SUMMARY
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To protect and promote the health of the children, number of schemes have been implemented in India, one such scheme known as Integrated Child Development Services (I.C.D.S.) it was launched in 1975, the objective of which is to improve the nutritional and health status of children below 6 years of age and to lay foundation for proper psychological, physical and social development of the child. To achieve the objective, a package of services comprising of supplementary nutrition, immunisation, health check-up, referral services, health and nutritional education and non-formal education is provided in an integrated manner to the children below 6 years of age and expectant and nursing mothers.

The package of services is delivered at a community centre known as Anganwadi centre in each village covering the population of about 1000. The key person who provides these services is designated as Anganwadi Worker (A.W.W.) who is invariably a female selected from the local community. Anganwadi Worker is assisted by a helper who is also from the same area. The work of 20 Anganwadi Workers is supervised by one mukhya sevika. The child development project officer (C.D.P.O.) is overall in charge of the project in one community development block.
It is an ambitious scheme with sizeable inputs and involving department of social welfare, health, education and rural development. The scheme since its inception, has received varied comments and observations (Sunder Lal, 1980 and Patowari, 1982) creating doubt in the minds of people and administrators alike. It was, therefore, thought desirable to evaluate the I.C.D.S. scheme in one of the project in Chirgaon, Jhansi (U.P.), where the scheme was started in 1980-81.

**AIMS AND OBJECTIVES**

The specific objectives of the present study are:

1. To study the nutritional status and morbidity of children below 6 years of age covered under I.C.D.S. scheme and compared with children not receiving I.C.D.S. care.

2. To assess the utilization of health services by the population in I.C.D.S. care in comparison to the population not receiving the I.C.D.S. care.

3. To see the impact of I.C.D.S. services on mortality status of children below 6 years of age by comparing it with the children not receiving the I.C.D.S. care.

4. To identify areas of relative inactivity in the I.C.D.S. scheme requiring of augmentation.

5. To suggest measures for more effective implementation of the scheme.
This is a comparative study of evaluation of I.C.D.S. (Integrated Child Development Services) Scheme in two Community Development Blocks — one covered by Integrated Child Development Services Scheme and the other not covered by it.

Chirgaon Community Development Block of district Jhansi in Uttar Pradesh, where Integrated Child Development Services (I.C.D.S.) Scheme was started in 1980-81 was selected as the I.C.D.S. block in this study. This block is also the Field Practice Area of the Department of Social and Preventive Medicine, M.L.B. Medical College, Jhansi (U.P.). The Chirgaon block has got a typical rural setting, representing truly the rural population of Bundelkhand in terms of their culture, beliefs, customs and medical facilities etc.

The Non-I.C.D.S. block in which study was carried out for comparison is Community Development Block, Baragaon. This Block was selected because this is adjacent to Chirgaon Block and as such socio-cultural factors, customs, beliefs etc. are similar to that of Chirgaon area except some additional-staff provided under I.C.D.S. Scheme.

All the children below the age of six years in all the household of the selected villages constituted the unit of study. The sampling unit in the study was a village. The sampling frame consisted of a list of all the 102 villages in Community Development Block Chirgaon (I.C.D.S.)
and all the 121 villages of Community Development Block Baragaon (Non-I.C.D.S.). There were 506 children below 6 years in the selected villages of Chirgaon and 499 children in Baragaon Block. Out of these 423 (83.60 percent) children in Chirgaon block and 403 (80.76 percent) in Baragaon block could be studied. Remaining children could not be studied because of non-availability of children or non-cooperation from the parents despite best efforts of the investigator.

The study was started on November 1, 1987 and continued till April 30, 1988. The study was carried out by door to door visit to every house in selected villages of I.C.D.S. and Non-I.C.D.S. area. All the children below the age of six years were studied with the help of a schedule designed to collect basic informations pertaining to bio-social characteristics, environmental conditions, antenatal care, type and place of delivery, birth attendant, feeding practices, growth and development, immunization status, present illnesses. Preferably the parents of the children were interviewed. If neither of the parents was available, some other adult member of the family was interviewed and a re-visit made to verify the facts. The informations were recorded on an interview schedule which had earlier been tested on a similar population.

Actual age of the child was recorded in years and months. A DETECTO weighing machine provided by UNICEF was used for recording the weight of children. Height was
measured by using a good steel measuring tape. After recording anthropometric measurements, every child was subjected to a complete general and systemic examination. Blood samples were collected for haemoglobin estimation which was carried out on the spot by Sahli's acid haematin method. Stool specimens were also collected for detection of ova and cysts of intestinal parasites in the faeces.

Data so obtained from the study was subjected to critical statistical analysis which consisted of examining possible associations of health status of the children studied with various socio-economic and other factors. Difference between I.C.D.S. and Non-I.C.D.S. blocks were examined statistically. For this Chi square test and tests for difference between percentages have been applied.

The following conclusions have been drawn on the basis of observations of this study.

There has been no significant difference in the age and sex composition of children of I.C.D.S. and Non-I.C.D.S. study groups. Majority of the population in both the I.C.D.S. and Non-I.C.D.S. groups were Hindus. More than half of the children in both the study groups belonged to families comprising more than 6 members.

The single largest number of children in I.C.D.S. group were second born and in Non-I.C.D.S. were first born. The difference was insignificant. The parents of majority of the children in both the groups were illiterate.
Agriculture was the main occupation of majority of the families of both the I.C.D.S. and Non-I.C.D.S. groups. Per capita monthly income of majority of the families of both the I.C.D.S. and Non-I.C.D.S. group was Rs. 60 - 139.

Open shallow wells was the common source of drinking water in I.C.D.S. and Non-I.C.D.S. groups. However, safe water supply, i.e. hand pumps were more in the I.C.D.S. area.

Insanitary methods have been the commonest mode of excreta disposal in both the groups. No significant difference was found in the housing condition except the environment surrounding the child's house was more hygienic in I.C.D.S. group than in Non-I.C.D.S. group.

Higher percentage of pregnant and lactating women in I.C.D.S. area had been utilising antenatal and postnatal care as compared to Non-I.C.D.S. area. Family planning services were also utilised more in I.C.D.S. area.

Anthropometric measurements - weight and height were found lower in Non-I.C.D.S. group children than in I.C.D.S. group children. Male children showed higher values than female children in both groups. Mean values of all measurements in both groups were lower than the I.C.M.R. Standards. Therefore the nutritional status of children in I.C.D.S. group was better than that of Non-I.C.D.S. group.

Higher prevalence of protein energy malnutrition grade III & IV was found in Non-I.C.D.S. group (9.2 percent) than I.C.D.S. group (4.7 percent).
vit. A deficiency was more prevalent in Non-I.C.D.S. group as compared to I.C.D.S. group, whereas there was no significant difference in the prevalence of angular stomatitis.

Borderline anaemia was found in both I.C.D.S. and Non-I.C.D.S. groups, though children having less than 7 gm% Hb. (severe anaemia) was more in Non-I.C.D.S. group than in I.C.D.S. group.

Except for head holding and sitting, all milestones were significantly delayed in Non-I.C.D.S. group. Both groups of children were breast fed but weaning was much delayed in case of Non-I.C.D.S. children.

State of personal hygiene was poor in Non-I.C.D.S. group children as compared to I.C.D.S. group.

Infections like upper respiratory tract infections, diarrhoea, dysentery, skin diseases and fever were some of the common forms of sickness found and were more prevalent in Non-I.C.D.S. group than in I.C.D.S. group. Higher percentage of Non-I.C.D.S. children were also sick at the time of study being carried out.

Mortality rate in I.C.D.S. area has been 100 as compared to 111.2 per 1000 live births in Non-I.C.D.S. area. The mortality rate in 0 - 5 years age group was found to be 26.7 per 1000 population in I.C.D.S. and 40.2 per 1000 in Non-I.C.D.S. group. Respiratory diseases and Typhoid fever were the major causes of mortality in I.C.D.S. group, whereas marasmus and diarrhoeal diseases in Non-I.C.D.S. group.
Crude birth rate was 16 in I.C.D.S. and 32 in Non-I.C.D.S. group per 1000 mid year population. Significantly more children, pregnant & nursing mothers availed of periodic medical check-up facility by ANMs/HV and other government agencies for medical care.

Home deliveries were a common feature of both I.C.D.S. and Non-I.C.D.S. groups, though the majority of birth attendants in I.C.D.S. group were trained as compared to Non-I.C.D.S. group where majority were untrained.

Coverage for all types of supplementary nutrition, Vit. A, Iron & folic acid tablets, supplementary food was significantly more in I.C.D.S. group as compared to Non-I.C.D.S. group.

Thus it is concluded that health status of children in I.C.D.S. group has been better than Non-I.C.D.S. group, but not significant enough to have an impact on mortality. Therefore, whether I.C.D.S. is commensurate to inputs provided is still a debatable matter.

The following suggestions and recommendations have emerged on the basis of foregoing conclusions.

1. Programme of adult education particularly of women need to be further strengthened.

2. Protected supply of water and sanitary disposal of excreta are the areas requiring immediate attention.
3. Regular supplies of vaccines, storage facilities at sub-centres and motivation of the parents for getting their children immunized, require a strategy for better achievement.

4. The work area of M.C.H. staff has been reduced with the expectation of effective and adequate coverage.

5. Purchase of supplementary food should be entrusted to the local village committee.

6. Officers of the respective departments be made responsible for imparting effective co-ordination amongst A.N.Ms and A.W.Ms.

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