**CHAPTER I**

**Introduction:**

Children are the first call on the agenda of human resource development not only because young children are the most vulnerable, but because the foundation for lifelong learning and human development is laid in these crucial, early years. It is now globally acknowledged that investment in human resources development is a pre-requisite for any nation’s economic development. Child survival, growth and development have to be looked at as a holistic approach, as one cannot be achieved without the others. There have to be balanced linkages between education, health and nutrition for proper development of a child. Children are the future human resources of the country and for this reason the Ministry of Women and Child Development implemented various schemes for welfare, development and protection of children. ICDS was one of them. ICDS is the world’s most unique and largest programme for early childhood development programme, which is being operated for the past three decades. In India, ICDS is currently the most significant government intervention for reducing maternal and childhood malnutrition, and has emerged as the world’s largest programme of its kind. The importance of a programme like ICDS is realised
when we consider some facts regarding the child population of India. India is home to the largest child population in the world with 158 million children, constituting 15.42 per cent of the population below 6 years as per 2001 census. A significant proportion of them lives in economic and social environment of poverty, poor environmental sanitation, disease, infection, inadequate access to primary health care, inappropriate child caring and feeding practices etc impeding the child's physical and mental development. ICDS is the foremost symbol of India’s commitment to her children - India’s response to the challenge of providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other. Also, early childhood (0-6 years) is the most crucial period in life of a child; it is during this period that the foundations are laid for the cognitive, social, emotional, physical/mental development of the child. Since its inception in 1975, ICDS has expanded remarkably in its scope and coverage, and today it covers around 7.6 million expectant and nursing mothers and over 36 million children less than six years of age. The programme provides a well-integrated package of services through a network of community-level Anganwadi centers (AWC).
There was more than 10.44 lakh such operational AWC nationwide as on March 31, 2009 spread over 6,120 operational projects (http://wcd.nic.in/icdsimg/sanoperAWCbenf311209.pdf) as retrieved on March 28, 2010. ICDS services include immunisation, health check-up and referral, child growth monitoring, nutrition and health education for women, supplementary feeding for children and pregnant and lactating mothers, and pre-school education for children aged 3-6 years. In 2000, an additional component focusing on adolescent girls nutrition, health, awareness, and skill development was introduced in some areas. As on March 31, 2009 more than 721.96 lakh children in the age group of 6 months to 6 years and about 151.47 lakh pregnant and lactating mothers were provided with supplementary nutritional benefits whereas a little over 340.60 lakh of children (aged 3-6 years) received pre-school education services under ICDS. ICDS objectives are consistent with the MDGs for reducing child mortality, improving maternal health, and eradicating extreme poverty and hunger. ICDS has the potential not only to improve the nutrition status of children and women, but also to break the lifecycle of malnutrition by improving health and nutrition of pregnant women and adolescent
girls. The biology of reproduction makes the nutrition of adolescent girls and pregnant women intrinsic to the attainment of improved nutrition for all. ICDS is one of the most studied interventions, and many studies indicate its positive role in tackling India’s health and nutrition problems. The available data indicates that maternal and child interventions have played an important role in substantially lowering infant and under-5 mortality rates, though direct attribution cannot be made to any specific programme (Cleason et al 2000). While the levels of both severely and moderately malnourished children have declined, it is not always clear whether these are due to ICDS intervention.

ICDS was launched on October 2, 1975 in 33 Community Development Blocks. The foundations for the introduction of ICDS programme were laid with the organised support to childcare, which was an objective promoted by the National Planning Committee appointed during the freedom struggle in 1939-40. The Constitution of India affirmed the State’s commitment to the welfare of children in its Directive Principles of State Policy. Based on the Directive Principles, the Central Social Welfare Board was set up on August 13, 1953 which in turn started schemes for providing care and medical attention to children and pregnant
women and for setting up child welfare centers under the Community Development Blocks.

The schemes that were subsequently taken up included the Applied Nutrition Programme (1963) and the Special Nutrition Programme (1970-71) aimed at increasing nutritional awareness, encouraging food production and distribution of nutrition-rich diet. These programmes were implemented through various agencies like Balawadi, Mahila Mandal, panchayats, and municipalities. The Balawadi nutrition programme was started in 1970-71 with the objective of providing nutrition-rich food to children of the 3-5 years age group from low-income families. Though many welfare schemes for children were being implemented through various agencies and departments, a study conducted by the Planning Commission brought to light that the benefits reached only a small percentage of the target groups at the local level. Besides, it was also observed that the various health care, educational and social welfare activities of different departments, which were all to be implemented in a co-ordinated manner, had no linking among them at the local-level. As a response to the weakness brought out by the Planning Commission study, a National Policy for Children was adopted by
Government of India in August 1974 declaring children as, "supremely important asset." It further said: “And children’s programmes should find a prominent part in the national plans for the development of human resources. It was felt that it shall be the policy of the State to provide adequate services to children, both before and after birth and through the period of growth, to ensure their full physical, mental and social development”. This policy provided the required framework for assigning priority to different needs of the child. Also, during 1975, the maternal mortality rates (MMR) and infant mortality rates (IMR) were extremely high (MMR – 853 per 1,00,000 live births and IMR – 134 per 1,000 live births) due to the severe drought the country faced. To stop the soaring rate of MMR and IMR, the then Prime Minister, Smt. Indira Gandhi, launched ICDS in a few places which were affected acutely by drought. ICDS was inaugurated in 33 blocks across the country on 2nd October 1975. Spread over 22 states and the Union Territory of Delhi, 19 of the blocks were rural, 10 tribal and 4 urban.

The ICDS programme has grown rapidly, especially in recent years. It started on an experimental basis in 33 development blocks1 in 1975. Today, 35 years later, it covers about 90 per cent
of all blocks in the country. Figure 1.1 shows the trend in the number of blocks (operational) covered by ICDS.

In general the average Indian child has a poor start to life. The infant and child mortality rates for Indian children— at 67 and 93 respectively, these are higher than the, other 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 suffers from moderate or severe malnutrition. One in three children does not get a full course of DPT (Diphtheria, Pertussis and Tetanus immunization), and only one in three has the opportunity to be in an early learning programme. Their parents also experience a disadvantage due to poverty as 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. The percentage of institutional deliveries is also very low. The country has high maternal mortality ratio of 540 deaths per 1,00,000 live births. The 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. In this context, the Government has
supported a monumental effort to improve the life chances of children. Integrated Child Development Services (ICDS) in India. It is the world’s largest integrated early childhood programme, with over 40,000 centers nationwide. Since its inception in 1975, the programme has matured and expanded, despite of many difficulties in adapting to the vastly different local cultures and 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. These services are delivered in an integrated manner at the Anganwadi, or childcare centre. Each centre is run by an Anganwadi worker
and one helper, who undergo three months of institutional training and four months of community-based training. The cost of the ICDS programme on the averages is 800-1200 per child a year.

**Statement of the Problem:**

The present Study is taken up in the backward district of Gulbarga in Hyderabad Karnataka Region which is also a backward region. The study is entitled as Integrated Child Services and child health Care- A Study in Gulbarga District.

The present study addresses the realties pertaining integrated child devolvement and child health care functions in the study area with special reference to the health status of children and their mothers. The present work also addresses the working nature of Anganwadis, ANM, ASHA workers who are regulating the ICDS scheme.

To the study intends to explore the socio-economic profile people who are beneficial of the ICDS programme. The present study is focused on existed system of health care units and other factors related to the supplying of quality food, nutrients, vaccinations, and other related aspects. On the other hand the
present study emphasized on awareness about role of government schemes among the rural women for their better health, particularly children.

**Objectives the Study:**

- To study the Child health Status in India and Karnataka
- To examine the Importance, need and functioning of ICDS programme in India and Karnataka.
- To study the profile of study area
- To understand the socio-economic conditions of the respondents of the study area
- To understand the health status and health problems of children and women of the study area
- To analyze work nature and role of Anganwadis centers, ASHA and Anganwadi workers of the study area
- To analyze the status of Anganwadi centers of the study area.
- To probe the level of awareness among women about child health, nutrition and development
To offer suggestions based on the analysis of the centers in the Study area.

**Hypotheses:**

- The services rendered by the Anganwadi Centers are not satisfactory.
- The focus of the centers is on immunization and nutrition programme.
- The awareness about nutrition and child health care is low among rural women.
- Monitoring of child health care system is not effective in the study area.

**Limitations of the Study:**

The present study is limited Kalaburagi district of Karnataka state and hence the findings cannot be generalized to the entire country. The reliability and accuracy of the data cannot be assured completely as it is dependent on the responses from the households and Anganwadi workers. The personal limitations of the researcher also need to be mentioned here.

**Methodology:**

The study is based on both primary and secondary data. The data plays a very important role in the carrying of the research
work without which it will not be a research work only and it becomes a laymen’s record and that will not be accepted as a research work. The two sources of data are classified as secondary data and primary data.

**Secondary Data:**

The secondary source is a document or recording that relates or discusses information originally presented elsewhere. The secondary data on the rural women and child health status were collected from the leading research journals, books, websites, etc. reports etc.

**Primary Data:**

Collection of Primary data is an important step in every research study. The researcher visits household or Panchayat Offices, and collected information by observation and dialogue. Primary data is also collected from the respondents through interview schedules. The researcher personally interacted with the women members and collected information on their personal, socio-economic, educational, and occupational prospective.

**Variables Studied:**

The following variables are included in the analysis

1. Demographic Variables:

2. Economic Characteristics:

3. Social Characteristics:
4. Health status variable:

5. Working nature and status of child health care centers

**Sample Size and Selection Procedure:**

Taking into consideration the limitations of the researcher’s considering the all the factors considering or taken into account such as, time factor, research nature and the other factors, it was decided to study a total sample 28 Anganwadi workers from the 7 Talukas, in Kalaburagi district, due to large area of the district. The children and their mothers data was collected by interviewing them. Total about 280 respondents were interviewed during the study period, of which, 32 (Afzalpur), 37 (Aland), 38 (Chincholi), 54 (Gulbarga), 39 (Chittapur), 47 (Jewargi) and 33 (Sedam) respectively.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Name of the Taluka</th>
<th>No of respondents</th>
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<tbody>
<tr>
<td>1</td>
<td>Afzalpur</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>Aland</td>
<td>37</td>
</tr>
<tr>
<td>3</td>
<td>Chincholi</td>
<td>38</td>
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<tr>
<td>4</td>
<td>Gulbarga</td>
<td>54</td>
</tr>
<tr>
<td>5</td>
<td>Chittapur</td>
<td>39</td>
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<tr>
<td>6</td>
<td>Jewargi</td>
<td>47</td>
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<tr>
<td>7</td>
<td>Sedam</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>280</strong></td>
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**Preparation of Interview Schedule and Pre-Testing:**

In accordance with the objectives of the study an exhaustive interview schedule was prepared both in Kannada, the regional
language of Karnataka and English. The Interview Schedule is composed using different scales like dichotomous, multiple choice, descriptive and rating. In addition to this, the researcher adopted personal observation technique to ascertain the attitudes of women members due to the personal attitudes and societal nature, etc.

**Coding and Tabulation:**

The data was manually coded by the researcher. It took about four months. Coding was checked and rechecked to get perfection. A tabulation plan was prepared. The coded data were tabulated; statistics were applied to find out the relevance of the primary data. The data which finally got through the provided information from the respondents. The data is analysed with simple statistical techniques like percentage and ratios. The focus is more on qualitative analysis.

**Limitations of the Study:**

The present study is limited Kalaburagi district of Karnataka state and hence the findings cannot be generalized to the entire country. As the geographical territory of Gulbarga district is vast to cover and the population is also more to cover, it has not become possible for the researcher to survey all the children of the
stated region. Hence, the present study has covered totally 28 Anganwadi workers and respondents in 7 Talukas of the Kalaburagi district.

Chapterization:

The research report is organized into six chapters with two appendices as under.

The first chapter provided brief background information to the research topic. Here research problem is clearly defined. The significance of the study and statement of the problem is discussed. The importance of this research topic is stated briefly. The clear aims and objectives are presented. The scope and limitations are discussed in this chapter. Some generalizations and assumptions are set to be as hypothesis of the study. The details of the research methods used for the present research study are discussed. The research methodology consists of several methods which are employed during the study period. It includes the selection of research topic, collection of data, selection of sample size, variables to be studied and analysed, research methods and tools used, etc. The first chapter is designed under the title “Introduction to the Study.”
Before conducting any research topic, there is necessary to know about the research gap in the studies that are already conducted. Hence, the studies have been conducted and published in the secondary literature such as research papers, books, journals, articles, conference and seminar papers that are reviewed in the second chapter under the title “Review of Literature”.

As the present study deals with integrated child development services in the country, state and selected research area. There is need to study about the child health status and existed services from the various institutions in the study area particularly in the rural areas. For this purpose, the third chapter analysis under the title integrated child development services- an overview

Geographical territory plays an important role in the status and development of the people. As such it is also applicable to the present selected study area i.e. Kalaburagi District. Hence, there is need to present detail account on Kalaburagi District in general and children and their mothers, with reference to the child health care system in particular. The Fourth chapter covered the area, demography, population, literacy, education,
employment, occupation, environment, etc of the study area under the title “Profile of the Study Area”.

Socio-economic and educational aspects are significant in assessing the knowledge of people towards child health and health care system. Further, the information related to health such Anganwadi centres, type of food providing, regular visiting of concerned officials, child health care centres working conditions, etc have impact on the health status of children. The primary data collected from the respondents on these aspects are analyzed, interpreted and discussed in the fifth chapter under the title “Results and Data analysis: Evidences from the field”.

After the analysis and interpretation of the primary data, certain findings and outcomes are obtained from the present research study and summary of the study are stated. Useful suggestions are proposed for the improvement and promotion of health of child health status, and health care system. Hence, the sixth chapter is written under the title Findings, Conclusion and Suggestions.