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Contents

Research Studies on Women and Children

CHILD LABOUR

1. International Labour Organization, New Delhi. (2009).
Childhood restored : stories of success and hope. New Delhi : ILO. 162 p.

Abstract : The INDUS Child Labour Project was launched in 2004 in 21 districts across 5 states, namely Tamil Nadu (5), Maharashtra (5), Madhya Pradesh (5), Uttar Pradesh (5) and Delhi (1). All the districts had concentrations of children employed in hazardous industries and the aim was to get them out of hazardous work into schools and vocational training centres, and create an enabling environment for the elimination of child labour. In 2007, the ILO-IPEC-INDUS Child Labour Project had run for 4 years. As per Census 2001, there were 12.6 million child workers in India, and attempts are on to eliminate child labour in 250 districts of India. PARYAY and Bal Vikas Academy conducted a survey for the INDUS Project in June-July 2004 to identify child labourers and the trades they were involved in. 6639 boys and 2599 girls were employed, total being 9238. In Virudhunagar in TN, children were involved in matchstick and fireworks industries but now child labour has been reduced. Entire villages have been declared free from child labour by panchayats and the local administration. The district administration has launched one of the best social awareness programmes; organized one to one meetings with parents, religious leaders, and small group meetings with self help groups (SHGs) and youth; organized massive awareness raising campaigns and a host of imaginative events. One of the effective programmes at social mobilisation has been the *nila palli* which in Tamil means 'moon school'. In this a crowd watches the talents of children who have started going to school, and children of all castes mix freely. SR Government Higher Secondary School at Jhiruthangal is a leading school; it has 3096 children from Classes 6-12, and of these 199 children are from INDUS run TECs. Here, story telling and play way methods are used for teaching. Life skills training helps former child labourers, they are given help with their homework, and remedial classes are organized after school hours. Eye check ups were done for school students after which eye drops and spectacles were given. Some children who preferred to stay back at home were counselled and encouraged to go for remedial classes. A residential school in Kundhalapatti village of Virudhunagar taluk was set up in 2007 under Sarva Shiksha Abhiyan, which had 35 children. It took care of the needs of children, giving them shelter, two meals, lessons in Maths, English, Tamil and Social Studies and the opportunity to make friends

and feel at home. In Amravati, a district of Vidarbha region of Maharashtra, child labour from nomadic tribes like Pardhi and Dombari were found in urban and semi urban areas, and their children worked as domestic servants, rag pickers, at construction sites, canteens, hotels, in fields, brick kilns and stone quarries. Government, non–Government and semi–Government organisations, social organisations and sensitive citizens and their forums worked collaboratively with INDUS team. The Zilla Parishad helped children in getting admission, gave books and provided the mid day meal. Trained TEC teachers simplified the content in text books to help the children learn. Women and Child Welfare District Committee opened its hostels to children who needed shelter. The Municipal Corporation provided children with free medical treatment. 5% of funds were available to Women and Child Welfare Department for eradication of child labour. The Maharashtra Centre for Entrepreneurship Development (MCED) provided vocational training to 1000 children in the age group 14-17 yrs, and ensured that they got a job or became self employed. In Amravati, child labour families felt that youngsters should earn a decent livelihood once their studies were over, which was a pull factor for greater enrollment in schools and retention of the children. These children prepared chalks, candles, wax lamps, jewellery, jute doormats, origami, clay items, festive lanterns, *agarbatti/ dhoop* (incense) sticks, screen and fabric painting, prepared rakhis, festive lanterns, greeting cards, envelopes, etc. Under INDUS project, children get a stipend of Rs 100. Work education provided in TECs is continued in lead schools. Children learn time management, decision making, self development, build confidence, learn meditation and life skills like control of mosquito breeding, purifying water, first aid, bank transactions, etc. By 2007, in Amravati district, total 1000 child labourers were trained, 662 were employed after training, 239 were self employed, and 99 were retrained. Presently, youngsters were given the freedom to choose the trade of his/ her liking, course timings were flexible, and marketing skills were taught to build confidence and generate self esteem. In Aurangabad, TEC teachers and volunteers went to invite children to the centre to ensure decent attendance. Bal Panchayat was organized for a group of girls and boys which took care of their health and hygiene needs. Children used to misuse pocket money for *gutka* (tobacco laced mouth freshener) or gambling, but they were counselled by teachers who taught them to deposit money in banks for safekeeping. So the idea of Bachat Bank (Savings Bank) was mooted. About 128 children attended courses that included dress making, jute goods manufacture, soyabean products and candle making. The Maharashtra Centre for Entrepreneurship Development (MCED) and the Child and Police Foundation Teen Channel (CAP Teen Channel) from Hyderabad offered training in tailoring (131), beauty parlour skills (311), information technology services (43 females and 55 males for computer education), customer relation (119), hospitality (86), and IT services (146). In Namakkal, Women's Development Corporation helped in formation of SHGs of mothers of rescued child labourers for promoting income generation activities. 44

SHGs were formed, 49 families got Rs 98,000 from a fund, Backward Welfare Department provided free accommodation in Government hostels for TEC children, Central Board for Worker's Education Department organized 19 training programmes for TEC children and 7 training programmes for TEC children's parents, NGOs and Rotary Club Welfare Department provided free materials like plates, glasses and mats for TEC children, and Rotary Club organized games, variety events, and five arts programmes. Collaborative efforts resulted in increased awareness about child labour.

Key Words : 1.CHILD LABOUR 2.REHABILITATION 3.REHABILITATION CHILD LABOUR 4.GOOD PRACTICES 5.MAINSTREAMING CHILD LABOUR 6.INDUS PROJECT 7.EDUCATION CHILD LABOUR 8.PARTICIPATION OF CHILDREN 9.VOCATIONAL TRAINING.

DESTITUTE CHILD

2. Anandraj, Hannah. (2000).
Children of female sex workers of Vijayawada, Andhra Pradesh - a statistical profile. Hyderabad : Roda Mistry College of Social Work and Research Centre. 4 p.

Abstract : The present study focused on the children of female commercial sex workers (FSWs) of Vijayawada, Andhra Pradesh, and brought out their profile as seen through a few select personal, familial and social variables. The study comprised 312 children. It was observed that majority of the children (170) belonged to the 6-12 years age group. The adolescent age group registered a steep decline. It was found that there were more girls in red light areas than boys. This trend was shocking for it indicated that more adolescent girls were bought /brought into these areas. Many of the respondents were educated. Major religions like Hinduism, Islam and Christianity were represented among the respondents. Majority of the children belonged to Hindu religion, only 36 children were working as child labour, and the rest of them were not working. Many children (181) were found to possess only a moderate level of vocational aspirations. Many respondents (151) showed moderate level of behaviour problems. Observation of familial variables revealed that 43.9% children were from small families, 52.9% children had educated members in the family, 46.9% children belonged to families having medium income which was found to be Rs. 1047.60 monthly. Majority of the children were brought up by both parents, and those who were brought up by a substitute mother were very few. Those who

had a moderate level of relationship with the mother were almost double the polar groups of those who were distant or closest to the mother. Mothers were mostly ignorant of the types, methods of prevention or treatment of STDs/HIV. With respect to mothers' aspirations for their children, those who had no aspirations ranged highest (135), followed closely by those with high aspirations (117) of making something out of their fledglings. It was found that more mothers (161) preferred educational facilities while fewer mothers (94) wanted monetary aid. It was observed that a majority of the children belonged to backward castes (243). Those with moderate peer influence (120) were found to be the highest in number, followed closely by those with low or high peer influence. Those who watched movies or TV moderately formed the largest group. It was recommended that education should be imparted to children by the Government and voluntary agencies to enlightenment their minds and further their growth opportunities.

Key Words : 1.DESTITUTE CHILD 2.CHILDREN OF PROSTITUTES.

3. Bureau of Police Research and Development, New Delhi. (2009). Child abuse : an overview. New Delhi : BPRD. 10 p.

Abstract : Around 40 million children under the age of 14 years are estimated to suffer from abuse and neglect around the world. The prevalence of child abuse is showing an increasing trend in India. India has a large child population and many children are vulnerable to abuse, exploitation and neglect. The present study assessed the inter-connected factors associated with child abuse to develop a comprehensive understanding of the phenomenon; evaluated the magnitude and forms of child abuse; aimed to sensitize the public about the serious danger of prevalence of child abuse, especially child sexual abuse in society; assessed the existing legal framework to deal with the problem; and attempted to draw inferences from a national study titled "Study on Child Abuse : India 2007" undertaken by Prayas Institute of Juvenile Justice. The survey was carried out across 13 states and covered a sample size of 12,447 children. It was observed that there were many definitions of child abuse but the originally used definition "Acts or omissions by a care giver leading to actual or potential damage to health and development, and exposure to unnecessary suffering to the child" was quite appropriate. It was found that younger children, 5-12 years of age, reported higher level of abuse. Boys, as compared to girls, were equally at risk of abuse, and persons in trust and authority were major abusers. 70% of the abused child respondents never reported the matter to anyone. It was observed that two out of every three children were physically abused. Out of

69% children who were physically abused in 13 sample states, 54.68% were boys. It was found that over 50% children in all the 13 sample states were being subjected to one on the other form of physical abuse, 88.6% were physically abused by parents, 65% school going children reported facing corporal punishment, and 50.2% children worked 7 days a week. 53.22% children reported that they faced one or more forms of sexual abuse, and 21.9% children reported facing severe forms of sexual abuse. Children in Assam, Andhra Pradesh, Bihar and Delhi reported the highest incidence of sexual assault. In 83% cases parents were the abusers and 48.4% girls wished they were boys. The study on child sexual abuse conducted among 2211 students (847 boys and 1364 girls) from schools in Chennai Corporation zone revealed that 939 children had faced at least one form of sexual abuse at some point of time, and 48% of the boys had been abused. The forms of sexual abuse prevalent were touching children's private parts (603), exhibitionism (384), forcing or tricking children to watch pornography (371), making children touch the offender's private parts (226), made to remove clothes (83), oral sex (131), and sexual intercourse (81). From the above it was concluded that sexual abuse is one of the most fundamental violations of children's rights, and was usually an underlying obstacle to their overall development. It was recommended that the present National Policy on Children, 1974 needed to be revised, and a mechanism created which may include child care and protection at village, block, district and state levels. This mechanism may involve parents, elected representatives of urban and rural local bodies, teachers, anganwadi workers, medical practitioners, police and social workers, and responsible members of the public among others. Media should be used to spread awareness on child rights. School teachers need to be trained to handle misbehaving students through guidance and counselling. Stringent laws should be enacted to completely curb child abuse and sex tourism in the country.

Key Words : 1.DESTITUTE CHILD 2.CHILD ABUSE 3.CORPORAL PUNISHMENT 4.SEXUAL ABUSE 5.DEFINITIONS OF CHILD ABUSE 6.CHILD SEXUAL ABUSE 7.SEXUAL HARASSMENT.

4. Manoharan, Arlene. (2002).
A Critique of the Juvenile Justice Act 2000 in the context of the adoption issue. New Delhi : Voluntary Health Association of India. 4 p.

Abstract : Adoption is dealt with under Section 41 of the Juvenile Justice Act 2000 (JJ Act), which outlines provisions for the social integration and rehabilitation of children coming under the Act. The present study covered

positive features of adoption under JJ Act 2000 and limitations of the JJ Act. It was observed that JJ Act empowers the Child Welfare Board (CWB) to give a child in adoption and requires the child's consent before adoption, when the child is able to understand and express his/her consent. JJ Act was silent on the issue of grandchildren. The Act was silent on the question of religion, which implied that persons of any religion can adopt a child of any religion. However, a closer look at the legalities may reveal limitations in this regard. It was revealed that in JJ Act 2000 there was no definition of adoption. There was no clarity as to whether there is a possibility of re-adoption of an adopted child if he/she is once again abandoned or orphaned, or whether the first adoption itself is irrevocable. Inter-country adoptions also came under the purview of the Guardians and Wards Act and hence no placement is possible under the JJ Act 2000. Another limitation was to recognize all children's homes and state government institutions for orphans as adoption agencies. It was recommended that the provisions for adoption under the JJ Act 2000 would need to be challenged. The Act fails to provide the much needed secular, child rights centric, gender just and enabling options that is the need of the hour. The immediate solution would be to push for an enabling legislation such as Special Adoption Act. Though this process would undoubtedly take time, it is not in the interest of children, prospective adoptive parents or genuine adoption agencies to push unresolved adoption issues through back door legislation such as JJ Act 2000. Moreover, this hegemonic approach itself needs to be challenged so that democratic, people oriented processes ultimately take precedence over the hasty political manipulations of those who have drafted and enacted this legislation without adequate basic policy clarity.

Key Words : 1.DESTITUTE CHILD 2.ADOPTION 3.JUVENILE JUSTICE ACT.

5. More, Chidvilas et al. (2006).
Micro level initiatives by NGOs working for marginalized groups in Pune city. Pune : Karve Institute of Social Service. 45 p.

Abstract : At the time of Independence in 1947, India inherited an educational system that was small in size and characterized by acute gender and regional disparities along with structural imbalances. Only 14% of the population was literate and only one child out of three had been enrolled in primary school. The Government of India acceded to the UN Convention on the Rights of the Child in 1992. Rights enumerated in the UN Convention include the Right to Education as one of the important components of the Right to Development. Extreme poverty and social deprivation keep the children of marginalized communities away from

educational opportunities. This study was carried out in Pune and covered 3 marginalized groups of children, namely children of brick kiln workers, street children and the children of commercial sex workers. Most of the brick kiln workers were marginal farmers who depend on agriculture for a living, but were forced to earn a livelihood elsewhere due to droughts and lack of finance to develop irrigation systems. The study also focused on the children of Rajasthani potters and Kannadiga construction labourers. In Pune, 5,500 sex workers reside in the district in 450 brothels (Apte et al, 2004). Parents agreed that they did not want their children to continue with the same occupation, and that their children need education to have a good job in future. India Sponsorship Committee (ISC) and Eklavya Bal Shikshan and Arogya Nyas (EBSAN) children came to the support classes after attending school, and they played different games, did their homework, got food, went through class notes, etc. Teachers were the main agents who were in direct contact with parents, children and NGO officials, and the ones on whom these NGOs actually relied to contribute to social change. Training sessions of teachers include understanding child psychology. Pune Municipal Corporation (PMC) schools play a vital role in providing education to a majority of the disadvantaged children. Initiatives are running of a night shelter cum school for children who live on railway platforms and providing basic education for 2 hours a day. Statistics showed that 1.63% of children in the school going age group were still out of school in Pune city. Key lessons that can be learned from the NGOs are convincing parents of the value and importance of education; education should be flexible and child centered; there is need for a uniform qualitative educational system to build the children's confidence and address issues in a loving and patient way to bring about change; NGOs need to cooperate with each other; and funds and other resources should preferably come from within the community. Social and language barriers that keep away the children of these marginalized groups from mainstream education should be removed. The importance and need of teachers and volunteers in giving educational assistance to these children should be recognized.

Key Words : 1.DESTITUTE CHILD 2.CHILDREN IN DIFFICULT CIRCUMSTANCES 3.MIGRANT WORKERS CHILDREN 4.STREET CHILDREN 5.CHILDREN OF SEX WORKERS 6.BRICK KILN WORKERS 7.INCLUSION 8.MARGINALIZED CHILDREN 9.EDUCATION 10.OUT OF SCHOOL CHILDREN 11.SPONSORSHIP 12.RIGHT TO EDUCATION.

6. NIPCCD, New Delhi. (2008).
Evaluation of scheme of assistance to homes for children (shishu greh) to promote in-country adoption. New Delhi : NIPCCD. ~160 p.

Abstract : Adoption of a child has been practiced for centuries in India. From 647 in-country adoptions in 1992 to 1,707 in 2004, there has been an increase in adoptions in a period of 14 years. Thus India is obliged to have laws which permit the adoption of children. In response to certain irregularities coming to light, the Central Adoption Resources Agency (CARA) issued guidelines for in-country adoption in 2004, which provide a common framework for the procedure that needs to be undertaken by adoption homes and institutions for adoption petitions under Guardianship and Wards Act (1860) (GAWA), Hindu Adoption and Maintenance Act (1956) (HAMA), and Juvenile Justice Act (2006) (JJ Act), and encourage adoption of destitute and orphaned children within the country. In order to encourage voluntary organisations to take on responsibilities for providing care, protection, nurture to children and to find placement for them in families for ensuring their proper growth and development, it has been felt necessary to strengthen the existing scheme for setting up Homes (Shishu Grehs) for children in the age group of 0-6 years in the country, preferably in rural areas. The present study was conducted to evaluate the performance of the grantee Shishu Grehs; ascertain the contribution of various institutions for in-country adoption i.e. CARA recognized placement agencies (Shishu Grehs) supported under this scheme, other state adoption agencies, unregistered orphanages/ homes/ nursing homes, etc; find out the limitations of existing laws; assess the role played by the State Government in promoting adoption through agencies and compare the advantages of State Government – run Shishu Grehs with those run by NGOs; find out the extent to which the prescribed child care standards are being implemented in Shishu Grehs; study the procedures followed in Shishu Grehs; explore the potential of the scheme to promote adoption in districts and states; and assess the appropriateness of stipulations relating to the number of adoptions by implementing agencies under the scheme. Data was collected from 54 organisations, out of which 34 organisations were directly implementing the Shishu Greh Scheme, 7 were CARA recognized adoption agencies and 13 were state recognized adoption agencies. It was found that most of the Shishu Grehs were getting government grants, voluntary help and donations, whereas a higher number of CARA recognized organisations were getting voluntary help and donations. It was found that a fixed amount of Rs. 6 lakh was provided for maintaining a unit of 10 children. Adoption agencies, besides doing adoption work, were also managing a number of activities like shelter home for children, crèche services, health camps, non formal education,

vocational training, etc. About 81% adoptive families had total income ranging between Rs. 10,000 and Rs. 20,000 per month. Among these families, 71% prospective parents were staying in nuclear families and 89% prospective adoptive parents were Hindus. Data showed that the wife took initiative for adopting a child; 72% parents preferred to adopt a child with unknown background; 78% parents gave preference to a male child, and in 65% cases adoptive mothers had gynaecological problems. As far as improvement in the scheme was concerned, 26% functionaries wanted their salary to be enhanced, 23% felt that there should be timely release of grants, and procedures for obtaining grants should be simplified. Data showed that in the last 3 years, about 1363 children were received by these 34 organisations implementing the scheme as compared to 1104 children received by CARA recognized adoption agencies and 965 children received by state recognized agencies. Data showed that about 58% parents adopted the child in the age group 0-6 months which meant that most parents were adopting children through recognized agencies and not doing secret adoptions. 71% organisations had full time nurses in the home itself and had sufficient material for reading and writing. As far as supervision and monitoring were concerned, it was found that in 76% cases both physical and financial monitoring was done by District Social Welfare Officers. While implementing the scheme organisations faced problems like difficulty in finding orphans or destitute children. It was recommended that for effective implementation of the scheme, care should be taken regarding formulating of a uniform law for adoption, release of grants should be timely, and there should be no lack of budget for salaries of staff, etc.

Kew Words : 1.DESTITUTE CHILD 2.ADOPTION 3.SHISHU GREH SCHEME 4.ABANDONED CHILD 5.IN-COUNTRY ADOPTION 6.HOMES FOR ABANDONED CHILDREN

EDUCATION

7. Aggarwal, Y.P. and Chugh, Sunita. (2003).
Learning achievement of slum children in Delhi. New Delhi : National Institute of Educational Planning and Administration. 59 p.

Abstract : Basic education is a fundamental right and recently 86th Constitutional Amendment was enacted so that all children can receive good quality basic education. The main objective of the study was to identify the social, economic and organizational factors that are associated with education and achievement level of the learner in slums. The sample size was 30 schools (16 Govt. Schools

and 14 unrecognised schools) selected purposively from 6 slums in Delhi. Data was gathered from students by using various tools like Oral Achievement Tests for Grade 1 and Paper and Pencil Achievement Tests for Grade IV students to check their competencies in mathematics and languages (Hindi & English). Teachers were interviewed and students' profile and school schedule was scanned to elicite other relevant information. From previous studies it is known that economically backward people spend a large amount of money on their basic requirements, and education of their children becomes a second priority. 69% households had one family member working and only 24% households had 2 members working. In all, 40% families earned between Rs.1000-2000/- per month. Only 35% fathers had passed primary school and only 2% fathers had college education; whereas 65% mothers were illiterate and only 1.3% mothers had secondary education. In the sample 60.7% were boys and 39.3% were girls. 33% children got academic help from their family members, about 5% children were helped by their fathers, 23% by their mothers, 5% by their elder sibling, and 45% children were taking private tuitions. Text books and mid day meals have been provided to students in the Government schools to increase enrollment and retention in schools. Attendance and regularity of students was fairly good as 71% children had missed school for less than 10 days in an year, while only 3% had not attended school for more than 20 days in an year. Regularity of teachers was good as 75% children reported that teachers came to the classroom regularly and only 2% children said that most of the time teachers came late to class. 88% children reported that they were afraid of their teachers as they scolded and beat them. Around 72% children reported that they found maths to be the most difficult subject to comprehend. Out of 16 Government schools, 8 schools had pupil teacher ratio (PTR) in the range of 30 to 40, and only 3 schools had PTR between 70 to 80. Unrecognised schools had low teacher-pupil ratio and that could be one of the reasons for the better performance of these children in mathematics. The mean score for Grade-I competencies was 59.64% for mathematics and 55.65% for Hindi in Government. schools. However, for unrecognised schools the mean score for Grade-I competencies was 77.5% for mathematics & only 35.2% for language. Therefore, in Grade-I on the whole, mathematics competencies were better than language competencies. In Grade IV the average score in mathematics of students of Government schools was only 25%, while for unrecognised schools it was 40.1%. 41.6% students in Government schools attained scores above 30% in comprehension, whereas in unrecognised schools 42.6% students achieved scores above 30%. The goal of basic education is to give students the skills to communicate adequately, to solve basic mathematical problems and to apply this knowledge to every day situations. The performance of the slum children was much below the expected levels in both the subjects and in both the grades. Children of unrecognised schools have performed much better than children from Government schools in maths but not in language as most of the unrecognised schools have English

language as medium of instruction and probably these children could not get familiar with this language. Urban slum children face many problems such as child abuse, danger of infections due to unhygienic slum conditions, and poor infrastructure in schools. Teachers need to make children aware about the importance of personal and environmental cleanliness and hygiene. A network of government and private schools should be developed to share common resources. Teaching learning process should be child centric.

Key Words : 1.EDUCATION 2.SLUM CHILDREN 3.LEARNING ACHIEVEMENT 4.SLUM CHILDREN DELHI.

8. Devaraj, Amaidhi et al. (2005).
Quality education in Chamarajanagar district : district quality education project/ Vidyankura. Bangalore : National Institute of Advanced Studies. 43 p.

Abstract : Chamarajanagar district of South Karnataka has low literacy levels and a large population of Scheduled Castes (SC) and Scheduled Tribes (ST). An intervention was undertaken to improve the quality of elementary education in Government schools and Ashramshalas (Govt. aided schools) by building the capacities of all stakeholders involved. Main programes undertaken were School Community Contact Programme (SCCP) and Language Development Programme (LDP). SCCP's function was to strengthen linkages between school and community while LDP aimed at enhancing learning levels in Kannada and contributing to teachers' capabilities in multi-grade classrooms. One tribal residential school was Kolipalya Ashramshala and one Government school was Hegdehundi Lower Primary School. The Sociology and Social Anthropology Unit of NIAS launched the District Quality Education Project (DQEP) also called Vidyankura in 2002. DQEP chose 28 schools (16 Govt. schools and 12 Ashramshalas) on which the interventions focussed. DQEP began working with Kolipalya in December 2003, where a number of changes have occurred. It was found that enrollment increased, and more children lived at the school due to the availability of better infrastructure. Multi-grade classes were being conducted with inputs provided in the training, and trimester exams were being held for 5^{th} Grade. Also the headmasters (HM) held meetings with teachers together and they designed the time table and class plan, which they tried to follow. LDP was useful in communicating with younger children who were in the process of learning Kannada. Also, learning levels improved as was revealed during tests conducted by DQEP. Progress was made in efforts to involve and integrate the community with the school. HM engaged parents and the community in discussions about school development and children's learning levels. Teachers learnt how to identify children whose learning levels were low and gave them special attention. Overall, teaching methods improved through use of drama,

games and art activities conducted inside the classrooms. Factors that impeded DQEP interventions at school level were that teachers found it difficult to implement DQEP's inputs due to lack of facilities. HMs often faked enrollment numbers to get more supplies from the Government which they sold to make profit like soap, oil, bedding, grains, food and other provisions that were given to them sparingly. It was observed that Lambani children were fast in learning but Soliga children were "slow" in classroom learning. Hence they need more specialized inputs from teachers so that they can excel in the classroom. Also, Lambanis made frequent visits to schools and understood the importance of education, while the Soliga tribals did not realize the importance of education as their ancestors never studied. If parents monitor the school effectively, the inefficiency of a faulty Government system could be alleviated, as they could check that their children are treated well, they are learning the scheduled lessons, and receiving all supplies. Teachers and HMs have additional responsibilities in taking care of children, but they are absent from the school frequently, and the result is that children suffer. DQEP began working with Hegdehundi in January 2004, and the benefits were that the importance of sports was recognized as prizes were given to students for different competitions, alphabet charts were prepared in Kannada, and story writing sessions were conducted. General cleanliness of the school improved, and teachers faced less difficulty in selecting methods for different levels of children in a multi-capability situation. Enrollment campaigns were conducted and teachers visited children's homes and made their parents understand the value of quality education. Problems of co-ordination among teachers were noticed due to the methods of monitoring used by field workers after the intervention, and the presence of teachers in schools increased. Community in Hegdehundi was mostly illiterate and parents did not feel confident enough to monitor their children's academic activities, both at school and home. Meetings were organized but participation was poor which could be due to two reasons namely the date chosen was not suitable and secondly, people did not perceive such meetings to be important. Schools had less teachers, and they were over-burdened when only one of them was not present. Teachers did not welcome the inputs of the field workers as his activities were pre-planned, and the inputs provided by him were not framed towards solving specific problems faced by schools. Inspection mode monitoring affected the school field worker relationship. Good infrastructure and quality education are equally important conditions for overall development of children. Community had failed to contribute towards improving the quality of education. Parents' help is required if children's learning is to be improved. Regular monitoring and follow-up by resource persons is helpful for the overall functioning of schools.

Key Words : 1.EDUCATION 2.ASHRAM SCHOOLS 3.QUALITY EDUCATION 4.TRIBAL CHILDREN 5.EDUCATION SCHEDULED TRIBES.

9. Plan India, New Delhi. (2009).
Why are children out of school ? : a summary of the study 'Participatory approach to identify reasons for exclusion among out of school children' conducted in 4 states of India. New Delhi : PI. 20 p.

Abstract : Education is widely recognized as an imperative to ending poverty, a catalyst for human development that eliminates disparities of all kinds and opens the way for empowerment. Quality education through a formal school system, is the right of all children. The 86th Constitution Amendment Act (that added Article 21A to the Indian Constitution) affirms that every child, between the ages of 6 and 14 years, has the right to free and compulsory education, and the Right to Education Bill 2005 gives effect to this Amendment. However, despite this progress, a significant number of children in India, especially from disadvantaged groups, are still out of school. In June 2008, Plan commissioned a study to identify reasons for exclusion among out of school children, to identify the out of school children (who never enrolled, who dropped out and who enrolled but did not attend school) in the age group 6-14 years in areas where Plan operates, to get a deeper insight into the circumstances of communities and reasons for not sending their children to school. The study focused on four states – Bihar, Uttar Pradesh, Uttarakhand and Delhi. Plan's study revealed that in Uttar Pradesh 8.6% children and in Bihar 20.6% children were found to be out of school. In Uttar Pradesh 66% of the out of school children were never enrolled and the remaining 34% enrolled but dropped out. In Bihar, among 20.6% out of school children, the percentage of never enrolled children was 56% and enrolled, but dropped out were 44%. It also emerged that the percentages of irregular attendance of children among the school going children were 50.2% and 40.2% for Uttar Pradesh and Bihar respectively. It was found that unfriendly behaviour of teachers, use of abusive language and corporal punishment, schools are far off, lack of sports equipment and recreational facilities, and burden of work i.e. domestic chores and sibling care for girls, and farm work and cattle grazing for boys were the key factors that keep children out of school. In Delhi and Uttarakhand, regular students had strong push factors (family support) and a conducive learning environment at school. Irregular students had strong push factors (family support) but the learning environment at school was not so encouraging. Dropouts had little family support and the environment at school was not conducive to learning. Never enrolled children had no family support and the environment at school was not favourable. Community was not aware of various government schemes on education. Those who were aware failed to avail the benefits of schemes as they did not have essential documents like birth certificates and immunization cards. In Uttarakhand, geographical barriers like

mountainous terrain prevent children from pursuing their studies. Many villages are located on high mountains and there are no roads. Communities were also bound by tradition and failed to break the mould. It was recommended that a comprehensive and inclusive strategy needs to be developed for effective and sustained advocacy on the issue of exclusion in education.

Key Words : 1.EDUCATION 2.SCHOOL DROPOUTS 3.OUT OF SCHOOL CHILDREN 4.NEVER ENROLLED CHILDREN 5.REASONS FOR SCHOOL DROPOUT 6.UTTAR PRADESH 7.BIHAR 8.DELHI 9.UTTARAKHAND.

10. Yeaw, Jennifer et al. (2006).
Children as agents of change : a case study of the School Sanitation and Hygiene Education (SSHE) Pilot Project in Gaya District, Bihar. Patna : Asian Development Research Institute. 57 p.

Abstract : Bihar is situated at the lowest rung of the development scale, both economically and socially. With a population of about 83 million people, it is India's 3rd most populous state, and 40% people live below the poverty line. State's annual per capita income is Rs. 6015 (2002-03), less than one third of the national average of Rs. 19,041 (Economic Survey 2004-05, GOI). About 80% of the labour force is engaged in agriculture. Bihar ranks last in literacy, just 47% of the population is literate (59.7% males; 33.1% females). Class repetition and school dropout rates are quite high, the proportion of 'Out of School' children is estimated at 29% for boys and 46% for girls aged 6-14 years, based on attendance rates. Gaya is the 10th most developed district of the state with 63.8% literacy for males and only 37.4% for females (Census 2001). The School Sanitation and Hygiene Education (SSHE) Pilot Project in Gaya District, Bihar was identified by UNICEF KCCI as best practice for community based efforts at enhancing educational attainment through improvements in children's school environment and hygiene. SSHE Project aims to ensure children's right to safe, hygienic and child-friendly environment by providing sanitation, infrastructure in schools, coupled with hygiene education imparted by trained and capable teachers. Primary objective was to increase children's awareness of the importance of proper sanitation and hygiene, promote behavioural change, and make children serve as "agents of change" by transmitting hygiene education to their family and community. The success depended on 4 key characteristics: extent of children's participation, capacity and commitment of teachers, school community linkages and village specific characteristics. SSHE covers 6 villages in the study. The number of students in Turi Bujurg was 210, Khizarsarai 1567, Ghoraghat 119, Moramurdana 193, Siswar 298 and Rani Chak 163. All the villages were assigned 2 toilets each. Findings are based on response of

students, households and teachers. 100% students reported cutting their nails regularly, 78.9% took bath regularly, 84.4% took a bath on the day of the survey, but only 35.6% used soap for washing their hands. 70% respondents were aware of the negative effect of long nails and 77.8% were aware of the ill effects of irregular brushing. 61.1% students used school toilets "almost regularly", 18.9% used it 'sometimes', and 20% 'never' used school toilets. Reasons given for not using toilets were that toilets were locked (44%) and they felt embarassed to ask for the key, 28.9% said that toilets were not clean, 20% were not habituated to using toilets, and 6.7% said that toilets were broken. Only 35.3% used toilets at home. 96.7% reported that they received hygiene education at school, 78.9% said they participated in hygiene education related activities such as campaigns (68.9%); village cleaning (65.6%); competitions (22.2%); and sanitation demonstrations (17.8%). Only 54.4% students received SSHE books brought out by BEP with UNICEF support. Only 42.2% participated in cleaning school toilets, 40% participated in filling water reservoirs and checking for water leaks. Fewer students (22.2%) reported cleaning the water point area. 50% student monitors mentioned that they told teachers about their friend's improper hygiene habits, 43.7% instructed their classmates on proper hygiene behaviour, 6.3% did 'nothing' in such a situation. When sanitation facilities needed repair, 87.5% student monitors reported that they told teachers, 6.2% told VSS member, and 6.2% mentioned that they fixed it themselves. When sanitation materials such as soap or a nail cutter were not available, 81.2% student monitors reported that they told the teacher, 12.6% said they did 'nothing', and 6.2% replaced the material themselves. 79.36% boys and 80.5% girls claimed that they used the school toilet either 'sometimes' or 'almost regularly'. At community level, 41.3% households reported that they started cutting nails regularly, 52.5% cut their nails regularly before and after SSHE Project and 6.3% still did not cut nails regularly. 36.3% reported that they washed hands before eating after SSHE Project, 62.5% washed hands before and after SSHE project, and only 1.3% never practiced it before and after SSHE. 32.5% reported change in brushing habits since the inception of the project, while 66.3% brushed both before and after SSHE and only 1.3% did not brush teeth regularly. 28.8% bathed regularly since the start of SSHE, 70% bathed before and after SSHE, only 1.3% never bathed regularly. Only 3.8% used a home toilet since SSHE, 20% used a toilet both before and after SSHE, and 70% did not use a toilet at all. Out of 6 teachers interviewed, 3 had attended SSHE training, 2 had a separate curriculum for SSHE, others indicated that they taught hygiene as a part of environmental education. Only 41.2% household reported that they contributed to SSHE Project; 22.5% provided labour, 13.8% helped with maintenance, and 5% through other efforts. 43.8% respondents believed that the responsibility of maintaining school toilets should rest with the teacher, 20% households felt that villagers themselves should take responsibility for maintenance, Govt. should maintain (16.3%), and VSS (11.3%) should maintain. Only 2.5% stated that toilets should be maintained

by students. Participation of school monitors, community linkages and involvement of VSS was important for success of SSHE Project. Teachers, households and VSS members mentioned there was lack of educational infrastructure. Households being aware of hygiene, extreme poverty and access to personal sanitation prevented them from practicing such behaviour. Caste or political conflict had a negative impact on schools and success of SSHE project. VSS and community members were unsure about strategies to ensure sustainability of SSHE. It was recommended that on-going training opportunities should be provided as teacher turnover is a frequent occurrence in target villages; community mobilization should be undertaken by Bihar Education Project (BEP) and UNICEF for effectiveness of SSHE. Greater convergence with Total Sanitation Campaign (TSC) and social marketing will increase demand for household toilets.

Key Words : 1.EDUCATION 2.SANITATION 3.SCHOOL SANITATION 4.HYGIENE 5.CHANGE AGENTS 6.CHILDREN AS CHANGE AGENTS 7.TOILETS 8.BIHAR.

HEALTH

11. Dutta, Indranee and Bawari, Shally. (2007).
Health and health care in Assam : a status report. Mumbai : Centre for Enquiry into Health and Allied Themes. 108 p.

Abstract : Assam, the land of hills and valleys, of the mighty river Brahmaputra, lies in the northeastern corner of India. The Indian Constitution has made health care services largely a responsibility of the state governments. Since health is influenced by a number of factors such as food, housing, sanitation, protection against diseases, etc., the term 'health care' embraces a multitude of services provided to promote, maintain, or restore heath. Establishment of Primary Health Centres (PHCs) in India started in 1952. In 2003, the Crude Birth Rate (CBR) per 1000 population was 26.3, the Crude Death Rate (CDR) per 1000 population was 9.1 and Infant Mortality Rate (IMR) per 1000 live births was 67. By September 2005, Assam had 5109 Sub Centres (SCs), 610 PHCs and 100 Community Health Centres (CHCs). 5109 SCs had the required number of ANMs, but there were only 320 MPWs (Male) in position against the required 5109. All the 610 PHCs had the required number of Medical Officers (MOs), ANMs and Pharmacists but the post of Health Assistants (HA) (Male and Female), Nurses, Midwives and laboratory technicians were grossly under staffed. The 100 CHCs

are over staffed with physicians, but they are in dire need of surgeons and paediatricians. There is also a shortage of Obstetricians and Gynecologists, Nurses, Midwives, Radiographers and Laboratory Technicians in the CHCs. Janani Suraksha Yojana (JSY) integrates the cash assistance with antenatal care during pregnancy, and institutional care during delivery. In Dhemaji, Dhubri, Goalpara, Karimganj, Morigaon, Nagaon and N.C. Hills more than 80% women had home delivery, only 18% had institutional deliveries either in public or private facilities, lagging the all India average of 34%, and it was the lowest among all the major states of India. Dibrugarh, Jorhat, Kamrup, Nalbari, Sibsagar and Tinsukia were the only districts where more than 40% of the deliveries are safe deliveries as female literacy in these districts is more than 60%. Fully immunized children in Assam in 2004-05 were 422139 out of 681411, i.e. 61.95%. NFHS data showed that the three month prevalence of malaria in Assam had increased from 2710 in 1992-93 to 2974 in 1998-99 per 100000 population. The prevalence of malaria was more in rural areas compared to urban areas. The point prevalence of tuberculosis (TB) per lakh population was 368 in 1992-1993 but increased to 710 in 1998-1999. In 1998-99, only 50% TB cases were medically treated in Assam, while 79% cases were treated in India. Also the prevalence was more in rural areas. The prevalence rate of leprosy per 10000 population has been constantly declining since 1993. The prevalence rate of leprosy was more than 1 till 1999-2000, but it started declining gradually until it reached 0.41 in 2005. The first AIDS case was reported in Sep 1990. Till Oct 2006, total 1576 HIV positive cases, 456 AIDS cases (355 male, 101 female) including 41 deaths have been reported. Cancer cases registered in 2005-06 were 6596 of whom 61% were males and 39% were females. 6.3% of the revenue expenditure of the state was on medical and public health and family welfare in 1997-98, but it has been decreasing constantly. By 2006-2007, it became 6%. 60% households had drinking water and sanitation facilities in Assam, i.e. access to pump, piped drinking water, and the all India average was 78% in 1998-99. 63% households had toilet/ latrine facilities in Assam but only 35.9% households in India had this facility. Despite its rich natural resources and high concentration of business and economic activities among the north eastern states, Assam has not been able to achieve the desired health outcomes. National programmes for maternal and reproductive health, child health, family planning, etc. should be sincerely carried out. Thus, there is a clear need for more resources and investment in public health to attain better health objectives.

Key Words : 1.HEALTH 2.HEALTH SERVICES 3.HEALTH CARE 4.SITUATION OF HEALTH SERVICES 5.HEALTH SITUATION 6.ASSAM.

12. Nandan, Deoki and Malini, Shobha et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : a rapid appraisal on functioning of Janani Suraksha Yojana in South Orissa. New Delhi : National Institute of Health and Family Welfare. 26 p.

Abstract : The National Rural Health Mission (NRHM), under implementation since 2005, provides affordable and quality health care services to the rural population. The study was conducted in 2 blocks of each district namely Ganjam, Gajapati and Kandhamal of South Orissa. Utilizers and non – Utilizers (total 120), mothers (total 120), ASHAs, ANMs, PRI members, block level and district level health officers were included in the study. In Kukudakhandi block, expected versus recorded Janani Suraksha Yojana (JSY) deliveries in 2006-07 were 3254/ 1,237 (38%), in Gurandi (1,715/ 1,010 (58.9%), in Tikabali 1,064/ 874 (82%) and in Chakapada block it was 1,003/ 330 (33%); while there were more expected versus recorded JSY deliveries in Khallikote 2,696/ 3,472 (129%) and Mohanna 1,465/ 2875 (196%). The age of marriage was 16-18 years, showing an early marriage trend. Around 50% of the users were illiterate or just literate, and 82% non – users were housewives, in comparison to 78% in the users category. Orissa had below poverty line (BPL) population numbering 47% (Census 2001). About 44.3% of the users and 55.7% of the non – users were BPL card holders. 44.3% of the expected BPL population in the users category were availing of JSY services. There is a special need to propagate information about the JSY scheme among the non – users, among whom a big part (55.7%) are BPL mothers, who are deprived of JSY services. About 84% mothers had 3 or more ANC check – ups, which are expected with the enhanced coverage and support provided by JSY. In non – users the percentage of women who underwent 3 or more ANC check – ups dropped to 63.3%. Average IFA tablets usage among JSY users was 59.1%, and it was very poor among non – users (17.5%). Usage of TT was good with 2 doses taken by 88% of both users and non – users. For 94.2% users, the place of delivery was government health institutions and very few deliveries took place at home. For non – users, 57.5% deliveries took place at home, while a few (20.9%) went to private clinics and charitable hospitals. 21.6% of the non – users who delivered in government hospitals did not receive JSY compensation. The policy level suggestions included streamlining funds flow from states to PHCs, creation of core banking systems, release of cash assistance under the scheme on the day of delivery on the pattern of Rajasthan Axis Bank Model, and simplifying the paper work for releasing payments.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.JANANI SURAKSHA YOJANA 4.SAFE DELIVERY 5.INSTITUTIONAL DELIVERY 6.NATIONAL RURAL HEALTH MISSION 7.ORISSA.

13. Nandan, Deoki and Swain, Saraswati et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : a rapid appraisal of functioning of ASHA under NRHM in Cuttack, Orissa. New Delhi : National Institute of Health and Family Welfare. 37 p.

Abstract : The National Rural Health Mission (NRHM) was launched in April 2005 with a commitment to provide effective health care to the rural population throughout the country, with special focus on the 18 low performing states, including Orissa. The goal of this Mission is to create a village level social activist, designated as ASHA, to provide primary medical care, advise the villagers on sanitation, hygiene, antenatal care (ANC) and post natal care (PNC), escort expectant mothers to hospital for safe delivery, etc. The study was conducted in 2 blocks each in Jagatsingpur and Mayurbhanj districts. A total of 80 ASHAs were randomly selected for in – depth interviews. The most important activities enumerated by the ASHAs are accompanying the pregnant women to the hospital (92.5%); counselling them on ANC, PNC and safe delivery (84%); distribution of IFA and oral pills (87.5%); registration of pregnant mothers (68.8%); mobilizing the mothers for their children's immunization; and helping the ANMs on the immunization day (80%). Nearly 30% of the ASHAs were unable to motivate the community for construction of toilets and not able to organize meetings (28.8%); they were not able to take serious patients to higher level health facilities (12.5%); stay with the patients in the hospital (7.5%); do paper work of the JSY; maintain other registers/ records (3.8%); and distribute condoms and oral pills (2.5%). Distribution of medicines is a key factor for addressing the common ailments at the community level and also a catalyst for community acceptance and participation. But about 25% of the ASHAs interviewed had not even received medicine kits. Those who had received the kits found that the kits were incomplete. Most of the ASHAs indicated that the non – availability of transport facilities to pregnant women was a major problem. The charges for transportation were higher than the sanctioned amount. Also, a majority of the ASHAs were not getting incentives in time, and nearly 25% ASHAs had not received incentives for more than 6 months. Over 50% of the ASHAs mentioned that ANMs support them in counselling mothers on ANC, PNC, immunization, exclusively breastfeeding and family planning (66%), and nearly 33% in the supply of medicines and the appropriate doses to be administered (35%). Some ASHAs (15-20%) also mentioned that ANMs supported them on collecting information regarding births, deaths and maintenance of records and registers. Very few ASHAs (2.5%) said that AWWs extend support to them in organizing meetings at AWCs. The compensation given to ASHAs should be suitably increased. VHSC should be made functional

in every village. The transportation facility for taking pregnant mothers to health institutions should be streamlined by making available the Janani Suraksha Van in the PHC/ CHC area. Irregularity in the supply of medicine kits should be investigated and appropriate action should be taken. Activities like formulation of village health plan through HSC, awareness and motivation for construction of household latrines, motivation for family planning and adolescent education by ASHAs should be monitored by the health authorities.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.ASHA HEALTH FUNCTIONARY 4.NATIONAL RURAL HEALTH MISSION 5.ORISSA.

14. Nandan, Deoki and Mohanty, Manmath K. et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : a rapid appraisal of functioning of Village Health and Sanitation Committees (VHSCs) under NRHM in Orissa. New Delhi: National Institute of Health and Family Welfare. 27 p.

Abstract : The National Rural Health Mission was launched in 2005 to provide accessible, affordable and quality health care services to the rural masses across the country. The National Institute of Health and Family Welfare (NIHFW), in collaboration with UNFPA, through a project named 'Rapid Appraisal' of the Health Interventions (RAHI) has carried out a rapid assessment of various health care interventions under the mission. The study was conducted in 2 blocks each in district Bolangir, Kendrapada and Nabarangpur. Data was collected from 25 VHSCs through in – depth interviews with 24 ANMs/ ASHAs. The records of the various decisions taken by VHSCs in different meetings revealed that meetings were related to cleanliness and sanitation (50%), awareness about health programmes (30%), village survey (25%), immunization (10%), change of convenor from ASHA to AWW (10%), use of sub – centre untied funds (5%), and undertaking IEC through wall paintings (5%). The records of VHSCs in Loisinga and Patnagarh block of Bolangir district indicate that almost all committees (95%) were formed within 6 months prior to the study. Majority of members were found to be women (82%) and belonged to OBC category (69%), followed by SCs and STs (24%), and general category members (6%). PRI members constituted about 95% of the committee members. More than 60% of VHSCs did not have office bearers. The activities undertaken by VHSCs were creating awareness about health programme (30%); village surveys (25%); Participation in cleaning the surroundings of drains and tubewells (20%); providing help during immunization camps (10%); use of sub – centre untied fund (5%); and overseeing the IEC activity/ wall painting (5%). Also the average number of

members participating in VHSCs meeting was decreasing, and lack of proper follow up on the planned activity due to non – availability of funds was resulting in poor functioning of VHSCs. It was recommended that detailed instructions should be issued specifying membership of VHSCs, process of constitution, its integration with PRIs, and funds flow mechanism, with clear roles and responsibilities delineated. Financial information should be made available to functionaries of each block, PHC and Sub Centre. Programme guidelines should be clearly explained to the implementers and other service providers. IEC activities need to be intensified in the community on the provision and entitlements under the NRHM. Training should be imparted to the ASHAs, AWWs and ANMs regarding VHSCs and their functioning.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.VILLAGE HEALTH COMMITTEES 4.VILLAGE HEALTH AND SANITATION COMMITTEES 5.ENVIRONMENTAL SANITATION 6.ORISSA.

15. Nandan, Deoki and Dixit, Sanjay et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : a study on utilization of untied funds in sub-centres in Indore division under National Rural Health Mission. New Delhi: National Institute of Health and Family Welfare. 29 p.

Abstract : The goal of National Rural Health Mission (NRHM) is to improve the availability of and access to quality of health care specially designed for the rural poor, women and children. The strategies adopted under this are strengthening of health infrastructure, decentralisation of health care services, community participation and autonomy in functioning. 3 districts of Indore division were chosen, namely Dhar, Indore and Khandwa in Western Madhya Pradesh. 27 sub – health centres (SHCs) were taken from each district adding up to 81 SHCs. In a majority of cases the decision regarding the utilization of untied funds was taken in the Village Health Committee (VHC) meeting. At most SHCs more than 90% of Untied Funds (UF) were spent. At places where SHC building was not present, about 25% of the Untied Funds amount was shown to be spent on repair works, as against 60% where buildings were present. Money was spent on repair of toilets, water tank and water pipeline fittings and electrical fittings. Second major expenditure was on furniture. Other funds were utilized for stationery, purchase of health related articles (medicines, bandages, ointment) and cleaning of SHCs. At some SHCs 10% to 50% of the Untied Funds were unspent on emergency purposes (46%), and other works requiring larger sums of money (38%). Significant problems faced by over half of the ANMs were the non –

availability of the other signatory of the joint account, i.e. the Sarpanch. Mismanagement of Untied Funds was observed at various levels. For example, in some cases, the BMO took a major portion of the amount from the ANMs for carrying out minor jobs at the SHCs. Another problem faced by the ANMs was bringing the VHC members for meetings on Untied Funds. It was recommended that proper orientation of VHC members is necessary for effective utilization of untied funds; regular monitoring of utilization of untied funds should be done to ensure no mismanagement; printed guidelines for utilization of untied funds should be prepare in local language and distributed to individuals and used for upgrading the SC; orientation on utilization of UF should be provided by the MO to the VHC members and the Panchas and Sarpanchas by the Janpad Panchayat; an amount of Rs 3000/- each should be provided to the Sarpanch and the ANM for emergency purposes; and the UF amount should be released timely to the ANMs/ VHCs, that is, at the beginning of the financial year.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.NATIONAL RURAL HEALTH MISSION 4.UNTIED FUNDS 5.UTILIZATION OF FUNDS 6.SUB CENTRES 7.MADHYA PRADESH.

16. Nandan, Deoki and Pal, D.K. et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : an appraisal of Janani Sahyogi Yojana in Madhya Pradesh. New Delhi : National Institute of Health and Family Welfare. 36 p.

Abstract : The Janani Sahyogi Yojana (JSY) was implemented in Madhya Pradesh (MP) to understand the public private partnership as a viable option to increase institutional deliveries and thereby reduce the prevailing high maternal mortality rate (MMR). An appraisal of the JSY scheme was done in 4 districts of MP namely Bhopal, Indore, Jabalpur (with Katni) and Chhindwada (with Betul). The study sample comprised 4CMHOs, 32 PSPs and 100 beneficiaries of the scheme. Performance of Private Sector Providers (PSPs) under the scheme ranged from poor to very good. 68.8% officials in-charge of PSP developed their own strategies to implement this programme, and all CMOs planned innovative strategies to make the programme a success. 64% beneficiaries were informed about the scheme by local health workers, and 56% of the beneficiaries were accompanied by ASHAs/ AWWs to PSPs. Total deliveries in BPL/ non-BPL families (both normal and caesarean section) is 155/ 416 in Chhindwada with Betul district. Caesarean section (CS) rate among BPL families was highest for Jabalpur (with Katni) i.e. 67%, and the same for non–BPL families was highest for Chhindwada (with Betul) i.e. 71%. This also indicates that BPL patients are

not unnecessarily being forced for CS deliveries for the want of money. The total demand for family planning services was 60.5% in the state. Women with anaemia were 54%, of whom 16.6% had moderate to severe anaemia. This was higher among rural women. Under this scheme, 74-88% women got advice on nutrition, family planning and breastfeeding. The scheme should continue in future as it has expanded the choices and accessibility of services for BPL group of people. Efforts should be made to encourage the private sector to participate in the scheme in order to increase institutional deliveries and decrease maternal mortality. Efforts should be made to increase awareness about the scheme among beneficiaries by the Government as well as PSP through appropriate IEC strategies. A specific tool should be developed for effective implementation and monitoring of the scheme.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.JANANI SAHYOGI YOJANA 4.SAFE DELIVERY 5.NATIONAL RURAL HEALTH MISSION 6.MADHYA PRADESH.

17. Nandan, Deoki and Mohpatra, B. et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : an assessment of the functioning and impact of Janani Suraksha Yojana in Orissa. New Delhi : National Institute of Health and Family Welfare. 33 p.

Abstract : Since the inception of the National Rural Health Mission (NRHM), many health programmes have been implemented to address various health concerns and needs with the overall objective of improving the efficiency and effectiveness of the health system. The NIHFW, with financial assistance from UNFPA, initiated capacity building workshops on rapid appraisal methodologies and undertook appraisals of health interventions under NRHM, in collaboration with low performing states in India. The study was conducted in 3 districts of Orissa namely Balasore, Jagatsinghpur and Nayagarh. From these districts, 6 sub-centres (SCs) and 12 villages were selected. A total of 210 respondents were contacted. At the district, block and sub – centre level there was a shortage of medical and paramedical staff posing a major hindrance to the programme. 92% of ASHAs received modular training on JSY. 84% health workers (HW) (F) were trained on maintenance of accounts related to JSY and impress money. To sensitize community members wall painting, leaflets, local dailies and local TV and radio were utilized as means of IEC. Jana Mancha was organized in the district of Nayagarh to generate awareness among community members. Out of the 90 beneficiaries interviewed, 79% were informed about the JSY by the ASHAs, and 38% by the HW (F)s. In Jagatsinghpur district, only 50% of the focus

group discussion (FGD) participants were aware of the JSY. Interviews with non-beneficiaries revealed that 27% of them did not know about the JSY programme. Non-beneficiaries did not avail services under the JSY scheme as they were not aware of the scheme (27%), due to the non-availability of transportation facility (19%), 17% did not have faith in the government health system, and 8% stated non-availability of government hospital services. The GRAMSAT network should be utilized for cost effective and timely orientation of service providers; compensation should be given to the beneficiary soon after the hospital delivery; and regular payments/ salaries should be given to the ASHA. Effective messages should be developed using Jan Mancha banners and slogans, and an effective communication strategy should be in place. Infrastructure, supplies and human resources need strengthening at all levels under JSY. There is a need for repeated training and sensitization of MOs, Female Health Workers and ASHAs.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.JANANI SURAKSHA YOJANA 4.SAFE DELIVERY 5.INSTITUTIONAL DELIVERY 6.ORISSA.

18. Nandan, Deoki and Mishra, Ashok et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : an assessment of the process and performance of the Vijaya Raje Janani Kalyan Bima Yojana, Madhya Pradesh. New Delhi : National Institute of Health and Family Welfare. 19 p.

Abstract : The National Health Policy and National Rural Health Mission (NRHM) have the goal of reducing maternal mortality rate (MMR) in the country. The NRHM incorporates important schemes like Janani Suraksha Yojana (JSY) to increase the proportion of institutional deliveries to reduce maternal mortality in the country. Madhya Pradesh (MP) implemented an innovation namely 'Vijaya Raje Janani Kalyan Bima Yojana' (VRJKBY) as a supplement to this scheme. The study was conducted in 3 rural blocks and 1 urban area in the districts of Gwalior and Guna. Data was collected from State Officer in-charge, district and block level officers, beneficiaries (100) and non-beneficiaries (100) through in-depth interviews and FGDs. VRJKBY was well received by the eligible population, and there was a significant increase in the number of institutional deliveries during the implementation period. A large proportion of the BPL population was not aware about the scheme as BPL cards were not available easily. People were also unaware about other provisions under VRJKBY except cash incentives. AWWs and ANMs were the main sources of information for the beneficiaries, and majority of the non-beneficiaries could not utilize funds as the possible beneficiaries were not aware about the scheme (82% in Gwalior and

68% in Guna). Another reason for not utilizing benefits were non-availability of BPL cards. Deliveries were traditionally conducted at home. 2% respondents in Gwalior and 4% in Guna mentioned about the non-availability of doctors at PHCs. Majority of the members were not aware of the benefits provided under the scheme. There was no involvement of NGOs, SHGs, CBOs, or PRIs in the monitoring of the programme, and it was integrated with other health programmes. An effective well planned communication strategy is required to ensure success of the scheme; inter-sectoral coordination among stakeholders should be built upon; and initial orientation training should be given to implementers of the scheme. Community leaders and PRI members should be involved in planning and awareness generation about the scheme.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.INSURANCE SCHEME 4.JANANI SURAKSHA YOJANA 5.INSURANCE SCHEME WOMEN 6.JANANI KALYAN BIMA YOJANA 7.SAFE DELIVERY 8.INSTITUTIONAL DELIVERY 9.MADHYA PRADESH.

19. Nandan, Deoki and Jain, Neera et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-08 : assessment of functioning of the ASHAs under NRHM in Uttar Pradesh. New Delhi : National Institute of Health and Family Welfare. 27 p.

Abstract : The National Institute of Health and Family Welfare in collaboration with United Nations Fund for Population Action UNFPA, undertook rapid appraisal of various health interventions with the concurrence of Government of India under the “Rapid Appraisal of Health Interventions” (RAHI) project. The study was conducted in 4 districts of UP namely Varanasi, Moradabad, Lakhimpur – Kheri and Jalaun (Orai). Information was gathered from 4 District Nodal Officers (DNO), Deputy Chief Medical Officers (DCMOs), 12 Block Nodal Officers (BNO), 60 Accredited Social Health Activists (ASHAs), 43 Auxiliary Nurse Midwives (ANMs), 43 Anganwadi Workers (AWWs), Panchayati Raj Institution (PRI) members and 310 beneficiaries. The study evaluated the performance of functionaries at the grass roots level. All the DNOs, BNOs and ASHAs found the training useful while 37% ANMs did not have any opinion. Further training of ASHAs was suggested by all DNOs, BNOs and ASHAs. 16% of the ANMs stated that recurrent training to ASHAs affected their routine work. The involvement of the community, PRIs, NGOs, AWWs, etc. in health related activities was limited and poor. Out of the total institutional deliveries, around 75% were motivated and facilitated by ASHAs. Arrangement of and payment for transport were made by the ASHAs for 22% of the deliveries conducted at public institutions. It was also observed that in 6% of the home deliveries, ASHAs arranged for a trained dai/ ANM to be present at home. Funds were transferred

to sub-district level through e-banking. Almost all the BNOs had complete knowledge of the provisions of compensation money for ASHAs. Communication strategy should be designed to create awareness about ASHA scheme among PRI members and at the community level for better acceptance of ASHAs. To improve acceptance of the programme a medicine kit must be provided to ASHAs to help serve the community better. A process of community level monitoring, regular problem solving, and skill up-gradation should be developed as early as possible.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.ASHA 4.HEALTH FUNCTIONARY 5.SAFE DELIVERY 6.NATIONAL RURAL HEALTH MISSION 7.UTTAR PRADESH.

20. Nandan, Deoki and Haider, H. et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-2008 : a rapid appraisal of Sahiyyas (ASHA) in Jharkhand. New Delhi : National Institute of Health and Family Welfare. 18 p.

Abstract : The National Rural Health Mission (NRHM) proposes to appoint a community level health worker who has been named ASHA. ASHA acts as a first point of contact with the health care facility and the community in her village. In Jharkhand, Sahiyyas is the term used in place of ASHA. In Jharkhand, 10 blocks were randomly selected from 6 districts namely Ranchi, Hazaribagh, Jamtara, East Singhbhum, Gumla and Saraikela Kharswam. Information was collected from the women who delivered within the past 6 months (360; 36 per block); civil surgeons-cum-CMOs 6 (1 per block); Block Medical Officers (BMOs) 10 (1 per block); Sahiyyas 60 (6 per block); ANMs 10 (1 per block); AWWs 10 (1 per block); and village health committee members 10 (1 per block). Around 24.2% of the women who were interviewed had heard about Sahiyya; while 92.2% (80 women) of those women who have heard of Sahiyya could recognize her within the hamlet. Women were helped by Sahiyya for early registration with ANM, and community people were motivated to receive facilities and advice from the health care functionaries. Many women who knew about Sahiyya (40.8%) got advice from her to go to a rural or private hospital (7%) in case any complication occurred during delivery. About 88.6% women said that they received ANC during their last pregnancy; 86% pregnant women were registered with ANMs; around 89% women received TT during their antenatal checkups; and around 19% went for institutional deliveries. Around 88% of the women who received post natal check up got checked by a doctor, 9% women got checked by ANM/ nurse. Women also got help from Sahiyya and AWW to avail this service, and got help from ANM to avail JSY scheme. Proper incentives should be given timely for Sahiyya's work; and capacity building training should continue in the field of maternal and child health, including basic health and hygiene and adolescent

health. Communication and interaction on regular basis with all health functionaries can lead to effective decision making.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.ASHA 4.SAHIYYA 5.HEALTH FUNCTIONARY 6.SAFE DELIVERY 7.VILLAGE HEALTH COMMITTEE 8.ANGANWADI WORKERS 9.INNOVATIONS HEALTH SERVICES.

21. Nandan, Deoki and Srivastava, V.K. et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-2008 : a rapid appraisal of organization and utility of health melas in Uttar Pradesh. New Delhi : National Institute of Health and Family Welfare. 31 p.

Abstract : Popularly known as the "Parivar Kalyan Avam Swasthya Mela", Health Melas (fairs) are an instant and massive awareness campaign on public health services being rendered by the Government and non-Government organisations (NGOs), and they are able to disseminate information on preventing various diseases. These Melas provide health care facilities such as laboratory services, consultation, treatment and medicines. This study was undertaken in 9 districts of U.P. namely Banda, Jalaun, Unnao, Hardoi, Aligarh, Moradabad, Azamgarh, Basti and Sonebhadra. A total of 1,03,009 beneficiaries visited the Melas. Of these, 52,599 were males, 40,965 were females and 9,445 were children. Unnao district recorded the maximum number of beneficiaries (12,219) who received health care. The lowest attendance was at Aligarh (6,997). The 9 Melas together had 28 staff nurses to take care of the patients, and of these 5 each were available in Moradabad and Aligarh. But while Aligarh had 168 paramedics, Jalaun had none. Unnao had the maximum number of pharmacists (30), but Moradabad had only 7 of them. According to 60.4% of the beneficiaries, the main purpose of their visit to the Melas was to get medicines. Almost the same pattern was found in all the districts, except Basti, where the percentage who came for medicines was 82%. In Moradabad and Azamgarh, 30% respondents visited the melas out of curiosity. The maximum number of beneficiaries (14.4%) sought help for tooth problems, and only 6% sought help for heart problems. Almost a similar number of beneficiaries received services for other health problems. About 73.5% stakeholders felt that services provided at Health Melas were better than those at Health Centres. Health Melas should preferably be organized in remote areas where accessibility to health services is difficult or is not available. A powerful communication strategy should be adopted to motivate people to utilize the services provided at health melas.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.HEALTH CAMPS 4.HEALTH MELAS 5.HEALTH SERVICES 6.NATIONAL RURAL HEALTH MISSION 7.UTTAR PRADESH.

22. Nandan, Deoki and Badgaiyan, Yogendra et al. (2008).
RAHI Rapid Appraisal of Health Interventions 2007-2008 : a rapid appraisal of the Swasth Panchayat Scheme in the state of Chhattisgarh. New Delhi : National Institute of Health and Family Welfare. 24 p.

Abstract : The present study was conducted in 27 villages of Chhattisgarh state with an objective to understand the functioning of the Swasth Panchayat Scheme and to make any mid term corrections during its implementation phase. Primary data was collected from two groups of mothers, 300 women who gave birth in the last one year and 300 mothers of the children aged 12 months to 35 months, using semi-structured schedules. It was observed that there was a quantum leap in indicators such as institutional delivery (13.37% to 21.66%), skilled delivery (26.74% to 36.11%), immunization coverage (81.05% to 92.59%), ANC coverage (82.70% to 94.44%) and recording of birth weight (57.39% to 67.77%). It was found that blood test, urine examination and blood pressure measurement were practically not done in any antenatal case. ANC services provided at the health centre were limited to provision of iron folic acid tablets and TT injections. There was increased community awareness about routine immunization and regular search for children who could be immunized to ensure 100% immunization. Most pregnant women received three ANC visits and services were provided by both ANMs and Mitanins. There was a lack of facilities at Sub centers e.g. blood pressure measuring instruments, lab facility for urine examination, etc. It was found that transport facilities for pregnant women were lacking in many villages leading to an increased number of home births, but in some villages panchayats arranged for transport while in most cases relatives arranged the transport. Community was well oriented towards institutional delivery, but non-availability of incentives under JSY (Janani Suraksha Yojana) was a major concern. Training sessions were organized under the scheme which was mainly attended by PRI members and Mitanins. There was lack of participation of ANMs in training programmes, and lack of community participation and interest among community members. Village Health Committees (VHCs) were not actively involved in monitoring health programmes in the village. It was found that there was limited knowledge on various issues and programmes among PRI (Panchayati Raj Institution) members, ANMs (Auxiliary Nurse Midwife) and Mitanins. It was recommended that an efficient system should be developed for fund flow under the JSY to ensure that the benefits reach pregnant women on time; to reduce the number of home deliveries and deliveries conducted by unskilled persons; to increase the level of participation of ANMs during training programmes to ensure

effective implementation of the programme; to conduct training needs assessment of PRI members and Mitanins to bridge the gaps in training and actual implementation at the field level; and ensure specific training for various issues.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.SWASTH PANCHAYAT 4.MCH SERVICES 5.INNOVATIONS HEALTH SERVICES 6.HEALTH INTERVENTIONS 7.SAFE DELIVERY 8.IMMUNIZATION 9.VILLAGE HEALTH COMMITTEE.

23. Nandan, Deoki and Gupta, S.B. et al. (2008).
RAHI Rapid Appraisal of Health Interventions : a rapid appraisal of organization and influence of RCH camps in selected districts of Uttar Pradesh. New Delhi : National Institute of Health and Family Welfare. 26 p.

Abstract : The National Rural Health Mission (NRHM), implemented since 2005, provides accessible, affordable and quality health care services to the rural population. Reproductive and Child Health (RCH) camps in Uttar Pradesh (UP) are being organized at the block level. The study was carried out in 8 districts of Uttar Pradesh, 2 each from eastern, western, central and the Bundelkhand region (Jhansi, Banda, Allahabad, Jaunpur, Rampur, Moradabad, Kheri and Sitapur). The study was carried out in 16 blocks of these 8 districts and assessed 16 RCH camps. Most of the medicines (including those for RTI/ STI, gynaecological diseases, sterilization, antibiotics, pain killers) were available in sufficient quantities in most camps, except for iron and folic acid tablets, which were available only at 43.75% places. The registration table was observed in all the camps, but tables for ANC, immunization and counselling for family planning (FP) or HIV/ AIDS were present in only over half of the places, and examination table was seen only in 12.5% of the RCH camps. Most of the camp sites were clean (81.25%), had drinking water facilities (87.5%), and urinals/ lavatories (75%). Seating facility for clients/ patients should be available in the form of mats *durries*/ chairs as it was seen to be present in only around 50% camps. Almost all the camps (93.75%) had electricity/ generators. Around 50% of the camps had an OT and mini-labs (37.5%), laparotomy facilities (31.25%), and non-scalpel vasectomy (NSV) facilities (37.5%). 50% paramedical workers reported about work overload, and 33.33% complained about lack of staff. CMOs wanted paramedical manpower to be increased to improve the quality of RCH camps. 25% CMOs were of the opinion that the budget for camps should be increased, while 25% CMOs wanted re-orientation training for ANMs, ASHAs and other

paramedical staff. Funds should be increased and vehicles should be provided by the CMO office for transporting beneficiaries who reside at distances from camp sites. Adequate funds should be provided to compensate doctors. Improved OT conditions are required to make RCH camps better, followed by the permanent posting of a surgeon at the PHC level. Improving sitting and transport facilities, followed by drinking water and toilet facilities, will help ensure better quality of RCH camps.

Key Words : 1.HEALTH 2.HEALTH INTERVENTIONS 3.RCH CAMPS 4.UTTAR PRADESH.

24. Save the Children, London. (2009).
Every one : the next revolution : giving every child the chance to survive. London : SC. 34 p.

Abstract : Nearly 9 million children die every year before the age of five years, that is, nearly 1 child every 3 seconds. Just under 4 million children die within the first month after birth, during the newborn period. Nearly 3 million babies die within one week of birth, including up to 2 million who die on the first day of their lives. 97% of these children die in low or middle income countries, and infant mortality is disproportionately high among the poorest and most marginalised communities. 97% of all child deaths are reported from 68 low and middle income countries. Half of these deaths, 4.7% million occur in Africa and around 3.8 million newborn and child deaths are in Asia. Also child mortality rate (CMR) (child deaths per 1,000 live births) is 148 per 1,000 live births in Sub-Saharan Africa and 78 per 1,000 live births in South Asia, up to 25 times the rates in the industrialized countries (6 deaths per 1,000 live births). In India nearly 2 million children under five die every year more than in any other country. Its record on newborn and child mortality (72 per 1,000 live births) is worse than that of neighbouring countries such as Bangladesh (61 per 1,000) and Sri Lanka (21 per 1,000 live births). The under-five mortality rate is 16/ 1000 in Kerala, 21/ 1000 in Goa, 96/ 1,000 in Uttar Pradesh, 94/ 1,000 in Madhya Pradesh and 85/ 1,000 in Rajasthan. The under-five mortality rate (U5MR) for the lowest wealth quintile in India is 92/ 1,000 compared with 33/ 1,000 for the highest wealth quintile. The National Rural Health Mission (NRHM) aims to bring infant mortality down to 30 per 1,000 births by 2012. 51% of all deaths of children under five occur in six countries namely India, Nigeria, the Democratic Republic of Congo (DRC), Pakistan, China and Ethiopia. Pakistan reduced its average child mortality rate by 23% between 1990 and 2007, but the figure for the poorest quintile is only 3%. More than 90% of deaths among under-fives (U5MR) are due to pneumonia,

measles, diarrhoea, malaria, HIV/ AIDS, and neonatal conditions that occur during pregnancy and during or immediately after birth. Poverty, inequality and discrimination are important underlying causes of high child mortality. We need to push the health and nutrition of mothers and young children higher up on national and international agendas. We need to document what some communities and countries have achieved and demonstrate how these successful cases can be replicated elsewhere. In 1900, the IMR in UK was 140 per 1,000 live births, and in USA 100/ 1,000 live births. The comparable figures in 2007 are 5 and 7. These countries reduced their child mortality (CM) by investing in health care, sanitation and clean water. Rising income led to improved diets, and the provision of universal education and greater access to family planning led to healthier families. In 1978, a landmark international conference on health was held in Alma Ata bringing together representatives from 134 nations and 67 non-governmental organisations (NGOs) and key UN agencies. It stressed the importance of equity, community involvement, adopting an integrated approach to health, the use of appropriate technology, affordable health care, and health education. Later on same elements of the Alma Ata approach were taken forward by UNICEF in the context of the 'child survival and development resolution.' This brought forward concepts like growth monitoring and the promotion of better nutrition; oral dehydration therapy to treat childhood diarrhoea, breastfeeding to ensure that young children were appropriately nourished; immunization against 6 deadly childhood diseases; food supplementation; child spacing through support for family planning; and female education. The overall package was renamed GOBI-FFI. It is sad to know that 68 countries that account for most newborn and child deaths are making no progress at all, or have child mortality rates that are actually worsening. Yet 17 countries (25%) are on track to meet MDG4 (Millennium Development Goal 4). It was recommended that credible national plans should focus on newborn babies, prioritize equity, mobilize additional resources, train and deploy more health workers, tackle undernutrition, and increase the focus on children in emergencies in order to reduce the number of child deaths.

Key Words : 1.HEALTH 2.INFANT MORTALITY 3.CHILD SURVIVAL 4.INFANT MORTALITY INDIA.

ICDS

25. Balsekar, Ameya et al. (2005).
Child welfare and community participation: a case study of the ICDS programme in Trivandrum district, Kerala. Thiruvananthapuram : Institute of Social Sciences. 58 p.

Abstract : Inspite of Kerala being ahead on many social indicators, the situation of malnutrition among children continues to be a challenge. This paper attempted to assess the functioning of the ICDS anganwadis at the grass roots level. 5 anganwadi centres (AWCs) were selected from each block based on a system of grades given to them by the ICDS Department of Thiruvananthapuram district. Premkadavila block was funded under the general state government ICDS funding, while Kazahakuttam was funded by World Bank. ICDS projects have 100% coverage in Kerala. The anganwadis of Kerala are graded as A (very good, 75-100), B - (Good, 50-74), C - (Average, 35-49), D - (Below Average, 20-34), E - (Poor, Below 19). The grading system is based on the presence of better infrastructure, quality of preschool education, and supplementary food provided. It was found that 60% of the children aged 0-6 years were in normal grade of nutrition from 2003-2005, 32% of the children were in Grade I malnutrition, 8% of the children were in Grade II, and only 0.06% children were in Grade III and IV category, which indicated that severe malnutrition was almost non-existent. It was also found that the nutritional status of mothers in anganwadi catchment areas in Kazhakuttom was below in Grade B and Grade C AWCs compared to those in Grade A. In Kazhakuttom, 78% of the children were in normal nutritional grade, 56% children had normal weight in Grade C AWCs, and 93% had normal weight in Grade D AWCs. Comparing the weights of children at the time of enrolment and current weights, it was found that Grade D anganwadis had shown remarkable improvement. The Grade of an anganwadi centre could not completely explain the nutritional status of the children enrolled. It was also found that the nutritional status of enrolled and non-enrolled children were similar. AWCs with good grades were also the ones that were functioning well as an institution. AWCs in remote locations appeared to have achieved better outcomes. In Grade A AWC of Perumkadavila Panchayat, the Panchayat president helped in the construction of the anganwadi building out of the block funds. The new ward member helped to build the wall and toilet, while the community collected money for the floor. It was found that three agencies namely the panchayat, the AWW of the ICDS system, and the local community were

working efficiently in close coordination towards the welfare of the AWC in Perumkadavila. Kerala still faces challenges in the areas of child health and nutrition. It is, therefore, important to bring more members of local communities under the ambit of the ICDS programme. It was also recommended that AWCs should be more responsive to the needs and demands of parents, particularly teaching of the English language. The active involvement of larger sections of the community can be ensured through higher preschool enrolment; by extending the supplementary nutrition programme to cover all pregnant and nursing women and all 0-3 years olds; the problem of low birth weights and persistent under nourishment in the high risk 0-3 years age group could be better addressed; and poorer, marginalized and vulnerable groups should be specifically targetted.

Key Words : 1.ICDS 2.COMMUNITY PARTICIPATION IN ICDS 3.NUTRITIONAL STATUS 4.PRESCHOOL CHILDREN 5.FUNCTIONING OF ANGANWADIS 6.KERALA.

26. Darnal, Srijana et al. (2005).
The changing role of anganwadi workers: a case study on IMNCI in Valsad district, Gujarat. Pune : BAIF Development Research Foundation. 48 p.

Abstract : Gujarat is the second most industrialized and urbanized state of India. 45% of Gujarat's children were malnourished (2005-06), and female literacy rate was 54% (2001). Between 1991 and 2001, the sex ratio decreased dramatically (934 to 921 girls born for every 1,000 boys). Population growth in the state increased from 21.19% in 1991 to 22.48% in 2001, while India's decreased from 23.86% to 21.34%. 33% children are born with low birth weight. IMR in Gujarat dropped steadily from 145 in 1971 to 62 in 1995 due to implementation of the immunization programmes throughout India. The main causes of infant and child mortality in developing countries are diarrhoea, malaria, measles and malnutrition. National Family Health Survey II (NFHS-2, 1998) data also includes fever (27% prevalence in the last 2 weeks), Acute Respiratory Infection (ARI-17%), diarrhoea (13%) and malnutrition (45%) as causes of child mortality. The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) is a new UNICEF and Government of India strategy to reduce the Infant Mortality Rate (IMR) and under-five mortality rate (U5MR). IMNCI strategy aims to improve skills of functionaries providing health services to children and the community by providing intensive training. By June 2005, 457 of the 1700 health and nutrition workers in Valsad district had been trained. Pilot scheme was implemented in Valsad district, having a large tribal population. A sample of 24 frontline

functionaries from 4 PHCs and 13 villages were interviewed, as also AWWs, mothers, health functionaries, AW Supervisors, MOs, trainers and the Chief District Health Officer. 13 villages and Dharmpur and Valsad Panchayats were connected to 4 PHCs. Post training majority of AWWs knew that they should visit newborns 3 times within the first 10 days after birth, and issues like health problems of children should be discussed. AWWs possess some medication in medicine kits to treat some common ailments of the community, especially those living in remote areas. Some villages are quite dispersed and remote, and ANMs and AWWs do not get transportation allowance, hence some households that need IMNCI the most may not be receiving benefits. IMNCI stresses the importance of using chart books to assess and classify illnesses in children and refer serious cases to hospitals. Many AWWs were not able to use the chart books, or even know when they should be used (to assess serious illnesses). It was recommended that AWWs should be given additional training; structured assessment should be done; practice of using ANMs and Multi-Purpose Workers (MPWs) to translate lessons into local dialects should be promoted; and use of visual aids should be increased. The importance of teamwork and communication between health and ICDS functionaries should be emphasized during training and implementation. UNICEF needs to redesign the format of registers and make the contents simpler. ANMs and AWWs should receive some monetary incentives for travelling to remote areas.

Key Words : 1.ICDS 2.ROLE OF ANGANWADI WORKERS 3.CHANGING ROLE OF ANGANWADI WORKERS 4.IMNCI 5.INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESSES 6.INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES 7.TRAINING OF ANGANWADI WORKERS 8.CASE STUDY 9.GUJARAT.

27. Jones, Nicola et al. (2007).
Local institutions and social policy for children : opportunities and constraints of participatory service delivery. New Delhi : UNICEF. 33 p.

Abstract : The Millenium Development Goals (MDG) in India aim to reduce child mortality, eradicate hunger and promote gender equality. 4 mandals were selected across the 3 main agro – climatic regions of Andhra Pradesh (AP) on the basis of (a) community poverty status and human development indicators, and (b) caste composition. There was variation in poverty and human development indicators across the 4 sites, namely: - Amrabad mandal, Mehboobnagar district, Telengana region (south); Attur mandal, Cuddapah district, Rayalseema region; Kataram mandal, Karimnagar district, Telengana

region (North); and Seethampet mandal, Srikakulam district, coastal Andhra region. The objective was to gather information on the structure and functioning of the committees in practice; barriers and catalysts to inclusive and effective participation, and the view points and attitudes of parents, school children, frontline service providers and government officials regarding the committees' impact. All Mothers' Committee (AMC) and Village Education Committee (VEC) members were provided with adequate information about their mandate, role and responsibilities. Concerns were articulated about the lack of accountability of the Committee to the wider community. Mothers' Committees were set up to improve user participation in public services, and there are limited provisions for children's voices to be heard. Instead of addressing children's concerns, ECs were frequently concerned about securing their future political advancement. In Committees with active members and/ or support from proactive service providers, there was a consensus that the outreach of local public health and education services had improved. Social sector or child related issues are rarely discussed in gram sabha or gram panchayat meetings. EC members who were well connected were able to secure funds from local politicians but none of the MC members were effective at fund raising. Where ECs were not functioning the teachers did whatever they wanted, and did not bother about the children, as the Education Committee was not available to check them. Health extension work should be formally recognized and compensated; whereas Mothers' Committees need to be reconfigured as an independent monitoring body with sufficient powers to make a difference to the quality of maternal and child health and early development services. Explicit accountability mechanisms ensure that committee chairpersons are accountable to other parents as well as the wider community. More structured opportunities to interact with authorities develops an institutional channel to articulate common concerns among committee members. Careful devolution of a wider range of responsibilities to schools, anganwadi centres and local governments allows for meaningful local participation, and this should be further strengthened.

Key Words : 1.ICDS 2.COMMUNITY PARTICIPATION IN ICDS 3.MOTHER'S COMMITTEES 4.EDUCATION COMMITTEES 5.COMMUNITY MOBILIZATION 6.MONITORING GOVERNMENT PROGRAMMES 7.COMMUNITY MONITORING 8.SARVA SHIKSHA ABHIYAN 9.BARRIERS TO PARTICIPATION 10.PROBLEMS COMMUNITY PARTICIPATION.

LABOUR

28. Singh, Ajit Kumar and Jafri, S.S.A. (2008).
Diagnostic study of chikan handicraft of Lucknow. Lucknow : Giri Institute of Development Studies. 35 p.

Abstract : Chikankari or chikan craft refers to delicate and artistic embroidery on a variety of textile fabrics like muslin, silk, chiffon, organza, doriya, organdi and synthetic textiles. At first, designs are printed on the cloth with washable colours mainly indigo. There are 32 types of stitches done in chikan work like Jali Murri, Phanda, Bakhia, Hool, Keel, Tepchi, Dhoor, Joda-Pattee, Ghas-patti, Hath-Katee, etc. It is done on a number of products such as kurta; ladies top, shalwar-kameez, saree, sherwani-kurta, dupatta, tray covers, napkins, bed covers, table covers, etc. Lucknow has been famous for its Chikankari for centuries. Its introduction is attributed to Queen Noorjahan, wife of Mughal emperor Jehangir. The present study was undertaken to find out the income levels and living conditions of the workers engaged in chikan embroidery industry, study their problems, and suggest suitable intervention strategies for improving the conditions of chikan workers. Interviews were conducted with 26 entrepreneurs and 104 chikan workers. An entrepreneur employed 38 workers including agents, salesmen, cutting masters, traders, chikankars, washermen, etc. Hardly 5% of the employees were engaged on regular salary basis. All accountants, 50% helpers and 20% salesmen were employed on salary basis. The rest were given daily wages or paid on piece rate/ commission basis. Monthly salary for regular workers varies from a low of Rs. 1000 in case of middlemen/ agents to Rs. 3000 for cutting masters and tailors. Similar differences were found in wages paid to different categories of workers employed on daily wages. Cutting masters and tailors are paid around Rs. 150 per day while printer, washerman and salesman get around Rs. 100 per day. The Chikankars get a pitiable wage of Rs. 32 per day. Gross profit margins vary from a low of 13% for an ordinary sherwani to 35% for ladies kurta. For most items the gross profit margins were between 20% and 25%. Net margins are lower and returns to the entrepreneurs are quite high. Average increase in production was about 20%. Around 10% entrepreneurs reported exporting goods to foreign countries. For occupational distribution, the sample covered was 63 chikankars, 6 cutting masters, 6 tailors, 6 washermen agents and 14 printers. Out of total chikan craft workers interviewed 60.6% were engaged as chikankars followed by printers (13.46%) and agents (8.7%). Monthly household income of the sampled workers was Rs. 4039. It varied from a low of Rs. 2879 in case of chikankars to Rs. 8766 in case of printers. There was high level of poverty among chikan workers as the per capita income of a chikankar household was only Rs. 538. Chikan work provided around 25% of

their total income. The income from other sources was relatively less. Daily working hours for chikankars and cutting masters were about 7 to 8 hours, while other workers like tailors, printers and washermen worked for about 10 to 11 hours daily. Generally work was available for around 25 days in a month. Around 67% chikankars got work through agents and the remaining 33% got work directly from traders. Majority of other category of workers in chikan craft got their orders for work directly. 70% got work regularly. Only 57% chikankars got payment regularly. A small number of cutting masters got regular payment. It was suggested that minimum wages for workers engaged in the chikan craft industry should be prescribed and strictly enforced. Minimum piece rates for different types of work should also be prescribed, taking into account the value of the product and time taken to produce it. An Advisory Council for the craft may be set up, with participation of entrepreneurs, workers, NGOs and Government, which may fix the minimum wages and suggest promotional and welfare measures and supervise enforcement of the policies. The workers should be organized into self help groups with the help of Government agencies and NGOs.

Key Words : 1.LABOUR 2.CHIKAN INDUSTRY 3.CHIKAN EMBROIDERY 4.UNORGANIZED SECTOR.

NUTRITION

29. Bhaskarachary, K. and Longvah, T. (2008).
Nutrition News, 2008, July, 29(3) : effect of washing and cooking on B-carotene content of some common Indian foods. Hyderabad : National Institute of Nutrition. 6 p.

Abstract : Vitamin A deficiency (VAD) remains widespread in many countries of south east Asia and global efforts are aimed at elimination of VAD and its consequences. The present study was conducted to screen the total carotenoid and β carotene content in cereals, pulses, vegetables, spices and condiments and also the effect of washing and cooking on its retention in some green leafy vegetables (GLVs) and carrot varieties which are rich sources of β carotene. It was found that the values of total carotenoids ranged from zero (rice) to 1780 mg (maize) and the β carotene content ranged from zero (rice) to 171 mg (maize). Total carotenoids and β carotene also varied significantly in pulses and ranged from 40 ug (soyabean) to 1720 ug (Bengal Gram). Pulses were better sources of β carotene (0-157 ug/100g) than cereals. Among the vegetables studied yellow pumpkin (1176 ug/100g), green chillies (1018 ug/100g), portulace oleracia (Hindi:

kulfa, Telugu: pappukura) (1699 ug/100g), field beans (554 ug/100g), and french beans (393 ug/100g) were rich sources of β carotene. It was found that majority of the Asians (>85%) depended on plant foods to meet their requirement for vitamin A. Indians, particularly, consume less than 50% recommended dietary allowances (RDA) for vitamin A through plant foods. Among the spices and condiments, ariel (mace or japathri) (2.14 mg/100g), similax (commonly used in rice preparation) (2.03 mg/100g) and red chillies (1.13 mg/100g) contained significant amount of β carotene. Cloves (0.6 mg/100gm), fenugreek seeds (0.9 mg/100g) and turmeric (0.05 mg/100g) had low amount of β carotene. As far as washing of GLV was concerned, it was found that minimum losses were observed when the vegetables were washed before cutting. Hence, it clearly indicated that washing vegetables before cutting helped in minimizing loss of carotenoids. The highest losses for β carotene when samples were washed after cutting were observed in Basella (19.5%) and lowest in curry leaves (12.2%). Curry leaves had the lowest losses (8.4%) for β carotene and total carotenoids (9.0%), whereas the highest losses for β carotene were observed in Amaranth and Basella, and ranged from12-20% for β carotene and 13-18% for total carotenoids. Thus minimal losses were observed when the vegetables were washed before cutting. In the study comparison was made of steam cooking with modern methods of cooking such as microwave cooking. GLV and other vegetables retained more than 65% (60-90%) of total carotenoids and β carotene (60-70%) when cooked using any method. This indicated that percentage retention of β carotene and other carotenoids were similar irrespective of cooking methods. It was found that there were significant carotene losses (57%) in traditional cooking methods as the cooking time increased to 100 min at 100 degrees Celsius in commonly consumed carrot variety (Early Nantes) and US developed – III carrot. It was recommended that there is a need to educate the community about proper methods of food preparation like washing the vegetables, especially GLVs, before cutting to avoid carotenoid losses and to derive the benefits of consuming carotenoids rich foods to prevent vitamin A deficiency.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.B CAROTENE 4.VITAMIN A DEFICIENCY 5.EFFECT OF WASHING.

30. Goyal, Nidhi and Sundararaj, Pushpa. (2009).
NFI Bulletin, 2009 Apr, 30(2) : Are we unknowingly consuming trans fats and abused oils ?. New Delhi : Nutrition Foundation of India. 4 p.

Abstract : Eating out has become an important social activity, both at personal and professional levels due to changing dietary and lifestyle practices. This survey was conducted for eliciting information about the deep fat frying practices in food service establishments in Delhi. Information was also obtained about

baking practices and the fats used as shortening for baking purposes. The survey was conducted on 20 food service establishments located in north (3), south (10) and central Delhi (7), and included fast food joints (FF), bakery shops (B), restaurants (R) and halwai shops (H). A questionnaire was developed to elicit information. The manager, unit manager and the handling person was interviewed. Personal observation was also recorded. A wide variety of food items were sold and they varied with the type of establishment. Groundnut oil was the most commonly used frying medium and 9 (45%) establishments were using this oil, 4 used it exclusively while the remaining 5 used it along with vanaspati. Vanaspati is used as a shortening agent, and it was disturbing to note that as many as 35% of the establishments surveyed were still using it as a DFF (deep fat frying) medium. During deep frying, oils/ fats are subjected to various chemical reactions which include oxidation, hydrolysis, isomerization, polymerization and cyclization. Respondents of 2 establishments had some awareness regarding the harmful effect of vanaspati and reported that it produced bad cholesterol. The Ministry of Health and Family Welfare, Government of India has issued a notification that the amount of trans fatty acids in grams present in the product should be declared. As a result of frying at high temperatures a multitude of products are formed like free fatty acids, trans fatty acids, mono and diacylglycerols, oxidized monomers, dimers and polymers. One of the restaurants in the study reported that the used oil was sold at lower cost to roadside vendors, who re-used the deteriorated oil for cooking and frying purposes. The survey highlights a pending need for regulations to ban the use of vanaspati and for regulations and monitoring of commercial deep fat frying practices in terms of the type of equipment and temperature used for frying, norms for frying oil, quality, criteria for determining deterioration of frying medium and discard of abused frying medium in order to ensure long term good health of the consumers.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.FATS 4.TRANS FATS.

31. Institute of Applied Statistics and Development Studies, Lucknow. (2006). Some statistical investigations to assess gender bias and nutritional deficiency in the states of Uttar Pradesh and Uttaranchal. Lucknow : IASDS. 7 p.

Abstract : In all countries men fare better than women on most socio-economic indicators, although the degree of disparity varies. In many households across India, boys get preference over girls in matters of nutrition, education, health care, etc. Therefore, there is need for examining several issues of nutritional

significance in the light of gender differences for effective planning. The present study assessed the gender bias and measured the extent of gender inequality in dietary intakes in intra-household food consumption according to age groups (1-5, 6-10, 11-17, 18-39, and 40-59 years) with respect to percentage shortfall from Recommended Dietary Allowance (RDA), nutritional deficiency i.e. Protein Energy Malnutrition (PEM), and micronutrient deficiencies. The study covered 25,000 individuals, 55 districts of Uttar Pradesh and 9 districts of Uttaranchal. Dietary intakes were recorded using 24 Hour Recall Method to assess nutritional status and nutritional deficiency disorders. It was observed that in age group 1-5 years, 95-96% boys and 85-96.4% girls consumed green leafy vegetables (GLV) upto 60% of RDA in Uttaranchal and Uttar Pradesh respectively, which was quite high as compared to other food stuffs. Similarly, higher consumption of fruits, upto 60% of RDA was observed in 98.3-100% boys and 97-100% girls in Uttar Pradesh and Uttaranchal respectively. In the age group 6-10 years, higher consumption of GLV and fruits was observed upto 60% of RDA among boys (90.6-95.8% and 97-100%) and girls (92.7-94.8% and 97-100%) in Uttaranchal and Uttar Pradesh respectively. This was higher than that of other food stuffs. It was observed that in the age group 1-5 and 6-10 years most food stuffs had consumption above 25%, and GLV (95-96.9% for boys; 85.3-96.4% for girls) and fruits (98.3%-100% for boys; 97-100% for girls) have very high consumption. However, some evidence of gender inequality is noticed in the age group 1-5 and 6-10 years, but these were not statistically significant whereas gender inequality in the age groups 11-17, 18-39 and 40-59 years was found significant in consumption of GLV, milk and milk products, and fat and oil respectively. It was found that in the age group 11-17 years, in Uttar Pradesh, the consumption of GLV was in favour of boys, and other vegetables was in favour of girls, which was statistically significant. However, in Uttaranchal the consumption of milk and milk products and sugar and jaggery was significantly higher for girls than boys. It was also observed that in the age group 40-59 years, females of both the states had significant higher mean consumption level of fats and oil than men. It was also found that almost the whole population had intakes of Vitamin A and riboflavin below RDA. Further, there was some indication that consumption of fruits, GLV, and milk and milk products had some effect in preventing Vitamin A deficiency (presence of Bitot's spot) as individuals without any symptom of Bitot's spot had higher intake of these items. Therefore, it is recommended that food stuffs should be consumed as per RDA as they are directly related to nutritional deficiencies. Nutritional counselling sessions should be provided to combat nutritional deficiency and gender bias in society.

Key Words : 1.NUTRITION 2.NUTRITIONAL DEFICIENCY 3.CHILD NUTRITION 4.MALNUTRITION 5.MALNUTRITION CHILDREN 6.GENDER BIAS 7.DISCRIMINATION AGAINST GIRLS 8.UP 9.UTTARAKHAND.

32. Pettifor, John M. (2009).
NFI Bulletin, 2009 Apr, 30(2) : Vitamin D and calcium nutrition in children in developing countries. New Delhi : Nutrition Foundation of India, New Delhi. 8 p.

Abstract : The past few decades have seen renewed interest in Calcium and Vitamin D nutrition, particularly concerning their roles in the prevention of osteoporosis and fractures in the elderly and in preventing rickets in children. The role of Vitamin D is its central action in controlling intestinal calcium absorption and to a lesser extent bone resorption through its active metabolite, 1, 25-dihydroxyvitamin D (1,25-$(OH)_2$ D). This vitamin together with parathyroid hormone plays critical role in maintaining normal calcium homeostasis. Factors influencing the amount of Vitamin D formed in the skin include the latitude of the country, almost no ultra violet (uv) light reaches the earth during the winter months at latitudes above 37° N or S), the degree of atmospheric pollution, cloud cover, the extent of skin covered by clothing, the degree of melanin pigmentation in the skin, and the duration of exposure to UV radiation. The high prevalence of Vitamin D deficiency among pregnant women was 42% in north India. Factors that may be responsible for high prevalence of Vitamin D deficiency during pregnancy in many developing countries include the degree of skin pigmentation, extensive skin coverage by clothing, and social beliefs and customs that result in pregnant women not spending time out of doors. Studies that investigated the effect of maternal supplementation on the Vitamin D content of breast milk have shown that maternal supplementation at a dose of 6400 IU/d results in a dramatic increase in anti rachitic activity of breast milk. Several studies in India have emphasized that both Vitamin D deficiency and dietary calcium deficiency alone can result in rickets, but it is likely that the majority of patients with nutritional rickets have varying degrees of combined Vitamin D insufficiency/ deficiency and low dietary calcium intakes. Results suggest that the calcium contents of the diet influence Vitamin D requirements, with low intakes being associated with an increased catabolism of 25-OHD, and thus an increased requirement for Vitamin D to maintain an acceptable Vitamin D status. Thus, very low dietary calcium intakes do have deleterious effects on bone homeostasis, but it appears that the vast majority of children living in developing countries show no ill effects from dietary calcium intakes substantially below those recommended in some developed countries. More research needs to be done to assess the requirements of Vitamin D and calcium in children in developing countries, and practitioners should be cautious about accepting recommendations developed in industrialized nations for children who have very different dietary patterns and lifestyles.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.CALCIUM 4.VITAMIN D 5.CHILD NUTRITION 6.FATS.

33. Rajagopalan, S. (2009).
NFI Bulletin, 2009 Jan, 30(1) : Nutrition: policy, planning, participation and practice. New Delhi : Nutrition Foundation of India. 2 p.

Abstract : Raising the level of nutrition, standard of living and improvement of public health were declared as primary duties of the State by Article 47 of the Constitution. Recommended Daily Allowances (RDAs) for the country prescribed by Indian Council of Medical Research (ICMR), give the quantity of each nutrient needed by age/ sex/ activity groups. Schemes for poverty eradication were developed. The Fifth Five Year Plan implemented a cohesive 'Minimum Needs Programme' covering education, water supply, health, sanitation and nutrition for the vulnerable sections of the population. Based on a number of field level studies, Integrated Child Development Service (ICDS) scheme was developed as a National Programme addressing issues related to child development and nutrition. The Government of India (GOI) adopted the National Nutrition Policy in 1993 considering the long term benefits of 'Nutrition for All'. The National Nutrition Policy aims to identify the causes of malnutrition and formulate and launch effective sustainable intersectoral strategies to achieve nutritional security in the country. Recently GOI has launched a National Nutrition Mission under the chairmanship of the Prime Minister to facilitate effective implementation of the National Nutrition Policy. During the 11th Five Year Plan major food based nutrition programmes in India are National Rural Employment Guarantee (NREG), Public Distribution System, Annapurna Scheme, Antyodaya Anna Yojana, Integrated Child Development Services, Mid Day Meal Scheme, Nutrition Programme for Adolescent Girls, etc. These programmes supply either rice or wheat to alleviate hunger. Micronutrient deficiency problems are not covered by these schemes. There are three other programmes to combat major micronutrient deficiencies - those of iron, iodine and Vitamin A in mothers and children. These programmes are Programme to Control Blindness due to Vitamin A Deficiency, wherein a massive dose of Vitamin A is administered; National Anaemia Control Programme, National Iodine Deficiency Disorders (IDD) Control Programme, and Universal Iodisation of Salt. Nutrient intake less than 50% of RDA are seen throughout the life cycle, as per the data generated by National Nutrition Monitoring Bureau (NNMB), and National Family Health Survey (NFHS-3), which shows that 42.5% of the children below 5 years are underweight; 48% children below 5 years are stunted, 19.8% children below 5 years are wasted; 36% adult women and 34% adult men suffer from chronic energy deficiency (CED) with low body mass index (<18.5). The NFHS-3 Survey also highlighted the presence of widespread anaemia throughout the life cycle as 79% of the children aged 6-59 months and 50% women in the reproductive age group are

anaemic. Thus, the impact of the current set of programmes on improving nutritional status is unacceptably low. Every household, especially poor households, should be aware of all the welfare and health programmes to which they are entitled. It is necessary to develop an entitlement card for each household to enable them to know their entitlement and take steps to access them. A national programme can utilize the services of Home Science colleges to develop dietary guidelines in the local language and guide women's self help groups (SHGs) and non-government organisations (NGOs) in helping households to diversify their diets.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.NUTRITIONAL STATUS 4.COMMUNITY NUTRITION.

34. Shetty, Prakash. (2009).
NFI Bulletin, 2009 October, 30(4) : biotechnology for reduction of micronutrient malnutrition. New Delhi : Nutrition Foundation of India. 8 p.

Abstract : Hunger world wide is now estimated to affect over 854 million people, most of them (820 million) in the developing world. Globally, the prevalence of vitamin and mineral deficiencies is remarkably high. The World Health Orgranisation (WHO) estimates that while 3.7 million deaths per year in children are attributable to underweight, deficiencies of vitamin A, iron and zinc each caused an additional 750,000-850,000 deaths. Micronutrients including vitamin, mineral and trace elements are essential chemical compounds that are present in small amounts in food and fulfill many important functions in our body. A sustainable approach to reducing micronutrient malnutrition among vulnerable populations in developing countries is to enrich major staple food crops with micronutrients through plant breeding strategies assisted by biotechnology, and offering direct and indirect benefits to producers and consumers in developing countries. Plant breeding is a new strategy for improving nutrition. Crop breeding programmes can readily manage nutritional quality traits, which, for some crops, are highly heritable, simple to screen, and offer the possibility of increasing the content of several micronutrients in the same variety. Biotechnology on the other hand, not only offers the opportunity to increase crop yields and thereby increase the availability of food (quantity), but also has the enormous potential to improve the quality of staple foods and thus contribute to better nutrition of populations. The production of golden rice was a major event in the use of biotechnology to address the problem of micronutrient malnutrition (pro vitamin A) by bringing about a qualitative improvement in the nutrient content of a cereal. Biotechnology offers a repertoire of techniques and helps in identification of the genes responsible for increasing nutrient content. It is recommended that effective

nutritional interventions, including breastfeeding, complementary feeding and micronutrient supplementation, with the judicious use of biotechnology, may further the economic development of developing countries while helping to tackle the problem of malnutrition in their midst.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.MICRONUTRIENT DEFICIENCY 4.MALNUTRITION 5.STRATEGY FOR COMBATING MALNUTRITION 6.COMBATING MALNUTRITION.

35. Tontisirin, K. et al. (2009).
NFI Bulletin, 2009 Jan, 30(1) : Improving nutritional status at national and community levels: lessons from South Asia. New Delhi : Nutrition Foundation of India. 8 p.

Abstract : Improving the nutritional status at individual, household and national levels is one of the widely agreed upon objective of many international conferences and summits held in the last decade. In 2001-03 there were still 854 million undernourished people worldwide, of whom 820 million were in developing countries, 25 million in transition countries, and 9 million in industrialized countries. South Asia comprises seven countries: Bangladesh, Bhutan, India, Nepal, Maldives, Pakistan and Sri Lanka. The region is home to approximately 23% of the world's population, yet in 2005, over 33% of the world's poor and undernourished persons lived in the region. High intake of sugar, which is a characteristic feature of the changing dietary trends in Asia, is noted to be approximately 12% in India, Sri Lanka, Pakistan and the Maldives compared to only 3% in Bangladesh and less than 2% in Nepal. Sri Lanka has the highest consumption of edible oils, followed by India (10.8%, all types of oils). The prevalence of undernutrition in the total population is highest in Bangladesh (30%) and it is 20% in India. India has high prevalence of under five stunting (43-51%) and high incidence of underweight among children (47-48%). Dietary modification and diversification indicators can be used to assess nutrition improvement in community based programmes. The ultimate goal of nutrition improvement programmes is to impact the target communities, and improve the lives and nutritional status of the population. Dietary improvement can be done by information, education and communication (IEC), and increasing food production (community fish ponds, poultry farms and home gardens). For micronutrient deficiency food fortification could be done by increasing the percentage of households using iodized/ double fortified salt; fortification of other foods; and improving basic health services. In India undernutrition among total

population was 20%, under five stunting was 45% and underweight population under age five years was 47%.

Key Words : 1.NUTRITION 2.RESEARCH NUTRITION 3.NUTRITION STATUS 4.MALNUTRITION 5.FOOD SECURITY 6.COMBATING HUNGER 7.HUNGER 8.COMMUNITY NUTRITION 9.UNDER FIVES 10.SOUTH ASIA.

RURAL DEVELOPMENT

36. Balakrishnan, Maya et al. (2005).
Documentation of the micro planning process and its impact on village development in Nandurbar district, Maharashtra. Pune : Yashwantrao Chavan Academy of Development Administration. 55 p.

Abstract : The micro planning programme spearheaded in Maharashtra state by UNICEF is a part of a new paradigm of rural development. Conceptually, it is a process of empowering individuals at the grass root level with the goal of shifting from a provider-beneficiary approach to development to a partnership approach wherein local communities and development functionaries work together in planning, implementing and monitoring village level programmes. The Health Micro Planning Programme was initiated in Nandurbar District in July 2003. This programme aims to initiate political mobilisation of villages through a five day exercise. The main objective of the study was to document the process of social change brought about by the village micro planning exercise. Additional goals of the programme were to improve health awareness, to instigate health behaviour change, and to build human capacity in order to enable communities to be self reliant in planning solutions to their own development problems. The study took place in 3 villages, i.e. Pati, Mohanpada, and Rajvihir village of Nandurbar district, Maharashtra. The study participants included village residents, village leaders, Government workers and Government officials, village volunteers, UNICEF facilitators, block coordinators, consultants and district coordinators. After the intervention it was found that there was improved garbage disposal, resulting in improved cleanliness seen across the three villages. There was increased building of soak pits and drainage systems resulting in improved village sanitation. There was increased awareness and demand for Government programmes such as maternal and child health services (MCH), anganwadi services (ICDS), medical services, and available Government schemes that provide for improved water access, roads and other infrastructure. There was increased awareness about personal health issues such as hygiene, maternal

health care, safe drinking water, etc. The five day programme, with several participatory exercises, had mobilized the village community to form strong groups such as Yuva Mandal (Youth Groups) and SHGs. Based on these observations, it was concluded that any programme seeking to empower communities must take into account the pre-implementation context in terms of prior mobilisation efforts, physical resources and available infrastructure. In communities that have had no prior mobilisation efforts, continued efforts to provide capacity building and material resources are needed to sustain the impact of programmes like ‘‘micro planning’’.

Key Words : 1.RURAL DEVELOPMENT 2.MICRO PLANNING 3.COMMUNITY MOBILIZATION 4.MOBILIZING COMMUNITY 5.ICDS SERVICES.

37. Barma, Dibesh Deb, Fedotova, Tatiana and Tozana, Rajkumari. (2006). The Open Defecation Free Campaign in Osmanabad district, Maharashtra. Tuljapur, Maharashtra : Tata Institute of Social Sciences. 43 p.

Abstract : Total Sanitation Campaign (TSC) was launched at the national level in 1999 and in Osmanabad district of Maharashtra in 2003. The goal of Open Defecation Free (ODF) villages is one of the TSC objectives, which aims to solve problems such as faecal contamination of drinking water sources, the transmission of water and sanitation related diseases, and environmental degradation. 2 villages of Osmanabad district of Maharashtra were selected namely Bornadiwadi (model village) and Wanegaon (initial stage of the ODFC) on the basis of population size. Participatory Rural Appraisal (PRA) technique, focus group discussions (FGD) and semi-structured interviews were used for primary data collection. Secondary data was obtained from research reports of government, Tata Institute of Social Sciences and UNICEF. Information was gathered from Gram Panchayat members, Sarpanch and Upp Sarpanch, 3 ICDS helpers from 3 Anganwadis, an ICDS supervisor, 7 school teachers, school students and Swachata Doots (SDs), 3 elderly people, 2 families during house visits, Village Water and Sanitation Committee (VWSC) members, youth groups and adolescent girls, 6 staff members of Osmanabad Zilla Parishad, 5 members of SSP and staff of TISS rural campus. Major health improvements were observed due to reduced water contamination, and less chance of flies acting as disease transmission vectors through food and water contamination. Surface and ground water contamination was reduced and quality of drinking water was enhanced. School students, women and VWSC members cleaned the village, waste management improved and specific locations were allocated for waste

disposal. Implementation of ODFC was a driving force for mobilizing the village community towards a common goal. As open defecation spaces are far from the village, villagers save time once they acquire the habit of using toilets located near their homes. Women welcomed this initiative as they do not have to leave their homes for open defecation. In Bornadiwadi, SHGs were given importance as their financial contribution was essential for implementation of ODFC. Government schemes such as Jal Swarajya (safe and pure drinking water) and Hariyali (forest and water management) are brought to villages to bring development projects to rural areas. Awards instituted at state and national level enhance people's empowerment, build self confidence and lead to a better image of villages. Due to ODFC, rural people in these villages avoided visiting relatives in neighbouring villages who did not have toilets. Children who acquire this habit would ensure an open defecation free environment in rural areas in future also. Working towards a common goal contributes to unification of Gram Panchayat and different political parties in the village. Villages that win awards use the prize money for village development.

Key Words : 1.RURAL DEVELOPMENT 2.SANITATION 3.ENVIRONMENTAL SANITATION 4.TOILETS 5.COMMUNITY MOBILIZATION 6.OPEN DEFECATION FREE CAMPAIGN 7.SELF HELP GROUPS 8.YOUTH GROUPS 9.OSMANABAD 10.MAHARASHTRA.

38. Bhatewara, Indira, Sangtam, Lemlia T. and Khan, Sumaira. (2006). Role of youth in micro planning : a case study of impact and effective strategies for sustainability. Tuljapur, Maharashtra : Tata Institute of Social Sciences. 44 p.

Abstract : Micro planning is a process which aims at involving people from the grass roots level in their own development. The involvement of youth in the micro planning process was studied in Latur district. The process has been initiated in more than 754 villages spanning 5 blocks of Ausa, Ahmedpur, Nilanga, Latur and Udgir. 3 villages were chosen for the study. The micro planning process brought to light the issue of unclean surroundings, so youth initiated a cleanliness and tree plantation drive. Youth started activities like blood donation camps, extra classes for dropout students, and talks by experts were held in old buildings misused previously for defecating and dumping garbage. This enhanced their organizational skills and boosted self esteem. Youth realized the importance of awareness about HIV/AIDS and were motivated for new income generation activities. They were united and developed personal skills and individuality through various activities. After micro planning was initiated youth took up the

issue of care of women during pregnancy and demanded good care and hygienic conditions in medical centres during delivery; families also took better care of them. SHGs in the village consisted of 11-12 women each which managed loans among themselves at an interest rate of 3% for expenditure on nutritional needs of malnourished children, building toilets, meeting dowry demands during weddings, etc. Every member was able to read and write her own name. Youth groups were also involved in community development, including child development. Adolescent boys received counselling and guidance for problems and were directed to undertake new initiatives, such as extra classes for dropouts, and information about cleanliness and hygiene through games and demonstrations. Schools now had classes up to 10th Grade as the importance of education was realized. Youth brought a change in sanitary habits of people, enhanced toilet use and created awareness about proper disposal of waste water of households. Youth spread awareness about preventive care for chikungunya, AIDS, etc. through skits, and clarified misconceptions about AIDS which had a positive influence on people's attitude towards safe sex practices. The Panchayat became more accountable. Youth submitted a complaint to the Medical Officer (MO) of PHC regarding service delivery of health workers, and the rapport between youth and health professionals improved. In Jawali village youth were sensitized to gender issues. Earlier most girls could not come out of their homes due to parental pressure, but after sewing classes were initiated girls came out of their homes and women's participation increased. Young men and women attended agricultural exhibitions which provided information about agro based businesses. Youth felt that villages should be addiction and open defecation free places. Women went to hospitals for treatment of illnesses and some went for deliveries. They adopted better health practices. Jawali had 4 SHGs having 11-12 members each. Various issues were discussed like domestic violence, alcoholic husbands, lack of education, low status of women and lack of organisation among women themselves. Women's marginalization was reflected in the absence of their representation and leadership in the Gram Panchayat and Gram Sabha. In Jawali the Sarpanch and Panchayat were skeptical of youth efforts but in Lakhangaon they were cooperative. Youth took up child care issues and meetings were open to all. Members were concerned about ill effects of superstitious beliefs and contacted 'Andhashraddha Nirmulan Samiti' to dispel superstitious beliefs from the minds of people. Youth influenced people in starting sanitation and health awareness drives and campaigns. Number of people picking up condoms increased after they were sensitized to the AIDS issue. In Karkatta, transport facilities were taken care of and many girls and boys went out of the village to pursue higher education. A library was started by youth which was fully functional with daily newspapers, periodicals and magazines. Community members took specific responsibilities in the Action Plan and in carrying activities forward. Women convinced their husband to built toilets. They dug soak pits in houses to dispose waste water. They used dippers to draw water

from containers, added Medichlor to drinking water, and eradicated chikungunya. Women got support from savings groups, they were able to read and write, and made dairy products and sold them. They took responsibility to stop child marriages in the village and became confident and courageous to ask husbands about their earnings. Women encouraged their daughters to get educated, earn for themselves and be independent and self-reliant. Women started anti-addiction campaigns which reduced incidents of domestic violence. People were mobilized for programmes like Jal Swarajya and Total Sanitation Campaign. Impact on the community as well as health workers was greater and the rapport was much better than in the other two villages. People should be mobilized to develop their own local area.

Key Words : 1.RURAL DEVELOPMENT 2.MICRO PLANNING 3.ROLE OF YOUTH 4.CHECKLIST FOR CHILDREN 5.CHECKLIST OF SOCIAL INDICATORS.

39. Chakraborty, Bindiya et al. (2006).
Sanitation and hygiene in rural Jharkhand : experiences in programmatic implementation. Ranchi : Xavier Institute of Social Service. 41 p.

Abstract : Water and Environmental Sanitation Programmes have been in operation in India since the early 1960s. Rural sanitation covered only 22% of the population in 2001 and expanded at 1% per year for 2 decades from 1981-2001 (UNICEF, 2004). This study assessed the implementation of Water and Environmental Sanitation (WES) programmes in Dumka district of Jharkhand, where over 38% of the population belong to marginalised communities and sanitation coverage reaches merely 4% of the rural population. 4 villages chosen for the study were Asansol, Basmata, Jonka and Sikandra. Information was collected from adult and child residents, Panchayat Heads and representatives of NGOs working in the area. Villages like Jonka and Asansol have received WES facilities and villagers have been exposed to sanitation and hygiene education. Basmata and Sikandra have been receptive to WES education. Sikandra had partial sanitation coverage, Basmata had toilets for only 1 year, and the entire community considered toilets to be a necessity. In Jonka, the absence of political leadership and a village committee made synchronized collective action difficult to achieve. In contrast, Basmata had a history of collective organisation around common objectives. Women's SHGs and community committees had widespread support and participation from village residents. Their support plays a major role in achieving full sanitation. The degree to which village residents understood the aims and intended outcomes of the intervention, including their

roles and responsibilities, was an important component of success. Government representatives can have a positive impact on the degree to which a programme achieves participation and ownership by community members. In Basmata, Government provided reeling machines to produce silk as an income generating activity. This led to other positive outcomes. Sustainable behavioural change can be brought about only by sanitation education. The presence of separate toilets for girls and boys in schools is a key determinant of female retention rates in schools, hence more such toilets should be built.

Key Words : 1.RURAL DEVELOPMENT 2.SANITATION 3.ENVIRONMENTAL SANITATION 4.TOILETS 5.COMMUNITY MOBILIZATION 6.JHARKHAND.

40. Dutta, Debarun, Kuruvilla, Ann George and Namy, Sophie. (2006). Impact of micro planning on social exclusion. Pune : Yashwantrao Chawan Academy of Development Administration. 52 p.

Abstract : Social exclusion is a holistic framework for understanding inequalities, that seeks to uncover the subtle causes that limit participation from certain members of society. Although the Constitution and Government policies embrace equality as a fundamental virtue, exclusion remains prevalent in India, standing as an obstacle to further human development. Micro planning uses a participatory approach to encourage the involvement of the most maginalised individuals. This case study is an attempt to evaluate the impact of micro planning on social exclusion in Jalodhi village, located in the district of Chandrapur, Maharashtra. Jalodhi is mainly agricultural, and has a mixed population of scheduled castes (125), scheduled tribes (154), and other backward castes (581). Studies have found that SC/ST population has “lower access to capital assets like agricultural land, has lower urbanization rate and employment diversification away from agriculture and high dependence on wage labour, has high under employment, etc”. In this study, covering 20 SC/ST and 2 OBC households, 8 families were below poverty line (BPL), 3 were SC/ST and 5 were OBC households as per Gram Panchayat records. 3 of 5 Gram Panchayat members from Jalodhi represent the lower castes, but SC/ST reserved seats do not exert equal power. 40% SCs were not educated, 11% OBCs were educated upto 11-12 Standard and 9% were educated upto Class 12 and above. All 40 respondents indicated that they felt comfortable entering public spaces and attending marriages and festivals. 65% of marriages still occur among women below the age of 18 years, only 70% mothers breastfed their children exclusively for 6 months, and 62% deliveries were attended by skilled personnel. 75% women made contributions to the family income. 9 out of 11 loans were used for

agriculture, and in 2 cases non-agricultural investments were made. Only 10 women participated in the Gram Sabha as compared to 27 men. 54 girls and 53 boys were enrolled in Talodhi's primary school (FGD with teachers). 3 women in Talodhi had education beyond Class 12 as compared to 11 men. No incident of maternal mortality was reported, and 78% of the women surveyed practiced family planning. Only 35% women had institutional deliveries, despite free universal health care. After the intervention, women became capable of going to banks on their own and making business transactions. They become more bold and daring due to involvement with SHGs. In 1991, 119 women were literate compared to 220 men but by 2001, 216 women were literate compared to 298 men. Jalodhi had 100% enrollment of children in primary school and 10% dropout rate in 1999 (NYK data). No discrimination was reported in the school, and children from all caste groups sat and ate together, and had equal access to water and sanitation. IMR was 36 (Sample Registration System, 2004) and the prevalence of underweight children was nearly 50% (1999, National Family Health Survey 2). 68% of the respondents had a monthly per capita income of less than Rs 500, and these were either landless persons or owned less than five acres. It was recommended that monitoring activities such as monthly meetings and the regular revision of the village plan should be restarted; gram sabha meetings should be rescheduled; strong links between the elected body and villagers should be formed; and SHGs must be encouraged to develop awareness of their rights and entitlements and pursue new avenues for income generation.

Key Words : 1.RURAL DEVELOPMENT 2.MICRO PLANNING 3.INCLUSION 4.INCLUSION OF CHILDREN 5.SOCIAL INCLUSION 6.SELF HELP GROUPS 7.VULNERABLE GROUPS 8.MAHARASHTRA.

41. Fahimuddin. (2008).
Working of National Rural Employment Guarantee Scheme in Sitapur district : study report. Lucknow : Giri Institute of Development Studies. 27 p.

Abstract : National Rural Employment Guarantee Scheme (NREGS) is a legislation enacted on August 25, 2005, which provides a legal guarantee for 100 days of employment in every financial year to adults of rural households willing to do public work related unskilled manual work at the statutory minimum wage. The present study was conducted in 2 gram panchayats namely Imipur Grant and Runcot of Khairabad block of Sitapur district. A total of Rs 7555 crores was

allocated under NREGA for Sitapur district during 2007-08. Each block of the district got 5-6% of the total allocation. Among 19 blocks of the district, Pahla block received maximum 9.16% while Aliya block received minimum 3.52% of the total allocation. During 2006-07 and 2007-08, 4 types of work were undertaken like Ponds, Kharanja, Minor Irrigation and Plantation. In 2007-08, utilization of the sanctioned amount on wage component was low for ponds (60.49%) and minor irrigation (21.55%) as compared to Kharanja (93.62%). During the initial year of implementation of the NREGA, total job card holders were 894 but in the subsequent year 2007-08 their number was only 132. Women job card holders were only 12, SC card holders were in the majority (96), followed by OBCs (26) and minorities (10) in 2007-08. This showed that people were not coming forward to demand jobs as the pace of the programme is increasing while the situation should have been otherwise. Beneficiaries reported that only 50% families were listed under BPL category. 38% beneficiaries were landless and 52% beneficiaries had less than 1 acre holding. 56% of the NREGA beneficiaries reported that women's participation was not 33%. Majority felt that roster based applications for the work was not followed and most of them did not go beyond their village for work. On an average 1 person per family got employment and during 2006, 2007 and 2008, each person got employment of 78 days, 75 days and 90 days respectively, which was less than the promised 100 days of employment. Thus, more employment days need to be provided to workers under NREGA in the district. Around 70% of the beneficiaries reported that project work was prepared in Gram Sabha (village) meetings and 66% informed that they participated in these meetings. Only 50% of the NREGA beneficiaries reported that the details of sanctioned work and its amount was read out in Gram Panchayat meetings and list of the work was displayed on the notice board of Gram Panchayats. Various discrepancies were reported in the payment of wages by the NREGA workers. It is mandatory in the NREG Act that workers must be paid within 7 days of end of work, but 30% of them reported that they did not get the payment within the stipulated time. 50% said that their payment remained due after completion of the work, and only 50% of the total workers were paid the minimum wages prescribed under the NREG Act. Women are given less wages on the pretext of their being women. When workers failed to finish work within the stipulated time, their wages were reduced. Impact of the NREG Programme on providing greater employment and income opportunities to rural workers has been positive. Assets created under the programme have been mostly of durable nature. The programme has boosted the overall development of villages. It was recommended that the stipulated number of days of employment should be provided.

Key Words : 1.RURAL DEVELOPMENT 2.NREGA 3.NATIONAL RURAL EMPLOYMENT GUARANTEE SCHEME 4.RURAL EMPLOYMENT 5.EMPLOYMENT GUARANTEE SCHEME.

42. Gray, Sarah, Narayan, Camille and Thomas, Sajan. (2005).
Partnerships for hygiene and sanitation promotion : the case of UNICEF Gujarat and the Vasudhara Dairy Union, Valsad. Pune : BAIF Development Research Foundation. 45 p.

Abstract : According to the World Health Organisation's 'Global Burden of Disease 2002' estimates, diarrhoea accounts for nearly 15% of under five mortality each year in developing countries, numbering about 1.6 million deaths. Some of the major diseases affecting children under five years are Hepatitis A, polio, typhoid, E. coli, diarrhoea and cholera which are associated with unsafe drinking water, sanitation and hygiene conditions, and are transmitted via the oral-faecal contamination route. From 2003, UNICEF Gujarat and the Vasudhara Diary Union (VDU) in Valsad district, Gujarat have developed a partnership to implement UNICEF's Child Environment Corner (CEC) as a tool for promoting low cost sanitation and hygiene education. In 1999, the VDU implemented a low cost latrine programme, which allows members to borrow Rs. 3,500 on an interest free loan basis to be used for construction of household toilets. So far 35 dairy cooperative societies have financed the construction of 765 toilets in members' homes. 466 out of 681 Cooperative Societies (72%) were managed and run by women. VDU established its own scheme to finance milch animals and had helped 398 diary cooperatives (DCs) (11670 women members) with finance for purchasing milch animals. Presently, 150 out of 750 households in the village had toilets, 46 of them financed by the Diary over the last 3 years. The CEC training materials offer basic guidance on skills for monitoring the programme. UNICEF needs to monitor and measure behavioural change to assess the field situation. Non-dairy members are also encouraged to attend DCS and SHG meetings to learn about the linkage between child survival, sanitation and hygienic practices.

Key Words : 1.RURAL DEVELOPMENT 2.SANITATION 3.ENVIRONMENTAL SANITATION 4.HYGIENE 5.CHILD SURVIVAL 6.DAIRY COOPERATIVES 7.SELF HELP GROUPS 8.TOILETS 9.VALSAD 10.GUJARAT.

43. Gupta, Kasturi et al. (2005).
The Impact of the Total Sanitation Campaign on household sanitation in West Bengal : a case study of Amdanga and Haldia blocks. Kolkata : Institute of Social Sciences. 52 p.

Abstract : Sanitation is a combination of personal, domestic and environmental hygiene referring to a series of hygienic practices in the private (i.e. households) and public (i.e. schools, work places, community spaces, etc.) spheres, namely

use of proper toilets, clean water, clean surroundings, proper garbage disposal, etc. Democratic decentralisation has promoted the success of the Total Sanitation Campaign (TSC) in West Bengal (WB). In WB, there are 7 committees which form the institutional structure for the devolution of the TSC. They are: State Level Co-ordination Committee, Task Force, Zilla Parishad, District level Co-ordination Committee, Block level Co-ordination Committee, Village Health and Education Committee and Village Water Committee. This case study compares the results of the sanitation programme in 2 blocks of WB, Amdanga (Purba Medinipur) and Haldia (North 24 Parganas). The major political obstacle to achieve overall effect and impact in the context of TSC has to do with Panchayat priorities in terms of development. Second obstacle was linked with political party dynamics. Main economic obstacle to achieve the desired TSC objectives in terms of latrine coverage was financial constraints at the household level. Contrary to published reports and interviews with officials, women's participation in the TSC has been low. Social obstacle to achieve desired TSC objectives is related to the degree of involvement of the NGO. Cultural obstacle to the achievement of TSC objectives is the way of life of many rural families, and involves a series of daily household practices which are part of a mentality and cannot be transformed easily. Effects of TSC were increase of latrine coverage throughout WB; improved sanitary practices in rural households; increased awareness of sanitation due to education and awareness campaigns; improvement of health conditions in rural areas; decrease in diarrhoea and cholera cases; and improved environmental conditions in several villages. Before 2002-03, less than 500,000 households had a latrine, but by 2004-05, more than a million households had been covered. A misconception among bureaucrats at the state, district, block and panchayat levels was that lack of sanitation results from lack of literacy. In Moricha (Amdanga block), the Panchayat adopted several tactics to convince the households to buy a latrine. These involved subsidies for kerosene in exchange of the purchase of a latrine. In Haldia some pressure tactics were adopted such as threats of public denunciation of families. The sale and finance pattern of toilets is quite consistent with the costs. Rural Sanitary Marts (RSM) have adopted an effective social marketing strategy which has geared up its revenues. Political leaders from various parties have united on the vision of Nirmal Gram (Clean Village). Audit agencies have the responsibility for monitoring and evaluating the TSC in villages. All sectors of the industry and departments of the Government have to be involved in the campaign for it to become a success story. Family members being educated was a major factor contributing to the success of the programme. Participation of women is necessary for the TSC to work and be implemented in every household. Monitoring exercise should be done by independent monitoring agencies for

proper installation of latrines, that is size of pits made and nearness to water bodies.

Key Words : 1.RURAL DEVELOPMENT 2.SANITATION 3.ENVIRONMENTAL SANITATION 4.TOILETS 5.SCHOOL SANITATION 6.TOTAL SANITATION CAMPAIGN 7.COMMUNITY MOBILIZATION 8.WEST BENGAL.

44. Ovung, Nchum et al. (2007).
Village planning : empowering people through self help. Lucknow : Social Consultancy Services. 43 p.

Abstract : The Village Planning (VP) intervention is a Government of Uttar Pradesh (UP) and UNICEF initiative implemented by the Sarathi Development Foundation (SDF) in Lalitpur district of UP. The research investigated three main problems, firstly, whether the success of village planning in generating demand for services is matched by a similar improvement in service delivery; secondly, whether the benefits of the village planning intervention extended to socially excluded groups; and thirdly, whether the benefits of the VP intervention would be sustainable beyond the period of UNICEF's funding and SDF's involvement in the village. On key social development indicators, Uttar Pradesh performs worse than India as a whole on almost every measure; and the number of people living below the poverty line (BPL) was 31.2% in UP compared to 26.10% in India. Infant Mortality Rate is 80 in UP and 63 in India. Children fully immunized were 44% in India but only 28.7% in UP; the percentage of population over 7 years who are literate was 56% in UP and 65% in India. The VP exercise seeks to bring change in 18 key indicators across three blocks namely Birdha, Talbehat and Jhakhaura. It has succeeded in increasing the number of mothers initiating colostrum and breastfeeding from 39% to 86.2%; it has increased the number of children in the age group 14-18 years with knowledge of AIDS from 0% to 41.3%; it has increased the school enrollment of children in the age group 6-14 years from 91.2% to 98%; full immunization increased to 49.4% from 39.9%; decrease in child marriage was negligible, from 56% to 55.4%; institutional deliveries increased upto 28.8% from 19.1%; use of iodized salt increased to 53.7% from 15.4%; and it has ensured that 36.7% (or 140 of 381) of the non-functioning hand pumps were repaired. There was increase in use of toilets and birth registration to 62.4% and 66.4% respectively. The coverage of toilets has barely increased from 0.7% to 1.4% in Sunaura and from 3.5% to 14.5% in Jamalpur. In Sironkhund the use of toilets increased from 38% to 78%. From the reassessment of Lalitpur district, where village planning has so far taken place, it was seen that different indicators have shown improvement. More efforts need to be focused on breaking down the barriers to ST community members accessing

key services; village planning must place more emphasis on educating the Pradhan, volunteers and community members on the government schemes whose benefits they are entitled to in order to prove what village planning can accomplish. For ST community members field coordinators should initiate a process for speedy sanctioning of rations. Hence village planning has been fairly successful in generating demand for services on the part of the community. But this increased demand still needs to be met by an equal and opposite improvement in supply.

Key Words : 1.RURAL DEVELOPMENT 2.MICRO PLANNING 3.VILLAGE DEVELOPMENT 4.SELF HELP 5.ICDS SERVICES 6.COMMUNITY INVOLVEMENT.

45. Prasad, B.N. (2009).
Impact assessment of National Rural Employment Guarantee Scheme in Uttar Pradesh, Sonbhadra district. Lucknow : Giri Institute of Development Studies. 73 p.

Abstract : Gandhiji said, ''If villages prosper the country will prosper, if villages sink the country will sink''. Keeping this in view, the Indian State has initiated a number of development measures for all round development of India. Poverty and unemployment are two major problems India faces. The central Government launched ''National Employment Guarantee Scheme'', the NREG Act received President's assent on 5th September 2005, and was notified on 7th September 2005. It was initially introduced in 200 backward districts on 2nd February 2006, and later extended to another 130 districts from 1st April 2006, thus covering a total of 330 districts. From 1st April 2008 the scheme has been launched in 604 districts in India. In UP the scheme was launched in the first phase in Hamirpur and Sonbhadra districts. The study assessed impact of the scheme on livelihood conditions; participation of the under-privileged sections; female empowerment; strengths and weaknesses of the scheme; and aimed at suggesting measures for effective implementation. 2 villages from all 8 blocks of Sonbhadra district were selected for the sample survey, covering a total of 16 villages. The sample was 400 households who participated in the scheme and 135 non-beneficiary households. 4 sets of questionnaires were used namely Block Level Schedule, Gram Panchayat Level Schedule, Beneficiary Level Schedule and Non-Beneficiary Level Schedule. Sonbhadra is one of the most backward districts of UP, and SC population is 48.57% in rural areas and 13.22% in urban areas. Out of the total work force (main + marginal), 73.13% are engaged in primary sector; 34.79% are cultivators and 38.34% are agricultural labourers. Other occupations

and Household Industry had 24.38% and 2.49% workers respectively. This indicates the importance of NREGS for poverty alleviation and employment generation in rural areas of the district. The scheme was found to be beneficial as rural connectivity improved, water conservation has helped crops and cattle, *khet talab* (field ponds) improved the condition of the population, migration to urban areas reduced, etc. In 2006-07, 22.41% works were completed while in 2007-08, only 18.74% works were completed. 87.50% block officials said that funds reached the Gram Panchayat within 15 days, but this was not confirmed. 97% admitted that workers do not receive dated receipts for their application for work. The number of families who got 100 days of employment in 2006-07 and 2007-08 was 7.02% and 8.32% respectively. Women's participation has been satisfactory at 29.59% and 32.35% respectively during 2006-07 and 2007-08, which was higher than Hamirpur, where it was 23.25% and 23.67%. Majority of the beneficiaries were in 15-45 years age group. Sources of income revealed that NREGS was the 6th source in 2007-08, contributing 11.11% share of the income. 99.50% beneficiaries were unaware of unemployment allowance and 99.25% mentioned that shade, medical, and crèche facilities were not available at work sites. Their standard of living was low as 92.59% people were living in temporary homes and none of them had electricity connection. 70% were engaged in non-agricultural activity and 94% in construction sector. 89% said that officials did not accept their application for registration, 64% applied but were still waiting for job cards, 40.74% reported that discrimination prevailed on the basis of caste, religion and sex. More than 59% respondents wanted to work but did not get work, 30% reported that they did not have job cards, in almost 5% cases payment was pending, and 6.36% faced problems as they had small children. It was suggested that Office of Block Programme Officer and Gram Panchayat should be strengthened by increasing manpower. Technical staff should be properly paid for better coordination between staff and NREGS staff. Number of Panchayat Mitras should be increased through written exam. Families who got 100 days of employment in both years was low, which must be checked. Non- completion of on-going projects needs strict monitoring. People's participation can be increased through meetings of gram sabha, rallies, *nukkad natak* (street plays), etc. Committees, grievance cells, etc. should be made functional, and training and orientation programmes for NREGS staff should be organized. Newly elected Pradhans must be a part of capacity building programmes. A copy of NREG Act should be made available at Gram Sabha level.

Key Words : 1.RURAL DEVELOPMENT 2.NREGS 3.NATIONAL RURAL EMPLOYMENT GUARANTEE SCHEME 4.RURAL EMPLOYMENT 5.EMPLOYMENT GUARANTEE 6.ROLE OF PANCHAYATS.

46. Prasad, B.N. (2008).
Impact assessment of National Rural Employment Guarantee Scheme in Uttar Pradesh, Hamirpur district. Lucknow : Giri Institute of Development Studies. 80 p.

Abstract : In the 59th year of Independence, Indian Parliament passed "National Rural Employment Guarantee Act" (NREGA) in September 2005, towards partial fulfillment of a Constitutional obligation under Article 41, which provides non justifiable 'Right to Work' to every citizen of the country. NREGS was initially introduced in 200 most backward districts on 2nd February 2006, and later extended to 130 districts from 1st April 2006, thus covering a total of 330 districts. From 1st April 2008 the scheme has been launched in all 604 districts of India. The objective of the study was to analyse the processes during initiation and execution of NREGS in UP. 350 beneficiary households (BH) from 14 villages of Hamirpur district were selected, and 115 non-beneficiary households (NBH) were also covered. The study was conducted during 2006-07 and 2007-08. The total BPL population was 339258, of whom 183185 were males and 156073 were females. The total BPL population comprises 56798 (31%) males and 47654 (30.53%) females of SC category, 86254 (47.08%) males and 72869 (46.68%) females under OBCs, 22388 (12.23%) males and 19860 (12.73%) females under General Category, and 17745 (9.69%) males and 15690 (10.06%) females under Other Category. In 2007-08, Rs. 20197 lakh was sanctioned and Rs. 11748 lakh was utilized i.e. 58.17% of the sanctioned funds. Flow of funds from block to panchayat and beneficiary level was delayed due to reasons like favouritism and unethical demands made by block officials and unfavourable behaviour of bank employees, etc. Number of families employed for 100 days during 2007-08 was 18.13%. Women's participation was 23.67% in 2007-08, which was less than 33% norm of the scheme. NREGS is the 7th major source of income of beneficiary households. In 2007-08, 2225 offers were obtained and accepted, and 904 works were completed. Selection of work is done through open meeting of local panchayat and is approved by district panchayat. Main works selected by Gram Panchayat are water conservation, connecting roads, construction of dams, medh bandi (28.57% each), plantation of trees, construction of bridge/culverts and ponds (14.29% each). To make NREGS successful wide publicity was given – messages, notices and information including the labour rate were given in newspapers (71.42%), meetings of Gram Sabha, through writing on walls (57.14%), *nukkad natak* (street plays) and pamphlets (28.57%), and departmental meetings (14.29%). Work distribution was communicated through *munadi*/ *nagada* (drums), meetings (28.57%), gram panchayat officers, telephone and weekly staff meetings (14.28%). 85.71% respondents did not get offers either from Forest Department or Irrigation Department. 85.71% officials

said that they attended meetings of social audits, discussed the works with villagers, and formed committees to look at the under construction and constructed assets under NREGS. 71.43% block officials said that there was no provision for maintenance of assets created under NREGS. 98.57% panchayat pradhans said that on-going projects have been prepared at district level and 1.47% pradhans mentioned that it was done at panchayat level. 90% pradhans said that wages were now paid through banks, 7.14% mentioned post offices, and 2.86% said it was paid in cash. 90% respondents admitted that applicants got work within 15 days, 7.14% said that it took a month, and 2.85% said that it took more than a month. Only 30% pradhans admitted that Gram Panchayats read in front of Gram Sabha the projects sanctioned, amount granted and expenditure incurred on projects in the past 6 months. To improve the implementation of NREGS it was recommended that money should reach in time (42.85%), sufficient funds should be allotted, there should be increase in number of bank employees, technical staff should be appointed in gram panchayats at block level (28.57%), there should be separate staff for NREGS, solution should be found to problems in opening of bank accounts, and arrangement of conveyance for field staff (14.29%) should be made.

Key Words : 1.RURAL DEVELOPMENT 2.NREGS 3.NATIONAL RURAL EMPLOYMENT GUARANTEE SCHEME 4.RURAL EMPLOYMENT 5.EMPLOYMENT GUARANTEE SCHEME.

47. Vestrheim, Kristin et al. (2007).
Decentralized planning process : awareness and actions for improving key social indicators. Kolkata : Centre for Studies in Social Sciences. 43 p.

Abstract : The government programme of Strengthening Rural Decentralisation (SRD) focuses on the establishment and implementation of pro-poor participatory planning for sustainable local development in the 6 most backward districts of West Bengal. It is a holistic programme that covers livelihoods and social and infrastructural issues and operates through panchayati raj institutions (PRIs). The study covered 2 Gram Panchayats (GPs) of Sonathali and Beko in Kashipur block of Purulia district. 3 villages (Koshijurhi, Lori and Pabra) of the Sonathali GP and 2 villages (Myasaradih and Beko) of Beko GP were covered. The total number of households was 2,633 in Sonathali and 2,358 in Beko. Sonathali was observed to be better than Beko, which could be attributed to the implementation of SRD and better performance of panchayat officials. Awareness among villagers led to increased demands for social action and better service delivery at the community level. In Beko, the panchayat office held no specific campaigns

and meetings on health and education. General health problems prevailing in both blocks were reported to be jaundice, typhoid, diarrhoea, viral fever, tuberculosis, measles and malaria. Low access to safe and clean drinking water, poor handling and purification of water, risky sanitary practices and undesirable hygiene habits contributed to the disease burden. In Koshjurhi at least one tube well was seen, but in Lori the well dug by the Gram Unnayan Samity (GUS) was dry. Most people in Sonathali understood the importance of good personal hygiene and habits relating to the handling of water but they were unable to practically translate this awareness into their every day behaviour. In Myasaradih GS, there was lack of awareness of good personal hygiene practices related to the handling of water and washing of hands. In primary school it was observed that hygienic habits had not been stressed upon by school officials. Children were observed washing their plates in a dirty pool near the toilets and they reported that their teachers never explained about hygienic practices. In Sonathali, sanitation remained a difficult task for panchayat functionaries to address and resolve. Purulia ranked the lowest i.e. 17th among the districts of WB. Some families had toilets in their houses. Pradhan (Village Head) reported that 70-80 household toilets were constructed in 2006. However, only 60% of those having toilets used them. A major reason for failure in toilet construction was that villagers preferred the comfort zone of defecating in open fields. The Government scheme of providing Rs.225 for constructing toilets for BPL families has not been successful as most families wanted toilets of better quality. In Beko, some progress was made for providing toilets in homes under schemes like Indira Awas Yojana, Sampoorna Grameen Rozgar Yojana, etc. Around 40% households in GP had latrines. In Myasaradih there was a toilet at the primary school. Although women have expressed a need for toilets, no demand was made to the Panchayat and GUS. Staff at primary school and ICDS centre in Myasaradih GS encouraged toilet training among children as many felt uncomfortable using toilets. Awareness level in Sonathali was high on issues concerning the health of women and children, knowledge about the benefits/necessity of consuming iron folic acid tablets, breastfeeding, use of institutional delivery, family planning, avoiding early pregnancy, etc. but this did not translate into every day practices. Most women in both Lori and Koshijurhi never consumed IFA tablets because they induced nausea. Most mothers recognized the importance of breastmilk, but women in SHGs of Lori did not feed infants colostrum. Institutional deliveries are increasing in panchayats and are around 40-50%. However, most deliveries take place with the help of trained '*dais*' (midwives). Knowledge of family planning methods like oral contraceptives and condoms was minimal. Early marriage is common in Sonathali as most parents view the girl child as an additional burden on the family. In Beko, there was low awareness on maternal and child health. Awareness about education is quite good in Sonathali and there are no dropouts. In Koshijurhi there were 141 children enrolled in the primary school. In Koshijurhi and Lori mid day meals were

attracting and retaining children in primary schools. But institutional problems like poor standard of teaching, irregular supply of books, absenteeism, etc. hamper the positive progress made in raising educational consciousness in the community. In Beko GP, 361 children were enrolled in school and 8 teachers were employed. In Myasaradih there were 54 children and 2 teachers in the primary school and dropout rate was 5%. Teachers did not impart sex education even though it was a part of the curriculum. In Sonathali there were 22 ICDS centres and the ICDS centre in Myasaradih covered 96 families with 53 children aged 0-6 years, about 20 children came to the AWC, and ICDS worker reported serving food to 40-45 children and mothers every day. Villagers need to be informed about the activities and functions of the GUS and GP and they should be actively involved in the process of planning and implementation.

Key Words : 1.RURAL DEVELOPMENT 2.MICRO PLANNING 3.DECENTRALISED PLANNING 4.COMMUNITY INVOLVEMENT.

SCHEDULED CASTES/ SCHEDULED TRIBES/ OTHER BACKWARD CLASSES

48. Dar, Anandini et al. (2007).
Access to protection of dalit girls : an inquiry : the case study of Garhi Chhaju, Haryana. New Delhi : Indian Institute of Dalit Studies. 54 p.

Abstract : The study investigates the issues of protection faced by Dalit girl children, and the focus was on the access to protection in a rural setting. The village of Garhi Chhaju in Haryana was chosen for this investigation and four main institutions were identified as protectors: the family, panchayat, school and police. The National Crime Records Bureau (NCRB) 2005 recorded a 3.8% increase in crimes against children from 2004 to 2005. Another main area of concern is corporal punishment, and a study on child abuse conducted in 2007 reported that 69% of the respondents had undergone corporal punishment in school. Dalit children in India have been subjected to or been witness to several instances of rape, beatings, deaths, sexual harassment and untouchability. Haryana is a state where Dalits comprise as much as 19.5% of the population. The girls from Garhi Chhaju attending Standards 6, 7 and 8 in the government school were selected as respondents. Being Dalit increased vulnerabilities to issues of sexual harassment, violent abuse and constraints in accessing protection, which arise from just being economically disadvantaged, being Dalit as well as being girl children. 11-14 year old Dalit girls in Garhi Chhaju were

often eve teased and taunted by boys from Jat community from both Garhi Chhaju and Jorsi and this was the major reason for girls to drop out of school. Most Dalits in Garhi Chhaju did not have toilet facilities in their homes. The women and girls of these families are targeted with the intention of irritating or reprimanding the Dalit boys, and as a result girls face violence, sexual harassment and abuse. Upper Castes use members of the SC community for perpetrating atrocities on SCs knowing that the 'Prevention of Atrocities on SCs Act' cannot be used to punish them. At the Government Girls' Middle School in Jorasi corporal punishment is considered to be the most efficient means of disciplining, and while some parents did express concern against corporal punishment, they were violent on their own children at home. Both dalits and non-dalit in Garhi Chhaju expressed disdain towards the corrupt practices of police. In Garhi Chhaju, parents mostly reacted to issues of sexual harassment or violence through informal coping mechanisms which implied restricting the girl at home and discontinuing their education. The Special Component Plan in India stipulates a monthly stipend for dalit girl children to support and aid their education. If the distance from middle school to home is more than 2 km the government provides bicycles to girls. This stipend of Rs.350 per child per month is being distributed to girls in government schools. Regular monitoring system for evaluating the performance of local institutions such as panchayats and schools should be formulated and implemented.

Key Words : 1.SCHEDULED CASTES 2.SC GIRLS 3.PROTECTION OF GIRLS 4.PROTECTION OF SC GIRLS 5.PROBLEMS OF ADOLESCENT GIRLS 6.EVE TEASING 7.SEXUAL HARASSMENT 8.HARYANA.

49. Fahimuddin. (2009).
An Evaluation of Pre-Matric Scholarship Scheme for OBC students in Uttar Pradesh and Uttarakhand. Lucknow : Giri Institute of Development Studies. 73 p.

Abstract : Education is one of the important components of effective development of weaker sections. The Government of India constituted a Working Group for the Development and Welfare of Backward Castes. Based on this, a Centrally Sponsored Scheme of Pre- and Post Matric Scholarships for the Other Backward Castes (OBC) students was launched in 1998-1999. Under the scheme, students in Classes 1-5 and students in Classes 6-8 were given scholarship of Rs. 25 and Rs. 40 a month respectively. This study evaluated the success and failures of the scheme in UP and Uttarakhand, and aimed to suggest suitable modifications, if needed. This study also assessed the

relationship of the scheme with the dropout rate, quality of educational attainments and timely receipt and disbursement of funds. The sample covered five districts from UP and two districts from 2 regions of Uttarakhand. The total number of OBC students in 4 districts of UP were 300, Allahabad (95), Barabanki (61), Jalaun (42), Moradabad (51) and Shrawasti (51). The number of sampled OBC students in 2 districts of Uttarakhand were 141, Udham Singh Nagar (85), Haridwar (56). One block was selected from each district, and from each block 2 schools were selected. From each school, 10% of all students were interviewed who were OBCs and received the scholarship. Data showed that 3 crore (30 million) students received pre-matric scholarships in UP, out of 3.14 crores students who received all types of scholarships at primary and upper primary levels. 96% OBCs received pre-matric scholarship. The number of students who received pre-matric scholarship was 1.14 crores in western region, 1.20 crores in eastern region, 47.36 lakh students in central region, and 17.24 lakh students in Bundelkhand region respectively. Of the total amount earmarked for Pre-Matric Scholarships, 53.87% was spent on OBCs, 27.63% on SCs, 0.25% on STs, 7.58% on Minorities, and 10.67% on General Students. In primary schools in Moradabad, Allahabad, Shrawasti and Jalaun the whole scholarship was disbursed to OBCs students. 82.47% of the funds were spent on Pre-Matric Scholarships, while 17.53% was spent on Post-Matric Scholarships in UP during 2008-09, upto 15.10.2008. In Uttarakhand, disbursement of amount received was 100% in Udham Singh Nagar and Haridwar district during the years 2003-04 to 2007-08. 48% of total OBC students took admission in Class 1 in UP, and 39% in Uttarakhand, 25% in Class 2 in UP and 29% in Uttarakhand. In rural areas children start studies late as parents have lesser understanding of the importance of education. Around 93% OBC students were getting Pre-Matric Scholarship in UP but in Uttarakhand only 7% OBC students got the scholarship. 94% OBC students get free books, all get mid day meals (MDM), 37% get free dress, 59% had furniture to sit in class, and only 36% get games items in UP, but all get free books, MDM and games items in Uttarakhand. Problems in receiving the Pre-Matric Scholarship at primary schools (PS) are frequent cancellation of fixed date followed by delay in payment, less payment in UP, while in Uttarakhand the situation was better. 25% students faced one or the other problem in upper primary schools (UPS) of UP, but students of Uttarakhand did not face such problems. Pre-Matric Scholarships in PS in UP and Uttarakhand augment the family income, and are used for consumption purposes and health care needs, thus fulfilling their varying needs. Pre-Matric Scholarships at UPS in UP and Uttarakhand are used by the parents of students for purchasing books, buying clothes and treatment of illness. Majority of Class V and Class VIII students had mid level achievement in Hindi, English and Maths in UP and Uttarakhand. Thus, OBC students were neither very good nor poor in studies. More than 70% of the parents in UP were engaged in agricultural activities. 32% parents of UPS students in Uttarakhand and 28% in UP worked as agricultural

labourers. More than 45% parents of students in PS in UP had annual income less than Rs. 20,000 while in Uttarakhand 59% parents of students have income within Rs. 20,000 to Rs. 40,000. Annual income of parents of UPS students in UP was 42% below Rs.20,000 and in Uttarakhand it was 36% below Rs.20,000. Only 13% parents in UP and 2% parents in Uttarakhand reported scholarship as the reason for enrollment of their children to PS, but nearness of school to village and better education were the main reasons behind higher enrollment. Free education was an incentive in UP and Uttarakhand. In UPS in UP, 11% parents mentioned that scholarships were the reason for higher enrollment. In Uttarakhand only 4% gave scholarship as the main reason for admission of children in UPS. 31% parents in UP and 100% parents in Uttarakhand reported irregular payment of scholarships in PS. In UPS, 26% parents in UP and 100% parents in Uttarakhand reported irregular payment of scholarships. It was found that payment of Pre-Matric Scholarship to OBC students in UP and Uttarakhand did not lead to substantial increase in enrollment and continuation of studies. It was recommended that amount of scholarship should be increased. Coverage of scheme should be extended to all OBC students in UP and Uttarakhand. It should be ensured by the Department of Welfare that malpractices such as less payment are stopped. It should be mandatory that details of scholarship like name of recipient students and amount and date of disbursement should be written on the walls of the schools. The scheme deserves to be continued.

Key Words : 1.SC/ST/OBC 2.PRE-MATRIC SCHOLARSHIP SCHEME 3.OTHER BACKWARD CLASSES 4.SCHOLARSHIPS OBC 5.UTTAR PRADESH 6.UTTARAKHAND.

50. Holzwarth, Simone, Kanthy, Soumya and Tucci, Rosarie. (2006). Untouchable in school : experiences of dalit children in schools of Gujarat. New Delhi : Indian Institute for Dalit Studies. 58 p.

Abstract : In 1999, 120 million children in the world were out of school of whom 38% were from South Asia (UNICEF, 2004). To fulfil the commitment to the 3rd Millennium Development Goals (MDG) to achieve Universal Primary Education (UPE) by 2015, the Government of India (GOI) aims to provide quality education upto Class 8 as stated in the 83rd Constitutional Amendment in 1997. In 1971, only 29.45% of the total population was literate, but by 2001 it was 65.38% (GOI, 2001). In 2000, GOI started the Sarva Shiksha Abhiyan (SSA) to provide quality education for all children, and UNICEF was a partner in this initiative. All children aged 6-14 years were to be provided relevant elementary education by 2010. Dalit children (SCs) face hardship in school because of their caste. Formally

known as ‘‘untouchables’’ they have been renamed ‘‘dalits’’ meaning ‘‘broken people’’. Dalits perform occupations like manufacturing leather (chamars), sweeping, and removal of human waste (valmiki), rendering them ‘‘achchut’’ (untouchable). Traditional rules prohibit physical contact with them. Constitution penalises discrimination based on exploitation, exclusion and humiliation. About 48.1% of Dalits in rural India live below the poverty line as compared to 31.3% of the total population. As per Census 2001, 46.85% dalits were educated, 80.58% were dropouts between Classes 1-10, and often it is difficult for dalits to attain higher education. The study focused on 2 locations in Surendranagar district, the boarding school in Katariya (run by the Navsarjan Trust) and the village school in Gosal. In addition, the school in the village of Bhalgawada was included for observational purposes. 21 dalit children were covered: 10 from Gosal and 11 from Katariya, who were in Classes 5-7. 70% dalit children do not go to the houses of dominant caste children and vice versa. 13% SC children reported that upper caste children visit their homes, and 17% dalit children reported that there were reciprocal visits. Dalits had to depend on the dominant caste women to receive water, and wait in line until served, as they were not allowed to directly access the public source of drinking water. Dalits face hostile environment with overt untouchability while exchanging items and money in shops. 81% dalits were denied access to temples; only 19% were allowed to go inside. Dalits are given tasks such as removing animal carcasses, gathering wood for funeral pyres and wedding rituals, spreading dung and mud in others residences, work in fields, and for these tasks they were paid nominal wages. Dalit children reported that the result of their touch required fetching water for purification. Dalits were allowed to stand up or sit on the floor of the dominant castes. Children used to hesitate to move through a dominant caste area to avoid humiliation, taunts and teasing. In Gosal, 9 students responded that dalits and non-dalits never sat together. 50% students reported that teachers did not punish the dalits more than non-dalits, while 42% students reported that teachers punished dalits more than non-dalits. 50% dalit children reported that the teacher favoured upper caste children over dalits, while 42% said the teacher did not favour any one. 76% children said that dalits and non-dalits played together in school while 24% reported that dalits and non-dalits never played together in school. 71% dalit children do not play with other communities outside school. 33% dalit children reported that they were comfortable asking the upper caste students for help, but a majority (58%) said they were uncomfortable asking the higher caste students for help. On many occasions, in subtle ways dalit children are blocked from participating in cultural activities. Uniforms and books are given to all children but dalits and girls receive a higher stipend. Sometimes there was delay in receipt of payments. Positive discrimination sometime breeds further resentment within the dominant caste children and acts to brand the dalits. 78% reported that they wanted to go to secondary school. Dalit children should be included in Government of India’s and UNICEF’s education strategy, along with girls, urban

poor, working children and tribal children. Caste based discrimination should be countered through campaigns, teacher training, strategic planning and implementation of government programmes, and working with NCERT and NUEPA to include social issues in the curriculum.

Key Words : 1.SCHEDULED CASTES 2.UNTOUCHABILITY 3.SC CHILDREN 4.SCHOOL CHILDREN 5.DISCRIMINATION AGAINST SC 6.GUJARAT.

51. Prasad, B.N. (2008).
Changing status of dalits and emanating rural social formation in Uttar Pradesh : resilience and metamorphosis (Bijnor District). Lucknow : Giri Institute of Development Studies. 59 p.

Abstract : Uttar Pradesh (UP), India's diverse, most populous and key political state, is rich in natural resources but inhabited by poor people. Economy of the state is characterized as backward, with low level of income and productivity, preponderance of agrarian sector, low level of urbanization and literacy, under developed infrastructure and low level of investment. The present study is an attempt to analyse the socio-economic factors, e.g. educational attainment, employment status, awareness level, health situation, etc of dalits and their resultant impact on the emerging rural structure of the state. Two block of Bijnor district were selected i.e. Mohamedpur Devmal and Najibabad. 2 villages from Najibabad, Akbarpur Anola and Kashirampur and 2 villages from Mohamedpur Devmal i.e. Bagarpur Garhi and Tarikampur Roopchand were selected. 20 dalit households were selected from each village, thus the sample size consisted of 80 dalit households (HHs). The state's literacy rate was 56.27% (males 68.82%; females 42.22%). The literacy rate of Bijnor district is little higher (58.08%) (males 68.78%; females 46.10%). Total work participation rate in the district is 28.24% (males 46.45%; females 7.92%). The state's work participation rate is 32.50% (males 46.80%; females 16.50%). As per the industrial category, the proportion of other workers is maximum in the district (36.51%), followed by cultivators (29.26%), agricultural labourers (28.08%) and household industry workers (6.16%). Electrification of villages is better compared to the state figures. Problem lies at the level of power supply, where although villages are electrified the people hardly get electricity even for domestic uses. Overall, rural infrastructure is quite limited in Bijnor, which is a major impediment for sustainable rural development. The availability of educational infrastructure at primary and secondary levels is better as compared to the state, and the number of primary and secondary schools per hundred sq. km. is also satisfactory. Teacher student ratio at primary school is same in the district and state but this

situation is better for senior schools in the district as compared to the state. Number of allopathic hospitals and primary health centres (PHCs) per 100,000 population are higher in the district but number of beds in different categories of hospitals and number of child/ women welfare centres per 100,000 population are far less than the state average. Only 2 out of 4 sampled villages had all weather *pucca* (tarred) roads, and 2 villages had *kutcha* (non-permanent) and *pucca* roads. All sampled villages were electrified, and 4 villages had 575 electricity connections, of which 86.96% connections were for domestic use, 11.13% for agricultural use, and 1.91% for commercial purposes. No public or private wells were found in the 4 sampled villages. The number of public hand pumps was 20 in Tarikampur Roopchand and Kashirampur each. Private hand pumps were 250 in Kashirampur, 200 in Tarikampur Roopchand, 125 in Bakarpur Garhi and 50 in Akbarpur Anola. Literacy rate of 4 sample villages was 45.88% (males 46.53%; females 43.33%). Literary rate was higher in Akbarpur Anola (56.85%) and least in Kashirampur (25.22%). Other workers in the sampled villages were 740, followed by agricultural labourers (495), those engaged in animal husbandry (285), cultivators (125), construction workers (120), trade and commerce (36), transport and communication (31), household industry (11), and those engaged in non-household industry (8). The value of 50% residences was between Rs.50,001 to Rs.100,000, followed by 45% upto Rs.50,000, and 5% between Rs.100,001 to Rs.200,000. Maximum HHs had no electricity connection (76.25%), and they used oil lamps only. Surveyed HHs depended on their own hand pumps (41.25%) or public hand pumps (56.25%) for drinking water and other uses. 42.50% and 43.75% households got water within their premises. As toilets were not available most of them went out for their daily routine. They used wood as a fuel for cooking 88.75%. 45% have Khadanja road in front of their houses, 37.50% had *kutcha* road, 10% had *pucca* road, and 7.50% had *kutcha* - *pucca* (mixed) road. Most of the HHs lived below the poverty line, and had very few assets. 23.75% households (HHs) had a fodder machine, followed by 16.25% who had other agricultural equipments, 5% had pump sets, 3.75% had a bullock cart, 2.50% had a plough, and 1.25% had a sprayer. Cycles were used for transport by 77.50% HHs, 30% had radios, 27.50% had mobiles, 20% had an electric fan, 16.25% had furniture, 12.50% had a television, and 8.75% had a sewing machine. Only 3.75% HHs had LPG gas for cooking. As far as financial assets were concerned, majority of households (86.25%) intended to keep their money in banks and 52.50% kept their assets in the form of gold/ silver ornaments. 86.25% of the total HHs belonged to BPL category, but BPL Cards were issued to only 15% households. 66.18% dalit HHs reported that they were discriminated against by Gram Pradhan. All HHs who had BPL Cards, received ration from Public Distribution System (PDS). 25% BPL Card holders had problems due to insufficient quantity, 25% reported bad quality, and 16.67% reported dishonesty by PDS trader. 75% HHs said that there were lack of employment opportunities in the village, and due to scarcity of additional sources

of income, there was widespread poverty. Villagers wanted skill development programmes to be organized by government so that they could establish small cottage industries. Allotment of agricultural land was their priority.

Key Words : 1.SCHEDULED CASTES 2.STATUS OF SCHEDULED CASTES 3.DEVELOPMENT 4.EDUCATION SCHEDULED CASTE CHILDREN 5.LOANS FOR SC 6.DEBT SC 7.EMPLOYMENT SC 8.BIJNOR 9.UTTAR PRADESH.

SOCIAL DEFENCE

52. Ashok Kumar et al. (2007).
Juvenile justice institutions in India or child care institutions in India : an assessment. New Delhi : NIPCCD. 322 p.

Abstract : Children in conflict with law or child offenders, commonly referred to as juveniles or juvenile delinquents, are covered under the Juvenile (Care and Protection of Children) Act 2006. The number of such children has increased over the years, from 17,203 in 1994 to 32,145 in 2006. The Juvenile Justice Act (JJA) 2000 and its Amendment Act 2006 defines a child as a person up to the age of 18 years. The juvenile justice system in India is designed to trace two categories of children, those in conflict with law, and those in need of care and protection, which includes children who are begging, in prostitution, neglected children, abandoned children, abused children and street children, all of them with different needs and vulnerabilities. This study was conducted in 25 states and one union territory (UT) to assess the existing status of implementation of JJA; to create a national database on infrastructure and services under the JJA; to assess adequacy of infrastructure vis-a-vis standards prescribed in the Act and rules framed under the Act by respective states; to compare norms listed in the rules for the implementation of the Act in States for quality care and support for children; and to identify gaps and problems in the implementation of JJA. A total of 1135 Children's Homes were created under the JJA of which 69.25% were covered. Although Special and After Care Homes were fewer in number but 93.55% and 49.06% respectively were covered for the present assessment. It was observed that Shishu Grehs and other Homes were more crowded in terms of lack of space in dormitories, classrooms, and recreation rooms. Most of the Homes engaged doctors on part time/ contract basis and around 80% Homes had para medical staff. 57% children were between 6-14 years of age and about 33% children were in the age group 14-18 years. Maximum number of children were staying upto 3 years in Homes, followed by 3-5 years, and more than 5

years. Only 0.5% children died within institutions; about 6% were sent to hospital for treatment and died there only. Minimum standards of care and protection of children were prescribed in JJ Amendment Act 2006, and subsequent rules on the same were released in October 2007. More than 70% Homes had either a formal school within the premises, were providing non formal education classes, or provided some sort of coaching in their Homes. A total of 22% Observation Homes, 17% Special Homes, 30% Children's Homes, 14% Shelter Homes and 12% Aftercare Homes were not having school facilities within the premises. However, a total of 46.38% children were attending school outside the premises of different Homes. About 20% of the total children lodged in After Care Homes were also attending school outside the premises, and 39% Homes were having library facilities. Children were imparted vocational training in 14 different trades, the most common among them were electrical trade (1252 children), teaching (1012 children), printing (314 children) and fitter's job (279 children). About 11% Children's Homes and Shelter Homes were also imparting vocational training in different trades. 62% Homes had shown their inability to offer vocational training. 31% Homes were making efforts to take their children out of the Homes for exposure visits. As per the guidelines, medical facilities had to be made available to the children/ juveniles, and 36% Homes had a medical care unit inside the Homes; 43% each in Special and Children's Homes, and 33% Shelter Homes, 21% Observation Homes, and 19% After Care Homes had a medical care unit inside the premises. The most common diseases among children were tuberculosis (TB) (9%) and sexually transmitted diseases (STDs) (8%). Very few children (0.9%) had HIV/AIDS related problems and 16% children of different Homes had severe chronic diseases. It was observed that 42% Homes provided television and radio facilities. About 53% Homes were organizing cultural programmes inside the Homes and 34% were organizing the same outside the Homes. About 38% children were adopted so far since different Homes were established, and about 32% children were given for foster care and only 4% children were given assistance under sponsorship programme. It was recommended that vocational training in trades like computers, educational programmes like bridge courses, etc. should be provided for school dropouts. Minimum standards of care in terms of infrastructure (bathroom, toilets, etc.), clothing, bedding, diet, etc. should be provided, and Rule 44 should strictly be adhered to by each Home.

53. Equations, Bangalore. (2009).

Scott free! protecting children against sexual exploitation in tourism : challenges and imperatives in the Indian situation. Bangalore : Equations. 9 p.

Abstract : Ministry of Tourism, Government of India data indicates that the foreign tourist arrival in India, which was 2.29 million in 1996, reached 5.08 million in 2007. The number of domestic tourists recorded as 140.12 million in 1996 increased to 526.56 million in 2007. The tourism industry contributed 5.9% to the country's gross domestic product (GDP). Child exploitation in tourism is an organized and serious crime and is growing. The present study (2008), gave clear evidence of prostitution and sexual abuse of male children in well known and revered pilgrim tourist sites of Tirupati (Andhra Pradesh), Puri (Orissa) and Guruvayoor (Kerala). In 2007, Tirupati temple drew over 20 million visitors mostly domestic tourists and non resident Indians (NRIs). In Tirupati, Equations Team interviewed nine male children, aged eight to eighteen years. It was observed that sexual abuse took place in hostels, lodges, deserted construction sites, playgrounds, parks, cinema theatres, railway stations, stadia, cemeteries, etc. Domestic tourists often use small lodges and rooms in bars for this purpose. These children earned Rs. 500-2000 per day. Children continued to work in small hotels inspite of being poorly paid as it brought them into contact with customers who came both to eat and to have sex with hotel boys. It was found that children took up prostitution as they were the single male earner of the family and family members saw less risk, as the social stigma was less and fear of pregnancy did not exist. In Jagannatha temple, Puri, the number of domestic tourist arrivals were nearly 6 million and foreign tourist arrivals were around 42000. In Puri, Equations interviewed 13 male children aged 6-18 years, 8 from Pentakuta and 5 from the Puri beach area. It was found that sexual abuse took place in places like railway stations, hotels, small local food joints (called dhabas), lodges, on the beach, massage parlours and local prostitution houses. It was observed that in exchange for sex they got what they wanted such as good clothes, food, going around to see new places, watch movies, money and sometimes even satisfying family needs. Most of the children had sex with a wide range of tourists, some who paid just Rs. 50 while others paid Rs. 200 per day, and the rates differed from day to day. In Guruvayoor, Kerala where the famous Shri Krishna temple is located, over one million domestic tourists and about 1500 foreign tourists visited the site in 2006. Equations could not find any evidence of foreigners being involved in sex tourism in Guruvayoor. It was recommended that Governments, international agencies and the tourism industry must approach child exploitation with a sense of urgency and outrage. They need to play proactive, decisive and demonstrated roles in protection of children, and promise that tourism will be ethical, humane and non-exploitative. The Ministry of Women and Child

Development should enact a comprehensive act so that sexual abuse and exploitation of children (both male and female) is considered a very serious crime, the crime should be non-bailable, and severe deterrent punishment should be imposed on offenders.

Key Words : 1.SOCIAL DEFENCE 2.CHILD PROSTITUTION 3.SEX TOURISM 4.CHILD SEXUAL ABUSE 5.SEXUAL EXPLOITATION 6.LEGISLATIVE MACHINERY 7.BOYS ABUSE.

54. Kanth, Amod K. et al. (2004).
Juvenile justice system and rights of the child. New Delhi : Prayas. 137 p.

Abstract : Rights of the child and juvenile justice are issues which need to be addressed by one and all – citizens, civil society organisations and Governments. Juvenile Justice (Care and Protection of Children) Act, 2000, incorporates liberal thinking, international resolutions and national concerns with children and their problems based on interventionist approach; it protects and promotes children and juveniles facing adversity, and envisages a range of services which would enable them to participate in change and develop into constructive citizens. Boys and girls, aged 18 years or below, are covered by this law. This study was conducted by Prayas, a non-profit and non-political organisation, with a main objective to critically evaluate the organization, functioning and effectiveness of juvenile justice system in India with a view to improving the situation of children and juveniles, and to help them get reintegrated into the social mainstream. The study covered the state of Bihar and the NCT of Delhi. 494 institutionalized children aged 6-20 years had been contacted, out of these 38.3% were from Delhi and the remaining were in Bihar. It was observed that a majority of the children were Hindu (78.3%), followed by Muslim (19.2%), Sikh (1.2%) and Christian (1%). Nearly 25% of the children were illiterate and 76.2% were literate and had some schooling. The size of their family ranged from 3-10 (average size was 5.32 members). Children were working in wayside hotels or dhabas as labourers or daily wage workers, doing rag picking, selling water or eatables, working as domestic servants, working as porters at bus or railway stations, etc. Their monthly income, according to them, was as low as Rs 30 and as high Rs 10,000 (average income was Rs.1230.50). It was observed that family groups having step mother, step father, father dead, mother dead, both parents dead or mother who had deserted the family constituted high risk groups. Vulnerable children and juveniles come from low socio-economic strata of society, many of them have had indifferent role models and most of them had been a victim of push pull factors or adverse circumstances. It was found that 25% of the police

officers, both from Bihar and Delhi, have conducted enquires following directions from Juvenile Justice Board (JJB). While 38% of the children thought that most of the policemen performed their duty so that people could be safe, 7.7% of them felt that none of them do so. In Bihar, JJBs or Juvenile Magistrates have the necessary infrastructure. It was observed that during the year 2001, in 37.5% of the institutions run by voluntary organisations, escapes (children running away from the institution) have taken place. It was observed that most voluntary run institutions pay more attention to vocational training of resident children, i.e. candle making, computer typing, cutting, tailoring, repair of electric gadgets, auto repair, etc., as compared to government run institutions. Coordination and networking are a pre-condition for effective juvenile justice for many reasons. It was observed that a few police officers did interact with voluntary organisations, that too in Delhi. Similar was the case of the interaction or coordination with the members of Child Welfare Committee (CWC) and JJB. It was recommended that Special Juvenile Police Units (SJPU) should be constituted in all the districts, and appointment of a Juvenile or Child Welfare Officer (CWO) may be expedited on a priority basis. State governments and union territory administrations may constitute child welfare committees and Juvenile Justice Boards in adequate numbers to handle children and juveniles effectively and expeditiously. It was also suggested that Government of India may extend grants to state governments, municipal authorities and Panchayati Raj Institutions (PRI) to augment or modernize children's services in the country.

Key Words : 1.SOCIAL DEFENCE 2.JUVENILE JUSTICE 3.JUVENILE DELINQUENTS 4.RIGHTS OF THE CHILD 5.JUVENILE JUSTICE SYSTEM 6.RUNAWAY CHILDREN 7.INSTITUTIONAL CARE 8.OBSERVATION HOMES 9.INSTITUTIONS FOR CHILDREN 10.NUTRITIONAL STATUS 11.NUTRITIONAL STATUS INSTITUTIONALIZED CHILD 12.INSTITUTIONALIZED CHILD.

WOMEN WELFARE

55. Barman, Mita. (2002).
Persecution of women : widows and witches. Kolkata : The Indian Anthropological Society. 171 p.

Abstract : Bengal had the highest proportion of widows according to the Census of India. In West Bengal, 59% females in the age group 70-79 years and 72% females in the 80+ age group were widows according to Registrar General and

Census Commissioner of India (1998). The present study covered women who were widows and were without protection, and women who were prosecuted as witches in regions of West Bengal. The objectives of the study were to assess the condition of Bengali Hindu widows; to examine the beliefs associated with witches and witchcraft among the Santhal tribal community in West Bengal, and to study the use of gender as a regulatory mechanism in society. It was estimated that the population of Bengali widows was about 3000 in Vrindavan after a number of widows were sent there due to the natural calamity of floods in Bengal in 2000. It was found that the Dayabhaga laws of inheritance prevalent in Bengal gave limited rights to a widow in her husband's property. Rich and elite widows stayed at home, while the poor widows were sent to pilgrimage towns. In the early 20th Century in Bengal, it was observed that women from zamindar (land owning) families controlled the assets from *andar mahal* (inner palace) in the absence of a male heir or if the heir was minor. Female labour work force participation in West Bengal was found to be one of the lowest in the country. As far as Santhal society was concerned, it was found that in India, after the Bhils and Gonds, Santhals were the third largest tribal group. The practice of witch hunting was wide spread among them, especially to identify the root cause of ill health or misfortune, and the victims were generally women and mainly widows. Widows were alone without the support of a husband, family and sometimes even children. In Santhal society, widows had land rights so the exclusion or elimination of single women, mainly widows, resulted in direct material gain and inheritance of property. During 1991-2000, witchcraft related violence was found to be highest in Jalpaiguri and 33% victims were males. Many acts of violence, caused by factors like rivalry or drunkenness, were passed off as witch killing. After Jalpaiguri (70 cases), the other districts where witch killing was reported were Malda (29 cases), Purulia (21 cases), Dinajpur South (10 cases), Dinajpur North (9 cases), Hooghly (7 cases), Darjeeling (7 cases), and the lowest numbers were in Burdwan (3 cases) and Midnapur (3 cases). It was found that lack of employment and other related problems were the complementary features responsible for continuance of the witch killing practice. Therefore it is recommended that education programmes should be started to reduce the level of ignorance and eradicate unscientific superstitions and myths. It was also suggested that avenues for income generation should be started in tribal areas so that people have alternative means of earning a livelihood.

Key Words : 1.WOMEN WELFARE 2.WITCHES 3.WIDOWS 4.EXPLOITATION OF WOMEN 5.PERSECUTION OF WOMEN 6.WEST BENGAL.

56. Bureau of Police Research and Development, New Delhi. (2009).
A Noiseless crime : sexual harassment against women employees at private hospitals in Tirunelveli city : an empirical analysis. New Delhi : BPRD. 13 p.

Abstract : Sexual harassment of working women exists in various forms like discrimination, torture, attempted rape, rape, physical contact and advances, demand or request for sexual favours, remarks with sexual connotations, showing pornography and other unwelcome physical, verbal or non-verbal conduct of a sexual nature. The Indian Penal Code (IPC) deals with cases of sexual harassment of women under Sections 294, 354 and 509. The present study covered 80 respondents from among the women workers working in private hospitals in Tirunelveli city, and also included women from working women's hostels, hospitals, nearby bus stops, residential houses of respondents, etc. They were asked to respond to the queries based on their experience only from the last 3 years preceding this interview. It was found that 70% of the women workers in private hospitals were sexually harassed at their work place. 53.75% of the respondents were sexually harassed within a year from joining the job. About 62.5% of the women workers at private hospitals faced sexual harassment and victimization within the workplace, 6.25% were sexually harassed through mobile phone or telephone, about 45% perpetrators of sexual harassment incidents were married persons. Various forms of harassment faced by respondents were physical contact (17.5%), demand or request for sexual favours (16.25%), sexually coloured remarks (11.25%), showing pornography (2.5%), and unwelcome body language (12.50%). 80% respondents accepted that they knew or had witnessed the sexual harassment incidents of their female colleagues. This showed the intensity of sexual harassment at work place. Women workers accepted that sexual harassment at work place would affect their physical and mental state and personal safety and security. Of the 56 victims of harassment, no one came forward to lodge a police complaint against the harasser because it would affect their marriage (8), fear of family suspicion (6), feeling of shame or social stigma (6), fear of losing their job (8), not wanting to approach the police (5), and having no support from others (3). It was recommended that a special law should be implemented against sexual harassment, and awareness through posters, media such as TV, radio about Supreme Court guidelines should be spread by voluntary organisations and self help groups. Gender sensitization counselling should be given to male workers of both medical and non-medical staff at private hospitals. The Government should initiate and seek sponsors for research on sexual harassment.

Key Words : 1.WOMEN WELFARE 2.SEXUAL HARASSMENT 3.SEXUAL HARASSMENT AT WORK PLACE 4.HOSPITALS 5.PRIVATE HOSPITALS 6.TAMIL NADU.

57. Grover, Shalini. (2009).
Lived experiences : marriage, notions of love, and kinship support amongst poor women in Delhi. Delhi : Institute of Economic Growth. 33 p.

Abstract : Marriage is recognized as a crucial and life changing event for most Indian women, and their experiences of conjugal relationships, love and intimacy have recently begun to be the focus of scholarly research. There is an increase in the number of love marriages induced by modernity. Arranged marriages are typically within castes and initiated by parents while love marriages are self chosen unions preceded by pre-marital relationship based on love. Newspaper reports show that couples in Haryana who violate caste endogamy, or whose marriages breach customary rules of *gotra* (clan) and village exogamy, have to contend with extreme violence not only from their families but also from caste panchayats. Pervez Mody's studies have focused on violence, family exclusion and socio legal adversities that couples in north India face when opting for and forming a union of their choice. Madhu Kishwar's (1994) portrayal of arranged marriage as 'backward' and a love marriage as 'progressive' needs to be challenged. He also said that arranged marriages are stable since the 2 families establish strong bonds through regular reciprocal exchanges, and the material and psychological support extended by parents mitigates women's vulnerability in the marital home. A disadvantage of love marriage is by rejecting parental choice, a woman may lose family ties. In south India marriages are entered into with close kin (cross-cousins) in nearby and familiar locations, rather than with strangers in far off places. Close kin marriages enable women to exact better treatment from their affines than those in north India. Alienation is associated with a negative image of long distance marriages. Among the poor in urban north India, women marry into neighbourhoods that are within easy reach of their natal homes. Field work for this study was undertaken between November 2000 and April 2002 in Mohini Nagar, a low income neighbourhood in south Delhi, comprising both *bastis* shanty settlements, (jhuggi-jhonpri colonies) and resettlement colonies. In Mohini Nagar, South Delhi, spousal conflict was visible. While inter-personal differences can stem from a number of causes, marital tensions arise when men are unable to fulfil their role expectations as providers. As the husband is the one who takes responsibility for long term welfare of the family, economic fulfillment attracts women's highest praise, being synonymous with the expression of love. Many women were compelled to find a job because of personal shortcomings like excessive drinking of husbands, loss of job, etc. Women in marital crisis go to their natal homes which are located in Mohini Nagar or other parts of Delhi, 40 minutes to an hour by public transport. Also

Mohini Nagar data on arranged marriages illustrates that natal families in both slums and resettlement colonies offer shelter as well as emotional, financial and practical support to their married daughters during periods of domestic distress. Women affirm that by financially supporting their husbands, male insecurity and jealousy may deepen and lead to violence which is associated with insecurity, low self esteem and failure in men (Moore, 1994). Agarwal (1994) made a compelling case correlating women's welfare with land rights on par with men. It has been argued that access to micro credit loans increases women's voice in intra-household negotiations and leads to decreased violence against them (Kabeer 2001). Women stress that at times it is essential to leave children with fathers and the latter will not abdicate their responsibilities completely. Data indicates that marriage breakdowns are not irrevocable, rather the door remains open between husbands and wives allowing for future reconciliation. In Meerut, north India, Sylvia Vatuk (1972) described gradual but fundamental structural changes in the kinship system in middle class migrants families. Married daughters in Meerut frequently visited their parents, younger siblings spent long time with married sisters, and married sisters were found to be living closer to the natal home and keeping in touch with their families after marriage. Vatuk attributes changes to a bilateral shift in urban kinship in line with migration to the city. Husbands in Mohini Nagar complained that wives spent an unnecessary amount of time with their mothers which created conflicts between couples, aroused intense jealousy and violence, and led to conflicts regarding women's future rights in the conjugal home. In Mohini Nagar, although the practice of arranged marriages remains hegemonic, modern courtship is a visible trend among sections of young people. Love happens between neighbours. Uberio (1998) said in an 'arranged love marriage' in Mohini Nagar, the couple hopes that their parents will come around to socially accept and approve them publicly through the act of hosting the wedding. While an 'arranged love marriage' represents the best of both worlds from the couple's view point, they usually encounter dissent and opposition from their parents. On elopement and runaway marriage, literature (Chowdhry: 2007; Mody: 2002) revealed that couples who face violent reprisals in north India are compelled to escape from their homes and break away from families. In Mohini Nagar, couples who initially broke away from their families often reunite with them later. Love marriages in Mohini Nagar did not result in permanent ruptures, although some daughters have completely cut ties with their natal kin.

Key Words : 1.WOMEN WELFARE 2.MARRIAGE 3.LOVE MARRIAGE 4.ARRANGED MARRIAGE.

58. Jones, Nicola, Mukherjee, Madhuri and Galab, S. (2007).
Ripple effects or deliberate intentions ? Assessing linkages between women's empowerment and childhood poverty. New Delhi : UNICEF. 39 p.

Abstract : Women's empowerment is an effective strategy to reduce poverty. Women's Self Help Groups (SHGs) help to improve household well-being, lead to better outcomes for children, and promote social capital development through community involvement in poverty alleviation initiatives. One of the most common initiatives has been the provision of micro finance to SHGs. Women's empowerment leads to demands for better child-related services. 3 rural and 1 urban site was selected across the three main agro-climatic regions of Andhra Pradesh. These 4 sites are Amrabad, Mehboobnagar district, Telengana region (south); Anantapur, Anantapur district, Rayalseema; Seethampet, Srikakulam district, coastal Andhra region; and Attur Mandal, Cuddapah district, Rayalseema region. Findings revealed that average education expenditure (Rs. per child) among members of District Poverty Initiatives Programme (DPIP) SHGs and non-members were - for the category Poorest of the Poor, All Age Groups (5-18 years), Boy Non-Member Rs.320.9, Boy Member Rs.367.7, Girl Non-Member Rs.204, Girl Member Rs.255.5; for the Poor category All Age Groups (5-18 years), Boy Non-Member Rs.410.12, Boy Member Rs.504.2, Girl Non-Member Rs.239.8, Girl Member Rs.369.4; for Not So Poor category, All Age Groups (5-18 years), Boy Non-Member Rs.1069.7, Boy Member Rs.830.7, Girl Non-Member Rs.365.8, and Girl Member Rs.688.4; for Non-Poor category All Age Groups, Boy Non-Member Rs.1455.5, Boy Member Rs.719.9, Girl Non-Member Rs.1125.8 and Girl Member Rs.541.3. SHG women informed that Sarpanch was not entrusting any work like road construction to women, and they had been largely disappointed. Hence there was a mismatch between expectations and practice. Some rural women purchased milch animals which provided a modest income. Women's empowerment contributes to positive spillover effect on child well-being. Awareness channels including lectures by community public health workers, eye camps, vaccination programme, nutritional programme and home visits by SHG organizers promoted child well-being. Women became more aware of the need for educating children rather than sending them to work. To improve the impact SHGs have on children's well-being the following reforms were suggested - long term poverty reduction and women's financial empowerment will take place if SHG members have access to sustainable income generating opportunities; SHGs ability to carry out community monitoring and service provision roles should be assessed and strengthened; and literacy programmes

should be included in women's empowerment. A need exists to provide structured opportunities for SHG members to participate in democratic spaces.

Key Words : 1.WOMEN WELFARE 2.SELF HELP GROUPS 3.WOMEN'S EMPOWERMENT 4.EMPOWERMENT WOMEN 5.CHILD WELL BEING 6.WELL BEING OF CHILDREN 7.POVERTY ALLEVIATION 8.CHILDHOOD POVERTY.

59. Lawyers Collective Women's Rights Initiative, New Delhi. (2009).
Staying alive : third monitoring and evaluation report 2009 on the protection of women from Domestic Violence Act, 2005. New Delhi : LCWRI. 213 p.

Abstract : Violence against Women (VAW) is one of the most wide ranging yet under recognized human rights violations. Acts of VAW are a global phenomenon prevalent in all socio-economic structures and educational classes. In 1993, with the adoption of United Nations (UN) Declaration on Elimination of Violence Against Women, international law defined the concept of VAW for the first time as "any act of gender-based violence that results or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." In the Indian context, as a result of deep rooted cultural norms and patriarchal values, domestic violence is viewed as a private family matter that should be settled within the home without any need for unnecessary external intervention. Lawyers Collective Women's Rights Initiative (LCWRI) played a key role in drafting and campaigning for the law. This resulted in the enactment of the Protection of Women from Domestic Violence Act, 2005 (PWDVA) on 26 October 2006 and is one of India's key achievements to date in our mission to empower women through the law. This attempts to address gaps in the Indian legal system by recognizing a woman's rights to a violence free life by classing domestic violence as a Human Rights issue and a deterrent to development. One of the unique features of PWDVA, though it is primarily a civil law, is that an element of criminal law is incorporated within it to ensure more effective implementation. The key focus state for 3rd Monitoring and Evaluation Report (M&E Report) was Delhi (intervention state) where LCWRI conducted trainings and Rajasthan (comparison state) where there was no intervention. A sample of 250 police officers per state was chosen for the survey. The training in Delhi was on a gender sensitive approach through sessions that examined domestic violence as a Human Rights issue and discussed its impact on women. Findings from pre- and post assessment showed that PWDVA vests the Judiciary with discretionary power to provide timely relief and justice to aggrieved women. There was a positive shift observed in the normative role ascribed to men and women after the training. 40% Magistrates disagreed with the statement 'the

primary role of the man in the family should be that of the provider' compared to 15% before the training. Similarly 67% disagreed that 'the primary role of a woman is to take care of her children and other members of her family' after the training compared to 37% in the beginning. 10% change in attitudes was observed after training, 38% felt that welfare of the family came before the rights of the women. 95% considered PWDVA as an empowering law. Training contributed to the awareness that divorced women can file a case against their husbands (pre- 52% to post 88% scores) and women in live-in relationships can file a case against the partner's mother (pre-18% to post 48% scores). 88% women realized that in a domestic relationship women have the right to reside in the shared household whether or not she has any right, title or beneficial interest in the same. In 92% cases, husband provides the wife with an alternate accommodation, and after training 36% interpreted this as a right to reside in the shared household if it is owned by the husband. Findings from NIPCCD training programme shows a reduction in the number of participants who were of the opinion that DV could be resolved through counselling, that live-in relationships should not be covered under the law, and that beating one's daughter did not amount to domestic violence. Women approached Protection Officers (POs) directly as the State Governments conducted many awareness workshops and campaigns with regard to the PWDVA, and the public was made aware of the existence of the PO. Over a period of 3 years there has been a marked decrease in the number of cases in 15 districts. This is an important trend in this year's M&E Report. 27% POs in Delhi and 40% in Rajasthan assume that a daughter can file a case against her mother, and a mother-in-law against her daughter-in-law (20% in Delhi and 60% in Rajasthan). Surprisingly, 47% POs in Delhi and 34% POs in Rajasthan wrongly assume that a female domestic worker can file a case under this law against her employer. 100% POs were convinced about Protection Order and Maintenance Order in Delhi but only 7% POs were convinced about division of property and divorce. 90% POs in Delhi said that women approached them with complaints of being beaten and subjected to economic abuse. Slapping, name calling and forced sexual abuse in marriage were common, and 50% POs reported that women approached them regarding these issues. In Rajasthan, being beaten was the main complaint with 69% POs reporting this offence, followed by 67% for slapping, 41% for scolding, and 35% for refusing to give money. The pattern is similar across states with the exception of sexual violence, which was much higher in Delhi (53%) and least in Rajasthan (8%). This could be due to the socio-cultural milieu of the state and comfort levels of women in reporting these forms of violence. In Rajasthan 9 POs (90%) reported that women came to the police station (PS) with complaints of domestic violence on their own. Most of these women were between 20-40 years of age. 67% POs in Delhi and 58% POs in Rajasthan informed that women facing domestic violence had approached their PS in the last one year, of these 48% in Delhi reported that cases of domestic violence were recorded at PS. In

Rajasthan 80% POs confirmed that cases of domestic violence were recorded at their PS. 21% POs reported that women came with complaints of coercive sex. In Rajasthan 62% officers reported that women approached them with complaints of being slapped, followed by 38% reporting that women were scolded and refused money. 34.9% POs in Delhi and only 3.5% POs in Rajasthan reported that women approached the PS as they did not want to get married forcibly. 89% women in Rajasthan and 88% women in Delhi wanted the police to advise the husband and family members to stop violence, but only 9% women in Delhi and 7% women in Rajasthan were sent to health centres for treatment of their injuries. It was recommended that in order to be effective the law ought to be responsive to the needs of its users and practices of stakeholders. Training must focus on sexual, emotional and verbal abuse also. Counselling should be provided to restore women's self esteem, provide emotional support and assist them in making informed decisions as to whether they want to initiate legal proceedings. It was strongly recommended that the courts do not hesitate to grant *ex-parte* or *ad-interim* orders where there is a prima facie case and where the denial can lead to imminent harm and danger. There is a need for guidance with regard to procedures followed by the authorities having discretionary power.

Key Words : 1.WOMEN WELFARE 2.DOMESTIC VIOLENCE ACT 3.IMPLEMENTATION OF DOMESTIC VIOLENCE ACT 4.PROTECTION OFFICERS 5.ROLE OF PROTECTION OFFICERS 6.JUDGEMENTS.

YOUTH WELFARE

60. Ram, Usha et al. (2009).
Youth in India : situation and needs 2006-2007 : Rajasthan. Mumbai : International Institute for Population Sciences. 279 p.

Abstract : This study was conducted to identify key transitions experienced by married and unmarried youth in India. Young people aged 10-24 years number almost 315 million and represent 31% of the Indian population. The number are expected to increase and peak at around 358 million in 2011 before stabilizing at around 336 million by 2026. While today's youth are healthier, more urbanized and better educated than earlier generations, social and economic vulnerabilities persist. In the course of transition to adulthood, young people face significant risks related to reproductive health, and many lack the knowledge and power to make informed choices. This study was conducted in Rajasthan between March

and November 2007, and covered 10,002 married and unmarried young women and men. Work profiles varied widely, in total 60% young men and 50% young women reported that they had been engaged in paid or unpaid work. Young men were engaged in unpaid work (22%) and paid work (49%), and young women were engaged in unpaid (41%) and paid work (25%). More rural than urban youth had ever worked (63% versus 58%), and more rural young women had worked (64% versus 30% urban young women). 22% of young men and 36% young women had started paid or unpaid work before they were 15 years old. Young men in rural and urban settings worked in unskilled non-agricultural and skilled manual labour (74% and 73%). Few young men, even in rural areas reported agricultural occupations (19%) probably due to small land holdings. Young women in rural areas worked as agricultural labour (45%), unskilled non-agricultural labour (29%), and skilled manual labour (17%). Leading occupations in urban areas were skilled manual labour (51%); administrative, executive, managerial and clerical occupations (22%); and unskilled non-agricultural labour (17%). 13% young women and 5% young men reported unemployment. Differences by marital status indicate that unmarried young men were more likely than married young men to report unemployment (8% and 3%) respectively. Among young women, differences in unemployment were negligible; however urban married women (15%) were somewhat more likely than unmarried women (11%) to report unemployment. Married young men were more likely to have experienced work related mobility than unmarried men (20% versus 14%), perhaps because married men tended to be older and have more work experience than the unmarried men. 38% young men and 35% young women reported work related mobility, and had remained outside their home, village or neighbourhood for 3 months or longer. Most young women (93%) compared to just 5% young men were often engaged in housework. More than 50% young men reported “sometimes” participating in housework. 90% young men compared with 61% young women reported shopping for groceries sometimes. Tasks such as collecting firewood or fetching water and paying electricity or phone bills were performed by both young men and women. 86% young women and 68% young men are engaged in work inside the home and less likely to be engaged in tasks that violated norms restricting their mobility outside home. 12% young men and 22% young women had attended vocational training programmes. 19% young men compared to 5% young women had watched “blue” or pornographic films. More married than unmarried youth were exposed to pornographic films, 22% versus 17% among young men, and 7% versus 1% among young women. 29% and 15% of urban and rural young men respectively and 8% and 4% of urban and rural young women were exposed to pornographic material. 40% young men and 60% young women with both parents living acknowledged that they witnessed quarrels between their parents. Just 1% young men and women reported that they witnessed their mother beating their father, but 14% young men and 15% young women reported witnessing their

father beating their mother. Differences by marital status and rural – urban residence were narrow, but married respondents were slightly more likely than the unmarried, and the rural respondents slightly more likely than the urban to report witnessing their father beating their mother. Young women were more likely than young men to have savings (38% versus 23%). 41% and 18% married and unmarried young men had some savings. Urban young men (34%) and rural youth (19%), and urban young women (45%) and rural young women (36%) reported that they had some savings. 14% young men and 9% young women had a bank/ post office account. Married young men were more likely than married young women to own an account (25% versus 7%). Rural urban differences were apparent and more rural respondents owned a bank account (22% versus 11% among young men and 16% versus 7% among young women). 92% young men reported opening an account themselves, but only 40% young women had an account. Married persons were more likely than unmarried ones to operate their account on their own, and rural urban differences were negligible for both genders. 89% of young men compared to 75% of young women had held hands with a romantic partner; 71% and 47% respectively had kissed a romantic partner; and 45% and 19% respectively had experienced sex with a romantic partner. 50% young men in rural areas, compared to 31% of them in urban areas, and 25% and 8% of young women respectively, reported pre-marital sex with a romantic partner, a finding that may be attributed to the greater opportunities for privacy in rural compared to urban areas. 5% young men and 1% of young women mentioned that pre-marital sex occurred in a romantic relationship with a person of the opposite sex. Fewer than 1% reported the experience of forced sex (0.1-0.2%) or sex in exchange for money/ favours (0.0-0.1%). Casual sex was reported by 1% of the young men but not a single young woman. Just 0.2-0.5% of married young men and women reported having sex with their spouse before marriage (including some who had sex with a romantic partner whom they later married). Young men who reported having sex with the same gender were (0.3%) and sex workers (1%). In all, 14% young men 1% young women reported about pre-marital sexual relationships. Rural young men and the married ones are more likely than their urban counterparts to have experienced pre-marital sex (17% rural young men versus 11% rural married young men; 20% urban versus 15% married urban young men). Some young men (3%) and women (2%) had initiated sex before the age of 18 years. 3-4% of rural youth compared to 1% of urban youth had their sexual debut before the age of 18 years. 76-82% of the youth reported that they communicated with their spouse on whether to have children or how many children to have. Urban youth were more likely than rural youth to communicate on these matters (85-87% urban youth versus 74-80% rural youth). Almost all youth reported that they were very or reasonably happy with their married life. 68% and 50% respectively were very happy, and 31% and 47% respectively were reasonably happy with their married life. 1% and 5% of young men and women reported to have verbally

humiliated one's wife in the presence of others. 13% and 18% of young men and women reported the experience of slapping as a form of violence, 3-7% reported twisting the wife's arm or pulling her hair, 1% young men and 4-5% young women also reported that they had been pushed, shaken or had something thrown at them, punched, kicked, dragged or beaten. Hardly any young women (0.3%) reported an extra marital sexual encounter; in contrast, 3% young men, 2% urban young men and 4% rural young men, reported an extra marital sexual encounter. Among young men, 2% reported having extra marital sex in the last 1 year. Young women (16%) were more likely than young men (3%) to report symptoms of genital infection. While married and unmarried young men were equally likely to have experienced symptoms of genital infection, married young women were more likely than the unmarried ones to report these (21% versus 6%). Young rural women were more likely than their urban counterparts to have experienced genital infections (17% versus 12%). Majority of young men (91%) reported difficulty in finding employment as the biggest problem they faced (58%); followed by poverty (16%); concerns about lack of amenities or infrastructure i.e. water and sanitation, roads and electricity (12%); and lack of educational opportunities (5%). Young women mentioned that lack of amenities and infrastructure (30%), difficulties in employment (18%), poverty (17%), and lack of opportunities for education (14%) were the main problems they faced. Almost 80% young women reported facing these problems. Interventions for youth should focus on universal school enrolment and increase in levels of school completion; promote youth employment; promote youth agencies and gender equitable norms among youth; provide opportunities for formal saving for young women; promote youth participation in civil and political processes; provide family life or sex education for youth in school and out of school; and intensify efforts to eliminate the practice of early marriage.

Key Words : 1.YOUTH WELFARE 2.SITUATION OF YOUTH RAJASTHAN 3.EDUCATION RAJASTHAN 4.SEXUAL BEHAVIOUR 5.PRE-MARITAL RELATIONS 6.MARRIAGE 7.EARLY MARRIAGE 8.EMPLOYMENT 9.REPRODUCTIVE HEALTH 10.RAJASTHAN.

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