INTRODUCTION
"Many things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made and his senses being developed. To him we cannot answer 'Tomorrow'. His name is 'Today'."

Gabriela Mistral
CHAPTER I

1. INTRODUCTION

In all countries children are loved and have a special place in people's lives, but a large number of them become a cause for sorrow because of illness or untimely death. The situation is specially grave in developing countries where hunger and diseases are main reasons for a colossal waste of life at an early age. These children do not die due to any exotic or grave illnesses but due to common diseases like diarrhoea, respiratory infections or from diseases easily preventable by immunisation. Malnutrition is another contributory factor leading to infections, and infections in turn, increase energy demands and decrease food absorption, so even the food that is available to these children is not absorbed thus making them more vulnerable to further infections.

India, one of the developing countries, has made a tremendous progress in almost all fields, such as agriculture, production, industrial development, technological advancement and improvement of health status of people during the past 35 years, resulting in the remarkable decrease in death rate (from 29.4 per 1000 in 1941-51 to 14.6 per 1000 in 1975-85) and spectacular
increase in life expectancy at birth (from 32 years in 1951 to above 54 years at present). However, in spite of vast strides taken in many fields, the health status of children specially below 6 years of age has not improved adequately. The major problem in our country is that about 80 percent of the total population lives in rural areas where basic requirements of life are not available. Poverty, ignorance, illiteracy, lack of medical facilities etc. further enhance the morbidity and mortality in this age group.

High mortality in infants and pre-school children is a common feature of all developing countries including India. The basic causes of high infant mortality being the poor nutritional status of infants, over exposure to massive doses of pathogenic micro-organisms and community's excessive fertility (Chandra Shekhar, 1972). These causes interact, supplement and reinforce each other.

Pre-school children are most seriously affected by protein energy malnutrition, nutritional anaemia and vitamin deficiencies because the nutritional requirements of these children are proportionally higher for body weight than those of adults and also, for cultural reasons and economic constraints, they are given less nutritious diet. In addition, they are often affected by intermittent infections. Poor placental transmission of iron from anaemic mother, improper weaning, deficient dietary iron
intake, G.I.T. disorders and parasitic infections are some of the important factors responsible for high prevalence of anaemia in this age group. In rural areas other contributing factors are superstition, ignorance, false beliefs and poor environmental conditions.

Child bearing and rearing practices of the people are closely interwoven into the matrix of their socio-cultural milieu. A joint WHO/UNICEF meeting in Geneva in October '79 highlighted the child health problem related to infant and young child feeding practices. It states that poor infant feeding practices and their consequences are one of the major problems of the world and a severe obstacle to social and economic development. Breast feeding has been accepted as natural diet for newborn baby by nearly all Indian rural mothers but variations may be in practices of supplementary feeding.

To protect and promote the health of the children, number of schemes have been implemented in India, one such scheme known as Integrated Child Development Services (I.C.D.S.) was launched in 1975, the objective of which is to improve the nutritional and health status of children below 6 years of age and to lay foundation for proper psychological, physical and social development of the child. To achieve the objective a package of services comprising of supplementary nutrition, immunisation,
health check-up, referral services, health and nutritional education and nonformal education is provided in an integrated manner to the children below 6 years of age and expectant and nursing mothers.

The package of services is delivered at a community centre known as Anganwadi centre in each village covering the population of about 1000. The key person who provides these services is designated as Anganwadi Worker (A.W.W.) who invariably a female and selected from the local community. Anganwadi Worker is assisted by a helper who is also from the same area. The work of 20 Anganwadi Worker is supervised by one Mukhya Sevika. The child development project officer (C.D.P.O.) is overall incharge of project in one community development block.

It is an ambitious scheme with sizeable inputs and involving department of social welfare, health education and rural development. The scheme since its inception, has received varied comments and observations (Sunder Lal, 1980 & Patowari, 1982) creating doubt in the minds of people and administrators alike. It was, therefore, thought desirable to evaluate the I.C.D.S. scheme in one of the project - Chirgaon, Jhansi (U.P.), where the scheme was started in 1980-81.
**Aims and Objectives:**

The specific objectives of the present study are:

1. To study the nutritional status and morbidity of children below 6 years of age covered under I.C.D.S. scheme and compared with children not receiving I.C.D.S. care.

2. To assess the utilization of health services by the population in I.C.D.S. care in comparison to the population not receiving the I.C.D.S. care.

3. To see the impact of I.C.D.S. services on mortality status of children below 6 years of age by comparing it with the children not receiving the I.C.D.S. care.

4. To identify areas of relative inactivity in the I.C.D.S. scheme requiring augmentation.

5. To suggest measures for more effective implementation of the scheme.