Chapter-IV

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OBSERVATION & RECOMMENDATIONS

The ICDS Scheme will be 33 years old this year. It has achieved some success, yet the problems, which mean to address, remain substantial. It is clear that for a scheme that has been in operation for more than three decades, the benefits are still far too limited and maternal and child health and nutrition are still areas of major concern to modify. Even today around one-third of the Indian children and more than half in rural areas are born with low birth weight. The majority of women still do not get proper nutrition and healthcare during pregnancy. It is observed during the course of data collection that the way the programme is being implemented; it effectively ends up concentrating mainly on the 3-6 years age group children. While children under three years are usually enrolled in the programme, their involvement remains nominal and there are no facilities to allow for reaching out to such children and their mothers are home in an effective way.

Therefore the observation, modifications and improvements desired by respondent mothers of the beneficiary children through interactions at the time of data collection has been made a part of study. They are as follows:

It is observed that more than 40 percent AWCS (Anganwadi Centres) across the Hindu and Muslim belt are running in rented buildings, and rest of the Anganwadis are housed in local club buildings.

The status of Anganwadi building, irrespective of rented or club buildings, more than 46 percent Anganwadi Centre are running in pucca building, 21 percent in semi-pucca building and 1.5 percent in kutcha

houses and more than one percent are covered with tin or tiles surrounded by bamboo ply. It is also observed that more than 45 percent Anganwadis have no toilet facility and 40 percent have reported the availability of only urinal and the rest have neither toilet nor the urinals.

It is found that adequate space is a major problem in the Anganwadi centres, particularly in the urban slum areas. Neither outdoor nor indoor space is available to organise any effective play activities. Children are found to sit packed, one against other. The Anganwadi worker is helpless as she is unable to find suitable space within the rental limits.

Anganwadi workers cannot maintain the records in respect of age and date of birth of the children properly, left along the growth, charts and weight registers. There is further problem of overloading the task assigned to Anganwadi workers apart from their original assignment. These are related to Health Department Services such as creating awareness on diarrhoea and ORS, upper respiratory infections, directly observed treatment system for tuberculosis, AIDS awareness, motivation and education on birth control methods, and Total Literacy Programmes, Sarva Siksha Abhiyan of Education Department etc. Now it is needless to say that all these amounts to more than a full-time activity, yet the Anganwadi workers and helpers that they are no more than voluntary workers who receive a Paltry monthly "honorarium" and are called "part-time workers" for the purpose. So in any case there are simply not enough of them to cater to all of these varied demands even with in a small population.

The timing of the Anganwadi centres also effectively rules out many of the poorest households since the AWCs are open only for four hours a day. When both parents are working, which is typically the case among the

labours of urban slum households in many operational areas of North Kolkata, it becomes very difficult for parents to deliver and pick up the child from the centre in time, and so children in such households get excluded from the service. Few of the Anganwadi centres reported that they were not able to monitor growth of the children. The reasons given were non-availability of growth charts, lack of skill in filling the growth chart and weighing scale are not in working conditions etc.

Coverage of children for immunization was found to be higher in Integrated Child Development Services (ICDS) areas (Triple Antigen, BCG and Polio) which is a good indication of child health but expectant mothers in ICDS areas not received Tetanus Toxied (TT) vaccine as compare to non –ICDS area.

It is also observed from the study that the major percentage of mother respondents fall below 20 year of age and they belong to Muslim community, which indicate that they got married before attending the age of marriage. Same time literacy level of respondent mothers coming from both Hindu and Muslim especially mother of the Muslim community 22.37 percent are illiterate, among them 15.53 percent are Bihari mothers, whereas among all Hindu mother respondents 8.94 percent are illiterate in which 6.05 percent are Bihari Hindu mothers. Again 24.21 percent Muslim mothers are literate, can only sign their name and among them 13.68 percent are Bihari Muslim mother. In case of Hindu mothers respondent 8.69 percent are literate but no formal education.

Literacy level and occupation are correlated as reflected from the study, and it happens that 27.64 percent of Muslim mothers of both Bengali and Bihari are housewives and among them 19.21 percent are Bihari mothers

and 8.43 percentage Bengali mothers; in which percentages of Bihari mothers are higher than the Bengali Muslim mothers. The percentage (14.74 percent) of Hindu mother respondents, both Bengali and Bihari Hindu are lower in respect of their occupational status than the Muslim mother respondents. With regards to the engagement as domestic helper in the nearest locality the percentage (14.22 percent) of Hindu mother is higher than the Muslim mothers as language is a factor to Bengali mothers which give them additional advantages.

Size of the household stands for the number of persons living together in a family. The average family size has been found to be 5.05 members, although it varies to a certain extent with religions groups. It is 5.9 percent for Bengali and Bihari Muslim and 5 percent for both Bengali and Bihari Hindus. It indicates that the Muslims generally have larger family members, especially the number of children are higher than what Hindu families is generally have. Muslim couples are not interested to adopt family welfare planning methods.

Examination has been made about the monthly income of the Hindu-Muslim households in the study area and it appears that 33.96 percent Hindu and Muslim mothers replied that their family income is below Rs.1000/- per month and among them the percentage of Hindu mothers (18.16 percent) is higher than the Muslim mothers, followed by 33.15 percent respondent mothers, both Hindu and Muslim expressed that their family income ranges between Rs.1001/- to Rs.2000/- and sometimes it varies, but not exceeds Rs.2500/- per month. Here the percentage of Muslim mothers (13.94 percent) is lower than the Hindu (19.21 percent) mothers and in the income category of Rs.2001/- to Rs.4000/-, the percentage of Muslim mother respondents (10.26) is higher than the Hindu mother (7.10).

The majority of both Hindu and Muslim slum dwellers appears to be engaged in sales related activities including Hawking on the street, tram, bus and footpath with its share of 36.05 percent and 22.01 percent are wage labours and 32.02 percent do not have any regular or steady source of income, but they use to earn their livelihood from different sources. The remaining categories include domestic servants, rag pickets, etc. This group which is the poorest among the poor, constitute near about 6.8 percent. It has been observed that the Bihari Hindus and Bihari Muslims are the worst sufferers among all slum dwellers.

It has been found that both communities' respondents live in pucca, semi-pucca and kutcha houses. The percentage of these structural types in the slums of North Kolkata is pucca 55.1 percent, semi pucca 27.4 percent and kucha 17.5 percent. There are houses with roof made of tiles, asbestos or tins which have floors having kucha or pucca both. It is also observed that 90 percent of these slum dwellers have one small room in each family.

Assets of the family are one of the important indicators of economic status. It is observed that among all reported cases (380) of Hindu and Muslim mothers, 54.0 are found to have assets which include television, radio, sound system, tailoring machine, etc. and the remaining have no assets. Among those who have assets, the majority are Muslims who constitute 27.8 percent as against 22.3 percent Hindus. It appears from the study that Muslim street dwellers have the superior economic status in the slums than Hindus.

In most of the cases (39.47 percent) neighbours are the sources of information about the Anganwadi centre of the locality. And some of them from friends, from their family members and from Anganwadi workers.

Some of them reported that when the centre started distributing food, the news went round the locality without any organised publicity, and local people informed them.

The study has also attempted to find out the reasons behind them for sending their children to the Anganwadi centres. As far as 43.95 percent respondents send their children to Anganwadi centre for food and education, and among them 31.31 percent out of 43.95 percent use to send their children to the centre for food only, which includes 15 percent Bihari Muslim mothers and 4.47 percent Bengali Muslim mothers. So most of the mother respondents send their children to Anganwadi Centre (AWC) for food and among them the percentage of Muslim mothers are higher than Hindu mothers.

Regarding mothers' sensitization about the package of services provided to their children at the Anganwadi centre, it appears from the study that 35.78 percent Hindu and Muslim mother respondents know about availability of food, 22.89 percent about pre-school education and food, 22.12 percent about immunization and above mentioned services. Most of the Hindu Muslim mother respondents of the beneficiary child are aware that their children are provided with supplementary nutrition, pre-school learning and immunization. But nobody is found able to say the food value of the distributed food at the centre to their children.

For pre-school education at the Anganwadi Centre (AWC), respondents know very little. There is no formal structured curriculum in AWC and no flexibility which encourages the children. Now the Anganwadis are reduced to just feeding centre or "Khichuri Centre" with some automatic and mechanical activities, such as songs, rhymes, etc. thrown in primarily to

please the visitors. The mothers also reported that their children are not given any slate or books and not given any home-task by Anganwadi workers. Most of the mother respondents said that they did not observe any behavioural change such as washing hand with soap after using toilet, wash hand before and after meals, brushing teeth regularly, respect elders after attending pre-school learning, and they are not satisfied with pre-school learning of their children.

With regards to the supplementary nutrition, all of the respondents knew that food is given from the centre to their children but they don't know this supplementary nutrition meets the nutritional deficiencies of their children or not. Inspite of the fact that the need for supplementary nutrition is greater for the children between 1-3 years than those in the 3-6 years age group, yet it is found that more children from the latter age group are covered under ICDS. Some of the mothers reported that the food items served as supplementary nutrition to their children from the centre were not much acceptable to the community. The reasons reported were being difficult to digest, sometimes causes loose motion, not tasty and not fit for consumption. They told the Anganwadi Centre (AWC) should arrange rice, dal, curry for their children which are common and acceptable to the children beneficiaries groups.

Referral services is another component of ICDS Programme, which include ante-natal care of expectant mothers, post-natal care of nursing mothers and care of new born infants, care of children under six years of age. Most of the mothers reported that though the Anganwadi workers referred the cases to the Kolkata Metropolitan Clinic or Hospital, but no good services were available from the clinic or Hospitals and medicines are not available and they also mentioned of the unhygienic environment

prevalent in the hospitals / clinics. In Government hospital if you pay to the middleman than you will get good services. In such situation they did not find any option without going to Private Practitioner for their child.

Immunization of children against six childhood killer diseases viz. diphtheria, whooping cough, tetanus, poliomyelitis, tuberculosis and measles would ensures effective control of childhood morbidity and mortality caused by these diseases. But according to the respondents nothing has been done in this respect except the children lying in the age group of 1 to 6 years who are attending the centre. Most of the mothers of the beneficiary children know that vaccine or injection is given to their children, and mentioned the names of Triple Antigen, BCG and Polio, but they don't know the purpose for which this immunization is given to their children.

Some workers of few Anganwadi centres reported that they are not able to monitor the growth of the children. The reasons given were non-availability of growth charts, lack of skills in filling growth chart, weighing scale not in working conditions, etc.

Although deficiencies of micro-nutrients like vitamin A, the B-group of vitamins and iodine manifest slowly, they have severe handicapping consequences for the growing children. No vitamin B group tablets are given in the ICDS network although it is known that 39.58 percent children suffer from parasitic infections which decrease haemoglobin level. It is the time to look into it.

Most of the Hindus and Muslims mother respondents of the beneficiary children have the knowledge of vitamin A oil and it is meant for preventing night blindness and burning eyes, but 73.68 percent mother respondents

don't know the names of the food which helps in prevention of burning eyes and meet the deficiency of vitamin A.

It is observed that almost all the mother respondents of the beneficiary children know that during diarrhoea of their children they need to give sugar and salt solution to their children. But very surprisingly some Bengali and Bihari Muslim mother told that, in addition to these they use to give "*Pani from Pirbaba*" (water from Pirbaba) to their children as a solution to the disease.

More interestingly they know from Anganwadi workers that during diarrhoea a child should be given plenty of water, liquid food or semi solid food or ORS, but in practice they are not applying it to their child because of the belief that by giving more water or watery food will increase the frequencies and quantity of loose motion. This is the practice of most of the Muslim mothers. It appears that during illness of their children the mothers use to go to the govt. Hospitals or Kolkata Municipality Corporation clinic for the treatment. But a large section of Muslim mothers told that (27.36 percent) they use to visit local Pirbaba or Hakim for their child's treatment as it is less expensive and they have faith on them.

Nutrition and Health Education is an integral part of ICDS and is imparted to nursing and expectant mothers and also women in the age group of 15-45 years (for the reproductive age groups).

But it has been indicated during data collection that this component is not being implemented effectively. Indifferent attitude of the Anganwadi workers, lack of interest, low skill and knowledge about the subject matter makes the programme ineffective which should be the focal point on the part of programme planners and policy makers. Moreover most of the Hindu

& Muslim mothers (53.16 percent) during pregnancy they should take extra amount of food and it is difficult for them to arrange special types of food deceiving the others family members.

As regards to the functioning of the centre, most of the respondents reported that the centre open in time as the key of the centre kept with the helper who resides in the locality itself. But the workers of the centre generally do not come in time as she comes from a reasonable distance.

It is also observed that the number of children in the age group 0-1 year covered under this programme is very small because in most of the centre the types of readymade or supplementary food available cannot be eaten by the children. Moreover, DPT, Polio and Tuberculosis against which immunization is provided, are not the major killers in the area covered in the study and till recently the programme had no place for diarrhoea control which is a major killer of infants in this area.

The ICDS guideline lists a series of periodical examinations of the health of the children and pregnant and lactating mothers. However, such examinations hardly took place.

Except supplementary nutrition, ICDS has done much less than expected in providing health check-ups, health education, pre-school education, referral services. A large number of ICDS children in the Muslim belt are not under nourished as they use to eat beef meat from their early childhood which contains high protein and less costly.

It is observed that community participation in ICDS is far below the desired level. Beneficiaries have a low awareness of the package of services, its advantages and possible benefits they can derive from it. Both

participation and involvement of the community in the ICDS Programme and activities was minimal. It is learnt from the mother of the beneficiary child that the Anganwadi workers are also not interested to involve the mothers of the beneficiary child in day to day activities of Anganwadi Centre (AWC) as the mothers will know the faults of the Anganwadi functionaries as well as the lacunas of their activities, and it will be harmful for them to maintain service.

Recommendations:

The study aims to identify factors related to the performance and effectiveness of the programme to determined its feasibility, develop solutions to implementation problems and carry out improvement of the programmes itself. So the modifications and improvements desired by mother respondents are being made a part of recommendation and they are as follows:

Space is a major problem in the Anganwadi centres, particularly in the urban slums. There is a need to upgrade the physical infrastructural facility of Anganwadi Centre (AWC). It may be a good idea to try to locate the Anganwadi centres wherever possible, within the local primary schools, especially in cities the municipal primary schools are always better off in terms of space in comparison with the Anganwadi centres. If not classrooms, at least verandas and compound space of the school may be available which could be utilized to organize play activities and for all other purposes which may deem fit.

Coverage of children under supplementary nutrition and particularly that of under three, should be increased through exhaustive door to door survey, encouraging consumption of food at the Anganwadi Centre and enhancing mother awareness about appropriate weaning practices and supplementary foods for under 0 – 3 years children.

Sharing food supplements by other members of the family is quite common in "take-home-food" system. This, though difficult in view of the pervasive poverty to avoid, needs serious consideration.

There should be a sustained and intensified effort to provide integrated nutrition and balance diet education at the Anganwadi centres. Community radio and TV sets if available at the centres will be effective tools for conveying useful messages to the community besides encouraging their participation in ICDS programme.

Implementation of Nutrition and Health Education (NHE) was found to be far below the desired level. It is suggested that supervisors should be given the responsibility to hold formal Nutrition and Health Education (NHE) sessions regularly in Anganwadi centres under their charge.

Nutrition and Health Education (NHE) should be practical and down to the earth, and not talk about proteins and vitamins. Emphasis should be an additional family food during pregnancy and lactation and importance of breast feeding starting soon after birth, so that the baby gets the benefit of colostrums, and against pre lacteal feeds and water feeding during and after an illness has to be stressed.

Pregnant women should be advised to seek ante-natal care and take iron tablets and two doses of tetanus toxied. Importance of delivery by a trained health worker should be explained. Family planning should be stressed both in the interest of the mother's health as well as for the child.

There is a tremendous scope for improving the implementation of pre-school education components. The children are usually in varying ages from 2 years to 6 years old. In a large group, what usually happens is that the older children perform most of the activities while the younger ones remain passive on lookers. The programme will be more meaningful and effective if the children are divided into small groups so that it is ensured that all children participate actively. Each small group may be a mix of

younger and older children so that a child-to-child approach may be followed and the older children are encouraged to take the younger ones alone in the learning process. But this can result only if the Anganwadi workers are interested and effective.

Regarding immunization, it is rightly said that immunization against vaccine preventable diseases is half the protection from malnutrition as well. It is therefore imperative that health component of Integrated Child Development Services (ICDS) is properly planned in close collaboration with Primary Health Centre (PHC) functionaries. The Anganwadi worker is expected to maintain the register of all new born and pregnant women and ensure that all the enrolled beneficiaries are immunized on time. She has to motivate the mothers, gather the beneficiaries and keep close liaison with Auxiliary Nurse Midwife (ANM) and Lady Health Visitor (LHV) for this purpose. Joint home visits and joint immunization sessions are planned by Anganwadi Workers (AWWs) and Auxiliary Nurse Midwife (ANMs) with Anganwadi as the focal point at the slum.

The Medical Officer, Lady Health Visitor (LHV) and the Auxiliary Nurse Midwife (ANM) should undertake regular health check-up of children below six years attending Anganwadi. The Anganwadi workers have to keep record of this service and pursue the Auxiliary Nurse Midwife (ANM) and Lady Health Visitor (LHV) so that all the children are covered regularly specially the severely malnourished. Children should be checked up frequently, at least once in every month. This involves as curtaining the underlying medical causes of persistent malnutrition and taking remedial measures well in time. It is also well known that malnutrition and disease are closely correlated and form a vicious circle which requires suitable interventions.

The child beneficiaries suffered from serious ailments should be referred by Anganwadi workers to PHC or hospital for a detailed check-up and necessary treatment should be made as and when the situation demands. The Anganwadi workers have to fill in a referral slip for this purpose. The counter part of this slip has to be kept for follow-up. A medical kit is also has to be supplied to each Anganwadi centre for primary treatment.

Community participation revealed itself as a very weak link of ICDS programme. It is imperative that community representative should be involved right from the preparatory stage of initiating a project. Effective ways of Anganwadi participation need to be evolved. Anganwadi workers apparently do not have the requisite skills for promoting participation. Some of the recommendations that come up from the study as are hereunder:

a) There is a need to have a short-duration preparatory phase to raise awareness of the community regarding Integrated Child Development Services (ICDS) before launching the centre in that area;
b) The Integrated Child Development Services (ICDS) package should be made flexible to meet the needs of the community;
c) Self-help should be encouraged as per the capabilities and status of the community;
d) The training of project functionaries should be strengthened to impart them specific skills to elicit community participation.

Integrated Child Development Services (ICDS) should be more away from being a centre based services delivery programme to home based behaviour and practice enhancement programme. It is useful to bear in mind that the child spends not more than 3 hours at Anganwadi centres and rest of the time he/she spends in her/his home and community environment.

Beside health care and immunization,referral services should be given special attention under the new health policy. ICDS can drop these components as a direct responsibility and should be remodelled to become the focal point of convergence of all health activities for children and pregnant and lactating women.

Health education should not be confined to pregnant and lactating women but should cover all women living in the community who seek it. A special target should be the adolescent girl.

With the universalisation of immunization and child survival and safe motherhood programme Integrated Child Development Services (ICDS) should concentrate on mobilizing community and involving women more intensively in proper infant feeding practices, improving maternal nutrition in pregnancy and lactating, home sanitation, personal hygiene, birth spacing and focus on the discrimination of girl child.

The target for pre-school education should include girls in the 6-11 years age group who cannot go to primary school. They should be given supplementary nutrition. A number of such girls are already accompanying infants but are not formally a part of the system.

The common problems encountered such as cough and cold, fever, diarrhoea, worm infestation, skin and eye infections should be included in NHE. The advices should be simple and down to the earth.

Ready-to-Eat (RTE) food has replaced the local food is a part of the Integrated Child Development Services (ICDS) programme while it is convenient and saves the workers' time, it does not provide an opportunity for Nutrition & Health Educations (NHE). It is a lump of food, the

ingredients of which are not visible. It is looked upon as a special "nutrition" food-superior to the household food. It is important to stress the household diet and ways of improving it at low cost.

The quantity of food that a child needs, and the number of times he needs to be fed has to be emphasized. A child of 1-2 years needs half the food his/her mother eats. It may sound incredible but is nonetheless true. It has to be stressed that the food should not be watery and that some oil should be added to increase the energy density. A more effective interaction with the health functionaries will be beneficial for mother of the child as well as Nutrition & Health Educations (NHE).

Reaching the under-three has always been a problem in Integrated Child Development Services (ICDS) inspite of the fact that the early years are the most crucial years and the enrichment/deprivation that take place at the stage has important implications for subsequent development. It is therefore, important that attempt should be made in the Anganwadi to reach out to homes and make parents aware of the importance of early stimulation. The job chart of the Anganwadi worker should include regular home visits as per as possible and practicable.

As the focus gets shifted from the centres to the home where the women and children live, the child will start receiving attention much before his/her 0-3 age period (the first point of contact in ICDS Today), from the time he/she is still in the womb. Today the Anganwadi worker is swimming upstream trying to handle a large number of low birth weight babies. Tomorrow she will be in a position to prevent that by coordination better health and nutrition services as well as encouraging supportive social practices for the expectant mothers.

Finally, to achieve the overall objectives and the stated goals of the project it is imperative to take concerted steps at all levels to strengths Integrated Child Development Services (ICDS) programme so that every child could gain right for survival, protection, participation and development which make them able to live securely and realize the full potential in life.