Chennai Kids to Reach for the Stars at NASA

Express News Service

Chennai: A batch of 750 students from four schools in the city are set to leave for the United States and Canada on a study-cum-pleasure tour for a fortnight from May 1 on what's already being lauded as a once in a lifetime opportunity as the kids are going to NASA, Orlando, to see what they have learnt and learn what they will see.

A ceremonial flagging-off function for this space camp was held at Hotel Accord Metropolitan in T Nagar on Sunday.

The energy and enthusiasm of the students from Chettinad Vidhyashram reverberated around the hall. The other schools are M K M Matriculation Higher Secondary School, Porur, Velammal school and Montford school.

750 KIDS WILL LEARN ROBOTICS, HEALTH SCIENCES AND PARTICIPATE IN A WORKSHOP

In her welcome address, Shrimathy Kesan, Director of Space Kids Agency Services, said that the children will learn robotics, health sciences and participate in a workshop in Canada. Last year the camp had only 650 children but this year they have increased the strength by 100.

Diplomats Jennifer McIntyre, US Consulate General, and Marie-Claude Mallet, Vice-Consul and Senior Trade Commissioner of Canadian Consulate, were present. But the star of the day was former NASA astronaut Marsha Ivins who spoke about her time in space and the thrills of lifting a $1.4 billion space lab with robotic arms.

McIntyre said the camp would not only give them an opportunity to learn about our universe but also help them develop problem-solving skills and use team work to overcome challenges.

New Indian Express, April 30, 14

Free insulin shots for children

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NEW DELHI: Diabetic children from poor families in the city will be provided free insulin injections under an initiative by the Delhi Diabetic Forum (DDF).

DDF, established more than 20 years ago to detect and educate people about the disease and conduct research, has formed a separate unit to organise programmes for children with Type I diabetes wherein pancreas stops producing insulin.

A committee of seven doctors and members of the forum will invite references of children from economically weaker sections who need insulin daily.

"Under this one-year DDF programme, free insulin will be provided to poor and needy children at their doorsteps. Special educational camps will be organised on a quarterly basis to educate the kids and their parents," said Dr SK Wangnoo, senior consultant, department of endocrinology, Apollo Hospital, and also a member of the diabetic forum.

"Type I diabetes is a chronic disease associated with insulin deficiency. Children with the type of diabetes need insulin for survival as their pancreas does not produce the hormone," he explained.

Type I, also known as juvenile diabetes, generally afflicts children at a young age and to survive the patient needs doses of insulin.

There are more than a million juvenile diabetics in India. Every year, 27,000 diabetic children (two to 14 years of age) around the world die of the disease, out of which more than 12,000 are from India.

"There is no count of how many die undiagnosed. Among those who are diagnosed with juvenile diabetes, 70% come from poor families," said Dr Ashok Damir, vice-president, DDF.

Hindustan times, April 2, P.7

बच्चों में बढ़ रही है ऑर्थराइटिस की समस्या

ज्ञानप्रकाश/एसएनबी

नई दिल्ली। बच्चों में आर्थराइटिस की समस्या तेजी से बढ़ रही है। एम्स व सफदरजंग अस्पताल के अस्थि रोग विभाग के वैज्ञानिकों की देखरेख में 1 से 12 वर्ष के बच्चों पर किए गए एक अध्ययन में पता चला है कि 30 फीसद बच्चे आर्थराइटिस की गिरफ्त में हैं। इनमें से 20 फीसद बच्चे ऐसे हैं, जिनका जन्म दिल्ली में हुआ है, जबकि बाकी के 10 फीसद बच्चे दूसरे राज्यों के ग्रामीण इलाकों के हैं। अध्ययन की शुरुआत वर्ष 2009 में हुई थी। अब तक इस आयु वर्ग के 11, 230 बच्चों की स्क्रीनिंग की जा चुकी है।

सफदरजंग अस्पताल के इंडियन इंस्टीट्यूट ऑफ आर्थोपैडिक सेंटर के निदेशक डा. दीपक चौधरी ने कहा कि आज के दौर में बहुत सी बीमारियां ऐसी हैं, जो बच्चों को उनके बचपन से दूर कर रही हैं। ऐसी ही एक बीमारी है 'जूवनाइल रयूमेटायड आर्थराइटिस'। जूवनाइल रयूमेटायड आर्थराइटिस एक ऑटोइम्यून डिस ऑर्डर है। इसमें हमारा शरीर अपने ही सेल्स को नहीं पहचान पाता। हमारा इम्यून सिस्टम जो नुकसानदायक बाहरी पदार्थों को शरीर के अंदर आने से रोकता है, अपने ही स्वस्थ सेल्स और टिश्यूज पर अटैक करता है। इसके परिणामस्वरूप शरीर में सूजन हो जाती है। इस बीमारी को मुख्यतः तीन वजह मानी जाती है। पहला जेनेटिक मेकअप में गड़बड़ी से बच्चों को यह बीमारी हो सकती है। अन्य वायरस भी इसका कारण हो सकते हैं। अध्ययन में पाया गया है कि इस बीमारी की गिरफ्त में वे बच्चे ज्यादा आ रहे हैं, जिनके अभिभावक आराम तलब जिंदगी जीते हैं।

बीमारी के लक्षण : लगातार सूजन, दर्द, अकड़न जो सुबह या सोकर उठने के बाद बहुत तीव्र हो जाती है। इस बीमारी में सुबह उठने पर लंगड़ापन महसूस होता है। तेज बुखार और त्वचा पर रैशेज पड़ना भी इसके लक्षण हो सकते हैं। संतुलित आहार व संतुलित जीवनशैली से बच्चों में इस रोग पर काबू पाया जा सकता है।

Rashtriya Sahara, April 1, P.8

मासूमों पर मंडराता बीमारी का खतरा

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शहर के दो सौ आंगनबाड़ी केन्द्रों पर पिछले दो माह बच्चों का नियमित टीकाकरण नहीं होने से सुरक्षा चक्र टूटने पर बच्चों के बीमार होने का खतरा मंडरा रहा है। आरसीएच निदेशक द्वारा हाल ही में एक आदेश जारी कर टीकाकरण के सेशनों की संख्या को घटाने से जीएनएम का केन्द्रों पर पहुंचने के प्रति रुझान कम हो गया है। सूत्रों की मानें तो पहले टीकाकरण में लगी जीएनएम को एक माह में टीकाकरण के 20 सेशन करने होते थे। उन्हें प्रत्येक सेशन के उन्हें 175 रुपए दिए जाते थे। नए आदेश में इनकी संख्या घटाकर प्रति जीएनएम चार कर दी गई है। इसके लिए उन्हें प्रति सेशन साढ़े तीन सौ रुपए मिल रहे है। काम व पैसा कम मिलने से जीएनएम टीकाकरण के प्रति रुचि नहीं ले रही है।तीन दिन पहले शहर के चिडिया का टीबा में दो माह से बच्चों का टीकाकरण नहीं होने पर नाराज महिलाओं ने आंगनबाड़ी केन्द्र पर हंगामा भी किया था।

शिशु रोग विशेषज्ञ डॉ. मदन सिंह फगेडिया ने बताया कि छोटे बच्चों में रोग प्रतिरोधक क्षमता बहुत कम होती है। ऐसे में उनमें संक्रमण होने की संभावना बढ़ जाती है।

Rajasthan Patrika, April 22, P.11

69.5pc children anaemic in India: Govt

NEW DELHI, April 27 – The government today said 42.5 per cent children below five years were underweight and 69.5 per cent were anaemic in the country.

According to a survey conducted in 2005-06, 42.5 per cent of children under five years of age were underweight and 69.5 per cent were anaemic, Women and Child Development Minister Krishna Tirath told the Lok Sabha.

She was replying to a question if India has the highest number of children suffering from malnutrition in comparison to other countries.

Tirath said as per a United Nations International Children's Education Fund data, the percentage of underweight children in India at 43 per cent was far above than many other nations. – PTI

Assam Tribune, April 28, P10

'World Autism Awareness Day celebrated, not observed'

Chennai: Occasions like World Disability Day, World Down Syndrome Awareness Day or World Water Day are said to be observed, rather than celebrated. But World Autism Awareness Day was a reason for celebration on Monday. The colour of the day was blue – to denote shining a light on autism. Balloons, streamers and decorations in blue were all over the Vidya Sagar campus.

What is a celebration without a party? A '*Chikki Tikki*' party was organised for students of the school. Most autistic children have gastrointestinal problems and are recommended a Gluten Free Casein Free (GFCF) diet. With this in mind, the *Chikki* (sweet) and *Tikki* (savoury) were made according to diet requirements, and everyone present enjoyed the snack.

Shirin Mammen, coordinator, says, "We would like to spread awareness of this dietary requirement for autistic children. We would also like to encourage restaurants and cafes to include items which are GFCF, much like they have special menus for diabetics."

A nationwide Skype meeting is also being held for mainstreaming children with autism. Three students of Vidya Sagar, who have been included in mainstream schools, will be participating. The Spastics Society of Tamil Nadu also celebrated the day on their Taramani campus.

New Indian Express, April 3, P.1.

WORLD AUTISM AWARENESS DAY

Doesn't respond when called, sometimes appears deaf

Does not point with the index finger to indicate interest

Lack of pretend play or unusual and repetitive pretend play

Avoids eye contact

Likes sameness in everyday routine, does not enjoy change

Extreme restlessness, hyperactivity or extreme passivity

Difficulty in mixing and playing with other children

Not responsive to normal teaching methods

Did You Know That...

Autism, or Autism Spectrum Disorders (ASD) affects the way the brain processes information, and prevents individuals from properly understanding what they see, hear, and otherwise sense, resulting in difficulties in social relationships, communication, and behaviour.

- There are around 10 million people in India with ASD; 80% of these are boys
- Symptoms of autism can range from a mild social and learning disability to a severe impairment.
- Some children with autism do not ever develop speech, some rarely use language to communicate, and some can go on to graduate from college
- What causes autism is not yet known; hence there is no cure
- Autism shows no social, educational, economic, caste, or religious bias

- Parents! -

- Autism is a complex condition. If you suspect that your child may have autism, start intervention right away.
  Don't wait for your child to be 'older' or till she/he receives a diagnosis
- The route to helping your child lies in understanding autism and the unique ways it manifests in your child
- There is no cure for autism, but every child with autism can learn and progress
- Suitable education can contribute significantly to improve the long-term opportunities of children with autism

Ministry of Social Justice & Empowerment, Govt. of India

TODAY IS POLIO SUNDAY

Be proactive and take your child (below 5 years of age) to the nearest Polio booth for two drops of OPV today. Don't just wait for Health Workers to visit your place

Remember, the only way to counter polio is through OPV. OPV vaccine is completely safe.

PULSE POLIO SUNDAY

8th April, 2012

National Rural Health Mission, Assam

Assam Tribune, April 8, P7

More baby deaths in West Bengal, 13 die in 72 hours

UNABATED Mamata blames it on poor healthcare in rural areas; govt says Bengal has 4th lowest infant mortality rate

HT Correspondent
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MALDA: Infant deaths returned to haunt Malda Medical College and Hospital (MMCH) once again after a gap of two months with nine infants dying between Wednesday evening and Thursday morning. In the last 72 hours there have been as many as 13 deaths.

Since the summer of 2011, West Bengal has been plagued with several instances of infant deaths. The state-run MMCH, around 400 km to the north of Kolkata, was also in the news this January, when 20 babies admitted here died.

In the past, chief minister Mamata Banerjee, who holds the health portfolio, blamed the deaths on the poor healthcare system in the rural areas. After Thursday's casualties Dr Asit Biswas, spokesperson of the state health department, maintained that the state has the "fourth lowest infant mortality rate in the country". He added, "From the health department we have taken all possible measures to curb the crib deaths at MMCH."

"The babies who died in MMCH were suffering from several ailments and the mothers of most of them didn't even get enough nutrition during their pregnancy. This is the main reason behind the deaths," said Biswas.

There are more than 100 babies in the facility and many of them are critical.

"On an average, one or two babies die in this hospital every day. Most of them were referred to this hospital from other areas. Some babies were brought from Jharkhand and other districts at the very last stage," said a senior doctor from MMCH.

"A number of women have given birth to babies in MMCH even before they attain the marriageable age of 18 years. As a result, they gave birth to sickly and underweight babies, who lack immunity," said another doctor.

Guardians, however, blamed staff for negligence. "My baby is critical, but the doctors aren't attending to him properly. They have turned down my appeal to shift him to the newborn care unit. The nurses, too, behave rudely," said Rahim Sheikh, a resident of Chanchol, Malda.

DEATHS OVER YEARS

January, 2012: 18 infants died in Malda District Hospital

November 10, 2011 6 infants died in Malda District Hospital

October 28, 2011 12 infants died in Burdwan Medical College and Hospital

October 26, 2011 11 infants died in BC Roy Hospital, Kolkata

June 2011 18 infants died at BC Roy Hospital, Kolkata

Nov 2006 14 babies died at BC Roy Hospital, Kolkata

Aug 2002 22 infants died BC Roy Hospital, Kolkata

Hindustan times, April 6, P10

70% of infants die in 1st month

New Delhi: Nearly 70% of infant deaths (within the first year of birth) in the country in 2010 took place during the first 29 days of life (neonatal).

While Jammu & Kashmir has the dubious distiction of leading the list with 82.1% infant deaths being neonatal, it is followed by Maharashtra (78%), Himachal Pradesh (77.5%), Punjab (74.2%), West Bengal (74%), Rajasthan (73.4%) and Madhya Pradesh (70.8%).

The Registrar General's latest data Sample Registration System 2010 says India saw nearly 32,000 fewer children dying in 2010 before reaching one month of life, compared to the previous year. This also means 88 fewer deaths per day. But even then, 8.62 lakh children died in 2010 within 29 days of life. This however is just a 3.6% dip from 2009. At the national level, the neonatal mortality rate dipped by just one point to 33 but ranges from 19 in urban areas to 36 in rural areas.

Among the bigger states, neonatal mortality ranges from as high as 44 in Madhya Pradesh to 7 in Kerala. Neonatal mortality rate in UP and Odisha was 42, Rajasthan 40, Chhattisgarh 37, Assam and Haryana 33.

Newborn Mortality

- India saw **32,000 fewer children dying in 2010** before reaching one month compared to 2009. This means 88 fewer deaths per day
- **8.62 lakh children died in 2010** within 29 days of life
- At national level, the neonatal mortality rate dipped by just one point to 33, but ranges from 19 in urban areas to 36 in rural areas

States with the highest neonatal mortality rate 2010

States recording highest decrease in neonatal deaths in 2010 (against 2009)

Three states have recorded an increase in neaonatal death

In comparison, states with lower neonatal mortality included Tamil Nadu 16, Delhi 19, Maharashtra 22, West Bengal 23, Karnataka and Punjab 25. In absolute numbers, UP recorded the highest number of neonatal deaths (2.3 lakhs) followed by Madhya Pradesh (85,000), Bihar (84,000), Andhra Pradesh (45,000) and Maharashtra (42,000). Three states have actually recorded an increase in neonatal deaths — Delhi by 6.6%, Jharkhand 4% and Kerala 1.5%.

Himachal Pradesh has recorded the largest dip — 14% in neonatal deaths in 2010 followed by Andhra Pradesh 10.2%, Maharashtra 10%, Gujarat 9.5% and West Bengal 9%. Bihar recorded the lowest dip in neonatal mortality in 2010 over the previous year — 0.1% followed by Assam 0.4%, Karnataka 0.5%, Rajasthan 2.6% and Odisha 3.8%. Under the country's flagship National Rural Health Mission, neonates are now a major focus of child health both for mortality and morbidity reduction.

Speaking to TOI, NRHM chief Anuradha Gupta said "Decline in India's under five mortality rate has been steady and consistent. The Infant mortality rate too has seen a sharp decline in rural areas which is highly encouraging. Neonatal care is now our focus. A new home based new born scheme that we have rolled out will be a real game changer. We are also promoting better child care practices including better hygiene."

The scheme envisages Accredited Social Health Activists (ASHAs) to visit homes of new mothers six times within 42 days to encourage safe practices and early detection and free referral of sick babies. During this time, ASHAs will have to record the birth weight of the child in the maternal and child protection cards (MCP), immunize newborns with BCG vaccine, the first dose of the oral polio vaccine and the DPT vaccine and make the entries in the MCP card. They will also have to register the births and both the mother and child will have to be safe at the end of the 42nd day.

Times of India, April 3, P.9

A compassionate and matchless initiative of the Government of Assam

More than 800 children have already benefitted from this scheme

What is Congenital Heart Disease?

- ❑ It is a defect in the structure of the heart and great vessels which are present at birth.
- ❑ It either obstructs blood flow in the heart or vessels near it, or cause blood to flow through the heart in an abnormal pattern.
- ❑ Every year a significant number of babies are born with a congenital heart defect.
- ❑ Treatment for the same is very expensive.

Government of Assam will bear the following expenses under this unique scheme:

- ◆ To and fro air-fare between Assam and Kolkata or Bangalore for the patient and a guardian
- ◆ Total Medical Expenses incurred at Narayan Hridayalaya Hospital, Bangalore and Kolkata
- ◆ Food and lodging expenses during treatment for patient and a guardian

National Rural Health Mission, Assam

Assam Tribune, April 7, P 14

बच्चों की मौत की बड़ी वजह है डायरिया

नई दिल्ली (एसएनबी)। उल्टी, दस्त (डायरिया) से बचना है तो आएसो सोया मिल्क का सेवन करें। दुनिया भर में पांच साल से कम उम्र के बच्चों की मौत का दूसरा सबसे बड़ा कारण है बार-बार दस्त आना यानी डायरिया। इस बाबत अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स) के इन्टरनल मेडिसिन के प्रो. डा. एन. राव ने कहा कि गर्मियों के दिनों में बच्चे ही नहीं वरन् हर उम्र के लोगों में डायरिया होने को एक आम समस्या के रूप में देखा जाता है।

सोया दूध गाय के दूध का सुरक्षित विकल्प हो सकता है। इसमें लैक्टोज फ्री फॉर्मूले का प्रयोग किया जाता है जिसे बच्चे आसानी से पचा लेते हैं। उन्होंने कहा कि दुःखद यह है कि आजकल राष्ट्रीय राजधानी क्षेत्र (एनसीआर) में दुकानों से सोया आधारित प्रोटीन फॉर्मूले वाले उत्पाद गायब हो गए हैं। जिसके चलते न सिर्फ माता-पिता बल्कि बाल रोग विशेषज्ञ भी चिंतित हैं।

- ▶ सोया दूध गाय के दूध का सुरक्षित विकल्प है
- ▶ इसे बच्चे आसानी से पचा लेते हैं
- ▶ बच्चों में डायरिया : निदान व रोकथाम विषय पर कार्यक्रम

विशेषज्ञों के मुताबिक इस तरह का दूध उन बच्चों को दिया जाता है जो लैक्टोज पचाने में अक्षम होते हैं। शिशुओं और 10 साल तक की उम्र के बच्चों में दस्त की समस्या का उपचार करने के लिए आहारीय प्रबंधन में भी इन विकल्पों का उपयोग किया जाता है। डा. राव ने यह बातें ' बच्चों में डायरिया : निदान/रोकथाम' विषयक एक कार्यक्रम में कहीं।

इस अवसर पर बीएलके सुपर स्पेशिलिटी हॉस्पिटल के नियोनैटोलॉजिस्ट डा. कुमार अंकुर ने कहा कि डायरिया होने पर रोगी के शरीर में आंते कमजोर हो जाती हैं और लैक्टोज को पचा नहीं पातीं। ऐसे में दूध के विकल्प के तौर पर सोया दूध उन बच्चों को दिया जाता है जो दस्त से ग्रस्त होते हैं। सोया दूध में लैक्टोज को पचाने की क्षमता के चलते माता-पिता के लिए किसी अन्य विकल्प को अपनाना बहुत मुश्किल हो जाता है। जिसके चलते छह महीने से कम उम्र के शिशुओं का मामला चिंता का विषय बना रहता है क्योंकि जिन खाद्य उत्पादों के उपयोग की सलाह आमतौर पर दी जाती है वे ऐसे बच्चों के मामलों में इस्तेमाल नहीं किए जा सकते और दस्त के दौरान लैक्टोज युक्त खुराक के साथ शिशुओं की पोषण संबंधी जरूरत पूरी करना कठिन हो जाता है। इस बाबत वरिष्ठ आहारविद डा. भाची सोहल ने कहा कि उन माता-पिता के लिए हालात बहुत चिंताजनक हो जाते हैं जिनके शिशु दस्त से परेशान होते हैं। जिनमें अन्य सामान्य लक्षण हों जो कि जठतंत्रिय हो सकते हैं जैसे पेट में ऐंठन, दर्द, उदरवायु, पेट फूलना, सूजन, मितली, उल्टी। ऐसे बच्चों के सही उपचार के तरीकों में तरल व इलैक्ट्रोलाईट थेरेपी, बैक्टीरियल संक्रमण में जरूरी सही एंटीबायोटिक और सोया दूध शामिल हैं शामिल है जो गुर्दों के माध्यम से होने वाली कैल्शियम की क्षति को रोकता है।

यह भी : दुनियाभर में पांच साल से कम उम्र के बच्चों की मौत का दूसरा सबसे बड़ा कारण दस्त है, विभिन्न कारणों से मरने वाले पांच बच्चों में से एक मौत इस वजह से होती है। लगभग 15 लाख बच्चे हर साल दस्त की वजह से मृत्यु का शिकार हो जाते हैं। 6 महीने से कम उम्र के बच्चों को इससे ज्यादा खतरा रहता है क्योंकि अधिकतर दवाएं उन्हें नहीं दी जा सकती। शिशु अवस्था में सबसे ज्यादा तेजी से बढ़त होती है, ऐसे में इस किस्म की बीमारियों का ठीक से इलाज न किया जाए तो बच्चे की वृद्धि पर विपरीत प्रभाव पड़ता है।

Rashtriya Sahara, April 17, P 7

Children vaccinated against polio on National Immunisation Day

Two more incident-free years required for India to be declared polio-free

Express News Service

Chennai: On the occasion of National Immunisation Day on Sunday, over 170 million children were vaccinated against polio in vaccination booths set up across the country. This has been followed by 5 days of door-to-door immunisation activity.

Though the NID is a Government of India initiative, in Chennai groups like the Rotary organised vaccination booths manned by volunteers and located strategically at transit points such as bus stands and railway stations.

A child is administered oral polio vaccine

Members of Rotary International, a partner of the Global Polio Eradication Initiative, joined the fight against the dreaded disease. Deepak Kapur, chair of Rotary International's India National PolioPlus Committee, said, "In February this year India achieved the status of a non-polio endemic nation. It has to maintain the status for another two years to be certified polio-free by the World Health Organisation. Import of polio from neighbouring countries and the reemergence of the disease are major threats to the campaign. But sustained efforts will help us achieve the goal."

Equipped with lessons from their own countries, foreign Rotarians from the US and Japan added impetus to Indian immunisation efforts. Rotary India PolioPlus also distributed information, education and communication (IEC) materials like banners, whistles, caps and aprons for the NID activity. The Rotary India PolioPlus committee has been actively involved in social mobilisation, and political, bureaucratic and religious advocacy to make immunisation acceptable to all sections of society. Rotary also organises Polio Corrective Surgery and Rehabilitation Camps for polio-affected children.

New Indian Express, April 17, 12

170 लाख से भी अधिक बच्चों को दी पोलियो खुराक

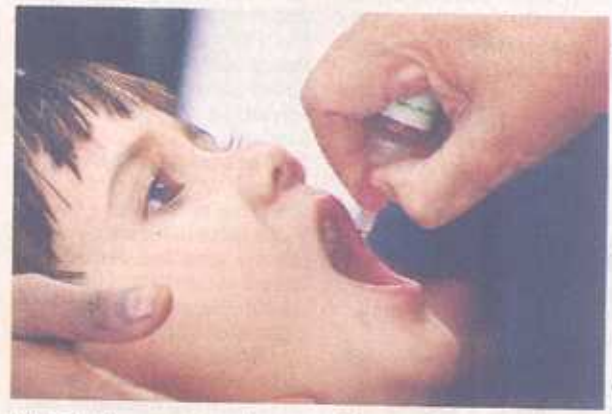
भारत क प्रथम पालया मुक्त वष के उपलक्ष्य और इस भयंकर बीमारी से हमेशा के लिए निजात पाने हेतु भारत सरकार और स्वयंसेवी संस्थाओं द्वारा निरंतर प्रयास किए जा रहे हैं। 'राष्ट्रीय पोलियो उन्मूलन दिवस रविवार' के अवसर पर देशभर में 5 दिवसीय अभियान के तहत 170 लाख से भी अधिक बच्चों को घर-घर जाकर पोलियो खुराक दी गई। दिल्ली सरकार और रोटरी इंटरनैशनल इंडिया के तत्वावधान में राजधानी दिल्ली की विभिन्न पुनर्वास कालोनियों, स्लम बस्तियों में स्वास्थ्य कार्यकर्ताओं ने पोलियो उन्मूलन कैम्प और पोलियो से बचाव के मिशन पर कार्य किया।

विश्वव्यापी पोलियो से मुक्ति अभियान में कार्यरत प्रमुख संस्था रोटरी इंटरनैशनल इंडिया पोलियो प्लस कमेटी के चेयरमैन दीपक कुमार ने कहा कि पोलियो मुक्त भारत विश्व स्वास्थ्य संगठन के प्रदान दर्जे को स्थापित रखने की दिशा में अगले दो वर्षों तक निरंतर पोलियो उन्मूलन पर कार्य करने की चुनौती का सामना करना होगा तभी इस लक्ष्य को प्राप्त किया जा सकता है।

Punjab Kesari, April 23, P 9

Off WHO list, India to help Pak fight polio menace

ARCHANA JYOTI ■ NEW DELHI



The war against polio virus in Pakistan will be now fought with help of India. A decision in this regard was taken at a recent meeting in New Delhi with the officials of the UNICEF, where concerns were raised regarding increase in polio cases in the neighbouring nation.

According to the UNICEF, Pakistan registered 198 cases of polio in 2011, rising from 144 cases in 2010. Over the last few months, the country has reported nine cases of polio.

This situation across the border is not healthy for India which, after registering a polio-free-year, has been recently taken off the list of polio-endemic countries by global health body World Health Organisation (WHO). India registered a no-polio year in February.

For the next two years, if India does not report any polio cases, it will be officially called "polio free".

But as Pakistan remains in the grip of the crippling disease, it will be Herculean task for India to achieve the target.

"There is always a threat of polio virus getting imported from the neighbouring nation and in such a scenario all our efforts undertaken so far will go waste. Hence this is in our interest to help Pakistan in its efforts to eliminate the polio virus," a senior health official told *The Pioneer*.

The fear is not without reason as the polio virus from Pakistan has already re-entered in China after a gap of 10 years. Though China after intense vaccination programme managed to curb the disease, the threat of polio for continues so long as there is polio virus circulation in any part of the world. The deadly P1 virus knows no boundary and it travels faster and infects children at higher rate through infected water or unhygienic food.

An exchange of delegation will take place soon between the India and Pakistan. Doctors from India will visit the neighbouring nation to strengthen its polio elimination programme. Pakistan will also be pitching in at the polio booths at Attari and Wagah where India is taking preventive measures for polio import.

"To counter polio threat from Pakistan, India has intensified surveillance for the disease through active search in the health facilities in Amritsar and other nearby districts and blocks of Punjab, Rajasthan, J&K and Gujarat that share a common border with Pakistan" the official added.

Pioneer April 23 P 5

प्रदेश को पोलियो मुक्त राज्य का दर्जा मिलना तय : राव नरेंद्र

गुड़गांव, 15 अप्रैल (हप्र)। हरियाणा प्रदेश को पोलियो मुक्त राज्य का प्रमाण-पत्र मिलना लगभग तय है। प्रदेश में लगभग पिछले 27 महीनों से पोलियो का कोई भी मामला सामने नहीं आया है।

यह बात हरियाणा के स्वास्थ्य मंत्री राव नरेन्द्र सिंह ने आज गुड़गांव गांव के प्राथमिक स्वास्थ्य केन्द्र में पल्स पोलियो अभियान की शुरूआत करने उपरान्त उपस्थित लोगों को सम्बोधित करते हुए कही। इस अवसर पर स्वास्थ्य मंत्री व खेलमंत्री सुखबीर कटारिया ने बच्चों को पोलियो रोधी दवा पिलाकर अभियान की शुरूआत की। इस अवसर पर स्वास्थ्य मंत्री ने कहा कि हरियाणा राज्य में आखिरी पोलियो का मामला 13 जनवरी, 2010 में मेवात जिला के पुन्हाना में पाया गया था, उसके बाद से अब तक लगभग 27 महीनों बाद भी राज्य में पोलियो का कोई भी केस नहीं मिला है। यही स्थिति तीन वर्ष तक लगातार सुनिश्चित करने उपरान्त प्रदेश को पोलियोमुक्त राज्य का प्रमाण-पत्र मिल जाएगा।

स्वास्थ्य मंत्री ने बताया कि इस वर्ष प्रदेश में चलाया जा रहा यह दूसरा पल्स पोलियो अभियान है जिसके तहत प्रदेश के पांच वर्ष तक के लगभग 42 लाख बच्चों को पोलियो रोधी दवा पिलाई जाएगी। पल्स पोलियो अभियान के लिए प्रदेश में 16649 बूथ बनाए गए हैं, जिन पर स्वास्थ्य विभाग, शिक्षा विभाग, इंडियन मेडिकल एसोसिएशन और विभिन्न सहायता समूहों आदि के 60 हजार से भी ज्यादा वैक्सीनेटर अपनी सेवाएं देंगे। पूरे अभियान के दौरान लगभग 3200 सुपरवाइजर पल्स पोलियो अभियान पर नजर रखेंगे। स्वास्थ्य मंत्री ने बताया कि गुड़गांव गांव के प्राथमिक स्वास्थ्य केन्द्र की मरम्मत के लिए सात लाख रुपए की राशि जारी की जा चुकी है और अगर केन्द्र के सौन्दर्यीकरण के लिए ज्यादा राशि की जरूरत होगी तो उसके लिए भी स्वीकृति दे दी जाएगी।

इससे पूर्व खेल मंत्री सुखबीर कटारिया ने लोगों को सम्बोधित करते हुए कहा कि ये नन्हें बच्चे प्रदेश का भविष्य हैं।

इनके स्वास्थ्य का ध्यान रखना परिवार व राज्य सरकार की जिम्मेदारी है, जिसके लिए राज्य सरकार हरसंभव प्रयास करती है।

इस अवसर पर हरियाणा स्वास्थ्य सेवाएं निदेशक डा. पंकज वत्स, गुड़गांव के सिविल सर्जन डा. प्रवीण गर्ग, उप सिविल सर्जन डा. एम पी शर्मा व डा. शशि, डब्ल्यूएचओ के डा. धीरेन्द्र त्यागी भी मौजूद थे।

Dainik tribune, April 16, P.3.

4.5 Lakh City Kids Get Polio Drops in Round II

Express News Service

Chennai: The second round of the Intensive Pulse Polio Immunization (IPPI) programme is believed to have reached almost 4.5 lakh children in the city on Sunday.

In order to reach children all across the State, as many as 2 lakh government employees and health workers were roped in.

Though an official tally has not been released as yet, the estimates say that as many as 72 lakh children received their second round of immunization.

Considering that just about 70 lakh children were administered the immunization drops on February 19, this increased number indicates that most of the children received their follow-up dosage and that more children were covered.

The drops were administered at all government hospitals, Primary Health Centres, block level dispensaries and even in places like bus stands, railway stations and markets.

Thanks to increased accessibility and better awareness, a large queue of parents and children turned up for the polio immunization shots.

IN ORDER TO REACH KIDS ALL ACROSS TN, 2 LAKH GOVT EMPLOYEES AND HEALTH WORKERS WERE ROPED IN

Close to 40,000 booths were set up in the State. Of these, 900 were mobile units meant to reach rural areas.

In Chennai alone, the Corporation had organised as many as 1,126 booths and about 4,500 workers were made to toil through Sunday to reach the 4.5 lakh kids who turned up for their shots.

The Corporation handled the job commendably well as they had to take care of the IPPI programme in the newly integrated areas in Greater Chennai, especially in parts of Kancheepuram, Chengalpet and Tiruvallur.

According to Health Department officials, the official numbers are expected soon.

New Indian Express, April 16, P.3

कैम्प में पिलाई 100 बच्चों को पोलियो रोधी दवा

गुड़गांव जिले के गांव मोहनपुर में श्रीमती संतरा देवी हैल्थ एंड एजूकेशन ट्रस्ट के चेयरमैन डा. बलराज यादव विशेष शिविर में बच्चों को पोलियो रोधी दवा की खुराक पिलाते हुए। - हप्र

गुड़गांव, 17 अप्रैल (हप्र)। प्रदेश से पोलियो को खत्म करने में निजी संस्थाएं भी सहयोग दे रही हैं। ऐसी ही गुड़गांव की एक संस्था श्रीमती सन्तरा देवी हैल्थ एंड एजुकेशन ट्रस्ट है, जो लगातार पोलियो उन्मूलन अभियान में अपना सहयोग देती रही है। गत रविवार से शुरू हुए पल्स पोलियो अभियान में भी इस संस्था के चेयरमैन डा. बलराज यादव व उनकी टीम ने मोहनपुर गांव में कैम्प लगाकर बच्चों को पोलियो रोधी दवा पिलाई। रविवार को मोहनपुर गांव में लगाए गए कैम्प में 5 वर्ष तक के लगभग 100 बच्चों को पोलियो रोधी दवा पिलाई गई। कैम्प में बाबूलाल, कृष्ण, नागरमल, मनोहर लाल, सन्तरा देवी, कांशीराम, रामचन्द्र, रामदयाल, रूपचन्द, ओमप्रकाश, राजेन्द्र, गुगन और फकीरा सहित अन्य गांववासियों ने भाग लिया।

The Tribune, April 18, P.3

How India surged ahead in the fight against polio

After decades of uninspiring performance across several public health measures and persistent news of the rise of infectious and non-communicable diseases, we had, at the start of the year 2012 something to cheer.

Overcoming the well known difficulties presented by our large population and expansive geography, January 2012 came with the welcome news that India had completed 12 polio-free months. Not a single case had been reported during the previous year – a vital milestone indicating that we are nearing victory in a hard fought battle. The whole world stood up to applaud the massive effort of the government and the thousands of volunteers who have made this possible. Until, less than a decade ago, India had thousands of new polio patients each year, more than 50 per cent of the worlds reported cases. All but 4 countries in the world became polio-free – only India, with Pakistan, Nigeria and Afghanistan continued to be polio endemic.

Doubts were cast, "Can polio be eradicated from India at all?"

In the wake of such pessimism, the news of India coming off the endemic countries' list came as a renewal of the spirit and revival of hope that the world can achieve the goal of being polio-free.

The war against the disease is still not over; India needs two more years without a polio incidence to be certified polio-free by the World Health Organisation (WHO). Efforts need to be sustained to prevent a comeback of the virus and to ensure that all children are well protected.

The Polio Summit 2012, organised by the Indian government and Rotary International was testimony to the fact that India would soon join the list of polio-free countries and not be the last to do so.

India's success against polio was not achieved easily – it required tremendous dedication, cooperation at all levels and many resources. Above all, it required a strategy and advocacy with the policy makers. With the initiative of Rotary at the World Health Assembly in 1988 all the nations of the world took the decision to eradicate polio from the face of the earth. Indian government too joined the decision with good intentions but wasn't resourceful during the initial period. High population and lack of adequate infrastructure were the main hurdles. Malnourishment and poor sanitation added to the various constraints including social and cultural resistance against the vaccine at times.

Need for radical change

It was quite apparent that political commitment and some radical change in administration were needed as a policy to get a real start. Rotarians in India were all geared up but it was clear that the programme would only succeed if the Central and state governments in the country would be in the driving seat. Advocacy with and sensitisation of the political and bureaucracy leadership began with a successful immunisation effort in October 1994 in Delhi known as Pulse Polio with all the children up to the age of 5 years immunised in a single day. This led to the meeting attended by the health ministers of all the states of the country. Simultaneously, the government of India adopted the strategy of National Immunisation Days in 1995.

Thanks to administrative authorities, NGOs and professional bodies, the programme moved forward with enthusiasm and optimism. The National Polio Surveillance Project of the WHO through effective surveillance strengthened the polio programme and the Type 2 poliovirus was eradicated in 1999. Introduction of the monovalent polio virus vaccines helped reduce the number of cases but the see-saw between Type 1 and Type 3 poliovirus continued to play a knotty game. By this time, most of the country became polio-free but UP and particularly Bihar was becoming the epicenter of polio. In 2009, India accounted for 741 out of 1600 for total cases reported globally.

Despite the programme fatigue, the Indian government continued to play a sterling role to reach out to every child, especially in the high risk areas administering the required doses. Around this time, the bivalent oral polio vaccine was developed and introduced to target P1 and P3 virus strains. Newborns were covered and vaccinated with special emphasis on hygiene, clean drinking water and better sanitation conditions. Migrants to other states were identified and immunised. With these endeavours India recorded only 42 cases in 2010. And then the only case in 2011 was reported on 13 January, in West Bengal.

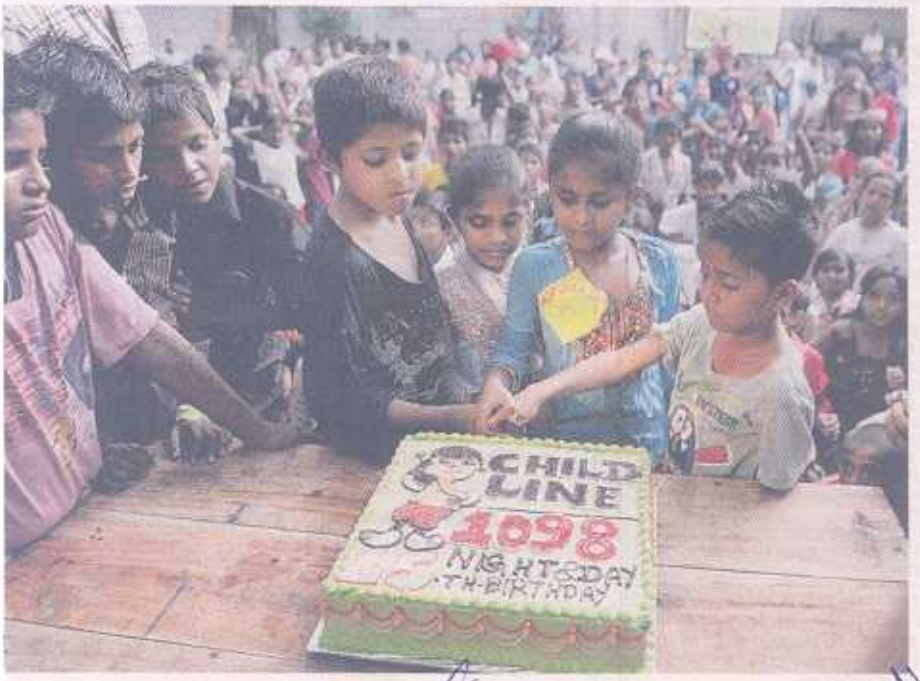
It would have been impossible to achieve this milestone without the unwavering support of the humanitarian organisations. In 1985 Rotary (a global service organization) approached WHO and UNICEF to launch PolioPlus programme and make it the biggest public health activity of the world. Rotary became the spearheading partner with governments around the world – across 209 countries. Anuradha Gupta, Additional Secretary, Health and Family Welfare, GOI very rightly observed at the recent Polio Summit, "it is extremely important to achieve the goal, but it is equally important to first set the goal. Rotary set the goal of polio-free world" – a well deserved recognition to Rotary. Rotary over the years has contributed over a billion dollars to the campaign, much through WHO and UNICEF towards implementation of polio eradication activities. A fundraising milestone of US$ 200 million was reached by Rotary in response to US$ 355 million donated to the Rotary Foundation by Bill and Melinda Gates Foundation to support polio immunisation activities.

India remains at risk of polio virus importation from across the borders and the threat of its re-emergence in the country are genuine. A polio-free country like China has been challenged with an importation outbreak in 2010 and so were few other polio-free countries in the past. Comprehensive plans made in consultation with the neighbouring and other endemic countries to prevent the importation and at the same time sharing of knowledge to help bring these countries achieve zero status must be explored.

India is on the brink of becoming polio-free and so is the world. India has shown the light and let that light burn brightly to the ultimate celebration of victory. The real accomplishment and celebration then will be the redeeming of the promise to the children of the future.

Deccan herald, April 18, P.11

Off the record, 7m births



Saira Kurup | TNN

The deadline to achieve universal birth registration in India passed two years ago, and the country is still playing catch-up. According to Unicef's State of the World Report 2012, the births of just 41% of India's children under five years have been registered. A closer look at the rural-urban divide shows more disturbing data — only 59% of urban children and just 35% of rural children have been registered.

But why should BR, a state subject, matter at all in a country which continues to battle with more critical issues like high infant mortality and child malnutrition? Well, for one, BR is an important source of demographic data for socio-economic development and population control — the first identity for a new-born. It is mandatory under Indian law to register all new-borns within 21 days of birth, but of the estimated 26.2 million children born in the country every year, more than 7.6 million reportedly go unregistered.

The major reasons for that are ignorance, illiteracy and poverty. Experts say that the high percentage of home deliveries (59%, according to NFHS-3 or National Family Heath Survey) and the large floating population in urban areas, street children and orphans complicate the issue. There's systemic failure, too. For instance, in 2003 a national campaign was begun to issue birth certificates, but it lost direction soon after. "The campaign was meant to be in three phases. Today, there is no information about the third phase. It was not a sustained campaign. It's become a bit of a joke," says Bharti Ali, co-founder of Haq, Centre for Child Rights.

Haq's 2011 report 'Twenty years of CRC (convention on the rights of the child)' points out: "The government's apathy in the importance of birth registration is reflected in the availability of data on birth registration. Different sources suggest different levels of both births as well as death registration. For example, in 2007 the NFHS-3 found that 41.5% of Indian children aged 0-4 are registered. For the same period, a survey carried out by the office of the registrar general of India indicated that 62.5% of children were registered, a difference of approximately 20 percentage points."

A number of development programmes, including maternal and reproductive health, immunization programs, need accurate, up-to-date fertility and mortality data. In the absence of reliable numbers, asks Plan India executive director Bhagyashri Dengle, "How can we know how many children are there of school-going age, for instance? How does the government allocate resources for development programmes without such data? A statistician would just have to anticipate the numbers."

At the individual level, people don't realize the importance of a certificate till the need arises. "The birth certificate is required for school admissions, health insurance for the poor, for employment in the formal sector. We see so many cases where children remain in lockups because their age cannot be verified," says Bharti.

Moreover, much of the available data is not gender-specific, which makes it difficult to highlight the specific situation of girls. "Without a birth certificate, how do you prove a girl is a minor to prevent child marriage?" asks Bhagyashri. With no proof of victims' age, crimes against minor girls often go unpunished. Targeted schemes for children such as the Ladli Yojana and other such conditional cash transfer schemes cannot be accessed by the needy for lack of age proof.

Bharti asks, "If we can have house-to-house census and regular national polio immunization drives, why can't we ensure 100% birth registration with a house-to-house drive?" Another problem is that birth registration does not necessarily ensure a birth certificate. Currently, the certificate is issued only when the record of birth is shown to the issuing authority and an application is made. In rural areas, people are forced to make several visits to the local municipality or panchayat, spend several hundred rupees and lose workdays to get a birth certificate. They just give up.

Experts recognize the gravity of the situation. Chairperson of National Commission for Protection of Child Rights, Shantha Sinha, says, "It's unbelievable that an average 20 births that occur in a village annually cannot be registered. The responsibility of frontline people like anganwadi workers, who need to inform the gram panchayat about the births, has to be fixed. And that, in addition to awareness campaigns."

There's hope, though, as some of the worst performing states have shown marked improvement. Rajasthan, which had 22.6% BR of both adults and children in 1996, improved to 83% in 2007; MP too has improved its overall BR from 45% in 1996 to 73% in 2007. "It needs to be seen as a basic right and a certificate of citizenship," says Sinha. Only then, perhaps, would BR be seen to be as important as getting a new car registered.

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FIGURING IT OUT

Birth registration of children under 5 years in % (NFHS-3)

	Urban	Rural	Total
India	59.3	34.8	41.1
Goa	95.3	93.9	94.7
Mizoram	94.6	92.1	93.3
Kerala	91.0	87.5	88.6
UP	22.7	3.2	7.1
Bihar	13.7	4.7	5.8

Source: 'Twenty Years of CRC — A Balance Sheet' by Haq, Centre for Child Rights 2011

Times of India, April 29, 2013

देश में 29 फीसद नवजातों की मौत की वजह संक्रमण

नई दिल्ली, 24 अप्रैल (भाषा)। देश में नवजात शिशु मृत्यु दर प्रति हजार 33 है और 29 फीसद नवजातों की मौत का कारण संक्रमण होता है।

स्वास्थ्य और परिवार कल्याण मंत्री गुलाम नबी आजाद ने मंगलवार को राज्यसभा में बताया कि मरने वाले नवजात शिशुओं की मौत के 29 फीसद मामले निमोनिया, सेप्टीसेमिया और गर्भनाल में संक्रमण की वजह से होते हैं। समय पूर्व प्रसव के कारण 24 फीसद व जन्म के तुरंत बाद सांस लेने में अक्षमता की वजह से 19 फीसद नवजातों की मौत हो जाती है। राजीव प्रताप रूडी के सवाल के लिखित जवाब में आजाद ने बताया कि महापंजीयक की रिपोर्ट के मुताबिक नवजात शिशुओं की मौत के सर्वाधिक 44 फीसद मामले मध्यप्रदेश में, 42 फीसद मामले ओडिशा में और 40 फीसद मामले राजस्थान में हुए हैं।

आजाद ने मलेरिया के बारे में पूछे गए कनिमोई के सवाल के जवाब में बताया कि वर्ष 2010 के दौरान इस बीमारी से देश भर में 1018 लोगों की मौत हुई। मलेरिया से ओडिशा में सर्वाधिक 247 लोगों की मौत हुई, जबकि महाराष्ट्र में इस बीमारी ने 200 लोगों की और अरुणाचल प्रदेश में 103 लोगों की जान ली।

तारिणीकांत राय के सवाल के जवाब में आजाद ने बताया कि प्रायोगिक तौर पर साढ़े तीन साल का ग्रामीण स्वास्थ्य परिचर्या पाठ्यक्रम शुरू करने पर विचार किया जा रहा है। उन्होंने बताया कि इस पाठ्यक्रम को जिला अस्पतालों में पढ़ाए जाने का प्रस्ताव है। यह पाठ्यक्रम खासतौर पर उन लोगों के लिए तैयार किया गया है जिन्होंने जिले के अधिसूचित ग्रामीण क्षेत्रों से स्कूली शिक्षा पूरी की है और बारहवीं की परीक्षा पास की है। उन्होंने बताया कि प्रस्तावित पाठ्यक्रम का मकसद ग्रामीण क्षेत्रों में रहने और व्यापक प्राथमिक स्वास्थ्य देखरेख के लिए सेवा प्रदाताओं का एक वर्ग तैयार करना है।

Jansatta, April 25, '12

47% of global measles deaths in India

New Delhi: Nearly half of all deaths due to measles globally occurred in India in 2010.

While mortality due to measles dipped from 5.35 lakh in 2000 to 1.39 lakh globally in 2010, India recorded 47% of those deaths in comparison to 16% of global deaths in 2000.

New research by the World Health Organization (WHO), Penn State University and the US Centers for Disease Control and Prevention (CDC) has found that while globally, measles mortality fell by 74% between 2000 and 2010 that is still short of the 90% target, in India the numbers dipped by 26% during the same period.

Published in the British medical journal, The Lancet, the study blamed India's relatively low measles vaccine coverage (74%) as the reason why the disease remained a major cause of death in the country.

Saying that India lags behind even Africa (76%), the study — spearheaded by Dr Peter Strebel, department of immunization, vaccines and biologicals of WHO — says "Delayed implementation of accelerated disease control in India stalled momentum towards the 2010 global measles mortality reduction goal."

India in 2010 recorded nearly 30,000 new cases of measles, and recorded 65,500 deaths.

The study added, "Our findings suggest that the goal of reducing measles mortality by 90% from 2000 to 2010 has not yet been met. The highly infectious nature of measles virus requires maintenance of very high levels of population immunity through high routine coverage. Measles remains widespread in India because of delayed implementation of mass vaccination campaigns. We expect planned vaccination rounds targeting 134 million children and the introduction of a routine second dose in some states of India during 2011–13 to substantially reduce measles mortality by 2015."

Union health ministry officials say India has introduced the second dose of measles vaccine in 2010. "India started giving a second dose of vaccine to children through routine immunization in 21 better performing states where coverage for measles vaccination was more than 80%.

In the remaining 14 high-risk states, we are carrying out the campaign in a phased manner. These 14 states also include second dose of measles vaccination under the routine immunization programme, six months from completion of the campaign," a ministry official said.

According to him, the second dose is expected to prevent estimated 60,000-100,000 child deaths annually.

The WHO study says measles mortality has been reduced by more than three-quarters in all regions of the world except in south-east Asia. Dr Strebel had earlier said that anti-measles efforts had suffered from inadequate funding and lack of political commitment since 2008.

Most children in India are immunized against measles at the age of nine months, as part of routine immunization programme, which includes polio, DTP and BCG vaccines.

South-east Asia, excluding India, had 79% vaccine coverage in 2010. The global coverage for measles vaccination overall was 85%.

Over 1 billion doses of measles vaccine were delivered through supplementary mass vaccination campaigns in the last decade, and were the main driver behind the huge fall in mortality.

According to Dr Strebel, Millennium Development Goals that aims to reduce child mortality by two-thirds by 2015 will be missed if measles outbreaks continue to spread.

The challenges, however, include competing public health priorities, weak immunization systems, sustaining high routine vaccination coverage and plugging the $298 million funding gap for global anti-measles efforts.

Times of India
April 24, 12

GRIM PICTURE

- Globally, **measles mortality has fallen 74% between 2000 and 2010**, but falls short of the 90% target
- Estimated global measles **mortality decreased from 5.35L in 2000 to 1.39L in 2010**
- **India called a concern as it recorded 47%** of estimated measles mortality in 2010 followed by the African region's 36%
- Southeast Asia, excluding India, accounted for **8% of measles deaths in 2010**
- **India's relatively low measles vaccine coverage (74%) is blamed for measles** remaining a major cause of deaths in the country
- **1 billion doses of vaccine were delivered through mass vaccination campaigns** in the last decade
- **Measles, a highly infectious viral disease,** begins with fever and is followed by cough, running nose, conjunctivitis and rashes all over the body
- **Measles spreads through contact with fluids from a person's nose and mouth and is 90% contagious**
- **Fatality rate from measles in developing countries is 10%**

The road to universal health care

"The best form of providing health protection would be to change the economic system which produces ill health, and to liquidate ignorance, poverty and unemployment. The practice of each individual purchasing his own medical care does not work. It is unjust, inefficient, wasteful and completely outmoded ... In our highly geared, modern industrial society, there is no such thing as private health — all health is public. The illness and maladjustments of one unit of the mass affects all other members. The protection of people's health should be recognised by the Government as its primary obligation and duty to its citizens."

These are the words of the distinguished Canadian surgeon, Norman Bethune, who, in 1936, called for universal health protection in which health services would be provided to all through public funds. He pointed out that the major causes of ill health among the poor in Canada, at that time, were: financial inability to pay, ignorance, apathy and lack of medical service. These are true of present-day India, where health insecurity continues to increase with growing economic prosperity.

What is UHC?

Universal health coverage (UHC) has now been widely adopted by Canada and many other developing countries both as a developmental imperative and the moral obligation of a civilised society. India embraced this vision at its independence. However, insufficient funding of public facilities, combined with faulty planning and inefficient management over the years, has resulted in a dysfunctional health system that has been yielding poor health outcomes. India's public spending on health — just around 1.2 per cent of GDP — is among the lowest in the world. Private health services have grown by default, without checks on cost and quality, escalating private out-of-pocket health expenditures and exacerbating health inequity. While the National Rural Health Mission and the several government funded health insurance schemes have provided a partial response, out-of-pocket expenditure still remains at 71 per cent of all spending, without coverage for outpatient care, medicines and basic diagnostic tests.

The High Level Expert Group (HLEG) established by the Planning Commission has submitted a comprehensive framework for providing UHC in India. A health entitlement card should assure every citizen access to a national health package of essential primary, secondary and tertiary care, both inpatient and outpatient. The HLEG is very clear that services included under UHC must be tax funded and cashless at delivery. User fees are to be abolished because they are inefficient, inadequate and iniquitous. Contributory social insurance is not appropriate for countries like India where a large segment of the workforce — close to 93 per cent — is in the unorganised sector and vast numbers are below or near the poverty line.

Four priorities

Increasing public spending on health is the first immediate requirement. The President of India has affirmed that "to attain the goal of universal health care, my Government would endeavour to increase both Plan and Non-Plan public expenditure in the Centre and the States taken together to 2.5 per cent of the GDP by the end of the 12th Plan." However, even the doubling of public financing will not be adequate to support all the components of a fully evolved UHC. Priorities need to be defined.

The first priority for achieving UHC, as the Prime Minister has pointed out, should be "a determined effort to strengthen our public health systems." Primary health care must be improved, starting with sub-centres, the first health post for the community. By staffing them with well-trained non-physician health care providers, both facility-based and outreach services can be provided without being doctor dependent. District hospitals too should be strengthened to provide high quality secondary care, some elements of essential tertiary care and training to different categories of health care providers.

The second priority should be to improve the size and quality of our health workforce. Without this, the promise of UHC will remain an empty entitlement. Since primary health care is our first priority, resources must be devoted to the production of competent and committed community health workers for the frontline, mid-level health workers or AYUSH doctors for the sub-centres, and general and specialist nurses as

Hindustan
April 14, P.12

well as non-specialist doctors for primary health centres. More specialists are needed for higher levels of health care including the district hospitals. New nursing and medical colleges should be preferentially set up in States which presently have very few, linking them to district hospitals. Public health competencies must be increased through inter-disciplinary education which is aligned to health system needs. Improved management of all of these human resources must involve better incentives for recruitment and retention, cadre review and creation of well defined career tracks.

The third priority should be to provide essential medicines and diagnostics free of cost at all public facilities. At the same time, referral linkages and patient transport services should be improved to integrate primary, secondary and tertiary health care in the public system. Difficult to reach areas and vulnerable population groups should receive special attention, even as the principle of universality must be applied while designing health services.

The fourth priority must be to put in place the necessary public systems for UHC. Regulatory systems need strengthening — from hospital accreditation to health professional education and from drug licensing to mandatory adoption of standard management guidelines for diagnosis and treatment of different disease conditions at each level of health care. A national inter-operable Health Information Network is needed to improve governance, accountability, portability, storage of health records and management. Community participation must be supported to actively engage people in the design, delivery, monitoring and evaluation of health programmes. And finally, larger investments should be made in health promoting programmes in other sectors such as water, sanitation, nutrition, environment, urban design and livelihood generation.

Role of the private sector

The Kolkata Group led by Amartya Sen, in its 2011 Public Declaration, pointed to the many limitations of the private sector in health. "Influential policymakers in India seem to be attracted by the idea that private health care, properly subsidised, or private health insurance, subsidised by the State, can meet the challenge. However, there are good analytical reasons why this is unlikely to happen because of informational asymmetry (the patient can be easily fooled by profit-seeking providers on what exactly is being provided) and because of the 'public goods' character of health care thanks to the interdependences involved. There are also major decisional problems that lead to the gross neglect of the interests of women and children in family decisions." It is also well known that insurance schemes (whether funded by the Central and State governments) at best provide limited health care and at worst divert a large part of the health budget to expensive hospitalised tertiary and secondary care, to the great neglect of primary care.

Clearly, there is no alternative to a progressive strengthening of the public facilities and thereby reduce people's dependence on private providers. However, the public system may need to "contract-in" the services of willing private providers, to fill gaps in its capacity to deliver all the services assured under UHC. Such "contracted-in" private providers will have to deliver cashless services and would be compensated on the basis of pre-determined cost per package of health services rather than "fee for service" for each visit or procedure. In such an arrangement, the private sector acts as an extension of the public sector where needed and will not compete for the same set of services for the same people.

Final remarks

It is time to recognise that everyone, not just the poor, needs to be protected against rising health costs that can impoverish any family. We are on the threshold of a historic transition to guarantee health security for all Indians. UHC will greatly reduce out-of-pocket expenditures and provide much needed relief to people. Apart from improving people's health, adopting UHC is likely to generate millions of new jobs, enhance productivity, and promote equity. Statesmanship must assert itself to create a national framework of UHC that is capable of State-specific adaptations. It is time to give the people of India the efficient, affordable and equitable health system they desire, deserve and demand.

(K. Srinath Reddy is President, Public Health Foundation of India. A.K. Shiva Kumar is Member, National Advisory Council. Both were members of the HLEG on UHC).

No roads, no educational, medical facilities: Survey

More such revelations about 18 tribal villages in Tamil Nadu

R. Arivanantham

DENKANIKOTTAI (TAMIL NADU): Over 18 tribal villages out of 24 situated on the hills and its periphery in Thalli and Kelamangalam panchayat unions are deprived of proper approach roads, medical facilities, education and other basic amenities, says a survey conducted by the Child Rights and You (CRY) recently.

The survey was conducted by the Rural Development Council (RDC), an NGO based in Denkanikottai headed by Gowri.

On the sidelines of the public hearing conducted here on Saturday, Ms. Gowri and S. Dominic, Manager, CRY, told *The Hindu* that the RDC worked with the marginalized community i.e. Irular tribal women and children residing in and around five hills in Denkanikottai taluk.

According to the survey, out of 1,394 Irular children only 83 are going to school. With the intervention of CRY, five anganwadi centres were established in five villages.

The children are ready to go to school, but they have to travel at least 15 to 20 km from their hamlets atop the hills.

This was due to poor transport and road facilities, thus, violating the provisions of Right to Education (RTE) Act.

The study with the support of a medical team on height, weight and nutrition aspects clearly indicates that children between 0 and 5 years and 80 per cent of pregnant women in Kodagarai, Thozhuvapetta and Kottayurkoil hamlets are malnourished, look pale and almost 70 per cent of them are severely anaemic.

IN DIRE STRAITS: *A woman with her four malnourished children at the public hearing organised by the Child Rights and You (CRY) at Denkanikottai in Krishnagiri district on Saturday.* — PHOTO: SPECIAL ARRANGEMENT

The main aim of the study was to mobilize community health care, reduce infant mortality and pressurizing the government machinery to establish anganwadi and health centres in the hilly terrains.

About 130 children and 20 pregnant women were screened by the medical experts to ascertain their growth chart. The study shows that many children were on the verge of death and malnourished. Eighty per cent of women and 70 per cent of children were anaemic.

The haemoglobin level in the students was only 8 per cent as against the normal 13 per cent. Rampant child marriages is one of the reasons for malnutrition among women and children.

In continuance of the survey, a public hearing was organised at a marriage hall in Denkanikottai on Saturday.

The participating women and men vent their anguish towards the government and district administration.

When one of the panel members Dr. Krishnamoorthy asked the villagers whether they were ready to take up self-employment like collection of forest gatherings and marketing the same to government agencies jointly, Veerabadran, a ward member of Siddique Nagar, expressed his desire for the same.

Ms. Gowri said that the Kodagarai hamlet with a population of 1,500 was deprived of health centre as the people had to take patients in a stretcher.

Many of them died on the way to hospital. Recently, a 23-year-old pregnant woman Papathiammal of Kodagarai died on the way to hospital.

S. Dominic said that "the tribal children are the most marginalized in Tamil Nadu. Special attention should be given to meet the shortages. The deplorable state of the child should be given immediate attention."

First survey

He also said that this was the first survey conducted by CRY and the same would be replicated in Nilgiris and other hilly areas wherever the tribals are living in large numbers.

The other panel members were Dr. K. Krishnan, Executive Director, Aadhivasi Solidarity Council of Vellore, Malar Amudhan, journalist from Chennai, and Jahnavi Devi, Development Consultant and Family Counsellor, Thalli.

Panel recommendations

The panel recommendations will submit its recommendations to the government.

These include urging the government to intervene in the issue and declare the tribal pockets as healthcare emergency region, need to strengthen health infrastructure, special measures with regard to poverty eradication, special PDS package for the region, and pre-school education with nutritious food for children below five years of age.

Hindu, April 2, p.18

अगर है जोड़ों में दर्द और सूजन तो बेजोड़ है धनिया

आर्थराइटिस यानी घुटनों में दर्द और सूजन। यह बीमारी लाइलाज मानी जाती है, लेकिन थोड़ी-सी सजगता और कुछ उपाय इसे नियंत्रित करने में बेहद कारगर सिद्ध हुए हैं। इसी कड़ी में एम्स में हुआ एक ताजा अध्ययन काफी उम्मीद जगाने वाला है।

अध्ययन के मुताबिक, भोजन में प्रमुखता से इस्तेमाल होने वाला धनिया आर्थराइटिस के मरीजों के लिए काफी फायदेमंद है और इससे हड्डियों के जोड़ों में होने वाली सूजन में कमी आती है। अखिल भारतीय आयुर्विज्ञान संस्थान में फार्माकोलाजी विभाग के प्रमुख डा वाई.के. गुप्ता के अनुसार धनिया से जोड़ों के सूजन में कमी होती है। इससे उन जैव रयासनों के स्राव पर रोक लगती है जिससे शरीर के किसी भी हिस्से में सूजन होती है।

आर्थराइटिस रोग में जोड़ों और उसके आसपास के उतकों में सूजन हो जाती है। इससे अन्य अंग भी प्रभावित हो सकते हैं। लंबे समय तक बने रहने वाले इस रोग की शुरुआत आम तौर पर 30 से 60 साल की उम्र में होती है। पुरुषों में यह अक्सर देर से होता है। कई बार युवकों में भी इस रोग के लक्षण देखे जाते हैं। एम्स के इसी विभाग में प्राध्यापक डा सुरेंद्र सिंह ने कहा कि आयुर्वेद, यूनानी जैसी पारंपरिक चिकित्सा पद्धतियों में धनिया के गुणों का जिक्र देखते हुए यह प्रयोग किया गया। उन्होंने कहा कि पारंपरिक रूप से कही जा रही बातों के वैज्ञानिक मूल्यांकन के लिए यह अध्ययन किया गया। उन्होंने कहा कि दो साल तक चले अध्ययन से पता लगा कि यह पशुओं पर काफी प्रभावी है। पशुओं और मानव समस्याओं में समानता को देखते हुए हमारा मानना है कि यह अध्ययन आर्थराइटिस के इलाज के लिए धनिया के पारंपरिक उपयोग को उचित ठहराता है।

क्यों होता है आर्थराइटिस

- **जीवनशैली** : आधुनिकीकरण ने मनुष्यों को भी मशीन बना दिया है। घर या दफ्तर अपनी कार से जाते हैं। सीढ़ियां चढ़ने के बजाय लिफ्ट का इस्तेमाल करते हैं। नतीजतन शरीर की गतिशीलता घटती जाती है।
- **तनाव** : काम का दबाव हमेशा तनाव पैदा करता है। यह तनाव शरीर पर नकारात्मक प्रभाव छोड़ता है।
- **घुम्रपान** : तकनीक पर निर्भरता तो बढ़ी ही है, घुम्रपान जैसी आदतें शरीर को और शिथिल कर देती हैं।
- **खान-पान** : दफ्तर के काम में हम इस तरह खोए रहते हैं कि अपने खान-पान पर ध्यान नहीं दे पाते।

लक्षण	बचाव	खुराक
हड्डियों के जोड़ों में दर्द और सूजन, ज्यादा चलने या सीढ़ी चढ़ने पर घुटनों में दर्द, एक ही मुद्रा में देर तक रहने के बाद खड़े होने में तकलीफ	हमें नियमित तौर पर व्यायाम करना चाहिए। याद रहे कि पथरीली या सख्त जमीन पर चलने की बजाय घास, मिट्टी या रेत पर चलें।	नियमित तौर पर विकित्सीय जांच में यदि कोई तत्व कम है, तो खान-पान सही कर उसे दूर करें।

Hindustan, April 2, P3

PM convenes meeting on universal health coverage

NEW DELHI: Prime Minister Manmohan Singh has convened a meeting to discuss the proposed reforms for achieving universal health coverage as suggested by the High-Level Expert Group (HLEG).

The meeting comes at a time when the World health Organisation (WHO) has reiterated its commitment to help countries reach universal health coverage. "We have been supporting the work of India's High-Level Expert Group tasked with producing a UHC [universal health coverage] strategy. Given the experiences of other countries that have achieved universal health coverage, I am convinced that the broad strategy outlined in this report will be successful and that within the period of 12th Five Year Plan, hundreds of millions of people in India will benefit from access to better health care," Margaret Chan, Director-General of the WHO has said in her letter to the Union Health Minister Ghulam Nabi Azad earlier this month.

"In particular, I would commend your government's emphasis on replacing inefficient and inequitable private financing [notably user fees] with much higher levels of public financing. As the World health report of 2010 demonstrates, this is a vital component of successful universal coverage strategies," Dr. Chan said in her letter. She appreciated the 'free medicine for all through public health facilities' initiatives, along with improved clinical quality standards and oversight.

The universal health coverage strategy with this initiative also makes a perfect sense given India's leading role in supplying quality generic medicines globally, Dr Chan said while assuring of the WHO's commitment to support India's universal health coverage goals.

Scheduled for April 10, officials from the Ministry of Health and Family Welfare, Planning Commission and members of the High-Level Expert Group that drafted the report on Universal Health Coverage for India, have been invited for the Prime Minister's meeting.

Instituted by the Plannin Commission in October 2010, the expert group was mandated to develop a framework for providing easily accessible and affordable health care to all Indians. It was chaired by Srinath Reddy, president of the Public Health Foundation of India and its report strongly recommended a reconfiguration of the entire health system, where the government will have a major role to play in making health care an entitlement to every citizen.

The group suggested that health care be offered as a National Health Package (NHP), covering all common conditions and high-impact health care requirements including in-patient and out-patient care free of cost.

Health care services

According to the panel, the health care services would be made available through the public sector and contracted-in private facilities (including the non-government organisations and non-profit groups). These service providers would not be allowed to accept any additional payments from individuals or through privately purchased insurance policies for non-NHP services. Private providers opting for inclusion in the universal health coverage system would be reimbursed at standard rates as per levels of services offered to the population, and their activities appropriately regulated and monitored.

While the Ministry of Health and Family Welfare already initiated the scheme of providing free generic medicines to those coming to the public health facilities for treatment, it has some reservations about public insurances scheme as suggested in report of the HLEG as it feels that given the choice of insurance people would still prefer to go to private sector for treatment. Importantly, insurance would not result in any kind of behavioural change that is needed to improve health of the people.

Hindu, April 1, P. 10

और मजबूत होंगे डॉट्स केंद्र

- घर तक दवा पहुंचाने की व्यवस्था में किया जाएगा सुधार
- टीबी नियंत्रण कार्यक्रम के तहत ऑनलाइन होगी व्यवस्था

नई दिल्ली, जागरण संवाददाता : टीबी में टोटल ड्रग्स रेजिसटेंस (टीडीआर) के बढ़ते मामले को देखते हुए अब इलाज के बीच ही दवा छोड़ देने वाले मरीजों पर विशेष निगरानी को और मजबूत किया जाएगा। ताकि जो मरीज डॉट्स केंद्र तक नहीं पहुंच पाते, उनके घर तक हर हाल में दवा पहुंचाई जा सके। आरएनटीपीसी (रिवाइज्ड नेशनल टीबी कंट्रोल प्रोग्राम) के तहत डॉट्स के ऑनलाइन केंद्रों को मजबूत करने की बात कही गई है। इस बाबत एम्स में बुधवार को कोर कमेटी की बैठक हुई।

बैठक में शामिल दिल्ली के टीबी नियंत्रण अधिकारी डॉ. एसके अरोड़ा ने बताया कि टीबी की और बेहतर जांच की व्यवस्था के लिए नई तकनीक अगले एक-दो वर्षों में डॉट्स केंद्रों पर लागू की जाएगी। इससे पहले सभी डॉट्स केंद्रों की ऑनलाइन व्यवस्था को अधिक सक्रिय बनाने की योजना है। एम्स के सभी विभाग के प्रोफेसर और टीबी नियंत्रण कार्यक्रम के नोडल अधिकारियों की सहायता से विभिन्न विभागों में आने वाले टीबी मरीजों को मेडिसिन विभाग में रेफर करने की बात कही गई। ताकि हर हाल में ऐसे मरीजों को पहला इलाज मिले। साथ ही उसको सही पता व अन्य संबंधित जानकारी हासिल किया जा सके।

डॉ. अरोड़ा ने बताया कि छह से आठ महीने तक चलने वाले टीबी के इलाज के लिए मरीज की जांच के बाद उसे घर भेज दिया जाता है। पंजीकृत होने के बाद ऑनलाइन जुड़े डॉट्स केंद्रों की मदद से मरीज के घर का पता लगा कर डॉट्स कार्यकर्ता दवा पहुंचते है। इस व्यवस्था को अब और दुरुस्त किया जाएगा। उन्होंने बताया कि हमारा मकसद दवा के सही समय की जानकारी देना है, ताकि मरीज कोर्स के बीच दवा ने छोड़ दें। कोर कमेटी में एम्स की डीन रानी कुमार, न्यूरोसर्जरी विभाग के डॉ. एसएस काले, डॉ. एसपी गर्ग सहित कई डॉक्टरों ने हिस्सा लिया।

100 मिनट में जांच की ट्रायल शुरू

टीबी की जांच के जांच के लिए विश्व स्वास्थ्य संगठन द्वारा प्रस्तावित 100 मिनट की जांच का ट्रायल दिल्ली के विभिन्न डॉट्स केंद्रों पर शुरू किया जा चुका है।

इसके परिणाम छह माह से एक साल के बीच में आने लगेंगे। इस व्यवस्था के लागू होने के बाद इसका शुल्क निर्धारित किया जाएगा क्योंकि इस जांच में इस्तेमाल होने वाली किट अपेक्षाकृत महंगी है। जबकि अब तक बलगम और कल्चर टेस्ट से टीबी के बैक्टीरिया का पता लगाया जाता है। इस जांच की रिपोर्ट आने में एक सप्ताह का समय लगता है।

Dainik Jagaran, April 5, P4,

Increasing Life Expectancy is Going to be a Huge Challenge: Minister

Express News Service

Chennai: Life expectancy is increasing in TN and 12.1 per cent of the population in the state is elderly. These demographic changes are accompanied by new challenges said the Minister for Health and Family Welfare on Tuesday.

Speaking at World Health Day celebrations on the theme of Ageing and Health at Madras Medical College, Dr VS Vijay, Minister of Health and Family Welfare said, "In TN, the life expectancy of a male is 68.5 years and for females it is 71.5 years. We have a huge challenge before us. There is need for long-term care and risks of chronic heath problems are on rise." World Health Day is observed every year on April 7 to mark the anniversary of the founding of the WHO.

A geriatric training centre was opened in MCC to train doctors from across the state, said V Kanangasabai, Dean, Madras Medical College.

Dr KS Surendran, Surveillance Medical Officer, National Polio Surveillance Project, WHO, also spoke on the occasion.

New Indian Express, April 4, P4

'Need a national debate on universal health coverage'

Aarti Dhar

NEW DELHI: Jan Swasthya Abhiyan on Friday called for a national public debate on the proposed universal health care system, saying that such an important issue cannot be rushed through and its various strands need to be understood, discussed and commented upon widely by the people.

"Definition of a clear, transparent and time-bound road map for strengthening and expanding the public health system while improving its functioning and accountability; this must include allocation of adequate, and enhanced budgets," a JSA statement said.

The statement issued after a two-day meeting of the nation working group meeting to discuss the High Level Expert Group's report on Universal Healthcare Coverage said enactment of adequate law guaranteeing the right to health, including National and State Health Acts, which would lay down the framework for regulation of the health system, particularly relevant for private medical providers.Providing entitlements must be accompanied by a clear framework for accountability and grievance redressal.

While developing and operationalising the universal health care system, highest priority must be given to significant expansion and improvement of public health services. Regulated private providers should not be competing with public providers for common resources, rather they may be in-sourced to provide services, but never as a substitute to the public sector, it said.

Ensuring forums for participation of community members, community-based groups and civil society organisations along with elected representatives and public health functionaries at various levels, for planning, monitoring and reviewing the functioning of the universal health care system should be included in the framework.

Organising a process of mapping and estimating the pattern of health care services required in each district and within each district in areas with special needs must be ensured.

This process must be transparent and widely discussed by people in each district, the Jan Swasthya Abhiyan said.

"We must be aware that the direction of developing universal health care in India must be towards strengthening the public health system and socialisation of health care, rather than promoting further expansion of unregulated, profit-oriented medical care. Hence a national debate is essential and there should be no haste in rolling out these concepts – even the looming large of the General elections should not become an excuse for the government to short circuit and distort the concept of Universal Health Care for narrow political gains," it said.

Hindu, April 7, 12

विश्व स्वास्थ्य दिवस

7 अप्रैल, 2012

हिमाचल के स्वास्थ्य क्षेत्र में बढ़ते कदम

अटल स्वास्थ्य सेवा

किसी भी आपातकालीन स्थिति में निःशुल्क एम्बुलैंस के लिये **108** डायल करें।

मातृ–शिशु सेवा योजना

सभी महिलाओं को गर्भावस्था से प्रसव तक निःशुल्क सुविधा। जन्म के बाद एक वर्ष की आयु तक सभी बच्चों का मुफ्त उपचार।

मुस्कान योजना

65 वर्ष से अधिक आयु वाले बुजुर्गों के लिए निःशुल्क डेन्चर।

पंडित दीन दयाल उपाध्याय निःशुल्क औषधि योजना

बी. पी. एल. रोगियों को 38 दवाईयां मुफ्त।

राष्ट्रीय स्वास्थ्य बीमा योजना

बी. पी. एल. परिवारों का निःशुल्क इलाज।

सूचकांक*	भारत	हिमाचल
कुल प्रजनन दर	2.5	1.8
शिशु मृत्यु दर	47	40
जन्म दर	22.1	16.9
मृत्यु दर	7.2	6.9

शिशु मृत्यु दर एवं नवजात मृत्यु दर में भारत में सर्वाधिक कमी दर्ज।*

*स्रोत : एस. आर. एस. 2010, भारत सरकार

जारीकर्ता : राष्ट्रीय ग्रामीण स्वास्थ्य मिशन हि. प्र.

Hindu, April 7, P.4

एक इंजेक्शन करेगा घुटने का दर्द दूर

नई दिल्ली | वरिष्ठ संवाददाता

घुटने के दर्द को दूर करने के लिए अब एक इंजेक्शन ही काफी होगा। ऑस्टियोआर्थराइटिस के शिकार 400 मरीजों पर कार्टिलेज के इंजेक्शन का सफल प्रयोग किया गया है। एक इंजेक्शन से 15 मिनट में दर्द को एक साल के लिए दूर किया जा सकता है।

एम्स के आर्थोपेडिक्स विभाग के डॉ. राजेश कुमार मल्होत्रा ने बताया कि विदेश में सफल प्रयोग के बाद भारतीयों पर कार्टिलेज के इंजेक्शन का प्रयोग किया गया। एक साल में दस शहरों के 40 केन्द्रों पर किए गए अध्ययन में देखा गया कि इंजेक्शन लगाने के बाद मरीजों को दर्द की शिकायत नहीं हुई। मरीजों की उम्र 35 से 50 साल के बीच थी।

डॉ. राजेश ने बताया कि इंजेक्शन को सिंगल शार्ट विसकोइंप्लांटिशन कहते हैं। देश में इस समय 1.5 करोड़ लोग आस्टियोआर्थराइटिस की वजह से घुटनों में दर्द से परेशान हैं। इनमें 35 साल के युवा और 62 साल के बुजुर्ग शामिल हैं। बुजुर्गों में कार्टिलेज इंजेक्शन के प्रयोग को सही समय पर प्रयोग किया जाएं तो परिणाम सफल हो सकते हैं।

दो तरह के कार्टिलेज

रिजैनरेटिव : इस प्रक्रिया में मरीज के कार्टिलेज का एक हिस्सा लेकर उसे लैबोरेटरी में बढ़ाया जाता है। प्रभावित जगह पर इंजेक्शन से प्रत्यारोपित कर दिया जाता है। यह बुजुर्गों के लिए अधिक कारगर नहीं, क्योंकि वृद्धों की कार्टिलेज लैब में विकसित नहीं की जा सकती।

आर्टिफिशियल : इस विधि में बाजार में उपलब्ध कार्टिलेज के इंजेक्शन को जोड़ों में लगाया जाता है। यह अधिक उम्र के ऐसे बुजुर्गों पर भी कारगर है, जिनकी घुटने की हड्डी क्षतिग्रस्त नहीं हुई है। ओपीडी या माइनर ओटी में यह इलाज किया जाता है।

Hindustan, April 8, P 3

खून की कमी नहीं होने देगा यह नमक

नई दिल्ली | विशेष संवाददाता

सेहत की बात

- नेशनल इंस्टीट्यूट ऑफ न्यूट्रीशियन के वैज्ञानिकों ने खोजी तकनीक
- टाटा ने उतारा बाजार में आयोडीन के साथ आयरन युक्त नमक

खून की कमी से ग्रस्त लोगों को एक नए किस्म का आयरन युक्त नमक राहत पहुंचाएगा। भारतीय चिकित्सा अनुसंधान परिषद (आईसीएमआर) द्वारा कुछ समय पूर्व नमक में आयोडीन के साथ आयरन भी मिलाने की तकनीक विकसित की गई थी। इस तकनीक का इस्तेमाल करते हुए टाटा केमिकल्स ने देश का पहला आयोडीन और आयरन युक्त नमक बनाया है।

यहां एक कार्यक्रम के दौरान आईसीएमआर के नमक तैयार करने वाले संस्थान नेशनल इंस्टीट्यूट ऑफ न्यूट्रीशियन (एनआईएन) के निदेशक डॉ. बी. शशिकरण ने बताया कि यह नमक महिलाओं, बच्चों और बुजुर्गों में आयरन की कमी को दूर करने में कारगर साबित होगा। स्वस्थ रहने के लिए प्रतिदिन 17 मिलीग्राम आयरन की जरूरत होती है। इस नमक से इसका 50 फीसदी यानी 8.5 मिलीग्राम मिल जाएगा।

शशिकरण ने कहा कि वैज्ञानिकों ने वर्षों की मेहनत के बाद यह तकनीक तैयार की थी। इसका परीक्षण चूहों और बड़े जानवरों पर किया गया। उन्होंने पाया कि आयोडीन और आयरन वाला नमक खाने वाले जीवों का हीमोग्लोबिन बढ़ रहा है। इसके बाद देश के कई हिस्सों में लोगों पर इसका परीक्षण किया गया। साथ ही विभिन्न प्रकार के भोजन में इसका जायका भी परखा गया कि कहीं इससे स्वाद में फर्क तो नहीं आ रहा। जो अंतिम उत्पाद तैयार किया गया, वह खाने में स्वादिष्ट है।

भारत सरकार के नमक आयुक्त एम.ए. अंसारी की तरफ से जारी संदेश में कहा गया है कि जिस प्रकार कुछ साल पूर्व नमक कंपनियों ने आयोडीनयुक्त नमक बनाने में सहयोग किया, वैसा ही योगदान उन्हें आयरन युक्त नमक लोगों तक पहुंचाने में करना होगा। एम्स के प्रोफेसर सी.एस. पांडव के अनुसार आयोडीन युक्त नमक से देश के बच्चों का आईक्यू सुधारने में मदद मिली है। इस नमक से उन्हें एनिमिक होने से बचाया जा सकेगा।

डॉ. शशिकरण ने कहा कि नमक की यह तकनीक निशुल्क है। कोई और कंपनी भी लेना चाहे तो इसे हासिल कर सकती है। उन्होंने कहा कि देश में 70 फीसदी गर्भवती महिलाएं और बच्चे, 50 फीसदी कुल महिलाएं और 24 फीसदी वयस्क पुरुष रक्त की कमी के शिकार हैं। इस नमक के सेवन से तीन वर्षों के भीतर खून की कमी से छुटकारा पाना संभव होगा।

Hindustan, April 6, P 2

सेहत बनाइए, मुसीबत मत बुलाइए

29 वर्षीय रोहित ट्रेड मिल पर दौड़ते हुए अचानक बेहोश होकर गिर गया। उसे तुरंत नजदीक के अस्पताल में भर्ती किया गया, पता चला कि दो साल पहले उसे हार्ट अटैक पड़ा, जिसकी वजह से दोबारा माइनर हार्ट अटैक हुआ है।

युवाओं पर जिम जाने का खुमार सिर चढ़ कर बोल रहा है, सिक्स पैक और फोर पैक के लालच ने जिम से सेहत पर पड़ने वाले खतरों को भी नजरअंदाज कर दिया है। कार्डियोलॉजिस्ट डॉ. उपेंद्र कौल कहते हैं युवाओं में 10 से 20 फीसदी तक हार्ट ब्लॉकिज की संभावना हो सकती है जो बीस साल की आयु के बाद ही स्पष्ट हो पाती है। लेकिन जिम में बहुत अधिक मेहनत से नसों में मौजूद वसा, कैल्शियम, कोलेस्ट्रॉल के कण खून में बिखर जाते हैं। कोलेस्ट्रॉल की अधिक मात्रा से दिल की धमनियों में अचानक रुकावट आती है जो हार्ट अटैक का कारण बनती है।

सफदरजंग अस्पताल के स्पोर्ट्स इंजरी सेंटर में तीन महीने पहले 34 वर्षीय एक ऐसे ही युवक का इलाज किया गया। युवक लंबे समय से सेहत बनाने के लिए बाजार में उपलब्ध एनर्जी फूड सप्लीमेंट का इस्तेमाल करता था। जिसकी वजह से पेट में गांठ बन गई और उसका तुरंत ऑपरेशन करना पड़ा। स्पोर्टस मेडिसिन विशेषज्ञ डॉ. जीएल खन्ना ने बताया कि शादी के लिए खुद को स्लिम करने के लिए एक युवक ने तीन महीने में 40 किलो वजन कम किया, इसके लिए नियमित चार से पांच घंटे ट्रेडमिल पर बिताए, हालांकि वह अपना वजन कम करने में सफल रहा, लेकिन इस तरह की एक्सरसाइज कार्डियक अरेस्ट का खतरा बढ़ाती है। इसी तरह के एक 56 वर्षीय व्यक्ति को उस समय दिल का दौरा पड़ा, जब वह जिम में 120 किलो के वजन पर वेट लिफ्टिंग की प्रैक्टिस कर रहे थे। एम्स के आर्थोपेडिक्स विभाग के डॉ. सीएस यादव कहते हैं कि नियमित व्यायाम सही है, लेकिन मेडिकल चेकअप के बाद ही व्यायाम के विभिन्न तरीकों को अपना चाहिए। फिटनेस एक्सपर्ट से सलाह के बाद ही वेट लिफ्टिंग, ट्रेडमिल या स्टिल साइकलिंग पर हाथ आजमाएं।

हद से अधिक कसरत न कर दे परेशान

नियमित व्यायाम, स्ट्रेचिंग और वार्मअप किए बिना जब जिम में अचानक शरीर पर अत्यधिक शारीरिक बोझ डाला जाता है तो ऐसी स्थिति को एक्सेसिव जिमिंग कहते हैं।

कंधे : जरूरत से अधिक वजन उठाने से कंधे डिस्लोकेट हो सकते हैं।

जिम में इस बात का खास ध्यान रखना चाहिए कि कोई विशेष व्यायाम आपके जोड़ों में दर्द की वजह तो नहीं बन रहा। अगर ऐसा है तो तुरंत उसे बदल लेना चाहिए। डॉ. सीएस यादव, आर्थोपेडिक्स, एम्स

किडनी : फूड सप्लीमेंट में प्रोटीन की अधिक मात्रा से किडनी खराब हो सकती है।

एनाबॉलिक एस्टीरॉयड के अधिक इस्तेमाल से टेस्टोस्टेरॉन पर विपरीत असर पड़ता है। रक्तचाप बढ़ने से किडनी के नियमित काम पर असर पड़ता है।
डॉ. एनपी सिंह, नेफ्रोलॉजिस्ट, मौलाना आजाद मेडिकल कॉलेज

कमर : अधिक वजन उठाने से स्लिप डिस्क का खतरा 50 फीसदी बढ़ जाता है।

तीस साल की उम्र के बाद जिम शुरू करने वाले युवाओं में स्लिप डिस्क का खतरा अधिक रहता है, जबकि 20 से 21 साल में जिम शुरू करने पर ऐसा नहीं होता।
डॉ. नवल भाटिया, स्पोर्ट्स इंजरी सेंटर

लिवर : एस्टोरॉयड से मेटाबॉलिज्म प्रभावित होता है, इससे लिवर हार्मोन का स्तर गड़बड़ाने लगता है।

एस्टोरॉयड का अधिक इस्तेमाल एंजाइम्स को बदल देता है, जिसकी वजह से लिवर की सामान्य सेल क्षतिग्रस्त होने लगती है। इसका विपरीत असर तब भी बरकरार रहता है, जब आप इसका इस्तेमाल बंद कर देते हैं। डॉ. रूशी देशपांडे

कूल्हा : लंबे समय तक एनाबोलिक एस्टोरॉयड का इस्तेमाल मांसपेशियों को तो मजबूत बनाता है, लेकिन यह कूल्हे के जोड़ को कमजोर कर उनमें दर्द बढ़ाता है।

घुटने : ट्रेड मिल पर अधिक समय बिताने से जोड़ों में परेशानी हो सकती है।

अगर कूल्हे और जांघ की लंबाई अधिक नहीं है तो घुटने पर नौ गुना अधिक दबाव पड़ता है, जिसकी वजह से ट्रेडमिल पर चलते कार्टिलेज की क्षति होती है। इसलिए लंबाई कम है तो ट्रेडमिल का कम इस्तेमाल करना चाहिए।
डॉ. दिनेश, फिजियोथेरेपिस्ट, मेट्रो ग्रुप ऑफ हॉस्पिटल

दिल : ऐसे लोग जिनके परिवार में पहले से किसी को दिल की बीमारी रही है, अधिक जिम जाने से ऐसे लोग कार्डियक अरेस्ट के अधिक करीब होते हैं। डायबिटिज होने पर भी अधिक जिम जाने से खून का थक्का जम जाता है और दिल का दौरा पड़ने का खतरा बढ़ जाता है।

क्या बरतें सावधानी

- जिम या व्यायाम करने से पहले दस मिनट वार्मअप जरूर करें

- किसी भी ऐसे लक्ष्य को निर्धारित न करें, जो आपकी क्षमता से बाहर हो

- हमेशा ऐसे व्यायाम या वेट लिफ्टिंग अपनाएं जो आपकी सेहत और वजन के अनुसार हो, इसमें महिला और पुरुष की एक्सरसाइज अलग है।

- किसी के कहने पर तुरंत ऐसे वर्कआउट को शुरू न करें, जिसकी आपको आदत नहीं है, जिम शुरू करने के बाद धीरे-धीरे घंटे बढ़ाएं

पोषक आहार

- कभी खाली पेट जिम न जाएं या वर्कआउट न करें
- जिम कराने से 30 से 45 मिनट पहले ओट्स खा सकते है या फिर फ्रूट जूस ले सकते हैं। इससे बर्न होने वाली कैलोरी संरक्षित की जा सकती है।
- आप किस तरह के फूड सप्लीमेंट ले रहे हैं, डॉक्टर को बताएं

इलस्ट्रेशन : श्रीकृष्ण पाटकर

Hindustan, April 8, P-2

Hospitals say prepared to fight flu

New Delhi: All government hospitals have been put on alert after six cases of swine flu were confirmed in the capital.

"The first case was reported from Gokulpuri in northeast Delhi in January. Other cases have been reported from Vasant Vihar, Dwarka and Ram Nagar near Loni. All patients have been discharged after treatment," Singh said.

Dr Sarman Singh, professor of microbiology at AIIMS, said the H1N1 virus did not pose a serious threat anymore. "In year 2009, when H1N1 cases were reported for the first time, we had no medicine or practical experience to deal with it. But now we have medicines and even vaccines needed to treat and prevent the disease," he said.

The surveillance officer said most of the patients had travelled recently. "An advisory, prepared by the ministry of health in view of the increasing number of cases, has been issued to all government hospitals," he added.

A senior health official with the Directorate of Health Services (DHS) said they had enough stock of medicines to deal with H1N1 influenza cases.

"We have an isolation ward for swine flu patients. The logistics are in place," said Dr Richa Dewan, medical superintendent of Lok Nayak Hospital.

Unlike in 2009 when H1N1 gained epidemic proportions, doctors say there is nothing to worry as a large portion of the populations has been exposed to the virus. "Most people have developed antibodies to fight the infection. Many people have even taken vaccination for the influenza virus," said Dr Sandeep Budhiraja, head of the medicine department at Max hospital, Saket.

Budhiraja said routine screening for the H1N1 virus is not required anymore. "Only the high-risk patients -elderly, people with diabetes, kidney problems, cancer patients and pregnant women – should get themselves screened for the infection after symptoms like fever, cough, prolonged sore throat, chills and body ache," he said. Health experts say timely medical help is crucial to reducing the risk of fatality. Frequent hand-washing and avoiding crowded places is among the few precautions one should take to avoid catching the infection.

Times of India, April 10, P 4

Graphic: Pratima

STAY ALERT FOR SWINE FLU

What is H1N1(swine) flu?

It is a contagious respiratory disease caused by Type A strains of the virus. The virus enters the body through inhalation of contaminated droplets or is transferred from a contaminated surface to the eyes, nose or mouth of a person

Treatment

H1N1 flu is sensitive to oseltamivir (Tamiflu) and zanamivir (Relenza). But these medicines should be taken under medical supervision

High-risk groups

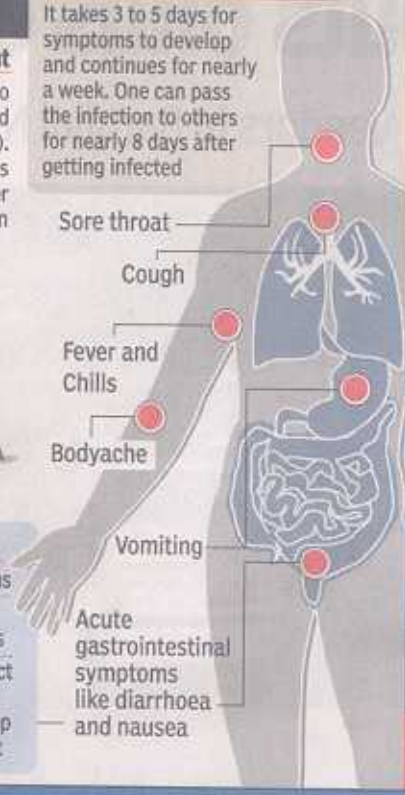
- Elderly
- Diabetics and kidney patients
- Cancer patients
- HIV+ & AIDS patients & anyone with weak immune system

See a doctor if you

- Suffer any symptoms
- Visited an area affected by H1N1 virus
- Have come in contact with a person with flu like symptoms, develop respiratory discomfort

Gestation period and symptoms

It takes 3 to 5 days for symptoms to develop and continues for nearly a week. One can pass the infection to others for nearly 8 days after getting infected



FACT FILE OF DELHI

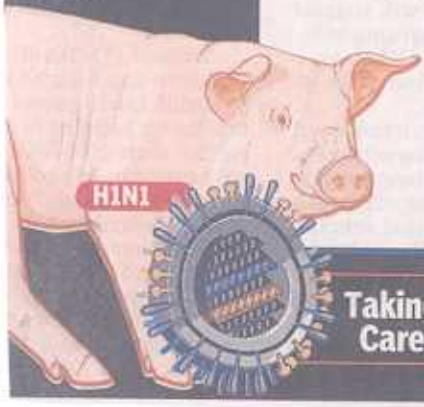
2012
6 CASES AND NO DEATHS

2011 cases | deaths
22 | 2

2010 cases | deaths
1,850
56

2009 cases | deaths
7,088
81

Cases reported in India so far
48,700 approx



Taking Care

- Maintain oral and personal hygiene
- If you eat pork, it should be well-cooked
- Wash your hands with soap before eating

Centre to monitor health indicators

TEENA THACKER
NEW DELHI, APRIL 15

In a move that could help strengthen dialogue with the states, plug communication gaps, quickly disseminate strategic initiatives of the ministry of health and understand the challenges on the ground so that necessary technical support could be rendered for improved progress and better implementation of government schemes, the Centre has proposed to monitor states on the basis of their health indicators.

This means that states with poor health indicators to be reviewed extensively vis-a-vis those showcasing good health indicators.

Officials in the health ministry say that the idea is to strengthen dialogue with the state, understand the challenges and constraints of implementation of schemes so that support for improved implementation can be rendered.

The states have been categorised into different groups like a, b and c. While, those which have the most adverse and populous states like Bihar, Uttar Pradesh (UP), Madhya Pradesh etc. would be taken up for much more rigorous review — once in every month and has been categorised in "a" group, there are certain others like Haryana, Orissa, Jharkhand etc. that will be reviewed once in two months — which means the "b" group. The others falling in "c" category are with those better health indicators and that are smaller like Tamil Nadu, Kerala, Dadar and Nagar Haveli and will be reviewed every four months.

"This categorisation has been done with regard to the health indicators, in order to give better attention to the states that require greater support. This will help know the constraints, depending on which extensive techiqual support can be rendered to these states," said Anuradha Gupta, additional secretary and Mission director, National Rural Health Mission (NRHM).

For example if the state has only 50 per cent immunisation coverage. The government of India can help by holding a workshop, help the state formulate a roadmap and can be given technical support so that improved planning can help in better implementation.

Asian Age, April 16, P 3

Fight diabetes and extra weight at once

Chennai: People with diabetes are often loaded with the additional responsibility of having to manage their weight. Though there is no conflict of interest, it is often a tussle for working people to try to reduce, and keep tabs on, both indices. "Type 2 diabetes often coexists with other high-risk conditions such as hypertension, high cholesterol and obesity which add to cardiovascular risk factors in these patients. Incretin-based therapies provide an answer to people suffering from diabetes and other illnesses associated with this disease," said Dr V Mohan, chairman and chief diabetologist of Dr Mohan's Diabetes Specialties Centre, at the National Incretin Summit. The event was organised by Dr Mohan's Diabetes Education Academy and supported by an educational grant from Novo Nordisk India. More than 200 leading doctors, consultants and diabetologists from across India attended the event. The idea behind the summit was to provide healthcare providers with expert perspectives on the use of Incretin-based therapies in Type 2 diabetes and to report future directions in research. With obesity and high blood pressure among the biggest challenges in managing Type 2 diabetes in India Incretins, particularly a class of Incretins called GLP-1 analogues (Glucagon Like Peptide-1), promise to bring significant relief to patients.

Although currently diabetes cannot be cured, it can be managed successfully with appropriate and adequate treatment. Addressing the issue is impeded by lack of information about diabetes as well as lack of prevention and education measures, agreed most doctors present at the summit.

FACT FILE

An extensive clinical trial called LEAD™ involving more than 6,500 people from 40 countries world over including India, by Novo Nordisk showed that:

- Treatment with the GLP-1 analogue (liraglutide) resulted in superior blood sugar control and resulted in better HbA1c.
- Blood pressure was significantly reduced in patients treated with the GLP-1 analogue
- Weight loss was significantly greater in the GLP-1 analogue (liraglutide) group

New Indian Express, April 30, P1

सुरक्षित भविष्य की पक्की नींव

करीब एक दशक पहले तक विश्व स्तर पर पोलियो के हर पांच में से चार मामले भारत के होते थे। लेकिन पोलियो उन्मूलन के प्रति हिन्दुस्तान की प्रतिबद्ध कोशिशों की सराहना की जानी चाहिए कि एक साल से अधिक वक्त बीत चुका है, मगर यहां पोलियो का एक भी केस सामने नहीं आया। भारत की इस कामयाबी पर पूरी दुनिया को गौर करना चाहिए। एक तो इसलिए कि यह उन मुल्कों के लिए एक मॉडल की तरह है, जहां पोलियो अब भी एक खास क्षेत्र या वर्ग में फैलने वाली बीमारी है। दूसरे इस कारण से कि इस सफलता ने स्वास्थ्य संबंधी अन्य चुनौतियों से निपटने में कामयाबी की हमारी उम्मीद को पुख्ता किया है।

जाहिर है, इन चुनौतियों में दुनिया भर की औरतों व बच्चों की सेहत सुधारने से अधिक महत्वपूर्ण बात कुछ और नहीं हो सकती। भारत में इसकी जरूरत कहीं अधिक है, क्योंकि दुनिया भर में प्रसव के दौरान सबसे अधिक स्त्रियों की मृत्यु और शिशुओं की मौतें यहीं पर होती हैं। एक आकलन के मुताबिक, हर साल हिन्दुस्तान में पांच साल से कम उम्र के 17 लाख बच्चे जिन कारणों से मौत के शिकार बनते हैं, उनमें से ज्यादातर मौतों को टाला जा सकता है। 60,000 से अधिक महिलाएं यहां प्रतिवर्ष गर्भावस्था या प्रसव के दौरान दम तोड़ देती हैं। निस्संदेह, भारत की चौंकाने वाली आर्थिक और सामाजिक तरक्की के कारण इन मौतों में तेजी से कमी आ रही है, फिर भी यह देश सहस्राब्दी विकास लक्ष्य की पटरी पर नहीं आ सका है, जबकि साल 2015 तक इन लक्ष्यों को हासिल करना है। खासकर, शिशु मृत्यु-दर और जननी मृत्यु-दर को कम करने तथा कुल स्वास्थ्य सेवाओं के सुधार के मामले में।

वैसे यह सिर्फ भारत की ही बात नहीं है। संसार भर में पांच साल तक की आयु के करीब 70 लाख बच्चे हर वर्ष ऐसी वजहों से मारे जाते हैं, जिन्हें आसानी से दूर किया जा सकता है। इसी तरह, करीब साढ़े तीन लाख महिलाएं गर्भावस्था के दौरान होने वाली दिक्कतों के कारण या बच्चे को जन्म देते समय मौत की शिकार बनती हैं। इसीलिए मैंने आज से दो साल पहले 'हर एक महिला, हर एक बच्चा' कार्यक्रम शुरू किया था। और इतनी कम अवधि में इस कार्यक्रम ने दुनिया भर में एक आंदोलन का रूप ले लिया है। विश्व की एक करोड़ साठ लाख मांओं व शिशुओं को बचाने के लिए पब्लिक-प्राइवेट पार्टनरशिप के तहत इस कार्यक्रम पर अरबों डॉलर की राशि खर्च की जा रही है। 'हर एक महिला, हर एक बच्चा' कार्यक्रम दरअसल इस बात की शिनाख्त करता है कि इस धरती की हर स्त्री का, इसके प्रत्येक शिशु का महत्व है। इनमें से हर एक किसी न किसी परिवार का सदस्य है और व्यापक अर्थों में विश्व समुदाय का हिस्सा भी। मैं मानता हूं कि इनकी सेहत की हिफाजत वास्तव में सुरक्षित भविष्य में निवेश करना है।

भारत इस कार्यक्रम के शुरुआती समर्थक देशों में से एक है। पिछले 18 महीनों में मैंने देखा है कि हिन्दुस्तान ने कितनी प्रतिबद्धता, कितने समर्पण भाव से राष्ट्रीय व स्थानीय स्तर पर इस कार्यक्रम को लागू किया है। भारत सरकार ने स्वास्थ्य सेवाओं में सुधार पर सालाना 3.5 अरब डॉलर से भी अधिक की राशि खर्च करने का फैसला किया है। इस राशि का बड़ा हिस्सा महिलाओं और बच्चों की सेहत सुधारने पर खर्च किया जाएगा। इसमें भी उन इलाकों पर खास ध्यान दिया जाएगा, जहां सर्वाधिक मौतें होती हैं।

भारत सामाजिक उत्थान के नए कार्यक्रमों का अगुआ देश बन गया है। मसलन, यहां ज्यादा से ज्यादा महिलाओं को इस बात के लिए प्रोत्साहित किया जा रहा है कि वे प्रसव के लिए स्वास्थ्य केंद्रों में जाएं, जहां मां और शिशु की मुफ्त में देखभाल की जाएगी। अभी हाल ही में श्रम व रोजगार मंत्रालय ने एक महत्वाकांक्षी कार्यक्रम की शुरुआत की है, जिसके तहत साल 2013 तक गरीबी रेखा के नीचे रहने वाले सभी 30 करोड़ लोगों को स्वास्थ्य बीमा मुहैया कराई जाएगी। वाकई, यह एक ऐतिहासिक उपलब्धि होगी और अन्य देशों को भी इसका अनुकरण करना चाहिए।

भारत नए-नए रास्तों की तलाश में टेक्नोलॉजी का इस्तेमाल कर रहा है। जैसे, मोबाइल फोन को ही लीजिए। साल 2014 तक इस देश के लगभग 97 फीसदी लोगों के पास अपना मोबाइल फोन होने की उम्मीद जताई जा रही है। ऐसे में, यह देखना वाकई दिलचस्प होगा कि सरकारी व निजी क्षेत्र की नई साझेदारी का किस तरह से स्वास्थ्य के क्षेत्र में इस्तेमाल किया जाता है। यह काफी संतोष की बात है कि हिन्दुस्तान के ज्यादा से ज्यादा उद्योगपति अपनी सामाजिक जिम्मेदारियों को पूरा करने की दिशा में कदम बढ़ा रहे हैं। भारत का निजी क्षेत्र महिलाओं व बच्चों की सेहत से जुड़े कार्यक्रमों की सहायता में आगे आ रहा है। इसकी वजह से डायरिया के मामलों में काफी कमी आई है, क्योंकि न सिर्फ जलापूर्ति की गुणवत्ता में सुधार हुआ है, बल्कि अब व्यापक आबादी की पहुंच में जिंक टैब्लेट और जीवन रक्षक घोल हैं। दो लाख से अधिक लोग इस रोग से हर वर्ष मरते हैं। यदि उन्हें ये बुनियादी दवाएं मिल जाएं, तो दस में से नौ लोगों की जानें बचाई जा सकती हैं।

यकीनन, अभी काफी कुछ करना है। लेकिन समाधान हमारे हाथ में है। हम मिलकर यह पक्का कर सकते हैं कि हर नवजात को सही पोषण मिले, हर गर्भवती स्त्री को सही वक्त पर सही चिकित्सा मिल जाए, और बीमार बच्चियों को भी वही देखभाल मिले, जो बच्चों को मिल रही हो। हम मलेरिया और टीबी को काबू में कर सकते हैं और एचआईवी से नई पीढ़ी को आजादी दिला सकते हैं। हमारे साझा प्रयास का लक्ष्य महिलाओं का सशक्तीकरण होना चाहिए।

मुझे बेहद खुशी है कि मैं एक ऐसे वक्त में दुनिया के सबसे बड़े लोकतंत्र में आया हूं, जब वह वैश्विक नेता की हैसियत में उभर रहा है। वह न सिर्फ घरेलू विकास को गति देने के लिए, बल्कि विश्व शांति के प्रयासों को भी प्रोत्साहित करने के लिए अपने प्रभावों का इस्तेमाल कर रहा है। तथ्य यह है कि उसने कई क्षेत्रों में सहस्राब्दी विकास लक्ष्य को हासिल कर लिया है या फिर उसके बिल्कुल करीब पहुंच गया है और इससे भविष्य के प्रति हमारी उम्मीदों को बल मिला है। महिलाओं और बच्चों की सेहत के क्षेत्र में मिलने वाली नई सफलताओं से इसकी तरक्की को और ताकत मिलेगी। यदि भारत पोलियो उन्मूलन की कामयाबी की तरह इस मामले में भी सफलता के परचम लहराता है, तो फिर वाकई सारा आकाश उसकी मुट्ठी में होगा।

Hindustan, April 25
P 10

Brain not fully developed till 25: Lancet

Despite its legal significance, 18 can no longer be regarded as the start of adulthood. According to the British Medical journal the *Lancet* brain goes on maturing and is not fully developed until at least the age of 25.

In a series of papers on adolescent health published in the *Lancet* on Wednesday, scientists have highlighted other alarming consequences shared among the total of 1.2 billion adolescents.

The *Lancet* revealed that injuries accounted for 40 per cent of deaths in 10-to 24-year-olds worldwide. This included injuries from car accidents and intentional harm caused by suicide and violence, with vehicle crashes the leading single cause of death.

The morbidity and mortality estimates suggested that adolescents are significantly affected by injuries and neuropsychiatric disorders. "Homicides, unintentional injuries related to road traffic accidents and suicides are major cause of death. Each year 1.4 million adolescents die from road traffic injuries, childbirth complications, suicide, AIDS, violence and other causes," it said.

Even though the experts say that more children have moved into older age groups, "yet too little attention and too few resources are devoted to issues facing older children," it added. The experts have noted that absolute number of adolescents is expected to rise until 2050. While mortality rates for children under the age of five declined by more than 80 per cent in many countries in the past 50 years, adolescent deaths had improved only marginally, they said.

The over all condition of girls do not seem to have improved. According to the special adolescent health issue by the *Lancet*-*Girls* still lag behind boys in secondary school enrolment and completion in many regions. In the least developed countries, more than a third of young women aged 15-24 years cannot read compared with a quarter of their male counterparts. Similarly, across developing countries (excluding China), 83 per cent of boys aged 15-19 years use some form of media on a weekly basis (either TV, radio, or newspapers and magazines) compared with 72 per cent of their female peers.

"About 60 per cent of adolescents living with HIV are girls. In fact, across developing countries (excluding China), male adolescents are more likely than female adolescents to have comprehensive and correct knowledge of HIV—at 30 per cent and 19 per cent, respectively — and more likely to use condoms," said the experts.

Early marriage is a common experience for many girls and raises the likelihood of early childbearing. More than a third of young women aged 20-24 years in developing countries (excluding China) were married or in a union by age 18 years.

Findings of scientific journal

- Brain goes on maturing and is not fully developed until at least the age of 25
- Scientists have highlighted other alarming consequences shared among the total of 1.2 billion adolescents

Asian Age, April 26, P5

कैंसर की चपेट में है युवा वर्ग

नई दिल्ली | आशीष मिश्र

अर्थव्यवस्था में सर्वाधिक योगदान देने वाला 15 से 35 वर्ष का आयुवर्ग कैंसर की चपेट में आ रहा है। जनसंख्या में 32 फीसदी हिस्सेदारी वाले इस आयुवर्ग के 1.5 लाख लोग प्रतिवर्ष कैंसर से अपनी जान गंवा रहे हैं। जबकि देश में हर साल कैंसर के कुल 10.8 लाख नए मरीज सामने आ रहे हैं। यह जानकारी एम्स के रेडिएशन एंड ऑनकोलॉजी विभाग के प्राध्यापक डा. जीके रथ ने गुरुवार को प्रेस क्लब में आयोजित एक कार्यक्रम में दी।

उन्होंने बताया कि ऊर्जा और जोश से भरा यह वर्ग अपनी जीवनशैली के प्रति लापरवाही बरत रहा है। डॉ. रथ कहते हैं कि करियर और परिवार जैसी तमाम जिम्मेदारियों के चलते युवा अपने शरीर के प्रति लापरवाह हो रहा है। रथ के मुताबिक सिर्फ 05 फीसदी कैंसर ही अनुवांशिक गुणों के कारण पनपते हैं जबकि इसके पीछे सबसे बड़ा कारण हमारी लाइफ स्टाइल है। युवाओं में असुरक्षित यौन संबंध, धूम्रपान, तंबाकू और गुटखे की बढ़ती लत कैंसर का बड़ा कारण बन रही है।

Hindustan
April 20, 12

यौन आजादी से युवक-युवतियों में फैल रहा है कैंसर

नयी दिल्ली, 19 अप्रैल (वार्ता)। समाज में तेजी से आ रहे खुलेपन, उपभोक्तावाद और पश्चिमीकरण के कारण बढ रही यौन स्वच्छंदता एवं उन्मुक्त यौन संबंधों के कारण किशोरों और युवकों में कैंसर का प्रकोप तेजी से फैल रहा है।

विशेषज्ञों का कहना है कि समाज में आ रहे खुलेपन के अलावा इंटरनेट तथा फेसबुक जैसी सोशल नेटवर्किंग साइटों, मोबाइल फोनों, डिस्कोथिक, हुक्का पार्लरों एवं आधुनिक मॉलों के कारण लड़के-लड़कियों के बीच असुरक्षित यौन संबंध तेजी से बढ़े हैं जिसके कारण एड्स के अलावा जानलेवा कैंसर का तेजी से फैलाव हो रहा है। किशोरों एवं युवकों में कैंसर के फैलाव एवं उनकी रोकथाम के उपायों पर चर्चा करने के लिये देश भर में कैंसर विशेषज्ञ दो दिवसीय राष्ट्रीय सम्मेलन में जुट रहे हैं जो इस तरह का पहला सम्मेलन है। शनिवार से शुरू हो रहे इस सम्मेलन की मेजबानी कर रहे फरीदाबाद स्थित एशियन इंस्टीच्यूट आफ मेडिकल साइंसेस (एआईएमएस) के अध्यक्ष डा. एन. के. पाण्डे ने आज यहां एक संवाददाता सम्मेलन में कहा कि हमारे देश में विभिन्न कारणों से किशोरों और युवाओं में कैंसर के दुर्भाग्यपूर्ण मामले तेजी से बढ़ रहे हैं। कैंसर से पीड़ित लोगों में से एक बड़ी संख्या 15 से 35 वर्ष के किशोरों एवं युवकों की है और भारत की आबादी का 40 प्रतिशत हिस्सा इसी आयु वर्ग के हैं।

Dainik Tribune,
April 20, 12

TB FEEDS ON FRINGES

Ignoring the influx

Dr Anil Bandivadekar, executive health officer of the Brihanmumbai Municipal Corporation, however, isn't as forthcoming with the figures. He says since no study has been conducted by the civic body to zero in on the number of TB patients who arrive at city hospitals from the Vasai-Virar belt, "no specific data is available".

The newly-formed Vasai-Virar Municipal Corporation's (VVMC) chief medical health officer, Dr Sunil Wadkar, says Nallasopara (E) has only one health post, but he quickly adds that there are four to five dispensaries in the area. "I have talked to the TB department and it is supposed to provide a TB health clinic. But, this will take time."

The municipal corporation does not have a full-time district TB officer (DTO). "He has additional an charge. By the time he familiarises himself with our problems, the officer changes," says a municipal worker. DTO Dr Sathe, who joined office two months ago, is on his way out, reveal sources. He was unavailable despite repeated attempts.

Nowhere to go

A social worker says Nallasopara (E) does not have a PHC; the closest one is at Nallasopara (W). Virar (E) has just one PHC for several slum settlements. Patients from there, too, travel to Nallasopara for treatment. "We need at least 10 to 12 community-level DOTS centres in the area, as the slum pockets are dispersed. Since most patients are migrant labourers, they don't have the money or the time to make this trip. This adds to the high default rate," adds the social worker.

Dr Anil Patel, a general physician from the same area, says the lack of awareness of TB and its treatment in poorly developed areas makes patients refuse to go in for tests. Every month, Dr Patel refers 25 patients to Mumbai's hospitals. "Most people don't want to visit DOTS centres because of the distance (from their home). Since there are no X-ray machines at these centres, those who want to get tested end up at Bhagwati, KEM or Nair hospitals," he adds.

A staffer at the Bhagwati Hospital has observed that 30-50% of the patients there are from Vasai and Virar. "Every day, more than 500 TB patients wait in the outpatient department for sputum testing."

Pratibha Gupta manages the lone DOTS centre between the expanse of Vasai and Nallasopara, at Santosh Bhavan. "Commuting long distances isn't the only problem patients face. There's no electricity or water available in their areas. Patients can't come to us, as they have to wait for the water tanker that comes once or twice a week. Those who have kids have no one to leave them with. So, their treatment suffers and the default rate climbs," she said.

Infrastructural problems

Most often, NGOs in and around the city have to shoulder the responsibility of conducting health awareness campaigns and service delivery (sputum collection, laboratory work and running DOTS centres).

An NGO member who has worked in the Vasai-Virar region for over a decade now blames the civic body for failing to reach out to patients. "The VVMC is a new civic administration and things are not in place. A TB control society can be set up only after the VVMC starts functioning properly. This will take time. The Revised National Tuberculosis Control Plan (RNTCP) says the population in this belt is 8-9 lakh, but we know that it's 12 lakh. The way the area is divided is also problematic."

Poor public transport services, the lack of awareness about the location of DOTS centres, shortage of power and water, which directly affects sanitation, and the number of affected patients in slum pockets have exacerbated the situation, complain social workers. To deal with this, NGOs have set up DOTS centres at dispensaries of general practitioners every 2-3km away.

A doctor associated with an NGO says ideally, a health post should cater to only 50,000 people under any national healthcare programme. But, sometimes, the ratio is as high as 1:1 lakh. He says the civic administration hit the panic button after the media scare on the drug-resistant strain of TB in January. "Because of the panic, the development which was supposed to take a year, took place in weeks. This did not take into account systemic issues, resources and problems of manpower. This is no way to deal with a problem."

D.N.A; April 16, P.2

At a rural hospital at Virar (W), a staffer says most patients, who are slumdwellers, arrive after their costly treatment with private doctors has failed. "By then, they develop resistance to drugs."

In 2011, 1,400 TB patients registered with the rural hospital and their default rate was 20%. "We need three TB units, but we have just one. We need at least 15 lab technicians. Also, we need to focus more on creating awareness about the disease. Patients don't even know that we exist. On paper, we get facilities for 6.5 lakh people, but the number of patients is twice as much," the official says.

Sewri hosp bears load

A senior doctor from the TB hospital at Sewri says up to 20% of patients are from the city's outskirts. The hospital is the only referral unit for Mumbai, Thane, Kalyan, Dombivli and Ulhasnagar. He clarifies that the hospital's facilities were originally meant only for Mumbai city, but they are not enough to deal with the additional burden. "We need to increase our bed capacity from 1,000. There is a need to modernise the hospital. We need advanced facilities, surgery and culture tests."

A health care worker complains that the workload on the laboratory reflects the state of the infrastructure. "In the primary line of testing, the lab gets 120 samples a day, but because they have other tests to conduct, like for malaria, diabetes, pregnancy and HIV, they can only test 10 a day. Other hospitals like KEM, Nair and Sion have only 30 beds. This is the main hospital. Where will people go?"

Owning to the high incidence of deaths at the Sewri hospital, as most patients arrive only in the last stage of the infection and after everything else has failed, many others are hesitant to visit it, claim NGOs.

Way forward

Under the RNTCP's two-year project, 120 pharmacists from Mumbai, Navi Mumbai and Kalyan-Dombivli areas have been trained with the help of city TB authorities to help detect and refer chest symptomatic (lung TB) cases, to create awareness about TB & DOTS centres and to act as DOTS medicine providers.

TB CASES REGISTERED

District	2005	2006	2007	2008	2009	2010
Mumbai	26,241	25,465	28,887	30,606	30,564	29,685
Thane	2,974	2,850	2,797	3,121	3,065	2,697
Navi Mumbai	1,550	1,684	1,756	1,783	1,865	1,905
Kalyan-Dombivli	1,849	1,675	1,845	1,947	2,164	2,100
Ulhasnagar	974	889	927	886	854	836

Symptoms and testing of pulmonary TB

Persistent cough, usually with spitting, for two weeks or more

Sputum smear microscopy is highly reliable, cheaper and easy to perform

Sputum examination and anti-TB treatment is free under the RNTCP

20%
of deaths from communicable diseases are due to TB

Overcrowding, malnutrition, HIV contribute to rise in TB cases

(Source: Indian Pharmaceutical Association)

EVERY DAY, IN INDIA

5,000
develop the disease

1,000
of the affected die (2 deaths every 3 minutes)

40,000
get infected

The country accounts for 1/5 of the global TB burden

18L
new cases of are registered, of which about 8 lakh are sputum-positive infectious cases

GET IT RIGHT

Myth: Tuberculosis is hereditary

Fact: It is a disease that is transmitted from person to person via air, during coughing, sneezing, laughing, singing, shouting and talking

Myth: Tuberculosis infection always develops into tuberculosis disease

Fact: It's not always so. Those with a weak immune systems, such as the very young and very old, HIV-afflicted and with cancer are more likely to develop active disease once infected

Myth: Tuberculosis disease and Tuberculosis infection mean the same thing

Fact: There are two types of tuberculosis: Tuberculosis disease and Tuberculosis infection. Tuberculosis infection is not contagious because the germ is inactive or latent. The person shows no signs or symptoms. A person with tuberculosis disease has the active germ within his/her body and experiences symptoms

WHO drops plan to target alcohol use reduction

Kounteya Sinha | TNN

New Delhi: In a highly controversial move, the World Health Organization (WHO) has dropped its plan to set a target for cutting down on alcohol use across the world over the next 13 years.

In January 2012, the WHO set a target to reduce per capita consumption of alcohol globally by 10% and another 10% reduction of heavy episodic drinking by 2025 as part of its global plan to reduce the burden of non communicable diseases (NCDs).

TAKING THE EDGE OFF

But an updated set of global targets for NCDs released to member states including India on March 22 strangely had no mention of alcohol. India's health ministry said, "Alcohol was let off the hook with the alcohol lobby forcing WHO into deciding against setting reduction targets on its consumption."

Globally, 3.2 lakh young people aged 15-29 years die annually from alcohol-related causes, resulting in 9% of all deaths in that age group. Around 6.2% of all male deaths are related to alcohol, compared to 1.1% of female deaths.

Nearly 62.5 million people in India drink alcohol with the per capita consumption being around four litres per adult per year. For every six men, one woman drinks alcohol in India. A Lancet study recently said alcohol raises the risk of as many as 60 different diseases. Drinking too much alcohol increases the risk of cardiovascular disease, blood pressure and leads to obesity.

Dr K Srinath Reddy, president of the Public Health Foundation of India, is one of the global experts helping WHO set these new NCD targets. He told TOI that alcohol was an important cause of cancer, high blood pressure, mental illness, road traffic accidents and liver diseases.

Dr Reddy said, "There is a clear need to prevent the harmful use of alcohol as stated in the WHO's global strategy for prevention and control of NCDs which were endorsed by the World Health Assembly in May 2011. The political declaration adopted at the UN high level meeting on NCDs in September 2011 was surprisingly weak on alcohol control measures such as higher taxes and curbs on advertisement of young persons and was dropped in the final resolution."

He added, "Now alcohol related target is also being dropped from the proposed monitoring framework. This is unfortunate since the danger of alcohol consumption among youngsters is rising all over the world including India."

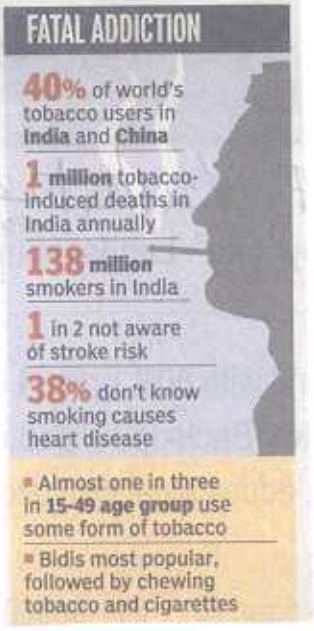
Times of India, April 23, P9

50% Indian smokers don't know it can kill

NEW DELHI: Smoking kills, but most smokers still don't know how. One in two Indian smokers isn't aware that tobacco addiction can lead to stroke and 38% that it can cause heart disease.

These are some of the startling findings of a World Heart Federation report that will be released at the World Congress of Cardiology (WCC) in Dubai on Saturday.

India is high on tobacco addiction. It has 138 million smokers and 28% of its people in the 15-49 age group use tobacco in some form or the other. Bidis are the most popular (48%) followed by tobacco-chewing (38%) and cigarettes (14%).



Every year, tobacco kills 1 million people in India. Heart disease caused by it accounts for the highest number of deaths (29%).

Data from Indian Heart Watch — the country's largest heart-risk survey of 6,000 people across 11 cities over five years — presented at the WCC on Friday found awareness among tobacco users shockingly low.

While people in smaller cities smoked more and ate more fatty food than fresh fruits and vegetables, those in the metros were less active. Obesity, high blood pressure and high cholesterol were uniformly high. Awareness and control rates of risk factors were low even among literate middle-class urban Indians.

Roughly one in three surveyed had hypertension but only 57% knew about it. Among those diagnosed with hypertension, 40% were on medicines and only 25% had it under control.

"To get people to quit tobacco, the policies must focus on clearly informing the people through effective measures, such as pictorial warnings on tobacco products depicting heart disease and stroke as real dangers," said Dr K Srinath Reddy, president, Public Health Foundation of India

Hindustan Times, April 21, P. 1+8

No fertile men in 50 yrs as sperm counts slide?

Mumbai: Blame it on growing levels of stress, obesity or pollutants in the air, counts of the microscopic sperm are falling and causing mega concern across the globe. One estimate holds that it has fallen by as much as 50% in the last 50 years.

Dr P M Bhargava, who worked out the Indian guidelines for assisted reproductive techniques (which are soon expected to become law), said the trend of falling sperm counts was noticed in the mid-90s in the West. "Some doctors in India believe sperm counts are falling locally too," he said, adding that western studies show that counts have been falling by 2% every year. "At this rate, there would be no fertile men left in the next 40-50 years," said the Hyderabad-based Bhargava.

A couple of years ago, a study from Scotland of 7,500 men who attended the Aberdeen Fertility Centre between 1989 and 2002 showed that average sperm concentrations fell by nearly 30%. Another study from Copenhagen found a newer reason apart from alcohol abuse, smoking and obesity for this decline -endocrine disrupters. "Many everyday substances such as plastic buckets (or milk bottles) emit chemicals that are similar to estrogen, the female hormone," said Bhargava. It is exposure to the female hormone-like chemicals that could be reducing the sperm count in men, believe a school of scientists. Commonly used pesticides such as DDT and dioxins have been named as culprits.

Infertility specialist Dr Aniruddha Malpani said endocrine disrupters are just one of the unproven theories floating around to explain falling sperm counts. "It is the most famous theory, but it hasn't been proven yet," he said. Rising infertility is a problem for both men and women due to late marriages and delayed child-bearing, he added.

Dr Anjali Malpani gives a statistical break-up of how sperm counts have been falling over the decades. "When we started Mumbai's first sperm bank two decades ago, we would get donors who would easily have counts of 40-60 million spermatozoa per millilitre," she said. But in 2009-end, the World Health Organization revised its definition of normal sperm count to 20 million per ml. So, the Malpani sperm bank rejects potential donors whose counts are below 15 million per ml. Sperm donation has undergone a sea change in Mumbai. "Two decades ago, when we set up the city's first sperm bank, we were asked how we could use such a word openly. It was difficult to get donors as men said they didn't want to run into lookalikes 20 years hence," said Malpani.

Times of India, April 22, P.1

We have weaker hearts than Americans: Study

TIMES NEWS NETWORK

Mumbai: There is now statistical proof to say that urban Indian lifestyles are queering the pitch for the Indian heart. Born with thinner arteries and at genetic risk for cardiac diseases, Indians are worsening their risk for heart diseases with poor physical activity, a high-fat diet and by steadily shunning fruits and vegetables.

A study released at the World Congress of Cardiology in Dubai on Thursday said four of five Indians led an inactive life and about half were on a high-fat diet. Called the Indian Heart Watch (IHW) study, spanning 11 cities and covering 6,000 men and women, it was offered as the first-ever study on risk factors for heart diseases in India. "The study showed risk factors are now at higher levels in India than in developed countries and regions such as the US and western Europe," said the study's researchers.

INDIA HEART WATCH

Survey size: 6,000 men and women from 11 cities ('06-'10)

	Female (%)	Male (%)
Physically inactive	83	79
High-fat diet	48	51
Smoked	0.5	12
Overweight	45	41
High BP	30	33
High cholesterol	25	25

Indian Heart Watch looked at three lifestyle factors — physical activity, diet and smoking — as well as biological factors like obesity, diabetes, high BP and cholesterol.

Cities, with their urban transport networks and fast-food joints, registered widespread physical inactivity. Even smaller towns had a higher incidence of smoking and low intake of fruits and vegetables. In sum, the research team comprising Jaipur-based cardiologist Rajeev Gupta, said improper urban social development was worsening cardiac risk factors among Indians. The Indian Heart Watch covered major cities such as Delhi, Mumbai as well as mid-sized towns such as Agra, Rohtak, etc.

Around 79% of men and 83% of women (who participated in the study) were found to be physically inactive, while 51% men and 48% women had high-fat diets. "About 60% men and 57% women were found to have a low intake of fruit and vegetables, while 12% men and 0.5% women smoke," the study said. Around 41% of men and 45% of women were overweight or obese. High blood pressure was reported in 33% men and 30% women, while high cholesterol was found in one-quarter of all men and women. Diabetes was also reported in 34% men and 37% women.

Times of India, April 02, P15

MILESTONES UNDER NRHM IN J&K

Now more people have access to Health Care Services than ever before

Health Indicators				
S No.	Indicator	(SRS 2005) J&K State	(SRS 2010)	
			J&K State	National Level
1	IMR	50	43	47
2	TFR	2.4	2.0	2.5
3	MMR	NA	70*	212**

SRS- Sample Registration System.
*Directorate of Economics & Statics J&K 2008.
**SRS 2007-09.

Performance of Health Institutions (Figure in No.s)				
S No.	Indicator	2008 (Jan- Dec)	2011 (Jan- Dec)	%age increase
1	OPD	10304442	15791868	53%
2	IPD	425122	785445	85%
3	Institutional Deliveries	76206	99545	31%
4	Lab Investigations	651599	1725618	165%
5	Revenue Generation in Rs.	516.09 Lakhs	1606.20 Lakhs	211%


World Health Day Celebrations -2012


Foundation of SDH R.S.Pura


Sub District Hospital Baderwah


SNCU at District Hospital Kathua


Newborn Care Unit


Delivery at Primary Health Centre

- Zero expenditure out of Pocket expenses under Janani Shishu Suraksha Karyakaram (JSSK) implemented in the State vide Govt. order No. 516-HME of 2011 dated 24/09/2011. 14879 normal deliveries, 3670 C-section deliveries & 1437 sick newborns have been benefitted under this scheme till date.
- 3.5 Lakh mothers benefitted under Janani Suraksha Yojana (JSY).
- Nearly 3.82 Lakh Village Health and Nutrition days held to provide Immunization to dropout children and Mother/ Child health care services at the Anganwadi centres.
- 271 MBBS Doctors & 438 AYUSH Doctors engaged under NRHM in the State.
- Second Female Multipurpose Health Workers (ANM) added for all 1907 Sub Centres out of which 1822 ANMs engaged till date.
- Additional 3628 Medical/ Paramedical staff engaged on contractual basis under NRHM to provide Health-care Services.
- 74 CHCs operationalised as First Referral Units (FRUs) and 170 PHCs made to function on 24X7 basis.
- 259 Baby Care Corners for paediatrics established till date.
- 67 Stabilization Units for paediatric care established at Community Health Centres.
- Five SNCUs made functional for neonatal care and nine more to be established in District Hospitals @ 55.00 Lakhs per unit.
- Over 9575 ASHAs have been selected to connect households with health facilities. ASHA's have been trained in different modules.
- Programme Management Units have been established at State, District & Block Level.
- 567 Rogi Kalyan Samitis (RKS) established in DHs, CHCs, PHCs.
- All Health Institutions have been strengthened by way of providing corpus funds, untied funds & annual maintenance grant.
- 6886 Village Health Sanitation & Nutrition Committees constituted & funds released thereof.
- Mainstreaming of AYUSH done by providing one AYUSH Doctor and one ISM Pharmacist at PHC level.
- Additional 75 AYUSH Doctors and MBBS Doctors provided for difficult areas.
- Rs 267 Crores provided for infrastructure development in the health department.
- 25 Doctors trained in DPHHM (Diploma in Public Health & Hospital Management) at NIHFW New Delhi & posted as Block Medical Officers.
- 2370 Doctors and Paramedics trained in different trainings.


NRHM Samelan at Budgam


NRHM Samelan at Leh


NRHM Samelan at Shopian


Workshop on HMIS/MCTS


Workshop on Maternal Health Strategies


Participation in Republic Day Celebrations

Issued in public interest by:

J&K Rural Health Mission

Hindustan times, April 21, P.15

7 YEARS OF NRHM

REACHING OUT TO PEOPLE OF THE COUNTRY

National Rural Health Mission was launched on 12th April 2005 :

To strengthen the hands of the State Governments in health care delivery.

To allocate more financial resources for health.

To bring sharper focus on rural, particularly marginalized and vulnerable populations.

Architectural correction through integration of vertical programmes, decentralization andcommunitization.

Indian Express, April 12, P.5

Increasing Human Resources

On a baseline of about 150,000 health workers, the NRHM added...

- 8722 Medical Officers
- 2914 specialists
- 10995 AYUSH doctors
- More than 13,000 programme management staff

- 69662 ANMs
- 33411 nurses
- 14529 Para-medicals
- 861,548 ASHAs

- As of 31st December 2011, 1.44 lakh human Resources have been engaged across the country.
- Major expansion of nursing education- 300% increase in seats
- Major increase in medical education: 38% increase in seats.

Increasing Central Funding

Increase of 21.5% per year during NRHM Phase (2004-06 to 2008-09) as against 10.8% per year in Pre NRHM period (2001-02 to 2004-05)

Total outlay for XIth Plan was Rs. 90558 Cr.

Rs. 70030 Cr released in the XIth Plan

(Source: Expenditure Budget Vol. I GoI 2001-02 to 2010) and 2010-11is Revised Estimate and 2011-12 Budget Estimates

Includes the expenditure on Health and Family Welfare, AYUSH and Health Research

Strengthening Community Processes

- Accredited Social Health Activist (ASHA) acts as interface between community and Health System. 8.61 lakh ASHAs have been engaged at village level.
- Village Health Sanitation and Nutrition Committees are constituted at Village/ Gram Panchayat level with representation from all sections of the community including the disadvantaged sections. 5.00 lakh VHSNCs have been constituted.
- Rogi Kalyan Samitis (Patient Welfare Societies) are set up at various hospitals to encourage involvement of the community in the management of Public Health services. 30,420 RKSs have been constituted at the health facilities.
- VHSNC and RKS are empowered with Untied grants.
- Community Monitoring programme is being encouraged.

TB and MDR-TB

DOTS strategy significantly improved case detection and cure rates beyond 72% and 87%, respectively

28 accredited labs have been set up across country to diagnose Multi Drug Resistant TB (MDR-TB) and 15 are under process which shall be completed till March 2013

6944 patients have been provided treatment for MDR-TB upto 2011

Strengthening of Health Facilities under NRHM

- 2329 Referral Hospitals have been strengthened to act as First Referral Units with CEmONC capacity – which means functional OT, laboratory and blood transfusion services,
- 8250 PHCs are currently functioning as 24x7 PHCs.
- 340 Newborn Intensive care & 1124 Newborn Stabilisation units

Infrastructure

- 20251 new constructions have been sanctioned.
- 18883 renovations have been sanctioned.

MMUs

- 1951 Mobile Medical Units provided in 442 districts for delivery of health care to difficult areas

Emergency and Referral Transport

- 7097 Emergency Response Vehicles
- 7458 ambulances added for providing referral transport services

Janani Shishu Suraksha Karyakram

Launched on June 1, 2011

Free Care to Mothers

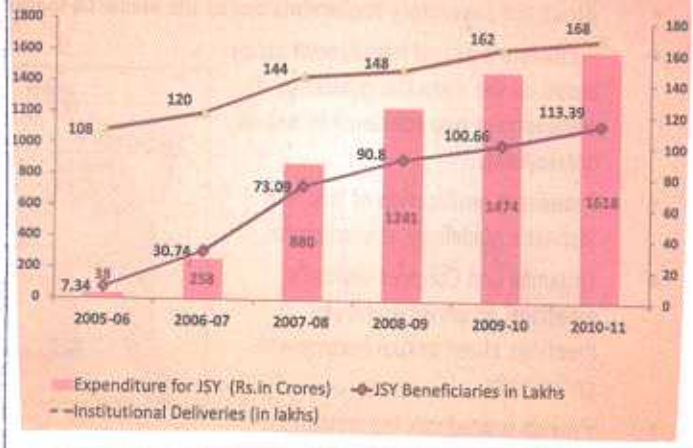
- Free and Zero Expense delivery and Csection
- Free drugs, diagnostics, blood and consumables
- Free diet during stay in facilities
- Free transport home to health institution, between health institutions in case of referral and drop back home
- Exemption from all kinds of user charges

Entitlements for sick New born till 30 days after birth

- Free treatment, drugs, diagnostics, blood and other consumables
- Free transport home to health institution, between health institutions in case of referral and drop back home
- Exemption from all kinds of user charges

Janani Suraksha Yojana

A phenomenal increase



Overview of Achievements

Disease Control Programmes

Malaria Mortality Reduction Rate	55% mortality reduction in malaria in 2010 as against 2006
Kala Azar Mortality Reduction Rate	44% mortality reduction in 2010 as against 2006
Dengue Mortality Reduction Rate	26% mortality reduction in dengue in 2010 as against 2006
Cataract operations	More than 6 Million Cataract Operations every year
Leprosy Prevalence Rate	Reduced from 1.8 per 10000 in 2005 to less than 1 per 10000 thereafter
Tuberculosis	72% case detection rate and 87% Cure rate.

Integrated Disease Surveillance Project (IDSP)

- Strengthened at state and district HQ. with 90% of districts report on weekly basis
- Compared to 553 outbreaks in '08; 799 outbreaks reported in '09 and 990 in '10, 1675 in 2011

National Centre for Disease Control (NCDC)

- To upgrade NCDC with an estimated Rs. 382 crores
- The objectives for the upgradation are to
  - Strengthen capacity of states and districts in outbreak investigation and response
  - Enhance NCDC's capacity to identify and characterize newer pathogens
  - Efficiently respond public health emergencies of international concern

Maternal Mortality Ratio

- Reduced from 254 per 100,000 live births (2004-06) live births to 212 per 100,000 live births (2007-09)

Infant Mortality Rate

- Reduced from 58 per 1000 (2005) live births to 47 per1000 live births (2010)
- Decline in Rural IMR greater than decline in Urban IMR

TFR

- Reduced from 2.9 (2003) to 2.5 (2010)

Polio

- India is taken off the list of endemic countries by WHO because of zero polio case for more than a year

सत्यमेव जयते

Ministry of Health and Family Welfare
Government of India

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

HIV test not must for getting jobs, proposes Bill

Subodh Ghildiyal | TNN

New Delhi: The HIV-AIDS (Prevention & Control) Bill says that testing for AIDS cannot be a pre-requisite for employment or for access to healthcare, education or public places. It would mean that HIV-afflicted people refused entry to public places like hotels or restaurants or denied purchase or renting of house can move an ombudsman. They can also move courts against discrimination.

Any person below 18 and a woman of any age will have the right to live in a shared property, as a safeguard against eviction due to stigma. The medical costs will be factored in during any maintenance settlement. This can help women in divorce cases.

The law would put in place a National Authority, in the form of a Department of AIDS Control (NACO), which will formulate guidelines and rules for protocols like treatment of HIV patients through anti-retroviral therapy or rules for blood banks or diagnostic centres.

An ombudsman in every state, as the forum to adjudicate violations, would help the aggrieved avoid time-consuming legal proceedings. The law seeks to deter rampant victimization of the HIV-positive. A key clause prescribes a jail term of three months to two years for any spoken or written word, or display of information or advertisement, which could expose HIV-positive to any form of hostility. This can also lead to a fine of up to Rs 1 lakh.

The law asserts no person can be forced to take an HIV test. For such a test, the authority would have to secure consent after due counseling on all pros and cons. Similarly, no HIV-positive person can be subjected to medical treatment without his consent — a decision which should be made after he has been informed about the risks and benefits of the treatment.

A judicial order would be the only exception to force an AIDS test on a person apart from "screening purpose" in a blood bank.

The HIV positive persons would finally enjoy guaranteed confidentiality. No person can be compelled to disclose his HIV status (except under a court directive).

In a strict deterrent, the law states that if a person reveals the identity of an HIV-positive, as information that is passed on as part of legal proceedings, he could face a fine of up to Rs 1 lakh.

To balance the threat of transmission with stringent non-disclosure law, a doctor can disclose his patient's HIV-positive status to his partner if he believes there is a risk of infection. However, he would have to guard against such disclosure about a woman if there is apprehension that it can lead to her being abandoned or facing violence.

The ombudsman can impose an initial fine of Rs 10,000, and thereafter Rs 5,000 a day for non-compliance of orders. To ensure that non-discrimination clause of Act is followed at workplace, every institution with over 100 employees would have to appoint a senior officer to deal with violations of the law.

Times of India, April 8, P8

Food free from fear

The Food Safety and Standards Authority of India (FSSAI) has asked the States to put in place an adequate and effective structure to administer the Food Safety and Standards Act, 2006, which came into effect from August 5 last year.

The Act essentially involves putting in place an effective enforcement machinery to ensure safety in foods that are consumed. It was drafted as a consolidated Act bringing under its jurisdiction various individual Acts including the Prevention of Food Adulteration Act.

In a letter to the States, K. Chandramouli, chairperson of the Authority has asked them to direct all concerned to initiate, set up and strengthen the implementing agencies so that "we could improve and put in place an adequate and effective structure to administer the Act."

"You would agree that this is a very stupendous task and would need a very well coordinated effort involving local bodies like the municipalities, town areas and panchayats. A very strong information, education and communication (IEC) effort with local training and capacity building for government staff would also need to be put in place," Mr Chandramouli said while adding that FSSAI would be supporting the States in terms of providing on-line software and material, training modules, training of trainers and resource persons. We have also sought budgetary support to strengthen the regulatory system in the 12th Plan, he said.

Under the Act, it is essential that enforcement structure includes the posting of the designated officers at the district level and at Food Safety Offices in the sub-district level who would enforce the Act. At the State level, the Food Safety Commissioner is the head of this machinery. Some States have already appointed a Food Safety Commissioner and also have in place the structure for the enforcement of the Act. The new Act is more holistic and science based and is less regulatory with graded penalties.

The Act has also defined a Central Advisory Committee with representation of all States to meet regularly to monitor, review and assess the implementation of this law. In the last meeting held in January, some of the issues which were common and relevant to all States were taken up and discussed, including training of manpower at the district and sub-district level in the areas of sampling, licensing and registration. "There is a need to supplement the manpower and strengthening of the system. The licenses are to be issued to all Food Business Operators (FBO) through conversion of their earlier licenses issued under the Prevention of Food Adulteration Act and in cases where FBOs have come into being, issuance of new licenses. Similarly, a large number of small time FBOs would need to be registered," Mr Chandramouli has said in his letter.

The Food Safety and Standards Act of 2006 is at par with international standards, ensuring improved quality of food for consumers and censure of misleading claims and advertisements by those in the food business.

FSSAI, established under the overarching legislation, lays down science based standards for food items and regulates their manufacture, storage, distribution, sale and import to ensure availability of safe and wholesome food for human consumption.

Hindu, April 5, '10

'Right to Health Bill in the pipeline'

Special Correspondent

CHANDIGARH: Union Parliamentary Affairs Minister Pawan Kumar Bansal said on Saturday that the Indian Constitution is the best in the world as it has "enough scope for amendments for its better functioning".

Speaking at a function here to commemorate the birth anniversary of the Constitution's founder B. R. Ambedkar, he said that the United Progressive Alliance Government had undertaken many development schemes to benefit the common men, especially the backward and the downtrodden.

Talking about unemployment, he said the Centre had started the National Rural Employment Guarantee Scheme to give 100 days' work to every family in the rural area and it was likely to be extended to urban areas also.

The Government had also implemented the Right to Education Bill under which 25 per cent of seats had been reserved for economically weaker sections in private schools to give them quality education.

A Bill on the Right to Health was in the pipeline, he added.

In Chandigarh, his constituency, 25,000 houses had been allotted to weaker sections of society and 8,000 more were nearing completion, he said.

Meanwhile, Chief Minister Bhupinder Singh Hooda at a meeting in Hisar announced that the scheme for construction and repair of houses of members belonging to Scheduled Castes, Vimukt Jaties and Tapriwas would now be known as Baba Saheb Ambedkar Makan Yojna.

As per the scheme, a grant of Rs. 50,000 is provided to the members belonging to Scheduled Castes, Scheduled Tribes and Tapriwas for the construction of *pucca* house and Rs. 10,000 for repair.

Mr. Hooda also announced a Rs. 21 lakh grant for Dr. B.R. Ambedkar Hostel.

He said Haryana was the only State providing scholarships to all the students belonging to Scheduled Castes, Backward Classes and those living below poverty line.

Hindu, April 15, P 7

WATCH WHAT YOU EAT

Daily nutritional requirements

Subject	Kilocalories	Carbohydrates	Salt	Total fat	Trans-fat
Adult male	2,320	290-348	6.0	39-78	2.6
Female	1,900	263-315	6.0	35-70	2.1
Children (10-12 yrs)	2,100	238-285	6.0	32-64	2.3

OTHER FINDINGS: If you consume a bottle of 300 ml of carbonated beverage, you exhaust your options of having any more sweetener for the day – in tea or coffee. It exceeds your sugar quota twice over. Pizza is high in refined carbohydrates.

urban Indian's affinity towards junk food has upset the scales of nutrition – resulting in obesity and cholesterol-related issues. A y by the Centre for Science and Environment has shown that most fast food products are rich in harmful trans-fat. An overview:

FINDING: A packet of 65-75 mg potato chips makes up for half your daily fat quota. Consumption of a packet of PepsiCo's Lays, as of March 2012, would make you exceed your trans-fat quota for the day. Lays contains 3/7 gm of trans-fat – despite claims that it is free of the substance.

THE DEFENCE: A PepsiCo spokesperson said their products, including Lays chips, were trans-fat free — as defined by Indian regulators. This was a fact that was reflected in regular analyses conducted at globally reputed and government-approved laboratories, he claimed.

FINDING: A packet of instant noodles makes up for 70% of your daily quota of calories in the form of refined carbohydrates, and more than half your salt quota. As opposed to the recommended intake of 6 gm of salt, a pack of Maggie Noodles contains 3.5 gm of the seasoning.

THE DEFENCE: A spokesperson of Nestle, which manufactures Maggie Noodles, said, "As per our analysis for many years now, the level of trans-fat in our products is within the international recommendation. Also, we comply with all the food regulations put forth by the Indian administration."

FINDING: Two pieces of KFC fried chicken exceed your trans-fat and total fat intake for an entire day. A single McDonald chicken burger, with 100 grams of french fries and 300 ml of carbonated drink, provides for as much as 47% of your daily calorie requirements.

THE DEFENCE: Claiming .hat all its products have "zero added trans-fat", Yum! Restaurants India, which runs KFC, said it meets stringent international and national guidelines. McDonald's said it uses palm oil because its trans-fat content is "so low that it is virtually undetectable".

Hindustan times, April 1, P.8

Don't skip meals

No matter how convenient packaged meals are, there's nothing to beat home food both for taste and nutrition.

DR. PAWAN GUPTA

When 23-year-old Shalini Kulshreshtha, a software engineer, moved to Delhi from Chandigarh, she realised that her health was going to take a beating due to her hectic lifestyle. Invariably, she ended up skipping the most important meal of the day: breakfast.

"There was simply no time to prepare and eat breakfast before leaving for work," says Shalini.

Shalini's story is not an isolated one. Experts believe that corporate culture combined with stiffer-than-ever competition has brought about major changes in the way we do things. The obvious casualties are a person's eating habits, hours of sleep, physical activity, and even inter-personal relationships.

"There has been a dramatic shift in lifestyle over the past decade," said Anuja Agarwal, Chief Dietician, AIIMS, New Delhi. "In terms of daily routine, activities important to one's health and wellness are being ignored. Gone are the days when you could exercise and enjoy a leisurely and nutritious breakfast before heading to work."

A FULL MEAL IN ITSELF...
PHOTO:M.KARUNAKARAN

Today, the availability of ready-to-eat breakfast cereals, instant foods, snacks as well as diet foods have radically revolutionised the way we eat. Even 20 years ago, the concept of packaged foods was not popular in India, especially when it came to perishable items like milk and juice. There were also concerns on the use of artificial flavouring substances and preservatives. Today whether it's packaged juice or food, the variety is mind-boggling. However nothing beats home food both in terms of taste and nutritional value.

Quick Fixes

Here's a mix and match menu to give your diet variety. Remember to space your meals evenly and work out regularly as well.

- **Breakfast**

Mushrooms on Toast
Daliya Salad
Grilled vegetable sandwich with mint/coriander chutney
Idli with sambhar,
Plain dosa
Milk with cornflakes or wheat flakes.
High fibre fruits like apples, papayas, muskmelons, oranges or watermelon.
Yoghurt, juice, lassi, fruit shakes (without sugar).

- **Lunch**

Two chapattis (multigrain flour), one bowl of rice, one bowl dhal (avoid tempering), one cooked vegetable dish and salad (avoid dressing).

- **Dinner**

Steamed salad (with yoghurt or olive oil dressing), grilled fish/chicken/paneer/gourd vegetable with a multigrain toast or multigrain chapatti, papaya salad

- **Bed time**

A glass of double toned milk

Hindu, April 15, P M6

50,000 malnourished kids died in 8 years

Shubhangi Khapre

The lack of food is rapidly killing tribal children even before they reach six, leaving 51,461 malnoursihed children dead across rural Maharashtra between 2004 and 2012.

The startling revelation has once again raised a debate within the government about the need to make higher allocations for the health, women and child development departments, even as the centre-state schemes evolved for the tribal population, which often goes without decent two-meals a day, appears to have remained on papers.

A senior officer in the tribal welfare department revealed, "The judicious utilisation of funds for the specific schemes is never implemented. Almost 45% of the funds, which remain underutilised, are diverted for other projects."

Another hurdle in preventing malnourishment is the severe lack of coordination among the various health-related departments, namely ministry of health (the nodal body), tribal ministry and women and child development and family welfare.

Citing that the budget session is on, a senior minister on conditions of anonymity said, "If we compare the child tribal deaths in 2004-05 with those in 2011-12, we can see a decline in the numbers, from 8,003 to 2,849. What has the government worried is the speedy progress of malnourishment cases from the rural areas to urban centres, which can be partly attributed to the migration for livelihood to cities, including outskirts of Thane, Nashik and Mumbai."

According to the World Health Organisation (WHO) parameters, severe underweight children among the tribals accounted for 22.3% population in the year 2011-12. This, even as minister for women and child welfare Varsha Gaikwad maintained that "Notwithstanding the reasons, the government is committed to eradicating malnutrition with help of a sustained long-term programme."

While issuing stern directives to the senior bureaucrats and ministers concerned to maximise fund utility for the stated purpose, chief minister Prithviraj Chavan argued that a progressive state cannot afford to let such a menace in its own backyard.

SHOCKING STATISTICS

22.3% The percentage of malnourished tribal (adivasis) children across the Maharashtra

2.58% The budget allocation for the general health sector for 2012-13

51,461 the total number of registered deaths of children between 2004 and 2012

27,765 the number of malnourished deaths during the 11th Five Year Plan (2007-12)

BUREAUCRATIC BLUNDERING

A major hurdle in preventing malnourishment is the severe lack of coordination among the various health-related departments, namely ministry of health (the nodal body), tribal ministry and women and child development and family welfare

The centre-state schemes evolved for the tribal population, which often goes without a decent two meals a day, appear to have remained on paper

The debate continues within the government about the need to make higher allocations for the health, women and child development departments

D.N.A, April 16, P5

Lessons from Melghat's health crisis

At a time when India plans a multi-pronged attack on malnutrition in 200 high-burden districts, it will pay to examine the cracks in state institutions that have led to past failures and can still derail well-intentioned plans.

Melghat, a tribal corner in the northeastern fringes of India's richest state—Maharashtra—is an apt example of almost everything that has gone wrong in India's response to malnutrition and child deaths.

Every 14th child dies in Melghat before reaching the age of six, often owing to malnutrition-related causes. The statistic has remained largely unchanged over the past five years and puts Melghat almost at par with less-developed sub-Saharan nations such as Senegal and Tanzania.

The fate of tribal children in Melghat mirrors that of children in other parts of tribal India and reflects the yawning chasm between tribals and others. Nearly one in two tribal families are poor in rural India, according to the latest official estimates, a ratio that is 40% higher compared with the rural average.

Melghat also demonstrates the ineffectiveness of state-sponsored schemes such as the National Rural Health Mission (NRHM) and the Integrated Child Development Services (ICDS) in improving child health.

India's poor record in tackling malnutrition has come to the fore once again after the recently published results of a survey led by non-governmental organizations (NGOs) such as the Naandi Foundation found rates of stunting or chronic under-nourishment to be 59% across 100 districts, 11 percentage points higher than what the National Family Health Survey (NFHS) recorded across India in 2006.

Just like everything else in the nation, the spread of malnutrition is uneven. The inequality in malnutrition rates is higher in India than in most other nations, a February report by Save the Children said.

Tribals are the worst affected and are the only social group that saw a rise in the rates of stunting between 1992 and 2006, according to NFHS data. Yet, malnutrition rates in the country can improve only if tribal malnutrition rates drop. As a World Bank report pointed out in 2005, a quarter of Indian districts—many of them tribal—account for over half of India's malnourished children.

In Melghat, a shoddy health care system and ineffective ICDS workforce have contributed to the stasis in child mortality rates but the root of the problem lies in the apathy of the political and administrative class that has failed to address either poverty and livelihood issues or deliver basic public goods.

The villages of Melghat—with treacherous roads, closed schools and mostly without electricity or piped water—appear to be in a time warp, left behind by India's famed engine of economic growth. In several villages, child deaths are more frequent than the visits of public servants.

Other tribal areas of the state with the second-largest tribal population in the country tell a similar tale. Maharashtra is one of the better-performing states when it comes to tackling malnutrition, but its progress hides deep inequalities.

Five tribal districts out of a total of 35—Amravati, Gadchiroli, Nandurbar, Nashik and Thane—account for a third of severely malnourished children in the state. The number of child deaths in some of these districts has grown in recent years. According to official estimates obtained through Right to Information applications by a Melghat-based NGO, Khoj, the number of child deaths went up 17% in Gadchiroli and 10% in Nandurbar in the past three years.

Melghat, composed of two blocks in Amravati district—Dharni and Chikaldhara—is special though, as it has the longest recorded history of child deaths and has seen decades of well-meaning judicial interventions starting 1993.

Media-savvy NGOs have managed to keep the spotlight on malnutrition and several politicians have made flying visits but life in Melghat has not changed much. A child in Melghat is thrice as likely to be severely malnourished compared with an average child in Maharashtra, according to ICDS data.

To be sure, the number of health centres has gone up in the past five years: a new rural hospital and a primary health centre (PHC) have been built, thanks to NRHM funding. The number of vacancies among PHC doctors has dipped to nearly zero.

Yet, such statistics hide more than they reveal. A third of PHC doctors are temporary, fresh out of college, and working for the government to fulfil their course requirements. Many doctors have been trained in traditional medicine but prescribe allopathic medicines with impunity. Although there are a few committed doctors, and the health

H.T. Mint, April 17, '09

department is better run than most other state agencies in Melghat, the overall quality of healthcare is poor.

Often, incompetent doctors get away even after making grave mistakes. When one-month-old Sachin Bethekar of Hatru village had diarrhoea in June, his parents took him to Hatru's PHC, where he was put on a saline drip till his stomach bloated. Sachin's distressed parents took him to a traditional healer or *bhumka*, who failed to help and he died the next day.

Saline injections to malnourished infants is a major cause of death in public hospitals although World Health Organization (WHO) guidelines forbid such treatment, said Ashish Satav, a physician and president of Melghat-based NGO Mahan. Nevertheless, the devastating impact of the saline drip finds no mention in the child death register at Hatru's PHC. It instead identifies the *bhumka* as the cause of death!

Health workers are as aware as other public servants that the chances of getting caught are slimmer than the chances of finding a healthy child in Melghat. Not surprisingly, such tales repeat themselves across Melghat. The details vary: in some villages, one came across stories of inadequate rations in crèches run under ICDS, in others of absent doctors, or of insensitive staff and petty corruption.

Sachin's uncle Sakharam Bethekar points out that this is not the first such experience the family has had in a public hospital: Sakharam's wife died while giving birth to a boy four years ago. Such incidents lead to a loss of trust in the public health system, said Bandu Sane, an activist with Khoj.

Across tribal India, the picture is equally bleak. A tribal child is 40% more likely to die before the age of five compared with an average Indian child not because he falls sick more often owing to malnourishment, but because he is half as likely to receive proper care, analysis of NFHS data by World Bank economists show.

Throughout history, tribals had a survival advantage over their peers, wrote demographer Arup Maharatna in his oft-cited book on the subject, *Demographic Perspectives on India's Tribes*. Till the early 1980s, tribal children had lower chances of dying compared with their closest social group, the scheduled castes, but mortality rates reversed in the past three decades as tribals lagged behind others in access to healthcare and basic amenities.

This decline in health of the country's most deprived social group has occurred precisely when the economy has grown at its most rapid pace ever, clocking an average of around 6% over the past three decades.

The blatant violation of norms and the years of neglect in Melghat arise from wide-ranging state failures and the inability of a weak tribal leadership to demand change. "Our leadership has failed us and anyone who takes up the cudgels on behalf of our community is either intimidated or bribed very easily," said Kalu Bethekar, a plain-speaking health counsellor at Hatru's PHC.

Funds for tribal development often lie unutilized or are diverted. In many tribal areas of the state, there is no officer to plan projects, since many consider appointments in such areas as a punishment posting.

Maharashtra is among the eight laggard states, which did not allocate funds in the tribal sub-plan—a part of the annual plan—in proportion to the tribal population of the state, despite repeated pleas from central government agencies, according to a 2011 tribal affairs ministry report.

Maharashtra has a 9% tribal population but allocated only 8.2% of its annual plan allocation to it. The actual expenses are invariably lower than what is planned. Maharashtra has spent less than 2% of its annual budget on the tribal plan on average in the past decade, according to a 2011 report by Thane-based NGO Samarthan, based on official statistics.

In 11 tribal dominated blocks of the state, an Integrated Tribal Development Project (ITDP) officer looks into the implementation of all projects related to tribal welfare. Such posts often lie vacant, and even when appointments are made they are for a brief period, according to the Samarthan report.

Melghat did not have a full-time ITDP nodal officer for several years and it is only recently, after repeated strictures from the judiciary, that the government has finally appointed one.

Even when funds are allocated, there is little accountability on how they are used and Hatru's PHC is a prime example. The health centre lacks a toilet and does not have electricity owing to a defective solar plant.

While there was no effort to build a toilet or hire a mechanic to get the solar machine repaired, NRHM funds worth over ₹4 million were spent on a new PHC building at Hatru that has remained unused for close to two years since it was built, apparently because of a leaky roof.

Unicef's framework on malnutrition identifies disease and inadequate dietary intake as the proximate causes of malnutrition while political and social systems that determine how resources are used and shared are identified as the underlying or structural causes.

In Melghat, all of these factors seem to have conspired together to deprive children of a chance at a healthy life.

Story in numbers

TRIBAL HEALTH INDICATORS

A tribal child is 25% more likely to be underweight and 40% more likely to die before five years of age compared with an average Indian child.

The proportion of low birth-weight children at around 23% as well as the proportion of neo-natal deaths at roughly 40% is similar for tribals and others.

However, more tribal children die in the 1-4 age group compared with others, according to the World Bank.

Tribals account for 11.7% of all children under five, but account for 14% of under-five deaths and 23% of all child deaths in the 1-4 age group in India.

Melghat, with an under-five mortality rate of 74, has twice as many children dying before the age of five as Iraq.

INDIA IN THE WORLD

Half the 7.6 million under-five deaths in 2010 occurred in only five countries: India, Nigeria, Democratic Republic of the Congo, Pakistan and China.

India (22%) and Nigeria (11%) together account for a third of all under-five deaths, according to the latest United Nations estimates.

With an under-five mortality rate of 63, India falls in the bottom quartile of countries in the world, according to the World Bank and ranks a lowly 165th.

Malnutrition statistics are worse: India is nearly at the bottom, with a third of the world's malnourished children. India's score in the global hunger index 2010 is described as alarming and the country is ranked a lowly 67th among 84 nations surveyed, below nations such as Sudan, Rwanda and Pakistan.

The global hunger index, developed by the International Food Policy Research Institute, is based on three key indicators: child malnutrition, rate of child mortality and percentage of people who are calorie-deficient.

PRAMIT BHATTACHARYA

In battle against vitamin A deficiency, push for better food rather than pills

AMID fresh findings on vitamin A deficiency in the country, and how poorly it is being addressed, nutritionists have stressed the need to do so with better food rather than medicines.

A study by the National Institute of Nutrition, Hyderabad, has found that coverage of the Vitamin A supplementation programme is poor. The study was conducted among 71,591 pre-school children in eight states. "Sub-clinical vitamin A deficiency... was observed in 62 per cent of the children. This was relatively high among Scheduled Caste and Scheduled Tribe children. The rate of coverage of vitamin A supplementation was 58 per cent," says Dr A Laxmaiah, assistant director, division of community studies, NIN, Hyderabad. He says the study shows that there is a need for focused attention on dietary diversification to prevent deficiency.

Professor Umesh Kapil of the department of human nutrition, AIIMS, says there is a need to look towards farms and not pharmacies for nutritional improvement in children. Raising the Indian Journal for the Practising Doctor, he has said vitamin A deficiency is better combated by educating people about eating food rich in the vitamin and by making these foods available to them.

Experts like Kapil feel the strategy should be one where the government resists the soft option of resorting to mega doses of vitamin A to escape the responsibilities of improving the diets of children. They say children of poor communities need more "food rather than pills, tablets, sprays".

According to WHO, clinical and subclinical deficiency of vitamin A in India is the highest in the world, though a universal programme has been in place for three decades. Of the 15 million people suffering from blindness in the world, one-fifth have become blind due to vitamin A deficiency. Annually, 30,000 to 40,000 children lose their eyesight due to it.

As per the National Family Health Survey, only 28.7 per cent of children between ages 12 and 35 months have received a vitamin A dose in the last six months. The strategies at national level to combat vitamin A deficiency mainly involve periodic distribution of high-dose vitamin A capsules twice a year to children six months to five years old, but less emphasis has been placed on dietary approaches to preventing and controlling vitamin A deficiency.

Indian Express
April 20, P 5

Gadchiroli's trudging doctors spell hope

One of India's most backward districts and Maharashtra's worst ranked in human development indicators, Gadchiroli, today finds itself at the forefront of a healthcare revolution that can potentially save millions of infant lives and help India rapidly reduce her abysmal infant mortality rate (IMR).

Under the aegis of the National Rural Health Mission (NRHM), India is replicating a unique model of using "barefoot doctors" to save infant lives, pioneered by an extraordinary team of physicians led by Abhay and Rani Bang and their Gadchiroli-based non-governmental organization, Society for Education Action and Research In Community Health (SEARCH).

With around 4,600 children dying each day, India has the highest number of child deaths in the world. Seventy per cent of under-five deaths occur in infancy and a majority of infant deaths occur in the first four weeks of life.

India's IMR, or the number of infant deaths per 1,000 live births, at 47, is close to that of poorer African nations such as Senegal and Ghana. Even neighbouring Bangladesh and Nepal have lower IMR. The country's IMR has declined only by 2 percentage points per year over the past five years despite the introduction of a cash incentive scheme for mothers who deliver at hospitals. At the current rate of decline, India will easily miss the millennium development goal of bringing down IMR to 27 by 2015.

Most deaths in the newborn period are preventable, and occur because households, communities and health facilities are often unable to provide required care, according to United Nations Children Fund (Unicef). Health workers are often unavailable and most are ill-equipped to provide newborn care.

SEARCH's strategy to curb infant deaths relies on training community health workers to diagnose and treat newborn diseases and has been dramatically successful in reducing IMR. Over a span of 15 years, SEARCH has been able to reduce IMR in its intervention area by 75% to around 30, by providing home-based newborn care (HBNC).

At a time when India plans to universalise basic healthcare, the Gadchiroli model has emerged as a cost-effective way to correct the nation's dismal child-health record. At $7 per disability-adjusted life years saved, SEARCH's intervention is more efficient in saving lives compared with other tested methods, such as micro-nutrient fortifications for malnourished children.

Behind SEARCH's success lies the meticulous research and undying perseverance of its founders, the Bangs, honoured as global heroes in health by *Time* magazine in 2005. Trained in public health at the US-based John Hopkins University, the couple returned to India in the mid-1980s to study the health problems of the rural poor, and founded SEARCH at Shodhgram (or research village) in Gadchiroli. Six hours away from Melghat, Shodhgram shows how the drive of a small but committed team can succeed where the state has failed.

Abhay Bang, 61, said he was inspired by the Chinese example of barefoot doctors. "The Chinese adopted a simple principle that said that healthcare must be available within that distance, which a mother on foot can walk with a sick baby," he said in an interview. In the Bangs' case, that principle meant providing care to the newborn at home.

Almost all Indian states barring Kerala and Tamil Nadu (which have low IMR) and Chhattisgarh (that already has a similar 'mitanin' programme) have initiated the first phase of implementing the Gadchiroli model. The National Health System Resource Centre (NHSRC)—a nodal agency for training community health workers or accredited social health activists (Asha)—is facilitating the training with inputs from SEARCH. Each Asha worker will be paid ₹250 for each infant each tends to, using NRHM funds. Around 30 batches of Asha trainers have been trained at Shodhgram so far.

"This is a first of its kind initiative at such a large scale," said Rajani Ved, adviser, community processes, NHSRC. While HBNC was emphasized when NRHM was started six years back, it is only now that the state is providing the training and incentives to health workers to implement the Gadchiroli model in right earnest.

Several aspects of the model have already been adopted in Nepal, Bangladesh, Pakistan and parts of Africa. Both the World Health Organization and Unicef have approved the Bangs' community based intervention as an effective strategy for infant and childcare.

The Bangs have helped focus the world's attention on neonatal deaths.

H-T Mint, April 18, P7

Deaths in the neonatal period or first four weeks account for roughly 40% of all under-five deaths and their proportion has grown by 10% since 1990, according to the latest Unicef estimates. Of the 3.3 million neonatal deaths globally in 2009, the Indian share of 28% was the highest, even as it accounted for fewer than 20% of live births in the world.

A 1999 *Lancet* research paper by Abhay Bang and his colleagues at SEARCH, based on their interventions in Gadchiroli, showed for the first time how very sick newborn babies could be saved even in poor nations with a novel cost-effective strategy. Bang's paper found a place in a 2005 compilation of "vintage papers" in the 180-year-old history of the prestigious medical journal.

Global impact is not new to the Bangs. Their earlier work on the widespread prevalence of sexual health problems among rural women had forced a big shift in maternal health policies from birth control to reproductive health in the late 1980s. Maternal health policies had until then focused only on family planning.

Their work on neonatal health turns conventional medical wisdom on its head. The traditional approach to improving maternal and child health lays emphasis on widening the reach of hospitals in underserved communities.

In contrast, the Gadchiroli strategy relies almost exclusively on people from within the community, usually uneducated traditional birth attendants and community health workers, to deliver care for the mother and her child.

These health workers, who have undergone rigorous training, form the backbone of SEARCH's intervention in 39 villages. They diagnose and treat infections such as sepsis and pneumonia, two major killers in the neonatal period. Their home visits start when a woman is pregnant and continue till her child is two months old.

In case of low birth weight or pre-term babies who are at the greatest risk of death, health workers visit roughly once in two days to check for signs of infection in the neonatal period. A system of rewards and penalties depending on whether or not the correct diagnosis is made and regular visits by a supervisor have ensured that the strategy has worked efficiently.

"Everyone including doctors of the village trust us to take care of their children's illnesses," said Anjana Uikey, one of Bang's "miracle workers" at Bodhli village in Gadchiroli.

After Abhay Bang's research was published in 1999, it has taken more than a decade of advocacy in partnership with a global alliance called Saving Newborn Lives (SNL)—supported by Save the Children USA and the Bill and Melinda Gates Foundation—and more field trials, to win acceptance at home and abroad.

A lifelong vision to see Indian villages become self-reliant in health propelled Bang. Brought up in Sevagram, Mahatma Gandhi's ashram at Wardha, Bang had decided early in life that he would follow the path laid out by his hero. "Gandhiji spoke of *gram swaraj* (free or self-reliant villages); I decided to work on *arogya swaraj* (self-reliance in health)," said Bang. The decision was not just about idealism but also a hardheaded assessment of reality: Qualified doctors are often unwilling to work in villages. "As long as rural communities continue to depend on outsiders for even basic health needs, they will continue to face neglect," said Bang.

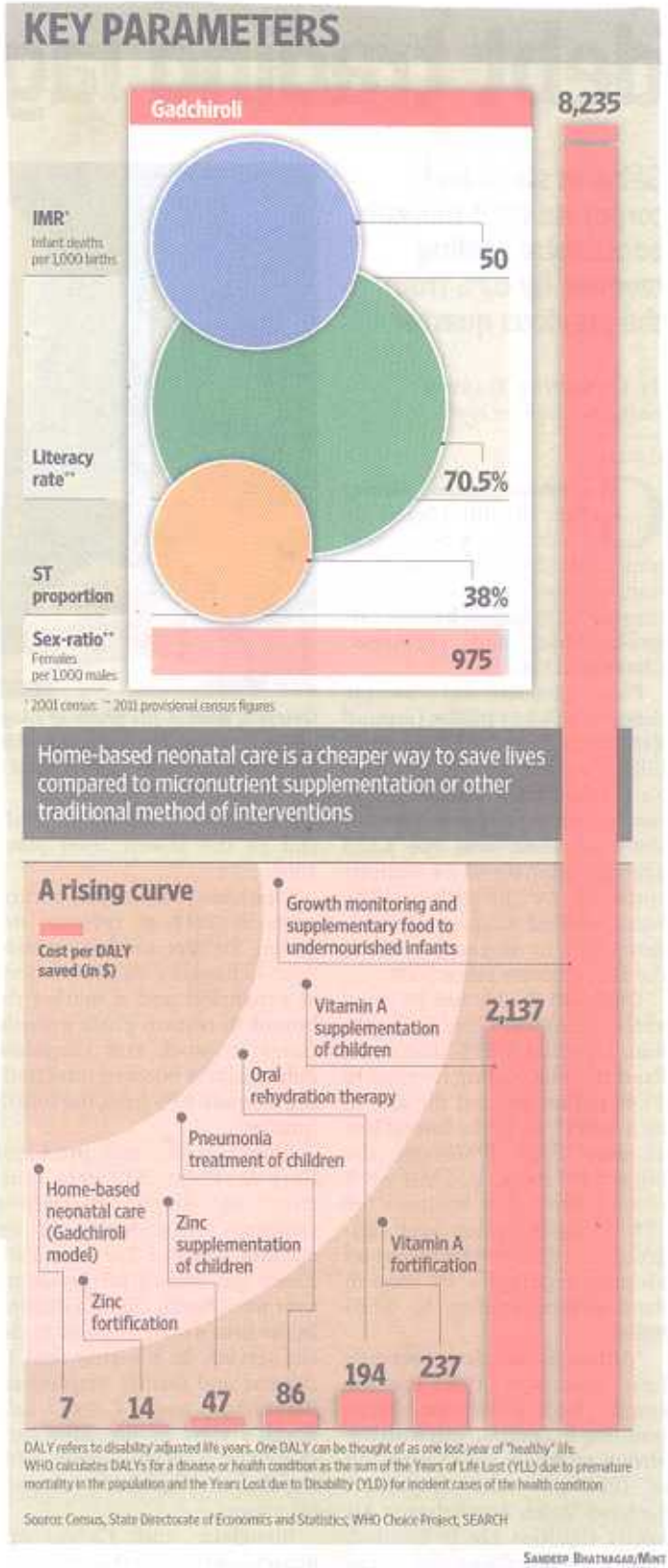
Only 47% of Indian women give birth at hospitals and the figure is much lower for rural areas, according to Unicef. And with 21% vacancies among general physicians and 50-60% vacancies among specialists at rural health centres, access to healthcare is skewed against the rural poor. The Gadchiroli model addresses precisely that gap.

The runaway success of the HBNC model raised doubts on whether this could ever be replicated. Sceptics questioned the wisdom of allowing uneducated health workers to administer injections. Others saw in SEARCH's work an island of success, which was possible only because of Bang's commitment.

To answer these doubts, the Ankur project was launched in 2001 to replicate the SEARCH model in seven different parts of Maharashtra in collaboration with local NGOs. In four years, neonatal mortality dropped by 50% and infant mortality by 47%. The Indian Council of Medical Research has also conducted field trials on HBNC in five different states of the country and while the results have not been published yet, the trials have shown significant impact, Bang said.

It is difficult to predict the success rate across the country as the SEARCH model is scaled up since a lot will depend on effective administration. Unlike in Gadchiroli, health workers nationally are selected by the government and not the Bangs, and the technical and moral support that SEARCH gives to its community workers while handling complications will be missing.

Bang is aware of the challenges. "There will be uncertainties in such a large scheme but we will remain focused on how to make things work because the number of lives at stake is in millions."


KEY PARAMETERS
Gadchiroli
8,235
IMR*
Infant deaths per 1,000 births
50
Literacy rate**
70.5%
ST proportion
38%
Sex-ratio**
Females per 1,000 males
975
* 2001 census ** 2011 provisional census figures
Home-based neonatal care is a cheaper way to save lives compared to micronutrient supplementation or other traditional method of interventions
A rising curve
Cost per DALY saved (in $)
Growth monitoring and supplementary food to undernourished infants
Vitamin A supplementation of children
2,137
Oral rehydration therapy
Pneumonia treatment of children
Home-based neonatal care (Gadchiroli model)
Zinc supplementation of children
Vitamin A fortification
Zinc fortification
7
14
47
86
194
237
DALY refers to disability adjusted life years. One DALY can be thought of as one lost year of "healthy" life. WHO calculates DALYs for a disease or health condition as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for incident cases of the health condition
Source: Census, State Directorate of Economics and Statistics, WHO Choice Project, SEARCH
Sandeep Bhatnagar/Mint

मप्र में 25% को पौष्टिक भोजन नहीं

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भूखे पेट सोने वाले लोगों की सर्वाधिक संख्या मध्यप्रदेश में है। प्रदेश में 25 प्रतिशत से अधिक आबादी 2160 कैलोरी से भी कम पर गुजारा कर रही है। शहरी आबादी का कैलोरी उपभोग स्तर तो 1854 किलो कैलोरी प्रति व्यक्ति प्रतिदिन ही है। यह आंकड़ा राष्ट्रीय औसत 1946 से 92 किलोकैलोरी कम है। इस मामले में सिर्फ पश्चिम बंगाल ही मध्यप्रदेश से पीछे है। देश में पोषण और कैलोरी उपभोग की नवीनतम स्थिति बयां करने वाले ये आंकड़े जारी किए हैं नेशनल सैम्पल सर्वे ऑफिस (एनएसएसओ) ने।

वर्ष 2009-2010 के लिए 18 राज्यों में किए गए 66वें राउंड के सर्वे के ये आंकड़े देश की विकास और उदारीकरण की कहानी की पोल खोलने वाले हैं। ग़ौर करने की बात यह है सभी प्रदेश में 1972-73 में ग्रामीण आबादी शहरी आबादी की तुलना में बेहतर कैलोरी उपभोग कर रही थी। पर ग्रामीण और शहरी आबादी का यह अंतर 2010 आते - आते लगभग नगण्य होता जाता है। अर्थात इन 40 वर्षों में ग्रामीण आबादी ने अधिक विपन्नता और अभाव भोगा है जबकि शहरों में तुलनात्मक रूप से उपभोग स्तर बेहतर हुआ है।

कैलोरी उपभोग (प्रति उपभोक्ता किलो कैलोरी) : 'बीमारू' प्रदेश

राज्य	वर्ष 72-73 शहरी -ग्रामीण	वर्ष 93-94 शहरी -ग्रामीण	वर्ष 99-2000 शहरी -ग्रामीण	वर्ष 2009-10 शहरी -ग्रामीण
मध्यप्रदेश	2229 -2423	2082 -2164	2132 -2062	1854 -1939
उत्तरप्रदेश	2161 -2575	2114 -2307	2131 -2327	1923 -2064
बिहार	2167 -2225	2188 -2115	2171 -2121	2013 -1931
राजस्थान	2357 -2730	2184 -2470	2335 -2425	2014 -2191
छत्तीसगढ़	- -	- -	-	1949 -1926
राष्ट्रीय	2107 -2266	2071 -2153	2156 -2149	1946 -2020

हजार आबादी पर घर

राज्य	0-2160 किलो कैलोरी स्तर ग्रामीण	शहरी
मध्यप्रदेश	268	258
उत्तरप्रदेश	170	243
बिहार	246	149
राजस्थान	107	157
छत्तीसगढ़	263	204
भारत	194	205

न्यूनतम कैलोरी और गरीबी

कैलोरी उपभोग के इन आंकड़ों की महत्ता इस बात से समझी जा सकती है कि योजना आयोग कैलोरी उपभोग के आधार पर ही देश में गरीबी रेखा और गरीबों की संख्या तय करता है। योजना आयोग ने गरीबी मापन के लिए कैलोरी उपभोग का यह स्तर शहरी क्षेत्र में 2100 और ग्रामीण क्षेत्रों में 2400 किलो कैलोरी तय कर रखा है। गरीबी के इस स्तर को योजना आयोग 'पूर्ण गरीबी' कहता है। वहीं एनएसएसओ ने प्रति व्यक्ति प्रतिदिन कैलोरी के लिए मानक स्तर 2700 तथा नेशनल इंस्टीट्यूट ऑफ न्यूट्रिशन ने 2320 किलो कैलोरी तय कर रखा है।

Rajasthan Patrika, April 5, P9

दो तिहाई भारतीय आज भी भूखे

नई दिल्ली. जहां सरकार देश में गरीबी कम होने के दावे कर रही है, वहीं देश की दो-तिहाई आबादी आज भी पर्याप्त कैलोरी युक्त भोजन लेने में असमर्थ है। नेशनल सेंपल सर्वे ऑर्गनाइजेशन (एनएसएसओ) की ताजा रिपोर्ट में यह तथ्य सामना आया है। रिपोर्ट के मुताबिक, न केवल गांवों में, बल्कि शहरों में भी स्थिति भयावह है। केंद्र की गरीबी दूर करने की तमाम योजनाओं का जनता को सीधे तौर पर कोई लाभ नहीं है। रिपोर्ट खाद्य पदार्थों में कैलोरी की मात्रा पर बनी है।

भूख के सरकारी आंकड़े

योजना आयोग की ओर से हाल ही में जारी आंकड़ों में आम शहरों और ग्रामीण के लिए पोषण की जरूरी मात्रा ये बताई गई थी-

शहरी के लिए	ग्रामीण के लिए
2100	2400
किलोकैलोरी प्रतिदिन	किलोकैलोरी प्रतिदिन

...और ये है सच्चाई

एनएसएसओ की रिपोर्ट में शहरी व ग्रामीण जनता को मिलने वाले पोषण के आंकड़े कुछ ऐसे हैं-

एनएसएसओ के आंकड़े वर्ष 2004-05 से 2009-10 के बीच के हैं। हालांकि 2020 तक यही स्थिति रहने की आशंका जताई जा रही है।

2320 किलोकैलोरी प्रतिदिन जरूरी है 18-29 वर्ष के व्यक्ति के लिए।

प्रोटीन की खपत भी कम

रिपोर्ट बताती है कि शरीर के लिए जरूरी प्रोटीन की खपत भी कम हो गई है। ग्रामीण क्षेत्रों में जहां यह तय मानक 1993-94 से 2009-10 के बीच प्रतिव्यक्ति 60.2 ग्राम प्रतिदिन से घटकर 55 ग्राम पर पहुंच गई है, वहीं शहरी क्षेत्रों में यह आंकड़ा 57.2 ग्राम से घटकर 53.5 ग्राम पर आ गया है।

Rajasthan Patrika, April 2, P.1

Stars for a cause

When the Prime Minister reacted to data in a hunger and malnutrition report a few months ago -- which put the figure of underweight children under five years at 42 per cent -- calling it a 'national shame', it was an admission of the extent of the problem.

But what it also did was for the government along with others to seek a solution. Public awareness, both in urban and rural India on this critical and complex issue of malnutrition is limited.

This is where a mass media campaign, slated to roll out soon, will play a prominent role. Film actor Aamir Khan will participate in the awareness campaign along with a core group which includes the Citizens' Alliance against Malnutrition, the United Nations Children's Fund and poet-ad guru Prasoon Joshi. The group is working with the government to design, produce and launch a campaign to alert and educate people in the simplest possible ways.

Using print, television, radio spots and outdoor advertising, simple, yet, appealing messages with 'an urban-rural flavour' will be put to parents, and other caregivers. Here, Prasoon Joshi's and Aamir Khan's creative genius and mass appeal are expected to be the clinchers. While this is certainly not Joshi's first public service campaign – he's been associated with the Pulse Polio and UN Millennium Goals for eradicating poverty campaigns, among others – Khan, one of the more socially aware individuals in the film industry, has also done his homework. As the UNICEF Ambassador "he has made every effort to fully understand the issue".

Khan's personal appeal promises to go a long way. Take the case of Parineeta Singh from Delhi. When she saw a report in a daily newspaper that her favourite star was in the city to shoot a film, she got really excited. The report talked about an ad campaign -- *'Kuposhan* (the Hindi word for malnutrition) *Bharat Choro'* -- which shows Khan interacting with children and telling them, "In 1947 India got Independence, but it's 2011 and we've not got independence from *kuposhan*". Parineeta had not heard of *kuposhan* but decided to look it up on the Internet. "The more I read, the more I was drawn to the subject. I had never thought that malnutrition was so widespread in our country. One shocking statistic really blew my mind – nearly half of the children under five in India are underweight, worse than in some countries in sub-Saharan Africa. I think it's great that Khan will talk about this; we all need to know."

There are two clear expectations of the campaign. First, to make sure that citizens understand what malnutrition is all about. And second, when people see part of the campaign that talks of interventions such as breastfeeding or complementary feeding or the right nutritional practices for mothers, over time it will create a positive behavioural change. *(Women's Feature Service)*

Hindu, April 9, 12

Governance Cannot Ignore Health and Well-Being of Citizens

Last week, a survey result published by the National Institute of Nutrition indicated that two-thirds of the population suffers from hunger. A recent report of Global Hunger Index rated India's nutrition levels at nearly the bottom of the list of countries, nearly at par with sub-Saharan countries. Some facts are disturbing:

- 35% of developing world's malnourished children are Indian.
- 20% of maternity deaths are directly attributed to anaemia; nearly 60% of women are anaemic (Government of India figures).
- Over 7 crore people suffer from goitre and Iodine deficiency disorders.
- Nearly 6 lakh child deaths occur annually due to diarrhoea.

The Planning Commission has recently discovered that fewer Indians are poor, through a sleight of hand by redefining poverty levels. The definition includes only calorie intake, as if 'man can live by bread alone'! No account is taken of micronutrient requirements (vitamin A, folic acid, iodine, iron, etc.) which are essential vitamins and minerals. Absence of these contributes to anaemia, stunting, deficient brain growth, and a host of severe crippling disabilities. Without even taking into account need for shelter, clothing and other such requirements, the issue of 'hidden hunger' relating to micronutrients has not even been thought of in the context of 'removal of poverty'. The programmes relating to 'mother and child' do not take into account the critical role played by micronutrients at child birth stage and upto the first five of the child's years. Sixty-five years after Independence, we are still unable to provide the basic inputs to our population to enable them to lead a healthy life, which is a fundamental right.

Hidden hunger, or micronutrient malnutrition, is a chronic lack of vitamins and minerals that often has no visible warning signs. Its consequences could nevertheless be devastating: hidden hunger can lead to mental impairment, poor health and productivity, or even death. Vitamin A, iron and zinc deficiency when combined, constitutes the second-largest risk factor in the global burden of disease. Nearly four lakh child births are precipitated every year in India due to vitamin A deficiency. Every year, about 70 lakh children are born mentally impaired due to iodine deficiency. Intellectual capacity is reduced by 15 per cent due to iodine deficiency. Two lakh babies are born every year with neural tube defects due to folic acid deficiency — 16 times the global average.

Diversification of the diet to increase the consumption of iron, vitamin A and other micronutrients on a daily or continuing basis is the necessary long-term measure to eliminate and prevent micronutrient deficiencies. Diet diversification, however, is viewed as difficult to implement in an inherently poor population — most citizens can't afford milk, fruits and poultry on a daily basis, not even on a weekly or monthly basis. Successful alternate solutions, nearly equally effective, are available in methods and practices all over the world. Vitamin A, folic acid and zinc supplementation are well accepted practices, though not pursued systematically across the board in all states.

Many options for food fortification are now readily available in tested packages. While iodisation of salt is a legal requirement, there is hardly any effective enforcement mechanism. Fortified wheat flour has been well proven, and has large potential; it was rolled out in Gujarat, but ran into operational bottlenecks, of the kind not unknown in India. Double fortified salt (to tackle iodine requirement as also to address anaemia) is now available, fully tested. There is, however, hardly any initiative to get these distributed universally. Fortification of rice is a potential new area under experimentation.

At the Copenhagen Consensus of 2008, the world's foremost economists rated micronutrient fortification as an extremely high global priority, in view of their exceptionally high ratio of benefits to costs. Recent estimates indicate that for as little as ₹5.4 per capita per year, the health condition of 20 crore most vulnerable Indians can be dramatically improved within five years. Clearly, there is insufficient awareness among policymakers, implementers, as well as the general public about the possibilities now available.

Tamil Nadu was the pioneer in introducing the mid-day meal scheme nearly four decades ago. That far-sighted policy has paid rich dividends, in that the state leads in nutrition levels among various states, despite being quite low by international standards. Most other states now implement the mid-day meal scheme, which offers a ready platform for fortifying food to combat vitamin and mineral deficiencies. As mentioned, the costs are way low compared to the potential benefits. India, fortunately, has the service network across districts, tehsils, and even gram panchayats to manage the delivery efficiently. It's just a question of policymakers and administrators understanding the issues and getting down to effective implementation. The results, over five years, can be dramatic in impact. In this largest democracy, will governance include consideration for the health and well-being of the below-average citizen?

New Indian Express, April 15, P. 4

बीमार न कर दे डिब्बाबंद खाना

The Washington Post के साथ विशेष साझेदारी

न्यूयॉर्क | सुजैन फ्रेकेल

बीते साल अमेरिका में हुए एक अध्ययन के दौरान शोधकर्ताओं ने सैन फ्रांसिस्को के पांच परिवारों को तीन दिन ऐसी खाद्य सामग्रियों का सेवन कराया, जो प्लास्टिक के संपर्क में थीं। फिर अध्ययन से पहले और बाद में लिए गए प्रतिभागियों के पेशाब के नमूने की जांच की।

शोधकर्ता इस बात को देखकर दंग रह गए कि महज तीन दिन की डाइट सेहत पर किस हद तक बुरा प्रभाव डालती है। उन्होंने पाया कि सभी प्रतिभागियों के शरीर में बाइस्फेनॉल-ए (बीपीए) का स्तर 66 फीसदी तक बढ़ गया। वहीं, थैलेट डीईएचपी की मात्रा 50 फीसदी तक कम हो गई। बीपीए का इस्तेमाल पॉलीकॉर्बोनेट प्लास्टिक को कड़ा बनाने के लिए किया जाता है, जबकि थैलेट डीईएचपी उन्हें लचीला बनाता है। ये दोनों ही तत्व कैंसर, डायबिटीज और दिल की बीमारियों को दावत दे सकते हैं।

शोध के नतीजे इस बात को साबित करते हैं कि अमेरिकियों के शरीर में पाए जाने वाले हानिकारक रसायनों का मुख्य स्रोत प्लास्टिक पैकेजिंग है। कुछ अन्य अध्ययनों से पता चला है कि कुकिंग के दौरान इस्तेमाल होने वाले दस्ताने, डिब्बाबंद सामग्रियों पर लगी सील और लेबल में प्रयुक्त स्याही से भी थैलेट्स खाने में प्रवेश कर जाते हैं।

ब्रेस्ट कैंसर फंड की अध्यक्ष जैनेट न्यूडलमेन ने कहा, 'यह एक बड़ा मुद्दा है। कोई इसे गंभीरता से नहीं ले रहा है।' आगे वह सवाल करती हैं कि 'किसी भी खाद्य सामग्री को सुरक्षित करार देना और फिर उसे असुरक्षित डिब्बो में पैक कर देना कहां तक उचित है?' बहरहाल, डिब्बा बंद खाद्य सामग्रियां कितनी हानिकारक आप खुद देख लीजिए।

पॉलिस्ट्रीन के कप में बिकने वाले इंस्टेंट नूडल्स में स्टीरीन के अंश पाए गए हैं, जिसे कैंसर को जन्म देने वाला कार्सिनोजन माना जाता है। सेब के जूस और बेबी फॉर्मुला में नॉनिलफेनॉल की मौजूदगी दर्ज की गई है। मक्खन में आग बुझाने वाले रसायन, पॉपकॉर्न में टेफलॉन तत्व और बीयर, मेयोनीज तथा चीज में पॉलीविनाइल क्लोराइड (पीवीसी) पाया गया है। पीवीसी से मस्तिष्क का विकास प्रभावित होता है। इसके अलावा ज्यादातर सामग्रियों में थैलेट डीईएचपी की मौजूदगी देखी गई है, जो शरीर में टेस्टॉस्टेरॉन हार्मोन के उत्पादन में बाधा पैदा करता है।

रहें सतर्क

- बीपीए, थैलेट डीईएचपी, स्टीरीन, नॉनिलफेनॉल और पीवीसी जैसे तत्व कर सकते हैं प्रवेश
- कैंसर, डायबिटीज और हृदयरोगों को देते हैं दावत, मानसिक विकास में पैदा करते हैं बाधा

हानिकारक तत्व

● पॉलीविनाइल क्लोराइड (पीवीसी) : अचार, चटनी और मसाले के डिब्बे तथा खिलौनों में ● पॉलीथाइलीन टेरिफ्थालेट (पीईटी) : सोडा, पानी और तेल की बोतल में ● पॉलिस्टीरीन (पीएस) : ट्रे, खाने के डिब्बे और कप में

Hindustan, April 21, P18

Tackling malnutrition: Tough challenges lie ahead

Nandini Chandrashekar

BANGALORE: The committee appointed by the High Court to look into tackling malnutrition in children, in its first meeting has decided to set up a 24-hour helpline for children who are severely malnourished and need intervention.

The committee headed by Justice N K Patil was formed by the High Court, following the registration of a suo motu case, after media reports on malnutrition deaths in Raichur.

The Committee comprises officials from the Health and Women and Child Development (DWCD) Departments and other people working in the field of child rights.

The High Court while constituting the committee, had directed it to submit an action taken report by June 15, 2012. The DWCD has been told to set up the helpline in two weeks time.

In addition, the Committee has also agreed upon the Department of Health and Family Welfare conducting a survey to segregate the children affected by malnutrition, based on the causes for it.

Nutrition centres

Nutrition and rehabilitation centres are also expected to be set up in one month's time and the Committee has also decided to set up district-level committees headed by district judges to address problems arising out of cases of malnutrition.

Focus will also be on including children of migrant labourers, construction workers and other marginalised sections, where children are likely to be excluded from intervention programmes.

A regional consultation will be held in all the five regions of the State, beginning with Gulbarga on April 23.

This is however, the beginning. The real problems, according to people involved in the consultations, will be the convergence between the DWCD and the Health Department.

The numerous programmes that have been conceived to serve the target section of women and children are implemented by these two departments, but independently and without any coordination.

However, with malnutrition in children and anaemia among pregnant women on the rise, coordination between the two departments has become crucial.

The success of a supplementary nutrition programme implemented by the department cannot be complete without health checkups and followups implemented by the Health Department.

Both the departments have their ground-level workers, like the anganwadi workers and helpers from the DWCD, and the auxillary nurse midwives and accredited social health activists from the Health Department.

Yet, both departments have failed to form any successful convergence, often working at cross purposes to the detriment of the deprived children and women.

This convergence is merely from a health perspective. The three sub-committees formed by the government to address child malnutrition and infant mortality, have also recommended the inclusion of the Public Distribution System and an effective monitoring system to be put in place to ensure issue of Antyodaya cards and BPL cards to all deserving families.

DH News Service

Deccan Herald, April 21, 12A

भूख से बिलख रहे हैं आदिवासी !

सर्वेक्षण में चौंकाने वाले आंकड़े आए सामने, राहत की सरकारी योजनाओं पर सवाल

उदयपुर. मेवाड़ का ऐतिहासिक वैभव और नैसर्गिक सौन्दर्य भले दुनिया को आकर्षित करता हो, लेकिन एक बड़ा सच यह भी है कि यहां के लोग भूख और कुपोषण से लड़ने में सक्षम नहीं हैं। आदिवासी बहुल क्षेत्रों में दो जून रोटी को लोग मोहताज हैं। सरकार के सारे जतन इससे निपटने में बेबस हैं। राष्ट्रीय प्रतिदर्श सर्वेक्षण संगठन का सर्वे इस हकीकत को उजागर करने में काफी है। इसके अनुसार भारत में कर्ज लेकर इलाज कराने का औसत दुनिया में सर्वाधिक है। इसमें दक्षिण राजस्थान सबसे आगे है। यहां के जिलों उदयपुर, डूंगरपुर, बांसवाड़ा, प्रतापगढ़, चित्तौड़गढ़ और राजसमंद में आदिवासी बच्चों में विटामिन-ए की कमी पाई गई है। इनमें 60-70 फीसदी बच्चे कुपोषण का शिकार हैं। ऐसे में केन्द्र सरकार का पोषण सहायक कार्यक्रम, समेकित बाल विकास सेवा और राज्य व केन्द्र प्रवर्तित कार्यक्रम पर सवाल खड़े हो गए हैं। इन क्षेत्रों में विकास के लिए खूब अनुदान आता है, लेकिन इसका लाभ जरूरतमंदों को ठीक से नहीं मिल पाता।

फाइल फोटो

काम की तलाश में गुजरात, मुम्बई तक पलायन

आंकड़ों के अनुसार आदिवासी क्षेत्र से प्रतिवर्ष करीब 1.3 लाख बच्चे भूख से मजबूर होकर काम की तलाश में गुजरात और मुम्बई तक पलायन करते हैं। यूनेस्को के अनुसार यह आंकड़ा करीब 50 फीसदी अधिक होना चाहिए। कई बच्चे सर्पदंश और विभिन्न नकारात्मक असर के काम से मौत का शिकार बन जाते हैं। इनमें आधे से अधिक लड़कियां हैं, जिनका यौन शोषण होने की आशंका रहती है।

सोमालिया से बुरा हाल

एक स्वयंसेवी संस्था की ओर से प्रतापगढ़ में किए सर्वेक्षण के अनुसार छोटी सादड़ी तहसील में 29 प्रतिशत बच्चे लम्बे समय से गंभीर कुपोषण का शिकार हैं। राष्ट्रीय स्तर पर यह आंकड़ा 7 फीसदी है। वहीं दक्षिण अफ्रीकी देश सोमालिया में इसका प्रतिशत 27 है।

क्या है सर्वे संस्था

भारत सरकार की ओर से संचालित राष्ट्रीय प्रतिदर्श सर्वेक्षण संगठन (नेशनल सेम्पल सर्वे ऑर्गेनाइजेशन) देश में चल रहे सरकारी और गैर सरकारी संगठनों और विभागों की ओर से किए जाने वाले कार्यों के सांख्यिकी नमूने जमा कर उनका विश्लेषण करता है। (का.सं.)

Rajasthan Patrika, April 29, P.10

Urban malnutrition in Maharashtra

Meena Menon

- 26 per cent of children in Mumbai are underweight: ICDS
- 'Need for centres giving special care to mother and child'

MUMBAI: Rising trends in malnutrition among children under six here and in other cities have prompted Maharashtra to introduce an Urban Malnutrition Mission from next month, official sources said. A quarter of children below six years in the city weighed at anganwadis are underweight, according to the latest monthly progress report (MPR) of the Integrated Child Development Services (ICDS). NGOs point to a severe crisis of primary health services and lack of adequate number of anganwadis in slum areas.

An ongoing anthropometric survey of children below six in the M-East Ward municipality of 20,000 families in slum and gaothan areas at Shivaji Nagar will be completed by month-end and will give an idea of the severity of the problem. Leena Joshi, director of the M-East Ward project of the Tata Institute of Social Sciences, feels malnutrition among children cuts across a large section of the city. The Human Development Report of the Greater Mumbai Municipal Corporation, 2009, said the M-East Ward with large slums in the north-eastern part of the city had the highest infant mortality rate (IMR) of 66.47 per 1,000 live births, almost double the State's IMR of 34.57. Ms. Joshi has earlier headed an NGO Apnalaya, which traced the level of malnutrition and deaths at Rafi Nagar part II, a slum at Shivaji Nagar, since 2006. "Our claim is that Rafi Nagar is not an exception. Poor communities have little access to public healthcare and depend on quacks. For instance, in M-East Ward, there are 105 beds in maternity wards for a population of 12 lakh. Inadequate services lead to home deliveries or [women] going to private clinics which are expensive," she said.

Jahan Ara ekes out a living from a small shanty which also passes off as a grocery shop. In December 2010, her seven-month-old son died of prolonged diarrhoea. He was one of the 20 children who lost their lives in 2010-2011 at Rafi Nagar (part II).

"Asif was a sickly child and had low birth weight," she says. At 29, she is very lean herself and hardly eats. Married at 15, she is left with a daughter and two sons, the oldest of the children being 12. Her husband doesn't work and ill-treats her. Her house was demolished three or four times and when Asif died, the family barely had a cover over its head. Her sister Anjum Sheikh, a social worker, had two deliveries at home, a common feature here. In addition, there is no food security. Anjum says that though 200 people were issued ration cards, there was no quota for them. She has been living here since 1996, and her house has been demolished at least five times. There is no sanitation and water comes from a tanker every afternoon to fill 50 large blue drums.

Squeezed between a fenced-off kabrastan and a waste-dumping ground, residents of Rafi Nagar part II live under a constant threat of demolition. The settlement came up in 1996, some say earlier, on a waste-dumping ground. There are some 850 shanties here and activists have been demanding basic amenities and even filed a court case in the wake of the rising child deaths. Last year, the Bombay High Court appointed a committee to look into the basic question of rehabilitation of the slum but it did not function and some NGO representatives were added to it to advise the panel on basic amenities.

Home deliveries, low birth weight and lack of basic amenities were putting a lot of women and children at risk. Ms. Joshi says the ICDS has to perform better and there is need to set up Child Development Centres in Mumbai on the lines of Melghat for special attention to the mother and the child.

Mumbai's malnutrition figures closely rival some really backward Adivasi regions of the State, like Amravati. According to the MPR for February for Mumbai as a whole, 26 per cent of the children are underweight. The total population of children under six is 4,45,209. Of these, 2,69,193 were weighed at ICDS centres and 1,99,180 were of normal weight. However, 64,735 (24 per cent) were moderately underweight and 5,278 (two per cent) severely underweight as per World Health Organisation guidelines. Of the severely underweight children, 589 are in the Shivaji Nagar area. For the city, there are a total of 5,153 anganwadi centres, which are not enough.

Dnyaneshwar Tarwade of Apnalaya, which has been monitoring the situation at Rafi Nagar part II since 2006, says the level of malnutrition was not as high seven years ago as it is now. After the December 2004 demolition of the slum, the situation took a turn for the worse and about 850 families, whose homes were razed to the ground, live precariously.

Apnalaya found that malnutrition levels were over 65 per cent in children under six at Rafi Nagar part II. Of the 220 children, at least 130 were malnourished based on the weight-for-age criterion. While it has set up crèches, a Nutrition Rehabilitation Centre and anganwadis at Rafi Nagar part II, the government-run anganwadis are barely working. The child deaths peaked to 20 during the period April 2010-March 2011. The 2005-2006 data for Rafi Nagar part II shows the number of deaths has been rising since, from four deaths that year. In 2011-2012, seven infants died till March.

Since April 2011, Apnalaya has also been monitoring eight bastis around the garbage dumping ground at Shivaji Nagar, where 7,500 families live. Only 25 anganwadis are there for a population of 50,000, when the number ought to be double that, says Mr. Tarwade. The latest data from February shows that of the 3,780 children below six years, 3,016 were weighed. Of these, only 217 had an above-normal weight. Forty-seven per cent, or 1,411 children, were normal weight, 901 were moderate underweight (30 per cent) and 487 were severe underweight (17 per cent). Almost half the children, Mr. he said, are below normal weight.

Hindu, April 23, P7

बच्चों को ज्यादा समय तक स्तनपान से थम सकता है उनमें एचआईवी का प्रसार

लंदन, 26 अप्रैल (भाषा)। एंटीरेट्रोवायरल थेरेपी (एआरटी) के साथ शिशु को ज्यादा दिनों तक स्तनपान कराने से मां से शिशु में होने वाले एचआईवची के प्रसार को कम किया जा सकता है और बच्चे के बचने की उम्मीद को बेहतर बनाया जा सकता है। एक नए अध्ययन में यह दावा किया गया है।

हालांकि छह महीने से पहले स्तनपान बंद करने से इन बच्चों को एचआईवी संक्रमण से नहीं बचाया जा सकता। इससे उनके बीमार पड़ने, उन्हें विकास संबंधी समस्याएं होने और उनकी मौत होने की संभावनाएं बढ़ जाती हैं। वर्ष 2004 से 2010 के बीच मलावी में 2,369 एचआईवी संक्रमित मांओं और उनके बच्चों पर किए गए एक अध्ययन में यह बात उभरकर सामने आई।

शुरूआती परिणामों में पाया गया कि छह महीने तक एआरटी दवाइयों का सेवन करने वाले मां और उनके बच्चों के मामलों में एचआईवी का प्रसार बच्चों तक कम हो गया। वहीं हर तीन में से एक बच्चा जिन्हें 28 हफ्तों के बाद स्तनपान कराना बंद कर दिया था, वे एचआईवी से संक्रमित हो गए। इससे पता लगता है कि एचआईवी से संक्रमित मांओं के अपने बच्चों को जल्द ही स्तनपान बंद करने से उनमें एचआईवी के संक्रमण की संभावना बढ़ जाती है।

Jansatta, April 27, P2

Poverty 'down', but not the hungry

Even as the debate rages on whether poverty measurement in India is accurate, a recent report on nutritional intake of Indians has come up with a chilling conclusion: two thirds of the country's population is eating less than what is required.

Even more worrying is that this trend continues despite a healthy economic growth rate over several years, and despite several mega programmes of nutrition delivery to children. Experts believe that this can only indicate widespread hunger and malnutrition, consequences of rampant poverty. Nutritional intake is measured in terms of calorific value of food consumed.

This has shockingly declined from 2,153Kcal per person per day in 1993-94 to 2020 in 2009-10 in rural areas and from 2,071 to 1,946 Kcal in urban areas according to the report of the National Sample Survey Organisation (NSSO), based on its 66th survey round. Even between 2004-05 and 2009-10, calorie intake per person per day dipped from 2,047 to 2,020 in rural areas and from 2,020 to 1946 in urban areas. This may raise questions about reported decline in poverty as claimed by the Planning Commission.

According to the National Institute of Nutrition, an average Indian male of age 18-29 years and weighing 60kg needs 2,320Kcal per day if he does only sedentary work.

MALNOURISHED INDIA

Planning Commission standard for minimum food intake
2,400 Kcal (rural) and **2,100 Kcal** (urban), per person per day

Nutrition Deficit | Calorific value of food consumed per day per person (in kilocalories)

Year	Rural	Urban
1972-73	2,266	2,107
1993-94	2,153	2,071
2009-10	2,020	1,946

Protein Deficit | Protein consumed per day per person (in grams)

Year	Rural	Urban
1993-94	60.2	57.2
2009-10	55	53.5

Source: NSSO

The Planning Commission had adopted 2,400 Kcal (rural) and 2,100 Kcal (urban) as the minimum daily requirement norm.

What about protein consumption, which is higher in affluent societies because more meat, eggs, fish and milk is consumed? According to the NSSO report, protein consumption too has fallen from 60.2g to 55g per person per day in rural areas and from 57.2g to 53.5g in the urban areas between 1993-94 and 2009-10.

The decline is across the board, but is sharpest in rural areas of Rajasthan, Haryana, UP and Punjab — where intake has fallen by 9-12g per person per day.

Fat consumption has risen by about 7g in rural and 6g in urban areas over this 16-year period in all major states. Average daily fat consumption per person was 38g in rural areas and about 48g in urban areas. These are averages over the whole population.

In reality, the situation is much more dire for the poor. About 90% of the poorest tenth of the population in both urban and rural areas consume food that gives them less than just 2,160 Kcal. Average calorie intake among the poorest tenth of the population is just 1,619 Kcal in rural areas and 1,584Kcal in urban areas, reveals the NSSO report. The richest 10% of the population consumes 2,922 Kcal in rural areas and 2,855 Kcal in urban on an average.

The NSSO report explodes the widely held perception that people in India, especially urban dwellers, are shifting to non-cereal food items like dairy products in a big way for their nutritional needs. Share of energy — calorie intake — from cereals has declined from 71% to 64% in rural areas and from 59% to 55% in urban areas over 1993-94 and 2009-10.

Times of India, April 1, P.14

ICDS benefits 10 cr infants, says govt

NEW DELHI, DHNS: The Integrated Child Development Scheme (ICDS), a flagship program of Government meant to fight malnutrition and ill health among infants, has reached 10 crore beneficiaries.

The data released by the ministry of women and child development reveals that about 43 per cent of beneficiaries are in the age group of 6 months to 3 years.

An increased access to the supplementary nutrition is important considering the severe malnutrition among Indian children.

According to UNICEF, "Forty three per cent of Indian children under five years are underweight and 48 per cent (i.e. 61 million children) are stunted due to chronic undernutrition, India accounts for more than 3 out of every 10 stunted children in the world."

Launched in 1975 with three gaols of addressing problem of malnutrition, ill health and holistic development through pre-school education among the children of 0-6 years age group, the ICDS attracted the attention of social activists, researchers and judiciary alike.

The Supreme Court has ruled many times on the universalisation of ICDS. In 2001, the SC ruled that an Anganwadi Centres(AWC) must be provided in each settlement and every child under six, adolescent girl, pregnant woman and lactating woman is entitled to supplementary nutrition under ICDS as per prescribed norms.

In 2006, it directed the Government of India to sanction and operationalise a minimum of 14 lakh AWCs in a phased and even manner.

Deccan Herald, April 18, 12

Keep television at arm's length

Television eats into your time. It is a stimulation that takes charge of your life. Statistics in the U.S. say that the average person watches more than four hours of television a day. This must be true for most Indians too. This is about one-fourth of one's waking hours! Imagine if you had that time, you could exercise, cook gourmet meals, pursue a hobby, write a novel or do volunteer work!

The evils of television are legendary. Eating in front of the TV set is common. It could end up adding more calories and obesity. People rarely have meaningful conversations while watching the idiot box. There is little time for parents and children, and watching TV together does not grow a relationship! Before the advent of television, families played together, went on picnics, took long walks together and pursued hobbies. Why don't families reap the real benefits of quality family time rather than watch dysfunctional families waging war on the screen? Having dinner together is a timeless ritual which has been taken over by watching weepy soap operas.

Television is known to interfere with sleep patterns, the body's circadian rhythms. Many people prefer watching TV to lulling their body to sleep with a book or music. Going to sleep with TV on your mind is to wake up exhausted. The greatest evil of TV according to me is a sedentary lifestyle. This mindless watching of re-runs and reality shows, sitting on the couch with a drink in one hand and a snack in the other can, lead to heart ailments, diabetes and other health problems. More time outdoors? You have to turn it off. Play an active game of football or badminton or just take a brisk walk on the beach. See what you have been missing with only the remote for company!

The American Academy of Paediatricians recommends that children less than two years should not watch TV at all — TV is linked with attention problems in kids. Children need to listen to intelligent adult conversation to build the capacity for linear thought. Let's face it. Progress comes from being in the real world — talking and interacting with people, reading inspiring literature, picking up valuable skills and not from isolation which is what TV perpetuates. The worst fact is that TV is addictive! No matter how noble your intentions are, once you are in front of the box, you will be ensnared by its sheer banality. Like any other addiction, we use TV to calm down, we are on edge when we don't watch it and we just don't seem to be able to control our hours of viewing! We often put off tasks like paying our bills, stocking up the larder or putting our homes in order for the pleasure of watching a clichéd saas bahu soap opera! The result is an overwhelming stress and guilt about the undone tasks and all those things we could have done in that precious time.

TV kills imagination. Everything is portrayed for you at the flick of a button, you just have to sit back and enjoy the product of someone else's imagination. Programmes are also loaded with commercials and a constant barrage is spawning desires. Fantasy becomes more satisfying than real life! Insidiously, television puts the viewer in a mental frame where he always wants something. A bigger TV set, a flashier car, more luxury products and the list goes on.

I do agree that television is a medium that can inform, inspire and educate. The clincher, however, is that why should we sacrifice our health, money and relationships for something that humanity has done well without for thousands of years?

Hindu, April 15, P-13

UP ban on junk food in schools

AMITA VERMA
LUCKNOW, APRIL 5

Children used to feasting on burgers, chips, colas and instant noodles will now be in distress. The UP government has sent a letter to all schools — ICSE, CBSE as well as UP Board — to ban sale of junk food within their premises and outside it with immediate effect.

The letter has been issued on instructions received by the Union health and family planning ministry.

The letter, addressed to all principals of primary and secondary schools, calls for a ban on the sale of all forms of junk food and carbonated cold drinks since these are known to lead to a host of diseases, including diabetes, high blood pressure and increased cholesterol levels.

"We have noticed that more and more children reach out for burgers, pakoras, chips and colas during lunch breaks and school canteens are recording brisk sales of such items. Parents also find it convenient to give the child some money instead of ensuring home made food in the tiffin. We have sent warning to parents earlier but it has had minimal impact. Time has now come to ban the sale of junk food on the campus and outside it," said a senior official in the education department.

The letter also warned the district inspector of schools (DIOS) of strict action if the orders were not implemented in their area.

The principal of a leading chain of school, however, welcomed the government order.

"We had attempted to sell sprouted moong dal, fruit chat and lassi on the premises but the canteen owner found no customers for this healthy food. With the ban on colas and chips, children will have to opt for whatever is available. We are informing he parents and from next week onwards, we will be starting a campaign to check tiffin boxes and any child found bringing noodles or any other unhealthy food, will lose marks in examination..." the principal said.

Asian Age, April 6, P.4

Shore up your child's vitamin D levels

If your child experiences lethargy, vitamin D deficiency could be one of the reasons

A recent survey by Ipsos Research shows that only 5 per cent of the mothers surveyed knew that the lack of vitamin D causes fatigue or lethargy. And only 4 per cent of them were aware of the fact that without it their child wouldn't be healthy or active. The general tendency among the mothers surveyed was to associate vitamin D with bone strength, with 87 per cent of them saying that vitamin D helps make bones stronger. There seems to be a lack of awareness among many mothers about the relationship between vitamin D and an active lifestyle.

Till recently, many medical researchers and doctors believed that vitamin D deficiency only caused diseases like rickets and softening of bones and teeth. But studies over the last two decades have shown that vitamin D is one of the leading causes of lethargy. A lack of vitamin D affects neuro-cognitive functions and sleep cycles, which end up resulting in fatigue and lethargy.Weakness, tiredness and a general lack of motivation; these symptoms are often attributed to ailments like anaemia or low blood sugar. However, based on recent research, these symptoms can also be attributed to a deficiency in vitamin D.

"The primary cause for vitamin D deficiency is the lack of exposure to sunlight. Vitamin D is naturally produced in the body with the help of ultraviolet rays present in sunlight. So if your child's exposure to the sun is limited, there is a good chance that they will be vitamin D deficient. This is also the reason why countries within the temperate zone have a higher instance of this deficiency," says clinical nutritionist, Dr Nupur Krishnan. What also causes this problem is the fact that vitamin D production is at its highest during early mornings and gradually becomes non-existent towards the end of the day. Most children today tend to be exposed to sunlight in the latter half of the day and are therefore, unable to get their regular fix of vitamin D.

"My son Jeet often had problems concentrating in class. He didn't seem enthusiastic at all. And considering he is a 10-year-old who should be full of energy, he preferred staying indoors and just lazing around," says Veena Sampat, a Mumbai-based homemaker. "We first thought he was going through a phase, but after a point we had to seek medical advice. It was only after we tested for nutritional deficiencies that we discovered he was vitamin D deficient," says Sampat.

RAVI LELE / INDIA PICTURE

Cases like these aren't as rare as you may think. With a lifestyle that often tends to promote sedentary indoor activities, many children today stay indoors, thus, increasing the possibility of being vitamin D deficient. In fact, according to a study in the New England Journal of Medicine, over 1 billion people suffer from vitamin D deficiency globally. "I always thought vitamin D helped in calcium absorption. But I had no idea that it aids to an active lifestyle. Plus with the amount of sunlight we get in India, I really didn't think that one could have a vitamin D deficiency. It was only after my daughter suffered from it did I discover these facts," says Astha Mistry, a homemaker whose 12-year-old daughter was recently diagnosed vitamin D deficient.

● So how can mothers deal with this problem?

"The easiest and the most advisable way to increase vitamin D levels is through exposure to sunlight during early mornings. Unfortunately, due to modern lifestyles the chances of that happening are very low. Therefore, one needs to increase their vitamin D levels through dietary intakes," says Dr Krishnan. Alternatively, mothers can also include dietary supplements in their child's daily routine to increase vitamin D levels. One of the easiest methods for this could be by consuming malted, milk-based beverages like Bournvita that are rich in vitamin D.

Vitamin D deficiency can become a nagging problem for many children. Fortunately, it can be tackled easily. So the best thing to do would be to let your child spend as much time in the morning sun as possible and try to include foods rich in vitamin D in your child's diet.

Times of India, April 1, P.3

Central kitchen for schools on the plate

Surendra Gangan

School education minister Rajendra Darda on Tuesday announced a mandatory system of a central kitchen for mid-day meals served at schools, which will out into place from the next academic year. The measure, according to Darda, is being taken to improve the quality of food and to curb instances of food poisoning among school students.

Replying to a seven-hour-long debate on the budgetary demands on the department, Darda cited a successful pilot central kitchen project at Aurangabad, which has helped provide quality food. In Mumbai, the project is currently underway on an experimental basis and it will be made compulsory from the next academic year.

Darda said the central kitchen will cook food for lakhs of school students. "I am of the opinion that those schools which do not need a mid-day meal facility be excluded from the scheme. But, the central government does not permit this," he added.

The minister reaffirmed that the department will ensure that

Marathi is treated as a second-language at ICSE and CBSE schools and hence, compulsorily taught till Class VIII.

Darda said a decision on action against schools and managements which have bogus students their rolls, found during the state-wide census conducted in October last year, will be taken at a cabinet meeting in the next few days.

Higher and technical education minister Rajesh Tope said a decision on the bifurcation of universities which have a large number of affiliated colleges will be taken in over a month. He also announced that 14 new girls' hostels, including two in Mumbai, will be opened to rein in the dropout rate among girl students.

D.N.A, April 11, P2

Mid-day meals: Centre asks States to adopt A.P. fund model

Aarti Dhar

NEW DELHI: With some States defaulting on payment of their share of funds for providing meals to children in government schools, adversely affecting the implementation of the Mid-Day Meal Scheme, the Centre has now asked all States to consider adopting Andhra Pradesh's model 'Green Channel Scheme.' The A.P. model makes funds available throughout the year.

"All States and Union Territories may take the lead from Andhra Pradesh and streamline the release of funds," a communication from the Human Resource Development Ministry says. It also asks them to furnish their expenditure position on time, along with the quarterly report.

An analysis of the annual plan proposals received from the States and Union Territories has revealed that only 3 meetings of the State Steering-cum-Monitoring Committee (SSMC), headed by the State Chief Secretary, were held in 2011-12, as against once every quarter as mandated in the guidelines.

The SSMC is an apex body at the State level for guiding, monitoring, and implementing the scheme.

Manipur has convened three meetings of SSMC; Haryana, Himachal Pradesh, Meghalaya, Odisha, Punjab, Uttar Pradesh, West Bengal, Chandigarh, and Daman and Diu two each; Andhra Pradesh, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Karnataka, Maharashtra, Nagaland, Tripura, Uttarakhand, Delhi and Lakshadweep one, while the remaining are yet to convene a meeting.

The Centre spent approximately Rs. 10,000 crore on the programme in 2011-12, excluding the contribution of the States and subsidy on food grain. The Centre provides 75 per cent funds, while the States contribute the remaining 25 per cent to implement the scheme. This helps prevent classroom hunger and also promotes school participation and retention at the elementary level. It also fosters social and gender equity. The government partly credits this scheme for the drop — from 21.59 percentage points to 16.68 percentage points — recorded between male and female literacy rates in the 2001 Census and the 2011 Census. While the overall literacy rate has increased by 9.81 per cent, it has improved by 11.84 per cent in the case of females.

Progress report

However, the latest progress report of the Mid-Day Meal scheme shows that at present, 72 per cent of the enrolled children have been covered. While Haryana, Arunachal Pradesh, Andhra Pradesh, Lakshadweep, Goa, Himachal Pradesh, Nagaland, Puducherry, Mizoram, Karnataka and Assam have reported more than 90 per cent coverage, in Bihar, Chandigarh, Jharkhand, Uttar Pradesh, Gujarat and Delhi the coverage is less than the national average. In fact, some States have even shown a drop compared to the previous year.

An analysis of data has shown that coverage is less than 70 per cent in 61 districts at the upper primary level, and 42 districts at the primary level.

Similarly, there is a mismatch between consumption of food grain and utilisation of cooking gas in various States. While utilisation of cooking gas is higher compared to food grain consumption in Gujarat, Puducherry, Goa, Haryana, Chhattisgarh, Chandigarh and Lakshadweep, it is the reverse in Mizoram, Andaman and Nicobar Islands, Kerala, Manipur, Assam and Nagaland.

Hindu, April 30, P.18

'How will ICDS complement early child care policy?'

Aarti Dhar

NEW DELHI: Neenv — a network of grass-roots non-governmental organisations working for children under six in urban poor settlements in Delhi — has sought more clarity on restructuring of the Integrated Child Development Scheme (ICDS) under the government's Early Childhood Care and Education (ECCE) policy.

The proposed ECCE refers to programmes for children from prenatal to six years, which cater for the needs of a child in all domains of development, including physical, motor, language, cognitive, socio-emotional, and creative and aesthetic appreciation, and provides synergy with health and nutrition aspects. This would cover developmental priorities for each sub-stage within the continuum including care, early stimulation/interaction needs for children under three, and developmentally-appropriate pre-school education for three to six-year-olds, with a more structured and planned school readiness component for five to six-year-olds.

Devika Singh of Neenv told *The Hindu* that the proposed policy had a strong public-private component, and this required more clarity. "How will the ICDS complement ECCE? Is this presumably based on the assumption that privatised arrangements of ECCE would take care of the education component, while the remaining services would be provided by the ICDS?"

This policy will be applicable to all early childhood care and education programmes/related services in the public, private and voluntary sectors in all settings across regions, that are offered to children under six (and could go by the nomenclature of anganwadis, crèches, play groups/schools, preschools, nursery schools, kindergartens, preparatory schools, *balwadis*, home-based care). According to Ms Singh, there are no clear guidelines on how the quality and standards of ICDS will be made to conform to the norms documented in the ECCE policy, and what the state would invest in terms of human resource, salaries, and training to bring about parity in quality.

A recent micro-study conducted by Neenv-Delhi FORCES in the bastis of Delhi showed that of in a survey of 1,380 households, 75 per cent of the women were working in the informal sector as domestic workers, factory workers, casual labourers, vegetable vendors, and home-based pieceworkers, while 68 per cent of them worked for more than four hours away from home with no provision of care for their children.

In the face of this reality, what does the state provide in terms of childcare and maternity support for this section of society? The Rajiv Gandhi National Crèche Scheme covers only 5.54 lakh children under six, out of a total of 16 crore children. ICDS doesn't provide crèches.

Similarly, maternity benefits, which enable a woman to stay away from work and breastfeed her child for six months, have been introduced only recently for the informal sector under the Indira Gandhi Matritva Sahyog Yojana (IGMSY) — that too, for 52 districts, and at Rs 1,000 per month for six months, if certain conditions are fulfilled.

It is interesting to note that during recent times one of the fastest-growing sectors has been domestic work (where care work is involved to a large extent) and "care workers" namely anganwadi workers, auxiliary nurse midwives, and accredited social health activists are all women, all underpaid, and all part of the informal sector. It tells us volumes of the low recognition given to "care work" and the intensity of care deficit, points out Ms Singh.

Hindu, April 23, P.5.

प्रजनन दर में 19 प्रतिशत की गिरावट

नई दिल्ली. पिछले एक दशक में देश की कुल प्रजनन दर में 19 प्रतिशत तक की गिरावट आई है। जबकि राज्यों में प्रजनन दर में काफी विभिन्नताएं सामने आई हैं। कुछ राज्य ऐसे हैं जहां औसत से ज्यादा प्रजनन दर में गिरावट दर्ज की गई है। उत्तराखंड में प्रजनन दर जहां 2.8 प्रतिशत है वहीं, केरल में वह मात्र 1.6 प्रतिशत पर सिमटी है। रजिस्ट्रार जनरल ऑफ इंडिया की ओर से नमूना पंजीकरण सिस्टम 2010 के ताजा आंकड़े शनिवार को ही स्वास्थ्य मंत्रालय के सुपुर्द किए गए हैं।

आंकड़ों के मुताबिक, वर्ष 2008 व 2009 में जहां प्रजनन दर 2.6 प्रतिशत थी वहीं, 2010 में यह 0.1 प्रतिशत गिरकर 2.5 प्रतिशत रह गई। वर्ष 2000 में यह 3.2 प्रतिशत थी।

शिक्षा की महत्वपूर्ण भूमिका

प्रजनन गिरने का सबसे बड़ा कारण शिक्षा का बढ़ता स्तर है। अनपढ़ महिलाओं के मुकाबले शिक्षित महिलाओं में प्रजनन दर कम है। हाईस्कूल तक शिक्षित महिलाओं की यह 1.9 है जबकि इंटरमीडिएट तक पढ़ी महिलाओं में यह 1.6 प्रतिशत पाई गई। आंकड़ों से महिलाओं की शिक्षा और प्रजनन दर में सीधा संबंध नजर आ रहा है। उदाहरण के तौर पर प्रजनन दर में पिछड़े राज्य बिहार में भी हाईस्कूल पढ़ी महिलाओं में भी संख्या दर 2 प्रतिशत से कम है, जो कि 1.9 प्रतिशत प्रजनन दर वाले महाराष्ट्र में अनपढ़ महिलाओं में यह 6 प्रतिशत तक पाई गई है।

दस राज्यों में कमी

आंकड़ों से पता चलता है कि दस राज्यों ने 2.1 प्रतिशत या उससे कम के लक्ष्य को हासिल किया है। हालांकि दस बड़े राज्य ऐसे हैं जहां अभी भी औसत से ज्यादा है। ऐसे राज्यों में बिहार (3.7), यूपी (3.5), मध्य प्रदेश (3.2), राजस्थान (3.1), झारखंड (3), छत्तीसगढ़ (2.8), असम (2.5), गुजरात (2.5), हरियाणा (2.3) और ओडिशा (2.3) शामिल हैं। इन राज्यों की कुल जनसंख्या देश की आबादी की आधी है। एजेंसी

Rajasthan Patrika, April 2, P2

गर्भवती महिलाओं की सेहत और नौनिहालों के पेट पर डाका

स्वामीनाथ शुक्ल

अमेठी, 3 अप्रैल। जिले में आंगनबाड़ी केंद्र मात्र कागजों में चल रहे हैं। यहां आने वाले बच्चे और गर्भवती महिलाएं भी कागजी हैं। जबकि जिले में असली बच्चों और गर्भवती महिलाओं की सेहत बिगड़ रही है। बाल विकास पुष्टाहार विभाग की हाटकुक योजना भी कागजों में है। केंद्रों के नाम का पोषाहार खुलेआम बाजार में बेचा जा रहा है। बच्चे और गर्भवती महिलाए कुपोषण का शिकार हो रहे है जबकि अधिकारी मालामाल।

विश्व बैंक की मदद से देश में नवजात शिशुओं, गर्भवती महिलाओं और शून्य से छह साल तक के बच्चों की संपूर्ण देखभाल के लिए आंगनबाड़ी केंद्र खोले गए हैं। लेकिन पुष्टाहार वितरण न होने के कारण बच्चे कुपोषण का शिकार हो रहे हैं और अधिकारी मालामाल। बाल विकास पुष्टाहार विभाग की महत्त्वाकांक्षी परियोजना से देश में कुपोषण के शिकार नवजात शिशुओं,व गर्भवती महिलाओं की देखभाल के लिए लाखों रुपए खर्च किए जा रहे है। लेकिन भ्रष्टाचार के आगे सरकार की यह परियोजना दम तोड़ रही है। योजना के तहत हर गर्भवती महिला को पुष्टाहार के लिए चार हजार रुपए की आर्थिक मदद मिलती है। यह मदद गर्भधारण के तीन महीने बाद से दी जाती है और शिशु के जन्म तक मिलती है ताकि जच्चा-बच्चा स्वस्थ रहें। लेकिन अभी तक यह योजना आम आदमी तक नहीं पहुंची है। जिला बाल विकास पुष्टाहार विभाग ने 2003 में सभी केंद्रों पर हाटकुक योजना शुरू की थी। इसका मकसद था कि सभी बच्चों को पकापकाया भोजन दिया जाए। पोषाहार के अलावा चार रुपए नकद देने का अभियान भी चलाया। हाटकुक योजना में सालाना अरबों रुपए जिले को मिल रहे हैं। लेकिन किसी भी केंद्र पर चूल्हा जलता नजर नहीं आया है। शासन ने हफ्ते का मीनू भी जारी किया। सोमवार को नाश्ते में पंजीरी और भोजन में खिचड़ी, मंगलवार को पंजीरी-दलिया, बुधवार को खिचड़ी, गुरुवार को पंजीरी-दलिया, शुक्रवार को गुड़-चना और खिचड़ी व शनिवार को पंजीरी और दलिया का मीनू है।

इन योजनाओं के तहत जिले के 16 ब्लाकों में संचालित 2045 आंगनबाड़ी केंद्रों पर 2045 कार्यकर्ता और 2035 सहायिका तैनात हैं। मिनी आंगनबाड़ी केंद्रों पर 372 कार्यकर्ता हैं। 16 ब्लाक विकास परियोजना अधिकारी हैं। लेकिन गर्भवती महिलाओं का कहना है कि उनकी देखभाल और सेहत के लिए सरकार ने भले ही खजाने का मुंह खोल रखा है। लेकिन उन्हें इन योजनाओं का पता ही नहीं है। आंगनबाड़ी केंद्र कहां चलते हैं किसी को नहीं पता। ये केंद्र केवल कागजों में चल रहे हैं। इसलिए गर्भवती महिलओं और बच्चों को पोषाहार मिलने का सवाल ही नहीं उठता है।

कुछ आंगनबाड़ी कार्यकर्ताओं का कहना है कि उन्हें कागज पर पोषाहार 10 से 12 बोरी रिसीव कराया जाता है लेकिन छह से सात बोरी ही मिलता है। इसके अलावा हाटकुक योजना की धनराशि उनके खाते में तभी भेजी जाती है जब विभागीय अधिकारियों को सुविधा शुल्क दिया जाता है। आंगनबाड़ी केंद्रों के रजिस्टर में दर्ज बच्चे भी कागजी होते हैं। आंगनबड़ी केंद्रों पर केवल कागजों में सौ से ज्यादा बच्चे और गर्भवती महिलाएं पोषाहार खा रही है।

Jansatta, April 4, P.7

बढ़ा गर्भपात का ग्राफ

गर्भपात के मामलों में 90 फीसदी इजाफा

जालोर

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मेरा हक
सूचना का अधिकार

इसे चिकित्सकीय परामर्श नहीं लेने की वजह मानें या फिर अन्य कोई गायनिक समस्या। कारण चाहे कुछ भी हो लेकिन गत साल की तुलना में इस बार महिलाओं में गर्भपात के मामलों में इजाफा हुआ है।

सूचना का अधिकार के तहत प्राप्त जानकारी के अनुसार वर्ष 2010 की तुलना में वर्ष 2011 में गर्भपात के मामलों में करीब 90 फीसदी का इजाफा हुआ है। जनवरी 2010 से लेकर दिसम्बर तक सामान्य चिकित्सालय में गर्भपात करवाने वाली महिलाओं की संख्या 203 थी। वहीं जनवरी 2011 से दिसम्बर 2011 तक यह आंकड़ा 393 तक पहुंच गया। ऐसे में गर्भपात के आंकड़ों में हो रहे इजाफे का सहज ही अंदाजा लगाया जा सकता है।

ये हैं कारण

चिकित्सकों के अनुसार गर्भपात के गायनिक कारणों में बच्चेदानी के बढ़ने, बच्चेदानी में गांठ होने, एंडोमेट्रियोसिस होने, पेपीलोमा होने, हिमोग्लोबिन व हारमोंस का अनुपात गड़बड़ाने समेत अन्य कारणों से गर्भपात होते हैं। कई बार अवांछित गर्भ ठहरने पर भी गर्भपात कराया जाता है।

190 फीसदी बढ़ा अपूर्ण गर्भपात

आंकड़ों पर गौर करें तो इनकम्पलीट एबॉरशन में वर्ष में 2010 की तुलना में वर्ष 2011 में 147 गर्भपात अधिक हुए है अर्थात इस साल में अपूर्ण गर्भपात में करीब 190 प्रतिशत का इजाफा हुआ। वर्ष 2010 में अपूर्ण गर्भपात के चलते अस्पताल में गर्भपात करवाने वाली महिलाओं की संख्या मात्र 76 ही थी। यह संख्या वर्ष 2011 में बढ़कर 223 तक पहुंच गई। वर्ष 2010 में फरवरी, मार्च और अप्रेल माह में अस्पताल में इस प्रकार का एक भी गर्भपात नहीं हुआ। जबकि वर्ष 2011 के मई माह में इस श्रेणी के सर्वाधिक 27 गर्भपात हुए। इसी तरह जून व जुलाई में 21-21 और नवम्बर में 20 गर्भपात हुए।

इनका कहना...

गर्भपात से बचने के लिए गर्भवती महिलाओं को समय-समय पर चिकित्सकीय परामर्श व जांच करवानी चाहिए।

-डॉ. शांतिलाल माथुर, स्त्री रोग विशेषज्ञ, सामान्य चिकित्सालय जालोर

Rajasthan Patrika, April 26, P11

Vrinda Malik

"The birth of a new life should bring happiness and joy to the family, but lack of basic knowledge and facilities often restricts the event to anxiety and concern," according to Dr Kranti Rayamane, maternal and newborn health expert at PATH, an organisation working on health issues. In 2005, PATH initiated the Sure Start Project aimed at ensuring the health and safety of mothers and newborns through behaviour change and community action. In a seven-year initiative, it has been working towards this goal in rural communities of Uttar Pradesh and among settlements of disadvantaged sections in Maharashtra's sprawling cities.

"Our only aim was to bridge the defence in the availability of infrastructure available and the lack of any human recourse development. The changes we seek are not abrupt or imposed. We train Accredited Social Health Activists (ASHAs) who are chosen from the community who in turn encourage community leaders, health workers, family members, and pregnant women to adopt best practices to improve health outcomes," Dr W.Sita Shankar, Director maternal and child health and natal care said.

In Uttar Pradesh, Sure Start works with the National Rural Health Mission and its ASHAs to promote healthy pregnancy practices for mothers in 5,520 villages. In Maharashtra, Sure Start implemented the project in selected slums of seven cities (Mumbai, Navi Mumbai, Nanded, Nagpur, Solapur, Pune, Malegaon).

The project carried out intensive activities including door-to-door surveillance for pregnancy through menstrual surveillance tools to ensure early registration of pregnancy, need-based Behavior Change Communication (BCC) for women and families, distributing printed health materials and using street theatre performances to promote healthy pregnancy, safe delivery and newborn care messaging.

Over the last two years, there has been a perceptible increase in the percentage of women registering their pregnancy within 12 weeks --from 41 per cent in 2008 it has gone up to 54 per cent in 2011. Institutional deliveries are also up from 78 per cent in 2008 to 88 per cent in 2011in the seven Maharashtrian cities. Sure Start works with 95 partners in Uttar Pradesh and Maharashtra, with the project funded by the Bill & Melinda Gates Foundation.

The key to the difference that the project has made is its ability to communicate and monitor. Issues are different in the urban – rural landscape, but they all fall under the same arch of logic and counselling. "Policy makers cannot wash their hands off by throwing money or creating infrastructure as a solution to problems that need to be solved by creating better communication and awareness. You can make a school but what if no one wants to go there," asked Tarun Vij, PATH's country programme director.

He explained that in rural areas the challenge is the lack of medical conditions and opinion makers need to be influenced, in most cases mothers- in laws and sarpanch leaders. However, in the case of Maharashtra, which has the largest urban population in the country there were a different set of issues. "Drastic change in immigration and drift from the traditional lifestyle has changed the social structure, often leading to nuclear families where women have an additional burden of contributing economically. Outreach to the community is the most basic aim of the programme, no matter how many hospitals are made, unless the families are convinced of the practices, there is no use of the infrastructure...Communities have an innate capacity to find solutions to problems they face, we only need to catalyse them by training someone from among them. The snowballing effect takes place when women respond to the story of another woman's healthy delivery. This is the best way to spread an idea." Mr. Vij said.

Hindu, April 26, P6

'Govt committed to curb maternal mortality rate'

CORRESPONDENT

NILAMBAZAR, April 18 – The newly constructed building of Karimganj GNM Nursing School was inaugurated by Himanta Biswa Sarma, Minister of Health, Education & Assam Accord etc on April 15. In this connection, an open meeting was held at the campus of nursing school near the civil hospital under the chairmanship of Jiten Borgoyari, Deputy Commissioner Karimganj.

Speaking at the meeting Sarma said that Karimganj has the highest percentage of birth and death of children as compared to the rest of the State and the country as a whole. But there are ample reasons for that, prominent among them being the outdated methods of treatment at government hospitals. Hence, the government has decided to upgrade the infrastructure and other medical facilities in hospitals in Karimganj and Hailakandi.

Sarma also said that government is committed to curb the maternal mortality rate in the State. He accepted that the two districts are way behind in terms of quality health services and stressed on awareness generation to avert mortality rates. Moreover he said that there have been a plethora of complaints against the work culture at Karimganj Civil Hospital. He informed that government would not send any medicine to the hospital on its own henceforth. A list of required medicines has to be sent by the authority based on which medicines will be sent.

Further, he informed that government has decided to improve the health facilities of the hospitals and in this backdrop Karimganj Civil Hospital will have a CT Scan unit and newborn care unit.

Later, the minister also attended a review meeting of the education deptt at the DC's conference hall. After threadbare discussion he directed the District Elementary Education officer Abdul Motin Choudhury to start the rationalisation process of the schools within 15 days. Then the minister visited the Karimganj Red Cross Hospital and Govt HS School.

In evening Himanta Sarma laid the foundation of South-Karimganj Govt Model College at Eraligool and then he received the award of 'Mou Abdul Jalil Choudhury Smriti puraskar' from Badarpur Title Maddrassa. In this connection a felicitation programme was held at Dewrail Title Maddrassa under the chair of Amir-e-Shariat Mou. Taibur Rahman Barbhuiya. Siddique Ahmed, Minister Co-operative & BAD Dept, MLA Jamal Uddin Ahmed, Kripanath Mallah, Kamalakha Dey Purkayastha and Monilal Goala, Parliamentary Secretary, Pratik Hajela, Director, NRHM were present among others.

Assam Tribune, April 19, P 8

Ministry of Health and Family Welfare
Government of India

NATIONAL RURAL HEALTH MISSION

FREE

FACILITIES UNDER JSSK

ENSURING SAFE MOTHERHOOD

Conference on the National Safe Motherhood Day on 11th & 12th April, 2012 at Jaipur

Deccan Herald, April 11, P19

Women too prone to Coronary Artery Disease

It has been found that women suffering from heart problems typically experience burning sensations under the breast bone or upper abdomen. These sensations are often coupled with sweating, light headedness and nausea. However, too often these symptoms are discounted or confused with indigestion or signs of menopause. As a result, studies show that women delay in seeking treatment, usually much longer than men with similar heart-related symptoms.

And women tend to be more tentative in reporting symptoms to their doctors. Doctors order ECGs or other cardiac diagnostic tests less often for women than for men. Just as there are differences in the way men and women experience and report heart-related symptoms, there are differences in the effectiveness of some diagnostic tests that are not as accurate tor women.

In about one–third of all women, the exercise stress test indicates abnormalities when there are none. During exercise, a typical healthy woman can produce heart rhythms that resemble the rhythms characteristic of Coronary Artery Disease (CAD). This may be due to fluctuations in estrogen levels in a slightly different way, doctors and technicians tend to be careful when using and interpreting echocardiography results in women.

While this test is usually reliable for women, breast tissue can conceal or blur the heart, making it difficult to obtain clear, conclusive pictures. Hence as a basic Sphygmocor non-invasive FDA approved simple test can be done for both men and women to find out the cardiac problems which are available only in few hospitals in Chennai.

As a rule, different heart conditions are signalled by slightly different symptoms. A myocardial infarction or heart attack occurs because part or all of the heart muscle sustains damage when the flow of oxygenated blood to the heart is cut off. Symptoms can include intense chest pain or prolonged, heavy pressure that radiates to the left shoulder and arm, the back, and even the teeth and jaw. Each year, more than 250,000 women in the United States die as a result of heart disease.

Studies show that doctors have been more likely to dismiss a woman's symptoms as indigestion or premenopausal symptoms and not to look for CAD as aggressively in women as they do in men. A woman's symptoms tend to be less likely to be identified as heart-related. The symptoms of CAD, and especially of myocardial infarction, can be significantly different in women than they are in men. Recognising these symptoms can make women more effective partners in fighting CAD.

On the event of World Health Day, Oxymed Hospitals offers complete Cardiac and ortho-related tests at concession rates.

For further details, contact Oxymed Hospitals Pvt Ltd, Anna Salai, Nandanam,044 42131010/1014/1016 or email oxymenhospitals@yahoo.com. *Website:* www.oxymedhospital.in

FEAR FACTOR

Forty five per cent of the women studied with symptomatic heart attacks died within one year as opposed to 10 per cent of symptomatic men. This may be due, in part, to the fact that symptoms that are common to men are used as the standard

Studies show that doctors have been more likely to dismiss a woman's symptoms as indigestion or premenopausal symptoms and not to look for CAD as aggressively in women as they do in men

As a result, studies show that women delay in seeking treatment, usually much longer than men with similar heart-related symptoms

New Indian Express
April 7, P7

'आशा' बताएंगी दो के बाद अब नहीं

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शादी के बाद पहला बच्चा कब हो और पहले व दूसरे बच्चे के लिए बीच कितना अंतराल रहे, ये जानकारियां अब मान्यता प्राप्त सामाजिक स्वास्थ्यकर्ता (आशा) घर-घर जाकर लोगों को बताएंगी। स्वास्थ्य मंत्रालय ने जनसंख्या नियंत्रण और बच्चों की अच्छी परवरिश के लिए नई योजना शुरू की है, जिसके तहत देश की 8.61 आशा कार्यकर्ताओं को नकद प्रोत्साहन राशि दी जाएगी।

सूत्रों के मुताबिक, यह योजना राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के तहत शुरू की जाएगी, जिसमें आशा कार्यकर्ताओं को 500 से 1000 रुपए तक अतिरिक्त राशि मिलेगी। ये राशि उन्हें तब ही मिलेगी, जब वे योजना के प्रावधानों को मानने के लिए दंपती को राजी कर लेती हैं।

योजना इसलिए महत्वपूर्ण

दरअसल, देश में 45 फीसदी मातृ मृत्यु 15-24 वर्ष की माताओं की होती है। इन मौतों का कारण बच्चे पैदा करने की सही योजना का न होना है। बिना देखभाल बच्चे पैदा करने से माताओं की सेहत पर बहुत बुरा प्रभाव पड़ता है, जो उनके आगे के जीवन के लिए अस्वास्थ्यकर रहता है। उन्हें खून की कमी से संबंधित बीमारियां ज्यादा होती हैं। ऐसे में बच्चों के भी स्वस्थ जीवन की संभावनाएं कम ही रहती हैं। पहले के दो साल बाद ही दूसरे बच्चे को जन्म दें, क्योंकि एक बार गर्भवती होने के बाद मां को दो साल स्वस्थ होने में लग जाते हैं।

क्या करेगी आशा?

जो दंपती को बताना होगा कि शादी के दो साल बाद पहला बच्चा करें। इसके लिए उन्हें पांच सौ रुपए मिलेंगे।

पहले बच्चे के तीन साल बाद दूसरे की योजना बनाए। इसके लिए भी आशा को पांच सौ रुपए दिए जाएंगे। दो के बाद तीसरे बच्चे की योजना न बनाए। इसके लिए 1000 रुपए अतिरिक्त दिए जाएंगे। (एजेंसी)

Rajasthan Patrika, April 13, 09

'60% bear 2nd child within 3 years'

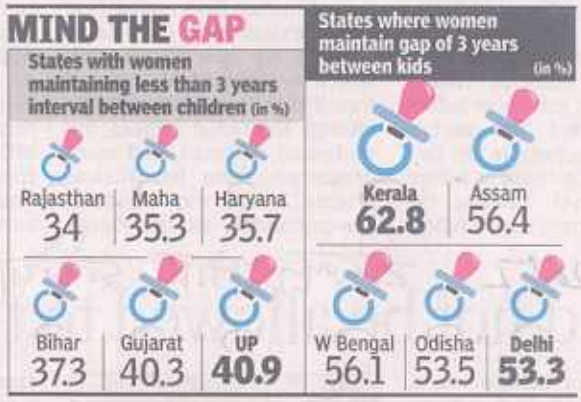
Kounteya Sinha | TNN

New Delhi: Almost 3 in 5 women (59%) are having their second child within three years of having their first. Andhra Pradesh leads the list of women not spacing their children adequately — 66%, followed by Rajasthan where just 34% women had their second baby three years after having their first.

Maharashtra recorded 35.3% women who had their second child after three years of their first followed by Haryana 35.7%, Karnakata 35.8%, Himachal Pradesh 36.6%, Bihar 37.3%, Tamil Nadu 40%, Gujarat 40.3% and Uttar Pradesh 40.9%.

According to the Registrar General of India's latest Sample Registration System (SRS) data 2010, submitted to the Union health ministry last week, just five states recorded over 50% women who had kept a gap of three years between two children.

They include Kerala 62.8%, West Bengal 56.1%, Assam 56.4%, Odisha 53.5% and Delhi 53.3%. Lack of proper spacing between two children is adversely affecting the mothers' health and children's chances of survival. Unicef says an average Indian woman delivers her second baby within 31 months of giving birth to her first child.



Nearly 30% women in India are keeping a gap of just 24 months years between two children. Union health ministry says a woman should ideally deliver her second child after a gap of at least three years from her first baby. If not done, second time mothers not only pose a threat to the growth of their foetus but also increase risk of a premature delivery.

Earlier studies have reported a higher incidence of low birth weight and premature delivery among babies conceived within six months of a previous birth, compared to those conceived 18 to 23 months following the last baby. Experts say it takes at least two years for a woman's body to recover from childbirth. Since nearly 52% of women in India are anaemic, a woman has to let her body replenish lost nutrients and the blood that she loses during delivery.

According to the latest SRS data, less than half – 44.5% women in Jharkhand kept a space of three years between two children, Jammu and Kashmir 47.7% and Chattisgarh 44.4%.

The SRS data says around 26.3% women had a gap of 12-24 months between two children. This included 32.5% in Andhra Pradesh, 29.6% in Bihar, 30.9% in Haryana, 32.3% in Himachal Pradesh, 30.3% in Punjab, 31.85 in Rajasthan and 30.4% in Tamil Nadu.

In Maharashtra nearly 30% women had their second child within two years of having the first while the figure stood at 17% in West Bengal, 26.8% in Uttar Pradesh, 14.7% in Kerala and 15.1% in Odisha.

One of the biggest reasons for this is that Indian men don't really swear by sterilization. The number of men undergoing a vasectomy — a 10-minute walk-in-walk-out operation — has dipped by about 22% in 2010-2011 as compared to the previous year. In absolute numbers, over 50,000 fewer men underwent vasectomy in 2010-11 as compared to 2009-10 — from around 2.7 lakhs to to 2.16 lakhs. The Union health ministry's latest data says, most states have seen a sharp dip in the number of men wanting to get involved in family planning. Bihar saw a 55% fall in the number of men opting for vasectomy in 2010-11 as compared to the previous year, while Orissa, Maharashtra and Uttar Pradesh recorded a 47%, Kerala (46%), Karnataka (45%) fall, respectively.

Times of India, April 11, P-17

BREASTFEEDING & ARV THERAPY CHECK HIV: STUDY

TEENA THACKER
NEW DELHI, APRIL 26

Antiretroviral therapy along with breastfeeding for a long period could help reduce HIV transmission from mother to child, a new study has revealed. In fact the study published in the *Lancet* has suggested that stopping breastfeeding before six months might increase infant morbidity. Experts say that the study gains significance for India where vertical transmission from mother to child is huge.

The Breastfeeding, Antiretrovirals, and Nutrition study conducted in Malawi between 2004 and 2010, included about 2,369 HIV-infected breastfeeding mothers and their babies were assigned to one of three 28-week regimens: maternal triple antiretroviral (849), daily infant nevirapine (852), or control group (668).

Asian Age, April 27, P5

Breast cancer has 10 sub-types: Study

ABANTIKA GHOSH
NEW DELHI, APRIL 19

REINFORCING the impression that cancer is really many diseases, researchers in the United Kingdom, Canada and Norway have reported in the journal, *Nature*, that breast cancer has ten different sub-types — in terms of the constitution of the cells and the genetic mutations driving their changes — and future treatment should be developed for each of these rather than trying to evolve a one-protocol-fits-all model.

The study — a collaborative effort of Cambridge University, University of Oslo, King's College among others, along with the METABRIC Group — analysed the genomic structure and cellular patterns of 2,000 breast tumours. All patients had been diagnosed 5-10 years earlier and their survival was mapped to understand if some breast cancers were less life-threatening than others.

Researchers analysed the DNA and RNA profiles of all these tumours and concluded that they constituted novel sub-groups with distinct clinical outcomes. There were some sub-groups that responded to oestrogen because of the presence of its receptor in the cells and others where the aberrations in the gene copies were such that they were more vulnerable to some drugs, so that the prognosis of these tumours is always better. Some forms of the disease had been triggered by drastic changes in the gene sequence of the cells (mutations), while others were missing entire sequences of genes present in normal cells (deletions).

The idea that cancer is many diseases is not new in the scientific world. Dr Siddhartha Mukherjee, in his Pullitzer-winning *The Emperor of All Maladies — A Biography of Cancer*, had dealt with it extensively. This is, however, the first time that a cancer of one particular part of the body has been so clearly classified at the genome level, opening new vistas for treatment.

"The study re-affirms cancer's status as a mysterious disease and makes it clear why it is such a difficult disease. Earlier this month, the *New England Journal of Medicine* carried an article on how, when researchers sequenced four quadrants of a breast and a kidney tumour, all four areas of each of them turned out to be different. The catch for developing future targeted therapies is in identifying the driver mutation and then targetting it," said Dr Shyam Agarwal, consultant oncologist at Sir Ganga Ram Hospital.

A driver mutation is mutation that triggers all the other changes in the genome of a cell that make it behave in the manner of a cancer cell. According to Dr P K Julka, professor of clinical oncology at AIIMS, onco-typing is one test done even now while treating breast cancer to decide the treatment module, but such minute sub-typing was not known earlier.

"They have broken the known sub-types into smaller groups. What this means is that cancer medicine will need to be more personalised. At present, we know about five types of breast cancer and, based on their risk profiles, we decide whether to do merely hormone therapy or start chemotherapy too," said Dr Julka.

Indian Express, April 20, P7

Fertility rate in India drops by 19% in 10 yrs

Among States, Punjab Records Biggest Decline At 28%

Kounteya Sinha | TNN

New Delhi: India's total fertility rate (TFR) — the average number of children expected to be born per woman during her reproductive years — has fallen by 19% over the past decade. Among bigger states, the percentage decline in TFR during this period the last decade varied from as high as 28% in Punjab to 5.6% in Kerala.

Maharashtra saw the second highest dip in TFR between 2000-2010 at 26.9%, followed by Haryana and Andhra Pradesh (25%), Uttar Pradesh (23%), Rajasthan (22%), Himachal Pradesh and West Bengal (21%).

The latest Sample Registration System 2010 data finalized by the Registrar General of India and sent to the Union health ministry on Saturday says India's TFR, which had remained stagnant in 2008 and 2009 at 2.6, finally has dropped by 0.1 points in 2010. India's TFR now stands at 2.5 as against a TFR of 3.2 in 2000. Education has been found to play a major role in determining TFR.

On average, an illiterate woman in India is bearing 1.2 children more than a literate woman (3.4 against 2.2). The TFR among women who have studied till at least class X was as low as 1.9. This further dips to 1.6 among women who have studied till class XII.

The link between female education and fertility is clearly brought out by the SRS data. For instance, even in Bihar, the state with the worst overall TFR of 3.7, women who are educated up to Class X or beyond have a TFR of 2.0 or less. On the other hand, even in Maharashtra, which has an overall TFR of 1.9, women who had no education had a TFR of 6.0.

According to the SRS 2010, ten states have achieved replacement level fertility of 2.1 and below. However, 10 big states still have a higher TFR than this. These include Bihar (3.7), UP (3.5), MP (3.2), Rajasthan (3.1), Jharkhand (3), Chhattisgarh (2.8), Assam and Gujarat (2.5), Haryana and Odisha (2.3). What's worrying is that these states together account for nearly half of India's population.

States which have recorded a dip in TFR in 2010 as against 2009 include Andhra Pradesh (1.9 to 1.8), Assam (2.6 to 2.5), Bihar (3.9 to 3.7), Chhattisgarh (3 to 2.8), Haryana (2.5 to 2.3), Himachal (1.9 to 1.8), J&K (2.2 to 2), Jharkhand (3.2 to 3), MP (3.3 to 3.2), Odisha (2.4 to 2.3), Punjab (1.9 to 1.8), Rajasthan (3.3 to 3.1), UP (3.7 to 3.5) and West Bengal (1.9 to 1.8). TFR in states like Delhi (1.9), Maharashtra (1.9), Gujarat (2.5), Karnataka (2) and Tamil Nadu (1.7) has however stagnated.

Kerala is the only state which has recorded an increase in TFR – from 1.7 in 2009 to 1.8 in 2010.

According to the National Population Policy 2000, India should have reached there placement-level fertility rate of 2.1 by 2010, and ought to attain population stabilization at 145 crore by 2045. Population stabilization is when the size of the population remains unchanged. It is also called the stage of zeropopulation growth. However, India now expects to reach the population stabilization TFR of 2.1 at 165 crore by 2060. Union health minister Ghulam Nabi Azad recently said "We have seen a steady decline in TFR that has come down by 42% from the mid-1960s. We may see a drop of 0.1 point in the TFR, which is currently at 2.6," Azad had said.

NO KIDDING

India's total fertility rate (TFR) dips by 0.1%, but an average woman in 10 big states still have children more than 2.1

TFR IN

2010	2009	2005	2001
2.5	2.6	2.9	3.1

10 BIG STATES THAT HAVE FAILED TO REACH REPLACEMENT FERTILITY LEVEL
(2.1 children or lesser) in 2010

Bihar	3.7
Uttar Pradesh	3.5
Madhya Pradesh	3.2
Rajasthan	3.1
Jharkhand	3
Chhattisgarh	2.8
Assam & Gujarat	2.5
Haryana & Odisha	2.3

10 STATES THAT HAVE REACHED REPLACEMENT FERTILITY LEVEL
(2.1 children or lesser) in 2010

Tamil Nadu	1.7
West Bengal	1.8
Andhra Pradesh and Himachal	1.8
Kerala and Punjab	1.8
Delhi and Maharashtra	1.9
J&K and Karnataka	2

➤ According to the National Population Policy 2000, **India should have reached** replacement-level **fertility** rate of 2.1 by **2010**

➤ India now expects to reach **population stabilization** of 2.1 TFR by **2060**

Times of India, April 1, P.7

India asked to scale up treatment for HIV+ mothers

Need for massive escalation of treatment, care services: UNAIDS

Aarti Dhar

- 'By 2015, we need at least 15 million people on treatment worldwide'
- "An unfinished agenda... stigma, discrimination, denial faced by HIV+ people is still very high"

NEW DELHI: Appreciating India's efforts in providing treatment to HIV-affected people, UNAIDS on Thursday asked it to scale up its health care services for HIV+ mothers and children.

"If we want zero AIDS-related deaths, India needs a massive scale-up of treatment and care services. By 2015, we need at least 15 million people on treatment worldwide," said UNAIDS country coordinator Charles Gilks here at a summit on "Good Practices, Innovations and Impact of National AIDS Control Programme-III".

Organised by the National AIDS Control Organisation (NACO), the three-day summit has brought together experts and community leaders who called for concrete strategies that are required to strengthen care, support and treatment in the next phase of the National HIV programme.

"We have an unfinished agenda....as stigma, discrimination and denial faced by HIV+ people is still very high," said Central Department of AIDS Additional Secretary Aradhana Johri.

While Mr. Gilks said India should focus to improve services for pregnant mothers, NACO Deputy Director General Mohammed Shaukat said though the number of Antiretroviral Therapy (ART) centres had gone up from 107 in 2007 to 355 in 2012, HIV+ persons are accessing them at a very late stage. "It is important for HIV+ people to start ART soon to improve the quality of life," he said.

NACO has already directed all ART centres to provide ART to anyone who has a CD4 count of 350 from 250 earlier. The CD4 count determines the immunity levels of a person affected with HIV.

Manoj Paradesi, who has been HIV+ for 18 years, said there is an urgent need to listen to voices of the community. The time has come to make drug dispensing units (ART centres) as complete Health Resource Centres which can provide quality counselling and information to HIV+ people, he said.

The third phase of the National Programme focuses on 'Targeted Interventions' (TIs) and a rapid scale-up of services for prevention, care and support and infrastructure. There are 9,459 Integrated Counselling and Testing Centres (ICTCs) in the country and 18.8 million people, including 7.3 million pregnant women used the voluntary counselling and testing facilities in 2011. Over five lakh HIV+ people are receiving free ART medicines, including 29,000 children. Seven Hundred and twenty-five Link ART centres have also been started to reduce the travel costs of people living with HIV/AIDS.

Koushalya of Positive Women's Network, who is living with HIV for more than a decade and is one of the pioneers who founded the movement led by women living with HIV, said: "The National AIDS Control Programme [NACP] III has given us ART, Prevention of Parent to Child Transmission and helped us dream big. There still are many vulnerable people, especially women, who have not been reached out to who are blissfully unaware of their risk. They have no idea about the services or the programme."

She fervently hoped that NACP IV would recognise and set it right.

Hindu, April 27, P.7

ON THE CARDS: LONGER LEAVE FOR PREGNANT WOMEN

Moushumi Das Gupta
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NEW DELHI: A government panel headed by the women and child development (WCD) secretary has recommended a review of the Maternity Benefit Act, 1961, with a view to increase the number of days of leave that a woman worker can take. It has also suggested giving the employee the choice of utilising the period of paid absence as per her convenience.

However, the panel has not spelt out by how many days the maternity leave should be increased. "It would be the government along with a stakeholder ministry like the WCD which will have to take a final call," said a government official.

Presently, central government employees are eligible for up to 180 days of maternity leave with full pay benefits. For state government employees, the paid leave period varies from 120 to 135 days. In the private sector, the period is of a maximum of 84 days.

The panel has also recommended an amendment to the Maternity Benefit Act to ensure that employers do not terminate the service of a woman during the period of her pregnancy under any pretext to avoid providing maternity benefits.

It has also suggested strengthening and undertaking gender sensitisation among existing committees for labour law implementation. "The committees should be made functional and special cells formed within existing committees to monitor the implementation of legislation for women workers," the report states.

These recommendations were made by a working group on women's agency and employment, which will form the basis of the 12th five year plan on women and child development issues presently being finalised by the Planning Commission.

Besides the WCD secretary, other members of the group include secretaries of various ministries like health, labour, etc.

Hindustan times, April 10, P 11

Tracking mothers and infants

AT DHORLEWADI primary health centre (PHC), 60 km from Baramati taluka in Pune district, auxillary nursing midwife (ANM) Jayashree Dalvi is busy feeding in data about the number of pregnant women who have registered last month. A health check-up camp will be held on Wednesday where vehicles will be sent to the homes of these pregnant women in the village to fetch them for the camp. Routine blood and urine tests to check their haemoglobin counts, blood pressure levels and other health checks will be done by inviting a gynaecologist from a private hospital. At the end of the camp, a nutritious meal will be served to all the women.

Dalvi, who has been working at the PHC for the last 25 years, says the Mother-Child Tracking Software (MCTS) project, initiated by the Central government to reduce maternal and infant mortality, has made it easier to register and track pregnant women and their children. The MCTS system, developed and installed a year ago, aims to track every pregnant woman and child in the 13 talukas of the district. "I have been given a target of covering a population of 6,000. We conduct our survey by visiting every house. On average every month, some 9-10 women are registered as pregnant," says Dalvi.

Vijaya Nimbalkar, 32, an ANM at Nere village in Bhor taluka, rides her two-wheeler in the remote areas of Bhor taluka to visit homes and identify women who are pregnant. "I have been given a target of covering a population of 11,500 in 12 villages. A colleague and I survey the homes, collect information and feed data in the 57 columns as part of the MCTS project. Information regarding the last menstrual period, date of delivery, vaccination, blood pressure check-up and so on are filled in by the ANMs and multipurpose workers (MPWs) at 96 PHCs in the district."

"Despite problems of loadshedding and the lack of enough medical facilities in some remote areas of Bhor taluka, pregnant women are now guaranteed assistance even during the wee hours of the morning," says Nimbalkar.

Both Dalvi and Nimbalkar are among the ANMs and MPWs who have been trained to identify pregnant women, track them, give them an Antenatal Care (ANC) card, register their identification and ensure that they are taken to hospitals for deliveries.

The health workers fill in all the requisite columns about the condition of the pregnant women and send a mail to the health officers of the Pune Zilla Parishad, who then activate their machinery to ensure that the women due for delivery that month are provided with transport and other health benefits.

The district health officials have compiled data on pregnant women who are due for delivery over the next three months and have taken steps to ensure that their requirements are met. For a year now, the mother-child tracking project has had a successful run in Pune district.

The rate of deliveries done at home has reduced by over four per cent. In 2010-11, 7.8 per cent of the 71,460 deliveries were done at home while the figure fell to 4.2 per cent from among the 73,249 deliveries performed in the district in 2011-12. The tracking software has now been installed in all the 96 PHCs and such has been the success of the programme in the rural areas of Pune district that even sterilisation drives have overshot the target.

Dr V S Kamalapurkar, district reproductive and child health officer, says that from 28 maternal deaths and 61,743 live births in 2010-11, maternal deaths have been brought down to 20 and the number of live births have gone up to 62,771.

ANMs have to ensure that the pregnant woman is looked after during the pregnancy and after the delivery and that everything—her vaccination shots, blood and urine tests and gynaecological check ups—is up-to-date. The infant is also monitored. Dr Sudhakar Kokane, a district health officer, said a toll-free number, 1800233460, had been announced, where requests could be made for free-of-cost vehicular transport.

Anil Kawde, CEO of Pune Zilla Parishad, says several initiatives have been launched by the centre such as the Janani Shishu Suraksha Karyakram to improve services for pregnant women and newborns. The centre has also provided the software to all districts in the states as part of the objective to bring down maternal and infant mortality rates. In Pune district, the infant mortality rate has been brought down from 19 for every 1,000 live births in 2010-11 to 15 per 1,000 live births. Kawde pointed out that new schemes to reach women in the remotest areas of the district would soon be launched.

Indian Express, April 29, P15

City is safe from swine flu: Experts

Somita Pal ● MUMBAI

Swine flu is now a concern only in rural and semi-urban areas, unlike the situation and cases in 2009, experts have said.

They have cited the 23-year-old woman from Dhule who died in JJ hospital on Thursday is an example of this. Her death has taken the swine flu toll in the state to 18 in the last two months.

According to experts from the National Institute of Virology (NIV), the H1N1 strain is the same which caused havoc in 2009 and won't affect those who have already been exposed to it. State and civic officials, therefore, are maintaining that H1N1 is not a concern in Mumbai if people take care of hygiene and there is no co-morbidity. There have been 14 positive H1N1 cases in the city so far and all have responded well to treatment.

Dr Pradeep Awate, head of Integrated Disease Surveillance in the state surveillance office, said, "Swine flu is affecting those who have not developed immunity and not been exposed to the strain before. The deaths this year have been from the state's unexposed pockets."

File photo

SO FAR...

This year, India has seen 689 positive cases and 36 deaths in the last two months. Of the deaths, 18 are from Maharashtra – 13 from Pune, three from Nashik and one each from Aurangabad and Dhule. The state has seen nearly 400 positive H1N1 cases in the last two months

Ruling out a resurgence of the 2009 swine flu pandemic in the state or a city like Mumbai, Awate added, "This is just a shift in the virus, not a drift in its form. Hence, we are not worried about a resurgence."

Reports from NIV said that genome sequencing of the H1N1 virus circulating at present was complete. "It is the same group that prevailed during the pandemic. Hence, it should die out within two to three weeks," said an official.

Experts have recommended H1N1 testing only to those who are hospitalised, those at high risk of complications, pregnant women and those who have compromised immune systems. Director of Haffkine Research Institute Dr Abhay Chaudhary said, "Influenza, in most cases, is self-limiting. Whether or not one takes the anti-viral, he/she should recover. If there are associated ailments, one should be cautious."

He maintained that those who died from swine flu in the state had additional complications, such as malignancy and cardiac problems.

D.N.A, April 14, P.1

आंगनबाड़ी में घट रही ग्रोथ!

चिकित्सा विभाग के अधिकारियों की बैठक लेते कलक्टर। पत्रिका

पाली. आंगनबाड़ी केन्द्रों पर बच्चों की ग्रोथ का रखवाला कोई नहीं है। वहां काम कर रही कार्मिकों को केन्द्र सरकार द्वारा बनाए गए ग्रोथ चार्ट को भरना नहीं आता। वहीं मेडिकल जांच के सभी इन्स्ट्रूमेण्ट्स खराब पड़े हैं। जिला कलक्टर ने चिकित्सा विभाग तथा महिला एवं बाल विकास विभाग के अधिकारियों को बुलवाकर इस संबंध में दिशा निर्देश दिए। आंगनबाड़ी पर बच्चों की प्रतिमाह वृद्धि की जांच के लिए ग्रोथ चार्ट तथा अन्य उपकरण उपलब्ध कराए जाते हैं। आंगनबाड़ी कार्यकर्ता बच्चे की जांच कर टीकाकरण तथा अन्य उपाय करती है। आंगबाड़ी कार्यकर्ताओं को ग्रोथ चार्ट भरना नहीं आता है। जिला कलक्टर ने गुरुवार को जिले के आंगनबाड़ी केन्द्रों का निरीक्षण किया तो इसका खुलासा हुआ। आंगनबाड़ी केन्द्र पर जन्म के समय बच्चे का वजन ग्रोथ चार्ट में नौ किलो सात ग्राम दर्शाया हुआ था वहीं पांच माह का होने पर उसका वजन एक किलो आठ ग्राम बताया गया है। केन्द्र पर रक्तचाप जांचने का उपकरण खराब मिला। हीमोग्लोबिनोमीटर तथा वजन करने की मशीन भी खराब मिली।

ममता कार्ड भरेगी एएनएम

जिला कलक्टर ने निर्देश दिए कि आंगनबाड़ी केन्द्रों पर भरे जाने वाले ममता कार्ड की सारी प्रविष्टियां एएनएम द्वारा की जाएंगी। ताकि प्रसूता व माता के सही आंकड़े सामने आ सकें। इसके अलावा कुपोषित व अतिकुपोषित बच्चों की संख्या भी ग्रोथ चार्ट सही नहीं भरा होने के कारण सामने नहीं आ पाती है। इस कारण जिले में इनका उपचार नहीं हो पाता है।

ठीक होंगे उपकरण

जिले के सभी आंगनबाड़ी केन्द्रों पर करीब पांच साल पहले उपलब्ध करवाए गए चिकित्सा जांच उपकरणों को एक माह में दुरुस्त करवाया जाएगा। जिला कलक्टर ने इन उपकरणों तथा जिले के अस्पतालों में लगे पलंग व आईवी स्टेण्ड पर रंग करवाने तथा शौचालय आदि की मरम्मत करवाने के निर्देश दिए।

Rajasthan Patrika, April 15, P11

In South, Women Most Unsafe in Andhra

Express News Service

New Delhi: Going by the number of cases of crimes against women, Andhra Pradesh has emerged as the most unsafe place among the four South Indian states, according to data collated by the National Crime Records Bureau (NCRB).

Andhra Pradesh fared the worst on incidents of rape and sexual offences on all aspects including number of cases reported and number of persons arrested, charge-sheeted and convicted.

In fact, the State has more than double the number of cases registered when compared to the other three states. And this has been so in the past three years consecutively (2008-2010). For example, AP has had 1,257, 1,189 and 1,362 cases of rape registered in the past three years each, while in the other states, the number was about 500.

The number of cases charge-sheeted and the conviction rates under rape category in Andhra are also double that of other states.

Similarly, sexual harassment cases are also highest in AP. If there were 4,562 cases of sexual harassment in AP last year, the figure was 83 for Karnataka, 537 for Kerala and 638 for Tamil Nadu.

The safest place for women, according to NCRB data, is Karnataka, which reported the least number of cases in both categories of rape and sexual harassment.

Arpana Popat of Centre for Women Development, however, says it is too sweeping to say that women are safer in Karnataka because the NCRB data says so. "It could also be a case of under reporting," she pointed out.

New Indian Express, April 29, P.1

No tolerating sexual harassment, says Brinda

KOZHIKODE: Asserting that the party would not brook any case of sexual harassment in the organisation, the Communist Party of India (Marxist) on Friday said it was committed to fight against the increasing violence against women and that it stood for stringent punishment to all criminals in such cases.

As the party congress adopted a 'Violence against Women' resolution, Polit Bureau member Brinda Karat stressed that the CPI(M) was "clear there is no case of sexual harassment and that if it ever occurs it will not be tolerated [in the party]...there is not a single case in which has been tolerated."

Ms. Karat's response came to questions about reports mentioning some party members being involved in such cases. With some sections of the media criticising the party for not accommodating women in decision-making apparatus, and questions on whether more women would find a place in higher echelons of the party, Ms. Karat said the matter would be known in three days' time when the new Central Committee would be reconstituted.

In the resolution on women adopted on Friday, the party expressed concern over the steep escalation in crimes against women and said it was alarmed by the "barbarity and savagery" of atrocities being committed at a time when women were entering public life, institutions of learning, and diverse work spheres in increasing numbers.

"The crude commodification of women and the portrayal of women as sex objects in the mass media is highly objectionable and is not only demeaning to women but creates an environment which trivialises the crime of sexual harassment and violence against women," it said. Crimes against women during the period 2006-2010, it said, shot up by 29.3 per cent while registered cases of domestic violence went up by five per cent over the previous year as did the rise in number of dowry deaths. Yet there was a campaign to dilute a section of the laws dealing with it.

Turing to cases of rape, it said in 2010 alone 94,000 cases were registered and the increase in the number of cases showed that the safety and security of women were deeply compromised. Many cases go unreported because victims who belonged to the poorer, socially oppressed, sections had little access to justice. "Shockingly, the conviction rate in crimes against women is just 26 per cent, which means that three fourth of the criminals get away scot-free. "The failure to punish the criminals and the long delay in the judicial process is undoubtedly one of the reasons for the increase in rapes and gang rapes being witnessed in several parts of the country," the resolution notes.

Taking on the Central government for not enacting laws including the one against child sexual abuse, it also said 12 years after the Supreme Court guidelines in the Vishaka case, there were no laws against sexual harassment at the workplace, which was also on the rise. It also protested against anti-women and "utterly insensitive" statements by some political leaders and pointed out how the BJP did not take action against MLAs watching pornographic films during Assembly session while the Congress in Rajasthan did its best to shield a senior manager and MLAs from charges of sexual harassment and murder of a dalit health worker, who threatened to expose their misdemeanours.

Hindu, April 7, P.6

FEMME FATAL

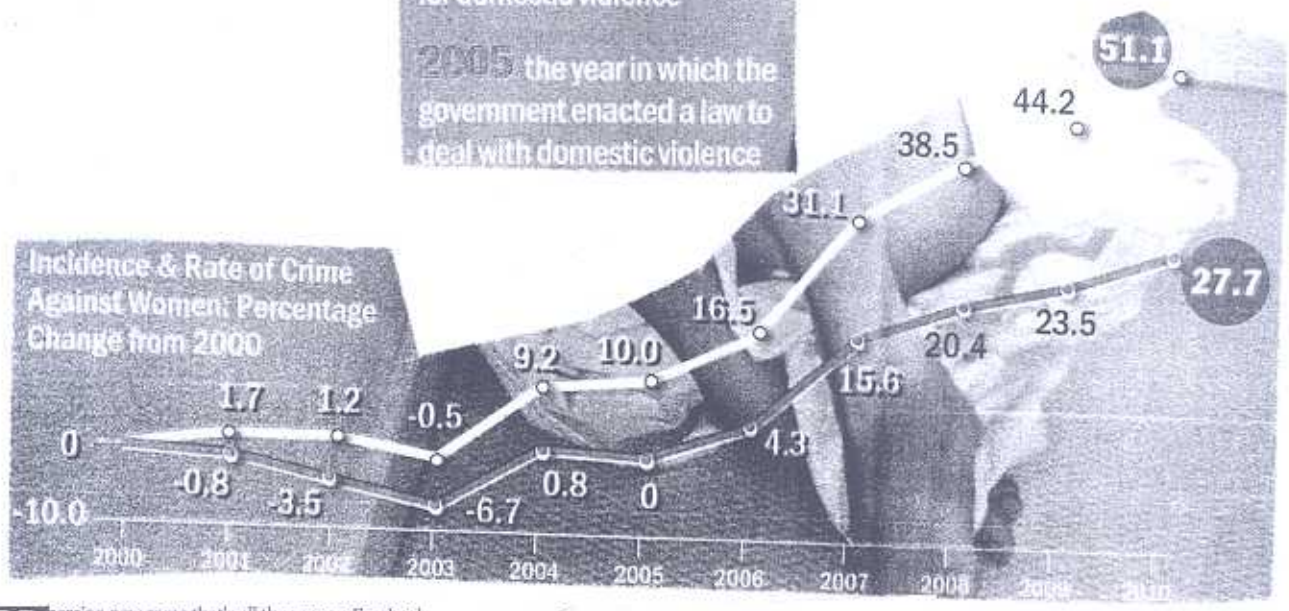
women in India in 2010, as per the National Crime Records Bureau

[illegible] crimes against women every day is what the NCRB figure translates into

[illegible]% of crimes against women are domestic violence cases

2% is the conviction rate in rape cases; it is 33% for dowry harassment cases, and 19% for domestic violence

2005 the year in which the government enacted a law to deal with domestic violence



There's a new game that's all the rage on Facebook these days. It's called Angry Brides. Just three months into inception and its already got close to five lakh gamers, 70 per cent of them women. Here's why. Prospective brides get to bash up dowry-demanding grooms and win points for it. The brid... (as in players) have to strike the dodging grooms with a weapon of choice — a pot, a pan, a ladle, a rolling pin, a broom, a slipper and a shoe. Each of these grooms comes with a heavy price tag; each blow decreases the groom's price and adds that money to the player's Anti-Dowry Fund. This money is then used to amass more artillery and level up. The game's home page shows an eight-armed woman, in what appears to be a reference to Goddess Durga, holding weapons ready for use. A caption below reads: "A woman will give you strength, care and all the love you need... NOT dowry."

If only it were that simple in the real world. If only life could imitate digital art. For unlike the virtual world, it is the bride who takes the hit in the real world. It is she who suffers at the hands of greedy grooms and greedier in-laws and is forced to return to her parents' home. That's if she's lucky to get away alive, when not, she is simply doused with kerosene and burnt to death.

Not just dowry-related atrocities but domestic violence, molestation and rape, abduction, sexual harassment and gender discrimination are the other grim realities that women have to grapple with every day. Pick up the newspaper on any given day, and you are bound to come across at least five such cases making headlines. A female foeticide in a remote Rajasthan village, an honour killing in the rural hinterland of Haryana, a minor molested in an urban slum, a BPO employee raped in the middle of the night on her way back from work, a bride burned for not getting enough or even

BPO employee raped in the middle of the night on her way back from work, a bride burned for not getting enough or even more dowry, a separated mother denied her child's custody, a widow shunned by her own relatives — the list is long and unsparing.

According to the latest figures available with the National Crimes Records Bureau (NCRB), the total number of crimes against women was 2,13,585 in 2010. Of these, as many as 94,041 were of cruelty by husband and relatives; 29,795 were kidnapping and abduction; 22,172 were rape; 40,613 were molestation; 9,961 were sexual harassment and 8,391 were dowry cases. Which means that on a single day, as many as 585 crimes against women were committed across the country.

If this tally isn't staggering enough, these figures only show the reported cases, the thousands that go unreported have not even been factored in. To add insult to injury, the conviction rate for reported cases is as low as 33 per cent in dowry harassment, 28 per cent in rape and 19 per cent in domestic violence.

LEGAL LACUNAE

Constitutionally speaking, there are enough laws in the land upholding the equality of women, but there are also enough loopholes for men to get around those laws. The reasons for low conviction rates in our country are primarily socio-economic, says lawyer and human rights activist Vrinda Grover. "Even if they do manage to report abuse and initiate a case, it is tough for women to sustain long trials because of factors like intimidation, social pressure and lack of resources," she says. The problem with our system is that we are unable to provide legal aid or adequate witness and victim protection, Grover adds.

Rashmi Anand (see box) is a case in point. When her husband threatened to drag the case through court for the next 20 years, she had no choice but to agree to an out-of-court settlement where she got no alimony or maintenance even though she was a housewife and her children were given a paltry sum as security for their future. Had she fought her case in court, there may have been a chance of her getting a better deal in the end, but it would have taken her as many as 20 years if not more to get that, she says. Plus where would she have found the money to support herself and her children and to pay the lawyer's fees? "By agreeing to a mutual settlement, I bought peace for myself and my children," she adds.

Anand was lucky. She managed to get out of a bad marriage. Not so Divya, 22, who was harassed by her in-laws for dowry and for not producing a male child. When she filed her complaint, Divya was clear she wanted a divorce, her *stridhan* back and maintenance for her child. Two years down the line, the case was still stuck in court, her resources and her patience had run out and "everyone" decided it was best she get back with her husband.

Many times, our judiciary fails our women as well, especially in cases of domestic violence, which account for nearly 45 per cent of crimes against women. As Grover adds: "The law mandates the right of every woman to lead a violence-free life. I have seen in many domestic violence cases that the courts try to persuade the couple to stay together at all costs. The objective is to keep the marriage intact, the family should be kept together — that the marriage is built on a battered woman's body does not seem to bother anyone. Unless this mindset is changed, women are less likely to get justice within our legal framework."

That is exactly what happened to Savita Nautiyal, 34, of Allahabad. Her husband had deserted her for another woman, but since he had not remarried, she could not furnish enough proof of his infidelity. Nor could she produce any concrete evidence of the physical and mental cruelty meted out by him. The court then advised Nautiyal to withdraw her case and mend fences with her husband for the sake of their two young children.

MORE PITFALLS

The inadequacy of our legal system also shows up in the fact that though there were various laws on crimes such as rape, abduction and murder, there was nothing to protect women from domestic violence, which constitutes such a large chunk. It was only as recently as 2005 that the government woke up to this reality and moved to enact the Protection of Women from Domestic Violence Act (PWDVA). Finally, Indian women can seek police protection and legal redressal on grounds of physical and mental cruelty meted out to them by their husbands and other family members.

Police protection is not easy to come by, though. Police stations are rampant with instances of victims being further demeaned by apathetic and insensitive policemen who have little respect for a woman's rights and dignities. A case in point is the rape of a minor in February, where the Noida police not only publicly disclosed the girl's name but her father's name and address at a packed press conference. In cases of sexual assault, Section 228-A of the Indian Penal Code deems disclosure of identity of a victim a punishable offence. The IPC section guarantees anonymity to women who complain of rape. This encourages a rape victim to complain against her attacker without facing public humiliation. Try telling that to the blabbering police officer who probably wasn't even aware of such a clause.

If a serious assault like rape is mishandled thus, the situation in cases of domestic violence is even worse. The problem is that most policemen receive little or no training on how work with such victims. As a result, they frequently do not respond to such cases and usually try to discourage women from making formal complaints. "There's enough serious crime happening across the country, our police force is ill-equipped to handle that. Cases of domestic violence therefore tend to be treated a bit casually," admits a senior male police officer on condition of anonymity. Clearly, a woman has to be murdered at the hands of her in-laws for her situation to be termed "serious".

Says Suman Nalwa, DCP of the Crimes Against Women Cell in Nanakpura, New Delhi: "Many times when a woman approaches a thana in her neighbourhood to report domestic violence, the attitude of the policemen there is to abdicate responsibility." Without giving her a proper hearing, they will quickly direct her to the women's cell, washing their hands off the problem. Even though gender sensitisation sessions are said to be regularly conducted at thanas across the country, this mindset of the policeman shows little or no signs of change.

Ruchira Gupta, convenor of Apne Aap, an organisation that works at rehabilitating sex workers says that at least other women get some sort of hearing, but sex workers are denied even that. Dismissed as a scourge on society, police apathy, coupled with police autocracy, is what they have to face every day. "The police have to understand that prostitution is a crime against women too. The woman is the victim here, not the criminal. They have to understand that it is the pimp and the customer who are the perpetrators, not the sex worker. When raids take place and arrests happen, it is usually the women who get arrested while the men are simply detained for a while and then let off."

SOCIOLOGICAL SCENARIO

Let's go back to the original Alpha Male, the king of kings, Maryada Purshottam Rama. He may have loved his wife, but he loved his so-called honour more. He may have crossed the ocean to rescue Sita from her abductor but she first needed to go through an *agni pariksha* before being accepted back into the family fold. If this wasn't humiliation enough, she was banished from the kingdom soon after because a washerman questioned her virtuosity. Men have continued to control women's destinies ever since and hundreds of years of such conditioning has caused women to be the weaker sex, still struggling to find an equal voice.

Most societies across the world are patriarchal and disrespectful of their women, and India is no exception, points out Padma Velaskar, professor of Sociology at the Tata Institute of Social Studies, Mumbai. "In fact its civilisational achievements notwithstanding, our country's cultural practices encompass some of the harshest strictures and sanctions against women. The caste system with its strong notions of honour and dishonour, respect and disrespect, superiority and inferiority, purity and pollution is inextricably linked to Indian patriarchy. Not merely disrespect, but an overall derogation and devaluation of women stems from this caste patriarchal order and is legitimised by it," she says. Historically, we have on the one hand the false glorification of upper caste women which makes their domestic oppression and devaluation invisible and unspeakable. On the other hand, society sees nothing wrong in the public humiliation through sexual and physical abuse of lower caste women, Velaskar adds.

Suman Vishwanathan, professor of sociology at the Jawaharlal Nehru University, Delhi, feels that lower class men have greater respect for women primarily because they are wage-earners as labourers or crafts people. When the city shreds them of their traditional workspaces, the levels of violence are immediately visible. This is a result of hunger and alcoholism which is often inter-related. Upper class women may be better off financially, but they take benign neglect in their stride and make sense of their own fate vis a vis their relationships within the family. Abuse of upper class women when they are young and separated from their families is now visible because tradition does not recognise their role as wage-earners, and does not respect their right to safe spaces. Which is why their exploitation occurs at the workplace or at the transport stand or anywhere they are, from any person who sees them as a possible victim.

Since the sex ratio is now problematised for Haryana and Punjab, it is possible that predatory qualities will surface regardless of class circumstances of either predator or victim, feels Viswanathan. The reason why stringent punishments are not forthcoming is because the victim is always first interrogated regarding her behaviour, and since traditionally women are supposed to secret themselves, the real story of their troubles rarely gets told.

The practice of dowry has contributed majorly to the disrespect of women down the years. As Viswanathan explains, dowry devalues the work of women as members of the household into which they are married. It is suggested that they will have to buy their way into a family because they are a burden to the family into which they are married, and the dowry gives them status without control over resources. In such cases, dowry is equivalent to groom price. Further, adds Viswanathan: "It is believed that *stridhan* is a form of pre-mortem inheritance so that a daughter will have no claim over her father's property once she is married. Claim to property is always the most tenuous of areas of jurisprudence and the identity of women is woven into it in terms of good conduct clauses at every point, whether in relation to her natal family or her conjugal family."

The case of Geetanjali Pathak, 26, comes to mind here. The daughter of a very prominent and wealthy doctor from Lucknow, she got married to the son of her father's colleague in February 2008. The wedding was a grand affair, with expensive gifts lavished on her in love, including jewellery worth ₹28 lakh, cash worth ₹10 lakh and a luxury car. When her father died two years later, her husband asked for an equal share in the property that was to be divided among her three brothers. The brothers refused, saying that her share amounted to the cash and jewellery that had already been given to her at the time of her marriage. Besides, she had already signed a document waiving her rights over her parental property. Geetanjali was thrown out of her house in the middle of the night and has since been staying with her mother. Unwilling to initiate proceedings in court for fear of a scandal, Geetajali's family has held several rounds of negotiations with her in-laws, seeking divorce by mutual consent. The issue is stuck over the question of cash and jewellery. "They insist no dowry was given, no gifts were exchanged," she says.

PSYCHOLOGICAL PARAMETERS

The single-most important cause of violence against women is the culturally ingrained, accepted and perpetuated thought pattern of male dominance in society. It results in depriving the girl child of basic equality in terms of nutrition, healthcare needs and education, says senior consultant psychiatrist, Dr Anandi Lal.

Dr Lal, who also heads the Department of Psychiatry and Allied Psychological Services, Pushpanjali Crosslay Hospital, Ghaziabad, says the most important consequence of violence is immense psychological distress in the victims. This takes the form of

low self-esteem, sleep disturbances, eating disorders, emotional distress, depression, and deliberate self-harm attempts. In younger victims, this can take the form of increased substance abuse and risky sexual behaviour.

Apart from significant psychological trauma, violence against women is associated with increased physical health problems like headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders and poor overall health. Another set of problems associated with sexual violence is unintended pregnancies as well as sexually transmitted infections, including HIV. Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight, adds Dr Lal.

Besides, growing up in a home where violence against the lady of the house is the norm, damages the physical and psychosocial development of a child. Younger children exhibit irritability, sleep disturbance and emotional distress in the form of temper tantrums. In school-going children it shows up as poor concentration in studies leading to decline in academic performance and maladjusted behaviour with peers. Older children tend towards delinquent behaviour, substance abuse, depression, psychosomatic illnesses and suicidal tendencies.

Counsellor and psychotherapist Nivedita Singh, founder-director of ANSHRS INDIA, points out that disrespect for women cuts across all classes. The issue is more of underreporting among the lower classes and non-reporting among the educated. In both cases, most of the abuse occurs in private with the home being the most dangerous. Other than physical and verbal, a lot of abuse is emotional where women are constantly invalidated, labelled, ridiculed, judged, blamed and their contributions 'minimised'. Mindsets have to change, both social and individual, says Singh, adding that this gendered mindset is not confined to men alone, but is a complementary process whereby on one hand it influences and encourages men to aggress, and on the other hand positions women into silent submission. This mindset has to be broken and mutual respect and equality of status have to become a way of being rather than mere rhetoric.

According to Singh, the treatment protocol should integrate a psycho-educational intervention promoting change for batterers and a psychotherapeutic intervention facilitating healing for domestic abuse survivors. "We need to facilitate healing through counselling, support group meetings and other empowerment programmes." It must also be noted that the intervention for abuse therapy is different from marital therapy. It is specifically designed to interrupt or break the cycle of domestic abuse and heal the injuries caused by intimate partner violence. Unlike traditional marital therapy, each person engages in the therapeutic process individually, and also with their partner, she explains.

Singh cites the case of an urban, upwardly mobile couple, Rohit, 42, an entrepreneur and Rhea, 37, a software professional. They had been married for 12 years and his wife now wanted a divorce. She said he had been emotionally and physically abusive all along but now the children were getting affected as well. She approached Singh's centre because before taking the final step of filing for divorce, as she wanted to give Rohit a chance to undergo therapy and see if the situation could be salvaged.

During the therapy, Singh discovered that Rohit's business was failing because of which he suffered from moderate depression and impaired self-worth. He had to undergo around 12 psychotherapy sessions to deal with his inadequacies and insecurities. Separately, Rhea too was counselled on ways to address her psychological scars and emotional pain. A combined marital therapy followed where the couple was taught effective ways to resolve conflict and rebuild their troubled marriage.

Singh believes that changes cannot happen in our social system overnight and concerted efforts have to be made towards creating awareness, educating women through building insights into their strengths, maximising their potential through information-sharing about their rights and choices, facilitating a building of skills through assertiveness training along with providing support and empathy — all this is bound to make a difference, both at the individual and the social level. Jyotsana Chatterjee of the Joint Women's Programme makes a fair point when she says that the women's question is not a question to be addressed by women alone. One cannot help but agree with her when she says: "The struggle for women's rights has to be fought by both men and women, only then will we be able to move towards a just and equal society."

CHILD SEX RATIO

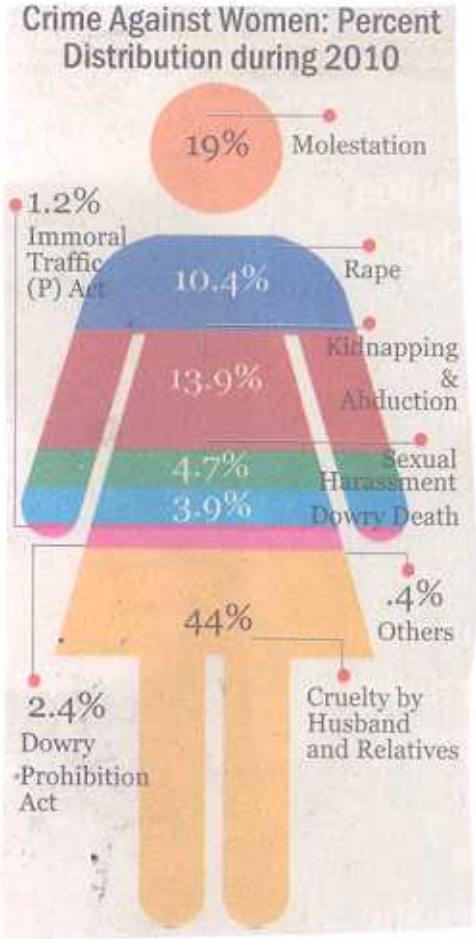
	914 Females	1000 Males
URBAN INDIA	902 Females	1000 Males
RURAL INDIA	919 Females	1000 Males

The worst hit are three districts in Haryana

Jhajjar	774 females	to 1,000 males
Mahendragarh	778 females	to 1,000 males
Malerna village*	370 female	to 1,000 males

*The sex ratio of babies at birth

Source: National Population Census data of 2011



New Indian Express, April 8, Pg 2

Crimes Against Women High in Villupuram Dist

by J Shanmugha Sundaram

Villupuram: Villupuram seems to have turned into an unfriendly district for women with the district recording the highest number of cases of rape, kidnap, abduction of women and young girls and dowry harassment, among the north zone districts in the State. On the contrary, Thiruvallur district has recorded the lowest number of crimes against women with a total of 89 in 2011.

According to details availed from the police department, a total of 2,044 cases of rape, molestation, dowry death and kidnap have been registered in north zone — Vellore, Tiruvannamalai, Kancheepuram, Cuddalore, Thiruvallur and Villupuram districts — in 2011. Of this, as many as 900 cases including 86 cases of rape and 274 cases of molestation, 187 abductions and 167 dowry harrassment cases - were registered in Villupuram district. The district has also recorded the highest number of dowry harassment cases. Of 314 cases of dowry harassment in the north zone district, 167 cases have been booked in Villupuram alone. With 57 cases, Cuddalore has recorded the second highest number of dowry harassment cases, while Kancheepuram and Thiruvallur districts have seen the least number of dowry harassment cases - nine and 12 cases respectively.

Of the 39 dowry deaths reported last year in the north zone, 16 cases were from Cuddalore, seven each in Villupuram and Thiruvallur districts, and six in Vellore. Interestingly, when it came to eve-teasing, only Vellore district recorded 10 cases with not a single case being reported from any of the other districts. The police department has also registered a total of 690 cases under various sections of Women Harassment Act.

Since January this year, a total of 35 rapes, 36 molestations, 79 kidnap and abductions and 42 dowry harassment cases have been reported in north zone.

ACCORDING TO DETAILS SOURCED FROM THE POLICE DEPARTMENT, A TOTAL OF 2,044 CASES OF RAPE, MOLESTATION, DOWRY DEATH AND KIDNAP HAVE BEEN REGISTERED IN NORTH ZONE — VELLORE

WEAKER SEX UNDER ATTACK

S.No	Districts	Rape	Molestation	Kidnap	Eve-teasing	Dowry death	Dowry harassment	Other (women harassment act)	Total
1	Kancheepuram	19	25	16	0	1	9	89	159
2	Thiruvallur	6	2	10	0	7	12	52	89
3	Viluppuram	86	274	187	0	7	167	179	900
4	Cuddalore	30	12	102	0	16	57	308	525
5	Vellore	25	27	78	10	6	45	8	199
6	Tiruvannamalai	19	8	65	0	2	24	54	172
	Zonal total	185	348	458	10	39	314	690	2,044

(STATISTICS DRAWN FROM CRIME RECORD BUREAU OF NORTH ZONE FOR 2011)

New Indian Express, April 7, P-4

Crimes against women rising in Mizoram

NEWMAI NEWS

AIZAWL, April 4 – Crime against women in Mizoram during the last five years was generally dominated by a high figure of rape and molestation and outraging of modesty.

This was revealed at a joint press conference of DIG (NR), SP CID (Crime) and SP Aizawl convened here today.

The police officials said crime against women and children like murder, cruelty meted out by husband, immoral traffic and assault contribute 6 per cent each to the total number of crimes against women and children.

A total of 172 incidents of crime against women were reported in the State during 2008 as compared to 183 during 2007, recording a decrease of 6.01 per cent during 2008. These crimes had continuously decreased during 2007 - 2009 with 183 cases in 2007, 172 cases in 2008, and 161 cases in 2009.

In 2010, the number of incidents have increased by 24 per cent recording a total of 200 cases as compared to 161 during 2009. The incidents of these crimes have decreased from 24 per cent during the year 2010 to -11 per cent during 2011 indicating a fall in the crimes.

A mixed trend in the incidence of rape has been observed during the last five years. "While we have observed an increasing trend during the year 2009 and 2010, a decreasing trend has been observed during the year 2008 and 2011," they revealed.

These cases reported a decline of 7.23 per cent in 2008 over 2007, an increase of 7.79 per cent in 2009 over 2008, again an increase of 10.84 per cent in 2010 over 2009 and a decline of 16.30 per cent in 2011 over 2010. The exact cause for the increasing trend during 2009 and 2010 cannot be determined.

Assam Tribune, April 5, P-7

REPRESSING DESIRE: SEX AND THE SENIOR CITIZEN

by Daniel Thimmayya

Chennai: Denying the joys of sexual intercourse to people over 50, is directly related to the increasing instances of child sexual abuse in the country, says noted sexologist Dr Narayana Reddy. After releasing an extensive study titled 'Sex and the Aging Indian', accumulated over two decades, Dr Reddy pointed out that a large number of 'elderly' people were denied sex, causing this problem. "It is almost an established train of thought in India that people lose the desire for sexual intercourse as they get older. Not only is this entirely false, it can also have very serious implications," said Reddy, who is best known for his work at the DEGA Institute here.

Comprising responses from 3,021 middle to upper class Indians, from 15 states, the study suggests that the frequency of sexual intercourse in the average Indian household reduces with age, "Agreed, there is a reduction in the drive and need as a person ages but that does not mean that it disappears. This is where we differ from the West, as it is more of a cultural issue in our country," he explained.

The survey shows that a person aged between 50 and 59 was likely to have sex 10 times a month but this number petered down to just once a month as they reached 70; women said that sex was almost non-existent after 65. While erectile dysfunction was the major deterrant for men, the husband's sexual issues were the top reason that women said they lost access to sex.

"I once had an elderly patient complain that even when he wanted to experience pleasure with his wife, his children and grandchildren were in the way. The thought that their parents would want to have sex never even occurred to them," said Reddy, with disbelief, "Otherwise siblings separate the parents to care for them on a rotation basis," he added.

As a study conducted in 2007 by the Ministry of Women and Child Development, UNICEF and others suggested that 69% of India's 390 million children suffered some form of sexual or physical abuse. As a result of long periods of repression or separation, the older generation's sexual energy turns toward children and drives up the child sexual abuse quotient, states Reddy.

Considering that 7.09% (214 persons) admitted to incest and 5.26% (159 persons) admitted to having had sex with a relative, the notion that the elderly are prudes can be dispensed with.

If you're still not convinced, 47.70 per cent persons admitted to having had pre-marital sex. As the youngest among them is 50 now, we're talking about pre-marital sex among middle to upper class Indians in the late '70s and early '80s.

New Indian Express
April 11, P2

SURVEY'S FINDINGS

THE STUDY WAS CONDUCTED BETWEEN 1990 AND 2010 IN THE 50-91 AGE GROUP

Sample size

3,021 Number of people surveyed

881 Female Respondents

2,140 Of them were males

94% Between 50 and 70 years of age

75% Are graduates and post-graduates

Masturbated **after marriage**

92.62% MALES

60.16% FEMALES

Who's Too Old to Have Fun?

Chennai: There's no age barrier to feel the need for sex and there's certainly no reason why people shouldn't enjoy it. While this is an established fact embellished in many American publications, Dr Narayana Reddy hopes that his study will establish that the same holds good for Indians.

One of the findings of his study was that 64.08% of the senior citizens surveyed admitted that they had access to explicit sexual material to get turned on.

This could include pictures, pornography or just movie clips of a sensuous nature, "It varies with age. If an 18-year-old can perform after just looking at a semi-clad woman's picture, a 60-year-old will need much more than that," explains Reddy.

Interestingly, it came to light that a majority of them were initiated into the practice of using explicit material by their spouse. As many as 60.81 percent said that either or both of them had the habit of using explicit material and had initiated the habit in their spouse.

Another interesting fact that the survey has thrown up is that fact that most people over 50 have a tendency to masturbate - a habit that 92% men and 60% women have continued after marriage. The difference comes through in their reason for this: most men blamed the wife not being available for ejaculating while women cited not having an orgasm during intercourse as a leading issue.

ONE OF THE FINDINGS OF HIS STUDY WAS THAT 64.08 PER CENT OF THE SENIOR CITIZENS SURVEYED ADMITTED THAT

THEY HAD ACCESS TO EXPLICIT SEXUAL MATERIAL TO GET TURNED ON

And finally, while this whole generation was not largely inclined towards oral or anal sex, there were 22% who said that they'd tried the former while a meagre 4% had given the latter a try.

Pre-marital sex: 1,191 males, 250 females; in all 47.7%

Affair: 646 males, 142 females; in all 26.08%

Exposure to sexual content: 70.75% males said porn turned them on; 47.90% females actively used pornographic content

Enjoy foreplay: 42.2% for 5-10 mins; 31.74% for under 5 mins

Show time: 64.48% for sex at night; 21.85% opted for day; 13.67% OK with any time

FREQUENCY
(number of times per month)

Age	Male	Female
50-59	10.35	10.21
60-69	6.21	6
70-79	2.15	0
80-89	1.64	0
90+	1	0

Why?

Spouse not available: 35.82% males, 37.36% females

Change in habit: 32.75% males

Inability to perform with partner: 12.46% males

Combination of all factors: 18.97% males

Husband's sexual problems: 29.81% females

First sexual encounter

With spouse: 44.3% males, 71.62% females

With friend: 9.72% males and 17.82% females

With brother/sister/father/mother: 139 men, 75 women

With other relatives: 141 men, 16 women

ILLUSTRATION: TAPAS

57% of boys, 53% of girls think wife beating is just

Kounteya Sinha | TNN

New Delhi: It's a shocking revelation in this day and age. Not just Indian men, but even adolescents — in the 15-19 age group — feel that wife beating is justified.

Unicef's "Global Report Card on Adolescents 2012", says that 57% of adolescent boys in India think a husband is justified in hitting or beating his wife.

Over half of the Indian adolescent girls, or around 53% think that a husband is justified in beating his wife. In comparison, 41% women in Bangladesh and 54% in Sri Lanka harbour a similar feeling. In Nepal, however, the prevalence of both men and women justifying domestic violence is inordinately high at 88% and 80%, respectively.

According to the report, societal attitudes that convey acceptance or justification of domestic violence are making girls and women more vulnerable to abuse. It says, "Available data for developing countries show that nearly 50% of girls and women aged 15-49 believe that wife-beating is justified... girls aged between 15 and 19 years hold the same views as women in the 45-49 age group."

The report explains that because of reporting bias, this may be an under-estimation of the actual size of the problem in several countries. Many factors contribute to the incidence of domestic violence. For instance, in many places, child marriage, gender-based power relations, women's low economic status and traditional practices or social norms perpetuate it.

Mission director for India's National Rural Health Mission Anuradha Gupta said spousal violence takes place both in developed and developing countries "though the degree would vary". She said, "When girls are brought up with the message that a woman's status in a family is inferior, she starts to accept whatever behaviour is meted out by her husband or in-laws." She added, "When a boy grows up seeing his father assault his mother, he starts to accept such a behavior and repeats it."

Ranjana Kumari, director of Centre for Social Research, said, "Most women think this is their fate. Education or economic prosperity alone can't improve the situation."

Times View

These findings on youth attitudes towards marital violence should not just be seen as shocking. They should also teach us the limitations of laws on domestic violence. Such laws may be important to help minimize violence against women. But they are clearly not enough, especially when the victim herself does not perceive any wrong in being beaten up. A strong legal framework to deal with domestic attacks must be backed up, therefore, by a sustained and intensive campaign to raise awareness on the issue among men and women. Steps to raise the levels of female education would play an important role.

Times of India, April 25, P7

बढ़ रही है 'दादी-नानियों' की संख्या

देश में 60 साल की बुजुर्ग महिलाएं पुरुषों को पीछे छोड़ चुकी हैं

कौंतेय सिन्हा (टीएनएन) ॥ नई दिल्ली

भारत की अधिकांश जनसंख्या भले ही युवा हो लेकिन इसका एक दूसरा पक्ष भी है। देश में 60 साल से ज्यादा उम्र वालों की तादाद भी तेजी से बढ़ रही है, खासतौर से महिलाओं की। अहम बात यह है कि यह विकसित देशों का ट्रेंड है जहां महिलाएं पुरुषों से लंबे समय तक जीवित रहती हैं।

रजिस्ट्रार जनरल ऑफ इंडिया के लेटेस्ट डेटा (सेंपल रजिस्ट्रेशन सिस्टम 2010) में यह नई बात पता चली है। स्वास्थ्य मंत्रालय को भेजे आंकड़ों के मुताबिक, 60 बरस या उससे ज्यादा उम्र की महिलाओं की संख्या 20 में से 17 राज्यों में काफी ज्यादा निकली है।

सात राज्य ऐसे हैं जहां 60 प्लस पुरुषों से महिलाओं की संख्या ज्यादा है। ये राज्य हैं : आंध्र प्रदेश (8.4 पर्सेंट महिलाएं, 7.1 पर्सेंट पुरुष), छत्तीसगढ़ (7.1 पर्सेंट महिलाएं, 5.9 पर्सेंट पुरुष), गुजरात (8.3 पर्सेंट महिलाएं, 6.8 पर्सेंट पुरुष), हरियाणा (6.9 पर्सेंट महिलाएं, 5.3 पर्सेंट पुरुष), महाराष्ट्र (9.7 पर्सेंट महिलाएं, 8.7 पर्सेंट पुरुष), पंजाब (9.4 पर्सेंट महिलाएं, 8.4 पर्सेंट पुरुष), राजस्थान (7.4 पर्सेंट महिलाएं, 6.2 पर्सेंट पुरुष)। केंद्रीय स्वास्थ्य मंत्रालय का अनुमान है कि 2016 में देश की 51 पर्सेंट जनसंख्या महज बुजुर्ग महिलाओं की होगी। सिर्फ तीन राज्य ऐसे थे जहां बुजुर्ग पुरुषों की संख्या महिलाओं से ज्यादा थी- असम, बिहार, जम्मू-कश्मीर। देश की जनसंख्या का 7.5 पर्सेंट भाग 60 प्लस उम्र वाला है।

देश में सात राज्य ऐसे हैं जहां 60 से ज्यादा उम्र के पुरुषों से महिलाओं की संख्या ज्यादा है

20 में से 17 राज्यों में 60 और 60 से ऊपर की महिलाओं की संख्या काफी ज्यादा है

बुजुर्गों की ज्यादा जनसंख्या वाले टॉप तीन राज्य

केरल	(11.8 पर्सेंट)
हिमाचल	(10.1 पर्सेंट)
तमिलनाडु	(10 पर्सेंट)

Navbharat times, April 3, P 12

Women take the lead in India's grey march

New Delhi: India may have a young population, but the number of those aged above 60 is rising rapidly too — and women are now a majority in this segment. This is in line with the trend in developed countries, where women tend to live longer than men.

The Registrar General of India's (RGI) latest data from the Sample Registration System (SRS), 2010, has confirmed feminization of India's elderly. Data sent to the Union health ministry on Saturday shows that the percentage of women in the age group of 60 years and above is higher in 17 out of 20 large states.

The difference in percentage of elderly women compared with 60-plus men is most acute in states like Andhra Pradesh (8.4 women to 7.1 men), Chhattisgarh (7.1 to 5.9), Gujarat (8.3 to 6.8), Haryana (6.9 to 5.3), Maharashtra (9.7 to 8.7), Punjab (9.4 to 8.4) and Rajasthan (7.4 to 6.2). The Union health ministry expects 51% of the elderly population will be women by 2016.

Only three states — Assam, Bihar and Jammu & Kashmir — have more elderly men than women.

The number of 60-plus women as a percentage of all women is highest in Kerala (12.6%), Himachal Pradesh and Tamil Nadu (10.3% each).

Overall, nearly 7.5% of India's population is aged 60 years and above. In rural India, 7.5% of the population is above 60, and the corresponding figure is 7% in urban areas.

Kerala (11.8), Himachal Pradesh (10.1%) and Tamil Nadu (10%) have the highest percentage of elderly in the country, followed by Manarashtra (9.2), Punjab (8.9) and Odisha (8.7). Jharkhand (5.7), Assam (5.5) and Delhi (5.7) record the lowest percentage.

According to United Nations estimates, the global population of those aged 60 years and above will more than double — from 542 million in 1995 to about 1.2 billion in 2025.

AUTUMN OF THE MATRIARCH

- Overall **7.5%** of India's population are **aged 60+**; majority are women
- **51%** of elderly population will be women by **2016**
- **India** to soon become home to the **2nd largest** number of elderly people in the world. **80%** of them are in rural areas
- **30%** of the elderly are **below poverty line**

- Percentage of women in the age group **60 yrs** & above is higher in **17 of 20 large states.** Only 3 states, Assam, Bihar & Jammu & Kashmir, have more elderly men than women

States with high percentage of women above 60+

AS % OF NO. OF WOMEN	
Kerala	12.6
Himachal	10.3
Tamil Nadu	10.3
Maharashtra	9.7
Punjab	9.4
Odisha	8.9

Times of India, April 2, P.1.

Bridging the gender gap

DETERRENTS FOR GIRLS

Lack of girls' toilets: Less than half of Indian schools have separate girls' toilets. The girls are often required to risk embarrassment and run to nearby fields or back home

Distance: On an average, an Indian school student has to travel 4km to go to primary school and 8km to go to secondary school. With crimes against young women a major concern, the longer distances deter parents from sending girls to school

Shortage of women teachers: This makes it harder for girls to voice their concerns, especially as they approach puberty in secondary school. Nationally, 45% of school teachers are women, but the percentage is very low in some states

Social prejudices: According to an expert, young boys frequently taunt girls for coming to school, suggesting that they should instead stay at home as has traditionally been the practice.

The primary school had no toilet but is just across the road from Nath's house. The daughter would just run home whenever she needed to use the toilet. "Her friends drop in too," said Nath. "She cannot do that when she goes to a higher school far from our house."

As the aspiration for a better future drives an unprecedented demand for educational opportunities across India, more and more parents are enrolling their daughters in school. Today, there are 94 girls in elementary school for every 100 boys. School drop out rates, traditionally much higher for girls than for boys, have also shrunk — from 10.3% in 2006 to 5.2% — and are now only marginally worse than for boys. But Nath's enthusiasm for her daughter's education, coupled with her worries, offers a warning against any complacency. Despite the improving enrolment and dropout rate figures, going to school is not as easy for girls as it is for boys.

On an average, a student who travelled 4km to go to primary school has to travel over 8km to go to secondary school, because the density of secondary schools is less than half that of primary schools. With crimes against young women a major concern in vast parts of the country, the longer distances act as a deterrent.

Social prejudices also continue to rail against equal opportunities, said VR Devika, founder of the Chennai-based NGO Aseema Trust, which works with school children. At National Service Scheme (NSS) camps for school children, girls are often made to sweep the rooms and compound. Young boys, Devika said, frequently taunt girls for coming to school, suggesting that they should instead stay at home as has traditionally been the practice. "Subjugation of the girl is so ingrained in society, that it begins to play out in school," Devika said.

The absence of adequate number of women teachers makes it still harder for girls to voice their concerns, especially as they approach puberty in secondary school. Nationally, 45% of school-teachers are women. But the number is skewed across states, with only 27% women teachers in Jharkhand, while the number is 25% for Tripura, 31% for Assam, 35% for Chhattisgarh and 37% for Bihar.

But toilets remain the single most commonly voiced concern for girl students and their parents across India.

Only 44% schools covered by the RTE Act have separate, functioning girls' toilets. In the rest, girls either need to risk embarrassment and run to nearby fields, or as in the case of Nath's daughter, run back home to use the toilet. Chhattisgarh has only 20% schools with usable girls toilets, while Jammu and Kashmir (22%) and Madhya Pradesh (23%) fare only marginally better. The northeastern states, including Assam (27%), also have few schools that provide working toilets for girls.

And resolving this crisis has proved harder than simply doling out money to build toilets. The state government deposited ₹95,000 into the Punjab National Bank account of No. 438 Khagrabari LP School in Assam's Chirang district for the construction of a girls' toilet on February 15 this year. But the money was withdrawn the same day, with the bank unaware and school officials claiming no knowledge of the transaction either. No. 45 Pub Kamarpara LP School, No. 960 Khagrabari LP School and No. 423 Tulsijhora LP School — all in Assam — suffered almost identically.

The girls will have to wait for toilets, India for equality in education.

44% schools covered by RTE have separate toilets for girls

5.2% dropout rate for girls in Indian schools in 2012

GENDER PARITY

Best states: Meghalaya, Lakshadweep, Mizoram

Worst states: Rajasthan, Chhattisgarh, Punjab

HT, April 24, P.2

Harassment bill to cover domestics

The Union Cabinet will on Thursday consider a bill aimed at cracking down on sexual harassment of women at the workplace, including domestic helps for the first time. The bill makes it mandatory for all workplaces, including homes, to set up an internal committee to redress complaints. The bill has been under discussion since 2006 and is now finalized after changes by a parliamentary panel in 2011.

New Delhi: A bill that seeks to provide a secure and enabling environment for women employees, including domestic workers, against sexual harassment at the workplace is likely to come up before the Union Cabinet on Thursday.

The bill makes it mandatory for all workplaces, including homes, universities, hospitals, government and non-government offices, factories, other formal and informal work places to constitute an internal committee for redressal of complaints.

The proposed legislation will reaffirm guidelines laid down by the Supreme Court in the case Vishaka vs State of Rajasthan, 1997, that recognizes harassment as a form of discrimination against women and violation

of the constitutional right to equality.

So far, implementation of the Vishaka guidelines has been patchy and restricted to the formal sector. Women bear the brunt of harassment with increasing number of cases of molestation and eve-teasing.

National Crime Records Bureau data shows an average of more than 50,000 incidents of molestation and eve-teasing annually over the last four years.

Domestic workers have been included as part of the bill for the first time following recommendations of the parliamentary committee. They comprise 30% of the female workforce in the unorganized sector. There are 47.50 lakh registered domestic workers in the country.

Moved by the ministry of women and child development (WCD), the proposed bill brings sexually determined behaviour (whether directly or by implication) including physical contact and advances, a demand or request for sexual favours, sexually coloured remarks, showing pornography, any other unwelcome physical, verbal or non-verbal conduct of sexual nature under the definition of 'sexual harassment'.

The bill has a wide definition of employees, including even those workers who may not receive remuneration but render service on a voluntary basis, contract workers, trainees, probationers or apprentices.

The aggrieved women will have the right to seek compensation that can be decided on the basis of mental trauma, distress, medical expenses incurred by the victim and loss of career opportunity. There is, however, a provision for fine in case of a false and malicious complaint.

The bill has been under discussion since 2006 and was finally tabled in Parliament in 2010.

It has now been brought after incorporating changes suggested by the parliamentary panel in 2011.

Times of India, April 26, P13

Money and marriage

Should women cheer now that the Union Cabinet has approved the Marriage Laws (Amendment) Bill 2010? If it becomes law, women will have the right to an equal share of property acquired after marriage and divorce will become easier. The additional ground of "irretrievable breakdown of marriage" has been added and there is a shorter waiting period when both parties want to end a marriage.

Most television talk shows have focused only on the urban, educated, middle class women. There is an assumption that divorce and partition of marital property affects only them. There are also crazy scenarios being created about a "divorce epidemic".

Exercising rights

In fact, we have to ask whether such a change in law will make any difference to the majority of women, especially those living in villages. Most women do not know that under law they are granted many rights. Even if they do know — such as the right of daughters to inherit a share of their parents' property — they are forced or persuaded to sign away their right. A recent study by the Rural Development Institute (RDI) of women's land rights in Andhra Pradesh and Bihar noted that more than half the Hindu women surveyed had signed away their right to land they would have inherited.

Inheriting property or land is crucial for many women seeking some form of economic security. Yet, this is precisely where their lack of knowledge or ability to exercise the right forces them to continue living in abusive and violent marriages. To walk out of such a marriage means walking into destitution. But if they fight for their right and succeed in getting their share, they are ostracised by their own community. Nothing has changed the entrenched belief that a woman, once she leaves her natal home, has no right to anything there and that the dowry she carries with her is adequate compensation.

The other side of ignorance about rights is the absence of supportive structures to help women claim their right. According to the RDI study, 61 per cent of women said they had never gone to a revenue office and of these 99 per cent said this was because men handled such matters. Of course, it did not help that the majority of the lower level revenue officials were also men. A simple step like appointing more women to such posts might begin to make a difference.

Several studies have shown that women who have the ability to stand on their own feet are less likely to tolerate an abusive marriage. Of course, there are always exceptions to this rule as is evident from the searing essay written by the young poet and writer Meena Kandasamy, "I Singe The Body Electric" (*http://www.outlookindia.com/article.aspx?280179*) where she speaks about the abuse she suffered within the first four months of getting married. Economic independence did not protect Meena from domestic violence but it gave her the courage to walk out.

Double-edged

What about women living in villages, in highly patriarchal societies, where the majority of women accept that beatings and abuse are part of what marriage is all about. In such societies, inheriting property can become a double-edged sword.

A fascinating study on the link between economic independence and domestic violence is by feminist scholar Prem Chowdhry for UN-Women (*http://www.unwomen-southasia.org/*economic_security.html). She could not have picked a more appropriate state for such a study. Haryana has one of the lowest female sex ratios in the country. It has become known for the horrendous incidence of so-called "honour" killings where young men and women are murdered merely for marrying a person of their own choice. According to the National Family Health Survey-3, 27 per cent of married women in Haryana have seen physical, emotional and sexual violence and 46 per cent of women and 33 per cent of men felt that a husband beating a wife was justified in certain circumstances. In such a State, where girls are not allowed to be born, can women escape such violence if they assert their right to a share of property?

As in the States surveyed by RDI, in Haryana too women tend to sign away their right to parental property. But now this has begun to change. With the spread of urbanisation, property prices are hitting the roof. Girls are now demanding their share, often egged on by their in-laws. Of course, there is no guarantee that they will have control over the money if they manage to get it. But the study cites many instances where the situation of women, and even of their daughters, has changed dramatically once they have money or property in their own name.

Studies like the one by Prem Chowdhry and many others firmly establish the link between women's economic independence — either by way of property or an assured income — and a reduction in domestic violence. Even as laws are changed in the name of empowering women, we have to take the first steps — of informing women of their rights and creating the supportive structures that will guarantee that they can exercise these rights.

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Hindu, April 4, 8?

THE END GAME

Sharing matrimonial property is, in fact, one of the divorce-related clauses proposed in the Marriage Laws (Amendment) Bill, 2010, which seeks to amend parts of the Hindu Marriage Act and the Special Marriage Act. The bill was cleared by cabinet on March 23 and, if passed by Parliament, could change divorce litigation. 'Irretrievable breakdown of marriage' could become a new ground for divorce, women could get matrimonial property rights and the six-month cooling period before a divorce would no longer be mandatory in cases of mutual consent.

The response to these proposed amendments has been as celebratory as condemning. In India, where the nuances of divorce depend on the social context, lawyers, counsellors and couples are fiercely divided about each clause.

To seek divorce by mutual consent, couples can file a case only after a year of separation, followed by a six-month cooling off time. The proposed waiver of this cooling period in the bill has evoked mixed reactions. "Some marriages are doomed from the beginning, so why should the couple wait for six months?" says Aishwarya Bhati, a lawyer from Delhi. Others believe speeding up divorces could hurt some couples. "I have seen couples reconciling during the cooling period," says Mumbai-based lawyer Anshumol Kumar.

When the bill was first presented to the Rajya Sabha in 2010, it chiefly sought to introduce 'irretrievable breakdown of marriage' as a new ground for divorce. In this 'no-fault' clause, either spouse can seek a divorce after three years of separation without having to prove the failure of the marriage in court. For many, this has been a long-standing demand. "Sometimes there is just no compatibility. It makes no sense to continue a relationship that's 'dead,'" says Abbas Mookhtiar, a Mumbai lawyer.

The proposition, however, faced opposition from women's rights groups, who believed the move would allow Indian men to end marriages easily, leaving non-working women with just a meagre maintenance or alimony. To empower women in such situations, a Parliamentary standing committee recommended equal rights to matrimonial property as a counter-clause, recognising housewives as performing an important, though unpaid, role in the home economy. "A woman's contribution to building a home has been recognised for the first time in India," says Mridula Kadam, a Mumbai-based lawyer, who says sharing property will be a balancing factor if the man misuses the 'irretrievable breakdown' clause.

But many women's rights activists believe that the proposed amendments are still not strong enough to guarantee the rights of women. 'Irretrievable breakdown of marriage', they feel, is a Western concept being imported without understanding the socially disadvantaged contexts of Indian women. "Here, the ratio of women and men filing for divorce is roughly 1:50," says Vandana Shah, a Mumbai-based counsellor who runs Ex-Files, a monthly newsletter for divorcees. "The wide ambit of 'irretrievable breakdown' will largely favour men, who find it easier to resettle after a divorce. Women will have to face more social stigma."

The sharing of matrimonial property is also an ill-defined clause, say activists, because it leaves the court to decide quantum of the share. "In most cases, wives have no property to their name and the husband's property is in his family members' names," says Persis Sidhwa, a lawyer from Majlis, a Mumbai women's rights group. "The law should clearly define guidelines for property distribution. It must not be left to judges' discretion."

Another concern is that the proposed amendments, applicable only to Hindus and those who marry under the secular Special Marriage Act, leave out minority communities. "If laws are made regarding women's empowerment and property rights, women of all religions should be considered," says Lekhi.

Delhi-based lawyer Geeta Luthra believes that the objective of the proposed amendments is to speed up divorce procedures and reduce the backlog of pending cases in courts. "Making divorces easier is not a solution," says Luthra. "Litigation goes on for years because the country does not have sufficient courts, and that is what needs to be addressed."

According to Shah, irretrievable breakdown of marriage and property distribution may be justified in principle, but Indian society is not yet ready to deal with their consequences. "We need to first work towards changing social mindsets regarding divorce, by bringing it to the forefront of public discussions," says Shah. "Legislations are also important, but we have a long way to go."

SHARING OF MATRIMONIAL PROPERTY

Rajya Sabha bill
Had no clause pertaining to this.

Parliamentary panel
Said women should have a share in matrimonial property if the couple divorce.

Government's draft bill
Said that the woman should get a share of all matrimonial property but the relevant court should decide how much in each instance.

IRRETRIEVABLE BREAKDOWN OF MARRIAGE

Government's draft bill
Supported this clause in the bill; clarified that a wife could oppose her husband's plea for divorce on this ground if she felt the divorce would render her financially vulnerable. The husband could not oppose a wife's plea.

Rajya Sabha bill
Sought to make this a new ground for divorce.

Parliamentary panel
Supported this clause but recommended that the bill define "irretrievable breakdown of marriage."

Hindustan times, April 1, P.10

Govt panel bats for would-be moms

New Delhi: To plug loopholes in the law on maternity benefits, a government panel has suggested an amendment forbidding the sacking of a pregnant employee on any ground.

The Planning Commission's working group which had been asked to review the Maternity Benefit Act 1961 has also recommended increasing the duration of maternity leave, though it did not specify by how days it should be increased.

The group wants the government to incorporate a clause in the act, saying, "No woman should be discharged from service during the period of pregnancy on any pretext."

A panel member said although the existing maternity law prohibits the sacking of a pregnant employee, there were many examples where employers have sacked pregnant women for 'misconduct' to avoid giving them maternity benefits. Under the existing law, a pregnant woman can be fired for gross misconduct.

"The move is to plug this loophole and ensure protection to pregnant employees," the member said.

The working group, which had been asked to review the Maternity Benefit Act, said there were many examples where employers sacked pregnant women citing 'misconduct' to avoid giving them maternity benefits

The panel, headed by the women and child development secretary, was in favour of making maternity leave flexible, allowing a mother to take it according to her convenience. As of now, women are entitled to 12 weeks of paid maternity leave. "Review the act with a view to increasing the number of days of leave that a woman worker can take and to give her the choice of utilizing the period of paid absence as per her convenience," the report said.

The panel also wanted the government to sensitize various committees for implementation of labour laws on issues relating to gender. These committees should be made functional and special cells should be formed to monitor implementation of legislation for women workers, the group suggested.

During the 11th Five Year Plan, the government has taken steps to ensure safe and secure motherhood through various schemes such as Janini Suraksha Yojana to encourage institutional deliveries and the Indira Gandhi Matritva Sahyog Yojana for conditional cash transfers to mothers during pregnancy.

Times View

Women form an increasingly larger part of the workforce and that trend is only likely to accelerate in future. It makes sense therefore for societies to adapt to this development. Clearly demanding that women choose between work and motherhood is unfair. It follows that employers must adjust to the fact that women will need to take long periods off for maternity. This is a small price to pay as a society for bringing in women into the mainstream of paid labour.

Times of India, April 10, '09

पति के किराए के घर में भी पत्नी का हक

हाईकोर्ट ने निचली अदालत के आदेश को किया खारिज

नई दिल्ली

दिल्ली हाईकोर्ट ने उस महिला को राहत दी है जिसे पति के किराए के घर से निकालने का आदेश दिया गया था। महिला अपने पति के किराए के घर में गई थी, लेकिन पति की अर्जी पर निचली अदालत ने यह कहते हुए महिला को घर खाली करने के लिए कहा था कि यह शेयर्ड हाउस होल्ड नहीं है। ऐसे में महिला का उस घर में रहने का अधिकार नहीं बनता।

हाईकोर्ट ने निचली अदालत फैसले को खारिज कर दिया। साथ ही महिला के खिलाफ जबरन घर में घुसने संबंधी मामले को भी रद्द करने का निर्देश दिया। महिला का अपने पति के साथ तलाक और घरेलू हिंसा कानून के तहत मामला चल रहा है।

न्यायाधीश सुरेश कैत ने अपने फैसले में कहा कि मौजूदा मामले में याचिकाकर्ता महिला का अपने पति से तलाक नहीं हुआ है अगर महिला अपने पति के घर में घुसी, तो वह गलत इरादे से नहीं घुसी थी। महिला के पति ने किराए पर घर ले रखा था।

ऐसे नहीं निकाला जा सकता

हाईकोर्ट ने सुप्रीम कोर्ट के एक फैसले का हवाला देकर कहा कि चाहे घर पति का हो या फिर किराए का महिला को उसमें रहने का पूरा अधिकार है। बिना कानूनी प्रावधान के महिला को इस तरह से घर से नहीं निकाला जा सकता। महिला याचिकाकर्ता ने हाई कोर्ट में अर्जी दाखिल कर कहा कि उनकी 26 दिसंबर 1975 को शादी हुई थी। शादी के बाद वह श्रीलंका और ऑस्ट्रेलिया में अपने पति के साथ रही। इस दौरान एक बेटा और बेटी हुई। बेटे की शादी हो चुकी है और वह लंदन में है।

Rajasthan Patrika, April 2, P. 2

शादी कार्ड पर वर-वधू की जन्मतिथि अनिवार्य

जयपुर, जासं : राजस्थान के भरतपुर जिले में बाल विवाह को रोकने के लिए जिला प्रशासन ने अनूठी पहल की है। अब शादी के कार्ड पर वर-वधू की जन्मतिथि भी छपवानी होगी। कार्ड पर 'बाल विवाह अपराध है' और 'विवाह के लिए लड़की की आयु 18 वर्ष व लड़के की आयु 21 वर्ष अनिवार्य है' भी छपवाना होगा। यह आदेश जिला कलेक्टर गौरव गोयल ने दिए। आदेश तत्काल प्रभाव से दो माह के लिए प्रभावी रहेगा। जिले में प्रिंटिंग प्रेस मालिकों को आदेश का पालन सुनिश्चित करने को कहा गया है। प्रिंटिंग प्रेस मालिक को कार्ड पर वर-वधू की जन्मतिथि अंकित करने के लिए उसका प्रमाण भी लेना होगा। इसकी अवहेलना करने पर छह माह की सजा व एक हजार रुपये जुर्माने का प्रावधान है। साथ ही प्रेस बंद करने की कार्रवाई भी की जा सकती है। जिला कलेक्टर गौरव गोयल ने बताया कि आखा तीज पर्व पर बाल विवाह रोकने की दिशा में यह प्रयास किए जा रहे हैं।

Dainik Jagaran, April 1, P. 17

दूसरी शादी के खिलाफ है देवबंद

मुजफ्फरनगर, 12 अप्रैल (भाषा)। इस्लामी मदरसा दारुल उलूम देवबंद ने मुस्लिमों से दूसरी शादी नहीं करने की अपील की है। अपनी पहली पत्नी के जिंदा रहते दूसरी शादी करने की इच्छा जताने वाले एक व्यक्ति के सवाल पर देवबंद ने कहा, 'भारतीय परंपरा में दोनों पत्नियों के साथ न्याय कर पाना मुश्किल है।' देवबंद की ओर से कहा गया, 'इस्लाम एक साथ दो पत्नियों की इजाजत देता है, लेकिन भारतीय परंपरा इसकी मंजूरी नहीं देती।' उत्तर प्रदेश इमाम संगठन के प्रमुख मुफ्ती जुल्फिकार ने कहा कि इस्लाम पति की ओर से बराबरी का दर्जा दिए जाने की शर्त पर दूसरी शादी की इजाजत तो देता है, लेकिन 'दोनों महिलाओं के साथ बराबरी का सलूक कर पाना मुश्किल है।'

Daimk Tribune April 13, P1.

Women to Gain More From Marriage Registration

The Union Cabinet's clearance for the proposal to make registration of marriages compulsory has been long overdue. That the Supreme Court had to take a proactive stand on the subject does not show the government in a good light. It should have on its own incorporated the provision to make marriage registration compulsory while enacting the law on registration of births and deaths in 1969. One reason for the hesitation was the fear that it would be considered an interference in the personal laws of some religious groups. Following the court's directive in 2006, states have been insisting on registration of marriages without any protest from any quarters.

If anything, this shows that well-meaning reforms of personal laws have wide acceptance. When the court invalidated the personal laws of Travancore Christians whereby the daughter's right to her father's intestate property was limited to ₹5,000, the decision was welcomed, rather than criticised. Ideally, the initiative to reform the law should have come from the legislature. Compulsory registration of marriages has a lot to commend itself. While the religiously inclined can have their marriages performed at religious places, they will have to get them registered by civil authorities. The government has been reluctant to introduce it for fear of fundamentalists.

Women stand to gain more from the compulsory registration of marriages because when marriages fail, it is women who suffer more. Often, they do not have any document to prove their marriages. In these days of computerisation, it should also be possible to detect fraudulent marriages at the time of registration. There are several types of marriages that have Hindu religious sanctity. Similarly, Islam allows a person to marry up to four times. In fact, if there is a conflict between the civil law and the religious law, it is the civil law that should prevail. Compulsory registration is, hopefully, a step in this direction.

New Indian Express, April 14, P8

Religion may be taken out of marriage registration

Mahendra Kumar Singh | TNN

The move has been prompted by the consideration to help those opting for inter-faith marriages, along with the need to make registration of marriages a simpler affair. It is recognized that those who marry outside their religion face harassment

New Delhi: The Union Cabinet is likely to consider a proposal that seeks to do away with the requirement to disclose one's religious affiliation for registration of marriages, as well as the demand of Sikh bodies that their marriages be registered under a separate law.

The move has been prompted by the consideration to help those opting for inter-faith marriages, along with the need to make registration of marriages a simpler affair.

It is recognized that those who marry outside their religion face harassment, including from the conservative sections of the bureaucracy.

Administrative convenience is the other consideration, with the law ministry suggesting that registration of marriages will become easier if a clause on marriage registration is added to the Births and Deaths Registration Act, 1969.

In its note to the Cabinet, the ministry has argued that since infrastructure to register births and deaths is already in place in civic authorities, it can easily handle registration of marriages once the law has been suitably amended.

As for the demand of Sikh bodies, they have argued that their marriages should be, as is the case with other minority communities — Muslims, Christians, Jews, Parsis — registered under a separate law.

Marriages of Sikhs along with those of Buddhists and Jains are currently registered under the Hindu Marriage Act: an arrangement which is being opposed by many Sikhs as part of their pursuit for a distinct identity.

These groups argue that their demand can be accepted by amending the Anand Marriage Act, 1909.

The Cabinet will be required to factor in view that meeting the demand will spark similar pitches from Jains and Buddhists: two other communities that have so far been comfortable with the practice, where their marriages are registered under the Hindu Marriage Act.

Times of India, April 11, P14

Cabinet to take up compulsory marriage registration today

EXPRESS NEWS SERVICE
NEW DELHI, APRIL 11

THE Union Cabinet is set to consider on Thursday a proposal to make registration of marriages compulsory, regardless of religious denominations, just like registration of births and deaths.

In fact, the proposal before the Cabinet is to amend the Registration of Birth and Deaths Act, 1969, to make registration mandatory. Until now, the registration provision was being added to specific marriage Acts as and when the demand arose.

The move was prompted by demands of the Sikh community to amend the Anand Marriage Act, 1909, to make registration mandatory for Sikh marriages. The community has been raising the issue for long as they point out that Muslims, Parsis, Christians and Jews already have separate Acts for registration of their marriages.

The key point, however, was the problems that arose with widespread complaints about women being exploited in NRI marriages. With women unable to produce a legal document to prove their marriage, chances of legal redressal became more difficult. It was felt that registration should be delinked from the marriage and made compulsory just like birth and death. This way, officials said, marriage Acts will not be separately amended while ensuring legal protection to women.

The Supreme Court, it may be noted, had as early as 2006 ruled that all marriages, irrespective of their religion, should be compulsorily registered and directed the Centre and state governments to frame and notify rules for this.

The Indian Express, April 12, P3

Infertility on the rise in urban areas, late marriage big factor

HT Correspondent
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NEW DELHI: Once considered to be a problem plaguing the West, infertility is rising alarmingly among urban Indian couples.

Health experts say that the gravity of the problem can be gauged by the fact that almost one in five couples in the metros have trouble conceiving on their own and need treatment.

"I get about 10-15 women in my OPD on a daily basis, who are unable to conceive. Our IVF centre is one of the busiest. In most cases, late marriage is a major contributing factor," said a senior gynaecologist at the All India Institute of Medical Sciences, requesting anonymity.

The peak fertility of girls is between 18 years and 25 years, and it is not unusual for girls to get married nowadays in their late 20s or 30s, by when there is already a significant decline in their fertility.

FERTILITY CHECK

- One in 5 couples in urban India cannot conceive without treatment
- One in 10 couples in the West face similar problem
- Late marriages (beyond 30 years) a major cause among women
- Past 40 years have seen a drop in the sperm count in men by 50%
- Smoking, alcohol, obesity, sedentary lifestyle major reasons for decline in the count

"Women lose fertility every month because of the falling egg reserve in their ovaries. Besides, gynaecological conditions such as uterine fibroids wherein tumours develop within the womb, become increasingly common when the first pregnancy is delayed to 30s that add to the problem," said Dr Renu Misra, clinical director, obstetrics and gynaecology, in-charge IVF unit, Sitaram Bhartia Institute of Science and Research.

The problem of infertility, particularly in India, is perceived more of a female problem, but experts say that men are responsible for this problem, either solely or partly in almost half the cases.

Although male fertility declines more gradually with age, there have been several scientific papers published in the past twenty years that indicate there was an overall decline in the sperm counts around the world. "In the last 40 years, the counts have fallen by nearly 50%," said Dr Misra.

The possible cause for this decline is attributed to smoking, alcohol, obesity and sedentary lifestyles, although it is difficult to quantitate the effect of these factors individually.

H.T, April 30, 12

Make moms first guardians: Panel

New Delhi: In a move to empower women, a government panel wants that a mother should be listed as the first guardian for all official purposes instead of a father, arguing that she primarily looks after the children.

"Since normally it is the mother who primarily looks after the children, she should be listed as the first guardian," the Planning Commission's Working Group said in its report.

The panel has recommended a review of all laws to make mothers equal guardians of their children. Currently, there is a practice of mentioning the father as the first guardian in all official documents such as school admission forms, birth certificates etc. The group has suggested that all existing regulations and rules ought to be revisited to ensure that the mother's signature as a guardian is universally accepted in all official records.

The recommendation is part of a slew of measures

MUM'S THE WORD

suggested by the group to make laws more gender sensitive. It also asked the government to revisit laws related to maintenance and guardianship to ensure separated women get adequate maintenance and custody rights over their children.

The suggestion, if accepted, would ensure women's first right over a child whether she is married or divorced, said a member of the group.

"Once all laws are relooked in light of the recommendations, the women will not be forced by any government or private agencies such as schools or passport offices to mandatorily disclose husbands' names," she said. "The existing laws on the issue are archaic and were conceptualized with a patriarchal mindset," said another member.

The group, headed by the women and child development secretary, wants to relook at all the laws that do not treat guardianship rights of mother on a par with those of the father. The panel, which argued that family law reform has been neglected, said the laws need to recognize a woman as an equal partner with her husband and her contribution to the household or the productive nature of work that fairer sex do.

The path-breaking recommendations would ensure that mothers have an equal right in care-giving as well as in crucial decision-making processes, financial or otherwise, affecting children's lives. The law commission in its 83rd report submitted in 1980 had suggested amendment in guardianship laws.

"The Guardians and Wards Act, 1890 was enacted 90 years ago. At the time, women had scarcely any rights; for them there was only social and legal degradation, material insecurity and other manifestations of dominance and false superiority of men," it had said.

The commission also recommended to amend Section 6 of the Hindu Minority and Guardianship Act, 1956, to allow the mother the custody of a minor till it is 12 years old. "It is necessary to allow the mother the custody of a child till it attains the age of 12 to prevent the father from using the child as a pawn for securing complete submission of his wife," the report added.

Times of India, April 11, P.14

National Rural Mission to link one woman from every poor family to SHGs

JAIPUR: The National Rural Livelihood Mission (NRLM) would connect at least one woman from every poor household across the country with self-help groups (SHGs) in five years, Union Minister of Rural Development Jairam Ramesh said on Friday.

"The objective of the programme is to ensure that in a five-year period one woman from every poor household becomes a member of SHG. Today we have three crore women who are members of SHGs, and we have to raise it to seven crore in five years," Mr. Ramesh said.

"By the end of five years, one woman from every poor household will be SHG member. The programme is for rural Below Poverty Line (BPL) households, but I am in the process to remove this restriction between the BPL and poor," the Minister said while delivering valedictory address on Micro-Finance and Livelihoods here.

Emphasising upon a flexible structure of guidelines in government programmes, Mr. Ramesh said operation guidelines for the Mahatma Gandhi National Rural Employment Guarantee Scheme are being revised. "Flexibility is required to take into account the special requirements of the States. Very soon, we will be revising the operational guidelines for MGNREGS," he said.

The Minister also underlined the need to create a regulatory space for micro-finance institutions (MFIs) so that they can function efficiently without adversely impacting the functions of SHGs.

Calling for leveraging the advantages of both MFIs and SHGs, he said they should be encouraged to produce social capital goods.

"Micro-finance cannot provide a definite answer to the challenges of poverty alleviation, but it can lead to financial inclusion by providing credit to the customer as per his own needs," he said.

Referring to the SHG scenario in Rajasthan, he said there is still an enormous scope for growth in this sector as the major share of bank credits for SHGs is claimed by southern States.

"Andhra Pradesh, Tamil Nadu, Karnataka and Kerala account for 75% to 80% of the money provided by banks for supporting SHGs. Strong SHG network is a phenomena seen in south India and it is a challenge for us to make it pan-India feature," he said.

The valedictory session of the two-day colloquium on Micro-finance and Livelihoods on the theme of "Enabling Poor, Impacting Lives" was also addressed by National Bank for Agriculture and Rural Development (NABARD) chairman Prakash Bakshi, who called for a change in the role of SHGs with the changing external environment.

Later in the day, Mr. Ramesh held a meeting with Rajasthan Chief Minister Ashok Gehlot. He told Mr. Gehlot that Rs.8,000 will now be given instead of Rs.3,200 to poor families in Rajasthan for constructing toilets under a sanitation programme.

Both leaders also discussed issues related with rural development and panchayati raj at the meeting in which senior State officials were also present. — PTI

Economists see a new role for micro-finance

Special Correspondent adds:

Micro-finance practitioners and financial experts participating in the colloquium threw new light on micro-credit, SHGs and marketing of products and services as crucial factors for chartering the course from micro-finance to livelihood promotion for lakhs of poor households across the country. Experts made important suggestions for expanding the SHG movement from saving and credit operations to creation of sustainable livelihood opportunities through some ground-breaking initiatives.

The two-day colloquium was organised jointly by Jaipur-based Centre for Micro Finance (CMF) in collaboration with Rajasthan Gramin Ajeevika Vikas Parishad.

Eminent economist and Rajasthan State Planning Board Deputy Chairman V. S. Vyas, who inaugurated the event, said the nationalisation of banks in 1969 had prompted them to address the needs of the rural poor and created an atmosphere leading to inclusive banking. Describing credit as a potent instrument for development and poverty alleviation, he emphasised the need to "graduate from micro-finance to livelihoods".

Sir Ratan Tata Trust secretary F.J. Gandavia said the Mumbai-based Sir Ratan Tata Trust was supporting the livelihood promotion activities for the past 10 years and suggested that clusters and federations of SHGs be formed in the rural areas to get better results of their activities.

Centre for Microfinance chairman Anil K. Khandelwal said the potential of the SHG sector was very high and it could revolutionise the entire concept of poverty alleviation at the grassroots. He said the quality of SHGs should be improved and attention shifted from merely increasing their number.

Hindu, April 7
P7

Debating the 'feminist approach' to sex work

Gloria Steinem's "feminist approach" to trafficking and prostitution is not shared by all feminists. Many of us do not believe that abolishing sex work will stop trafficking, nor do we think that the two are synonymous. The conflation of sex-work with 'trafficking' stems from the moralistic assumption that women can never voluntarily choose sex work as a profession and are always 'trafficked' into it. This idea has been conclusively challenged by the sex workers rights movement that has tirelessly argued that trafficking (that is induction into the trade through force, coercion or deception) is a crime whereas the exchange of sexual services between two consenting adults is not.

Just as all sex work is not linked to trafficking, all trafficking is also not linked to sex work. While it is certainly true that many women (and children) enter sex-work under violent and exploitative conditions, this is no different from other livelihood occupations in the unorganized sector such as agricultural and domestic work, construction and industrial labour. Ironically, those who demand the abolition of sex work to stop trafficking do not make the same argument for domestic work despite the fact that conditions, wages, working hours, levels of exhaustion are far worse for domestic workers.

Moralistic assumptions

It has been repeatedly pointed out that the statistics on trafficking' have no basis in a rigorous methodology, scientific evidence or primary research. A study undertaken by the Special Rappateur on Violence Against Women demonstrated the extreme difficulty of finding reliable statistics since so much of the activity happens underground. Consequently, 'trafficking' statistics are derived from figures relating to sex-work, migration and even numbers of "missing persons". By failing to distinguish between sex-work, migration and trafficking, 'abolitionists' like Steinem only serve to make the gender-neutral term synonymous with the female migrant.

Ironically, some of the best work on 'trafficking' in India is being done by the Self Regulatory Boards of the Durbar Mahila Swamanyay Committee (DMSC) which emerged out of the famous STD/HIV Intervention Project (SHIP) in Sonagachi, now an internationally acclaimed model sexual health project. The DMSC considers sex-work to be a contractual sexual service negotiated between consenting sexual adults and demands decriminalization of adult sex-work. If feminists like Gloria Steinem and organizations like Apne Aap want to end trafficking in sex-work, their best bet is to recognize sex-work as labour, support its decriminalization and empower the sex-worker to fight exploitation, coercion and stigma.

Gloria Steinem's talk was organised by the Women's Studies Programme, JNU, in collaboration with Apne Aap, and we had hoped that it would be an occasion for discussing the complexities of the issues involved. However, there were clearly differences in perspective—while there can be no disagreement that involuntary trafficking is a serious issue, the fact that women (and men) may have few choices in several situations, and may then 'choose' options that may not be in tune with the ideals of middle-class/upper caste women (and men) needed to be explored rather than dismissed.

In the open discussion that followed Ms Steinem's presentation, there were several participants who agreed with her positions. However, others pointed out that there were certain simplistic assumptions involved. For instance, Ms Steinem and Ruchira Gupta of Apne Aap refuse to recognize that unionized sex workers are voicing their own opinions—these women are dismissed as puppets of pimps and brothel owners—a gross simplification in view of the sheer numbers of women across the country who have unionised in a bid to claim human rights and dignity.

Need for a nuanced debate

Other voices of dissent pointed out to the need to look at issues of poverty and labour in general, and locate sex work within that context, and/ or within a larger context of violence rather than homogenise all prostitutes/ sex workers. While side-stepping rather than engaging with these questions, one of Ms Steinem's responses was that she would not mind if prostitutes, as she chooses to designate all sex workers, paid income tax—at the same time she advocated a strategy of penalizing but not criminalizing the client—, w these were to be achieved remained unclear.

We, in the Women's Studies Programme, feel the need for a far more nuanced discussion and debate on these issues—one in which women who express a different point of view are not dismissed as being in a denial mode. Given that some of these issues were raised in the open discussion and in the concluding remarks, it would have only been fair that some of these found reflection in the reporting on the event.

Hindu, April 6, P9

Body invasion is de-humanising

When I'm meeting with women and girls in prostitution in my own country as well as some countries of Europe, Africa and here in India, I've always asked what they would like for their daughter. So far, the answers have not included prostitution.

That's especially striking given the profound differences in their lives, from Manhattan call girls to women in the brothel line-ups of Sonagachi; from women in the counties around Las Vegas, the only places in the US where prostitution is legal, to bar girls from the villages of Ghana and the scheduled castes in Bihar where women are consigned to prostitution by birth. Indeed, the same seems to be true of prostituted males who serve male clients.

The truth seems to be that the invasion of the human body by another person – whether empowered by money or violence or authority -- is de-humanising in itself. Yes, there are many other jobs in which people are exploited, but prostitution is the only one that by definition crosses boundary of our skin and invades our most central sense of self. I know this is a subject that needs much more exploring, but I want to indicate it in shorthand because I think it's the source of the misunderstanding in these two letters in response to a lecture I gave at Jawaharlal Nehru University on April 2.

I did not say -- nor do I think, as Shohini Ghosh supposes -- that sex trafficking and prostitution are "synonymous." Though both are created by the same customers who want unequal sex, they represent crucial differences in a woman's ability to escape or control her own life. However, I would not equate prostitution with domestic work, as she does. That ignores the damage and trauma of the body invasion that is intrinsic to the former and should never be part of the latter. Also I don't think "consenting adults" is practical answer to structural inequality. Even sexual harassment law requires that sexual attention be "welcome," not just "consensual." It recognizes that consent can be coerced.

In addition, Kumkum Roy criticizes me for not using the term "sex worker." I know this term is common in AIDS policy and academia, but it turned out to be dangerous in real life. For instance, in places as disparate as Germany and Nevada in the US, government used the idea that prostitution is "a job like any other" to withhold welfare and unemployment benefits from women who failed to try it. Only protests by women's movements ended this form of procurement. As a popular term, I notice that prostituted girls and women say "survival sex," as more descriptive as well as a breach of human rights.

Finally, I devoutly wish that unions had improved conditions in brothels, kept children out of prostitution and lessened disease and violence, as they promised to do, but in fact, there has been a huge increase in trafficking, girls in prostitution have become younger and younger, and there is no independent evidence of lowering rates of AIDS. What the idea of unions has done is to enhance the ability of the sex industry to attract millions of dollars from the Gates Foundation for the distribution on condoms, despite the fact that customers often pay more for sex *without* condoms, and it has created a big new source of income for brothel owners, pimps and traffickers who are called "peer educators." I understand that that the traffic of women and girls into Sonagachi has greatly increased.

But there is good news. The old polarization into legalization and criminalization is giving way to a more practical, woman-centered and successful Third Way: Decriminalize the prostituted persons, offer them meaningful choices, prosecute traffickers, pimps and all who sell the bodies of others, and also penalize the customers who create the market while educating them about its tragic human consequences.

Those are turning out to be goals on which many people work together.

Legalising has not helped globally

Ruchira Gupta

Apne Aap believes that sex is different from sexual exploitation and as feminists we have a right to sex without domination. Apne Aap organises women and girls, who are victims and survivors of prostitution in numerous small groups of ten to resist the sexual exploitation of themselves and their daughters. These women are from poor, low-caste families and do not see their prostitution as "work" or a "choice." At best it is a survival strategy.

Body invasion is inherent to prostitution and differentiates it from livelihoods in the unorganised sector like agriculture and domestic work that Ms Ghosh talks about. In addition, I would like to point out to both Ms Ghosh and Ms Roy the uniformly disastrous results where ever the selling or renting of human beings for sexual purposes has been legalised and normalised. In Australia and the Netherlands where prostitution has been legalised, for instance, trafficking and the harms that come with prostitution have not decreased but increased. In Victoria, Australia, it not only allowed legal brothels to proliferate, but *illegal* brothels increased by 300 per cent in one year. A hospitable environment for sex tourists and other buyers drove up demand, local women and girls had too many alternatives to becoming the supply, and women and girls were trafficked from South East Asia. The same is true of Amsterdam where trafficked Eastern European and North African girls outnumber Dutch citizens in brothels. The Mayor of Amsterdam reports that the red-light district has become a centre for illegal immigration and money laundering. In Germany and in an area near Las Vegas in the US where prostitution has been legalised, government agencies tried to make applicants for unemployment benefits show that they had attempted to find "work" in the so-called "hospitality industry" of prostitution in order to become eligible for such benefits.

In the few countries that have legalized prostitution -- with the idea that it would reduce harm to prostituted women themselves, as is now being argued by some in India -- rates of assault and rape against prostituted persons have not dropped at all. In an upscale legal brothel in Australia, for example, rooms are equipped with panic buttons, but a bouncer reports that the women's calls for help can never be answered quickly enough to prevent violence by clients, which occurs regularly.

Finally, we must remember that the commodification of human beings focuses on women and children, usually poor or low-caste, and creates a separate class of human beings whose bodies can be rented or sold. It is the very opposite of the universal protection of human dignity enshrined in the body of the Indian Constitution.

महिलाएं प्रदेश की उन्नति में सक्रिय भूमिका निभा रही हैं : भयाना

निःशुल्क सिलाई मशीनें वितरित कीं

हांसी, 8 अप्रैल (निस)। हरियाणा की महिलाएं विभिन्न क्षेत्रों में सराहनीय कार्य करके समाज और प्रदेश की उन्नति में सक्रिय भूमिका निभा रही हैं। महिलाएं हमारे समाज की धुरी हैं और महिलाओं की रचनात्मक भूमिका के बगैर घर, समाज और राष्ट्र के विकास की कल्पना करना संभव नहीं है।

यह बात प्रदेश के मुख्य संसदीय सचिव विनोद भयाना ने स्थानीय बजरंग आश्रम में सिलाई कढ़ाई का प्रशिक्षण प्राप्त कर रही महिलाओं को निःशुल्क सिलाई मशीनें वितरित करने उपरांत सम्बोधित करते हुए कही। कार्यक्रम का आयोजन बजरंग आश्रम द्वारा किया गया था।

उन्होंने कहा कि महिलाएं प्रशिक्षण प्राप्त करके स्वयं का रोजगार स्थापित करके न केवल अपने परिवार का पालन पोषण कर सकती हैं बल्कि समाज को भी एक नई दिशा प्रदान करने में अपना महत्वपूर्ण सहयोग प्रदान कर सकती हैं।

इससे पूर्व मुख्य संसदीय सचिव विनोद भयाना ने आज हल्के के गांव शेखपुरा में गली के निर्माण कार्य का शुभारंभ किया और जनसभा को भी सम्बोधित किया। इस गली के निर्माण पर 8 लाख रूपए की राशि खर्च की जाएगी। यह गली 600 फुट लम्बी व 16 फुट चौड़ी होगी। उन्होंने कहा कि वे काम करने में विश्वास रखते हैं और हल्के के विकास के लिए उन्होंने करोड़ों रूपए मंजूर करवाए हैं।

Dainik tribune, April 9, P.5

'स्त्री की उन्नति पर ही समाज एंव राष्ट्र की उन्नति निर्भर'

उकलाना मंडी, 2 अप्रैल (एस)। स्त्री की उन्नति पर ही समाज एवं राष्ट्र की उन्नति निर्भर है । यह बात अग्रवाल वैश्य समाज की महिला प्रदेशाअध्यक्ष सुशीला सर्राफ ने अग्रवाल समाज की महिलाओं को सम्बोधित करते हुए कही । वैश्य समाज के बारे बतलाते हुए कहा कि भारत से अतुल्य भारत में वैश्य समाज के योगदान को भुलाया नहीं जा सकता । सुख सबकों बाटें-दुख सबका हरे ,इसी विचारधारा को अपनाने वालों को वैश्य कहा जाने लगा था । उन्होंने ने कहा कि आज अग्रवाल समाज को अपने हकों के लिए जागरूक होना पड़ेगा एवं समाज को उसकी शक्ति का ज्ञान करवाना होगा और वैश्य समाज को पुन सामाजिक आर्थिक ,राजनैतिक भागीदारी और नेतृत्व विकास आवश्यक है। इसके लिए राजनीति में सीधी भागदारी और नेतृत्व हो ।

उन्होंने ने बताया कि समाज में एक पहचान बनाने में महिलाओं की भूमिका पर विचार करने के लिए और संघर्ष की एक नीति को तैयार करने के लिए अग्रवान समाज द्वारा 6 मई को रोहतक में एक शक्ति-सम्मेलन का आयोजन किया जा रहा है। इस अवसर पर उन्होंने मंजू मितल को अग्रवाल वैश्य समाज के उकलाना हलके का महिला प्रधान मनोनित किया गया।

The Tribune, April 3, P6

'बालिकाओं और महिलाओं के सर्वांगीण विकास के बिना समाज अधूरा'

गुड़गांव, 18 अप्रैल (हप्र)। बालिकाओं एवं महिलाओं के सर्वांगीण विकास और सशक्तिकरण के बिना घर, समाज और राष्ट्र के विकास की कल्पना भी नहीं की जा सकती। इस बारे में जानकारी देते हुए उपायुक्त पी सी मीणा ने बताया कि बच्चों एवं महिलाओं के विकास के लिए समेकित बाल विकास विभाग द्वारा विभिन्न प्रकार की योजनाएं क्रियान्वित की गई हैं जिनमें ग्रामीण किशोर बालिकाओं को पुरूस्कार योजना, सर्वोत्तम माता पुरूस्कार योजना, किशोरी शक्ति योजना, महिलाओं के लिए खेल प्रतियोगिताएं, लाडली योजना, लाडली सामाजिक सुरक्षा पैंशन योजना, साक्षर महिला समूह, ग्रामीण स्तरीय महिला कमेटी का गठन व आंगनवाड़ी भवन निर्माण योजना शामिल हैं।

Dainik tribune, April 19, P3

पैसे देकर परदेस से ले आते हैं पत्नी

मध्यप्रदेश की लड़कियों को अन्य राज्यों में बेचने का ही नहीं, बल्कि दूसरे प्रदेशों से लड़कियां खरीदने का धंधा भी जोरों पर चल रहा है।

बुंदेलखंड में ओडिशा से खरीदकर लाई गई बालाएं कई घरों की बहुएं बन रही हैं। दमोह और छतरपुर जिलों में खासकर हटा ब्लॉक के मड़ियादो, पाटन, वर्धा, मलवारा, पाठा, बनौली, रजपुरा सहित दर्जनों गांवों में कई घरों में परदेशी बहुएं हैं। क्षेत्र में विवाह योग्य युवतियां नहीं मिलने के कारण यहां के लोग पैसे के बल पर ओडिशा से गरीब परिवारों की बेटियां लाकर घर बसा रहे हैं। हालांकि, इनका दावा है कि वे इन्हें बराबरी का दर्जा देते हैं। छतरपुर के बिजावर विकासखंड के नगदा गांव में भी कुछ पिछड़ी जातियों के परिवारों में ओडिशा की युवतियां लाई गई हैं।

भाषा बनी दीवार

वर्षारानी, प्रभारानी ने बताया कि वे अपने नए घर में काफी खुश हैं,

बिचौलिए सक्रिय, 10 से 25 हजार में करा देते हैं सौदा

पाठा गांव के परशु महाराज बताते हैं कि जब उन्हें विवाह योग्य युवती नहीं मिली तो उन्होंने बिचौलिए के जरिए ओडिशा के एक गरीब परिवार से 25 हजार रुपए में लड़की लाकर शादी की। भाई की शादी भी ऐसे ही गुप्तेश्वर की एक लड़की से ही हुई। दमोह जिले के ही पाटन गांव के देवदार यादव, गजपत यादव, सुंदर यादव भी बिचौलिए के जरिए ओडिशा से लड़की ले आए। वे मानते हैं कि उन्होंने पैसे दिए, लेकिन लड़की खरीदने की बात नकारते हैं।

लेकिन भाषा बड़ी समस्या रही। पहले इशारों में ही बात होती थी, अब धीरे-धीरे कामचलाऊ हिंदी सीखी है। उनका वोटर आईडी कार्ड भी बन गया है। राशन कार्ड में भी नाम दर्ज है।

6-7 साल में बढ़ा चलन

6-7 साल से बाहरी राज्यों की लड़कियों को लाया जा रहा है। सैकड़ों परिवारों में इन युवतियों को देखा जा सकता है।

नगाराम पटेल, स्वास्थ्य जन हटा

शादी का खर्च भी बढ़ गया है। ऐसे में लाखों खर्च करने से अच्छा 10-20 हजार रु. में ओडिशा से लड़की ले आना लगता है।

सुनील बजाज, एडवोकेट, हटा

Rajasthan Patrika, April 10, P.12

Omani bizman turns saviour for Vidarbha widows!

Nagpur

Widows of Vidarbha farmers who ended their lives unable to bear the stress of high debt have found a Good Samaritan in an Oman-based industrialist.

Krishnakumar Taori, the Group Managing Director of Hasan Juma Backer Trading and Contracting Co. LLC, engaged in mega construction projects in Oman, has come to the rescue of the distressed community of eastern Maharashtra.

Taori, who was born to a cotton farmer in a remote village Ghuikhed in Yavatmal, travelled last week to Pandharkavada and distributed token relief to widows and orphans.

"He distributed saris and blankets to 200 widows in the village, plus Rs.1, 000 cash per family which lost its breadwinner to the spate of suicides in the region," Kishore Tiwari of the Vidarbha Jan Andolan Samiti (VJAS) told.

Taori also agreed to bear the actual costs of vocational and academic education for the orphans from the village by way of fees and educational material, Tiwari added.

Saddened by the plight of his erstwhile native region, Taori, who earned his engineering degree from Nagpur, will return next week to finalise plans to set up a technical institute in his native village, Ghuikhed, he said.

"Taori will hold meetings with government and other officials to hammer out the modalities for setting up an ITI in this area which would immensely benefit the young population, especially the orphans."

Explaining Taori's largesse, Tiwari said he (Taori) was deeply disturbed by the spate of farmland suicides which have continued unabated in Vidarbha since the past few years.

"Accordingly, he decided to take the first step and distributed the token aid in memory of his mother, Kamlabai Taori to the widows of Pandharkavada village," Tiwari said.

Since the past five years, Taori is engaged in providing free education to tribal children of the backward Melghat, in Amravati district through the Eklavya Vidyalaya of Vanvasi Kalyanashram.

According to Tiwari, Taori now wants to increase his social presence by taking up the responsibility to educate the orphans, especially girls, to make them economically independent.

Free Press, April 24, 09

कैसे मिटे निरक्षरता का दाग

चूरू. शिक्षा का केन्द्र बनकर उभरता मरुधरा का चूरू जिला निरक्षरता का दाग नहीं धो पाया है। पिछले दस वर्षों के दौरान जिले ने भले ही भौतिक संसाधन जुटाने में प्रगति की हो लेकिन सबको साक्षर करने की लौ बेहद ही मंद रही है।

जिले में स्कूल और कॉलेजों का तेजी से विकास हुआ, जनसंख्या में बढ़ोतरी हुई लेकिन साक्षरता दर में आई गिरावट ने जिले की शैक्षणिक व्यवस्था व सरकार की ओर से साक्षर करने की संचालित योजनाओं पर पानी फेर दिया है।

जनगणना 2011 के आंकड़े जिले की यह सच्चाई बयां कर रहे हैं। प्रशासन के तमाम प्रयासों के बावजूद लोगों को साक्षर करने की मुहिम जिले में जोर नहीं पकड़ पाई।

इसी का नतीजा रहा है कि जिले की साक्षरता में 0.13 की गिरावट दर्ज की गई। इनमें ग्रामीण क्षेत्रों की साक्षरता को ठीक नहीं कहा जा सकता है। वर्ष 2011 में ग्रामीण साक्षरता 65.59 और शहरी क्षेत्र में 72.09 दर्ज की गई है।

शहरी और ग्रामीण क्षेत्र की साक्षरता में 6.4 प्रतिशत का अंतर है। जबकि 2011 की साक्षरता दर 67.46 है। इसमें ग्रामीण 64.98 और शहरी 73.63 प्रतिशत साक्षर है।

महिला साक्षरता में पिछड़े

जिला महिला साक्षरता में भी पिछड़ गया है। यहां पुरुषों के मुकाबले महिलाओं की साक्षरता में गिरावट आई है। जनगणना के आंकड़ों के अनुसार वर्ष 2001 में महिला साक्षरता 54.36 थी जो 2011 में घटकर 54.25 पर आ गई। यानी दस वर्ष के अंतराल में साक्षरता में 0.11 प्रतिशत की गिरावट दर्ज की गई है।

ग्रामीण महिला साक्षरता में गिरावट

जिले के ग्रामीण क्षेत्रों में जनगणना के आंकड़ों पर गौर करें तो यहां भी महिलाएं काफी पिछड़ रही है। 2001 में ग्रामीण क्षेत्र में महिला साक्षरता का प्रतिशत 52.33 था जो 2011 में घटकर 51.13 पर आया गया। एक दशक में 1.20 प्रतिशत की गिरावट आई। शहर में कुछ परिणाम सुखद आए हैं। 2001 की वनिस्पत 2011 में महिला साक्षरता में 0.89 प्रतिशत की बढ़ोतरी दर्ज की गई है।

Rajasthan Patrika, April 5, P11

'महिलाओं को अपनी ताकत को पहचानना होगा'

सोनीपत, 19 अप्रैल।(निस) राजीव गांधी राज्य पंचायती राज एवं सामुदायिक विकास संस्थान, नीलोखेड़ी (करनाल) द्वारा स्थानीय जिला परिषद भवन में पंचायत महिला एवं युवा शक्ति अभियान कार्यक्रम आयोजित किया गया। इसमें महिला सरपंचों, पंचों, आशा वर्करों सहित जिला के सभी खण्डों की लगभग 350 महिलाओं ने भाग लिया। कार्यक्रम अधिकारी श्रीमती वीना सहगल ने वहां उपस्थित महिलाओं को सम्बोधित करते हुए कहा कि आज का युग नारी सशक्तिकरण का युग है। महिलाओं को अपनी ताकत को पहचानना होगा। आज नारी हर क्षेत्र में अग्रणीय है। अकेले हरियाणा में ही लगभग 25 हजार विभिन्न पदों पर महिलाऐं कार्यरत है। हमारे देश की राष्ट्रपति महिला है तथा अन्य कई राज्यों में महिलाऐं मुख्यमंत्री जैसे पदों पर विराजमान है। श्रीमती सहगल ने कहा कि महिला सरपंचों के कार्य को सराहनीय बताते हुए कहा कि गांवों का विकास करने में वे पीछे नहीं हैं। डीडीपीओ हरि सिंह श्योराण ने कहा कि जिले में महिला सरपंचों की संख्या 100 से भी ज्यादा है। सरकार द्वारा अनेकों प्रकार की जन कल्याणकारी योजनाऐं चलाई जा रही है।

Dainik Tribune, April 20, P4

Naga women's fight for rights

Women throughout the world have been experiencing a transition into empowerment in the recent times. Despite that, however, issues relating to rights continue to remain a matter of serious concern particularly in ensuring that these rights are not violated and instead respected and protected by all. Societies across the globe have witnessed blatant denial of rights to women, and our India, too, is not an exception.

The recent case at hand is from Nagaland, where there has been a systematic design to deprive women from their right to be part of the decision-making process as enshrined in the 108th Amendment to the Constitution. The case, in fact, exposes the manner in which a male-dominated society has continuously attempted to keep women out of the decision-making process in the name of customary laws and certain other provisions.

The whole debate began when the election to civic bodies – four municipal committees and 15 town committees – was notified first on November 16, 2009, with the State Government notification also making it clear that 33 per cent of the seats have been reserved for women. Interestingly, while the law provides for considering all male members who were directly elected from those municipal wards, which had become reserve for women as deemed to have vacated their seats within 180 days from August 30, 2006, i.e., by end of February 2007, the Government of Nagaland permitted the male members to continue until the end of their term – some in 2009, some in 2010.

Despite that, however, the government did notify fresh election to the municipal and town councils on November 17, 2009, even before their terms had expired. But soon afterwards, the election was put on hold with the State Government saying that "certain groups expressed their opposition to the aforesaid amendment on the ground that the said amendment is contrary to the provisions of Article 371(A)(1) of the Constitution of India which provides that no act of Parliament relating to the Naga customary law and procedure shall apply to the State of Nagaland unless the Legislative Assembly of Nagaland by a resolution so decides." The State Cabinet also took a decision on December 16, 2009, postponing the election for an indefinite period.

Disappointed over this, the Naga Mothers' Association, with the help of Human Rights Law Network, challenged the Cabinet decision in the Gauhati High Court. After hearing both sides, a landmark judgment was passed on October 21, 2011 directing the Government of Nagaland to hold election to the municipal and town councils in the State with implementation of the 33 per cent reservation for women by January 20, 2012.

In December, when Dr Syeda Hameed, member of the Planning Commission, visited Kohima, she not only hailed the High Court's orders, but also said that the State Government was bound to follow the court order. She also described Naga women as "the strongest and the most empowered group" and said there was absolutely no reason why there should not be any woman in the State Legislative Assembly or civic bodies.

The women in Nagaland were further elated when the Governor on March 15 issued a notification spelling out 33 per cent reservation for women in the State's civic bodies. But this turned out to be shortlived, as those bodies opposed to reservation raised their heads again petitioning the State Assembly to stop women from becoming a partner in the decision-making process. While the Naga Hoho reiterated its stand that though it was not against empowering Naga women through nomination, it did not support reservation.

The Naga Hoho and other groups opposed to women's reservation also maintained that reservation would infringe on Article 371(A) of the Constitution that has given "absolute power" to the Naga people. They also said reservation for women would infringe on the customary and traditional practices of Nagas as Naga women were never subjected to discrimination. The Eastern Naga People's Organisation (ENPO), which claims to represent four districts – Kiphire, Longleng, Mon and Tuensang – had also supported the Naga Hoho and other organisations that are against reservation.

Criticising the anti-reservationist groups, Rosemary Dzuvichu, adviser to the Naga Mothers' Association, said the High Court had dismissed the petition of the State Government, saying reservation is a constitutional right which supersedes Article 371(A) and had nothing to do with customary laws as reservation of seats in municipalities was about election and not about any customary right. She also said people were unaware that the constitutional right was given to women by the 73rd and 74th amendments to the Constitution, which cite reservation in urban and local bodies and panchayat level supersedes Article 371(A) and no customary laws could surpass the constitutional rights.

A few days after the Governor's notification, the State Assembly passed a unanimous resolution referring the issue of 33 per cent reservation for women to a Select Committee for review and report to the Assembly within six months. Thus, the fate of the women's reservation has been sealed for another six months.

Meanwhile, the Joint Action Committee on Women Reservation (JACWR) has said that the resolution unanimously passed by the Assembly – to suspend all statutory process for conduct of election to the various municipalities – was not only a contempt of the Court order, but betrayal and discrimination of Naga women. The JACWR said it was "most unfortunate" that many Naga leaders were questioning the legality of the High Court order which had no connection with the process of election for governance of towns.

To sum up, one must listen to what Sano Vamuzo, chairperson of the Nagaland State Women's Commission, has said, "Ours being a patriarchal society, the men dominate and make all the decisions, including the ones for women who form half of the total population. This means that their voices are not represented and they are left out with their potentialities. One should not misunderstand the objective of reservation – this 33 per cent will not infringe upon the basic rights of men in our society. Even though the existing Naga customary law is gender biased in favour of the menfolk, the proposed 33 per cent reservation in Nagaland is in no way going to challenge or change the existing customary law on property rights, inheritance, etc. It is not to take away the power from men, but to give women a chance to participate and share the leadership responsibilities as partners in decision-making."

Assam Tribune, April 26, P6

Govt does U-turn on helmets for women

STAFF REPORTER ■ NEW DELHI

Under pressure from Sikh community leaders, the Delhi Government has done a U-turn on its stand taken in the Delhi High Court making helmets mandatory for Sikhs while driving and riding on two-wheelers. The Delhi Government is considering filing an appeal in the High Court stating a notification issued by transport department on June 1999 had made it clear that it will be optional for women riding on pillion to wear helmets. The decision was taken by the Delhi Government after Sikh bodies in the national Capital lodged their protest on the State Government move to bring all women pillion riders under the helmet rule. The attempt was shelved once when then Delhi Chief Minister Sahib Singh Verma tried to implement the helmet rule for women pillion riders.

Top sources told *The Pioneer* that the Delhi Government has decided to take U-turn on the helmet issue and it will file an appeal in the High Court after strong protest by Sikh bodies in the Capital. The issue of helmet rule for women was discussed at the review meeting of transport on Thursday and Chief Minister Sheila Dikshit was apprised about the transport department's blunder regarding helmet issue. The officials also informed that a notification of transport department dated June 1999 has made it optional for women pillion rider to wear helmet. Sources said that it was also revealed that the State Government was not consulted on this issue before filing such an important affidavit in the High Court. The issue of helmet was become a point of discussion at the transport department review meeting which convened to discuss the pending issues such as pending Bus Q shelters, cluster buses and the proposed auto policy for autorickshaws.

Later, the transport department has clarified that a PIL for making helmets compulsory for women as well is pending before the Delhi High Court and during the course of hearing in the matter held on Wednesday, the Delhi Government has filed a status report in the matter wherein it was indicated that the matter is under examination. The court has directed the Government of Delhi to complete this exercise within eight weeks. It is further reiterated that it is optional for a woman whether riding on pillion or driving on a motor cycle/two-wheeler to wear a protective headgear/helmet as per the existing legal provisions under rule 115(2) of the Delhi Motor Vehicles Rules, 1993.

The Delhi Government told the High Court on Wednesday it would amend the motor vehicle rules to bring all women riders, including those on pillion seats, under the helmet rule. The court was hearing a plea challenging a provision in the Delhi Motor Vehicles Rules which exempts women pillion riders from wearing helmets. As per the Motor Vehicle Rules 1993, Sikhs wearing turbans and women are exempted from wearing helmets while riding motorcycles and scooters.

The Delhi Government counsel Zubeda Begum informed the High Court that although it was mandatory for women pillion riders to wear helmets under the Central Motor Vehicles Act, the Delhi Government had made it optional in its Motor Vehicle Rules 1993. However, with HC questioning this relaxation, the Government had re-examined the matter and would amend the rules. The Government's submission prompted a bench of acting Chief Justice AK Sikri and Justice Rajiv Sahai Endlaw to grant two months time for carrying out the amendments. In the process, the High Court disposed the PIL.

GOVT DRAFT POLICY ON AUTOS SOON

New Delhi: The Delhi Government is working on a draft policy to finalise criteria for the 45,000 new three-wheeled scooter rickshaws (TSRs) and the installation of GPS — an issue over which the Government has burnt its fingers and which was discussed with autorickshaw unions at a review meeting of the transport department. Chief Minister Sheila Dikshit chaired the meeting. Transport Minister Arvinder Singh Lovely and other senior officials of transport department were present. During the meeting, it was also decided to rework the routes of grameen sewa and reviewed the delay in pending Bus Q shelters and arrival of cluster buses.

Pioneer, April 27, P3

महिला सवारी भी लगाए हेलमेट

नई दिल्ली | वरिष्ठ संवाददाता

राजधानी में दोपहिया वाहनों पर चालक के साथ बैठने वाली महिलाओं के लिए भी हेलमेट पहनना अनिवार्य हो जाएगा। हाईकोर्ट ने सुरक्षा का हवाला देते हुए दिल्ली सरकार को इसके लिए कानून में बदलाव करने को कहा है।

कानून में संशोधन के बाद पगड़ी नहीं पहनने वाले सिखों को भी हेलमेट पहनना जरूरी होगा। कार्यवाहक मुख्य न्यायाधीश ए.के सीकरी और जस्टिस राजीव सहाय एंडलॉ की पीठ ने कानून में बदलाव के लिए दो महीने का वक्त दिया है।

पीठ ने सरकार से इसकी रिपोर्ट पेश करने को भी कहा है, ताकि इसे जल्द लागू किया जा सके। हाईकोर्ट ने यह आदेश फिल्म निर्माता उल्हास पी.आर. की ओर से दाखिल जनहित याचिका पर दिया। उन्होंने सड़क हादसों में महिलाओं की मौत के बढ़ते ग्राफ के मद्देनजर सभी के लिए हेलमेट अनिवार्य करने की अपील की थी। साथ ही कहा था कि इसमें लिंग व धर्म के आधार पर भेदभाव नहीं किया जाना चाहिए। इस मसले पर दिल्ली सरकार भी कानून में बदलाव को राजी हो गई है। अधिवक्ता जुबेदा बेगम ने हाईकोर्ट में बताया कि सरकार मोटर वाहन अधिनियम के रूल-115 (2) में बदलाव करेगी। दिल्ली यातायात पुलिस पहले ही महिलाओं के लिए हेलमेट अनिवार्य करने की सलाह दे चुकी है।

मौजूदा स्थिति	अदालती फरमान
• दिल्ली मोटर वाहन एक्ट के रूल 115(2) में महिलाओं को हेलमेट पहनने से है छूट • केंद्रीय मोटर वाहन अधिनियम के मुताबिक, सभी का हेलमेट पहनना अनिवार्य है	• हाईकोर्ट ने दिल्ली सरकार को कानून बदलने के निर्देश दिए • कहा, सुरक्षा की लिहाज से सभी का हेलमेट पहनना जरूरी होना चाहिए • संशोधित कानून बिना पगड़ी वाले सिखों पर भी लागू

विश्व स्वास्थ्य संगठन के अनुसार दोपहिया दुर्घटनाओं में मौतों को रोकने में हेलमेट महत्वपूर्ण है। दुनियाभर में इसे अनिवार्य करके घायलों और मरने वालों की संख्या में क्रमशः 70 और 40 फीसदी तक की कमी लाई जा सकती है। गौरतलब है कि दोपहिया चालकों की 75 फीसदी मौत के मामला में सिर में लगने वाली चोटें जिम्मेदार होती हैं।

विश्व स्वास्थ्य संगठन के पूर्व निदेशक डा. एंडर्स नार्डस्ट्रॉम का कहना है कि हेलमेट अनिवार्य करने से हजारों जानें बच सकती हैं। साथ ही स्वास्थ्य बजट भी कम किया जा सकता है।

Hindustan
April 26, P1+2

Sheila shoots down mandatory helmet cover for women

HT Correspondent
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NEW DELHI: The Delhi government has put brakes on the transport department's move to make helmets mandatory for women on two-wheelers.

A day after the department told the Delhi high court it has decided to re-examine the law that makes helmets optional for women, chief minister Sheila Dikshit told HT the government's notification to the contrary had been "overlooked".

The June 1999 notification says wearing any kind of protective headgear while driving a two-wheeler or riding pillion shall be optional for women.

"The notification was issued after discussing the matter in the Delhi assembly and keeping the sentiments of a particular community in mind," Dikshit said.

"If the transport department has given any affidavit in court, they will have to rectify it."

The department's standing counsel on Wednesday told the court that a decision had been taken to amend Rule 115(2) of the Delhi Motor Vehicles Rules, which makes helmets optional for women. The court asked the department to undertake necessary steps within two months.

According to government sources, the transport department took the step without consulting Dikshit or transport minister Arvinder Singh.

Sikh groups have threatened protest if the government tries to change the helmet rule for women. But traffic police and road safety experts say fatalities among women two-wheeler riders would fall significantly if they wore helmets.

ON COLLISION COURSE

Fatalities are high among women two-wheeler riders

2012	11 (up to April 15)
2011	47
2010	48

THE CONTROVERSY

- Mandatory helmets for women an issue since 1990s
- Motor vehicles act made protective headgear a must for two-wheeler riders
- Exception made only for Sikh men wearing turbans

- After protests, Delhi government let women too ride two-wheelers without helmets

H.T, April 27, P.1.

हेलमेट न पहनने से हर साल होती है 50 महिलाओं की मौत

नई दिल्ली, जागरण संवाददाता : दिल्ली के संयुक्त पुलिस आयुक्त (यातायात) सत्येंद्र गर्ग ने हाईकोर्ट और सरकार के निर्णय का स्वागत किया है। दिल्ली में दुपहिया वाहन के पीछे बैठी महिलाओं के लिए हेलमेट पहनने को लेकर हाइकोर्ट ने यातायात पुलिस से भी राय मांगी थी, जिस पर विभाग ने कोर्ट के समक्ष अपनी राय देते हुए कहा कि दिल्ली में महिलाओं की सुरक्षा के लिए हेलमेट पहनना अनिवार्य हो।

गर्ग ने कहा कि यातायात पुलिस पहले से ही महिलाओं को हेलमेट पहनने की सलाह देने का अभियान चला रही है। जिससे वह सफर के दौरान सुरक्षित रहें। लेकिन अभी तक दिल्ली में महिलाओं के लिए हेलमेट पहनना वैकल्पिक था। जिससे महिलाएं हेलमेट नहीं पहनती थीं। अब कोर्ट की ओर से सरकार को दो माह का समय दिया गया है। इस दौरान यातायात पुलिस महिला वाहन चालकों और दुपहिया वाहन पर पीछे बैठने वाली महिलाओं को हेलमेट लगाने के प्रति जागरूक करेगी। जिससे वह अपनी सुरक्षा में कोताही न बरतें। आपको बता दें कि वर्ष 2010 में हेलमेट न पहनने के कारण 705 लोगों की मौत हुई थी, जबकि वर्ष 2011 में 662 और 15 अप्रैल 2012 तक 170 वाहन चालक बिना हेलमेट वाहन चलाने या वाहन के पीछे बैठने के दौरान सड़क दुर्घटना में मारे जा चुके है। सिर्फ महिलाओं का मामला देखें तो प्रतिवर्ष करीब पचास महिलाएं दुपहिया वाहन की सवारी के दौरान हेलमेट न पहनने से सड़क दुर्घटना में अकाल मौत का शिकार हो जाती है।

हेलमेट न पहनने से सड़क दुर्घटना में मारी गई महिलाएं

वर्ष	महिलाओं की मौत	पीछे बैठी महिलाओं की मौत	वाहन चला रही महिला की मौत
2010	48	40	08
2011	47	42	05
2012	11	11	00 (15 अप्रैल तक)

Dainik Jagaran, April 26, P2

SAFFRON PARTY TRAINS ITS SIGHTS ON WOMEN VOTERS

Rajat Arora
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NEW DELHI: With half of the seats reserved for them in the MCD house, women have taken the centrestage in the Delhi civic polls. The BJP, the ruling party in the MCD, has gone full throttle to woo women voters to its fold by promising a host of poll goodies to them in its election manifesto released on Sunday.

Called the "vision document", the manifesto promises to construct women toilets in unauthorised colonies and villages and ₹5,000 to girl students of MCD schools upon completing education till class V.

The manifesto also focuses on the deteriorating safety and security conditions for women in the national Capital. It also underlines the BJP's desperate bid to woo women, as the issue of law and order is not a civic subject.

For its campaign, the party has formed women only ward committees to interact with the women voters through door to door campaigning.

Apart from the manifesto, the advertisements released by the party touches upon issues that concern women such as increasing prices of LPG and grocery. Political pundits see this move as preparation for the assembly elections, slated to take place in a year-and-a-half from now.

"In our campaign, we are focusing more on issues that concern women be it healthcare, education, sanitation or security. We have promised to make the Capital a better place for women," said BJP leader Vani Tripathi.

Fifty per cent of the total wards in the Capital are reserved for women. In the budget announced for 2012 as well, the BJP-ruled MCD had allocated more funds for girl students and constructing public amenities for women.

H.T, April 9, P4

RISE OF THE AGGRIMBOS

MAKING A POINT

Like in the fundamental argument of Slutwalk, the Aggrimbos don't just want their right to look like bimbos, but also want the right to be taken seriously. This is what seperates them from the average pin-up star or starlet of the past. Consider the manner in which Pandey tweets about National Cleavage Day, offers to take her kit off, if India wins a match and another day in a tweet, offers her views on Abdul Kalam as President ("apolitical and intelligent").

Psychologist Namrata Sharma says, "What is riveting is the contradiction between their statements and strategies and that makes the observation worthwhile. The reason why the girls are being followed despite the fact that they got the society's collective goat is that they do represent an impeccable stagecraft that begs to be noticed." She adds, "One of the indicators that these girls are on a mission is their thickskin. They manage to keep a straight face despite the brickbats and hate that comes their way." Consider this: Earlier this year, Pandey created a flutter by welcoming the PM on Twitter and attaching a bikini-clad photo of herself along with it. She says, "I had to welcome him. If people have a notion that I would be lot less concerned with the PM's office and its proceedings then they are clearly wrong."

FEMINISM AND SEXUALITY

- The first wave of feminism between 1880 and World War1 saw a protest to free women from sexual repression.
- The early 1980s was the emergence of second wave and the period saw a debate between pro-sexuality feminists and anti-pornography feminists.
- The third wave of feminism we are experiencing now has women as powerful, in control, and celebrating their sexuality.

Many may hurl abuses, but many also sit up — and listen. Pandey was listed in the top 10 of Google Zeitgeist 2011 list of fastest rising celebs alongside Steve Jobs and Justin Beiber. Digital media company Pinstorm rated her online influence at 70.2, putting her ahead of actor Lara Dutta. Her morphed nude picture with cricketer Sachin Tendulakar's face put on a Hindu God and a Pakistani player bowing in front of her put up by a fan on Twitter, created a mini mayhem in Kolkata when a newspaper published it.

While Pandey says that all her actions are not aimed to make a feminist point, she does have a strong view on it. "If the society commands a girl to be embarrassed about her body it is a regressive notion and I want to take it by its horns."

The girls with their neo twist to feminism are in a way de-bunking the idea of sexy as we know it – important in a country where cops are still seen as viewing rape as 'asking for it'. Women's rights activist Pramada Menon, says, "Rakhi Sawant was an original. She made no bones about her body being made up. It's like announcing this is what you are getting. Not every one will say it. That is a radical modern change."

However, Nonita Kalra, editor, Elle India, is not convinced with the girls' idea of dumbing themselves down. "The blatant sexuality that the girls are promoting seems to based on the formula — let's take our clothes off, let's be stupid. There's no feminism there. Also post Sawant they all seem to be following the same model."

The girls' and their in-your-face sexuality is a far cry from what a generation of Indians believed was sexy when they saw Rekha, on screen. Her craft was sensual but in a carefully suggestive manner. Menon says, "At different stages people use different ways to get noticed." Kalra agrees, "The shock value changes with times, many years later may be the Rakhis and Poonams may seem modest."

THE NEW FEMINISM?

However, as with Slutwalk, which snowballed into a global movement after a Canadian cop suggested that women should dress carefully if they wanted to avoid unwanted attention, there are feminists who advise caution, and warn that while it is a well meaning reaction to currently dominant male viewpoints, it has its drawbacks. Madhu Kishwar, Senior fellow, Centre for the Study of Developing Societies says, "Any woman who uses sexuality as a tool of social or cultural improvement is playing a losing battle. I don't downgrade female sexuality but it's not an item on the road as purported by these women."

Activist Ritu Menon believes that women who talk about their individuality can't be representing a community. She says, "The aggressive bimbo is nowhere near the first, second or third wave of feminism. They are conforming to stereotype that women are sexual objects."

However, feminist Kalyani Menon Sen disagrees on typifying who can be a feminist. Sen says, "Claiming sexuality is a feminist right. If Poonam Pandey is bringing to fore vital aspects about liberation we can't say that a classified bimbo is not allowed to be a feminist. When people think 'sexuality' they may think of a nude bimbo, but sexuality is not about sex."

But is it true that a sexual provocation is necessary, especially in the subcontinent, which is laden with cultural conflicts. Rita Brara, Sociologist, says, "Each culture produces its own version of feminism. The aggressive bimbos are proporting a radical form of feminism that sets an agenda."

H.T, April 29, P15

आज की माताएं भी भूल रही हैं लोरियां

■ दीनानाथ साहनी, पटना

राज्य सरकार की यह अनूठी पहल है। अब माताएं नहीं, बल्कि बच्चे लोरी गाएंगे। एक सर्वेक्षण के मुताबिक हमारी संस्कृति से चंदा मामा दूर के, पुए पकाए गुड़ के..., छोटी-छोटी गैया, छोटे-छोटे ग्वाल... और लाडली ओ मेरी लाडली, सोने चली मेरी लाडली... जैसी स्नेह से भरी लोरियां गायब होती जा रही हैं। बिहार शिक्षा परियोजना परिषद ने इस संस्कृति की रक्षा के लिए 'मां की लोरियां' नाम की पुस्तक को सभी प्रारंभिक स्कूलों में पढ़ने वाले बच्चों तक पहुंचाने का बीड़ा उठाया है ताकि बच्चे 'लोरियों' को गुनगुना सकें और इसकी संस्कृति से परिचित हो सकें।

'सर्वे आफ मदर्स लोरी' विषय के तहत देश भर से जुटाए गए आंकड़े बता रहे हैं कि बिहार, दिल्ली और महाराष्ट्र की सिर्फ दो फीसदी माताओं को ही किसी लोरी की पंक्तियां याद हैं। उत्तर भारत में राजस्थान की माताओं की स्थिति इस मामले में काफी बेहतर है। अध्ययन के मुताबिक पौराणिकता एवं भारतीयता से ओत-प्रोत घटनाओं, सच्चाइयों, कहानियों व किंवदंतियों को अपने में बुनने वाली इन लोरियों को सुने बिना कभी बच्चे सोते नहीं थे, फिर वे चाहे शहरी हों या ग्रामीण। आधुनिकता की दौड़ में नौनिहालों को सीख देनी वाली यह अनोखी और बेमिसाल परंपरा खत्म होने को है।

- **बिहार, दिल्ली, महाराष्ट्र की सिर्फ दो फीसदी माताओं को याद हैं किसी लोरी की पंक्तियां**
- **बिहार के सरकारी स्कूलों में बच्चे पढ़ेंगे 'मां की लोरियां'**

राष्ट्रीय स्तर पर विभिन्न स्वयंसेवी संस्थाओं द्वारा मिलकर कराए गए एक अध्ययन के अनुसार प्रत्येक राज्य में विगत वर्ष दस हजार माताओं से बातचीत की गई। पता चला कि ग्रामीण अंचलों में लोरी सुनाने की परंपरा शहरों की अपेक्षा अधिक है। अध्ययन में कहा गया कि शहरों में माताएं बच्चों की चिल्ल-पों और शरारत से छुटकारा पाने के लिए उन्हें टीवी के सामने बैठा देती हैं या फिर कामिक्स बुक थमा देती हैं। इसके दुष्परिणाम सामने आ रहे हैं। बदलते वक्त की हकीकत काफी कड़वी है। जिनका सामना करने वाले बच्चे लोरियों से नहीं बहलते।

भारतीय समाज में लोरी का पारिवारिक, शैक्षणिक एवं सांस्कृतिक महत्व है। घर में रोते बच्चों को शांत करने के लिए माताओं से लेकर दादी-नानी लोरी गाकर सुनाती थीं। बच्चों को सुलाने के लिए भी लोरियां गाती थीं। मगर आज आधुनिक संस्कृति के चलते परिवार में लोरियों की लहरी सुनाई नहीं पड़ती। उसकी जगह टीवी ने ले लिया। बिहार शिक्षा परियोजना से प्रोत्साहन पाकर रीता देवी नामक महिला ने लोरियों की संस्कृति को पुनर्जीवित करने का प्रयास किया है।

चौंकाने वाले तथ्य

दस हजार माताओं में महज 164 ही लोरी सुना पाती हैं। इनमें महाराष्ट्र में 194, बिहार में 200, छत्तीसगढ़ में 222,उत्तर प्रदेश में 562, झारखंड में 671, हरियाणा में 533, पंजाब में 522, मध्यप्रदेश में 532, ओडिशा में 447, असम में 532, त्रिपुरा में 472, मणिपुर में 342, उत्तरांचल में 522, पश्चिम बंगाल में 455 और राजस्थान में सर्वाधिक 782 माताएं शामिल हैं।

Dainik Jagaran, April 8, P6

Macho brands woo pink brigade

The beginning of the year saw men's deodorant brand from Unilever, Axe, globally launch a fragrance - Anarchy - for women, surprising many. There is also a men's version. This is not an isolated initiative as many more conventionally male-targeted brands - Harley Davidson, Tag Heuer, Arrow, Revital, to name some - are targeting women consumers now."No longer are women sitting at home. They are out there buying cars, travel packages, smartphones, sensual and formal apparel, hard drinks and luxury products. They are earning and count financially," said Yamini Mandal, 35, an HR executive.

Still, you would hardly expect the macho Harley Davidson to target women, but that's exactly what it's planning in India. "Harley is still small in India, but women motorbike riders are growing. We will tweak Harley's communication and product strategy to lure women riders. Globally, women are a very important part of our ridership," said Anoop Prakash, managing director, Harley-Davidson India.

Tag Heuer, a unit of French luxury group LVMH, with its premium, sporty men's watches, plans to escalate sales of women's watches to 35% this year in India, up from the current 25%. "In a lifetime, if you can sell three luxury watches to a man, you can sell between five and 10 to a lady," said Frank Dardenne, general manager, LVMH Watch and Jewellery (India).

Most acclaimed wine makers are also out on a lady hunt. "Many wine brands are indulging women's preference for mild flavours, grape varietals, style and effervescence. These include Cavit - moscato and pinot noir - and Santa Margherita's Pinot Grigio. Francis Ford Copolla has a wine called Sofia - a Blanc de Blancs blend in stylish pink 187 ml cans - named after his daughter," said Aishwarya Nair, director, food and beverage, The Leela Palaces Hotels and Resorts.

J Suresh, managing director, Arvind Brands and Retail, said: "Lines demarcating the male and female consumer divide based on income, attitudes and expenditure are blurring, particularly in big cities. Women now have higher disposable incomes and are willing to spend more. This has motivated menswear brands to extend to women, like we did with Arrow Women and USPA Women."

Purnendu Kumar, senior vice president, Technopak, a retail consultancy, observed: "Consider this a bend, not shift, as most of the brands deny any plans to become complete female brands. The rejig is more popular in apparel."

Levi's launched its Curve ID denim range only for women. "We studied over 60,000 women. Each store carrying the line has trained experts to measure women, identify their ID and help them find the best fitting jeans by body type and style preference," said You Nguyen, senior vice president, women's merchandising and design, Levi's.

Colour, for women, is a huge attraction. Gadget makers such as Sony (Viao) and HP offer choices in orange, red, blue and yellow. "These colourful devices offer their owners a strong emotional appeal. Pink is very popular with women and since they are a large part of our users, we launched a special limited edition, the Pink N8 smartphone, preloaded with special Pink apps," said Viral Oza, director marketing, Nokia India.

"Colours in laptops are sizzling, bringing us more customers," said Ranjivit Singh, chief marketing officer, personal systems group, HP India. The company plans to refresh 50% of its colour range.

Products especially created for women will emerge across more product categories. A specifically-for-women tablet PC, launched recently by Milagrow, an India-based technology solutions company, is an example. The TabTop PC weighs only 275 gm and can fit into a woman's handbag.

H.T. April 9, P 23

'Protect women rights defenders'

Special Correspondent

JAIPUR: The National Commission for Women intends to work closely with the "women human rights defenders" in their battle against violence and discrimination against the fair sex and will launch a study at the national level for evolving a mechanism for their protection from threats and intimidation as well as against the widespread practice of implicating them in fabricated cases.

The NCW Chairperson, Mamta Sharma, announced this while addressing a multi-State consultation on the issues of women human rights defenders (WHRDs), organised by Shivi Development Society-Indraprastha Public Affairs Centre (IPAC), at the Institute of Development Studies here over the week-end.

The consultation was held for consolidating the views, opinions and ideas submitted by WHRDs from different regions of Rajasthan and to develop a State-level policy framework for their protection. Delegates from Rajasthan, Gujarat and Uttar Pradesh attended the day-long consultation. Ms. Sharma said the WHRDs could play a crucial role in eradicating gender discrimination which would ensure extension of benefits of all Government schemes to women.

'Resist foeticide'

She called upon women's non-government organisations to work for economic empowerment of the fair sex, which she said would ensure their security and protection against all kinds of risks.

The NCW chief called upon the participants to resist female foeticide and said that youths in the country would not be able to find brides for them in the next 10 to 15 years due to the dwindling number of girls in society.

"The Commission has noticed that 25 per cent of women complainants are harassed by the police in the rape cases. The behaviour of law enforcement agencies with women victims is generally not good," said Ms. Sharma. She also called for changing the mindset in favour of women's education in certain communities, including Dalits and Muslims.

The consultation was organised against the backdrop of U.N. Special Rapporteur on Human Rights Defenders in India Margaret Sekaggya stating in her recent report that WHRDs are at particular risk of various kinds of violence including prosecution. The event followed a series of regional meetings in Bikaner, Jodhpur, Kota and Udaipur where the working environment, challenges, problems and strategies for WHRDs were discussed.

Shivi Development Society-IPAC chief functionary Narendra Kumar said the WHRDs had done a phenomenal work despite numerous challenges for promotion and protection of women's rights in Rajasthan, leading to a better life based on dignity, justice and quality.

Rajasthan State Women's Commission Chairperson Laad Kumari Jain said there were three kinds of violence against women reported in the State -- gender-based discrimination, domestic violence and pre-birth violence in the shape of female foeticide. "It is most unfortunate that even the right to be born is being snatched from girls," she remarked.

Ms. Jain registered her protest against the practice of police forcing compromise in the cases of demand for dowry and domestic violence. She regretted that though women are in the forefront of savings, their economic condition is bad.

Manjula Pradeep of Gujarat-based Nav Srajan Trust said women's security, economic empowerment, right to property and participation in governance were the important aspects of work of WHRDs. Namrata Daniel of All-India Dalit Mahila Adhikar Manch, New Delhi, and Jaipur-based psychologist Asha Dutta also addressed the consultation

Hindu, April 1, P7

This year, women set to break the IIT gender wall

BUCKING THE TREND 30% more women applicants for today's IIT joint entrance

Vanita Srivastava
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NEW DELHI: The number of women applicants for Sunday's IIT-JEE has seen a phenomenal rise of 30% than last year. Of the 5.07 lakh candidates, 1.69 lakh are women.

With women so far accounting for only 10-12% of the IIT population, this year's exam trend could be a small but positive step in improving the gender ratio in the premier institute.

Just three months ago, Prime Minister Manmohan Singh had called for more women in the field of science, saying they were under-represented.

"The number of women students across the IITs is just around 10-12%. Logically it should be 50-50. But on more practical terms, 30% is attainable," said Dr Sanjay Dhande, director, IIT Kanpur.

Dr Dhande said consistently girls outperform boys in the boards and their numbers in the other engineering colleges too was high. It's only in the IITs that their count is low.

ONE OF THE REASONS FOR THE SURGE IN WOMEN APPLICANTS COULD BE THE DROP IN APPLICATION FEE

One of the reasons for the surge in women applicants this year could be the sharp drop in application fee — ₹200 offline and free of cost if registered online.

Till last year, both men and women from the general category had to pay ₹1,800 for offline and ₹1,600 for online registration.

IIT Guwahati director Gautam Baruah hoped the high number of women applicants translates into admissions this year. "Even if there is a 15% rise in women students, it will be a positive sign," said Baruah.

Hindustan times, April 8, P.1

MOTHER & CHILD

Separating one from the other

THIS bifurcation of a department is illogical and the decision is bereft of the compulsions of public administration. The West Bengal government has split the department of women and child development for no other reason than the fact that the minister and secretary had failed to pull together. The split, therefore, is embedded in inter-personal problems, a reflection on administrative coordination. The bifurcation is disingenuous in the extreme; surely there were other ways to get around the problem of a minister-bureaucrat tussle. In the net, as reported in this newspaper, both the newly-created departments ~ one for women and the other for children ~ have become virtually non-functional since the split was effected two months ago. Across the country, most importantly at the Centre, the ministry/department of women and child development is a composite entity. So too is the data on the mother and child ~ a critical index of societal development the world over. The split will almost inevitably impede coordination between the Centre and the state, essential for the dissemination of data on such critical issues as the dwindling girl child, pre-natal tests, and female foeticide. It isn't as if Bengal is wholly free of such familial aberrations though preferences and prejudices in this state may not be as pronounced as in certain other parts of the country. The issues pertaining to the woman and the child are inter-linked, if not the coordination between the minister and the department's secretary. Post-bifurcation, both departments appear to have been reduced to irrelevance; their work hasn't figured at cabinet meetings over the past two months. Policy decisions have been kept in suspended animation, movement of files held up, and recruitment of anganwadis stalled. In the event, the split will neither facilitate the development of the woman nor the child, which is perhaps the worst of both worlds. Given the administrative myopia, Bengal will scarcely be in a position to furnish its findings on the development of women and children to the Centre; the national data, which is advanced to the UN and other international agencies, is based substantially on the input from the states. The issue goes beyond federalism. Public administration can't afford to be so ridiculous.

Statesman, April 24, P8

Centre rejects women bodies' demand for combatting law

ANNAPURNA JHA ■ NEW DELHI

Notwithstanding a number of women being killed after being branded as witches, the Centre has rejected the women organisations' demand for specific legislation to deal with the social menace.

Minister of State for Women and Child Development Krishna Tirath has trivialised the murder of 178 women in the name of witchcraft in 2010 and 175 in the previous year as not being a large number. She has even claimed that the problem is localised despite such incidents being reported from as many as 11 States and left it to the States to formulate legislations to deal with them inviting strong protests from women groups.

All India Democratic Women's Association, which has been long demanding that the Government should bring a law to protect single, elderly women who are generally killed after being branded as witches with the basic aim to grab their property, has strongly reacted to the Minister's response terming it as "highly irresponsible".

AIDWA General Secretary Sudha Sundararaman said that it was totally unacceptable as it shows how the Government has failed to protect backward and marginalised sections of the society who are victimised by the rich and powerful in the name of pursuing witchcraft.

KILLING 'WITCHES'

MINISTER OF STATE FOR WOMEN AND CHILD DEVELOPMENT HAS TRIVIALISED THE MURDER OF 178 WOMEN IN THE NAME OF WITCHCRAFT IN 2010 AND 175 IN THE PREVIOUS YEAR AS NOT BEING A LARGE NUMBER. SHE EVEN CLAIMED THAT THE PROBLEM IS LOCALISED, DESPITE SUCH INCIDENTS BEING REPORTED FROM 11 STATES

Shockingly, Haryana despite being industrially developed and economically prosperous is having the dubious distinction of having the maximum number of such murders with 57 women falling victim to this heinous crime in 2010, according to National Crime Records Bureau. Such incidents are progressively increasing in the state from 25 in 2008 to 30 in 2009 and nearly doubled in 2010.

Despite low sex ratio forcing many men to buy brides from other States and sharing wife, the State appears to not have learnt any lesion and is now killing women by branding them witches.

"The situation shows that Haryana, which has performed better in growth indicators, has failed to change anti-women mindset of the society. The State, where honour killings by khap panchayats and other kinds of crime against women is prevalent, is now targeting and killing women by branding them witches also," Sundararaman said

Backward Odisha is not far behind with 31 women falling victim to such murder followed by Andhra Pradesh which reported 26 incidents, Madhya Pradesh (18), Jharkhand (15), Maharashtra (11) and Chhatisgarh (8). The social menace is prevalent in backward states like Bihar and Rajasthan and Meghalaya which has tribal society.

Interestingly, Jharkhand and Chhatisgarh, where campaigns were being followed by women organisations for legislations framed to deal with this menace, have shown marked improvement. Jharkhand had reported 52 such incidents in 2008 which was reduced to 37 in 2009 and 15 in 2010, while in Chhatisgarh, the figure for three years are 15, six and eight respectively, indicating a declining trend.

Pioneer, April 30, 15

Women corporators in fight for Right to Pee

Vishwas Waghmode ● MUMBAI

Seats are reserved for women in trains and buses and they also enjoy 50% reservation in the civic body. However, when it comes to public urinals, women have to first hunt for one and then pay for using it unlike men who don't have to shell out a *paisa*.

DNA in its front-page story on November 11, 2011, reported how women were wrongly charged for using public toilets. Subsequently, through its awareness campaign about urinary tract infection among women, *DNA* highlighted the issue of lack of public toilets for the fairer sex.

At least 35 NGOs who have started a signature campaign called 'Right to Pee' have now sought help from women corporators — who enjoy a majority in the civic body — to ensure clean toilets for women in the city. The NGOs want the toilets to provide facilities to change and dispose of sanitary pads.

"Though the civic body rules state that no one should

be charged for using public toilets, women are asked to pay," said Rahul Gaikwad of the Committee of Resources Organisation. "BMC officials assured us last year that the rule will soon be implemented effectively. However, nothing has happened so far."

"We have decided to take up the issue with women corporators. They must have faced similar problems and can raise the issue in the house," Gaikwad said.

The NGOs surveyed 129 public toilets in the city and found that many do not have boards stating that women can use them for free. Besides, the toilets were dirty.

"Fifty per cent seats are reserved for women in local bodies, there is 33% reservation for them in buses and there are ladies special trains. But it is very sad that the basic issue has been neglected. Women have had to suffer a lot because of it," said Minu Gandhi from NGO Apanalaya.

"Women must not be made to pay at public toilets. We will take up the issue with civic authorities," said Shiv Sena corporator Dr Shubha Raul.

D.N.A., April 23/11

Who picks up the tab?

In a landmark judgement last week, the Supreme Court set aside all the arguments that questioned the applicability of the Right of Children to Free and Compulsory Education Act, 2009 to private schools, especially those receiving no financial support from the government in any form.

Upholding the constitutional validity of the law which came into force in April 2010, the apex court made it clear that it was applicable to all the schools, except unaided minority schools.

It observed that the law envisaged a "reciprocal agreement" between the State and the parents, and it placed an "affirmative burden" on all stakeholders in the civil society. So, an obligation on the unaided non-minority schools to admit 25 per cent children from the disadvantaged groups and weaker sections in Class-I was not an "unreasonable restriction".

The government has hailed the apex court's decision, saying it brought clarity to the provisions of the Act. But, parents and private school managements across the country remain apprehensive as to how exactly the court's verdict was going to affect them.

One of the prime concerns of many private school owners is whether the government will adequately compensate them for admitting children from marginalised sections and providing eight years of free elementary education to them. The parents, on the other hand, are worried if the school managements would shift the financial burden on them by increasing the fees for the paying students.

The RTE Act stipulates that schools providing free and compulsory elementary education shall be reimbursed the expenditure to the extent of per-child-expenditure incurred by the state concerned, or the actuals charged for a student, whichever is less.

This in effect means the amount of reimbursement made by the government will not be adequate for those private schools charging fees higher than that of the government schools.

There are many schools in urban areas, especially in big towns and metro cities across the country, which have per-child education budget much higher than those in the government schools. There is every possibility that schools, especially those operating in low surplus, will consider shifting the burden of providing free education to children from marginalised sections on to parents of other children by increasing the fee.

"As 25 per cent children from disadvantaged and economically weaker sections are accepted, the school budgets will be affected as there will be fewer full fee-paying students whereas the costs will remain the same. The schools will have an option of settling for lower profits, if any, or passing on some of the losses to full fee-paying parents by way of a fee hike. Most schools will end up doing a mix of both," Sujit Bhattacharyya, Director of Indus World Schools, told *Deccan Herald*.

For schools, which operate at a "very low or negligible" surplus, there will be no option but to pass on the cost to other parents. Schools which are doing very well and making a reasonably healthy surplus may be able to absorb some or all of the costs, he added.

However, Human Resource Development Minister Kapil Sibal is not convinced with the contention that school fee should be increased to meet the situation, suggesting that there could be other "ways and means" to raise resources.

"You have many corporations who are committed to corporate social responsibilities with 2 per cent of their entire turnover (to spend on this head). Schools can actually tap those resources, so that there is no burden on parents," he suggested.

There is also a proposal of the HRD Ministry to subsidise uniforms and text books in the 12th Five Year Plan. "We are trying to do it, even for the disadvantaged children in private schools. We want the government to subsidise their uniforms and the text books," the HRD Minister said.

Sibal says that government's contribution towards reimbursement of expenditure incurred by schools on students from marginalised sections will vary from Rs 6,000 to Rs 19,000 annually (Rs 500 to Rs 1,583.33 per month).

But, this does not give a clear picture. The reimbursement has to be made by the state governments to the schools functioning in their respective jurisdiction and the amount to be released will depend on the per-child-expenditure on education incurred by the state concerned. The centre will bear 65 per cent of the expenditure while remaining 35 per cent will come from the state's coffers.

Per-child expenditure

According to a formula worked out by the HRD Ministry, the total annual recurring expenditure incurred by the appropriate government, from its own funds, and funds provided by the central government and by any other authority.

Deccan herald April 7

on elementary education in respect of schools established, owned or controlled by the said government or local authority, divided by the total number of children enrolled in all such schools, shall be the per-child-expenditure incurred by the government.

Hence, the amount of reimbursement against the expenditure incurred on students from disadvantaged and weaker sections would differ from state to state. The Delhi government spends Rs 14,300 per child per annum, but this may not be the same in case of, say, Karnataka.

A comparison of the annual expenditure on reimbursement and the eight per cent annual increase in expenditure stipulated by the Finance Ministry for release of subsequent installments under the 13th Finance Commission grant indicates "adequate availability of funds" for states to absorb the cost of reimbursement towards providing free education to children from marginalised sections.

The HRD Ministry officials too express confidence that there will be no shortage of funds towards reimbursement against 25 per cent quota in schools "at least in the initial three years". Nevertheless, they accept that much more funds will be required for effective implementation of the Act in the future.

An enhanced outlay of Rs 2,31,233 crore has been sanctioned by the Centre for RTE-Sarva Shiksha Abhiyan combined for the period 2010-11 to 2014-15 which takes care of additional funding requirement for implementation of RTE Act which includes additional teachers.

Things to do in 2012-13

- Fill up teacher vacancies and meet the pupil-teacher ratio of 30:1
- Complete mapping neighbourhood schools and identify children to be admitted for elementary education
- Prepare a data base of unaided schools, assess the number of children from disadvantaged and weaker sections to be admitted in such schools and the cost involved.
- Operationalise an effective mechanism for timely reimbursement of cost to schools.
- Initiate steps for curricular reforms, prepare age-appropriate syllabi and textbooks.

a separate head will now be created under this head only when the states' annual work plan comes for approval.

Apart from this, the RTE Act has given a wide description of disadvantaged groups and weaker sections which has to be clearly specified by the state governments concerned.

The Act says that disadvantaged group means a child belonging to Scheduled Caste, Scheduled Tribe, socially and educationally backward class or such other group having disadvantage owing to social, cultural, economic, geographical, linguistic, gender or such other factor, as may be specified by the appropriate government, by notification. Weaker section means a child belonging to such parent or guardian whose annual income is lower than the minimum limit specified by the appropriate government, by notification.

But, the law does not specify the order of preference to be followed by the schools while admitting children from disadvantaged groups and weaker sections. It has left it to the governments concerned to decide and specify in the RTE rules.

Funds shortage

But, the fact is that the right to free and compulsory education programme has been plagued by shortage of funds. The budgetary provision made in the last two years is only half of what was proposed by the HRD Ministry. While the ministry received Rs 21,000 crore in 2011-12 instead of Rs 43,903 crore, the allocations were only marginally increased to Rs 25,000 crore for 2012-13.

Moreover, the budgetary provisions made so far do not include any expenditure head towards reimbursement of money to private schools against implementation of 25 per cent quota. Ministry officials say,

The Supreme Court's thumbs up for the Right of Children to Free and Compulsory Education Act, 2009, better known as RTE, may have helped the Central Government up the ante for implementing the law from the coming academic year. The state governments are willing in spirit, but the flesh is weak. Will they succeed in making private school managements open their gates to underprivileged children? What are the issues at stake?

Bye bye for now in Karnataka

Muthi-ur-Rahman Siddiqui

Confused and messy. These two words best describe the state of affairs in the Karnataka Government on implementing the Right of Children to Free and Compulsory Education Act, 2009.

To begin with, Karnataka is more or less a loner in failing to notify rules to set the landmark legislation in motion. The State Cabinet approved the RTE draft rules on April 12, almost nine months after the legislation was supposed to have come into force here. Minister for Primary and Secondary Education Vishweshwar Hegde Kageri had gone to town that the law would be effective from July 5, 2011.

But little progress has been seen ever since though the draft rules underwent several revisions as objections and suggestions from the people and private schools were being incorporated. The Cabinet nod notwithstanding, the rules are still miles away from appearing in the government notification.

Kageri refuses to set a timeframe for notifying the rules, while G Kumar Naik, Secretary, Primary Education, insists the rules will be in place in about 10 days. Some more delay and the Act's implementation will get tougher. The government will be faced with an "extremely difficult" task of making top rung unaided schools, which have flouted the timetable and completed admissions for the coming year, fall in line. Naik's warning of derecognition of non-compliant schools may well remain just that.

Naik, however, argues that 25 per cent quota for poor students is only one aspect of the RTE Act, which covers a whole gamit of issues concerning quality education like pupil-teacher ratio, quality and qualification of teachers etc, which also need to be streamlined.

Sharing of expenditure incurred on implementing RTE is another bone of contention. Kageri has been lamenting the "shortage" of central funds. Sarva Shiksha Abhiyan (SSA), that has been tasked with implementing the RTE, says at least Rs 2,400 crore are needed. Though the Centre has fixed 65:35 ratio, the State Government insists the Centre must contribute 75 per cent. No agreement has been reached yet.

As things stand, full-fledged implementation of RTE may well get deferred to academic season 2013-14 in Karnataka.

Telephones outnumber toilets: Census report

Patna

Nearly 56 percent of families in Bihar have a mobile or landline connection, but about 77 percent of the population lack toilets, says a census report, highlighting the paradoxes in the state which has taken big leaps in development but also lagged behind in key areas.

"Till 2001, only 2.2 percent families were using any kind of telecom facility in Bihar, now over half of its population owns a phone, as around 98 lakh (9.8 million) mobile phones are in use," said the census report.

In contrast, only 23 percent of its population have access to toilets and 77 percent is forced to go for open defection.

"Bihar is full of paradoxes. Millions are living in the lantern age and have no access to toilets, but millions are using banking services and chatting over phones," Bhaskar Mishra, deputy registrar general of India, told IANS.

"It is amazing to note that nearly 56 percent of the total 1.89 crore (18.9 million families) in Bihar have mobile or landline telephone connections but a majority of them lack toilets," he said.

The latest report on houses, household amenities and assets in Bihar, released by the Census of India 2011, says the state is developing at a high rate, but millions are still without electricity, safe water and are defecating in the open.

Bihar has recorded a remarkable average growth rate of 11.3 percent over the last six fiscal years and improved school education, primary health and increased immunization and reduced infant mortality rate in the last few years. These are some indicators of change and development in the state.

Last year, the central government records showed that Bihar was the worst performer in the national Total Sanitation Programme campaign. It said one out of every six people without access to sanitation in India lived in Bihar.

The Bihar government launched a special scheme named after veteran socialist leader Rammanohar Lohia in 2007 to speed up construction of toilets, but its implementation has been lagging, to say the least.

Free Press, April 21, P3

Delete the errors to save the census

Have the census enumerators recently knocked on your door with swanky tablet computers in hand? If they have, it's because they have begun to go door-to-door in most States to complete the final phase of the Socio Economic and Caste Census (SECC). This mammoth exercise is being coordinated by more than 7,00,000 enumerators, data-entry operators, supervisors, trainers and government officials.

For the first time since 1931, this decennial exercise will also ask families for their traditional "caste" name. Also as a means-testing exercise, the SECC will single-handedly determine which of India's 250 million families will be eligible for a slew of anti-poverty subsidies — from old age pensions and health insurance to subsidies for housing and electricity. Most significantly, it may be the basis to decide which families receive low-cost foodgrains.

While there has been much debate on the criteria for evaluation used in this exercise, the on-the-ground methodology too needs scrutiny.

Last week, with a billowing dust storm to accompany us in the parched desert landscape of western India, a team of university students and I were witness to this historic exercise in a few villages.

The negatives

Basic information on each household from the National Population Register (NPR) is already pre-loaded on the tablet. Each family is first asked to verify this and then answer a number of additional questions. As we walked door-to-door with the enumerators, we found that each household interview usually does not last for more than 20 minutes. Some are wrapped up in 10.

Though the tablets designed by Bharat Electronics Ltd are sturdy and of a relatively low cost, the main problem with using them is that there is no paper trail for families to verify data. And often there is a slip.

For example, in one case we noticed that the operator had wrongly entered data that the household had two instead of one *kachha* room. This minor error could bar them from being declared as a poor family.

The operators are also inadequately trained. While the enumerators are usually government employees from secondary or high schools, the operators have been sourced from private companies sub-contracted on short-term contracts. In some States this has resulted in manpower shortages and delays.

The most important area of concern is the definition of a household. The Ministry of Rural Development has clarified that "if any female member of a household [for example, widowed, separated, second wives, single women, etc] decides to declare herself as a separate household, she should be recorded as a separate household."

All the enumerators and respondents we met were completely unaware of this provision. As a result a deserving, aged, visually handicapped, impoverished widow who lives with her sons **(see box)** could be pegged as being "above the poverty line" and lose her eligibility to earn old-age pension. Many enumerators also did not know the simple tech-fix of how to split data on households on their tablets.

Land is another question where anomalies could potentially exclude millions of deserving families. The trouble is that most enumerators do not even enquire whether the land owned by a household is irrigated and the number of crops sown each year — both key exclusion criteria.

On a positive note, since the census and poverty identification surveys have been combined for the first time, there is a greater chance of enumerators visiting many more households, unlike in the previous BPL survey exercises.

But this time around, too many villagers are not even aware of this exercise or its significance. Often they are not even at home when the enumerators arrive. So far, the data has also not been published at the *gram sabha* level for villagers to verify or apply for corrections.

In Peru

In fact, a similar exercise in Peru's Juntos programme is reported to have sown the seeds of discord as even small differences in assets can make a world of a difference to a household's official poverty status. Validation of eligible households through local assemblies too has proved to be divisive, pitching neighbours against each other.

While this unique Indian census is being conducted more systematically and professionally than previous BPL surveys, a number of important hurdles still do crop up on the ground. So before it is rolled out in more States in the summer, this would be the perfect time to refine it, clarify its implications and iron out loose-ends.

Hindu, April 12, P11

60% of population in most states below poverty line

Rajeev Deshpande | TNN

New Delhi: With almost all states showing more than 60% of populations below the monthly expenditure averages, the oft-repeated claim that 70% of India lives on less than $2 a day has a ring of truth in it. As yet there is nothing official about using monthly average expenditure as the poverty line and the government has said its calculations are based on the Tendulkar Committee formula.

The Tendulkar Committee had concluded that based on 2004 statistics, the number of poor was a high 37.2%, instead of the estimated 27.5% and based its findings by factoring in education, health and other amenities. The proposed committee is expected to account for such variables.

After facing criticism in March, when it reduced the urban and rural poverty lines to Rs 28.65 and Rs 22.42 from Rs 32 and Rs 26, the Planning Commission said it will set up a technical committee to go into how to measure poverty. It has also said the Tendulkar methodology will not be linked to benefits for underprivileged sections. Projections based on NSSO data present a disturbing picture as population cut offs for average consumption for almost all states fall between the sixth and seventh deciles, statistics for which are available in its report "Key indicators of household expenditure in India." Further fine tuned, they deliver a precise percentage of population below the average spends.

The large section of population below the expenditure curve also points to a worrying inequity in incomes, something that should concern planners as the government looks to target benefits for those who need them through initiatives like food security and employment guarantees.

India's schemes might be off target, or suffering from poor reach while benefits of economic growth are not meeting UPA-II's policy objectives of "inclusive growth" as it is evident from the data that there is a concentration of buying power in the top 30%-35% of the population.

The 60-plus% of population below the average monthly spending is clearly not progressing as fast as the segment whose income and expenditure is disproportionately influencing the statistical mean. This might point to the need to examine the nature of employment and be a wake-up call for efforts to improve skills.

Among the states, there is not much to choose between those often stigmatized as "backward" like UP and Bihar, Gujarat and Maharashtra. Even in the better off states, the percentage of rural populations below the average monthly expenditure line is above 60%. In urban areas, it is a shade under 60% for Gujarat, but almost 70% for Maharashtra.

POVERTY LINE & POPULATION BELOW IT

State-wise averages for consumption (Rs) and population under expenditure curve

State	Rural		Urban		State	Rural		Urban	
	Avg monthly spend	% below this	Avg monthly spend	% below this		Avg monthly spend	% below this	Avg monthly spend	% below this
Andhra	1,234	63.9	2,238	67.8	M'rashtra	1,153	61.0	2,437	69.1
Arunachal	1,546	64.0	1,947	61.9	Manipur	1,027	60.1	1,106	68.7
Assam	1,003	59.4	1,755	60.2	Meghalaya	1,110	61.0	1,629	59.8
Bihar	780	60.6	1,238	66.2	Mizoram	1,262	59.5	1,947	58.0
C'garh	784	62.1	1,674	66.0	Nagaland	1,476	60.8	1,862	60.8
Delhi	2,068	62.1	2,654	63.2	Orissa	818	62.4	1,548	67.0
Goa	2,065	61.2	2,644	62.5	Punjab	1,649	65.9	2,109	65.5
Gujarat	1,110	60.6	1,909	60.0	Rajasthan	1,179	67.0	1,663	65.3
Haryana	1,510	60.6	2,321	69.2	Sikkim	1,321	68.7	2,150	53.5
Himachal	1,536	64.5	2,654	64.9	TN	1,160	63.3	1,948	64.9
J&K	1,344	61.0	1,759	66.6	Tripura	1,176	63.8	1,871	64.4
J'khand	825	64.6	1,584	67.9	UP	899	62.8	1,574	70.0
K'taka	1,020	62.8	2,053	64.6	U'khand	1,747	83.6	1,745	62.6
Kerala	1,835	67.3	2,413	69.0	W Bengal	952	60.6	1,965	68.4
MP	903	64.0	1,666	66.8	All India	1,054	64.47	1,984	66.7

Average daily consumption expenditure per capita per day for rural areas is Rs 35.10 & for urban areas is Rs 66.10

Times of India, April 29, P.15

Rajeev Deshpande | TNN

New Delhi: Here are a new set of official statistics that can escalate the politically contentious debate on what constitutes the poverty line.

If the average monthly consumption expenditure is taken as the benchmark of what an individual needs to survive, the poverty line would be Rs 66.10 for urban areas and Rs 35.10 for rural regions, while about 65% of the population will be below this cut-off.

The figures, based on the 66th round of the national sample survey for 2009-10, provides a more realistic marker for estimating both the poverty line and the population below it than the Planning Commission's calculation of Rs 28.65 per capita per day for cities and Rs 22.42 for rural areas.

The rural and urban all-India averages for monthly expenditure are Rs 1,054 and Rs 1,984 per person daily, respectively, and if these are projected on the expenditure-population curve, the population below this works out to 64.47% (rural) and 66.70% (urban). Sources said the exercise was carried out as part of a study and is based on NSSO data largely available in the public domain. While the government is revising its parameters, the monthly averages might be a useful means of estimating where to draw the poverty line.

States slow on poverty census, deadline expires

Prasad Nichenametla
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FORGOTTEN TASK

- This is the first census to identify the poor and caste affiliations of the people in the country
- It will be an important input in the proposed right-to-food legislation
- The target of completing the job was 2011-end
- But in the absence of survey numbers, the Planning Commission's poverty estimates are based on expenditure.

NEW DELHI: Uttar Pradesh, which supposedly has a high proportion of the country's poor, has not begun the job of enumerating them even three-and-a-half months after the first deadline set by the Centre lapsed.

The project started in June 2011, with the target of completing the job by the end of 2011. The Centre then extended the deadline to April.

Bihar has covered just 0.1% of the population. While there is no word from Tamil Nadu, Kerala is said to have just begun.

In states where enumeration began months ago, the survey apparently is stuck. Odisha has covered 12% of the population, West Bengal a little better at 18%.

While in Maharashtra the coverage has been 42%, in others it is between 50 and 100%.

This is the first census to identify the poor and caste affiliations of the people in the country, which will be an important input in the proposed right-to-food legislation.

"With the last such survey carried out in 2002, a fresh list was due in 2007. But with some states not beginning till now and others stuck, I do not think we will have the enumeration results before December 2013. States may be fearing that the survey will show a reduced number of the poor (affecting their demand for grants, etc)," NC Saxena, former IAS and National Advisory Council member, told HT.

Union minister for rural development Jairam Ramesh has been writing to the states, asking them to expedite the process, but to no avail.

"Only about 18% of the population is covered. At this rate we expect the process in West Bengal to be completed only by the end of July," Ramesh said in his letter to chief minister Mamata Banerjee last week.

A senior official of the Bihar government told HT on the phone: "Unlike other states Bihar is entirely dependent on central support for foodgrains, etc. So it is very important for us to be cautious as to how to go about the survey. Anyway, we are trying to get the survey running by month end."

The government is spending ₹3,500 crore on this.

In the absence of survey numbers, the Planning Commission's poverty estimates are based on expenditure.

H T, April 24, P13

शिक्षा सुधारों के लिए राज्यों ने केंद्र से मांगा आर्थिक सहयोग

नई दिल्ली (ब्यूरो)। विज्ञान भवन में आयोजित एक बैठक में राज्यों के उच्च एवं तकनीकी शिक्षा सचिवों ने मानव संसाधन मंत्रालय द्वारा शुरु की जा रही योजनाओं से सहमति जताते हुए उन्हें प्रभावी ढंग से लागू करने के लिए केंद्र से पर्याप्त वित्तीय सहयोग की मांग की। बैठक में कपिल सिब्बल ने राज्यों के शिक्षा सचिवों से कहा कि हमें शिक्षा व्यवस्था को संस्था केंद्रित नहीं छात्र केंद्रित बनाना है। सिब्बल ने कहा कि सभी राज्यों को विश्वविद्यालय स्तर पर सेमेस्टर सिस्टम शुरु करने जोर देना होगा।

Amar Ujala, April 14, P18

Rural Health Mission to be audited for utilization of funds

Audits will look into the money released to the states in the last seven years, says Ghulam Nabi Azad

BY VIDYA KRISHNAN & LIZ MATHEW

NEW DELHI

The health ministry will conduct annual audits of the National Rural Health Mission (NRHM) to detect irregularities in the utilization of funds. Health minister Ghulam Nabi Azad has written to the state governments seeking their cooperation on this.

"We have decided to go for an audit of NRHM fund utilization across the states," Azad told reporters on Monday. "We will look into how much money has been released to the states in the last seven years. Wherever we have received information of irregularities, investigations have been initiated."

The NRHM was launched in April 2005 to reduce maternal and infant mortality rate in India. While the scheme runs in all 28 states, it focuses on 18 with poor health indicators.

Azad didn't specify which agency will conduct the audit.

The Comptroller and Auditor General (CAG), which audits central and state government books and looks into the efficiency of government programmes, had audited the accounts of NRHM in Uttar Pradesh on the state government's request.

However a CAG spokesperson said it has not yet been informed "about any such audit".

Amit Sengupta of the Jan Swasthya Abhiyan, a non-governmental organization advocating affordable healthcare, said the NRHM has done well in some states but the scheme's in-built audit system, called the common review mission, needs to be strengthened for better implementation.

"There is evidence that since NRHM's launch health indicators in various states have improved," said Sengupta. "It is essential to improve the in-built mechanism of checks and balances for financial and performance audits instead of banking on ad-hoc audits by CAG."

Besides irregularities in spending, Azad said the lack of qualified nurses and doctors have limited the success of NRHM, the UPA's flagship scheme to improve public health.

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Jairam Ramesh asks Azad not to wind up health survey

Mumbai: Rural development minister Jairam Ramesh has urged health and family welfare minister Ghulam Nabi Azad not to discontinue the National Family Health Survey (NFHS), till a credible alternative is in place.

In a 22 April letter, a copy of which has been reviewed by 'Mint', Ramesh questioned the comparability of data generated by the annual health survey (AHS) or the district level health survey (DLHS), which the government will be conducting in 2012-13, with the previous rounds of NFHS.

The government has decided to discontinue NFHS and instead roll out an integrated health survey called the National Health Survey (NHS) to replace AHS, DLHS and NFHS, 'Mint' reported on 12 April. The move was criticized by development experts and Ramesh's letter to Azad echoes their concerns. Development economist Jean Dreze and nutritionist Veena Shatrugna had questioned the move to discontinue NFHS. It is the three successive rounds of NFHS that established that child malnutrition rates in India are among the highest in the world.

Azad could not be reached for his comments and an email sent to him on 22 April remained unanswered.

Ramesh has suggested that NFHS be conducted at least once more to assess the impact of developmental schemes launched since 2005-06. The fourth round of NFHS can be a bridge between the earlier series and the proposed new survey, Ramesh wrote. Since authentic data on health and nutrition is scarce, "there is no immediate danger of any excess of surveys of this kind," Ramesh wrote. PRAMIT BHATTACHARYA

H.T., Mint, April 24, P.11

Vows and laws that trap

Every year, around this time when Hindus celebrate Akshay Tritiya, the government gets active trying to stop child marriages. Every year, hundreds of children are married off on this auspicious day, their parents thumbing their noses at the law of the land that bars minors from getting married. Every year there are volunteers, activists and occasional administrative officials running around trying to prevent the nifty nuptials. Then we see photographs of wide-eyed children in wedding garb in the papers the next day.

But this year, the government has reason to be pleased. In several states they have had some success, preventing scores of child marriages, and getting parents and even grandparents to sign bonds promising not to marry off their kids as long as they are minors. In the process, officials have been chased out by angry villagers, beaten up, their cars have been smashed, police stations ransacked and much protest registered. But vigilant volunteers, activists, the police and government officers have dodged the stones and sticks, picked their way through the shattered glass and steaming pots of wedding feasts, and stopped several illegal weddings.

Unfortunately, just stopping weddings and lecturing the angry poor about laws and the dangers of underage pregnancy cannot be enough. We need to give the underprivileged bound by blind tradition feasible alternatives. As long as girls are seen as a burden, poverty-stricken parents will try to marry them off early, to fulfil their social responsibilities while they can, to give their daughters acceptable male protection and shelter them from social stigma. Pretty often our well-meaning efforts are at best ineffectual, if not counter-productive.

Well-meaning but mindless rules and laws often end up punishing the victim. Like our dowry laws, where filing a case against dowry harassment could put you in jail for paying dowry in the first place. Which forces victims to avoid going to the police till it is too late — and they go to report the unnatural death of their daughter.

Our laws of suicide are another strange attempt at being cruel hoping to be kind. So if people do manage to save a desperate soul after a suicide attempt, the poor chap is likely to find himself, broken bones and all, in jail for the crime of trying to kill himself. So instead of rehabilitation and support to one who is so depressed that he wishes to die, we punish him further.

And to stop bribery, our laws treat both the bribe-giver and bribe-taker even-handedly as criminals. Even though it is well documented that almost 80 per cent of all reported bribes in India are paid out of compulsion, not real choice. More than half the bribes paid are just to access the delivery of a service we are entitled to. Then there is the bribe as protection fee, and bribing to receive your legitimate payments. A bribe-giver is never on par with a bribe-taker. A bribe-taker can withhold services or endanger lives to force you to bribe him.

A flagrant example of punishing the victim lies in our laws dealing with prostitution. For years the Immoral Traffic (Prevention) Act has been used to exploit and harass prostitutes, further victimising girls who are often forced into the trade. Instead of being treated as victims of trafficking, kidnapping or child rape, they are treated as criminals.

But there is good news. The higher judiciary is not always willing to treat victims of crime as criminals.

Last year, the Supreme Court made two significant rulings that refused to punish victims. In one case, it ruled in favour of decriminalising suicide, pointing out that one who attempts suicide was in desperate need of help, and punishing him/her would be unfair. In another case, it ruled that a woman and her family cannot be treated as an accused under the Dowry Prohibition Act for giving dowry. The woman is a victim and not culpable.

Asian Age
April 28, 12.

Third fastest economy but 2/3 households sans toilets!

It is ironical that a country which boasts of being the third fastest economy in the world does not have toilet facility for 65 per cent of its households. Keeping it in mind, sanitation is likely to see an exceptional hike of 675 per cent in fund allocation in the 12th Plan (2012-17).

Continuing its focus on developmental work in rural India, a Steering Committee of the Planning Commission has proposed an allocation of ₹44,116 crore (hike of 675 per cent over 11th plan) for sanitation and ₹1,22,570 crore (hike of 312 per cent over 11th plan) for drinking water in the 12th Plan.

While the Government goes gaga over the 9 per cent futuristic growth of the country, drinking water and sanitation portray the other picture of the growing India. According to National Sample Survey 2008-09, only 34.8 per cent households in the country have toilet facility and only 30 per cent households get tap water.

However, the committee finds that the growth in sanitation facilities has increased to 7-8 per cent annually in 2005-11, while it was as slow as 2 per cent annually in 2001-06.

The committee cited that one of the major drawbacks of the current approach to National Rural Drinking Water Programme and Total Sanitation Campaign is that water and sanitation are taken as independent activities.

Therefore, in the 12th Plan there is a need for integration of housing, water and sanitation. It also recommended that the Government should also converge water and sanitation programmes with the Mahatma Gandhi National Rural Employment Guarantee Act in the 12th Plan.

While replying to a question in the Rajya Sabha recently, Union Minister for Rural Development Jairam Ramesh had said it would take 10 years to achieve total sanitation in the country. There are about 2.60 lakh gram panchayats in the country. As per the latest Census data, only about 28,000 of them have achieved total sanitation.

Jairam had also said that at least 7-8 per cent of the rural habitations had drinking water source contaminated with excess arsenic, fluoride, iron, salinity or nitrate.

"As on April 1, 2009, there were 1,79,999 rural habitations where at least one drinking water source was contaminated with excess arsenic, fluoride, iron, salinity and nitrate, yet to be provided safe drinking water," he had said.

Earlier on March 6, the Joint Monitoring Programme for Water and Sanitation (JMP) report, released by UNICEF and WHO, said that in India 59 per cent of people (626 million) defecate in open. The report had pointed out that — "India is lagging behind 11 years to meet the Millennium Development Goal target, in which the Government has resolved that the statistics of open defecation (base 1990) would be halved by 2015."

Pioneer, April 2, P.1

FLAGSHIP PROGRAMME
- ICDS SCHEME

The flagship is flagging

Describing the Integrated Child Development Services (ICDS) scheme as "a flagship adrift", a social audit of this programme has brought out glaring deficiencies in its functioning.

The deficiencies range from shortfalls in the enrolment of beneficiaries, quality of the nutrition provided, irregularities in monitoring the growth of the children and in immunisation, absence of convergence with related services, gross inadequacy of infrastructure, exploitative service conditions of the anganwadi workers, almost neglect of pre-school education, and most important social discrimination against dalits.

Initiated in 1971, the ICDS covers 200 million children in the age group 0-6 years. The social audit was conducted in Anantapur district of Andhra Pradesh, covering 129 villages and 150 anganwadi centres, by the Council for Social Development, and has been compiled by former bureaucrat K.R.Venugopal. After several rounds of discussions on the primary data, it was unanimously agreed that shortcomings in the Anantapur district social audit were prevalent in the ICDS programme all over the country.

The ICDS is truly a flagship that is adrift. But it is indispensable for meeting all the needs of the children in this age group in a holistic manner. There is hardly any need of the children in this age group which is not built into this programme and hence it cannot afford to let this flagship continue to drift, the report says, while recommending converting anganwadi centers into crèches and involving the Panchayati Raj institutions for better implementation.

According to the audit, 40 per cent of the children in the age group of 0-3 years were not enrolled and 60 per cent of the anganwadi centres had no records of the number of children enrolled and the number children in that age group in the village. However, the audit showed hardly any worth while attendance in this age group of children at the centres considering the importance of early childhood care and stimulation for brain, cognitive, social and language development for this cohort.

In the age group of 3 to 6 year olds, 48 per cent of the children had not been enrolled while at two centres the enrolment numbers were inflated and much higher than the number of children in this age group in the area covered by these. As far as pregnant women are concerned, 38 per cent women were not enrolled in these centres, attributable to negligence on the part of the anganwadi workers including in regard to the conduct of the periodical house to house surveys. Part of the problem is also the lack of understanding of the instructions in regard to accounting for, and registering, pregnant women visiting their paternal homes. In 15 per cent, pregnant women who were to go to their parent's house were not enrolled. Similar was the case with the nursing motners, 29 per cent of whom were not enrolled. More shockingly, in 62 per cent of the anganwadi centres supplementary nutrition was not being supplied regularly. Under-nourished children were identified in 31 per cent anganwadi centres of the 154 which were audited. In many a centres, such under-nourished children were ignored while in another 15 per cent no additional supplementary nutrition was provided. In addition, there were serious shortcomings in the anganwadi centres in regard to health check-up of pregnant and nursing mothers due to lack of diagnostic equipments, medicines and referral facilities, infrastructure and service conditions including low salaries. The survey has suggested a salary of Rs 10,000 for the anganwadi workers and Rs 5,000 for helper. Regarding children with disability, the social audit report says that 36 per cent children with disability were identified of whom 15 per cent were referred to hospital but 29 per cent had no support. "This is another example of how the concept of inconclusiveness has not taken off in the programme," it points out.

Hindu, April 27, 09

GOVERNMENT OF ASSAM

- SCHEME FOR CHILDREN SUFFERING FROM CONGENITAL HEART DISEASE

A compassionate and matchless initiative of the Government of Assam

Department of Health and Family Welfare, Govt. of Assam presents an endearing and unique scheme for children suffering from Congenital Heart Disease

What is Congenital Heart Disease?

- ❑ It is a defect in the structure of the heart and great vessels which are present at birth.
- ❑ It either obstructs blood flow in the heart or vessels near it, or cause blood to flow through the heart in an abnormal pattern.
- ❑ Every year a significant number of babies are born with a congenital heart defect.
- ❑ Treatment for the same is very expensive.

More than 800 children have already benefitted from this scheme

Government of Assam will bear the following expenses under this unique scheme:

- ◆ To and fro air-fare between Assam and Kolkata or Bangalore for the patient and a guardian
- ◆ Total Medical Expenses incurred at Narayan Hridayalaya Hospital, Bangalore and Kolkata
- ◆ Food and lodging expenses during treatment for patient and a guardian

National Rural Health Mission, Assam

Assam Tribune, April 17, P14

Stress on 'Delhi Arogya Kosh' Scheme' for EWS

statesman news service

NEW DELHI, 24 APRIL: Delhi health minister, Dr AK Walia today emphasised the need to facilitate optimum utilisation of the 'Delhi Arogya Kosh Scheme' under which financial assistance is provided to the patients belonging to the Economically Weaker Sections (EWS). He urged the members of legislative assembly (MLAs) as well as the newly-elected municipal councillors of all the three municipalities and medical superintendents of government hospitals for the effective implementation of the scheme.

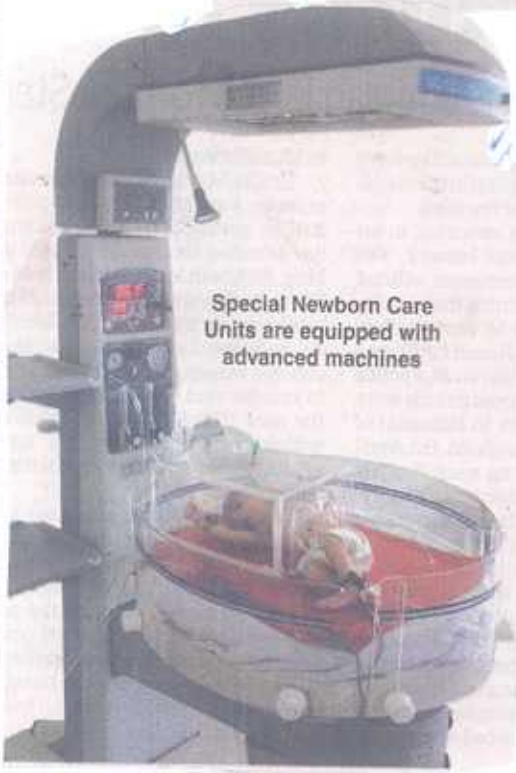
He also appealed the general public, especially those belonging to the weaker sections of the society to come forward and avail the benefits under the Delhi government scheme. Reviewing the scheme today, the health minister expressed concern that during the first three months of the implementation of the scheme, cases of only 30 eligible patients undergoing treatment in AIIMS, GB Pant, Ram Manohar Lohia, Lok Nayak Jai Prakash Narayan Hospital came before the governing body. Dr Walia said that the cases were approved and a total applied grant of Rs 26.32 lakhs was released to the patients for immediate treatment.

He said that there is manifold scope to extend the benefits to the poor sections of the society. Dr Walia also said that all those patients who have been issued either a BPL or Antodaya Ration cards are eligible under the Scheme.

In addition, the patients whose annual family income is upto Rs 1 lakh are also eligible. Patients have to apply in the office of Chief Medical Officer (Delhi Arogya Kosh) located in PWD Block near old 24 hour Canteen Block, Lok Nayak Hospital in the prescribed application form along with requisite documents.

Statesman, April 25, P3

Healthcare
for all at affordable cost



Special Newborn Care Units are equipped with advanced machines

Taking care of the infants

The Haryana Government has taken path-breaking initiatives and made telling interventions to take care of the newborn babies, and bring down the infant mortality rate (IMR). Indulgent doctors keeping round-the-clock vigil and watchful para-medical staff, aided by latest equipment, have enabled the Health Department of the Haryana Government to save the lives of more than 1,500 neonates between April and October, 2011.

Faribabad, Palwal, Yamunanagar, Ambala and Mewat account for most of these premature and low-birth-weight babies, some weighing as low as 700 to 800 grams each, and many suffering from hypothermia, birth and peri-natal asphyxia, respiratory distress and septicaemia.

Up to October, 2011, such facilities in ten high focus districts (HFDs) accounted for 18,073 live births, out of which 3,389 were low-birth babies. These came from Ambala 256, Bhiwani 169, Faridabad 281, Gurgaon 322, Kaithal 110, Mewat 158, Narnaul 1595, Palwal 99, Panchkula 22 and Yamunanagar 377.

To reduce the neo-natal mortality, the Health Department launched the following interventions in 2011-12:

Special New Born Care Units

These centres constitute the most important part of the facility-based care given to new-born babies.

Out of the ten high focus districts (HFDs), six SNCUs are operational in the districts of Faridabad, Yamunanagar, Mewat, Gurgaon, Ambala and Kaithal.

In the districts of Palwal, Bhiwani, Narnaul and Panchkula, such centres are nearing completion. Essential equipment like Open Care Radiant Warmers, Phototherapy Units, Resuscitator, Oxygen Concentrator etc. have already been supplied and installed in these districts.

However, these facilities will work as stabilising units until completion of the renovation process.

In the remaining 11 non-High Focus Districts, necessary medical equipment is being supplied, staff has been sanctioned and the recruitment process is on. The process of civil and electrical works has begun, and the units are likely to be functional by the end of the financial year 2011-12.

New-Born Stabilising Units

In the New-Born Stabilising Units, two to four open care systems, radiant warmers and other neo-natal equipment for essential and emergency newborn care are placed in a separate room, close to the labour room where sick and low-birth/premature newborns are stabilized before being referred. In keeping with the decision of the Haryana Government, free referral service is provided to all sick neo-nates. So far, 26 stabilising units are working at various SDHs/ CHCs/ FRUs across the state.

New Born Care Corners

Such corners have been operationalised at most of the primary health centres (PHCs) and community health centres (CHCs) in ten HFDs where reasonable number of deliveries are conducted.

AYUSH

The AYUSH Department of Haryana Government is providing healthcare services through the Institute of Indian Systems of Medicine and Research, Panchkula (IISMR), three ayurvedic hospitals, one unani hospital, six Ayurvedic Prathmic Swasthya Kendras, 456 ayurvedic dispensaries, 17 unani dispensaries and 20 homoeopathic dispensaries. Under the mainstreaming of AYUSH, six Panchkarma Centres at six district hospitals (DHs), 15 AYUSH wings in DHs, 92 AYUSH OPDs in community health centres (CHCs) and 50 AYUSH

OPDs in primary health centres (PHCs) have been set up in the last two years.

Save the Girl Child

Haryana is the first state in the country to launch prosecution under PC & PNDT (Preconception and Prenatal Diagnostic Techniques) Act, 1994, in 2001. The sex ratio has improved by 11 points in 2011 over 2001 census. As many as 69 court cases have been launched against violators of the PC & PNDT Act all over the state. Thirty persons have been convicted so far under the PC & PNDT Act 1994.

The problem of female foeticide is being dealt with by making serious efforts to improve the sex ratio in the state. 'Save Girl Child' campaigns have been launched throughout the state by involving various stakeholders like religious leaders, panchayats, educationists, Women and Child Development Department etc.

Healthy mother, healthy child

The Haryana Government is implementing various schemes like Janani Shishu Suraksha Karyakram, Janani Suraksha Yojana (state scheme), Jachcha Bachcha Scheme etc which have contributed to maternal health in a big way.

Incentives for institutional deliveries are paid to Staff Nurses and ANMs up to CHC level and covers antenatal and post-natal services. Incentives are given only on satisfaction of the mother and certification by community sub-committee. In fiscal 2010-11, payment to service providers has been paid for 18,119 deliveries up to November, 2011.

About ten per cent of the urban population of Haryana lives in urban slums. For providing health services to this segment, the Urban Reproductive and Child Health (RCH) Scheme was started in 2009. So far, two Urban RCH hospitals in district Faridabad are functioning as First Referral Units (FRUs).

The number of urban RCH centres which was 50 in 2009-10, increased to 86 in 2010-11 and 88 in 2011-12. Eleven specified urban RCH centres have been converted into 24x7 delivery centres.

The Delivery Hut Scheme provides 24-hour delivery services at specified sub-centres in the state. Up to November, 2011, 469 standalone sub-centres were functioning as full-fledged delivery huts. Accredited Social Health Activists (ASHAs) work as link workers between public health facility and community in the rural areas.

Decisions in a nutshell

- All funds/grants-in-aid under all schemes i.e. HRDF, pavement of streets, surcharge on VAT, Mukhya Mantri Anusuchit Jati Nirmal Basti Yojana, Special Development Works, State Finance Commission Funds, Central Finance Commission Funds, etc. will be transferred directly to Gram Panchayats.
- Administrative approval for all works to be undertaken under all schemes, except HRDF, would be given by Gram Panchayats, without any capping.
- Estimates will be prepared and technically approved by the Panchayati Raj engineering wing. For works up to Rs 10 lakh, technical approval would be given by Sub-Divisional Officer (PR); up to Rs 25 lakh by the Executive Engineer(PR); up to Rs 50 lakh by the Superintending Engineer(PR); and above Rs 50 lakh, by the Chief Engineer(PR).
- Separate estimates would be prepared for each type of work.
- For works up to Rs 10 lakh, Gram Panchayat will have the discretion to either execute the work itself (directly or through a local contractor) or entrust the work to the Panchayati Raj engineering wing.
- For works estimated beyond Rs 10 lakh, Gram Panchayat shall get the work executed through the Panchayati Raj engineering wing, which may get the work executed either departmentally or through a contractual agency.
- All works being executed by the Gram Panchayat (either itself or otherwise) shall be closely supervised by Panchayati Raj engineering wing.
- Bank accounts shall be opened in the name of Gram Panchayats with three operators, namely Sarpanch, Gram Sachiv and BDPO/SEPO. In normal circumstances, Sarpanch and Gram Sachiv would operate the account jointly but in special circumstances, reasons to be given thereof,the DC may direct the accounts to be operated by jointly by Gram Sachiv and BDPO/SEPO.
- Release of payments for the works executed would be made after technical verification by the Panchayati Raj engineering wing.
- For the works up to Rs 10 lakh, bill verification would be done by the Sub Divisional Officer(PR) and for works beyond Rs 10 lakh, the final bill would be verified by the Executive Engineer(PR).
- To ensure standardisation and quality and absolute transparency, the estimates, so prepared, shall specifically mention the quantities of various materials required.
- No withdrawals shall be permissible for advance payments.
- For auditing the accounts of Gram Panchayats diligently, Local Audit Department will be strengthened.
- Sarpanch/Gram Sachiv shall inform the concerned BD&PO/SDO(PR) before any work.
- BD&PO/SEPO shall inspect all the works regularly in terms of quality and quantity and shall ensure proper maintenance of cash books/pass books/ledgers/

vouchers/muster rolls/measurement books etc.
- In case of any unauthorised withdrawal, BD&PO/ SEPO shall ensure registration of a criminal case.
- The DC, ADC, District Development and Panchayat Officer and Deputy Chief Executive Officer, Zila Parishad shall mandatorily inspect development works at least to the extent of 1 per cent, 2 per cent, 5 per cent and 5 per cent of the total works, respectively.
- Members of Zila Parishads and Panchayat Samitis shall have the power to inspect the development works in their respective wards.

Taking care of the backward

Haryana Govt reaches out to SCs, BCs with concrete steps

The Haryana Government has taken definitive steps to ameliorate the lot of the Schedules Castes (SCs) and Backward Classes (BCs), equip and enable them to participate fully in the growth story of the state, and lead a life of self-respect and fulfillment.

The state government offers reservation to SCs/ BCs in matters of education, healthcare, housing and employment. A look at the plans of the government shows that it spends lot of money to restructure the lives of the deprived sections under countless number of schemes, some on behalf of the Central Government. The impact of these welfare schemes is fairly visible all around.

"We have chosen to focus on the welfare of the Scheduled Castes and Backward Classes who are mostly poor. The government has chartered the right course to uplift these people economically and socially through education, jobs, free plots and healthcare. And the results are heartening", says the Chief Minister, Mr Bhupinder Singh Hooda.

Concerned about the deprived sections who find it hard to make their both ends meet and cannot afford to send their children to school, the Haryana Government has come up with a number of schemes to incentive parents to send children to schools. And the incentives start from Class I.

Stipend for SC students

The Mukhya Mantri Anusuchit Chhatar Protsahan Yojana has been launched under which each SC student is entitled to a monthly stipend. Every month, from Class I to V, a male student gets Rs 100 and a girl Rs 150; from Classes VI to VIII, the amount is Rs 150 and Rs 200 for boys and girls respectively; for Classes IX to XII, it is Rs 200 for boys and Rs 300 for girls. And for science students of Classes XI and XII, an assistance of Rs 300 and Rs 400 is given to boys and girls, respectively.

The Haryana Government has chartered the right course to uplift Scheduled Castes and Backward Classes people economically and socially through education, jobs, free plots and healthcare. And the results are heartening.

Beginning academic year 2009-2010, the state started providing monthly assistance to the students belonging to the Backward Classes A and BPL category. From Classes I to V, each boy gets Rs 75 and girl Rs 150 per month; from Classes VI to VIII, Rs 100 and Rs 200; from Classes IX to XII, Rs 150 and Rs 300; and for science stream students, each boy will get Rs 200 and girl Rs 400. Annual assistance ranging from Rs 740 to Rs 1,450 is provided to SC students studying in Classes I to XII. Bicycles are given free of cost to the SC students studying in Classes IX and XI in 2007-08. Scholarships are given to motivate students of the deprived sections. Under the Post-Matriculation Scholarship, SC students of different classes are given a scholarship ranging from Rs 230 to Rs 1,200 and BC students get Rs 160 to Rs 750. Under the scheme Rs 195.56 crore has been spent on 2,90,605 students from March 2005 to November 2011.

Under the Rajiv Gandhi Scholarship for Excellence Scheme, Rs 750 each is given to middle class students and Rs 1,000 each is given to the students of High and Senior Secondary classes as incentives/scholarships to encourage brilliant students, who got first division. A total of 1.86 lakh students have benefitted under this scheme till November 2011.

Under the high education encouragement scheme, SC girls students are given scholarships from Rs 5,000 to Rs 14,000 for the study of science, commerce, technical and vocational subjects. So far, 475 girls students have been benefited, and a provision of Rs 2 crore has been made in the 2011-12 Budget.

In order to give financial assistance to SC/ BC students for appearing in competition or admission examinations, a committee under the Secretary, Scheduled Caste and Backward Classes Welfare Department, has been constituted for taking feedback from the market and finalise coaching days and the fee structure. ■

Times of India, April 19, P 11

Electoral dose: Free medicines for all

Neeraj Thakur ● NEW DELHI

With an eye on the 2014 general election, UPA-II is preparing to launch a mega health scheme which will facilitate the distribution of free medicines to everyone in the country, especially those living in rural areas, who rely heavily on public health services. Expected to be launched next year, the scheme is set to be the second biggest health scheme introduced by the government after UPA-1 implemented the National Rural Guarantee Programme.

DNA EXCLUSIVE

Sources said prime minister Manmohan Singh is closely monitoring the nitty-gritty of the scheme. The prime minister's office is working in close tandem with the Planning Commission and the health ministry to ensure the successful implementation of the scheme which will help the Congress-led coalition at the Centre to woo rural as well as urban poor.

"The need for implementing such a scheme was felt for long. We were working out the total financial burden which the Centre would have to incur. The share of the state governments was also calculated. The implementation of the scheme seems feasible now and so we have made the recommendations," an official from the Planning Commission told *DNA*.

The Planning Commission has prepared the scheme's blueprint in close consultation with a panel of 15 acclaimed health experts and activists from various states. According to the initial plan, the government will have to shell out approximately Rs30,000 crore for five years. The central government will pay 85% of the total project cost while the remaining expenses will be borne by the state governments.

The scheme is likely to be launched with much political fanfare in 2013 under the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM).

To bring down the cost of medicines down for the government, state governments will be asked to set up medical supply corporations (MSCs) which will buy essential drugs in bulk through a competitive tendering process. The government wants MSCs to be autonomous bodies, responsible for maintaining transparency in the drug procurement process.

"We will follow the Tamil Nadu model which is in place for 15 years. The states will have to set up cold storage facilities to store medicines purchased in bulk," the official said. Bulk procurement of generic medicines will be done under International Non-proprietary Names only.

The finance minister this year allocated Rs20,822 crore for the NRHM. However, with the new free-medicine-for-all-scheme, NRHM will get a fresh lease of life and a five-year extension. The allocation for the proposed scheme will be over and above the current allocations for NRHM and NUHM.

At present, the government spends around 1.1% of its GDP on providing health services to people. Once the new scheme is implemented, the share will go up to 2.5%. The government initially decided to give the scheme the "right" status such as the right to education. However, considering some loopholes in the system it decided otherwise.

DNA, April 13, p.1.

अब सभी को मिलेगी मुफ्त दवाई !

नई दिल्ली। शिक्षा का अधिकार, रोजगार का अधिकार और अब फ्री मेडिसन फॉर ऑल यानी सभी को मुफ्त दवाइयां। इसी साल से यह योजना लागू हो जाएगी और राष्ट्रीय ग्रामीण स्वास्थ्य योजना और राष्ट्रीय शहरी स्वास्थ्य योजना के तहत सार्वजनिक स्वास्थ्य सुविधा में मिलेगी। इस योजना पर करीब 29 हजार करोड़ रुपये का खर्चा आएगा जिसका 85 प्रतिशत हिस्सा केंद्र सरकार और 15 प्रतिशत राज्य सरकारें वहन करेंगे।

मुफ्त शिक्षा, मुफ्त भोजन के बाद मुफ्त दवाइयां बांटने का आइडिया सरकार को तमिलनाडु में चल रही योजना से मिला। तमिलनाडु में महज 210 करोड़ रुपये की मामूली रकम से सार्वजनक स्वास्थ्य केंद्रों पर मुफ्त दवाइयां दी जा रही हैं। खास बात है कि यह तब सफल हुआ जब तमिलनाडु ने जेनरिक दवाइयों की खरीद को प्राथमिकता दी। योजना आयोग ने उसी मॉडल पर फ्री मेडिसन फॉर ऑल नाम से योजना तैयार कर ली है। यह योजना इसी साल से लागू होनी है लेकिन 12वीं योजना को अंतिम रूप देने में समय लग रहा है इसलिए योजना को लागू होने में भी 5-6 महीने के समय लग सकता है। योजना के मुताबिक एनएचआरएम और प्रस्तावित एयूआरएम के तहत सभी को स्वास्थ्य केंद्रों से दवाइयां भी मुफ्त दी जाएंगी। चाहे अस्तपाल में भर्ती हो या ओपीडी में दिखा रहा हो। तमिलनाडु मॉडल का अध्ययन कर योजना आयोग ने अनुमान लगाया कि 12वीं योजना यानी 2012-17 तक 28,675 हजार करोड़ रुपये की जरूरत होगी। इनमें 85 प्रतिशत केंद्र सरकार देगी जो करीब 24374 करोड़ है। बाकी 15 प्रतिशत हिस्सा राज्य सरकारें देंगी।

आयोग के मुताबिक तमिलनाडु में प्रतिवर्ष 210 करोड़ खर्च होते हैं। यहां की 40 प्रतिशत आबादी सार्वजनिक स्वास्थ्य केंद्रों में इलाज कराने जाती है। योजना आयोग ने भी 40 प्रतिशत की आबादी पर गणना की है और इसमें 20 प्रतिशत अति गरीब को जोड़ा है जो कहीं इलाज कराने नहीं जाते। यानी 60 प्रतिशत की आबादी को मुफ्त दवाइयां देने के 5735 करोड़ रुपये चाहिए। तमिलनाडु में एक मरीज पर 20 रुपये खर्च आता है। यही खर्च राष्ट्रीय स्तर पर भी आ सकता है। इसके लिए जेनरिक दवाइयां लेनी होंगी। जेनरिक दवाइयां वह होती है जो किसी ब्रांडेड कंपनी द्वारा तैयार रिसर्च की जाती है और कापीराइट पंजीकृति करा दी जाती है।

10 साल बाद कोई दूसरी कंपनी या देश उसी साल्ट का उपयोग कर दवाई बना सकती हैं जब उसका कापीराइट समाप्त हो जाता है। चूंकि जेनरिक दवाइयों के लिए रिसर्च के लिए भारी भरकम राशि खर्च नहीं करनी पड़ी है इसलिए उसकी लागत कम आती है और उपभोक्ताओं को भी वह सस्ते में मिल जाती है। तमिलनाडु ने सिर्फ इसी काम के लिए तमिलनाडु मेडिकल सर्विस कारपोरेशन की स्थापना की है। योजना आयोग भी चाहता है कि केंद्र में भी एक स्वायत्त कंपनी बने और हर राज्य में भी बने। तमिलनाडु का मॉडल बिहार और राजस्थान सरकार भी अपनाने का प्रयास कर रहे हैं। राष्ट्रीय रोजगार गारंटी योजना भी केंद्र सरकार ने महाराष्ट्र सरकार से प्रेरित होकर लागू किया था।

Rashtriya Sahara, April 15, P.1.

NHRC Notice on Sumangali Scheme

Express News Service

New Delhi: The National Human Rights Commission (NHRC) has issued notices to the Chief Secretary of Tamil Nadu to free the enslaved girls absorbed by spinning mills under the Sumangali scheme in Tirupur.

The apex watchdog of human rights passed the order while acting on a petition filed in this regard by Supreme Court advocate and rights activist Radhakanta Tripathy.

It was an irony for old and poor parents who send their young daughters to work in spinning mills to earn money and can be married. But the girls get entrapped in a vicious circle of exploitation and abuse.

Sumangali in Tamil means a happily married woman. In Tirupur, it became a nightmare and often ended in death. It was nothing but a system of forced bonded labour of unmarried girls, Tripathy pointed out. Girls under the Sumangali scheme were supposed to be paid their wages sat the end of their contract which could be of one year to five years or more than that. And, if for any reason, their services were terminated over some petty issues, the girls would not be paid any money. The girls plight begin soon after they are spotted by agents who move around in poor pockets looking for people desperate for money to fix their daughters' marriage. Slavery still existed in one of the developed States like Tamil Nadu. The mills of Tirupur and Coimbatore flout labour laws and other humanitarian laws while dealing with the 'Sumangalis'. The girls suffer from anaemia, TB, lung infections, respiratory problems and menstrual disorders because of the unhygienic condition of their work and living.

Citing the tragic stories of 'Sumangalis', Radhakanta sought the intervention of the NHRC as the practice posed serious human rights violation. The petitioner requested the apex human rights watchdog to send special rapporteur or a team to study the situation and recommend to the State government to free the 'Sumangali girls' and ensure their basic human rights through preventive and punitive actions.

New Indian Express, April 7, PS

राष्ट्रीय स्वास्थ्य बीमा योजना के स्मार्ट कार्ड पर ही मिलेगा सरकारी सस्ता राशन

स्वास्थ्य बीमा कार्ड दिलाएगा राशन भी

■ राजकेश्वर सिंह, नई दिल्ली

- छत्तीसगढ़ ने की पहल, केंद्र ने दी योजना को हरी झंडी
- आरएसबीवाई के स्मार्ट कार्ड में ही दर्ज होगा राशन कार्ड का भी ब्यौरा

महज 30 रुपये में गरीबी रेखा के नीचे (बीपीएल) रहने वाले परिवारों को सालाना 30 हजार तक के इलाज की सुविधा देने वाला राष्ट्रीय स्वास्थ्य बीमा योजना का स्मार्ट कार्ड अब सरकारी सस्ता राशन भी उपलब्ध कराएगा। उत्तर प्रदेश, दिल्ली और महाराष्ट्र जैसे राज्यों में यह योजना भले ही फिसड्डी साबित हो रही है, लेकिन दूसरे राज्य इसे सिर-आंखों पर बैठा रहे हैं। भाजपा शासित छत्तीसगढ़ तो इस स्मार्ट कार्ड को राशन कार्ड के रूप में भी इस्तेमाल करने जा रहा है।

सूत्रों के मुताबिक, छत्तीसगढ़ सरकार ने बीपीएल परिवारों के इलाज के लिए चल रही राष्ट्रीय स्वास्थ्य बीमा योजना (आरएसबीवाई) को सरकारी सस्ते राशन की दुकानों से जोड़ने का खाका तैयार कर लिया है। राज्य में बीपीएल परिवारों के इलाज के लिए बनने वाले 64 केबी के स्मार्ट कार्ड में ही उनका सार्वजनिक वितरण प्रणाली (पीडीएस) से जुड़ा डाटा भी शामिल करने की योजना है। मसलन स्मार्ट कार्ड में उपभोक्ता के राशन कार्ड का नंबर और उस पर मिलने वाले खाद्यान्न आदि का विस्तृत ब्योरा भी दर्ज कर दिया जाएगा। उसके बाद गरीब परिवार उस कार्ड से इलाज के साथ ही हर महीने अपना राशन भी उठा सकेंगे।

सूत्रों की मानें तो योजना को चला रहे केंद्रीय श्रम व सेवायोजन मंत्रालय ने छत्तीसगढ़ राज्य सरकार की ओर से इस नई पहल के प्रस्ताव को हरी झंडी भी दे दी है। बताते हैं कि जब तक 64 केबी के नए स्मार्ट कार्ड नहीं बन जाते, राज्य सरकार तब तक मौजूदा स्मार्ट कार्ड (बायोमैट्रिक) को ही बीपीएल उपभोक्ताओं की पहचान के प्रमाण के रूप में उपयोग करने जा रही है। जबकि नए स्मार्ट कार्ड में उपभोक्ताओं के राशन कार्ड का पूरा ब्योरा तो दर्ज होगा ही, साथ सस्ते राशन की सरकारी दुकानों का भी विवरण उपलब्ध रहेगा।

राष्ट्रीय स्वास्थ्य बीमा योजना के तहत बीपीएल परिवारों को महज तीस रुपये के स्मार्ट कार्ड के जरिए सालाना 30 हजार रुपये तक के इलाज का प्रावधान है। श्रम व सेवायोजन मंत्रालय के उच्चपदस्थ सूत्रों के मुताबिक योजना वैसे तो देश के ज्यादातर राज्यों में प्रभावी ढंग से चल रही है, लेकिन उत्तर प्रदेश, दिल्ली और महाराष्ट्र जैसे राज्यों में यह काफी पीछे चल रही है। यह जरूर है कि स्वास्थ्य बीमा के स्मार्ट कार्ड को राशन कार्ड के रूप में भी इस्तेमाल से पीडीएस पारदर्शिता व बेहतर नतीजों से इंकार नहीं किया जा सकता।

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