Classification of Nutritional Status of Children under ICDS

Sl. No.	Name of tl.e Project	0-3 years						3-6 year			
		Normal	Grade I	Grade II	Grade III	Grade IV	Total	Normal	Grade I	Grade II	Gr I
1	Deodurga	1363	1906	1964	149	11	5393	1281	1792	1564	1
2	Lingasugur	1364	1990	1532	147	10	5043	1152	1551	1219	6
3	Manvi	2105	2856	2524	155	11	7651	1086	1507	1340	6
4	Raichur	2855	2646	2069	92	18	7680	1903	1952	1294	6
5	Sindhanur	2558	2398	2061	150	19	7186	1526	1678	1478	6
	Total	10245	11796	10150	693	69	32953	6948	8480	6895	3(

Population and Beneficiaries covered under ICDS Progr

Sl. No.	Name of the Project	Total No. of AWC	Total Population (as per 1991 census)	Population covered under ICDS	No. of villages	Villages covered under ICDS	Drinking water facility under ICDS	Beneficiaries				
								6-2	2-3	3-5	5-6	PM
1	Deodurga	171	176900	35040	188	164	164	3078	3078	2738	2738	855
2	Lingasugur	220	262000	41652	191	182	126	4365	3763	4605	2431	1100
3	Manvi	266	269300	51210	171	164	171	5852	3724	5586	3192	1330
4	Raichur	362	358800	56578	156	142	113	5847	5847	7312	6028	1733
5	Sindhanur	289	284800	52822	172	159	135	5344	5876	6100	5616	1445
	Total	1308	1351800	237302	878	811	709	24486	22288	28339	20003	6463

CH4

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CHILD SURVIVAL & SAFE MOTHERHOOD PROGRAMME

GUIDELINES

FOR

OPERATIONALISING

FIRST REFERRAL UNITS (FRUs)

CSSM PROGRAMME DIVISION

DEPARTMENT OF FAMILY WELFARE

GOVT. OF INDIA

1993

GUIDELINES FOR

OPERATIONALISING FIRST REFERRAL UNITS (FRUs) FOR EMERGENCY OBSTETRIC CARE (EOC)

INTRODUCTION

The basic strategy for enhancing Safe Motherhood under the CSSM Programme has the following three components :

I.Essential Obstetric Care for all - will increase the chances that any complications is detected early. In addition, since foetal and neonatal health is closely associated with the health of the mother, improved maternal health and safe delivery practices will have a positive impact on child survival.

II.Early Detection of Complications - will increase the chances of maternal survival. Many complications require prompt and appropriate action, which will be more feasible if problems are quickly recognized.

III.Emergency Obstetric Care - is critical for saving lives, since the majority of complications leading to maternal death can not be predicted. Reduction in maternal mortality will ultimately depend on whether these services are available and utilized by women who need them.

Some components of Safe Motherhood services, particularly those which will contribute to essential obstetric care for all , are already in existence as a part of the CSSM Programme in all districts of the country. The challenge now in areas such as IFA prophylaxis , TT immunisation and safe delivery is to improve coverage through better systems of service delivery and demand generation through communication efforts. These interventions can have a positive impact on the overall perinatal and maternal health.

The most important measure for reducing the maternal deaths now , however, is the provision of emergency care for women with obstetric complications. Since a large proportion of these complications can not be predicted, it is essential that adequate treatment is made available in time. Hence, the First Referral Units (FRUs) will play a pivotal role in reducing the maternal mortality by providing timely emergency care to women with obstetric complications.

WHY SET UP FRUs ?

The 'model plan' for primary health care , adopted by the country in 1978-79 envisaged that there would be a Community Health Centre (CHC) for every one lakh population

by the end of 7th Plan period. Every CHC is to have a minimum of 30 beds and 4 specialists (either qualified or specially trained to work as Surgeon, Obstetrician, physician and Paediatrician) so that it could provide specialised medical care to the cases referred by the Sub-centres and Primary Health Centres under its jurisdiction.

However , the CHC set up has remained weak in terms of providing the referral support to the outreach facilities ,particularly in the six States of Assam ,Bihar, M.P. ,Orissa , Rajasthan and U.P. This has been confirmed by the data collected under the Health Facility Survey , carried out in 21 districts of the country in 1992 by the Institute for Research in Medical Statistics (IRMS), an associate body of Indian Council of Medical Research (ICMR) . The Survey, which categoried all institutions at block headquarters, and/or those having specialist posts (sanctioned) as a potential referral institution , revealed that most of the block level institutions still remain, in structure, closer to the concept of a Primary Health Centre, having 6 to 10 beds, though having an average of 3-5 medical officers. The main aspects of the findings , in this regard for 6 of the districts covered in the survey , given below , will substantiate this observation :

District	Popn. (in lakhs)	Referral hospitals/CHC/Upgraded PHCs/ Block PHCs					
		Reqd.	Set up	no.having OBG specialist		no.having 30 beds	no.having ambulance
				Sanctioned	in position		
Gaya, Bihar	26.60	27	20	0	-	2	0
Dhar, M.P.	13.00	13	15	5	5	2	5
Raisen, M.P.	8.80	9	9	5	0	1	4
Jodhpur, Raj.	21.00	21	16	5	4	6	4
Kota, Raj.	12.00	12	10	1	1	4	5
Banswara, Raj.	11.00	11	10	3	1	5	8

It is in the above context of the poor availability of specialised emergency care for pregnant women , which has been a major cause of maternal deaths , that the CSSM Programme envisages setting up a network of sub-district first referral units (FRUs) ,through a process of selection from the existing institutions (CHCs, Block PHCs, upgraded PHCs and rural hospitals etc.)

SELECTING THE FRUs

Most States , during planning workshops , have adopted a goal / norm for providing one FRU for every 3 to 5 lakh population which means that the number of instituitons to be selected for developing the FRU network will range between 6 to 12 such units per district ,depending upon the population .

The identification of FRUs ,as noted above , is to be done through a process of selection from amongst existing CHCs, Block PHCs , Referral Hospitals , Upgraded PHCs and Rural Hospitals etc. , with due regard to availability of physical facilities (beds reserved for obstretic care and operation theatre etc.) manpower, particularly OBG specialist and performance of obstretic care services in the recent past. The process of identification should also include an indication of the strengthening required in terms of additional physical facilities and manpower that would be required for each of the recommended FRUs.

As mentioned earlier , IRMS (ICMR) has conducted a health facility survey (HFS) which provides details of the equipment, patient capacity, infrastructure and staff skills available at all government health institutions in the district. The States/Districts , who have been provided with the reports of the HFS done in 21 districts , should review the survey report, and finalise the institutions that are to be upgraded as FRUs.

For those districts where no HFS has been carried out, identification of units to be upgraded as FRUs should be made on the following criteria:

a) location; geographical distribution
b) availability of medical manpower
c) current utilization of services
d) basic infrastructure (building, electricity, and water supply)

As a minimum, facilities should have a labour room and an operation theatre. However, in districts where too few facilities meet these criteria, additional units may be chosen for upgradation in future.

FUNCTIONS OF FRUs

The functions that every FRU must perform and the minimum skills necessary for each of the functions are given below:

A: SURGICAL FUNCTIONS

SKILLS :
- Laparotomy & repair of rupture uterus
- C-Section
- Repair of cervical & vaginal tears
- Uterine evacuation for incomplete abortion (D&C)
- Amniotomy with or without Oxytocin
- Surgical treatment of severe sepsis

B: MEDICAL TREATMENT FUNCTIONS

SKILLS :
- Use of IV Oxytocin for augmenting labour
- IV infusion of iron
- Management of severe hypertensive disorder of pregnancy & eclampsia
- Management of haemorrhagic shock

C: BLOOD TRANSFUSION FUNCTION

SKILLS :
- Cross matching of blood
- Bleeding a donor & giving blood transfusion

D: MANUAL FUNCTIONS

SKILLS :
- Version
- Manual removal of placenta
- Forceps delivery
- Vaccum extraction
- Partography

E: ANAESTHESIA

SKILLS:
- General Anaesthesia
  - Ether
  - Inhalation
  - Intravenous
- Spinal Anaesthesia

F: NEONATAL CARE FUNCTIONS

SKILLS:
- Neonatal resuscitation
- Treatment of several pneumonia
- Severe dehydration or shock

D: EOC DRUGS

Certain drugs are generally required to manage common obstetric emergencies . A minimum list of such drugs has been compiled and is given below:

Drug Category	Name of Drug	
	Critical	Essential
Anaesthetics	Ether Inj.Atropine Inj.Diazepam Oxygen Inj.Thiopental Inj.Xylocaine-5% Inj.Xylocaine-2%	Nitrous Oxide Inj.Suxamethonium/ Catamine
Analglesics	Inj.Fortwin/ Pentazocine	Inj. Pethidine
Antiallergics	Inj.Decadron/Cortisone Inj.Phenergan/Promethazine Inj.Chlorpromazine	
Antianaemia		Tab. Iron Inj. Iron
Antidiabetics	Inj. Insulin	
Antihypertensive & CVS	Tab.Nifedipine Inj.Mephentine/ Dopamine	Tab./inj. Digoxin Propranolol
Antibiotics	Inj.Ampicillin Inj.Gentamycin	Inj.Benzyl Penicillin Inj.Procaine Penicillin Inj.Chloramphenicol Tab.Co-trimoxazole
Antimalarials		Tab/inj.Chloroquine Tab/inj.Quinine
Diuretics	Inj.Furosemide	
I.V. Fluids	Plasma Expanders Glucose 5% Glucose Saline/ Normal Saline Ringer's Lactate Sodium Bicarbonate	
Oxytocics	Inj.Ergometrine Inj.Oxytocin/Syntocinon	
Others		Inj.Tetanus Toxoid

Most of the drugs listed in the above table may already be on State approved drug lists and may have been supplied to the districts. However , a few critical ones , such as

plasma expanders , are rarely provided . Ensuring the availability of these essential medicines in adequate quantities at each FRU will be necessary if these institutions are to be appropriately prepared to cope with obstetric emergencies when they arise .

OPERATIONALISING FRUs

Action for improving the availability of Emergency Obstetric Care (EOC) at the identified institutions, that are to be developed into a network of FRUs, will be required in the following major areas :

i) improving physical facilities , if considered necessary . Resources for this activity will need to be identified either under the ongoing Area Development Project or under the Minimum Needs Programme .(Please see Notes on Funding at the end of this document .)

ii) ensuring availability of necessary equipment. While Govt. of India will procure and supply the equipment to 219 districts (all districts of Assam, Bihar, M.P., Orissa, Rajasthan and U.P. and Adilabad of Andhra Pradesh , Chickmaglure of Karnataka , North Arcot and Thirunelvelli of Tamil Nadu and South 24 Parganas of West Bengal) , procurement for the remaning districts will have to be organised by the State Govenments using the specifications provided by Govt. of India.[Ref. d.o.letter No.M-14015/13/91- UIP dated 7th September '92 from Mrs. Vineeta Rai, Joint Secretary ,MOHFW.]

iii) improving availability of specialists at the FRUs. This would include filling up of the specialists' posts that are available in the concerned district and reorganisation of specialists available till additional specialists become available .

iv) improving the EOC skills of non-specialist staff located at the FRUs . Funds for the skill development training to be carried out through an attachment of the FRU staff to the District Hospital or the nearest Medical College, will be provided under the CSSM Programme for all districts.

v) ensuring availability of essential EOC drugs at the FRUs. Procurement and supply of EOC drugs will be the responsibility of the State Governments.

vi) ensuring adequate maintenance of the EOC services and facilities .

vii) initiating regular monitoring of the FRUs

Immediate action ,however, must be initiated in the four critical areas namely, EOC drugs, skill development training , maintenance and monitoring . The issues and aspects that would need to be addressed , for each of these critical areas, is described in subsequent paragraphs .

EOC DRUGS:

(i) The State Govts. should

- ensure that all EOC drugs are included in the State approved drug list.
- prioritise and rationalise their drug procurement ploicy to ensure that all critical EOC drugs are available at the FRUs .
- allow that the drugs procured under family planning budget head can be used for EOC cases .
- authorise obstetrician/FRU Incharge to purchase critical EOC drugs from contingency funds in emergencies.

(ii) Critical EOC drugs must always be available in labour room, obstetric OT and obstetric emergency management ward. They should be displayed prominently on a list in the above areas and sister/staff nurse and M.O. Incharge should monitor their availability on a daily basis.

(iii) Quantities of EOC drugs supplied to CMOs and FRU I/Cs and the funds available for their purchase should be on the basis of the estimated number of complicated cases expected in the district/FRU. Each FRU should calculate its first year requirement on the basis of EOC cases managed in the past and expected EOC cases in the coming year(s).

SKILL DEVELOPMENT TRAINING:

(i) Those sub-district specialists/medical officers/paramedical workers who are already performing EOC functions should be oriented alongwith the district hospital specialists over a two-day period.

(ii) EOC skills training should be conducted by attaching FRU health personnel to institutions where EOC cases are being treated. This will allow for appropriate skill-based, hands-on training.

(iii) The following institutions are recommended as sites for EOC skills training in order of preference:

- District hospital.
- District hospital of a neighbouring district.
- Nearest medical college hospital.

(iv) Initially, skills development training of FRU staff should be organised. Subsequently, PHC medical officers, LHVs and MPWs should be trained in basic EOC skills by attaching them to the FRUs in a phased manner.

(v) Staff presently in position at FRUs should be trained on an immediate basis so that FRU become operational as soon as possible. Categories of FRU staff requiring training include non-specialist medical officers, laboratory technicians and staff nurses.

(vi) In addition to EOC skills, appropriate FRU staff should eventually be trained in management of newborn and paediatric emergencies also so that the FRUs become a nodal referral centre/institutiton for the entire range of MCH services included under the CSSM Programme.

(vii) Minimum criteria for hands-on practice should be specified which would have to be satisfied by FRU staff during training. The following schedule is recommended for the most comprehensive training requirement:

Personnel category	Training duration	Skills practice	Minimum hands on practice
Medical Offr. (in OBG)	3 months	Surgical functions Manual and medical treatment functions	C-Section: - Observe 15 - Assist 15 - Perform at least 5
Medical Offr. (in Anaesthesia)	3 months	Anaesthesiogical functions	Administer: -G.A.(Boyles)-5 -Spinal-5 -Intubation-5
Laboratory Technician	1 month	Blood cross-matching and transfusion	Cross-matching-10 Blood collection-10
Staff Nurse	1 month	OT training Assisting anaesthetist Manual procedures Blood transfusion Supportive care	

MAINTENANCE OF EOC FACILITIES:

(i) State Governments should allocate a proportion of their existing drug budgets to create a performance-linked miscellaneous purpose fund for the FRUs. It is recommended

that disbursements from out of this fund should be Rs.100.00 for each EOC admission to the FRUs and should be released quarterly on the basis of the monthly performance reports for the last quarter.

(ii) Each FRU should be allowed to spend its earning under the performance-linked miscellaneous purpose fund for the following items or activities :

- Locally procured consumables for general maintenance
- Disposables for blood transfusion
- Maintenance of OT and beds
- Repair of EOC equipment
- Local purchase of emergency requirements of EOC drugs

MONITORING OF EOC FACILITIES:

(i) To facilitate monitoring at FRUs, a Summary Case Sheet (prototype given at Annex I) should be introduced for all maternity admissions at FRUs .

(ii) An EOC Monthly Monitoring Report (prototype given at Annex II) should also be introduced. This should be filled by each FRU to capture necessary data. Reports should be based on data from Summary Case Sheets. These tools would be used to identify deficiencies in EOC coverage and FRU performance.

(iii) Standardization of existing records will facilitate monitoring and identification and gaps in EOC availability. Specific areas requiring improvement are recording of :

- Time of admission, diagnosis/complaints (admission register)

- Time of intervention (case sheets and OT records)

- Whether complicated or normal delivery (labour room register)

(iv) District/FRU personnel should be briefed in the use of monitoring tools during EOC orientation or skills training. The briefing should include :

- Hands-on practice in filling forms using existing available records

- Explanation of how data can be used to identify specific gaps in EOC availability (e.g. equipment, staff skills, supplies)

MONITORING OPERATIONALISATION

A regular monitoring of progress on selected milestones would help in accelerating operationalisation of EOC at FRUs. The State Governments should , therefore , review the progress of operationalisation of FRUs with the State Programme managers in every quarter . Suggested activities which may be monitored are the following :

- Assure all sanctioned FRU posts are filled
- Choose sites for training of district hospital personnel
- Issue guidelines incorporating critical and essential EOC drugs in State approved drug list
- Allocate a proportion of existing drug budget for EOC drugs to ensure uninterrupted supply to FRUs.
- Allow family planning budget head drugs to be used for EOC cases also.
- Allocate a proportion of health budget to be used for maintenance of FRUs.
- Authorize (if necessary) non-specialist staff to be trained in and carry out EOC functions
- Orient State CSSM core team in plans for EOC skills upgradation
- Organize two-day orientation for district hospital specialists and OB-GYN and paediatric specialists from FRUs.
- Issue guidelines for FRU monitoring using select indicators.
- Assure standardization of existing records (admissions register, case sheets, OT records, labour room register)
- Publicize availability of EOC at FRUs.
- Include messages on obstetric complications in State and District IEC activities.

Notes on Funding :

(1) The CSSM outlays , as they have been approved by the Govt. of India , include provision of essential equipment to the identified FRUs of the districts pertaining to the six States of Assam,Bihar, M.P., Orissa, Rajasthan and U.P. Skill development training of the medical and paramedical workers of the FRU staff , however , will be funded under the CSSM Programme for all districts.

(2) The identified FRUs may also need minor upgardations in terms of physical facilities like repair/renovation of operation theatre , construction of latrines , provision of a generator to ensure

availability of power during operations etc. The CSSM programme has not made any provision of funds for such upgradation. Funds for such upgradation in these states, which would obviously be institution/district specific , would have to be made available from the Area Development Projects and/or Minimum Needs Programme.

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27.1.1993

FRU_____ District_____

ANNEX.I

SUMMARY INDOOR PATIENT SHEET

To be filled upon discharge for all indoor cases of pregnancy, delivery, abortion and puerperum
(This does not replace bedside ticket)

Identification data: Name_____ Age___ Parity ___
Husband'sName_____Village/Ward_____PoliceStation_____

Admission info: Date of admission_____ Time of admission_____ Booked/Unbooked
Referred by: Self/TBA/Private Doctor/Subcentre_____ PHC/CHC _____
Distance travelled_____ Time taken_____ Mode of transport_____

Discharge info: Clinical diagnosis_____ Result: expired/cured/relieved/absconded or LAMA
Delivered in hospital: Yes/No **Referred to**_____Date & time of discharge_____
(Fill up reverse)

Classification:

____ Normal pregnancy
____ Normal delivery
____ Normal abortion/MTP

____ Complic. pregnancy[1]: toxemia/APH/severe anaemia
others (specify) _____
____ Complic. delivery[2]: obstructed/prolonged/PPH/others (specify)_____
____ Complic. abortion: sepsis/incomplete/others (specify)_____
____ Complic. puerperum: sepsis/PPH/others (specify)_____

(Stop here if Normal case)

Chief complaints **(in chronology; state labour pains in hrs)** 1. 2. 3. 4.

Condition on admission:

GC: Good/fair/poor/gasping
Pulse _____
BP _____
Temp _____
Others _____

Systemic (Positive findings only):
PA:
PV:

First treatment: Date _____ Time_____
Type (i.e., parenteral drugs & fluids)_____

Definitive treatment: Date _____ Time_____
Type (i.e., conservative or operative)_____

Major treatments given:

Surgical procedures **(exclude routine episiotomy)**	Yes/No	C-section___ Laprotomy___ repair pereneal tear___uterine evacuation___MTP___ other (specify)_____
Medical procedures	Yes/No	I.V/I.M. drugs_____: antibiotics____ oxtocics____ sedatives____ others_____ I.V. fluids____ Plasma expander____
Blood transfusion	Yes/No	#ofunits_____ Source_____
Manual procedures	Yes/No	forceps____ vacuum extraction____ manual removal of placenta____
Anaesthesia	Yes/No	local____ general____ spinal____

[1] any pregnancy requiring operative intervention, transfusion, antibiotics, management of hypertension, bleeding, or any other significant medical condition.

[2] any delivery requiring operative intervention (excluding routine episiotomy), transfusion, antibiotics or management of hypertension, severe anaemia, unusual bleeding, obstructed/prolonged labour, or unusual presentation (including breech).

P.T.O.

Referral information

Patient referred to _____ for following reason(s):

A. Lack of medicines (specify)____

B. Nonavailability of personnel to perform:

Surgery_____
Anaesthesia____
Manual procedures____
Blood transfusion____

C. Lack of equipment needed to perform:

Surgery_____
Anaesthesia____
Manual procedures____
Blood transfusion____

To be filled by 2nd referral institution:

IPD #_____
Result: expired/cured/relieved/absconded or LAMA
Delivered in hospital: Yes/No
Date & time of discharge_____

Kindly return form to 1st referral institution.

ANNEX. II

Emergency Obstetric Care Monthly Monitoring Report

FRU_____ District_____ Month/Year_____

		1-month period	Cumulative
1.	Total maternity admissions	_____	_____
2.	Total complicated maternity admissions	_____	_____
3.	Total deliveries	_____	_____
4.	Total C-sections	_____	_____
5.	Total complicated abortion cases	_____	_____
6.	Maximum admission-intervention interval for PPH cases	_____	_____
7.	Total maternal deaths	_____	_____
8.	Total blood transfusions for obstetric cases.	_____	_____
9.	Referred to other institutions		
	A. Outdoor maternity cases	_____	_____
	B. Indoor maternity cases	_____	_____
	C. Total	_____	_____
10.	Outcome of referred cases from previous month reported referred institution:		
	A. Total reported	_____	_____
	B. Total where outcome was maternal **death**	_____	_____

Technical Comments on the activities of ICDS programme support from TVS Medical Unit Hosur.

This comment has been written after a single visit to the Anganwadi center of Government of TN that has the support of TVS unit at Hosur. Hence it is limited to what had been observed at the time of visit.

The Situation:
The village Kothaguntapalli is about few kms from Hosur Factory. The Anganwadi is one the centres of ICDS. There was a teacher and an ayah manning the children, A typical Anganwadi center with lackluster in various aspects, this is attached to the primary school of the village. There was a 'Salter Scale ' hanging in the middle of the room. (perhaps to indicate that the center was an Anganwadi) There were about 25 children, out of enrolment 35. It was about a month since the centre had been opened for the current year.

The strength of Anganwadi Positive points ;The Govt of TN had provided the teacher with the chart which is almost a ready- reckoner for the teacher to classify the children according to the nutritional status. Naturally the teacher lacked in depth understanding of the purpose of the chart, She merely records the wt and had mentioned that most of the children were normal or in grade1 Similarly the chart had been given for the weight for the expectant mothers, who are also the beneficiary of the centre. Both the charts did not show the reference standards. I could not check the weight recorded as the register was not in the class. The fact that an effort to help the teacher to record the weight, utilising the figures provided in the chart shows the concern of the authorities.

The Ration given to the children as per the Governmental instruction is as under

WEANING FOOD (as found on the label) Composition per 100 g.

Cereal (wheat/Maize/ Bajra------ 52 g
Ragi ------ 05 g
Bengal gram ---- 12 g
Jaggery ----- 30 g

Nutritional facts per 100g Calories 350 Protein 8.5 g

The ration permitted of the ready mix to the children . The processed powder is mixed with boiled and cooled water to make into laddoos

50 g ball for the under two yrs and 100 g balls for the above 2 yrs upto 5yrs. As soon as the children arrive the balls are served The under twos have the laddos and return with the mothers while the anganwadi children get the midday meal as well . The ration per child /day are as Rice 80 g , dhall 10 g- oil 2 g In addition on Mondays potatoes are given, Tuesdays Greengram Thursdays 1 egg while on Wednesdays and Fridays no additional item is provided .
Through this meal as per the calculation the children get 290 calories and 6.5 g Protein thus during the day with laddo and meal the anganwadi children get in total 640 calories (RDA 1230)
15 g Protein (RDA 25 g)

The food provided during the day gives about 50% of RDA and is quite good. According to the 'consultant' of the team the normal status children in the class is to the extent of 70-80% (!) But the Team had also taken the wt of children who do not attend the anganwadi class and the wt recorded shows children with normal wt also to the extent of 75 % What is the impact of the meal provided ?

My observations: The support given by the Government of TN in providing a ready reckoner is a good start. But beyond this there were no information whether the the children are given any vitamin /mineral supplements. Whether the medical checkup was done or not, was not known. The children looked rather weak and stunted in growth.Though it is difficult to weigh the children of that age certain care need to be taken during weight recording. Since we did not see any data of individual child's growth rate one does not know whether the normal child is on the borderline or well above. There was no individual weight card. When the children are getting the calorie gap filled in with the meal and laddoos, there should be some difference between the anganwadi and non-anganwadi attending children. Weight alone is inadequate to rate the child's nutrtional status. Some of the standards, recommended maintained in India and elsewhere are stated below.

Standards available to assess the nutritional status of the children :

On the recommendations of the WHO the standards of National Centre for Health Statistics (NCHS)is the reference point recommended in India. The median value of NCHS is taken as Indian reference standard (copies enclosed) Normally the classification of nutritional status are Ht for age wt for age as well as wt for **ht.**

1. According to Gomez standard the classification details are :

Normal	above 90% of Indian standard
I st degree mal-nutrition	75-90 %
II nd degree	60-75
III rd degree	<60 %

Reference is 50th centile

2 The Indian Academy of Pediatrics (IAP)

Normal	above 80%
I st degree	70-80 %
II nd	60-70
III rd	50-60
Iv th	< 50%

To confirm the nutritional status weight alone is inadequzte. Height for age is also essential and weight for ht as well as wt for age(refer to the table) A proper medial checkup need to be done at the beginnng to check for possible infection or infestation ,other factors that would inhibit the absorption of the nutrients by the body,

With the average availability of 650 calories even the mal nourished should be able to show some improvement and move up in the scale. Since the teacher appears to be not so trained in the technical details including the weighing of the child in the balance ,A close observation whether the children are eating what is served would give more information about the children and the instruction received from their mothers.

It is said that every child has the same growth potential if properly nourished. It us thus necessary as not to accept lower standards as "Indian "

With my handicap of limited information received on the spot, I make the following suggestion for the TVS team who are graciously supporting the Government's effort in the area of child development The suggestions are:

1. Check the scale used by the Anganwadi as the spring needs to be strengthened.
2. Weigh the children individually as to wt for age ,measure the ht for age with reference to the NCHS 50th centile (as per the chart) of the Anganwadi group and record their status. Measurement of arm-girth would be also useful if the doctors have the time. This data of individual child , the team could keep in their office and not share with the teacher till certain facts could be deduce

3 The teacher can continue her exercise. This can be corrected once the doctors ares sure of the data. For this reason a close supervision of the anganwadi school children need to be done'
As to their eating habits alertness and interest. A close observation of children's eating habit is required to find out whether they do get their share and consume the food served. This one of the team members can do continuously for a week or two during the meal time The same person should make enquiries about the food that is given by the mothers at home to compute the food availability for the growing child

4. Provide the medical check up for possible corrections if required

5. The children should be weighed periodically (once in three months) to observe the growth during the period and also see the difference between Anganwadi and outside.
6. To weigh the other children bathroom scale (platform type) should be avoided..
7. Conduct under two advisory centers as this age is very crucial to promote the potential growth factor in the child
8. To conduct this it should be considered as Health-nutrtion education programme.
   - 8.1 Select intelligent mothers and train them on few facts of nourishment and health care of the under two yrs, and make them as para- teachers/mother-teachers to teach minimum of five mothers in their peer group,

8.2 Conduct nutrition and health education classes to give a holistic information on water ,hygiene and food requirements

8.3 The clinical classes should be a positive under two Programme and not just cater to the sick children alone. This would enable the mothers to a understand and help in maintaining the weight chart as well as provide possible adequate nourishment at home

8.4 Encourage the mother- teachers to participate and help the anganwadi specially during meal time. This can be done by the selected mother-teachers in turn A comparative findings of local situation with that of anganwadi will be useful for other areas alsowhere anganwadi programme is executed. In TN

With time bound project the TVS team can show the way to organize Under Twos in Anganwadi centres

The above activities are only a suggestion to improve the condition of the children and the approach to anganwadi with TVS support.

0

Nutrition - quality / qty.

cont. eden.

✓ Anganwadi worker -

✓ Comm. participation - → Mother's motivation.

ICDS - ~~6~~ balwadis - 500 children

Recording methods / data entering.

Table 1: MedianValues (50th centiles) of Heights and Weights of Boys and Girls (0-60 months) — NCHS

Age	Boys		Girls	
	Height (cms)	Weight (kg)	Height (cms)	Weight (kg)
Months				
0	50.5	3.3	49.9	3.2
3	61.1	6.0	59.5	5.4
6	67.8	7.8	65.9	7.2
9	72.3	9.2	70.4	8.9
12	76.1	10.2	74.3	9.5
15	79.4	10.9	77.8	10.2
18	82.4	11.5	80.9	10.8
21	85.1	12.0	83.8	11.5
24	87.6	12.3	86.5	11.8
27	88.1	12.9	87.0	12.4
30	90.4	13.5	89.5	13.0
33	92.7	14.1	91.7	13.6
36	94.9	14.6	93.9	14.1
39	97.0	15.2	96.0	14.6
42	99.1	15.7	97.9	15.1
45	101.0	16.2	99.8	15.5
48	102.9	16.7	101.6	16.0
51	104.8	17.2	103.4	16.4
54	106.6	17.7	105.1	16.8
57	108.3	18.2	106.7	17.2
60	109.9	18.7	108.4	17.7
Years				
5.0	109.9	18.7	108.4	17.7
5.6	113.1	19.7	111.6	18.6
6.0	116.1	20.7	114.6	19.5
6.6	119.0	21.7	117.6	20.6
7.0	121.7	22.9	120.6	21.8
7.6	124.4	24.0	123.5	23.3
8.0	127.0	25.3	126.4	24.8
8.6	129.6	26.4	129.3	26.6
9.0	132.2	28.1	132.2	28.5
9.6	134.8	29.7	135.2	30.5
10.0	137.5	31.4	138.3	32.5
10.6	140.3	33.3	141.5	34.7
11.0	143.3	35.3	144.8	37.0
11.6	146.4	37.5	148.2	39.2
12.0	149.7	39.8	151.5	41.5
12.6	153.0	42.3	154.6	43.8
13.0	156.5	45.0	157.1	46.1
13.6	159.9	47.8	159.0	48.3
14.0	163.1	50.8	160.4	50.3
14.6	166.2	53.8	161.2	52.1
15.0	169.0	56.7	161.8	53.7
15.6	171.5	59.5	162.1	55.0
16.0	173.5	62.1	162.4	55.9
16.6	175.2	64.4	162.7	56.4
17.0	176.2	66.3	163.1	56.7
17.6	176.7	67.8	163.4	56.7
18.0	176.8	68.9	163.7	56.6

Ref : WHO. Measuring change in nutritional status. Guidelines for assessing the nutritional impact of supplementary feeding programmes for vulnerable groups. WHO, Geneva, 1983.

Table 2: Median Values (50th percentile) Weight for

Height (cms)	Expected Weight (kg)		Height (cms)
	Boys	Girls	
50	3.3	3.4	94
51	3.5	3.5	95
52	3.7	3.7	96
53	3.9	3.9	97
54	4.1	4.1	98
55	4.3	4.3	99
56	4.7	4.7	100
57	5.0	5.0	101
58	5.4	5.3	102
59	5.7	5.7	103
60	6.0	6.0	104
61	6.3	6.3	105
62	6.6	6.6	106
63	6.9	6.9	107
64	7.2	7.1	108
65	7.5	7.4	109
66	7.7	7.7	110
67	8.0	7.9	111
68	8.3	8.2	112
69	8.5	8.4	113
70	8.8	8.6	114
71	9.0	8.9	115
72	9.2	9.1	116
73	9.5	9.3	117
74	9.7	9.5	118
75	9.9	9.7	119
76	10.1	10.0	120
77	10.4	10.2	121
78	10.6	10.4	122
79	10.8	10.6	123
80	11.0	10.8	124
81	11.2	11.0	125
82	11.5	11.2	126
83	11.7	11.4	127
84	11.9	11.6	128
85	12.1	11.8	129
86	12.3	12.0	130
87	12.6	12.3	131
88	12.8	12.5	132
89	13.0	12.7	133
90	13.3	12.9	134
91	13.5	13.2	135
92	13.7	13.4	136
93	14.0	13.6	137

Ref : WHO. Measuring change in nutritional status. Guidelines for a supplementary feeding programmes for vulnerable groups. WHO, G

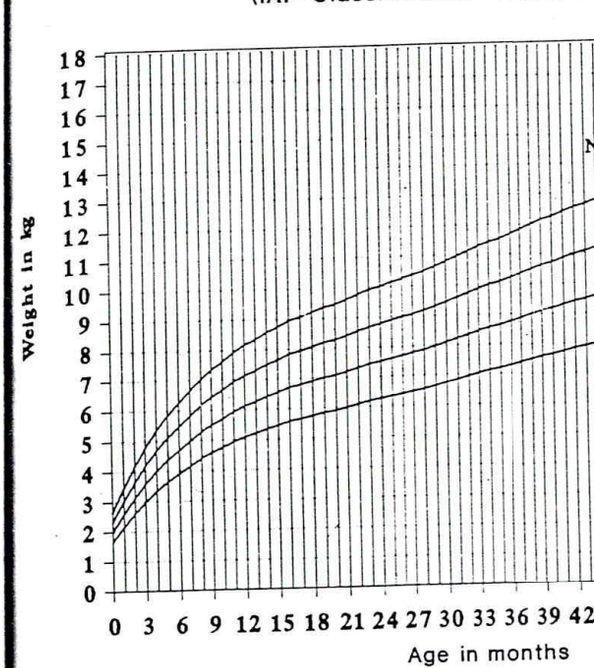
CLASSIFICATION OF NUTRITIONAL STATUS

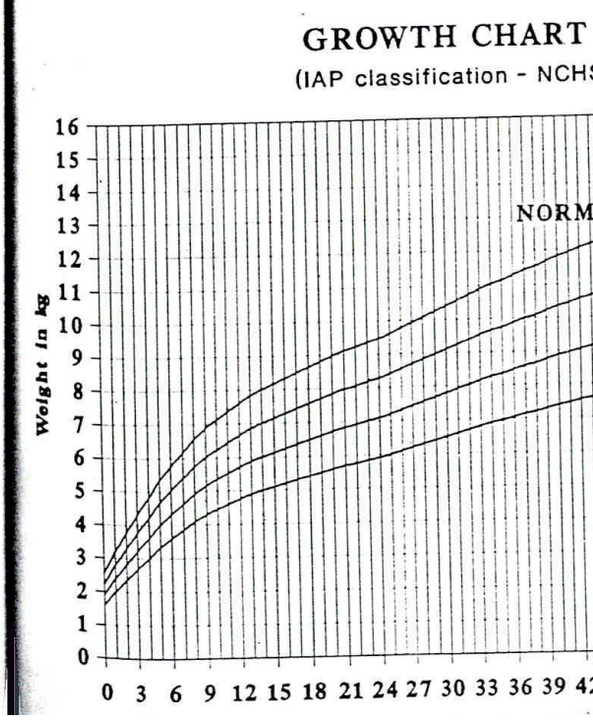
Relatively speaking, weight, height and arm circumference have come to be considered the most sensitive parameters for assessing nutritional status of under fives. Several methods have been suggested for the classification of nutritional status based on these measurements.

The anthropometric data can be expressed in a number of ways in relation to reference data: (a) by the use of mean and standard deviation values, (b) by calculating percentages of the median value of reference population which is assigned as 100 per cent, and (c) by comparing with percentiles of the reference data, where median value is the 50th centile.

Weight for Age

Various methods have been suggested to classify children into various nutritional grades using the body weights. The most widely used classification is the Gomez classification (Gomez et al., 1956), in which the children are classified as having first, second or third degree malnutrition if their weight for age is in the range of 75–90%, 60–75% or less than 60% respectively of the reference median. All children whose weight is 90% and above are categorised as normal. The selection of cut-off levels was based on the clinical/hospital experience in Mexico. Gomez et al. (1956) observed a marked difference in mortality during first 48 hours between children with second degree malnutrition (60-75% of median) and those with third degree malnutrition (< 60% of median). The Indian Academy of Paediatrics (IAP) recommends the following classification : 80%, 70–80%, 60–70%, 50–60% and < 50% as normal, first, second, third and fourth grade of malnutrition respectively (IAP, 1972). This classification is currently used by the Integrated Child Development Scheme (ICDS) for selecting beneficiaries and growth monitoring (Chart 1). As such, most of the classifications, based on weight for age use arbitrary cut-off points. Normal growth is considered to encompass values within two standard deviations of the mean. Since body weight does not follow Gaussian distribution, use of mean and standard deviations for classifying children into differenet grades of nutritional status may not be appropriate. To overcome these problems, Ramnath, et al. (1993), recommend use of 5th percentile of reference values as the cut-off point to classify children as normal and malnourished. They suggest that the weight below the 10th percentile values of the community (ICMR data) may be considered as indicative of severe degree of malnutrition. When these criteria were used, their analysis indicated that 80% of NCHS median appeared appropriate to decide whether children were normal or malnourished. The current criterion of 60% of reference median for grading the children as suffering from severe degree of malnutrition and 80% of reference median as cut-off between 'normals' and malnourished, appears to be the most reasonable. A summary of these classifications is given in Table-3.





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(KARNATAKA GROUP-I)

UDISHA - A DAWN IN ICDS TRAINING

The Training component of the ICDS Programme has now been recognised as the most important key to achieving the aims and objectives of the ICDS Training Programme, with the ultimate aim of moulding the ICDS functionaries into 'Agents of social and behavioural change'. Keeping in view the importance of the programme and its likely impact on the quality of the ICDS scheme, the administrative approval and guidelines for the implementation of the World Bank assisted ICDS Training Programme - Project - UDISHA have been issued vide Govt. of India letter No.:11-15/98-TR-I dt.19th May 1999. The Project Implementation Plan (PIP) for a period five years from 1st April 1999 has also been finalised and this is the basic working document for the implementing states, including Karnataka.

UDISHA envisages the upward revision of financial norms, integration and co-ordination of Training of ICDS functionaries and revision of Training Syllabus. The Southern Regional Centre of the National Institute of Public Co-operation and Child Development (NIPCCD) located at Bangalore is an apex body catering to the training needs of senior level ICDS functionaries like Asst. Directors/Programme Officers/CDPOs/ACDPOs etc., besides undertaking research and evaluation studies. During the current year NIPCCD has been requested to take up Evaluation of the 'Sandwich Training Programme for AWWs', 'Integrated approach to pre-school Education & Impact of Supplementary Nutrition in ICDS' etc.

There is only one Middle Level Training Centre (MLTC) at Ujire (Dakshina Kannada District) which is catering the Training needs of Supervisors. The State has 25 Anganwadi Workers Training Centres (AWTCs) which are run by KSCCW and other NGOs for training the AWWs & Helpers. The revised rates of honorarium as well as revised course grants as per the UDISHA guidelines have been sanctioned by the state Govt. during 1999-2000.

TRAINING STATUS OF ICDS FUNCTIONARIES AS ON 01.04.2000:-

	Sanctioned	In position	vacant	Trained	Untrained
CDPO	185	183	2	152	31
ACDPO	219	140	79	107	33
Supervisors	1862	660	1202	660	-
AWWs	40170	39277	893	38680	597
AWHs	40170	39890		27993	11897

The Physical & Financial progress achieved under project UDISHA during 99-2000 is as follows:-

I. *PHYSICAL PROGRESS:-*

Sl. No.	*ICDS Functionary*	*Trained during 1999-2000*	
		Trained in JTC	*Trained in RC*
1.	*CDPO*	*8*	*7*
2.	*ACDPO*	*9*	*13*
3.	*Supervisors*	*Nil*	*217*
4.	*AWWs*	*1999*	*6669*
5.	*Helpers*	*540 (OC)*	*Nil*

6. Sandwich Training for AWWs in 2 batches . 40+39 = 79 (AWTC Belgaum)

II. *FINANCIAL PROGRESS:-*

Budget Head of Account	*Opening Balance as on 1.4.1999*	*Grants released to the state during 1999-2000*	*Total grants available*	*Released to MLTC/ AWTCs during 1999-2000* + 3 workshops	*Balance with the State as on 1.4.2000*
2235-02-102-0-05	*3.26 Crores*	*1.15 Crores*	*4.41 Crores*	(1·70 Crores) Actual Expenditure increased 1·56 Crores 2·85 Crores approx.	(2·71 Crores)

STATE LEVEL TRAINING TASK FORCE:-

The Training component of ICDS has now been recognised as the most important key to achieve the aims and objectives of the ICDS Programme. The emphasis now is on quality improvement and enrichment of human resources available, with the ultimate aim of moulding the ICDS functionaries into agents of social and behavioural changes, convincing communicators who can effectively bring about the attitudinal changes required. Training of human resource development or capacity building (as it is other - wise known) assumes tremendous significance.

For regular monitoring and evaluation of ICDS training component the State Govt. has constituted the State Training Task Force vide its order dt. 25.04.98, with the following members:-

Director of Women and Child Development	*Chairman*
Regional Director, NIPCCD, Bangalore	*Member*
State Co-ordinator, ICDS, Central Technical Committee	*"*
Director, DPEP	*"*
Director, DSERT	*"*
Director, Health & Family Welfare	*"*
Asst. Technical Adviser, Food & Nutrition Board	*"*
Representative from KSCCW	*"*
Representative from MLTC, Ujire (on rotation)	*"*
Representative from UNICEF, Hyderabad	*"*
One CDPO (on rotation)	*Invitee*
One Supervisor (on rotation)	*"*
One Anganwadi Worker (on rotation)	*"*
Joint Director (ICDS)	*Convenor*

So far, three State Level Task Force Committee meetings were convened on 03.10.1998, 19.07.1999 and 12.01.2000 under the Chairmanship of the Director, Women and Child Development. The Proceedings of the above meeting are enclosed herewith for reference.

The basic function of Task Force is the integrate and co-ordinate all aspects of ICDS training at all levels and to recommend changes in the curriculum, strategies and methodology. The ultimate goal is to reorient and reutilise ICDS training to turn it into a dynamic responsive & human resource development programme.

For regular monitoring and evaluation of the ICDS Training Programme in the State, a STTF has been constituted vide Govt. Order No. DWCD:257/ICD/97 Bangalore dt. 25.04.98, for a period of two years. The tenure of this Task-Force has expired on 24.04.2000. Govt. has been requested to renew the same for another three years, i.e. upto 31.03.2004. Soon after the re-constitution / renewal, a meeting will be convened & syllabus revision in respect of Supervisors training is proposed to be taken up. A sub committee has also been constituted under the STTF to look into the revision of 30% module - based syllabus in respect of training of ICDS functionaries. The proposed revision in respect of JTC of AWWs has already been conveyed to the Govt. of India. (Copy enclosed)

State Training Action Plan for 1999-2000 included sensitization Programmes for Asst. Directors of Women & Child Development, Programme Officers of District ICDS Cells & Heads of MLTC/AWTCs. However formal approval of Govt. of India for conducting the above programmesis still awaited.

STATE TRAINING CALENDER:-

1. *15 CDPOs have been deputed to NIPCCD, Bangalore for Job Training with effect from 2nd May 2000. (copy enclosed)*
2. *a) Supervisors have been deputed to MLTC Ujire for 2 Refresher Courses commencing from 24.04.2000 & 08.05.2000 @ 25 per batch. (copy enclosed)*

   b) The appointment of Supervisors in the State has been delayed, on account of a pending court decision on additional marks to be allotted to rural candidates.

3. *The Training Calendar for 25 AWTCs, in the State has been finalised for the first quarter of the current year . (copy enclosed)*

STATUS OF RE-IMBURSEMENT CLAIMS:-

1. *The re-imbursement claims in the prescribed proforma are being finalised in two phases.*

a) From 4th October 98 to 31st march 1999.
b) From 1st April 99 to 31st March 2000.

Item wise details of expenditure have been called for from each training Centre / District Office and will be sent to Govt. of India shortly.

STATE TRAINING ACTION PLAN FOR 2000-2001.

(Other than regular training of ICDS functionaries)

1. *Vertical Workshop & Meeting (Taskforce ADs & POs meeting, AWTC & MLTC & other review meeting)*	-	*1,00,000*
2. *Crash course for statistical Assistants in consolidation of reports*	-	*8,00,000*
3. *Advocacy programme*	-	*15,00,000*
4. *Exposure tours*	-	*3,00,000*
5. *Talukwise training to Anganwadi workers regarding utility of Activity Bank*	-	*12,00,000*

6.	*Research study at AWTC / MLTC*	-	*6,00,000*
7.	*Training to elected Gram Panchayat Women Members*	-	*10,00,000*
8.	*Development of Resource Material in local language*	-	*45,00,000*
	Total		*1,00,00,000*

Director
Women and Child Development
Bangalore

1813 CH.OBS

National Programmes for Child Health

Integrated Child Development Service Scheme

GOM 1-22-1 (1)

- 1971 census – 228 million children upto 14 yrs [115 m upto 6 yrs / 113 m 7–14 yrs]

urban 42m / rural 186m

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- problem —
  - ↑ infant mortality
  - ↑ inci of malnutr.
  - GI tract infections
  - faulty + unsatisfactory dietary habits < food / prop.

So long there was only a sectoral approach to the needs of children. If an integrated service can be provided for the physical, mental + social devⁿ in early childhood, particularly to the weaker sections of the community, then wastage arising from infant mortality, physical handicaps, malnutr. stagnation in schools + poor development of mental capacities can be minimised. This integrated service sld be regarded as an investment in the future economic + social progress of the country.

In 1972, ministry for Planning suggested a scheme for ICDS. It was started formally on 2nd Oct 1975 in 30 Blocks.

- Objectives ① Improve nutritional + health status of 0–6 yrs
② Lay foundation for proper physical + social devⁿ of the child.
③ ↓ incidence of mortality, morbidity, malnutⁿ + school drop out.
④ achieve effective coordination of policy + implementⁿ between various Depts to promote child develop.
⑤ Enhance capability of mother to look after child.

- "Package of Health" – integrated + coordinated service.
ICDS package – ① supplementary nutrition ② Immunization
③ Health checkup ④ Referral service ⑤ Nutrition + health education ⑥ Pre-school education ⑦ Rural drinking water supply integrated with ICDS.

Beneficiaries – ① Pre-school child
② Mothers (15–44 yrs) – needed for proper devⁿ of child.

Beneficiary	Service
i) Expectant + nursing ♀	Health checkup / Suppl. nutrition / Tetanus / Nutrⁿ + Hlth educⁿ
ii) Other ♀ 15–44 yrs	Nutrⁿ + Hlth educⁿ
iii) Infants	Suppl. nutr., Immuniz., Hlth checkup, ref. services
iv) Children 1–2 yrs	– " –
v) Children 3–6 yrs	– " – + preschool non-formal education.

Supplementary nutrition – processed foods, foods prepared +

II) Nutrition Education – use of mass media, campaigns to saturate area, home visits by Anganwadi workers, short organized courses for 30 ♀, feeding + cooking demonstrations.

III) Immunization – SP, TB, D.P.T, OPV, – tetanus + typhoid for <6yr, Tetanus for ♀. Local PHC responsible for immuniz schedule – 0-3 mths – SP + BCG
3-6 " – DPT I
7-9 " – DPT II
12-18 – DPT booster, (SP)
5-6yrs – DT booster

IV) Health checkup – antenatal, postnatal, care of children <6yrs – U3 – record of ht + wt, milestones of growth + dev, Imm:, general checkup every 3-6mths, Rx of common ailments, deworming + prophylaxis by suppl: nutrition, refer serious cases to Dist. Hospital.

V Pre-school Non-formal educ: – children 3-5 yrs educated by institution of "anganwadi" + run by voluntary or govt. The anganwadi is the focal point for delivery of ICDS services. Nonformal / informal educ: does not mean formal learning, but exciting the curiosity of the child, development of its attitude + behavior patterns. Playthings made locally.

The anganwadi can be easily started with readily available "Balsevikas" who are already trained or a local ♀ with some educational qualification can be trained for 3 mths + given charge.

Functions of anganwadi workers –
1) Nonformal preschool education for 40 children of 3-5 yrs. Toys + play equipment etc should be rural in character.
2) Organising suppl nutrition programme for children/mothers
3) Giving health + nutrition education to ♀
4) Making home visits for educating parents, children.
Inducing ♀ to develop her child better.

– x –

Nutrition – Vit A for all <6yrs every 6 mths
oral drops 2 lakh IU. 66,000 μg.
– Iron + folic acid, Vit A + D, Calcium, Vit C.
– Mid-day school meal – high school
\ Balwadi

National programme for prevention of blindness – started in Nov 1976 – 80 mobile units each catering to a cluster of 5 contiguous districts – comprehensive eye health care approach.

National Goitre control Progr – 1962 – provision of [illegible] salt – plants by UNICEF.
[illegible] programme –

Applied nutrition programme

UNICEF is assisting in the implementation of the Applied Nutrition Programme in the form of implements, seeds, manure & water supply equipment. Wherever land is available the facilities provided by UNICEF shd be utilised in developing school gardens. The produce maybe utilised in developing school gardens. The produce maybe utilised in the school feeding programmes as well as for nutrition education.

MCH/FP service organiz:-

Rural - PHC - ANM/LHV.
Urban

National Programmes in Nutrition -

I Progs designed to improve the overall nutritional status
a) Applied Nutrition Programme
b) Supplementary feeding programmes.
c) Midday meal progr. for school children.

II Prog's aimed at overcoming specific deficiency diseases.
a) National goitre control progr.
b) Vit A prophylaxis progr.
c) Iron + folate distri - progr.

III Other
a) Integrated child Development Scheme
b) India Popul: Progr.

① Applied Nutrition progr.
- 1963 Govt of India aided by UNICEF, FAO, WHO
- to improve nutri. of preg. + nursing mothers + children.
- to stimulate the prod: of protective foods such as eggs, fish, milk, veg + fruits + by means of H.E. to promote their consumption by mothers + children who are the nutritionally vulnerable grp.
HE is an imp component - to teach the village people how they can increase + improve their food supply through their own efforts
- Trains various categories of personnel eg rural health workers, teachers, doctors, youth + women leaders.
- As one of the largest single prog's assisted by UNICEF in many countries
- More than 700 C.D.B in the country have been in the progr. for 5 yrs or more
- NO made the expected impact.
-

② Supplementary feeding programmes -
- eg Special Nutri- Progr. (SNP) for preschool children - 6 mths to 3yrs of age. - since Nov 1970
approaches (a) on the spot feeding of cooked food ready to eat preparation. In (b) the ... beneficiaries ...

3) Mid day meal progr.
- operating in many parts since '62-63 after being first organized in TN in 1957
- nearly 12 million children covered in '74 + 16 million expected to be covered in 1979.
- Two basic objectives are - improvemt in nutritional status + imparting nutr. edu.
- National Institute of Nutrition - Hyderabad.
+ National Nutrition Monitoring Bureau.

A no. of agencies are involved in the above progr.
- Dept. of Social welfare, Dept of Educ, Dept of Rural Dev, Dept of Health & Family Welfare + FAO, UNICEF, CARE, WHO + World Food Progr.

Child welfare agencies - (1) Indian Council for child welfare ICCW (2) Central Social welfare Board (3) Indian Red Cross Society (4) Kasturba gandhi Memorial Trust.

Activities - Daycare centres, Balwadis, - Nurseries, Recreation facilities - parks, libraries, play centres, Bal bhavans, films, Holiday homes

ICCW - since 1952, affiliated c International Union for child welfare - Network of State + District councils - services necessary for children to develop physically, mentally, morally, spiritually + socially.

Central Social welfare Board - Since Aug 1953. Functions in the 1) surveying needs + reqmts of vol. welfare organizations in the country (2) promoting + setting up social welfare organiz's on a vol. basis. (3) giving financial aid to deserving existing organizations + institutions. Semi official. Since 1958 "family + child welfare services in rural areas - teaching craft, social educ, literacy classes, maternity aid for women, distr. of milk, balwadis, organiz of play centres for children. under Ministry of Educ.

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Rep

Results of National Evaluation of ICDS (Various studies)

Nutrition :

- Adequate intake of all nutrients except Vit. A(1981, Singhal)
- Intake of protein was low (Joshi 1977)
- Caloric gap of 400-500 (Jyoti Kumari 1985)
- Improvement in severe malnutrition but not much impact on mild and moderate malnutrition.
- Rapid decline in Xerophthalmia over a period of two years in Tamil Nadu (Chandra 1984) due to ICDS.
- Malnutrition was attributed to various factors like poor socio-economic conditions, inadequate health & nutrition education, faulty weaning practices, lack of ante-natal care, low birth weight, repeated pregnancies, superstitions and beliefs, large sized families and insanitation (Bapat 1983)
- 90% had very poor home stimulation in terms of availability of toys, games and reading materials and provision of affection and warmth (Jyothi Kumari 1985)
- Taste important factor in quality of supplement consumed.
- The nutritional status of pre-school children improved and their level of Hb increased after deworming and or introducing suppl. Nutrition and iron therapy (Soundarajan 1985)
- Breast feeding, weaning at an early age and complete immunization identified as important determinants of nutritional status (Kamala 1985) & protection against diseases, IMR in every breast-fed and weaned infant was low (Mathur 1983).
- Anthropometric measurements indicated chronic malnutrition among the expectant mothers. 75% showed nutritional deficiency and 93% anemic and had inadequate intake of mineral and vitamins.

Immunization

- Only 52% mothers adhered to the immunization schedules. Reasons were ignorance, indifferent attitude, lack of awareness regarding schedule, non-availability of vaccines, fear of side effects, inconvenient timings (& fixed days) and long distances to be travelled (Khanna 1983)
- Not much studies on TT coverage of women.

Health And Nutrition Education (HNE)

- It was reported that HNE rarely conducted by AWW and only a small percentage of AWWs were rated satisfactory on skills in planning and implementation of HNE (Sharma 1986).
- Treatment by mothers of diarrhea improved where ORS was used or home based fluids.

Tackle the following issues :

- Women's low status and lack of decision making power → Empowerment.
- Information to recognize the signs of complications → Health education.
- Able to access care when complications develop → referral.
- Resources to reach an appropriate care facility in time → transportation.

Key lessons of past decade.

- Risk approach does not help to predict which women will develop complications and which women will not.
- Use of family planning methods does reduce unwanted pregnancies.
- Training of TBA's has not reduced MMR as they cannot handle emergencies/complications.
- The limited procedures carried out in the name of ANC and PNC have had little impact in lowering Maternal Mortality and morbidity. These services are more for the infants than for women. (paradigm shift to avoid turning two sets of distinct and legitimate needs into competing demands for appropriate care.
- More resources on ANC than into delivery and immediate post partum care, emergency obs. care and safe abortions.

Making every maternal death count :

- Improving / upgrading emergency obs.services.
- Training of professionally recognized community and facility based midwives, (including post partum care).
- Provision of safe, legal abortion services. (reason for1 in 6 global maternal deaths).
- Strengthening of private care to improve women's general health, beneficial ANC, PPC, FP, HE on pregnancy and its complications.
- Gradually replace TBA's with trained midwives n the community.
- Chronic maternal morbidity also to be tackled (poor repair of episiotomy and perineal tears, vesico-vaginal fistula and utero-vaginal **prolapse)**

Measuring Maternal Mortality (impact indicator)

- Sisterhood method/surveys (asking respondent about sister's birth histories, number reaching adulthood, number who have died, age at death, year in which death occurred, and years since the death, etc)
- Verbal autopsy.
- RAMOS (Reproductive age Mortality study)
- Confidential enquiries (ideal)
- Maternal Death Review (recommended by WHO for selected health facilities).

Impact indicators difficult to measure. So process indicators, which provide information on the actions to be taken to improve the situation. They are affordable and reflect changes immediately (responsiveness).

Table 1 (pg 26)

Improvement in safety of caesarians

Legalization of abortions and provision of safe services.

Leadership of midwives and obg. Specialists for better training and services.

Maternal deaths **audits.**

Community Participation

- Low or marginal community participation.
- ICDS functionaries also did not perceive the importance of community participation.
- Low level of community participation was attributed to lack of awareness and knowledge of ICDS scheme, ignorance, poverty, lack of time on the part of villagers, inadequate training of AWW, lack of transport facilities, etc (Ramdev 1982).
- Factors considered critical for strengthening and promoting community participation were, skills of the worker in eliciting community participation, existence of coordination committees, frequency of their meetings and involvement of local organizations. (Sharma A. **1986)**

Source : Preventing Maternal Mortality Evidence, Resources, Leadership, Action. Safe Motherhood Initiatives, RH Matters 1999.

Maternal Mortality

International conference on Population and Development in Cairo 1994, ICPD + 5 in 1999 at New York decided that Governments agree to reduce MMR by year 2000 of half of 1990 levels and at 2015 by a further half.

Key essential obs care

- Basic EOC - Parenteral antibiotics, parenteral oxytocic drugs, parenteral anti-consulsants, manual removal of placements, removal of related products and assisted regional delivery. (could be provided at community level also).
- Comprehensive EOC above and surgery (caesarian) and blood transfusion.

Reasons for decline in Developed countries.

↓ Levels of poverty

↑ Living conditions

Better nutrition

Greater autonomy of women

↑ Standards of OBG.

Aseptic practices in assisting deliveries.

Drugs to combat sepsis, eclampsia & Haemorrhage

Lower fertility rates by birth control