CHAPTER VIII

CHILD DEVELOPMENT PROGRAMMES
Children are the most important assets of a country because they will be the youth of tomorrow and provide the human potential required for a country's development. This is recognised by the Government of India as early as 1950s. Programmes for women and children were developed by the Central Social Welfare Board during the first and second five year plans and were reviewed. They felt the programmes needed to reorganisation in order to improve and enlarge its scope so that the women and children in rural areas could be better served. After 1967, the Ministry of Social Welfare, Government of India was made responsible for running the programme with the assistance from UNICEF.

Recently a three-day meeting was convened by the Planning commission, the Ministry of Urban Development, the National Institute of Urban Affairs (NIUA) and UNICEF. It brought together administrators, planners, social scientists and grass root level social workers, in what was claimed to be the first ever exercise of its kind, to take an indepth look at the various facets of urban explosion, with focus on its implications for the urban poor child.

The deliberations pin-pointed the factors contributing to the maladies afflicting urban poor children.
and examined the implementation of various government programmes to alleviate urban poverty and improve the educational, health and nutritional status of the children of the urban poor.

The extent of deprivation suffered by the slum dwellers in general and by the children and women in particular was highlighted through myriad of statistics, findings of studies and the field experience of the non-governmental organisations (NGOs). The lack of adequate access to safe drinking water, sanitation facilities, health care and schooling, which were basic to survival and development of any individual to full potential was brought out forcefully by the participants.

A study on slums in Delhi by the Azad Medical College revealed that the actual level of under-five child mortality was considerably higher than the average urban child mortality as projected by the National Sample Survey data. The Ludhiana study showed that immunisation was not as high as often claimed by the authorities and that despite geographical proximity to health centres significant proportions of child population of urban slums were never reached by the health system. (Gopalan 1991)

The needs of children and our duties towards them have been outlined in the constitution of India. The resolution on National Policy on Education, which has been adopted by Parliament, gives a direction to state regarding

The Planning Commission had already taken the initiative in setting up inter-ministerial study teams in 1972 on integrated child care services. Based on the recommendations of these teams, and with the fillip given by the 15 Point Programme enunciated in the document on the National Policy for children adopted by the Government of India in 1974, the fifth plan strategy was evolved to make a co-ordinated effort to have an integrated programme of package services for infants and pre-school children and for nursing and expectant mothers. Thus the Integrated Child Development Services Scheme (ICDS) was started.

During the year 1975-76, 33 projects were started in the country. Each project was extended to 67 more blocks in 1978-79. The major programme of the ICDS is to lay a consolidated foundation of the development of the offices, human resources by providing an integrated package of early childhood services consisting of (a) supplementary Nutrition, (b) Immunization, (c) Health Check-up, (d) Referral services, (e) Nutrition and Health Education and (f) Non-formal Education to children below 6 years of age and pregnant and nursing mothers in most backward rural or tribal blocks and urban slums (C. Nayana Tara Usha Ramkumar, 1988).
The objectives of the Integrated Child Development Services Scheme are:
i) to improve the nutritional and health status of children in the 0-6 age group,

ii) to lay the foundations for a proper psychological, physical and social development of the child,

iii) to reduce the incidence of mortality, morbidity, malnutrition and school drop-outs,

iv) to achieve effective co-ordination of policy and implementation amongst the various departments to promote child development and

v) to enhance the capability of the mother to look after the normal health and nutritional needs of the child by imparting proper nutrition and health education to her.

The administrative unit for ICDS projects is a community development block in rural areas, tribal development block in predominantly tribal areas and slums in urban areas. While selecting project areas, preference is given to areas predominantly inhabited by backward tribes and scheduled castes, economically backward groups and so on.

Delivery of Services:

Supplementary Nutrition: It is given to children below 6 years of age and nursing and expectant mothers from low income families as per the guidelines provided for selection.
of beneficiaries as per the guidelines provided by the department of Social Welfare. The amount of nutrition will vary according to the age of the child. Supplementary nutrition is given for 300 days in a year. Children suffering from third and fourth degrees of malnutrition are given special therapeutic food. The type of food prepared on the spot depends upon local availability, type of beneficiary, location of the project and administrative feasibility.

Nutrition and Health Education: It is offered to all women in the age group of 15-45 years especially for nursing and expectant mothers. Health and Nutrition Education is imparted through specially organised courses or talks in the project areas, home visits by anganwadi workers/supervisors, cooking demonstrations, use of mass media and so on.

Immunization: All children below the age of 6 years are to be immunized against small pox, diphtheria, tetanus, whooping cough, typhoid and tuberculosis. All expectant mothers are immunised against tetanus. Children of 5 to 6 years of age are given booster dose for diphtheria and tuberculosis and 2 doses for typhoid vaccination.

Health Check-up: It is provided for anti-natal care of expectant mothers, post-natal care for nursing mothers, care of new born babies and care of all children for 6 years of
Expectant mothers are given a health check-up and provided with iron and folic acid tablets. They are educated regarding the usefulness of breast-feeding and general care of infants. The health care for children under 6 years of age includes health check-up for children at regular intervals to keep track of their health and nutritional status, general check-up for every 3 to 6 months to detect incidence of diseases, malnutrition and also distribution of drugs for prevention of epidemics, deficiency and anaemia.

**Referral Services & Health Check-up:** Serious cases of malnutrition among children are referred to Primary Health centres (PHC), community health services and district hospitals. In certain areas and in certain cases, the scope of health check-up and treatment may be wider. Children requiring referral services in the upgraded Primary Health Centres (PHC), district hospitals are provided with appropriate facilities.

**Non-formal Education:** It is imparted to children of 3-6 years in anganwadi centres which are set up in each urban special unit with a population of 1,000. Pre-school activities are organised in order to develop desirable attitudes and behavioural problems among children. The child is encouraged and stimulated to learn at his/her own pace. Play and other activities are organised with inexpensive locally available materials and toys. No attempt is made to
achieve uniformity of teaching and learning procedures in anganwadi for all children for play and other activities.

Organisation:

The administrative unit for an ICDS project is a community development block or a tribal development block or a group of slums. At the project level, there is a child development project officer (CDPO), who is directly responsible for the implementation of the programme.

The focal point for the delivery of services is an Anganwadi Centre for a population of over 1,000. The anganwadi is run by an anganwadi worker who would be a village level worker assisted by a helper belonging to the same village/local community. The anganwadi worker must have either a Secondary School Certificate (SSC) passed or non-SSC. The Anganwadi worker is responsible for the organisation of pre-school activities, arranging supplementary nutrition for children, expectant and nursing mothers, giving health and nutrition education to mothers, making home visits to educate the parents to elicit community support and participation, maintaining files and records and so on.

The work of the anganwadi worker is assessed by supervisors who are supposed to guide and help them. Each rural/tribal/urban project would have 4 supervisors.
respectively. They are responsible for supervising the working of anganwadi centres through regular field visits, helping anganwadi workers develop community contacts, promoting intimacy between anganwadi workers and Child Development Project Officer (CDPO) assisting CDPO in various tasks of project organisation and implementation, periodic checking of records and registers maintained by each anganwadi centre.

The CDPO is directly responsible for each ICDS Project at the block level. The CDPO's supervise and guide the work of supervisors and anganwadi workers through periodic field visits and staff meetings. The CDPO is expected to enlist community involvement in the implementation of ICDS Programmes. At the state level the Department of Social Welfare is headed by a Director. The flow chart showing the administrative pattern of ICDS is presented below:
Administrative Flow Chart for Integrated Child Development Services (ICDS)

State Level

ICDS Director

Regional Deputy Director
R.D.D.

District Level
ICDS Programme Officer
Chittoor

Child Development
Project Officer
(C.D.P.O.)

Assistant Child Development
Project Officer
(A.C.D.P.O.)

Supervisors

Anganwadi Worker

Helper

National Level

Medical Director

Regional Director
R.D.

District Medical
& Health Officer
(D.M. & H.O.)

Primary Health
Centre (PHC)

Assistant Child Development
Project Officer
(A.C.D.P.O.)

Supervisors

Anganwadi Worker

Helper

These functionaries were helped at the block level by one medical officer, 2 lady health visitors and three auxiliary nurse midwives (ANMs). The Child Development Project Officer have 100 anganwadi centres under her control. The four female supervisors have multifarious duties to perform.
Financial Inputs:

The Department of Social Welfare of the Government of India provides funds to the State Governments to meet the additional expenditure arising out of the implementation of the ICDS Projects. These funds are in addition to the normal funds provided for the programmes which are already in existence.

The United Nations International Children’s Emergency Fund (UNICEF) also gives funds to some of the NGOs dealing with ICDS. The National Institute of Public Cooperation and Child Development (NIPCCD) gives instructions to the Integrated Child Development Services (ICDS). Besides, assistance is received from the UNICEF for the expenditure incurred on training, vehicles and other equipment. State Government also provide funds for supplementary nutrition at their own cost.

Training of Anganwadi Teachers: The anganwadi workers recruited from the local community were brought together for a training programme for three months, which gives them a good grounding in child nutrition and child and maternal health, in nutrition and health education of mothers and in community participation. Another one month training is imparted to them in functional literacy for women, which is a supportive programme of the ICDS.
Monitoring:

It has been mainly devoting its attention to the monitoring aspects of the programme by getting monthly progress reports directly from each CDPO. The reports received in a proforma gives details of the flow of finance to the project, the expenditure incurred, the training and positioning of project personnel, the physical facilities in the Primary Health Centre, Sub-centres and anganwadis, and the supplies received and services delivered in a month. Once in three months, a more detailed statement, indicating concrete achievements in certain directions, is also received from the CDPOs.

Integrated Child Development Services (ICDS) in the slum:

In 1983, RASS a voluntary organisation has undertaken the task of implementing the ICDS programme in Tirupati urban area. RASS is the first non-Government organisation (NGO) in the country entrusted with the task of implementing the ICDS Programme, funds for which are received from Government of India and Government of Andhra Pradesh and UNICEF has provided equipment for the purpose.

The ICDS programme under RASS covers a network of services that would benefit as many as 15,000 women and children. The services include, immunization, health check-up, supplementary nutrition, health education, non-formal pre-school education for the children in the age group of 0-6 years and pre-natal and post-natal care for mothers.
In addition to these package of services, non-formal education for school drop-out girls, training and assistance to ICDS mothers for income generating schemes, maternal and child health care centres are provided as extra-components under the ICDS Programme.

The ICDS was implemented in the slum under study during 1983 for carefully nursing children in the age group between first month to six years. Fifty per cent of young children from poor families in the country have nutritional deficiency. The Government adopts a programme of supplementary feeding for children and pregnant mothers with special emphasis on the economically weaker families of the society (Thakur, C.S., 1974).

The supplementary feeding for children and pregnant mothers was started in 1983 for a few children in the slum. The coverage was expanded to 80-90 children and expectant mothers in 1989-90. At first, they started in the anganwadi centre in the slum in 1983. As the response was impressive, they started another centre in 1986. Most of the pregnant women and their children consume the nutritional diet (flour) distributed by the anganwadi centre for a period of 6 days and the impact of nutrition programme was encouraging.

The anganwadi teacher explains the importance of nutrition and health education to all the women in 15-44 age group. The teacher visits the slum everyday and conducts,
Mahila mandali (women's organisation) meetings once in a month to guide mother and children in taking care of their health and keeping their house clean and hygienic.

The ICDS provides health-check-up and referral services for the children and expectant mothers. Some of them do not respond favourably to the referral services as they do not believe in modern medical treatment. However 50% of the mothers respond favourably to immunization programme. The anganwadi teacher plays a key role in the ICDS programmes.

Under the immunization programme half of the children and expectant mothers were immunized with B.C.G., D.P.T., and Polio, against small pox, D.T. Typhoid, Boosters. The teacher looks after health check-up and referral services for the care of the expectant mothers, new born infants and children under six years of age.

Non-formal education i.e. pre school is important to children of 3-6 years age. There are two anganwadi centres with 40 children each in the slum. Each centre has a teacher and a helper. But some of the children do not like to go to school. The teacher takes special care to those children who do not like to go to the school. The children learn alphabets both in Telugu and English, rhymes and stories, besides they learn some indoor and outdoor games.

Problems:

Very rarely the respondents make themselves bold to express their problems. As the majority of the
beneficiaries are engaged in labour work, they are not able to receive the services of ICDS such as nutrition and immunization programmes for pregnant women. A few of them have informed that non-availability of vaccine for immunization, non-supply of nutritious food on some days and non co-operation of the school helpers in taking their children to anganwadi centres. Regarding immunization of children, only a few beneficiaries seem to have faced the unsympathetic attitude of some of the health staff but this does not appear to be a major problem. Reference to pre-school education, some beneficiaries have expressed their opinion that children are disinterested and a few say that, children are afraid of being beaten by teachers. Further, respondents were interviewed to find out their chief source of information regarding ICDS. The source of information are supervisor, anganwadi worker and health guides. It appears that anganwadi teachers have played a major role in imparting knowledge about ICDS to the beneficiaries. Non-availability of people at home, superstitious and beliefs coming in the way of people do not permit them to avail themselves of the development programmes particularly child health and hygiene.

ICDS and Its Impact:

The mother plays a key role in the physical, psychological and social development of the child. Nursing and expectant mothers have to be brought into the scheme which aims at the welfare of children. Therefore, women between 15 and 44 are brought within the ambit of Integrated
Child Development Services. ICDS was started in 1963 at Tirupati. The slum has two anganwadi centres. The first anganwadi centre was started in April 1984 and the other in March 1986. Various services have been rendered by ICDS to the beneficiaries:

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Beneficiary</th>
<th>Type of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Expectant and nursing mothers</td>
<td>1. Health check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Immunization of expectant mothers against tetanus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Supplementary Nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Nutrition and health Education</td>
</tr>
<tr>
<td>2.</td>
<td>Other woman between 15 and 44 years</td>
<td>1. Nutrition and health education</td>
</tr>
<tr>
<td>3.</td>
<td>Children less than one year</td>
<td>1. Supplementary nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Immunization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Health check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Referral Services</td>
</tr>
<tr>
<td>4.</td>
<td>Children between 1 and 2 years</td>
<td>1. Supplementary nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Immunization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Health check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Referral services</td>
</tr>
<tr>
<td>5.</td>
<td>Children between 3 and 6 years</td>
<td>1. Supplementary nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Immunization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Health check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Referral services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Non-formal pre-school education</td>
</tr>
</tbody>
</table>
ICDS conducts the Mahila mandali (women's association) in the slum. The anganwadi teacher helps in conducting mahila mandali meetings once in every month. She gives suggestions to take care of their children's health, nutrition and education. For example, if a child suffers from vomitings and dysentery, the teacher advises the mothers to prepare the solution with sugar, salt, and water to give it to the child. Generally, the teacher visits every house and advises the mothers about the cleanliness of the house, personal hygiene and their children's health. The teacher gives the supplementary nutrition for the pregnant women, 0-6 years children and for low weight and malnutrition children every day. Children between 3-6 years go to anganwadi centres or school to take the nutrition diet.

In the initial stage, there were very few children in the centres. Gradually, the number of children was raised to 40 in each centre. First, the parents were not interested in the programme. Some of the parents said that the children who ate the nutritious diet (flour), suffered from dysentery. But now the parents understand the programme and take the flour to their children. The pregnant women take the flour with which they prepare chapatis, flour cake (kudumulu). The teacher gives 160 gms of flour to each pregnant woman and 80 gms to the child of 0-6 years.

The anganwadi teacher maintains primary health centres which is part of it. The anganwadi teacher provides
medicines to the pregnant women and 0-6 years children. The anganwadi teacher also provides Iron + Folic acid tablets to the pregnant women. The teacher gives medicines for fever, cough, cold, malaria, eye diseases, dysentery and vomitings of the children.

Non-Formal Education:

National Policy on Education (NPE) and the programme of Action (POA) envisage a large and systematic programme of Non-Formal Education (NFE) for habitations without schools, school dropouts, for working children and girls who cannot attend schools for the whole day (Government of India, 1988). NFE is visualised as child-centered, environment-oriented, flexible system to meet the educational needs of the comparatively deprived geographical areas and socio-economic sections of society. Stress is therefore, laid on NFE/POA on provision of adequate facilities, including modern technological aids, for the creation of an environment which would motivate children to participate in these programmes. Emphasis has also been laid on selection of dedicated persons from the local community to serve as instructors and on their training, good quality learning material is to be developed and provided free of charge to all pupils in the non-formal centres.

The expansion of NFE programme is in the form of projects. Approximately 100 NFE centres will comprise a project which would be taken up in a contact and contiguous
area, as far as possible with a (CD) Child Development block. The main functions at the project level would be (i) to select the supervisors, (ii) to generally supervise the programme, (iii) to promote intergency linkages to give development orientation to the field programme, (iv) to monitor the programme, (v) to ensure provision of materials and supplies and strengthening is also envisaged at the district and state levels. The programme is to be taken up through Panchayati Raj bodies and voluntary agencies.

The scheme of assistance to voluntary agencies for non-formal education for elementary age group children under the programme of universalisation of elementary education and the scheme for assistance for experimental and innovative programmes for education at the elementary stage, including NPE, have recently been revised to allot the project work to the voluntary agencies.

Funded by the Government of India, the programme provides instructions to the drop-out children so as to enable them to acquire minimum educational status. In addition, these children are taught certain vocational skills like carpentry, household electrical wiring, motor re-winding and toy making. Besides, the programme also covers community health and waste land development programmes in order to make the scheme more meaningful.

At the project level, there is a project officer is directly responsible for the implementation of the
programme. The project was initiated in 1981. This project is organised by the Rayala Seema Seva Samithi (RASS) and 100 Aniyatavidya centres are managed by this project in each urban and rural centres. The focal point for the delivery of services is anganwadi centre. Aniyatavidhya is run by an anganwadi teacher. The work of the Aniyathavidhya teacher is supervised by supervisors who are supposed to guide and help them. Each project has 4 supervisors and has maintained 100 schools. 8% female and 12 male teachers were working in these schools.

The project officer is directly responsible for the project at block level. Children between 6-14 years have the benefit of the aniyata education through the institution of anganwadi centres in each village and in each centre. The school is run at evening times i.e., from 6.45 PM to 8.45 PM. The working hours of the school is convenient for the working children and drop-outs.

Only 20 children studied in the aniyata school in the slum. But most of them are not interested to go to the school. The parents are not interested to send their children to the school and as such the children did not pass the stage-4 i.e., face-I. A few children enter the stage-II. So the non-formal education has not developed in the slum.

Pregnant Woman:

The district Social Welfare Officer organises various programmes for the poor pregnant women through
Rayalaseema Seva Samithi (RASS) office. The women for the first and second pregnancy get the benefit of Rs.20/- per month through the voluntary organisation (RASS). The pregnant women are not able to take proper diet during the pregnancy period. The women with very low income and broken families are also eligible for the benefit.

Women Income Generating Schemes (WIGS):

It was found that many women are involved or intend to involve in some or other economic activities to support their families as many of their male members give only part of their daily income for family needs and rest is spent on liquor, gambling and other activities whereas the income earned by women is entirely spent for the family and children.

Rayalaseema Seva Samithi (RASS) has been working in the field of women and child welfare since 1981. RASS, being the pioneer NGO, is implementing Government ICDS Programme in Tirupati urban slums and surrounding rural areas and added additional components like family planning, non-formal education and skilled training to improve the conditions of women along with other regular services of the scheme.

It was envisaged that child development through ICDS in low income families cannot be sustained unless the economic status of the mother is improved so as to enable
her to take better health and nutritional care of the child without depending on subsidies from government or RASS.

The major objectives of the programme are:

i) to identify and promote income generating activities for women,

ii) to develop and institute a credit delivery system to support women's economic activities,

iii) to train the unskilled and semiskilled women in appropriate income generating activities,

iv) to foster organisations of women around specific income generating activities so that they can carry out the business with minimal outside assistance in the long run and,

v) to enhance the capabilities of women to improve their health and nutritional status of their children.

The project executor supervises the programme through four associates and field level staff. In the first few months, the team was mainly involved in arranging bank loans but later found the need for organising women for savings and credit. Thus, the self help groups were promoted. The group formation and greater interaction with women gave an opportunity for the team to understand the complexities of Income Generation programmes for women.

Women were covered through various programmes of the project which include mainly promotion of income generation, self help, group formation, training and skill development.
a) Existing informal credit systems of urban slums:

Many of the poor who live in urban slums mainly depend on self-employment activities like small trading and petty business for their livelihood. There is a great fluctuation in their incomes as there is no continuity in the activity performed by them. One of the reasons for this is lack of credit availability is a reasonable interest rate. Many credit needs of these people are met by the existing informal credit systems. Following are the most prevalent among them, (a) Money lenders, (b) Pawn brokers, (c) Chits.

b) Need for savings and credit support:

The credit requirements of the poor varies from Rs.50-2000/- and sometime more. The regular credit needs of slum dwellers include consumption, health, emergencies, working capital for business, repaying old debts and other unforeseen expenses like festivals, deaths and ceremonies.

The amount required for these needs is generally small and range from Rs.100-500/-. Presently most of these needs are met by the local money lenders known as 'Tandal Wallahs'. The interest charged for these loan is @ Rs.10-15/- per month for a principle amount of Rs.100/-.

Process and System of Self help groups (SHGs):

Once the self-help group was promoted, the project team member explores the possibilities of supporting women
for income generation. The whole group and leaders will be involved in the process of identification and selection of beneficiaries for extending financial support. After selection, the team member prepares a profile of the beneficiary and the feasibility is made. Then applications of selected beneficiaries will be submitted for sanction of loan either through banks or pass involving fund.

Impact of WIG Schemes:

It is evident from this scheme that only four girls aged about 13 years and one woman were trained in tailoring, embroidery and in making readymade garments under vocational training programme. The training programmes are organised through the Mahila Mandali in the slum. The Mahila Mandali President recommends the eligible candidate for the programme. There are 35 members in the project. To begin with 10 members joined the programme during 1989-90 but later on the number was reduced to 5. The training programme has not much impact on the slum-dwellers due to various administrative factors. One of the drop-out girls said that the teacher did not teach properly. The teachers are interested in non-slum members as they pay Rs.30/- per month whereas the slum people pay Rs.10/- per month. Further, it is also informed that the teachers and other office staff do not treat the students properly but they treat them as their servants.
A self help group was organised on the 1st August 1990 with membership of 15-20 women. The leader of the group is a member in the Mahila Mandali. First week of every month, they meet at the Mahila Mandali centre or at the leader's house. The leader collects Rs.10/- from each member. The leader gives the money to the needy member, after noting her particulars in the accounts book. They collect interest @ Rs.5/- per month for a principle amount of Rs.100/-. This self help group was not viable as the lenders would not repay the money with stipulated terms and conditions as framed by them from time to time.

Generally, women do not have any source of income and the demand for credit was mainly for basic needs and health. Some of the families expressed that the scheme is good but the scheme is not improved in the slum.

Financial support for the people who own property (for security purpose) is another form of income generating scheme. This scheme supported 5 families for maintaining shops like flowers, petty shop, vegetables, cafe, and wet grinder. These beneficiaries get the money through the RASS fund. But this could not attract most of the poor people in the slum who were deprived of their own assets.

The Women Income Generating Scheme has not much impact in the slum.
8.1 Details of Beneficiaries supported by WIGS Project

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Programme</th>
<th>No. of Beneficiaries covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Promotion of Income generating Programme</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>Self help groups for savings &amp; credit</td>
<td>15</td>
</tr>
<tr>
<td>3.</td>
<td>Vocational training</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>


To sum up the child development programmes that have been implemented in the slums through a voluntary organisation Rayalasceema Seva Samithi (RASS), in 1983, Rayalasceema Seva Samithi (RASS) undertook the task of implementing the Integrated Child Development Services (ICDS) programme in Tirupati Urban area. The services include immunization, health check-up, supplementary nutrition, health education, non-formal pre-school education for the children in the age group of 0-6 years and pre-natal and post-natal care for mothers.

In addition to these package of services, non-formal education for school dropout girls, training and assistance to ICDS mothers for income generating schemes, maternal and child health care centres are provided as extra-components under the ICDS programme.
Most of the pregnant women and their children consume the nutritional diet (flour) distributed by the anganwadi centre for a period of 6 days in a week and the impact of nutrition programme was encouraging. However, a few mothers are not taking a good quantity of the flour as its taste is not satisfactory. Some of the mothers informed that the nutritive feeding (flour) is not valuable and suitable for their children's health as they suffer from indigestion. They could not understand the nutritive value of the flour because most of them are illiterate. Some of the women use the flour to prepare roti or chapati.

Under the immunization programme half of the children and expectant mothers were immunized with B.C.G., D.P.T. and Polio, against small-pox, D.T., Typhoid and boosters. The teacher looks after health check-up and referral services for the care of the expectant mothers, newborn infants and children under six years of age. Some parents are against immunization and referral services because they feel that after vaccination the children suffer from these diseases. These families try to cure the diseases through traditional way of curing. When the Health visitors or the doctor enter the slum, these parents hide their children to avoid vaccination.

Non-formal education prescribed is important to children of 3-6 years age. There are two anganwadi centres with 40 children each in the slum. Each centre has a teacher.
and a helper. Some children are disinterested and a few of them said that children were afraid of being beaten by teachers. A few parents are busy in labour work and they leave the houses at 7.00 a.m. and return at 7.00 p.m. They keep their elder children to look after the younger children. However, the elder children do not take much interest in sending the younger children to schools. The Aniyata or Chaitanya Bharathi is provided only to the school group of dropouts, working children, and illiterates in the age 6 to 14 years. The response of the children is not up to the mark as they attend irregularly.

Women Income Generating Schemes (WIGS) are also organised by RASS in the slum. But these schemes have no impact on the slum women. A few women and children were given training in tailoring. They said that teacher has not given proper training to them and they are unable to purchase sewing machines with their little knowledge in tailoring.

Non-availability of parents at home, poverty, superstitions and beliefs coming in the way of people do not permit them to avail themselves of the development programme particularly child health and hygiene.

In the ultimate analysis, the problem of the urban child is one of management. There is no lack of appreciation of the problem, no dearth of legislations and homilies. But what is lacking is management. There are different agencies
involved in different aspects of the problem. But there should be a nodal agency for looking after the needs of the urban poor through intersectoral co-ordination. The Ministry of Urban Development naturally lays claim but the other ministries are not prepared to part with their powers. There should be an inter-ministerial task force to coordinate the work of different agencies.