CHAPTER VI
FINDINGS, CONCLUSION AND SUGGESTIONS

With strong government commitment and political will, the ICDS program has emerged from amongst beginnings in 1975 to become India’s flagship nutrition program. Using a conceptual framework of the causes of under nutrition, this study brings out that many of the ICDS program components are well-designed to address the immediate causes of child under nutrition in India, even though as presented later substantial shifts in focus and improvements in implementation seems to be necessary if the program is to realize that potential.

The average Indian children have a poor start to life. Both infant and under-five mortality rates for Indian children – at 67 and 93 respectively – are higher than the developing country average. One in four newborns is underweight. Only about one in three is exclusively breastfed for the first six months. Nearly one in two children under five years of age suffer from moderate or severe malnutrition. One in three children does not get a full course of DPT (diphtheria, peruses and tetanus immunization), and only one in three has the opportunity to be in an early
learning programme. Just about one in five is protected against vitamin A deficiency. Their parents and caregivers experience grave disadvantages too. Forty-four per cent of India’s people live on less than $1 a day. Less than 30 per cent have access to adequate sanitation facilities. Skilled attendants handle fewer than half of all deliveries, a major factor in the country’s high maternal mortality ratio of 540 deaths per 100,000 live births. Less than half the country’s households consume iodized salt. Pervasive discrimination against girls and women is reflected in a range of adverse indicators, including nutritional and educational outcomes, and the declining ratio of girls to boys, particularly in the youngest age group. Against this backdrop, the Government has supported a monumental effort to improve the life chances of children. Integrated Child Development Services (ICDS) in India is the world’s largest integrated early childhood programme, with over the centers covered nationwide. Since its inception in 1975, the programme has matured and expanded, despite of difficulties in adapting to the vastly different local circumstances found on the Indian subcontinent. UNICEF helped launch the ICDS programme and continues to provide financial and technical assistance along with the World Bank. The programme today
covers over 4.8 million expectant and nursing mothers and over 23 million children under the age of six. Of these children, more than half participate in early learning activities.

The purpose of ICDS is to improve the health, nutrition and development of children. The programme offers health, nutrition and hygiene education to mothers, non-formal preschool education to children aged three to six, supplementary feeding for all children and pregnant and nursing mothers, growth monitoring and promotion, and links to primary healthcare services such as immunization and vitamin A supplements.

The ICDS program has been the subject of a large volume of research. Most evaluations have focused on the quality of infrastructure and inputs, and the execution of activities. There have been very few rigorous evaluations of the program’s impact on nutritional status or health behaviors, partly because there are few sources of data that permit the comparison of outcomes among recipients and non-recipients of the program. Consequently, many authors have been unable to use the statistically rigorous methodologies that would enable them to draw more reliable conclusions about the impact of ICDS. As a
result, some studies have found that the program is associated with improvements in nutritional status, while other studies have failed to find a positive effect. In future, to be sure of measuring the impact accurately, it will be necessary to have data on treatment and control populations, preferably over at least two time periods.

**Main Findings:**

**Anganwadi Centers:**

Among 28 villages 24 Village have Anganwadis (85.71%) with own buildings whereas, 4 Villages have Anganwadis (14.29%) without their own building. 24 (85.71%) Village have electrified Anganwadis, whereas, 4 Village (14.29%) have Anganwadis with electricity connection. 25 (89.29%) Villages have Anganwadis having separate drinking water facilities, whereas, 3 (10.71%) Villages have Anganwadis which have no separate drinking water facilities. 20 (71.23) Village had Anganwadis with kitchen room whereas, whereas 8 (16.67%) Village had Anganwadis without kitchen room. 20 (71.23) Villages had Anganwadis having Store Room whereas, 8 (16.67) Villages had Anganwadis with no Store Room. 18 (64.28%) Villages had Anganwadis having Independent Lavatory and 10 (35.71) Villages
had Anganwadis with no Independent Lavatory. All the Anganwadis i.e., 24 (100%) were having Educational instruments. All the Anganwadis i.e., 24 (100) were having Children’s’ playing instruments.

All the 28 (100%) Anganwadis were holding Checkups, Treatment to minor ailments, and Sending to health centers. All the 28 (100%) Anganwadis were monitoring the growth of children Through Weighing, Measurement etc. All the 28 (100%) Anganwadis were providing Immunization against poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles. All the 28 (100%) Anganwadis were providing Micronutrient supplementations like IFA and Vitamin A supplementation for malnourished children all the 28 (100%) Anganwadis were Health Education All the 21 (75%) Anganwadis were Supplementary nutrition like Hot meal Double rations for malnourished children etc. All the 28 (100%) Anganwadis were providing Preschool education The Anganwadi workers expressed heavy burden of work. They have to attend to many Government programmes. Therefore, they are focusing only on immunization and preschool education.
**Household Level:**

- There are about 2961 Anganwadi centers were identified. They are unevenly distributed in different talukas of the district. About 250 Anganwadis in Afzalpur Taluka, 415 in Aland Taluka, 342 in Chincholi Taluka, 499 in Chitapur Taluka, 404 in Gulbarga Rural, 456 in Gulbarga Urban, 314 in Jewargi, 309 in Sedam Taluka respectively.

- The sanctioned Mini QWCs were high in Jewargi Taluka (22), Chincholi Taluka (17), followed by Gulabrga Rural (16), Gulbarga urban (11) and Sedam Taluka (7) respectively. However, in Afzalpur Taluka and Aland Taluka, Chittapur there is no sanctioned mini AWCs in their areas.

- In the rural and Urban areas of Gulbarga, 300 male and 290 female registered Children (below 3 years) among them 00 were suffering malnutrition whereas, there 302 male 282 female Children (between 3-5 years) among them 00 were suffering from malnutrition. There were 100 pregnant women and 100 Kishories registered in the sample Anganwadis.

- Afzalpur taluka results reveals that there were 275 male and
255 female Children (below 3 years) among whom 03 were under malnutrition, whereas there were 270 male and 247 female Children between 3-5 years among whom 05 were under malnutrition. There were 150 pregnant women and 300 Kishories registered in the sample Anganwadis.

Aland Taluka results table reveals that there were 290 male and 272 female Children (below 3 years) among whom 01 were under malnutrition, whereas there were 265 male and 241 female Children between 3-5 years among whom 04 were under malnutrition. There were 160 pregnant women and 340 Kishories registered in the sample Anganwadis.

Chincholi Taluka shown in the above table reveals that there were 270 male and 250 female Children (below 3 years) among whom 02 were under malnutrition, whereas there were 272 male and 248 female Children between 3-5 years among whom 0100 were under malnutrition. There were 130 pregnant women and 390 Kishories registered in the sample Anganwadis.

Chitapur Taluka results reveals that there were 275 male and
252 female Children (below 3 years) among whom 04 were under malnutrition, whereas there were 268 male and 243 female Children between 3-5 years among whom 09 were under malnutrition. There were 140 pregnant women and 300 Kishories registered in the sample Anganwadis.

Jevargi Taluka results indicate that there were 280 male and 268 female Children (below 3 years) among whom 02 were under malnutrition, whereas there were 252 male and 239 female Children between 3-5 years among whom 03 were under malnutrition. There were 139 pregnant women and 240 Kishories registered in the sample of Anganwadis.

Sedam Taluka results reveals that there were 285 male and 260 female Children (below 3 years) among whom 05 were under malnutrition, whereas there were 248 male and 230 female Children between 3-5 years among whom 06 were under malnutrition. There were 150 pregnant women and 275 Kishories registered in the sample Anganwadi.

The above study reveals that, the existed Anganwadis of the study area are working effectively except some of the centers
were not working effectively in some aspects of the objectives which are more useful to the children initiated by ICDS.

The according to the data analysis it is clear that, despite of the existence of ICDS programme still 42.8 percent of the children are born with low weight. This indicates both the inadequacy of the centers and their low efficiency.

Majority of the Anganwadi centers are receiving the Supplementary Nutrition food in the form of Rice porridge, Ragi Milk, whereas Egg and Milk is not receiving at minimum quantity from the state government. There is need to address this and provide adequate quantity of Egg and Milk to the children in all the Anganwadi centers of the study area.

Among the 28 sample Anganwadis under the 7 Village panchayats, about 12 centers (42.85%) of Anganwadi workers stated that they are undertaking IEC activities in the their respective areas. Whereas more than half of the workers of Anganwadi centers are about 57.15% were felt that, they do not undertaking any IEC activities in their study areas.

The Information is provided in School Programmes reveals
that, about 85.42% were stated that, information is spreading by awareness at school programmes and about 14.28% were felt that the information is not providing by awareness at school programmes. This is a good method of providing the information. But this reaches to the children only and not to mothers.

Among the 28 sample Anganwadi workers under the 7 Village panchayats, about 05 (42.85%) Anganwadi workers felt that, ASHA workers visit the Anganwadi centers at interval of every week, and about 7.15 percent were felt that, ASHA workers visits the centers once in 15 days. While about 35.72% of respondents were felt that, visiting of ANM workers to the Anganwadi centers is once in the 15 days, followed by 14.28% of the respondents were stated that, ANM workers are visiting their centers monthly intervals in the study area.

Among the Anganwadis under the study area, all the 28 (100%) Anganwadi workers responded that they have given the list of Children to the Gram Panchayats.

Among the 280 respondents, 100 (35.7%) belonged to Hindu
religion, 80 (28.6%) to Muslim religion, 60 (21.4%) to Christian, 10 (3.6%) to Jain and 30 (10.7%) to Buddhist religion.

Among the 280 respondents, 150 (57.14%) belonged to Scheduled castes, 50 (17.86%) to Scheduled Tribes, 60 (21.43%) to other backward Classes and 10 (3.57%) to forward or upper castes.

Among the 280 respondents, 105 (35.50%) respondents earned a monthly income of Rs. 1000/- to 5000/- per month, 149 (53.21%) respondents earned a monthly income of Rs. 5000/- to 10,000/- per month and 12 (4.29%) respondents an income of Rs. 10000/- and above. Whereas, less than Rs. 1000/- earning respondents were only 5.00% of the total respondents of the study area.

Among the 280 respondents, 100 (35.7%) respondents were Antyodaya Card holders 160 (57.2%) respondents were BPL Card holders and 20 (7.1%) respondents were APL Card holders.

Among the 280 respondents, majority of the respondents (78.57%) were stated that, their Child/children were going to
Anganwadi centers of the study area regularly. Whereas, about 60 (21.43%) respondents were felt that, their child/children were not going to Anganwadi centers of the study area regularly.

Among the 280 respondents of the study area, majority of respondents are about 185 (66.07%) were felt that, quality of food providing to the children at respective Anganwadi centers of the study area, while 1/3 of the respondents (33.93%) were stated that, the quality of food which is providing at Anganwadi centers of the study area is not up to the mark in terms of quality. The quality is reported low by 33 percent of respondents. The percentage is more in Afzalpur and Chincholi Taluka.

Among the 280 respondents, Children of all the 280 (100%) respondents were stated that, there is seasonal changes in food which is providing in the local Anganwadi centers of the study area.

According to the data available, total 73 under nutrition children were identified in the study area. Among the 73 under nutrition children, maximum numbers of under nutrition
children were recorded in Jewargi Taluka, followed by Chittapur Taluka, Chincholi Taluka, Afzalpur Taluka, Aland Taluka, Sedam Taluka, Gulbarga rural and urban respectively.

Among the 280 respondents, majority of them are about 232 (82.85%) respondents were stated that, the quantity of food providing at different Anganwadi center are limited and while only negligible number of respondents (17.45%) were stated that, the food providing to children at Anganwadi centers are sufficient.

Among the 280 respondents, all the 275 (98.22%) respondents were felt that, they do make discrimination among children with respect to the gender. While very few number of respondents are about 1.785 were stated that, they never do discrimination among the children with respect to the gender while providing food.

The results clearly sate that, majority of them were married at early age so that they given birth to child at very young age. Majority of them were under 20 year’s age to 23 years. The family and other economical condition were influenced on their
early marriages and not having enough knowledge on women health with relation to the child birth also one of the factors on having child at young age.

Among the 280 respondents, 53.57% respondents were suffering from headaches, 58.93% (165) respondents were suffering from anemia, 126 (45.00%) complained about back pains, 24 (8.57%) respondents had Menstrual Problems and 42 (15.00%) respondents complained about body pains during the field investigation. Thus women in sample household suffer from different diseases.

Among the 280 respondents, majority of the respondents are about 245 (87.50%) were stated that, they do not have any kind of knowledge about nutritional food, whereas, about only 35 (12.50%) respondents were stated that, they have knowledge about nutritional food.

Among the 280 respondents, majority of them are about 142 (50.71%) respondents were stated that, they have the knowledge of checkups and vaccinations should be taken by pregnant women, while, equal number of respondents are
about 138 (49.29%) respondents said that, they do not have the knowledge of checkups and vaccinations should be taken by pregnant women.

Among the 280 respondents, all the 260 (92.9%) respondents were clearly stated that, they do not have any kind of knowledge of regarding vaccinations among the children of the study area, while only few number of respondents (7.18%) were responded that they have the knowledge of vaccinations children.

Among the 280 respondents, majority of them are about 240 (85.71%) respondents were felt that the Anganwadi workers inform about malnutrition in children is common phenomena followed by 8.93% of respondents were stated that, Nutritional food should be given to children who suffer from malnutrition and respondents are about 15 (5.36%) were stated that, Care should be given towards child’s health who is suffering from malnutrition respectively.

Among the 280 respondents, majority of them are about 252 (90.00%) respondents clearly stated that, they are not satisfied
about the services providing by the Anganwadi, while only 28 (10.00%) of the respondents were satisfied about the services providing by the Anganwadi. Hence it is clear that, there is increase the services of the Anganwadi center with effective by the local staff of the Anganwadi centers.

Among the 280 respondents, majority of them are about 92.9% respondents were stated that, they prefer food which is available at their places and time rather than the nutritional food,. Whereas, only 20 (7.1%) of the respondents were stated that, they prefer nutritional food to be given to child.

Thus, the lives of children and women (mothers) in many different settings around the world are changing dramatically. Still the gap exists between people and government or any agency which deals the health status of the people particularly children or women This could be considerably narrowed if all children and women (mothers) had access to modern medical, diet, other methods, including vaccinations and nutrients.
SUGGESTIONS:

The following suggestions are made by considering facts observed from study results:

- Anganwadis are the nodal points for the delivery of organized Integrated Child Development Services to the economically disadvantaged urban and rural population. Anganwadis handle such individually and collectively sensitive areas like primary clinical care for mother and child. Young children spend quite some time there for receiving nutritional food and attending non-formal preschool classes.

- Immunization and health check-up procedures are also arranged in the premises as well as certain basic medicines and inoculations are stored in the same place. It is thus imperative that Anganwadi premises are clean, spacious airy and confidence – inspiring.

- The beneficiaries of supplementary nutrition services, on the whole, are poorly satisfied with it. While they are reasonably satisfied about the punctuality, adequacy and visible effects of the food being served, they nurse particular grousers about its variety and the quality.
❖ The innovations through different taster, flavours and colours be introduced in the variety of the food and its quality be checked and supervised daily by the Child Development Project Officer (CDPO) for proper cooking, nutritional value etc.

❖ The Anganwadi Centers should maintain cleanliness and hygiene within and around the centre to prevent diseases among children.

❖ The NGOs should arrange camps and meetings to provide knowledge about nutrition to women.

❖ The street plays, slogans, Jathras should be organized to provide awareness about health and hygiene among the rural people.

❖ The Anganwadi centers should be provided with toys and games to attract the children to Anganwadi centers.

❖ The pregnant women should be given counseling about nutrition during pregnancy.

❖ The customary food habits of the households should be
changed and nutritional values should be added to food at home.

ียว There is growing demand for Anganwadi Centers as the child population is increasing. The Government should allocate more budgets to Anganwadi centers.

ียว The incidence of malnutrition is high among children in HK region. The Hyderabad Karnataka Region Development Board also should allocate more resources for provision of better food in these Centers and Schools.

ียว The counseling and follow-up are specialized social (work) services skills. These may be entrusted to professional counselor as already suggested above organization of immunization camps and immunization monitoring of children and N and Ex Mg are the intramural responsibilities of the Anganwadi functionaries which may be closely supervisors prompt medical care in case of reaction is another specialist function which may be entrusted to the paneled doctors.

↯ The segment in the Anganwadi training content should build and fine-tune their skills in this behalf. The Anganwadi also
should have immediate access to the paneled doctors for seeking guidance whenever necessary for properly guiding the beneficiaries.

❖ The panel of such honorary doctors be prepared and their names, addressed and telephone numbers be prominently displayed in the Anganwadis. So that in an emergency, the Anganwadi and the patient’s family may access them directly at all hours.

❖ Children, by instinct, abhor school, in case of Anganwadi. They are at least goaded by the nutritional food provided there. But food alone cannot sustain their enthusiasm they need toys and learning aids and a rapport with their teacher to hold them there. Moreover, their guardians have to be counseled for sending their words to the Anganwadi.

❖ The appropriate and creatively designed charts, diagram and pictures be prominently displayed in the Anganwadi to subtly convey the health and nutrition education massages to beneficiaries. The functionaries may also be prompted to regularly seek community leaders participation in the health
and nutrition education activities planned in the Anganwadi.

女人 have inferior status which directly effects on their health and limits their access to healthcare.

女人 The rural women have been seen to be a prominent site for gender based discrimination in matters of healthcare in a number of other studies too. Therefore the discriminatory values should be eradicated by providing awareness and education.
CONCLUSION:

The present study among the children and women (mothers) of Kalaburgai District clearly states that, the services or Integrated child development services and child health care system is functioning appropriately, but there should be more monitoring and punctuality is needed among the concerned authorities of the health sector including Anganwadis, ANM, ASHA other workers of the study area. The government must focus on progress and impact of the schemes rather implements the policies and their access to women and children.

Under this investigations, majority of the Anganwadi functionaries have expressed the inadequacy of their training to cope with the actually work situation. It is suggested that the training content of the functionaries be periodically evaluated and updated. Training Effectiveness Survey conducted at regular intervals among these functionaries would help in identifying areas needing major thrust, areas where trainees lack comprehension and areas where ground realities are different from the classroom explanation.
It is also suggested that the induction training content of
the functionaries include the basic of child psychology and child
development. Since, Anganwadi functionaries operated in highly
human interactive work environment, it is also suggested that the
training content also include refining of human relation,
communication and leadership skills. It would also be advisable
to introduce refresher training courses at regular intervals for
functionaries to keep their knowledge up-to-date.

The beneficiaries of supplementary nutrition services, on
the whole, are poorly satisfied with it. While they are reasonable
satisfied about the punctuality, adequacy and visible effects of the
food being served, they nurse particular grousers about its verity
and the quality. In fact, the deficiencies in these last two aspects
largely influence their overall satisfaction with the service.

The beneficiaries, as a whole, are fairly satisfied with the
health check-up service still all the five services aspects, namely,
health-monitoring prompt detection of incipient disabilities, first
aid for small injuries and medication for minor ailments, child
and mother health advice, may be strengthened further to
improve the service delivery.
The Health Referral is a much maligned service and beneficiaries on the whole are poorly satisfied with it. Hence all the five services aspects, namely, counseling, prompt referral, follow-up, moral support and need to be strengthened thoroughly to improve service delivery. Non-availability of specialist doctors at the needed hour is a particularly severe impediment in the delivery of health referral service through Anganwadis. Hence, it is suggested that a panel of such honorary doctors be prepared and their names, addressed and telephone numbers be prominently displayed in the Anganwadis.