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Research Studies on Women and Children

CHILD LABOUR

1. Sekar, Helen R. (2007).
Child labour : situation and strategies for elimination. NOIDA : V.V. Giri
National Labour Institute. 108 p.

Abstract : International Labour Organisation (ILO) estimated that 317 million children are involved in work in 2004. According to the survey of ILO (2006), 69% of working children are in agriculture, 22% are in service sector, and 9% are in the industry sector. In India (2001), the number of child labour has been estimated to be 12,591,667. Some states are showing a decreasing trend of child labour, namely Andhra Pradesh (1363339), Kerala (26156), Gujarat (485530), Orissa (377594) and Tamil Nadu (418802). The National Child Labour Project (NCLP) implements model programmes consisting of key elements such as: stepping up enforcement of the prohibition of child labour, providing employment to parents of children, expanding formal and non-formal education, promoting school enrolment through various incentives such as payment of stipend, raising public awareness, and evaluation. Presently NCLP are operational in 250 districts spread over 20 states of India such as Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Mizoram, Nagaland, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh, Uttarakhand and West Bengal. NCLP address the issue of child labour by establishment of special schools, provision of vocational training, involvement of parents in various income and employment generating activities, withdrawal of children from factories, creating a work environment through awareness generation, and enforcement of the Child Labour Act, 1986. So the emphasis should be on sensitization of parents, employers and working children. This could be done by designing an year long calendar of activities which may include staging of *nukkad nataks* (street plays), publicity through local radio programmes/ wall posters and by conducting rallies and other related events. Project societies are required to set up child labour special schools by encouraging voluntary efforts for imparting formal/ non-formal education and voluntary training, nutrition, stipend and health care services. In the 10th Plan, child labour elimination efforts were linked with the scheme of SSA of the Department of Elementary Education and Literacy of Ministry of Human Resource Development. The functioning of the projects is to be monitored and reviewed by the State Department of Labour. A number of areas where intervention of the State Government is essential are finalization of

the uniform curriculum, course content, etc; coordination with State Education Department for facilitating enrollment of children passing out of special schools; finalization of craft and pre-vocational training module for children enrolled in special schools; ensuring inspection of the Child Labour Projects and sending periodic inspection reports to the Ministry of Labour and Employment, etc. The Indus Child Labour Project operational in Aligarh, Allahabad, Ferozabad, Kanpur and Moradabad in Uttar Pradesh recognizes that working children belong to specific sections of the population that continue to be marginalized. Its goal is to target marginalized populations of children in selected areas and to improve their attendance, performance and retention in the education system. The key strategies of the programme are enrolment in public elementary education, withdrawal from work and provision of transitional education, strengthening vocational training, strengthening public education of child workers and social mobilization. The beneficiaries are identified young child workers (5-8 years) who will be directly enrolled in regular schools; older child workers (9-13 years), who will be provided with transitional education and support services; adolescent workers (14-17 years) who will be provided vocational training; and parents of working children will be organized into self help groups (SHGs) and later provided with skills for additional income generation. International Programme for the Elimination of Child Labour (IPEC) has the objectives to enhance the capability of ILO constituents and Non-Government Organizations (NGOs) to design, implement and evaluate programmes for child labour elimination; to identify interventions at community and national levels which can serve as models for replication; and create awareness and social mobilization for securing elimination of child labour.

Key Words : 1.CHILD LABOUR 2.ELIMINATION 3.STRATEGIES FOR ELIMINATION 4.SITUATION OF CHILD LABOUR.

CHILD WELFARE

2. Bajracharya, Ashish et al. (2006).

The empowerment of women from the excluded communities in Bihar : a documentation of the Nari Gunjan model. Patna : A.N. Sinha Institute of Social Studies. 56 p.

Abstract : Bihar is one of the poorest, least developed and educationally backward states of India. Over half the population is illiterate and only 33% of the females can read and write. In Bihar, rural literacy rate among the SCs is

12% compared to 47% for the general population. The gender gap in attendance at school was as much as 25% and the rural gender gap was greater by 10 to 25% points compared to urban areas. For girls from the Musahar (rat eating) community in the villages surrounding Patna, getting an education was a distant dream only a few years ago. But many of these girls are now beginning to see a ray of hope. They can now be seen going to Nari Gunjan (NG) Kishori Kendras (centres for adolescent girls) outside of Patna. NG has been working for the education and empowerment of girls aged 8-20 years from the Musahar community, where literacy rates were as low as 4.6% for the general population and a dismal 1.3% for females. More than 1500 girls are enrolled in over 50 centres. It provides SC girls elementary education, vocational training and life skills at 50 alternative educational centres (Kishori Kendras). This study documents successful aspects of the programme and suggests areas of improvement in order to replicate the programme in comparable excluded communities. The villages selected were Bata and Deegha Halt (in Danapur Block) and Neejampur, Nagwan and Kurkuri (in Phulwarisharif Block). Participatory Rural Appraisal (PRA) technique was used to gather information. NG provided schools; hostels; literacy skills; vocational skills like tailoring, etc; awareness about rights related to education, etc; games and songs; remedial training; organized discussions on issues such as child marriage, women's rights, HIV/AIDS, etc; provided a platform to encourage public speaking skills among girls; imparted health education; organized parents meetings; supported women's self help groups (SHGs); training on effective teaching methodologies; designed interesting teaching learning material (TLM); and sensitized teachers towards the Musahar community. The impact of NG was increased awareness of the importance of girls' education; perception of increased self well-being; transformation in knowledge, attitude and practices related to health and hygiene; and ripple effect on girls education. NG's efforts were able to get girls into the formal school system through bridge courses, and its long lasting impact was felt on the larger SC communities and future generations. The capacities of SHGs should be built to further empower these vulnerable groups. Advanced training such as computer skills and English may be taught to students residing at the hostel. Employment policies foster the integration of educated and qualified girls from the Musahar community.

Key Words : 1.CHILD WELFARE 2.ADOLESCENT GIRLS 3.WOMEN WELFARE 4.EMPOWERMENT WOMEN 5.NARI GUNJAN PROJECT 6.MUSAHAR COMMUNITY 7.EMPOWERMENT ADOLESCENT GIRLS 8.SCHEDULED CASTE GIRLS 9.VOCATIONAL TRAINING 10.BIHAR.

3. FORCES Delhi, New Delhi. (2008).
District migration identity and entitlements. New Delhi : FORCES. 53 p.

Abstract : The unorganized workforce of the construction industry largely comprises poverty stricken families, who are pushed out of their rural settings in search of employment and food. The present study was done on migrant construction workers to assess their socio-economic status and examine the health and nutritional status of children on the sites, and the child care and health seeking practices of migrant families. Data was collected from 425 migrant households in Delhi (325 families from sites with mobile crèches and 100 families from sites without any intervention). The study showed that most of the migrants were from agricultural backgrounds and were in the age group 26-40 years. Literacy levels were found to be low, especially among women (11%), and almost half of the families belonged to backward classes. Majority of the migrants covered were from Chhattisgarh (52%), followed by Bihar (15%), MP (13%), UP (8%) and West Bengal (8%). The main causes of migration were unemployment (31%), indebtedness (23%), and low wages and irregular income in villages (81%). It was found that families largely migrated with their younger children, and older children were usually left in the village in the care of their grandparents. 419 families had a total of 65 under six children. Most of the families with children below 6 years with them on the site sent the children to the Mobile Crèches (MC) centre, wherever it was available. Mothers in non-MC sites took their young children to work and fed them on the site. The presence of Mobile Crèches did encourage and provide support to families to send their children to school. Majority of the men (72%) and women (73%) worked on the site for 8 hours a day and the minimum wage was Rs.133.45 per day in Delhi. Around 15% of the male workers mentioned that their skills had increased and of these 91% had been in the industry for 2 years. Accommodation had been provided to workers mostly on the site. Around 93% of the workers on the MC sites have rated the safety and security provisions for children as good and all the workers on non-MC sites rated it as poor. Findings on the nutritional status of children showed that the highest concentration of malnourished children was in Grade II (30%) and Grade I (29%) categories. The workers in both MC (94%) and non-MC sites (100%) were mainly dependent on Registered Medical Practitioners (RMPs). A doctor was available only twice a month in the centre for immunization, weighing and providing consultation on good child care practices. The study clearly showed that mobility from village to city was not upwards by any means: women earned less than men, they had no opportunity to raise their skill levels, and there was no access to state services or maternity entitlements.

There is an urgent need to address the rights of children to good health, safety and development through implementation of laws, government programmes and schemes. Also required are long term measures that address rural poverty, labour rights and gender concerns.

Key Words : 1.CHILD WELFARE 2.MIGRANT CHILDREN 3.MIGRANT WORKERS 4.CHILDREN OF MIGRANT WORKERS 5.SLUM CHILDREN.

4. Ganguly Thukral, Enakshi, Ali, Bharti and Bild, Emily. (2008).
Still out of focus: status of India's children 2008. New Delhi : HAQ Centre for Child Rights. 233 p.

Abstract : The importance of early childhood care and education (ECCE) can not be under estimated as 80% of brain development takes place in the first three years of life. In India, 10.5 million children die every year before the age of five years from preventable diseases. According to 2001 Census, the population of children aged 0-6 years in India is 164 million amounting to 15.93% of the total population. 6 million of these children are slum dwellers, where basic services seldom reach. Of the 60 million children in the age group 3-6 years, 34 million children are currently covered by pre-schooling initiatives, either under the ICDS or other private initiatives. Roughly 1.75 million Indian children die each year before reaching their first birthday. Infant and child mortality rates are much higher in rural areas, among SC and ST; and among females. According to National Family Health Survey – 3 (NFHS-3; 2005-06) in India 69.5 % children aged 6-59 months are anaemic and 48% are stunted. In Uttar Pradesh, 46% children are under developed both physically and mentally, because they do not get sufficient quantity and quality of food to eat. In 2007 an estimated 500 children across India were diagnosed with paralytic polio. Nearly 8.5 million people are suffering from TB in India, every year 1.8 million new cases are found and almost 0.37 million die from TB (MOHFW Annual Report 2006-07). Recent studies conducted showed that over 300,000 children are orphaned due to TB every year, while over 100,000 women are rejected by their families once they contract the disease. According to NFHS-3 only 44% children aged 12-23 months are fully vaccinated in India (58% in urban areas and 39% in rural areas). 79.1% children between the ages of 3-6 years and 56.2% married women in the age group 15-49 years were found to be anaemic in 2006. Every day around 1000 children die due to diarrhoea in India which means 41 children lose their lives every 60 minutes. According to Annual Sentinel Survey 2007, 70,000

children below 15 years of age were infected with HIV. About 52% children in India either do not attend school or drop out before Class VIII, which shows that we are still a long way from universalisation of elementary education. According to NCRB a total of 18,967 cases of crimes against children were reported in the country. In 2006 the total number of juveniles apprehended for various crimes were 32,145. In 2004-05 according to National Sample Survey Organization (NSSO) 8.6 million children were employed. The number of convictions of employers of child labour in 2004-05 were 1380, and total number of convictions from 1997-98 to 2004-05 were 21,436. The total number of children kidnapped and abducted in 2006 were 23,991, and children were abducted and kidnapped for adoption (107 cases), begging (23), camel racing (0), illicit intercourse (2625 cases), marriage (10674), prostitution (340), ransom (630), revenge (471), sale (12), selling body parts (1), slavery (113), unlawful activity (548), and others (8447). Cross sectoral interventions are urgently required if the needs and rights of young children are to be realized. Efforts should be made to ensure that all children in the country receive quality education, especially those from SC/ ST communities, differently abled and minority groups. All efforts must be made to retain children in school and parents and communities should be socially and financially empowered to ensure this. Child protection needs to be accorded the highest priority in the Centre's and States' policies, programmes and schemes. Since child protection is a state subject, the states have a far greater responsibility of ensuring implementation of the country's political commitments towards its children. While more efforts are made to train children in need of care and protection housed in children's homes, no such efforts are made for children in conflict with law. It has to be recognized that if not given an opportunity to get back into society with respectability, they will be forced back into crimes.

Key Words : 1.CHILD WELFARE 2.SITUATION OF CHILDREN 3.STATUS OF CHILDREN 4.CHILD PROTECTION 5.ADOPTION MALPRACTICES 6.CHILD LABOUR 7.CHILD TRAFFICKING 8.INSTITUTIONAL CARE 9.MALNUTRITION 10.CHILD HEALTH 11.OUT OF SCHOOL CHILDREN 12.JUVENILES.

EDUCATION

5. India, Min. of HRD, Deptt. of Education, New Delhi (2008)
Analysis of budgeted expenditure on education 2005-06 to 2007-08.
New Delhi: I-MHRD. 92 p.

Abstract : The total amount of budget provisions on the revenue account made for education for the year 2007-08 by Education Departments of the states/ UTs and the centre worked out to be Rs.131662.08 crore (Rs.99310.36 crore in the state sector and Rs.32351.72 crore in the central sector), which was 13.82% more than the revised estimates of Rs.115671.32 crore for 2006-07. This amount constitutes 11.27% of the total budget provisions made on the revenue account in the states and at the centre. It is observed that states are contributing about 74.99% of the total revenue expenditure on education in the country while the centre contributes about 25.01% to the education sector as a whole. The Education Department at the centre spent Rs.32,351.72 crores during 2007-08, while the states spent Rs.99,310.36 crores on education. Elementary education accounted for Rs.52.32% of the total expenditure on education in 2007-08, followed by Secondary Education (28.76%), University and Higher Education (11.83%), and Technical Education (5.33%). The revised expenditure on education by the centre and states/ Union Territories amounted to Rs.139722.38 crore (Rs. 138022.04 crore under Revenue Account, Rs.1686.78 crore under Capital Account and Rs.13.56 crore under Loans and Advances), comprising Rs.30638.25 crore by the centre and Rs.109084.13 crore by the states/ UTs. The total revised estimate for education formed 5.46% of the total revised estimates of expenditure. The revised estimates for 2006-07 provided by the Education Departments of the centre and states rose to Rs.111731.66 crores (Rs.24250.50 crore for the centre and Rs.93121.16 crore for the states) constituting 4.59% of the total revised estimates on all the three accounts (Revenue Account, Capital Account, Loans and Advances). This amount comprised Rs.115671.32 crore under the Revenue Account, Rs.1686.78 crore under the Capital Account and Rs.13.56 crore under Loans and Advances. The actual expenditure on education by the centre under the Revenue Account was Rs.23209.77 crore (Rs.17823.18 crore under Plan and Rs.5386.59 crore under Non-Plan) which constituted 5.28% of the total central expenditure (Revenue Account). The actual expenditure on education by the states/ union territories was Rs.90018.94 crore (Rs.13792.53 crore under Plan and Rs.76226.41 crore under Non-Plan) and formed 20.01% of the total expenditure (Revenue Account) for all states/ union territories. It was seen that total expenditure on education was highest 4.28% in 2000-01, which came down to 3.39% in 2004-05, and has thereafter increased but at a very slow rate. Centre's share for education

showed an increasing trend from 0.53% in 2000-01 to 0.92% in 2007-08, while States' share declined from 3.75% in 2000-01 to 2.75% in 2007-08. The total budgeted capital expenditure outside the Revenue Account proposed for education amounts to Rs.1902.40 crore forming 0.13% of the total capital expenditure outside the Revenue Account for all states/ UTs. This percentage was highest in the case of HP (2.18%) and lowest in the case of Kerala (0.01%). Among union territories, it ranged from 1.94% in Delhi to 8.95% in Puducherry. A provision of Rs.12.46 crore was made for loans for education by the Education Departments of all states/ UTs taken together, constituting 0.06% of the total loans and advances for Education Department. The highest percentage was in the case of Goa (27.14%) and lowest was in UP (0.98%). No provision for loans were made in states other than Goa and UP. No provision for loans was made by the UTs. The total Revenue Account for the Education Department was Rs.131662.06 core, which comprises Rs.96522.49 crore for states, Rs.2787.86 crore for Union Territories and Rs. 3287.86 crore for the centre. According to the state-wise distribution of funds for education by the Education Departments under the Revenue Account, the highest amount of Rs.12087.78 crore was proposed by Maharashtra, followed by UP Rs.9932.56 crore and West Bengal Rs.6288.07 crore. The expenditure incurred by Ministries of Railways, Defence, Labour and Employment, Social Justice and Empowerment, Culture, Tribal Development, Development of North Eastern Region and Ministry of Women and Child Development mainly goes towards elementary and secondary education sectors and therefore expenditure incurred by these ministries has been counted towards elementary and secondary education sectors.

Key Words : 1.EDUCATION 2.BUDGET FOR EDUCATION 3.EXPENDITURE ON EDUCATION 4.GOVERNMENT SPENDING EDUCATION.

6. India, Min. of HRD, Deptt. of Education, New Delhi. (2008).
Results of high school and higher secondary examinations 2005 and 2006. New Delhi : I-MHRD-DE. 224 p.

Abstract : Education comprises all deliberate, systematic, organized and sustained forms of communication designed to promote and bring about learning. The present report assesses important statistics of examination results of the High School, Higher Secondary and Intermediate/ Pre-university Examinations conducted by various Boards in the country. During the year 2006 approximately 140.12 lakh students appeared in the Annual Secondary/ High School Examination out of which 89.35 lakh students passed (63.7%). In the supplementary examination about 11.54 lakh students appeared and 5.73 lakh

students passed (49.65%). Among all the boards the pass percentage was highest viz. 96.03% (95.32% for boys and 96.94% for girls) in case of council for Indian School Certificate Examination (ISCE) and lowest in the case of NIOS (Open School Board) 31.18% (30.11% for boys and 33.3% for girls). The pass percentages for regular and private candidates were 66.18% and 42.79% respectively. The overall pass percentage of SC and ST students of Secondary Examination during 2006 (Annual and Supplementary) was 60.38% and 53.04%. At all India level, the number of students who appeared in the Secondary/ High School Examination increased from 134.87 lakh in 2005 to 140.12 lakh in the year 2006. Pass percentage of High School Examination for girls was 67.55% and for boys it was 61.36% in 2005. It was 70.15% for girls and 66.23% for boys in 2006. It was found that in the Secondary Examination, the female participation increased from 67 girls for 100 boys in 2005 to 71 girls for 100 boys in 2006. During 2006 84.33 lakh students appeared in Annual Higher Examination and about 9.96 lakh students appeared in Supplementary Examination. The overall pass percentage of Higher Secondary Examination (Annual and Supplementary) was 72.71%. The overall pass percentage in annual and supplementary was 74.10% for regular and 59.52% for private students. The overall pass percentage of SC students (Annual and Supplementary) was 65.62% and for ST students it was 59.56%. At all India level there was increase in the annual average growth rate (11.81%) in the year 2006 as compared to 2005 in the Higher Secondary Examination, the female participation decreased marginally from 70 girls for 100 boys in 2005 to 68 girls for 100 boys in 2006. There is need to improve higher education in the country by doing proper planning and assessing the availability of manpower.

Key Words : 1.EDUCATION 2.HIGH SCHOOL EDUCATION 3.GIRLS EDUCATION 4.SC/ST EDUCATION 5.EDUCATION SC/ST.

7. Khandelwal, B.P. (2007).
Evaluation in elementary teacher education: Report of the Committee on Streamlining Procedures and Practices of Evaluation in Elementary Teacher Education Programme. New Delhi : National Council for Teacher Education. 91 p.

Abstract : This study evaluated the theoretical and practical aspects of teachers training in India. The curriculum of elementary teacher education covers 3 components namely – theory of education; practice of teaching; and *practicum* (project work, sessions work, co-curricular activities, etc). Evaluation should therefore assess trainees performance on all the three components. National

Council for Teacher Education (NCTE) constituted a Committee of experts to evaluate elementary teacher education courses; evolve a framework for evaluation; and assess student teachers' knowledge, professional proficiencies and soft skills in teaching, classroom management, organization of co-curricular activities, and evaluating pupils. Teachers education programme facilitates the trainees preparation for performing the role of an instructor, a facilitator of learning, and an evaluator. Effective teaching involves the skills of introducing a new lesson, stimulating pupils' interest and sustaining their motivation, helping pupils to learn new concepts framing thought provoking questions, organizing classroom interaction, etc. A TEI organizes exploratory visits to schools, observation of classroom teaching, practicing blackboard/ whiteboard writing, preparation of lesson plan writing, practice teaching, supervised teaching, and training workshops. During practice teaching lesson plans, teaching proficiency, teaching learning material, administration of tests, case study, action research, children's preparation for participation in co-curricular activities are assessed, and weights are suggested for different activities. Co-curricular activities could be literary, artistic and cultural; community living and community work; and games and sports. Trainees should be able to express themselves through the medium of various arts such as music, visual and performing arts, language, arts, etc. Values like cooperation, tolerance, service, sacrifice, etc. need to be inculcated for community living and community work. Educational tours, excursions or picnics provide opportunities for community living and practicing the values essential for living together in harmony. Community work includes cleanliness drives, literacy campaigns, social forestry, etc. The students' performance should be assessed on a five point scale separately for each component, and a letter grade from A to E may be assigned. Numerical value from 1 to 5 may be assigned for each letter grade and then composite over all grades may be calculated. The Committee suggested that theory and practical components should be assigned equal weightage in the final assessment, as well as in internal and external assessments. Viva-voce should be conducted at the end of 2nd year jointly by internal and external examiners, and each team of evaluators should have one internal examiner and one external examiner. TEIs should organize group discussions twice - first towards the end of first year and then sometime in the second half of the second year. Portfolio evaluation may be conducted along with the viva-voce by the team of examiners. The Examining Agency should also appoint a Moderation Board to oversee the maintenance of internal assessment records in different institutions and to undertake necessary measures to ensure inter-institution comparability.

Key Words : 1.EDUCATION 2.TEACHERS TRAINING 3.EVALUATION
TEACHERS TRAINING 4.KHANDELWAL COMMITTEE REPORT.

8. Mehta, Arun C. (2008).
Elementary education in India - where do we stand ? : State report cards
2006-07. New Delhi : National University of Educational Planning and
Administration. 71 p.

Abstract : The National University of Educational Planning and Administration (NUEPA) has created a comprehensive database on elementary education in India known as District Information System for Education (DISE). NUEPA has successfully developed school report cards (RCs) of more than 1 million primary and upper primary schools/ sections and these are available for 2005-06 and 2006-07. These RCs provide quantitative information and descriptive reports about individual schools. The number of schools imparting elementary education under DISE range from 8,53,601 schools in 2002-03 to 11,24,033 in 2005-06 and 11,96,663 in 2006-07. In 22 states, the ratio of primary to upper primary schools/ sections is better than the national average of 2.45. But in some states like Andhra Pradesh, Assam, Bihar, Jharkhand and West Bengal the ratio needs to be improved. The percentage of government and government aided schools is as high as 86.63% which shows that nine out of every ten schools imparting elementary education in the country are funded by the government. Schools imparting elementary education across the country vary in size. About 7.91% and 16.01% schools have enrolment between 1-25 and 26-50. There has been an improvement in the student-classroom ratio. About 40 students sit in a classroom in primary schools. And in some states the ratio has been higher, namely Bihar (92), Jharkhand (79) and Uttar Pradesh (53). During the period 2002-03 to 2006-07, the number of schools with computers increased impressively. Maharashtra has the highest number of schools (28,882 schools, 33.42%) with computers, while at all India level 6.51% primary schools had computers, compared to 11.05% independent upper primary schools. Schools with ramps increased from 4.63% in 2002-03 to 26.61% in 2006-07, which helps in attracting more physically challenged children to schools. Nutritious food is being provided to all children under the Mid Day Meal Scheme. 29% schools managed by the government and aided schools had kitchen-sheds in school. 30% and 23% of such schools are in rural and urban areas. The percentage of schools with kitchen-shed varies from 80% in Tamil Nadu to 3% in Jammu and Kashmir. The percentage of primary schools having attached pre-primary sections increased from 14.27% in 2002-03 to 26.69% in 2006-07. In 2005-06, 852,920 schools (71.27%) received Total Literacy Mission (TLM) grants. Gross Enrolment Ratio (GER) at primary level is estimated to be 110.86% while Net Enrolment Ratio (NER) is estimated to be 92.75%. GER in upper primary

classes is estimated to be 64.72%. In 2006-07, Gender Parity Index (GPI) in primary and upper primary classes in 609 districts was 0.93 and 0.87. Improvement in girls enrolment is reflected in girls share to total enrolment. In primary classes the share of girls enrolment in 2006-07 was 48.09% compared to 47.79% in the previous year. At primary level, SC and ST enrolment with respect to total enrolment was 20.11% and 11.36% respectively. Share of OBC enrolment in primary and upper primary classes is 42.18% and 41.23% respectively. The enrolment of Muslim children at primary level is 9.39% and 7.52% at upper primary level. 40 districts in the country have 25% Muslim students in primary classes. Most of these districts are from the states of Assam, Bihar, Jammu and Kashmir, Karnataka, Uttar Pradesh and West Bengal. In 2006-07, 1.42 million disabled children were enrolled in elementary classes, of whom 1.04 million were in primary and 0.38 million in upper primary classes. The dropout rate in 2005-06 was 8.61% in primary grades against 9.96% during the previous year. States like Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh and Tamil Nadu reported over 90% retention rate at primary level. Examination results are an indicator of learners' achievement. About 44.96% boys and 45.12% girls passed Grade IV/ V with a score of 60% and above compared to 38.83% boys and 40.06% girls who scored 60% and above marks in Grade VII/ VIII. The all India average reveals that on an average there were 4.4 teachers in a school in 2006-07 that imparted elementary education compared to an average of 2.9 teachers per primary school. All schools together had 41.86% female teachers. Pupil-teacher ratio (PTR) at primary level was 36 : 1. and upper primary level was 32 : 1. Bihar had high PTR at 67 : 1 at upper primary level; and 65 : 1 at primary level. The percentage of schools having para-teachers is very high in Rajasthan (17.98%), Madhya Pradesh (30.71%) and Chhattisgarh (16.53%). The percentage of teachers involved in non-teaching assignments was 11.36%. Share of SC and ST teachers in government schools is 12.2% and 8.82% respectively. Few areas of concern are : states may need to expand upper primary schooling facilities; more teachers are needed in single teachers schools; dropout rates need to be checked; quality of education needs to be improved in terms of results and learning attainment; and states may be advised to monitor district specific educational development index (EDI).

Key Words : 1.EDUCATION 2.PRIMARY EDUCATION 3.ELEMENTARY EDUCATION 4.STATE REPORT CARDS 2006-07 5.SARVA SHIKSHA ABHIYAN 6.STATISTICS 7.STATISTICS EDUCATION.

9. Pratham, New Delhi. (2009).
Annual status of education report (rural) 2008 : provisional : January 13,
2009. New Delhi : Pratham. 193 p.

Abstract : Annual Status of Education Report (ASER) evaluates the education situation in India. It focused on basic reading, comprehension and arithmetic. ASER 2008 assessed curriculum in early grades and indicators like time, school time table, maps, famous people, and currency tasks. ASER design assigns a few tasks to all sampled children on a massive scale – almost 500,000 children across India. ASER is a common man’s tool for understanding what children know and should know, and assesses children’s learning and achievement. One aspect noticed is the trend of increasing enrolment in private schools. In the 6-14 years age group children enrolled in private schools increased from 16.4% in 2005 to 22.5% in 2008, and the increase was significant in many states. Large scale investment has taken place in the government education system under Sarva Shiksha Abhiyan (SSA), partly financed through the collection of education cess since 2004. In the context of the right of children to free and compulsory Education Bill, 2008 25% allocation of seats has to be made to children from the neighbourhood who belong to economically weaker sections. The states that report the greatest improvement in ASER 2008, in decreasing order are Nagaland, Kerala, Goa, Jammu and Kashmir, Himachal Pradesh, Punjab, Rajasthan and Karnataka. In the case of Kerala and Goa, nearly half of all enrolled children in the 6-14 years age group attend private schools. Four out of five of these states have high investment in the public education system, financially and socially. Schools under private management rose from 15.15% in 2004-05 to 18.86% in 2006-07. In 2005, ASER investigators visited one government/ private school in each of the sample villages and collected data on school facilities and teacher and student attendance. In 2007, children were also asked whether they paid for additional tuitions. ASER 2008 adds information on household assets and village infrastructure variables. According to ASER between 2005 – 2008, the percentage of rural 6-14 year olds going to private schools has increased from 16.4% to 22.5% at the all India level. In Kerala, the enrolment in private schools increased from 22.4% in 2005 to 49% in 2008. In the ASER 2008 sample, about 50% of private school children came from homes which had “pucca” walls and roof. The corresponding number for government school children was 25%. According to ASER 2008 findings, nationally the proportion of 7-10 year olds not in school is 2.7% and the proportion of 11-14 year olds not in school is 6.3%. In Bihar, children (6-14 years old) not in school have dropped steadily over the last four years from 13.1% in 2005 to 5.7% in

2008. Over the same period, the proportion of girls (11-14 years old) not in school has dropped from 20.1% to 8.8%. Children in Chhattisgarh showed improvement in reading. The proportion of children in Standard III who could read a Standard I level text book increased from 31% in 2007 to 70% in 2008. The proportion of Standard V children who could read a Standard II level textbook in 2007 was 58% which rose to 75% in 2008. In Madhya Pradesh 86.8% government school children in Standard V could read Standard II level text. In Kerala and Himachal Pradesh 73-74% children in Standard V can read Standard II text in government schools. In Madhya Pradesh and Chhattisgarh maths skills have improved over the last year. In Madhya Pradesh, Standard III children who can solve a subtraction problem increased from 61.3% in 2007 to 72.2% in 2008; and 78.2% children of Standard V in Madhya Pradesh could correctly solve a division problem, which was the highest. In Chhattisgarh (2008), 77.8% children in Standard II could identify numbers up to 100. Children in Standard III who could do subtraction increased from 21.8% in 2007 to 63.5% in 2008. In Uttar Pradesh, Tamil Nadu, Karnataka, Andhra Pradesh and Gujarat about 50% children in Standard V could tell the time. Children in Bihar, Jharkhand, Orissa, Haryana, Jammu and Kashmir, Punjab and Uttarakhand were also above the national average. In Madhya Pradesh, Kerala, Chhattisgarh and Maharashtra more than 75% children in Standard V could tell the time. ASER 2008 explored village infrastructure and household characteristics to find links with education. Primary schools are available within 1 Km. of 92.5% rural habitations, 67.1% villages have government middle schools and 33.8% villages have government secondary schools. STD booths are present in 58.5% villages, and *pucca* (permanent) roads connect 71.9% villages to the outside world. In the age group 6 to 14 years, there is a decline in the percentage of children out of school in every state. In 2006, only 2 states namely Kerala and Himachal had less than 2% children out of school. In 2008, Uttarakhand (1.0%), Madhya Pradesh (1.9%), Maharashtra (1.5%) and Tamil Nadu (0.6%) also had very few children out of school. In the 11-14 years age group in 2008, there were four states namely Kerala (0.3%), Tamil Nadu (1.1%), Himachal Pradesh (1.1%) and Uttarakhand (1.8%) where there were less than 2% children out of school. From 2006 to 2008, Bihar showed the steepest drop in proportion of children out of school. In the rural sector, the highest percentage children out of school in the age group 6-14 years was in Orissa (7.2%) and the lowest was in Kerala (0.2%). Also, the number of children in Standard 1-2, who could read letters and words was highest in Kerala (98.6%) and lowest in Tamil Nadu (54.7%).

Key Words : 1.EDUCATION 2.PRIMARY EDUCATION 3.RURAL EDUCATION 4.OUT OF SCHOOL CHILDREN.

10. Sharma, Suresh. (2009).
Literacy and school attendance in India. New Delhi : Institute of Economic Growth. 35 p.

Abstract : The Indian Constitution mandated free and compulsory education for all children up to the age of 14. 'Operation Blackboard' and 'Sarva Siksha Abhiyan' are state sponsored movements that aimed at universal enrolment and providing the basics. The 55th Round of the National Sample Survey (NSS), was conducted in 1999/2000 and estimated primary school attendance, school attendance and primary completion rates. The study finds that the largest marginal effects are association with household living standards, access to electricity and expenditure on elementary schooling. The National Family Health Survey (NFHS) was used to provide an opportunity to cross-check the results of one study against the other. Nearly 21 million children of primary school age in India were out of school in 2006, more than in any other country. According to data from the nationally representative NFHS-3, 2006 primary school net attendance rate (NAR) in India was 83%, but secondary school NAR was 53.7% only. States with the highest primary school net attendance rates between 98% and 99% are Himachal Pradesh, Kerala and Tamil Nadu. 6 other states also have primary NAR values above 90%, namely Assam, Goa, Gujarat, Maharashtra, Mizoram and Uttarakhand. In 6 states, fewer than four out of five children of primary school age are in school namely : Andhra Pradesh, Bihar, Jharkhand, Meghalaya, Nagaland and Sikkim. The lowest primary school attendance rates are observed in Bihar (59%) and Meghalaya (60%) which are two of the poorest and economically least developed states of India. The main reason for not attending school as mentioned by children aged 6-17 years in 2006 were that they were 'not interested in studies'; of these, 35% boys and 21% girls were in rural areas. The next most commonly reported reason for dropout is that it 'costs too much' for both boys and girls, followed by 'required for outside work for payment in cash or kind' for boys and 'required for household work' for girls, repeated failure for both the genders, 'required for work on family farm/family business' for boys, and finally 'required for household work' for 10% boys and 15% girls. It is note worthy that growth in female literacy rate has been higher than that of male literacy rate, narrowing the gap between both during the 1980s and 1990s. This could be explained due to the implementation of programmes like DPEP, literacy promotion programmes through NLM and Adult Literacy Programme, etc. Data from the 1991 and 2001 Census showed that in the population aged 7 years and above literacy rates rose substantially in the 1990s from 52% to 65%, an increase of 13 points. Some states experienced particularly rapid literacy increases. In Madhya Pradesh and Rajasthan, literacy rates rose by 20 to 22% points respectively. Also large increases were apparent in states like Uttar Pradesh and Andhra Pradesh. However Bihar and Gujarat made poor progress. Any major improvement in national literacy in future will

depend crucially on its progress among the north Indian states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. Between 1981 and 2001, the literacy rate of the population increased by 21.82% points and the female literacy rate went up by 24.41% points. The concept of 'quality of education' has focused on learning achievement, relevance of the curriculum to labour markets, social, cultural and political environment in which the learner finds himself/ herself. The conditions of learning include teachers and facilities and on an average there are 150 students in each school, and private schools have higher average enrolment (222) than government schools (133). All schools together have an average of 36 students per classroom (2006-07) compared to 39 in 2005-06. The student per classroom ratio is higher in primary schools (40 students per classroom) compared to other school types. 84.89% schools had drinking water facilities; 58.13% schools had common toilets, 42.58% schools had girls toilets; and 13.43% schools had computers in 2006-07. The highest pupil-teacher ratio in 2006-07 was in primary schools (39:1), followed by elementary schools (34:1), integrated higher secondary schools and independent upper primary schools (29:1), and upper primary attached to secondary and higher secondary schools (27:1). Government initiatives to improve school education are Sarva Shiksha Abhiyan (SSA), Mid Day Meal Scheme and Para Teacher Schemes. The SSA campaign aims to universalize elementary education (Grades 1 to 8) by the year 2010. SSA envisages a pupil teacher ratio of 40:1; establishment of alternative schools and education guarantee scheme (EGS) schools in small habitations; establishment of block or cluster level resource centres, establishment of bridge courses for dropouts; in-service training for teachers; grants for teaching learning materials; initiate measures to close caste and gender gaps in education, give free text books to female and low caste students; give special facilities to girls; and give grants to districts to support students with disabilities. Under the Mid Day Meal Scheme (MDM) lunch is provided to about 120 million children every school day and this is the world's largest school meal scheme. In states like Kerala and Tamil Nadu, the destitutes and aged are also allowed to take the MDM, and in Gujarat the scheme covers children from Grades 1 to 7. By 2002 about 220,000 para teachers had been appointed, and by 2004, their number had risen to about 500,000. Para teachers have educational qualifications below the government primary school regular teachers, and are employed on salaries that are one-fifth to one-half of government teacher salaries in order to (1) expand schooling in a low cost way; (ii) increase the number of instructors in single teacher schools and (iii) to reduce high pupil teacher ratios. The impact of these new interventions has not been studied in detail, and this is required if suitable policy modifications need to be made.

Key Words : 1.EDUCATION 2.SCHOOL ATTENDANCE 3.LITERACY 4.OUT OF SCHOOL CHILDREN.

11. UNESCO, Paris. (2009).
EFA Global monitoring report 2009 : education for all : overcoming inequality : why governance matters. Paris : UNESCO. 463 p.

Abstract : This report tracks annual progress towards the Education For All (EFA) Goals, and offers a comprehensive overview of the state of education in the world today. Getting young girls into school and retaining them in the education system is one of the most effective strategies for closing gender gaps in education. Income based disparities are mirrored in differences in average years of education attained by people 17-22 years. In India people from the poorest 20% have an average 4.4 yrs. of education compared to 11.1 years for people from the richest 20% of the population. In India, rising wage inequalities are closely linked to wide wage gaps between people with tertiary education and those at lower attainment levels. At the global level, the poorest 40% of the world's population is living on less than US \$2 a day. Levels of education also have an important bearing on maternal mortality. Around 10% children of women with secondary education, 20% children of women with primary education, and 40% children non-educated women were born without antenatal care. In India, women with secondary and higher education are having 8-9% of the severely stunted children, whereas percentage of severely stunted children was about 25% among non-educated women. Child mortality is one of the most sensitive indicators of well being for children under 5 years. Each year around 10 million children die before they reach the age for starting primary school (UNICEF 2007). India accounts for one in three malnourished children in the world. Improved access to preschool can enhance both education outcomes and equity. A programme in India's Haryana state resulted in a 46% decline in dropouts among lower caste children. Pre-primary enrolment ratio was 19% in 1999, which increased to 40% in 2006. Number of out of school children has been decreasing every year. India is one of the three countries who are on track to achieve TNER (Total primary net enrolment ratio) in excess of 97% by 2015. TNER for 2004-07 in India is 94%, and the projected TNER for 2015 is 99%. India invests only about 3.3% of GNP (Gross National Product) on education. In urban India around 96% of the total increase in primary enrolment between 1993-2002 is estimated to be due to growth in private schools unaided by Government, and while growth in private enrolment was slower in rural India, it still accounted for 24% of the increase in rural areas. The EFA Global Monitoring Report offers a caution to governments, donors and the international community. Current trends indicate that universal primary education will not be achieved by 2015. Too many children are receiving an education of such poor quality that they leave school without basic literacy and numeracy skills. Deep and persistent disparities based on wealth, gender, location, ethnicity and other markers of disadvantage are acting as a major barrier to progress in education. If the world's Governments are

serious about Education For All, they must get more serious about tackling inequality and improving quality of education.

Key Words : 1.EDUCATION 2.PRIMARY EDUCATION 3.EDUCATION FOR ALL 2009 4.SCHOOL EDUCATION 5.PRESCHOOL EDUCATION.

HEALTH

12. Chatterjee, Meera et al. (2008).
Sparing lives: better reproductive health for poor women in South Asia.
New Delhi : World Bank. 266 p.

Abstract : Every year about 185,000 South Asian women die from causes related to pregnancy. India's U5MR (Under-5 Mortality Rate) between 2001 and 2005 was estimated as 74 per 1000 children born, and for 2005-06 it was 52 (IIPS and Macro International Survey: 2007). The five countries (Bangladesh, India, Nepal, Pakistan, Sri Lanka) had a total estimated population of 1,362 million in 2001, over one-fifth of the world's total. Together they account for 98% of South Asia's population. Women in the reproductive age group (15-49 years) constitute 23% to 27% of the country's population, while adolescents constitute 20% of the population. The prevalence of anaemia among 15-49 years old women in India was 51.8%. While the sex ratio in most parts of the world is expressed as the number of males per 1000 females, India and other parts of South Asia report sex ratio as the number of females per 1000 males. In India 65% of the pregnant women received some antenatal care and 53% received intranatal care, only 30% received any attention post-partum. Among the five countries, the maternal mortality ratio (MMR) in 2000 was highest in India (540), Nepal (539) and Pakistan (500), and 25-30% lower in Bangladesh (380). Educational attainments are high in Sri Lanka with equal access to schooling, and they are rising in the other 4 countries. Gender gaps in schooling indicators are commonly about 20%. For example in India, 86.7% boys in the 15-19 years age group are literate compared to 62.4% girls. India's third National Family Health Survey (NFHS 3, 2005-06) reports that one in five women aged 15-19 years experienced physical violence in the preceding year, and this was more among poor illiterate women (IIPS and Macro International, 2007). In India 60% urban and 54% rural 15-19 years old boys could identify two ways to prevent HIV infection (NACO and UNICEF, 2002). Over the past 25 years, there has been only a marginal increase in the age at marriage in India, the median age has increased only from 15.8-18.3 years for girls. At present, in India, 25% to 50%

adolescent girls are married. Among ever married women in the 25-49 years age group, well over half were married by the age of 18, i.e. below the legal age. Adolescent fertility rates are high in Bangladesh (134), India (107) and Nepal (110), and low in Sri Lanka (27). In Nepal 25% women are underweight and in India the proportion was 42% in 1998-99 and 47% in 2005-06. HIV infection in the adult population was 0.06% in Pakistan and Sri Lanka, 0.3% in Bangladesh and India, and 0.5 in Nepal. In 2006, about 1.7 million persons in 15-49 years age group were estimated to be HIV+. Evidence from India indicates that young women (15-24 year olds) have a higher rate of HIV infection (0.96%) than young men (0.46%) and adults in general (0.8%) (UNICEF/ UNAIDS/ WHO, 2002). 60% of HIV infections in India are in rural areas. In 2006, awareness about AIDS had increased in Bangladesh to 67% among women and 85% among men, while in India to 61% among women and 83% among men. The prevalence of anaemia among 15-49 years old women in India was 51.8%. In 2006 anaemia among young children in India was 70%. Nearly 50% neonatal deaths are of LBW (low birth weight) babies in India. Use of family planning methods in 2005-06 was higher among Hindus (50%) and Christians (49%) than among scheduled castes (47%), scheduled tribes (43%) and Muslims (36%) (IIPS and Macro International, 2007). In India unmet need for family planning was estimated to be 18.2% among poorest quintile of married women and 8.1% among the richest quintile (IIPS Macro International, 2007). In India in 2005-06 ANC (antenatal care) coverage was 74.5% among Hindus, 71.7% among Muslims, 80.8% among Christians, 70.8% among SCs and 62.1% among STs. In India only 8.4% of live births to poorest mothers took place in public institutions compared with 24% among the richest quintile mothers. It was recommended that use of skilled birth attendants should be increased including referral in case of need; use of EMOC (Emergency Obstetric Care) should be increased; use of PNC (Pre-natal Care) should be increased including management of PPH (Post Partum Haemorrhage), treatment of infections and depression, and breastfeeding counselling; use of IMNCI (Integrated Management of Neonatal and Childhood Illnesses) should be increased; use of unsafe abortion facilities should be reduced, and there should be improvement in safe abortion services, where it is legally allowed, and post abortion care for adolescents and unmarried women should be improved and increased.

Key Words : 1.HEALTH 2.REPRODUCTIVE HEALTH 3.MATERNAL HEALTH 4.CHILD HEALTH 5.NEWBORN CARE 6.IMMUNIZATION 7.BEST PRACTICES 8.GOOD PRACTICES 9.MATERNAL MORTALITY 10.DEFINITIONS HEALTH 11.HEALTH SYSTEM 12.ASIA 13.SOUTH ASIA 14.SRI LANKA 15.INDIA 16.PAKISTAN 17.BANGLADESH 18.NEPAL.

13. Chawla, Manisha, Shiv Shankar and Gupta, S.D. (2006).
Assessment of referral transport scheme for emergency obstetric care
under RCH Phase I Rajasthan. Jaipur : Indian Institute of Health
Management Research. 52 p.

Abstract : The Reproductive and Child Health (RCH) Programme was initiated in India during 1997-98. In Rajasthan, 7 districts were covered in Phase - I, 11 districts in Phase - II and the remaining 14 districts in Phase - III. Most maternal deaths are due to obstetric complications and “Referral Transport scheme” (RTS) aims at improving access to and proper utilization of Emergency Obstetric Care (EOC) services. Out of a total of 32 districts, the Referral Transport Scheme was implemented in 19 districts. This study assessed the availability and utilization of benefits under the scheme. Information was collected from 60 women who had used the scheme and whose names were on the record of listed users and 60 unlisted users who had undergone either complicated or institutional deliveries. Type of complications were delayed or obstructed labour, excessive bleeding, fits, high blood pressure, etc. Study was conducted in districts of Churu, Baran and Jodhpur. A sum of Rs. 70.8 lakhs was released for all the districts but only Rs. 12.58 lakh (17.7%) had been spent for 3,101 women. Out of the total listed users, more than 90% had faced emergency obstetric problems related to pregnancy. 83% of such users reported to have had emergency problems during delivery, 37% during pregnancy and 13% after delivery; 31.7% had anaemia, 20% had delayed labour and 15% had bleeding. 62% went to Government hospitals to manage the emergency and 14% had chosen private hospitals. In Baran, 93% went to a Government hospital, whereas in Churu 65% opted for a Government hospital and 27% chose a private hospital. In the case of non-users, more than 80% experienced such problems, 21.7% reported anaemia as their emergency problem, 15% bleeding, and 15% delayed labour. Only 78% of those who were listed in the RCHO had heard about the scheme. In Churu 40% of the listed users had never heard about the scheme, while in Baran almost all listed users knew about it. However only 5% of the non-users reported knowledge about the Transport Scheme. Out of the women who knew about the scheme, 66% got the information from the ANM/Nurse/Midwife/LHV, whereas the doctor was the source of information for 27% of the listed users. For the 7% remaining women, PRI members and other health care professionals were the source of information. In Baran, a doctor had given this information to 40% of the users whereas in Churu, more than 80% were given information by the ANM/Nurse/Midwife/LHV. Out of 60 listed users

only 47 had heard about the scheme and 37 women reported receiving money for the transport used to reach the health facility. In Churu, 9 women out of 30 listed users had received money for the transport used to reach the health facility for delivery. The ones who did not receive the money had to wait for about 2- 4 months. In Baran, 8 women got the payment with an average delay of 1- 2 months and 2 women did not receive any funds at all. Among the women who had heard about the scheme and used it effectively, the main constraints faced were getting the forms attested in the case of 12.8% of the users and getting the payment in time for 25.5% of the users. 54% of the actual users availed this facility because of complications during pregnancy or delivery, while the rest of them availed it for having institutional/safe delivery. The data shows an increasing trend and positive attitude towards institutional/ safe delivery among the rural population. A large number of deliveries (36.7%) were conducted at Community Health Centres, while among non-users home was found to be the most popular place of delivery (30%) even in case of complications. 23% users and 15% non-users had chosen the district hospital for delivery. Only 3.3% of the listed users reported having had home deliveries. In Churu, 33.3% went to the district hospital and private hospitals, whereas in Baran, 53.3% went to the CHC, 33.3% to the PHC and none to private hospitals. Average distance between a PHC and a CHC was 31.5 km in Churu, 20 km in Baran and 27 km in Jodhpur. Time taken to travel from a PHC to the CHC was approximately 1 hour in Churu, 45 minutes in Baran and more than 1 hour in Jodhpur. Cost of travel from a PHC to a CHC was Rs. 277 in Churu, Rs. 233 in Baran and Rs. 369 in Jodhpur. Clear and specific guidelines should be circulated to the concerned district officials about selection of the Panchayats. All Government health care providers should go for induction training and introduction to current schemes before their posting. Fund disbursement should be health institution based and not person based. Awareness generation and education at the community level should be strengthened for the proper implementation of this scheme. ASHA (Accredited Social Health Activist) and NGOs should be involved in IEC activities, and counselling and motivation of the potential beneficiaries should be undertaken. A proper monitoring system and a management information system should be developed, and the number of health facilities expanded, as distance from the health facility was one of the factors obstructing the usage of the scheme.

Key Words : 1.HEALTH 2.TRANSPORT SCHEME 3.PREGNANT WOMEN
4.REPRODUCTIVE CHILD HEALTH 5.OBSTETRIC CARE 6.JANANI
SURAKSHA YOJANA 7.RAJASTHAN.

14. Countdown to 2015 Core Group, New York. (2008).
Countdown to 2015 for maternal, newborn, and child survival : the 2008 report on tracking coverage of interventions. New York : CCG. 15 p.

Abstract : The countdown to 2015 Collaboration tracks coverage for interventions that are essential to attain Millennium Development Goals (MDG) 4 and 5 and elements of MDGs 1, 6 and 7. It also tracks coverage of proven interventions and measures of mortality reduction and nutrition levels in countries with the highest burden. 68 countries had 97% of maternal and child deaths in 2005. Maternal mortality ratio (MMR) were defined as very high (550 or more); high (300-549); moderate (100-299) or low (below 100). Data for the 2008 countdown cycle showed that 16 of 68 countries (24%) were on track to meet MDG 4. These included seven countries (Bangladesh, Brazil, Egypt, Indonesia, Mexico, Nepal and the Philippines) that had been included in the 2005 countdown report. Six of the remaining nine countries were included in the countdown process for the first time in 2008 (Bolivia, Eritrea, Guatemala, Laos, Morocco and Peru). The other three countries (China, Haiti and Turkmenistan) had been assessed at 2005 countdown and were not on track, later they made demonstrable progress toward MDG 4 between 2005 and 2008. Of the 68 countries, 56 (82%) had either high or very high rates of maternal mortality. India's mortality in children below 5 years was 76 deaths per 1,00,000 live births in 2006, which should decrease to 38 deaths per 1,00,000 live births as per MDG 4 target for 2015. Only 3 countries (Azerbaijan, China and Mexico) had low maternal mortality. Lifetime risks for maternal death ranged from one in seven in Niger to one in 1300 in China. Sub-Saharan Africa accounted for 50% of the world's maternal deaths and South Asia for 45%. Of 26 countries with no reduction of mortality in children younger than 5 years, all had high or very high maternal mortality. Skilled attendance, oral rehydration therapy, and care-seeking for pneumonia increased by 2% or less compared with increases of 4-7% for tetanus immunization in pregnancy and antenatal care. Skilled attendance at birth reached half of the women and babies in these 68 countries and is affected by logistical factors (such as long distances to health facilities and high transport costs) and by supply factors, including non-existent or poor quality services. Integrated Management of Childhood Illness (IMCI) continues to receive less than 1% of investment in maternal, newborn and child health, hence it is not surprising that progress is slow. Undernutrition has been shown to be the underlying cause of 3.5 million child deaths every year and at least 35% of the disease burden in children younger than 5 years. Maternal undernutrition increases the risk of death of the mother at birth and might be associated with at least 20% of maternal mortality. In 33 of the 68 countries, at least 20% of children were moderately or severely underweight and in 62 countries, stunting prevalence was greater than 20%. In India, in 1998-99, 44% children below 3

years were underweight, which declined to 41% in 2005-2006. Exclusive breastfeeding in India was 46% in 1998-1999, which remained the same in 2005-2006. Progress towards goals depends on the availability of reliable and timely data to guide decision making in countries.

Key Words : 1.HEALTH 2.MATERNAL MORTALITY 3.CHILD MORTALITY 4.MATERNAL AND CHILD MORTALITY 5.CHILD SURVIVAL 6.MILLENNIUM DEVELOPMENT GOALS 7.REDUCTION INFANT MORTALITY 8.REDUCTION MATERNAL MORTALITY.

15. National AIDS Control Organization, New Delhi. (2008).
HIV sentinel surveillance and HIV estimation in India 2007 : a technical brief. New Delhi : NACO. 24 p.

Abstract : The 2007 Round of HIV Sentinel Surveillance (HSS) was conducted across the country from October 2007 to January 2008 at 1134 sentinel sites. Surveillance was conducted among ANC clinic attendees, STD clinic attendees, female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU), migrants and truckers. Methodology adopted was unlinked Anonymous Testing of consecutively selected samples at service points such as ANC clinics, STD clinics, Drop in centres, De-Addiction centres, etc. National AIDS Control Organization (NACO) conducts HIV Sentinel Surveillance and estimation with the support of two National Institutes: National Institute of Health and Family Welfare, New Delhi and National Institute of Medical Statistics, ICMR, New Delhi. ANC sites which have greater than 3% positivity and high risk group sites (STD/FSW/MSM/IDU) with greater than 15% positivity were investigated. Overall 41 sites were investigated and the findings validated. Samples collected for HSS are tested in 300 laboratories across the country. At the national level, the overall HIV prevalence among different population groups in 2007 were MSM 7.4%, IDU 7.2%, FSW 5.1% and STD clinic attendees 3.6%. The prevalence among ANC clinic attendees was low 0.48% (age adjusted). States with high HIV prevalence among IDU are Maharashtra (24.4%), Manipur (17.9%), Tamil Nadu (TN) (16.8%), Punjab (13.8%), Delhi (10.1%), Chandigarh (8.6%), Kerala (7.9%), West Bengal (7.8%), Mizoram (7.5%) and Orissa (7.3%). At the state level, HIV prevalence among FSWs is very high in Maharashtra (17.91%), followed by Manipur (13.07%), Andhra Pradesh (AP) (9.74%), Nagaland (8.91%) and Mizoram (7.2%). Other states like Gujarat, Karnataka and West Bengal have HIV prevalence greater than 5% among FSWs. Among MSMs, high HIV prevalence is recorded in the states of Karnataka (17.6%), AP (17.04%), Manipur (16.4%),

Maharashtra (11.80%), Delhi (11.73%), Goa (7.93%) and Gujarat (8.40%). In all, 11 states have shown greater than 5% HIV prevalence among MSM. Among STD clinic attendees, AP continues to show highest prevalence (19.72%; 7.60%-39.20%), followed by Maharashtra (16.18%; 7.20%-32.20%), Karnataka (7.15%; 1.60%-10.80%), and TN (12.04%; 1.60%-38.40%), Mizoram (7.13%) and Goa (5.60%). HIV epidemic among IDU was high in Maharashtra (24.4%), Manipur (17.90%), TN (16.80%), Punjab (13.79%), Delhi (10.10%), Chandigarh (8.64%), West Bengal (WB) (7.8%), Kerala (7.8%), and Orissa (7.3%). 6 states have shown HIV prevalence between 1% and 5% among IDUs - namely Meghalaya (4.17%), A.P. (3.71%), Assam (2.14%), Karnataka (2%), Nagaland (1.90%) and U.P. (1.29%). Estimated adult HIV prevalence in India in 2007 is 0.34% (0.25%-0.43%). Among males, HIV prevalence is 0.40% and among females it is 0.27%. Estimated adult HIV prevalence remains greater than 1% in Manipur (1.57%) and Nagaland (1.20%) in 2007. AP has an estimated adult HIV prevalence of 0.97%, while Karnataka and Maharashtra have estimated adult HIV prevalence less than 1%. TN, WB, Gujarat and Delhi have estimated adult HIV prevalence of 0.4%. The total number of people living with HIV/AIDS (PLHA) in India in 2007 is estimated to be 2.31 million (1.8-2.9 million). Females constitute around 39% of the burden (0.9 million), children below 15 years constitute 3.5% of the estimated numbers of PLHA, while elderly people whose age is greater than 49 years constitute 7.8% of PLHA. Adults aged 15-49 years constitute 88.7% of the estimated number of PLHA. The highest number of PLHA are in AP and Maharashtra, with nearly half a million PLHA in each state. Besides TN and Karnataka, WB, Gujarat and U.P. are estimated to have a higher burden, and there are more than 0.1 million PLHA in each of these states. The 4 south Indian states contribute 60% of all PLHA in the country, and along with WB, Gujarat and UP they contribute 80% of PLHA in India. Though Manipur and Nagaland have the highest HIV prevalence in the country, due to small population size, the estimated number of PLHA in these two states is less than 25,000. Kerala, Bihar and Rajasthan have more than 50,000 PLHA each though the HIV prevalence in these states is low.

Key Words : 1.HEALTH 2.AIDS 3.HIV/AIDS 4.AIDS PREVALENCE 5.AIDS SURVEILLANCE.

16. Sharma, Suresh. (2007).
Immunization coverage in India. Delhi : Institute of Economic Growth.
27 p.

Abstract : Immunization forms the major focus of child survival programmes throughout the world. Almost 3 million children die each year of vaccine preventable diseases (VPDs) and many of these children reside in developing countries. Nearly 34 million children are not completely immunized, and almost 98% of them reside in developing countries. Immunization against common childhood diseases has been an integral part of mother and child health (MCH) services in India and it was reinforced by the Declaration of Health Policy in 1983. Vaccination against polio using oral polio vaccine (OPV) was added to the programme in 1979-80, and BCG vaccination against tuberculosis was added in 1981-82. Vaccination against measles was included in 1985-86. In 1985, the Universal Immunization Programme (UIP) was launched to protect all infants (0-12) months against 6 serious but preventable diseases namely tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis and measles. Data sources on immunization coverage include secondary data from the National Family Health Survey 1998-99 (NFHS-2), Uttarakhand and all-India, the Coverage Evaluation Survey (CES-2001); RCH Programmes' Rapid Household Survey (1998-99), and RCH Programmes Rapid Household Survey (2002-04). The sample consists of ever-married women in the 13-49 years age group. The Rapid Household District Surveys performed in 1998/9 and again in 2002/3 show that of the 236 districts that can be currently compared, 174 (74%) showed a decrease in infant full immunization rates. Comparing the 2002/3 results with 1998/9, a significantly greater percent of districts showed 40% full immunization coverage (43% compared with 30%). A significantly lower percent of districts had 60% full immunization coverage (35% compared with 45%). A specific Immunization Strengthening Project (ISP) was designed to run from 2002-2003, which had 3 objectives namely: polio eradication, strengthening routine immunization and strategic framework development. The percentage of children who are fully vaccinated ranges from 13% in Nagaland to 91% in Tamil Nadu. In 15 states, Nagaland (13%), Meghalaya (14%), Assam (17%), Arunachal Pradesh (22%), Bihar (23%), Rajasthan (25%), U.P. (26%), Jharkhand (27%), M.P. (30%), Tripura (31%), J&K (32%), Mizoram (33%), Manipur (34%) and Uttarakhand (44%) full immunization is below the national average 46%, and in only 10 states/union territories i.e. in Maharashtra (71%), Karnataka (71%), Punjab (73%), Goa (77%), Kerala (79%), H.P. (79%), Dadra and Nagar Haveli, Pondicherry and T.N. (91%) is full immunization above 70%. Almost half of the children in the age group 12-23 months in Bihar have not received a single vaccine and it ranges from 20% to 45% in Jharkhand, U.P., Rajasthan, Arunachal Pradesh, Uttarakhand, Assam; and between 10% and 20% in Meghalaya, M.P., Mizoram, Nagaland, and Haryana. The highest vaccination

coverage was recorded in Ratnagiri and Kolhapur districts of Maharashtra and Toothukudi district of Tamil Nadu, where 99% children received the complete schedule of vaccination. In 12 more districts - Sindhudurg (Maharashtra), Uttar Kannada (Karnataka), Yanam (Pondicherry), Ariyalur, Chennai, Dharmapuri, Dindigul, Erode, Namakkal, Pudukkottai, Theni and Virudhunagar (all in T.N.), the vaccination coverage is 95% or more. The districts with high coverage are in Tamil Nadu (all 30 districts), 14 districts in Karnataka, 10 districts in Kerala, 8 districts in Maharashtra, 6 districts in H.P. and Punjab, 4 districts in Haryana, all four districts in Pondicherry, 2 districts in Gujarat and 1 district in Orissa, Daman and Diu and Dadra and Nagar Haveli. The 64 districts that have a poor performance i.e. where coverage is below 20% are 19 districts each in U.P. and Bihar, 12 districts in Rajasthan, 8 districts in M.P., 5 districts of Jharkhand and 1 district in Uttarakhand. Other than these districts, 41 districts are from north-eastern states (15 districts in Assam, 6 districts each in Arunachal Pradesh and Nagaland, 5 districts in Meghalaya, 3 districts in Mizoram and 2 districts of Tripura; 9 districts in Jammu and Kashmir and one district in Gujarat also fall under this category). On the other hand, there are 226 districts in India where less than 5% of the children did not get any vaccine. Besides, there are 17 districts where 60% or more children did not get a single dose of any vaccine - these are 9 districts in Bihar, 5 districts in Jharkhand and 1 district each from Arunachal Pradesh, UP and Nagaland. In Kausambhi district of UP (67%), Sahibganj (69%) and Deoghar (72%) of Jharkhand, Jamui (73%), Paschim Champaran (74%) and Kishanganj (79%) of Bihar, two-thirds or more children did not receive even a single dose of vaccine. 69% children received polio vaccine at the time of birth in urban areas whereas this proportion was only 33% in rural areas. Only 28% children of non-literate mothers are fully vaccinated compared to 56% children whose mothers were educated to a level below high school and 74% of mothers who had at least completed high school. Hindu children (47%) are much more likely than Muslim children (36%) to have received each of the recommended vaccinations. SC/ST were disadvantaged groups and immunization coverage among them was found to be lower than that for children from other groups. Programme management skills of the lower and mid level managers should be strengthened to address the high dropout rates and low proportion of fully immunized infants. Routine immunization services should be re-vitalized in urban areas; and Muslims, illiterate parents, and populations residing in the plains should be focused on. Regular immunization services should be on a fixed day and at a fixed place. The issue of poor utilization of immunization services, obstacles and lack of awareness or motivation should be addressed through professionally designed behavior change communication (CBC) interventions. Eradication of polio in the next few years will provide opportunities to introduce newer vaccines in the programme.

Key Words : 1.HEALTH 2.IMMUNIZATION COVERAGE.

HUMAN DEVELOPMENT

17. FORCES, New Delhi. (2002).

Sibling care : a status report from the slums of Delhi : bachchon ko sambhalte bachche.-- New Delhi: FORCES. 31 p.

Abstract : Lakhs of children residing in the *jhuggi bastis* (slums) of Delhi have suffered from several problems related to health, sanitation, drinking water, education, etc. The present study was done in 17 *bastis* of Delhi to highlight the denial of child rights of both the sibling care givers and the young children, and to present the picture of neglect by the government and civil society towards the issue of lack of support services for early childhood care and development. Data was collected through group discussions with women and children, and general information was also gathered from these *bastis* (New Ashok Nagar, Nizamuddin, Kirbi Place, Jawalपुरi, Jagdamba Camp, Nangloi A Block, Banuwal Nagar, Mangol Puri F G Block, Sanjay Camp, New Mazdoor Camp, Nand Nagari Extension Part-I, Udyog Nagar Part-II, New Sham Nagar, Indira Camp No. 3 Vikaspuri, Yamuna Pushta, Rohini Extension Sector 25, and Dwarka Sector 16 A). The study found that in most *bastis* basic facilities (e.g. dispensaries, schools, anganwadis, open playground area, etc.) were seen only in the *pucca* (permanent) settlements. Out of 17 *bastis* only in Nizamuddin (E) basti, 7 anganwadis were found working, whereas in resettlement colonies like Nangloi (A Block), Sunder Nagri (Extn.), Mangol Puri (F/G Blocks) and Neb Sarai, which were *kuccha* (non-permanent) settlements, these services were not available. The facility of government run crèches was not available even in a single *basti*. In these *bastis*, non-government organizations (NGOs) were providing crèches services for working mothers. It was noted that many children from poor families had dropped out from school at primary and middle school levels, and worked either in lowly paid jobs or took care of their younger siblings at home and helped in domestic chores. More than 85% women who worked had home-based child birth with the help of traditional birth attendants (*dais*). It was found that in *kacchi bastis* and *jhuggi* settlements there was one water source per 200 households. Majority of women mentioned that their age at marriage was between 13-18 years, and their age at first child birth was between 15-17 years. On an average, women were pregnant 5-8 times and there were 3-7 child births per women. Almost all women reported poor health after successive child births. In all the households where women's earnings were crucial to meet the family needs, the women returned to work as early as 5-7 days after child birth or took leave for 20-25 days, at the most. Because of the working status of women they could not exclusively breastfeed their infants for more than a month or two. Negligible facilities for early child care in all *bastis*

was the focal point of all group discussions. About 80% of the women desired that their daughters should receive education upto 8th Class, but all of them felt that their sons should study upto 10th or 12th Class. Almost all women felt that girls should be married at the age of 17-18 years or more and sons should be married only when they were able to bear the economic burden of the family. Most children stated that they were shouldering household responsibilities including the task of looking after their younger siblings when their mothers went out for work. Children articulated the need for support services to lessen their burden of child care responsibilities. There is a need for all individuals, groups, and institutions working on child rights and women issues to be more pro-active in demanding better services and entitlements for young children and working women in the unorganized sector.

Key Words : 1.HUMAN DEVELOPMENT 2.SIBLING CARE 3.CHILD CARE 4.WORKING MOTHERS 5.SLUM CHILDREN 6.CRECHES 7.DELHI.

ICDS

18. FORCES Delhi, New Delhi. (2007).
ICDS in Delhi : a reality check. New Delhi : FORCES. 36 p.

Abstract : This study was conducted to evaluate the status of the performance of ICDS services in the city of Delhi. Out of a total of 28 projects, 27 were covered, including 242 AWCs and 2970 beneficiaries and functionaries. It was found that 96% anganwadi centres (AWCs) were on rent, 57% centres had toilets and 58% centres had clean drinking water. 82.23% AWWs mentioned that there was scarcity of equipment like weighing machines, education kits, etc. In 39% centres there were complaints of poor quality of food. In Najafgarh area there were specific complaints of insects and dirt found in the food material supplied. Children over six months had been receiving food from the AWC regularly. Some beneficiaries mentioned that the quantity of food given was one *katori* (bowl). So the number of beneficiaries was more, but less quantity of food was distributed. In 26% centres AWWs complained about irregular food supply. Polio vaccination was irregular, and a major problem was that there was no fixed food supply. Only 82 out of 2861 (2.87%) beneficiaries were taking food in the centre. 76% beneficiaries shared supplementary nutrition (SN) with their family members and rest of them (21%) took SN to their home and consumed it themselves. Only 4 centres had data on Grade I and 17% centres on Grade II malnutrition. Only one centre offered medical intervention, and around 9% centres offered double ration. 85% children were immunized by the ANMs in PHCs and dispensaries in Delhi. 87% AWCs had data on immunization for

children below 3 years and only 67% for children aged 3-6 years. As per AWC data 46% reported TT immunization of pregnant women whereas the data collected from beneficiaries showed that 88% pregnant women were immunized. 88% beneficiaries mentioned that they received iron tablets from PHCs. Many AWC records were not updated. Data on Vitamin A distribution was available in 9% of the centres but the survey on beneficiaries revealed that 25% children below 6 years had received Vitamin A. 84% AWWs mentioned that the Medical Officer (MO) had not visited the centres for more than six months. ANMs were more regular visitors, and 51% of them visited AWCs once a month. But as per the AWWs' experience only 28.5% ANMs had been supportive. Preschool activities were irregular. There was inadequate space for PSE activities and inadequate teaching aids. Children in the 0-3 years age group were left out and mothers of children below 3 years did not receive any input on the learning needs of these children. In 44% centres no children were attending PSE, 45.62% AWCs had an average of 14 children, and in the remaining 11% centres no children were found. 57.83% AWCs had no space for PSE activities. 93% AWWs had received job training and 82% had attended the week long refresher course. Apart from that 10% AWWs were trained on RCH (Reproductive Child Health), 27% on AIDS and 18% on nutrition. 96% AWWs mentioned that they did not receive payment on time, so the worker does not feel motivated to come to the centre every day. 14% AWWs mentioned that they had received support from CDPOs, 40% AWWs had received support from beneficiary families, 12% from Mahila Mandals, 6% from local MLAs, and all AWWs had received support from Supervisors and ANMs. Only 2.89% AWWs had special training on disability. It showed that enough attention was not given to disability in this scheme, and this should be specified in the guidelines of the scheme. Awareness, sensitization and community participation needs to be addressed. The State needs to review its policy on handing over AWCs to NGOs. NGOs role as community mobilisers, trainers, etc. would improve outcomes of the scheme. State systems need to be responsible for implementation of services and should be accountable to the people.

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3.EVALUATION OF ICDS DELHI 4.FUNCTIONING OF ANGANWADIS 5.DELHI.

19. Griffin, Liam, Maheswaran, Namboodiri Sowmya and Dawkins, Zoe. (2006). Management of child malnutrition in Rajasthan : a special plan of action. Jaipur : Indian Institute of Health Management Research. 51 p.

Abstract : Child malnutrition is a sensitive issue in Rajasthan following media reports in 2005 of starvation deaths among tribal groups in the southern part of

the state. Child malnutrition in Rajasthan has increased over the past decade from 41 to 52% (Gupta 2001). This is due to subsistence livelihood based on pre-agricultural technology, the geographical isolation of these communities, lack of access to health services (including free health services), and poor food security. The Special Plan of Action (SPOA) strategy has been designed to target the management of child malnutrition within the Integrated Child Development Services (ICDS) programme of the Government of India. The SPOA strategy was initiated in November 2004 and has been implemented in 7 districts namely Jhalawar, Alwar, Tonk, Baran, Rajsamand, Jodhpur and Dholpur. The objectives of SPOA strategy are: to empower ICDS teams to deal with large numbers of Grade III/ IV children; to adapt WHO Standard Protocols for managing Grade III/ IV children to the local situation; to empower families, caregivers and the community to establish community based monitoring systems (CBMS) for managing Grade III/ IV children; and to strengthen referral management through Nutrition Corners in hospitals. Baran district was selected to assess effectiveness of the SPOA strategy among tribal groups. This district had high rate of child malnutrition and starvation deaths had been reported in the area in 2005. Baran district is home to the Sahariya tribe, the only 'Primitive Tribal Group' in Rajasthan. National Institute of Nutrition (NIN) Survey (2004) found that 72% of Sahariya children aged 1-5 years were underweight and 24% of these children were severely underweight (Rao, 2006). The SPOA strategy focuses on interventions and capacity building at 3 levels (i) AWCs, (ii) family-based interventions, and (iii) district hospitals. ICDS teams further train AWC staff including the AWW and Helper, and Sahyogini for identification, treatment and/or referral of malnourished children. Staff are trained to recognize various grades of malnutrition (I-IV) through proper weighing and recording practices; provide supplementary food (baby mix and *murmure*, take home food, and nutritious daily cooked meals at AWCs); include preventive and therapeutic capacity building at the family level; include education on proper feeding and breastfeeding practices disseminated by the AWW and Sahyogini in each village, and targeted feeding of at risk and malnourished children, and pregnant and lactating mothers. The Department of Health and Family Welfare (DHFV), Government of Rajasthan, has allotted separate ward space for a Malnutrition Treatment Corner (MTC) in 7 district hospitals, including Baran district hospital through the use of adapted and indigenized WHO protocols, such as F-75 Starter Diet and F-100 Catch-up Diet. F-75 is a kind of fortified milk (non-lactose version) and F-100 is a type of puffed rice cereal (typically served with milk). UNICEF and DWCD are the principal agents in the development and facilitation of the SPOA strategy. There is a hospital referral system for severely malnourished children. The SPOA strategy involves many actors from the government to community levels, including ICDS teams, NGOs, community

groups and MTC staff. Under the SPOA strategy, UNICEF provides supplementary food and daily meals, which are guaranteed by the Government of Rajasthan. Sahyoginis are women recruited from local villages who must have a minimum of 8th standard education. Since SPOA strategy was adopted Sahyoginis priorities have shifted towards an increased focus on malnutrition. Bharatiya Shiksha Shodh Evam Nirdeshan Sansthan is the only NGO under the auspices of the ICDS programme for the purpose of malnutrition management support. Akshaya Patra, an NGO working in Baran district, operates independently of the ICDS though with similar objectives. It provides food for children at the AWC via a mid day meal programme. In some villages SHGs exist and among them some women are mothers and caregivers, and these provide an essential community link for cluster workers and ICDS staff. They also support AWC services by raising community awareness. UNICEF has conducted training of MTC staff for the effective management of child malnutrition with complications (such as bipedal oedema, hypothermia and severe wasting). Specialised training has been provided along with indigenization of standard WHO protocols – specifically the F-75 Starter Diet and F-100 Catch-up Diet. The total number of children enrolled in 4 of the AWCs were Badodhiya 54, Digodhpar 103, Kishanganj First 105 and Dhikoniya 136. Number of Grade III/IV children in the 4 AWCs were Badodhiya 3 (5.5%), Digodhpar 5 (4.8%), Kishanganj 1 (0.9%) and Dhikoniya 21 (15%). MTC records revealed that 52 of the 88 patients admitted to the MTC since 2 months were Sahariya children. Nutritious food given at AWCs has been of great help in alleviating conditions related to poverty. There was an evident increase in the awareness regarding child malnutrition among women and caregivers. To improve the accessibility of MTCs for remote communities, mobile MTC services were provided. The underlying causes of malnutrition such as poverty and inequality need to be addressed by the Government of Rajasthan in order to address the problem of malnutrition. IEC materials need to be redesigned to make them more user – friendly and considerate of illiterate and culturally diverse target groups. Additional training needs to be provided to medical and paramedical staff working in the MTC on counselling to improve their sensitization to patients and caregivers.

Key Words : 1.ICDS 2.NUTRITION IN ICDS 3.CHILD NUTRITION 4.CHILD MALNUTRITION 5.MALNUTRITION CHILDREN 6.COMBATING MALNUTRITION 7.NUTRITION MISSION 8.NUTRITION REHABILITATION 9. NUTRITION SURVEILLANCE. 10.RAJASTHAN.

20. Gunajit, Kalita, Snowden, Hannah and Ghosh, Sujata. (2006).
The Effectiveness of the Mother and Child Protection Card as a
community management tool : a case study. Indore : NIPCCD Regional
Centre Indore. 49 p.

Abstract : Over 157 million children live in India marking it a country of unmatched human resource potential. However, while India has the highest percentage of malnourished children in the world, realising this potential is unlikely. Additionally, the fact that over 33% of Indian women indicate high levels of nutritional deficiency further emphasizes the urgency of effective initiatives in India, which confront issues related to the health of mothers and their children. The broad objective of this study was to determine the effectiveness of the MCP Card as a community management tool. Mother and Child Protection Card is a folding pictorial tool designed to assist the mother to understand and monitor individual progress of maternal and child health and psychosocial development. The ultimate common goal is improving MMR (Maternal Mortality Rate) and IMR (Infant Mortality Rate) and reducing child malnutrition. The study was carried out in Shivpur district, Madhya Pradesh. The study sample constituted Chief Medical Health Officer (1), District Programme Officer(1), Child Development Programme Officer (CDPO) (2), Supervisors(4), Anganwadi Workers (AWWs) (10), Auxiliary Nurse Midwives (ANMs) (5), NGO representatives (2), and Mothers (94). The sections studied were respondents background, service provision, use of MCP Card, service demand and directive for improvement. It was observed that mothers' understanding about health and child care issues had increased through use of MCP Card. However, individual interpretation of the pictures in MCP Card varied considerably among illiterate mothers who were unable to put the pictures into context with the written captions. It was found that communication was generally good among primary service providers, and between service providers and mothers. The complementary Cohort Register was repeatedly raised as a key convergence tool as it monitors service delivery and promotes referral services by identifying cases needing attention. In facilitating demand, the MCP Card is an effective community management tool, which empowers mothers to take responsibility and action for mother and child health. For the Card to be more effective in achieving its end goal of improving both maternal health and the holistic health and development of children, it needs to be implemented along with effective and functionally converging schemes. MCP Card should be modified to ensure that illiterate mothers understand the Card, thereby enhancing the demand for services. There should be special training for illiterate women. Only then would it reach its full potential as a tool to

reduce high infant and maternal mortality rates (IMR and MMR), malnutrition and vital psychosocial neglect, thereby improving social indices and the quality of life of mothers and children.

Key Words : 1.ICDS 2.MOTHER AND CHILD PROTECTION CARD 3.CHILD HEALTH 4.MATERNAL HEALTH 5.COMMUNITY MANAGEMENT 6.COMMUNITY MONITORING 7.MONITORING HEALTH STATUS.

21. Hamakawa, Tomohiro et al. (2007).
The Integration challenge : child development through immunization and nutrition in a tribal community of Jharkhand. Ranchi : Xavier Institute of Social Service. 49 p.

Abstract : Child health in rural India lags behind that of the country's more populous urban centres, but even within rural districts, disparities in access to and delivery of health service abound. This case study examined the implementation of the ICDS in Ghutia village (comprising main village and Sabar Tola), a rural community in the East Singhbhum district of Jharkhand; a predominantly rural Indian state with a large number of tribal and low caste groups. The integration of services as proposed under the ICDS to improve the growth and development of children was inadequate in this village. This inadequacy, combined with shortcomings of village planning initiatives and the lack of a community voice, has hampered the success achieved by an otherwise laudable immunization programme. The objectives of this study were to identify the factors that led to successful implementation of the Government of Jharkhand Routine Immunization initiative in Ghutia village; the factors that contribute to the lack of improvement of child nutrition in the same village; and the patterns of discrimination in the village in the provision of health services and their impact on disparities in child health and nutrition for the tribal population of the village. The Team visited 36 households with children under 5 years, and the key informants were the District Commissioner, UNICEF officers, Devnet NGO staff of Integrated Village Planning, village head man, ANM and AWW. It was observed that in both the ANM's records, IVP/AWW's records, the village as a whole reached a perfect full immunization level in 2007. However, the primary data collected by team workers showed that 94.7% children had received full immunization. It was found that most of the children in the main village receive immunization at home, either during ANM's regular visit or during catch up rounds. At the same time, all the mothers in the Sabar Tola take their children to the nearby AWC (about 2 km from their Tola) to avail immunization services. It was observed that mothers in Ghutia showed poor response to the THR (take home ration) service as they had

received THR on only one or 2 occasions. THR seems to be working as an incentive for mothers to bring their children to the AWC for immunization especially for Sabars. The nutritional status in terms of anthropometry and dietary intake of under 3 years children in both Ghutia main village and in the Sabar Tola was exceedingly poor. Weight for height measurements, a more sensitive measure of malnutrition revealed that more than 30% children exhibited severe or acute malnutrition. It was reported that 50% of the Sabar children went hungry because of insufficient food. Villagers could not avail health services at Government Centres because of long waits and long distances. Some Ghutia residents consulted doctors in the nearest metropolis, Jamshedpur, which was 40 km away. Access to clean water was a pressing issue and was a reason for frequent illnesses especially diarrhoea. It was found that IVP data exactly mimicked the local AWW's records. The Team discovered little evidence of efforts to build the capacity of youth volunteers, to transfer responsibilities from NGO workers to local leadership, or to ensure what would happen after UNICEF terminated financing of the project. The Team recommends specific measures not only to revamp access to the ICDS but also to improve the availability and quality of nutrition and immunization related services offered under the scheme. The situation of the Sabars is even more challenging, as they face discrimination both from residents in the main village and health workers. Many even treat them as "untouchable". The roots of this discrimination, like the intertwined underlying causes of child malnutrition, run deep in Ghutia village. Long term changes in access to economic opportunities and education must combine with efforts to ensure equitable improvement in child health and development, regardless of caste or tribe. Improved nutrition should require behavioural change and transformation of economic and political environments. There is need for strong governmental vigilance over the ration resources, which are reportedly being manipulated by the service providers.

Key Words : 1.ICDS 2.NUTRITION IN ICDS 3.CHILD NUTRITION 4.CHILD HEALTH 5.IMMUNIZATION 6.INTEGRATED APPROACH 7.SABAR TRIBE 8.TRIBE SABAR 9.TRIBAL CHILDREN 10.JHARKHAND.

22. Holland, Silas R. et al. (2006).
UMANG for the future : community based strategies to address adolescent anaemia in Uttar Pradesh. Lucknow : Lucknow Univ. 76 p.

Abstract : The prevalence of anaemia in India is very high, and 85% pregnant women and 75% children suffer from anaemia (IIPS: 2000). In India the major cause of anaemia is inadequate dietary iron and related micronutrient (folate, vitamin B12) consumption. This dietary shortfall is due to various socio-economic and cultural factors which include food insecurity, poor nutritional awareness,

gender discrimination, infection/disease and cultural eating habits. UMANG (Uplifting Marriage Age, Nutrition and Growth) is a project developed through partnership between the Government of Uttar Pradesh (GOUP), UNICEF, and local UP NGOs which targets adolescent girls (AGs) through the distribution of iron folic acid tablets (IFA) and family life education (FLE) in order to combat the alarmingly high levels of anaemia (haemoglobin below 12gm/dl) found in AGs across the state. UMANG uses the ICDS (KSY) and health systems for reaching AGs. AGs are given weekly IFA supplementation, nutrition, health education, FLE and they are mobilized into AG groups. The Integrated Child Development Services (ICDS) Department has outreach to more than 600,000 villages across India and there are 140,000 AWCs in UP alone. The participatory tools used were 'Draw and Write', 'Problem Tree', social mapping and photostory technique. UMANG has project sites in 2 districts namely Lucknow and Gorakhpur. UMANG project has 2 partner NGOs Vatsalya in Lucknow and Nari Vikas Sewa Samiti (NVSS) in Gorakhpur. The study covered AGs, 14 AWWs/ Nodal Teachers, and other stakeholders. About 54% of the AGs surveyed accessed UMANG through the AWC, 29% accessed UMANG through the school, and 17% through change agents. 93% AGs reported that they take at least 4 IFA tablets per month and 61% take on extra responsibility to pass IFA tablets on to friends/ family. After participating in UMANG project, 86% AGs felt confident and 95% declared that they had improved their eating habits. Almost 72% AGs felt comfortable teaching FLE to others reflecting ownership of the UMANG project by AGs and the impact it is having on the community. About 62% AGs could name an example of gender discrimination, even if they couldn't define the term. AG interventions can be a means of achieving significant improvements in MMR, U5MR, and population stabilisation. The existing government infrastructure related to health and education, with particular attention to monitoring system, needs to be strengthened and adequate training should be given to government workers.

Key Words : 1.ICDS 2.ANAEMIA ADOLESCENT GIRLS 3.NUTRITION 4.NUTRITION IN ICDS 5.UMANG PROJECT 6.ADOLESCENT GIRLS ANAEMIA.

23. Jain, Shailja and Agrawal, P.L. (2007).
Assessment on the impact of nutritional supplementation to children under ICDS scheme in Gird block, Gwalior, M.P. Gwalior : Govt. K.R.G. PG Autonomous College, Dept. of Home Science. 6 p.

Abstract : This study was conducted to assess the impact of nutritional supplementation in terms of nutritional grading and nutritional deficiency

diseases among children in the age group 0-6 years in rural Gird block, Gwalior. Out of 85 AWCs in rural ICDS Gird block only 10 AWCs were covered. 813 children from ICDS group (429 boys and 384 girls) from Gird and 500 children (258 boys and 242 girls) from non-ICDS group were selected from Hastinapur. These children were assessed using dietary recall method, anthropometric measurement and clinical survey by making anganwadi and domiciliary visits. In both the groups most of the children belonged to low socio-economic class. Daily intake of nutrients was deficient in both the groups when compared with ICMR values of RDA. In ICDS group 35.92% children were in normal nutritional grade. The prevalence of Grade I, II, III and IV malnutrition in ICDS group was found to be 42.19%, 17.35%, 4.55% and 0% respectively. In non-ICDS group 26.40% children were normal, 41.20% children were in Grade I malnutrition. 26.20% were in Grade II, 5.40% were in Grade III, and 0.80% were in Grade IV malnutrition. Mid upper arm circumference in the lowest age group 0-1 years in both sexes showed no significant difference in nutritional status of ICDS and non-ICDS children. Grown up boys and girls aged 3-6 years from ICDS block had better nutritional status than those from non-ICDS block. There was hardly any difference in the nutritional status of ICDS and non-ICDS groups. The ICDS scheme may be very attractive but beneficiaries do not realize its importance. Proper and sufficient nutritional supplementation provided to beneficiaries may help children towards leading a nutritionally sound and healthy life and combat malnutrition.

Key Words : 1.ICDS 2.IMPACT OF ICDS NUTRITIONAL STATUS 3.NUTRITIONAL STATUS PRESCHOOL CHILDREN 4.NUTRITION AND ICDS 5.GIRD BLOCK 6.MADHYA PRADESH.

24. Mustaphi, Piyali. (2005).
Addressing malnutrition through surveillance and innovative community based strategies. New Delhi : UNICEF. 21 p.

Abstract : In West Bengal, almost every second child is underweight, and the State's child malnutrition stands at 49%, above the country's average of 44%. 16.3% children below the age of 3 years were classed as moderately to severely malnourished (NFHS 2, 1998). More than 66% of the children aged 6-35 months, were anaemic (2000). The system of data collection and compilation in Integrated Child Development Services (ICDS) comprised filling out 300 data fields in 2 formats (5 copies at project/ block level). This data was collated for 12-14 AWCs by Supervisors, and submitted to be forwarded routinely without being analysed or used by functionaries at any level. Inconsistencies in the data

were not located, nor was data used for monitoring the programme. This project aimed at streamlining and simplifying the process of data collection by the Integrated Child Development Services (ICDS) functionaries and making the formats user-friendly to enable field level analysis and utilization of the data for monitoring and improving the nutrition levels of young children. The Surveillance and Monitoring tools were – Mother and Child Protection Card; Community Growth Chart; SMART Register; Cohort Register; Community Mapping Sheets; Whiz Map; and Colour Coding (green: good; yellow: intermediate; red: poor). Two steps made it easier to develop macro-micro linkages in nutrition surveillance and a focused intervention programme. Firstly, streamlining of data made it easier for all the stakeholders at state, district, block and project levels to identify geographical pockets of malnutrition. Secondly, the use of colour coding for streamlining the ICDS Management Information System (MIS) also improved visibility of malnutrition to a large extent. In West Bengal in March 2003, barring 2 districts, all others had a weighing efficiency of less than 50%. After the training intervention, in April 2005, 5 districts have achieved a weighing efficiency of more than 70%, while the average has reached to over 60%. Purulia district has 20 ICDS projects and 2,512 AWCs. In March 2003, 10 projects were below 50% in weighing efficiency, but by April 2005 all projects had crossed 70% in weighing efficiency. Moderate and severe malnutrition in children aged 0-3 years in West Bengal was 20.41% in March 2003, which reduced to 18.09% by April 2005. Reduction of moderate and severe malnutrition in 168 AWCs of Dakhin Dinajpur was from 25% to 5% in two years. The following are some of the highlights of the impact of nutritional surveillance. In Dakhin Dinajpur, a positive deviance district, there was extensive use of resource map and community growth chart; mothers regularly contributed food for Nutrition Counselling and Childcare Sessions (NCCS); there was preponderance of girl children at the entry stage; ‘ripple effect’ was observed resulting in improvement of nutritional status of siblings; there was improvement in child care practices and awareness, and steady improvement in nutritional status of children. To mothers/ caregivers the position of the child on the growth chart became an important concern. Functionaries at the project and district levels were motivated when they were able to relate to the data mapping and colour coding that was being used in spreadsheets and in GIS maps. Mapping and colour coding proved to be a powerful communication tool, specially while addressing non-experts. States like Orissa, Uttar Pradesh and Andhra Pradesh have asked UNICEF to assist in setting up Nutrition Surveillance System in their states also.

Key Words : 1.ICDS 2.NUTRITION SURVEILLANCE 3.COMMUNITY MONITORING 4.NUTRITION IN ICDS 5.MALNUTRITION 6.MONITORING MALNUTRITION.

NUTRITION

25. Binay Kumar et al. (2006).
Adolescent anaemia control programme in Gujarat – what works and why ?. Vadodara : Govt. Medical College Vadodara, Dept. of Preventive and Social Medicine. 33 p.

Abstract : Anaemia affects over 2 billion people worldwide and it is especially prevalent in India, where 74% children under 3 years, and more than 90% adolescent girls (13-19 years) are anaemic (UNICEF, 2004). Adolescent girls (AGs) are specially vulnerable to anaemia due to increased iron requirements during periods of rapid growth and loss of iron during the monthly cycle. The state of Gujarat has identified anaemia among adolescent girls as an area of focus, and in March 2000 initiated the Adolescent Girls Anaemia Reduction Programme (AGARP) on a pilot basis in Vadodara district. The programme, operating in 25 districts of Gujarat, aims to decrease anaemia prevalence among adolescent girls through Iron and Folic Acid (IFA) supplementation and nutrition and health education. In Vadodara district alone, approximately 2,50,000 adolescent girls, of whom 65,000 are enrolled in over 400 secondary and higher secondary schools were covered (Kotecha et al. 2003). The strategy includes supervised consumption of iron folic acid (IFA) tablets distributed weekly to girls enrolled in Classes 8-12 and increasing awareness about anaemia among AGs through dissemination of Information Education Communication (IEC) material. The monitoring process and delivery route has 3 main inputs which are IFA tablets, IEC material and training. Fieldwork was conducted in 4 districts of Gujarat: Anand, Narmada, Panchmahal and Vadodara. Semi-structured interviews were conducted with the Principal and Liaison Teachers (LT) at each school. Establishment and integration of the anaemia control programme into the school system allows tablets to be distributed routinely on weekly basis. Girls in Classes 8-12 are provided orientation yearly by the LT of each school. Occasionally, technical experts are invited to sensitize AGs about the programme. UNICEF and the Government of India worked in collaboration in 16 districts, while in the remaining 9 districts ACP was supported by Government of Gujarat. The programme succeeded in reducing anaemia among AGs in Vadodara district from 74.7% at baseline to 53.2% over a 17 month period. Also the haemoglobin levels of 83% AGs showed improvement. Hence consumption of IFA tablets in the presence of teachers was essential. AGs perceive IFA tablets as sources of nutrition as opposed to medicine. Adequate IEC material needs to be delivered and IEC material delivery should be incorporated in the monitoring process. Schools should keep a record of IEC material delivery, and

information about anaemia and the importance of iron supplementation for AGs should be made available to the community at large, especially parents. There is a need to supplement their diets with IFA tablets throughout their life.

Key Words : 1.NUTRITION 2.ANAEMIA ADOLESCENT GIRLS 3.ANAEMIA CONTROL PROGRAMME 4.SCHOOL GIRLS. 5.ADOLESCENT GIRLS 6.GUJARAT.

26. Krishnaswamy, Kamala. (2009).
NFI Bulletin, 2009 Apr, 30(3) : bioactive substances and functional foods.
New Delhi: Nutrition Foundation of India. 8 p.

Abstract : Throughout the world, including Asia, consumers are looking for health foods that not only prevent diseases but promote health and well being. Mounting health care costs and the consumer's desire to maintain health and quality of life, have focused the attention of biomedical researchers and public health scientists on diets and disease prevention. Food and food ingredients singly or in combination have been investigated for their biological effects that could potentially protect against cardiovascular pathology, cancer risk, inflammation, immune suppression, bone problems, neurological damage, suboptimal performance levels, problems associated with the gastrointestinal tract and hormone related problems, besides actively promoting good all round health and general well being. Bioactive compounds like simple phenols are found in most vegetables/ spices, beverages; carotenoids are in green, yellow, orange vegetables, fruits; flavonoids are in vegetables, fruits, tea; glucosinolates are in cruciferous vegetables; organosulfides are in allium vegetables; and lycopene and limonene are found in tomatoes and citrus fruits. More than 500 compounds have been identified and tested for biological functions and mechanism of action. Some families of fruits and vegetables have characteristic components that may confer a particular health benefit. Green, leafy vegetables are sources of folate iron, calcium and carotenoids. All these components as well as other phytochemicals have potential health benefits. Dietary fibers are cardio protective, as they reduce risk factors for cardiovascular disorders. Fibers reduce the toxic components in faeces and have prebiotic effects (fructans). Fenugreek seeds incorporated into the diet at 5%, 10% and 20% level produced a hypolepedemic effect. The seeds contain 48% by weight of fiber and 2% omega 3 fats which have several biological effects, and the dietary guidelines of all countries suggest the inclusion of fish for prevention and management of CVD. A long term study with fish oil showed 20% reduction in total mortality, 30% decreased mortality on account of cardiovascular events and 45% decrease in sudden death. Functional foods such as soy protein (25 gm) flavonoids, nuts

(1.5 ounces almonds), viscous fibre plant sterols (1.3 g) and plant stanol esters (4 g) all reduce density lipoprotein (LDL) by 4-7%. Turmeric in its anti-cancer effects reduces, inhibits or delays tumours in skin, oral cavity, forestomach, duodenum, stomach, colon, breast, prostate, liver, lung and ovary and has also been found to have beneficial effects in blood cancer. Curcumin and turmeric both are antimetagenic antioxidants, curcumin offers protection against ischemic injury to heart, chronic inflammatory lung diseases, hyaline membrane diseases in pre-term infants, inflammatory bowel disease, multiple sclerosis, Alzheimer's disease, renal injury due to drugs and toxins, scleroderma, reduces diabetes and its complications. Although these foods are known by different names such as nutraceuticals, dietary supplements or functional foods, they hold significant promise in promotion of human health and disease prevention. Thus, health professionals, nutritionists, regulatory toxicologists and government regulatory bodies should work together to plan appropriate regulations to provide the ultimate health and therapeutic benefits to mankind.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.FOODS
4.FUNCTIONAL FOODS 5.MEDICINAL VALUE OF FOODS 6.NUTRITION
EDUCATION.

27. Menon, Purnima, Deolalikar, Anil and Bhaskar, Anjor . (2009).
India State Hunger Index : comparison of hunger across states.
Washington D.C : International Food Policy Research Institute. 32 p.

Abstract : India has the largest number of hungry people in the world. There are three inter-linked dimensions of hunger - inadequate food consumption, child under weight (under five), child mortality (under five) - measured to assess and compute Global Hunger Index (GHI). The India State Hunger Index (ISHI) represents the index calculated using a calorie undernourishment cut off of 1,632 Kcal per person per day to allow for comparison of the India State Hunger Index with the Global Hunger Index. The Hunger Index of India was calculated for 17 major states in the country, and it covered more than 95% of the Indian population. It revealed India's continued lacklustre performance at eradicating hunger, and India ranks 66 out of the 88 developing countries studied. The objective of the ISHI was to focus attention on the problem of hunger and malnutrition in India. It was found that not a single state in India fell in the "low hunger" or "moderate hunger" category defined by the GHI 2008. Instead most states fell in the "alarming" category and Madhya Pradesh fell in the "extremely alarming" category. Four states namely Punjab, Kerala, Andhra Pradesh and Assam fell in the "serious" category. India State Hunger Index was found to be 23.30. The Hunger Index was found to be high in Punjab (13.63), Kerala (17.63),

Andhra Pradesh (19.53), Assam (19.83), Haryana (20.00), Tamil Nadu (20.87), Rajasthan (20.97), West Bengal (20.97), Uttar Pradesh (20.13), Maharashtra (20.80), Karnataka (23.73), Orissa (23.80), Gujarat (24.70), Chhattisgarh (26.63), Bihar (27.30), Jharkhand (28.67), and Madhya Pradesh (30.87). It was also found that nutrition programmes in India were not effectively delivering and achieving the set objectives, although strides had been made on the public health front to ensure sustained reduction in child mortality. But it was observed that improvement in child nutrition and nutrition situation in the country were not satisfactory. Therefore it is suggested that States need to invest in direct nutrition programmes and poverty alleviation interventions even during periods of sustained economic growth. It was also suggested that investments need to be made to strengthen agriculture, improve overall food availability and access to the entire population, and to improve child nutrition and mortality outcomes.

Key Words : 1.NUTRITION 2.HUNGER INDEX 3.HUNGER 4.STATE-WISE HUNGER 5.GLOBAL HUNGER INDEX 6.UNDER FIVE MORTALITY RATE 7.CHILD NUTRITION 8.UNDER WEIGHT CHILDREN 9.CALORIE CONSUMPTION.

28. MS Swaminathan Research Foundation, Chennai. (2008).
Report on the state of food insecurity in rural India. Chennai : MSSRF.
174 p.

Abstract : The malnutrition scenario in India is a cause for deep concern. 40% children below 3 years are underweight and 45% are stunted; 22% to 30% children are low birth weight babies; 36% adult women and 34% adult men suffer from chronic energy deficiency (CED); anaemia has increased from 74% in 1998-99 to 79% in 2005-06 in children under 5 years, and from 52% in 1998-99 to 56% in 2005-06 in young women. FAO (1983) stated that food security meant that all people at all times have physical and economic access to the basic sufficient food they need. To ensure food security the main food security safety nets that the Government has put in place include (i) Targeted Public Distribution System (TPDS); (ii) Supplementary feeding programmes such as ICDS, Mid Day Meal Scheme (MDM) and food support to the 'poorest of the poor' known as 'Antyodaya Anna Yojana (AAY); (iii) Food for Work Schemes and programmes of food distribution to old and destitute persons and supplementary nutrition for adolescent girls. In 2006-07, production of food grains was 211.78 million tonnes. Access to food is linked to the purchasing power of households, and food insecurity in this study has been assessed on the basis of percentage of persons consuming less than 1890 Kcal/cu/day (kilo calories/ consumer unit/

day). As per NSSO Survey 2004-05 covering 19 major states of India, the percentage of persons consuming less than 1890 Kcal/ cu/ day declined marginally from 15.1% in 1999-2000 to 13.2% in 2004-05. People in many states were consuming less than 1890 Kcals/ cu/ day indicating that hunger is wide spread. These states are Andhra Pradesh (12.5%), Assam (8.9%), Bihar (10.0%), Chhattisgarh (16.2%), Gujarat (17.1%), Haryana (7.8%), Himachal Pradesh (2.8%), Jammu and Kashmir (2.4%), Jharkhand (13.8%), Karnataka (20.5%), Kerala (17.5%), Madhya Pradesh (16.0%), Maharashtra (19.7%), Orissa (15.4%), Punjab (6.4%), Rajasthan (5.2%), Tamil Nadu (23.4%), Uttar Pradesh (8.0%), and West Bengal (11.9%). The Targeted Public Distribution System (TPDS) has not achieved its stated objectives. It has not reduced food subsidy nor leakages or diversion, but it has excluded large numbers of poor and nutritionally insecure persons from access to PDS, and seriously worsened food security for a substantial segment of the population. On 31 March 2006 the ICDS system provided supplementary nutrition to 22.7 million children aged 6 months to 3 years, 24 million children aged 3-6 years, and 9.5 million pregnant and lactating mothers. In the NIPCCD study on ICDS it was reported that ICDS has played a role in improving maternal and child nutrition and in lowering infant and child mortality. Supreme Court issued orders on ICDS dated 28 November 2001, 29 April 2004, 7 October 2004, and 13 December 2006 stating that Government of India should operationalize a minimum of 14 lakh AWCs in a phased manner to cover all hamlets and habitations, and provide all services including supplementary nutrition to every person who is entitled to them as prescribed under ICDS norms. The necessary funds should be made available to meet the Government's legal obligation in the light of the Supreme Court's directives. The National Programme of Nutritional Support to Primary Education reaches out to about 12 crore children in 9.5 lakh schools/ EGS centres across India. It has improved the nutritional status of children in Classes I-V, as well as enhanced school enrolment and attendance. It was recommended that there needs to be much greater integration between MDM scheme and government interventions in health and nutrition. The PDS can be improved and made more effective through certain policy interventions and reform. The case for universal PDS with a uniform affordable price is compelling. The state of Tamil Nadu has continued with universal PDS. There is need for more focused direct investment in nutrition and health even in states that are categorized as food secure or have high rates of economic growth, but do not emerge as food secure.

Key Words : 1.NUTRITION 2.FOOD SECURITY 3.HUNGER
4.MALNUTRITION 5.ICDS 6.MID DAY MEALS 7.PUBLIC DISTRIBUTION
SYSTEM.

29. Unisa, Sayeed, Chattopadhyay, Aparajita and Roy, Tarun Kumar. (2007). Causes of anaemia among women in West Bengal. Mumbai : International Institute for Population Sciences. 4 p.

Abstract : Anaemia is the inadequate or defective formation of haemoglobin or defective maturation and formation of red blood cells. The most common and severe type of anaemia is that in which the body is running low on iron. During pregnancy anaemia increases prenatal risks for mothers and neonates, and also increases overall infant mortality. In India 52% of the women have some degree of anaemia, which is a very large public health concern. Anaemia level was examined for all Primary Sampling Units (PSUs) of West Bengal selected in National Family Health Survey – II (1998 – 99; NFHS-II). A total of 559 ever married women in the age group of 15-49 years residing in households were interviewed. Three levels of anaemia were identified mild anaemia (10-10.9 g/dl for pregnant women and 100-11.9 g/dl for non pregnant women), moderate anaemia (7-9.9 g/dl) and severe anaemia (less than 7.0 g/dl). 94% women in the sample had anaemia, 49% women were moderately anaemic, 45% were mildly anaemic and less than 1% women were severely anaemic. Two methods of haemoglobin measurement were used to explore anaemia prevalence in women. In cyanmethemoglobin method (CYAN-MATH) i.e. laboratory method or procedure a fixed quantity of blood is diluted with a reagent (Drabkin solution) and haemoglobin concentration is determined after a fixed interval in an accurate well calibrated photometer. In the second method i.e. Helliges method screening test, which is less costly, a few drops of blood are collected after a small prick on the finger and the blood is tested for anaemia immediately after its collection. Correlation between CYAN-MATH and Helliges haemoglobin reading was found to be 0.88g which is quite high. Prevalence of anemia was examined using clinical signs namely pallor of eyelids palms, nails and tongue. Iron supplement was given to 352 women whose haemoglobin level was less than 12 g/dl at the time of baseline. A follow-up survey was carried out after one month of giving them iron tablets, and 63% of the women showed improvement, but 2.6% remained at the same level. Analysis shows that increase in the hours of work (5 hours and above) and increase in the nature of household work from mild to hard is positively associated with a rise in the anaemia levels from moderate to severe. Heavy blood loss during menstruation, feeling of tiredness with severe back pain, and clotting of blood during menstruation have a positive association with higher levels of anaemia. Currently breastfeeding women are found to be more anaemic. Among those who are consuming lemon, *amchur* (raw mangoes) / *imli* (tamarind)/ amla (gooseberry) daily or at least once a week, a large proportion of them are not severely anaemic compared to those who are irregular in Vitamin 'C' consumption. The basic reason for high prevalence of anaemia in the study area is the poor nutritional status of women, their reproductive health

problems and non-scientific method of cooking. Anaemia can be prevented to a great extent if proper knowledge is disseminated to the members of households.

Key Words : 1.NUTRITION 2.ANAEMIA WOMEN 3.ANAEMIA 4.WEST BENGAL.

RURAL DEVELOPMENT

30. Chaturvedi, Sameer et al. (2006).
Panchayat and community based monitoring system in Sehore district Madhya Pradesh. Bhopal : Samarthan Centre for Development Support. 40 p.

Abstract : Various programmes have been implemented but they have failed to yield results due to lack of awareness and demand from citizens. In order to change this, Community Based Monitoring System (CBMS) is a concept wherein members of a village form a committee which monitors the delivery of services by the Government, the activities of the Panchayat, and also tries to bring about a change in the habits, behaviour and attitudes of the villagers. The present study examined the state of a CBM initiative, implemented by NGO Samarthan; issues of awareness; effectiveness of CBMS; strengthening local governance; factors which facilitate success; and the possibility of replication on a large scale. The study was conducted in 5 villages of Sehore district namely Rajukhedi (88 households); Manpura (60 households); Laudia (120 households), Bijlon (300 households); and Amla (125 households). Data was collected through interviews and focus group discussions (FGDs) with local stakeholders. Villagers identified the major obstacles to development as the following: access to clean drinking water, open defecation, poor roads, gender inequality, teacher absenteeism, infrequent ANM visits, an inefficient postal delivery system, lack of women's participation in the village decision making process, etc. In Manpura, it was observed that there have been some improvement in hygienic behaviour, i.e village became open defecation free which was made possible by the effort of the Village Water and Sanitation Committee. It was also found that women's requirement regarding drinking water was ignored by men in the Gram Sabha as they considered collecting water to be "women's work". In Bijlon, it was observed that lack of awareness and lack of coordination were the most significant barriers to success of the CBMS initiative, for instance, land that was allotted for a hand pump was eventually sold and the new owner dismantled the hand pump. In Amla and Laudia villages, economic condition of the households and socio-cultural factors such as caste and class gave rise to conflicts which were major inhibiting factors to formation of 'Self Help Groups' and women were denied the

space and credibility for inclusion in CBM process. It was found that in Rajukheda, where the intervention has been going on for four years, there was an extremely high level of awareness. In Amla, however, where the intervention was only 2 months old, only those directly involved in the initiative were aware of CBMS. It was found that signs, billboards and charts are ineffective, unless accompanied by oral communication and door to door campaigns. As far as the effectiveness of CBMS initiative was concerned, the process was highly successful in ensuring monitoring of programmes and improving the delivery of government services. However the process was not successful in monitoring the activities of the Panchayat state officials and functionaries. The level of success achieved in the area of self monitoring was also unclear. It was observed that the involvement of Youth Groups, Self Help Groups (SHGs), and a supportive Panchayat can contribute to the success of an intervention. It was recommended that CBMS should be used as a mechanism of social inclusion by engendering a culture of participation. After forming Youth Groups and SHGs organizers should determine the specific needs of the village and encourage the formation of other groups accordingly.

Key Words : 1.RURAL DEVELOPMENT 2.COMMUNITY MONITORING
3.GOVERNMENT PROGRAMMES 4.HEALTH 5.EDUCATION 6.WATER
7.SANITATION 8.CASE STUDY 9.SEHORE 10.MADHYA PRADESH.

31. Prakash, Anubha, Kennedy, Jonathan and Arthur, Kristi K. (2006).
A Case study of the community monitoring project. Bangalore : Institute
for Social and Economic Change. 39 p.

Abstract : Community Monitoring Project (CMP) is a programme that addresses issues of health, education and nutrition at the village level. It was initiated in February 2002 in Karnataka state by Mahila Samakhya Karnataka (MSK) and UNICEF. The objective of this case study was to determine the impact that CMP had on community awareness about the services available under ICDS to women and children; to help women monitor these services; and to create awareness about good health and nutrition of the individual and families, especially during pregnancy and vulnerable age group of children 0-3 years. The impact was assessed in July 2006. The cumulative impact of CMP was increased rates of polio immunization; more expectant mothers sought antenatal care; improved mid day meals; improved standard of teaching; and provision of free books and uniforms motivated parents to send their children to school, thereby promoting enrolment and retention in schools. Observations suggest that the CMP has improved awareness, availability and access to basic government services. Another important achievement is the increased participation of women in community activities that has challenged traditional gender roles. In spite of

these improvements CMP fails to challenge the rigid social structure of caste and community that creates obstacles to women's social opportunities. It tended not to engage the most deprived and marginalized members of the community. Those that were overlooked include the Lambani community, Muslims migrants and the very poor who do not have time to attend meetings. It also failed to attract the participation of women from upper classes and upper castes who play an instrumental role in improving the well being of the whole community. Among lower caste women too, only a small cadre was actively participating in the CMP. Therefore, there is a pressing need to broaden the base of active participants in terms of numbers and diversity of background. Further more, the structure of relevant line department at block level was not compatible with the demands of CMP. These shortcomings limit the ability of the CMP to benefit the community and threaten sustainability of the project after the withdrawal of funding and implementing agency. There is need to ensure that SWASTH plus consolidates and builds upon the gains that have been achieved in the services of health; education and nutrition through CMP. In order to gain maximum benefits from interventions, the funding and implementing agencies must ensure that (1) services of medium to short term programmes that have been implemented in the project area are compatible and complementary; (ii) the community has ownership and creative control over the programme objectives; and (iii) the programme is flexible enough to take into account the heterogeneous nature of communities in India.

Key Words : 1.RURAL DEVELOPMENT 2.COMMUNITY MONITORING
3.MONITORING 4.MONITORING GOVERNMENT PROGRAMMES 5.ICDS
6.COMMUNITY BASED MONITORING 7.HEALTH PROGRAMME 8.VILLAGE
DEVELOPMENT 9.EDUCATION 10.CASE STUDY 11.RAICHUR
12.KARNATAKA.

SOCIAL DEFENCE

32. State Commission for Women Delhi, New Delhi. (2009).
Need assessment of sex workers : a study. New Delhi: DCW. 43 p.

Abstract : During the Mughal era, areas of Chandi Chowk, Fatehpuri, Chawari Bazaar and Daiwada had pockets where sex workers could be found. Marginalisation makes children vulnerable to trafficking and commercial sexual exploitation, and natural calamities, illiteracy, cultural and religious traditions, low level of awareness, inequality and societal discrimination have contributed to the booming sex trade and influx of minors in this profession. There are about 100 brothels operating in G.B. Road in Delhi and around 4000 sex workers live here.

Out of 400 sex workers interviewed, 60.25% were between 21 to 30 years of age, 32.7% were between 31 to 40 years, 4.25% were between 41 to 50 years, 2% were between 51 to 60 years, 0.5 were between 11 to 20 years, and 0.25% were between 61 to 70 years. 62% of the girls and women had been inducted into sex work while they were minors and adolescents. Aged sex workers who are no longer able to get clients get involved in criminal activities or are thrown out on the streets to beg. 41.6% of the sex workers (SW) in the age group 21 to 30 years were literate and could read and write fairly well. Illiteracy was found to be highest in the age group 31 to 40 years (26.5%). Sex workers in Delhi came from Andhra Pradesh, (28.7%), Rajasthan (14.2%), Uttar Pradesh (13%), Karnataka (11.5%), Maharashtra (11%), Madhya Pradesh (7%), West Bengal (6.5%) and Bihar (3.5%). From states such as Haryana (0.75%), Uttarakhand (0.5%), and Gujarat (0.5%), there were less than 1% sex workers. Also, sex workers from Nepal constituted less than 1% of the sample. The major reasons for getting into sex work were poverty (41.25%), forceful initiation (37.5%) and traditions (15%). Sex workers got into the profession by voluntary initiation (39%), induction by their own relatives (34%), by pimps (20.25%) and *kotha malkins* (brothel owners) (3.75%). 41% respondents said that their families knew about the type of work they were engaged in, 51.5% said that their families did not know, 22.2% said that their families considered it wrong, 30% said that their parents were happy with the work since they were the earning members, while 27.7% said that their parents understood the forced circumstances under which they had to work. Sex work is conducted mainly through *kotha malkins* (45%), 27.5% SWs operate independently, while pimps and *adhias* act as intermediaries in 27.5% cases. 60.7% of the sex workers mentioned that they have children (322 total; 31.6% girls and 68.32% boys). About 56.39% children of sex workers were staying with them, 13.5% children were staying with relatives, 19.5% children were staying with others, and 10.5% SWs said that their children were either in boarding schools or in orphanages. 42% of the sex workers were satisfied with their present situation, and 45% of them had no answer to this question. 54% sex workers did not wish to change anything about the present situation, but 18.7% said that they did want to make some changes like changing society (22.6%), own their own Kotha (9.3%), earn more money (6.6%), do something new but did not know exactly what (20%), and those who wanted to quit were only 9.3%. 52.5% sex workers did not want to leave the profession, and 20% of them had no answer to this question. 38.7% sex workers perceived their future to be good while 27.5% said that they had never thought about their future. Preventive measures have to be taken in source areas, and some kind of rehabilitation package should be made available to women who are 50 years and above. Community awareness programmes need to be undertaken and education opportunities made available for young girls. Women's centres should be established at the source areas where women and girls can go for information, counselling and support services. Prevention strategies like creating

a database of districts, including complete data of the number of families and girls in each family, should be maintained by local authorities with local NGOs. Effective poverty reduction programmes should be undertaken like devising appropriate analytical tools to undertake poverty assessments and gender assessments, and identify multiple vulnerability potential for groups like the youth, especially girls. There need to be better linkages between trafficking prevention strategies and education, empowerment and poverty alleviation efforts. Special information campaigns should be taken up in high risk communities and special programmes for sex workers' families should be devised to create alternative livelihood opportunities. Rehabilitation of sex workers would require sustainable re-integration efforts through assistance, counselling, psycho-social therapy, skills training, micro enterprise support and job placements. Government has taken steps to combat trafficking and conducted a baseline survey, but researchers need to refine their methodologies to adequately capture the extent of exploitation that prevails and take further action to fight such impunity. Government can make provisions for day and night crèche facilities and formal and non formal education. Life skills training and other job opportunities should be made available to younger children so that they are not forced to enter this profession. Provisions for boarding school facilities for children of sex workers should be given by the government either free of cost or at affordable rates. Women and girls in sex work need to be rescued and rehabilitated, and provided specialized counselling to deal with the psychological trauma they undergo. Government needs to introduce rehabilitation programmes that focus on all aspects viz: social, economic and psychological. Increase in the policing of sex work will be met with hostility from majority of women in sex industry as this is their livelihood. Police and law enforcement agencies need to show positive response to their problems, and provide supportive action.

Key Words : 1.SOCIAL DEFENCE 2.PROSTITUTION 3.SEX WORKERS
4.NEEDS ASSESSMENT SEX WORKERS 5.NEEDS OF SEX WORKERS
6.G.B.ROAD 7.REHABILITATION SEX WORKERS.

SOCIAL WELFARE

33. Ashok Kumar et al. (2008).
Database on voluntary organizations: Vol.2: 2007-08. New Delhi :
National Institute of Public Cooperation and Child Development. 540 p.

Abstract : This project was undertaken by NIPCCD to assess the needs of VOs regarding capacity building and disseminate information about the expertise and

service facilities available with them. Out of 402 VOs, the maximum number of organizations were from the state of West Bengal (12.44%), followed by Andhra Pradesh (11.69%), Uttar Pradesh (8.21%), Maharashtra (7.96%), Delhi (6.97%), Tamil Nadu (6.47%), Rajasthan (5.22%), Kerala (4.98%), Bihar (4.73%) Gujarat (4.48%), Karnataka (4.23%), Assam (3.98%) and Manipur (3.73%). The more recently established VOs 1996-2000 were from the states of Uttar Pradesh (15.15%), Andhra Pradesh (12.12%), Maharashtra (9.09%) and West Bengal (9.09%). An overwhelming number of VOs 395 (98.26%) reported that they had registered themselves under various Acts. An overwhelming number of VOs 394 (98.0%) were working on issues related to awareness and preventive measures against HIV/ AIDS. It was observed that 197 organizations (49%) had both women and children as their targets. A large number of VOs (89.30%) were engaged in providing training, conducted workshops (81.09%), advocacy work (74.38%) and networking (61.19%). Other activities being undertaken by VOs included consulting (43.53%), fund raising (42.79%), institutional service delivery (41.79%), research and documentation (39.05%), assistance to other organizations (37.3%), and other non-institutional service delivery (37.31%). Out of 402 VOs, 121 (30.10%) did not report their budget amount. Only 11 organisations (2.74%) reportedly had an annual budget of Rs. 5 crore and more, while the budget of 24 organisations (5.97%) fell in the range of Rs.1-5 crores. Only 4 organisations (1%) had an annual budget of less than Rupees one lakh, whereas a large number of organizations had their annual budget in the range of either Rs.1 to 5 lakh (12.44%) or Rs. 5-10 lakh (12.19%). The major form of support from the community was received in the form of cash donations (72.58%), labour (72.58%), and kind (60.20%). Fund raising is an essential activity as it helps the organizations to sketch their missions and visions in front of donors, and helps them plan the extent to which they can carry out their activities. About 52.97% organizations raise funds largely by collecting donations, and 28% VOs generated funds mainly through sale of their products. Fees of vocational training courses (13%), membership fees (11%), membership subscription (8%), and management contribution also helped to generate funds. The other fund raising activities included consultancy fee (5.41%), lending money (2.70%), micro credit and service charges (2.16%), etc. Out of 402 VOs, 142 VOs had products for sale: 26% manufactured handicraft products, readymade garments (21.99%), products made by self help groups (12.77%) and stationary items (11.35%). Many VOs were engaged in the production of products whose raw material was region-specific such as bamboo (10.64%), coir products (8.51%), jute products (4.26%), wool products (1.42%), and spices (7.10%). About 60% VOs mentioned that they had expertise in the field of education (17.09%), followed by SHG formation (13.34%), child related issues (12.50%), health and hygiene (11.67%), skill development (11.25%), women related issues (10.84%), reproductive and child health (7.09%), etc. The other areas of expertise as reported by VOs included agriculture inputs (8.34%), watershed

development (5.84%), project formulation (5.00%), micro credit (3.75%), etc. About 372 VOs (92.54%) reported the status of infrastructure available with them: 54.04% had their own building, 47% had hired infrastructure, 14% had taken buildings on lease, and 7% VOs were operating from donated buildings. 78.22% VOs had classrooms, 73% had lecture halls, 69% had a conference room, 24% had hostels, and 34% had guest room facilities. 62% VOs made their infrastructure available to other organizations, either free or on payment basis.

Key Words : 1.SOCIAL WELFARE 2.VOLUNTARY ORGANIZATIONS
3.DATABASE ON VOLUNTARY ORGANIZATIONS.

34. Centre for Budget and Governance Accountability, New Delhi. (2009).
How did the UPA spend our money ? An assessment of expenditure priorities and resource mobilization efforts of the UPA Government. New Delhi : CBGA. 104 p.

Abstract : The study was an attempt to assess the expenditure priorities and resource mobilization efforts of the UPA Government over its five year term, from the perspective of the disadvantaged sections, who constitute a majority of the population, with the objective of demystifying their policy priorities and its implication for the disadvantaged sections. The notification of Right to Information Act, and Bharat Nirman Programme for augmentation of key infrastructure across rural India have also been significant policy measures taken by the Government. The National Rural Health Mission (NRHM) introduced in 2005-06 has added the important component of a flexible resource pool for the states. Likewise, Sarva Shiksha Abhiyan (SSA) was accorded a lot of importance as one of the flagship schemes of the UPA Government. However, public spending on education as a proportion of GDP has been stagnant between 3% (2004-05) to 3.2% (2006-07) since the beginning of the UPA regime, though the commitment made was to spend 6% of GDP on education. The Union Government's expenditure on education increased to Rs.373665 crore (2008-09) from Rs.271849 crore (2007-08). The enrolment at primary level also increased from 124,615,546 (2005-06) to 134,132,183 (2007-08). The Union Government accorded higher priority to health and family welfare in the Union Budget (UB) during 2004-05 to 2007-08. In 2003-04 only 1.58% of the UB was spent on health, and the share of health gradually increased to 2.11% in 2007-08, but in 2008-09 and 2009-10 it was not done, which reflects the declining priority of UPA Government on health. Infant Mortality Rate (IMR) was 57 for India during 2005-06 and total fertility rate was 2.68. Expenditure on rural economy was 10.65% in 2003-04, and was doubled to 22.24% in 2008-09. Allocation for some major schemes on women's health were Rural Family

Welfare Services, Urban Family Welfare Services, RCH Programme and development of nursing services. The National Rural Employment Guarantee Scheme (NREGS) was implemented which made 100 days of wage employment available for unskilled workers. Within the Union Budget, the aggregate outlay for child specific schemes as a proportion of total budget outlay was increased upto 4.93% in 2007-08 from only 2.2% in 2003-04, but the revised estimates for 2008-09 showed a significant decline to 4.13% of the total Union Budget. The total tax revenue in India has fallen sharply from 16% of the GDP in 1989-90 to 13.8% of GDP in 2001-02. The magnitude of resources committed to development of women has remained very low at about 5% of UB. For child survival and health related interventions, and for protection of children in difficult circumstances the allocations have remained grossly inadequate during the UPA Government's tenure. The mere introduction of a statement in Budget documents, such as the one on Gender Budgeting or Budgeting for Children or Budgeting for Dalits and Adivasis does not ensure any improvement in the situation of disadvantaged sections of our population. Hence, despite its avowed focus on the flagship social sector schemes, the UPA Government has not brought about very significant improvement in the development outcomes in the social sector. Hence, some of the serious concerns pertaining to the poor and disadvantaged sections of our population, would need to be addressed by the next Union Government.

Key Words : 1.SOCIAL WELFARE 2.BUDGET SPENDING 3.GOVERNMENT SPENDING 4.EXPENDITURE SOCIAL SECTOR 5.UPA GOVERNMENT SPENDING 6.SOCIAL SECTOR SPENDING.

35. NIPCCD, New Delhi. (2009).

Existing models of corporate - voluntary organizations partnership in social sector. New Delhi : NIPCCD. 294 p.

Abstract : Corporate social responsibility (CSR) as a strategy is becoming increasingly important because of 3 identifiable trends – changing social expectations, increasing affluence and globalization. To assess the nature of assistance rendered to voluntary organisations (VOs) and the activities supported by corporates, NIPCCD undertook this study and mailed questionnaires to 118 VOs. In all 95 VOs responded, of whom 50.52% were functioning at regional level, 42.10% at national level and only 7.36% at the international level. Multiple responses were received to the question on activities undertaken. The major issues supported by VOs were health (85.26%), 80% each for education and women's empowerment 78.94% for livelihood and

income generation programmes, followed by HIV/ AIDS (54.73%), disability and relief work/ rehabilitation (45.26% each). About 69.47% organizations engaged in both discussion/ seminars and networking; 68.42% provided counselling services; survey/ research was undertaken by 66.3% VOs; SHG formation was supported by 65.26% VOs; research/ documentation and assistance to other VOs was offered by 61.05% each; and policy advocacy was undertaken by 58.94% VOs. Some VOs were found to be engaged in fund raising, service delivery, relief work and fund disbursement (49.47%, 48.42%, 45.26% and 31.57% respectively). Target population covered by VOs were women (91.57%); children (90.52%); urban/ rural slum population (78.94%); adolescent/ youth (66.31%); tribal population and marginal farmers/ labourers (49.47%); 45.36% mentioned helping other NGOs/ Foundations/ Trusts; and 44.21% VOs reported working with disabled/ challenged persons. Majority of the VOs (72.63%) manage their activities by receiving funds from private/ individual donors, followed by government grant-in-aid (70.52%), and local fund raising (57.89%). Out of 95 VOs, 40 VOs were working in partnerships with corporates, and all except 2 of them were interested in continuing with such partnership in future. About 50.52% VOs expressed their willingness to work in collaboration with corporates in future. The nature of support being received by VOs from corporates was financial assistance (92.5%); setting up of functional units (school/ IGP unit/ kiosk, etc.) (37.5%); technical advice (32.5%); marketing avenues (27.5%); training of staff/ apprenticeship/ SHG groups (25%); rehabilitation of victims of natural calamity (22.5%); policy advocacy (17.5%); setting up of dwelling units/ rural infrastructure/ short stay homes, etc. (12.5%); others (10%); material support (7.5%); and sponsoring events/ programmes (5%). Partnership with corporates assisted VOs in sustenance of the organization (82.5%) and maintaining a particular programme/ activity; networking (42.5%); establishing their credibility in the community (12.5%); provided opportunity to follow best practices in accountability (10%); and transparency (5%).

Key Words : 1.SOCIAL WELFARE 2.CORPORATE SOCIAL RESPONSIBILITY 3.PARTNERSHIP 4.NGO-CORPORATE PARTNERSHIP 5.VOLUNTARY ORGANIZATIONS 6.CORPORATE HOUSES 7.BUSINESS HOUSES 8.NETWORKING 9.FUNDING SOCIAL SECTOR.

STATISTICS

36. Gupta, Soumya, Ramchandani, Shona and Wada, Chieko. (2007).
Universal birth registration : focus on training as a medium of change in
Rajasthan. Jaipur : Indian Institute of Health Management Research.
36 p.

Abstract : About 67% of the world's children have been accorded their first and most fundamental right: birth registration (BR) and a birth certificate (BC). This is in breach of the 1989 United Nations Convention on the Rights of a Child, Article 7, which binds signatory Governments to ensure the registration of every child born in their area of jurisdiction. BR serves as legal proof of a child's existence, proof of place of birth, and to an extent his/her nationality. These are required while applying for domicile, passport, driving license, and for participation in electoral processes. It also provides the child hurdle-free access to social services provided by the state. A birth certificate could be an effective tool to protect the child from physical abuse and sexual exploitation (child marriage, child labour, child trafficking, etc.); aid in adoption issues and access to juvenile justice system. Although birth registration has been in existence in India since the mid 19th Century, it was not made compulsory till the enactment of the Registration of Births and Deaths Acts (RBD Act), 1969. The Registrar General of India is the central authority coordinating civil registration work, but implementation is the responsibility of the states, and registration of a birth can take place only at the Registration Unit within whose jurisdiction the birth has taken place. Birth should be registered within 21 days of its occurrence in both urban and rural areas to get a free birth certificate. India's current BR rate of 63.8% implies that of the 26 million births occurring annually, 9.4 million go unregistered. Despite states like Kerala, Tamil Nadu and Gujarat where BR rates are above 90%, the national average is dragged to a dismal 63.8% due to the 7 poorly performing states where BR rates are as low as 20.4% (Bihar). A survey conducted by UNICEF in 2005 revealed that of the 38.46% children under 10 years whose births were registered, just 21% had a BC. There is no uniform system for tracking the issuance of BCs in the country. To respond to this issue, India aims for Universal Birth Registration (UBR) by 2010. Rajasthan, like other states, has formulated rules under the RBD Act 1969 after enacting the Rajasthan Registration of Births and Deaths Act (Rajasthan RBD Act) in 1972, which was revised in 2000. The BR rate in Rajasthan has increased from 56.9% in 2004 to 78.01% in 2006, which was 14.2% above the national average of 63.8%. While the BR rate is almost 100% in urban areas, the rural registration rate was just 61.36% (2006). Karauli has a rural BR rate of 9.43%, whereas for Sikar BR was 98%, so the increase in BR rates over the past 2 years cannot be

generalized to every district in Rajasthan. The primary stakeholders in the intervention included the Government of Rajasthan, Department of Economics and Statistics, UNICEF and IIMR. An initiative was launched to increase the demand for BR under which training was given to (1) Block Development Officer (BDO), (2) Child Development Project Officer (CDPO), (3) Community Medical Health Officer (CMHO), (4) Panchayat Extension Officer (PEO), (5) Block Education Officer (BEO) at the district and block level; and the Panchayat Secretary, Auxiliary Nurse Midwife (ANM), and Anganwadi Workers (AWW) at the grass roots level. The community was contacted during interaction under programmes like ICDS and JSY. Information, Education and Communication (IEC) activities were undertaken at various levels. The issues that contribute to low BR rates in Rajasthan are low public awareness of the need for registering births, low access to the local registration machinery, lack of pro-active measures by the Government to improve BR, low functionary awareness and execution of job responsibilities, marked inter and intra-district differences in rates of BR and BC, degree to which information is transferred from one level to the next, and lack of coordination between informants and registrars. Functionaries reported BR to be 100% but actual records revealed BR to be 40-50% only. The National Campaign (NC) on Issuance of Birth Certificates and awareness generated under the Janani Suraksha Yojana (JSY) raised BR from 57% in 2005 to 89% in 2006 in Tonk District, while in Alwar BR went up from 36.38% (2004) to 59.43% in 2006. It was recommended that more departments should be included; enforcement systems, monitoring systems and public access to BR functionaries should be increased. To reach out to remote and inaccessible areas Mobile Registration Units should be deployed.

Key Words : 1.STATISTICS 2.BIRTH REGISTRATION 3.CIVIL REGISTRATION SYSTEM 4.REGISTRATION OF BIRTHS 5.TRAINING OF FUNCTIONARIES.

WOMEN WELFARE

37. George, Alex. (2004).
Globalization and loss of employment of women : a case study of Nellore.
Secunderabad : Centre for Health and Social Sector Studies. 34 p.

Abstract : A shift from the cultivation of rice and cereals to commercial crops and aquaculture aimed at the global market, and to some extent the internal market, is taking place in various parts of Andhra Pradesh. Nellore district

presents a typical case, where all these different but related shifts can be studied. The objective was to study the impact of commercial cultivation for the global market on women. This survey was conducted in six mandals of Nellore district, where the shift in cultivation from paddy to aquaculture, horticulture and floriculture was being experienced. The study covered 100 women labourers in each of the 12 villages in six mandals. Thus 1200 women labourers aged 15-60 years were taken and data was collected through interviews. In Nellore district, women on an average got only 3.29 days of work in a week and 10.85 days of work in a month. 53% women worked as rice labourers and 13% women worked in aqua farms during the reference week of the study. The number of days women were employed in aqua farms in the reference week was only 3.58 and just 9.65 during the reference month. The daily wage for women in rice cultivation was Rs.30.27, in aqua culture Rs.28.92 and Rs.26.49 in horticulture. The mean daily wage in floriculture was extremely low at just Rs.18.43 per day. The sample also consisted of SCs (45%), BCs (29%) and STs (24%). 89% (1067) women informed that they got an average of 22 days of employment in rice cultivation in a month in the corresponding crop season prior to the shift cultivation. 13% (157) women got employment in aquafarms, with an average of 3.58 days per week and the wage earned by an aqua labourer was Rs.28.92, which was less than the wages earned in rice cultivation. 15% (178) women got employment in horticulture during the reference week, the mean number of working days were 3.36 per week with an average wage of Rs.26.49 per day. Horticulture included lemon, chilli, groundnut, mango, sapota and vegetables which are crops of commercial nature. These crops gave a few days employment to the women labourers. Only 6% (74) women got work in horticulture, the mean number of work days available was 5.04 per week and the mean wage reported was Rs.18.43 per day, far less than the wage in other crops. 9% (109) labourers were engaged in other agricultural work, with 2.87 days of work per week and wages of Rs. 28.44. Other agricultural work included work in cotton, tobacco, sugar cane and sunflower farms. These crops gave employment to women labourers on irregular basis of 3-4 months per year. Shift in cultivation from paddy to aquaculture, horticulture and floriculture, and the introduction of harvesting machines in some villages has virtually replaced human hands from harvesting. New crops not only reduced employment but had in no way helped in pushing up wages, and women were the main sufferers. State and district level workshops of officials from departments of rural development, women and child development, labour, agriculture and environment, and activists, farmers, labour union leaders, labourers, human rights activists, members of women's groups, literary writers and media persons should be conducted as part of the advocacy efforts in this direction.

Key Words : 1.WOMEN WELFARE 2.EMPLOYMENT WOMEN
3.GLOBALIZATION 4.WOMEN LABOUR 5.AGRICULTURE AND WOMEN.

38. NIPCCD, Regional Centre, Lucknow. (2009).
Short stay homes in Uttar Pradesh: a status appraisal. Lucknow :
NIPCCD-RCL. 213 p.

Abstract : A status appraisal of Short Stay Homes (SSHs) in UP was conducted by NIPCCD, Regional Centre Lucknow, Central Social Welfare Board, State Social Welfare Board (UP), and Social Welfare Department of Government of UP. The study covered 8 short stay homes, i.e. 25% of the total 30 SSHs functioning in UP, situated at Lakhimpur Kheri, Raebareli, Kanpur, Pratapgarh, Mirzapur, Allahabad, Deoria and Saharanpur. SSHs were implementing a variety of programmes like women helpline, family counselling centres, crèches, SHGs, vocational training, income generation activities, rehabilitation, medical care, campaigns, and other programmes in the areas of health, education, agriculture and welfare. The inmates residing in SSHs were victims of marital disputes and family discord (50.55%), victims of harassment and facing moral danger (34.26%), destitute women (10.66%), victims of trafficking (2.25%), and 2.24% women had runaway from home. 63.48% were unmarried and only 36.5% were married. Regarding educational status it was found that 11.23% were illiterate, 65.73% were educated upto 8th Standard, 15.16% were matriculate, 5.61% were intermediate and 2.24% women were graduates. To ensure appropriate rehabilitation, voluntary organizations should find suitable individual placement for each inmate. Police often made the situation adverse and hazardous for women therefore officials of SSHs avoided the involvement of police. Police need to play a constructive role in the matter. It was also suggested that every police station, anganwadi centre, PRI member (at village, block and district level), health centre personnel, elected representatives (MLAs and MPs) of the area, etc. should be aware of the services provided by SSHs, and a list of SSHs with complete addresses and telephone numbers needs to be prepared and supplied to them.

Key Words : 1.WOMEN WELFARE 2.SHORT STAY HOMES
3.INSTITUTIONS FOR WOMEN 4.WOMEN IN DISTRESS 5.INCOME
GENERATION.

39. Ram, Usha. (2008).
Childlessness and its consequences in India : levels, patterns and
differentials. Mumbai : International Institute for Population Sciences. 4 p.

Abstract : The inability of women to have children becomes a cause to subject them to social discrimination and places restrictions on their participation in social events and celebrations. This study was based on the National Family Health Surveys 1998-99 and NFHS 2005-06. In India 13% of ever married women aged 15-49 years were childless in 1981 (Census) (13.4%) in rural areas and 11.3% in

urban areas), compared to 16% in 2001 (15.6% in rural areas and 16.1% in urban areas). Over 50% of the married women in the 15-19 years age group were childless in 1981, which increased to 70% in 2001. The age specific childlessness rate (ASCR) in 30-34 years age group was 4% in 1981 and 6% in 2001. Rural General Marital Childlessness Rate (GMCR) in southern states ranged from 15% in Kerala to 18% in Tamil Nadu, and in northern states from 15% in Madhya Pradesh to between 17-20% in Bihar, UP and Rajasthan. In urban areas Kerala had lowest GMCR among southern states and GMCR varied between 14-18% among northern states. GMCR for Hindu women in 1981 and 2001 was 13.31% and 15.79% respectively, for Muslim women in 1981 and 2001 it was 11.71% and 16.07% respectively, for Christian women in 1981 and 2001 it was 8.96% and 15.89% respectively, and for women of other religions in 1981 and 2001 GMCR was 10.61% and 13.95% respectively. The GMCR for illiterate women and women who were graduates and above was 13.71% and 20.93% respectively in 2001, while in 1981 for illiterate women and women who were graduates and above GMCR was 12.97% and 14.66% respectively. About 64% and 75% districts in 1981 and 2001 respectively fell in Medium Prevalence Districts (MPD) group. Nearly 28% districts in 1981 fell in LPD group, which declined to 3% in 2001. About 4% districts in 1981 fell in MPD which increased to 22% in 2001 indicating a dramatic shift in the positions of the districts from low to high prevalence of childlessness. Factors affecting likelihood of childlessness are closely associated with place of residence, religion, standard of living index, educational and economic activity status, age at marriage, body mass index (BMI), reproductive morbidity status, and caste (at significance level of 5% among young women aged 15-34 years). Among older women aged 35-49 years childlessness was greater for those with schooling, economically active, married after age 18 years, having medium BMI, substance users and had reproductive morbidity in the past. Consequences of childlessness were marital disruption. Over 4% of younger childless women aged 15-34 years were divorced/ separated/ deserted as against just 1.5% among those with children. Over 23% of the childless women aged 35-39 years and 5% of them aged 15-34 years living in southern states experienced marital disruption in comparison to just 3% and less than 3% respectively for women with any children. 11% of older childless women experienced marital disruption in the north and north-eastern region as compared to less than 3% among women with children. Gender based violence in which the proportion of women who experienced violence from husband/in-laws was 16-22% for older childless women compared to 13-21% for women who had children. The analyses further showed that the women who remain childless face many adverse results in the form of divorce/desertion and discrimination.

Key Words : 1.WOMEN WELFARE 2.CHILDLESSNESS 3.CONSEQUENCES OF CHILDLESSNESS.

40. Shinghal, N.K. (2002).
Crimes against women : role of Section 498-A IPC in states of Delhi and Haryana : study report. New Delhi : Bureau of Police Research and Development. 118 p.

Abstract : There are growing cases of cruelty and torture of married women particularly for dowry, some times even culminating in killing of or commission of suicide by victimised women. The present study assessed the effectiveness of legislation related to torture of married women and atrocities by husbands and their family, particularly under Section 498 A IPC. Section 498 A IPC covers any wilful conduct under certain circumstances when it is likely to drive the woman to commit suicide or cause grave injury or danger to life, limb or health. Section 304 IPC covers dowry death caused by burns or bodily injury other than under normal circumstances; death within 7 years of marriage; being subjected to cruelty or harassment for dowry soon before death. Section 306 IPC was made to facilitate successful prosecution of the husband and his relatives. The study was undertaken in Delhi and 3 districts of Haryana. The objectives of the study were to assess the adequacy of special legal provisions relating to dowry; examine their implementation in practice, deficiencies, difficulties or misuse; and suggest amendments, if any necessary, to make the laws more effective for preventing marital violence against women. In Delhi, during 2000, 3382 complaints of marital cruelty were received, out of which 543 were pending and 847 criminal cases were registered under Section 498-A/ 406 IPC, 1336 cases were mutually compromised and in 656 cases *Stri Dhan* (married women's assets) was returned. In Faridabad, Haryana, 1201 complaints relating to marital harassment were received during 1995-1999, out of which in 7% (89) cases *Stri Dhan* was returned, 18% were motivated or false cases, and 63% and 12% were criminal cases registered after enquiry under Section 498 A/ 406 IPC and other sections, respectively. In Gurgaon, 429 complaints were received relating to marital harassment, out of which 18% (36) were mutually compromised or *Stri Dhan* was returned, 10% (44) cases were closed due to inadequate evidence, 15%, 51% and 70% were the criminal cases registered after enquiry under section 498 A IPC, 498 A/ 406 IPC and dowry deaths, respectively. In Sonapat, 13 cases were reported under Section 498 A IPC, 26 cases were under Section 498 A/ 406 IPC and 15 cases were reported under dowry deaths in the year 2000. It was found that there are deficiencies in Section 498 A IPC which are (i) lack of proper elucidation or illustration of the terms "grave injury and danger to mental health"; emphasis on dowry related violence and non-inclusion of violence not so related, in clear and specific turns under the sections; absence of any provision for protection or relief to the victim; non-compoundable and non-bailable procedures under this section; and the quantum of punishment is often much less than the maximum of 3 years. The basic lacunae under Section 304 B IPC were the

limited acceptability to cases of unnatural deaths being connected to dowry demand related harassment/ torture; defining the term “dowry demand” as implied under “Dowry Prohibition Act”; and limitation of applicability to unnatural deaths to within 7 years of the marriage only. In the present social context, unless the basic issue of “violence against women” is taken into consideration, the law will continue to remain deficient and inadequate. Therefore, more intensive and focused efforts will have to be made, with the help of media, to improve legal awareness about the implications and requirements of these laws among people, and inform and educate them about the need to take timely notice of harassment and violence rather than taking an ostrich-like attitude, both to prevent a bigger tragedy as well as to make the implementation of these laws more effective.

Key Words : 1.WOMEN WELFARE 2.DOWRY 3.DOWRY DEATH 4.CRIME AGAINST WOMEN 5.IPC SECTION 498 A.

41. Siwal, B.R. (2008).
Gender framework analysis of empowerment of women: a case study of Kudumbashree programme. New Delhi : NIPCCD. 85 p.

Abstract : Kerala is considered to be one of the most successful states in poverty reduction in the country. It is primarily because of its high level of education and health. It seeks to achieve change through decentralization and empowerment of women’s groups. Recent policy initiatives include participatory planning, decision making and implementation, combined with fiscal devolution. Kerala’s population density is 819 persons per square kilometre and it stands 3rd in density, West Bengal being first and Bihar claiming the second position. Crude birth rate in Kerala is 16 in 2001. Kerala is the most literate state in the country with a literacy rate of 90.92%. 65% women in India marry before the age of 18 years, but in Kerala only 7% women do so. The average age at marriage in Kerala is 23.5 years for women and 27 years for men. For every 1000 widowers there are 762 widows. As girls marry late the child bearing age has also gone up accordingly. 97.3% deliveries take place in hospitals, and MMR in Kerala is 140 per one lakh deliveries, and low birth weight babies are also minimal in number. Divorce rates are high in Kerala, and it ranks 1st in Asia. Trivandrum district ranked first with 1850 divorces having taken place during 2002. Girls commit suicide because of failure in examination. The suicide rate continues to be 29.6 per 1 lakh population for the last three years (2002). Reported offences are available under six categories of crime – rape, kidnapping and abduction, dowry deaths, cruelty by husband and relatives, molestation and sexual harassment. In

the ascending order of total crimes against women, Kerala ranks 24th among states/ UTs. The male work participation rate (WPR) in Kerala has increased from 42.22% to 50.4% i.e. by 8.18% within a span of 30 years, but in the case of women it has increased only by 0.7%, whereas in India it has increased from 14.22% to 25.7%. The well known Kudumbashree initiative of the Government of Kerala is a women oriented poverty eradication programme with women's empowerment as one of its major goals. It was begun in 1998 by the Government of Kerala with the aim of eliminating poverty within 10 years, by 2008. Kudumbashree followed a strategy which includes: (a) convergence of various government programmes and resources at the community-based organization level, (b) efforts to involve the CDS structure in local level anti-poverty planning, and (c) development of women's micro-enterprises and thrift and credit societies. This study assessed the measures taken for economic empowerment with special focus on micro-credit and micro-enterprises development in rural and urban areas of Thiruvananthapuram, Alappuza, Malapuram and Kasargod districts. The grass root level poor women are organized through Neighbourhood Groups (NHGs) consisting of 20-40 women with 5 volunteers – community health volunteer, income generation volunteer, infrastructure volunteer, secretary and president. Main functions and activities of Kudumbashree (other than SHG and micro-enterprises) are lease land farming, ashraaya, HRD, Bal Sabha (children's NHG), community health, micro housing project for poor, solid waste management/ clean Kerala, special employment programme for educated youth, special school for disabled children, and nutrimix - the baby food products production project. The motivating agents of SHGs were the officials of Kudumbashree and animators of NGOs. In the functioning of SHGs, proper documents like account books, registers, reports were maintained, women participated in the decision making process in the family, decisions were taken on consensus during meetings, and thrift collected was used by community members for needs such as treatment, delivery, death and education of children. Micro-enterprise development is viewed as an opportunity for providing employment to women below the poverty line to enhance their income and standard of living. The Kudumbashree definition of Micro Enterprise includes investment ranging from Rs.5000 to Rs.2.5 lakhs. This encourages innovative business ideas. In 2007 there were 18,969 enterprises in urban and rural areas, covering enterprises like goat rearing and dairying, catering units, job clubs, health care enterprises, computer hardware and data entry units in IT sector, innovative enterprises like Clean Kerala Business for solid waste management, and coir products. Micro-enterprises raised the income and satisfaction in meeting basic needs. Changes were brought about in existing power relations in favour of poor marginalized women, and changes were also attempted in knowledge, attitude and behaviour of both men and women. Awareness was built about women's situation, discrimination, rights and opportunities as a step towards gender equity; and capacity building and skills development was

undertaken. Kudumbashree organized women into Self Help Groups (SHGs) for economic independence and freedom from moneylenders. Women's income leads to increased expenditure on their well being and that of their children. Opportunities for saving and credit are linked to the panchayats. As Kudumbashree was supported by the Government, a declining spirit of volunteerism was evident. Observers of civil social affairs in Kerala pointed to the danger of bureaucratization of Neighbourhood Groups (NHGs). Women activists have involved positively in the new institutions of local self government and development. Kudumbashree has promoted the active presence of women in politics. Kudumbashree has developed a culture of learning by doing and reflection. Group activities have led to cohesion and reduced the feeling of vulnerability. Women reported that violence diminished as men realized the importance of the economic contribution of women to the household. Women became more aware of child care services and availed the facility of supplementary nutrition for lactating mothers. Many SHG members were willing to start their own micro-enterprises and expected Kudumbashree to help them in this venture. Kudumbashree staff spent its energy mainly on micro-enterprise activities. NHGs have shown the potential for public action against social and economic injustice. Kudumbashree needs to make arrangements for quality control of products of SHGs and organize regular training programmes for new and old women entrepreneurs. The agenda of SHGs needs to include social justice and equity issues, although women have taken up issues related to violence against women even in the absence of support from NHGs.

Key Words : 1.WOMEN WELFARE 2.KUDUMBASHREE 3.SELF HELP GROUPS 4.GOVERNMENT NGO 5.EMPOWERMENT WOMEN 6.INNOVATIVE PROJECT WOMEN 7.BEST PRACTICES 8.ECONOMIC EMPOWERMENT OF WOMEN.

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Support services to counter violence against women in Kerala : a resource directory. New Delhi : UNIFEM. 151 p.

Abstract : Although Kerala is advanced on many indicators of human development, the incidence of violence against women is also high. The study was a response to the long felt need of access to information on resources and support services available for women who were victims of violence. Kerala has a total population of 31,838,619 which includes 15,468,664 males and 16,369,995 females (Census of India 2001). Kerala has surged forward in achieving formal literacy (90.92%), reducing fertility rate, infant and maternal mortality rate,

achieving higher life expectancy, etc. The Human Development Report of UNDP, in the section which discusses the Gender Development Index (GDI) for 16 Indian states, places Kerala at the top of the list in terms of basic female capabilities. Kerala is the only Indian state to have a favourable female sex ratio (1058 females for 1000 males), though the sex ratio is not uniform in all districts. The highest sex ratio of 1054 is found in Pathanamthitta district and the lowest in Idukki district which has 993 females per 1000 males. This indicates the high status of women in Kerala. But, in the younger age group the female sex ratio is decreasing, and male children constitute 12.48% while female children constitute 10.95% of the population of Kerala. A recent survey report revealed that there were 10,000 foeticides occurring in Kerala per year. The survey found that a majority of parents think that girl children are a cause of tension and a burden for them. According to Census 2001, female literacy in Kerala was 87.86% compared to 94.20% for males. Kerala has one of the highest suicide rates in the country, and according to National Crime Records Bureau, 1547 housewives committed suicide in the year 2000. Child marriage is still practiced in some parts of Kerala, despite having high literacy. It was found that it has increased in Northern Kerala where 36% girls are getting married before 18 years. Women in Kerala have poor participation and representation in politics, and out of 144 seats in the state assembly, the number of women has never been more than 13(10%). The State Women's Commission has received about 15,000 complaints within 2 years of its inception, 80% of which are related to sexual and family violence. According to State Women's Commission, in 1996, 191 cases of dowry deaths and 300 cases of dowry related violence were reported. Rape and other atrocities numbered almost 500, while there were 228 cases of sexual harassment. The sex ratio is satisfactory but it is decreasing specially in the 0-6 years age group. Violence against women is increasing steadily in Kerala and society is yet to recognize this reality and act to change the situation.

Key Words : 1.WOMEN WELFARE 2.VIOLENCE AGAINST WOMEN
3.DIRECTORY VOLUNTARY ORGANISATIONS WOMEN 4.SUPPORT
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