CHAPTER - I
INTRODUCTION

1.1 The Health

Health is one of the crucial factors in human life. World Health Organization (WHO) insists on physical, mental and social wellbeing of an individual. Malnutrition stands as an obstacle in obtaining the physical wellbeing of people. Malnutrition is the result of unbalanced diet. Unbalanced diet would mean the lack of and the wrong proportion of nutrients in the food we eat. Despite India’s 50% increase in GDP since 1991, more than one third of the world’s malnourished children live in India, and half of them under the age of three are underweight. Nutritious food certainly provides a healthy life to the human beings. Ill health is the result of malnutrition and it obstructs the growth of children. The health and nutritional investment is a direct return in terms of longevity and improvement in the physical and mental development of the human population. Children are the pillars of the nation. Knowing this truth the policy making bodies across the world have taken several positive steps for children’s welfare. Many special schemes also have been under taken by organizations concerned with child welfare and their health care, because the childhood consists of
potentialities, strength and innocence to learn the world systematically. Many diseases like Diptheria, Pertusis, Tetanus, Teuberculosis, Measles and Polio are killing the human beings in general and the children in partially.

The insufficient health care facilities provided to children create lot of inconveniences and the health rights of the children are being denied enormously. The nutritional activities of the organizations in connection with the children identify the gap between children’s health care and nutritional status and insist that in man’s life journey health plays a paramount role in shaping the personalities in children.

The contribution proceeds to discuss in depth the major issues in child development related to

- work and employment
- education
- health and nutrition
- entertainment and leisure time activity
- physical and social handicaps
- legislation for social defense
- training resources
- governments role both at the policy making and administrative levels
- role of voluntary efforts
Each of these issues deals with historical tents, the present position and the likely future course of development. One of the major obvious causes for malnutrition in India is gender inequality. Due to the low social status of Indian women, their diet often lacks in both quality and quantity. Women who suffer malnutrition are less likely to have healthy babies. In India, mothers generally lack proper knowledge in feeding children. They do not breast-feed their children or feed them poorly. Consequently, new born infants are unable to get adequate amount of nutrition from their mothers. Deficiencies in nutrition inflict long-term damage to both individuals and society. Compared with their better-fed peers, nutrition-deficient individuals are more likely to have infectious diseases such as pneumonia and tuberculosis, which lead to a higher mortality rate. In addition, nutrition-deficient individuals are less productive at work. Low productivity not only gives them low pay that traps them in a vicious circle of under-nutrition, but also brings inefficiency to the society, especially in India where labor is a major input factor for economic production. On the other hand, over-nutrition also has severe consequences. In India national obesity rates in 2010 were 14% for women and 18% for men with some urban areas having rates as high as 40%. Obesity causes several non-communicable diseases such as cardiovascular diseases, diabetes, cancers and chronic respiratory diseases. Subodh Varma, writing in The Times of India, states that on the Global Hunger Index India is on place 67 among the 80 nations
having the worst hunger situation which is worse than nations such as North Korea or Sudan. 25% of all hungry people worldwide live in India. Since 1990 there have been some improvements for children but the proportion of hungry in the population has increased. In India 44% of children under the age of 5 are underweight. 72% of infants and 52% of married women have anemia. Research has conclusively shown that malnutrition during pregnancy causes the child to have increased risk of future diseases, physical retardation, and reduced cognitive abilities.

1.2. The Health Status of Indian Children

India occupies only 2.4% of the world’s land area, it supports over 16% of the world’s population. Only China has a larger population. Almost 40% of Indians are younger than 15 years of age. About 70% of the people live in more than 5, 50,000 villages and the remainder in more than 200 town and cities. Over thousands of years of its history, India has been invaded from the Iranian plateau, Central Asia, Arabia, Afghanistan, and the west, Indian people and culture have absorbed and changed these influences to produce a remarkable racial and cultural synthesis.

Religion, caste, and language are major determinants of social and political organization in India today. The government has recognized 18 languages as official Hindi is the most widely spoken. Although 83% of the people are Hindu, India also is the home of more than 120 million
Muslim, the world’s largest Muslim populations. The population also includes Christians, Sikhs, Jains, Buddhists, and Parsis.

The caste system reflects Indian occupational and religiously defined hierarchies. Traditionally, there are four broad categories of castes (Varna’s), including a category of outcastes, earlier called “untouchables” but now commonly referred to as “dalits”. Within these broad categories there are thousands of castes and sub-castes, whose relative status varies from region to region. Despite economic modernization and laws countering discrimination against the lower end of the class structure, the caste system remains an impotent source of social identification for most Hindus and a potent factor in the political life of the country.

Health is needed to every one for physically and mentally. Physical health is the primary and base of mental health. Especially children health is the base of men life. India is a developing country, people living in the vast area, they live not only similar area. The Geographical area can be divided in to rural and urban and hills. The people have live in both places. In India almost half of the Children under age of five are stunted or too short for their age, which indicates that they have been undernourished for some time. 20% are wasted or too thin for their height. 43% are underweight which takes into account both chronic and acute under nutrition. Due to this IMR (Infant Mortality Rate) may be increased (IMR in India-58/1000). The child health depends the others
health and wealth. Child health is not an Independent one it always depends the others. So it may be called challenged health. Challenge health having multiple barriers, one is internal barrier and another one is external barrier. Internal barrier like Malnutrition and ill health, The external barriers like socio-economic and cultural problems etc., In the internal barrier like malnutrition have developed by improper and inadequate food and unsafe drinking water and poor hygiene, poor sanitation are create to fever, cough, running nose, and diarrhea, etc., The External barriers like parents behavior, dependents rights, socio-economic condition, cultural problems and administration/management problems etc., These two barriers stop their children health in different stages of their age. Women in India will have an average of 2.7 children in her lifetime. In rural areas are 3.0 children per woman and urban areas are 2.1 children per women. Median interval between births in India is 31 months. 11% of births take place within 18 months, 28% of births occur within 24 months and more than 60% occur with in three years. But Research shows that waiting at least three years between children reduces the risk of infant mortality.

More than one in 18 children still die within the first year of life. One in 13 dies before reaching age five. But the girls in India face a higher mortality risk than boys. Children born to mothers under age 20 or over age 40 are more likely to die in infancy than children born to mothers in prime child bearing ages. Infant mortality is 77 per 1000 for
teenage mothers compared with 50 for mothers age 20-29. Having children too close together is especially risky. Infant mortality in rural areas is 50 percent higher than in urban areas. Less than 44% of children 12-23 months only fully vaccinated against the six major childhood illnesses. 5% of the children have received no vaccination at all. 46% of Children less than 6 months are exclusive breast fed as WHO recommends. 55% of Children are put to the breast within the first day of life. However mother in India breastfeed for an average of 25 months, which is slightly longer, the minimum of 24 months recommended by WHO for most children. Infant breastfeed denied by their mothers due to their behavior and family condition is one of the barriers of child health.

Sufficient food and adequate food to the children is must for health, due to family condition the health care is not providing to the child. Lack of health care activities in the child health, the child is live with malnutrition. They can easily affect by many diseases then may go to die. Child marriage, young age pregnancy, adequate pregnancy, poor literacy, human behavior, poor income of the family, lack of transport, lack of communication, more number of children in family, increasing unemployment, lack of health providers, lack of administration problem, poor management, cultural setup, political setup also compress the child health.
1.3. The Importance First Six Years of Children

The first six years of life in human beings have a great and lasting influence on the quality of life of a human being. The health, nutrition, education and development opportunities given to a child at this stage to a large extent determine his or her health and well being for the entire lifetime. In spite of all indicators showing that greater investments are urgently needed, the results of the third National Family Health Survey (NFHS-3, year-2004-2005) shows not only the poor state of children under six years of age but also that the progress is very slow. Almost half (46%) of all children under three are underweight (an improvement of only one percentage point compared to NFHS-2 which was carried out eight years back) and almost 80% of children in the age group of 6-35 months are anemic. Only 23% of babies are breastfed within one hour of birth, and just about 46% are exclusively breastfed for the first six months. Only 44% of all children in the 12-23 months age group have received all recommended vaccines and only half the pregnant women had at least three antenatal checkups. As many as 57 of every 1000 children die before they reach the age of one year. The care of young children cannot be left to the family alone - it is also a social responsibility. Social intervention is required, both in the form of enabling parents to take better care of their children at home, and in the form of direct provision of health, nutrition, pre-school education and related services. Interventions for children under six years (early
childhood care and development) must broadly address at least three dimensions, child health, child nutrition and child development/education. The must necessarily be provided simultaneously in the same system of care. India has the highest number of flu-related pneumonia deaths among children, with more than 3,70,000 children under the age of five dying due to pneumonia of which 7 percent die of flu-related pneumonia, a study has shown.

India contributes about a fourth of the global influenza pneumonia deaths in children under the age of five. D.Harish Nair, India is the world leader for pneumonia mortality in children under the age of five contributing to about a fourth of the global pneumonia deaths. Influenza is the second most common infection identified in children with pneumonia and contributes substantially to the burden of hospitalization and mortality in young children.

1.4 Malnutrition Problem in Different States of India

Malnutrition is a widely prevalent problem in India and one of astonishing magnitude. According to the National Family Health Survey (1992-93), more than half (53%) of children below four years of age are under nourished. In 1998, 29.1% children between 1-5 years of age suffered from moderate and 12.3% from severe under-nutrition. Nutritional adequacy is one of the key determinants of the health and well being of the children. Under-nourishment not only retards physical
development but also hampers the learning and cognitive process, leading to sluggish educational, social and economic development. 170 million children under six years of age constitute 17.5% of India’s population (Census: 2001). One in three of these children is born with low birth weight and is thus denied the best possible start in life. The high incidence of low birth weight compounded with inadequate care and restricted access to health services translates into high rates of child malnutrition and threatens the process of healthy development, culminating in a high infant mortality rate. India has a high IMR of 90 per 1000 children, with Orissa top with 96.7 IMR followed by Mathya Pradesh (89.5), Uthara Pradesh (84.4) and Rajasthan (81.2) (Registrar General: 2001). ICDS, a major programme to tackle the problem of malnutrition and the ill health of mothers and children, was initiated in 1975, following the adoption of a National Policy for Children. This programme is now the single largest programme for the country’s children with 4,348 operational ICDS Projects (GOI: 2001-02). Despite almost 30 years of its implementation, 47% or about 37 million children under three years of age are underweight in India (NFHS II: 1998-99). Furthermore, in the given hierarchical nature of the society the benefits of most development programmes are usurped by the better off sections, depriving the marginalized Children under six years of age need good nutrition, education and care in order to meet their full potential of health, well being and capacity for the rest of their lives. However,
children under six (particularly those under two) and their needs rarely get any recognition in policies, programs and budgets. Their feeding, development and care is assumed to be the responsibility only of the family.

Children are citizens with rights, and society has the responsibility for ensuring that they are given adequate and appropriate care. The only government programme that addresses the rights and needs of this age group is the Integrated Child Development Services (ICDS). The ICDS is supposed to address the health, nutrition and pre-school needs of all children below the age of six. However, the coverage of ICDS is quite limited, and the quality of the programme is also quite poor. “Universalisation with quality” is urgently required to protect the fundamental rights of children under the age of six.

In November 2001, the Supreme Court ordered the government to universalize ICDS. Further detailed orders were passed in 2004, which spelt out that ICDS should never be restricted to BPL (Below Poverty Level) families, and prohibited contractors from supplying nutrition to Anganwadis; instead it directed that funds should be spent by village communities, Self-Help Groups (SHG) and Mahila Mandals for “buying grains and preparation of meals”. The entitlements of children under six were further strengthened by the landmark order of December 13, 2006, which ordered the government to ensure “Universalisation with quality”
within a time frame. The order clearly states that all ICDS services (supplementary nutrition, growth monitoring, nutrition and health education, immunization, referral and pre-school education) must be extended to every child under the age of six, all pregnant women and lactating mothers and all adolescent girls. The policy and programmes of the restructured ICDS programme that is supposed to meet the nutritional, health, learning and development needs of children below six years of age are in the process of being finalized. Any policy on early childhood care and development should focus on providing holistic and comprehensive care for children under six and contain the following essential components.

- A system of food entitlements, ensuring that every child receives adequate food, not only in terms of quantity but also in terms of quality, diversity and acceptability.

- A system of child care that supplements care by the family and empowers women. Such care needs to also address their learning needs and must be provided by informed, interested adult cares, with appropriate infrastructure.

- A system of health care that provides prompt locally available care for common but life threatening illnesses. Such a system needs to address both prevention and management of malnutrition and disease.
1.5. Breast Feeding and Its Relevance

According to WHO report 2011, around 171 million children, aged less than five years are stunted annually, while 115 million suffer from wasting, around 3.9 million children (35% of total deaths) die because of exposure to nutritional risk, including under weight, sub-optimal breast feeding and vitamin and mineral deficiencies - particularly of vitamin A, iron, iodine and zinc. Children from birth to one year should be weighed every month and during the second and third year, at least every alternate month. If there is no weight gain for two months, something is wrong. Breast milk alone is the best possible food for the first four-to-six months of a child’s life. By the age of four months, the child needs supplementary foods in addition to breast milk. A child under three years of age needs food five or six times a day. A child under three years of age needs a small amount of extra fat or oil added to the family’s normal food. All children need foods rich in vitamin –A. After an illness, a child needs extra nourishment to catch up on the growth lost during the illness. Talking, playing, and showing loves are essential for a child’s physical, mental and emotional growth. Babies should be breastfed as soon as possible after birth. Virtually every mother can breastfeed her baby. Frequent sucking is needed to produce enough breast milk for the baby’s needs.

Energy requirement of Infants and children, recommended by WHO,
0-6 months - 108 kcal per kg per day
6-12 months - 115 kcal per kg per day
1-3 years - 1240 kcal per kg per day
4-6 years - 1690 kcal per kg per day.

1.6. The Children and Social Development

Child rights are fundamental freedoms and the inherent rights of all human beings below the age of 18. These rights apply to every child, irrespective of the child’s parents / legal guardian’s race, colour, sex, creed or other status. The essential message is equality of opportunity. Girls should be given the same opportunities as boys. All children should have the same rights and should be given the same opportunity to enjoy an adequate standard of living. At CRY, we focus on the 4 basic rights of children. In 1992, India ratified the United Nations Convention on Rights of the Child. The charter of child rights (CRC) is built on the principle that “All children are born with fundamental freedoms and all human beings have some inherent rights”. The charter confers the following basic rights on all children across the world.

**Right to survival** - to life, health, nutrition, name and nationality

**Right to development** - to education, care, leisure, recreation

**Right to protection** - from exploitation, abuse, neglect

**Right to participation** - to expression, information, thought and religion.
Integrating child development into manpower and human development is an essential component of social development, which in fore needs to be given its legitimate role, in consonance with economics growth, in the reshaping of the nations future. Development is a holistic process in which it is important to maintain a balance between its economic and social components and social components and between its material and human components. No clear cut attitude has yet emerged to meet our special problem of one of the largest dependent population in the world and to integrate it with overall development. The item of expenditure upon children and youth must be considered by policy makes as of equal importance to investment in other fields. It is not just the financial aspect that should concern as but whole structure of family society and the ability of the natural incentives of the people to improve their own lot.

Modern research and analysis of the vast problems of childhood have made it abundantly clear that all people are not natural parents and that adults have been consistently more concerned with their own problems than those of their children than is generally recognized.

The international year of the child, 1979, has consequently become the focal point for a global assessment of what remains to be done and a fame greater awareness of the vital resources to the nation that a child actually is provided the right investment is made in its growth and development.
At every age there are special needs and this indicates these parameters.

0-2 – inoculation, preventive health care, nutrition, proper weaning, love and security
3-6 – preventive health care, mental stimulus in pre-school activity, love and security.

Maia Montessori revolutionized the thinking about education with her pre school systems and consistence proof that the first six years of human life are the ones of most rapid growth and capacity to absorbed. It is in this age group that habits, value systems and disciplines are implanted into the human child and only too few people realize how critical this is in the development of character, since what is once learnt is not readily unlearn. Investment in the 0-6 year age group of children is only one step in the making of a man.

We pledged in 1950 for creation of a new social order free from poverty, ignorance and disease so that major values of equality, freedom and justice could be made accessible to all. We have been looking forward, since then, for a bright future for the society with healthy and enlightened people enjoying a good quality of life. The assurance for good health was reiterated though WHO declaration of Health for All by 2000 AD. There has been effort on the part of the government for health reconstruction by expanding medical and health facilities, provision of more personnel and extended network of medical institutions reaching
out even to the interior rural and tribal areas. Many specific programmes for the improvement in health situation have been launched by the state and the central governments. There has been a continued effort to involve people for their health. Voluntary organizations too have come forward for support. But the situation is worsening. People are growing more and more disease-ridden. Morbidity is on increase. The pessimism about health situation in this part of the world is reflected in various assessments. It is increasingly being accepted that health and disease are influenced by life situations that transcend the direct impact of physico-chemical forces. It is a fact that diseases of the present time are largely due to the conditions of living. In the developing societies like India, nature continues to play havoc with the health of people. People suffer on account of natural hazards like drought, foods and storms, insufficient low quality water and similar natural disasters. In addition there are pests, insects and many microorganisms that directly affect people’s health. The deconstruction of environment, pollution of water, industrialization, unthoughtful use of technology and the resulting imbalances in the ecosystem have been hazardous to physical, social and psychological well-being of the people. Believes, value system, behavior patterns, habits, practices and traditional technology harbor the cultural groups of adversities to health, Similarly, income distribution, social differentiation, affordable habitat, unguarded and misdirected social development, and unsafe use of men again technology and unrestricted
growth of population are directly or indirectly contributing to the deteriorating health scenario in India.

Children under six years need of good nutrition, education and care in order to meet their full potential of health, well being and capacity for the rest of their lives. Their feeling, development and care are assumed to be the responsibility of the family. The children are the citizens with rights, and society has the responsibility for ensuring that they are given adequate and appropriate care. The entitlements of children under six were further strengthened by the landmark Order of December 13, 2006, which ordered the government to ensure “Universalisation with quality” within a time frame. The order clearly states that all Integrated Child Development Services (Supplementary nutrition, growth monitoring, nutrition and health education, and immunization, referral and pre-school education) must be extended to every child under the age of six and all the pregnant women and lactating mothers.

The policy and programmes of the ‘restructured’ ICDS programme that is supposed to meet the nutritional, health, learning and development needs of children below six years of age, are in the process of being finalized. Any policy of early childhood care and Development should focus on providing holistic and comprehensive care for children under six, and contain the following essential components. A system of food entitlement, ensuring that every child receives adequate food, not
only in terms of quantity but also in terms of quality, diversity and acceptability. A system of child care is that supplements care by family and empowers women. Such care needs to also address their learning needs and must be provided by informed, interested adult cares, with appropriate infrastructure. A system of health care is that provides prompt locally available care for common but life threatening illnesses. Such a system needs to address both prevention and management of malnutrition and disease. Further early child care programmes should cater to the needs of the different age groups with different strategies. The three crucial age groups are:

- **Children 0-6 months of age** – the period of recommended exclusive breastfeeding
- **Children 6 months to 3 years** – until entry into pre-school,
- **Children 3 years to 6 years** – the pre-school years, until entry into school.

1.7 **Gender Discrimination**

Structure of society and the hierarchical position of genders are clearly effected though the state of their health. Gender issue is, therefore, quite significant while talking of health. Women are the most vulnerable group exposed to adversities of life. On the other hand, they significantly contribute to the health of the people. The issue of women’s health is associated with a number of observations such as health problems of men and women vary considerably due to their biological make-up and also their position in the socio-cultural valuation, their
reproductive role exposes them more to infections and diseases resulting in morbidity or death, they are socially discriminated against from the time their gender is identified at the time of birth and now even before they are born. The emerging nutritional problems are obesity and related health problems, nutritional blindness, etc. the average Indian suffers from protein–calorie malnutrition, caused by insufficient intake of food and non-availability of protein-rich foods, particularly by growing children, and pregnant and lactating mothers. Nutritional diseases are as follows protein-energy malnutrition, A-vitaminosis, obesity and other hyper alimentation, diseases of blood and blood forming organs.

Discrimination against women and girls in key aspects of health, nutrition, economic activity and social empowerment is prevalent across South Asia. It results are plainly evident in child and maternal health outcomes for the region and its principal countries. These includes South Asia is the only region of the world in which girls are more likely to be underweight than boys. In most of the developing countries, the death rates for girls are higher than the death rates for boys, indicating the socio-cultural patterns that discriminate against girl. The discrimination takes several forms. Young girls may not get the same health care and nutrition as young boys. The effect of discriminating socialization of girl children may seen from this deteriorating, sex ratio, higher mortality rate, low literacy and ill-treatment in families. “Missing girls” are seen especially from certain states and pockets of our country.
1.8. Health and Care of the Children

Man source is the main source to manage and handling all other sources. The fertility rate should be healthy also the offspring growth is must for healthy and active management. National wealth is under the control of Children wealth. Nutritional status is an indicator of the overall well being of the population. Children’s current nutritional status during preschool ages reflects not only the nutritional status of the population as whole, but also an indicator of the overall living conditions of the society.

The Nutritional status of children in TamilNadu has improved considerably over the years and the present status of Normal children has improved from 41.4% (1992-93) to 60% (2003-2004). In the world, causes of 1.7 million global vaccine preventable deaths among children-2005. 0-1year 8%, 1-4 years 24% and 5-9 years 48% 10-14 years and above 15 years like 14% and 6% respectively. 4% of all deaths recorded have been among less than five years –World Health Report-2007. Tamilnadu Government in the year 1982 Nutrition centers was opened for improve the health and nutritional status of children under the name of former chief minister Puratchi Thalaivar MGR Nutritious Meal Programme. Time of opening this scheme was used to the 2-5 years children. Further it was modified in the time period. Now in the state of Tamilnadu nutritious schemes implementing through the Anganwadi centers. In Tamilnadu 42,279 Anganwadi centers are functioning in 434
projects of World Bank assisted ICDS-III and General ICDS. In Salem District there are 2517 ICDS centers are functioning. Beneficiaries of the project: Children 0-6 years etc., those children availing services including health facilities through Anganwadi centers. The requirement of food commodities for each Nutritious Meal Programme center is supplied by the Tamil Nadu Civil Supplies Corporation. In Tamilnadu, Salem has 70 Primary Health Centers (PHC’s) out of 1421 Primary Health Centers, and 398 Health Sub-Centers (HSC’s) out of 8706 numbers of Health Sub-Centers in Salem district functioning for giving primary care to public as well as giving preventive care to the public especially children.

Hazards related to health are essential a biological and physiological phenomenon but these have a very close affinity with culture. These occur in a social context and reflect the intimate association with other human beings. In such a level of culture, the attitude of people towards health and its related hazards is governed by customs, traditions, values and pattern of interaction, directly or indirectly. In the Indian context, the problems of health hazards are guided by religious beliefs, dogmas and practices. These practices have pervaded the life of an average Indian.

The concept of disease is closely associated with health and nutrition. Disease is considered as maladjustment with the environment to which numerous factors contribute. Physical environment factors may likely to impair health and promote disease, include water supply, air,
climate, weather radiation and nature of soil. Socio economic factors of environment include diet, occupational density and movement of people, sanitation, habits and customs. Disease in any given place is the result of a combination of geographical circumstances which being together such environmental hazards to man at the most auspicious time.

1.9. **Mother as a Health Promoter**

As a household manager, woman is in a position to shape the food habits and the dietary pattern in the family. She can control family environment, promote health, and prevent spread and occurrence of diseases. However, her contribution to the health of people depends largely on her awareness and freedom to act. The multicolored canvas of Indian society, culture, health traditions and health situations provided for development of varying approaches to health issues. Health is not simply the result of an individual’s state of being; health is intimately connected with the way in which people construct reality, with the way in which communities including administratively created communities function, with the ways in which health expertise work in the context of the nation. It is being believed that health should be seen as a product of interplay of societal and the natural forces. A parent is the best observer of a child’s development. So, all parents should know the warning signs which mean that a child is not making normal progress and that something may be wrong.
“Research has shown clearly that mothers are pivotal to the integrity of the family and the community as economic as well as social units”. In the first place, their work secures the health and well-being of the family; in the second place, their economic contribution in food production and distribution, other unpaid work, and also wage labour—although it has never been adequately quantified—provides the bedrock on which the community is built and can develop. High rates of maternal mortality therefore strike at the heart of the development process.

Nothing is more important than the health of the children. As a parent, it is their duty to make sure that they are following the right child health care. They have to protect their children from many different things and make sure that they are giving right child health care to keep them safe. They have to take their children to the doctor for annual check ups, depending up on children’s age and health condition. Weight is an indicator of the individual’s physical development. “The diet of a pregnant woman is closely linked to the health and development of her child both before and after birth” Babies grow very rapidly- Birth weight is doubled within six months and tripled by twelve months- development of the brain continues through this period. Both intellectual and physical achievements depends as an adequate diet.

1.10. The Ideal Phenomenon of Health

The WHO sets the standard of positive health as a goal to be attained by the people. The WHO’s definition of health envisages three
dimensions- physical, mental and social well-being. A person who enjoys health at these three planes is said to be in a state of positive health. The attainment of positive health implies that a person should be able to express as completely as possible the potentialities of his genetic heritage and this is possible only when the person is allowed to live in healthy relationship with his environment, an environment that transforms genetic potentialities into phenotypic realities.

Ideal health will, however, always remain a mirage because every thing in our life is subject to change. Health in this context may be described as individual’s ability to adapt and modify according to the changing condition of life. In working positive health the doctor and the community health expert are in the same position as the gardener or fame faced with insects, moulds and weeds. Their wok is never done.

Health is multidimensional concept and many conceptual and methodological issues complicate its practical use as a descriptor of the quality of life. Therefore, it is not nearly as easy as we might first assume to define what it means for a person to be healthy, as opposed to being ill. In an effort to lend some coherence to world-wide reporting, the following definition was offered at the inauguration of the WHO: “health is a state of complete physical, mental and social well-being and satisfaction”. A different definition given from a sociological perspective comes from Parsons who describes health as a state of optimum capacity for the effective performance of valued tasks. Parsons focuses attention
on social importance of health because healthy individuals are able to function well in order to perform social roles while ill-health reduces their ability to do so. One must exercise caution, however, before imputing casual relationships between health and social variables. For one thing normality is a relative evaluation, people are seldom perfectly healthy, even in the absence of pathological symptoms.

The vast majority of the populations of the world still have no access to decent health care. Rural populations in developing countries are particularly underprivileged with respect to health care. There is a misdistribution of health resources not only between countries but also within countries. The WHO has set the goal of ‘Health for All by the year 2000’ that is an acceptable level of health for everybody within next twenty-five years. Its achievement depends upon urgent action by individuals, communities, the health professions and national governments. It calls for a new economic and social order.

There is a complex relationship between nutrition, health, environment, particularly in the urban sectors. There was relatively high level of dissatisfaction with the quality and quantity of the diet and this was generally attributed to their lack of purchasing power to buy more and better food. Malnutrition and under nutrition have complex links with fertility, infection, family size, physical and mental growth and the development and immunity mechanism of the body. The basic etiological factors of protein energy malnutrition are. 1. Inadequate diet, both in
quantity and quality (this is primarily due to poverty and ignorance) and 2. Infections and parasitic diseases, notably diarrhea, respiratory infections, measles and intestinal worms.

1.11. Under Nutrition and Communicable Diseases

Diarrhoea and acute respiratory infecting are still killing hundreds of infants and children every year and under-nourishment is common in children under 5 years. Nutrition is the combination of processes by which, the living organism receives and utilizes the material necessary for the maintenance of its functions and for the growth and renewal of its components. Nutrition means affording nourishment. While the country is yet to overcome under-nutrition among children and communicable diseases, it is increasingly facing problems over-nutrition and obesity especially in urban high-income group children. Research studies in India are highlighting the possibility that under-nutrition in childhood might be one of the predisposing factors for over nutrition and obesity.

Malnutrition is more common in India than in Sub-Saharan Africa. One in every three malnourished children in the world lives in India. Malnutrition limits development and the capacity to learn. It also costs lives: about 50 percent of all childhood deaths are attributed to malnutrition. In India, around 46 percent of all children below the age of three are too small for their age, 47 percent are underweight and at least 16 percent are wasted. Many of these children are severely malnourished. The prevalence of malnutrition varies across states with
Madhya Pradesh recording the highest rate (55 percent) and Kerala among the lowest (27 percent).

Providing adequate nutrition to children is a very serious issue in India. The Government’s initiative for improving nutrition in children involves three steps: 1. a commitment to reduce malnutrition and low birth weight though national and state level policies, 2. The use of a community-based approach to address malnutrition and child development, 3. provision of Vitamin A and iron supplements to address damage caused by vitamin and mineral deficiencies.

There are numerous other contributory factors like poor environmental conditions, large family size, poor material health, failure of lactation, premature termination of breast feeding, and adverse cultural practices relating to child eating and weaning, such as the use of over diluted cows milk and cooking water from cereals and delayed supplementary feeding.

High maternal mortality is closely linked to the poor health of the mothers and the poor health of the mothers is closely related to the poor health of the children they bear and the health status of the population. The major nutritional concerns in India are those related to maternal under nutrition, high infant and child mortality, impaired growth and development of children and frank under nutrition.

The levels and distribution of income, the social and cultural practices and perceptions, the choice of technology with its impact on the
occupational and natural environment, all these factors influence and are in turn influenced by the physical and mental health status of a society as well as children.

Management of breastfeeding among working mothers, breast milk, and especially colostrums in the long term, prevents atherosclerosis, hypertension and obesity, it also prevents allergy to nonspecific proteins and develops immunity. So, breast fed babies have low incidence of respiratory infection, dental caries and allergy etc., recent evidence shows that breast milk promotes rapid brain growth and breast milk feeding is associated with higher IQ. Breastfeeding also benefits the family as it saves money and time and is “the best Investment”. It also saves indirectly because breastfed babies are less severely ill. World Alliance for Breast feeding Action (WABA) organizes to celebrate world breast feeding week “during the first week of August”, every year to strengthen the breast feeding culture. The quantity and quality of Breast milk report on the WHO collaborative study on breast feeding, “Psychological, Physiological and sociological factors may affect the quantity of breast milk”.

**Iodine Action on Health**

An adequate supply of iodine is essential for normal brain development. “The effects of iodize deficiency on growth and development are now denoted by the term Iodine-Deficiency Disorders (IDD)”.

These effects are seen at all stages of development and particularly in the fetus,
the neonate and the infant ie, in periods of rapid growth. An adequate supply of iodine is essential for normal brain development.

1.12. Government Programmes on Health and Nutrition

1.12.1 Tamil Nadu Started Immunization Programmes

Tamil Nadu started immunization programme against six Vaccine Preventable Diseases viz. Diptheria, Pertusis (Whooping cough), Tetanus, Measles, Poliomyelitis and Tuberculosis during 1978, annually around 12.5 lakhs pregnant women and 11.5 lakhs infants are benefited by Immunization Programme. Because of effective implementation of Immunization services, there is a drastic reduction in the incidence of vaccine preventable diseases. There is no case of Diphtheria, Pertusis, Neonatal Tetanus, Poliomyelities. The incidence of measles is reported around 2000 cases annually. The state adopted the policy of fixed day / fixed place immunization strategy. On every Wednesday, 8706 village Health Nurses visits to villages in their area and around 1500 Health workers in urban areas to carryout immunization activities.

1.12.2 Special Programme for Pregnant Women

Dr.Muthulakshmi Reddy Maternity Benefit scheme, under this scheme, cash assistance of Rs.12,000/- is given to pregnant women falling poverty Line to compensate the wage loss during pregnancy and to get nutritional food to avoid low birth weight babies. Unlike previous strategy this scheme now fixed criteria for payment in three installments, one during Ante-natal period, one after delivery and third after child
immunization. The eligible mothers list for payment is generated from web based database.

1.12.3. National Rural Health Mission (NRHM)

Hundred mobile medical units have been established to provide outreach services to unreached vulnerable group of population. 1539 patient welfare societies, which have been constituted in primary health centers, 12,618 village health water and sanitation committees, have been formed in the village Panchayats for improving the sanitation and hygiene.

1.12.4 Maternal Education and Child Survival

Surveys consistently report that mortality rates are lower among the children of more educated mothers. To a large extent, differences in mortality rates reflect differences in family living standards, access to health care and similar influences. But recent studies have suggested that the mother’s level of education itself has a substantial direct impact and is perhaps the most important of all social and economic influences on child mortality.

1.13. Importance of Healthy Weight

Reaching and maintaining a healthy weight is important for overall health and can help you prevent and control many diseases and conditions. If you are overweight or obese, you are at higher risk of developing serious health problems, including heart disease, high blood
pressure, type 2 diabetes, gallstones, breathing problems, and certain cancers. That is why maintaining a healthy weight is so important: It helps you lower your risk for developing these problems, helps you feel good about yourself, and gives you more energy to enjoy life. Many factors can contribute to a person’s weight. These factors include environment, family history and genetics, metabolism (the way your body changes food and oxygen into energy), and behavior or habits.

Energy balance is important for maintaining a healthy weight. The amount of energy or calories you get from food and drinks (energy IN) is balanced with the energy your body uses for things like breathing, digesting, and being physically active (energy OUT)

- The same amount of energy IN and energy OUT over time
  
  = Weight stays the same (energy balance)

- More energy IN than OUT over time = weight gain

- More energy OUT than IN over time = weight loss

To maintain a healthy weight, your energy IN and OUT don’t have to balance exactly every day. It’s the balance over time that helps you maintain a healthy weight.

You can reach and maintain a healthy weight, if you

- Follow a healthy diet, and if you are overweight or obese, reduce your daily intake by 500 calories for weight loss
- Are physically active
- Limit the time you spend being physically inactive

The family will be considered as the unit for targeting intervention rather than focusing on individual children, women, adolescents etc. The Policy incorporates the lifecycle approach as a strategy to interrupt intergenerational transfer of malnutrition. The lifecycle approach involves clear recognition of all the socio-biological phases in human life, followed by identifying and addressing nutrition requirements across all phases from before conception to old age. Nutrition challenges vary as one progress through lifecycle. Adequate nutrition for pregnant women and young children is crucial for physical and mental growth and essential to avert health problems and costs in future. Malnutrition prevention strategies among mothers and children are known to benefit several generations. The eight major nutritional challenges identified needing concerted action are (i) Low Birth Weights, (ii) Childhood under-nutrition (iii) Undernourished adults (iv) Pandemic Anaemia (v) Extensive persisting Vitamin A deficiency (vi) Adult Chronic diseases accentuated by early under-nutrition (vii) Escalating obesity rates (viii) Sustaining iodisation programmes.

The Action Plan for ‘Malnutrition free State’ in the Tenth Plan encompasses extra feed for malnutrition children at Anganwadi centers and extra carry-home food for adolescent girls and severely malnourished children, massive IEC campaigns, training to mothers in preparing home based nutritious food, extra ration for families under Andyodaya scheme,
food security under food for work programme to BPL families suffering from malnutrition, income generation to mothers engaged in SHG groups, health and nutritional needs of adolescent girls, pregnant and lactating women, opening of additional anganwadi centers and crèches, coverage of all the areas both rural and urban in the State, establishment of community food banks in villages, changed focus from `management of malnutrition’ to `prevention of malnutrition’ etc.

1.15. Integrated Child Development Services (ICDS) Scheme

Launched on 2\textsuperscript{nd} October 1975, today, ICDS Scheme represents one of the world’s largest and most unique programmes for early childhood 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.

The revised Population norms for setting up a Project, Anganwadi Centre and Mini-AWC are as under:

**Projects:**

- Community Development Block in a State should be the unit for sanction of an ICDS Project in rural/tribal areas, irrespective of number of villages/population in it.
- The existing norm of 1 lakh population for sanction of urban project may continue.
Further to this, for blocks with more than two lakh population, States could opt for more than one Project (@ one per one lakh population) or could opt for one project only. In the latter case, staff could be suitably strengthened based on population or number of AWCs in the block. Similarly, for blocks with population of less than 1 lakh or so, staffing pattern of CDPO office could be less than that of a normal block.

**Anganwadi Centres**

**For Rural/Urban Projects**

400-800 Population - 1 Anganwadi Center (AWC),

800-1600 Population - 2 AWCs and

1600-2400 Population - 3 AWCs, thereafter in multiples of 800 population one Anganwadi Center (AWC).

For Mini – AWC: 150-400 Population 1 Mini-AWC

**For Tribal / Desert, Hilly and Other Difficult Areas/ Projects**

300 - 800 Population- 1 AWC

For 150 - 300 Population -1 Mini AWC

For Children in this age group **0 – 6 months**, States may ensure continuation of current guidelines of early initiation (within one hour of birth) and exclusive breast-feeding for children for the first 6 months of life.
For children in this age group 6 months to 3 years, the existing pattern of Take Home Ration (THR) under the ICDS Scheme will continue. However, in addition to the current mixed practice of giving either dry or raw ration (wheat and rice) which is often consumed by the entire family and not the child alone, THR should be given in the form that is palatable to the child instead of the entire family.

For the children in this age group 3 to 6 years, State has been requested to make arrangements to serve Hot Cooked Meal in AWCs and mini-AWCs under the ICDS Scheme. Since the child of this age group is not capable of consuming a meal of 500 calories in one sitting, the States are advised to consider serving more than one meal to the children who come to AWCs. Since the process of cooking and serving hot cooked meal takes time, and in most of the cases, the food is served around noon, States may provide 500 calories over more than one meal. States may arrange to provide a morning snack in the form of milk/banana/egg/seasonal fruits/micronutrient fortified food etc.

- To improve the nutritional and health status of children in the age-group 0-6 years;
- To lay the foundation for proper psychological, physical and social development of the child;
- To reduce the incidence of mortality, morbidity, malnutrition and school dropout;
- To achieve effective co-ordination of policy and implementation
amongst the various departments to promote child development; and

- To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The above objectives are sought to be achieved through a package of services comprising:

- Supplementary nutrition,
- Immunization,
- Health check-up,
- Referral services,
- Pre-school non-formal education and
- Nutrition & Health education.

The concept of providing a package of services is based primarily on the consideration that the overall impact will be much larger if the different services develop in an integrated manner as the efficacy of a particular service depends upon the support it receives from related services.

Three of the six services namely Immunization, Health Check-up and Referral Services delivered through Public Health Infrastructure under the Ministry of Health & Family Welfare. This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anemia. All families in the community are surveyed, to identify children below the age of six and
pregnant & nursing mothers. They avail of supplementary feeding support for 300 days in a year. By providing supplementary feeding, the Anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities.

Growth Monitoring and nutrition surveillance are two important activities that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to detect growth faltering and helps in assessing nutritional status. Besides, severely malnourished children are given special supplementary feeding and referred to medical services.

**Immunization**

Immunization of pregnant women and infants protects children from six vaccine preventable diseases—poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles. These are major preventable causes of child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus also reduces maternal and neonatal mortality.
Check-ups

This includes health care of children less than six years of age, antenatal care of expectant mothers and postnatal care of nursing mothers. The various health services provided for children by anganwadi workers and Primary Health Centre (PHC) staff includes regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, de-worming and distribution of simple medicines etc.

Services

During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are referred to the Primary Health Centre (PHC) or Health Sub-Centre (HSC). The Anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer of the Primary Health Centre/ Sub-centre.

Formal Pre-School Education (PSE)

The Non-formal Pre-school Education (PSE) component of the ICDS may well be considered the backbone of the ICDS programme, since all its services essentially converge at the anganwadi – a village courtyard. Anganwadi Centre (AWC) – a village courtyard – is the main platform for delivering of these services. These AWCs have been set up in every village in the country. In pursuance of its commitment to the cause of India’s
Children, present government has decided to set up an AWC in every human habitation/settlement. As a result, total number of AWC would go up to almost 1.4 million. This is also the most joyful play-way daily activity, visibly sustained for three hours a day. It brings and keeps young children at the anganwadi centre - an activity that motivates parents and communities. PSE, as envisaged in the ICDS, focuses on total development of the child, in the age up to six years, mainly from the underprivileged groups. Its programme for the three-to six years old children in the anganwadi is directed towards providing and ensuring a natural, joyful and stimulating environment, with emphasis on necessary inputs for optimal growth and development. The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. It also contributes to the universalization of primary education, by providing to the child the necessary preparation for primary schooling and offering substitute care to younger siblings, thus freeing the older ones – especially girls – to attend school.

**Nutrition and Health Education**

Nutrition, Health and Education (NHED) is a key element of the work of the anganwadi worker. This forms part of BCC (Behaviour Change Communication) strategy. This has the long term goal of capacity-building of women – especially in the age group of 15-45 years –
so that they can look after their own health, nutrition and development needs as well as that of their children and families.

**Funding Pattern**

ICDS is a Centrally-sponsored Scheme implemented through the State Governments/ Union Territory (UT) Administrations. Prior to 2005-06, 100% financial assistance for inputs other than supplementary nutrition, which the States were to provide out of their own resources, was being provided by the Government of India. Since many States were not providing adequately for supplementary nutrition in view of resource constraints, it was decided in 2005-06 to support to States up to 50% of the financial norms or to support 50% of expenditure incurred by them on supplementary nutrition, whichever is less.

From the financial year 2009-10, Government of India has modified the funding pattern of ICDS between Centre and States. The sharing pattern of supplementary nutrition in respect of North-eastern States between Centre and States has been changed from 50:50 to 90:10 ratios. So far as other States and UTs, the existing sharing pattern of 50:50 continues. However, for all other components of ICDS, the ratio has been modified to 90:10 (100% Central Assistance earlier).

**ICDS Team**

The ICDS team comprises the Anganwadi Workers, Anganwadi Helpers, Supervisors, Child Development Project Officers (CDPOs) and
District Programme Officers (DPOs). Anganwadi Worker, a lady selected from the local community, is a community based frontline honorary worker of the ICDS Programme. She is also an agent of social change, mobilizing community support for better care of young children, girls and women. Besides, the medical officers, Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) form a team with the ICDS functionaries to achieve convergence of different services.

**Role & Responsibilities of AWW, ANM and ASHA**

Role and responsibilities of AWW, ANM & ASHA have been clearly delineated and circulated to States/Uts, dated 20 January 2006.

- To elicit community support and participation in running the programme.
- To weigh each child every month, record the weight graphically on the growth card, use referral card for referring cases of mothers/children to the sub-centers/PHC etc., and maintain child cards for children below 6 years and produce these cards before visiting medical and Para-medical personnel.
- To carry out a quick survey of all the families, especially mothers and children in those families in their respective area of work once in a year.
- To organize non-formal pre-school activities in the Anganwadi of children in the age group 3-6 years of age and to help in designing
and making of toys and play equipment of indigenous origin for use in Anganwadi.

- To organize supplementary nutrition feeding for children (0-6 years) and expectant and nursing mothers by planning the menu based on locally available food and local recipes.
- To provide health and nutrition education and counseling on breastfeeding/ Infant & young feeding practices to mothers. Anganwadi Workers, being close to the local community, can motivate married women to adopt family planning/birth control measures.
- AWWs shall share the information relating to births that took place during the month with the Panchayat Secretary/Gram Sabha Sewak/ANM whoever has been notified as Registrar/Sub Registrar of Births & Deaths in her village.
- To make home visits for educating parents to enable mothers to plan an effective role in the child’s growth and development with special emphasis on new born child.
- To maintain files and records as prescribed.
- To assist the PHC staff in the implementation of health component of the programme viz. immunisation, health check-up, ante natal and post natal check etc.
- To assist ANM in the administration of IFA and Vitamin A by keeping stock of the two medicines in the Centre without
maintaining stock register as it would add to her administrative work which would effect her main functions under the Scheme.

- To share information collected under ICDS Scheme with the ANM. However, ANM will not solely rely upon the information obtained from the records of AWW.

- To bring to the notice of the Supervisors/ CDPO any development in the village which requires their attention and intervention, particularly in regard to the work of the coordinating arrangements with different departments.

- To maintain liaison with other institutions (Mahila Mandals) and involve lady school teachers and girls of the primary/middle schools in the village which have relevance to her functions.

- To guide Accredited Social Health Activists (ASHA) engaged under National Rural Health Mission in the delivery of health care services and maintenance of records under the ICDS Scheme.

- To assist in implementation of Kishori Shakti Yojana (KSY) and motivate and educate the adolescent girls and their parents and community in general by organzing social awareness programmes/ campaigns etc.

- AWW would also assist in implementation of Nutrition Programme for Adolescent Girls (NPAG) as per the guidelines of the Scheme and maintain such record as prescribed under the NPAG.
- Anganwadi Worker can function as depot holder for RCH Kit/contraceptives and disposable delivery kits. However, actual distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANM or ASHA as decided by the Ministry of Health & Family Welfare.
- To identify the disability among children during her home visits and refer the case immediately to the nearest PHC or District Disability Rehabilitation Centre.
- To support in organizing Pulse Polio Immunization (PPI) drives.
- To inform the ANM in case of emergency cases like diahorrea, cholera etc. Role and responsibilities of Anganwadi Helpers
  - To cook and serve the food to children and marchers
  - To clean the Anganwadi premises daily and fetching water.
  - Cleanliness of small children.
  - To bring small children collecting from the village to the Anganwadi.

**UDISHA Training**

UDISHA is a nation-wide training component of the World Bank assisted Women and Child Development Project to improve the quality of services under ICDS. “UDISHA” training will particularly help develop the Anganwadi Workers as ‘Social change Agents’. Governments of India have allocated Rs. 25.41 crores for the implementation of training in
Tamil Nadu for the period 1999-2004 (5 years). The components of this training programme include regular training, innovative training and IEC materials.

**Pradhan Mantri's Gramodaya Yojana Scheme**

The PMGY is a new scheme introduced by Government of India to improve the nutritional status of the children under 3 years in unreached and uncovered areas. The nutrition component of PMGY specifically outlines the objectives of eradicating malnutrition among children below 3 years by increased nutritional coverage of supplementary feeding of these children through the ICDS scheme. The additional Central assistance provided for the scheme to the State Government is in the form of 70 percent loan and 30 percent grant. For the Tenth plan, an outlay of Rs. 125 crores is provided for this scheme. During 2002-03, as against the outlay of Rs.2500.00 lakhs, the anticipated expenditure is Rs.2500.00 lakhs. A sum of Rs.2500.00 lakhs is proposed for 2003-04.

**P.T.MGR Nutritious Meal Programme**

The Noon Meal Programme (NMP) introduced in 1982 provides a substitute hot meal in centres to combat hunger. Starting with rural preschoolers, the scheme was expanded in phases to cover urban areas, school children upto 15 years of age, pregnant and lactating women and various categories of pensioners for social security. This feeding is covered under the State budget. From 1995 onwards, under the National
A programme of nutritional support, free rice at the rate of 100 grams per child per day for 10 months in an academic year is being given to primary school children studying in I to V standards and one free meal every day at noon meal centre for a period of 4 months to pregnant women getting cash assistance under National Maternity Benefit scheme. This NMP programme has three main components such as nutrition, preschool education and health care.

The nutritious noon meal prepared with rice, dhal, oil and vegetables containing a caloric value of 358.2 to 780.3 and 8.62 gm to 12.55 gm of protein is served every day with the minimum ration of 142 gm to 266 gm per day per beneficiary.

Besides 20 grams each of potato, green gram (full form) and black bengal gram (full form) containing 158.2 caloric value and 8.54 gram of protein value for three days in a week are supplied in lieu of supply of eggs. Under pre school education, the organiser is given training on pre school activities. Educational equipments, charts, books and play materials are supplied to each centre. Each child is treated as an individual and the seeds of learning are sown in the baby’s mind. Extraordinary attention is given to this task. Under health coverage, periodical health check-up and immunization are being done to cover all the children enrolled in the Child Welfare Centers through the Primary Health Centers in the rural areas and Municipalities. The Public Health Department ensures health care through their staff.
1.16. International Partners

Government of India partners with the following international agencies to supplement interventions under the ICDS:

- United Nations International Children’ Emergency Fund (UNICEF)
- Cooperative for Assistance and Relief Everywhere (CARE)
- World Food Programme (WFP)

**UNICEF** supports the ICDS by providing technical support for the development of training plans, organizing of regional workshops and dissemination of best practices of ICDS. It also assists in service delivery and accreditation system where the capacity of ICDS functionary is strengthened. Impact assessment in selected States on early childhood nutrition and development, micro-nutrient and anemia control through Vit. ‘A’ supplementations and deworming interventions for children in the age group of 9-59 months is also conducted by UNICEF from time to time.

**CARE** is primarily implementing some non-food projects in areas of maternal and child health, girl primary education, micro-credit etc. Integrated Nutrition and Health Project (INHP)-III, which is a phase out programme of INHP series, would come to an end on 31.12.2009.

**WFP** has been extending assistance to enhance the effectiveness and outreach of the ICDS Scheme in selected districts (Tikamgarh & Chhattarpur in Madhya Pradesh, Koraput, Malkangir & Nabrangpur in
Orissa, Banswara in Rajasthan and Dantewada in Chhattisgarh), notably, by assisting the State Governments to start and expand production of low cost micronutrient fortified food known as ‘Indiamix’.

Under this the concerned State Government are required to contribute to the cost of Indiamix by matching the WFP wheat contribution at a 1:1 cost sharing ratio.

**WHO Growth Standards in ICDS**

The World Health Organization (WHO) based on the results of an intensive study initiated in 1997 in six countries including India has developed New International Standards for assessing the physical growth, nutritional status and motor development of children from birth to 5 years age. The Ministry of Women and Child Development and Ministry of Health have adopted the New WHO Child Growth Standard in India on 15th of August, 2008 for monitoring the Growth of Children through ICDS and NRHM.

**Implications**

- Change in current estimates.
- Increase in total of normal weight children.
- Increase in severely underweight children.
- Increase in underweight children (mild/moderate and severe) in age group of 0-6 months.

The new charts would now help us in comparing growth of our children within projects, districts, states & also other countries.
1.17. Prevalence of Diseases in Salem District (Study Area)

Every year, in Salem district many measles cases were found and recorded by the officials and controlled diseases. In the rural area of Salem, year 2009 January to June they found 75 cases were registered, Year 2006 and 2007 they registered 144 and 178 cases. In Tamilnadu in 858 measles cases were registered in the year 2008, in Salem they found 71 cases only registered. In other killing diseases like AIDS, 29977 cases registered in Tamilnadu, In Salem 2727 cases was registered, Salem got fifth place in the state in AIDS case in the year Oct-2007. Due to this the Children health and Nutrition status is decreased even though the Government sector taking many activities to develop the health and Nutrition for Children below the six years age group. Therefore the systematic study is must for controlling, creating awareness to the public and point out the health care management, managing the circumstances as well as used to the base of the management peoples.