Chapter - VII

SUMMARY, FINDINGS, CONCLUSIONS

AND SUGGESTIONS
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Introduction

Today's child is tomorrow's citizen. As such, unless and until today's child is made up for making up tomorrow, there will be no progress, social and economic. This involves the anticipation and activisation of social and economic momentum. Economic momentum, in this context, refers economic growth/development which presuppose formation of capital-human capital – health, knowledge, skill, and experience that make an individual more productive.

Making of the child as the maker of the future entails the following four - child survival, child development, child protection and child-centred community participation in the process.

Child survival rests on availability of child (and child bearing mothers), health care; child development is connected with both the physical and cognitive standards of the child as reflected in nutritional and educational statuses; Child protection demands safeguarding the child from all sort of exploitation. These three components are so integrated that concerted efforts are needed to proceed further, which anticipates community participation.

Matters related to the overall development of the child have been in the agenda of nations for long. The World Health Association in 1977, followed by 1978 Alma Ata declaration, the "Health for all by the year 2000" movement, gained momentum. The goal was to be
achieved by implementing Primary Health Care as the key strategy. When the United Nations in 2000 declared the eight "Millennium Development Goals", two of the goals (reducing child mortality and improving maternal health) are related to child survival and development.

**I.C.D.S.**

India has also been in the forefront in matters of child care. In the early days, child care was attended to as one item of social welfare and now it has reached the stage of being treated as a matter of ‘right’. With the directives of National Constitution, provisions in the number of laws enacted granting right and entitlements to children, National policies and programmes enabling the civil society and the community to fulfill their obligations to help to meet the basic needs of the child, the five year plans also from the start are articulating programmes and strategies for child development. All these blossomed forth into the Integrated Child Development Services (ICDS) in 1975.

The prime objective of ICDS is to lay foundation for proper psychological and social development of the child. The scheme, centrally sponsored, is manned at the local level by a community based worker called the Anganwadi worker, trained for the purpose. The scheme is one of the most comprehensive programme for providing integrated health, nutrition and education service, supplementary
nutrition, non-formal pre-school education, immunization, health check-up, referral service, nutrition and health education.

The present study "Impact of integrated child development scheme on the nutritional and Health status of children in Kanyakumari district, attempts to analyse the working of the scheme at a district level.

Objectives

The study has the following objectives:-
(a) to review the existing child schemes in the district.
(b) to examine the working of the Anganwadis.
(c) to study the impact of ICDS on the nutritional and health status of the children
(d) to study the impact of ICDS on the nutritional and health status of children and
(e) to offer suggestions for betterment of the scheme in the district.

Methodology

Across the nine blocks of the district, there are a total of 1,409 Anganwadi centres and from among them 50 centres have been selected randomly and from each selected centre, ten children were selected from the Anganwadi registers by using simple random sampling method. Personal interview with a prepared Interview schedule was used to collect the primary data.
Chapterisation

The study has seven chapters. Covering:

i) Introduction

ii) Review of Past Studies

iii) Methodology of the study

iv) The profile and scope for the health sector and integrated child development scheme in the study area.

v) An overview of integrated child development scheme in India and Tamil Nadu.

vi) An analysis of the socio-economic, health and nutritional status of the sample children’s: the hypothesis tested

vii) Summary, Findings, Conclusions and Suggestions.

FINDINGS

A. Personal Profile

1. Out of the 500 sample children of the study, 279 are males and 221 are females. The sex ratio comes to 884 per 1000 which is lower than the sex ratio of 1,010 for the district in 2011.

2. Viewing the distribution of children by sex and by birth order, it is found that 62.46 percent (183 out of 293) are males.

3. A large percentage (73.6) of children are of the 0.3 years age. This establishes the need for special care and attention of the health of not only the new born children, but also of the pregnant and lactating mothers.
4. Children of the study can be classified as those who hail from the rural area and those live in urban areas - 48 percent live in rural areas and 52 percent occupy urban areas in the district. In a district where the process of urbanization is widespread, (82.47 percent being urban population) this is only natural, and its impact is verified in features like the nature and mode of delivery, child health and immunization status.

B. The Social Background

1. So far as the community affiliation is concerned, 46.87 percent of respondent households belong to the backward castes. This pattern of distribution is not different from the pattern that prevails at the district level.

2. It is found that 90.2 percent of the respondent’s families are of the nuclear type. With the non-availability of grandparents - the specialists in baby care - at hand, this add to the responsibility of the parents to look after their own children, and that provides an opportunity to the Anganwadis to develop themselves as second homes to the younger ones.

3. That it is possible to bring up the children in a sufficiently informed atmosphere is yet another finding of the study. A quarter of the parents have studied up to the middle school level. 13.8 percent of mothers and 17.6 percent of fathers up to the high school level, 17 percent of the both crossed that stage to reach the higher secondary stage. Evidently such parents are well informed of the art and science of child care, and also are of the what and how of the schemes like ICDS.
C. **The Economic Background**

Regarding the economic background of the families, 72 percent have a monthly income of Rs.5,000 – 7,500, and the monthly expenditure of 50.52 percent of respondents comes to Rs.2,000-4,000. It is the occupation of the members of the family that is the main source of income. Here, a majority (47.2%) of the fathers of the children are only daily wages earners. It may be argued that being a high wage district, wage earners of the district can afford to bear private costs of feeding, educating and nursing their children. The argument holds no water as the opportunities for wage employment in agriculture is fast declining in the district (once again, because of high wages) with all out mechanization. So far as mothers of children are concerned, 92 per cent of them (numbering 460 out of 500) are only home – makers; 3 are agricultural labourers, 5 are wage employed, 14 are in business and 18 are self-employed. It is said that the self-help groups in the villages are helping them in finding new sources to subsist such as tailoring, flower – stringing, beedi rolling, running petty provision shops supplying eatables, vegetable/ fish vendors and the like. Nowadays, women are engaged in contributing their part in finding work through the M.G.N.R.E.G.S.
D. Health of the Mother and child

1. It is found that while 54.40 percent have given birth to their children under normal delivery, 45.60 percent have undergone caesarian section; along with, it is found that while in rural areas caesarian section is in high order (123 out of 228), In the case of urban areas normal delivery is found to be higher (155 out of 272).

   A chi-square test attempted in this context has shown that there is a significant difference between the type of delivery and the residential status of the respondents.

2. Regarding the place of delivery, 82.80 percent of the mothers have given birth to their children in government hospitals. Though, there is some difference between rural and urban areas in this respect (40.20 percent in rural and 42.60 percent in urban areas). The chi-square test attempted in this context shows that this difference is not significant.

3. Turning to the health of the children, only 5 percent of rural children and 31.40 percent of urban children are very healthy. This difference is found to be not significant in a chi-square test.

4. Immunisation aims at prevention of the toll of many diseases of the sample children 99.40 percent are fully immunized : 52.00 per cent hail from urban areas and 47.40 per cent from the rural areas (the differences are not significant). It is worth recording
that the educational level of the mothers of children is not a binding factor of status of immunization, for 17.80 percent of illiterate mothers and 17.40 percent of those with primary school education have seen their children fully immunized. A Chi-square test shows that there is no significant difference between the level of education of the mothers of children and the level of immunisation of children. The credit goes to the system as such - to the Anganwadis that are in charge of the system locally.

5. A survey was made of the incidence of illness of children at the time of the survey. It was found that 56.80 percent of children had fever, 32.20 percent had diarrhea, at the time of the survey. There were no children who were affected by measles during the reference period, which, it is claimed, reflects the impact of immunisation programmes implemented. Even though the pattern of morbidity is different in the rural and urban areas, a chi-square test reveals that the difference is not significant.

**E. Nutritional Status**

The rise of malnutrition in children during the first two years of life is indicative of poor infant feeding practices. It is essential that the baby gets the first breast milk called colostrum. In the survey it is found that all children are fed with colostrum. There are three options of feeding - breast feeding, breast feeding with baby food feeding and baby food exclusively. Thirty nine percent of the sample
children are breast fed, 61 percent are having both breast feeding and baby foods. (It is found that at the district level, all the children enrolled for feeding are fed under ICDS (SNP) and a large number are fed under ICDS (NMP with egg/ banana added). Those who fed baby food believe that it makes the baby strong and healthy and gives extra nutrition, 40 percent of them are satisfied with their baby's weight and are highly satisfied with baby food. Nearly 40 percent of baby food users spend Rs.400-600 monthly on baby food.

**F. Anganwadi centres**

Anganwadi centres provide nutritious meals and do regular health checking of the children attending the centres. Hence attending Anganwadi centres is an important factor determining the health status of the children, It is found that 67.40 percent of the children attend regularly the Anganwadis - 38.20 percent are very healthy and 24.20 percent fairly healthy and only 5 percent unhealthy. A chi-square test also shows that there is a significant difference between the health status and the regularity of attending the Anganwadi centres by the sample children.

**G. Hypothesis tested**

**Hypotheses - 1**: "Breast feeding is more popular in rural areas than in urban areas". Breast feeding is practiced in both rural and urban areas (Vide Table 6.17) the slight difference that is noticeable is not significant as found out in the chi-square test. Further in urban
areas the duration of breast feeding is also relatively higher (vide table 6.18). As such, this hypothesis is not acceptable.

**Hypotheses - 2** : *ICDS organised immunization programme is highly effective*. The hypothesis is substantiated as a chi-square test (vide table 6.26) found a significant difference between the health status and immunization status of the sample children.

**Hypotheses - 3** : *Children attending regularly the services provided by Anganwadi are gaining height, weight and health*. The contents of table 6.20 and 6.21 show that those children who attend the Anganwadi service regularly have gained in height, weight and health, more so in the case of urban centres. Thus the hypothesis is valid.

**Hypotheses - 4** : *The Anganwadi centres are fully equipped with to make available the facilities expected from them*. The contents of table 6.28 shows no shortage of factors for supplementary nutrition, immunisation and health care: on this ground this hypothesis is validated.

**Hypotheses - 5** : *A strong correlation exists between socio economic factors and health related ICDS variables*. In order to find out the relative efficacy of factors that influence the health status of children, a correlation matrix was prepared (Section 5 of chapter 6) which shows that the impact of socio-economic factors like income, level of education or type of family have significant influence on the health related ICDS variables. On this ground this hypothesis is validated.
CONCLUSIONS

The present study fully concurs with the statement of Programme Evaluation Organization of the Planning commission that, "There is no doubt that the ICDS is well conceived and well planned to address the main cause of child under-nutrition". The review of the coverage of ICDS in the study district shows that all eligible children (13,913 of the 2-3 age group and 16,906 of 3-5 age group) have been provided with nutritious food (in 2014). The mothers of the child beneficiaries report the health gain that their children have acquired by regularly attending the Anganwadi programmes.

Some findings of the sample survey give some clues to the principal factors that lie behind the significant progress of ICDS in the district. Since biological reproduction lies with women, the rearing and caring of children are considered as natural extension. The present study also reveals that it is the mother's awareness of immunization programmes that has effected full coverage of immunization programmes. A distinguished feature of the study area is that the literacy status of the women in the district is comparatively high (when compared with that of the state - 92.17 per cent as against 80.30 per cent). This helped to widen the range of awareness of programmes such as Immunisation, supplementary nutrition or pre-school education. Further, it is found that nuclear family is the norm in the district and with the consequence of non-availability of grandparents
to take care of the baby at home, the need for somebody to be in charge of the baby is felt. This gap is filled up by sending the child to the Anganwadi and in this context, the Anganwadi plays the additional role of a Crech.

Thus, Women’s participation, women’s education, Women’s emancipation and women’s empowerment, emerge as the principal factors that accomplish child survival and child development.

**SUGGESTIONS**

Being dependent on the willing and wholesale participation of women, the ICDS functionaries should enlist the backing and support of women’s bodies in the locality - the native Women Self-Help Groups. It is said that the responsibility of cooking and delivering of supplementary nutrition may be outsourced to the Self Help Groups.

The ICDS, though a Centrally sponsored programme with a top heavy hierarchy of administrative structure, needs restructuring as a local peoples’ programme, inviting and encouraging peoples’ participation not only in decision making but also in sensitizing them - in reminding them that what the state is doing is what the peoples in isolation or the society as a whole, ought to do. Individuals can show the way. The researcher on her visit to the villages was informed of such model individuals. One household celebrates the birth day of its members at the Anganwadi, greeting the children with sweets and play things; another has supplied korai mats to the Anganwadi that enables the children to relax and sleep comfortably.
It is reported that the Anganwadi lack the required infrastructure to deliver their service satisfactorily. The survey has shown that in some Anganwadi centres there is no place for children to play, no weighting machine, no teaching aids to impart pre-school education. Here private participation has a role assigned to play.

Further, Angawadi workers are over burdened, underpaid, and mostly unskilled. There is no security of job for most of them. The recent demonstration and strikes of these workers bear testimony to this. Their recruitment procedure and service condition needs restructuring.

The ICDS is a multifaceted body anticipating the full cooperation of multiple departments of health, food supply, education and finance. This demands convergence in the working of individual departments towards the achievement of a common goal. To cite a suggestion, the periodical visit of a health personnel from the nearly primary health centre to the Anganwadi is essential to make the referral services of the Anganwadi more effective.

It is suggested by most studies on ICDS that vertical implementation of programmes cannot realise the potential benefits of the scheme and this again, invite decentralization: The Gram Sabha should be utilised to sensitisise people about entitlement of goods /medicines / other facilities, the rights of child and services available at Anganwadi centres. At that stage, the ICDS blossoms into a programme of the state, for the child, directed by the peoples themselves.