out Entry register to be maintained.In addition to maintenance there is a need to upgrade facilities such as kitchen equipment's, laundry machines.

KEYWORDS: *1.WOMEN WELFARE 2.EVALUATION OF WORKING WOMEN 3.WORKING WOMEN 4.WORKING WOMEN HOSTEL(WWH) 5.MWCD 6.DAY CARE CENTRE 7.IMPLEMENTING AGENCIES 8.WWH SCHEME 9.PRE-SCHOOL CHILDREN 10.DIFFERENTLY ABLED WOMEN.*

Acknowledgement

Guidance and Support	:	M.A. Imam Director
		Dr.P. Krishnamoorthy Additional Director
Project Incharge/s	:	Smt. Vandana Thapar Joint Director
		Smt. Vandana Sharma AssistantDirector
Abstracting	:	Ms. Astha Chandra ProjectAssistant
Computer Support	:	Pawan Kumar