CHAPTER VI

SUMMARY AND CONCLUSIONS
About 40 per cent of India's population are children. Most of these children are born and live in absolute poverty, as more than one-third of the population of the country live below poverty line. Absence of nutritional food, hygienic living conditions, medical care, introduction to good education and protection from several deadly diseases are the major problems faced by the children in India.

Considering the seriousness of the problems faced by children, the Government of India has introduced Integrated Child Development Services (ICDS) programme in 1975. The programme aims at improving the nutritional and health status of the children, lay the foundation for proper psychological, physical and social development of the children, help in reducing the incidence of mortality and morbidity and school drop-out rate.

This programme is under implementation since 1975 in Anantapur District. This district is severely drought prone and consequently the problems of children are much worse as compared to many well endowed regions. To achieve success in such a district the programme must be planned and executed much more sincerely as compared to other districts. To understand the impact of the ICDS programme the present
study is taken up with five important objectives. They are 1) to understand the basic components of ICDS programme, 2) to examine the impact of ICDS programme on the nutritional status of the target children and mothers, 3) to assess the impact on immunization practices, 4) to assess the impact on health awareness through ICDS, and 5) to examine the attitudes of the people towards ICDS.

To assess the impact of ICDS programme at field level hundred sample households are interviewed with a pre-designed schedule. These households are represented by only women as respondents. The methodology adopted in choosing the households is multistage random sampling. In doing so fifty urban slum women and fifty rural women are selected as respondents.

THE PROBLEMS OF WOMEN AND CHILDREN IN INDIA

The cultural, social and economic bias against women in India is reflected in their excessive mortality, poor health, inadequate access to health care and medical services and increasing gap between men and women in literacy, education and training for employment and employment status. The majority of the Indian women are considered to be silent, passive, oppressed and more
neglected than anywhere else in the world, because of the existence of the host of social evils and traditional customs which subjugate them subjectively. The problems faced by women are much more severe if they come from such households who are living below the poverty line. All these socio-economic problems faced by women will have ill-effects on the children of the country.

The problems faced by children are reflected in many a facet. The infant mortality is as high as 80 per thousand. As many as 57.0 per cent of the child deaths occur due to lack of any medical treatment. Few fatal diseases like typhoid, anemia, phuemonia are also causing severe child loss. Only 16.2 per cent of rural children are enjoying normal nutritional food. Rest of them are facing either mild, moderate or severe malnutrition. Further, only about 41.2 per cent of the child births are attended by trained persons. It must be recognised here that, most of the problems faced by the children are the reflections and consequences of socio-economic standards of the people of the country. The problems faced by children have become main social problems in Indian context. Owing to these problems, the ICDS gains in importance, as this programme is aimed to serve the children in an holistic approach.
INTEGRATED CHILD DEVELOPMENT SERVICES PROGRAMME

The programme was initially launched in a small way covering 33 Community Development Blocks in India. By 1992 the ICDS was covering 2696 of the total 5092 Community Development Blocks. Main objectives of the ICDS are 1) to improve the nutritional and health status of children in the age group of 0 to 6 years, 2) to lay the foundations for proper psychological, physical and social development of the child, 3) to reduce the incidence of mortality, morbidity, malnutrition and school drop-out rate, 4) to achieve effective coordination of policy and implementation amongst the various departments to promote child development, and 5) to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutritional and health education. To realise these objectives the following package of services were included in ICDS. They are 1) supplementary nutrition, 2) immunization, 3) health check-up, 4) referral services, 5) nutrition and health education, and 6) non-formal pre-school education. The package of services was intended to reach the following groups, viz., children below six years of age, expectant and nursing mothers and woman in the age group of 15 - 45 years.
The administrative unit for the location of ICDS project is a Community Development Block in rural areas, a tribal development block in tribal areas and a group of slums in urban areas. For ground level dispersal of the services, Anganwadi centres are located at a rate of one each for 1000 population in rural and urban areas and 700 in tribal areas. The key person at this Anganwadi centre is Anganwadi worker.

WORKING OF ICDS IN ANANTAPUR DISTRICT

The first Anganwadi centre was sanctioned in 1975 in Anantapur District. By the end of 1992-93, the total number of centres sanctioned were 2,252. Of them 2,099 centres are functioning, which works out to 93.2 per cent.

The average number of mothers per Anganwadi centre in Anantapur district is 18.5 as compared to 27.1 in case of both India and Andhra Pradesh. The average children per Anganwadi who are given supplementary nutrition works out to 62.52 in India, 73.41 in Andhra Pradesh and 59.65 in Anantapur. A comparison on the same lines in case of mothers works out to 12.03, 15.85 and 12.30 respectively for India, Andhra Pradesh and Anantapur. The average children per Anganwadi receiving pre-school education is 36.53 in
India 39.33 in Andhra Pradesh and 29.41 in Anantapur. No comparative figures are available regarding immunization for India, Andhra Pradesh and Anantapur. Same is the case with nutrition and health education.

In Anantapur district there is lot of gap between sanctioned administrative positions and the actual member of personnel working for ICDS. If at all any basic reason is need to be identified for the failure of the programme, the large number of vacancies (about 50.0 per cent) of the supervisory positiones seem to be the prime reason.

SOCIO-ECONOMIC PROFILE OF THE SAMPLE HOUSEHOLDS

The distribution of different communities is fairly spread in urban areas in our sample. But in rural areas hindus have more representation. The total sample is fairly distributed to different caste groups. All our sample respondents are within the reproduction age group i.e., between 15 and 45 years. About 60.0 per cent of our respondents are illiterates and even among literates 27.0 per cent had their education only upto primary level. About two-thirds of the households are having four or five people per household.
As many as 68.0 per cent of our samples are living in single room houses. Among them 14.0 per cent are living in huts. Drinking water problem is still faced in our sample rural areas. The household assets owned by our sample are mostly a radio or a bicycle. The landed property and other productive assets are very small for our sample households. The sample households are spread to different occupations. In rural areas the main occupations followed by the sample are either agriculture or agricultural labour. In urban areas, the main occupations represented in our sample are non-agriculture labour, petty trade and tailoring. In our total sample 44.0 per cent of the total households are not to be included as the ICDS beneficiaries, if the norm of Rs. 500 income per month is strictly adhered to. In urban areas 54.0 per cent of the households do not fall under the income eligibility criteria as compared to 34.0 per cent from among rural households.

IMPACT OF ICDS ON SOCIAL DEVELOPMENT

There are 50 expectant mothers and 50 nursing mothers in our sample. Among the total expectant mothers of both rural and urban areas, 82.0 per cent received antenatal care and as many as 94.0 per cent received immunization benefit. In case of the other three components,
viz., supplementary nutrition and health education and family welfare services, the benefits are received only by a small section of the sample. Between rural and urban areas, the benefits received differ substantially, with an edge in favour of urban areas.

From among the total 50 nursing mothers, 86.0 per cent received post-natal care, 14.0 per cent received supplementary nutrition, 26.0 per cent received nutrition and health education and 56.0 per cent received family welfare services. In case of post-natal care and supplementary nutrition, the urban respondents are better placed as compared to rural respondents.

Before the initiation of ICDS no delivery took place in hospitals as compared to 11.5 per cent of deliveries in rural areas taking place in hospitals after ICDS. In case of urban areas, only 8.7 per cent of deliveries took place in hospitals before the initiation of ICDS as compared to 30.6 per cent of deliveries taking place in hospitals after ICDS.

Only 2.5 per cent of the deliveries have taken place with the help of trained personnel before the introduction of ICDS. Such percentage has increased to 36.3
between the period of introduction of ICDS and after ICDS. Which means, considerable decline of involvement of untrained persons in delivery cases. Before ICDS all the deliveries in rural areas took place with untrained persons, but after the introduction of ICDS in as many as 29.5 per cent of the deliveries the trained persons have attended. In urban slum areas, only 8.7 per cent of the deliveries were attended by trained persons before the introduction of ICDS, and such percentage has increased to 41.2 per cent after ICDS.

In all the 80 deliveries took place before ICDS, all post-natal care instructions were received from elderly women. After the ICDS, 30.7 per cent of the rural and 28.9 per cent of the urban post-natal cases received instructions from elderly women. Which means a substantial decline of elderly women's role in post-natal care.

There are 50 children who are below one year of age in our sample. Of this 62.0 per cent of the children received supplementary nutrition, 16.0 per cent received the benefit of immunization, 38.0 per cent received health check-up facilities and only 14.0 per cent received referral services from Anganwadi workers. In the case of rural areas, 55.4 per cent received supplementary nutrition, 72.7 per
cent received immunization benefit, 36.3 per cent received health check-up benefit and 9.1 per cent received referral services. In all these four types of benefits, urban children are slightly better placed as compared to rural children.

There are 47 children who are aged between 1 and 3 years. Of them, 65.9 per cent received supplementary nutrition, 91.5 per cent received immunization benefit, 23.4 per cent received health check-up benefits and only 8.5 per cent received the referral services. Between rural and urban areas, urban children are slightly better placed in receiving these benefits.

There are 64 children who are aged between 3 and 6 years of age. Of them, 71.8 per cent received supplementary nutrition, 82.8 per cent received immunization, 12.5 per cent received health check-up benefits, only 3.1 per cent received referral services and 71.8 per cent received non-formal pre-school education. Between rural and urban areas, urban children are better placed in receiving ICDS benefits as compared to rural children who are aged between 3 and 6 years.
Only 20.0 per cent of the total sample have said that the supplementary nutrition food supplied is acceptable. The rest of 80.0 per cent expressed different reasons for not showing their acceptability for supplementary nutrition. The reasons they have sighted in the descending order are not tasty, not fit for consumption, not cooked properly, poor quality of raw materials, causes diseases and difficult to digest. Between rural and urban areas, not much of a difference can be observed regarding the acceptability of nutrition food.

Only 32.0 per cent of the sample respondents are completely informed of the types of immunization and periods of immunization to the mothers and children. There are 47.0 per cent of the respondents who have medium level of knowledge, 17.0 per cent have low level of knowledge and 4.0 per cent have no knowledge about the immunization schedule. Between rural and urban areas, the level of knowledge is less among rural women as compared to urban women.

As many as 31.0 per cent of the sample respondents still believe that the diarrhoea occurs due to 'change of months' in age of the child and 'local god' beliefs. According to 57.0 per cent of the sample
respondents, the diarrhoea occurs due to dehydration and as many as 10.0 per cent of our sample expressed no knowledge regarding the causes for the occurrence of diarrhoea. The main source of knowledge of diarrhoea curing methods are available from television, doctors, ANMs, elders and Anganwadi workers and Anganwadi helpers. In our total sample, only 37.0 per cent have received diarrhoea curing instructions from Anganwadi workers and helpers. As many as 29.0 per cent of the sample have expressed their preference for ready made oral rehydration mixture available in the market. The home made sugar and salt solution was preferred by 37.0 per cent of the sample. Crude and village medicines were preferred by 16.0 per cent of the sample and 18.0 per cent of the sample preferred directly approaching the doctors.

Of the total 50 post-natal mothers, 31 have adopted family planning methods. Of them, 22 have gone for tubectomy operation and none of the husbands of our sample have undergone vasectomy operation. Of the 31 respondents adopting family planning methods, 20 have gone for the family planning through ICDS functionaries and 11 on their own initiation without the prompting of ICDS functionaries.
Though 22 people have undergone tubectomy operations, only 10 people have undergone the tubectomy operation with two children. All the other 12 respondents have undergone operation with three or more children. This indicates the failure of ICDS personnel to some extent in educating the small family norm.

The ICDS beneficiaries themselves are not fully aware of this scheme, indicating failure of the propaganda machinery in providing necessary public awareness campaign about the programme.

From among the ICDS functionaries field level workers are more known to respondents as compared to district level officials.

About half of the respondents have said that the Anganwadi centres are conveniently located. None of the respondents have regularly visited the Anganwadi centres. As many as 48.0 per cent of the sample respondents never visited the Anganwadi centre. Of the rest, 22.0 per cent said that they did not visit the centre regularly and 32.0 per cent said that, they have visited the centre only once or twice.