

A Study on the Functioning of ICDS in Coimbatore District

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Introduction

I INTRODUCTION

Children are our future and most precious resource. The quality of tomorrow's world and perhaps even its survival will be determined by the well being, safety and the physical and intellectual development of children today.

Nearly 40 percent of the population of India are children, with 16 percent below six years of age. They are a critical human resource whose growth and well being will determine to a large extent the course of India's social and economic future (Sharma, 1987).

Introducing the National Policy on children in 1974, our late Prime Minister Smt. Indira Gandhi (1984) exhorted that nature has endowed each child with curiosity, sensitivity and intelligence and these qualities must be developed so that the child may realise its full potential and make the world richer.

Despite the progress achieved since Independence, the quality of life of most children remains sadly below the standards envisaged by national policy makers. This is neglected through parameters such as high levels of infant mortality and morbidity rates and incidence of malnutrition and nutrition related diseases leading to temporary or irreversible disabilities and low literacy rates coupled with high rates of school dropout.

It is estimated that 241 lakhs of our children below one year, die each year in India and another 15 lakh die before they celebrate their 5th birth day. About 400 children die per hour from diseases that are preventable or manageable. One third of the child population below the age of six, that is around 40 million children do not have access to minimum essentials of health and nutrition. Such impoverished conditions needless to say, pose a serious threat to the development of human resource and ultimately to national development (Sharma, 1987).

Surveys carried out by the National Nutrition Monitoring Bureau in 10 States of the country indicate for the year 1982, that as per the Gomez classification, 1.5 to 15.2 percent children (1-5 years) were severely malnourished and 17.4 to 44.4 percent were in the moderate degrees of malnutrition. The lowest figure was for Kerala and the highest for Gujarat (UNICEF, 1983). Childhood mortality and morbidity lead to a substantial drain on the human resources of a country and may neutralise the benefits of economic progress (Morely, 1983 and Bose, 1986).

Poverty adversely affects the state of the children and entangles them in a vicious cycle. Among the poor, children are neglected at an early age who grow up in a bleak social and physical environment with consequent ill effects such as deprivations for good food, clothing,

shelter and schooling. Most of them remain functionally illiterate and are again doomed to a life of poverty (NIPCCD, 1984).

As the World Bank President Barber Canable (1988) has rightly pointed out that the stubborn fact of the eighties was that growth had been inadequate, poverty was still on the rise and the environment was poorly protected. Unchanged, these realities would deny our children a peaceful, decent and livable world.

From the moment of conception to the end of the first six months of life, the environment of the child is the mother. In that period the decisive factor in the child's survival and growth is the mother's nutrition and health. The key to child health lies in the emphasis given to all round improvement of the mother, her physical condition, economic status, health and nutrition and education (Gopalan, 1985).

Child welfare means and can mean nothing short of the total well being of the child. It comprises the totality of measures such as economic, administrative, technical and educational or social intended to give each individual an equality of opportunity for growth and development (Chowdhry, 1980).

Since India's Independence, the country's major development effort has been to improve the living standard of its poor. The Government has been greatly concerned about safeguarding and enhancing the development of children, particularly those from weaker sections of society. Welfare services for the young child, therefore, have become an integral part of the country's developmental plans.

The thrust on the various nutrition programme initiated in the country has been on the supplementary nutrition for children and their mothers with varying degrees of importance on related aspects such as food production, health check up, and immunization and health and nutrition education. The major nutrition programmes were the Applied Nutrition Programme - ANP (1963). Family and Child Welfare Projects (1967) Special Nutrition Programme - SNP (1970), Balwadi Nutrition Programme (1970) and Integrated Child Development Services - ICDS programme (1975).

Besides the centrally sponsored programmes, certain State Governments had also introduced nutrition intervention programmes on their own with or without financial assistance from external agencies. To cite a few, the Tamilnadu Integrated Nutrition Project - TINP (1980) initiated with the assistance of the World Bank, and the Tamil Nadu Government Chief Minister's Nutritious Meal Programme (1982)

now renamed as Tamil Nadu Government's Nutrition Meal Programme.

The National policy for children adopted in 1974 has emphasized the need to accord priority to children in the country's developmental efforts. The policy statement focusses on preventive and promotive aspects of child health and nutrition for expectant and nursing mothers. It thus aims to provide adequate services for children, both before and after birth and throughout the period of growth to ensure their full physical, mental and social development.

Today ICDS started in 1975 remains the single largest countrywide nutrition intervention programme for child development and adopts a holistic approach to improve both pre-natal and post-natal environment of the child. As such, mothers are also included in the programme's outreach. The programme aims to achieve four objectives.

1. To improve the nutritional status of children 0-6 years via supplementary feeding to 'selected' beneficiaries.
2. To encourage school enrolment via early pre-school stimulation programme for children 3-6 years old
3. To enhance the mother's awareness via health and nutrition education and

4. To co-ordinate with health departments to ensure delivery of the required health inputs including immunization to children and mothers, so that both mortality and morbidity rates decline over time. A package of six services are thus delivered through ICDS. (Figure.1)

- health checkup
- immunization
- referral services
- supplementary nutrition
- non-formal education
- nutrition and health education to mothers

This programme is centrally sponsored but administered by the State Governments. The responsibility for financing ICDS is shared between the Government of India and the States. The ICDS is a bold effort to overcome the stagnation and ineffectiveness of most traditional programmes for mothers and young children. The goal of ICDS is not merely to reduce morbidity and mortality but to lay the foundation for proper psychological, physical and social development of the child (Ghosh, 1981).

With a humble beginning in 1975 with 33 projects (each covering one hundred Anganwadis) today the programme has expanded to cover 1605 projects spread in all states and union territories of the nation.

SERVICES AND BENEFICIARIES

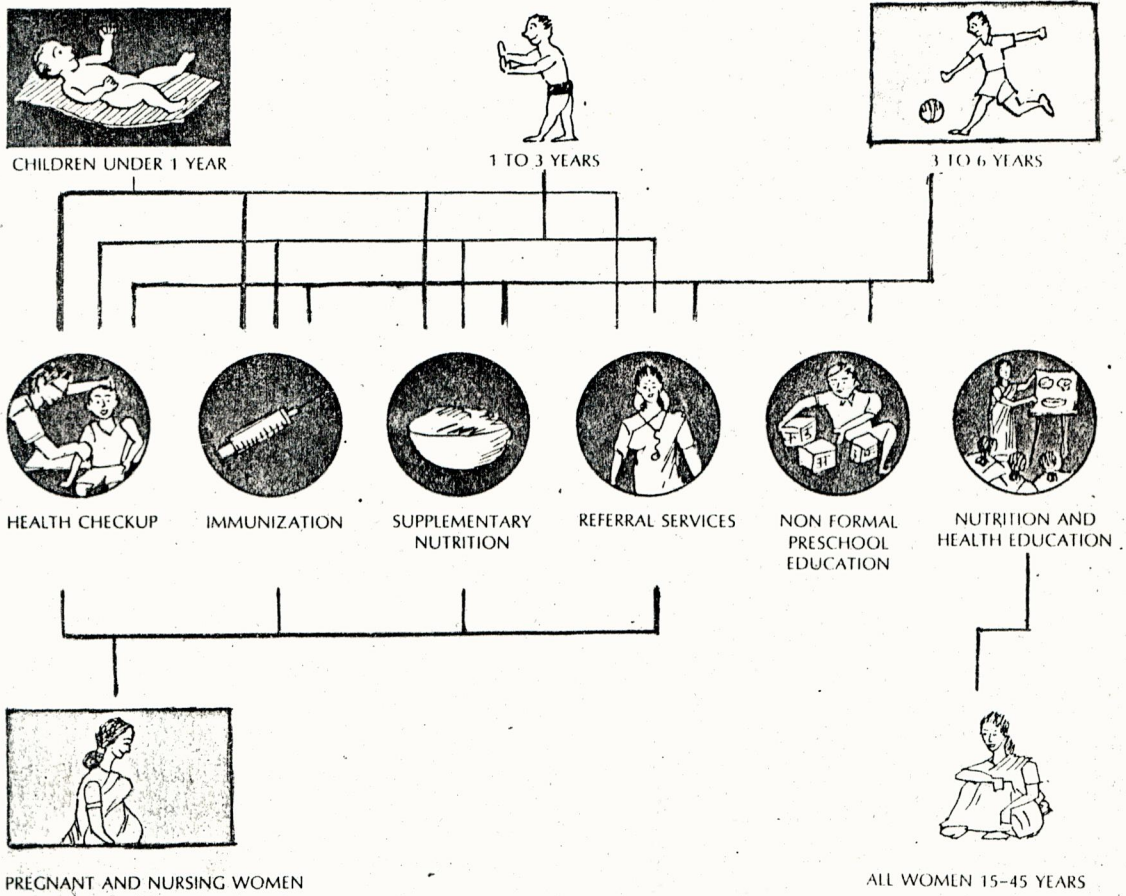


Fig 1.

The programme seeks to introduce major changes at the village level to create an environment congenial to child development. It provides access for young children to existing health services and offers them a mental stimulation by drawing on various - government non government and community resources. The degree to which this new structure influences the lives of children is dependent upon social attitudes which sometimes must be developed or altered. Changes of this nature occur gradually and are not easy to quantify.

ICDS programme had been in operation for the past sixteen years in Coimbatore District and it would be useful to assess both the qualitative and quantitative achievements of the programme. Hence the study on ICDS in Coimbatore was undertaken with following specific objectives.

1. Understand the functioning of ICDS
2. assess the coverage of the programme over the years
- and 3. other suggestions for the improvement of the programme.

Review of Literature

II REVIEW OF LITERATURE

The literature pertaining to this study were reviewed under the following headings.

- A. Significance of Childhood
- B. Importance of Children in National Development
- C. Measures to promote the Health of Children in India
- D. Integrated Child Development Services Programme
- and E. Research Highlights

A. Significance of Childhood

Bhandari (1983) says that 'Child is the father of man. The quality of an individual adult depends to a large extent on the opportunities he has to develop and grow as a child'.

Nayyar (1979) suggests that for a peaceful world of tomorrow we must begin with the children today. An investment in children is indeed an investment in the nation's future. A healthy, educated child of today is the active, intelligent citizen of tomorrow. A nation's children are its supremely important asset and the nation's future lies in their proper development (Ramamurthi, 1979).

Childhood is the most critical period in the life of an individual. Special importance is attached to the first six years of a child's life as these constitute the

formative period of the child development during which the foundations of the personality structure is laid (UNESCO, 1976).

Muralidharan (1969) says that the preschool age is the most impressionable age in one's life. Moreover the rate of development at this stage is so rapid whatever is learnt at this age gets so deeply embedded in him that it becomes difficult to change it later on. This is the period during which the foundations are laid for all future growth and development and preschool years are the most plastic and impressionable years of an individuals life (Misra, 1976).

This is a very sensitive period, involving varied experiences in child-child, child-teachers, child-parents and community relationship (Swaminathan, 1969 and Bhai, 1969).

Preschool period is the most sensitive period of child's life during which achievements are marvelously great and this is the period when right and wrong attitudes towards life and the world are formed and the child gets rightly adjusted to his social relations in his little world (Modak, 1968).

Ambron (1975) gives out the suggestion of Scott (1968) that the preschool years are of great important not only for social and emotional one but also for intellectual growth.

Rao (1970) characterises this age group as the most receptive to intellectual stimulation research evidences reveals that these years of the period in which one's level of ultimate development and achievement is practically fixed.

Bloom (1970) exhorts that the preschool years are the years in which general learning pattern develop most rapidly and failure to develop appropriate achievement and learning in these years is likely to lead to continued failure throughout the life of an individual adversely.

B. Importance of Children in National Development

A Nation's children are its supremely important asset and the nation's future lies in their proper development. An investment in children is indeed on in investment in the Nation's future. A healthy and educated child of today is the active and intelligent citizen of tomorrow (Government of India, 1978).

Effective national policies and plans regarding children can make a decisive contribution to all other long term development activities and particularly to the success of the programmes aimed at raising the quality of life of lower income groups and at building national capacities and self reliance.

The most important economic goal is to strive to protect the health and development of the next generation of young children in poorest regions. It is these children who will essentially lead our country out of economic stagnation and into an era of rapid development (Zeitkin, 1985).

The protection afforded to the mental and physical development of children is an investment in human capital and in the last two decades there has been a growing realisation that human capital formation has perhaps been the neglected factor in the struggle for economic development (Theodore, 1981).

Hans Singer (1985) said at an UNICEF symposium 'Any long term policy of human investment or human capital formation must start with today's children. Malnutrition amongst children has more devastating and more irreversible and more long term effects on the future productivity of children than in the case with adults (Singer, 1985).

Children below five years of age constitute nearly 13 percent of the population of India (Gopalan, 1987). The future of any nation is dependent on its children. They have to be adequately fed, properly clothed and reasonably sheltered. They have to be provided with congenial and conducive environment to grow and develop

into good citizens. Their latent potentialities must be allowed to flower and blossom by the adult world. Due attention to the proper development of our children in their formative years will ensure speedy progress of the nation on all fronts (Chilans, 1982 and Gangrade, 1982).

C. Measures to promote the Health of Children in India

Health and human development form integral components of the overall socio economic development of any nation. "Health which is a state of complete physical, mental and social well being and not merely the absence of illness disease or infirmity is a fundamental human right, health is the greatest asset in life".

Good nutrition is the foundation for health. It is the starting point for the welfare of the individuals and good nutrition is indispensable for satisfactory growth during infancy and childhood (Venkatachalam, 1983).

One third of India's child population below the age group of 6 years do not have access to minimum essentials of health and nutrition. While 80 to 90 percent of these children show retarded growth, one to two percent of them show severe protein energy malnutrition and 35 to 50 percent suffer from anaemia (Sharma, 1987).

Malnutrition has been one of the major causes of ill health and is a problem of considerable magnitude

in India and in most other countries extensive nutrition surveys have shown that women of child bearing age and young children living in rural and urban slum areas are the worst affected groups suffering from varying degrees of Protein Energy Malnutrition (PEM), nutritional anaemia and vitamin deficiencies (Swaminathan, 1983).

Women's status of health is closely related to the nutritional status of the child. Undernourished mothers frequently give birth to low birth weight babies jeopardising both the children's survival as well as their growth and development potential. It is estimated that 21 million low birth weight babies are born annually of which 20 million are in the developing countries. It is this segment of population that enters labour force with low education and low productivity. It is very important that health and nutrition well being of the mothers are given priority because they are the producers of the future labour force. Food taboos often restrict good foods at the critical time of pregnancy and lactation maternal morbidity. Frequent births, heavy household work and lack of opportunities contribute to the low health profile of women and girls in the 40 to 50 percent of the population below the poverty line (DEW, 1986).

In India, women's health is mainly threatened by, poverty, large size families early marriages, repeated

pregnancies, high mortality among mothers and children, ignorance, illiteracy and lack of material resources of food, shelter, clothing and employment. Women's health is one of the major programme activities of the WHO and is broadly subdivided into (a) maternal and child health care (b) human reproduction (c) nutrition and (d) health education. The objective of this programme activity is to assist Governments in their efforts to reduce infant and maternal mortality to advise on various aspects of family planning, to sponsor and coordinate studies on the scientific aspects of human reproduction in collaboration with FAO, to advise on ways of solving problems of malnutrition and to promote the education of all members of the family in the basic requirements for healthy living.

In most countries, it has been proved that a higher level of education for adult women has a most positive effect on the health of their children which also requires the improvement of the mother's health status. Just as the importance of women's educational level for improving their health and that of their children has also been proved at the family level, when the mother's educational level is higher, infant mortality diseases regardless of the family's socio-economic level. This is true if the father is also literate (UNICEF, 1982).

To tackle the problem of malnutrition among children it is therefore necessary to educate women, especially rural mothers of all pre-schoolers about health and nutrition (Mittal, et al., 1982).

Supplementary feeding programmes in pre and primary schools constitute one of the most promising and effective measures to overcome malnutrition among the children and mothers (Devadas, 1983). Supplementary nutrition means identifying and fulfilling the deficiencies of calories, protein, minerals and vitamins in the existing diets (NIPCCB, 1984).

The inter relations between the mother's diet during pregnancy, the infants birth weight and subsequent health status proved by numerous studies have led many countries to establish food supplementation programmes for pregnant and or lactating women along with those for children. Their objective is to increase the mother's food intake in order to improve the nutritional status of the mother *and* child Supplementation may enable mothers to be more active physically during their pregnancy and breast feeding period when the mother is more active, her relationship with her child improves and this in turn contributes to the child's better psycho-motor development (ADAIR, 1985 and Pullitt, 1985).

Many feeding programmes have been in operation in India over the past three or more decades under the auspices of government and or voluntary bodies (Swaminathan, 1970, Puri et al, 1984 and Sharma, 1986).

The chief among the nutrition programmes were:

1. Applied nutrition programme (1963)
2. Family and child welfare feeding programme (1967)
3. Balwadi nutrition programme (1970)
4. Special nutrition programme (1970)
5. Tamil Nadu Integrated Nutrition Project (1980)
- and 6. Tamil Nadu Chief Minister's Nutrition Noon Meal Programme (1982)

These programmes were coordinated by different departments of the Central Government. Their cost, organization, manner of operation and evaluation differed from each other.

1. Applied Nutrition Programme

This programme was started in 1963, and was one of the early nutrition intervention programme aimed at stimulating self help for optimum use of available resources through a combination of nutrition education of the mothers and increased production of food at the village level. The programme was designed to bring to community development blocks an integrated package of

nutritional inputs including programmes to increase the local production of protective foods, organisation of supplementary nutrition feeding programmes for needy women and children and nutrition education of mothers through Mahila Mandals, schools, community development and health personnel and personnel of other development agencies. The feeding programme by and large was confined to children in the age group 0 to 5 years and pregnant and nursing mothers belonging to vulnerable groups.

2. Family and Child Welfare Feeding Programme

The family and child welfare project was approved by the Government of India in the Ministry of Social Welfare in June, 1967 and was implemented from 14th November, 1967.

The main objectives of the scheme were:

1. to provide integrated basic social services to children
2. to offer basic training to women and young girls in home craft, health, education, nutrition and child care as well as essential health and maternity services for women
3. to assist women in the villages through Mahila Mandals and other agencies to obtain supplementary work and income and thus augment family welfare
- and 4. to promote cultural, educational and recreational activities for women and children.

The scheme of family and child welfare project was reviewed by an evaluation committee appointed by the ministry which submitted its report in 1970. The committee felt that the objectives of the scheme should be broad based and they should be broken into operational coverage of services. The committee also suggested that the State Governments should assume increasing responsibilities in running and maintaining the programme of family and child welfare on their own.

3. Balwadi Nutrition Programme

The Balwadi Nutrition Programme was started in 1970 with the object of providing supplementary nutrition to children in balwadis in order to meet one fourth of the daily protein requirement. This programme was also fully funded by the Central Government and implemented through national level organisations namely, the Central Social Welfare Board, Indian Council for Child Welfare, Harijan Sevak Sangh and other voluntary agencies. The grants under this programme were meant to provide supplementary nutrition diet to the children of low income group families. Each Balwadi child in the age group of 3-5 years was given 300 calories and 10-12 years of protein per day. The coverage of the programme in 1980-81, 605 of balwadies with 2.29 lakh beneficiaries.

4. Special Nutrition Programme

The Special Nutrition Programme was launched by the Government of India in 1970 with the object of providing supplementary nutrition to pre-school children, pregnant women and nursing mothers from the weaker section of the community in urban slums, tribal and backward rural areas. This programme emphasised control of protein - calorie malnutrition among the vulnerable groups living in depressed and relatively inaccessible areas. It was envisaged that children below one year of age would receive about 200 calories and 8 to 10 gms of food quality protein, children between 2 and 6 years of age 300 calories and 10-12 gms. of protein and expectant and nursing mothers 500 calories and 25 gms of protein. The feeding programme initially intended for 250 days a year was later extended to 300 days.

Besides the national programmes, a few state Governments have initiated feeding programmes of their own. For instance Tamil Nadu Government in 1980, initiated the Tamil Nadu integrated Nutrition Project (TINP) and in July 1982, the Honourable Chief Minister of Tamil Nadu, Dr. M.G. Ramachandran embarked on a new scheme for feeding over six million poor children in the age range of two to ten years. This new programme brought under one umbrella all the different types of feeding programmes. The other unique feature

of this venture was feeding on all the 365 days of the year and serving a fresh hot meal on the spot (Devadas, 1987).

5. Tamil Nadu Integrated Nutrition Project

The Tamil Nadu Integrated Nutrition Project (TINP) was sponsored by the Government of Tamil Nadu (1980) aided by the World Bank for the mass nutrition rehabilitation of high risk groups of the population, namely children between six months to six years, Pregnant women and lactating mothers. Approaching malnutrition from three angles namely education, health and food supplementation, the project aims at significant reduction in the incidence of malnutrition, morbidity and mortality rate of children. TINP is in operation in six districts of Tamil Nadu, namely Madurai, Pudukkottai, Ramanathapuram, Tirunelveli, Chengalpet and North Arcot covering 9000 villages in 169 blocks with one million children in its purview (Devadas et al., 1987).

6. Tamil Nadu Chief Minister's Nutrition Meal Programme

This programme was started in Tamil Nadu in July 1982 and it currently covers 8.3 lakh children between 2 and 15 years age. This number includes 2.1 lakh children in 2 to 4 years age group. 4.6 lakh children in the 5 to 9 years age group and 1.6 lakh children in the 10 to 15 years age groups.

Objectives of the programme

1. provide more than one-third of the nutritional requirements and thus help ^{to} promote health, growth, development and learning ability of the children.
2. enthuse children to go to school and improve school attendance.
3. foster sound social behaviour among children and dispel feelings of difference between various castes.
4. inculcate good dietary and personal hygiene habits and promote awareness on the importance of environmental sanitation.
5. Impart health/nutrition education to children parents and the community.
6. Provide employment for women below the poverty line and 7. Bring about a gradual socio-economic transformation among the poor communities (Devadas, 1983).

The estimated cost of this operation was Rs.160 crores for the year 1986-87.

International year of the child

The UN General Assembly declared 1979 as the International Year of the Child (IYC). The major aims of the year as laid down in this resolution may be summarised as follows:

- a) To encourage all countries rich and poor to review their programmes for the well being of children

and to mobilise support for national and local action programmes according to each country's conditions, needs and priorities.

- b) To highlight awareness of childrens' special needs among decision-makers and the public.
- c) To promote recognition of the vital link between programmes for children on the one hand and economic and social profers on the other and
- d) To some specific practical measures to benefit children in both the short and long-term on the national level

Spending on such services as health and education and especially on the protection of children's normal growth should not automatically be listed on the consumption side of the national economy. For they are the most basis of investments in human capital.

Seventh Plan

The 7th Five Year Plan is quite ambitious and it has set definite targets for reducing material and childhood mortality and incidence of low birth weight and attaining 85 percent to 100 percent coverage in immunisation. It broadly envisages the targets as follows. Net reproduction rate of 1 percent by 2000 A.D., maternal mortality rate 2.3 per thousand by 1992, infant mortality rate 87 per, 1000 live births by 1992; and post neonatal mortality rate 40 per 1000 live births by 1992 (UNICEF 1985).

Expanded Programme of Immunisation (EPI)

A significant part of high morbidity and mortality among infants and children can be attributed to a few common communicable diseases which can be prevented by immunization under the expanded programme of immunisation. Vaccination against these diseases is provided. The objectives of the immunization programme during the seventh plan will be to reduce the incidence of diphtheria, whooping cough, tetanus, poliomyelitis, childhood tuberculosis and typhoid fever, by making vaccination services available to all eligible children and women by 1990. Efforts would be directed to achieve self sufficiency in the production of vaccines their quality control and distribution will also be ensured measles immunisation will be included in the EPI.

In order to achieve the objective of universal immunisation it will be essential to augment the inputs of trained manpower. 'Cold chain' equipment, transport facilities and other essential supplies and equipment. Immunisation services will be provided through all health institutions and health care. Camps and teams and the 'cold chain' will be suitably strengthened for vaccine storage. The epi-demiological pattern to diseases will form the basis for programme operations, surveillance of disease would be suitably strengthened to document the impact of services, information dissemination and health education

will be promoted to raise the health consciousness of people as well as to provide support to health workers.

Health services for school - age children

The health care programme for school-age children will emphasise the detection of correctable disabilities which will prevent major handicaps later. The multiplier effect of education of children and of child-to-child extension are important aspects of the comprehensive child health care programme. Appropriate programmes of health services for children both in schools and in the community will be organised.

UNICEF Commitment for the plan of operations, 1985-89

The Government of India in collaboration with international agencies like UNICEF has been exploring the way and means to take the challenges in the field of child health, welfare and development. Government of India represented by Roma Mazumdar (Secretary to Government of India, Department of Women's Welfare, Ministry of Human Resource Development) and UNICEF, represented by David P.H. Haxton (Regional Director, UNICEF, South Central Asia) signed a plan of operation on 3rd March 1986 in New Delhi, for the survival, protection and development of Indian children. This was another important step in the continuing co-operation between the international communities and

Indian people, in the field of enhanced services to children. UNICEF's huge commitments in favour of Indian children are shown in Table I.

TABLE I

UNICEF COMMITMENT FOR THE PLAN OF OPERATION 1985-89

Programmes	General Resources	Supplementary resources	Total
<u>Part I - Convergent services</u>			
1. Integrated Child Development services	42,400	-	42,400
2. Urban Basic services	9,200	-	9,200
3. Women's Development	9,200	-	9,200
4. Social Inputs in Area Development	7,400	-	7,400
<u>Part II - Technical services</u>			
5. Education	26,000	-	26,000
6. Health	25,000	22,000	47,000
7. Nutrition	8,000	4,500	12,500
8. Water and Environmental Sanitation	30,600	-	30,600
9. Prevention of childhood disability	4,100	-	4,100
10. Support for destitute children	5,000	-	5,000
<u>Part III - Awareness and Capacity Building</u>			
11. Development information	2,300	-	2,300
12. Programme communication	2,700	-	2,700
13. Monitoring and evaluation	500	-	500
14. Development support activities	2,600	-	2,600
	<u>1,75,000</u>	<u>52,300</u>	<u>2,27,300</u>

The emphasis of UNICEF is to support and supplement convergent services viz. ICDS, urban basic services, women's development and social inputs in area development.

SAARC Initiative

The conference of SAARC (South Asian Association of Regional Co-operation) countries was held in New Delhi at the behest of India. It was a historic initiative by the political leadership to the development of our 410 million children in the region in meeting the needs of all children especially health, nutrition, sanitation, education and communication. In the field of child health, immunization, oral rehydration and iodination of salt were defined as the important areas.

It was realized that out of 34 million children born each year 4 million do not live to see their first birth day and another 2 million do not survive until their 5th birth day. The adverse situation of the children of the region is due to low birth weight, malnutrition, ill health, growth retardation, slow learning, low productivity, low learning capability and unemployment. Enriching the mother-child life cycle was considered as the most important step in survival of children.

D. Integrated Child Development Services Programme

In pursuance of the National Policy for children the

Integrated Child Development Services scheme was formulated the blue print for which was drawn by the Ministry of Social Welfare, Government of India in 1975. The scheme called for coordinated and concerned efforts by different ministries, Departments and voluntary organisations considering the magnitude of the task. It was decided to set up 33 projects in 1975-76 - 19 in rural 10 in tribal and 4 from in urban areas on an experimental basis. Formally launched on October 2, 1975, these projects were later spread to all other states and the Union territory of Delhi with 1605 projects. (Figure 2)

The Government of India intends to extend the programme further to cover 50% of all poor children below the age six years (approximately 23.7 million by the end of the seventh plan). The estimated cost of expansion is approximately US 1000 million (at September 1985 exchanging rate), of which US 400 million will be provided by the Government of India and the rest by the State Governments. These do not include the cost of health inputs staff, drugs referral services, which are provided to ICDS through the primary health care system.

Objectives

The objectives of the ICDS are to

- Improve the nutritional and health status of children the age group 0.6 years.

ICDS was born on October 2, 1975. It was the 106th birthday of Mahatma Gandhi, the Father of the nation.

The plan was launched with only 33 projects. Within 10 years, it has expanded to 1356 projects.

ICDS today covers 1428 of a total of 5092 community development blocks and 177 urban slums in the country.

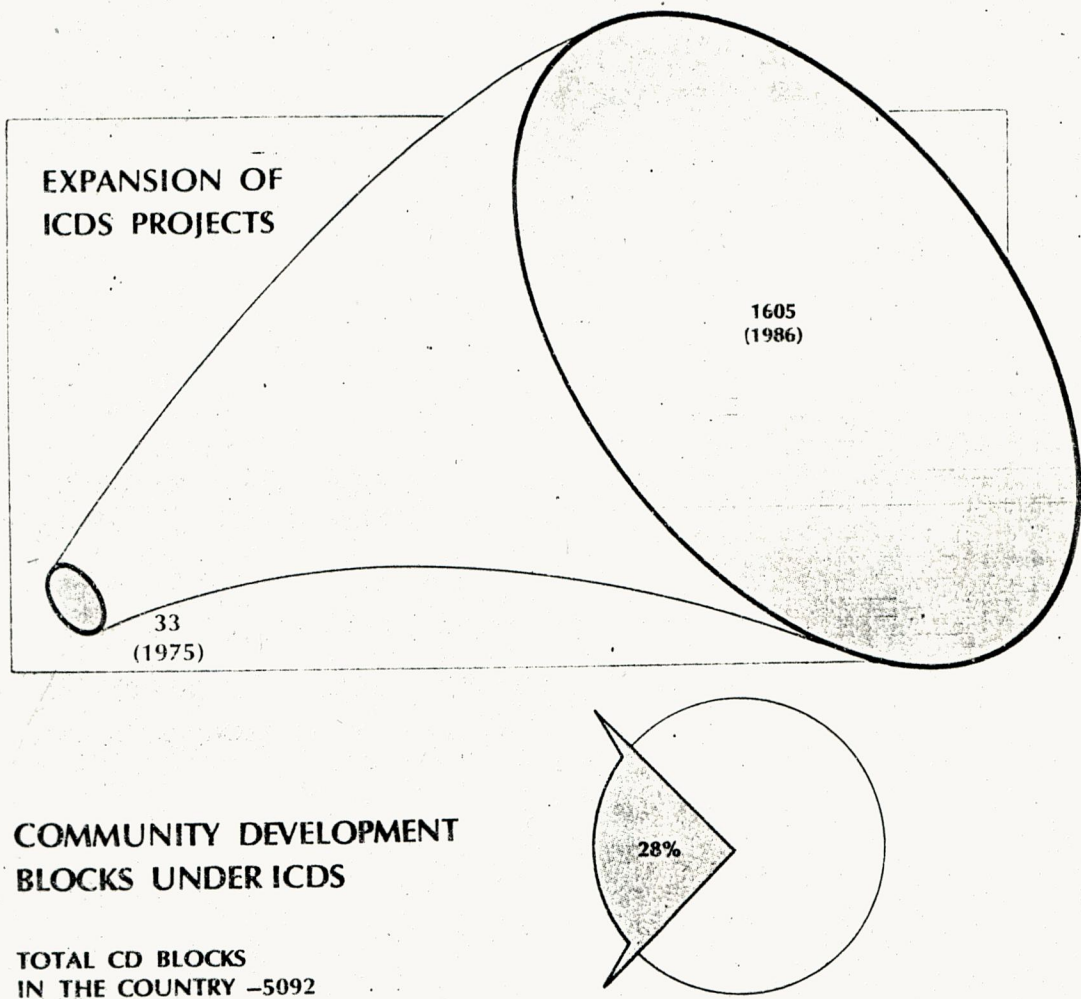


Figure 2

- Lay the foundations for proper psychological, physical and social development of the child.
- Reduce the incidence of mortality, morbidity malnutrition and school drop-out.
- Achieve effective coordination of policy and implementation amongst the various departments to promote child development and
- Enhance the capability of the mother to look after the normal health and nutrition needs of the child through proper nutrition and health education (Chowdhry, 1984).

Package of services

The services under ICDS coverage at the same time on the same group of children. This pattern is based on the concept that services for children must operate together for any of them to have durable value, and for their total impact to be more than the sum of their separate efforts. For instance, supplementary feeding for malnourished children becomes effective if accompanied by health check-ups, diarrhoea management, clean water, mental stimulation and basic health education for mothers. In selecting the services, therefore, priority is given to the most urgent needs of children as well as to the mutually reinforcing relationship between the closer services. Cost effectiveness and administrative feasibility are two other important considerations. Thus

the package of services includes periodic health check ups . referral medical services, monitoring of growth, immunization, supplementing feeding, non-formal pre-school learning and nutrition and health education for mothers (UNICEF, 1989).

Supplementary nutrition

Supplementary nutrition means identifying and fulfilling the deficiencies of calories, proteins, minerals and vitamins in the existing diets avoiding cut backs in the family diet and taking other measures for nutritional rehabilitation.

Supplementary nutrition will be given to needy children below six years of age and to nursing and expectant mothers from low income families. Generally speaking, the aim is to supplement the nutritional intake by about 300 calories and 8-10 gms of protein for children below 6 years of age and about 500 calories and 20-25 gms of protein for pregnant women and nursing mothers. The supplementary nutrition will be given for 300 days in a year. The average cost of food is estimated as 25 paise per child per day and 50 paise for the pregnant women per day the average cost per day in case of severely malnourished children is estimated as 60 paise per child.

Immunization: Right from the birth children are exposed to various health hazards including communicable diseases. ICDS plans to give immunization against tuberculosis

diphtheria, whooping cough, tetanus, measles and polio for all children under one year of age and immunization against tetanus to all the expectant mothers.

Health check up

This service includes antinatal care of new borns and care of children under 6 years of age. The health check up and medical care will be rendered by the ANMs and LHVs under the guidance of the PHC primary health care of a simple nature is also supposed to be rendered by the Anganwadi workers (AWWs). For this purpose AWWs are given a medicine kit which would be replenished at regular intervals after checking the expenditure register.

Referral services

The purpose of referral services is to provide medical care of an appropriate standard according to the seriousness of the disease as well as follow up care of cases that have been treated or given medical attention.

Pregnant mothers and children with problems requiring specialised treatment will be referred by the ANM or LHV to the PHC/upgraded referral hospitals. The cases needing further attention or treatment will be referred by the medical officer of PHC referral hospitals to the Taluk/City/District Hospitals as the case may be. The medical officer incharge of PHC will refer such cases with the

referral card prescribed for the purpose. In case of an urban project the cases will be referred of the appropriate health clinics/hospitals.

Nutrition and Health Education

The nutrition and health education component of the ICDS aims at effective communication of certain basic health and nutrition messages with a view to enhancing the mothers awareness of the child's needs and her capacity to look after there within the family environment. Nutrition and health education is required to be given to all women in the age group 15-44 years and other members of the family.

Non-formal pre-school education

Non formal pre-school education is very crucial component of the package of services envisaged under ICDS as it seeks to lay the foundation for proper physical and social development of the child non formal education is imparted to children in the age group of 3 to 5 years at the Anganwadi.

Thus ICDS is a package of interested services for the pre-school child with nutrition pre-school education, immunization, health checkup and mothers' education. Nutrition can't be viewed in isolation. Health and hygiene

are closely related to it. What is required is an integrated approach so that nutrition forms part of the Anganwadi (literally court yard and play centre) a focal point for the delivery of service at the community level (Chowdhry 1984). Thus the ICDS the biggest child welfare/developmental programme of the country and has emerged as a single major integrated social development programme of the eighties in the developing countries.

Administrative set up

The Ministry of Human Resource Development is responsible for the overall monitoring of the programmes through a central cell established in the department of Women and Child development. (Figure 3)

All services in ICDS are expected to coverage at the same time on the same group of children so as to have a desirable impact. This calls for coordination between sectors providing health nutrition and other services in the existing government infrastructure to make it a cost effective programme (NIPCCD, 1987).

The unit for the location of the ICDS project is a Community Development Block in the rural areas, a tribal development block in the tribal areas and a group of slums in urban areas. In the selection of projects, preference

Integrated Services

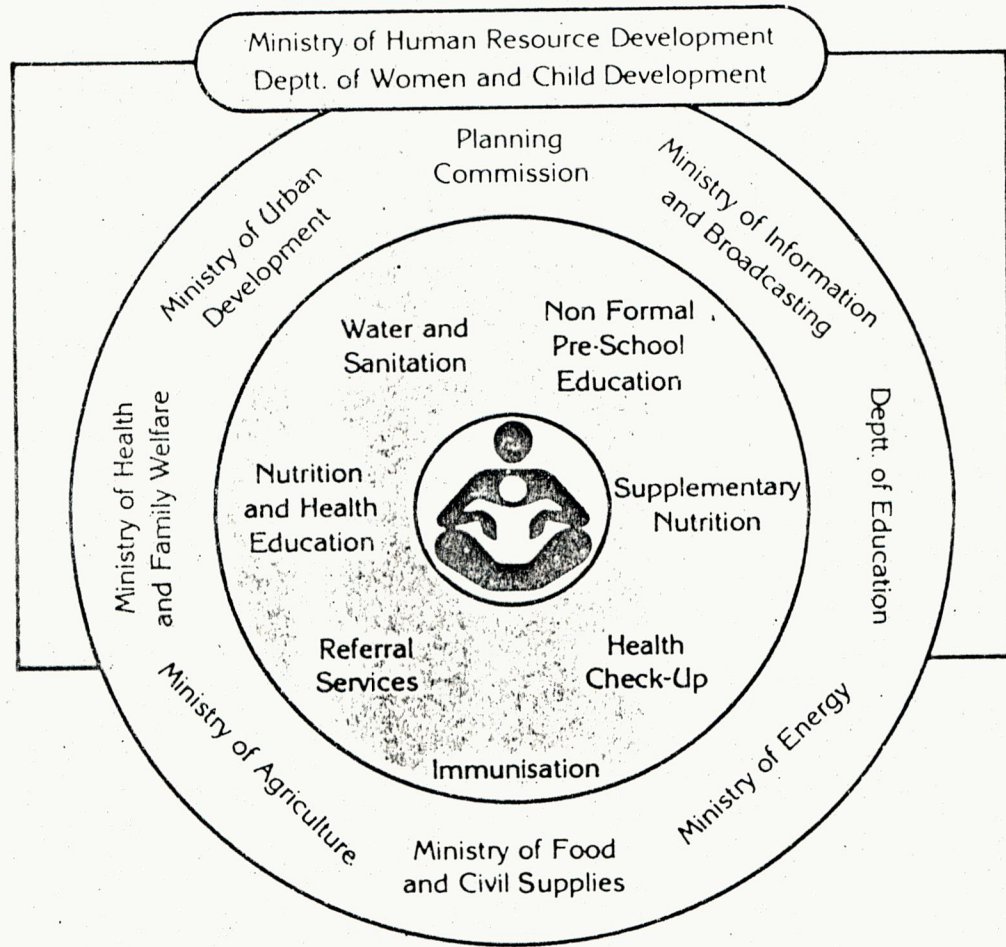


Figure 3

is given to areas inhabited by scheduled castes and scheduled tribes, backward areas, drought prone areas, nutritionally deficient areas and areas poor in development of social services.

Fig. 4 gives the administrative set up of ICDS at various levels.

An anganwadi is the focal point for delivery of the package of services to children and mothers right in their community in the village or a ward in slum areas.

The responsibilities of the AWW include non-formal pre-school education for the older children, organisation of supplementary feeding after identifying eligible children and mothers, imparting health and nutrition education to women, educating parents by home visits, eliciting community support and participation, primary health care for children and mother and referring the needy to medical personnel (under the health department) liaising with local organisations like mahila mandals and finally maintaining records and furnishing reports.

AWW receives supervision and guidance from a supervisor who normally looks after 20 AWWs. A full time child development project officer is in charge of each ICDS project. The health infrastructure in ICDS is provided

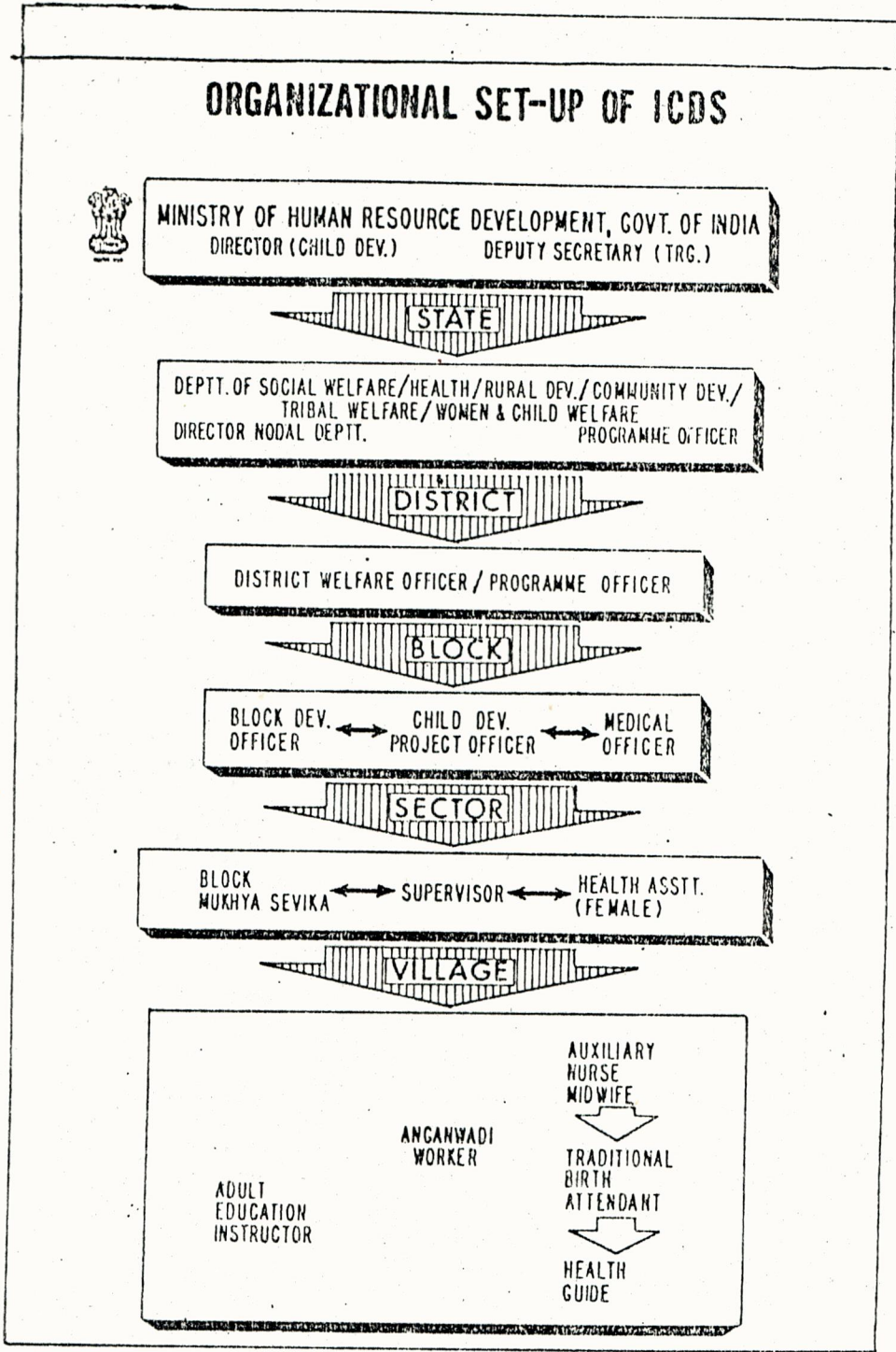


Figure 4

by one ANM, one LHV supervise the work of four ANMs and one doctor per block. All these health services are the responsibilities of the Health Department. ICDS is a multi departmental endeavour, and its success critically hinges in coordination between the two departments at the local level. Its success also depends to a great extent on the content and quality of training imparted to various functionaries in the programme.

Since ICDS is a multi departmental and inter sectoral endeavour, coordination machinery is set up at all levels. At the district level the Deputy Commissioner or Collector is responsible for coordination. The implementation of ICDS Districts having four or five ICDS projects have been sanctioned ICDS cells (Miglani, 1986).

At this state level, the secretary of the department of social welfare or the Nodal department as decided by the state government is responsible for implementation.

At the Government of India level, the Department of Women's Welfare, Ministry of Human Resource Development is responsible. (Figure 5)

E. Research Highlights on ICDS

Ever since the inception of ICDS, evaluation studies have been conducted by the programme evaluation of the

THE STRUCTURE OF ICDS

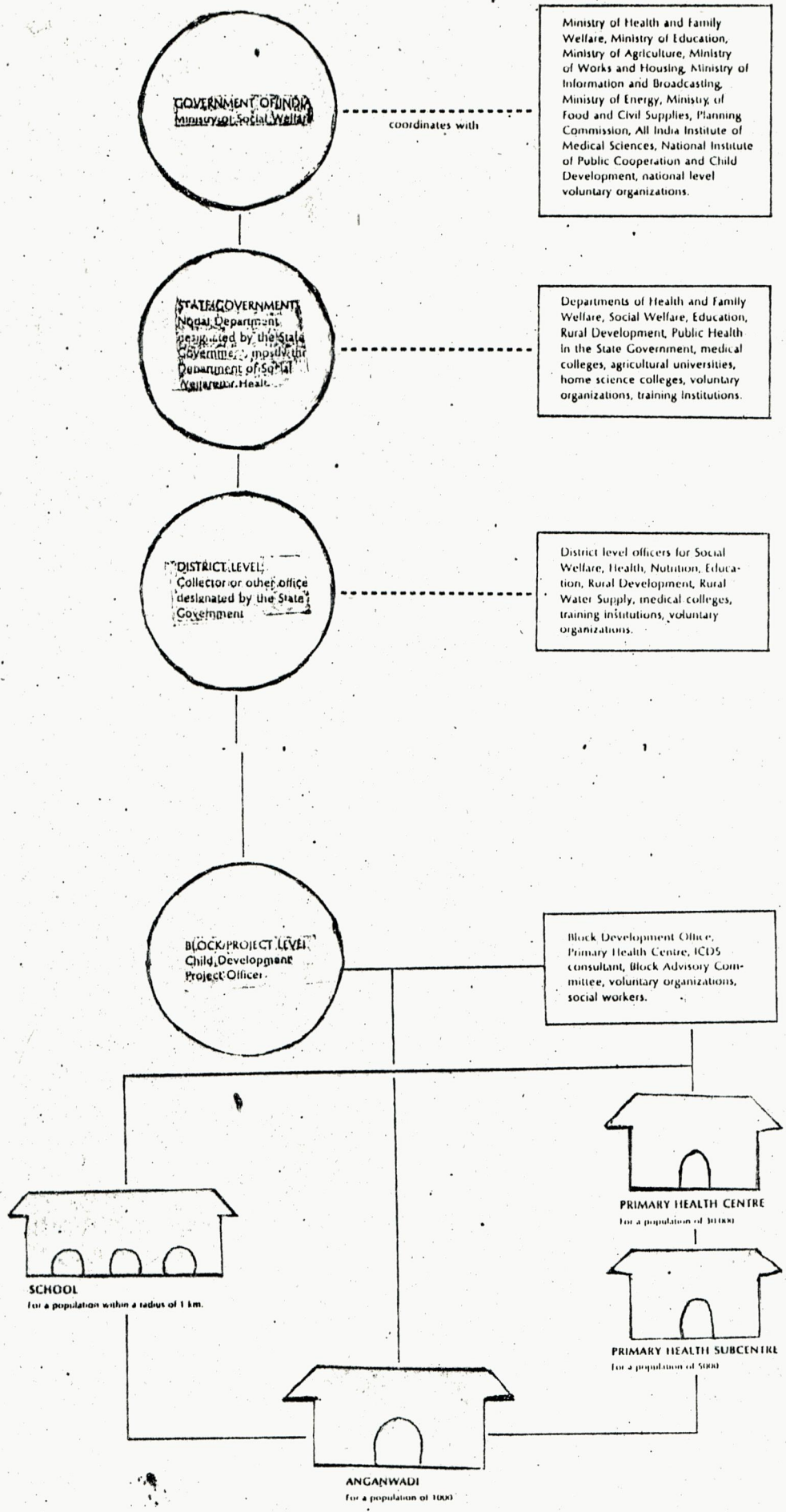


Figure 5

Planning Commission, All India Institute of Medical Sciences (AIIMS) Home Science Colleges and other Institutions.

The evaluation by the Programme Evaluation Organisation (PEO) of the planning commission conducted in 1976-77 and in 1977-78 brought out deficiencies relating to coordination, identification of target beneficiaries, supervision of Anganwadis etc. In the positive side it showed that two thirds of the beneficiaries under different services (Tandon, 1984).

However the World Food Programme (WFP) reported that women beneficiaries formed only 12.5 per cent of the total two million beneficiaries of the programme operated in ten states of the country. The rest were child beneficiaries (NIPCCD 1983). The evaluation of ICDS conducted by the National Institute of Nutrition (NIN) in nine states of the country also revealed that the participation of women ranged from 11 per cent in Maharashtra to 18 per cent in Orissa with Kerala, Madhya Pradesh and Uttar Pradesh showing 11 to 13 per cent participation and Bihar, Rajasthan and West Bengal showing only about 4 per cent participation of women (Swaminathan, 1983).

The surveys conducted by ANMs have shown progressive improvements in the delivery and utilisation of nutrition

and health services through ICDS. For instance, a survey covering a sample of 304 Anganwadis and 43108 children from 89 projects conducted in 1982, showed considerable improvement. In relation to health check-up administration of Vitamin A and immunization (Bose, 1986). Many Anderson (1981) conducted a detailed and painstaking research in two districts of Gujarat and Maharashtra. According to this study the coverage of essential health services for pregnant women (Such as tetanus typhoid immunisation was very low at 20 per cent, coverage of DPT for children in the age group 1-3 years was less than 10 per cent and near a half of the severely malnourished under threes were not reached by supplementary nutrition. In brief, this study showed that both health and nutrition coverage of women and children under three was far from satisfactory considering that the incidence of malnutrition is highest among them reaching them inadequately is a major short coming of ICDS.

An action research on the management of severely malnourished children by village workers in ICDS in India was under taken. In 406 Anganwadis wherein 4292 children with severe protein energy malnutrition were followed up every week for 6 to 12 weeks by 33 consultants.

Eighty five per cent children improved 6.3 per cent had no change 3.6 per cent deteriorated. 3 per cent

died and 2.1 per cent were list to follow up. Diarrhoea fever and apparent respiratory illness were contributing to the death in 42.6 percent, 38 percent and 34.9 percent of fatal cases. Prevalence of severe malnutrition and fatality were higher in younger children less than 3 years of age compared to older ones between 3 to 6 years of age refered from village centre to larger health facilities was not utilised by majority of the relatives of the sick children. It is concluded that village level management of severely malnourished children by a local workers is an acceptable and effective approach at low cost (Tandan, 1984).

The largest ICDS evaluation study based on the data collected by the ANMs monitoring cell, was conducted by Tandon (Subbarao, 1989) and this pointed out that the prevalence of severe malnutrition (Grades III and IV) declined as shown below:

Non-ICDS (Baseline 1976)	..	19%
Non - ICDS (Repeat Survey 1983)	..	11%
ICDS (1983)	..	8%
IMRICDS Projects (1982-83)	..	88/100
National average (1981)	..	110/1000

Compared to the baseline figures ICDS projects do slow lower levels of malnutrition.

Information collected by the monitoring cell from 39 ICDS projects on a continuous basis for the years 1978-79, 82, 84 and 1984-85 revealed that there were three categories.

- a) those showing definite improvement in nutritional status
- b) those showing no definite trend and
- c) those showing definite deterioration.

There were also cross-classified according to location viz. rural, urban and tribal. Definite improvement was reported in less than half of the projects whereas in nearly a quarter of the projects, there was an actual deterioration in nutritional status.

Out of the 10 projects with negative results three were tribal and the remaining seven rural which were extremely backward with an irrigation ratio less than 10 percent, very low levels of overall development and a high proportion of SC and ST population.

The above finding of poor nutritional impact in a significant number of projects based on in direct evidence is confirmed by a recent study done at NIPPCD in 1988 based in direct evidence collected from 26 projects spread over ten states. For example, this study pointed out significant inter-project variation in the number of feeding days ranging

from 30 to 300 across projects. Clearly no improvement in nutritional status would be expected if the feeding components were neglected. The precise numbers of projects showing no improvement and the reasons for poor performance will become clearer only when the monitoring cell collects longitudinal information on the nutritional status of children (both beneficiaries and eligible non-beneficiaries) in the same project areas, along with the socio-economic backwards of the households. It would then be possible to assess the performance of different components in the same project (abstracting from regional effects) and that of each component across the regions (Sukka Rao, 1989).

In another study 20 Anganwadi centers from each of the four projects in Coimbatore city were studied. The findings are thus

- 84 percent infants pre-school children and pregnant women and 75 percent lactating mothers benefitted from the feeding programme on a regular basis.
- 97 percent centres carried out the immunisation programme regularly and
- the health check up and referral services were carried out regularly as per the strategy of the ICDS.

However only 44 percent AWWs were satisfied with the environmental sanitary facilities. All the AWWs suggested

immediate construction of toilet, compound wall and drainage facilities (Jaya and Saroja Ben, 1984).

A comparison of 50 Anganwadies in Coimbatore and 50 in Wynad District Kerala was made. As for immunization it was 90 and 70 percent respectively in Coimbatore and Wynad for health check up it was 80 and 100 percent respectively and 70 percent of the Anganwadies provided nutrition and health education in both the centres. Home visits were extensively done in Coimbatore as well as in Wynad.

No formal pre-school education was given regularly in all the anganwadies studied following a planned programme schedule.

Major problems highlighted by the AWWs in Coimbatore were parent's resistance for immunization, insufficient supply of medicines, inadequate aids and materials for educational purposes, lack of spacious building and meagre allocation for fuel, inadequate supply of food vessels, plates, aids, equipment and money for fuel were predominant problem faced by Wynad AWWs (Nalini Devi and Nalini, 1984).

The other important services offered by ICDS have also been evaluated by many scholars. The most recent comprehensive studies being those of NFI (1988) and Sharma (1987). Both these studies were based on large,

comprehensive samples drawn from many states. The NFI study pointed out that weaklings with the health infrastructure persisted in most locations. The percentage of trained medical officers to total posted to look after ICDS activities was very low in most states. Thus the evidence suggests that health links appeared weak at all layers of health infrastructure. The referral system was poor. The AWW neither kept satisfactory records nor did they feel responsible to forward identified cases. The situation could be attributed to under utilisation or non-availability of health services.

Indirect evidence about the quality of ICDS services can also be gained from statistics on the trained personnel and on the supervisory rations. These appear to be significant interstate differences in the distribution of trained workers and supervisors. The percent of Child Development Project Officers (CDPO) trained varied from a low 31 percent in Rajasthan to 100 percent in Orissa, those of supervisors from 53 percent in Madhya Pradesh to 98 percent in Kerala. The net study also pointed out that even though the training manual prepared were good, the actual training carried out in 200 centres spread over the country was apparently of uneven quality.

Bhatnagar and Singhen (1984) studied the knowledge attitude and expectation of women participants towards ICDS

programme in two randomly selected villages of Andhra Pradesh. It was found that a majority of the participants had little knowledge of the ICDS programme and on the whole. The respondents had low expectations from the scheme younger women beneficiaries coming from nuclear families had higher awareness as compared with their older counterparts.

In an urban ICDS project of Andhra Pradesh, Gandhi (1984) assessed the extent of community participation in the programme. He reported that 51.54 per cent of anganwadies were being supported by way of rent-free accommodation by the youth club.

In a study by NIPCCD (1984) the information collected from 42 Anganwadies in Kanjhwala ICDS block showed that there was a lack of communication between AWWs and various local organisation. The community was providing only marginal assistance in Anganwadi activities on the other hand the AWWs had not made a conscious effort to establish community contacts.

The study conducted by the Gandhigram Rural Institute shows that the scheme has been well received. The children look smarter and the attendance in schools has improved. Further nearly 1.50 lakh people mostly rural widows have found jobs as cooks and helper (Bhandari, 1983).

As evaluatory study on the supplementary Feeding Programme for Anganwadi children in the rural areas around Hyderabad

the programme and endorsed the need for its continuation since they realised that it has benefitted their children. Economic and social status, literacy and availability of time were found to be some of the factors which influenced not only the attitude but also the active participation on the community in the programme.

The experiences of the Ministry of Human Resource Development, Department of Women and Child Development, Government of India, assessed the experiences of ICDS. The facts speak that the studies and surveys made by The Planning Commission, The All India Institute of Medical Sciences and a number of Medical Colleges, National Institute of Public Cooperation and Child Development, Home Science Colleges and many academicians have also studied the ICDS in depth. To date over 700 surveys, 260 research papers, 125 MD and Ph.D. thesis have been reported.

It made an impact of the remarkable improvements in Child Development indicators. Here are just a few: (Figures 6, 7, 8, 9, 10, 11, 12, 13 and 14)

THE FACTS SPEAK

STUDIES AND SURVEYS

There have been many independent evaluations by

- The Planning Commission,
- The All India Institute of Medical Sciences and a number of medical colleges,
- National Institute of Public Co-operation and Child Development,
- Home Science colleges, and
- Many academicians have also studied the ICDS in depth. To date over 700 surveys, 260 research papers, 125 MD and PhD theses have been reported.

MAJOR FINDINGS

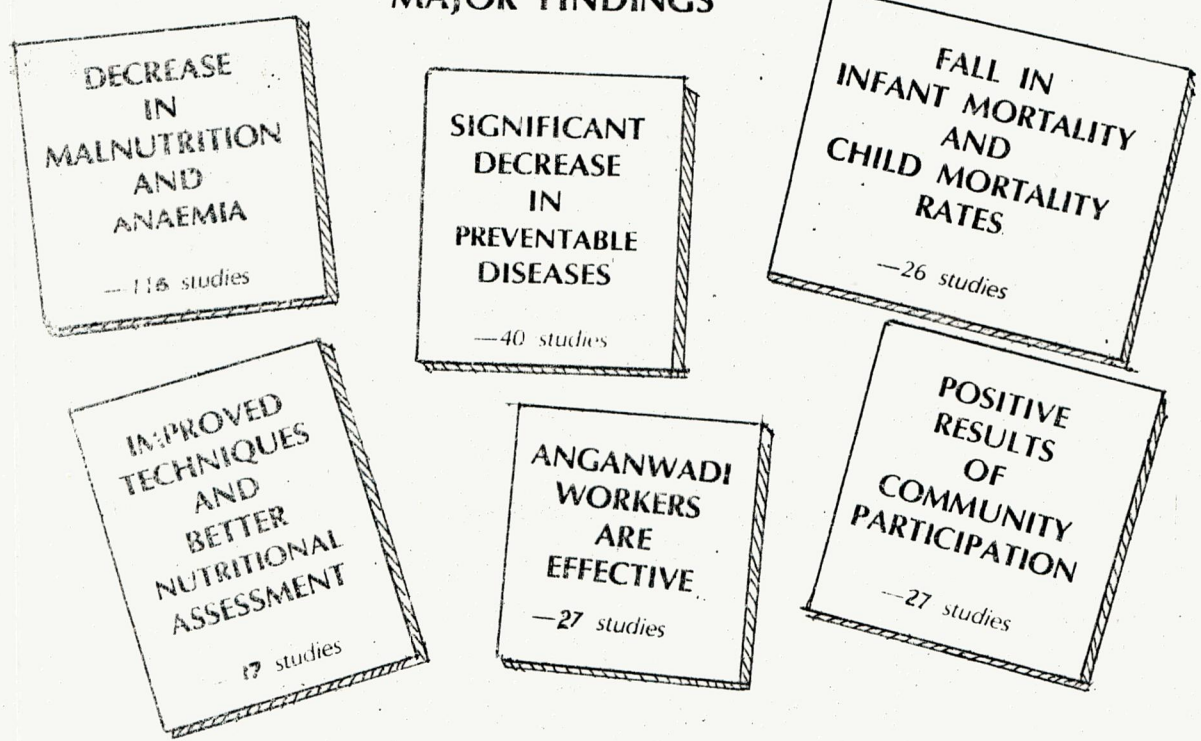


Figure 6.

MAKING AN IMPACT

These studies found remarkable improvements in child development indicators. Here are just a few:

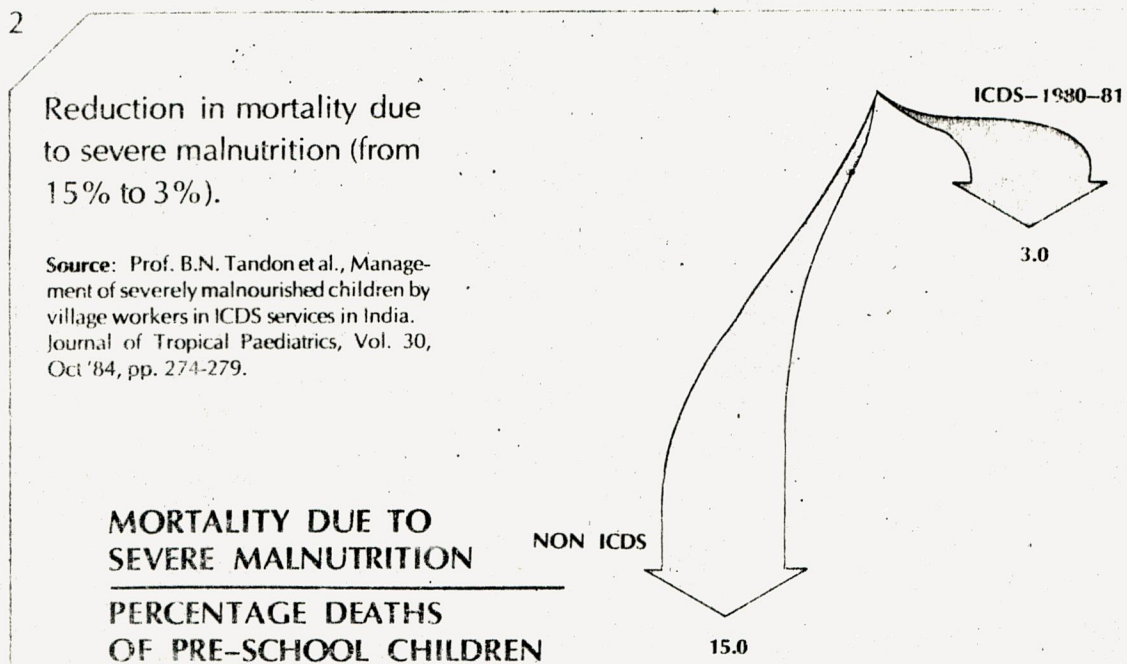
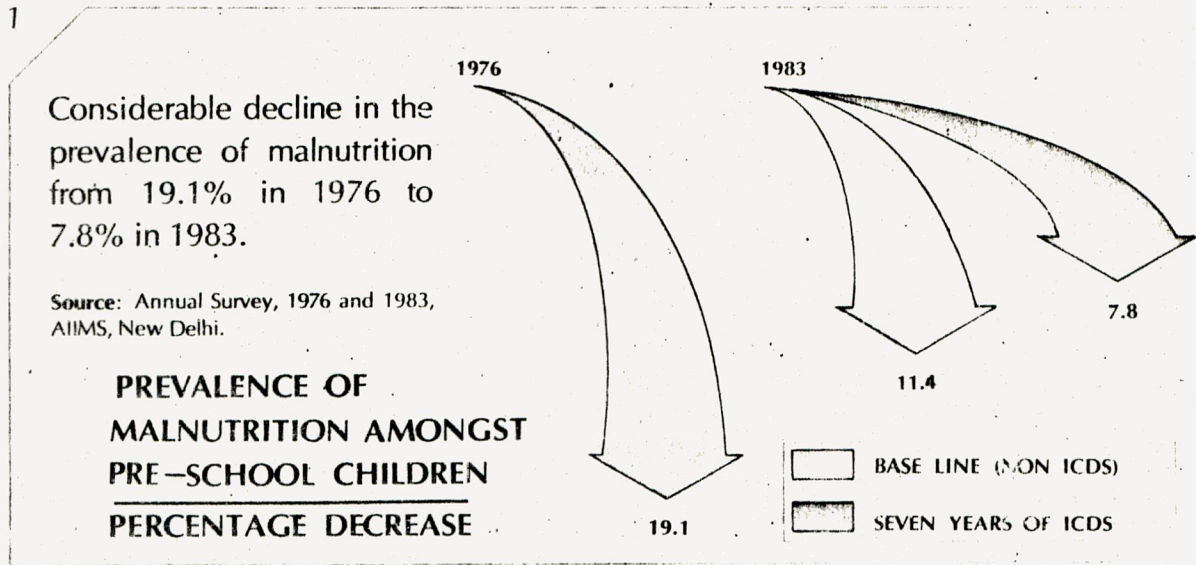
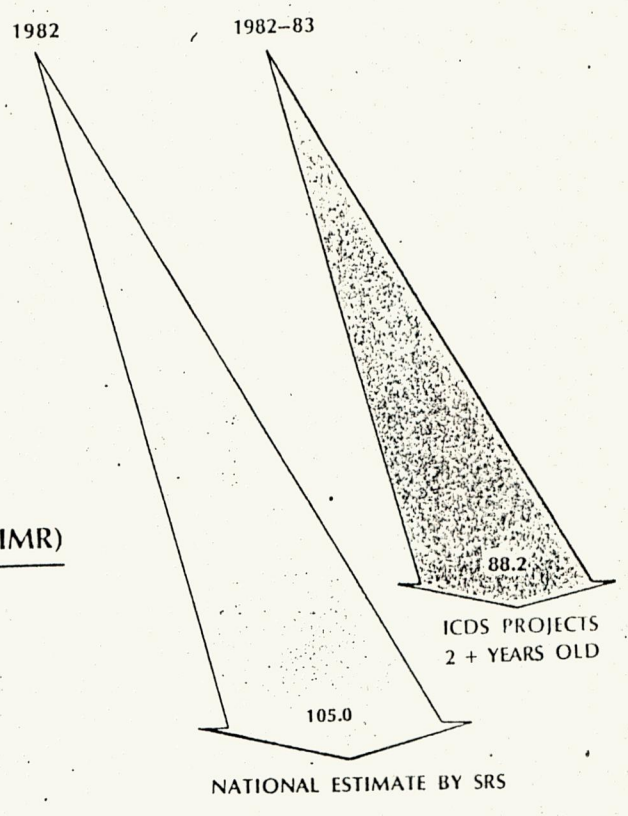


Figure 7.

Reduction in infant mortality (from 110 national average to 88.2 per 1000 births in ICDS projects).

Source: Birth and death study 1982-83, AIIMS, New Delhi.

IMPACT OF ICDS ON INFANT MORTALITY RATE (IMR) PER THOUSAND



Early childhood mortality (0-4 yrs) of both sexes decreased significantly.

Source: Birth and death study 1982-83, AIIMS, New Delhi.

SEX SPECIFIC MORTALITY RATES (0-4 YRS) PER THOUSAND

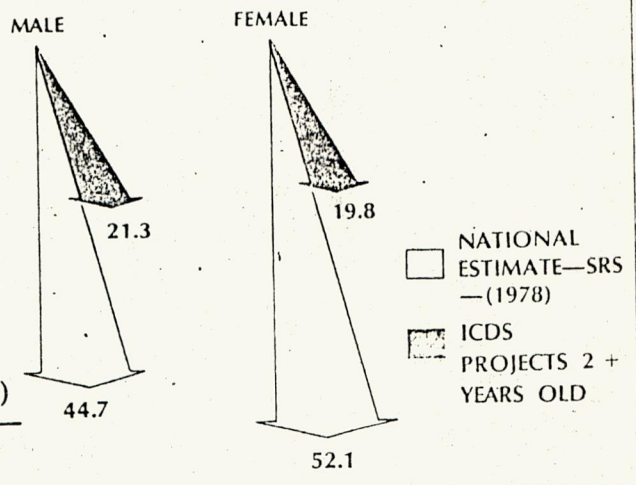


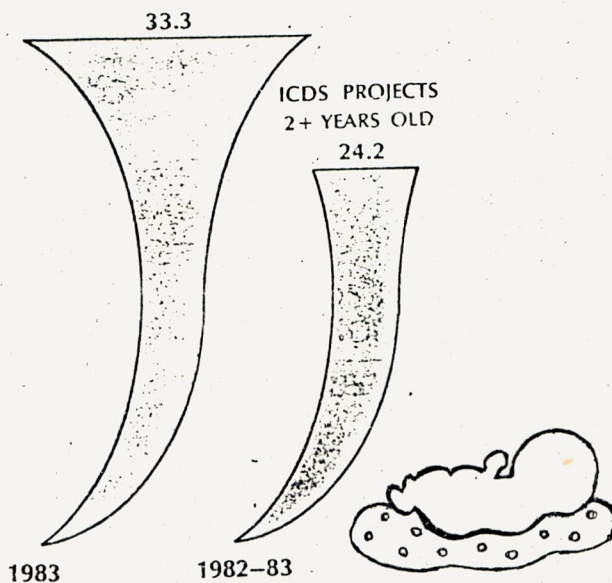
Figure 8.

A quiet influence on family planning as evident from the decline in the birth rate (24.2 as against the national average of 33.3).

Source: Birth and death study 1982-83, AIIMS, New Delhi.

INFLUENCE OF ICDS ON BIRTH RATE PER THOUSAND

NATIONAL ESTIMATE BY SRS



Improvement in school enrolment and reduction in school drop-out rate.



Figure. 9.

Improved immunisation coverage of 60% or above for BCG, DPT and Polio which is significantly more than non-ICDS blocks in the corresponding period.

Source: Annual Survey 1976, 1983, AIIMS, New Delhi.

ESSENTIAL IMMUNIZATION OF PRE-SCHOOL CHILDREN PERCENTAGE COVERAGE

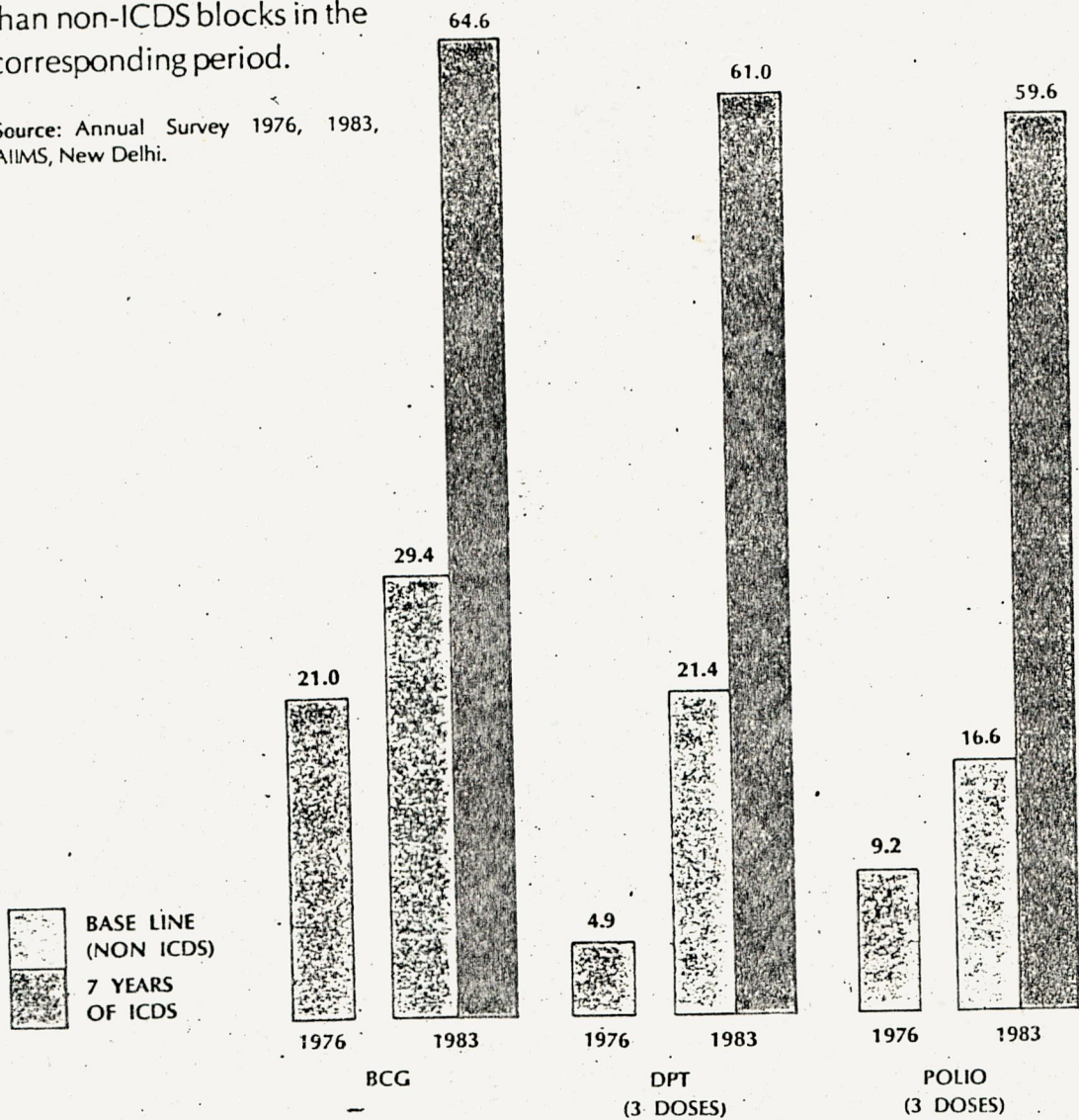


Figure. 10 .

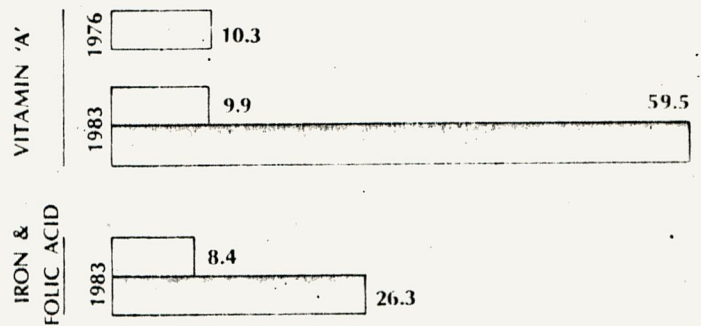
8

Increase in the distribution of Vitamin A, Iron and Folic Acid and supplementary nutrition to pre-school children.

Source: Annual Survey 1976, 1983, AIIMS, New Delhi.

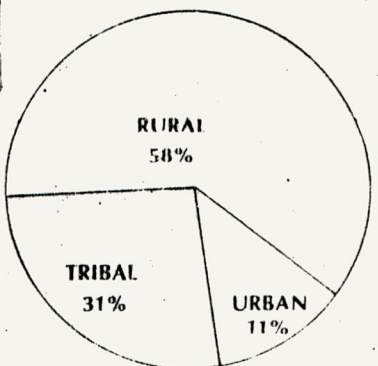
PROPHYLAXIS COVERAGE

PERCENTAGE OF PRE-SCHOOL CHILDREN



9

Significant improvement in the flow of services to the tribal areas (figures for each parameter were very high when compared to non-ICDS blocks during the corresponding period).



LOCATIONWISE BREAK UP OF ICDS PROJECTS



Figure.11:

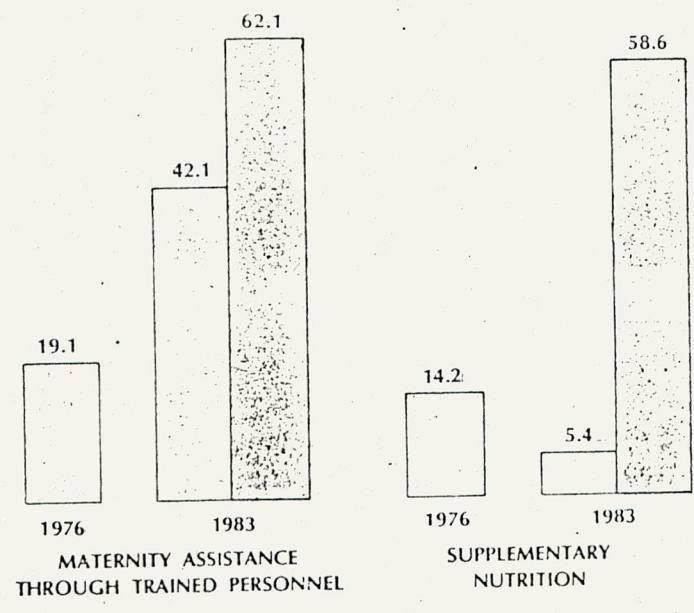
Significant improvement in the four antenatal services and consequently better co-operation from mothers in the family welfare programme.

Source: Annual Survey 1976, 1983, AIIMS, New Delhi.

MATERNITY & NUTRITIONAL SERVICES TO WOMEN

PERCENTAGE COVERAGE

 BASE LINE (NON ICDS)
 7 YEARS OF ICDS



PREGNANT WOMEN: ANTENATAL CARE

POST-NATAL CARE TO LACTATING WOMEN

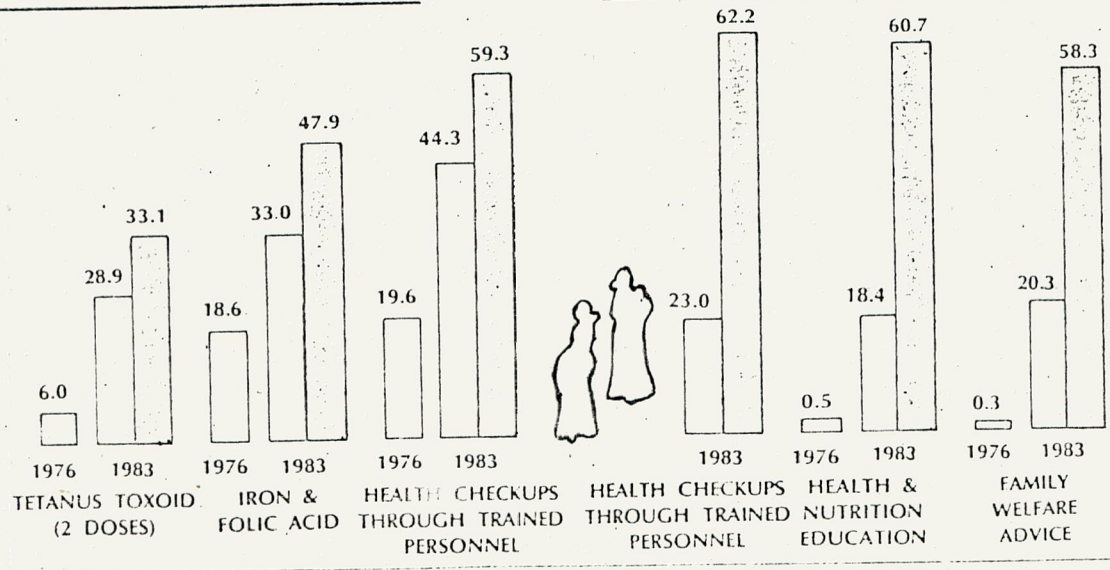


Figure.12.

11

Increase in maternity assistance through trained personnel and post-natal care reaching about 60%.



12

Gradual growth of community participation. (People have contributed building materials, labour and food in varying degrees; there is much greater awareness of the programme and the health and nutritional needs of children among mothers).

3

The coverage of beneficiaries has been consistently growing to reach millions of people belonging to the poorer sections of society, from psycho-social stimulation activities through pre-school education.

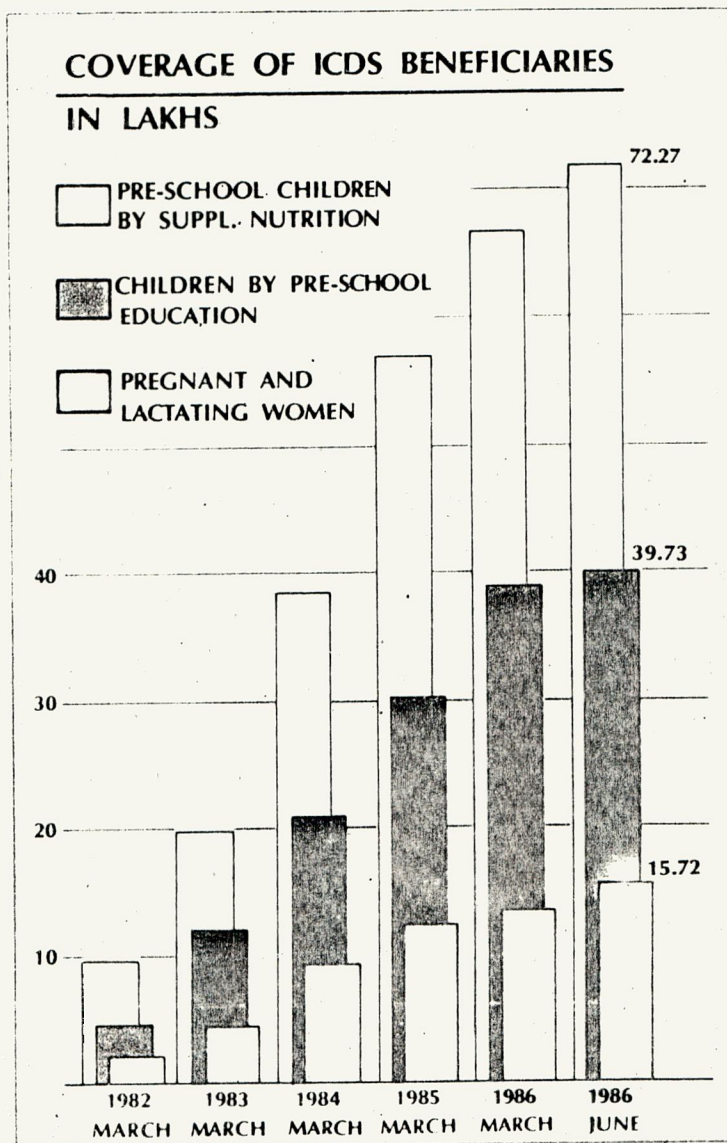
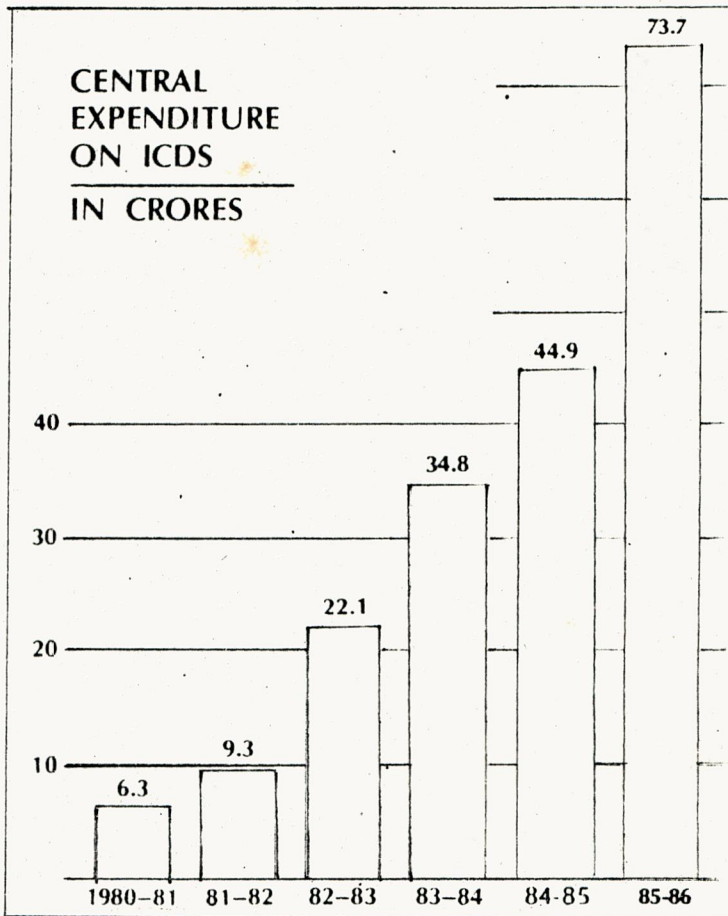


Figure. 13.

14

The allocation of funds in the Central Budget has been considerably increased.



15

Successful involvement of the academic community belonging to medical, home and social sciences for survey, research and training functions; and employment of about 2.50 lakh women as part-time honorary workers with increased awareness of better child care.



Figure.14.

Methodology

III METHODOLOGY

The methodology for this study consisted of the following steps:

- A. Selection of the area and centres
- B. Selection of the samples
- C. Selection of the method
- D. Collection of the data
- and E. Analysis of the data

A. Selection of the area and centres

In Coimbatore district, Integrated Child Development Service Scheme is being operated through 378 anganwadis distributed in four urban projects. Twenty five centres from each project areas such as Puliakulam, Kuppankonampudur, Selvapuram and Singanallur were selected to carry out this study because of the easy approachability of the investigator (Fig. 15).

B. Selection of the samples

One hundred samples (Anganwadi workers) were selected from four project areas.

C. Selection of the method

The interview method was adopted for eliciting information regarding the functioning of ICDS.



COIMBATORE CORPORATION MAP INDICATING ICDS CENTRE

Figure 15

Interview as a two way method which permits an exchange of ideas and information. It is unique, in that it involves the collection of data through direct verbal interaction between the interviewee and interviewer. It requires the actual physical proximity of two or more persons and generally requires that all normal channels of communication can be open to them. As a research techniques, the interview is a conversation carried out which with the definite purpose of obtaining certain information by means for the spoken word, (Singh, 1984).

Hence interview schedules were prepared for the Anganwadi workers (Appendix I) and as well as the Child Development Project Officers (Appendix II) which were pretested and finalised. The information gathered through interview with the Anganwadi workers was supplemented and strengthened by the personal observation of the Investigator.

A survey was conducted in the selected hundred anganwadies to estimate the amenities available in the centres. For this purpose a check list was developed and administered (Appendix III).

D. Conduct of the study

The investigator met the respective Child Development Project Officers and Supervisors and found out the dates of the area meeting during which all the Child Development Project Officers/Supervisors/Anganwadi Workers met and discussed the various aspects of the ICDS scheme. The investigator attended

these monthly meetings to establish a good rapport with the ICDS officials and Anganwadi workers. Then she selected the centres with the approval of the concerned Child Development Project Officers/Supervisors and Anganwadi workers. The purpose of the study was explained to them and their help was requested with the help of the officials the investigator selected one hundred centres which distributed in all the four project areas.

The investigator went in person to all the selected centres interviewed the anganwadi workers and observed the functions of centres in action. The interview with the anganwadi workers were possible with the cooperation rendered by the officials concerned with the ICDS programme.

E. Analysis and interpretation of the data

The data obtained were consolidated, tabulated and analysed in terms of the following aspects and presented in Chapter IV.

- A. Background information of the Anganwadies and Anganwadi workers
- B. Supplementary feeding programme
- C. Immunization
- D. Health checkup and referral services
- E. Non-formal preschool education
- F. Play equipment
- G. Health and nutrition education
- H. Population education for mothers
- I. Administrative details
- J. Amenities in the Anganwadies

Results and Discussion

IV RESULTS AND DISCUSSION

The findings of this study have been organised under the following headings:

- A. Background information of the Anganwadies and Anganwadi workers
- B. Supplementary feeding programme
- C. Immunization
- D. Health checkup and referral services
- E. Non-formal preschool education
- F. Play equipment
- G. Health and nutrition education
- H. Population education for mothers
- I. Administrative details
- J. Amenities in the Anganwadis

A. Background information of Anganwadies and Anganwadi workers:

1. Number of children enrolled in Anganwadies:

Table I gives a clear picture of the total number of children enrolled in 100 Anganwadis in selected project areas of Coimbatore District.

TABLE I

NUMBER OF CHILDREN ENROLLED

S.No.	Age of children	Number enrolled
1.	0-2	1,158
2.	2-6	3,872
	Total	5,030

In the selected hundred Anganwadies, 5030 children were enrolled, out of which 1158 were infants and 3872 were the preschoolers. This depicts that on an average each Anganwadi caters to 50 children below six years of age.

2. Educational qualification and marital status of the Anganwadi workers:

The educational qualification and marital status of the Anganwadi workers are shown in Table II.

TABLE II

EDUCATIONAL QUALIFICATION AND MARITAL STATUS OF THE
ANGANWADI WORKERS

S.No.	Particulars	Number of Anganwadi workers
		N: 100
<u>I. Educational level</u>		
	S.S.L.C.	15
	P.U.C.	2
	10th Standard	22
	Higher Secondary	61
<u>II. Marital Status</u>		
	Married	79
	Unmarried	21

The educational qualification of the Anganwadi workers ranged from 10th standard to P.U.C. This is perhaps because the minimum qualification for being appointed as teachers in the Anganwadi is S.S.L.C.

As for the marital status of the Anganwadi workers, excepting twenty one per cent, all the others were married.

3. Duration of the training of the Anganwadi workers

The training period of the Anganwadi workers is shown in Table III.

TABLE III

DURATION OF TRAINING PERIOD HAD BY THE ANGANWADI WORKERS

S.No.	Year	Duration			Number of Anganwadi workers
		10 days	2 months	3 months	
1.	1982	✓			14
2.	1983			✓	42
3.	1986		✓		26
4.	1989			✓	18

Forty two of them had received training in 1983 for 3 months, 14 Anganwadi workers were trained for 10 days in 1982, 26 of them had training in 1986 for 2 months and

18 of them had received training for 3 months in 1989, the duration of training for a majority of the Anganwadi workers is three months without any refresher training. Refresher training will help the Anganwadi ^{workers} to develop skills and enhancement of knowledge. So it is necessary to give them refresher training.

Songs, story, preparing charts, making indigenous play equipment, importance of preschool education, nutrition and health education, environmental sanitation and their importance, maintenance of records and registers, various types of games, child care, various types of immunization and their needs were the components of training as remarked by all the Anganwadi workers.

4. Details of transfer had by the Anganwadi workers

The details of transfer of the Anganwadi workers are shown in Table IV.

TABLE IV

DETAILS OF TRANSFER

S.No.	Number of transfers had	Number of Anganwadi workers
1.	Working in native place without transfer	66
2.	Transferred once	24
3.	Transferred twice	10

Since special efforts had been taken to appoint the local girls under ICDS, 66 of them were working in their own native places. The others were transferred but not more than twice. This aspect of appointing local girls for the post of Anganwadi worker is a welcome feature that pattern should be continued.

B. Supplementary feeding programme

The details of supplementary feeding programme are discussed below in terms of number of beneficiaries in the feeding programme, problems, quantity of food served, menu plan and nutrition for the children of third degree malnutrition. (Figure 16)

1. Number of beneficiaries in the feeding programme

The beneficiaries in the feeding programme were infants, preschool children, pregnant women and lactating mothers. The beneficiaries in the selected centres are numbered in Table V.



SUPPLEMENTARY NUTRITION



SUPPLEMENTARY NUTRITION

Figure 16

TABLE V

NUMBER OF BENEFICIARIES IN THE FEEDING PROGRAMME

S.No.	Beneficiaries	Number Benefitting		Percent
		Enrolled	Regular feeding number	
1.	Infants	1,158	1,091	94
2.	Preschool children	3,872	3,523	91
3.	Pregnant women	841	679	85
4.	Lactating mothers	1,198	855	75

From the Table V it is clear that the attendance for the feeding programme was normally good. Ninety four per cent of the infants, ninety one per cent of preschool children and eighty five per cent of the pregnant women and seventy five per cent of the lactating mothers seem to benefit from the feeding programme on a regular basis. (Figure. 17)

2. Problems in supplementary feeding

Forty seven percent said that they do not encounter any problems whereas 53 percent had faced problems. The problems in supplementary feeding as expressed by the Anganwadi workers are given in Table VI.

COVERAGE OF ICDS BENEFICIARIES

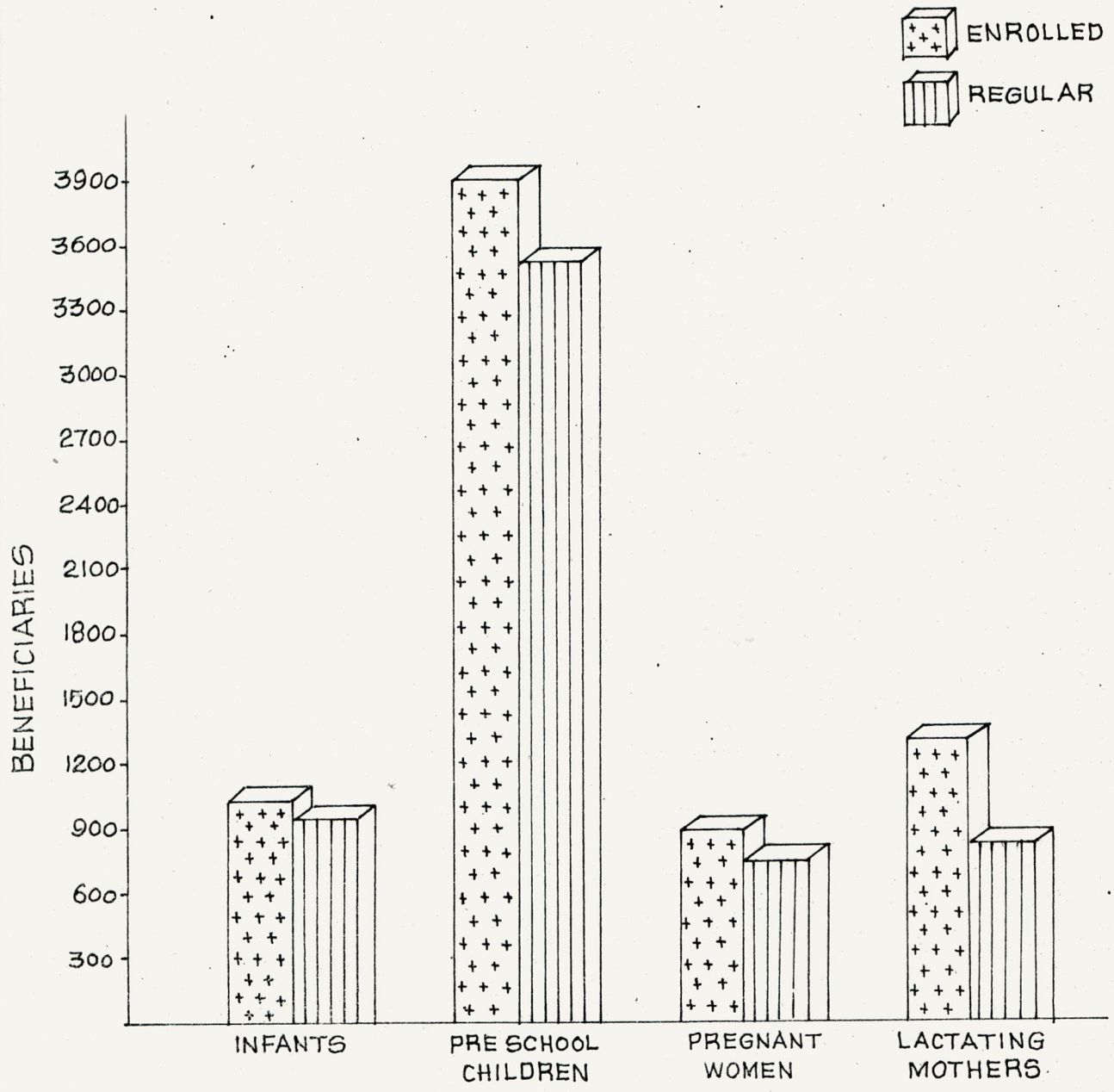


Figure 17

TABLE VI

PROBLEMS IN SUPPLEMENTARY FEEDING

S.No.	Problems	Number of Centres	Percentage
1.	Insufficient money for fuel	42	79
2.	Irregular attendance of children	26	49
3.	Food sought by non-beneficiaries	13	24
4.	Inadequacy of Ayahs	12	22

The problems given by the Anganwadi workers were insufficient money for fuel, irregular attendance of children, food sought by non-beneficiaries and inadequacy of Ayahs in relation to feeding programmes.

3. Quantity of food served

For children of 75 per cent of the centres, the quantity of food served was sufficient. Anganwadi workers of the remaining centres reported that the quantity of food served was not sufficient for the preschoolers and women. They unanimously stressed that the children of the low income families consume more than the allotted 80 gms.

of rice, since they might not have had their breakfast.

4. Menu plan

Though all the centres had menu plan, they did not follow the menu pattern given by the instructors. They gave the mixed rice on all the 360 days. When the investigator enquired about this they pointed out that they are not able to follow the menu due to the meagre allotment of the money for vegetables and non-availability of the vegetables near the Anganwadi.

5. Supplementary nutrition to the children of third degree malnutrition

The health records revealed that twelve out of 5,030 children were suffering from third degree of malnutrition. These children were not fed by supplementary feeding, because provision had not been made from the Government as yet. Though as per the reports of the NIPCCD (1982) the priority should be given to the severely malnourished children offering therapeutic diet, it is not implemented in all the project areas.

C. Immunization

1. Type of immunisation given

It is found out that 97 centres did not have any hurdles in immunising the children. Though the other three centres

also carried out the programmes, it was not regular. The type of immunisation and the number of beneficiaries are presented in the following Table VII.

TABLE VII

TYPE OF IMMUNISATION GIVEN

S.No.	Vaccines	Number of centres N = 100	Number immunised	Percentage
1.	BCG	72	4120	82
2.	Polio	70	4007	80
3.	Small Pox	57	2564	50
4.	Whooping Cough	54	2516	50
5.	Tetanus	29	986	19
6.	Diphtheria	22	702	16

BCG, polio vaccine, small pox, whooping cough, tetanus and diphtheria were the various kinds of vaccines given to the children. Eighty two per cent of the children had given BCG vaccination, 80 per cent of the children had given polio vaccination. Fifty per cent of the enrolled children (0-6 years) had been vaccinated against small pox and whooping cough (Fig. 18). The children were also given vaccination against tetanus and diphtheria.

TYPE OF IMMUNISATION GIVEN

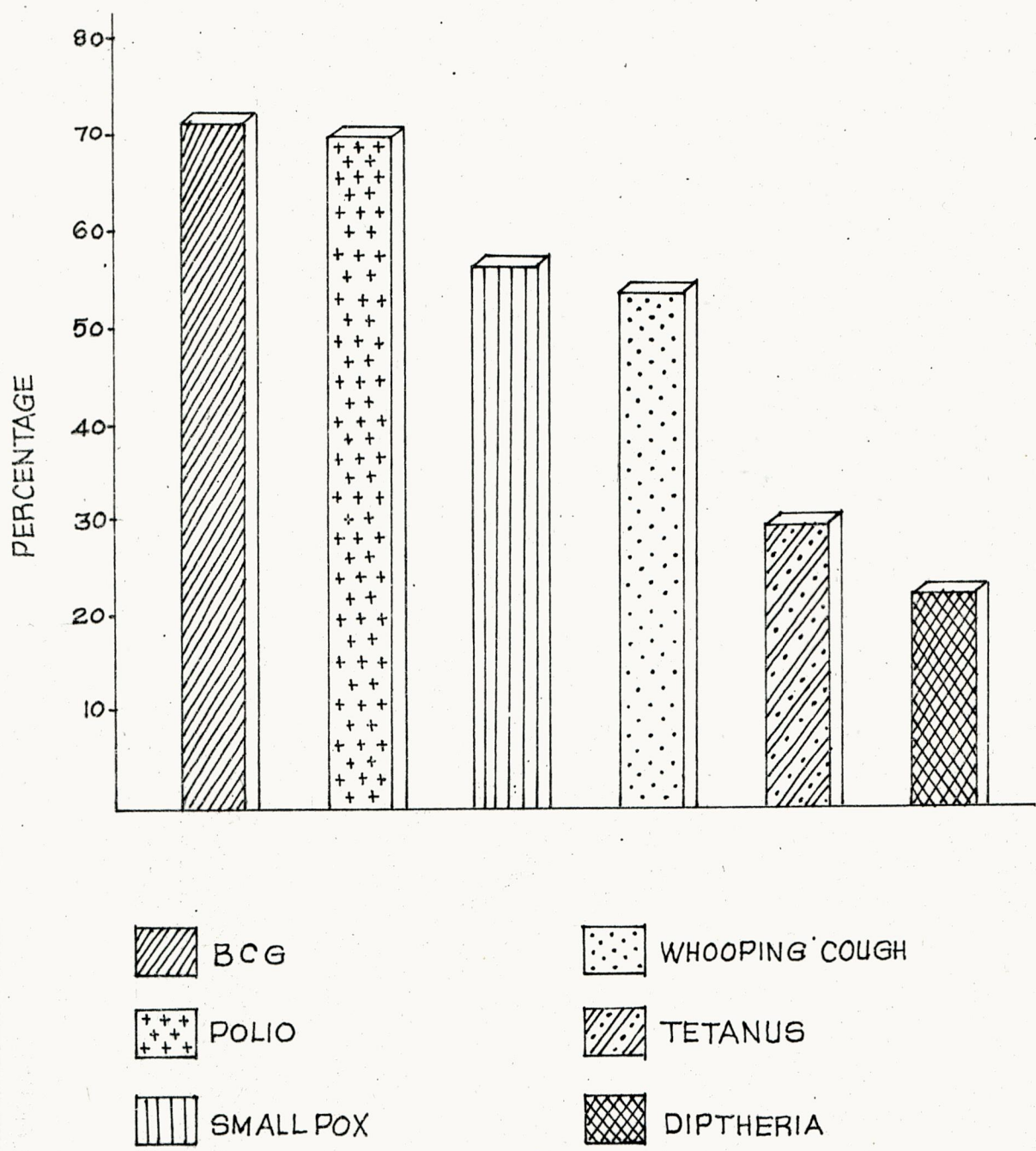


Figure. 13

2. Immunisation for pregnant women

It is painful to see that out of 841 pregnant women enrolled, only 324 were given tetanus injection. Even though there was provision, the pregnant women did not utilise it properly. Perhaps this aspect needs to be propagated intensively through different types of educational media.

3. Supply of oral dose for children

All the centres provided oral doses of medicine to the children. The type of oral doses and number of beneficiaries are tabulated below.

TABLE VIII

SUPPLY OF ORAL DOSES FOR CHILDREN

S.No.	Type of oral doses	Number of centres N = 100
1.	Paracetamol Syrub	61
2.	'B' Complex	60
3.	Piperazine Citrate	52
4.	A and D Capsule	49
5.	Eye and Ear drops	43
6.	Polyvitamin	34
7.	Avil calcium	25
8.	Iron Capsules	25
9.	Contrimoxazole mixture	18

Various kinds of oral doses given to children are listed out in the table. Paracetamol syrup, 'B' complex, piperazine citrate and vitamin A and D capsules were the common medicines issued in majority of the centres.

The various drugs enlisted in the table are being used by the ICDS centres reveal the prevalence of ailments/sicknesses in children. The investigator found that the anganwadi workers were very sure of the specific drug to be given for specific symptom of ailment. The distribution of medicine in the centre served as a point of contact for the parents.

4. Services of Medical Officers

The details pertaining to the personnel involved in health check up and the help rendered are presented in this table.

TABLE IX

FREQUENCY OF MEDICAL OFFICERS' VISIT

S.No.	Frequency	Number of Centres N = 100
I. <u>Doctor</u>	a) Once in a week ..	30
	b) Once in a fortnight ..	33
	c) Once in a month ..	37
II. <u>ANM</u>	a) Once in a week ..	38
	b) Once in a fortnight ..	36
	v) Once in a month ..	26

Thirty seven and twenty six centres were visited by the doctors and Auxillary Nursing Mid-Wives respectively once in a month. One third of the centres were visited by the personnel once in a fortnight and others had the personnel for health check up once in a week. During their visit to the Anganwadi Centres, doctors carried out the health check up and immunisation. Along with these two activities, Auxillary Nursing Mid-wives distributed medicines as per the prescription of the doctor.

5. Problems in conducting the immunisation programme

Among the 100 centres, 50 per cent did not encounter

any problems in carrying out the immunisation programme, while the other half had the problems such as poor attendance of the children and inability to take the children to the place where the health check up is arranged. The problem might be solved if the Anganwadi worker is motivated properly to elicit from the community a place close by the Anganwadi to render immunization services.

6. Environmental sanitation

Details regarding environmental sanitation around the Anganwadi are shown in Table X.

TABLE X
ENVIRONMENTAL SANITATION

S.No.	Views	Number of Centres	Percentage
1.	Satisfied	44	-
2.	Not Satisfied	56	-
	<u>Aspect of dissatisfaction</u>		
1.	Lack of toilet facilities	21	38
2.	Public using the surrounding undesirable	36	64
3.	Stagnation of water	19	33

Forty four per cent of the Anganwadi workers were satisfied with the existing environmental sanitary facilities. The rest were not satisfied because the centres lacked toilet facilities and were built around unhygienic surroundings such as cattle shed and stagnated waterpools.

When the investigator asked the Anganwadi workers to suggest the ways to improve the environmental sanitation, they pointed out that construction of toilet facilities, compound walls and drainage would solve the above mentioned problems. As WHO (1984) suggests improvement of the environment by providing safe drinking water and sanitation in and around the welfare centres might go a long way in the achievement of good health in children. This aspect needs immediate care on the part of the planners of welfare services for young children.

D. Health check up and referral services

Infants and small children are more susceptible to numerous communicable diseases. Widespread among these are polio, tuberculosis, measles, diphtheria, whooping cough and tetanus. It is worth mentioning here that as per the provision of the scheme, the health check up and referral services were carried out regularly and intensively for children in ninety seven centres. (Fig 19)



HEALTH CHECK UP FOR PREGNANT WOMEN



HEALTH CHECK UP

Figure 19

The most common services offered to children of 0 to 6 years were taking height/weight, giving tetanus injection and distributing vitamin tablets (Fig. 21). Tetanus injection, vitamin tablets and health checkup were given to pregnant women (Fig. 20). But for lactating mothers no health check up/referral services were carried out.

E. Non-formal preschool education

Ninety six per cent of the Anganwadi workers conducted nonformal educational programme for children in the Anganwadis. However, in four centres the Anganwadi workers felt that they were too busily occupied in administrative requirements and found only little time to conduct the activities for children.

The components of nonformal education is envisaged through two methods namely - Theme Approach and Play way method. More than 75 per cent of the centres followed play way method for which the Anganwadi workers had reasoned out that it was found more interesting by the children and encouraged creativity in children. This aspect needs to be adopted in all the Anganwadies since the play way method enables the child to be creative and imaginative.

The schedule followed for preschool education is given in Table XI.



MATERNITY ASSISTANCE THROUGH TRAINED PERSONNEL

Figure 21



IMMUNIZATION FOR PRE SCHOOL CHILDREN

Figure - 20

TABLE XI

PROGRAMME SCHEDULE FOR PRE SCHOOL EDUCATION

Forenoon								Afternoon	
Days	10.00 to 10.20 a.m.	10.20 to 10.40 a.m.	10.40 to 11.00 a.m.	11.00 to 11.10 a.m.	11.10 to 11.30 a.m.	11.30 to 11.45 a.m.	11.45 a.m. to 12.00 Noon	12.00 Noon to 2.00 P.M.	2.00 to 4.00 p.m.
Monday	Prayer Informal Talk	Action Songs	Organised games		Language education	Exercise to all 5 senses	Number activities	- SUPPLEMENTARY FEEDING, REST AND RELAXATION -	Free Play
Tuesday	Prayer Informal Talk	Story telling	Exercise		Language education	Action songs	Do's and Don'ts for daily life		Number activities and language education
Wednesday	Prayer Informal talk	Songs	Science Experience	I N T E R V A L	Language education	Story telling	Number activities		Puppet show
Thursday	Prayer Informal talk	Story telling	Organised games	I N T E R V A L	Number activities	Science experience	Songs		Free Play
Friday	Prayer Informal talk	Songs	Exercises	I N T E R V A L	Number activities	Creative activities	Creative activities		Mother's Meeting
Saturday	Prayer Informal talk	Recollection of all the activities	Songs and story Recollection		Recollection of all activities	Recollection of sense activity and science experience	Recollection of all activities		Free indoor play

The schedule in the Anganwadies includes prayer, informal talk, songs, stories, exercises, science experience, language lessons, numeracy, games, creative activities, dramatisation and recollection of all the activities. (Figure 22)

2. Activities liked and disliked by children

The views of the Anganwadi workers regarding the preschool activities liked and disliked by children are given in Table XII.

TABLE XII
ACTIVITIES LIKED AND DISLIKED BY CHILDREN

S.No.	Activities	Number of Centres N = 100
<u>I. Activities liked</u>		
a)	Songs	92
b)	Stories	89
c)	Group games	78
d)	Drawing	12
<u>II. Activities disliked</u>		
a)	Sleeping	16
b)	Writing	12
c)	Reading	10



PRE SCHOOL EDUCATION CHILDREN

Figure - 22

The Anganwadi workers remarked that the songs, stories, group games and drawing were the most liked activities of the children against sleeping, writing, reading which were not liked by children. Recent studies have proved that for a child, games are a way of observing, understanding and learning, and so more games which could be organised without spending money need to be innovated and taught to the Anganwadi workers.

3. Aspects taught and aids used

Details regarding the aspects taught and aids used are presented in Table XIII.

TABLE XIII
ASPECTS TAUGHT AND AIDS USED

S.No.	Aspects taught	Number of Centres N: 100
<u>1. English</u>		
	a) Reading alone ..	100
	b) Reading and writing ..	92
<u>2. Tamil</u>		
	a) Reading alone ..	100
	b) Reading and writing ..	88
3.	<u>Number:</u> Reading and writing ..	100
<u>4. Aids used</u>		
	a) Black board ..	100
	b) Charts ..	87
	c) Flash cards ..	58
	d) Beads ..	26

In all the centres, children were taught to read alphabets and words both in English and Tamil and also they were trained to read and write the numbers. Experiences in writing of English alphabets and words were given in 92 centres and exercises in writing of Tamil were offered in 88 centres. These learnings were thrust on the children regardless of their age. The Anganwadi workers need to be trained on the age levels at which the various experiences could be offered.

With regard to the aids, black boards were used predominantly in all the centres, followed by charts (87 centres) and flash cards (58 centres), beads were used (26 centres) as an aid to impart number and colour concepts. Different coloured wooden beads were given to children for threading, not only to inculcate the ability for counting but also to help in eye hand coordination, and to teach colour concepts (Saraswathi and Shargava, 1983). In service courses on the use of indigenous materials for teaching concepts could enhance the knowledge of the Anganwadi workers in aspect and lead to improved practices.

F. Play Equipment

Availability of indoor and outdoor equipment in the centres is shown in Table XIV.

TABLE XIV
AVAILABILITY OF THE EQUIPMENT

S.No.	Equipment	Number of Centres N = 100
<u>I. Indoor equipment</u>		
Yes	..	95
No	..	5
<u>II. Outdoor equipment</u>		
Yes	..	32
No	..	68

Though all the centres were provided with the equipment kit, it is disheartening to note that 5 centres were not having enough indoor equipment for the children. Only 32 centres had outdoor equipment. The rest did not have due to the lack of storage facilities and open area. It is imperative that open space is offered to the young children in the Anganwadi, since they love to jump, run, hop and experiment in the outdoor area.

2. Use of play equipment as viewed by Anganwadi workers

The uses of play equipment as viewed by Anganwadi workers are summed up in Table XV.

TABLE XV

USES OF PLAY EQUIPMENT AS VIEWED BY ANGANWADI WORKERS

S.No.	Uses	Number of centres
1.	Increase eye hand coordination	54
2.	Promotes the physical development	50
3.	Promotes the concept of size and shape	50
4.	Promotes the social development	45
5.	Brings out the latent	38
6.	Promotes the colour concepts	36
7.	Helps to let out the emotions	32

Even though they were all trained anganwadi workers, they were not aware of the various uses of the play equipment fully. It is disheartening to note that not even 60 per cent of them had stated the various values of play equipment since play equipment is very vital for young children. Intensive training needs to be planned in this aspect of the Anganwadi workers.

G. Health and Nutrition Education to Mothers and Children

Among the selected centres only 70 per cent of them had organised health and nutrition programmes to mothers. Though the nutrition and health education was expected to be

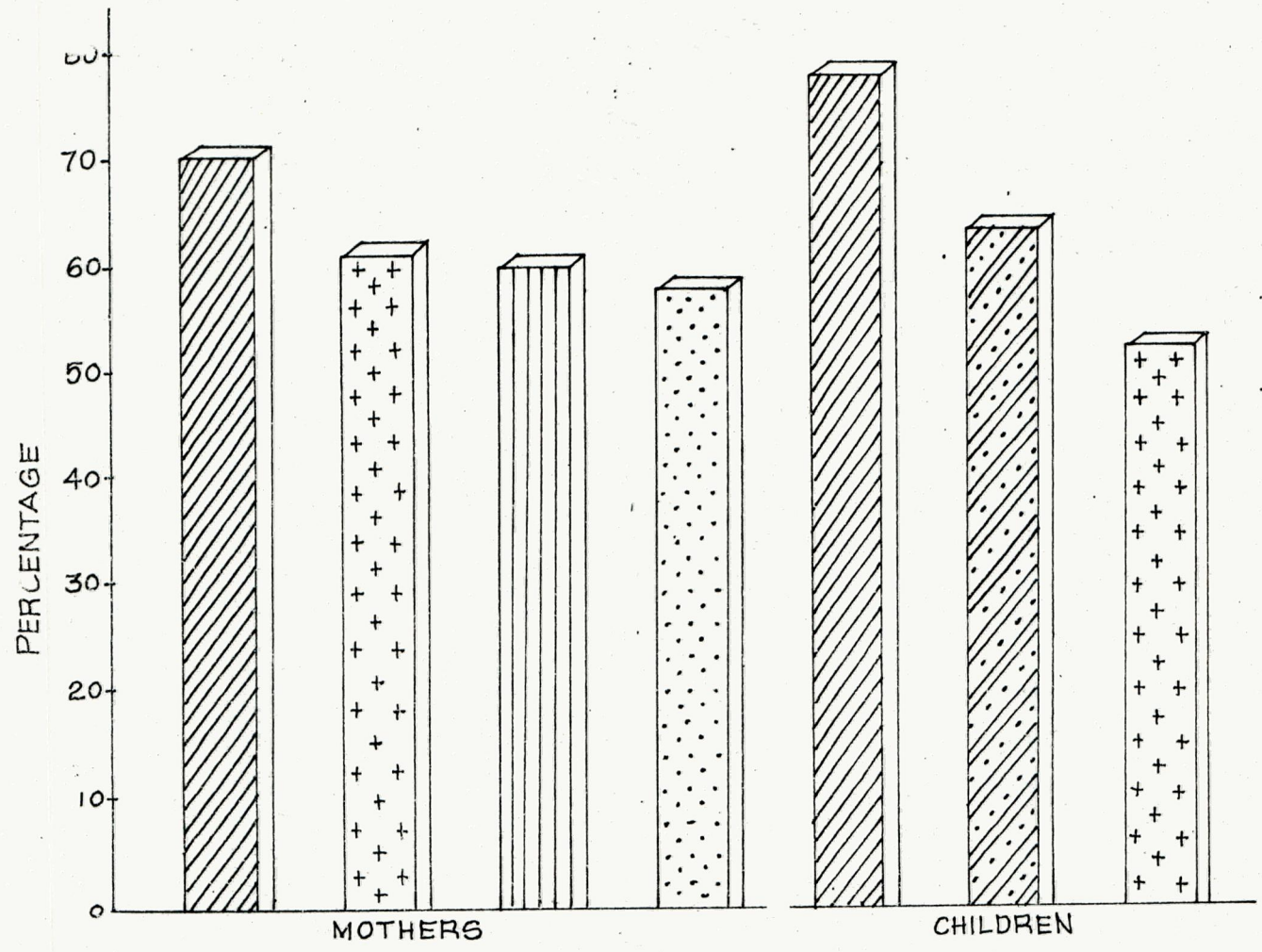
given to all women in the age group 15-45 years, the findings were found to be negative and no mention had been made about the problems faced in the delivery of this service. It had been well informed to the Anganwadi workers during their training period that health education must be carried out regularly. The topics the Anganwadi workers had chosen for the education are listed in the following table XVI and in figure 23

TABLE XVI
HEALTH AND NUTRITION EDUCATION

S.No.	Topics	Number of centres
1. <u>Mothers</u>		
	a. Importance of good nutrition and nutritive requirements for vulnerable age groups	70
	b. Environmental sanitation	62
	c. Need for immunization	60
	d. Common ailments and prevention	57
2. <u>Children</u>		
	a. Importance of good nutrition	78
	b. Personal cleanliness	64
	c. Environmental sanitation	52

The centres organised health and nutrition education to mothers on the importance of nutrition, nutritive

HEALTH AND NUTRITION EDUCATION








-  IMPORTANCE OF GOOD NUTRITION
-  ENVIRONMENTAL SANITATION
-  NEED FOR IMMUNISATION
-  COMMON AILMENTS AND PREVENTION
-  PERSONAL CLEANLINESS

Figure. 23

requirements, environmental sanitation, need for immunization and common ailments and prevention. They imparted the information through home visits and group meetings.

The children in the Anganwadi were educated on environmental sanitation, importance of nutrition and personal cleanliness through informal talks, songs and stories.

H. Population Education

Poor response to the aspect population education, was noticed in the Anganwadi workers. Only 42 centres had taken preliminary efforts to educate the mothers to limit the family size. Anganwadi workers expressed diffidence with regard to this aspect. Hence special training and education in this field perhaps would help them in knowing how abouts of population education and effective implementation of the same.

I. Administrative details

In Tamil Nadu, since ICDS is operating in combination with the State Government Nutritious Noon Meal Scheme, the AWW had two helpers one from ICDS and the other from the nutritious meal programme.

To monitor the programme, there were four supervisors and four ANMs per project to look after the health aspects. To coordinate the programme there were four CDPOS (one per project) all centrally co-ordinated by the ICDS Cell Officer.

The details of the functionaries are discussed as follows:

- a. Profile of the AWWs and helpers
- b. Role of the supervisors
- c. Role of the ANMs
- and d. Role of the CDPOS

The AWWs were responsible for enrolment of children and other beneficiaries, distribution of nutrition supplements, non-formal preschool education for children, arranging for the health checkup of the beneficiaries, education for mothers, eliciting community participation and maintenance of records and registers.

There were 27 registers and records maintained by the AWWs which are enumerated below:

1. Beneficiary Register
2. Preschool children Attendance Register
3. Home visit Day
4. Mother's Meeting Record
5. Beneficiaries Enrolement Register
6. Visit Record
7. SNP Attendance Register
8. Egg Beneficiary Record
9. Birth/Death Register
10. Visitors Record
11. Anganwadi Worker's Attendance Register

12. Ingredients Register
13. Income Expenditure Register
14. Records of Distribution of Iron and Folic Acid Tablets
15. 'At risk' children Register
16. Weight Records
17. Immunisation Record
18. DAP - Record
19. Daily Diary
20. Programme Planning Record
21. Radio Programme Register
22. Pregnant and Lactating mother's Record
23. Food Expenditure Record
24. Anganwadi Worker's Monthly Progress Report
25. Beneficiary Registration Card
26. Anganwadi Activities Record
27. Stock Register for Equipment

b. Role of the Supervisors

All the 16 Supervisors had undergone training in ICDS and put in one to seven years service in ICDS. Prior to joining the ICDS, they had served as Gramsevikas (Rural Welfare Officer - Women) and Mukhyasevikas (Extension Officer - Social Welfare) and had therefore experience in field work ranging from 10-30 years.

While 50 per cent had stated that they supervised each Anganwadi twice a month, the other 50 per cent could

visit the Anganwadis only once a month due to non-availability of transport facilities and inaccessibility of the centres.

Table XVII indicates the types of help offered by the Supervisors to the AWWs.

TABLE XVII
HELP PROVIDED BY THE SUPERVISORS

S.No.	Help provided	Percentage stating (N:16)
1.	Planning Preschool activities	100
2.	Arranging for Referral services	100
3.	Taking heights and weights and filling in health cards	100
4.	Conducting mothers meeting	100
5.	Teaching preschool songs to children	94
6.	Guiding AWWs to keep the Anganwadi and surrounding clean	56
7.	Training AWWs and helpers	18

All the supervisors had reported of doing their routine tasks such as planning pre-school activities, arranging for referral services, taking heights and weights and filling in health cards and conducting mother's meetings,

while 94 per cent had indicated teaching pre-school songs to children, 56 per cent of guiding AWWs to keep the Anganwadis and surroundings clean and 18 per cent had stated that they had imparted training to the workers.

All the supervisors had mentioned of checking the records maintained by the AWWs as their major regular activity.

c. Role of the ANMs

All the 16 ANMs had seven to thirteen years work experience. They work under the technical guidance of the medical officer of the respective ICDS projects. Table XVIII shows the job responsibilities of ANMs.

TABLE XVIII
JOB RESPONSIBILITIES OF ANMs

S.No.	Responsibilities	Percentage stating (n:16)
1.	Enlisting children and/or pregnant women for immunization	100
2.	Conducting immunization camps	100
3.	Maintaining birth/death records	100
4.	Arranging for health check up of children and women	100
5.	Distributing Iron and Folic acid to pregnant women	100
6.	Giving after care services	88
7.	Ensuring cooperation from other functionaries	75
8.	Assisting AWWs in home visits	75
9.	Helping AWWs in mothers meeting	75

In addition to health related activities such as enlisting members for immunization, maintenance of birth and death records, health check up of children and expectant women and distribution of iron and folic acid to beneficiaries, the ANMs had also stated that they work with the AWWs in education programmes.

d. Role of the CDPOS

Three out of the four CDPOS selected for the study were graduates. The experience of the CDPOS varied from 28 to 32 years in the field of extension. They had undergone special training in ICDS.

While two CDPOS had reported of visiting each Anganwadi in their circle atleast once a month, the other two had indicated the frequency of their visits as twice a month.

The tasks of CDPOS were multifarious both in terms of guiding the supervisors and AWWs in the day-today conduct of the ICDS and in fulfilling to educational objectives of ICDS such as conducting mothers' meetings and establishing liasion with local organizations. They also had the task of ensuring supplies to Anganwadis on time. Another major task was to verify the records maintained by the AWWs.

There were a number of records to be maintained by the CDPOS themselves such as monthly monitoring reports, monthly

progress reports, supplementary feeding reports, beneficiaries report and visits report to be sent to the Director of Social Welfare, District Programme Officer, All India Institute of Medical Sciences and Department of Social Welfare, Government of India.

In order to identify the difficulties and constraints in the implementation of ICDS, the CDPOS were asked to specify the problems faced by them. Their responses indicated a variety of factors which hamper their discharging of duties such as Inadequate involvement of the community, lack of proper physical set up of Anganwadis, political interference, caste feelings, lack of interest of the AWWs, lack of play materials and equipment and non accessibility of Anganwadis due to improper roads were the problems expressed by the CDPOs.

The difficulties encountered related mainly to community support and inadequate facilities in the Anganwadis. Lack of interest on the part of the AWWs also posed problems.

When questioned as to how they would plan to improve the status of Anganwadis, the responses are given in Table XIX.

TABLE XIX

SPECIFIC PLANS OF CDPOS FOR STRENGTHENING THE PROGRAMME

S.No.	Specific plans of CDPOS	Percentage stating (n:4)
1.	Initiating steps for enrolling more children	100
2.	Arranging for publicity through radio programmes by the Anganwadis children	100
3.	Enhancing mothers to participate more effectively	100
4.	Eliciting male member's support for the programmes	100
5.	Motivating mothers to participate more effectively	100
6.	Organising short field trips for the children	75
7.	Arranging for incentive for the workers	75
8.	Improving the environmental sanitation	75
9.	Organising mahila mandals	75
10.	Strengthening training for the functionaries at various levels	75
11.	Encouraging AWWs to compose new preschool songs	50
12.	Arranging for film shows	50
13.	Mobilising support by local leaders	25

The suggestions were positive and indicated the interest of the CDPOS in improving the ICDS programme.

J. Amenities in the Anganwadis

The amenities available in the Anganwadis included indoor and outdoor space storage facilities, drinking water, toilet facilities etc. (Fig. 24).

While 44 per cent Anganwadis were located in their own Corporation building exclusively built for ICDS, the rest of them functioned in rented buildings or in schools and private houses.

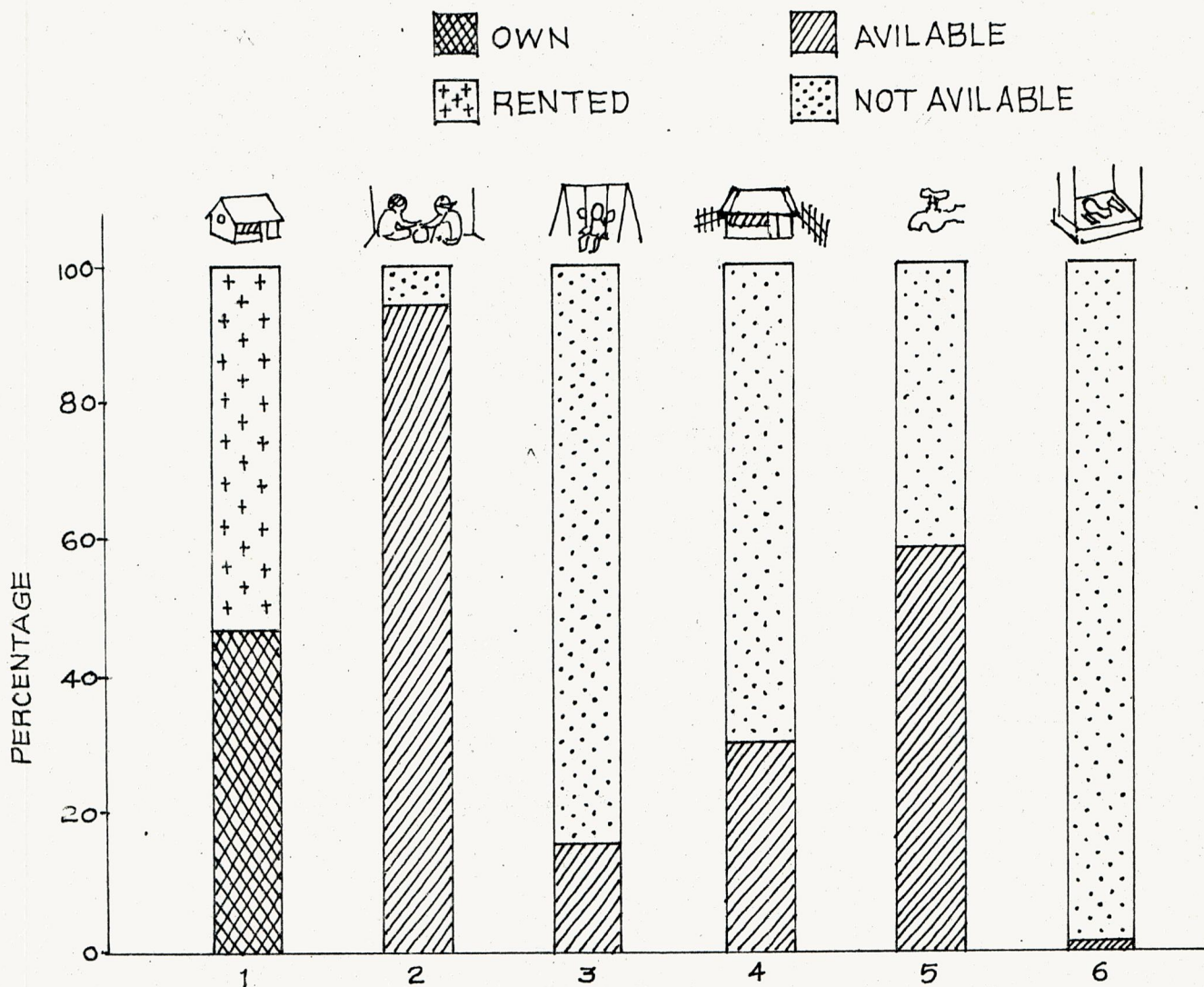
Out of the 100 Anganwadis, 96 per cent had indoor space available for play and creative activities and 16 per cent had out door space available.

Almost all the Anganwadis were located in safe places, posing no threat or hazards from traffic. However only 30 per cent were located in hygienic surroundings, while the rest 70 per cent had in their vicinity uncovered drains, heaps of garbage and slush.

As for efforts taken to improve the surroundings, 65 per cent AWWs reported of giving complaints to the Corporation authorities through their CDPOS.

With regard to storage space for provision, 69 per cent AWWs expressed adequacy of space, 59 per cent Anganwadis had drinking water available at their premises. Among the remaining 17 per cent received drinking water through Corporation lorries, while 24 per cent got it from nearby schools. Clean and closed containers were used for storing water. However only one per cent of the total Anganwadis had toilet facilities. This is the biggest missing link in the programme.

AMENITIES AVAILABLE IN THE ANGANWADIS



- 1. BALWADI OWN, RENTED
- 2. INDOOR SPACE AVILABLE
- 3. OUT DOOR SPACE AVILABLE
- 4. HYGIENIC SURROUNDINGS
- 5. WATER FACILITIES
- 6. TOILET FACILITIES

Figure 24

Summary and Conclusion

V SUMMARY AND CONCLUSION

The study on "Functioning of ICDS in selected centres" was carried out in 100 Anganwadies situated in Coimbatore District. The results of this study are summarised below:

1. In the selected hundred Anganwadies, 5030 children were enrolled, out of which 1158 were infants and 3872 were the preschoolers.
2. The educational qualification of the Anganwadi workers ranged from 10th standard to P.U.C. All the Anganwadi workers were married except twenty one per cent.
3. Forty two of them had received training in 1983 for 3 months, 14 Anganwadi workers were trained for 10 days in 1982, 26 of them had training in 1986 for 2 months and 18 of them had received training for 10 days in 1989.

The components of training were songs, story, preparing charts, making indigenous play equipment, importance of preschool education nutrition and health education, environmental sanitation and their importance, maintenance of records and registers, various types of games, child care, various types of immunization and their needs.

Since special efforts had been taken to appoint the local girls under ICDS, 66 of them were working in their

own native places. The others were transferred but not more than twice. This aspect of appointing local girls for the post of Anganwadi worker is a welcome feature and this pattern should be continued.

Ninety four percent of the infants, ninety one percent of the preschool children and eighty five percent of the pregnant women and seventy five percent of the lactating mothers seem to benefit from the feeding programme on a regular basis.

Forty seven per cent said that they do not encounter any problems whereas 53 per cent had faced problems. The problems given by the Anganwadi workers were insufficient money for the fuel, irregular attendance of children, food sought of non-beneficiaries and inadequacy of Ayahs in relation to feeding programmes.

For children of the 75 per cent of the centres, the quantity of food served was sufficient. Anganwadi workers of the remaining centres reported that the quantity of food served was not sufficient for the preschoolers and women. They unanimously stressed that the children of the low income families consume more than the allotted 80 gms of rice, since they might not have had their breakfast.

Though all the centres had menu plan, they did not follow the menu pattern given by the instructors. They

gave the mixed rice on all the 360 days, when the investigator enquired about this they pointed out that they are not able to follow the menu due to the meagre allotment of the money for vegetables and non-availability of the vegetables near the anganwadi.

The health records revealed that twelve out of 5,030 children were suffering from third degree of malnutrition. These children were not fed by supplementary feeding, because provision had not been made from the Government as yet.

Eighty two percent of the children had given BCG vaccination, 80 per cent of the children had given polio vaccination. Fifty per cent of the enrolled children (0-6 years) had been vaccinated against small pox and whooping cough.

It is painful to see that out of 841 pregnant women enrolled, only 324 were given tetanus injection. Even though there was provision, the pregnant women did not utilise it properly.

Paracetamol syrup, 'B' complex, piperazine citrate and Vitamin A and D. Capsules were the common medicines issued in majority of the centres.

Thirty seven and twenty six centres were visited by the doctors and Auxiliary Nursing Mid-wives respectively

once in a month. One third of the centres were visited by the personnel once in a fortnight and others had the personnel for health check up once in a week. During their visit to the Anganwadi centres, doctors carried out the health check up and immunization. Along with these two activities Auxiliary Nursing Mid-Wives distributed medicines as per the prescription of the doctor.

Among the 100 centres, 50 per cent did not encounter any problems in carrying out the immunization programme, while the other half had problems such as poor attendance of the children and inability to take the children to the place where health check up is arranged.

Forty four percent of the Anganwadi workers were satisfied with the existing environmental sanitary facilities. The rest were not satisfied because the centres lacked toilet facilities and were built around unhygienic surroundings such as cattle shed and stagnated waterpools.

Various kinds of oral doses were given to children Paracetamol syrup 'B' complex, piperazine citrate and vitamins A and D, capsules were the common medicines issued in majority of the centres.

The construction of toilet facilities, compound walls and drainage were the suggestions given by the Anganwadi

workers to improve the environmental sanitation. The health check up and referral services were carried out regularly and intensively for children in ninety seven centres.

The most common services offered to children of 0 to 6 years were taking height/weight, giving tetanus injection and distributing vitamin tablets and health check up were given to pregnant women. But for lactating mothers no health check up referral services were carried out.

Ninety six percent of the Anganwadi workers conducted nonformal educational programme for children in the Anganwadis. However, in four centres the Anganwadi workers felt that they were too busily occupied in administrative requirements and found only little time to conduct the activities for children.

The components of non-formal education is envisaged through two methods namely Theme Approach and Play way method. More than 75 per cent of the centres followed play way method for which the Anganwadi workers had reasoned out that it was found more interesting by the children and encouraged creativity in children. This aspect needs to be adopted in all the Anganwadies since the play way method enables the child to be creative and imaginative.

The Anganwadi workers remarked that the songs, stories,

group games and drawing were the most liked activities of the children against sleeping, writing, reading which were not liked by children.

In all the centres, children were taught to read and write the numbers. Experiences in writing of English alphabets and words are given in 92 centres and exercises in writing of Tamil were offered in 88 centres.

With regard to the aids, black boards were used predominantly in all the centres, followed by charts (87 centres) and flash cards (58 centres) beads were used (26 centres) as an aid to impart number and colour concepts.

Though all the centres were provided with the equipment kit, five centres were not having enough indoor equipment for the children. Only 32 centres had outdoor equipment. The rest did not have due to the lack of storage facilities and open area.

Even though they were all trained anganwadi workers, they were not aware of the various uses of the play equipment fully. Not even 60 per cent of them had stated the various values of play equipment since play equipment is very vital for young children. Intensive training needs to be planned in this aspect of the anganwadi workers.

Among the selected centres only 70 per cent of them had organised health and nutrition programmes to mothers.

Though the nutrition and health education was expected to be given to all women in the age group 15-45 years, the findings were found to be negative.

The centres organised health and nutrition education to mothers on the importance of nutrition, nutritive requirements, environmental sanitation, need for immunization and common ailments and prevention.

Poor response to the aspect 'population education' was noticed in the Anganwadi workers. Only 42 centres had taken preliminary efforts to educate the mothers to limit the family size. Anganwadi workers expressed difference with regard to this aspect. Hence special training and education in this field perhaps would help them in knowing how abouts of population education and effective implementation of the same.

To monitor the programme, there were four supervisors and four ANMs per project to look after the health aspects. To coordinate the programme, there were four CDPOS (one per project), all centrally co-ordinated by the ICDS Cell Officer.

The Anganwadis were responsible for enrolment of children and other beneficiaries, distribution of nutrition supplements, non-formal preschool education for children, arranging for the health checkup of the beneficiaries,

education for mothers, eliciting community participation and maintenance of records and registers. There were 27 registers and records maintained by the Anganwadis.

All the 16 Supervisors had undergone training in ICDS and put in one to seven years service in ICDS. While 50 percent had stated that they supervised each Anganwadi twice a month, the other 50 percent could visit the Anganwadis only once a month due to non-availability of transport facilities and inaccessibility of the centres.

All the supervisors had reported of doing their routine tasks such as planning pre-school activities, arranging for referral services, taking heights and weights and filling in health cards and conducting mother's meetings, while 94 percent had indicated teaching pre-school songs to children, 56 per cent of guiding AWWs to keep the Anganwadis and surroundings clean and 18 per cent had stated that they imparted training to the workers.

All the supervisors had mentioned of checking the records maintained by the ANMs as their major regular activity.

All the 16 ANMs had seven to thirteen years work experience. They work under the technical guidance of the medical officer of the respective ICDS projects.

In addition to health related activities such as enlisting members for immunization, maintenance of birth

and death records, health check up of children and expectant women and distributing of iron and folic acid to beneficiaries, the ANMs had also stated that they work with the AWWs in education programmes.

Three out of the four CDPOs selected for the study were graduates. The experience of the CDPOs varied from 28 to 32 years in the field of extension. They had undergone special training in ICDS.

The tasks of CDPOs were multifarious both in terms of guiding the supervisors and AWWs in the day-to-day conduct of the ICDS and in fulfilling to educational objectives of ICDS such as conducting mothers meetings and establishing liaison with local organizations. They also had the task of ensuring supplies to Anganwadis on time. Another major task was to verify the records maintained by the AWWs.

There were a number of records to be maintained by the CDPOs themselves such as monthly monitoring reports, monthly progress report, supplementary feeding reports, beneficiaries report and visits report to be sent to the Director of Social Welfare, District Programme Officer, All India Institute of Medical Sciences and Department of Social Welfare, Government of India.

The difficulties encountered related mainly to community support and inadequate facilities in the Anganwadis. Lack

of interest in the part of the AWWs also posed problems.

The suggestions given were positive and indicated the interest of the CDPOs in the ICDS programme.

The amenities available in the Anganwadis included indoor and outdoor space storage facilities, drinking water, toilet facilities etc.

While 44 percent Anganwadis were located in their own Corporation buildings exclusively built for ICDS, the rest of them functioned in rented buildings or in schools and private houses. Out of the 100 Anganwadis, 96 per cent had indoor space available for play and creative activities and 16 percent had outdoor space available. With regard to storage space for provisions, 69 per cent AWWs expressed adequacy of space, 59 per cent Anganwadis had drinking water available at their premises. Among the remaining 17 percent received drinking water through Corporation lorries, while 24 per cent got it from nearby schools; clean and closed containers were used for storing water. However only one percent of the total Anganwadis had toilet facilities. This is the biggest missing link in the programme.

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Appendix

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND
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CHECKLIST TO EVALUATE THE AMENITIES IN THE ANGANWADI

ICDS Centre No. :
Project No. :
Place :
Name of the investigator :
Name of the AWW :

S.No.	Item	Criteria	Evaluation	
			Yes	No

- | | |
|---------------------------------------|---|
| 1. Tenancy | 1. Corporation Building
2. Maternity Hospitals Campus
3. Schools
4. Private House
5. Any other |
| 2. Physical set up | 1. Indoor space - adequate
2. Outdoor space - adequate
3. Good lighting
4. Good ventilation
5. Surroundings <ul style="list-style-type: none"> a. Uncovered drains b. Heaps of garbage c. Cattle shed/
Animal shelter d. Slush and stagment water e. Any other |
| 3. Toilet facilities in the Anganwadi | a. Available
b. Not available |

S.No.	Item	Criteria	Evaluation	
			Yes	No
4.	If available its availability	a. Usable b. Not usable		
5.	Container in which the drinking water stored	a. Mud pot b. Brass drum c. Metal drum d. Any other		
6.	Conditions of storage of drinking water	a. Unclean b. Moderately clean c. Clean		
7.	Storage of rations	a. Separate storage space available b. Available space sufficient for storage c. Rations stored in bags d. Rations stored in containers		

8. Personal hygiene of selected children:

Name of the children	Conditions				Over all remarks		
	Hair	Nails	Face	Dress	Good	Fair	Poor
1.							
2.							
3.							
4.							
5.							

SCHEDULE TO ELICIT INFORMATION FROM THE ICDS
FUNCTIONARIES FROM THE CDPO
A CHILD DEVELOPMENT PROJECT OFFICER

Date :

Place:

1. Identification :
Name of the CDPO :
Educational Qualification:
Work experience in ICDS :
In other (specify) :
No.of Anganwadis in your circle:
2. How frequently are you visiting the Anganwadis?
3. Normally what do you do during your visits to the Anganwadis?
 - i. Guide in initiating Background survey
 - ii. Ensure supplies
 - iii. Check Anganwadi Records
 - iv. Convene meetings/training with supervisors
 - v. Convene meetings training with Anganwadi workers
 - vi. Liaison with health staff
 - vii. Liaison with local organisation
 - viii. Liaison with local leaders / individuals.
 - ix. Any other (Specify)
4. What are the periodic reports do you send your officials
Reports
5. What specific plans do you have to strengthen Anganwadis?

ஒருங்கினந்த குழந்தைகள் வளர்ச்சித் திட்டம் பற்றி அறிந்து கொள்ள உதவும் வினாத்தாள்:

1. பொது விவரங்கள்:

1. மைய எண் .
2. விலாசம்

3. அங்கக்வாடி பணியாளரில் பெயர்

4. திருமணம் ஆவரா () ஆகாதவரா ()

5. கல்வி தகுதி ()

ஆரம்பப்பள்ளி ()

உயர்நிலைக் கல்வி ()

மேல்நிலைக் கல்வி ()

பட்டதாரி ()

6. பயிற்சி பெற்றவரா? ஆம் () இல்லை ()

7. ஆம் எனில் எங்கு எப்போது, எத்தனை நாட்கள் பயிற்சி அளிக்கப்பட்டது.

எண் . பயிற்சி அளிக்கப்பட்ட இடம் காலம் கதைப் பற்றி

8. இத்தகையதில் தங்களுக்கு எத்தனை வருட அனுபவம்?

9. அங்கக்வாடி பணியாளராக சேர்ந்தது முதல் ஒரே இடத்தில் பணியாற்றி வருகிறீர்களா? அல்லது மாற்றாதி வந்துள்ளீர்களா?

ஆம் இல்லை ஆம் எனில் எத்தனை முறை காரணங்கள்
மாற்றலாகியுள்ளது

9. உங்களுக்கு அளிக்கப்பட்ட பணிகள் யாவை?

10. உங்களுக்கு உதவியாளர் உள்ளவரா?

ஆம் () இல்லை ()

11. ஆம் எனில் எத்தனை உதவியாளர்கள் உள்ளனர்? அவர்களது பணிகள்.

12. தங்களது பணிகளை யார் மேற்பார்வையிடுகிறார்கள்?

மேற்பார்வையிடுபவர்

கறம் யோசனை

எவ்வளவு நாட்களுக்கு
ஒரு முறை

2. பள்ளி முல் பருவக் கல்வி பற்றிய விவரங்கள்:

1. உங்கள் பனியில் தற்போது உள்ள குழந்தைகளில் எண்ணிக்கை எக்க?

வயது	ஆண்	பெண்

2. குழந்தைகள் எவ்வாறு தேர்ந்தெடுக்கப்படுகிறார்கள்?

3. பள்ளி முல்பருவக் கல்வியில் குழந்தைகளுக்கு எவ்வெக்க பயிற்றுவிக்கிறீர்கள்?

- கதை சொல்லுதல். ()
- பாட்டு ()
- வெளிப்புற விளையாட்டுக்கள் ()
- அறிவியல் அனுபவம் ()
- எண்ணியல் கற்பிக்கும் விளையாட்டுக்கள் ()
- எழுத்தியல் ()
- இதரவை ()

4. உங்களுடக் குழந்தைகள் சகஜமாக பழக அனுமதிக்கிறீர்களா?

ஆம் () இல்லை ()

5. ஆம் எனில் எந்தெந்த விதங்களில்?

6. பள்ளியில் உள்ள பொருட்களும் அவற்றை உபயோசிக்கும் முறைகளும்:

எண்.	பொருட்கள்	இருப்பவை	பயன்படுத்தாதவை	பயன்படுத்தப்பவை
1.	பொம்மைகள்	:	:	:
2.	எண்ணெய் பலகை	:	:	:
3.	போஸ்டர்கள்	:	:	:
4.	படப்புத்தகம்	:	:	:
5.	பயிற்சி புத்தகம்	:	:	:
6.	மற்றவை	:	:	:

6. குழந்தைகளுக்கு பள்ளி முன்பருவக் கல்வி நிகழ்ச்சிகளை எப்படி நடத்துகிறீர்கள்?

1. கொடுத்தள்ள அட்டவணைப்படி நடத்துதல்.
2. தாங்களே தயாரித்து நடத்துதல்.

7. குழந்தைகளின் திறமை எவ்வாறு மதிப்பீடு செய்கிறீர்கள்?

8. குழந்தைகளின் சராசரி வருகை எவ்வளவு?

9. குழந்தைகள் வராமலிடுகக் காரணங்கள்?

10. பள்ளி முன்பருவக் கல்வியில் நன்றாக பங்கேற்கும் குழந்தைகளை எவ்வாறு ஊக்குவிக்கிறீர்கள்?

ஆம் () இல்லாவிடில் ()

11. அவ்வாறு நன்றாக பங்கேற்காத குழந்தைகளை எவ்வாறு ஊக்குவிக்கிறீர்கள்?

12. பள்ளி முடிபருவக் கல்வி நிகழ்த்தி நடத்துவதற்கு பெற்றோர்கள் உதவி செய்கிறார்கள்?

ஆம் () இல்லை ()

13. ஆம் எனில் எந்தெந்த வழிகளில்:-

1) பாட்டு, கதைகள் சொல்லிக் கொடுப்பதில்

2) உபகரணங்கள் தயாரிப்பதில்

14. பள்ளி முடிபருவக்கல்வி நிகழ்த்தி நடத்துவதில் ஏதாவது புதுமை செய்கிறீர்களா?

ஆம் () இல்லை ()

15. ஆம் எனில் குறிப்பிடுக.

நாடகம்

லிவிமா

பாட்டுக்கள் இயற்ற்தல்

கதைகள்

16. கல்வி பயில்விப்பதில் உள்ள சிரமங்களை எவ்வாறு சமாளிக்கிறீர்கள்?

3. சந்தனவுத் திட்டம்:

1. தற்போது பள்ளிக்கு வருகின்ற குழந்தைகளில் எண்ணிக்கை?
ஆம் () பெண் ()
2. சென்ற ஆண்டு இந்த ஆண்டு எண்ணிக்கைகளில் மாறுபாடு இருந்தால் காரணங்கள் என்ன?
3. எந்தகூடு குழந்தைகள் இத்திட்டத்தினால் பயன் அடைகிறார்கள்?
ஆம் () பெண் ()
4. எந்தகூடு கர்ப்பிணி பெண்களும், பாலாட்கும் தாய்மார்களும் பயன் அடைகிறார்கள்?

பயன் அடைவோர்	எண்ணிக்கை
கர்ப்பிணிகள்	
பாலாட்கும் தாய்மார்கள்	

5. பள்ளிக்கு வராத சிறு குழந்தைகள் (0 - 2 வகுடம்) இத்திட்டத்தில் பயன் அடைகிறார்களா?
ஆம் () இல்லை ()
6. இவர்களை தவிர வேறு எவருக்கேளும் மதிய உணவு வழங்கப்படுகிறதா?
ஆம் () இல்லை ()
7. ஆம் எனில் யாருக்கு வழங்கப்படுகிறது? எண்ணிக்கை என்ன?
8. உணவு வகைகளை பற்றி யார் திட்டமிடுகிறார்கள்?
9. எவ்வாறு வழங்கப்படுகிறது?

10. கீழ்க்கண்ட பொருட்கள் உள்ளனவா?

பொருட்கள்	போதுமாக அளவு	போதாமை இல்லை
1. சகமக்கும் பாத்திரம்		
2. பரிமாறும் கருவிகள்		
3. மணிகை பொருட்கள்		
4. விளக்கு சாதகங்கள்		
5. தண்ணீர் வசதி		
6. அருப்பு எளிக்க போதுமாக விறகு		
7. சகய்ப்பதற்கும் பரிமாறலுக்கும் போதுமாக இடவசதி		

11. பள்ளி குழந்தைகளுக்கு கொடுக்கப்படும் உணவில் அளவு எவ்வளவு?

குழந்தைகள்	அரிசி	பருப்பு	பச்சை காய்கறிகள்	எண்ணெய்
2 - 5 வயதுள்ள குழந்தைகள்				

2 - 5 வயதுள்ள குழந்தைகள்

12. 2 வயதிற்கு கீழ் உள்ள குழந்தைகளுக்கும் கரிப்பிணி பெண்கள், பாளாட்டும் நாய்மார்களுக்கு எவ்வளவு உணவுகள் கொடுக்கப்படுகின்றன?

கொடுக்கப்படும் உணவு	உணவில் அளவு	பயன் அடைவோர்
		கரிப்பிணிகள்
		பாளாட்டும் நாய்மார்கள்
		குழந்தைகள்

13. யார், யார் உணவுகளை கையத்திலேயே உண்கிறார்கள் அல்லது வீடுகளுக்கு எடுத்துச் செல்கிறார்கள்?

14. குழந்தைகள் உண்ணும் போது தாய்மார்களை அழைக்கிறீர்களா?

ஆம் () இல்லை ()

15. குழந்தைகள் உணவுகளை விருப்பமாக உள்ள எக்க வழிகளை கையாளுகிறார்கள்?

16. குழந்தைகள் உணவுகளை வீணாக்காமல் உண்கிறார்களா?

ஆம் () இல்லை ()

17. உணவுகளில் காய்கறிகளையும், கீரைகளையும் அகற்றாமல் சார்க்கிறீர்களா? உணதவியாளர் சமைக்கும் போது அவர்களிடம் உணவு தயாரிக்கும் முறை பற்றி எடுத்துச் சொல்வீர்களா?

ஆம் () இல்லை ()

18. சத்துக்களை வீணாகாமல் சமைக்கும் முறைகள், கடைப்பிடிக்கும் முறைகள் யாது?

19. உணவு மீந்து விட்டால் எக்க செய்கிறீர்கள்? யார் தயாரிக்கிறார்கள்?

20. தாய்மார்கள் உதவி செய்கிறீர்களா?

4. மருத்துவ பரிசோதனையும் தடுப்பதும்:

1. குழந்தைகளுக்கு மருத்துவ பரிசோதனை செய்யப்படுகிறதா?
ஆம் () இல்லை ()
2. ஆம் எனில் யாரால் எப்போது செய்யப்படுகிறது?
3. உங்கள் பள்ளி குழந்தைகளுக்கு தடுப்பூசி போடுகிறீர்களா?
ஆம் () இல்லை ()
4. ஆம் எனில் எங்க எங்க தடுப்பூசி போடுகிறீர்கள்?
5. குழந்தைகளுக்கு தடுப்பூசி யாரால் எப்போது போடப்படுகிறது?
6. குழந்தைகளுக்கு வேறு ஏதாவது மருந்து கொடுக்கிறீர்களா?
ஆம் () இல்லை ()
7. ஆம் எனில் குறிப்பிடுக.
8. தற்போது இருக்கும் குழந்தைகளின் தடுப்பூசி போடுப்படாதவர் இருக்கிறார்களா? ஆம் எனில் காரணம்.
9. கர்ப்பிணி நாய்மார்களுக்கு மருத்துவ பரிசோதனை / தடுப்பூசி / மாத்திரைகள் கொடுக்கப்படுகிறதா?
ஆம் () இல்லை ()
10. ஆம் எனில் யாரால் எப்போது கொடுக்கப்படுகிறது?
11. பாளாட்டும் நாய்மார்கள் இத்திட்டத்தில் பயன் அடைகிறார்கள்?
ஆம் () இல்லை ()
12. ஆம் எனில் அவர்களுக்கு எங்கெங்க மருத்துவ உதவிகள் வழங்கப்படுகிறது?

12. தடுப்பூசியில் அவசியந்தகத் தாய்மார்களுக்கு எவ்வாறு எடுத்துக் கூறகிறீர்கள்?

13. தடுப்பூசி போட்ட பின்பும் கையகடந்த/நாய் காக்கப்பட்ட குழந்தைகள் உள்ளகரா?

ஆம் () இல்லை ()

14. ஆம் எனில் எவ்வகை காரணங்கள்?

15. கைகடந்த எவ்வாறு எடுக்கப்படுகிறது?

16. குரோக்கியமில்லாத குழந்தைகள் வளர்த்திக்கு அளிக்கும் முக்கியத்தகம் யாகு?

5. சத்துணவு சுகாதாரக் கல்வி:

1. இத்திட்டத்தில் பயில் அடையல்களுக்கு சத்துணவு சுகாதாரக் கல்வி அளிக்கப்படுகிறதா?

ஆம் () இல்லை ()

2. ஆம் எனில் யாருக்கு அளிக்கப்படுகிறது.

3. தாய்மார்கள் கட்டம் நடத்தப்படுகிறதா?

ஆம் () இல்லை ()

4. ஆம் எனில் மாதத்திற்கு எத்தனை முறை?

5. சாதாரணமாக கட்டத்திற்கு வரும் தாய்மார்களில் எண்ணிக்கை எவ்வளவு?

6. தாய்மார்களுக்கு நீங்கள் எந்தப்பற்றி முக்கியமாக எடுத்துக் கூறுகிறீர்கள்?

7. சத்துணவு சுகாதாரக் கல்வி நடத்த எவ்வெவ்வ முறைகளை கையாளுகிறீர்கள்?

பேச்சு ()

பாட்டுக்கள் ()

8. நீங்கள் அளிக்கப்படும் கல்வியை தாய்மார்கள் பின்பற்றுகிறார்கள்?

ஆம் () இல்லை ()

9. ஆம் எனில் எவ்வாறு.

10. உங்கள் பள்ளியில் கட்டம் நடத்துகாத யார் மேற்பார்வையிடுகிறீர்கள்?

மருத்துவ சேவை

1. நோயுற்ற குழந்தைகளை மருத்துவ விடுதிகளுக்குப் பரிந்துரை செய்திருக்கிறீர்களா?

2. சென்ற வருடம் எவ்வாறு பரிந்துரைக்கப்பட்ட குழந்தைகளிடம் எண்ணிக்கை?

எதற்காக	எங்கு	விளைவுகள்

3. மருத்துவ விடுதிகளில் உணிகள் பரிந்துரை ஏற்கப்படுகிறதா?

ஆம் () இல்லை ()

4. இத்திட்டத்தில் உண்டாகும் நன்மைகள்?

7. பொதுவாகவை :

1. இத்திட்டத்தினால் உண்டாகும் நன்மைகள்?

2. இவ்வ நடைமுறையில் உள்ள சிரமங்கள்?

3. இத்திட்டம் நன்கு செயல்பட உதிகளியுலோசனைகள்?