DCWC Research Bulletin

Vol. XII Issue 1 January – March 2008

2008

Documentation Centre for Women and Children (DCWC)

National Institute of Public Cooperation and Child Development (NIPCCD)

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New Delhi – 110016

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CHILD WELFARE

1. Ganguly Thukral, Enakshi et al. (2008).
Budget 2008-09 and children : a first glance. New Delhi : HAQ Centre for Child Rights. 19 p.

Abstract : Budget for children (BFC) is not a separate budget. The present report (BFC) is an attempt to disaggregate the child budget from the overall budget, and specify the allocations specifically made for the benefit of children. Analysis of the budget reveals that children received on an average, 3.10% of the Union Budget from 2000-01 to 2006-07. In 2007-08 their share was 4.8%. In 2008-09, their share is 4.98% of the Union Budget. There is an increase of Rs. 3.75 (0.21%) crore in the health sector, but there is a fall in the budget allocation for Child Health in proportion to the total budget in 2007-08 (from 0.268 to 0.244%). The Economic Survey 2007-08 observes that a majority of the states have introduced user charges for services in Public Health facilities, even while stating that access of poor and needy patients to health care must not suffer because of the levying of user charges. There is a reduction in the allocation for Pulse Polio Immunization from Rs. 1289.38 crore in 2007-08 to Rs. 1042 crore this year. An outbreak of Polio was witnessed in 2006 with the spread of Polio virus, and during 2007 a total of 471 cases were reported. There is an increase of Rs. 904.2 crore (19%) in the allocation on ICDS. In January 2008, 1,052,638 Anganwadis were sanctioned, and in June 2007 there were 863,472 operational Anganwadi centres. There was a short fall of 7.68 lakh Anganwadis to achieve universalization of ICDS. The salaries of Anganwadi Workers have been increased from Rs. 1000 to Rs. 1500 per month, and Rs. 838.80 crores of the Rs. 904.2 crore increase will go towards meeting this expense, while only an additional Rs. 65.4 crores is available for implementation of the ICDS programme over the last year's budget. There is a fall in the budget for Rajiv Gandhi Crèche Scheme (fall of 6.70%). The allocation for Protection of Children has increased from 0.045% of the Union Budget to 0.056%, which is largely due to the increase on allocation for the Integrated Child Protection Scheme (ICPS) from an allocation of Rs. 85.50 crores in 2007-08 to Rs. 180 crores. The Ministry had requested for Rs. 3000 crore to implement ICPS for 5 years. But the Planning Commission reduced this to Rs. 1000 crore. The Finance Minister has allocated Rs. 180 crore in 2008-09. The budget figures for both Mid Day Meals (MDM) and SSA (Sarva Shiksha Abhiyan) for the year 2008-09 is Rs. 21100 crore. There is an increase of 6.3% in both the programmes. The collection through the education cess has increased to 23.33%. The budget allocation for Child

Development in 2008-09 is Rs. 6539.63 crore. The figure for Child Health is Rs. 1828.58 crore. The budget for Child Protection is Rs. 418.76 crore. For School Education the budget is Rs. 28,640.02 crore. The Child Budget is Rs. 37426.99 crore, Union Budget is Rs. 750,883.53 crore, hence the Child Budget is 4.98% of the Union Budget. According to NFHS-3 (2006), 38.4% of children under 3 years are stunted, and 45.9% of the children under 3 years are underweight. Under ICDS, 1,223,725 children aged 3-6 years were yet to receive supplementary nutrition and pre-school education as on March 2007. Although 6284 ICDS projects were sanctioned, 5885 projects were operational as on June 2007. About 2.5 million children die in India every year accounting for one in 5 deaths in the world, with girls being 50% more likely to die. Polio, malnutrition, HIV/ AIDS and diabetes need urgent attention. According to hospital statistics, in 2002 Delhi alone had about 4000 to 5000 diabetic children though it is estimated that there might be an equal number of such undiagnosed cases. Childhood anaemia is rampant and appears to be on the rise as 79.2% of children aged 6-35 months (underthrees) are anaemia (NFHS-3). Only 43.5% of children aged 12-23 months were fully immunized (NFHS-3). Only 40.7% births in India were institutional deliveries (NFHS-3). The Budget for Children in the Health Sector was Rs. 1828.58 crore. Budget for strengthening of Immunization Programme and Eradication of Polio was Rs. 1508.43 crore. All crimes against children have shown an increase in 2006. One in every 10 children is sexually abused at any point of time. Over 44,000 children go missing every year, of whom more than 11,000 children remain untraced. For Short Stay Homes the budget is Rs. 15.90 crore; for the Prevention and Control of Juvenile Social Maladjustment for the budget is Rs. 18 crore; for Improvement of the Working Conditions of Child/ Women Labour the budget is Rs. 156.06 crore; for Street Children it is Rs. 9 crore; for scheme for Welfare of Working Children it is Rs. 6.3 crore; for Shishu Griha Scheme Rs. 2.7 crore; and for Central Adoption Resource Agency (CARA) it is Rs. 3.8 crore. According to MHRD (2006), 1.34 crore children in the age group of 6-14 years are out of school. Drop out rate in Classes I-X is 62.38%, and 46% children from STs and 38% from SCs are out of school. The District Primary Education Programme has a budget of Rs. 50 crore in 2008-09; Kasturba Gandhi Balika Vidyalaya has a budget of Rs. 80 crore; Nutritional Support to Primary Education was allocated Rs. 80000 crore. For Sarva Shiksha Abhiyan the budget is Rs. 13,100 crore. The Budget for Integrated Education for Disabled Children is Rs. 70 crore. National Scheme for Incentive to Girls for Secondary Education was allocated Rs. 45 crore. The budget for Girls and Boys Hostels was Rs. 55 crore and Rs. 38 crore respectively.

Key Words : 1.CHILD WELFARE 2.BUDGET FOR CHILDREN 2008 3.BUDGET FOR CHILDREN 4.CHILD BUDGET 5.SPENDING ON CHILDREN 6.GOVERNMENT SPENDING ON CHILDREN

2. Goa Initiative for Mainstreaming Child Rights, Panaji. (2007).
Status of children in Goa : an assessment report 2007. Panaji, Goa : GIMCR. 133 p.

Abstract : The Government of Goa has set up various mechanisms to safeguard the rights of children and to cater to their needs. The aim of this study was to carry out a rapid and comprehensive assessment of the situation of children and the current strategies followed. The Project Committee prepared a format to collect the information from resource persons. It was found that the sex ratio in Goa has been steadily declining from 1066 in 1961 to 975 in 1981 and 961 in 2001, though it is higher than 933 for India as a whole. The majority of child workers belong to families that have migrated to the state in search of employment due to extreme poverty and displacement. Some children were also those who had run away from home and come here in search of work. Children were mainly employed in the unorganized sector where they were engaged in selling plastic bags, fish, vegetables, fruit in the market, as domestic workers, at construction sites, in garages, in shops as sales persons or helpers, in small hotels and restaurants, as shoe shiners, selling peanuts/ beer/ handicrafts, as masseurs on the beach, as sand sifters, and in many other kinds of work in order to sustain themselves and their families. Most of the children were unaware of health facilities and unsure about how to access these. Child workers often turned to substance abuse and alchohol as a route to escape tensions. 1.4% of the children from migrant communities were beggars. There was reluctance to report sexual abuse and only 0.27% reported the same. 3% children appealed for help. Goa Police records showed that between 1996 and 2001, 93 boys and 109 girls were missing, and of these 16 boys and 23 girls remained untraced. The average age of trafficked girls has reduced over the years; the age group now is 13 to 15 years. In 2005-06, 81 girls from north Goa and 29 girls from south Goa benefited from Balika Samridhi Yojana. According to the 2001 Census of Goa, the state has 15,749 differently abled people, but not more than 3% of the disabled children were in schools. According to Goa State AIDS Control Society (GSACS: 2006), the total number of HIV cases detected in Goa from 1987 to 2005 was 7,908. In 2005, there were 11 ICDS projects and 1012 AWCs covering 36,248 children. Only 30% AWCs had permanent buildings, 45% had toilets and 35% had water facilities. 20% AWWs were Higher Secondary pass. They spent 40% of their time on SN activities, 15% on PSE, 20% on records, and less time was spent on home visits, and health activities. NFHS-2 (1998-99) reported a strong male child preference in the state, and 3.9% of all the pregnancies resulted in induced abortions, which was more than twice the all India average. Many women in Goa are anaemia and deliver low birth weight babies. Adolescent girls are also anaemic. In Goa there were more children enrolled in schools not managed by government, but even here there was a gender divide.

There were 600 cases of mentally ill children at Sangath Centre and there was an increase in the number of children being referred with disorders like mental handicap, learning disabilities/ dyslexia, autism, hyperactivity disorders, and behavioural problems among teenagers such as stealing and aggression, conduct disorders and emotional problems such as depression. It was recommended that the M/o Women and Child Development needs to develop an overall child rights approach to benefit children. Comprehensive rules should be formulated for the implementation of Goa Children's Act, monitor its implementation, and ensure that barriers to its effective implementation are overcome. Accountability of voluntary organizations should be monitored through publication of their annual reports.

Key Words : 1.CHILD WELFARE 2.SITUATION OF CHILDREN GOA 3.CHILD PROTECTION 4.GIRL CHILD 5.DISABLED CHILD 6.CHILD RIGHTS 7.CHILDREN'S HOMES 8.GOA CHILDREN'S ACT 9.ADOPTION 10.AIDS AFFECTED CHILDREN 11.GOA.

3. National Commission for Women, New Delhi. (2004).
Discrimination of girl child in Uttar Pradesh : Roshni : a research study. New Delhi : NCW. 46 p.

Abstract : Discrimination against girl child, a subject of great socio-legal significance, is not only a highly sensitive matter but also relates to vital issues concerning gender justice and the right to equality as enshrined in the Constitution of India. The present study was done to assess the root causes of son preference that resulted in harmful and unethical practices like female infanticide and sex selection before birth, and also to devise purposeful lines of action in order to eliminate all forms of discrimination against the girl child. The study was conducted in urban and rural areas of Agra, Uttar Pradesh. Agra district has a total population of 788,394 out of whom 440,405 were rural and 347,989 were urban residents. Data was collected through interviews and surveys. Most of the urban women respondents had been married between the age of 18-23 years, while 50% of the rural women had been married by the age of 15 years. All the women, whether urban or rural, had their first child within 2 years of marriage. Decisions regarding family planning were mostly taken by males in both urban and rural areas. 50% rural women mentioned that they did not practice any form of family planning. Around 50% rural men and 64% rural women preferred a son, while 72% urban men and 78% urban women mentioned they would prefer a daughter. The urban respondents probably gave this response because they knew the purpose of the study and being qualified educated professionals they wanted to look good and felt it was an appropriate

reason to give. They were lying because when they were queried as to why they wanted a boy, they did not deny the desire for a son and gave reasons such as a person could got *moksha* (salvation) only if he was cremated by his son, a son was a support in old age, etc. The study found that 34% rural women had 5-9 pregnancies and 16% had over 10 pregnancies in order to have sons. The respondents, both male and female, of urban areas denied ever having undergone a sex determination test, while almost all had one son and one daughter. In rural areas it was found that most boys had over 2 brothers, 20% had 3 brothers and 20% had 4 brothers. In rural areas it was found that over 90% of the women respondents were uneducated. Female literacy was found to be the single most important factor in determining the success of family planning and primary health services. Around 90% rural men, 38% urban men, all the rural women and 72% of the urban women preferred educating a son since they felt a boy would earn and add to the family income. Many respondents mentioned that they wanted to educate a boy because there was no fear in allowing a boy to go outside his village. Only 18% of the urban men felt that media had a negative impact on girls. Around 76% rural men and 78% rural women felt that girls were less intelligent and incapable of taking independent decisions. Around 14% rural women mentioned that more nutritious food was served to sons. Around 80% girls from both rural and urban areas felt that they were not discriminated against by the family. Over 75% rural women mentioned that the family was considered unlucky if they had only daughters. This was due to socio-cultural pressures. Over 90% urban male respondents felt that it was the right of males to scold a woman if she made a mistake. Findings of the study strongly reinforced the need for well-focused affirmative action, not merely on the part of government agencies, but equally importantly, also on non-government and civil society organizations to ensure that girls' rights are acknowledged.

Key Words : 1.CHILD WELFARE 2.GIRL CHILD 3.DISCRIMINATION AGAINST GIRL CHILD 4.SON PREFERENCE 5.UTTAR PRADESH.

4. Sinha, Geeta. (2002).
Declining sex ratio : extent of female foeticide and infanticide in the states of Bihar, Jharkhand, Uttar Pradesh and Uttarkhand. New Delhi : All India Women's Conference, Ujjawal Women's Association. 85 p.

Abstract : The adverse sex ratio in India is a cause of great concern. One of the reasons for the fall in female sex ratio is the widespread practice of female foeticide. The present study was conduct in Bihar, Jharkhand, Uttar Pradesh and Uttaranchal. The main objective of the present study was to examine the incidence and trend of declining female sex ratio (especially in the 0-6 years age group). Activities of a Patna based NGO, ADITHI were also studied. A total of 4445 respondents were interviewed, at least 1000 from each state. In each state, a mix of castes and religion was taken up. The communities, categorized on the

basis of their practice of female foeticide (FF) are: 1. Red: 11 communities consisting of 1703 respondents with highest perceived probability/ practice of female foeticide/ infanticide; 2. Blue: 1132 respondents from 9 communities showing some probability/ practice of female foeticide/ female infanticide; and 3. Green: 20 communities with a sample size of 1610 having no probability/ practice of female foeticide/ infanticide. Findings indicated that 11 communities showed definite signs of FF and some of them had reached alarming proportions. These were Brahmins, Pandas and Banias of Deoghar, Banias of Firozabad, Brahmins and Dhanuks of Godda, some communities from Garhwal hills and Haridwar town, some non-muslim communities of Saharanpur, some communities from Mirapur and those of Dumra block of Sitamarhi. The study revealed that 9 communities comprising 1132 respondents identified under Blue category had some respondents reporting some probability and practice of FF. There were 1610 respondents among whom no practice of FF or FI was reported. The study also revealed comparisons between communities falling under Red, Blue and Green categories on 3 antecedent variables, i.e., TCV (Traditional Culture Value), ATGCF (Attitude Towards Girl Child/ Female), MSEE (Modern Socio-Economic Expectations). Red communities in comparison to either Blue or Green seemed relatively higher on the TCV Scale, i.e., women were viewed as symbols of family prestige. Similarly, Blue communities compared to Green communities were higher on TCV scale. Red category communities were higher on socio-economic expectations than either Blue or Green communities. Similarly, in the case of Green communities about 40% were aware of SD/ FF techniques, but about 90% had either no access to them or had access with difficulty. A local NGO, ADITHI, started several interventions in Dumra block of Sitamarhi (Bihar). The measures were quite successful and the practice of infanticide has now been replaced by foeticide. Another NGO, Bal Mahila Kalyan, is working in the field of rehabilitating the dais who were actually conducting the infanticides. 90% of the respondents were unaware of SD/ FF related government laws. Results clearly reveal that awareness or impact of laws concerning sex-determination test and female foeticide are not much different from laws on dowry. It was recommended that NGOs must carry on active propaganda to show the value of the girl child. Anti-dowry and anti sex-determination test and foeticide campaign should be carried out vigorously. All government programmes for the welfare of girls and women should be implemented vigorously to reduce and eliminate gender bias. There is need to change this perception and government policies can greatly help in doing so. Legislation should be made more elaborate in scope, more preventive and participatory in nature, and strict and exemplary punishment should be awarded to violators.

Key Words : 1.CHILD WELFARE 2.FEMALE FOETICIDE 3.FEMALE INFANTICIDE 4.DECLINING SEX RATIO 5.SEX DETERMINATION TEST 6.BIHAR 7.JHARKHAND 8.UTTAR PRADESH 9.UTTARANCHAL 10.UTTARAKHAND.

5. Bhutia, Tashi Yangzom. (2006).
Corporal punishment in Chennai schools : a study. Chennai : Manitham. 24 p.

Abstract : Corporal punishment is a method that has been implemented by schools since times immemorial to enforce discipline among students and it is also used as a means to deter students from committing similar offences in the near future. The present study was done to assess the corporal punishment given in Chennai schools. Data was collected from more than 20 schools by interviewing teachers, students, parents, journalists and school principals in Chennai, Tamil Nadu. Interviews with students revealed that corporal punishment was still used in spite of instructions not to use it. But some senior students mentioned that corporal punishment was justified because they felt that most of the juniors were ill disciplined and corporal punishment was the only means to discipline them. Majority of the school principals and teachers mentioned that they did not use corporal punishment at all which was not true. Several stakeholders (journalists, advocates, personnel from the education department, writers and political leaders) mentioned that corporal punishment should not be totally eliminated, but simple forms of punishment like canning, etc. in the right spirit, not with the intention to hurt the child, could be given. Many teachers mentioned that they did not resort to corporal punishment but they employed other means of punishing children like making them write impositions, giving them physical exercises, making them pay a fine, cutting off their lunch time or play time, or making them learn lessons thoroughly. According to parents, corporal punishment could harm children's dignity, and they felt that other methods could be used like giving advice, explaining things to them in a friendly environment, and using non-violent means. Corporal punishment should be removed from schools and other alternatives like counselling, parents' teacher meetings, making the student learn lessons, etc. should be preferred.

Key Words : 1.EDUCATION 2.CORPORAL PUNISHMENT 3.DISCIPLINING 4.PUNISHMENT 5.SCHOOL.

6. Chand, Vijiya Sherry and Amin - Choudhury, Geeta. (2006).
Shiksha sangam : innovations under the Sarva Shiksha Abhiyan. Ahmedabad : Indian Institute of Management Ahmedabad. ~100 p.

Abstract : The Sarva Shiksha Abhiyan (SSA) is the flagship elementary education programme of the Government of India and has been in operation since 2002. This report focussed on some of the interventions initiated by selected states under Sarva Shiksha Abhiyan (SSA) umbrella, in response to

local needs and demands. The innovative interventions were identified in 13 states, namely Andhra Pradesh, Delhi, Gujarat, Haryana, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh, Uttaranchal and West Bengal. The interventions were grouped into 6 categories: the education of girls, alternative schooling and educational guarantee interventions, inclusive education for the disabled, quality improvement initiatives, distance education, and school management and child trafficking systems. The innovations reported were that the education of girls showed a distinct focus on providing platforms for expression through alternative settings such as camps for gifted girls, the creation of platforms or '*manch*' through which social issues and gender discrimination were addressed, or developing extra curricular skills. The focus had been on all round development to ensure higher levels of self-confidence and interactive skills. The ten innovations reported under Alternative Schooling extend the concepts of mobile schools and various bridging approaches like boat schools for the excluded children of fisher folk, bus schools for urban deprived children or special focus groups like children residing near brick kilns, tent schools and various forms of residential care centres run entirely by the state or with NGO collaboration. These innovations played an important role in reducing the number of out-of-school children. The study showed that in 2006, about 3 million children with disability have been identified and 1.83 million were enrolled. States like Andhra Pradesh and Uttar Pradesh have focussed on innovative residential bridge courses (RBC) for children with special needs (CWSN) in order to prepare them for school. In 2006, 61,161 CWSN were covered through AIE (Alternative and Innovative Education)/ EGS (Education Guarantee Scheme) in 15 States and 74,170 were under home based education in 15 States. Children with severe disability were prepared for schools or given life skills training through NGOs (as in Himachal Pradesh and Uttaranchal), or resource teachers (as in Kerala). Some states like Tamil Nadu and Haryana have special or model schools, other states (Himachal Pradesh, Kerala, Andhra Pradesh and Gujarat) have converged their activities with the District Disability Rehabilitation Centres, the Red Cross, and government corporations. Another innovation was Distance Education (EDUSAT) which was launched in 2004 and had provided a fulcrum for developing video/ interactive distance education inputs for teachers' capacity building. For all states, the video medium was new and so their activities have to be innovative and effective. Other varieties of state level innovations found were school management and child tracking systems. The linking of civil works to an educational purpose like teaching rainwater harvesting was also another innovation to be encouraged. Strategies should made to focus on a problem area identified by national guidelines, and monitoring and assessment systems should be established whenever possible, to facilitate modifications to the interventions.

Key Words : 1.EDUCATION 2.SARVA SHIKSHA ABHIYAN 3.INNOVATIONS EDUCATION 4.INNOVATIVE PROJECTS 5.CONVERGENCE OF SERVICES.

7. Mehta, Salial et al. (2006).
Impact of corporal punishment on school children : a research study. New Delhi : Plan International India. 95 p.

Abstract : Corporal punishment of children is a worldwide phenomenon. The present study looks at the incidence and extent of corporal punishment on school children and its impact on them. The study was conducted by Plan International with SAATH, an NGO, in 41 schools of four states in India (Uttar Pradesh, Andhra Pradesh, Bihar and Rajasthan). The other NGOs involved were Gram Niyojan Kendra, Adithi, Urmul - SETU, and Arthik Samta Mandal. The research team interacted with 1591 children, 215 teachers, and a multitude of stakeholders. Findings of the study showed that corporal punishment stood out as a common theme in all 41 schools and surrounding communities the team visited. Almost all the parents accepted that children invited punishment by their behaviour, but whether they should be punished moderately or severely depended on the stamina the children possessed. The research team saw a stick in the classroom or in the hands of teachers everywhere it went. In more than 20 schools the team visited, the students actually showed or pointed out the stick with which they were beaten. The most common forms of punishments were hitting with hands and stick, pulling hair and ears, and asking the children to stand for long periods in various positions. Threatening to be physically violent is also used as a punishment to create fear among children. The team also came across more severe forms of corporal punishment afflicted on children such as being kicked severely, making them starve, tying them with a rope to chairs/ poles followed by beatings, assigning physically strenous work both at home and outside, etc. A child often faces a series of punishments for the same/ single 'offence'. The team came across a number of cases where the sequence of punishments started with the teacher. The same child was then punished by the head teacher for having 'invited' the punishment. Yet another round of punishment – generally, beating – awaited the same child at home if the parents came to know that she/ he had been punished in school. At schools, the incidence of corporal punishment was found to be quite common and alarmingly frequent. It was found that there were 05 beatings per day per class, not counting other moderate forms of punishment. Inflicting punishment on children was a part of the teachers 'tool kit' or a 'justified' extension of the teacher's repertoire. The team did not witness any act of corporal punishment being inflicted on school children in its presence, but it caught a large number of teachers in the act of threatening (Uttar Pradesh); rushing towards a group with a cane in his hand (Bihar), shouting abusively (Rajasthan), and even merely using the language of the eyes (Andhra Pradesh). Discussions with teachers across all the 4 states, especially Uttar Pradesh, Bihar and Andhra Pradesh, revealed that there were just too many students for them to handle, and 'punishments' came in handy to

control this crowd. Almost all teachers, particularly in Uttar Pradesh and Bihar, pointed out the severe lack of time they spent inside (a) classrooms with students and (b) in schools. They were held accountable to so many non-teaching tasks by the Government that they could hardly concentrate on their job. The team felt that while the younger teachers were not very prompt at inflicting punishment, very senior teachers also now repented the fact that they used the rod too frequently. The research team found that at home it was not just mothers beating daughters and fathers beating sons, both parents were involved in beating all their wards, irrespective of gender. In all four states the team visited it came across vociferous groups of children reporting some of the cruelest forms of punishment they received at home like making children starve (Bihar); inflicting burns on their hands (Uttar Pradesh); tying to a chair with rope followed by severe beating; beating children followed by pouring chilly powder down their throat (Rajasthan); tying a thick wooden rod along the child's underarms and the back of the knee and then keeping her/ him suspended from the ceiling for long hours (Andhra Pradesh). 54.7% children said that they should never be punished. 19% of the children in Rajasthan believed that they are meant to be punished. 51.5% children in Rajasthan believed that punishment should be legally banned. 31.2% children in Uttar Pradesh, 28.8% children in Bihar and 3.2% children in Andhra Pradesh wanted corporal punishment to be banned. It was recommended that an effective strategy would be to influence the community through (a) information dissemination, (b) ground work and (c) advocacy campaigns. Serious complaints should be formally investigated and disciplinary procedures exercised against the erring teachers and parents. While these organizations can levy pressure or prosecute teachers, only social boycott or some other form of sustainable social pressure can influence/ convince parents. The team felt that local level NGOs can contribute a lot here. Parents need to be sensitized immediately, as parents have the most immediate connection with children.

Key Words : 1.EDUCATION 2.CORPORAL PUNISHMENT 3.DISCIPLINING 4.PUNISHMENT 5.CHILDREN'S PARTICIPATION.

ICDS

8. Haryana, Dept. of Economics and Statistics, Chandigarh. (2004).
Evaluation study of ICDS in Haryana 2002-03. Chandigarh : HAR-DES. 102 p.

Abstract : Economic and Statistical Organization, Planning Department conducted a study to evaluate the functioning of ICDS in Haryana. In all, 48

AWCs and 576 beneficiaries were selected. In 2001-02, the expenditure on Supplementary Nutrition (SN) component of ICDS was borne by the Central Government (57%) and by the State Government (43%). The trend of availing SN by expectant women/ nursing mothers during the years 1999-2000 to 2001-02 was decreasing. The achievements under immunization for children was 100% or above whereas for T.T. of mothers was 84%. In non-formal preschool education the achievement was 98%. All AWWs were fully trained, while 33 (69%) helpers were not trained. It was found that the achievements under SNP was 76% in 6 months – 3 years age group for enrolled children, 83% for 3 years – 6 years children, and 74% for pregnant and nursing mothers enrolled. A total of 16,324 children were weighed and it was found that 6583 children were normal (40%), 6105 children were in Grade I (37%), 3502 were in Grade II (21%), 127 were in Grade III (1%), and 7 were in Grade IV malnutrition (0.42%) respectively. Only 4889 (32%) beneficiaries were medically checked up either by ANM/ LHV or Medical Officers during the preceding three months. Out of a total of 9302 families, 7323 (79%) were visited by ICDS staff. A total of 4839 (83%) children received PSE benefit, out of which 2549 (53%) were males and 2290 (47%) were females. Around 126 (88%) pregnant women received folic acid tablets from AWCs. Out of 288, 178 (89%) expecting women got ante-natal care from AWWs and were satisfied with their advice. Out of 144 nursing mothers, 97% were visited by AWWs after delivery. Out of 144 sampled beneficiary women, 139 (97%) breastfed their babies. 98% women were taking care of their children and their children were found to be in good health. Around 88% women adopted family planning norms. SN was distributed on an average of 25 days in a month. 62% children took SN to their homes thus defeating the very purpose of the scheme. Around 96% children's mothers mentioned that SN items were of good quality. 90% beneficiary children came to AWCs for other reasons like getting non-formal education, health care and learning good habits. 93% beneficiaries were in favour of the prevailing system of SN. Only 18 (56%) Gram Panchayats extended help to AWWs in organizing cultural functions in AWCs to attract public participation. 60% AWCs were running in Panchayat/ Government buildings, whereas 40% were run in rented/ private buildings. The weight record of 283 (98%) children out of 288 was maintained using register/ card system. Members of Mahila Mandals took active part in AWCs. The performance of ICDS was found to be satisfactory in SN, PSE and immunization programme, but supervisory staff, P.O., CDPO and supervisors should increase their visits to further improve the programme. Condition of AWCs need more attention, the participation of local community like panchayats should be sought, and public health, PWD and Electricity Departments may provide better facilities in AWCs.

Key Words : 1.ICDS 2.EVALUATION OF ICDS HARYANA 3.ADMINISTRATION OF ICDS 4.NUTRITION IN ICDS 5.ICDS SERVICES 6.PRESCHOOL EDUCATION IN ICDS.

9. Indian Institute of Management Bangalore, Bangaluru. (2005).
Social assessment of ICDS in Karnataka. Bangaluru : KAR-DWCD. 215 p.

Abstract : A social assessment of ICDS in Karnataka was initiated by UNICEF. 240 AWCs from four districts namely Kolar, Dharwad, Gulbarga and Mysore were covered. It was found that pre-school education (PSE) was the weakest link of the ICDS programme. Toys, playground and teaching equipment were not available in a number of centres. The training imparted to AWWs did not offer the required competencies and skills to carry out pre-school activities. Parents were not happy with mere games and oral skills taught under pre-school activities. The supplementary nutrition (SN) and Amylase Rich Food (ARF) was not of good quality and distribution was not regular. Storage facilities, measuring scales and cooking facilities were not available or were inadequate. Lack of proper coordination with the health department and absence of mission mode had made the immunization programme less effective. Proper buildings constructed at the right locations were a major problem. Clean drinking water was not available in many AWCs. Lack of proper transportation facilities for CDPOs and supervisors had an impact on functioning of the scheme. ACDPOs were deputed for other duties and many times did not have any delegation of power to take decisions regarding monitoring and implementation. As their post did not have proper job description and their services were not well streamlined in ICDS. The PRIs namely ZP, TP and GP did not fully participate in ICDS activities. The AWTCs and Middle Level Training Centres (MLTCs) had good physical infrastructure, but more full time faculty were needed for enriching the training programme. Some AWTCs did not have adequate physical infrastructure. In both MLTCs and AWTCs, UDISHA package was implemented. As there was no reading and writing in the pre-school component under ICDS, this motivated parents to admit children of 4 years either to government or nearby private schools. There is a need to improve the buildings and provide proper toilet facilities, clean drinking water and proper storage facilities. Proper scales to measure SN, and standing scales to weigh pregnant women and adolescent girls need to be supplied. Modernization of offices of ICDS at the taluk and district level should be given utmost importance. The post of ACDPOs should be abolished, instead CDPOs should be posted in every project with a maximum of 150 centres. The Management Information System (MIS) should not be confined to stating the number of PHCs, PHUs, SCs school enrolment, etc. It should, at any given point of time, be able to provide information on the status of a number of facilities in terms of how it is supporting the ICDS programme and its current status.

Key Words : 1.ICDS 2.EVALUATION OF ICDS KARNATAKA 3.EVALUATION OF ICDS 4.SOCIAL ASSESSMENT OF ICDS 5.MALNUTRITION 6.COMMUNITY PARTICIPATION IN ICDS.

10. National Council of Applied Economic Research, New Delhi. (2001). Concurrent evaluation of Integrated Child Development Services : National report Vol. 1 & 2. New Delhi : NCAER. ~200 p.

Abstract : The Ministry of Women and Child Development entrusted the National Council of Applied Economic Research (NCAER) for conducting a nationwide evaluation of the ICDS Scheme to help the Government in initiating corrective measures to make the programme more effective. Nearly 4000 projects, 60,000 AWCs, 4000 Mukhya Sevikas and 1.80 lakh beneficiary households with children in the age group of 0-1 years, 1-3 years and 3-6 years were selected. It was found that nearly 66% of the eligible children and 75% of the eligible women were registered at AWCs. Less than 3% children were severely malnourished, except in Bihar, where severe malnutrition among children 13-36 months was 28%, children 6-12 months was 6%, and in children aged 37-72 months was 5%. Most states indicated low levels of severe malnourishment. About 11.3% of the children were moderately malnourished and children in the age group of 37-72 months reported higher incidence of moderate malnourishment. More than 75% AWWs were matriculate in the northern and eastern part of the country. Gujarat and Rajasthan had the lowest percentage of matriculate functionaries. About 84% of the functionaries had received training, mainly pre-service training. More than 80% children were immunized against all major diseases. More than 90% of the women mentioned that they received tetanus toxoid vaccination, but the referral system was found to be quite weak in many states. Most AWWs and community leaders were not in favour of ICDS functioning under the panchayats, either due to lack of interest or inadequate knowledge and awareness of the importance of women and child development. The community and panchayats, both provided space and other infrastructural support to AWCs, and helped in identifying beneficiaries. Community participation was mainly from mothers and family members of beneficiaries whose children derived benefits from the programme. Participation of beneficiary women and adolescent girls in AWC activities was very low. Majority of households reported that they needed the services of SN, PSE, immunization and NHE provided under the ICDS programme, and they were satisfied with the delivery of these components. Of the 26 states in the country, Mizoram, Meghalaya, Orissa, Gujarat and Goa were the top 5 states due to adequate infrastructure, better profile of functionaries and efficient functioning of the AWCs. Arunachal Pradesh, Bihar, Jammu and Kashmir, Nagaland and Uttar Pradesh were ranked low. There was lack of one to one correspondence between the overall performance and the household perception of the benefits received from the programme in Arunachal Pradesh, Assam, Goa, Gujarat, Himachal Pradesh, Punjab, Tamil Nadu and Uttar Pradesh. In a majority of the states, the weight register, health and referral register received less attention. Orissa, Arunachal Pradesh and Punjab scored

over other states in maintenance of records. The performance of Sikkim was poor. The coordination between various departments at micro level was weak. There is need for strengthening both inter and intra-departmental coordination for smooth delivery of the programme services. Training of functionaries should be more focused, and special skills and training are required to identify children having disabilities. Package of services provided under ICDS should be based on local socio-economic and cultural population needs.

Key Words : 1.ICDS 2.EVALUATION OF ICDS 3.MALNUTRITION 4.PRESCHOOL EDUCATION 5.COMMUNITY INVOLVEMENT 6.ADOLESCENT GIRL.

11. Paul, Dinesh, et al. (2003).
Evaluation of medicine kit provided to anganwadi worker. New Delhi : NIPCCD. 150 p.

Abstract : This study was conducted by NIPCCD to evaluate the extent of utilization of medicine kit provided to AWWs in the northern, southern, north eastern and central region ICDS projects. A total of 640 AWCs, 150 ANMs, 16 CDPOs, 4-5 Supervisors, 1280 beneficiaries and 100 community leaders were selected for the study. The availability of medicine kit was found to be very poor in all the four regions. Almost half the AWCs were without a medicine kit. Medicine kits were available in 48.7% AWCs in northern, 48.1% AWCs in southern, 17.5% AWCs in north eastern and 42.5% AWCs in central region respectively. ORS packets were received by 66% AWCs of the northern region followed by 55% in the southern region, 24.6% in the north eastern and 22% in the central region. More than half the AWWs of northern and southern region mentioned that they received iron and folic acid tablets from ANMs; in contrast AWWs of north eastern and central regions, did not received IFA tablets and contraceptive pills. All the CDPOs and 96.8% supervisors mentioned they were very particular to check the date of expiry of medicines. All the CDPOs of northeastern region observed the colour of the medicines and the leakage in tubes (medicines) when they received the medicine kit and during their visit to AWCs. 75% CDPOs of northern region and 50% of the northeastern region took the help of medical officers to check the medicines, but this practice was not widely prevalent. Proper storage space was available only in 66.8% AWCs in the northern region, 60.6% AWCs in the southern region and 65.6% AWCs of the central region. In the northern region, 63.5% AWWs stored medicine kits either in lofts/ cardboard boxes/ tin drums/ benches/ stools or kept them on the table in polythene bags. 68.1% AWWs of the central region felt that the medicines provided in the kit did not cover all the illnesses prevalent in their area. Lack of

transport facilities and dissatisfaction of the community towards the facilities available at the sub-centres and PHCs were the main reason mentioned by AWWs for weak referral services under ICDS. More than half the AWWs of northeastern region (55.1%) received specific training in the usage of medicine kit. Around 86.1%, 93.7% and 79.8% AWWs were able to tell the correct dosage of paracetamol tablets/ syrup and mebandazole tablets. Mothers mentioned there was lack of coordination among the functionaries. All mothers were well aware of the existence of the AWs, and they knew about the services provided by AWCs. The utilization of services for all regions ranged from 28.7 to 84.9%, and was highest for SN (84.9%) and PSE (84.8%), and lowest for Health and Nutrition Education (28.7%). The community leaders of northern region (75%) and central region (63.6%) were not aware of the availability of medicine kit at AWCs. It is essential that the functionaries of the two streams, health and ICDS, work in close cooperation with each other in a coordinated manner. Feasible mechanisms for promoting interaction and functional linkages must be identified and institutionalized.

Key Words : 1.ICDS 2.MEDICINE KIT 3.KNOWLEDGE OF ANGANWADI WORKER.

12. Pawan Kumar and Garg, Meenakshi. (2008).
Quick appraisal of supplementary nutrition component of ICDS 9th and 10th January 2008 : report on ICDS project Udupi and Karkala, Udupi District, Karnataka. Karnataka : Kasturba Medical College, Dept of Community Medicine, Manipal. 23 p

Abstract : ICDS has the potential to interrupt the inter-generational transmission of under nutrition by addressing the health and nutrition needs of pregnant mothers before the birth of the child, and those of adolescent girls well before they experience motherhood. The present intervention study was carried out in Udupi and Karkala districts of Karnataka. The projects in operation cover 175 taluks and 10 urban areas. There were a total of 19,092 children between 6 months to 3 years in both the projects, of whom 17,906 (93.79%) were registered and 17,781 were availing the benefits of supplementary nutrition (SN). Similarly out of 18,640 children between 3-6 years in both the project areas, 14,586 (78.25%) were registered and 13,953 were availing SN. Number of pregnant women in these two projects were 3601 and of them 3,442 (95.59%) were registered and 3,427 (99.56%) were availing benefits under ICDS. Out of 4,262 nursing mothers, 4,048 (94.98%) were registered and 4,025 (99.43%) were availing the benefits from ICDS. There were 41,909 adolescent girls in both the projects of whom 1,460 were registered and availing benefits. In each AWC, there were 406 children between the age group of 6 months to 3 years, of whom

341 (83.99%) were registered and 335 (98.24%) were availing the benefits of supplementary nutrition (SN). Similarly, out of 361 children between 3-6 years in the sample area, 239 (66.21%) children were registered and 231 (96.65%) were availing benefits. The number of pregnant women in the sample was 96, and 90 (93.75%) were registered and availing the benefits of SN. There were 75 nursing mothers of whom 71 (94.67%) were registered and all of them were availing SN. There were 572 adolescent girls in the sample areas and 18 girls were registered in 10 anganwadi centres. Amylase Rich Energy Food was given to the beneficiaries after mixing it with lukewarm water and made into *Laddus*/ Porridge. The composition of Amylase rich energy food (AREF) is whole wheat (roasted), *Soya* dhal (steamed), defatted *Soya* flour (roasted), Bengal gram (roasted), powdered sugar, vitamins and minerals (premix) and malted *ragi*. The CDPOs of both the projects had official vehicles. HCF is given for four days whereas semi-cooked AERF *laddus*, were given for two days in a week. SN was given for 300 days in a year. Hot cooked food (HCF) was being given at all the AWCs, but most AWCs had a common kitchen and storage space together (70%), which cannot be considered sufficient to cook for beneficiaries. Availability of a safe source of drinking water and provisions for safe storage is a must for an AWC and this is particularly necessary when hot cooked food is served. It was found that all the AWCs have a source of drinking water. While 40% of the AWCs have tap water connection, 60% depend on insanitary well water source which is not always safe. Only 80% of the centres have adequate utensils for cooking hot food, but in almost all the centres (100%) there were adequate utensils for serving the food. Community and SHGs may have contributed towards utensils. CDPOs felt that the Hot Cooked Food (HCF) provided was very well accepted, whereas the contacted supervisors (100%) admitted that it was only partially acceptable to the targeted beneficiaries, and 20% of the AWWs and community leaders were also of the same opinion. All the beneficiaries felt that the HCF given to them was somewhat acceptable taste-wise, but it became very monotonous to have the same food over and over again. It was concluded that hot cooked food was preferred by the beneficiaries and the functionaries. It was recommended that there is a need for infrastructure improvement in terms of providing separate storage space in the AWCs, ensuring supply of safe drinking water to the AWCs and its appropriate storage. Utensils for cooking and serving in the AWCs should be made available in adequate quantity. Better supervision and monitoring by the functionaries as well the community would ensure improvement in the quality of cooking and the right amount of food being distributed to the beneficiaries. Coverage of beneficiaries needs to be improved. Supervision of the AWCs by the supervisor in particular, needs to be made more regular and intensive.

Key Words : 1.ICDS 2.NUTRITION COMPONENT IN ICDS 3.NUTRITION IN ICDS 4.TAKE HOME RATION 5.SUPPLEMENTARY NUTRITION 6.HOT COOKED FOOD.

13. SEDEM, Society for Economic Development and Environmental Management, New Delhi. (2005).

Nutritional status of women and children and working of ICDS in flood-prone districts of Bihar with executive summary. New Delhi : SEDEM. ~170 p.

Abstract : Functionaries of SEDEM had observed that the general health of women and children was extremely poor, and health facilities and AWCs services were also very poor in flood-prone districts of Bihar. SEDEM conducted the study to evaluate the working of ICDS programme, including analysis of the distribution of supplies. The study was conducted in five districts namely Patna, Vaishali, Samastipur, Madhepura and Saharsa. 30 AWCs were selected from 28 projects for the study. The inter-generational cycle of malnutrition continues in the flood-prone districts of Bihar. The health status of pregnant women was uniformly below par, with 84% being anaemic and below normal BMI. 33.85% nursing mothers had normal Hb count, 66.15% were anaemic and the mean BMI was 7.88% below the ICMR reference point for women. Majority of the women had below par health status from childhood to adolescence and motherhood. Only 2.63% female children in the age group 6-36 months had normal weight for age, 6.58% normal weight for height, and 13.16% normal height for age. While female children 36-72 months gained on all indicators as compared to male children, the percentage gain was marginal. Overall 25.77% children had normal Hb count, and 74.23% were anaemic. About 36.54% children had mild anaemia, 35.4% had moderate anaemia, and 2.28% had severe anaemia. The mean BMI of registered adolescent girls (AGs) was below par by 12.4% while BMI of non-registered AGs was below par by 9.61%, which was significantly below normal as compared to the estimated ICMR reference point of 18.98 for 14+ AGs. 36% registered AGs had normal Hb count while 64% were anaemic. Among non-registered AGs, 38% were normal and 62% were anaemic. None was observed to be severely anaemic. Taking the registered and non-registered AGs together, the mean BMI was 12.47% below normal. The quality of services of the six components of ICDS (SN, PSE, NHE, immunization, health check-up and growth monitoring, and referral services) was uniformly sub-standard. Physical facilities for pre-school activities were uniformly poor. 240 women and 60 AGs were selected from AWCs to document their perception of AWC services; and many did not even know that they were registered. 19% mothers had reported premature death of a child. There were no specific social practices that deprived mothers and children of a proper diet. 72.7% women had never been invited to an AWC. 80% had never received SN during pregnancy; 80% had never received a course of Iron and Folic acid (IFA) tablets. Nearly 70% of the AWCs were run by the husband of AWWs. AWC facilities were poor on all counts: poor pre-school facilities, irregular SN, irregular supplies, non-availability of ANMs, majority of AWCs had no

relevant records, which indicated a very casual way of working and weak supervision. Majority of AWWs mentioned that training programmes were not conducted properly. 56.67% AWCs get water logged during the rainy season and remain closed for long duration. It was suggested that once ICDS staff is trained, undertaking should be furnished by the trainee that he/ she is fully trained. If after training these functionaries fail to meet the standards of working, they should be summarily removed. All trainers should be similarly appraised. It was recommended that women should learn to grow their food to achieve 80-100% RDA (Recommended Daily Allowance) for their households.

Key Words : 1.ICDS 2.NUTRITIONAL STATUS WOMEN AND CHILDREN BIHAR 3.NUTRITION AND ICDS 4.NUTRITIONAL STATUS ICDS BENEFICIARIES 5.FLOOD PRONE AREAS 6.ICDS BIHAR 7.LACUNAE IN ICDS 8.MALNUTRITION BIHAR 9.BIHAR.

NUTRITION

14. AMS Consulting, Ranchi. (2007).
Process documentation of Gumla Anaemia project. Ranchi : AMSC. ~90 p.

Abstract : Anaemia is widely prevalent in many regions of India. Gumla district was identified as a priority area for anaemia eradication. Multiple interventions were taken up by the Government of Jharkhand to reduce anaemia in partnership with MOST (India), the USAID micronutrient programme along with Vikas Bharti, a local NGO, as the implementing partner. This study was conducted in 5 blocks of Gumla district and covered 424 villages. The Gumla Anaemia Project was undertaken to improve the health status of pregnant and lactating women and adolescent girls (AGs) by reducing the prevalence of anaemia through awareness generation, training of functionaries, and community involvement. It was found that the training modules prepared covered in detail the project process and issues on awareness and knowledge on anaemia and its causes and consequences. Village Health Workers (VHWs) were not given any regular honoraria under the project. They were discouraged by their family members to perform their duty, and no refresher training/ orientation of VHWs was organized after the initial training by Vikas Bharti, and VHWs became complacent and less motivated. Pregnant women mentioned that the visit/ meetings with the ANM and the AWW were the greatest motivation for them, and women had tremendous faith on them. The regular meetings of the VHW and the social support group members to share the outcome of their visits with pregnant

women were very useful. At several places all AGs were given Iron and Folic acid (IFA) tablets to consume in the presence of everybody to make IFA popular and to ensure that tablets were consumed. Not able to meet the growing demand for IFA in their area was the most common woe of ANMs. When the supplies at the sub-centres were exhausted, the ANMs would collect it from the PHC. The AGs of Ghaghra mentioned that they never got any IFA tablets. Women confessed that earlier when they used to receive IFA tablets they would throw them away and not consume them. The best friend and mentor of pregnant women was the ANM and then the AWW. When they suffered from the side effects of consuming IFA tablets, they consulted the ANM/ AWW of their area. After women were made aware of the consequences of anaemia, many more women started consuming IFA. Husband and other family members also encouraged them to regularly consume IFA and supported them when they suffered from side effects. Earlier their husband/ family members would suggest that they discontinue IFA consumption. AGs were also encouraged by their family members to consume IFA. Vikas Bharti had been working for the people of the area on various fronts and the community people had faith on Vikas Bharti. Women should keep track of the number of IFA tablets consumed by them, and some tests should be done in hospitals to check the haemoglobin level changes after the consumption of IFA tablets. Male members need to be educated about anaemia as the women were ready to consume IFA tablets but the men resisted. Regular supply of IFA should be ensured in AWCs, so that there is no discontinuation in the consumption of IFA tablets.

Key Words : 1.NUTRITION 2.ANAEMIA PREVENTION 3.GUMLA ANAEMIA PROJECT 4.NUTRITION IN ICDS 5.ICDS AND NUTRITION 6.MINORITY DISTRICTS 7.ADOLESCENT GIRLS 8.PREGNANT WOMEN 9.BEHAVIOUR CHANGE.

15. CUTS, Centre for Consumer Action, Research and Training, Jaipur. (2007). Measuring effectiveness of Mid Day Meal Scheme in Rajasthan : participatory expenditure tracking survey : final report. Jaipur : CUTS-CART. ~40 p.

Abstract : Food insecurity, and the threat it poses to the health and development of children, is of critical concern to governments in developing countries. The study was done to develop and test a participatory process to track the expenditure and quality of implementation of the Mid Day Meal (MDM) scheme, thereby enhancing the accountability of service providers towards citizens. A total of 211 schools in all blocks of Chittorgarh district were covered. Schools were chosen on parameters like size, access, backwardness of the location, etc. In all

422 teachers, 2,210 students, 2,210 parents and 211 cooks were interviewed to know about their perception on the different aspects of the Mid Day Meal (MDM) Scheme. It was found that all government and government-aided primary schools had the provision of MDM on each working day. Under MDM scheme, each student of Class I to V was to be served a cooked meal that comprised 300 calorie and 8-12 grams of protein, on each working day of school. It was revealed that 89 to 95% different stakeholders (parents, teachers, students and cooks) accepted that children consumed MDM at school. Around 27% parents and 11% students reported that MDM was insufficient and not as per the requirements of a growing child. About 88% students responded that they had proper arrangements of drinking water in schools. It was found that enrollment and retention had increased in about 64% of the schools over the last 3 years due to MDM. Girls' enrollment reportedly increased in only 58% schools. Only 23% parents felt that the quality of education was good, 58% termed it satisfactory. But in the survey it was found that only 53% of the students could read and 48% could write well. On analysis it was revealed that 68% of the teachers spent more than 1 hour in managing MDM and this could reflect on overall teaching quality. Around 61% schools had toilets, but these were being used in only 21% schools because of lack of water facility. 92% children did not washed hands with ash/ soap before eating (not provided in schools) and 95% did not clip their nails. Most schools lacked appropriate cooking and storage space/ facilities. About 95% schools did not have a kitchen shed, and 62% of the cooks interviewed mentioned that MDM was cooked in an open space. Only 36% of the schools had separate storeroom for MDM supplies. Only 21% of the schools received funds every month, while the rest got it in 3 months, 6 months and once in 2 months. It was found that 69% of the selected schools received food grains on the stipulated time. On analysis it emerged that only 23% of the schools received food grains after getting it weighed. The study showed that wheat and rice of above fair average quality was received in 97% cases. The quality of MDM prepared was good and it was found that 75% of the cooks were being monitored and checked for the quality of food prepared by them. Though Mid Day Meal scheme would prove to be a milestone towards achieving the goal of universal education for all as targeted, but looking at the slow process in this direction, more concentrated efforts are needed with private-public participation in the process. Local Governments are constitutionally responsible for education and related activities. Ways should be found to enthuse local governments to take on these responsibilities and be accountable to its citizens.

Key Words : 1.NUTRITION 2.MID DAY MEAL SCHEME 3.EVALUATION MID DAY MEAL SCHEME 4.MID DAY MEALS 5.SCHOOL LUNCH PROGRAMME 6.SCHOOL EDUCATION 7.RAJASTHAN.

16. De, Anuradha, Noronha, Claire and Samson, Meera. (2005).
Towards more benefits from Delhi's mid day meal scheme. New Delhi : Collaborative Research and Dissemination. 23 p.

Abstract : The Mid Day Meal scheme is a welfare scheme to improve the nutritional status of school children and improve enrolment. The present research assessed the current functioning of cooked mid day meal scheme in Delhi. Kitchens were visited, 12 schools were surveyed, and teachers and suppliers' employees were interviewed. The investigators between spent 2.5 to 3 hours in each school. It was found that the meal arrived between 8.30 and 9.30 a.m. in morning schools, and between 1.30 and 2.30 p.m. in evening schools. The food was cooked in Centralised kitchen by separate organizations each serving a large number of schools. Usually it came in enormous aluminium containers in a Maruti van or truck, and was kept outside the Principal's office until it was time for distribution. There were no complaints of food getting spoilt because of time lags at any point between the cooking and the eating of the meal, although this could happen due to the heat in Delhi. Preparation of food began 4-5 hours before it reached the schools, where it often remained for 30 minutes to 1 hour before it was served. Serving the meal was a smooth procedure. The distributor sent his own people (1-3 persons) to serve the meal. Children in Class 5 sometimes helped the distributor with moving the container to just outside the classes and in some cases with handing out the *pooris* or *parathas*. The entire process of serving and eating was generally done within half an hour. However, the actual teaching time disrupted in each school varied with the general level of school functioning. The process of serving began 15-30 minutes before recess; the more functional schools began classes when the time for recess was over; the less functional ones allowed recess to continue well beyond the allotted time. The quality and quantity of the meal served was good, and the menu had the approval of the children. They enjoyed their meal, and the favourite items were, *dal chawal* (lentils rice), *chole chawal* (chick peas rice), and *pooris* (fried bread). In a few schools the teachers mentioned that there had been worms and other pests in the food in the past. Lack of hygiene was a major problem found. Although some of the distributors wore disposable gloves while serving the food, little emphasis seemed to be placed on their general cleanliness or training. No one insisted that children wash their hands before meals, and only the rare child did so. Inadequate infrastructure and poor usage of existing facilities aggravated the problem of poor hygiene. Parents were not impressed with the mid day meal as an incentive for regular attendance. It was recommended that the government should prepare a simple list of do's and don't's for suppliers, teachers, and children, which if shared with parents, could ensure better implementation of the mid day meal scheme.

Key Words : 1.NUTRITION 2.MID DAY MEALS DELHI 3.MID DAY MEALS 4.SCHOOL LUNCH PROGRAMME.

17. Deodhar, Satish et al. (2007).
Mid day meal scheme : understanding critical issues with reference to Ahmedabad city. Ahmedabad : Indian Institute of Management Ahmedabad. 38 p.

Abstract : The concept of nutritional support to education is not new in India and it dates back to 1925 when Madras Corporation developed a school lunch programme. The broad objective of this study was to identify some of the critical issues associated with MDM scheme and to evaluate the efficiency in delivery system and service quality. The study was carried out using a three fold approach: (a) field visits were organized to 3 schools located in Gomtipur, Sabarmati and Ellisbridge, Ahmedabad, and the kitchen of an NGO food service provider, Stri Shakti, was visited; (b) working of the MDM at the macro and micro level was documented; and (c) laboratory testing of food items prepared and raw materials was done in terms of nutrition and safety, and compared with the prescribed minimum requirements. The study found that in 2005-06, a total of 31,152 schools (86% of the total primary schools in Gujarat) with 3.8 million beneficiaries (47% of the students enrolled) were covered under this scheme. Ahmedabad Municipal Corporation (AMC) covers 563 schools under 61 Mid Day Meal centres. It caters to 1.3 million beneficiaries which is about one-third of the total number of beneficiaries in Gujarat. The expenditure for MDM scheme per child per day (PCPD) is around Rs. 2.40 for Standards 1-5, and Rs. 3.40 for Standards 6-7. For Standards 1-5 food grains are provided by states/ local bodies by utilizing their own funds along with those available under various centrally sponsored schemes. The budget outlay has increased from Rs. 9,000 lakhs in 1999-2000 to Rs. 18,400 lakhs in 2004-2005. Each kitchen centre had a supervisor, two cooks and helpers and staff as per the strength of children. In the kitchen of Stri Shakti, rice, *dal, puri, channa*, *khichdi* and *dal baingan* was served. Kitchen staff wore clean uniforms and caps. The overall process of cleaning the grains, sorting and roasting was being done quite hygienically. Materials supplied by State Government were of reasonable quality. All the cooking utensils looked clean and were made of stainless steel. It was observed that 10% children left school after the meal. It was observed that despite paid employees hired under the scheme, teachers had to spend time to serve food to the students. Often recess time was not enough for the teachers to serve food and have their own lunch as well. The food quality evaluation tests were carried out at St. Xavier's Laboratory on the prepared meal samples collected from the schools and the NGO Stri Shakti. Samples of *khichdi, sabzi* and cooked rice were low in quantities of protein and iodine. However, the provision of calcium seems to be quite generous. The provision of fat and iron was close to the proportional requirements of the expected 300 calorie diet. Except for wheat in Sabarmati school and *tuar dal* in Stri Shakti kitchen, all other samples had levels of uric acid

much higher than the stipulated rules of PFA. This only points to the possibility of the presence of rodents in storage areas, either in schools or at the warehouses of Food Corporation of India (FCI). Presence of aflatoxins is a serious concern. On the basis of the above findings it was suggested that the implementation of MDM scheme may be wanting on the grounds of nutrition and food safety. The weekly menu shows a variety of meals offered, however, the condiments and seasonings being very similar each day, the sensory variety may be lacking. In terms of calorific and nutritive intake, proportionate amounts of protein and iodine are not being provided through the meals. The HACCP system (Hazard Analysis and Critical Control Points) should be incorporated for ensuring safety in food delivery.

Key Words : 1.NUTRITION 2.MID DAY MEAL SCHEME 3.SCHOOL LUNCH PROGRAMME 4.GUJARAT.

18. IBFAN, Asia International Baby Food Action Network, New Delhi. (2007). The State of the World's Breastfeeding South Asia report : tracking implementation of the global strategy for infant and young child feeding. New Delhi : IBFAN. 103 p.

Abstract : Breastfeeding has been accepted as the most vital intervention for reducing infant mortality and ensuring optimal growth and development of children. This report provides information on the findings and action taken by countries over the past two years. It deals with infant and young child feeding practices, policies, and programmes, the status of child malnutrition and survival in South Asia. South Asia has about 1.4 billion people and the highest number of under-five deaths and under-five children who are underweight. More than 70 million out of 146 million under-five under weight children are in South Asia. These countries are struggling to attain the required pace of reduction of child mortality. According to IBFAN Asia Pacific 2006, the region has 37,145,000 annual estimated births with under-five mortality rate (U5MR) of 97 contributing significantly to the global burden of under-five mortality. More than 77 million children under the age of five years are underdeveloped and undernourished. According to the Global Strategy for Infant and Young Child Feeding, malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five. Over 66% of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life. Less than 35% infants worldwide are exclusively breastfed during the first 4 months of life. Malnourished children who survive are more frequently sick and suffer life-long consequences of impaired development. The challenge is significant in many countries of South Asia where neonatal mortality represents at least 50% of infant deaths. In South Asia, more than 1,400,000 babies are

estimated to die during the first month of life, and another 2,200,000 during 2 to 12 months. In India alone, about 1,100,000 babies die during the first month of life, and another 500,000 during 2 to 12 months of age. The primary causes of neonatal deaths are neonatal infections (52%), asphyxia (20%), and low birth weight (17%). Most of the infectious deaths are from diarrhoea and pneumonia. As about 66% of all child deaths occur during infancy, action is needed during that period. The World Breastfeeding Trends Initiative (WBTI) is an innovative flagship project of IBFAN Asia that aims at initiating action worldwide to ensure optimal infant and young child feeding practices. The WBTI toolkit helps to colour, rate and rank a country by practice. The colour rating ranges from 'Green, Blue, Yellow and Red' reflecting excellent to poor state of infant feeding. Given the role breastfeeding plays in contributing to all eight Millennium Development Goals (MDGs), the WBTI provides all nations an opportunity to track their implementation of the Global Strategy. The WBTI initiative builds effective partnerships around mother and child health. WBTI process provides increased flow of pertinent information to decision makers and leads to capacity building and policy formulation support. The coverage of key/ critical breastfeeding interventions is low in the whole of South Asia. The rate of adequate complementary feeding in South Asian Countries varies from 22% to 98%. India falls in Grade D in Red colour (35%). The data on initiation of breastfeeding within one hour reveals that it varies from 16% to 75%, for India it was 16% and India fell in Grade 'D' (Red colour). Exclusive breastfeeding varied from 10% to 68% in South Asia, and India was categorized as Yellow in Grade 'C' with 46%. There is an urgent need to create a positive environment for optimal breastfeeding in all these countries. It was recommended that effective resource allocation is needed to change the status for indicators that are now in the 'Red'. All political parties and forums should take stock of the situation and provide the necessary impetus to move forward to the next level of achievement. National governments should adopt comprehensive policies on infant and young child feeding.

Key Words : 1.NUTRITION 2.BREASTFEEDING 3.INFANT AND YOUNG CHILD FEEDING 4.GLOBAL STRATEGY ON INFANT FEEDING 5.SOUTH ASIA.

19. Mallikharjuna Rao, K. et al. (2007).
Diet and nutritional status of adolescent tribal population in nine states of India. Hyderabad : National Institute of Nutrition, National Nutrition Monitoring Bureau. 6 p.

Abstract : Tribal population constitutes about 8% of the total population in India, with varying proportions in different states. A close relationship exists between

the tribal ecosystem and their nutritional status. Inadequate health care facilities, ecological degradation, etc. further aggravate the situation. Community development blocks, where more than 50% of the population is tribal, are covered under Integrated Tribal Development Projects (ITDP), while Modified Area Development Approach (MADA) is adopted in smaller areas. In India, currently there are 194 ITDPs and 259 MADA Pockets functioning. The present study was carried out by NNMB, NIN, Hyderabad during 1998-99 on the diet and nutritional status in tribal areas of nine states viz., Andhra Pradesh, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu and West Bengal. Trained Medical Officers, nutritionists and social workers conversant with the local language were involved. In each state, 120 villages were selected randomly from the list of ITDP villages. From each selected village, 40 households (HHs) were covered, by adopting probability proportional to the size of different tribes. Anthropometric measurements such as weight, height, mid upper arm circumference and fat fold at triceps were taken of all the available individuals in the selected HHs. 24 hour food recall method was also adopted. Anthropometric data of 12,789 adolescents from 4,772 HHs was collected, 6,088 boys and 6,701 girls and dietary information of 5,562 adolescents (2,701 boys and 2,861 girls) was gathered. The average intake of all the nutrients by adolescent boys and girls of the various tribes was below the Recommended Dietary Allowances (RDA) in all age groups. The extent of deficit in the intake of micronutrients such as Vitamin A (80-85%), iron (70-80%), free-folic acid (50-55%), and riboflavin (40-50%) was relatively more, compared to that of energy (10-40%) and protein (20-30%). The deficit in the intake of energy was higher among boys than girls in older adolescents (13-17 years), compared to younger adolescents (10-12 years). Compared to their rural counterparts, the intake of all nutrients of tribal adolescents were lower except for Vitamin A and Vitamin C. More than 50% boys and girls had intakes of less than 70% RDI. The proportion was higher with regard to Iron (96% for boys and 90% for girls), followed by riboflavin (88% for boys and 80% for girls) and Vitamin A (78% each for boys and girls). Significant gender differentials were observed with regard to the intakes of energy, iron, thiamin, riboflavin and niacin, with higher proportion of boys consuming less than 70% of RDI. The prevalence of conjunctional xerosis and Bitot spots, the signs of Vitamin A deficiency, were found to be 4.9% and 2% respectively. About 3% of the adolescents had angular stomatitis, indicative of B Complex vitamin deficiency. The prevalence of Goitre was 3.5%, which was relatively higher among girls (5%) than boys (1.8%).The mean height and weights of tribal adolescents were below NCHS standards among all age/ sex groups and were comparable with rural adolescents. The median body mass index (BMI) by age/ sex, though comparable with their rural counterparts, was below the median NHANES reference values. The overall prevalence of stunting (height for age <median -2SD) was 42% among boys and 46% among girls, which was higher than that reported for their rural counterparts (39% each for boys and girls). The overall prevalence of underweight (weight for age <median

-2SD) was significantly high (51%) among boys and girls (43%). The prevalence of underweight among tribal boys was comparable with that of rural boys, while it was relatively higher among tribal girls compared to rural girls. About 63% of the boys and 42% of the girls had BMI values less than 5th centile of age/ sex specific BMI values (NHANES), indicating high prevalence of under nutrition which was marginally lower among tribal boys compared to rural boys. Stunting was significantly higher among children of joint families (46.8%) compared to nuclear (44.5%) or extended nuclear families (40.6%). The proportion of children with stunting was relatively more (47%) among daily wage earner families. The study revealed that the tribal population is at a higher risk of under nutrition, because of socio-cultural, socio-economic and environmental factors influencing the food intake and health seeking behaviour. Low female literacy (14.5% against 47%), high maternal (992 against 195) and infant mortality (85 against 64) have been reported among tribal population as compared to their rural counterparts. The study concluded that the adolescents enter womanhood with poor nutritional status and are exposed to the risks of bad obstetric outcomes. Inadequate healthcare facilities, illiteracy and socio-economic disadvantage among the tribal population perpetuate the vicious cycle of under nutrition. Therefore the study recommended that there is a need to evolve comprehensive programmes for the overall development of tribals with special focus on adolescents.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.NUTRITIONAL STATUS ADOLESCENT 4.NUTRITIONAL STATUS TRIBAL 5.TRIBAL ADOLESCENT.

20. People's Vigilance Committee on Human Rights, Varanasi. (2005). Report of people's tribunal on starvation in eastern Uttar Pradesh. Varanasi : PVCHR. 62 p.

Abstract : Right to food is an inalienable and fundamental right, with equal footing to that of right to life. The present study was carried out to investigate the situation of food insecurity among marginalized communities in eastern Uttar Pradesh (UP), and to investigate the hunger and starvation deaths in Varanasi, Mirzapur, Kushinagar, and Sonebhadra districts. In the study, the cases that came before the Tribunal spoke of how the Government has neglected the starving vulnerable groups of eastern UP. Villagers have not received wages after participating in work schemes, and records are made up by Government bureaucrats to give a false impression of the functioning of schemes. All the victims who deposed before the Tribunal were from the poorest sections of society, and many were from the lower castes of Hindu society. In all cases the victims had complained to the authorities responsible for administration regarding the issues they faced. In all cases the responses from the responsible authorities were none or to the minimum extent, which according to this Tribunal is a

criminal neglect of their duty for which the responsible officers must be punished in accordance with the law of the country. The state representatives refused to answer any questions asked by the Tribunal, though prior notice was served to the representative state agencies before the hearing. Further, international pressure by FIAN International, along with a continuous and massive campaign by the PVCHR (People's Vigilance Committee for Human Rights) and the Bunkar Dastkar Adhikar Manch led to success in the struggle against state apathy. Necessary steps ensured the right to food in the case of two weaver families who experienced starvation deaths. Deaths due to starvation had been widely reported from the village of Shankapur in Varanasi district (UP), where around 400 weaver families suffered from severe hunger and malnutrition. Due to decline in the weaving industry, many families lost their jobs and did not have any source of income. Neither did they get access to the Antyodaya Anna Yojana Scheme (AAY) Red Card, dedicated to the poorest of the poor, to avail subsidised food grains although they possessed the Red Card. The weavers were struggling to survive under these precarious circumstances. A look at the food schemes implemented in these districts presented a very grim picture. In Varanasi, Sonebhadra, Jaunpur, Khushinagar and Mirzapur, from where the starvation deaths were reported, only 31% of the children in 0-6 years age group were covered by ICDS. In 64 projects, nearly 9% of the anganwadi centres were not reporting to the Department of Women and Child Development. The staffing of these projects was also very poor where 19% of the sanctioned anganwadi workers and 30% of the sanctioned anganwadi helpers in Mirzapur, and 11% of the sanctioned AWWs and 12% of the sanctioned AWHs in Jaunpur were not appointed. In the case of employment related schemes, the five districts have utilized only 78% of the allocated funds and 56% of the sanctioned food grains under the Sampoorna Gramin Rozgar Yojana (SGRY). Mirzapur performed worst, with only 39% utilization of food grains. This is despite the fact that Mirzapur is a poor district, and here the percentage of agricultural labourers to main workers is 33.78% and percentage of marginal workers to main workers is 3.39%. The proportion of agriculture workers and marginal workers to main workers is much higher here than in Uttar Pradesh on an average. A Hong Kong based Regional Group accused local officials of deliberately ignoring starving people in Betwa because of caste hatred. On the basis of the findings, the study recommended that district-wise enquires on reported hunger deaths should be made to provide necessary assistance to these families. To ensure that all AWCs are operational and reporting, and all vacancies are filled in ICDS projects, the Government must ensure that welfare programmes initiated by the Union Government do not fail in implementation at the state level.

Key Words : 1.NUTRITION 2.HUNGER DEATHS 3.MALNUTRITION 4.STARVATION DEATHS 5.LACUNAE IN ICDS 6.ICDS 7.PUBLIC DISTRIBUTION SYSTEM 8.LACUNAE IN GOVERNMENT PROGRAMMES 9.RIGHT TO FOOD 10.UTTAR PRADESH.

21. Radhika, M.S. et al. (2006).
Effect of Vitamin A deficiency during pregnancy on maternal and child health. Hyderabad : National Institute of Nutrition. 6 p.

Abstract : Vitamin A has a critical role in normal vision, cell differentiation, proliferation and maintenance of epithilial cell integrity. The present study involved 736 women in their third trimester of pregnancy (32-36 weeks) and their infants from a local government hospital catering to low socio-economic status (LSES) and from a private nursing home for women belonging to high socio-economic status (HSES). All the women received 75-100 tablets of Fefol (60 mg iron and 500 mg folate). All the participants underwent a detailed obstetric, clinical, anthropometric and biochemical examination. Height and weight of pregnant women was measured, maternal postnatal weight was recorded within 48 hours of delivery, and the body mass index (BMI) was calculated. More than 33% women were primigravidae and approximately 32% had BM<20 kg/ $m^{2.}$ Mean birth weight (SD) of the infants was 2.88 (±0.51) kg while 9.4% were preterm. Night blindness (NB) was observed in 2.9% of the women studied. However all the women having night blindness belonged to LSES. Mean (SD) serum retinol was 27.1 (±11.35) mg/ dl. 35% of the women had serum retinol ≥30mg/ dl while 3.5% of the study population had very low serum retinol (<10mg/ dl). Mean haemoglobin (SD) was 9.3 (±1.93) g/ dl. 41.2% women had moderate to severe anaemia (<9g/ dl), while 45.4% had mild anaemia (9-10.9g/ dl). About 13.4% women were normal with Hb≥11g/ dl. 116 women (15.8%) developed pregnancy induced hypertension (PIH) during the course of the study. Odds ratio (OR) for spontaneous preterm deliveries and PIH were significantly higher when serum retinol levels (kg/ dl) were <19 and <20 by univariate analysis which however, was not sustained after adjusting for the confounding variables. It was observed that Vitamin A deficiency was a problem at clinical as well as sub-clinical level in pregnant women in their third trimester. Mild as well as sub-clinical Vitamin A deficiency has been widely reported to be associated with an increased risk of morbidity and mortality in children. However, the impact of Vitamin A deficiency during pregnancy on maternal and fetal health has not been documented. There are no cut-off levels for serum retinol to define sub-clinical/ biochemical deficiency of Vitamin A in pregnant women, unlike in children. However, measuring serum Vitamin A concentration along with dietary intake and correlating them with breast milk levels suggested a level of 30 mg/ dl below which the Vitamin A status may be defined to be deficient in pregnancy. A significantly increased risk for spontaneous preterm delivery (OR=1.74, 95% CL 1.03-2.96), moderate to severe anaemia (OR=1.82, 95% CI 1.28-2.60), and PIH (OR=1.56, 95% CI 1.02-2.38) was observed when the serum retinol levels were <20mg/ dl. Based on these functional effects, a level of serum retinol 20mg/ dl

was suggested as the cut off to define Vitamin A deficiency in the third trimester of pregnancy. Even after adjusting for the various confounding factors spontaneous pre-term delivery and anaemia were significantly associated with serum retinol <20mg/ dl suggesting the role of Vitamin A deficiency. The observation of co-existence of anaemia and low retinol levels in this study is interesting particularly because all the women received iron supplements during pregnancy. It is well established that Vitamin A is essential for non-heam iron absorption and utilization. The mechanism of spontaneous pre-term deliveries in Vitamin A deficiency needs further studies. The study suggests that irrespective of iron intakes in pregnancy, low retinol levels may have a possible contributory role in limiting iron utilization and aggravating pregnancy anaemia. Nevertheless, due to the complex inter-relationship between anaemia, low BMI and low serum retinol levels, the contributory role of Vitamin A, if any, in the development of PIH may be difficult to be ruled out, and prospective intervention studies might provide an answer. The study concludes that Vitamin A deficiency with serum retinol <20mg/ dl appears to be an important problem in pregnancy, and is significantly associated with spontaneous pre-term delivery and moderate to severe maternal anaemia.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.VITAMIN A DEFICIENCY 4.MATERNAL AND CHILD HEALTH 5.UNDERNUTRITION CHILDREN 6.PREGNANCY OUTCOME 7.PRETERM INFANT 8.PREMATURE INFANT.

22. Rao, Veena S. (2008).
Malnutrition, an emergency : what is costs the nation. New Delhi : CAPART. 109 p.

Abstract : Malnutrition is a complex phenomenon with multiple causes, multiple manifestations, and it is inter-generational. This paper highlights the epidemic proportions of malnutrition in India. As per NFHS 3, 21.5% of the infants born are of low birth weight. According to NFHS 3 (2005-06), infant mortality rate (IMR) was 57 infant deaths per 1000 live births. 61.3% of infant mortality is related directly or indirectly to maternal/ child malnutrition and infant deaths are due to prematurity (30%), pneumonia (14.5%), respiratory infection (11%), anaemia (2.9%) and diarrhoea (2.9%). Stunting (deficit in height for age), wasting (deficit in weight for height) and under weight (deficit in weight for age) are critical indicators of nutritional status of children. The NFHS 3 data revealed that 46% children below 3 years of age were under weight, 38% were stunted and 19% were wasted. During the last decade, there has been only marginal decline in malnutrition. The prevalence of under weight is higher in rural areas (50%)

compared to urban areas (38%), higher among girls (48.9%) than among boys (45.5%), and higher among scheduled castes (53.2%) and scheduled tribes (56.2%) than among other castes (44.1%). Among vulnerable groups the prevalence of under weight reaches as high as 60%. Child malnutrition is mostly the result of high levels of exposure to infection and inappropriate infant and young child feeding practices, specially during the first 2 to 3 years of life. The maternal mortality (MMR) in 2001-03 was 301 per one lakh child births. The major causes of MMR are haemorrhage, sepsis, hypertension, obstructed labour, abortion, adding up to 67%, which are directly related to anaemia, malnutrition, and poor access to institutional deliveries. As per NFHS 3, in 2005-06, 51% mothers across the country had received at least three antenatal care visits during pregnancy and only 48% births were attended by a trained attendant. Almost 30% of the women in India have a Body Mass Index (BMI) below normal, thereby indicating chronic energy deficiency. The improvement between NFHS 2 and 3 has been a marginal 3%. The incidence of anaemia among ever married women aged 15-49 years has risen from 51.8% in 1998-99 to 56.2% in 2005-06. The prevalence of anaemia among pregnant women aged 15-49 years has also increased from 49.7% to 57.9%. In India, only 44.6% and 87.9% of households have access to toilet facilities and safe drinking water respectively. According to the National Nutrition Monitoring Bureau (NNMB) report (1996-97) about 30% of households consume less than 70% of the daily energy requirements. Micronutrient deficiencies, particularly of Vitamin A and iron are widely prevalent. About 80% of the individuals consume diets which provide less than half of the RDA for these micronutrients. About half the adults and elderly suffer from chronic energy deficiency as measured by body mass index (<18.5). The Productive Life Expectancy denotes the life time productive period of an average individual. For each nutrition deficiency disorder the productivity loss is expressed as percentage loss of the expected level. High Productivity Loss (50%) was assumed for cretinism and total blindness due to Vitamin A deficiency. This account for 3.9% of Gross Domestic Product, highlighting that nutritional disorders contribute to a significant Productivity Loss, which India can ill afford. CAPART, and autonomous body under the Ministry of Rural Development, Government of India, with a mandate of funding NGOs, prioritized the issue of malnutrition as an unaddressed gap in human resource development, and formulated a model scheme for promotion of community initiatives to combat malnutrition and provide income generation in backward regions of India. It adopted the Inter-Generational cycle approach, focused on health awareness, and promoted dietary supplementation by low cost, indigenous energy rich foods, locally prepared by women's self help groups. The scheme serves a dual purpose of combating malnutrition and providing income generation for women's self help groups, who produce, distribute and market the energy rich foods in the community. Two pilot projects have been undertaken in the Tribal blocks of Jawar and Mokhade in Thane district, Maharashtra that suffer from chronic malnutrition. CAPART is implementing these projects jointly with an

NGO, MITTRA-BAIF. The report suggested a blueprint for a National Programme to Combat Malnutrition. Beginning with enhanced political commitment, it seeks to revitalize the dormant National Nutrition Council headed by the Prime Minister, and urges it to set up a High Powered Committee to formulate a National Programme to Combat Malnutrition. The programme components suggested were Awareness Generation, supply and popularization of Low Cost Nutritious Energy Foods, Food Fortification and strong Monitoring and Evaluation system.

Key Words : 1.NUTRITION 2.MALNUTRITION 3.MICRONUTRIENT DEFICIENCY 4.MATERNAL NUTRITION 5.CHILD NUTRITION 6.COMBATING MALNUTRITION 7.COST OF MALNUTRITION 8.STRATEGIES TO COMBAT MALNUTRITION.

23. Sharma, Sushma et al. (2006).
Evaluation of mid day meal programme in MCD schools. New Delhi : Nutrition Foundation of India. ~60 p.

Abstract : Mid Day Meal programme (MDMP) is the popular name for the school meal programme in India. A nutritious meal is provided to the children of primary and nursery schools. In Delhi, the MDMP is run by three agencies namely Municipal Corporation of Delhi (MCD), New Delhi Municipal Corporation (NDMC) and Delhi Government. There are more than 1800 schools and 0.9 million students are enrolled. The study was carried out by trained field investigators in 410 schools and covered 72 Food Service Providers (FSPs). Storage area was assessed for pest control measures and washing area for the availability/ use of hot water and soap. The service units spread over 12 zones of Delhi, were mostly located in interior areas and were not easily accessible. Some of the FSPs had the cooking units in highly unhygienic environments with open drains in front of the service units or garbage dumps in close proximity. In most cases, the cooking area was partially covered and had natural light/ ventilation. In case of service units operating in courtyards, there were greater chances of the food getting exposed to dust and insects; and considering the fact that cooking for the morning shift started before daybreak, artificial lighting was inadequate. All the service units visited used LPG gas as the cooking fuel, and big burners were used to cook food in large vessels. Keeping two gas cylinders in close proximity to each other/ hot oven could be risky. Water supply was mainly from the Delhi Jal Board. Continuous water supply throughout the day was not available in most areas. Personal hygiene of the cooks/ food handlers was not up to the mark. In service units visited in the initial rounds, food handlers did not wear aprons/ headgear or cooking gloves. However, due to repeated instructions in the service units visited later on, most of the food handlers did wear aprons, headgear and in some cases even gloves. Towards the end of the academic session, out of the 18 menus initially planned by MCD, only 8 were finalized for use under the

MDMP on the basis of preferences of children and keeping the quality of food in view, in order to minimize the chances of contamination. A total of 72 units in Round I and 51 service units in Round II were visited and evaluated. It was observed that there was not much change in the two rounds of evaluation. More than 30% of the service units were graded as poor in both the rounds. In 70% cases there was no change in overall grading of service units, 59% maintained their grading as 'fair' and 11% as poor. However, in 28% cases there was deterioration, while only 2% service units registered improvement. For receiving the MDM most of the children brought their own tiffin boxes/ steel plates. Majority of the children took their utensils home for washing. Over 80-85% of the children did not wash their hands before eating their meals, even though they ate with their hands during the first year of evaluation, but during the second year it was observed that only 35% of the children did not wash their hands before eating. Quantity of meal served per child per day was found to be mostly between 150-200 grams. It was found that children relished Rice S*ambar, Puri Aloo /*soyabean and they did not relished Vegetable D*alia*, Sweet D*alia* and *Moong Dalia.* In most schools the time taken for distribution of the meals was about 15-30 minutes. However, in 15.6% cases the distribution took more than 45 minutes. Children were served either in the school corridor (48.5%) or in the courtyard (40.5%). When MDM was not supplied in some schools they distributed RTE food/ fruits in 1.7% cases and in 5.1% cases children were asked to bring lunch. Food handling and distribution at schools was done by personnel employed by the FSPs (70.5% cases). With regard to preference for cooked meals or ready to eat food items, 73.0% of the children preferred cooked meals, 24.9% preferred ready to eat food, and 2.1% liked both cooked and RTE food. It was recommended that MCD must continue to put MDM programme on the top of their agenda. Stakeholders collaboration is essential. A simple monitoring and evaluation system is required. Educability must go hard in hand with education. Field experience and capacity building from top to bottom is important.

Key Words : 1.NUTRITION 2.MID DAY MEAL SCHEME 3.READY TO EAT FOOD 4.QUALITY OF FOOD 5.HOT COOKED FOOD 6.SCHOOL LUNCH PROGRAMME 7.DELHI.

SCHEDULED CASTES

24. National Human Rights Commission (NHRC), New Delhi. (2004).
Report on prevention of atrocities against scheduled castes. New Delhi : NHRC. 299 p.

Abstract : Despite elaborate provisions in the Constitution of India and other laws, it is an unfortunate reality that social injustice and exploitation of scheduled castes (SCs) and scheduled tribes (STs) and other weaker sections still persists.

The present report, prepared by National Human Rights Commission, reveals the atrocities and crimes committed on SCs and the steps which NHRC could take to check them. The report reveals the humiliation which SCs and dalits suffer even today. It was found that the total number of reported criminal cases of atrocities against SCs under the IPC, Protection of Child Rights Act, and Scheduled Tribes and Scheduled Castes Act in 1999 was 25,093. In a study, an NGO in Gujarat covered 11 atrocities prone districts for four years and found that 36% of atrocities cases were not registered under the Atrocities Act, and in 84.4% cases, the Act was applied. According to the Report of National Commission on Scheduled Castes/ Scheduled Tribes 2000-2001 there were 486 (2.05%) murders, 3,298 (13.89%) cases of grievous hurt, 1034 (1.36%) rapes, 260 (1.09%) arson cases and 18,664 (78.61%) other offences that took place against SCs. The maximum number of atrocities against SCs registered in 2002 were in UP (8,462), Rajasthan (6,679), MP (4,122), AP (2,711), Gujarat (1,699) and Karnataka (1,254). Fewer cases were registered in Tamil Nadu (996), Maharashtra (793), Bihar (568), Kerala (529), Uttaranchal (112), Haryana (54), Punjab (34), Jharkhand (26), Delhi (15), and West Bengal (14). Only one case each was registered in Goa and all the Union Territories, except in Puducherry where there was no case. There has been substantial increase in the provision of financial assistance during the last 2 years for the implementation of Central Acts. During the year 2001-02 Rs. 29.06 crore were released. The funds released to states bear no correspondence to the volume of atrocity cases there. The drawl of assistance by some states is extremely low despite the sizeable percentage of SC population and also high incidence of cases of violence against SCs. Perhaps non-registration of cases under the Act may be the reason why the state is not claiming adequate assistance. The study reveals that under Prime Minister's Rozgar Yojana (PMRY) 13.26% of the total loans were sanctioned by banks to SC/ ST beneficiaries which accounted for 15.63% of the total amount sanctioned during 2000-01.The Sixth Report of the National Commission on Scheduled Castes and Scheduled Tribes (2000-01) observed that in most states, monitoring and vigilance committees at state and district levels have either not been constituted or its meetings are not held on a regular basis. Annual reports are not submitted by the Ministry of Social Justice and Empowerment as per law. Appointment of special prosecutors is often influenced by political consideration, and states are not implementing relief and rehabilitation packages. The report also reveals that the SCs occupy 11.29% of the posts in Group A, 12.68% in Group B, 15.78% in Group C and 19.99% in Group D under the Central Government. In Group D posts, SCs occupy 65.57% of the total posts of *safai karmacharis* (sweepers). In public sector insurance companies, in Class I category their representation in the total strength was 15.38%, in Class II category it was 12.40%, in Class III it was 17.24%, and in Class IV it was 31.35%, including those of *safai karmacharis*. In the country's 256 universities and about 1100 colleges funded by UGC, there are about 3.42 lakh teaching positions, but SCs and STs comprise only 2% of the teaching staff, and about

7500 teaching positions meant for these communities are vacant. It is recommended that a manual on the implementation of Protection of Civil Rights Act, 1955, SCs, and STs Act may be prepared with the help of Human Rights Organizations/ Social activists and NGOs working with and for scheduled castes, specifying necessary steps for their effective implementation, along with the specifying to implement responsibility of concerned functionaries at various levels in dealing with their different provisions. This manual may be translated by states into regional languages and made available to all the functionaries, police, civil organizations and judiciary, and all those responsible for implementing the Act. Ministry of Home Affairs should set up a Cell - Civil Rights Act, 1955, and SCs/ STs Act, 1989. State Governments should expeditiously identify atrocity prone areas and untouchability prone areas and thereafter prepare a Plan of Action for eliminating untouchability and reducing the incidence of violence.

Key Words : 1.SCHEDULED CASTES 2.ATROCITIES ON SCHEDULED CASTES 3.ATROCITIES PREVENTION 4.PREVENTION OF ATROCITIES 5.ROLE OF NHRC 6.ROLE OF GOVERNMENT 7.WOMEN'S RIGHTS.

SOCIAL DEFENCE

25. Good Hope, Tirumangalam, Madurai Dt, Tamil Nadu. (~2006).
Trafficking in women : an empirical study with special reference to Tamil Nadu : final draft report. Tirumangalam, Tamil Nadu : GH. ~180 p.

Abstract : Women are particularly vulnerable to trafficking due to the persistent inequalities they face in status and opportunity. The present study was carried out to assess the problems of victims of trafficking and study the factors influencing trafficking of women. The study was conducted in 29 districts of Tamil Nadu and covered 250 commercial sex workers (CSWs), and data was collected through interviews and field surveys. Women in trafficking were found to be between 28 to 37 years. Almost all CSWs were illiterate. Majority of the respondents (71.2%) were full time CSWs. Only 8.8% respondents had a family history of commercial sex work. It was found that 22.7% and 4.5% of the respondents had mothers and daughters jointly involved in CSW. Most of the respondents (93.2%) did not belong to an area/ village which was prone to CSW and trafficking. Majority of the respondents (70.6%) who reported that CSW was very common in their area/ village stated that poverty was the major reason for the prevalence of CSW, and 29.4% of the respondents felt that backwardness and lack of livelihood avenues were the reasons for notoriousness of the area/ village. There were 42 types of parental occupations of the respondents which

ranged from agriculture (24%) to petty business (0.4%). The parental occupation of 26.40% of the respondents was daily wages. 54.8% CSWs earned between Rs. 1,001 and Rs. 2,000 before taking up commercial sex work. About 30% respondents served two clients per day; this was more prevalent in central, northern and southern regions; and 24.8% respondents attended three persons in a day, which was concentrated more in the western region. 14.4% respondents met four persons in one day which was more in eastern, northern and southern regions. 60.5% respondents who had the habit of saving put their savings in organized sectors viz., post offices, LIC and nationalized banks, which was more in northern and western regions. Major portions of 26.7% respondents' savings were in private chit fund agencies, and they were at risk of not getting back their money. 37.6% respondents mentioned that brokers and brothel owners charged Rs. 251 to Rs. 500 from the clients for every encounter, which was more in eastern and northern regions, and very low in central regions. Almost half of the respondents suffered from physical ailments such as body pain, stomach ache and boils; 67.2% respondents suffered form sexually transmitted diseases (STDs) after involvement in CSW; and 1.6% of the respondents were infected with HIV/ AIDS in the eastern region. 30.8% of the respondents had not suffered from any infectious diseases so far. 37.6% respondents rarely went for medical checkups and this was more in central and northern Tamil Nadu. 29.6% of the respondents went for regular monthly checkups in central and southern regions. 95.5% respondents were aware of AIDS, but 5.6% of them were not using condoms properly. 38.0% respondents suffered from depression and anxiety frequently. 17.6% of the respondents were caught by police under ITPA Act 1956. Among them 47.7% were caught by the police once, as during the first arrest, a nexus is built between the police and brokers, and a financial agreement is made between them. Of the 17.6% respondents who were caught by the police, only 9.2% respondents were arrested by the police and brought for trial. Two respondents (8.7%) were arrested only on suspicion. Only 6.8% respondents disclosed that their brokers had illegal dealings with policemen. It was suggested that special Swadhar hostels, exclusively for the victims of trafficking should be opened in all the five regions. The staff of such special Swadhar Hostels should be oriented on rehabilitation of the victims of trafficking. Assessment of the entrepreneurial interest of the victims should be done to conduct entrepreneurial development training for victims. An intensive training programme on various skills to take up micro enterprises should be conducted. Financial assistance from banks should be arranged for the victims to enable them to start enterprises.

Key Words : 1.SOCIAL DEFENCE 2.TRAFFICKING 3.PROSTITUTION 4.CHILD PROSTITUTION 5.HIGH RISK GROUP 6.AIDS 7.REHABILITATION SEX WORKERS 8.REHABILITATION PROSTITUTION 9.MENTAL HEALTH PROBLEMS 10.TAMIL NADU.

26. Gram Niyojan Kendra, Ghaziabad. (2007).
Study on girls/ women in prostitution in India : a summary. Ghaziabad : GNK. 28 p.

Abstract : This study was undertaken to assess the situation of women in prostitution and their children, and suggest measures for their welfare and rehabilitation. It covered 31 states/ union territories, and 9,927 persons were interviewed – 9,500 sex workers (SWs) and 427 persons connected with the issue. It is estimated that there are 3 million women/ girls in prostitution, comprising 2.48% of girls/ women in the age group 15-35 years. 90% of the total SWs were between 15-35 years of age. Comparison with earlier available data revealed that there was an increase of 50% in the number of girls/ women in prostitution during the years 1997 to 2002-03. In the 6 metro cities, the number has doubled during the last 10 years. There is greater demand for girl children in prostitution because of the prevalent myth that sex with a virgin/ minor can cure STDs, they are easier to handle/ manipulate, and they provide income for a longer period of time. The 11 forms of prostitution identified were street/ common prostitution; brothel prostitution; shifting/ mobile prostitution; call girls; commuting prostitutes; concubines; cage prostitution; home based prostitution; singing and dancing girls; and prostitution under various garbs such as masseurs, escorts, etc. Religious prostitution/ *devdasis* were mainly confined to Andhra Pradesh, Karnataka and Maharashtra. Singing and dancing girls were common in Bihar and Uttar Pradesh, and disguised prostitution (under various garbs) was mainly in Delhi, Maharashtra and North Eastern States. Andhra Pradesh (14.73%) and West Bengal (11.32%) together accounted for over 25% of the total respondents. 1794 areas spread over 378 districts were the predominant supply areas of prostitutes. Prostitution was prevalent in 121 districts spread in 27 states/ UTs. About 4-5% of the SWs were foreign nationals from Bangladesh, Nepal, Bhutan and Burma; and Delhi and Mumbai were the preferred destinations. About 54% SWs were from vulnerable groups like scheduled castes (SCs), scheduled tribes (STs), and other backward class groups (OBCs). Continued backwardness of the region, lack of livelihoods, lack of education and awareness were contributory factors. Rise in the number of prostitutes from general caste groups was also seen because of increase in poverty, globalization, etc. About 62% women in prostitution were illiterate, and prostitutes in Goa, Haryana, Jharkhand and Punjab were totally illiterate. SWs from Tamil Nadu and Kerala were at least functional literates, but call girls/ mobile and brothel based SWs had better education. The parental families of 90% of SWs did not own any land/ animals, and only 10% had income above Rs. 3,500 per month, which was the reason why they were in the trade. The maximum span of work life for 90% FSWs was 15 years. About 27.4% girls/ women joined prostitution because their family members inducted them, and in about 7% cases mothers inducted them.

Mothers have inducted them in 46%, 14% and 13.08% cases in Bihar, Rajasthan and UP respectively. 70% of the respondents were trafficked. Group sex is emerging as a new phenomenon so as to cater to more than 1 client at a time. Lowest earnings were of street/ red light area based SWs, and earnings ranged between Rs. 2,000 to Rs. 24,000 per month. Call girls earned between Rs. 40,000 to Rs. 800,000 per month, but 20-70% of their income was shared among various people (protectors, middlemen, etc.). Prostitution adversely affected their mental health and social well-being. They often lived a life of bondage and faced the dilemma of duality. The new plan of providing licenses to prostitutes was not accepted by a majority, as they feared exposure, segregation, isolation and stigmatization from society. 51% SWs had children, and on an average 1.93 children per woman. These comprised 69.9% of married (formally/ informally) prostitutes. Female children were more than male, and the sex ratio was 1081. Children of SWs lacked education, functional skills, and had limited opportunities for proper growth and development. Various government and non-government plans and programmes for SWs have received impetus after 1985, and after enactment of legislation like SITA/ PITA/ ITPA, other important programmes include AIDS prevention, rescue and rehabilitation, control/ prevention of the entry of minors in this trade, etc. However, post rescue work is limited mainly to institutionalization. It was recommended that the conceptual differences between trafficking and prostitution should be demarcated. Prostitution due to poverty should be reduced/ eliminated; rehabilitative measures undertaken; and control/ preventive measures strengthened. Law enforcing authorities, police, planners and NGOs should collaborate to prevent trafficking. High supply zones should be identified, and development programmes undertaken to improve the quality of life in urban and rural areas. Awareness of families should be increased, and parents should not entrust their daughters to strangers. Prostitution should be considered as a socio-legal and human problem by law enforcing agencies. Victims who want to come out of this trade should be identified and rehabilitated. Surprise checks of transit areas like hotels/ motels, restaurants, cyber cafes, bus and railway stations, etc. should be carried out. Credentials of persons offering bail for SWs should be checked, otherwise SWs would be re-inducted into the trade after rescue operations. Rehabilitation of SWs entails organizing formal/ informal education and vocational training; providing medical care and treatment facilities; organizing counselling and guidance centres; arranging free legal aid; encouraging the formation of cooperatives; and involving NGOs in their rehabilitation. To rehabilitate the children of prostitutes admission should be secured in schools; freeships and scholarships arranged; self employment opportunities provided; child guidance centres opened; and health facilities provided. Mother should be accepted as the legal guardian of children. Panchayats can play an important role in preventing prostitution/ trafficking at the village level. Rural development and employment programmes should be effectively implemented. The mind set should be changed and the girl child valued. NGOs can help in the rescue and rehabilitation process by managing

homes and other residential care services; providing counselling and legal aid services; organizing area development programmes; and creating public opinion in favour of girl prostitutes.

Key Words : 1.SOCIAL DEFENCE 2.PROSTITUTION 3.CHILDREN OF PROSTITUTES.

27. Mathur, Punita. (2003).
A Comparative study of psychological and environmental factors among female criminals and non-criminals. Jodhpur : Jai Narain Vyas Univ., Dept. of Home Science. ~100 p.

Abstract : Till a few decades ago, crime was considered to be predominantly a male phenomena, but as women increasingly join the mainstream of society, their share in crime has increased considerably the world over. The present study was done to compare the psychological and family environmental factors among female criminals and non-criminals. The variables used to assess the psychological factors were Anxiety (An), Phobia (Ph), Obsessive Compulsive (OC), Conversion Reaction (CR), Hysteria Dissociate (Hy. D), Neurotic Depression (D) and Neurasthenia (Neu). The family environmental factors consisted of 3 dimensions, i.e. relationship dimension, personal growth dimension and system maintenance dimension. Data was collected through interviews. A sample of 60 respondents was selected out of which 30 were female criminals and 30 were non-criminals. The female inmates were taken from the Central Jail of Jodhpur and Jaipur whereas non-criminals were randomly selected from within the municipal limits of Jodhpur, Rajasthan. The analysis of psychological factors showed that the mean scores of female criminals were significantly higher than the mean scores of female non criminals on anxiety (30.8>15.6), obsessive compulsive (24.7>11.13), conversion reaction (!7.23>8.5), hysteria dissociate (13.3>5.6), neurasthenia (15.9>8.16) and phobia (15.6>7.4). But no significant difference was observed on depression factor. All these factors depicted that female criminals as compared to non-criminals were less able to concentrate and had difficulty in making decisions. They were extremely sensitive and had a sense of helplessness, which reflected the acute feeling of inadequacy in the face of inner and outer stresses perceived as threatening. It was also found that female criminals had obsessive thoughts and compulsive behaviour problems, which marked lack of control over environment and themselves. It was revealed that female criminals have passive aggressive personality and inadequacy to cope independently. Female criminals defend their ego in the situation that was perceived as dangerous. The study showed that they have prolonged frustration, discouragement, hopelessness, self–centered attitude and poorly depressed hostility. Both the groups have low stress

tolerance, rigid conscience to development and proneness to guilt feeling. On the family environmental factors, female criminals as compared to non-criminals were less attached to their family members, and also the families of female criminals were less concerned about them. The family environment of female criminals as compared to non-criminals was poor and impoverished. They were not encouraged to be independent and self-reliant which was necessary for the development of achievement. The families of female criminals as compared to non-criminals failed to provide opportunities for intellectual and cultural activities or recreation. The families of both groups gave emphasis to religious values and issues, and the family environment did not have any rigid rules and procedures. The status of women is a problem in almost all societies, so it was suggested that family members and educationists should safeguard women, as women play a primary role in the family and should be given equal status in society.

Key Words : 1.SOCIAL DEFENCE 2.WOMEN CRIMINALS 3.FEMALE CRIMINALITY 4.WOMEN OFFENDERS 5.ENVIRONMENTAL FACTORS 6.PSYCHOLOGICAL FACTORS 7.DELINQUENCY 8.SOCIOLOGICAL FACTORS.

28. Pandit Govind Ballabh Pant Institute of Studies in Rural Development, New Delhi. (2006).

A Study of children dependent on prostitutes in selected areas of Uttar Pradesh. New Delhi : PGBPISRD. ~220 p.

Abstract : Sexual exploitation and trafficking in children is an alarming global problem. This study was carried out in Uttar Pradesh (UP) to examine the social problem of trafficking and prostitution of children and women, and assess the status of children depending on prostitutes. The study was carried out in Lucknow, Kanpur, Meerut, Allahabad, Sultanpur and Hardoi. The field survey was carried out in juvenile homes, aftercare homes, shelter homes, etc. It was observed that the main occupation of the respondents was dancing, singing and theatre play. About 50% of the respondents were married, while more than 33% respondents were unmarried. Most respondents were from families where the annual family income was less than Rs. 20,000 or between Rs. 35,000 to Rs. 50,000. The average monthly income from dancing, singing and theatre play was computed to be Rs. 3,291 while the average income from private service was recorded to be Rs. 1,927. Most respondents revealed that they have been in the profession for the last 10 years and more. Most of them had migrated from rural areas to urban areas and small districts. Most of the respondents were literate or had low education. Only 5% respondents were found to be graduates. The professionals lived mostly in nuclear families, and the average size of their family was 4.46 members. About 40% respondents reported that their sisters and

daughters were also engaged in the family profession. About 60% respondents accepted that they had received vocational skill and professional education. Only 27% professionals owned their houses, while the rest were living in rented houses. About 20% respondents did not have toilet facilities. Most of the children surveyed were in the age group of 11-14 years and 15-18 years and they were mainly girls. About 28% children had dropped out of the education system. The main reason for dropping out was found to be family tradition. Most of the children who dropped out were in the higher age group. About 27% children admitted that they were discriminated against due to their social affiliation/ belongingness. 6% children were also engaged in sexual networking. 13% children were abused. About 58% children were found to be school/ college going students, while 35% children were engaged in the family profession. About 29% respondents reported that child specific programmes have been launched in their areas. About 58% professionals said that they were harassed by police, and 40% respondents revealed that they were harassed by local anti-social elements. The professionals were of the view that a ban on the profession bar dancing, prostitution, etc. would affect them badly. It was recommended that schemes need to be introduced for the welfare, employment and rehabilitation of prostitutes. Day care and night care centres are needed in red light areas for the children of prostitutes. There should be a social and financial security system for erstwhile prostitutes so that their dependence on their daughters' income from prostitution may be reduced. The children of prostitutes and erstwhile prostitutes, including bar dancers, *tawaifs*, professional singers and dancers should be extended the benefits of scholarship, fellowship and other educational incentives so that these children may be empowered educationally and are able to join the national mainstream.

Key Words : 1.SOCIAL DEFENCE 2.CHILD PROSTITUTION 3.PROSTITUTION 4.TRAFFICKING 5.TRAFFICKING OF WOMEN AND CHILDREN 6.EXPLOITATION 7.SEXUAL ABUSE 8.CHILDREN OF PROSTITUTES 9.LIST OF ORGANIZATIONS PROSTITUTION 10.UTTAR PRADESH.

SOCIAL WELFARE

29. Arora, Monika, et al. (2008).
Association between tobacco marketing and use among urban youth in India. New Delhi : Health Related Information Dissemination Amongst Youth (HRIDAY). 11 p.

Abstract : The tobacco industry undertakes various activities to increase the sale of tobacco products. The present study investigated the receptivity to tobacco marketing and exposure to tobacco advertisements with tobacco use among

urban youth in 2 cities of India. The project covered 32 schools in Delhi (16 schools) and Chennai (16 schools). A self-administered questionnaire survey was conducted covering 11,748 students who represented 94% of the sample at baseline: 5,889 (50.6%) students were from Delhi, 7,153 (61.4%) belong to government schools, 6,386 (54.9%) were males, and 6,165 (52.9%) were in Grade 6. In this study 24.8% of sixth grade and 9.3% of eighth grade students had ever used tobacco, and 6.7% and 2.9% respectively were current users. Of the 493 students who responded that they had a favourite tobacco advertisement, 238 recollected specific brand names. A total of 52 brands were listed including smoking and chewing forms of tobacco products. Of the students reporting brand names, the average number of brands reported was about one per student. Although a few students (n=3) reported up to 5 brands, most reported just one (n=186), and others reported about 2 to 4 brands (n=49). There were more favourite advertisements reported for chewing tobacco (n=236) than smoking tobacco (n=83). Among smoking forms, Wills, a cigarette brand name of Indian Tobacco Company, was the most reported tobacco brand followed by Gold Flakes of ITC, and Red and White of Godfrey Phillips India Ltd. Among advertisements of chewing tobacco product brands, Pan Parag was the most reported brand. Of the 11,642 students, 11,568 (99.3%) responded to questions of receptivity to tobacco advertising; of these 5.8% (n=665) were categorized as moderately receptive, and 64.5% (n=7465) were categorized as not at all receptive. Of the 11,642 students, 10,877 (93.4%) responded to the questions related to exposure to tobacco advertising. About 37% students reported having seen tobacco advertisements at more than 4 places, about 50% reported to have seen tobacco advertisements at 1-4 places, and 13.2% reported not having seen any tobacco advertisement on any of the 7 places listed in the survey. The index of exposure to tobacco advertising was significantly associated with current use of any tobacco product among these students. The relationship between exposure to advertising and tobacco use did vary by grade for both ever-tobacco use ($p<0.06$) and current tobacco use ($p<0.05$). The dose response relationship was present for sixth graders, but not for eighth graders. The relationship between exposure to advertising and ever tobacco use also varied by gender ($p<0.05$). The prevalence of ever tobacco use increased with exposure levels among girls ($p=0.2$), but not among boys ($p=0.66$). The relationship does not vary by gender, however, the prevalence of current tobacco use increased with increased exposure to tobacco advertising for both boys and girls. All the psychological factors studied showed a significant positive association with the exposure index, except for intentions to chew tobacco. Students who reported greater exposure scored higher on all psychological risk factors, indicating that they were at greater risk for tobacco use as compared to students who reported having not seen any tobacco advertisement. Among various psychological risk factors, exposure to advertising had the strongest relationship with perceived prevalence of chewing tobacco and smoking tobacco. It was recommended that a comprehensive ban should be imposed on tobacco advertising in order to

effectively lower tobacco prevalence rates. Current legislation in India needs to be effectively enforced, and loopholes in the legislation need to be tightened to avoid advertising and promotion of tobacco products through surrogate means such as brand stretching.

Key Words : 1.SOCIAL WELFARE 2.DRUG ABUSE 3.TOBACCO 4.YOUTH.

30. Centre for Budged and Governance Accountability, New Delhi. (2008). Budget 2008-09 : reaffirming rhetoric ?: response to the Union Budget 2008-09. New Delhi : CBGA. 78 p.

Abstract : With the UPA Government approaching the fifth and last year of its tenure, hopes reigned high from the Union Budget 2008-09. The Centre for Budget and Governance Accountability (CBGA) has attempted to demystify this budget from the lens of the disadvantaged sections of society. The economy has shown steady growth and in 2008-09, tax collections are expected to be around 13% of GDP. In spite of the increasing tax collections and growing GDP, the Government has failed to make sufficient investment in the social sectors. The National Common Minimum Programme (NCMP) promise of spending 6% of GDP and public resources for education remains unfulfilled with the combined outlay for the education departments of centre and states remaining at a meagre 2.84% of GDP in 2007-08. Mid Day Meal scheme has been extended to upper primary classes in Government and Government aided schools in all blocks, which is a welcome step. Sarva Shiksha Abhiyan (excluding the NER Component) decreased from Rs. 12.020 crore in 2007-08 (RE) to Rs. 11,940 crore in 2008-09 (BE). The Finance Minister has proposed to increase allocation on health by 15% to 16,534 crore in 2008-09. Since 2005-06, health expenditure of States and Union Government taken together has remained stagnant at around 0.99% of GDP, which is not even one third of the promised 3% of the GDP on health. The proposed allocation for National Rural Health Mission (NRHM) is Rs. 12,050 crore which is a mere 11.4% increase over 2007-08 RE. The Government has introduced Rashtriya Swasthya Bima Yojana that will provide a health insurance cover of Rs. 30,000 for every worker and their family in the unorganized sector falling under the Below Poverty Line (BPL) category, and has allocated Rs. 205 crore as the Centre's share. This is a meagre amount, and it seems the Union Government is proposing to shift the major burden of the scheme to states. Total allocations for women show a very marginal increase from 3.3% to 3.6% of the total government expenditure, a mere 0.3% increase. The budget provisions for Early Childhood Care and Development for the year 2008-09 was Rs. 6,695.33 crore. Allocation for Child Development as a proportion of total Government expenditure was 0.89% for 2008-09. Budgetary provisions for Child Health were Rs. 4,064.33 crore, which was 0.54% of total

expenditure of Union Government. Budgetary provisions for Child Education were Rs. 29,009.55 crore (3.86%). Budgetary provision for Child Protection was Rs. 429.9 crore for the year 2008-09 which was 0.06% of the total expenditure. Total outlays for Child Specific Schemes was Rs. 40,199.11 crore, total outlays from Union Budget was Rs. 750,884 crore, and total Child Specific outlays as a proportion of total outlays from Union Budget was 5.35%. The Union Budget outlay for ICDS has been increased from Rs. 4,857 crore in 2007-08 to Rs. 5,665 crore in 2008-09. Increase has been proposed in the allocations for Ministry of Minority Affairs from Rs. 362.83 crore to Rs. 1,013.83 crore, but still there are no schemes to address the specific vulnerabilities of Muslim women. Women specific allocations in agriculture as a percentage of total allocations in agriculture have increased while in higher education, priority for women has gone down. Allocations for RCH have gone up from Rs. 1,629.17 crore last year to Rs. 2,504.75 crore. There are some new interventions for the scheduled castes and scheduled tribes, namely special focus on SC/ ST women in National Rural Employment Guarantee Scheme (NREGS), Rs. 130 crore allocations to make Jawahar Navodaya Vidyalayas accessible to SC/ ST students in 20 districts that have large concentration of SC/ ST population. The total plan outlay earmarked for scheduled castes as a percentage of total Government expenditure has declined from 7.90% in 2007-08 (BE) to 7.51% in 2008-09 (BE). A close review of plan outlay for the North Eastern Region (NER) reflects an ambitious and satisfactory allocation for the NER, amounting to 6.8% of the plan outlay. It was recommended that there is an urgent need to invest a large amount of funds for creation of irrigation facilities to realize the irrigation potential. There should be fair reconciliation of conflicting interests of different regions; adequate total development with accountability; infrastructure development; economic growth; greater economic linkages with neighbouring regions; and better governance and democratic legitimacy. These should form the foundation of durable peace and prosperity of the country and the NER region.

Key Words : 1.SOCIAL WELFARE 2.BUDGET 2008-09 3.SOCIAL SECTOR SPENDING.

31. Reddy, Srinath K. and Gupta, Prakash C. (2004).
Tobacco control in India : report. New Delhi : India, Ministry of Health and Family Welfare. 378 p.

Abstract : Tobacco is used in a wide variety of ways: smoking, chewing, applying, sucking, gargling, etc. National Household Survey of Drug and Alcohol Abuse in India (NHSDAA), conducted in 2004, reveals that there were 1,860 tobacco users in the 12-18 years category, 7026 in the 19-30 years category,

5,186 in the 31-40 years category, 4,193 in the 41-50 years category, and 3,638 people were in the 51-60 years category. NFHS-2 (1999) reported that tobacco use among men was 46.5% and 13.8% among women aged 15 years and above. The prevalence of smoking among men was reported to be lower than the NSS (1996) (29.3% vs 35.3%) where most respondents were males, and the prevalence of smokeless tobacco use among women was higher (12% vs 8.6%). NHSDDA (2003) found the prevalence of tobacco use to be highest in South Bihar (94.7%), followed by Uttar Pradesh (87.3%), and the lowest rate was found in Kerala (20.6%). The Global Youth Tobacco Survey (GYTS-2000-04) supported by WHO and CDC revealed that 17.5% school students in the age group of 13-17 years were current users of tobacco. Among students aged 13-15 years, 14.6% were current smokeless tobacco users. Users ranged from 2% in Himachal Pradesh to 55.6% in Bihar. Current smoking in India was reported by 8.3% students. It ranged from 2.2% in Himachal Pradesh to 34.5% in Mizoram. The GYTS India results show that non-cigarette tobacco use (13.6%) was three times more common than current cigarette smoking (4.2%). Over one-third of students (36.4%) were exposed to second-hand smoke inside their homes and nearly half (48.7%) outside their homes. The exposure to second-hand smoke inside the home ranged from 9.9% in Punjab to 79.0% in Meghalaya; and outside the home it ranged from 23.5% in Punjab to 84.4% in Meghalaya. The study reveals that the toxic effects of tobacco include Mutagenicity, Carcinogenicity and Genetic damage in humans. Nearly 3000 chemical constituents have been identified in smokeless tobacco, while close to 4,000 are present in tobacco smoke, and many of them are harmful. Tobacco contains tobacco-specific nitrosamines (TSNs), formed during fermentation and curing of tobacco, which are carcinogenic. The Nicotine content of different tobacco products is Pandharpuri 54.77 mg/ g, Zarda 26.20 mg/ g, Masheri Br.1 6.02 mg/ g, Masheri Br.23.08 mg/ g, Rawa Tobacco 116.91 mg/g, Rawa Masheri 4.99 mg/ g, Beedi filter 42.05 mg/ g, Cigarette tobacco 14.19 mg/ g, and Beedi tobacco 35.15 mg/ g. According to US General's Report (2004), tobacco is responsible for the death of 1 in 10 adults, with 2.41 (1.80 – 3.15) million deaths reported in developing countries, and 2.43 (2.13 – 2.78) million deaths reported in developed countries. Among these, 3.84 million deaths were in men. The leading causes were Cardiovascular diseases (1.69 million deaths), Chronic Obstructive Pulmonary disease (0.97 million deaths), and Lung Cancer (0.85 million). 50% of the unnecessary deaths due to tobacco occur in middle age (35-69 years), robbing around 22 years of normal life expectancy. To control tobacco consumption several initiatives have been taken. Under Ministry of Health and Family Welfare (MOHFW) the Government of India has set up Central Health Education Bureau (CHEB) and its state branches called the State Health Education Bureaus. Every year, the CHEB conducts activities on 31 May, which is designated as No Tobacco Day. Directorate of Advertising and Visual Publicity (DAVP) creates awareness among the masses about various public and social health issues. WHO – SEARO (South East Asia Regional Office) initiated an year long

campaign in January 2000 to curb tobacco consumption in South East Asia. National Tobacco Control Cell (NTCC) developed 13 anti-tobacco television advertisements targeting the entire spectrum of tobacco products used in India. Kalyani programme was launched by Ministry of Health in collaboration with Prasar Bharati in 2002 to telecast a weekly health show on Doordarshan. It discusses issues related to six diseases including those related to tobacco use. The different varieties of unmanufactured tobacco and its value in Rs. in million in 2003 was Flue-cured Virginia (Rs. 4857.94 million), Burley (Rs. 746.58 million), Sun Cured natu (Rs. 127.96 million), Top leaf/ jutty (Rs. 74.13 million), Lal chopadia (Rs. 143.04 million), Judi (Rs. 32.82 million), and others (Rs. 108.62 million). It was suggested that a National Coordination Body (such as a National Commission for Tobacco Control) should be created through an initiative of the Union Ministry of Health and Family Welfare. This body should have representatives of key stakeholder groups. It should help to catalyze policy, create partnerships, facilitate implementation at multiple levels, monitor performance of NPTC related activities, and provide advice to central and state Governments on the methods and means by which programme implementation can be strengthened. Such a body should ideally have the status of a statutory body but should remain fully autonomous. Mechanisms should be evolved to obtain more precise estimates of morbidity and mortality attributable to tobacco use in India. Health facilities should be completely tobacco free, over and beyond what is required by the law.

Key Words : 1.SOCIAL WELFARE 2.DRUG ABUSE SMOKING 3.SMOKING 4.TOBACCO 5.TOBACCO CONTROL 6.HEALTH HAZARDS 7.HEALTH HAZARDS SMOKING.

WOMEN WELFARE

32. All India Women's Conference, New Delhi. (2006).
A Study of short stay homes and old age homes. New Delhi : AIWC.
~350 p.

Abstract : Short Stay Homes (SSHs) are residential institutions which provide accommodation, shelter and support services to women in distress who are victims of social discrimination. The main objective of the study was to devise a model home with adequate support structure to rehabilitate and empower women in distress. The study was carried out in 10 SSHs in 7 states, and included 258 residents, 56 management and staff, and 12 administrators. Findings revealed that only 3 out of 10 Homes had sufficient outside space which could be utilized

for activities of inmates, as children's playgrounds, etc. In two Homes the space was utilized for installing biogas plant, water storage tanks and other infrastructural requirements. In all Homes economic activities were carried on inside the Home in 2 or 3 separate rooms. In the living area there were adequate bedrooms, bath/ toilet facilities and office area in all except 2 Homes. It was observed that in view of the extraordinary rise in rents it was difficult to find new premises for shifting the Home, at a reasonable distance from the town, even though due to seepage and disrepair, this was an urgent need in 2 cases. The occupancy of Homes was on an average 80-85%. Girls and women in the age group 15-35 years are admitted if they are from one of these categories : women at risk in their own homes, victims of domestic violence, dowry harassment, deserted/ divorced women, those abandoned by companions, and unwed mothers. The Homes provide board and lodging facilities, toilet and bath facilities, and are perceived by residents to be in the range of 'adequate to good'. Maintenance of cleanliness and hygiene is up to the desired level in almost all Homes. In all Homes inmates cook food 3 times a day in the case of wheat based menus and twice a day in rice eating regions. *Dal* (pulses) and vegetables are a part of the diet. It was found that in the eastern region non-vegetarian items are cooked twice a week. The food is adequate in quantity, but the nutrition value can be increased by the addition of low cost, locally available nutritious grains like *ragi*, or gram wheat powder (*sattu*), which was done only in one Home. Most Homes had weekly or fortnightly visits by a doctor who was paid Rs. 600 per month. The nature of counselling and rehabilitation given in SSHs can be assessed from the responses of beneficiaries when questioned on the benefits of counselling. Inmates from below the poverty level, who formed 54% to 82% of the population in 5 Homes, and comprised 62% to 85% of the group having low literacy, could perceive benefits ranging from 'nil' to 'very little' from counselling. In contrast, inmates of four Homes who were 54% to 100% from lower middle class, and had education levels of 70% to 100% of high school and above, could perceive a great deal of benefit 'from the guidance provided by the Counsellor'. On an average, only 1% of all respondents except from three Homes, found that counselling helped to solve their problems. From the data it can be presumed that the present methods of counselling become much more effective when supported by other services. It was concluded that poverty and deprivation are the two biggest adversities which women of all castes have to deal with. It was recommended that there is need for regular in- service orientation programmes for administrative personnel. There is also need to provide professional training for raising competence levels of Wardens, Counsellors, Rehabilitation Officers, and Accountants to coordinate with police and civic authorities for extending help to SSHs. Instead of sanctioning grants on the basis of quarterly inspection reports, grant sanction should be for 5 years, after 2 year assessment periods. Staff salaries should be raised to be at par with salaries of government staff similarly employed; and HRA and annual increment should be provided. Utilization of non-recurring grants should be specified in detail to ensure

expenditure on facilities for inmates. A manual should be provided for administration and service delivery.

Key Words : 1.WOMEN WELFARE 2.SHORT STAY HOMES 3.AGED 4.OLD AGE HOMES 5.HOMES FOR AGED 6.WOMEN IN DISTRESS 7.CASE STUDIES.

33. Asian Society for Entrepreneurship Education and Development, New Delhi. (2007).

Comparative study of SGSY and NABARD supported SHGs initiatives in Northern India (UP, Rajasthan and Haryana). New Delhi : ASEED. 143 p.

Abstract : The Self Help Group (SHG) movement has attained new heights for community banking programmes in India. The present study was done to assess the differential effectiveness of SHGs promoted under the guidelines of NABARD (National Bank for Agriculture and Rural Development) and those promoted by SGSY (Swarnjayanti Gram Swarozgar Yojana); to assess the sufficiency and efficacy of bank linkages provided to SHGs; and assess the socio-economic impact of SHGs. The study was conducted in the states of Uttar Pradesh, Rajasthan and Haryana in 12 selected districts. The total number of SHGs selected was 880. Data was collected by SHG office bearers, official stakeholders of NABARD and SHGs, NGOs and from official documents. Around 65% members in NABARD supported SHGs were found to be landless. In the case of SGSY supported SHGs, about 82% members were found to be landless who met the general criterion of being below the poverty line (BPL). Above 14% members in NABARD supported SHGs and about 9% members in SGSY supported SHGs were found to be matriculates. In the case of NABARD SHGs, about 58% women members were capable of reading and writing as against 67% male members. The study found that a little less than half of NABARD supported SHGs (5 out of 12) and two-thirds of the SGSY supported SHGs (12 out of 18) held less than 48 meetings in a year, which was very few. On the whole, NABARD supported SHGs appeared to be a little better than SGSY supported SHGs in this respect. The situation was not that good in the case of SGSY SHGs in record keeping, and the records available with them varied between 86% to 100%. There were 115 SHGs which did not have one or the other three main registers. However, all the registers which they kept were being maintained by SHG members themselves. Bank linkage was relatively quicker in the case of NABARD supported SHGs than SGSY supported SHGs. It was found that the highest number of SHGs, i.e. 139 (29.57%) in the case of SGSY SHGs, got bank linkage after 18 months of their formation. Men dominated SHGs were able to

establish contacts with bank officials earlier than women only SHGs. The study revealed that 19.83% NABARD supported SHGs and SGSY supported SHGs were such in which inter-loan repayment was completely stopped by all the members who received the loans. There were at least 136 out of 291 SHGs (46%) in which all the members were regular in making loan payments. There were a few SHGs in the NABARD group which got their CCL (Cash Credit Limit) sanctioned within 7-10 days, whereas a few others got their CCL sanctioned after 2 months of the application being made. In the SGSY supported SHGs a greater number of SHGs had not started income generating activities after having received bank loans after CCL was sanctioned, whereas in the case of NABARD supported SHGs, almost all the CCL sanctioned SHGs might have started income generating activities. There is need to expose and be sensitive to the field realities and capacity building issues of SHGs. Also, SHGs should be monitored more rigorously to ensure regular and timely savings and contribution, regular holding of SHG meetings, and members' attendence in them.

Key Words : 1.WOMEN WELFARE 2.SELF HELP GROUPS 3.NABARD ASSISTED SELF HELP GROUPS 4.SGSY ASSISTED SELF HELP GROUPS 5.SHGS 6.HARYANA 7.RAJASTHAN 8.UTTAR PRADESH.

34. Dave, Parul et al. (2005).
Mental health and aging : focus on women with depression. Vadodara : M.S. Univ., Women's Studies and Research Centre.181 p.

Abstract : Depression is one of the most common mental disorders that can affect anyone regardless of age, race, class or gender. Depression in older women may be more complex due to the difficulty in recognizing depression and their double disadvantage of being women and elderly persons. The present study examined the prevalence of depression and other mental health disorders by assessing the records of psychiatric units of all the major private and public hospitals and private practitioners in six major cities of Gujarat, namely Vadodara, Ahmedabad, Bhavnagar, Rajkot, Jamnagar and Surat. It also assessed the nutritional, psycho-social and cultural aspects of the population. 24 hour dietary recall method was used to assess nutritional intake, and anthropometric measurements were used to assess nutritional status. Women above 40 years of age who had a moderate degree of depression, were interviewed. The number of men who availed mental health services was higher than that of women, both retrospectively (56% men; 44% women) and prospectively (54.5% men; 44% women), except for the prospective data in Jamnagar, where the number of women was slightly higher than that of men. The most prevalent disorders were depression (50%), schizophrenia (60%), bipolar

disorder and anxiety disorders (0.8%). The cases of depression were high in Surat (retrospective (32.2%; prospective 34.3%), Ahmedabad (retrospective 30.6%; prospective 25.3%), Vadodara (22.5%), Bhavnagar (22.2%) and Rajkot (21.5%). In Bhavnagar, the percentage of depression was 27.3% in retrospective data and 17% in prospective data. In Rajkot, depression was 29% prospective data and 13.9% in retrospective data. Depression was highest in the age group 61-75 years (33.4%), followed by the age group 41-60 years (31%). Menopausal and associated changes explain the higher prevalence of depression in women in the age group of 41-60 years. Across the six major cities, schizophrenia ranked first among all mental disorders - in Vadodara (retrospective 34.1%; prospective 30.7%) and Jamnagar (retrospective and prospective 19.1% each. The study found that depressed women had a history of alchohol dependence. Only 4.62% had minimal depression, 11.29% women had mild depression, and 18.18% women had severe depression. Least nutrient intake was seen among low income women above 60 years of age. Further, younger depressed women from the middle income group showed a higher significant difference ($p \leq 0.05$) and better nutrient intake with respect to energy, iron, folic acid and amino acids compared to older depressed women of the same income group. Findings also revealed significant difference ($p \leq 0.05$) with poor intake of folic acid, selenium, vitamin B6 and B12. The study also revealed that the prevalence of major health problems was higher in middle income women. Locomotor problems ranked first (52%) in all the income groups, followed by oral cavity problems (43.3%) and cardiovascular problems (31%) in middle income women above 60 years of age. Nearly 33% depressed high income women aged 40-60 years reported respiratory and gastrointestinal (23.3%) problems. Over half the women with depression in the 40-60 years age group, from both low and middle income groups, were still menstruating, while 60% of their counterparts in the high income group were not menstruating. Complaints like ‘backache’, change in vision, pain in joints and limbs, slight memory loss and dizziness were reported mainly by women above 60 years of age which could be associated with ageing. The most commonly reported psychological symptoms reported by 60-80 of the depressed women were ‘feeling tired’, ‘irritation’ and ‘depression’, ‘loss of interest in most things’, ‘isolation’, and ‘nervousness’, which were reported by half the women. The study concluded that depression is not a disease but a serious illness with biological, psychological and social aspects relevant to its cause, symptoms and treatment. The study recommended that research is needed in the use of herbal medicines for the treatment of depression that could show pronounced benefit in improving the health status.

Key Words : 1.WOMEN WELFARE 2.MENTAL HEALTH 3.WOMEN'S HEALTH 4.DEPRESSION 5.WOMEN'S MENTAL HEALTH 6.AGED WOMEN 7.STRESS 8.LIST OF HOSPITALS VADODARA 9.LIST OF DOCTORS VADODARA 10.VADODARA 11.GUJARAT.

35. Nanavati, Arti. (2004).
A Situational analysis of women and girls in Gujarat. New Delhi : National Commission for Women. 391 p.

Abstract : The situation of women in Gujarat presents a paradox, as the state is far advanced economically, but the status of women is still low. The present study indicated the situation of women in Gujarat on health and nutrition indicators, and also studied the judicial system and legal rights accorded to women. Data was collected through survey from 25 districts. The sex ratio (female per 1000 males) was 955 in rural Gujarat, 935 in urban areas, and 947 for the state as a whole. The sex ratio reversed in favour of females after the age group of 50-54 years. The young dependency ratio was found to be 54% for the state, which was slightly higher in rural areas (60%) than urban areas. The total dependency ratio was as high as 67%, and was 74% in rural areas, and 59% in urban areas. 54% females were currently married and 35% have never been married. The percentage of never married was higher for males (45%) than females (35%). The incidence of child marriage at ages younger than 15 years has reduced substantially. Maternal mortality was found to be 437 deaths per 1,00,000 live births, during 1992-93 (NFHS-1) which appears to have increased to 540 deaths per 1,00,000 live births during 1998-99, as per the recent NFHS-2 estimate. The proportion of widows among women aged 6 years and above is slightly more than 9%. Women who availed any antenatal care increased from 79% among illiterate women to as high as 99% among women who have high school education and above. The level of infant and child mortality rate sharply declined with increasing education of women, and ranged from a high of 77 infant deaths per 1000 live births for illiterate women to a low of 35 per 1000 for women with at least high school education. Similarly, the risk of children under age five dying before their fifth birthday was found to be highest (117 per 1000 live births) among illiterate mothers as against a low U5MR of 38 among those mothers who had at least high school education. Female literacy rate increased from 48.9% in 1991 to 58.6% in 2001. Gender differences in literacy levels in Gujarat are 22% in favour of males. Gujarat ranks 15th in term of male literacy and 21st in female literacy among all states and union territories of the country. The lower enrolment and retention rate of girls, especially those belonging to scheduled castes and scheduled tribes, in the formal education system has a bearing on their economic status, independence and empowerment. Property inheritance is male oriented and women rarely own or inherit houses. Most women, irrespective of their age, education, class or employment, perform a variety of chores to maintain a household, with no or very little assistance from family members or paid help. According to 2001 Census, (provisional) women's work participation rate (WPR) in Gujarat was 28%. However, this does not reveal the entire picture, as the

household work done by women is not fully enumerated. Women from minority and other disadvantaged groups experience more violence compared to the other groups, though all women are equally vulnerable to violence. The media in Gujarat, be it the press, cinema, television or radio, has by and large, remained conservative and tradition bound, and portrays women in stereo typed and retrogressive roles. Gujarat has initiated innovative programmes such as 'Mahila Samakhya' and introduced policies like free education for girls at all levels, and 30% reservation for women in all state government services. Benefits of most of the development and welfare schemes are available only to women between the age of 18 and 60 years and to widows who do not have a son, thus reinforcing the patriarchal attitude. The study recommended that there is a need for multi-disciplinary research, encompassing different facets of women's lives. More research is needed to assess the quality of life of women, the efficacy of services and programmes and policy formation. Both macro and micro level studies, with focus on gender, would help in understanding the needs of women. Coordinated research, documentation and dissemination of research findings should be the responsibility of academic institutions. This may be made possible by establishing a network of interested academic and research institutions.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN GUJARAT 3.SITUATION OF WOMEN 4.DEMOGRAPHIC PROFILE OF GUJARAT 5.EDUCATION WOMEN 6.FAMILY WELFARE 7.WOMEN LABOUR 8.CRIME AGAINST WOMEN 9.PROGRAMMES OF DEPARTMENT OF SOCIAL WELFARE 10.POLITICAL EMPOWERMENT 11.EMPOWERMENT WOMEN 12.GUJARAT.

36. National Commission for Women, New Delhi. (2006).
Night shift for women : growth and opportunities : a research study. New Delhi : NCW. 64 p.

Abstract : Women are the backbone of any economy and shape the future of the country. Night shifts have been in existence for a long time; and employment of women by top employers increases their productivity, quality and international competitiveness. The present study was carried out to study the role of women in the present economic and business environment in India. The sample consisted of 272 participants, including 216 women doing night shift work at least for the past 6 months, 56 employers and supervisors, and various key persons of leading organizations like universities, police authorities, law enforcing agencies, hospitals, industrialists, etc. The age of participants ranged from 20 to 50 years; and they were randomly chosen from different BPOs, hospitals, textiles, garments and leather units from 9 different cities. Findings revealed that 28.9%

women employees felt insecure in night shift work, the rest 71.1% did not feel insecure. Bangalore and Ludhiana were found to be highly insecure zones, where 44% and 45% women felt insecure. 83% of the population was satisfied with duration of night shift work. 13% of the respondents faced difficulties during commuting, while 87% were satisfied with the arrangements made by their employers. Commuting problems were faced more by women of Kolkata (18%), Mumbai (17%) and Pune (17%). Only 8.6% respondents were satisfied and got child care facilities within company premises. In metropolitan cities, percentage of nuclear families working in night shifts is higher (24%) than in other cities like Ludhiana (13%), Pune (14%), Hyderabad (14%) and Chennai (14%), and in Delhi and Mumbai the percentage of nuclear families was found to be higher. 13.3% of women employees faced many problems resulting in mental tension, if they had to work night shifts. This response came in mainly from workers in textile and leather industry units. Mental harassment was more in Ludhiana (27%), Kolkata (19%), Pune (17%) and Delhi (14%), whereas it was less in Mumbai (9%), Hyderabad (8%) Chennai (7%) and Bangalore (6%). Majority of the employees (96.2%) were satisfied with the number of women employees working in one shift at a time. About 13.5% night shift working women faced social problems. There was no in-house training on self-defence, security, safety and health related issues in Ludhiana and Pune. In Chennai, Kolkata, Hyderabad and Bangalore only 2% respondents, and in Mumbai only 5% respondents received in-house training. Insecurity was more in leather (45%) and textiles units (34%), in hospitals (14%) and least in BPOs (only 8%). The level of satisfaction was 84% in BPOs, 78% in leather units and 75% in textile industry units. Less commuting problems were faced by BPOs (4%) and hospital employees (6%). Insecurity was high in small scale firms (45%), but lower in medium scale firms (26.4%) and large scale firms (13%). 96% employees in large scale firms, 84.7% employees in medium scale firms and 76.3% employees of small scale firms reported the duration of night shifts to be appropriate. Insecurity was observed to be high among low skilled women (34%), 8% among highly skilled women, and 29% among moderately skilled women. 93.1% highly skilled women were satisfied with their employers as compared to their low skilled counterparts (78%). Low skilled women also tend to feel maximum mental harassment (18.9%), and it was least among highly skilled workers (4.5%). 95.7% of the employers perceived the environment to be safe for female employees unlike 28.9% of the employees who felt insecure while working in night shifts. There was a consensus among employers (85.4%) and employees (83%) that the length of night shifts was satisfactory. 93.6% of the employers felt that commuting facilities being provided to their women employees at night were satisfactory, but only 87% of the employees agreed. 23.4% of the employers felt that the child care facilities provided, in-house training and pay packages provided were adequate. The study recommended that night shift work for women should be facilitated. The Factories Act should be amended to allow women workers in night shifts. This is a progressive step and women should be

safe during night shifts. If the rules and conditions regarding women working in night shifts are strictly enforced, this could be a success story and bring economic prosperity to the nation.

Key Words : 1.WOMEN WELFARE 2.WORKING WOMEN 3.NIGHT SHIFT 4.CALL CENTRE 5.BUSINESS PROCESS OUTSOURCING 6.DOCTORS 8.NURSES 9.NIGHT WORK WOMEN 10.NIGHT WORK.

37. National Commission for Women, New Delhi. (2007).
Working condition of women in call centres : issues and remedies. New Delhi : NCW. 60 p.

Abstract : The growth of employment in call centres has been phenomenal in the recent past and a large number of women are employed in call centres. The protection and safety issues of women employees require immediate attention. The present study was carried out to assess what measures could provide a safe and secure working environment to women working in call centres. India has the second highest growth rate of call centres at 86%, next only to Philippines where the growth is a staggering 100% according to 2003 statistics. According to NASSOM the number of people employed in call centres is expected to touch 1.2 million by 2007. The industry employs around 40,000 women in Haryana alone. It was found that Mumbai based business process out sourcing (BPO) Company Trace Mail employs 2,000 people at its Navi Mumbai Office. Roughly 45% of them are women who work 8.5 hour shifts, attending calls from clients across the world. About 45 to 50% women are in non-technical jobs and about 25-30% women handle technical functions. AT INFOWAVZ International, another BPO company, 33% of its 800 employees are women. The number of female employees had shown a 10% increase from 25% to the current 35%. The women employees in 24x7, a customer care company based in Bangalore, has also increased from 25% to 40% in the last two years. ICICI located at Mumbai's Bandra – Kurla complex, employs 2,400 people, of whom over 60% are women in the age group 22 to 27 years. The average strength of female staff in India's $1.4 billion (Rs. 6,650 crore) call centre industry ranges between 30 and 60%. Software analysis of women employees in the information technology industry reveals that more women employees are visible at call centres in north and western India, while the trend is yet to catch on in the South, except for Bangalore. The number of women employed at the agent level and the middle management level was high. While women seem to predominate customer support services, few women are to be found at the department head level. Sleeping disorders were observed among 83% women and voice loss was reported by 8.5% women. Other health problems found were ear problems

(8.5%), digestive disorders (14.9%) and eye-sight problems (10.6%). Call centre employees were under constant stress because of their workload, competitive pressure and surveillance. Workers are monitored for the number of calls, the average call time and the time between calls. Night shift work has also been cited as one of the major reasons for women leaving their jobs along with high stress levels and long working hours. Public transport service facilities during night hours are minimal, and normally call centre employees are provided company contract transport that allows them to travel to and from their work place. Safety of the transportation provided by employers is an emerging concern. National legislations that exist today do address the issue of women working in night shifts and to an extent protection is also provided. However, keeping in view the peculiar nature of call centre work, which is invariably at night, these protective provisions may not be useful. Working conditions, environment and policies across call centres vary to a large degree. There is no uniform legislation or guideline that enables their monitoring and supervision. The study recommended that no women should be denied employment in BPOs/ call centres on the ground that the employment entails working night shifts. Contrary clauses in various existing legislations should be suitably amended. Women workers should not be dismissed for reasons connected with pregnancy or child birth. Employers should ensure that adequate facilities are provided from the place of work to the nearest point of their residence. Call centres should also ensure that a security guard escorts women in official transport.

Key Words : 1.WOMEN WELFARE 2.WORKING WOMEN 3.CALL CENTRES 4.BUSINESS PROCESS OUTSOURCING 5.NIGHT WORK 6.NIGHT SHIFT 7.NIGHT WORK WOMEN.

38. Nongbri, Tiplut. (2006).
A Situational analysis of women and girls in Meghalaya. New Delhi : National Commission for Women. 127 p.

Abstract : Meghalaya is one of the seven sister states that comprises India's enchanted North East. The study raises pertinent questions, not only about the position of women and matrineal institutions, but also about the role of the state. In Meghalaya, women are actively engaged in productive activities. According to Census 2001, women's work participation rates are highest in rural South Garo Hills (45.3%), East Garo Hills (43.5%), West Khasi Hills (42.5%) and Ri-Bhoi (41.6%), and least in the urban areas of West Garo Hills (14.8%) and East Khasi Hills (19.9%). Among the matrineal tribes of Meghalaya, authority lies with the mother's brother and the father is not devoid of power. The Khasi family stands rather unique in the annals of history in the way in which authority within the

household is divided between the dominant males belonging to both sides of the family. In a Khasi family, the youngest daughter inherits the bulk of the family property, along with the ancestral home and other heirlooms. The position of women among the Garos appears to be even harsher although like the Khasis, descent and inheritance among Jaintias is matrilineal and residence is uxorilocal. Data on the enrollment of students in the age group of 11-14 years shows that the ratio of girls who are admitted into schools is higher than boys, but boys have greater chances of remaining in the education system whereas girls tend to drop out more readily. In the years 1998-99, 63.3% women and 67.8% children were reported to be anaemic, with 2.4% and 4.3% respectively, suffering from severe anaemia. Maternal mortality in Meghalaya was found to be high, 450 per 100,000 live births. According to NFHS 2 (1998-99), according to 29.9% mothers received no medical attendance at the time of child birth, 17.3% mothers received government approved doctors' attention, while 13% received other nurse/ midwife's attention, and 3.5% mothers received government approved nurse/ midwife's attention. In 1998-99, 17.5% deliveries took place in medical institutions. According to Human Development Report (2001) there were 42 rape cases, 12 molestation cases, 16 kidnapping and abduction cases, and 1 dowry death case registered in Meghalaya. A study conducted by Impulse NGO Network, a local NGO working with street children in Shillong, revealed that not only were some street children subjected to sexual exploitation, but also the fact that the North-East has become a transit point for trafficking of women and children. On the political front, women's participation in political bodies is critical for their development, and also necessary to fill the gap between promises made in the Constitution and policy measures, and the actual exercise. Evidence suggests that where women have access to education, sustainable income, health care facilities, and social and political rights, the quality of life is definitely better for all concerned. To achieve this, the state has to ensure greater efficiency of its administrative machinery and be more responsive to the material needs and the social and political rights of women. An integrated approach to women's health should be adopted that goes beyond the limited concern with women's reproductive and nurturing role to include some of the newly emerging diseases which afflict a large segment of women outside the reproductive age such as cancer, tuberculosis, diabetes and the threat of HIV/ AIDS.

Key Words : 1.WOMEN WELFARE 2.SITUATION OF WOMEN MEGHALAYA 3.SITUATION OF WOMEN 4.DOMESTIC VIOLENCE 5.FEMALE FOETICIDE 6.EDUCATION 7.LITERACY RATE 8.HEALTH AND FAMILY WELFARE 9.FAMILY COUNSELLING CENTRES 10.SELF HELP GROUPS 11.EMPOWERMENT OF WOMEN 12.CRIME AGAINST WOMEN 13.TRAFFICKING OF WOMEN AND GIRLS 14.TRAFFICKING MEGHALAYA 15.MEGHALAYA.

39. Society for Promotion of Art, Culture, Education and Environmental Excellence (SPACE), Gangtok, Sikkim. (2002).
Violence against women and domestic violence in Sikkim : a research study : final report. 71 p.

Abstract : Domestic violence is widely prevalent in Sikkim. The study was conducted by SPACE with the objective of gathering inputs from government and non-governmental representatives, media person and social workers, etc. Namchi, Geyzing, Gangtok and Mangan towns were selected for data collection. The main objective was to explore the causes of domestic violence (DV)/ violence against women (VAW) in the state of Sikkim. In Sikkim there were 42% men and 58% women. The tradition of dowry is in vogue in Sikkim, but its implications are not as severe as among the communities elsewhere in India, wherein daughters-in-law have to pay with their lives for their inability to satiate their in-laws desire for dowry. Only two cases of trafficking have been recorded so far. Victims of VAW and DV prefer to remain silent about their individual suffering since they believe that disclosing their woeful fate to others will only invite censure and ridicule instead of help from any quarter. Almost 98% of the respondents admitted, in varying degrees, that they were aware of one or the other kind of VAW and DV perpetrated in society. 50% respondents reported about wife battering by husbands under the effect of alchohol, or polygamous desire to bring home another wife, or jealousy and distrust, and so on. Almost 4.8% of the violence and battering was committed by in-laws mostly with the tacit approval of the victim's husband. Cases of adultery, murder, rape, incest, etc. are not unheard of in Sikkim. All the respondents were themselves victims of verbal abuse by their in-laws, husbands, offspring, and people in general, to varying degrees. Compared to the other districts, the extreme northern district revealed lesser degree of VAW and DV, which could be due to the traditionally built-in gender equation in the family and social system of the Northern Bhutias. Very few Christians were encountered during this research in the context of domestic violence. 82.2% of the respondents were Hindus, 15.6% Buddhists, while the Christians were only 2.3%. Here is another glaring example of the impact of the religious orientation. The traditional forms of VAW are non-existent among Christians although the other two types, psychological and physical violence against women, as well as domestic violence have been recorded. Tradition seems to play a big role in perpetuating violence against women. 34% of the reasons for VAW can be ascribed to obsolete traditional beliefs, closely followed by the impact of alchohol, which was approximately 27%. The effect of drugs and other intoxicants, the desire to assert control on the wife, and habitual compulsions, etc. are other preponderant causes of VAW. With regard to awareness about human rights and the legal provisions to safeguard their interests, 86% of the women of Sikkim were ignorant, 9.80% were aware to some extent, while 4.6% of them were content with information gathered from hearsay.

Among the small percentage of women who were aware of the law, more than 20% believed that the legal provisions were not implemented, while the rest were ignorant about the implementation process and the procedures involved in demanding legal protection and justice. Majority of the women of Sikkim (48%) are economically dependant on their parents, brothers, etc. and 39% on their husbands. Those who are economically independent are only 13%. More than 63% of the people were unaware of the existence of rehabilitation and counselling centres run by the state or NGOs. It was recommended that an integrated approach should be adopted to deal with the problems of VAW or DV by incorporating value orientation within the matrix of awareness raising programmes. Workshops should be organized to discuss the efficacy of value orientation methods as long term strategies to curb violence against women. Awareness should be increased of human values to sublimate the baser tendencies and indulgences of people, and help in nurturing mutual understanding and love.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE 3.DOMESTIC VIOLENCE SIKKIM 4.VIOLENCE AGAINST WOMEN 5.CASE STUDIES 6.GENDER DISCRIMINATION 7.ATROCITIES ON WOMEN 8.NORTH EAST WOMEN 9.SIKKIM.

40. Sunny, Celine, et al. (2005).
A Situational analysis of domestic violence against women in Kerala. Kalamassery, Kerala : Rajagiri College of Social Sciences, Research Institute. 213 p.

Abstract : Women in India are subject to violence not only from husbands but also from members of both, the natal and marital home. This study was carried out to assess the incidence of domestic violence against women in Kerala. Survey of the registered/ recorded cases of domestic violence was done to enlist 100 victimized women from each district. A total of 1540 respondents (1400 respondents + 140 key persons) were covered under the study. Information was also collected from teachers, elderly persons, religious persons, representatives of SHGs and panchayati raj institutions (PRI) members. Almost 80% of the victims of domestic violence (DV) were between 20-40 years of age. Data showed that DV was more against women who were adults or middle aged. 68% of the respondents had only secondary/ higher secondary school education. Illiterates constituted 4.9% of the sample, and 8.9% and 3.1% were graduates or post graduates respectively. 75.4% of the husbands of respondents were alcoholics. 15.2% mentioned that their husbands were drug addicts. 13.6% victims were attacked by their in-laws. 30% of the respondents were

psychologically hurt by their in-laws. Extra marital affairs and dowry were reported by 12.1% and 10.2% victims respectively. Kottayam district had comparatively a higher number of victims (48%) who mentioned financial constraints as the leading cause of DV. Lack of property, dowry and property disputes were stated by 6.8%, 5.9% and 5.3% of the victims respectively. Sexual maladjustment was reported by 7.9% of the victims. A total of 81.6% of the victims had suffered physical violence. 21% stated hitting and kicking as the frequent manifestations of DV. 17.1% had to bear physical brutality daily. Beating was experienced daily, frequently and occasionally by 14.2%, 42.7% and 31.7% of the victims respectively. Hitting, kicking, slapping, threatening using weapons, and forced sex was experienced on a daily basis by 40.9%, 25.1%, 7.7%, 1.3% and 2.6% women respectively. Infliction of physical violence on a daily basis was comparatively higher in the districts of Idukki and Alappuzha, with 23.1% and 38.6% women stating demeaning as the most common mode of hurting them. 28% and 15.9% victims mentioned threatening and threat of abandoning them as the commonest mode of psychological torture. Demeaning as a manifestation of psychological violence was occurring greatly (more than 50% each) in the districts of Kannur and Palakkad. Threatening was comparatively higher in the districts of Kozhikode (48%) and Pathanamthitta (47%). Infidelity was found to be 35% and 34% in Kasargod and Ernakulam districts. 40.4% and 20.1% victims had to suffer psychological strain on frequent and occasional basis. 74.6% of the respondents were physically injured by the attacks on them, and of them 26.7% and 31.7% respectively were very seriously and seriously injured. 46% of the victims were denied one meal; two meals were denied to 16.1% victims. 98% of the victims had experienced mental depression due to domestic violence. 40.9% victims reacted to domestic violence by going to their parents' home. 35% of the victims always thought of ending their lives. With the prevailing status of domestic violence against women in Kerala, it was recommended that Domestic Violence Bill should be passed by Parliament at the earliest. The laws regarding drug addiction and dowry should be strictly enforced to reduce the occurrence of domestic violence. Measures should be taken to deal severely with alcoholics who perpetuate domestic violence. All police stations should be equipped with special aid cells to provide assistance to victims of domestic violence.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE 3.VIOLENCE AGAINST WOMEN 4.SITUATION OF WOMEN 5.SITUATIONAL ANALYSIS OF WOMEN 6.CAUSES OF DOMESTIC VIOLENCE 7.CASE STUDIES 8.KERALA.

Acknowledgement

Guidance & Support : **Dr. Dinesh Paul**

Dr. Sulochana Vasudevan

Compilation & Abstracts : **Meenakshi Sood**

Punita Mathur

Dr. Anindita Shukla

Abhilasha Mishra

Purnima Thakur

Computer Support : **Pawan Kumar**

Ashok Mahato

Sundara Prabha