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1: Am J Clin Nutr 2001 Jan;73(1):53-60

[Related Articles, Books, LinkOut](#)

Anthelmintic treatment of rural Bangladeshi children: effect on host physiology, growth, and biochemical status.

Northrop-Clewes CA, Rousharn EK, Mascio-Taylor CN, Lunn PG

Human Nutrition Research Group, School of Biomedical Sciences, University of Ulster, Coleraine, Northern Ireland, United Kingdom.

BACKGROUND: The effect of helminth infestation on the nutrition, growth, and physiology of the host is still poorly understood. Anthelmintic treatment of children in developing countries has had varying success in terms of growth improvements. **OBJECTIVE:** The objective of this study was to assess the effect of regular deworming on child growth, physiology, and biochemical status. **DESIGN:** The study was a 12-mo longitudinal intervention in 123 Bangladeshi children aged 2-5 y. Treatment (mebendazole) or placebo tablets were administered every 2 mo for 8 mo and again at 12 mo. Weight, height, midupper arm circumference, intestinal permeability, plasma albumin, alpha(1)-antitrypsin, and total protein concentration were assessed every 2 mo. **RESULTS:** Treatment with mebendazole reduced the prevalence of *Ascaris lumbricoides* from 78% to 8%, of *Trichuris trichiura* from 65% to 9%, and of hookworm from 4% to 0%. There was no significant difference in the growth of treated children compared with those given placebo tablets. No changes in intestinal permeability or plasma albumin were observed after deworming. Significant decreases in total protein ($P=0.001$) and alpha(1)-antitrypsin ($P=0.001$) were observed in the treatment group, independent of infection status. Serum immunoglobulin concentration after deworming. A significant increase in the prevalence of *G. intestinalis* (from 4% to 19%) in the treatment group was associated with a short-term reduction in weight ($P=0.02$) and higher intestinal permeability ($P<0.001$) in infected subjects. No long-term effects of *G. intestinalis* on growth were observed. **CONCLUSION:** Low-intensity helminth infections, predominantly of *A. lumbricoides* and *T. trichiura*, do not contribute significantly to the poor growth and biochemical status of rural Bangladeshi children.

Publication Types:



Publication Types:
Clinical trial
Randomized controlled trial

PMID: 10694769

- 5: *Trop Med Int Health* 1999 Nov;4(11):744-50
Related Articles, Books, LinkOut

The impact of population level deworming on the haemoglobin levels of school children in Ifuga, Tanzania.

Beasley NM, Tomkins AM, Hall A, Kihania CM, Loni W, Nduma B, Issae W, Nokes C, Bundy DA

Wellcome Trust Centre for the Epidemiology of Infectious Diseases, University of Oxford

The impact of albendazole (100 mg) and praziquantel (40 mg/kg body weight) treatment of school children was compared with placebo according to the presence of anaemia (haemoglobin concentration < 11.0 g/dl) and heavy (> 5000 epg) or light (< 5000 epg) hookworm egg load. The study was conducted in rural Ifuga. Medication was administered in September 1994 and children were followed up in January 1995. Overall, anthelmintic treatment reduced the fall in haemoglobin concentration compared with that observed in the placebo group (-0.11 g/dl vs. -0.35 g/dl, $P=0.02$). Anthelmintic treatment was of greatest benefit to the 9% of children with both anaemia and heavy hookworm egg load ($+0.67$ g/dl vs. -0.67 g/dl) and was also of significant benefit to the 38% of children with anaemia and light hookworm egg load ($+0.07$ g/dl vs. -0.21 g/dl). It was of no significant benefit to children who were not anaemic. This study suggests that single-dose anthelmintic treatment distributed in schools in this area achieves haematological benefits in nearly half of children infected with *S. haematobium* and geohelminths (37% of total population).

Publication Types:
Clinical trial
Randomized controlled trial

PMID: 10588768

- 6: *Int J Epidemiol* 1999 Jun;28(3):591-6
Related Articles, Books, LinkOut

A controlled evaluation of two school-based anthelmintic chemotherapy regimens on intensity of intestinal helminth infections.

Albonico M, Stoltzius RJ, Savioli L, Chwaya HM, d'Harcourt E, Tielisch JM

Ivo de Carneri Foundation, Milan, Italy.

BACKGROUND: School-based deworming programmes have been promoted as a cost-effective strategy for control of nematode infection in developing countries. While numerous efficacy studies have been conducted, there is little information on actual programme effectiveness in areas of intense transmission. **METHODS:** A randomized trial of a school-based deworming programme was conducted in 12 primary schools on Pemba Island, Zanzibar. Four schools each were randomized to control, twice a year deworming with single dose mebendazole or three times a year deworming. Baseline and 12-month follow-up data on helminth infection using the Kato-Katz technique, demographic information and nutritional status were collected on 3028 children from March 1994 to May 1995. **RESULTS:** Intensity of infection measured as eggs per gram of faeces (epg) declined significantly for *Ascaris lumbricoides*, *Trichuris trichiura* and hookworm infections in both treatment groups. *A. lumbricoides* infection intensity declined 63.1% and 96.7% in the twice and three times per year treatment groups compared to the controls. *T. trichiura* infection intensity declined 40.4% and 75.9% respectively and hookworm intensity declined 35.3% and 57.2% respectively compared to control schools. **CONCLUSIONS:** These results suggest that school-based programmes can be a cost-effective approach for controlling the intensity of intestinal helminth infection even in environments where transmission is high.

Publication Types:

- Clinical trial
- Multicenter study
- Randomized controlled trial

PMID: 10405869

7: Adv Parasitol 1999;42:277-341

[Related Articles, Books, LinkOut](#)

Control strategies for human intestinal nematode infections.

Alborico M, Crompton DW, Savioli L

Scientific Committee, Ivo de Carneri Foundation, Torino, Italy.

In recent years significant progress has been made in understanding the ecology, epidemiology and related morbidity and development of new tools for the control of soil-transmitted helminths. Such knowledge has recognized the impact of helminth infections on the health of infected groups and has created a rational basis for their control. Schoolchildren harbour some of the most intense helminthic infections, which produce adverse effects on health, growth and scholastic performance. However, although great effort has been put into targeting school-age children, women of child-bearing age and pre-school children are two other groups at high risk of morbidity due to intestinal nematode infections. Highly effective and safety-tested, single-dose anthelmintic drugs are now available, permitting periodical deworming of school children and other high-risk groups at affordable prices. Four anthelmintics against all intestinal nematodes are included in the WHO Essential Drug List (albendazole, levamisole, mebendazole and pyrantel). Recently ivermectin has also been registered for use against *Strongyloides stercoralis* in

Vitamin A supplementation but not deworming improves growth of malnourished preschool children in eastern Zaire.

Donnen P, Brassier D, Dramaix M, Vertongen F, Zbindela M, Muhairwa M, Haumart P

School of Public Health, Free University of Brussels (ULB), Brussels, Belgium.

A randomized controlled trial was conducted in eastern Zaire to assess the effects of high dose vitamin A supplementation and regular deparasitation on the growth of 358 moderately malnourished preschool children, discharged from the hospital. The treatment groups received either vitamin A (60 mg of oily solution of retinyl palmitate, 30 mg if aged <12 mo) every 6 mo or mebendazole (500 mg) every 3 mo; the control group received no supplementation. Anthropometric data were gathered at baseline and after 6 and 12 mo of follow-up. Serum retinol concentrations were measured at baseline and after 3 mo. The three groups did not differ in sociodemographic indicators, age and sex composition, nutritional status and serum retinol concentrations at baseline. In children who were vitamin A deficient at baseline, adjusted mean weight and mid-upper arm circumference (MUAC) increments were higher in the vitamin A-supplemented group than in the control group [annual increment in weight and MUAC in vitamin A vs. control group: 2.088 vs. 1.179 kg ($P = 0.029$) and 2.24 vs. 0.95 cm ($P = 0.012$), respectively], whereas growth increment did not differ between the dewormed group and the control group. In children who were not vitamin A deficient at baseline, growth increment did not differ between the vitamin A-supplemented and control groups, whereas weight gain was lower in the dewormed group than in the control group. Vitamin A-supplemented boys gained more weight and height than control boys, whereas vitamin A-supplemented girls gained less height than control girls. Dewormed boys and girls gained less weight than control boys and girls. Programs to improve vitamin A status by high dose vitamin A supplementation may improve growth of preschool children who are vitamin A deficient, whereas deworming does not.

Publication Types:

Clinical trial

Randomized controlled trial

PMID: 9687551

10: Am J Clin Nutr 1998 Jul;68(1):179-86

[Related Articles, Books, LinkOut](#)

Effects of the Zanzibar school-based deworming program on iron status of children.

Stoltzfus RJ, Albonico M, Chwaya FM, Tielsch JM, Schutze KJ, Savioli L.

Center for Human Nutrition, Department of International Health, The Johns Hopkins School of Public Health, Baltimore, MD 21205, USA. rstoltzf@jhsph.edu

We evaluated the effects of the Zanzibar school-based deworming program on the iron status of primary school children. Parasitologic and nutritional assessments

1002), 1 school in which students received twice-yearly deworming (n = 952), and 4 schools in which students received thrice-yearly deworming (n = 970) with 500 mg generic mebendazole. Schools were randomly selected for evaluation and allocated to program groups. Relative to no treatment, thrice-yearly deworming caused significant decreases in protoporphyrin concentrations and both deworming regimens caused marginally significant increases in serum ferritin concentrations. The average annual changes in protoporphyrin concentrations were -5.9 and -23.5 micromol/mol heme in the control and thrice-yearly deworming groups, respectively (P < 0.001). The average changes in ferritin concentration were 2.8 and 4.5 microg/L, respectively (P = 0.07). Deworming had no effect on annual hemoglobin change or prevalence of anemia. However, the relative risk of severe anemia (hemoglobin < 70 g/L) was 0.77 (95% confidence limits: 0.39, 1.51) in the twice-yearly deworming group and 0.45 (0.19, 1.08) in the thrice-yearly deworming group. The effects on prevalence of high protoporphyrin values and incidence of moderate-to-severe anemia (hemoglobin < 90 g/L) were significantly greater in children with > 2000 hookworm eggs/g feces at baseline. We estimate that this deworming program prevented 1260 cases of moderate-to-severe anemia and 276 cases of severe anemia in a population of 30,000 school children in 1 y. Where hookworm is heavily endemic, deworming programs can improve iron status and prevent moderate and severe anemia, but deworming may be needed at least twice yearly.

PMID: 9665112

11: East Afr Med J 1998 Jan;75(1):16-8

[Related Articles, Books, LinkOut](#)

Prevalence of intestinal parasites in Kenyans with dyspepsia.

Ogutu EO, Karja C, Kang'ethe SK, Nyong'o A

Department of Medicine, University of Nairobi, Kenya.

Dyspepsia and intestinal worm infestation are both common clinical conditions in a developing country like Kenya and thus this study was designed to look at the correlation between the two in a referral gastroenterology clinic at Kenyatta National Hospital. One hundred and twenty five patients with dyspepsia had their stool, duodenal aspirate and duodenal biopsy analysed for evidence of intestinal parasites. Seven (5.6%) were found to have various types of intestinal parasites with giardia lamblia comprising 42.8% of worms isolated. 71.4% of patients with dyspepsia and worm infestation had their symptoms improved after deworming, but the low prevalence of intestinal parasite in dyspeptic patients makes routine deworming not cost effective. Stool examination had the best yield for intestinal parasites.

PMID: 9604529

12: Eur J Clin Nutr 1997 Nov;51 Suppl 4:S16-21

[Related Articles, Books, LinkOut](#)

Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention, Atlanta, Georgia, USA.

Various approaches to improving iron status are discussed. Success in controlling iron deficiency worldwide will require the exploration and demonstration of all possible options. The approaches, which are not mutually exclusive, include iron supplementation, nutrition education, reducing intestinal parasites (particularly hookworm), expanding fortification of processed foods, and developing crops that are more iron bioavailable. Coordination with existing health and nutrition programs can enhance progress toward better overall nutrition. For example, in the development of food fortification or of crops with higher nutritional value, the combination of multiple micronutrients can be considered. Within the primary health care system, iron supplementation and deworming can be coordinated with other health care activities. The ultimate success in control of iron deficiency will depend on how well the various intervention approaches can be integrated within the current framework of public health, food processing, and agriculture development.

Publication types:

Review
Review, tutorial

PMID: 9598788

13: J Nutr 1997 Nov;127(11):2187-93

[Related Articles, Books, LinkOut](#)

School-based deworming program yields small improvement in growth of Zanzibari school children after one year.

Stoltzfus RJ, Albonico M, Tetsch JM, Chwaya HM, Savioli L.

Center for Human Nutrition, Department of International Health, The Johns Hopkins School of Public Health, Baltimore, MD 21205, USA.

Efficacy trials of antihelminthic therapies conducted in Africa have reported improvements in children's growth, but nutritional evaluations of large-scale deworming programs are lacking. We evaluated the first-year effect on growth of a school-based deworming program in Zanzibar, where growth retardation occurs in school children. Children in four primary schools were given thrice-yearly mebendazole (500 mg) and compared with children in four schools that received twice-yearly mebendazole and children in four non-program schools. Evaluation schools were randomly selected and allocated to control, twice-yearly or thrice-yearly deworming. Approximately 1000 children in each program group completed the 1-y follow-up. Children <10 y old gained 0.27 kg more weight ($P < 0.05$) and 0.13 cm more height ($P = 0.20$) in the twice-yearly group, and 0.20 kg

more weight ($P = 0.07$) and 0.20 cm more height ($P < 0.01$) in the thrice-yearly group, compared with the control group. Children <10 y old with higher heights-for-age at baseline had higher weight and height gains in response to deworming. In children >10 y old, overall program effects on height or weight gains were not significant. But in this age range, younger boys had significant improvements in height gain with thrice-yearly deworming, and children with higher

dealing of children and health education. A control program based on these principles was initiated in the estate sector after this study was completed.

PMID: 8771940

17: Pediatrics 1996 Jun;97(6 Pt 1):871-6

Related Articles, Books, LinkOut

Effect of removing *Ascaris* on the growth of Guatemalan school children

Watkins WT, Pollitt E

Department of Pediatrics, University of California, Davis 95616, USA.

OBJECTIVE. To determine whether successful deworming for 6 months in children with high levels of *Ascaris* improves physical growth. **SUBJECTS.** Two hundred twenty-eight children (mean age, 9.7 years) in a highland Indian town in Guatemala. **DESIGN.** Children were randomly assigned to receive albendazole or placebo at baseline and 12 weeks. Children and field workers were both blind to the group assignment. **CURIOUS MEASURES.** Children's heights, weights, and mid-upper-arm circumferences were measured at baseline and 12 and 24 weeks. Fecal egg counts were taken at 0, 2, 12, 14, and 24 weeks to estimate the helminth burden (eggs per gram of feces [epg]). **RESULTS.** Baseline helminth prevalences were *Ascaris*, 91%, and *Trichuris*, 82%. *Ascaris* intensities were high: half of the children had moderate burdens (10 000 to 50 000 epg), and 25% had heavy burdens (> 50 000 epg). *Trichuris* burdens were light (72% < 1000 epg). The albendazole and placebo groups did not differ at baseline in epg, age, anthropometry, or socioeconomic status. The two rounds of treatment successfully reduced the *Ascaris* burdens but had less effect on *Trichuris*. At 6 months the treatment group showed a small gain in weight (0.18 kg) compared with the placebo group but no improvement in height or mid-upper-arm circumference. **CONCLUSIONS.** The successful removal of *ascaris* in a population of school-aged children with relatively high loads may have modest effects on weight gain. *Ascaris* is one of the most common infections in school-aged children, but its effect on the host may be less than that of other helminths.

Publication Types:

Clinical trial

Randomized controlled trial

PMID: 8657529

18: Trans R Soc Trop Med Hyg 1996
Mar-Apr;90(2):156-61

Related Articles, Books,
LinkOut

The effects of deworming on indicators of school performance in Guatemala

Watkins WT, Cruz IR, Pollitt E

Intestinal helminths are among the most common infections in school-age children. Of 246 children, aged 7-12 years, attending school in rural Guatemala, 91% carried *Ascaris lumbricoides* and 82% carried *Trichuris trichiura*. These children were randomly assigned to receive either albendazole or placebo at 0 and 12 weeks in a double-blind study of the effects of deworming on indicators of school performance. Albendazole successfully rid the children of *Ascaris* but it was less effective against *Trichuris*. The children's performance in tests of reading and vocabulary were measured at 0 and 24 weeks, the Penbody picture vocabulary test was given at 24 weeks, and attendance was measured throughout the school year. Comparison of the treated and placebo groups showed no positive effect of deworming. The treated children were largely free of *Ascaris* for at least 6 months, but during that period we could not detect any improvement in reading, vocabulary, or attendance. The effects of being *Trichuris*-free were not examined because of the limited effectiveness of albendazole against this worm at the dosage used.

Publication Types:

Clinical trial

Randomized controlled trial

PMID: 8761577

19: World Health Forum 1996;17(4):367-8

[Related Articles, Books, LinkOut](#)

More nutrients, fewer parasites, better learning

Gopalchis T

Tira Consultancy Services, Nagavaraipalaya, Bangalore, India.

By 1997 it is intended that all of India's 160 million primary-school children will be given a free daily midday meal. Since 1994 almost 3 million such children in Gujarat, already benefiting from this initiative, have been receiving, in addition, supplements of iron, iodine and vitamin A, and deworming treatment with albendazole. As a consequence there have been significant, highly cost-effective and sustainable improvements in growth rates and haemoglobin levels, and

decreases in the prevalence of ocular signs of vitamin A deficiency and in intestinal parasitic infections.

PMID: 9060232

20: Ann Dermatol Venereol 1996;123(4):240-6

[Related Articles, Books, LinkOut](#)

[Chronic trichuriasis and toxocara canis infection. A case-control study].

[Article in French]

health clinic, but this facility was predominantly used by women living nearby in Pallakandi. Because of the cultural and social constraints on female activities, women living further from the clinic, in Sheikha, preferred to send their husbands to a pharmacy in the nearby town to buy deworming treatment. As a consequence, these households were at a relative disadvantage in respect of the low exposure of women to health education and the greater financial cost of deworming treatment. The study highlights the influence of social and cultural factors on treatment-seeking behaviour, which in turn affect women's exposure to health education and biomedical knowledge of helminths. Further questions are raised, however, on the ability of women to implement preventive measures and the impact of health education on rates of parasitic infection.

PMID: 7839659

25: Ann Hum Biol 1994 Jul-Aug;21(4):315-24

Related Articles, Books, LinkOut

An 18-month study of the effect of periodic anthelmintic treatment on the growth and nutritional status of pre-school children in Bangladesh.

Roushan EK, Mascie-Taylor CG

Department of Biological Anthropology, University of Cambridge, UK.

An 18-month study was conducted from February 1989 to August 1990 to examine the effect of regular deworming on child growth and nutritional status. A sample of 1402 children, from 2 to 6 years old, were divided into a treatment group and a control group. The 688 children in the treatment group received a 500 mg single dose of mebendazole, while the 714 children in the control group were given a placebo. Height, weight and mid-upper arm circumference (MUAC) were

measured on monthly household visits. Growth was measured in terms of the change in height-for-age, weight-for-age, weight-for-height and MUAC over 18 months. The initial prevalence of infection was estimated from a random sample of 96 children (49 treated, 47 control). The initial overall prevalence of *Ascaris lumbricoides*, *Trichuris trichiura* and hookworm was 71, 44 and 10% respectively. The final prevalence of infection, estimated from a random sample of 265 children, was *A. lumbricoides* 6%, *T. trichiura* 6% and hookworm 2% in the mebendazole group compared with 64, 18 and 19% respectively in the placebo group. Despite the successful treatment of helminths, there was no significant improvement in the growth of treated children compared with their untreated counterparts in terms of the change in z-scores of height-for-age, weight-for-age, weight-for-height and MUAC. The factors which may have contributed to this outcome are discussed.

Publication Type:

Clinical trial

Randomized controlled trial

PMID: 9650233

26: J Trop Pediatr 1994 Feb;40(1):49-51

Related Articles, Books, LinkOut

UDISHA SUMMARY

April 6, 2001

Introduction

The objective of UDISHA- the WB assisted ICDS Trg Programme is to develop all the functionaries of ICDS into agents of social change (From April 1999 for 5 years). Additional funds have been provided for staff honorarium including provision for guest speakers. The staff honorariums have been raised. Training teams for field trg of AWW will be constituted from members of AWTC, DIET, Health Dept., ICDS, Mahila Samakya/FNB/WDP/DWCRA, DPEP Gender Trainers

The training infrastructure is being upgraded- AWTC, MLTC. A State Resource Unit is proposed to work under the ICDS Directorate.

Three kinds of training are covered under UDISHA: Job Training Course (JTC), Refresher Course (RC) & Orientation Course (OC)- See Table-1 for Summary. The Udisha activities are followed up by the State Training Task Force.

Training of AWW & Helpers

Institution based job trg at the AWTC and field for a period of 7 months. The number of trainees will be 35 per batch. Each AWW will be paid an incentive of one months salary on satisfactory completion. Refresher Training of AWW every two years at AWTC or by Training Teams. Training of Helpers will be done by the AWTC. There are a total of 25 AWTC in Karnataka all run by NGOs.

Training of Supervisors

Presently, the Middle Level Training Centres (MLTC) organise a 80 day course for Supervisors. Under UDISHA the Supervisors will undergo a refresher trg every 2 years. The Karnataka MLTC is in Ujire (DK) and run by an Organisation of the Dharmasthala Temple.

Training of CDPO/ACDPO

The responsibility is with NIPCCD.

Joint Training with the Health Department

ICDS-Health functionaries will undergo joint training. This is the responsibility of the Health Department.

Training of Trainers

The training of the Instructors of AWTC & MLTC will be conducted by NIPCCD. Provision

is also made for training of NIPCCD staff in other institutions.

Other Training Programmes

The objectives of the ICDS will be communicated to Sarpanch, Panchayat members.

Other Financial Commitments

Provision has been made for the following:

1. Development, Printing, Distribution of all training and IEC materials and kits for AWW on early learning
2. Organisation of workshops, seminars etc ,
3. Operational Research & Evaluation Studies; MIS on Training.

TABLE-1:SUMMARY OF TRAINING COURSES

(Note Numbers in Parenthesis refer to trainees per course)

Functionary	Course		Institution
	<u>JTC</u>	<u>RC</u>	
AWW	3 months (35)	15 days (40)	AWTC
Supervisors	80 days (25)	11 days (25)	MLTC
CDPO/ACDPO	60 days (25)	12 days (25)	NIPCCD
	<u>Orientation</u>	<u>Refresher</u>	
Helpers	13 days (50)	7 days (50)	AWTC
MLTC Instructors	12 days (20)	8 days (20)	NIPCCD

Adolescent Health

The Karnataka Government provides facilities for improving health of adolescent youth through its various departments viz. Health & Family Welfare, Women & Child Development, Education, Women's Development Corporation, Sports & Youth Affairs, Rural Development and Panchayati Raj, etc. The main interventions are School health programme, Health Education, Nutrition, income generation and other schemes. This project will aim to strengthen the implementation of all these schemes. A sub committee will be formed consisting of one member from each of these departments and with a rotating head. The sub-committee will be responsible to the project to implement the various schemes which will have a positive impact on the health of adolescent youth.

Health & Family Welfare

- Under the **RCH Programme** adolescent girls are being provided Iron supplements (to combat Anaemia > 60%) and also deworming once a year (Albendazole 400 mg) to improve their health. Through the **arogya sanghas** and **anganwadis** girls are given Nutrition education on how to prepare and eat a balanced diet prepared from locally available low-cost food. She is taught about personal hygiene, menstrual hygiene, and also screened and treated for Reproductive tract infections (RTI's). She is also taught about population education, gender sensitization, health facilities available and family life education.
- Under the **IPP VIII (India Population Project urban) and IPP IX (rural)** Health promotion is provided to adolescent girls. The training covers the changes during adolescence, nutrition, family planning and sex education, personal hygiene, environmental sanitation and school health. It encourages enrollment in schools and also targets school dropouts. These activities are organised through SHE (Social Health and Environment) clubs. The SHE clubs (covering 5000 population) in urban areas also provide vocational training like in radio repair, electrical and electronic work, and tailoring.
- The GOK has recently launched a pilot project in a few selected districts of **supplying sanitary pads** for rural girls/women at subsidized rates (Rs 20/- for 10 pads).
- Under a **Border Cluster Programme** covering few pockets in the border districts like Gulbarga, Bidar, Bijapur, etc. UNICEF also through the health infrastructure is providing Iron supplements to adolescent girls.
- There are no specific schemes addressed to adolescent boys at present by the health department, except for health promotion and school health program organised with the education department.

N.B. Successful implementation of various available schemes of various Departments for Adolescent health would be a litmus test for inter-sectoral co-ordination & implementation.

Education

The education department focuses on improving health through education of girls. It provides free education for all girls' upto PUC in all government schools, along with free uniform and books. It also has schemes to reach the school dropouts.

- Under the World Bank DPEP (District Primary Education Programme) the backward districts of the State have been covered to provide better education facilities to children in primary schools (half the state covered).
- The non-DPEP districts have also been recently covered under the *Janashala* scheme.
- Under the *School health programme* all school children are medically examined once in four years i.e in Std I, Std IV and Std VII. They are also given DT or TT immunization., These are done with the close cooperation of the Health department. .
- Schemes to include life skill education, sex education and fortify the existing health education/promotion activities are also being planned.

Women & Child Development

The WCD department has many programme targeting adolescent girls.

- Under a scheme called *Jagruti* covering 15-18 years old girls in school the adolescents are taught about health, nutrition, family planning, family/home making (home science), vocational support, preparation for parenthood, and more about family life skills. Each girl is given a first aid kit to take home and if she completes her education upto VII Std is given a cycle and a NSS certificate of Rs 1000/-.
- Under *Vikasini* girls above 18 years (<Rs 10000/- annual family income) are given loans of Rs 10000/- with 25% subsidy (Rs 5000/- only can be spent on infrastructure and the remaining used for rotation).
- *Child Labour Rehabilitation* covers children under 14 years of age and the Deputy Commissioner of Districts have been asked to strictly implement the same.
- *Rural girl child attendance scholarship* provides Rs 25/-pm from Std V to VII and Rs 50/-pm from Std VIII to X as an incentive to the parents (<Rs 10000/-annual income) to send their girl child to school. The child must get 40% marks to continue her scholarship.
- Daughters of commercial sex workers, prisoners, alcoholic fathers/husbands (<Rs 15000/-annual income) are also eligible to get scholarship to attend school @ Rs100/-pm from Std V to VII , Rs 150/- pm from Std VIII to X and Rs 300/- pm from PUC to Degree.

- *Namma Magulu, Namma Shakti* covers girls from 6 to 18 years. Rs 2500/- is deposited in LIC (Life Insurance Corporation) for the girl. From 6-9 years Rs 200/- pa is given (from the interest), 10-13 years Rs 300/-pa and from 14-17 years Rs 400/- pa is given to the family. If the girl has continued going to school till 18 years and atleast passed VII Std and not yet married, then she will get a total of Rs 8400/- as a lumpsum amount.
- *Balika Samruddi Scheme* covers families, which have two girl children. Rs. 500/- is given as a one-time grant and if the girl is regular till SSLC the entire education is taken care of by scholarship cum Central government. This is applicable for girls born after 15th August 1997.
- *Adolescent Programme* This is under implementation. From 100 anganwadi centres three girls will be selected in the 11-15 years age group. They will be given three days training including health education from the health department. Then for 6 months they will be beneficiaries of their anganwadi centres and will assist the anganwadi worker. 300 girls will be covered per district.

Women's Development Corporation

They provide training for urban girls for self-employment (family annual income <Rs 12000/-) in tailoring , embroidery, electrical and electronic repair.(@ Rs 100/-pm during training and WDC will provide the materials necessary to start their work when they finish).

- Under another scheme Rs 5000/- to Rs 25000/- loan is given under self-employment scheme. *Devadasi Rehabilitation scheme* assists Devadasi's (Raichur, Bijapur and Belgaum) through financial assistance.
- *Udyogini* is also a scheme to assist girls above 18 years of age to start petty business by giving loans upto Rs 50000/-(25% subsidy for all and 40% subsidy for SC/ST's.)

Sports and Youth Affairs

Have a number of schemes for encouraging sports among adolescent girls and boys. Low cost sporting activities like football, volleyball, basketball, kho-kho, kabaddi and other games will improve the overall health of the adolescents and also increase school attendance.

Rural Development & Panchayatiraj

Since more than one-third of the panchayat members are women, they have a major role to play in the health of adolescent girls. They will be trained / sensitised on adolescent health issues during the project period in a phased manner.

Role of NGOs

Since the government does not have the capacity to implement most of the above mentioned schemes and neither has given adequate publicity for the same, the quantum of beneficiaries has been abysmally low. The NGOs could play a proactive role in making the beneficiaries aware of these various schemes and to bridge the gap between the people and the government. Many NGOs are actively involved in providing specific health interventions to the adolescent youth in rural and urban areas.

Role of NGOs

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31st March 2001

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Community Health Cell
Koramangala – Bangalore.

• **Balika Samruddhi Scheme** covers families which have two girl children. Rs. 500/- is given as a one-time grant and if the girl is regular till SSLC the entire education is taken care of by scholarship cum Central government. This is applicable for girls born after 15th August 1997.

• **Adolescent Programme** This is under implementation. From 100 anganwadi centres three girls will be selected in the 11-15 years age group. They will be given three days training including health education from the health department. Then for 6 months they will be beneficiaries of their anganwadi centres and will assist the anganwadi workers, 300 girls will be covered per district.

Women's Development Corporation

• They provide training for urban girls for self-employment (Family annual income <Rs 12000/-) in tailoring, embroidery, electrical and electronic repair. (@ Rs 100/-pm during training and WDC will provide the materials necessary to start their work when they finish).

• Under another scheme Rs 5000/- to Rs 25000/- loan is given under self-employment scheme • **Devadasi Rehabilitation scheme** assists Devadasi's (Raichur, Bijapur and Belgaum) through financial assistance.

• **Udyogini** is also a scheme to assist girls above 18 years of age to start petty business by giving loans upto Rs 50000/- (25% subsidy for all and 40% subsidy for SC/ST's.)

Sports and Youth Affairs

Have a number of schemes for encouraging sports among adolescent girls and boys. Low cost sporting activities like football, volleyball, basketball, kho-kho, kabaddi and other games will improve the overall health of the adolescents and also increase school attendance.

Rural Development & Panchayatiraj

Since more than 1/3rd of the panchayat members are women, they have a major role to play in the health of adolescent girls.

HEALTH FACILITIES FOR ADOLESCENT YOUTH IN KARNATAKA

Project “ Dimension for early pregnancy in urban & rural India”

Introduction

The Karnataka Government provides facilities for improving health of adolescent youth through its various departments viz. Health & Family Welfare, Women & Child Development, Education, Women's Development Corporation, Sports & Youth Affairs, Rural Development and Panchayati Raj, etc. The main interventions are School Health programme, Health Education, Nutrition, income generation and other schemes. These will be covered department wise.

Health & Family Welfare

- Under the *RCH Programme* adolescent girls are being provided Iron supplements (to combat Anaemia > 60%) and also deworming once a year (Albendazole 400 mg) to improve their health. Through the *arogya sanghas* and *anganwadis* girls are given Nutrition education on how to prepare and eat a balanced diet prepared from locally available low-cost food. She is taught about personal hygiene, menstrual hygiene, and also screened and treated for Reproductive tract infections (RTI's). She is also taught about population education, gender sensitization, health facilities available and family life education.

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- Under the *IPP VIII (India Population Project urban) and IPP IX (rural)* Health promotion is provided to adolescent girls. The training covers the changes during adolescence, Nutrition, Family Planning and sex education, personal hygiene, environmental sanitation and school health. It encourages enrollment in schools and also targets school dropouts. These activities are organised through SHE (Social Health and Environment) clubs. The SHE clubs (covering 5000 population) in urban areas also provide vocational training like in radio repair, electrical and electronic work, and tailoring.

- The GOK has recently launched a pilot project in a few selected districts of *supplying sanitary pads* for rural girls/women at subsidized rates (Rs 20/- for 10 pads).

Under a *Border Cluster Programme* covering few pockets in the districts on the order like Gulbarga, Bidar, Bijapur, etc. UNICEF also through the health infrastructure is providing Iron supplements to adolescent girls.

There are no specific schemes addressed to adolescent boys at present by the health department, except for health promotion and school health program organised with the education department.

Education

The education department focuses on improving health through education of girls. It provides free education for all girls' upto PUC in all government schools, along with free uniform and books. It also has schemes to reach the school dropouts. Under the

- World Bank DPEP (District Primary Education Programme) the backward districts of the State have been covered to provide better education facilities to children in primary schools (half the state covered). The non-DPEP districts have also been recently covered under the *Janashala* scheme.

- Under the *School health programme* all school children are medically examined once in four years i.e in Std I, Std IV and Std VII. They are also given DT or TT immunization., These are done with the close cooperation of the Health department.

- Schemes to include life skill education, sex education and fortify the existing health education/promotion activities are also being planned.

Women & Child Development

The WCD department has many programmes targeting adolescent girls.

- Under a scheme called *Jagruti* covering 15-18 years old girls in school the adolescents are taught about health, nutrition, family planning, family/home making (home science), vocational support, parenthood preparation, and more about family life skills. Each girl is given a first aid kit to take home and if she completes her education upto VII Std is given a cycle ~~also~~ and a NSS certificate of Rs 1000/- also.

- Under *Vikasini* girls above 18 years (<Rs 10000/- annual family income) are given loans of Rs 10000/- with 25% subsidy (Rs 5000/- only can be spent on infrastructure and the remaining used for rotation).

- *Child Labour Rehabilitation* covers children under 14 years of age and the Deputy Commissioner of Districts have been asked to strictly implement the same.

- *Rural girl child attendance scholarship* provides Rs 25/-pm from Std V to VII and Rs 50/-pm from Std VIII to X as an incentive to the parents (<Rs 10000/-annual income) to send their girl child to school. The child must get 40% marks to continue her scholarship.

- Daughters of commercial sex workers, prisoners, alcoholic fathers/husbands (<Rs 15000/-annual income) are also eligible to get scholarship to attend school @ Rs100/- pm from Std V to VII , Rs 150/- pm from Std VIII to X and Rs 300/- pm from PUC to Degree.

- *Namma Magalu, Namma Shakti* covers girls from 6 to 18 years. Rs 2500/- is deposited in LIC (Life Insurance Corporation) for the girl. From 6-9 years Rs 200/- pa is given (~~at~~ interest), 10-13 years Rs 300/-pa and from 14-17 years Rs 400/- pa is given to the family. If the girl has continued going to school till 18 years and atleast passed VII Std and not yet married, then she will get a total of Rs 8400/- as a lumpsum amount.

*A Proposal for strengthening
the
Public Health Institute, Bangalore*

Public Health Institute is an important arm of State Health Services.

Any Health problem affecting the community is the business of Public Health Institute. Hence it is necessary that the Institute should develop skills to gather Health intelligence, forewarn epidemics, diagnose diseases, find source of infection, suggest methods to prevent the spread of the disease.

To achieve these aims the Public Health Institute should have following three wings.

1. Department of Epidemiological studies.
2. Diagnostic Laboratory and
3. A Surveillance set up

Department of Epidemiological studies: At present there is no such wing under Health Services. Whenever there is an outbreak of an epidemic an official of the rank of Deputy Director / Joint Director is deputed to the area to make a study which is hardly useful in containment of the disease in real terms. This is mainly due to the fact that Epidemiological investigative skill can be developed only after a few years of constant work in the field. The work has to be backed up by clinical studies by a person who is preferably qualified in tropical diseases and by laboratory investigations.

Recommendations:- The Epidemiological Training Institute, Mandya (which is defunct now) may be attached to Public Health Institute.

Diagnostic Laboratory: It should have facility to analyse Biological samples and also non-biological samples like food, water and chemicals.

Under the NSPCD programme of Central Government a Regional lab for communicable diseases is being established at PHI., during the current year. Proposal has already been submitted to establish a leptospira and Brucella lab and also Viral diagnostic laboratory at PHI under this programme.

Constitution of Rapid Response Team: at Public Health Institute, a RRT will have to be constituted for Rapid deployment to epidemic affected areas.

A field lab will have to be developed to assist the Rapid Response Team.

Personnel required:

A. Technician	-	5
B. Epidemiologist	-	1
C. Entomologist	-	1
D. Clinician	-	1
E. Group 'D'		

Laboratory kits for rapid diagnosis of the diseases will have to be made available to the field lab.

A diesel vehicle with the sufficient space to carry the personnel and also act as the laboratory will have to be provided.

The field lab should be equipped with the rapid diagnostic kits, florescent microscope sample collection and transportation kits.

The Institute should constitute as rapid response team as envisaged by the NICD, Delhi at its earliest.

Further, mechanisms for rapid control of vector population, rapid water purification facility etc., should be available for rapid deployment to the sites of epidemics. Such facilities should be developed and established for deployment at Public Health Institute.

Posting of Microbiologist to this Institute: The Health laboratory is another name for Microbiology laboratory. There are two posts of Bacteriologists in this institute and both of them are vacant. The work of the institute is hamstrung by the absence of microbiologists. It is requested that two microbiologists be posted immediately to this institute. There is an urgent need for another two microbiologists with sufficient experience in leptospira, Brucella, Viral Diagnostic procedures. These two Microbiologists can be hired on contract basis immediately.

PUBLIC HEALTH INSTITUTE
SHESHADRI ROAD,
BANGALORE

ANNUAL ADMINISTRATIVE REPORT
2000-2001

ANNUAL ADMINISTRATIVE REPORT

AN 5

On

PUBLIC HEALTH INSTITUTE BANGALORE 2000-2001

Public Health Institute:- is the state level health laboratory in the department of Health & Family Welfare Services. It is headed by the Joint Director (Laboratories). The Institute houses the following laboratories :

1. *Diagnostic Bacteriology Lab:-* Here stool samples of patients suspected to be suffering from cholera are examined.

The section also conducts bacteriological analysis of food samples to determine fitness for consumption under PFA Act. Samples are also received for examination, from food processing industries and from general public.

2. *Water bacteriology Lab:-* This is the biggest water testing laboratory in the State and tests water for potability purposes. Samples collected under PFA and from industries manufacturing mineral water and also from general public are tested here.
3. *Chemical Examiner's Laboratory:-* The samples received from Lokayuktha under prevention of corruption act. are tested here.

Alcohol contents of drugs, samples from excise Dept., and narcotic samples are also analysed here. Blood and Urine samples are analysed to find out the presence of alcohol/Narcotic substance in them.

4. *State food laboratory:-* State food laboratory is an important wing of Public Health Institute. Food samples collected by food Inspectors from all over the state are analysed here for adulteration.
5. *Laboratory for Chemical Examination of Water:-* Chemical analysis of water is done here. Samples are received from Industries, mineral water manufacturing unit and from general public.

Effluents released from industries are also examined under factories act to prevent contamination of water by toxic substances in the effluents released by the factories.

II Administration

2.1 Organisational set up / heirachial set up the Department from State Head Quarters down to the lowest level.

A detailed report on organisational set up is enclosed herewith.

2.2. Officer incharge during the year 1999-2000

Dr. B.Y.Nagaraj, Joint Director (Labs) upto end of February 2001.

Dr. Kamath, Deputy Director (Bact), is (I/C) Joint Director (Labs) from 1.3.2001.

2.3. Additional Staff sanctioned during the year.

- Nil -

2.4. Staff strength at the end of the year i.e. on 31.3.2000.

Statement enclosed.

2.5. Promotions, Transfers, Postings – in brief

2.6. Training of Departmental Staff

1) Orientation Training has been given to 85 Food Inspectors.

2) 27 District Surveillance Officers have been trained to impart the training to the Laboratory Technicians in their Districts.

55 Laboratory Technicians have been given in laboratory procedures to run laboratories attached to Primary Health Centres.

2.7. Tours by the Head of the Institution:- Inspection of Surveillance Centres and PHC Labs of Mangalore, Udupi, Chitradurga, Davanagere, Kolar was done by Dr. K.R.Kamath, Deputy Director (Bact).

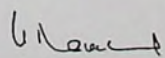
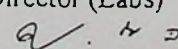
III FINANCE

3.1 Revenue / Income during the year – Total and sourcewise, comparison with corresponding figures of last two years and reasons for variations.

*IV. 1. A BRIEF STATEMENT ON WORK TURNED OUT DURING THE YEAR
1998-99, 99-2000 and 2000-01*

Section	1998-1999	1999-2000	2000-2001
<i>Diag. Bact. Section:</i>			
1. Stool Samples examined.	2078	2213	2341
2. Food samples analysed:	32	70	86
<i>Water Bact. Section:</i>			
1. Water samples tested:	2143	2580	3467
<i>Chem. Examiner Lab:</i>			
1. Spiritous drugs tested:	80	170	-
2. Alcoholic drinks	14	32	180
3. Blood and Urine	55	41	67
4. Lokayukta samples	108	101	154
5. Narcotic drugs	-	-	5
<i>Food Laboratory:</i>			
1. Samples tested under PFA	1812	1722	638
2. Other food samples	1423	243	850
<i>Water testing lab:</i>			
1. Sample tested	444	355	857
2. Effluents	20	-	4
<i>Regional Food Laboratory:</i>	273	192	200
<i>Pesticide Laboratory:</i>	159	94	-
<i>Training Programme:</i>			
1. Food Inspectors Training	-	-	85
2. Other Trainings:	-	-	82

2. Major herdless/difficulties met if any and remedial measures taken may be indicated:- All the vacant posts to be filled up.


 Joint Director (Labs)


Nutrition of Lactating Mothers

- ❖ A lactating mother requires 1000 calories extra per day to meet the needs of production of mother's milk for the new born baby.
- ❖ A good nutritious diet prepared from low cost locally available foods, family support and care, and a pleasant atmosphere in the family helps improve lactation and ensures health of both the mother and the baby.

Diet

- Include more of cereal, pulse and green leafy vegetable in daily diet
- Take vegetables and one seasonal fruit a day
- Take milk, butter milk, fluids and lot of water
- Egg, meat, fish are beneficial
- Energy dense foods like ghee/oil and sugar are necessary to meet the increased energy needs. Traditional preparations like panjiri, laddoo are useful

Rest

- Breastfeed in a relaxed state. Any type of mental tension decreases milk secretion

IFA tablets

- Take iron and folic acid tablets for first six months of lactation

HUMAN LACTATION – SOME FACTS.

By Dr. Asha Benakappa, MD,DNB,DCH,LMC
Asst.Prof. of Pediatrics, Bangalore Medical College, Bangalore-2
City Co-ordinator, Breastfeeding Promotion network of India
Phone:-6693173

A Landmark resolution recommending that infant be “ Exclusively breastfed for 6 months” was passed by the full assembly at the 54 th world assembly last May(WHA-54.2)

Exclusive breastfeeding is defined by WHO as no other food or drink, not even water, except breast milk for 6 months of life, but allows the infants to receive drops & syrups(vitamins, minerals & medicines).

The resolution settles a seven years controversy over at least two aspects of the baby food issue- the optimal duration for exclusive breastfeeding and the marketing of complementary foods for infants. It provides more clarity on the scope of the code: a breast milk substitute is any food marketed for use before the age of six months, ie. all milk, including infant formula, cereals, juices & teas recommended for an earlier age may not be promoted.

The resolution recommends the introduction of safe and appropriate complementary foods with continued breastfeeding from 6 months to 2 years of age or beyond. This means that, while complementary foods may be promoted for after 6 months, the liquid part of the child’s diet should still be breast milk. Any replacement is a breast milk substitute ie. follow on formulas are substitutes and may not be promoted.

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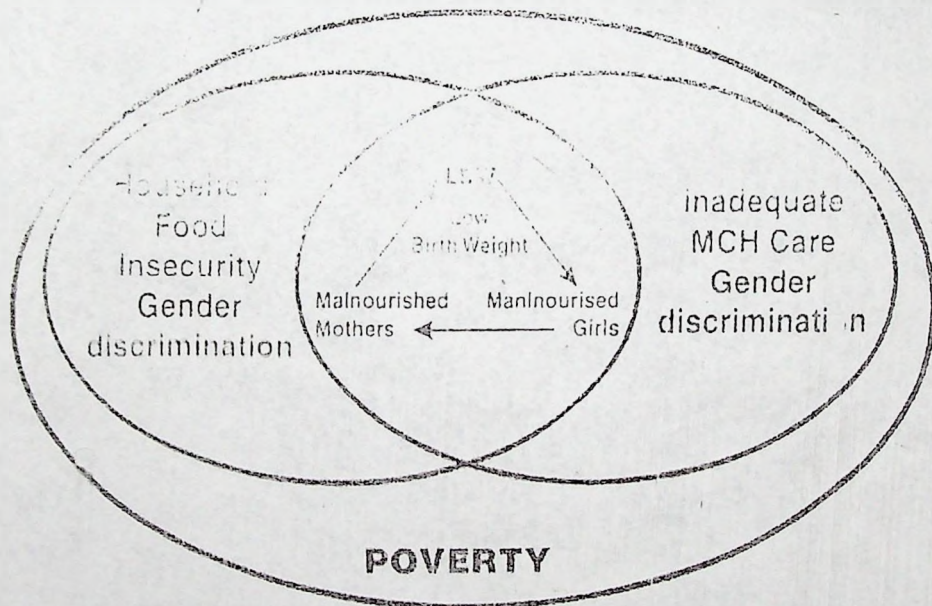
AN 7

20th NATIONAL NUTRITION WEEK

1-7 September 2001

BREAK THE CYCLE OF MALNUTRITION AND IMPROVE WOMEN'S HEALTH

Cycle of Malnutrition



Maternal Malnutrition Perpetuates Intergenerational Malnutrition

Food and Nutrition Board
Department of Women and Child Development,
Ministry of Human Resource Development,
Government of India
Shastri Bhavan, New Delhi.

1/11

**20TH NATIONAL NUTRITION WEEK
1-7 SEPTEMBER 2001**

**THEME : BREAK THE CYCLE OF MALNUTRITION AND IMPROVE
WOMEN'S HEALTH**

One of the major problem that India is facing today is the problem of malnutrition. The latest National Family Health Survey 2 (1998-99) reveals that one-quarter of children in our country are born with low birth weight, half the children presently suffer from protein energy malnutrition, one-third of adults suffer from chronic energy deficiency and three quarters of the population suffer from various nutritional and micronutrient deficiencies. India has a high infant mortality rate of 67 per thousand live births and an extremely high maternal mortality rate of 437 per 100,000 births.

Women and children are the worst sufferers of the ravages of various forms of malnutrition because of their increased nutritional needs and low social power. Various achievements in other sectors like agricultural production, food sufficiency and industrial capabilities do not seem to have influenced the nutritional status of these vulnerable groups. Low literacy levels, lack of awareness about nutrition and health, and poverty contribute to this dismal situation.

Nutrition of women throughout their life cycle is not only important for their own health but determines the nutrition and health of the future generations also. A female infant born with low birth weight, that is birth weight less than 2.5kg, is already malnourished and hence starts life with a disadvantage. Intrauterine growth retardation (IUGR) during pregnancy is the main cause of low birth weight, and maternal malnutrition and nutritional anaemia during pregnancy is the major determinant of the IUGR. Gender discrimination within home is often manifested in unequal access to food and inferior quality of food provided to girl children as compared to male children in the family throughout the childhood. The effects of years of neglect become visible during adolescence. A girl, therefore, generally grows into a malnourished adolescent girl.

For various socio-economic and cultural reasons, girls are married early, invariably in their teens. The NFHS 2 (1998-99) reveals that the median age of girls at marriage in India is 16 years and 61% of all women were married before the age of 18 years. Thus, a large percentage of adolescent girls are forced to enter into reproductive life even before they are adults themselves. Early pregnancy further aggravates both under-nutrition and anaemia and results in adverse outcome of pregnancy including a low birth weight baby. Under-nutrition and anaemia among pregnant women and adolescent pregnancies are the main contributory factors for low birth weight babies. A low birth weight baby girl will be subjected to similar

conditions and attitudes and will repeat this cycle, thus making the problem of malnutrition an inter-generational cycle.

Thus, for preventing the low birth weight and breaking the inter-generational cycle of malnutrition it is important to ensure nutrition and care of women throughout their life cycle. Ensure nutrition, health and care of the girl child right from birth through adolescence and adulthood by adopting the following measures:

- Give the girl and the boy child equal nutrition.
- Educate the girl child as much as possible.
- Give her adequate nutrition during adolescence as this is the second and last growth spurt in her life.
- Give her basic knowledge of food, nutrition and health to enable her to take care of herself.
- Do not marry her before 19 years and give her family life education.
- First pregnancy should be after the age of 21 years.
- Provide good nutrition, health care and family support during pregnancy and lactation.
- Encourage women to breastfeed immediately after birth so as to feed "colostrum" to the new born and to adopt proper infant feeding practices.
- Reduce the workload of women by sharing the manual and household work and adopting appropriate rural technology for making her work easier so as to improve her nutrition and health.

Some nutritional guidelines for ensuring care of the low birth weight baby, infant's nutrition through appropriate feeding practices, nutrition of adolescent girls, pregnant and lactating mothers are annexed.

SOME NUTRITION GUIDELINES

Care of Low Birth Weight Baby

- ❖ New born baby with less than 2.5 kg weight is a low birth weight baby
- ❖ Low birth weight makes the child start life with disadvantage as the child is already malnourished and requires extra care. Mother's milk is the only food a low birth weight baby should be given
- ❖ In rural areas where the facility of the incubators may not be available, mothers should be advised to keep the low birth weight baby close to the chest, under a woolen garment in winter. This helps the baby in two ways, (i) the child gets warmth of the mother's body and (ii) the baby can suck the milk as and when he likes. In other words, he may not be strong enough to suck the milk like a normal baby continuously for 10-15 minutes and may need to suck more often for shorter duration.
- ❖ Low birth weight baby should be given breast milk and nothing else for the first six months. Any other food, if introduced during early stages, may cause infection in an already under weight child and may prove to be fatal.
- ❖ Pre-lacteal feeds are harmful and should be discouraged
- ❖ Skin to skin contact between mother and child immediately after the childbirth helps early and successful establishment of lactation and feeding of "colostrum" to the baby which provides natural immunity to the child.

Nutrition of Adolescent girls

- ❖ Nutrition of adolescent girls is extremely important for the health of the future mother and the new born baby.
- ❖ A good nutritious diet alongwith iron and folic acid supplements (100 milligrams and 500 microgram folic acid tablets) once a week is important for the health of the adolescent girls.
- ❖ Delaying the age of marriage and the first child birth is extremely important to enable the adolescent girls to develop fully so as to be able to take the burden of pregnancy.
- ❖ Girl's marriage after the age of 19 years and first pregnancy after the age of 21 should be promoted.
- ❖ Knowledge of maternal and child health and family life education should be imparted to all adolescent girls.
- ❖ Skill development training in scientific methods of cooking and food preservation is also helpful to adolescent girls.
- ❖ Educate the girls since female illiteracy is an important determinant of malnutrition.

INFANT AND YOUNG CHILD NUTRITION

Infant Feeding: Breastfeeding and Complementary Feeding

Breastfeeding

- ❖ A child requires both exclusive breastfeeding for first six months and complementary feeding from six months of age with continued breastfeeding for 2 years and beyond for good health.
- ❖ **Early initiation of breastfeeding**, that is within half an hour of birth in normal deliveries (and 4-6 hours in caesarean deliveries) is important to establish successful lactation and feeding of "colostrum" (mother's first milk) to the baby.
- ❖ **Exclusive breastfeeding** for the first six months of life is important to prevent infections in early infancy and reduce infant mortality, particularly in low socio-economic strata.
- ❖ **Prolonged breastfeeding upto two years and beyond** provides all the benefits of the mother's milk to the child like high quality protein, vitamin A and anti-infective properties.

World Health Assembly 2001 has passed a resolution advocating exclusive breastfeeding for the first six months of life for all segments of the population. Complementary feeding with home based foods introduced from 6 months of age alongwith continued breastfeeding for 2 years and beyond has also been recommended.

Complementary Feeding

- ❖ Complementary feeding is extremely essential from six months of age to meet the growing needs of the growing baby.
- ❖ Roasted flour of any cereal mixed with boiled water and sugar should be the first complementary food for the child and should be started on the day the child becomes six months old. An 'Annaprashan' ceremony is an Indian tradition. Annaprashan Abhiyaan for promoting complementary feeding should be taken at anganwadi level and in the community.
- ❖ Family food without spices can be mixed and made into semi-solid consistency suitable for the child. For instance, half a roti soaked in half katori of unspiced dal when mixed thoroughly, can serve the purpose of khicheri for the young child, which is a nutritious food for the baby.
- ❖ Leafy vegetables are important for the child as they provide iron, beta carotene (vitamin A), folic acids besides other nutrients. Boiled and mashed leafy vegetables should be given to the child atleast for 3-5 days in a week.
- ❖ Seasonal fruits like banana, papaya, mango should be mashed and fed to the child.

- ❖ Roasted cereal and pulse mix like sattu can be prepared and stored for a month and fed to the child by reconstituting with boiled water or milk whenever required.
- ❖ A tea spoon of oil and sugar must be added to the food of the child so as to make the food energy dense as child can not consume bulky foods but requires more energy per unit of body weight.
- ❖ Mixed foods alongwith breast-feeding should be continued upto two years.

Ensuring adequate and frequent complementary feeding of infants will help prevent onset of malnutrition during the period 6 months to 2 years.

Growth Monitoring and Promotion (GMP)

- ❖ Weighing the child regularly and plotting the weight on the health card is an important tool to monitor the growth of the baby

Hygiene

- ❖ Hygiene in preparation of foods for the baby and in feeding is extremely important to prevent infections.

Feeding During Illness

- ❖ Continue feeding during illness as child requires more nutrition to make up for the loss of nutrients during infections

Care of the Pregnant Women

- ❖ A pregnant woman needs -
 - An adequate nutritious diet
 - Adequate rest during last trimester
 - Iron and Folic Acid tablets throughout the pregnancy

Diet

- Increase food intake
- Whole grain, pulses and legumes, sprouted pulses, leafy vegetables, jaggery, dates, groundnuts, til are foods of plant origin having good iron content. Include more of these in the daily diet.
- Include green leafy vegetables in daily diet right from the beginning as all foliage provide "folic acid" much needed during early months.
- Consume one seasonal fruit daily
- Milk, curd, butter milk, egg, meat, fish are helpful
- Iodised salt should be consumed as pregnant women requires sufficient iodine for brain development of the child in the womb
- Take plenty of fluids/water
- Take small and frequent meals

Rest

- Heavy work should be avoided throughout the pregnancy
- Rest (in lying down position) during third trimester is important to enable adequate flow of nutrients from mother to the child

Iron and Folic Acid tablets

- IFA tablets should be consumed throughout the pregnancy
- Iron tablets may cause black stools which are harmless
- Iron and folic acid tablets prevent anaemia and helps a women to deliver a normal healthy baby
- The folic acid deficiency can cause "Neural tube defects" in the new borns

Visit to Anganwadi Centres of ICDS
near Hanur of Kollegal Taluk.

AN 9

The Anganwadi centre of Chamaraj Nagar District in Kollegal was visited on the 26th of March. The main purpose was to observe the supplementary feeding programme in operation at the Anganwadi the quantity served and the ability of the children to consume the served portion, as well as the issues related to the preparation of the food. I am thankful to Dr. Sr. Aquinas and Sr. Anice who welcomed us and made arrangements for me to visit the Centre during the operation of the feeding programme. The Holy Cross Comprehensive Rural Health Project covers this village which was visited, and they have women's groups, Self-help Groups and the women trained under Women and Health Project.

The Village visited was K. Gundapura. This village has two Anganwadi centres and both the centres were visited by me one at the time of the preparation of the food and serving of the same to the children present. The other centre was visited to discuss with the worker her routine and the support services available. This village comes under Basappana Dotti Panchyat.

Anganwadi 1 (Actually this is the second centre started after a lapse of some years after the first)

Anganwadi Worker
Helper

Smt Suguna
Smt Parvathi.

Though Sr. Anice and self reached the village at 10.30, giving time for the centre to start the activities, the teacher had not turned up, but few of the children were there with vessels in their hand clutched closely, to take the cooked food home. The children were moving and running and the helper Parvathi was not able to manage or even start the programme with them. utilising the time we enquired about the food that was cooked by the helper and the supply made to the centre. In the meanwhile Smt Suguna arrived and she had some personal problems to reach on time from about 3-4- km away. The information gathered from the teacher are as under.

The Food Supply: The Centre is supplied with Bags of Poorvaka Ahara (Energy Food) and Rice, The ready mix ahara and the rice are to be served alternatively. The lable on the bag reads that this was designed by CFTRI and the composition of the Poorvaka Ahara is: Wheat, Groundnut cake, Soy Powder, Bengal gram dhal, Jaggery, with mineral mix and salt added. The ratio with which these were mixed was not shown on the bag. This had been produced by Agro-Kendra.

The nutrition Factor 100 g of this Ahara has 12-14 g Protein
and 350-380 Cal.

Rice is also supplied along with Palmolein Chillies Mustard salt.

Ln
3/4/01

Per month The following ration is supplied.

Poorvaka Ahahara 75 kg

Rice	70 Kg.
oil palmolein	3 pkts
chillies (red)	1/2 kg
Mustard	1/2 kg
Salt	2 kg.

The fuel supply was supposed to be the responsibility of the Panchayat but this is not being met by the Panchayat.

Smt Suguna informed as that for some time she personally paid for the fuel and now along with the ration 2 1/2 maunds of fuel is being supplied by the CDPO. Whether this is the latest policy and not persuade the Panchayat to take up the responsibility is not clear

This monthly ration had been fixed based on the number to be fed.

<u>No: of Children taken into account</u>	No of pre-school Children 3-6yrs	23
	1-3 yr children	31
	below 2 yrs	08
	Mothers Pregnant & lactating 8+4	12/

Allowance of Food per head	Children	Energy Food	80 g
		Rice	60 g

Adults interestingly in this category the worker and the helper are included as additional

Energy Food	160 g
Rice	120

As per the number specified and the daily ration allowed the food calculation comes to

Energy food required for 62 children and 14 adults per day comes to 7.200 kg
Per month of 24 days feeding days the Energy food requirement is for
12 days only (the other 12 days are for rice) 86.4 Kg
while the supply for these feeding days is in the order of 75.0 kg

Rice As per the allowance of 60g the requirment per day 5.4 kg

For 12 days Feeding programme 64.8 kg

The shortage is not felt by the Worker as not all children attend the class every day and they can easily adjust !. The design is to feed the children in the class and make them take the cooked food for the sibling and another quantity if the mothers included. **Mothers do not come to the centre as they cannot and the children do take the food and some time the helper goes to the door step and provides.**

The actual observation of the children : Amongst the 20 and odd atleast 12 of them were between 1-3 yrs and very few were the 3-6 yrs. Evidently the mothers sent them to collect the food. I was there when the rice bhath (rice chithra aana) was being prepared, rice cooked and seasoned. Office had supplied new plates and glasses for the children to eat Yet the children were clinging on to their vessel and eagerly waiting for the food to be served in the vessel. The serving portion appeared to me as 40g of raw rice only. Even this portion was too much for the children of 1-2 yrs. Children were advised to start eating after the serving and they were pecking at the food perhaps keen in taking the food home. The teacher said that after serving she would concentrate on record maintenance and children would eat by themselves. Obviously she does not find it necessary to observe them eating and the quantity they can consume. It is the helper who gives the additional serving

The helper had prepared , according to her, 4 kg of rice for that particular day.

I requested the helper to prepare the laddu which she normally prepares with Energy food of the quantity of 40 g (weighed from the store near by) The resultant product was in the size of cricket ball. The taste was of mild sweet. The Workers informed that the mothers do not eat the energy food and give it to the children when ever the child wanted at home. The mothers thought that they could well if the centre supplied uncooked flour for them to make rotis, almost demanding the supply of flour for the week. It is also doubtful whether the mothers do consume the rice or again give it the children.

Suguna had maintained the records of supply and it was upto 23rd of March. the following two days were holidays. While we were observing the children we wanted her to teach and it was the normal pattern of saying some rhymes and the children repeating.

Growth Charts of the children

A thick booklet had been supplied to the centre as per the pattern. I doubt whether the purpose of the growth chart had been explained to Anganwadi worker or not. It appeared like routine plotting of the reading. This centre has no weighin scale but takes from the other one, which is understandable. She first notes down the reading on a notebook every month along with attendance. When time permits she plots on the chart. She had no time to look at the growth trend of the children. But this is done regularly every month

I was a surprised to see the pencil marking on the chart. When I enquired the reason she said that she was asked to do so so that these recording could be erased and make a clean chart for the new entrant in the class. When I checked with the weight of the child and the child that was present it was found that the child was a healthy child to start but constantly had been on the grade II status. Suguna could not answer our question on as why the child lost the weight. She could only

say that the child was sick but now she was eating.. The growth Chart had no meaning for the Anganwadi worker, as it really takes a lot of time and effort to weigh all the children with only the helper to assist. The Children appeared to be anaemic and stunted growth could be seen in some of the children. I could not stay there to see the quantity that the worker would be distributing to the mothers, as it would mean spending another hour or two with the worker, as mothers do not come to the centre.

There are many related issues to be discussed and this will be done after the report on the second centre. In the meanwhile we met few of the women of the sangha and the expectant mother.

This discussion was to find out as to why the mothers rejected the Ahahar Mix. According to the women the laddu is prepared with cold water and they would rather have the atta to be given to prepare their own roti. I donot give much weightage to their remark as there would always some complain or other but still whether this mix is suitable for the adults is to be questioned. The name itself suggests that it is weaning diet. Mothers keep their share and give it to the children when ever they are hungry. This also means that the children do not get any whole some food at home. Are we not defeating the purpose of feeding at the Institution ?

THE SECOND ANGANWADI CENTRE in the same village. Actually this is the original centre and the first visited was started later, This centre is equipped with weighing scale and the teacher is much more experienced.

Teacher	Nagalakshmi
Helper	Gowramma

The attendance at the centre was not full as the day was after Ugadi. The children were very cheerful and Nagalakshmi has good relationship with them. Apart from the ration amount that the centre gets it was a news to us that the PHC at Ramapura supplies the iron tabs to be given to the children. The strip contained Folic acid and ferrous sulphate and the Vitamin A is in the form of liquid and concentrated. The teacher regularly gives these to the children before the food is served. I requested the teacher to weigh a child to see the calibrations and the method of weighing. She has a hook to hang but somehow manages.. the children were fairly healthy. Nagalakshmi expressed full cooperation with the Health department. She is an experienced teacher and is confident about her work. When we returned to the first centre to observe the children being served, Sr. Anice asked about the medicine supply. Then the teacher pulled out the carton from the store. Obviously this is not being utilised by the teacher ..

There are many questions that came as a result of this visit and these need to be discussed carefully. The intention of the Government is quite obvious but lack of supervision and entire dependence on the teacher need to be discussed.

Addressing Adolescent Malnutrition to Improve Women's Nutrition

Dr Farhat Saived, UNICEF, Hyderabad.

Adolescents form the largest and an important segment of our society, with one-fifth of them constituting the total population. As per WHO (1986), defines adolescence as the period of transition from childhood to adulthood, in the age range of 10-19 years. Thus, it is the largest ever generation in human history. Globally, they account for one-fifth of the population and, in India, 21% of the total population comprises of adolescence. (National Youth Policy, 2000).

This^{is} also the period when second and the last growth spurt occurs in an individual and therefore, their nutritional and health needs in particular cannot be ignored. There is now data available, which shows that the state of adolescent boys is equally vulnerable as the adolescent girls, from nutrition, stand point. However, girls are at a greater nutritional risk due to the added demand of reproduction. For a girl, especially from poorer segments, low socio-economic status of the families compounds the problem of under nutrition, with consequent effect on growth. In addition, under nutrition reduces the reproductive, physical and mental capacities of girls and continues to result in low birth weight and fetal loss. Thus, it is quite evident that if India wishes to achieve the goals of Health for All and adequate Nutrition for All, it must attend to the problem of under-nutrition among the adolescent girls. In this regard, the nutritional status of a girl should be of a particular concern. The cycle appears simple but the consequences are serious.

Nutritional status of a girl child will affect her own nutritional status when adolescent and attains puberty. This in turn will influence the nutritional status when^{she} is an adult woman of child bearing age. As she enters into pregnancy and early childhood in this nutritionally deprived condition, not only^{her} ability to perform the tasks^{of} a mother are affected, but also the growth and development of the child are equally affected.

^t Thus, The girl child, whose growth is retarded in uterus and early years of life, arrives to the stage of motherhood with poor nutritional status. And the cycle continues. We must therefore, closely examine the outcome of the intergenerational malnutrition cycle by understanding and analyzing each of its components.

Food Intake: An important aspect of nutrition of adolescent girls is the increased nutritional requirements during their growth spurt and also during their reproductive age period, to account for the additional function of child bearing and child rearing. Adequate nutrition during adolescence implies adequacy of dietary intake and or body stores of both macro as well as micronutrients. There is ample data to show that the dietary intakes of nutrients of a majority of rural and underprivileged population of both sexes are below the desirable levels. However, women and adolescent girls are much worse off than their male counter parts. Thus a girl continues to grow poorly with inadequate nutrient reserves. The situation precipitates with the onset of menarche.

Menarche: Menarche is a physiological phenomenon, which marks the onset of puberty. Menarche is generally delayed in girls from the poor families and who are under nourished. In fact, this is Nature's compensation for growth-retardation suffered by these children during their early childhood, because of under-nutrition. One important nutrition consideration during menarche is in meeting the extra demand for iron which, it imposes due to the loss of iron during the monthly cycle of menstruation. When these demands are not adequately met it results in iron deficiency anemia. With other nutrients also not being met, the situation worsens to result in more serious future consequences.

Gender: It has been found that gender discrimination in intra-household food allocation may limit the food intake of the adolescent girls. Gender discrimination needs to be examined with a broader perspective. In India, gender differences are mostly unfavorable to girls, and are far more glaring with respect to, literacy, school enrolment and dropout, and opportunities for vocational training. This is not so in case of health and nutrition care, morbidity and mortality. Sporadic reports do point out that, parents seek institutional medical attention more frequently for their sons than their daughters. Severe malnutrition is more prevalent in girls than in boys. The data also concludes that mortality rates in females throughout childhood and reproductive periods are higher than in males.

Thus, an adolescent girls nutritional status is influenced by these factors and the situation deteriorates with the social stigma of a large percentage of girls are pushed into early marriage, after menarche in India. We must remember that the growth process in undernourished girls continues for a longer period of time than those from the affluent classes.

A girl of 15 – 16 years is still a child, she enters adulthood only after she crosses 18 years and her growth is complete only between 18 and 20 years. Therefore, it is even more important that conception is delayed till about 18-20 years. These issues of early marriage and followingly early child bearing are of concern because they affect a young mother's nutritional status a great deal, either directly or in indirectly. They thus influence her education and employment which in turn exerts considerable influence on household nutrition. In Andhra Pradesh, the age at marriage is lowest with mean age of 14.9 years (MICS,2000). Thus, considerable proportion of adolescents is of greater obstructive risk, due to malnutrition and chronic illness during there early years of life. As of now, there is little evidence to suggest that the growth retardation suffered in early childhood can be compensated for, in adolescence. Also, there are known studies to determine whether malnourished children with growth-retardation, respond to nutritional and health interventions, during adolescence.

Anemia: Adolescent is yet another vulnerable period in human life cycle when nutritional requirements increase due to the adolescent growth spurt. Recent data from UNICEF, Hyderabad, shows that 72% of rural and 80% of urban adolescents suffer from varying degrees of anemia. Anemia in severe forms is associated with increased maternal deaths especially during pregnancy. It is also associated with an increased risk of premature delivery and a higher incidence of low birth weight infants. These in turn are at a greater risk of perinatal and neonatal morbidity and mortality and substandard growth and development in later life.

It is becoming increasingly evident that control of anemia in pregnancy may be more easily achieved, if satisfactory iron status of the adolescent girls can be ensured prior to marriage. It is evident that growing adolescents are likely to give birth to smaller baby than mature women of the same nutritional status. This is probably due to the competition between: growing adolescent and the growing fetus for nutrients. Adolescent pregnancies also confer a higher risk of maternal and infant mortality and preterm-delivery.

This discussion clearly indicates that while most direct interventions aim at reducing young child nutrition, they may fail to prevent in early years when it predominantly occurs. Prevention should start much earlier. An increasing understanding of the importance of women's nutrition is important– both for the quality of her life as well as those of her children.

Evaluation of effectiveness of good growth monitoring in south Indian villages

AN 11

Sabu M George, Michael C Latham, R Abel, N Ethirajan, E A Frongillo Jr

Summary

We conducted a community intervention trial in 12 villages in Tamil Nadu, India to evaluate the benefits of growth monitoring. The villages were divided into 6 "growth-monitoring package" of intervention villages (GMP) and 6 "non-growth-monitoring package" of intervention villages (NGM). A functioning primary health care system was in place in all 12 villages. One village nutrition worker in each of the 12 villages implemented a set of interventions including health and nutritional education. About 550 children under the age of 60 months were studied over 4 years in GMP villages and a similar number of children in NGM villages. The interventions were identical in the two sets of villages except for the use of growth charts in education in the 6 GMP villages. The nutrition worker in the NGM villages had the same contact time as in the GMP villages but advised mothers without the benefit of growth charts. The research team, independently of the nutrition worker, did anthropometric studies on children in all villages every 4 to 5 months. Comparisons were done by calculating monthly gains in stature, and weight, and the significance of differences observed was adjusted for age and sex. After 30 months of interventions, similar improvements in growth were seen in GMP and NGM children. The interventions seemed to have improved the nutritional status of young children in both groups of villages. In view of the lack of additional benefit from growth monitoring over other educational interventions, we question its use as part of child survival programmes in India.

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See *Commentary* page 319

Introduction

The use of growth charts in developing countries was started by Morley about 35 years ago in Ilesha, Nigeria.¹ Morley now admits that the charts were useful for health workers in the clinic but that mothers failed to understand the growth curve.² The Ilesha chart, and what later became known as growth monitoring and promotion, was taken up by others,³ and became part of UNICEF's growth moni-

toring, oral rehydration, breast feeding, and immunisation (GOBI) strategy.⁴ Growth monitoring was advocated as an effective, simple, and inexpensive way to prevent most child malnutrition, but this view has recently been questioned because of the lack of evidence that growth charts are a better educational tool than health and nutritional education without growth charts.^{5,6} Our research was influenced by this concern. We studied the additional benefit of growth monitoring (regular monthly weighing and use of growth charts) conducted under the best possible conditions. 12 villages were divided into 6 "growth-monitoring package" of interventions (GMP) villages and 6 "non-growth-monitoring package" of interventions (NGM) villages. NGM villages received the same interventions as did GMP villages except for growth monitoring, ie, education without growth charts.

Subjects and methods

This 4-year field study was conducted in the K V Kuppam block in the state of Tamil Nadu, India. We describe here only the 12 intervention villages, but we also obtained limited data from 4 comparison villages where no interventions were introduced. The complete study design is described elsewhere.⁷ For several years, the Rural Unit for Health and Social Affairs (RUHSA) of the Christian Medical College and Hospital, Vellore, has provided primary health care in this block through rural clinics in each of the 18 peripheral service units. The 12 study villages were non-adjacent, poor agricultural communities that were distributed among 10 peripheral service units. Each had a population of about 13 000. Growth monitoring had not been conducted in the villages before. Our data showed that 70% of families lived in mud huts with one or two rooms, about 99.5% defaecated in fields, and fewer than 0.5% used kerosene or petroleum gas as the primary cooking fuel (the rest used bio-mass).

Extensive field work was done over 9 months from September, 1986. From the data collected, 6 pairs of villages were formed so that villages within each pair were similar with respect to caste composition, access to a main road, cropping practices, and distance from rural clinics. Some villages were served by more than one clinic. GMP or NGM treatment was randomly allocated within each of the 6 pairs so that villages served by a given clinic received the same intervention. This ensured the independence of the two treatments. One mother from each village was selected as the village nutrition worker after consultation with community and local primary health care workers. The nutrition worker was responsible for the educational interventions. There were two supervisors, one for GMP and one for NGM villages. We do not believe that this was a source of bias because the performance of the supervisors was similar. Preschool children in the 12 study villages were eligible for inclusion and all children born after initiation of the interventions were offered enrolment in the study.⁸ Children were dropped from the study at 60 months of age. Children with severe congenital abnormalities (identified by a paediatric surgeon who examined all children in the last year) were excluded from the

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Characteristic	GMP	NGM
	No (%)	No (%)
Social		
Harijan caste	164 (29.1)	181 (32.9)
Other castes	400 (70.9)	370 (67.2)
Nuclear family	303 (53.7)	305 (55.4)
Consanguineous	237 (50.8)	248 (55.5)
Landless	132 (28.3)	121 (27.1)
Demographic		
Mean preschool children per mother	823 (1.5)	811 (1.5)
Mean birth order	823 (2.8)	811 (2.8)
Mothers reporting stillbirth	28 (5.0)	27 (4.9)
Mothers reporting abortions	55 (11.7)	66 (12.5)
Mothers reporting deaths of children	164 (29)	144 (26)
Service use		
Mother had 3 tetanus toxoids in pregnancy	335 (40.7)	368 (45.4)
Home delivery	582 (70.7)	562 (69.3)
BCG immunisation	583 (70.8)	646 (79.7)
Tubal ligation in mother	180 (31.9)	138 (25.1)

Table 1: Characteristics of the two treatment groups

data analysis.⁴ This exclusion did not affect the outcomes of our study.

Data, including anthropometric measurements, were obtained by trained field workers, not by the nutrition worker responsible for the interventions.⁵ Baseline data are presented from interviews with 1115 mothers who had 1634 preschool children born between April, 1982, and May, 1988. Children were weighed in all the villages in April, 1987, to ascertain the willingness of the communities to accept weighing. Baseline and final anthropometric measurements were done in July, 1987, and December, 1989, and intermediate anthropometric assessments were done every 4 to 5 months. The take-up rate was about 90%. Information on socioeconomic status was collected in August, 1989.

The following interventions were provided to both GMP and NGM groups:

- The nutrition worker visited homes twice a month to provide education on health and nutrition. Educational films were shown in the villages.
- Immunisations were provided in the village, antenatal services at the rural clinic, and family planning services at the rural hospital.
- Curative care was provided at weekly rural clinics. If needed, patients were referred to the RUHSA rural hospital or to the teaching hospital in Vellore.
- Children aged between 1 and 5 years were dewormed with albendazole or pyrantel pamoate about every 4 months.
- Vegetable and fruit seeds and saplings were distributed to home gardens.

In GMP villages, growth monitoring was done by the nutrition worker every month. Growth charts were used to educate mothers. Growth monitoring was done in the child's home to ensure high take-up rates and the best possible understanding of the growth charts by mothers. We have described elsewhere⁷ that growth monitoring was successfully implemented in GMP villages, and resulted in correct use of growth charts, good understanding by mothers, and improved growth of children. Nutrition workers visited the households the same number of times and spent the same amount of time with mothers in NGM and GMP villages. The content of educational messages in both groups was identical but it was imparted to mothers in NGM villages without the use of growth charts. The anthropometric assessments for research purposes were done by an independent set of workers. Neither the nutrition worker nor mothers in NGM villages were informed how their children were growing with respect to weight.

The nutrition workers had 2 months of training from RUHSA health educators. The interventions were started in July, 1987. However, growth monitoring was not started when planned because many community members were unwilling to allow their children to be weighed. From July, 1987, to January, 1988, each nutrition worker visited homes and weighed children with the supervisor. These visits were used to motivate mothers to

Age (mo)	Baseline		Final	
	GMP (%)	NGM (%)	GMP (%)	NGM (%)
3-11	16.3	15.0	15.8	17.9
12-23	21.9	19.2	22.2	21.7
24-35	19.4	20.2	21.7	20.2
36-47	20.2	19.6	21.5	20.6
48-59	22.1	25.9	18.8	19.6
Total no	515	505	558	535

Table 2: Age distribution of children

appreciate the significance of weighing. During this interim period the nutrition worker imparted education without using the growth charts in GMP villages. In January, 1988, the supervisor distributed growth charts to all mothers in GMP villages. Over 50% of the charts had at least four weights already plotted and so most mothers could see the growth of their child from the first month of growth monitoring in February, 1988.⁷

Statistical analyses were done with SYSTAT (SYSTAT Inc, Evanston, Illinois, USA) and SAS (SAS Institute Inc, Cary, North Carolina, USA). Changes in nutritional status were analysed by dividing the study children into three age groups: 3 to 23 months, 24 to 44 months, and 45 to 59 months, according to the age of the child at the time of each assessment. These age groups were used because the World Health Organization growth standards have a discontinuity at 24 months,⁹ and the three age groups are characterised by different growth rates. Infants under 3 months of age were excluded because some were temporarily absent and because prenatal factors have a major influence on their growth. Comparisons were done by calculating monthly gains in stature and weight at consecutive intervals. The significance of differences in changes observed per month between the two treatment groups was calculated after adjustment for age and sex. The above analyses were done on the assumption that the child and the village each contributed to random variation. These analyses were done with the mixed-model procedure in SAS, which estimated the variances and adjusted for the village effects.⁸ The inter-village variances amounted to only 8% or less of the total variances. This sample size of younger children is adequate to detect a mean difference of 22 g per month in weight gain between the two treatment groups and of 0.8 mm per month in length gain. This study has the potential, therefore, to detect differences that are of public health significance.

Results

The GMP and NGM villages were similar with respect to caste, percent of nuclear families, mean birth order of the study child, and mean number of preschool children per mother (table 1). The study families in the two groups were also similar with regard to consanguinity of the parents and landlessness. The use of pre-existing services such as antenatal care and childhood immunisation was 5-8% higher in NGM villages, but use of family planning services was higher in GMP villages.⁸ The duration of breast

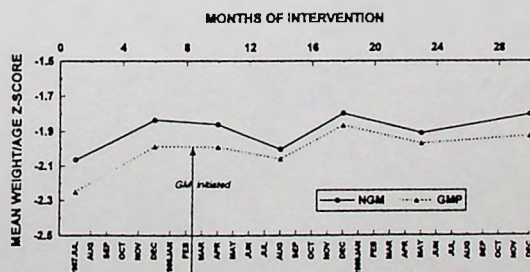


Figure 1: Mean Z-scores of weight for age in children aged 3 to 23 months in two groups by calendar month of intervention and duration

GM = growth monitoring.

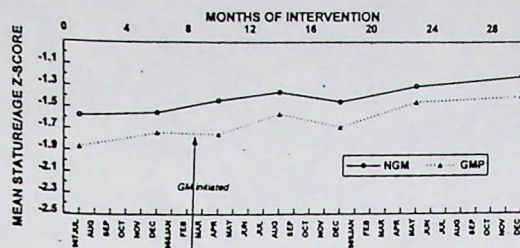


Figure 2: Mean Z-scores of height for age in children aged 3 to 23 months in two groups by calendar month of intervention and duration

GM = growth monitoring.

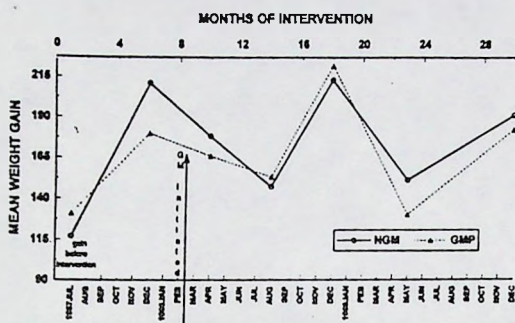


Figure 3: Mean weight gain (g per month) in children aged 3 to 23 months in two groups by calendar month of intervention and duration

Incremental weight gains for each interval are plotted at the end of the interval. GM = growth monitoring.

feeding was longer and weaning was later in GMP villages. GMP villages also used more traditional weaning foods and less infant formula than NGM villages. The age distribution of children measured at baseline and at the final examination was similar (table 2). The groups of children were similar with respect to mean weight for stature, but the mean stature for age and weight for age measurements were lower in GMP villages.⁸ Consistent seasonal patterns in growth (attained stature and weight) in GMP and NGM villages indicate the similarity of the two groups of villages in terms of response to seasons (figures 1 and 2). The weight gains were twice as large in the good growing season (last interval of the year) compared with the poor growing season (second interval of the year, figure 3).

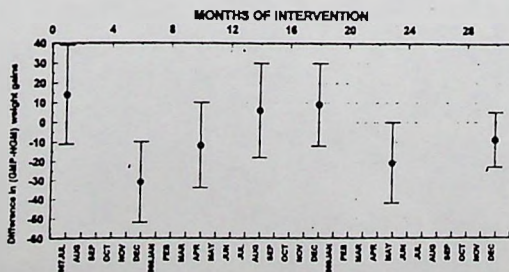


Figure 4: Difference (GMP minus NGM) in mean incremental weight gain (g per month) in children aged 3 to 23 months in two groups by calendar month of intervention and duration

Difference for each interval is plotted at the end of the interval. Values are means and SEMs.

	GMP		NGM		p
	No	Mean [SEM] length gain (cm per month)	No	Mean [SEM] length gain (cm per month)	
Jul 87-Dec 87	166	0.87 [0.03]	160	0.83 [0.03]	0.216
Dec 87-Apr 88	154	0.90 [0.03]	167	1.06 [0.03]	0.0001
Apr 88-Aug 88	152	1.00 [0.04]	167	0.99 [0.03]	0.814
Aug 88-Dec 88	152	0.82 [0.03]	164	0.82 [0.03]	0.885
Dec 88-May 89	175	0.98 [0.03]	160	1.04 [0.03]	0.056
May 89-Dec 89	197	0.87 [0.02]	177	0.89 [0.02]	0.603

Table 3: Mean [SEM] length gain in children aged 3 and 23 months

Figures 1 and 2 show the attained weights and statures of children aged between 3 and 23 months measured at regular intervals during the intervention. These figures indicate that there were similar improvements in both treatment groups over 30 months of intervention, and that improvements in GMP villages started even before growth monitoring. Figure 3 shows the relation between monthly weight gain and the duration of intervention. What is notable are the improvements in weight gain (figure 3), weight for age Z-scores (figure 1), and stature for age Z-scores (figure 2) in younger children of both GMP and NGM groups in the period after the baseline examination and introduction of interventions in July, 1987. The weight gain for younger children in GMP villages was marginally greater than in NGM villages between April, and July, 1987, before the initiation of other non-growth-monitoring interventions. However, the weight gain of young children in GMP villages in the first interval after the initiation of non-growth-monitoring interventions was significantly less than in NGM villages. The differences in weight gain between the two groups for other intervals were not significant ($p > 0.05$, figure 4). The monthly gain in stature showed similar patterns (table 3).

Improvements in nutritional status of younger children occurred in all 12 intervention villages. There were improvements in children of both caste groups, especially in Harijan children. In GMP villages the improvements in mean weight for age Z-scores of younger children from baseline to the final assessment were from -2.20 to -1.82 in Harijans and -2.27 to -1.97 in other castes, and in NGM villages were from -2.24 to -1.88 and -1.98 to -1.78 , respectively. Similar changes were also observed in stature for age Z-scores. In older children aged between 24 and 59 months the patterns of attained weights and stature, and of monthly weight and stature gains, were similar in both groups of villages but, as expected, gains were much smaller than in younger children.⁷

Discussion

The observation that the gains in stature between December, 1987, and April, 1988, in GMP villages were significantly less than those in NGM villages, and the fact that this followed the pattern of inadequate weight gains in GMP villages for July to December, 1987, is consistent with reports by others, which suggest that children need to put on adequate weight before they gain much height.¹⁰ The weight gains in the first interval after the initiation of non-growth-monitoring interventions in July, 1987, were significantly less in GMP villages than in NGM villages because a substantial amount of the time of the nutrition worker was spent convincing the families to accept weighing. The finding that there were improvements in GMP villages even before the introduction of growth monitoring,

and that the gains were similar in both groups after the initiation of growth monitoring in GMP villages (figures 3 and 4) over the entire duration of interventions, suggests that no additional benefit resulted from the growth-monitoring component. The growth charts in our field conditions did not seem to be a better educational tool than education without charts. Doubts about the usefulness of growth charts were raised in 1988 because of the marked seasonal changes in the growth of older children in Nepal.¹¹ Our data in young children support this observation. Even with our optimal field conditions, the successful growth-monitoring efforts could not overcome the marked seasonal impact on growth. This finding challenges the usefulness of growth charts to promote growth of children in areas where seasonal changes may have a substantial impact.

Until recently the main criticism of growth monitoring was the appropriateness of the technology.¹² Our study is the first to evaluate the effectiveness of growth monitoring with GMP and NGM villages. Why did the growth charts, which mothers understood and used appropriately, not lead to even better growth than nutritional and health education without weighing and charting? Growth monitoring is conceptually a very simple and attractive idea. Furthermore, mothers' perceptions of growth are inadequate. Although it seems very plausible that sensitising mothers to the faltering growth of their children (by looking at growth patterns) could stimulate them to provide additional care, child care is only one of the many responsibilities that a mother has. There is also the assumption that mothers have access to more resources (including time) and have more decision-making powers to reallocate these limited resources towards providing better child care than they actually possess. Our experience is that almost all mothers desire to provide better care but are overwhelmed by their workload and are often discouraged by the apathy of other family members towards the well-being of their children. In these villages mothers felt helpless on many occasions because of frequent verbal abuse and, not uncommonly, physical violence, alcoholism, and/or promiscuity of their husbands.¹³ Our experience suggests that growth monitoring can become an additional burden to an already overwhelmed mother. Mothers do not seem to need such visualisation to be persuaded to take necessary actions to improve the growth in their children. The mother responds to the worker's suggestions and attempts to change her practices when she is convinced that the worker does care for her child. In our study area the mother gets additional support from the worker to persuade the decision-making members of her family to take action. The mother's improved self-esteem coupled with the confidence that she can get support to provide better child care appeared to be gained with or without the use of growth charts. These improvements in self esteem of women seem to have facilitated better growth in children belonging to the lowest caste (Harijans) despite the higher socio-economic status of families of other castes. This appears to be due to the greater autonomy Harijan women have compared with women of other castes.¹⁴

In a centre-based nutritional programme the interaction between mother and worker may be minimal and rather impersonal with little or no participation from the mother. In our study the entire community was involved because of the home visits by workers. The practicality of a village worker spending one hour per month with the mother of every child in the home can be questioned. With our field conditions, however, this seemed to be the least amount of

effort necessary to get the mothers and the community really involved in growth monitoring.^{15,16} Furthermore, the effort of initiating growth monitoring in GMP villages resulted in substantially lower weight or length gains in younger children of GMP villages in intervals of the first year (figure 3 and table 3).

Until now, claims of successful growth monitoring have not separated benefits of the growth chart from benefits of other interventions that have been implemented with growth monitoring.¹⁷ Furthermore, the claims of successful growth monitoring, as in the Tamil Nadu Integrated Nutrition Program, have been based on anecdotal and impressionistic evidence.^{16,18} Our study suggests that one of the ways of achieving a greater sense of "community ownership"¹⁹ of government nutrition programmes is to facilitate the transition from the "centre" to the home-based approach. In many parts of India this home-based promotion of the growth of children without growth charts and monthly weighing will be more acceptable to the community because cultural prejudice against weighing is recognised. Home visits can also influence the decision makers in the family to provide better child care.

The effectiveness of growth monitoring in other countries needs to be established. In other cultures where the status of women may be better, where families have more resources to take care of their children, where there is greater community cohesiveness than in rural India, and where there is a well-developed primary health care infrastructure, growth monitoring may be effective.

This work was supported in part by grants from the Thrasher Research Fund, UNICEF, India, and the Rockefeller Foundation. We thank SmithKline Beecham (India) for the donation of albendazole and Ross Labs for the arm circumference tapes. We are indebted to Dr R L Parker, Dr B M Pulimood, Dr K E Mammen, Dr A V Puranik, Dr T J John, Dr T Cherian, Dr C E Taylor, Dr J E Rohde, others,⁷ and the field staff for their contributions. The paediatric surgeon's visit was made possible by grants from the CMC Research Committee and from the Department of Paediatric Surgery, CMC Hospital, Vellore, India.

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Personal paper

Deep-vein thrombosis and pulmonary embolism

John Black

The differential diagnosis between myocardial infarction (MI) and pulmonary embolism (PE) is rarely discussed in textbooks. My experience suggests that this is a serious omission. PE should be considered, as well as MI, in any patient with dyspnoea or atrial fibrillation of recent origin for which there is no obvious cause.

In 1968, about 10 days after a transatlantic flight, I experienced an aching pain in the left buttock and lumbar region. 2 days later my left leg swelled up over a matter of minutes, and the lumbar pain disappeared. I can find no reference to lumbar pain as a premonitory symptom of deep-vein thrombosis (DVT) but have since come across another doctor with an identical history. The lumbar pain may have been due to venous congestion from thrombosis of a pelvic¹ or lumbar vein, and this may have been relieved when the venous return diminished, due to extension of the thrombus into the femoral and great saphenous veins. After initial treatment with heparin followed by warfarin the swelling gradually subsided, leaving only some dilated veins in the calf and round the internal malleolus.

Nothing further happened until 1987 when I noticed mild exertional dyspnoea with a regular pulse. The same night I was woken by a grossly irregular heart beat which was confirmed as atrial fibrillation by a general practitioner the next morning—and by an electrocardiogram when I was seen in the afternoon by a cardiologist. The fibrillation was intermittent, each attack lasting 2-3 hours. The provisional diagnosis was paroxysmal atrial fibrillation due to an MI, though the ECG showed no evidence of infarction. A normal rhythm was rapidly restored by digoxin, and I returned to London where I was seen by another cardiologist who also thought an MI to be the most likely diagnosis. Both resting and exercise ECGs were normal, as were a chest X-ray and an echocardiogram. There had been no change in the veins in my left leg.

Over the next two weeks I maintained normal rhythm but the dyspnoea varied unpredictably in severity. At its worst, usually after mild exertion, I experienced a bursting pain in the precordium. One morning, after running for a bus, I

suddenly felt cold and clammy. Unwisely I continued with my journey, but on the way back I felt so ill that I abandoned the bus and took a taxi home, where I telephoned my wife at work and our general practitioner's surgery. When she heard that I had taken a taxi my wife knew at once that something was seriously wrong. The doctor I spoke to was not our usual one and needed to be convinced that I was not suffering from influenza before he agreed to visit me. By the time my wife and the doctor had arrived I was feeling better, and my pulse and blood pressure were normal. An appointment was made to see the cardiologist and I was admitted to hospital. Chest X-rays, ECGs, and a coronary angiogram were normal, but a pulmonary arteriogram revealed occlusion of the upper branch of the right pulmonary artery. After a short course of heparin I was given warfarin for 6 months.

2 months after stopping the warfarin, I went on holiday on an overnight flight, with very little leg room. A week later a small area of venous thrombosis on the dorsum of my left foot developed. On my return to London I noticed frequent extrasystoles, and after a few days I once more had mild dyspnoea on exertion. A ventilation-perfusion scan revealed three areas of hypoperfusion in the right lung. A recurrence of PE was diagnosed and I was admitted and given heparin for a week and warfarin indefinitely.

Lumbar pain as a presenting symptom of DVT may be more common than its absence from published work suggests. Aeroplane journeys, especially overnight flights, are a well-known risk factor for DVT and PE. For some weeks before the first episode of PE I had been editing a book while seated on a wooden slatted chair. This probably initiated a venous thrombus which lodged in the pulmonary artery. The initial diagnosis of MI was justified though it could be debated whether an infarct severe enough to cause dyspnoea and atrial fibrillation would have failed to produce any ECG abnormality up to 3 weeks later. Atrial fibrillation, and less commonly, atrial flutter occur in 7-10% of cases of MI² but in only 3% of episodes of PE³ and in many textbooks the association of PE with arrhythmias is not mentioned. The development of extrasystoles during the second episode may well have been an indication of strain on the myocardium since it is well recognised that extrasystoles often precede atrial fibrillation. Although

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(J Black FRCP)



ICDS

Mother-Child Protection Card



Name of pregnant woman _____ Age

Mother's education: illiterate/primary/middle/school final/graduate

Husband's name _____

Date of the first day of the last menstrual period / /

Expected date of delivery / /

Child's Name _____

Date of birth / / Birth Weight gms

Girl Boy

Birth Registration: Yes/ No Birth order: primi/not primi

Address _____

Anganwadi _____

SHC / Clinic _____

PHC / Town _____

Registration No. Date



ICDS

Mother-Child Protection Card



Name of pregnant woman _____ Age

Mother's education: illiterate/primary/middle/school final/graduate

Husband's name _____

Date of the first day of the last menstrual period / /

Expected date of delivery / /

Child's Name _____

Date of birth / / Birth Weight gms

Girl

Boy

Birth Registration: Yes/ No

Birth order: primi/not primi

Address _____

Anganwadi _____

SHC / Clinic _____

PHC / Town _____

Registration No. Date

Regular checkup is essential during pregnancy

Months	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
Registration									
ANC									
Blood pressure									
Weight									
T.T. Injection									
Iron Tablets									

Additional investigation and information about pregnancy

Place of Delivery

Hospital

Dai

TBA

Delivery Kit

Family welfare

5 Cleans

yes no

As soon as you see any of these danger signs rush to the hospital



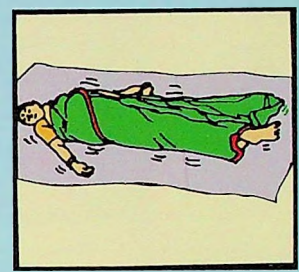
Bleeding during pregnancy or delivery



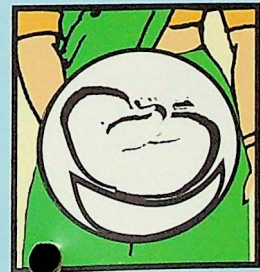
Severe Anaemia with or without breathlessness



High fever during pregnancy or within one month of delivery



Convulsions or fits, blurring of vision or severe vomiting



Absent movements of the baby or abnormal presentations - oblique or breech



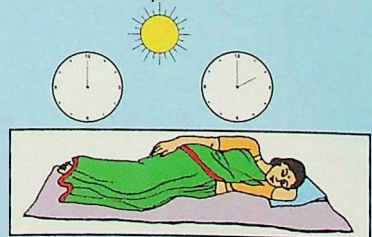
Bursting of water bag without any pain

Care During Pregnancy

How families can help



Take more than usual amounts of food, plenty of green leafy vegetables and use only iodised salt



Take at least two hours of rest during the day

A healthy child gains weight regularly

Continue breastfeeding and feeding of regular food during illness. On recovery, feed the child increased amounts of usual foods.

RECORD OF ILLNESS

Fever

In case of high fever, start cold, wet sponge on the forehead and limbs as you take the child to a doctor.



Diarrhoea

Give increased amounts of fluids to drink. If loose motions do not stop, take the child to a doctor and continue feeding the usual foods. Give ORS and breastfeed.



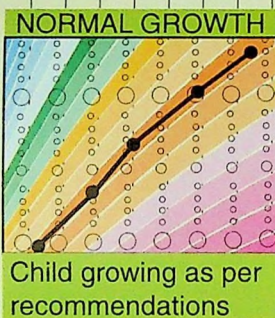
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If the child has rapid breathing and/or difficult breathing such as chest in-drawing, start antibiotics prescribed by the worker and take the child to a doctor.



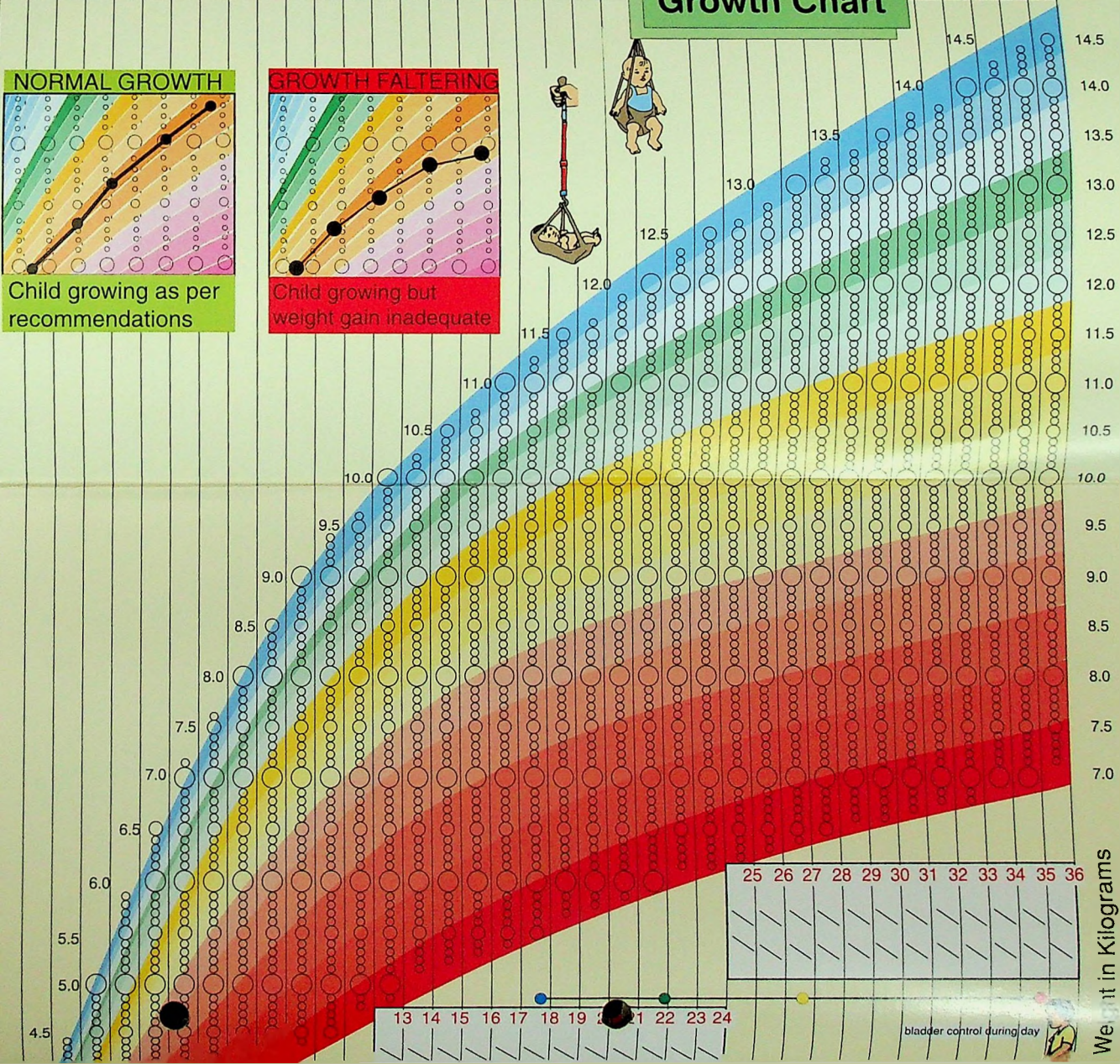
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36

Details of Immunisation	
1st year (0 to 12 months)	
Date	
/ /	
B.C.G.	
Date	Date
/ /	/ /
DPT - 1	Polio - 1
Date	Date
/ /	/ /
DPT - 2	Polio - 2
Date	Date
/ /	/ /
DPT - 3	Polio - 3
Date	Date
/ /	/ /
Measles	Vitamin A
Date	Date
/ /	/ /



Growth Chart

Weight in Kilograms



2nd year (12 to 24 months)	
Date	Date
/ /	/ /
DPT	Polio
Date	Date
/ /	/ /

The Times of India
7th August, 2001

WORLD BREASTFEEDING WEEK

1-7 AUGUST 2001

Breastfeeding in the Information Age

Know these facts about breastfeeding

.....and their advantages

Ideally

Breastfeeding should be initiated immediately after child birth (within half an hour).

BUT only 15.8% infants get breast-milk within an hour of birth in our country.

Infant should be breastfed exclusively for first 6 months.

BUT only 19.4% infants are exclusively breast fed for first 6 months in India.

Infants should be given home based complementary foods (dalia, khichri etc.) from 6 months of age while continuing breastfeeding.

BUT only 49.4% infants are given some complementary foods from 6 months of age in India.

Breastfeeding should be continued upto two years of age and beyond.

BUT in India only 59% infants are breast fed upto 2 years.

This helps in establishing successful lactation;
Enables feeding of 'colostrum' to the baby, a concentrated source of vitamin A, protein and anti-infective constituents that provides natural immunity to the child;

It benefits the mother also in several ways

Breast milk provides all the nutrients that a baby needs during the first 6 months.

Any liquid or solid food other than breast milk given during this period causes diarrhoea which may sometimes be fatal.

Any feed other than breast milk suppresses lactation.

A growing infant's increasing requirements can not be met by breast milk alone after 6 months.

Infant requires adequate and frequent complementary feeding alongwith breastfeeding for optimal growth and development.

Breast milk provides valuable nutrients to the child during this active growth period.

Breastfeeding alongwith complementary feeding prevents malnutrition in children



DO YOU KNOW?

World Health Assembly 2001 recommends exclusive breastfeeding for the first six months of life for all segments of society.

Knowing these facts about Breastfeeding and communicating the same to as many people as possible is our moral duty towards the future citizens of this country.



Food and Nutrition Board

Department of Women and Child Development
Ministry of Human Resource Development
Government of India
Shastri Bhavan, New Delhi.



Breastfeeding Promotion Network of India (BPNI)

Position Statement on: HIV and Infant Feeding

Breastfeeding is the optimal way to feed an infant. It greatly improves quality of life by providing unique nutritional, immunological, economic, ecological, psychological and child spacing benefits. Breastfeeding also enhances maternal health.

Breastfeeding saves lives. Infant mortality continues to be very high in India and artificial feeding contributes to a major part of this. Malnutrition is rampant among infants and this can be prevented to a significant extent by breastfeeding.

HIV transmission and infant feeding

Transmission via breastfeeding to uninfected infants born to women with HIV infection is estimated to occur in 1 in 7 cases. The risk of HIV transmission through breastfeeding is highest among women who become infected whilst breastfeeding.

Mothers, health workers and organisations such as BPNI are faced with a dilemma concerning decisions about infant feeding. Given the evidence regarding the risk of HIV transmission through breastmilk, it is vital for policies to be developed with regard to breastfeeding by HIV positive mothers.

Recommendations

1. Priority should be given to policies and programmes, which aim to prevent women of childbearing age and their partners from becoming infected with HIV in the first place. Appropriate preventive measures should be taken to reduce mother to infant HIV transmission.
2. The general principle "irrespective of HIV infection rates, breastfeeding should continue to be protected, promoted and supported" as enunciated by UNAIDS¹ should be followed.
3. Women should be "empowered to make fully informed decisions"¹ about infant feeding and supported in their decision.
4. Voluntary and confidential counselling and HIV testing should be made available for women of childbearing age and their partners. For those women who are aware of their HIV status, information should include the benefits of breastfeeding, additional risk of transmission of HIV via breastmilk, risks and possible advantages and disadvantages associated with other methods of feeding. This should be done in a supportive environment, which minimizes any possible discrimination or stigmatization.

5. Women should be informed about the alternative methods of feeding such as using heat-treated (62.5°C for 30 minutes) expressed breastmilk, wet nursing, etc. and the use of a cup rather than bottle to minimize risks of artificial feeding.

6. BPNI advocates adherence to the "Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992" and the World Health Assembly Resolution, 1994 which also recommends that there are no donations or low cost supplies within any part of the health care system.

7. Research Needs

(a) There is an urgent need for more research on HIV transmission through breastfeeding, and interventions that may permit breastfeeding to be available to the infants of HIV infected women in Indian situation.

(b) Research should be funded and conducted in a transparent and independent manner by those who do not have a commercial interest in the outcome. Financial support for research and information of HIV and infant feeding matters should not create conflicts of interest.

BPNI January 1999

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3. *WHA Resolution 47.5, 9 May 1994. Eleventh Plenary W.H.O. Geneva.*

Members of the Committee on HIV & Infant feeding, BPNI

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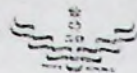
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MALNUTRITION A CHALLENGE



Malnutrition is a multi-faceted problem interfering with all efforts for development of human resources.

- ❑ Nutrition is an important indicator of the development of a country.
- ❑ India's Human Development Index (HDI) Rank is 132 in the world reflecting a major deficiency in the quality of life of people.
- ❑ Malnutrition in children and women is associated with high morbidity and mortality.
- ❑ Malnutrition is responsible for low productivity leading to poor social and economic progress.
- ❑ Chronic malnutrition in children results in stunting, poor cognitive development and poor learning ability.
- ❑ Women and children are worst affected by malnutrition.
- ❑ High prevalence of low birth weight, high malnutrition in 0-2 year olds, poor nutrition of adolescent girls coupled with early marriage and teenage pregnancies result in an inter-generational cycle of malnutrition.
- ❑ Even mild and moderate deficiencies of micronutrients particularly of iron, vitamin A, folic acid and iodine result in poor growth, development and immunity in the population.
- ❑ Foodgrain production has increased fourfolds during the last five decades but food security at the household level is yet to be achieved.
- ❑ Poor access to sanitation facilities and safe drinking water leads to high rates of infection which further perpetuates malnutrition.
- ❑ Malnutrition being invisible often gets neglected.

Malnutrition is a "Silent Emergency" which needs to be tackled on war footing

The Government of India recognises malnutrition as an impediment to national development and is implementing a number of Direct and Indirect Nutrition Programmes to combat malnutrition.

Determinants of young child malnutrition:-

- Female Illiteracy
- Poor nutritional status of girl children and adolescent girls
- Early marriages of girls
- Teenage pregnancies
- Chronic energy deficiency and anaemia in pregnant women
- Low birth weight babies
- Late initiation of breastfeeding
- Delayed and inadequate complementary feeding
- Ignorance about nutritional needs of infants
- Poor hygienic practices in feeding infants
- Infection and Intestation

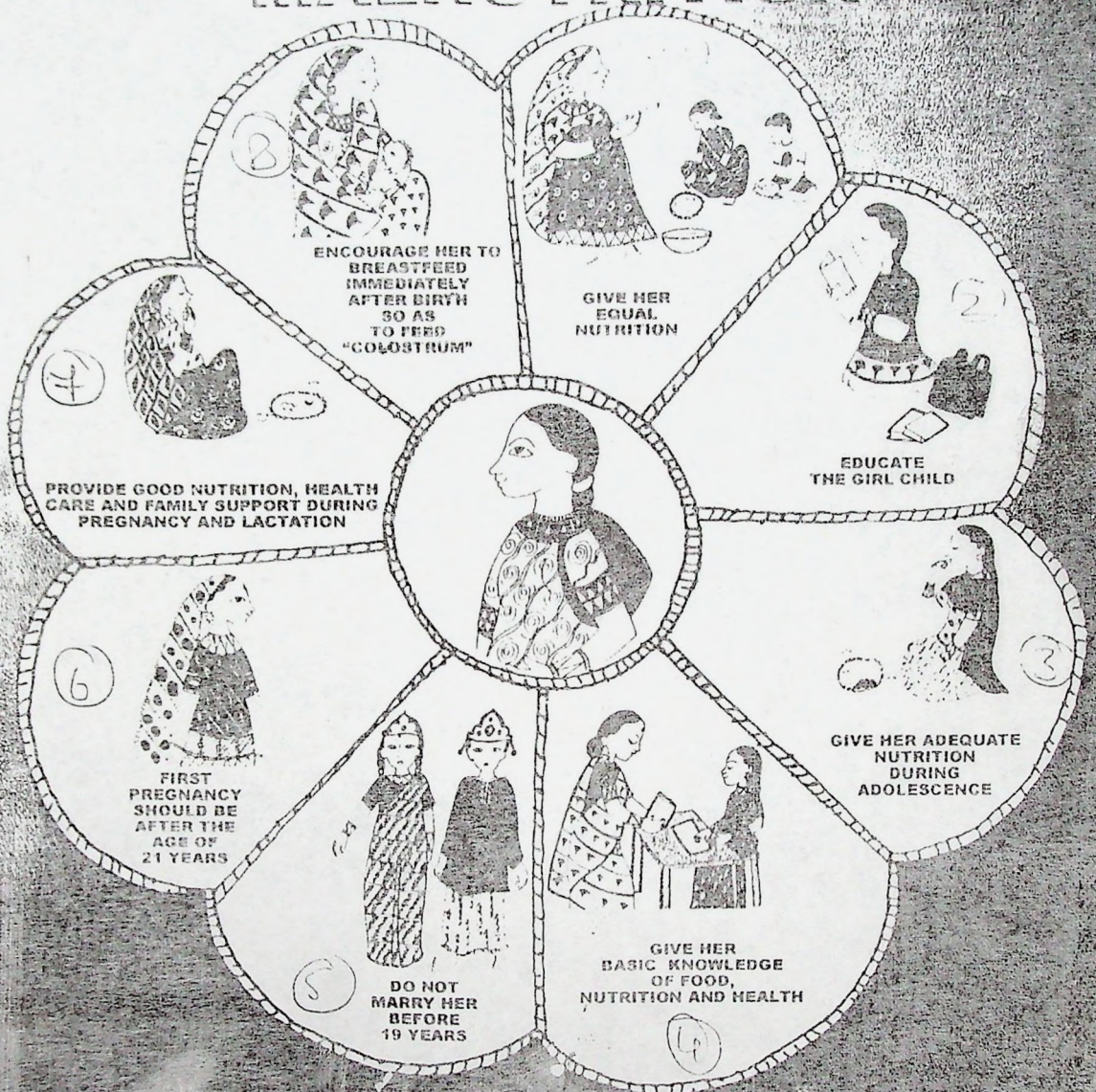
Together we can make it work: A partnership between government and people

Malnutrition can be eradicated by ushering in "Nutrition Revolution"

**Ministry of Human Resource Development, Department of Women and Child Development
Government of India**

AN 12

ENSURE NUTRITION OF THE GIRL CHILD AND ERADICATE MALNUTRITION



NUTRITION OF THE GIRL CHILD WILL HELP PREVENT LOW BIRTH WEIGHT IN THE NEW BORN AND BREAK THE INTERGENERATIONAL CYCLE OF MALNUTRITION



FOOD AND NUTRITION BOARD
DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT, MINISTRY OF HUMAN RESOURCE DEVELOPMENT
GOVERNMENT OF INDIA, BHADRABHAWAN, NEW DELHI - 110 001

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Inst
Quack

ಕರ್ನಾಟಕ ಸರ್ಕಾರ

ನಂ: 01/2022/ಸಿ:ರಿಸಿ:ಪಿ:ಪಿ ರಜ:ಆಂ:2000-2000

ಆರ್ಥಿಕತೆ ಇಲಾಖೆ

ನಿರ್ದೇಶಕರವರ ಕಛೇರಿ
ಮಹಿಳಾ ಮತ್ತು ಮಕ್ಕಳ ಅಭಿವೃದ್ಧಿ
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ANV-14

ವಿಷಯ: ವಿಶ್ವವಿದ್ಯಾರ್ಥಿ ಸಂವಿಧಾನ ಅಡಿಯಲ್ಲಿ ಯೋಜನೆಯಡಿ ಯುಪಿ
2000-2002 ನೇ ಸಾಲಿಗೆ ಅಂಗನವಾಡಿ ಕಾರ್ಯಕ್ರಮದ
ಸಹಾಯಕಿಯರ ತರಬೇತಿ ವೇಳಾಪಟ್ಟಿ

ಉಲ್ಲೇಖ: ಕೇಂದ್ರ ಸರ್ಕಾರದ ಆದೇಶ ಹಾಗೂ ಮಾರ್ಗದರ್ಶನ ಪತ್ರ ಸಂ:
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ಕೇಂದ್ರ ಸರ್ಕಾರದಿಂದ ಅನುಮೋದಿತವಾದ ಉದ್ದೇಶ ಯೋಜನೆಯಡಿ ಮಾರ್ಗ-
ದರ್ಶನದಂತೆ ಸಮಗ್ರ ಅಭಿವೃದ್ಧಿ ಯೋಜನೆಯ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಅನುಷ್ಠಾನ-
ಗೊಳಿಸುವ ಕಾರ್ಯಕ್ರಮದ ಅಂಗವಾಗಿ ಕಾರ್ಯಕ್ರಮ: ಸಹಾಯಕಿಯರಿಗೆ 2000-2002 ನೇ
ಸಾಲಿಗೆ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮ ಸಮೀಕರಿಸಲ್ಪಡಲಾಗಿದೆ. ಆದ್ದರಿಂದ ಉಲ್ಲೇಖಿತ ಮಾರ್ಗದರ್ಶನದಂತೆ
ಅಭಿವೃದ್ಧಿ ತರಬೇತಿ ಮುಗಿಸಿ, 2000-2002 ನೇ ಸಾಲಿನ ಶೈಕ್ಷಣಿಕ ವರ್ಷಕ್ಕೆ ಮಾರ್ಗದರ್ಶನದಂತೆ
ಸಹಾಯಕ ನಿರ್ದೇಶಕರು ಮತ್ತು ಅಭಿವೃದ್ಧಿ ಯೋಜನಾಧಿಕಾರಿಗಳು ಸಲ್ಲಿಸಿರುವ ನಿಯಮಿತ
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ದಿನ) ಜೂನ್ 2000 (ವರೆಗೆ) ಅನುಬಂಧದಲ್ಲಿ ವಿವರದಂತೆ ಅಂಗನವಾಡಿ ಕಾರ್ಯಕ್ರಮದ ವ್ಯಕ್ತಿ-
ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮದ ವಿವರ ತರಬೇತಿ ವೇಳಾ ಪಟ್ಟಿ ಸಿದ್ಧಪಡಿಸಲಾಗಿದೆ.

ಇದೇ ತರಬೇತಿ ವೇಳಾಪಟ್ಟಿಯಂತೆ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮವನ್ನು ನುಡಿಸಿ
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(ಆರೋಪಿಸಿ ಪ್ರಾರಂಭ ಮತ್ತು ಅಂಗನವಾಡಿ ತರಬೇತಿ ಕೇಂದ್ರ ಅಧಿಕಾರಿಗಳನ್ನು ಹೊಂದಿರುವವರಿಗೆ)
ಸಹಾಯಕಿಯರ ಆದ್ಯಂತ ನಂಬಿಕೆಯುಳ್ಳ ಸಹಾಯಕ ನಿರ್ದೇಶಕರು: ಅಭಿವೃದ್ಧಿ ಯೋಜನಾ-
ಧಿಕಾರಿಯವರು ಮತ್ತು ಸಹಾಯಕ ನಿರ್ದೇಶಕರುಗಳು ಕಾರ್ಯಕ್ರಮದ ವಿವರವನ್ನು ತರಬೇತಿ ಕಾರ್ಯದರ್ಶಿಗಳಿಗೆ
ಅರ್ಪಿಸಿ ದಿನವೇ ಸಂಬಂಧಿಸಿದ ತರಬೇತಿ ಸಂಸ್ಥೆಗಳಲ್ಲಿ ಮಾಹಿತಿಗಾಗಿ ನಿಯೋಜಿಸಲಾಗಿದೆ.
ಅಭಿವೃದ್ಧಿ ತರಬೇತಿ ತಂಡದವರಿಗೆ 2000 ರಿಂದ 2002 ರವರೆಗೆ ಕಾರ್ಯಕ್ರಮದ ವಿವರವನ್ನು
ನಿಯಮಿತವಾಗಿ ಕಡ್ಡಾಯವಾಗಿ 2000-2002 ನೇ ಸಾಲಿನ ಕಾರ್ಯಕ್ರಮದ ಅಡಿಯಲ್ಲಿ ಯೋಜನೆಯಡಿ
ನಿಗದಿತ ಸಂಖ್ಯೆಗಿಂತ ಹೆಚ್ಚಿನವರನ್ನು ಕಡ್ಡಾಯ ಸಂಖ್ಯೆಯಲ್ಲಿ ತರಬೇತಿ ಪಡೆಯುವ ಹಿತರಾಗುವಂತಿಲ್ಲ.
ಇದನ್ನು ನಂಬಿಕೆಯುಳ್ಳ ಸಹಾಯಕ ನಿರ್ದೇಶಕರವರ ಜವಾಬ್ದಾರಿಯಾಗಿ ನುಡಿಸಲಾಗಿದೆ.

ತರಬೇತಿ ಸಂಸ್ಥೆಯು ಮುಖ್ಯಸ್ಥರು ನಿರೂಪಿಸಿದ ಯೋಜನೆಯ ಅಧಿಕಾರಿ-
ಗಳನ್ನು ಮಾಹಿತಿಗಾಗಿ ವ್ಯಕ್ತಿಸಿ ನಿರೂಪಿಸಿದ ಬಗ್ಗೆ ಉಪವಿಭಾಗೀಯ ಅಧಿಕಾರಿಗಳು
ತರಬೇತಿ ತುರ್ತಾದ ಹಿತರಾದ ತಕ್ಷಣ ಹಿತರಾಗುವಂತೆ ಸಂಖ್ಯೆ, ವಾಸ್ತವ ಪ್ರಯೋಗ ಇತ್ಯೆ,
ಇದನ್ನು ತಿಳಿಸಿ ವಿವರವನ್ನು ತಪ್ಪದೇ ತಂಗೆ ಸಂದೇಶದ ಮುಖಾಂತರ ಜಂಟಿ ನಿರ್ದೇಶಕರು:
(ಸಹಾಯಕ) ಇಲಾಖೆ, ಪ್ರಧಾನ ಕಛೇರಿ, ಬೆಂಗಳೂರು, ಇವರಿಗೆ ತಿಳಿಸುವುದು.
ತಪ್ಪಿದರೆ ಸಹಾಯ ಸಂಸ್ಥೆಯು ಅನುಗ್ರಹಿಸುವುದು. ತರಬೇತಿ ಅಧಿಕಾರಿಯಲ್ಲಿ

JTC - Job by Course for AWC
 RC - Ref. Course for "

ANNEXURE

AN 13

TRAINING PROGRAMME CALENDER PERTAINING TO 24 AWTCS IN KARNATAKA FOR THE 1ST QUARTER OF 2001-2002 (16.4.01 TO 14.7.2001)

Sl. No.	Name of AWTC with address	April 2001	May 2001	June 2001	July 2001
1	2	3	4	5	6

1.	AWTC, C/o KBCCW, Vevekanand Nagar, Mysore	JTC from 16.4.01 to 14.7.01			
		K.R.Nagar	-	20	
		H.D.Kote		7	
		Pirivapatna		11	
		Naniand		2	
				40	

2.	AWTC, Shivabasavanagar, Belgaum	JTC from 16.4.01 to 14.7.01			
		Sindagi	-	7	
		Indi		8	
		Muddebihal		15	
		Bijapur		5	
		Basavana Bagevadi		5	
				40	

3.	AWTC, Ullal, Mangalore [DK]	R.C from 16.4.01 to 30.4.01 Mangalore [R] - 40			
		R.C from 7.5.01 to 21.5.01 Belthangadi - 40			
		R.C from 26.5.01 to 9.6.01 Sulva - 40			
		R.C from 14.6.01 to 28.6.01 Bantwal - 40			

ತಂದೆ ವಿಧಾರದ ಅಂಚು, ನವೆಂಬರ್ ವ್ಯವಸ್ಥೆಯನ್ನು ಸಂಸ್ಥೆಯು ಭವಿಷ್ಯಕ್ಕೂ. ಅಲ್ಲದೇ
 ತಂದೆಗೆ ಮುಕ್ತಾಯವಾಗ ಕೂಡಲೇ ಬಾಣ್ಣೆ ಪರದೆಯನ್ನು (ಬಣ್ಣ-ನೋಟದ ವಿವರ
 ಕೂಡಲೇ ತಂದೆಗೆ ವರದಿಯನ್ನು) ಸಹಾಯಕ ನಿರ್ದೇಶಕರ ಮುಖಾಂತರ ಕೇಂದ್ರ ಕಛೇರಿಗೆ
 ಸಲ್ಲಿಸುತ್ತಾಡು.

ಸಹಿ : ಬಿ.ವಿ.ವಿ.ವಿ.ವಿ.
 ನಿರ್ದೇಶಕರು
 ಮಹಿಳಾ ಮತ್ತು ಮಕ್ಕಳ
 ಅಭಿವೃದ್ಧಿ ಇಲಾಖೆ ಬೆಂಗಳೂರು

ಪ್ರತಿಯನ್ನು ಸೇರ ಕೆಳಕಂಡವರಿಗೆ ಸೂಕ್ತ ಕಾಗುಣ ಸೂಕ್ತ ಮಕ್ಕಳಿ ರವಾನಿಸಿ

- ೧) ಸಂಬಂಧಿಸಿದ ಜಿಲ್ಲಾ ಸಹಾಯಕ ನಿರ್ದೇಶಕರು, ಮಹಿಳಾ ಮತ್ತು ಮಕ್ಕಳ ಅಭಿವೃದ್ಧಿ ಇಲಾಖೆ
 ಸಂಬಂಧಿಸಿದ ಮೇಲಣ್ಣೆ ಅಧಿಕಾರಿಗಳಿಗೆ
- ೨) ಸಂಬಂಧಿಸಿದ ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರ ತರಬೇತಿ ಸಂಸ್ಥೆಯ ಮುಖ್ಯಸ್ಥರುಗಳಿಗೆ
- ೩) ಸೋಡರ್ ಆಫೀಸರ್, ನಿವೃತ್ತಿ, ಯುಎಂಇ ನ್ಯಾಟಿನ್, ಬೆಂಗಳೂರು-೨೫
- ೪) ಕೇಂದ್ರಾಧಿಕಾರಿಗಳು, ಪ್ರಧಾನ ಕಛೇರಿ, ಬೆಂಗಳೂರು
- ೫) ಕಛೇರಿ ಪ್ರತಿ.

(Handwritten Signature)
 ನಿರ್ದೇಶಕರ ಪರವಾಗಿ
 ಮಹಿಳಾ ಮತ್ತು ಮಕ್ಕಳ
 ಅಭಿವೃದ್ಧಿ ಇಲಾಖೆ ಬೆಂಗಳೂರು

JTC - Job by Course for AWC
 RC - Ref. Course for "

ANNEXURE

AN 13

TRAINING PROGRAMME CALENDER PERTAINING TO 24 AWTCs IN KARNATAKA FOR THE 1ST QUARTER OF 2001-2002 (16.4.01 TO 14.7.2001)

Sl. No.	Name of AWTC with address	April 2001	May 2001	June 2001	July 2001
1	2	3	4	5	6
1.	AWTC, O/o KSCCW, Vavakanand Nagar, Mysore	JTC from 16.4.01 to 14.7.01			
		K.R.Nagar	-	20	
		H.D.Kote		7	
		Pirivapatna		11	
		Naniandud		2	
				40	
2.	AWTC, Shivabasavanagar, Belgaum	JTC from 16.4.01 to 14.7.01			
		Sindagi	-	7	
		Indi		8	
		Muddebihal		15	
		Bilapur		5	
		Basavana Bagevadi		5	
				40	
3.	AWTC, Ullal, Mangalore [DK]	R.C from 16.4.01 to 30.4.01 Mangalore [R]	-	40	
		R.C from 7.5.01 to 21.5.01 Belthangadi	-	40	
		R.C from 26.5.01 to 9.6.01 Sulva	-	40	
		R.C from 14.6.01 to 28.6.01 Bantwal	-	40	

1	2	3	4	5	6
4.	AWTC, Sihineeru Kola Extn., Mandva	R.C from 16.4.01 to 30.4.01 Chamrainagara	-	40	
		R.C from 7.5.01 to 21.5.01 K.R Nagar	-	40	
		R.C from 26.5.01 to 9.6.01 Gundlupet Yelandur	- 20 20	40	
		R.C from 14.6.01 to 28.6.01 Chamrainagar	-	40	
5.	AWTC, C/o KSCCW, Mumabad Road, Gulbarga	R.C from 16.4.01 to 30.4.01 Gulbarga [R]	-	40	
		R.C from 7.5.01 to 21.5.01 Afzalpur	-	40	
		R.C from 26.5.01 to 9.6.01 Gulbarga [R]	-	40	
		R.C from 14.6.01 to 28.6.01 Afzalpur	-	40	
6.	AWTC, C/o KSCCW, Near Kodagu Vidyalaya, Madikeri	R.C from 16.4.01 to 30.4.01 Madikeri	-	40	
		R.C from 7.5.01 to 21.5.01 Rantwal	-	40	
		R.C from 26.5.01 to 9.6.01 Puttur	-	40	
		R.C from 14.6.01 to 28.6.01 Belthangadi	-	40	
7.	AWTC, C/o KSCCW, 5th Main, Shettihally Cross Road, Javanagar [E] Tumkur	R.C from 16.4.01 to 30.4.01 Madhusiri	-	40	
		R.C from 7.5.01 to 21.5.01 Madhusiri	-	40	
		R.C from 26.5.01 to 9.6.01 Koratagere	-	40	
		R.C from 14.6.01 to 28.6.01 Madhusiri	-	40	

R.C from 14.6.01 to 28.6.01
Bangalore Central - 40

R.C from 26.5.01 to 9.6.01
Bangalore South - 201 - 40
Bangalore North - 201

R.C from 7.5.01 to 21.5.01
Bangalore North - 40

R.C from 16.4.01 to 30.4.01
Bangalore North - 40

R.C from 14.6.01 to 28.6.01
Bangalore North - 40

R.C from 26.5.01 to 9.6.01
S.S Ashram - 301 40
Bangalore State 101

R.C from 7.5.01 to 21.5.01
Bangalore South - 40

R.C from 16.4.01 to 30.4.01
Bangalore CI - 40

39

Jamakandi - 15
Hunnanda 4
Badami 11
Mudhola 3
Badalkote 6

JTC from 16.4.01 to 14.7.01

Hunnanda - 39

JTC from 16.4.01 to 14.7.01

1 2 3 4 5 6

11. AWTC.
C/O KSCCW.
Grahams' Street,
Anekal

10. AWTC.
C/O KSCCW.
Near R.T. Nagar Office,
Bangalore

9. AWTC.
C/O S.V.V Sanaha.
Humnabad Taluk,
Amlnabad,
Badalkote District

8. AWTC.
J.G.V.S Samshe,
Badami Taluk,
Gulednada,
Badalkote District

 1

 2

 3

 4

 5

 6

12. AWTC,
 C/O KSCCW,
 B.R Road,
 Kanakapura

Sumanjali Sevashrama - 20
 Anekal
 Kanakapura

40

13. AWTC,
 C/O KSCCW,
 Ambedkar Nagar,
 Kadur,
 Chickamagalur Dist

R.C from 16.4.01 to 30.4.01
 Talikere - 40

R.C from 7.5.01 to 21.5.01
 Chickamagalur - 40

R.C from 26.5.01 to 9.6.01
 Kadur - 40

R.C from 14.6.01 to 28.6.01
 Kadur 301 - 40
 Koppa 101

14. AWTC,
 C/O KSCCW,
 Somavva Layout,
 Shimoga

R.C from 16.4.01 to 30.4.01
 Chickamagalur - 40

R.C from 7.5.01 to 21.5.01
 Sringeri - 151
 Mudigere 251 - 40

R.C from 26.5.01 to 9.6.01
 Talikere - 40

R.C from 14.6.01 to 28.6.01
 Chickamagalur - 40

JTC from 16.4.01 to 14.7.01

15. AWTC,
 C/O KSCCW,
 F.J. Extension,
 Davanagere

Hanagal - 10
 Ranibennur 12
 Shigov 13
 Hirekerur 5

40

1	2	3	4	5	6
16.	AWTC. T.A.E Society. Harabanahalli. Davangere Dist	RC from 16.4.01 to 30.4.01 Bvadaai	-	40	
		RC from 7.5.01 to 21.5.01 Hancal	-	40	
		R.C from 26.5.01 to 9.6.01 Ranibennur	-	40	
		RC from 14.6.01 to 28.6.01 Shiccov	-	40	
17.	AWTC. KLE Society. Ankola. U.K District	JTC from 16.4.01 to 14.7.01			
		Yellapura	-	10	
		Bhatkal		5	
		Ankola		2	
		Siddapura		7	
		Mundacod		10	
		Jovida		4	
				38	
18.	AWTC. Tapovana. Yellapur Taluk. U.K Dist	RC from 16.4.01 to 30.4.01 Hirekerur	-	40	
		RC from 7.5.01 to 21.5.01 Shiccov	-	40	
		RC from 26.5.01 to 9.6.01 Haveri	-	40	
		RC from 14.6.01 to 28.6.01 Haveri	-	40	
19.	AWTC. C/o KMC. Manipal	JTC from 16.4.01 to 14.7.01			
		Mangalore [R]	-	40	
20.	AWTC. Northern Extension. Hosoline Road. Hassan	JTC from 16.4.01 to 14.7.01			
		Mangalore [R]	-	23	
		Mangalore [U]		5	
		Sullya		8	
		Puttur		4	
				40	

ONE day workshop for ADs / POs / CPOs
for improved delivery of ICDS Services.

ಮಾರ್ಗಸೂಚಿ:-

ಎಲ್ಲರಿಗೂ ತಿಳಿದಿರುವಂತೆ ತಾವೆಲ್ಲರೂ ಈಗಾಗಲೇ ಸಾಕಷ್ಟು ಸಮಯದಿಂದ ತಿಳಿ
ಅಭಿವೃದ್ಧಿ ಯೋಜನೆಯ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಅನುಷ್ಠಾನಗೊಳಿಸುವಲ್ಲಿ
ಯಶಸ್ವಿಯಾಗಿರುವುದಿಲ್ಲ. ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಅನುಷ್ಠಾನಗೊಳಿಸುವಾಗ ತಮಗೆ
ಸಾಕಷ್ಟು ಸಮಸ್ಯೆಗಳು ಕಂಡುಬಂದಿರಬಹುದು ಹಾಗೂ ಇದನ್ನು ನಿವಾರಿಸಲು
ಸಲಹೆ ಸೂಚನೆಗಳಿದ್ದರೂ ತಾವೆಲ್ಲರೂ ತಮ್ಮದೇ ಆದ ತಂತ್ರಜ್ಞಾನ ವನ್ನು
ಆಳವಡಿಸಿರಬಹುದು. ಆದರೂ ಇವುಗಳನ್ನು ದಾಖಲು ಮಾಡಲು ಸರಿಯಾದ
ಪದಾವಕಾಶ ಇಲ್ಲದಿದ್ದ ಕಾರಣ ಈ ಪ್ರಶ್ನಾವಳಿಯನ್ನು ತಯಾರಿಸಿ ಕ್ಷೇತ್ರ
ಮಟ್ಟದಿಂದ ಸೂಕ್ತ ಮಾಹಿತಿಯನ್ನು ಪಡೆದು ತಿಳಿ ಅಭಿವೃದ್ಧಿ ಯೋಜನೆಯ
ಸೇವಾ ಸೌಲಭ್ಯಗಳನ್ನು ಉತ್ತಮಪಡಿಸಲು ನಿರ್ಣಯಿಸಲಾಗಿದೆ. ಈ
ಪ್ರಶ್ನಾವಳಿಯನ್ನು ಕ್ಷೇತ್ರ ಮಟ್ಟದ ಅಧಿಕಾರಿಗಳು / ಸಿಬ್ಬಂದಿ
(ಮೇಲ್ವಿಚಾರಕರು, ಸಹಾಯಕ ತಿಳಿ ಅಭಿವೃದ್ಧಿ ಯೋಜನಾಧಿಕಾರಿ ಮತ್ತು ತಿಳಿ
ಅಭಿವೃದ್ಧಿ ಯೋಜನಾಧಿಕಾರಿ) ಯವರು ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರನ್ನು
ಸಂದರ್ಶಿಸಿ ಅವರ ಬಿಚ್ಚುಮನಸ್ಸಿನ ಅಭಿಪ್ರಾಯವನ್ನು ಪಡೆದು ಭರ್ತಿ ಮಾಡಿ
ಸಲ್ಲಿಸುವುದು. ಸೂಕ್ತ ಉತ್ತರಕ್ಕೆ ಟಿಕ್ ಗುರುತನ್ನು (✓) ಹಾಕುವುದು.

ತಿಳಿ ಅಭಿವೃದ್ಧಿ ಯೋಜನೆಯ ಸೇವಾ ಸೌಲಭ್ಯವನ್ನು ಉತ್ತಮಪಡಿಸಲು ಬೇಕಾದ
ಮಾಹಿತಿ ಬಗ್ಗೆ ಪ್ರಶ್ನಾವಳಿ

ಭಾಗ - 1

1. ಜಿಲ್ಲೆ:
2. ಯೋಜನೆಯ ಹೆಸರು:
3. ಗ್ರಾಮದ ಹೆಸರು:
4. ಅ) ಅಂಗನವಾಡಿ ಕೇಂದ್ರದ ಹೆಸರು ಮತ್ತು ಕೋಡ್ ಸಂಖ್ಯೆ:

ಅ) ಆಂಗ್ಲನವಾಜಿ ಕೇಂದ್ರ ಪ್ರಾರಂಭವಾದ ದಿನಾಂಕ:

5. ಆಂಗ್ಲನವಾಜಿ ಕಾರ್ಯಕ್ರಮ ಹಸಯ:

6. ಪಯಸ್:

7. ಐಕ್ಯಾಹಾರ್ತ:

ಅ. ಎಂಟನೇ ತೆಂಗಡಿ ಪಾಸ್

ಆ. ಎಸ್.ಎಸ್.ಎಲ್.ಸಿ. ಪಾಸ್

ಇ. ಎಸ್.ಎಸ್.ಎಲ್.ಸಿ. ಪೂರ್ವಾಗಮವರು

ಈ. ಪದವೀಧರರು

8. ತರಬೇತಿ ಆಗಿದೆಯೇ: ಹೌದು : ಇಲ್ಲ

ಅ. ವೃತ್ತಿ ತರಬೇತಿ

ಆ. ಪ್ರೀನ್ಟಿಂಗ್ ತರಬೇತಿ

9. ವೈಯಕ್ತಿಕ ಜೀವನ:

ಅ. ಐವುಹುಡು:

ಆ. ಅನಿವಾರ್ಯತೆ:

ಇ. ಏರ್ಪಡೆ:

ಈ. ಲಿಬ್ರೇರಿಯನ ಪರಿವಹನ:

ಉ. ಪರಿಶೋಧನೆ:

10. ಜಾತಿ:

ಅ. ಹಿಂದಿ:

ಆ. ಮುಸ್ಲಿಂ:

ಇ. ಸ್ಥಳ:

ಈ. ಕ್ರಿಶ್ಚಿಯನ್:

ಉ. ಪರಿಶೋಧಕರ ಪಂಗಡ

ಉ. ಇತರ:

11. ಆಂಗ್ಲನವಾಜಿ ಕಾರ್ಯಕ್ರಮಗಳ ಸಮೀಕ್ಷಣೆ ಮತ್ತು ಅಭಿಪ್ರಾಯ

12. අපට යොදාගන්නේ කුමන ක්‍රමයක්ද?

13. අපගේ සමාජයේ පවතින ප්‍රධාන ගැටලු කුමනවාද?

ආ. සමාජවාදය

ඈ. සමාජවාදය

ඉ. සමාජවාදය

ඊ. සමාජවාදය

14. අපගේ සමාජයේ පවතින ප්‍රධාන ගැටලු කුමනවාද?

ආ. සමාජවාදය

ඈ. සමාජවාදය

ඉ. සමාජවාදය

15. අපගේ සමාජයේ පවතින ප්‍රධාන ගැටලු කුමනවාද?

ආ. සමාජවාදය

ඈ. සමාජවාදය

ඉ. සමාජවාදය

ඊ. සමාජවාදය

16. අපගේ සමාජයේ පවතින ප්‍රධාන ගැටලු කුමනවාද?

ආ. සමාජවාදය

ඈ. සමාජවාදය

17. අපගේ සමාජයේ පවතින ප්‍රධාන ගැටලු කුමනවාද?

ආ. සමාජවාදය

ඈ. සමාජවාදය

ඉ. සමාජවාදය

18. අපගේ සමාජයේ පවතින ප්‍රධාන ගැටලු කුමනවාද?

ආ. සමාජවාදය

ඈ. සමාජවාදය

ඉ. සමාජවාදය

19. ಅಂಗನವಾಡಿ ಕೇಂದ್ರವನ್ನು ಸೂಕ್ತ ಸ್ಥಳದಲ್ಲಿ ಪ್ರಾರಂಭಿಸಲಾಗಿದೆಯೆ?

ಹೌದು: ಇಲ್ಲ

ಇಲ್ಲ ದಿದ್ದಲ್ಲಿ ಕಾರಣ:

ಆ. ಸೂಕ್ತ ಸ್ಥಳಾವಕಾಶವಿಲ್ಲ ದಿರುವುದು

ಆ. ಸ್ಥಳೀಯ ರಾಜಕೀಯ ಒತ್ತಡ

ಇ. ಸಮುದಾಯದ ಸಹಕಾರವಿಲ್ಲ ದಿರುವುದು

20. ಕ್ರೀಡಾ ಸಮೀಕ್ಷೆ ನಡೆಸುವಲ್ಲಿ ಇರುವ ಸಮಸ್ಯೆ:

ಆ. ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಗೆ ಕೌಶಲ್ಯತೆ ಇಲ್ಲ ದಿರುವುದು

ಆ. ಮಾರ್ಗಸೂಚಿಯನ್ನು ಪಾಲಿಸದಿರುವುದು

ಇ. ಸರ್ವೆ ನವೀಕರಿಸದಿರುವುದು

ಈ. ಸರಿಯಾಗಿ ಜನನ ದಾಖಲೆ ಮಾಡದಿರುವುದು.

ಉ. ಸಮುದಾಯದ : ಕುಟುಂಬದ ಸಹಕಾರ ಇಲ್ಲ ದಿರುವುದು

21. ಫಲಾನುಭವಿಗಳನ್ನು ಆಯ್ಕೆ ಮಾಡುವಲ್ಲಿ ಸಮಸ್ಯೆ ಇದೆಯೆ?

ಇಲ್ಲ : ಇದೆ

ಇದ್ದಲ್ಲಿ

ಕಾರ್ಯಕರ್ತೆಗೆ ಜ್ಞಾನ : ಉತ್ಸುಕತೆ : ಕೌಶಲ್ಯತೆ ಇಲ್ಲ ದಿರುವುದು

ಸಮುದಾಯ : ಕುಟುಂಬದ ಮಧ್ಯಸ್ಥಿಕೆ

ಜನರು ವಲಸೆ ಹೋಗುವುದು

ಇತರೆ.

22. ಗರ್ಭಿಣಿ ಬಾಣಿಯರ ಹಾಜರಾತಿ ಕಡಿಮೆ ಇರಲು ಕಾರಣ

ಆ. ಗರ್ಭಿಣಿ ಬಾಣಿಯರಿಗೆ ಜ್ಞಾನದ ಕೊರತೆ

ಆ. ಗರ್ಭಿಣಿ ಬಾಣಿಯರು ಪೂರಕ ಪೌಷ್ಟಿಕ ಆಹಾರ ಇಷ್ಟ ಪಡದಿರುವುದು

ಇ. ಆಹಾರ ಪಡೆಯಲು ನಾಚಿಕೆ

ಈ. ನಿಗದಿತ ಪ್ರಮಾಣದಲ್ಲಿ ಆಹಾರ ಸರಬರಾಜು ಆಗದೇ ಇರುವುದು.

23. ಪೂರಕ ಪೌಷ್ಟಿಕ ಆಹಾರ ನಿಗದಿತ ಸಮಯದಲ್ಲಿ ಹಂಚಲು ಸಮಸ್ಯೆ ಇದೆಯೆ?

ಹೌದು: ಇಲ್ಲ

ಹೌದಾದಲ್ಲಿ ಕಾರಣ

ಆ. ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯ ಜ್ಞಾನ : ಕೌಶಲ್ಯತೆ ಹಾಗೂ ಉತ್ಸುಕತೆಯ ಕೊರತೆ

ಆ. ಆಹಾರ ನಿಗದಿತ ಸಮಯದಲ್ಲಿ ಸರಬರಾಜಾಗದಿರುವುದು

ಇ. ಪೋಷಕರಿಗೆ ಆಸಕ್ತಿ ಇಲ್ಲ ದಿರುವುದು

ಉ. ಮಕ್ಕಳು ಆಹಾರವನ್ನು ಇಷ್ಟ ಪಡದಿರುವುದು

ಉಾ. ಅರ್ಹರಲ್ಲ ದ ಫಲಾನುಭವಿಗಳಿಗೆ ಆಹಾರ ವಿತರಿಸಬೇಕೆಂಬ ಸಮುದಾಯದ

ಒತ್ತಡ

24. ಪೂರಕ ಪೌಷ್ಟಿಕ ಆಹಾರಕ್ಕೆ ಎಲ್ಲ ಫಲಾನುಭವಿಗಳು ಹಾಜರಾಗುವಂತೆ ಮಾಡಲು ಯಾವ ಕ್ರಮ ಕೈಗೊಳ್ಳಲಾಗಿದೆ

ಆ. ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರ ಮನೆ ಭೇಟಿ ಮೇಲ್ವಿಚಾರಣೆ

ಆ. ಸಮುದಾಯಕ್ಕೆ ಶಿಕ್ಷಣ ನೀಡುವುದು

ಇ. ಕುಟುಂಬದ ಪುರುಷ ವ್ಯಕ್ತಿಗಳಿಗೆ ಮನದಟ್ಟು ಮಾಡುವುದು

ಈ. ಆಗಾಗ ತಾಯಂದಿರ ಸಭೆ ನಡೆಸುವುದು

ಉ. ಶಿಶು ಅಭಿವೃದ್ಧಿ ಯೋಜನಾಧಿಕಾರಿಗಳು ವಲಯ ಭೇಟಿ ಮಾಡುವುದು

25. ಹೆಚ್ಚಿನ ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರು ಅಂಗನವಾಡಿ ಕೇಂದ್ರದಲ್ಲಿ ಮಕ್ಕಳು ಆಹಾರ ತಿನ್ನುತ್ತಾರೆಂದು ಹೇಳುತ್ತಾರೆ. ತಮ್ಮ ಅಭಿಪ್ರಾಯದಲ್ಲಿ ಎಷ್ಟು ಶೇಕಡಾ ಮಕ್ಕಳು -

ಆ. ಕೇಂದ್ರದಲ್ಲಿ ತಿನ್ನುತ್ತಾರೆ - ಶೇ.

ಆ. ಮನೆಗೆ ತಂದು ತಾವೇ ತಿನ್ನುತ್ತಾರೆ - ಶೇ.

ಇ. ಮನೆಗೆ ತಂದು ತಮ್ಮ ತಂಗಿಯರೊಂದಿಗೆ ಹಂಚಿ ತಿನ್ನಲು - ಶೇ.

ಈ. ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರು ಮಕ್ಕಳನ್ನು ಕೇಂದ್ರದಲ್ಲಿ

ಇಟ್ಟುಕೊಳ್ಳಲಾಗದ ಕಾರಣ - ಶೇ.

ಉ. ಇತರೆ

26. ಕೆಲವು ಮಕ್ಕಳು ಪೌಷ್ಟಿಕ ಆಹಾರವನ್ನು ಮನೆಗೆ ತರಲು ಬೇರೆಬೇರೆ ಕಾರಣಗಳಿರಬಹುದು. ಆದರೆ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯದಲ್ಲಿ -

ಆ. ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರು ಮನೆಗೆ ತೆಗೆದುಕೊಂಡು ಹೋಗುವಂತೆ ಹೇಳುತ್ತಾರೆ

ಆ. ಎಲ್ಲಾ ಮಕ್ಕಳು ಕೇಂದ್ರದಲ್ಲಿ ಆಹಾರ ತಿಂದಾಗ ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರು ಶಿಶು ಪಾಲಿಸಲು ಆಗುವುದಿಲ್ಲವೆಂದು

ಇ. ಆಹಾರವನ್ನು ಮನೆಗೆ ತಂದು ಇತರ ಆಹಾರದೊಂದಿಗೆ ಬೆರೆಸಿ ರುಚಿಯಾಗಿ ತಿನ್ನಲು

27. ಗರ್ಭಿಣಿಯರಿಗೆ ಚುಚ್ಚುಮದ್ದನ್ನು ತೃಪ್ತಿಕರವಾಗಿ ನೀಡಲಾಗುತ್ತಿದೆ ಎಂದು ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರು ಹೇಳುತ್ತಾರೆ. ತಮ್ಮ ಅಭಿಪ್ರಾಯದಲ್ಲಿ ಯಾವ ಮಟ್ಟದಲ್ಲಿದೆ.

ಆ. ಹೆಚ್ಚಿನ ಗರ್ಭಿಣಿಯರು ಅಂಗನವಾಡಿ ಕೇಂದ್ರದಲ್ಲಿ ಚುಚ್ಚುಮದ್ದು ಹಾಕಿಸುತ್ತಾರೆ

() ಕೆಲವು ಗರ್ಭಿಣಿಯರು ನೀರ ಕಡೆಗೆ ಹೋಗುತ್ತಾರೆ.

ಇ. ಕೆಲವರು ಎಲ್ಲಿ ಗೂ ಹೋಗುವುದಿಲ್ಲ

ಈ. ಗರ್ಭಿಣಿಗೆ ಚುಚ್ಚುಮದ್ದಿನ ಪ್ರಾಮುಖ್ಯತೆ ಬಗ್ಗೆ ಸರಿಯಾದ ಮಾಹಿತಿ ಇಲ್ಲ.

ಉ. ಚುಚ್ಚುಮದ್ದಿನ ಸರಬರಾಜು ಸರಿಯಾಗಿಲ್ಲ

28. ಮಕ್ಕಳಿಗೆ ಪೂರ್ಣವಾಗಿ ಚುಚ್ಚುಮದ್ದು ಹಾಕಲಾಗಿದೆ ಎಂದು ಹೆಚ್ಚಿನ ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರು ಹೇಳುತ್ತಾರೆ. ತಮ್ಮ ಅಭಿಪ್ರಾಯದಲ್ಲಿ ಯಾವ ಮಟ್ಟದಲ್ಲಿದೆ.
 ಆ. ಹೆಚ್ಚಿನ ಪೋಷಕರು ಮಕ್ಕಳಿಗೆ ಚುಚ್ಚುಮದ್ದು ಹಾಕಲು ಅಂಗನವಾಡಿ ಕೇಂದ್ರಗಳಿಗೆ ಬರುತ್ತಾರೆ
 ಆ ಕೆಲವು ಪೋಷಕರು ಬೇರೆ ಕಡೆ ಹೋಗುತ್ತಾರೆ
 ಇ. ಕೆಲವು ಮಕ್ಕಳನ್ನು ಎಲ್ಲಿಗೂ ಕರೆದುಕೊಂಡು ಹೋಗುವುದಿಲ್ಲ.
 ಈ. ಮಕ್ಕಳ ಚುಚ್ಚುಮದ್ದಿನ ಬಗ್ಗೆ ಪೋಷಕರಿಗೆ ಸರಿಯಾದ ಮಾಹಿತಿ ಇಲ್ಲ
 ಉ. ಚುಚ್ಚುಮದ್ದಿನ ಸರಬರಾಜು ಸರಿಯಾಗಿ ಇಲ್ಲ.

29. ಚುಚ್ಚುಮದ್ದಿನ ಕಾರ್ಯಕ್ರಮ ಕುಂಠಿತವಾಗಲು ನಿಮ್ಮ ಅಭಿಪ್ರಾಯದ ಪ್ರಕಾರ
 ಆ. ಸಮುದಾಯಕ್ಕೆ ಚುಚ್ಚುಮದ್ದಿನ ಪ್ರಾಮುಖ್ಯತೆ ಬಗ್ಗೆ ಅರಿವು ಇಲ್ಲ ದಿರುವುದು
 ಆ. ಚುಚ್ಚುಮದ್ದಿನ ಬಗ್ಗೆ ನಂಬಿಕೆ ಇಲ್ಲ ದಿರುವುದು
 ಇ. ಚುಚ್ಚುಮದ್ದು ಹಾಕಿಸಿದ ನಂತರ ಮಗುವಿಗೆ ಏನಾದರೂ ತೊಂದರೆ ಆಗಬಹುದೆಂಬ ಭಯ.

30. ಅಂಗನವಾಡಿ ಕೇಂದ್ರದಲ್ಲಿ ಒದಗಿಸುತ್ತಿರುವ ಸೇವಾ ಸೌಲಭ್ಯಗಳ ಬಗ್ಗೆ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯ.

ಆ. ಆರೋಗ್ಯ ಸೇವೆ -

1. ಸಮಾಧಾನಕರವಲ್ಲ 2. ಸಾಧಾರಣ 3. ಉತ್ತಮ 4. ಅತ್ಯುತ್ತಮ

ಆ. ಪೌಷ್ಟಿಕ ಆಹಾರ -

1. ಸಮಾಧಾನಕರವಲ್ಲ 2. ಸಾಧಾರಣ 3. ಉತ್ತಮ 4. ಅತ್ಯುತ್ತಮ

ಇ. ಶಾಲಾಪೂರ್ವ ಶಿಕ್ಷಣ -

1. ಸಮಾಧಾನಕರವಲ್ಲ 2. ಸಾಧಾರಣ 3. ಉತ್ತಮ 4. ಅತ್ಯುತ್ತಮ

ಈ. ಸಮುದಾಯ ಭಾಗವಹಿಸುವಿಕೆ -

1. ಸಮಾಧಾನಕರವಲ್ಲ 2. ಸಾಧಾರಣ 3. ಉತ್ತಮ 4. ಅತ್ಯುತ್ತಮ

ಉ. ಆರೋಗ್ಯ ಮತ್ತು ಪೌಷ್ಟಿಕ ಆರೋಗ್ಯ ಶಿಕ್ಷಣ -

1. ಸಮಾಧಾನಕರವಲ್ಲ 2. ಸಾಧಾರಣ 3. ಉತ್ತಮ 4. ಅತ್ಯುತ್ತಮ

31. ತಮ್ಮ ಅಭಿಪ್ರಾಯದಲ್ಲಿ ಶಾಲಾಪೂರ್ವ ಚಟುವಟಿಕೆಗೆ ಯಾರ ಸಂಖ್ಯೆ ಅತಿ ಕಡಿಮೆ
 ಅ) ಹುಡುಗಿಯರು
 ಆ) ಹುಡುಗರು

32. ವರ್ಷಕ್ಕೆ ಎಷ್ಟು ಶೇಕಡಾ ಮಕ್ಕಳು ತಮ್ಮ ಅಂಗನವಾಡಿ ಕೇಂದ್ರದಿಂದ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗೆ ದಾಖಲಾಗುತ್ತಾರೆ.
 ಅ) ಹುಡುಗಿಯರು ಶೇ. -----
 ಆ) ಹುಡುಗರು ಶೇ. ----

33. ತಮ್ಮ ಅಭಿಪ್ರಾಯದಂತೆ ಸಮುದಾಯವು ಹಾಗೂ ಪೋಷಕರು ತಮ್ಮ ಕೇಂದ್ರದಿಂದ
ಬಿನ್ನನ್ನು ಬಯಸುತ್ತಾರೆ.

ಆ. ಯಾವುದೇ ಭಿನ್ನ ಭೇದ ವಿಲ್ಲದೆ ಸಮುದಾಯದ ಎಲ್ಲ ಮಕ್ಕಳಿಗೂ ಪೂರಕ
ಪೌಷ್ಟಿಕ ಆಹಾರ ಕೊಡಬೇಕು

ಆ. ಪೂರಕ ಪೌಷ್ಟಿಕ ಆಹಾರದ ಪ್ರಮಾಣ ಈಗ ಇರುವುದಕ್ಕೂ
ಹೆಚ್ಚಿ ಗೆಯಾಗಬೇಕು.

ಇ. ಮಕ್ಕಳನ್ನು ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರು ಹಾಗೂ ಸಹಾಯಕಿಯರು
ಮನೆಯಿಂದ ಕರೆದುಕೊಂಡು ಬರಬೇಕು

ಈ. ಮಕ್ಕಳಿಗೆ ಅಂಗನವಾಡಿ ಕೇಂದ್ರದಲ್ಲಿ ಓದಲು ಬರೆಯಲು ಕಲಿಸಬೇಕು

34. ಪೋಷಕರಿಗೆ ಶಾಲಾಪೂರ್ವ ಶಿಕ್ಷಣದ ಬಗ್ಗೆ ಅರಿವಿದೆ ಎಂಬ ಬಗ್ಗೆ ತಮ್ಮ ಅಭಿಪ್ರಾಯ

ಆ. ಕೆಲವರಿಗೆ ಮಾತ್ರ

ಆ. ಎಲ್ಲರಿಗೂ

35. ಅಂಗನವಾಡಿ ಕೇಂದ್ರದ ರಿಜಿಸ್ಟ್ರರುಗಳ ನಿರ್ವಹಣೆ ಬಗ್ಗೆ ತಮ್ಮ ಅಭಿಪ್ರಾಯ.

ಆ. ಸಮಾಧಾನಕರವಲ್ಲ ಆ. ಸಾಧಾರಣ ಇ. ಉತ್ತಮ ಈ. ಅತ್ಯುತ್ತಮ

36. ಅಂಗನವಾಡಿ ವಲಯದಲ್ಲಿ ಸೇವಾ ಸೌಲಭ್ಯಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ಸಾಕಷ್ಟು ಸಂಪರ್ಕ
ಸಾಧನೆಗಳು ಇವೆಯೆ.

ಅ) ಇಲ್ಲ ಆ) ಇದೆಯೆ

ಇದ್ದಲ್ಲಿ (ಭಿತ್ತಿಪತ್ರ, ಚಾರ್ಟ್, ಇತರೆ)

37. ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರ ಯೋಜನೆಯ ಸೌಲಭ್ಯಗಳ ಬಗ್ಗೆ ಸಮುದಾಯಕ್ಕೆ
ಅರಿವು ಮೂಡಿಸಲು ಈ ಕೆಳಗಿನ ಸಂದರ್ಭಗಳನ್ನು ಉಪಯೋಗಿಸುತ್ತಾಳೆಯೆ?

ಆ. ಉರ ಹಬ್ಬ: ಜಾತ್ರೆ,

ಆ. ಮನೆ ಭೇಟಿ

ಈ. ಸಮುದಾಯದ ಸಭೆ

38. ಅಂಗನವಾಡಿ ಕೇಂದ್ರ ಯಶಸ್ವಿಯಾಗಿ ಕಾರ್ಯಗತಗೊಳ್ಳದಿರಲು ಕಾರಣ

ಆ. ಸ್ಥಳೀಯ ನಾಯಕರ ಸೂಚನೆಯಂತೆ ನಡೆದುಕೊಳ್ಳದಿರುವುದು

ಆ. ಸಮುದಾಯವು ಆಗಾಗ್ಗೆ ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರ ಬಗ್ಗೆ
ದೂರುತ್ತಿರುತ್ತಾರೆ

ಇ. ಸಮುದಾಯಕ್ಕೆ ತಮ್ಮ ವಲಯದ ಅಭಿವೃದ್ಧಿ ಬೇಕಾಗಿಲ್ಲ

39. ಅಂಗನವಾಡಿ ಕೇಂದ್ರದ ಬಗ್ಗೆ ಸಮುದಾಯದ ಅಭಿಪ್ರಾಯ

ಅ. ಅಹಾರ ಹಂಚುವ ಕೇಂದ್ರ,

ಆ. ಮಕ್ಕಳ ಆರೈಕೆ ಬಗ್ಗೆ ತಾಯಂದಿರಿಗೆ ಶಿಕ್ಷಣ ನೀಡುವ ಕೇಂದ್ರ,

ಇ. ಸಮುದಾಯಕ್ಕೆ ತಾಯಿಮಗುವಿನ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ಮಾಹಿತಿ ನೀಡುವ ಕೇಂದ್ರ,

ಈ. ಮಗುವನ್ನು ಪ್ರಾಥಮಿಕ ಶಾಲೆಗೆ ದಾಖಲಿಸುವುದಿಲ್ಲವೆಂದು ಹಾಗೂ ಉತ್ತಮ ಪ್ರಗತಿಗೆ ಶಿಕ್ಷಣ ನೀಡುವ ಕೇಂದ್ರ.

40. ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯ ಬಗ್ಗೆ ತಮ್ಮ ಅಭಿಪ್ರಾಯ:

1. ಸಮಾಧಾನಕರವಲ್ಲ 2. ಸಾಧಾರಣ 3. ಉತ್ತಮ 4. ಅತ್ಯುತ್ತಮ

ಬಾಗ - 2

1. ಮೂಲಮೂಲ ಸೌಕರ್ಯಗಳು:-

ಆ. ಕಟ್ಟಡ ಮತ್ತು ವಿಸ್ತೀರ್ಣ:

1. ಸ್ವಂತ 2. ಬಾಡಿಗೆ 3. ಖಾಸಗಿ 4. ದೇವಸ್ಥಾನ 5. ಶಾಲೆ
6. ಇತರೆ

ಆ. ಕುಡಿಯುವ ನೀರಿನ ಸೌಲಭ್ಯ:-

1. ಬೋರ್‌ವೆಲ್ 2. ನಲ್ಲಿ 3. ಬಾವಿ 4. ಇತರೆ

ಇ. ಕುಡಿಯುವ ನೀರಿನ್ನು ತರಲು ಮತ್ತು ಸಂಗ್ರಹಿಸಲು ಇರುವ ಸೌಕರ್ಯಗಳು.

ಇದೇ: ಇಲ್ಲ

ಇಲ್ಲವಾದರೆ ಅವಶ್ಯಕತೆ ಇರುವ ಸಾಮಗ್ರಿಗಳು.

- ಉದಾ: 1. ಬಿಂದಿಗೆ 2. ನಲ್ಲಿ ಇರುವ ಡ್ರಂ 3. ಬಕೆಟ್ 4. ಇತರೆ

ಈ ಶೌಚಾಲಯದ ವ್ಯವಸ್ಥೆ ಇದೆಯೇ?

ಇದೇ: ಇಲ್ಲ

ಉ. ಆಟದ ಮೈದಾನ

ಇದೇ: ಇಲ್ಲ

ಉಾ. ಪೀಠೋಪಕರಣಗಳು:

ಇದೇ: ಇಲ್ಲ

ಇಲ್ಲ ದಿದ್ದಲ್ಲಿ ಬೇಕಾದ ಪೀಠೋಪಕರಣಗಳು

1. ಜಮಖಾನಗಳು

2. ಕುರ್ಚಿಗಳು

3. ಟೇಬಲ್

4. ಆರೋಗ್ಯ ತಪಾಸಣೆ ಮಾಡಲು ಚಿಕ್ಕ ಸ್ಕೂಲ್

5. ಸ್ಪೀಲ್ ಗಾಡ್, ಬ್ ರ್ಯಾಕ್

6. ಕಫೆ ಹಲಗೆ

7. ಇತರೆ

2. ಪೂರಕ ವೃತ್ತಿ ಕ ಆಹಾರ ಸೇವೆಗಳು:

ಸ್ಥಳಾವಕಾಶ

ಇದೇಇಲ್ಲ

ಪಾತ್ರೆಗಳು: ಉಪಹಾರ ತಯಾರಿಕೆಗಾಗಿ ಈಗಾಗಲೇ ಸರಬರಾಜಾಗಿರುವ ಪಾತ್ರೆಗಳು ಸೂಕ್ತವಾಗಿದೆಯೆ. ಇಲ್ಲವಾದರೆ ಯಾವ ರೀತಿಯ ಪಾತ್ರೆಗಳು ಅಗತ್ಯವಿದೆ.

ಕ್ರಮ

ಸಂಖ್ಯೆ

ವಿವರ

ಸಂಖ್ಯೆ

1.

2.

3.

3. ತಯಾರಿಸಿದ ಆಹಾರ ವಿತರಣೆಗೆ ಪಾತ್ರೆ ಇದೆಯೆ. ಇಲ್ಲದಿದ್ದರೆ ಯಾವ ರೀತಿ ಪಾತ್ರೆಗಳು ಅಗತ್ಯವಿದೆ.

ಕ್ರಮ

ಸಂಖ್ಯೆ

ವಿವರ

ಸಂಖ್ಯೆ

1. ಸ್ಟೀಲ್ ಸೌಟು

2. ಸ್ಟೀಲ್ ತಟ್ಟೆ

3. ಸ್ಟೀಲ್ ಲೋಟ

4. ಅನ್ನದ ಕೆ

5. ಕಾಳು ನೆನಸಲು ಪಾತ್ರೆ,

6. ಗಂಜಿ ತಯಾರಿಸಲು ಪಾತ್ರೆ,

7. ಇತರೆ

4. ಆಹಾರ ಪದಾರ್ಥ ಶೇಖರಣೆಗಾಗಿ ಡಬ್ಬುಗಳು ಇದೆಯೆ.

ಇದೇಇಲ್ಲ

ಇಲ್ಲದಿದ್ದರೆ ಅವಶ್ಯಕವಿರುವ ಡಬ್ಬುಗಳು

ಕ್ರಮ

ಸಂಖ್ಯೆ

ವಿವರ

ಗಾತ್ರ

ಸಂಖ್ಯೆ

1. ಪ್ಲಾಸ್ಟಿಕ್ ಡಬ್ಬಿ

2. ಸ್ಟೀಲ್ ಡಬ್ಬಿ

3. ಅಲ್ಯೂಮಿನಿಯಮ್ ಡಬ್ಬಿ

4. ಇತರೆ

5. ಉಪಹಾರ ತಯಾರಿಕೆಗೆ ಇರುವ ಉರುವಲು ವ್ಯವಸ್ಥೆ

1. ಗ್ಯಾಸ್ ಸ್ಟೋವ್

2. ಸಿಮೆಂಟ್ ಸ್ಟೋವ್

3. ಕಟ್ಟಿಗೆ

4.

ಕಟ್ಟಿಗೆಯಾಗಿದ್ದರೆ ಹೊಗೆರಹಿತ ಒಲೆ ಇದೆಯೆ

3. ಶಾಲಾಪೂರ್ವ ಶಿಕ್ಷಣದ ಸೇವೆಗಳು :

1. ಶಾಲಾಪೂರ್ವ ಶಿಕ್ಷಣದ ಚಟುವಟಿಕೆ ನಡವಲು ಸ್ವಭಾವಕಾರಿ ಇದೆಯೆ.

- | | |
|--------------------|------------|
| 1. ಒಳಾಂಗಣ ಆಟಗಳಿಗೆ | ಇದೆ : ಇಲ್ಲ |
| 2. ಹೊರಾಂಗಣ ಆಟಗಳಿಗೆ | ಇದೆ : ಇಲ್ಲ |

2. ವೇಳಾಪಟ್ಟಿ ಪ್ರಕಾರ ಶಾಲಾಪೂರ್ವ ಶಿಕ್ಷಣದ ಚಟುವಟಿಕೆಗಳನ್ನು ನಡವಲು ಸಾಕಷ್ಟು ಸಲಕರಣೆಗಳು ಇದೆಯೆ. ಇದೇಇಲ್ಲ

ಇಲ್ಲ ದಿದ್ದಲ್ಲಿ ಅಗತ್ಯಕವಿರುವ ಸಾಮಗ್ರಿಗಳು:

<u>ಆಟೋಪಕರಣ</u>	<u>ಪಾಠೋಪಕರಣ</u>	<u>ಕಚ್ಚಾ ಸಾಮಗ್ರಿಗಳು</u>
ಉದಾ: ಮರದ ಕುದುರೆ	ಕಪ್ಪು ಹಲಗೆ	ಬಾಕಪೀಸ್
ಸೀಸಾ	ಚಿತ್ರ ಪಟಗಳು	ಕ, ಯಾನ್
ತ್ರಿ, ಚಕ್ರ, ಸೈಕಲ್ ಗಳು ಇತರೆ	ಪ್ಲಾಶ್ ಕಾರ್ಡ್ ಗಳು ಇತರೆ	ಬಣ್ಣದ ಪೇಪರ್ ಇತರೆ

3. ಶಾಲಾಪೂರ್ವ ಶಿಕ್ಷಣದ ಸಾಧನೆ ಸಲಕರಣೆಗಳ ಶೇಕರಣೆಗೆ ಸಾಕರ್ಷವಿದೆಯೆ?

ಇದೆ : ಇಲ್ಲ

ಇಲ್ಲ ದಿದ್ದಲ್ಲಿ ಬೇಕಾದ ಸಲಕರಣೆಗಳು:

ಉದಾ: 1. ಟ್ರಂಕ್ 2. ಲ್ಯಾಕ್ಸ್ 3. ಇತರೆ

4. ಆರೋಗ್ಯ ಸೇವೆಗಳು

1. ಬೆಳವಣಿಗೆ ಪರಿಶೀಲನೆ

1. ಯಾವ ರೀತಿಯ ಯಂತ್ರವಿದೆ:

ಆ. ಸಾಲ್ವರ್ ಸ್ಕೇಲಾಃ ಬಾರ್ ಸ್ಕೇಲಾಃ ಫ್ಲಾಟ್ ಫಾರಂ

ಆ. ಸರಿ ಇದೆಯೆ

2. ಮಕ್ಕಳ ತೂಕ ಮಾಡುವ ಯಂತ್ರ ಮತ್ತು ಚೀಲ ಸಾಕಷ್ಟಿ ದೆಯೆ.

3. ಬೆಳವಣಿಗೆ ಪರಿಶೀಲನೆ ಪುಸ್ತಕ ಸಾಕಷ್ಟಿ ದೆಯೆ.

2. ಔಷಧಿ ಪೆಟ್ಟಿಗೆಯಲ್ಲಿ ಸಾಮಾನ್ಯ ಖಾಯಿಲೆಗಳಿಗೆ ಬೇಕಾದ ಔಷಧಿಗಳು ಇದೆಯೆ?

ಇಲ್ಲದಿದ್ದರೆ ಯಾವ ಔಷಧಿಗಳು ಬೇಕು

1.

2.

3.

4.

3. ಕಬ್ಬಿಣಾಂಶ ಮಾತ್ರ ಸಾಕಷ್ಟು ಸರಬರಾಜಾಗುತ್ತಿ ದೆಯೆ?

ಇದೇಇಲ್ಲ

4. ಒ. ಆರ್. ಎಸ್. ಸಾಕಷ್ಟು ಸರಬರಾಜಾಗುತ್ತಿ ದೆಯೆ?

ಇದೇಇಲ್ಲ

5. ವಿಟಮಿನ್ ಎ ಸಾಕಷ್ಟು ಸರಬರಾಜಾಗುತ್ತಿ ದೆಯೆ?

ಇದೇಇಲ್ಲ

6. ಆರೋಗ್ಯ ತಪಾಸಣೆ ನಡೆಸುವಾಗ ಬೇಕಾಗಬಹುದಾದ ಸಾಧನಗಳು: ಇದೇಇಲ್ಲ

ಉದಾ: ಮಕ್ಕಳ ಎತ್ತರ ಅಳೆಯುವ ಟೇಪ್: ತೂಕ ಮಾಡುವ ಯಂತ್ರ: ಚಿಕ್ಕ ಸ್ಕೂಲ್

5. ಆಹಾರ ಮತ್ತು ಆರೋಗ್ಯ ಶಿಕ್ಷಣ ಸೇವೆಗಳು

ಪೌಷ್ಟಿಕ ಆಹಾರ ತಯಾರಿಕಾ ಪ್ರಾತ್ಯಕ್ಷಿಕೆ ತಾ ಶಿಭಿರ ಮತ್ತು ತಾಯಂದಿರ ಸಭೆಗಳನ್ನು ನಡೆಸಲು ಅವಶ್ಯಕ ವಸ್ತುಗಳು ಇವೆಯೆ?

ಪ್ರಾತ್ಯಕ್ಷಿಕೆಗೆ ಬೇಕಾಗುವ ಸಲಕರಣೆಗಳು

ಉದಾ: ಚಾಕು : ಚಿಕ್ಕ ಪಾತ್ರೆಗಳು : ಬಾಂಡ್ಲಿ : ಜಾಲರಿ : ಕತ್ತರಿ : ಇತರೆ

ತಾಯಂದಿರ ಸಭೆ ನಡೆಸಲು ಬೇಕಾಗುವ ಸಾಧನ:

ಉದಾ: 1. ಆರು ಮಾರಕ ರೋಗ ಲಕ್ಷಣವಿರುವ ಚಿತ್ರಪಟಗಳು

2.

3.

4.

5.

ಆಂಗನವಾಡಿ ಕೇಂದ್ರಕ್ಕೆ ಸರಿಯಾದ ಬೀಗ ಇದೆಯೆ? ಇದೆ : ಇಲ್ಲ

ಆಹಾರ ಪದಾರ್ಥಗಳ ಕೊಠಡಿಗೆ ಸರಿಯಾದ ಬೀಗ ಇದೆಯೆ? ಇದೆ : ಇಲ್ಲ

ಐ.ಇ.ಸಿ. ಯೋಜನೆಯಲ್ಲಿ ಒದಗಿಸಬಹುದಾದ ಸಲಕರಣೆಗಳಲ್ಲಿ ಯಾವುದರ ಅಗತ್ಯ ಇದೆ:

1. ರೇಡಿಯೋ ಟೀಪ್ ರೆಕಾರ್ಡರ್

2. ಕ್ಯಾಸೆಟ್

3. ಗಂಟೆ(ಸಮಯ ಪ್ರಜ್ಞೆಗೆ)

4. ಗಡಿಯಾರ

5. ದೊಡ್ಡ ಜಮಖಾನೆಗಳು

6. ಪ್ಲಾಸ್ಟಿಕ್ ಚಾಪೆಗಳು

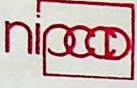
7. ಆಹಾರ ಮತ್ತು ಪ್ರಾತ್ಯಕ್ಷಿಕೆ ತಾ ಶಿಭಿರಗಳನ್ನು ನಡೆಸಲು ಆಹಾರ ಪದಾರ್ಥಗಳ ವಿರೀದಿಗೆ

8. ಪೌಷ್ಟಿಕ ಆಹಾರ ಮತ್ತು ಆಹಾರದ ಬಗ್ಗೆ ಶಿಕ್ಷಣ ನೀಡಲು ಚಿತ್ರಪಟಗಳು ಮತ್ತು ಮಾದರಿಗಳು.

9. ಇತರೆ

ಅಧಿಕಾರಿ / ನಿಬ್ಬಂದಿ

ಸಹಿ.



राष्ट्रीय जनसहयोग एवं बाल विकास संस्थान
NATIONAL INSTITUTE OF PUBLIC COOPERATION AND CHILD DEVELOPMENT

Dr. Usha Abrol
Regional Director

No.NI/SRC/GMD/WKS/2001-2002/ 150

9.4.2001

Dear Dr. Ravi Narayan

Sub: Workshop on finalisation of Growth Monitoring Card
(April 16 – 19, 2001)

In continuation to our earlier letter of even number dated 4th April 2001, this is to further inform that the anticipated outcomes of the above mentioned workshop are as follows:

- The final version of the growth-monitoring card. We have received several comments from other experts (including from the meeting of the Hindi card held in Delhi), which need to be examined and finalised by the expert group and Karnataka/Andhra Pradesh government (Day – I).
- The draft version of the 3 – 5 year old card will be ready for discussion and finalisation (Day – I).
- The finalisation of the training modules on the card being prepared by the Osmania Medial College and NIN (Day II – and III).
- Review and finalisation of the Dular Kit and similar material from other states to form an additional information/support kits for frontline workers/village development committees Day II and III).
- Finalisation of the entire package and the roll out plan for Karnataka and Andhra Pradesh (Day I- IV).

You are kindly requested to go through the material and share your views in the workshop in order to make the deliberations of the workshop more focussed.

As mentioned in the earlier letter also the board and lodging arrangements would be made in the Institute's hostel. You are requested to kindly confirm your detailed programme and requirement for lodging if any.

We look forward your valuable contribution in the workshop.

With regards,

Dr. Ravi Narayan, Community Health Cell,
St. John's Medical College, Sarjapur Road,
Bangalore – 34.

Yours sincerely,

Usha Abrol
(Usha Abrol).

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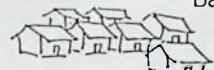
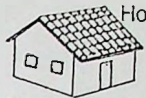
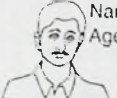

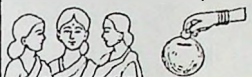
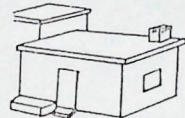
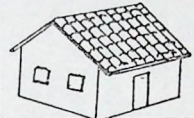



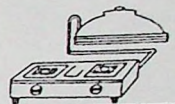




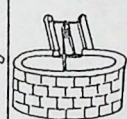
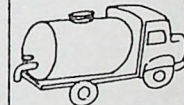

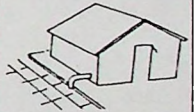



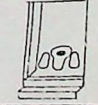


30 *Ky* *12/4* *Usha Abrol* *RN*

Monitoring of Maternal and Child Care Services at Block Level







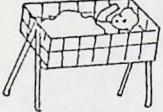









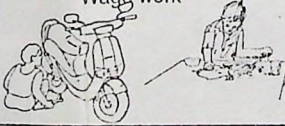


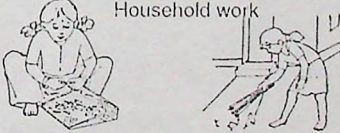
12 Crucial questions for monthly monitoring the outreach of services at block level

1. No. and names of villages where there are pregnant women who have completed 8 months and are not immunized with TT.
2. No. and names of villages where 100% of children of 9 month age are not fully immunized?
3. No. and names of villages with high risk pregnancy and nursing mothers (early age, anemia cases, hypertension, history of caesarian, first delivery after 35)
4. No. of villages having more than 4 severely malnourished children (grade-III and IV) for every 1000 population aged less than 6 years (175/100 children) to ensure check up of fresh reported cases and arrange for medicines for this group.
5. Villages having an infant death to be visited for investigation.
6. No. of villages with even one of low birth weight for follow up investigations.
7. No. of villages having a maternal mortality
8. villages falling in the highest 25% in diarrhoea/ARI incidence in children aged 0-6 years for follow up and arrange of awareness education.
9. No. of villages where feeding programme in AWC is less than 20 days for follow up by ICDS/CDPO, Supervisor.
10. No. of villages where enrollment of children 5-10 years is less than 100% for follow up by CRCs and BRCs.
11. No and names of villages where is enrollment of children 5-10 years is less than 90% for arranging special campaigns.
12. No. of villages where more than 10% of the enrolled children have the cumulative attendance of less than 80% for immediate follow up by the BRC.

Details of infrastructure facilities

 City		 Basti			 House / address				
 Name of head of household Age		 Name of wife			 Member of Thrift Group				
		Housing			Cooking Fuel				
		Pucca house 	Tiled house 	Thatched house 	Wood /Coal 	Kerosene 	Gas 		
Year									
2000									
2001									
2002									
2003									
		Lighting		Water Source			Drainage		
		Kerosene 	Electric 	Tap 	Hand pump 	Well 	Tanker 	Water let out 	Drain 
Year									
2000									
2001									
2002									
2003									
		Garbage Disposal			Sanitation				
		Open 	Dustbin 	Open defecation 	House toilet 	Open 	Bathroom 		
Year									
2000									
2001									
2002									
2003									

FAMILY FACT SHEET

No of children	1	2	3	4	5	
year						
2000						
2001						
2002						
2003						
Age of children	0-1 years	1-3 years	3-5 years	6-11 years	11-14 years	
year						
2000						
2001						
2002						
2003						
Child services accessed	Attending creche 0-3 years	Attending AWC 3-5 years	Attending primary school 6-11 years	Attending UPS school 11-14 years		
year						
2000						
2001						
2002						
2003						
Working children	Wage work	Sibling care	Unpaid work outside	Household work		
year						
2000						
2001						
2002						
2003						

PARENTING

CARD IA

The first three years after the birth of the child are times of rapid growth and development. The foundation for future health and intelligence are laid at this time. The care given by the family at this time will determine whether the child will live a successful life or not.

Even as a child needs food for the body to grow, food is needed for the child's mind to grow. For the small child this food is made up of.

Love and affection

Being Talked to

Play

Love and affection

A baby is the greatest gift a family can have. Bringing up the baby is both a joy and a responsibility meant to be shared by father, mother, grandparents and other family members living in the home. In return the infant will learn to love and respect all those who took part in caring for the infant**

The birth of a baby is a community event and a source of happiness. Elders may have a great deal of wisdom to impart in helping you care for your baby. (picture of a naming ceremony).

Use a lot of laughter and praise in encouraging your baby to do the things you want. A child who grows up with love will also be loving and will have a good opinion about herself or himself. This positive self esteem will prove a valuable asset in meeting the difficulties of future life.

When correction is needed never beat your child. A firm "no" will serve the purpose.

Play

Play is the natural inclination of every child. Children learn through play. Play helps the child develop concentration, vision and hearing, touch, imagination, concepts, movement and expression. Parenting is fun and joyful. Playing together is a good way to enjoy the company of your child. The precious days of early childhood never come back. Use them well.

Play must be supervised to ensure safety. What does a small child play with?

Everyday items in the house can be used as toys. Expensive toys need not be bought.

Talking to your child

Why should you talk to your child?

A child learns to speak by hearing others speak to him or her, the more you talk to your child the more the child will learn to talk.

Language helps the child to develop understanding and will later help in studying well.

As family members your efforts in talking to your child give the child this special advantage ***

When can you start talking to your child?

Soon after birth a child will find the sound of the mother or father's voice very comforting.

How do you speak to a new born baby ?

Talk very gently when the child is lying quietly with eyes open and smile at the child.

You can say pleasant words which will not have meaning but which sound loving.***

Softly sing the songs traditional for babies and small children.

Later when your child begins making sounds or saying words, praise your child so he/she may say the words again.

CARD I B

Birth to three months

G

- Being held securely gives the child great comfort .The feel of the mothers skin when given the first feed soon after birth helps in creating the first bond between mother and child . *As other family members become involved by carrying, talking and playing with the infant, the infant learns who his or her own people are and begins to smile at them and recognize them .
- Develop a regular routine for your baby. Have meals, baths, naps and bedtime at about the same time everyday. (Picture with a clock)
- Respond immediately to your baby's cries. Crying is the only way a baby can tell you something is wrong.
- Gentle rocking or walking with the baby will soothe the baby. Carry the baby around with you .**
(Picture)

T

- Talk very gently when the child is lying quietly with eyes open and smile at the child. Say pleasant words which will not have meaning but which sound loving like telling the child how special the child is .
- Softly sing songs.
- The infant will respond to the tone of the voice and by the second month will be smiling back at you.
- By the third month the child may say ooh and aah sounds*.

P

- Tie a small colourful object on top of the baby's bed. It could be made of colourful cloth, ribbons or paper or a bought toy You will often see the new born gazing at the object and if you move it the child will follow its movement.**
- Place a small rattle in the hand and the child will hold it and shake it from 3 months onwards***

M

- The infant at birth has spontaneous movements of both arms and legs.
- Place the infant on the stomach and show the child a toy, the infant will be able to lift his head up. *** Hold the baby in your lap in a sitting position. At 3 months the head is held steady when in a sitting position.
- Play Talk with your baby Play with your baby Show affection for your baby

CARD II A

Three months to six months

- *General.*
- The baby is now settling into a routine ,sleeping and feeding at about the same time every day
- .Massage your baby gently before the bath talk soothingly during the bath and while feeding the child
- *T Lang.*
- By six months the child makes sounds like ga ga
- By six months the child will be laughing aloud
- Call the child's name softly behind each ear –the child will start turning to sound
- *Play*
- Place a toy in front of the child so that the child will try to reach for it and pick it up.
- Offer two small toys to the child so that the child will transfer them from one hand to another and later hold them each in one hand and later bang them together.
- By six months the child will play peek a boo Cover your face with a cloth and then remove the cloth The child will be fascinated when you reappear and will soon be able to pull the cloth off even when placed on the child's face. The child will laugh and ask for this game to be played over and over
- Let the baby feel objects of different textures
- *Motiv /movement*
- When the head is steady the child can be held in a sitting position so the baby can see what is going on. ***
- Roll a ball to your baby and get him or her to roll or toss it back to you.***
- Play Talk with your baby Play with your baby Show affection for your baby

- CARD II B

- Six to twelve months

- G

- Stick coloured pictures from calendars ,newspapers old magazines ,on the wall Point these out often*Paste some pictures in a n old note book and show the pictures

- T

- Imitate the child's sounds and try to get the baby to make the same sounds back The child will appear to imitate the way you talk by eight months As you smile and encourage the child the first words take meaning like ama nana thatha ava and delight the family Long before the child can say words the child can understand words like ***

- where is thatha ,nana ?

- where is your nose -your ears ?***
where is the light ?

- P

- Show the child games like pat a cake , byebye ,how to find a hidden object by partly hiding a toy and then covering it fully***

- Take a box or a plate and show how it can be banged with a spoon like a drum

- Show the child how to bang two toys together

- Take a katori and show the child how to put objects like nimbus in the container and then empty them out ***

- Let the child pick up small bits of food with thumb and fingers like puffed rice(P)

See the child does not put harmful objects in the mouth

Your child will learn to drop an object several times on the floor and expect you to pick it up. Be patient the child is learning that things fall when released.

- M

- Place your child in a sitting position in a corner to prevent falling over This will help the child to sit independently by 7 months. (P)

- Provide the child a secure support by sitting on the floor and placing the child's hands on your shoulders or knees so the child will gradually be able to stand independently.**

- While your baby is sitting, place a toy out of reach and attract the baby's attention to get the toy by crawling on hands and knees.***

- When your baby can stand well alone, have your baby walk into your arms to get a toy or a hug. This will encourage the bay to take a few steps.** If your baby is not yet ready to walk alone wait a few weeks and try again.

- **Talk with your baby Play with your baby Show affection for your baby**

- CARD IIIA

- One to two years

- G

- Show your child how to eat with his hands or with a spoon. Initially the child may spill food but will gradually learn to eat independently. (Orissa card)
- While you are washing clothes or dishes, making *rotis* or sweeping the floor, let your child pretend to help you. (P)
- Let the child take off his or her own clothes, shorts and shirt. Let him learn to start putting on clothes. Give the child a shirt to practice unbuttoning and later buttoning on. (P)
- Take your child out with you, to the bus stop or market and talk about the things you see. (RB)
- Hide and let your child find you. At first make it easy for your child to find you. *
- Teach the child to blow bubbles. (P)
- T
- Initially the child will say single words like “*neelu*”, “*kukka*” As you keep telling him the names of different everyday objects. In the second year the child combines words
- “*neelu ee kukka akda*” and so on. Encourage your child to put words together.
- Help your child learn to talk by having him or her name things you see like, dog, goat, tree. ***
- Have your child ask for things he wants instead of only pointing at them. ***
- Ask the child to bring some item to you like bring the ball ***
- P
- Let the child play with a small amount of atta to roll into balls or *rotis****
- Show your child how bowls and dishes of different sizes can be put one inside the other.***
- Give the child a paper and pencil or slate and chalk and encourage scribbling **
- Your child will like to throw things on the floor and expect you to pick it up each time. Be patient as your child is learning how things fall.

- M

- Give your child a toy cart with wheels to pull. The child will learn to take steps backwards as he pulls the cart along. (P)
- If there are low steps near your house hold the child’s hand and help the child walk up one step at a time. **
- Hold your child’s hands initially and show your child to jump across a small piece of cloth on the floor till the child gradually learns to do it independently**
- Show your child how to kick a ball. The ball can be made of crumpled newspaper enclosed in a rag. **
- **Talk with your baby Play with your baby Show affection for your baby**

CARD III B

- Two to three years
- G
- Tell children stories about themselves, about other family members*** (group with other kids baby on the lap)
- Teach the child to say his or her name
- T
- Teach the child colours ,green like leaves, yellow like haldi, red like tomato, blue like the sky. (Several mothers may not know colours) (*Use earlier concepts pictures*)
- Words like up and down, in and out, under and on top eg “Put the red tomato in the basket”. Teach the child to sort things “put the nimbus on the plate” “put the tomatoes in the bowl ”***
- Teach the child other opposite words like, hot and cold, day and night, big and small.
- P
- Teach the child to count using coins or stones or shells, one two three ...
- Show the child how to draw a line , a circle (P sibling)a face.
- By the age of three the child can understand big and small, shapes and colours if these have been told to the child
- M
- Show your child how to bounce and catch a ball.
- Show your child how to stand on one foot and then the other, initially holding on to you for support and later independently. By about 3 years the child can stand for a few seconds at a time (P)
- Teach your child to jump with both feet together

- **Talk with your baby Play with your baby Show affection for your baby**

- Same girl or boy growing up identified by dress /features
- Diagrams =number of boys/girls
- (P) only child in picture

- *mother

- **father

- *** Grandmother =grandfather

◦ SAFETY TIPS FOR YOUR CHILD

- As your child learns to crawl and walk he/she will like to explore the environment. Keep it safe
- Keep small objects like beads or buttons which the child may swallow out of reach.
- Keep sharp objects like knives, blades and sticks out of reach of your child.
- Do not let your child play near the stove or with matches as he grows older
- Keep all medicines locked.
- Do not keep poisons like pesticides in the house.
- Do not give the child bows and arrows, these could even blind the child.

Toys that may break easily could injure the child.

- Do not let your child play with plastic bags, burst balloons or wires.
- Protect your child from electrical sockets and wiring.
- Windows should have bars and the child should be kept under close watch if the door is open.
- Do not let your child eat dirt.
- Do not expose the child to loud noises.

IMPORTANT
Please make sure
enjoys ASAP

CC: LMA
Ref: CCT

AN 16

Recommendations from Consultation on:
Developing a Communication Strategy for ECC SGD for the Northern Region and
Consideration of a Home-Based Card
Consultation of NIPCCD and UNICEF
28-29th Nov., 2000 Delhi

A meeting was held on 28-29th of November, 2000 in Delhi with representatives of 5 states to define the role of communication in the ECC SGD framework. The meeting was designed to sketch out a communication strategy, define the role of a mother-held growth monitoring card in the process, evaluate whether it would be useful or not, and develop plans for next steps.

Consensus items:

1. There should be some form of mother- or family-held card as the core part of the ECC SGD communication strategy. The card should define key elements of the intervention. It will result in immediate feedback to being given to caregivers, resulting in to use triple A in counseling them.
2. The format of the card can vary from state to state. However, each should meet certain quality criteria, such as being field-tested and locally adapted, and should be directed to all decision-makers.
3. Elements that should be added to the home-based growth card in use in several states include the following: psychosocial care, feeding style, and care for girls and women, plus sanitation/hygiene messages.
4. Growth monitoring and promotion and use of the card should be a part of the regular work of the AWW and it should be positioned that way; it should not be seen as a "new job" or additional burden for her¹.
5. In order for this strategy to work, the supervisors and CDPOs need to be in agreement (to be "on board."), and advocacy efforts are needed.
6. The card has to be part of a larger communication strategy.
7. The card should be used as a support for communication and be a part of a normal program, subject to programme monitoring from field to center and vice versa.
8. Training for the AWW is needed to strengthen the capacity of the AWW worker to use the card. All functionaries need to be trained. The AWW cannot do it alone, where needed, teams should regularly visit the villages to support these efforts (within existing programmes).
9. States may decide whether or not to use the milestones, but all cards must contain the Care for Development messages. States which choose not to use them in the card may use them for materials for the AWW.
10. Implementation should be at least for one block. Cards should be given to all children in the AWC, not just those receiving the supplement, as outreach of the program is intended to be broader than just those with supplementary food. Materials should be accessible for non-literate women. These issues will be dealt with in pretesting.

¹ The home-based card will eventually replace the current growth chart (blue book) used by the AWW, the Family Welfare immunization card, and the Antenatal Care card.

Recommendations for Actions:

1. NIPCCD will constitute a communication working group at NIPCCD HQ, including other sectors and partners, including Family Welfare, DWCD, and UNICEF, World Bank (add CARE since they have worked on cards in the past?). FEBRUARY 26th is proposed as the meeting of the task force, to be called by NIPCCD.
2. NIPCCD will gather existing materials related to the use of a card that can be used for developing communication materials, and will adapt these to the purpose of supporting the card with information and training.
3. UNICEF/NIPCCD will support the setting up of communications working groups in each state. States may develop resource centers and a state resource group.
4. NIPCCD/UNICEF will help organize 2 regional workshops or state workshops on the communication strategy for ECC SGD.
5. NIPCCD/UNICEF will support the field testing of the card, as part of the communication strategy, in 4 Hindi-speaking states (UP, Bihar, Rajasthan, and MP) as well as Delhi. A protocol will be developed by NIPCCD with UNICEF input.
6. NIPCCD/UNICEF will support an evaluation study of the current Mamta and Dular card strategy, in order to derive lessons learned.
7. NIPCCD/UNICEF to initiate the process for development of an ECC SGD card prototype that can be adapted locally.
8. This effort must be done quickly; a timetable must be prepared for the first six months of 2001 to complete the field testing. Field testing will be done in the three stages: face validity, assessment of functioning in the field, and programme trial.

Components of a communication strategy:

- Identification who one should communicate with - mother, parents in law, etc.
- Information and materials that the AWW has that explains the card, with specific recommendations for each milestone that are related to the care for development recommendations.
- Refresher training for the AWW, supervisor, and CDPO on how to use the card and support materials.
- Training in interpersonal communication for the AWW (as well as supervisors).
- Advocacy for the importance of the Care for Development component: all have to be convinced of its benefit and the risk of not using it.
- Social mobilization strategies for increasing community involvement.
- Folk plays, print, pamphlets, mass communication

Specific Recommendations on the format of the Card:

Many individuals, both at the conference and at other times have made (these comments).

Page 1:

1. Title should be "family growth card" and include a picture of a father on the first page.
2. Include sub-center/clinic/hospital address on card
3. State should have flexibility to incorporate local practices on this page.
4. This card should be a birth registration card and as such be launched by the PM!!!

Page 2: "regular check-up is essential during pregnancy"

1. Color code the boxes to indicate what it is that she should do - e.g., outline three boxes for ANC check-ups to indicate that this is what she should do.
2. Indicate what normal blood pressure is, or at what level one should be concerned
3. For weight, indicate what the weight ought to be, and amount of weight gain per month (1 kg per month)
4. Indicate when the TT injections should be done by color coding the box
5. Indicate how many iron tablets should be taken by color coding the boxes when she should take them, and show the maximum number she should take (30 per month for 3 months)
6. Add iodized salt intake to the chart (not clear how).
7. Instead of Place of Delivery, title this section Preparation for Delivery. Change the items as follows:
 - List the five cleans in some way (show them all).
 - Triangle was not clear (family welfare)
 - Show some form of transport for safe delivery.
 - The heading over the picture with the purse should say ANM, not TBA.

Danger Signs:

Heading should say, "If you or anyone in your family sees these danger signs, rush to the hospital"

Need a picture of Edema

Growth Chart Page:

1. Use colors to indicate grade 1, 2, 3, and 4 (or lines)
2. Question the value of the "record of illness: - would it be used? Could just have the descriptions without the chart. Descriptions need more pictures, fewer words.
3. Instead of the risk factors listed under the "Special Care Is Needed" section, list key newborn care practices. Some of these are:
 - Weigh your child at birth.
 - Keep the child warm.
 - Begin breastfeeding within an hour of birth. (Show picture of good attachment?)
 - Do not bathe the child for the first 2 days.
 - Protect the child from people who have coughs, colds, or are ill.
 - Give no other foods or fluids except breastmilk.
4. For the milestones, the team in Bihar added color bars for each year, and the form is much clearer. However, it becomes even more evident that there is a need for an indicator that goes from 2 to 3.

5. Use only three dots instead of four (red, yellow and green) to indicate milestones.
6. Need a milestone that goes into the third year.

As children grow they need more food:

- Use bullet points instead of writing it out – too many words.
- In 6-9 month period, indicate need for consistency of purees.
- For micronutrient intake, in two places, indicate that the child needs green and yellow vegetables. Perhaps here use the image or background of the Indian Flag as a reminder?
- The breastfeeding picture is still a bit troublesome.
- The child from 6-9 months, and 9-12 months, is not shown being fed. Better to use the picture of the child being fed for the earlier periods of time.

Playing and talking with the child helps her grow well
Change “her” to “the child”

A few of the Care for Development messages could be changed. The chart below shows the relationship between the care recommendations and the indicators on the other side. There is a pretty good correspondence except for some indicators, primarily the motor ones. With the card, one could make up a series of recommendations for each indicator by turning to the care recommendation for that age group.

Pictures to change:

- Help your child to count – should have a series of pebbles, etc., to count.
- 6-12 months: child with pillow behind looks like he is in a sickbed – can you have him sitting upright (common for 6-12 months)
- Add one more father in the pictures? Four mothers, the back of one father.

Care recommendations in italics are different from the ones shown on the chart. I would recommend changing the first one.

Age	Care Recommendation	Indicator
From birth onwards	<ul style="list-style-type: none"> ◦ Smile at your child, look into her eyes ◦ <i>Show your child that you love him or her.</i> (card says, hug and cuddle your child)	Smiles in response
From 4-6 months	<ul style="list-style-type: none"> ◦ Have large colorful things for your child to see and reach for ◦ <i>Talk to your child and get a conversation going (not on the card)</i> 	Reaches for object Tracks a pencil with eyes Gestures bye bye Turns to voice
From 6-12 months:	<ul style="list-style-type: none"> ◦ Give your child clean safe items to handle, and things to make sounds ◦ Respond to your child's sounds 	Scribbles Picks up with thumb and finger Says “mama, papa” Utters sounds
From 12 to 24 months:	<ul style="list-style-type: none"> ◦ <i>Give your child things to stack up, to put into containers and take out.</i> (not on card) ◦ <i>Play games like “bye”, and encourage your child to name things (first part not on card)</i> 	Puts 3 pebbles in cup Indicates wants Names 1-4 objects Says 1 other word
From 24 to	<ul style="list-style-type: none"> ◦ Help your child count <i>and compare</i> 	Unscrews bottle cap

36 months:	<p><i>things; make simple toys for her.</i></p> <ul style="list-style-type: none"> <i>Encourage your child to talk and answer your child's questions. Teach your child stories, songs, and games</i> 	Points to 2 parts of body
	(no care messages related to these)	<p>Head steady sits without support</p> <p>Sits up from lying</p> <p>Stands alone</p> <p>Bladder control</p> <p>Feeds self</p> <p>Imitates housework</p> <p>Walks well</p>

NOTE FOR RECORD

FOLDER: I SAFE MOTHERHOOD

1. The nurse should look healthier than the mother should.
2. In the second picture, (after the title), which depicts the TT immunization, it may be noted that the usual practice in AP is to take the first shot in the third trimester. Therefore, it was suggested it may be shifted and placed after the illustration (over leaf) on IFA supplements.
3. (Overleaf, again). The diet of the mother shown in the illustration needs no change except that the picture of the live cock should be removed. Consumption of eggs can be encouraged by making them more prominent, as they make small and out of focus.
4. In the last picture, where a gap exists, show the picture of delivery kit as in folder II illustration 1.

FOLDER: II CARE OF NEWBORN

1. The second illustration can be done away with, as it may prove fatal and the doctors advice only on technical training.
2. Overleaf – the illustration giving prelacteal feeds should also mention and show 'water' and include it in the message as not to be given, to promote exclusive breastfeeding.
3. To add-breast milk contains substances which help developing the brain and body of the baby.
4. To add-after delivery, mother needs good food and rest and she should continue breast feeding and taking rest till the child is 2 years of age.

FOLDER: III COMPLEMENTARY FEEDING

1. The picture of 'nuts' to be removed from 1st and 2nd illustrations.
2. Put pictures of dal-rice-pulses in messages mentioning the diet of the mother..
3. Also do not mention that ' the toddler should be able to consume half of what his father eats', as the mothers are unable to estimate the quantity.

FOLDER: IV IMMUNIZATION

1. The pictures of the child with six different diseases need to improvise to be more realistic.
2. In the following illustrations, include picture of father along with the child's mother, at the time of immunization.
3. Page 1, last picture, the site of injection should be correct and clear in the illustration.
4. The hand holding the chin/neck should be made gentler.
5. The ANM/nurse should in look healthy and cheerful. She looks more sick than the mother.

FOLDER: V VITAMIN 'A'

1. The sources of Vitamin A can have more pictures of locally available foods. Add guava as a source of Vitamin A.
2. The picture of the Bitot's spots and keratomalacia to be more clear.
3. (Overleaf). In the first illustration- a line in the text to be included that 'vitamin A in the food can be made available to the baby through breast milk, when a lactating mother consumes these sources in her meal.

FOLDER: VI IRON SUPPLEMENTATION

1. The second illustration, showing picture of IFA tin, can be included in the folder on Safe Motherhood and be placed over leaf, with the second Illustration. The message should also carried to this folder and it can form part of the message already given.
2. This folder on IRON SUPPLEMENTATION can then be deleted from the set.

FOLDER VII (DIARHOEA)

1. Picture of homemade ORS that can be prepared from salt and sugar in water to be added along with other ORS that are shown.
2. The illustration-giving picture of packet of ORS should also have 5 glasses of water and the message should include that the contents of 1 packet to be dissolved completely in 1 liter or 5 glasses of water.
3. If possible sketch showing dehydration symptoms such as the skin loses elasticity-the skin is pinched with fore fingers, on removing, the pinch-mark remain.

FOLDER: VIII A.R.I.

1. The child should look according to the age mentioned. In most pictures he/she looks older than the age specified in the message.

FOLDER: IX ADOLESCENCE

1. (Overleaf), change the picture of the mother placing her hand on the throat of her daughter.
2. As the last illustration of this folder, add pictures of women who have made marked achievements as doctors, engineers, pilot, police etc.

SAFETY TIPS

1. All medicines, poisons, disinfectants, matches, small and sharp objects should be kept out of his reach.
2. Check toys before you buy – ensure that they are safe and non-toxic.
3. Your windows, doors and stairs should have gates or bars to keep him safe.
4. Don't let him play with plastic bags, telephone and television cables and other wires.
5. Avoid exposing to loud noises.
6. Install electrical sockets at a height or make them child proof.
7. Keep the child away from fire.
8. Keep the containers filled with water covered and away from the child's reach.

**Early Childhood Care Practices: Twenty Key Actions
for Families and Communities
to Improve a Child's Survival, Growth and Development***

16 March, 2001

UNICEF India Country Office

Action	Supported by
<i>Pregnancy</i>	
1. Ensure that the pregnant woman receives timely health care services (ante-natal clinic checkups, Tetanus Toxoid vaccinations, pregnancy registration by 16 th week, Iron-Folate tablets every day, and access to adequate safe delivery facilities); gains at least 10 kilos during pregnancy; is provided with and eats more food containing adequate micronutrients such as iron and folate, vitamin A, iodine; gets adequate rest and relaxation; avoids heavy labour and stress; has at least a two year inter-pregnancy interval; is informed about the advantages of exclusive breastfeeding for her own health and for delaying ovulation, is provided with support for preparation for breastfeeding, and has access to information and services for birth spacing	ANM
<i>Birth through 3 years</i>	
2. Protect the infant from hypothermia immediately after birth; hold infant often and breastfeed exclusively and on demand (a minimum of 6-10 feeds per 24 hours) from within an hour of birth to about six months.	AWW, ANM
3. Ensure that men and boys, as well as women and girls actively participate in early child care; touch, hold, care for, feed, and bathe; maintain eye contact, interact with, communicate and play with the child as often as possible	
4. Complete the child's full course of scheduled immunisations (BCG, DPT x 3, OPVx 3, and measles); participate in preventative and promotive health care services such as growth monitoring and promotion, and deworming.	ANM, AWW
5. Promote child's mental and social development; and respond to the child's needs for care; stimulate the child's development through talking, playing, and engaging in other age-appropriate physical and affective interactions with the child. <i>From birth onwards:</i> <ul style="list-style-type: none"> • Smile at your child, look into his or her eyes • Show your child that you love him or her. <i>From 4-6 months</i> <ul style="list-style-type: none"> • Have large colorful objects for your child to see and reach for • Talk to your child and start conversations with him or her (sounds or gestures) <i>From 6-12 months:</i> <ul style="list-style-type: none"> • Give your child clean safe items and objects to make sounds with to play and handle • Respond to your child's sounds <i>From 12 to 24 months:</i> <ul style="list-style-type: none"> • Give your child objects that he or she can stack up; items to put into containers and take out. • Play games like "bye-bye" and "peek-a-boo", and encourage your child to name people and objects <i>From 24 to 36 months:</i> <ul style="list-style-type: none"> • Help your child to count and compare things; make simple toys for him or her to play with. • Encourage your child to talk; answer your child's questions; teach your child stories, songs, and games. 	AWW
6. At about six months of age, feed your child freshly-prepared energy and nutrient rich, locally-available, and age-appropriate complementary foods, while continuing to breastfeed up to at least two years or longer, if possible.	
7. From six months onward, give your child complementary foods frequently (2-3 times a day until the 8 th month, and at least 4 times a day thereafter); patiently, persistently and with good humour, help your child to eat, responding to the child's hunger cues and using meals and feeding as a learning opportunity.	

Action	Supported by
<i>Birth through preschool</i>	
8. Provide your child with adequate amounts of micronutrients (vitamin A, iron, iodine, zinc and others) in his or her diet and through supplementation and through giving your child foods that are fortified; ensure that your child and your entire family consumes only iodised salt.	AWW, ANM
9. If your child has diarrhea, continue to breastfeed him or her on demand; if the child is six months or older, feed him or her more often, offer more fluids, and if the diarrhea persists, give your child ORS.	
10. Recognise the signs that a sick child requires treatment outside the home (e.g., Acute Respiratory Infections; fever; vomiting; persistent diarrhea); take him or her to a health facility that provides appropriate services; strictly follow instructions for medical care and treatment upon returning home and feed him or her more often following illness.	ANM
11. Dispose of feces (including children's feces) safely; wash your child's hands and your own with soap and safe water after defecation; before preparing meals and before feeding your child or eating.	
12. Provide a safe environment for your child, including a clean and danger-free home and play area; prevent child accidents and injuries by removing dangerous objects and substances; provide your child with safe water for drinking and bathing.	
13. Teach your child to wash hands and use a toilet or another safe place for depositing feces and urine from about 18 months.	
14. Check to see if your child has slow development or low activity levels; talk to health service providers (AWW, ANM, and supervisor) about this; provide a child who seems slow to learn with additional encouragement and time for learning.	AWW, referral
<i>Young children, school-aged children and adolescents</i>	
15. Prepare household food to maximize nutritional value and store it hygienically.	
16. In malaria- and dengue fever endemic areas, provide your child with an insecticide-treated mosquito nets, and ensure that she or he sleeps under it each night; remove sources of stagnant water including tins, puddles and small pools; clean up cesspools in communities.	ANM, sanitation worker
17. Ensure that your child's environment is free from physical and verbal abuse and violence; protect your child from neglect; take appropriate action when abuse, violence, or neglect has occurred.	Community, AWW
18. Support girls and women in the following ways: <i>Infant girls:</i> Ensure that girls have equal access with boys to adequate food, including breastfeeding, health care, and psychosocial care from birth. <i>school aged girls:</i> Ensure that your daughter has equal access to school as a boy does; and that she is able to complete at least primary school <i>adolescents:</i> Provide your adolescent daughter with iron folate tablets, and ensure that she consumes them weekly for 52 weeks per year; Enable her to delay her marriage and first birth until at least 18 years; educate your son and daughter on birth spacing, nutrition, parenting skills, and care for children and women. <i>Women:</i> Enable women in your family to engage in activities outside the home; protect them from verbal and physical abuse and violence; treat them with dignity and respect	Community pressure
19. Adopt and sustain appropriate behavior that prevents the spread of HIV-AIDS; provide care for HIV/AIDS affected people, including orphans, widows, elderly parents, etc.; educate your children and other family members on ways to prevent HIV-AIDS, and how to care for HIV-AIDS patients	
20. Strengthen your family's ability to provide care through information and training, and through supporting policies such as maternity leave; breastfeeding in the workplace, parental and paternal leave, etc.	govt., civil society

* an expansion of the 16 Key Family and Community Practices agreed upon in Durban in 1999 which incorporates Care Initiative issues.

Could be added:

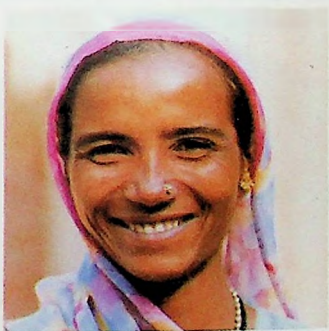
Actions by Community:

Action	By Whom
22. Monitor quality of services (health care, education, etc.) provided; raise objections when services are inadequate; work with authorities to provide better services	Community boards
23. Monitor the well-being of pregnant and lactating women and malnourished children and provide support to families with young children	Community committees
24. Prevent child abuse/neglect; protect women and children from abuse and neglect; and take appropriate action when it has occurred.	Community committees
25. Ensure that men actively participate in early child care, including all dimensions of the above – i.e. the responsibility for child care lies with men and women, boys and girls.	How?
26. Adopt and sustain appropriate behavior regarding prevention and care for HIV/AIDS affected people including orphans	How and who?

Actions by Policy makers (could be a much longer list).

Action	By Whom
27. Strengthen the family's ability to provide care through information, training, and policies such as maternity leave legislation	govt.
28. Protect women from exposure to breastmilk substitute advertising	Policy makers
29. Provide special support for mothers with low birth weight babies	ANM
30. Ensure that micronutrient supplements are available	Services
31. Ensure that iodized salt is available and right price	Services
Etc.	

*List based on a combination of three sources: IMCI Family and Community Practices, practices listed in the DWCD book of tasks for the AWC, and care practices and resources for care in the Care Initiative, also for ECC for SGD.



CHETNA

The Beginning

CHETNA, which means 'awareness' in several Indian languages, is an acronym for Centre for Health Education, Training and Nutrition Awareness. It was established in 1980 as a project to improve the impact of supplementary feeding programmes for women and children, in Gujarat, India.

Mission : CHETNA's mission is to contribute towards the empowerment of disadvantaged women, adolescents and children so that they become capable of gaining control over their own, their families' and communities' health.

Presently, CHETNA works for education, awareness and empowerment, by supporting and strengthening the work of functionaries of Government and Non-Government Organisations (NGOs), Individuals and Educators,

working to improve the health of women, adolescents and children.

Geographical Outreach

CHETNA primarily works in the States of Gujarat and Rajasthan, In India.

CHETNA's Ideology

- Strengthening existing efforts prevents duplication.....

CHETNA supports ongoing efforts of Government and Non-Government Organisations, health professionals and community groups to improve their work related to health and development concerns of the community.

- Information leads to empowerment.....

CHETNA realises that information is an indispensable input in the process of development and is critical in terms of policy making and programming.

CHETNA makes efforts to bridge the communication gap that exists between the grassroots and policy makers, funders and programme implementors ensuring that information on experiences of innovative, viable and relevant development is disseminated widely.

- **A participatory approach is the cornerstone of empowerment and it is particularly essential at the field level...**

Participation enables people to take greater control over their lives, over the problems which confront them and the solutions which challenge them.

Community based development requires that people define their own health needs, and that solutions come from their own context. Focusing on health and nutrition, CHETNA uses participatory methods to empower women and children.

- **Drawing from the knowledge of the community...**

CHETNA makes efforts to demystify modern health knowledge and share factual information with the community. Strengthening existing health systems, it also draws on the richness of traditional health knowledge and practices and encourages people to use the knowledge they already possess to address their health concerns.

- **Need-based education respects people's differences...**

CHETNA plans and develops need-based education and training modules and materials which are responsive to priorities of the people themselves. Every training session, each information package, and every activity is tailored to meet people's felt needs.

- **A life cycle approach...**

CHETNA addresses the health concerns of women from infancy to old-age including, early childhood, school age, adolescence, adulthood and

old-age through the activities of its two Resource Centres namely, **Child Resource Centre (CHEITAN) and Women's Health and Development Resource Centre (Chaitanyaa).**

CHEITAN

Committed to Children...

- **A child centred and gender sensitive perspective...**

CHEITAN works with a child-centred, gender sensitive perspective, valuing each child and recognising her/his right to blossom and grow as an individual not merely as an investment for future but, for what s/he is today.

- **Giving children a choice in learning...**

Curious and creative, children quickly grasp health and nutrition messages and can be assisted to take control of their own health, that of their families' and communities'. Using a 'cafeteria approach' to health education, CHEITAN encourages children to select the information most useful to them.

- **Learning by doing...**

Through games, puppet shows, songs, drawing, painting, story telling, children are encouraged to take part in shaping their own health and nutrition messages. To make learning interesting, CHEITAN develops and uses activity-based, innovative approaches.

- **Children as partners in health...**

CHEITAN does not consider children as passive recipients of health care. Instead, it realises that children are capable and have a right to be considered as partners in health. It recognises that they are effective change agents for the health and development of the community.

Vision

CHEITAN envisages empowered, healthy and happy children who can contribute to the development of the Nation.





Mission

To empower children and adolescents to become active partners of their own health, that of their families' and communities', by equipping adults working with them.

Areas of Intervention

Early childhood care and development (0-6 years) Health and education of school age children (6-14 years) Health & development of adolescents (15-18 years).

CHAITANYAA Committed to Women.....

● Health in the social context.....

Women's health problems reflect the diversity of social, cultural, economic and physical environment. Efforts to improve the health of women must be linked with an understanding of the underlying issues and causes. Chaitanyaa's efforts to improve women's health are a part of the broader struggle to improve their overall status and condition.

● Empowerment through awareness.....

Chaitanyaa works to raise women's and adolescents' awareness through providing opportunities and tools to reflect on their social, political and

cultural status and encouraging them to take action to improve the quality of their lives.

● An Integrative and holistic approach.....

Chaitanyaa recognises that women's health encompasses their social, physical and psychological well being and these need to be addressed in an integrative manner.

Chaitanyaa does not see women merely in their role as mothers. As a comprehensive approach, it considers focus on all stages of women's lives important.

● A gender sensitive and realistic perspective.....

Chaitanyaa recognises that gender discrimination is one of the important determinants of women's low health status. Therefore, understanding and addressing the implications of gender relations and enlisting the participation of men and the community, is central to its efforts in enhancing women's health and development.

In its analysis and approach, Chaitanyaa considers the totality of the political, economic and social factors that shape women's environment particularly, which

affect women's ability to control and improve their health status.

Vision

Chaitanyaa envisages an egalitarian and just society where empowered women and adolescents live healthy lives.

Mission

Its mission is to enhance women's and adolescents health status by empowering them to gain control over their own health and development concerns.

Area of Intervention

Health and development of adolescents (12 -19 years), Nutritional status of women (20 years and above), Violence and Women's Health concerns, Maternal Health, Reproductive Health, Psychological Health, Occupational Health, Promotion of beneficial Traditional Health Practices and Role of Panchayat in Improving women's adolescents' and community's health.

Activities of CHETNA

- * Training : Trainings are conducted by CHETNA as a strategy for sensitisation, capacity building, information sharing and networking. Capacity building is done through

conducting short term & long term trainings, workshops on specific concerns of children, adolescents and women from time to time, depending on the felt need.

- * Documentation of Innovative efforts, development and dissemination of IEC materials :

Innovative methods of imparting health education are tried out by both the resource centres of CHETNA at the field level. Such efforts are documented to enable sharing of experiences and replication.

From time to time, education and training materials are designed and developed after extensive field testing for creating awareness at the community level and for sensitising policy makers.

CHETNA has also developed innovative and creative health and nutrition communication materials such as flash cards, flip charts, booklets, manuals, pamphlets, learning kits and audio-visual material. These have been found to be effective to impart health and nutrition messages to children, adolescents and women particularly, among the illiterate community.



* **Networking** : Networking to share experiences, exchange materials and ideas with individuals and organisations at the regional, state, national and international level is facilitated through :

- A quarterly newsletter
- Trainings
- Exhibitions
- Organising and participating in issue-based events/meetings/work-shops/seminars/conferences.

With the growing organisation and user needs, CHETNA is now preparing to supplement its traditional channels of communication such as, personal contacts, reports, newsletter, meetings and press releases with computer based communications.

* **Advocacy** : CHETNA advocates on concerns/issues critical to health and development of women and children through-sharing of views, experiences and documents at the state, national and international forms. eg.

- contributing in policy documents of Government of India or in country papers to be presented at International forums.



- providing input during appraisal and evaluation missions in Health, Education and Development Programmes of Women and Children.

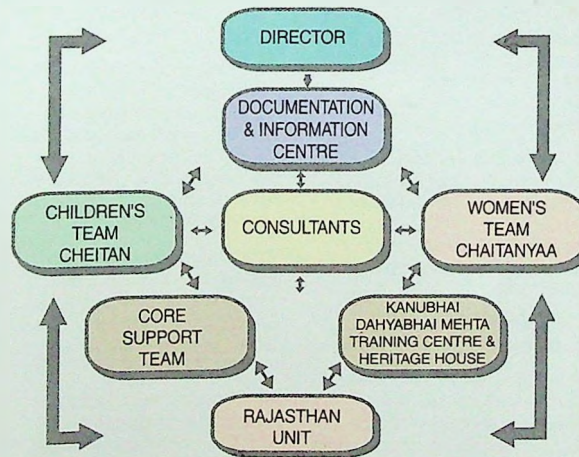
Newsletter : CHETNA publishes a quarterly newsletter, CHETNA News, in English. The objectives of this newsletter are to provide readers with information useful for strengthening service delivery, to share field level experiences of the CHETNA team, advocate and promote innovative programme interventions related to health education, training, nutrition awareness and above all to serve as a tool for networking. It covers all major activities of CHETNA and some other organisations, information on new resources and sources for further information.

CHETNA's Documentation and Information Centre

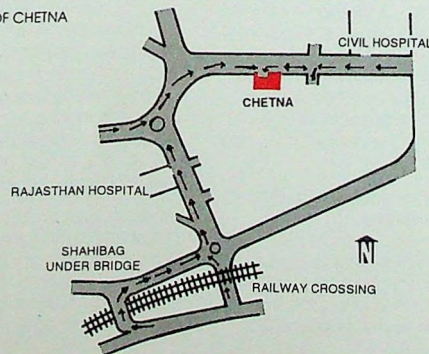
A Documentation and Information Centre has also been established at CHETNA specifically, to address the information needs of individuals, Government and Non-Government organisations, working in the field of women's health and development and child health and education.



CHETNA'S ORGANISATIONAL CHART



LOCATION OF CHETNA



For further information please contact :

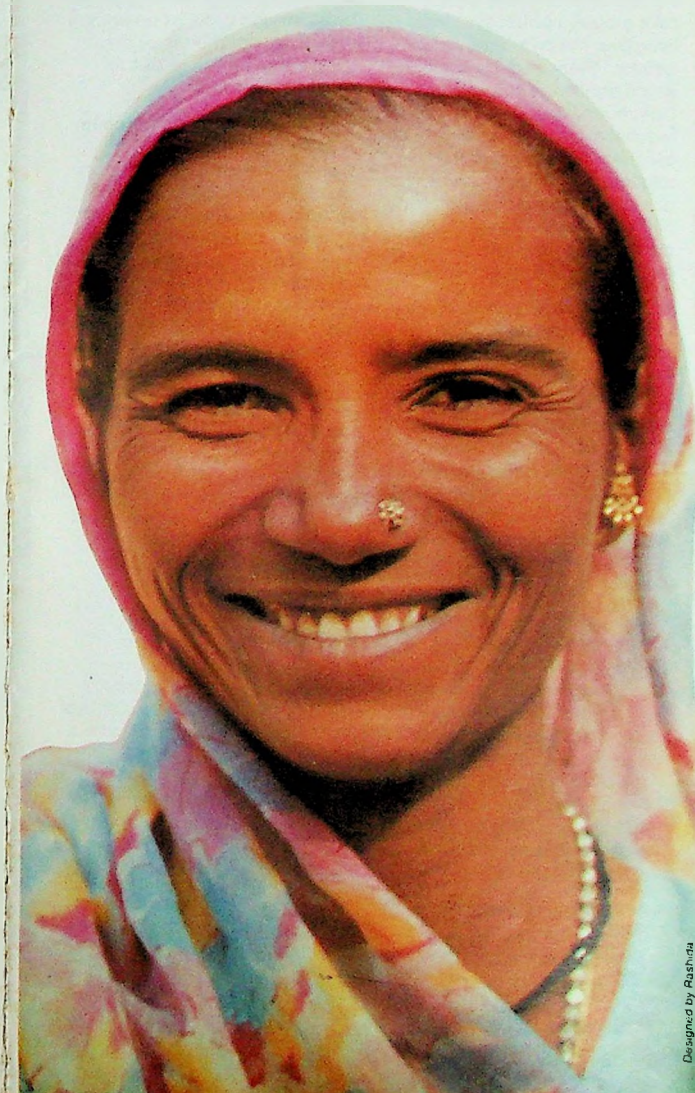


CHETNA

Centre for Health Education Training and Nutrition Awareness

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February - 2000



Logical Framework Analysis

Narrative Summary	Expected Results	Performance Measurement	Assumptions and Risk Indicators
<p><u>Project goal</u> Reduce all form of malnutrition through life cycle</p>	<p><u>Impact</u> -Reduction in LBW rate -Reduction in malnutrition in children between 0-3 years -Reduction in anaemia/malnutrition among adolescent girls -Reduction in anaemia in women and children</p>	<p><u>Indicators</u> -LBW rate -% of underweight children -% of stunted children -% of wasted children -IMR -% of children with anaemia -% of adolescent girls with anaemia -% of pregnant women with night blindness -% of women with goiter <u>Means of Verification</u> -Establish baseline. Follow up with implementation reports and community monitoring, mid term survey and final end line survey</p>	<p>-Political/social/economic conditions continue to favour of INP -Sustained community interest - Magnitude of the problem and inadequacy of existing interventions</p>
<p><u>Object Purpose</u> To improve the quality coverage and the use of nutrition related services at AWCs in collaboration with and support from health sector</p> <p>Empower women so that they are able to demand improved health and nutrition services for themselves and their children</p>	<p><u>Outcomes</u> - Improved package of service based on community needs, provided to mothers, adolescent girls and children</p> <p>-Number of SHGs formed and operational</p>	<p><u>Indicators</u> -% of mothers bringing children for growth monitoring every month -% of mothers taking and feeding supplementary nutrition -% of women who made three or more antenatal visits -number of contacts with health and nutrition teams for counselling -intake of IFA tablets by pregnant and lactating women and adolescent girls -% of children getting Vitamin A supplementation -% of families consuming iodized salt</p> <p>-number of functional supplementary food producing units -good feeding practices in the families -good child caring practices -good health seeking practices -number of specific actions taken at community level to improve health and nutrition of women girls and children</p>	<p>-Districts continue to allocate high priority to improvement of services -Funding agencies provide timely funds required for implementation -Local support for change is received and maintained -SHGs are able to sustain in terms of production and economic management</p> <p><u>Risk Management</u> -encourage linkages, communication and collaboration between the key stakeholders -encourage districts/ blocks / villages to have their own best strategies -District core group / nutrition committee will develop and manage activities</p>

	-Strengthen community capacity to participate in and monitor the progress of the project	-proportion of community receiving technical assistance to promote participation <u>Means of verification</u> - Continuous assessment - Monthly monitoring by SHGs	
<u>Project Resources</u> ▪ Technical Assistance ▪ Training ▪ Equipment ▪ Materials ▪ Management	<u>Outputs</u> -Improved capacities of key functionaries -Improved planning, monitoring and reporting -Development of Improved need based training material -Food production units -Local specific IEC material - Provision for food fortification -Revision of school curriculum -SHGs able to participate in GMP sessions, conduct counseling sessions, and monitor the nutrition situation - Community has the knowledge about low cost local nutritious foods and their benefits - Community is able to grow and preserve fruits and vegetables -Regular supply of IFA tablets and Vitamin A	<u>Indicators</u> -Extent of knowledge and skill of functionaries - Timelines and quality of plans -Quality of training materials and modules -proportion of flour mills modified to fortify flour -Quality of local specific IEC material produced and used -Effectiveness of school curriculum for nutrition education -% of SHGs participating in GMP, Nutrition counseling and monitoring -% of functionaries received training -% of women of SHGs received training -% of training sessions that allowed participants to learn in participatory manner and apply into practice during training - % of community members who have the knowledge of good child caring practices -% of severely malnourished children treated -% of field workers who keep track of G-I and II children and provided help -% of mothers who can interpret growth chart -% of families received seeds and provided training in production and preservation of fruits and vegetables % of children adolescent girls and women who received supplements	-WCD, GOK continues to implement current project -Full participation of key stakeholders including community - Timely approvals and clearances from DEA and DFA -Use of local expertise -use of flexible approach to adapt to changing needs and circumstances

(total no of functionaries-27860, total no of training programmes for 30 participants/programme-929)

Rs 41,80,500 x 3

(d) 5 day training of SHGs @ Rs 5000/programme
(216000 members, 30 women from each AWC, 30 women in each programme, therefore one programme for each AWC, therefore 7200 programmes)

Rs 3,60,00,000 x 3

3. Cost of IFA to adolescent girls @ Rs 15/year/girl
for 14,48,700 girls Rs 2,27,30,500/ year

Cost of IFA to pregnant women for extra 90 days/year
(33465 women) Rs 7,69,595/year

5 (a) Hiring a consultant for preparation of IEC material.

(b) Translation and adaptation and reproduction of IEC material, TV and radio spots Rs 37,00,000

6 Fortification of flour
(to be decided)

7(a) Base line and end line surveys Rs 20,00,000

(b) Monitoring and Evaluation for 7200 AWCs @ Rs 500/centre
Rs 36,00,000 x 5

8 Cost of seeds and saplings to be distributed to community @
Rs 50/family (Rs 5000/ village) Rs 2,83,00,000

9 Establishing 4 NRUs , one in each district at PHC level
training to LHVs - Rs 1500
cost of medicine and diet (Rs 5+15) /day for 15 children
Rs 20x15x30x12x4= Rs 4,38,000+ 1,60,000 (40,000x4 years)

10. Cost of setting up and running PMU at State level
Rs 40,00,000 + 1,00,00,000 (@ Rs 20,00,000/year)

11. Cost of Vitamin A supplementation (if not provided under RCH)

Year- wise cost of the project: (# time schedule has been shown for year 1 only and likely to change)

Month#	Activity	Cost					Proposed Source		
		Year 1	Year 2	Year 3	Year 4	Year 5	Government	UNICEF	MI
Oct-Dec 2000	District level workshops	4,00,000						.	
Jan-Feb 2001	8 Block level workshops	1,60,000		1,60,000		1,60,000		.	
Jan-Jun 2001	929 grass root level training programmes	41,80,500		41,80,500		41,80,500		.	
Feb-Dec 2001	7200 training programmes for SHGs	3,60,00,000		3,60,00,000		3,60,00,000		.	
Jan-Jun 2001	Baseline and line survey	10,00,000				10,00,000		.	.
Jan-Jun 2001	Development and printing of IEC material, preparation of radio and TV spots, includes hiring of consultant too	22,00,000	10,00,000		3,00,000		.	.	.
Feb-Jul 2001	Operationalising Chakkia for fortification of atta	To be decided						.	.
Jan-Apr 2001	Setting up Programme Management Unit (PMU) at State level Non recurring cost Recurring cost	40,00,000 20,00,000	20,00,000	20,00,000	20,00,000	20,00,000		.	.
Feb- Dec 2001	Establishing SHGs food production units	2,16,00,000						.	.
	Nutrition and health education by SHGs	28,80,000 14,40,000	14,40,000	14,40,000	14,40,000	14,40,000		.	.
Feb-Dec 2001	Initiating production of supplementary food	106.34.20.747	106.34.20.747	106.34.20.747	106.34.20.747	106.34.20.747		.	.
Feb 2001 onwards	Initiating distribution of IFA tablets to adol. Girls and to pregnant women for extra 90 days(at present govt is giving IFA to pregnant women for 90 days only)	2.35.00.000	2.35.00.000	2.35.00.000	2.35.00.000	2.35.00.000		.	.
Aug 2001	Initiating monitoring including community based monitoring in phases	36,00,000	36,00,000	36,00,000	36,00,000	36,00,000		.	.
Jul 20001	Distribution of seeds	2.83.00.000							
Jul-Dec 2001	Establishing NRUs at PHCs	4,38,500	40,000	40,000	40,000	40,000			
	Sub Total	119.50.79.247	109.49.00.747	113.52.41.247	109.49.00.747	113.62.41.247			
	Total								

Annex II

9. Risks

- a) The root causes of malnutrition in India are complex and deeply entrenched. They include environmental, cultural, educational, technological and political factors in addition to conditions of poverty, poor health and illiteracy. The process of attitudinal change may be slow.
- b) Although the ICDS program has many accomplishments to its credit, its own evaluations have pointed out many problems that need policy and institutional reform to be overcome. These might have repercussions on the performance of the project.
- c) Failure to obtain the necessary approvals and clearances on timely basis from DEA and Ministry of Finance may result in delays in project implementation.
- d) At the community and district level, the project must continue to receive strong community and political support and participation if the SHGs and NRUs are to function effectively. This to a large extent depend on local leadership, IEC, political and administrative commitment.

The first three risks will best be managed by ensuring the active support and involvement of the Government of Karnataka and the Zila Parishads, and by close and harmonious working relationships between DWCD and MOFHW, with other government agencies and NGOs. The best way to make this happen is the smooth functioning of the PSC, an effective IEC component and careful monitoring and evaluation. The fourth risk will be managed by encouraging communication and participation of local panchayat and community. Enabling the district core groups and nutrition committees to develop and manage their own strategies and activities to meet their local needs will also be helpful. However, the

PROJECT COST

1. Cost of Supplementary Nutrition

Total number of beneficiaries 19,42,321

(includes 0-2 infants, preschool children, adolescent girls, pregnant and lactating women)

Cost of supplementary nutrition @ Rs 1.50/ ben/day for 365 days

Rs.106,34,20,747/year(for 5 yrs)

(break up for supplementary nutrition for one kg energy and nutrition dense food in the form of panjiri or bar will be -rice/ragi/jowar- 500 gms Rs 3.00

pulse - 150 gms Rs 3.00

nuts 50 gms Rs 1.50

(cost will reduce with the bulk purchase) sugar

250gms Rs 4.00

oil 50 gms Rs 2.50

fuel Rs 0.50

grinding+premix Rs 0.50

Total 1000 gms Rs15.00

(food will be sold to each beneficiary at the rate of Rs 2.00/ kg)

2. Support to SHGs

(a) Setting up supplementary food units @ Rs 15000 per unit

Rs 2,16,00,000

(for total of 7200 AWCs, one unit for a cluster of 5 AWCs will therefore 1440 units)

(b) For nutrition education, demonstration for preservation, dehydration and cool chambers @ Rs 2000 per unit one time grant and Rs 1000 per year

Rs 28,80,000

Rs 14,40,000/year x 5

(for 5 yrs)

3. Training

(a) 4 District workshops @ Rs 1 lakh/ workshop

Rs 4,00,000

(b) 8 two days Block level workshops @ Rs 10,000/day/workshop

Rs 1,60,000 x 3 (includes 2 refresher trainings also)

(c) 3 day joint training of grass root level functionaries from each sector @ Rs 1500/day/programme

- f) The project will be audited annually by an external auditor. The audit reports will be reviewed by the PSC.

8. Anticipated Results

Expected results at the impact level and indicators of progress towards these results are in table -1

Expected Results (Impact)	Impact Indicators
* 30% reduction in LBW rate	LBW rate
*Reduction in malnutrition in children between 0-3 years within 5 years	*Infant mortality rate *% of underweight children *% of stunted children *% of wasted children *% of children with anaemia *% of pregnant women with night blindness * % of IDD cases
*Reduction in anaemia by 50% within 5 years	*% of anaemia in pregnant and lactating women *% of adolescent girls (11-19 yrs.) with anaemia

Project Purpose and Outcomes

The purpose of this project is to support and strengthen Government's on going programmes for improving nutritional status of the community by contributing a substantial input in terms of community support through. SHGs of local women and voluntary organizations and strengthen linkages with the health services.

Expected outcomes	Outcome Indicators
1. Improved package of services provided to mothers and children at the district level, based on community needs	1. Increase in appropriate use of nutrition and health services such as: - % of mother bringing children for GMP every month - % of children getting fully immunized before one year. - % of women getting health and nutrition

	<p>counseling</p> <ul style="list-style-type: none"> - % of children taking Vitamin A supplementation -% of pregnant and lactating women getting IFA.
2. Women become empowered to demand and provide improved nutrition to the children and themselves.	<ol style="list-style-type: none"> 1. No. of SHGs formed and operational. 2. Good feeding practices (breastfeeding, complementary feeding use of new foods in children's diet, increase in the number. of times a child is fed, active feeding etc.) 3. Good caring practices. 4. Good health seeking practices. 5. % of mothers with children under 2 years who can interpret growth chart information. 6. % of mothers washing hands after use of toilet and before handling food. 7. % of adolescent girls consuming IFA supplements 8. % of families consuming iodized salt
3. Improvement in knowledge and skills of field level workers and their supervisors' training	<ul style="list-style-type: none"> - % of field functionaries trained - % of mothers counselled - % of training sessions that allowed participants to put new knowledge and skills into practice during training
4. Improvement in knowledge, skills and behaviour of women of SHGs	<ul style="list-style-type: none"> - No. of SHGs providing fortified supplementary food to ICDS - No. of nutrition and health education sessions conducted by SHGs - No. of home visits conducted by SHGs
5. Provide facility for fortification of local cereal	<ul style="list-style-type: none"> - No. or % of families eating fortified atta
6. Establishing NRUs to manage severely malnourished cases.	No. of severely malnourished children (whose condition has improved) .
7. Strengthen community capacity to participate in and monitor the progress of the project.	-Proportion of community receiving technical assistance to promote participation.
8. Strengthen the capacity at State, District and Block level to provide high quality support and training to functionaries of the project.	<ul style="list-style-type: none"> -Proportion of functionaries provided training. - Number of institutions developed and strengthened.

the child and child's family would be paid follow up visits by the Lady Health Visitor to prevent relapse.. She will monitor the progress of the child and give practical advice. She will weigh and examine the child clinically and refer the child back to the unit if necessary, using specific referral criteria. She will be assisted by ANM/AWW during the visit

6.6 Monitoring and Evaluation: Monitoring and evaluation of any intervention programme is necessary to assess the progress and impact of the project, to check if the objectives are realistic and appropriate or if they need be revised, whether the interventions being implemented as expected and accepted by target population and having no undesirable side effects.

If the monitoring and evaluation is done together with the community it will serve two purposes : Firstly, it is a management tool that helps people improve their efficiency and effectiveness. Secondly, it is also an educational process that helps participants increase their awareness and understanding of the various factors that affect their lives. In so doing it increases people's control over the developmental process.

Proposed strategies: i) Baseline survey to assess the nutrition situation both quantitative as well as qualitative. ii) mid term and end evaluation to measure the achievement. iii) regular monitoring of the process and the achievements. The existing monitoring formats of ICDS may be reviewed and modified if required for making them result oriented. A small number of key indicators may be identified to help monitoring and management at each level.

- iv) A system of collating the information received from the grass root area at the district and state level for taking corrective actions
- v) Introduction of community based monitoring.

Active community members can be part of the monitoring teams.(This responsibility can also be given to SHGs) In participatory monitoring methods and indicators are simple and are designed to provide timely information required for taking action at community as well as government level. CDPO /supervisor can organize a monthly monitoring meeting where problems and their possible solutions can be discussed. This information can also complement the data collected by ICDS functionaries for MPRs and will be collated at District level

7.0 Project Management

- a) Responsibility for the project within the Government of Karnataka will lie with the Department of Women's and Child Development (DWCD/SW). The Secretary DWCD will be assisted by the PMU to ensure that the project receives the necessary resources and facilities etc., authorizations, and cooperation of the Karnataka government agencies.
- b) Overall direction of the project will be provided by a Project Steering Committee (PSC) headed by the Secretary, DWCD (GOI) and consisting of Secretary DWCD (Karnataka Government); Director WCD GOK; the MI Director/South Asia Region; Chief, CDN UNICEF-India; the Project Manager; representatives of the four District Councils. The PSC will meet every six months to consider and approve the strategies and work plans for the project, review and accept the regular reports of the Project Manager, approve reports to the Government of Karnataka and the funding agencies, and resolve issues that can not be settled at the working level.
- c) The project will be managed by an independent Project Management Unit (PMU) established within /outside DWCD/Karnataka and headed by a Project Manager reporting directly to the PSC. The Project Manager will be accountable for the implementation of the Management Strategy and Workplan of the project, for the smooth functioning of the PMU and the efficient administration of project resources, and for the preparation and timely submission of narrative and financial reports to the PSC.
- d) Upon approval of the project and engagement of the Project Manager, the Project Manager will prepare a detailed Management Strategy and a Project Workplan for consideration and approval of the PSC. The Management Strategy will set out the specific roles and responsibilities of all project stakeholders, the management and decision-making systems, and a Work Breakdown Structure for the various project components. The Workplan will be reviewed and updated at each meeting of the PSC.
- e) The Project Manager will submit to the PSC quarterly financial reports, semi-annual narrative reports, and a comprehensive annual report.

that horticultural interventions can motivate families to produce some vegetables and consume them too. Large scale production of vegetables and fruits in Karnataka also makes it imperative to take simple techniques of food processing, especially drying, to people so that vegetables can be dried and preserved when are in glut. This will reduce post harvest losses as well as ensure consumption of vegetables during off-season. Cash return may also be obtained from the sale of surplus produce, which would make horticulture a sustainable enterprise. Therefore the objectives of horticultural intervention in the project are: (i) to develop nurseries in a cluster of villages (ii) to supply saplings and seeds to SHGs at subsidized rates (iii) to encourage growing of at least one perennial and one seasonal crop in the homes, community, AWCs, schools (iv) to ensure consumption of fruits and vegetables by community using nutrition counselling, and (v) to generate awareness about home based food processing and use of low cost cool chambers for preventing spoilage of food

Methodology: (i) SHGs and AWWs will be provided training in raising fruits and vegetable plants suited to the taste and climate of different project districts and in preservation of vegetables and fruits with the help of District agriculture and horticulture extension centers in collaboration with Horticulture Research Institute, Bangalore (ii) Seeds and saplings of plants will be distributed to the community free of cost. (iii) Awareness generation among community about preservation of fruits and vegetables in season and use of low cost cool chambers. This responsibility can also be given to SHGs which can work under the supervision of AWWs and Supervisors.

6.5 Health Services

6.5.1 Strengthening Linkages with Health System: Health and nutrition are strongly interlinked. Hence it is necessary that intervention for prevention and management of the two sectors be delivered as a combined package at the community level. To do this, it is essential that functionaries of health and ICDS work together as a team. They can work together to empower families and the communities to choose appropriate practices to meet their health and nutritional needs at home and use appropriate facilities when required.

The Border Cluster Strategy-Under GOI, UNICEF MPO has the objective of strengthening RCH services in clusters of 4-5 districts located on the inter-state borders of 16 States with the goal to demonstrate a significant impact in the reduction of IMR, MMR, and malnutrition. It is envisaged that clustering

will enhance the impact and cost effectiveness of activities that address common problems in these districts. *Gulbarga and Raichur* districts of Karnataka which are the project districts also have been identified for implementation of this strategy. The following mechanism will be adopted for building and strengthening teams:

- joint training of AWWs, ANMs, TBAs and SHGs
 - joint communication drives
 - AWW as depot holder for ORS, IFA tablets
 - joint household visits for problem cases
 - joint updating of records, immunization register or weight records
 - support of ANM in GMP sessions
 - joint meetings with MSS or SHGs
 - joint review meetings at block district and state level
- Some more innovative activities can be identified at district level.

6.5.2 Setting up Nutrition Rehabilitation Units: In Karnataka 2.6% of children suffer from severe malnutrition. (-3 sd weight for height criterion) The presence of oedema or wasting indicates severe malnutrition. The children may or may not have conditions like dehydration, severe anaemia, life threatening infections, hypoglycemia, hypothermia, severe vitamin A deficiency, apathy and anorexia. Malnourished infants under 12 months of age have a greater risk of dying than older malnourished children. Residential care is essential for initial treatment and for the beginning of rehabilitation of a child with severe malnutrition. The child should be admitted to the hospital (CHC) with facilities for special nutrition care. When child starts eating satisfactorily and gaining weight he or she can usually be managed at non-residential rehabilitation centre which can be set up at a PHC. Close cooperation between hospital and centre is necessary to ensure continuity of the care. It may be relevant to point out here that it is better to prevent severe malnutrition than drain precious resources on management.

Services to tackle severe malnutrition will be initiated at CHC/PHC level as a pilot project in one block of each district. After a minimum stay in the health centre, the mother will be taught about appropriate feeding, how to adapt family foods , give frequent feeds, continue breastfeeding to provide enough energy and nutrition for rapid catch up growth. After the discharge,

form of either laddoos or bars. Food will be enriched with vitamin and mineral premix. 100 grams of this food will provide 400 calories. For infants the mixture can be reconstituted in warm water before feeding and would not require any cooking. Acceptability trials of food will be done on the local community before taking a final decision on the type of food. One kilogram of food can be purchased from SHGs for Rs 15, which includes the transportation cost also.

Since it will be logistically appropriate to provide the entire monthly quota once a month as take home ration, the food mix may be packed in one kg packets. Severely malnourished children will be fed at the site. Non compliance can be checked to some extent by strengthening IEC to mothers and families

Production of food by locally placed SHGs will be cost effective due to reduction in transportation cost of locally available raw food and distribution of processed food. The food production units managed by SHGs will be established in the accommodation provided by village panchayat. Except for grinding of food, all other processing of food will be done by women of SHGs. Grinding will be done at village flour mill which will have the provision of mixing the vitamin and mineral premix also (*wherever possible chakkis will be modified for mixing vitamin and mineral premixes to flour. Otherwise women will be trained to mix the premix manually*). Extra food produced in the food-producing units can be sold out in the market at an agreed rate. This will be helpful in improving the economic situation of the SHGs.

(The value of anything given free is not adequately appreciated. Therefore it will be considered whether a nominal cost, say 2.00 p per kg for supplementary food may be recovered. Having paid for the food, it will directly ensure consumption by the beneficiaries. The funds so collected can be utilized as additional working capital for the SHGs. However, this decision may be taken at the forthcoming meeting of Secretary WCD, GOK, UNICEF and MI.)

6.2.2 Fortification of Local Cereals: The rationale of fortification of flour (cereals and millet flour) is that it is widely consumed in fairly large amount everyday. It can be fortified with lower levels of micronutrients

(.25% of RDA.), which helps in preventing any discolouration or quality problem. As 80% of villages in project Districts have electricity operated flour mills and most of the villagers get grinding of the cereal done from those mills; this will be a cheap and effective method for preventing micronutrient malnutrition. It will also not require any change in food habits of the people. The premix (containing iron, folic acid and vit A) will be mixed with the flour at the end of milling process by a specially designed mixer. Fortification of flour in the initial phase will be supervised by an official designated by the Zila Parishad C.E.O. and later this responsibility can be overtaken by SHGs. The consumer will be made aware of the fortification and acceptability trials will be carried out.

6.3 Supplementation

6.3.1 Distribution of IFA supplements to under threes, adolescent girls, pregnant and lactating women: IFA tablets are distributed to infants and pregnant and lactating women under the govt programmes. In order to improve the health status of girls even before they are pregnant, this project envisages to include adolescent girls also in the beneficiaries of this service. This also plans to improve efficiency and effectiveness of existing delivery mechanism and counseling of women for better compliance. Pregnant women will get IFA tablets for 180 days instead of 100 days.

6.3.2 Strengthening and support of the coverage of the current Vitamin A supplementation programme for children upto the age of 6 years: The present coverage which is about 80% at the first dose is not sustained later particularly because the later doses are not linked to immunization. It is therefore planned to strengthen IEC and educate SHGs to extend the coverage and sustain the later doses.

6.4 Dietary Diversification

Intervention on Micronutrient-rich Horticulture Produces: A long term and sustainable solution to combat micronutrient deficiencies is regular intake of foods rich in these nutrients. Efforts aimed at dietary diversification can be sustainable only when the food sources of iron and vitamin A are locally available. Food and agriculture policies thus need to accord higher priority to improving production, preservation and distribution of vegetables and fruits. It has been observed in different parts of the country

A consultant will be hired for preparation of IEC material specific for Karnataka.

6.1.3 Training: Key to the implementation of strategies of the project is AWW and support to them is augmented through SHGs plus ICDS supervisors CDPOs and District level officials will be a major component of the project's early stages. It is expected that ICDS functionaries, even though have knowledge, will need to be introduced to community based participatory activities. They also need to develop counseling skills. Therefore, along with orientation to project interventions focused on the life cycle approach they will also be provided training to develop counseling skills. Other influential change agents who are in contact with women and their families are ANMs, TBAs, primary school teachers, NGOs, PRI members and rural development workers. Empowered with the correct information and communication skills, these change agents can play an important role in changing the nutrition situation. Teachers have the other special role of influencing the young minds. Therefore combined training of all key personnel will ensure transmission of the same information to the target group, reinforcement of advice being given and minimal contradiction.

The following training programmes will be organized for the different categories:

- (i) Two days training of trainers for CDPOs, AWTCs, MLTCs, DPOs, MOs, ICDS and health supervisors, NGOs
- (ii) Joint training for 3 half days for AWWs, ANMs, MPWs, school teachers, TBAs rural development workers, and NGOS
- (iii) 5 days training of women of self help groups

Characteristics of training: All training should be participatory; on-going, process oriented; skill oriented and practical; community-based and multi-targeted.

Four CFNEUs of FNB placed in Karnataka and Hyderabad will provide training at block level. Training to grassroot level workers and SHGs will be provided by 23 AWTCs of Karnataka and NGOs in the State and nearby places.

6.2 Food Fortification

6.2.1 Distribution of Fortified Supplementary Food to Vulnerable Groups-During the last three decades a number of research studies and evaluations of supplementary feeding programmes have been undertaken in many countries. It has been shown that supplementary nutrition has immediate as well as long-term effect on growth and development. Nutrition care to pregnant women was found to be the most cost-effective means of preventing perinatal deaths. Supplementary food is being distributed under the ICDS scheme for the last 25 years. However, the quantum of improvement in the nutritional status of women children is below the intended level. Attrition could be due to irregular and poor supply of food, poor participation of the beneficiaries, monotony of supplementary food provided, or sharing and substitution of food in the family. It has been planned to overcome some of the problems in the project so that the beneficiaries get the advantage of supplementation.

Supplementary food will be distributed to all the beneficiaries of ICDS i.e., children between the age group of 6m-2years, pre-school children, pregnant and lactating women for 365 days of the year. As the project is adopting the life-cycle approach to address malnutrition, adolescent girls will also be included in the beneficiaries of the programme. Pregnant women will be entitled to the supplements from their first prenatal consultation and 12 months after delivery. More attention will be paid to children below 2 years as this age group is in chronic state of starvation for both macro and micronutrients.

Type of food : The supplementary food to be distributed in the project district will be carefully planned keeping in view the required nutrition density, taste preference, low cost, cultural acceptability. Ready to use precooked fortified mix based on locally available raw material would be used. This hygienically prepared RTE will be a combination of cereal, pulse in the ratio of 3:1 with the addition of nuts, sugar or jaggery and oil. However, the choice of raw material can be left to the Districts. A single food mix will be prepared for all categories of beneficiaries initially. However, it can be processed later on according to local preferences for different age groups. Different recipes will be suggested for adding variety to the food for infants and small children. In order to improve the acceptability by mothers and adolescent girls food can be supplied in the

strategies for working of SHGs can be worked out at Distt level as the strategy cannot be the same for the entire district and would depend on a number of factors including geographical location of villages.

Each group can be provided a seed capital of Rs.15,000 for establishing the units. Recurring expenditure needed is expected to be raised from sale proceeds of products processed.

Women of SHGs will be provided training in purchase of quality raw ingredients, economy of wholesale purchase, safe storage, food processing and fortification, hygiene and sanitation control and packaging. They will also be oriented towards nutrition and health needs of vulnerable groups and good child care practices. Hands on skill training for raising of annual and perennial vegetable and fruit plants will also be provided. They will also be provided skill based training in preservation and drying of fruits and vegetables.

6.1.2 Information Education and Communication (IEC)

Many good practices are operationally simple and do not require heavy expenditure or extra labour, but require change in behaviour of people. For example, initiation of breastfeeding immediately after birth, feeding of colostrum, timely introduction of complementary feeding for infants, minor changes in food preparation methods and addition of some locally available greens in the daily diets and care of girl child can bring about observable changes in nutritional status of people.

Desirable behavioral changes related to nutrition and child caring practices at household level and in the community can be initiated and sustained only through effective communication support and demonstration of some positive results of good practices adopted by the community. This broadly aims to stimulate demand for the services, improve feeding and child caring practices, encourage pregnant women for early registration and for availing MCH services, prepare adolescent girls for safe motherhood and promote community participation.

At present most of the programmes emphasize on awareness generation or providing information only. Most of the field level workers are lacking counseling skills and have weak communication skills; they also lack IEC

tools (e.g. counselling cards) to help them conduct IEC sessions more effectively. IEC strategies in the project can be creative and can help in taking advantage of all opportunities that present themselves to integrate key messages into ongoing events, including everyday unprogrammed (opportunistic) encounters in the villages. These can be weekly markets, health melas, specific health education days, religious functions, mahila mandal meetings, home visits, baby shows, literacy programmes etc.

All the field level workers, formal and informal service providers can be closely involved for enlightening the community and bringing out behavioural change. Joint training programmes will be organized for AWWs, ANMs, school teachers, rural development workers, SHGs, members of VECs and TBAs. Additionally AWWs and ANMs will be provided training in development of counseling skills so that they will help the mothers to adopt nutrition friendly behaviour. They will also receive training in PLA techniques which can help in moulding people's behaviour in participatory manner.

Another strategy for establishing good nutritional practices is to promote sound nutritional practices in the young children. Nutrition topics will be included in school syllabus after reviewing the existing one. Young children can also become very responsible message carriers to the families and community.

Interpersonal as well as mass media channels will be used for IEC. It is also proposed that the roles of Supervisors from ICDS and health sectors be further strengthened in interpersonal communication to support the efforts of AWWs, ANMs, TBAs. For all communication themes to be addressed interpersonal aids will be developed or selected from the already existing ones and translated in kannada. These will include a set of counseling cards meant to be used for one to one communication, a set of demo teaching aids. Short messages for radio broadcasting will be developed to communicate key behavioral issues to people. Cassettes of these messages can be distributed at the block level also. Metal stencils with pictorial nutrition messages will be prepared at District level and distributed to all CDPOs for painting messages on the walls of villages.

Based on community needs assessment and decentralized planning process, it will lead to simultaneous improvement through these groups.

The project will be implemented through the development of community level teams of SHGs, AWW, ANM and school teacher for improved outreach to ensure that beneficiaries of all the groups are receiving counseling about appropriate nutrition, health and care.

SHGs formed in the *Stree Shakti* project will be established to produce appropriate supplementary food, generate awareness and disseminate messages to the community for developing healthy habits and monitoring. The women panchayat members at village as well as *taluk* level will be used as resource persons for advocacy and community mobilization.

The AWW, supervisors and ACDPOs will extend their help and cooperation to the groups and liaise with them. At *taluk* level the programme will be coordinated and monitored by CDPOs.

A District Nutrition Committee headed by C.E.O./ District Collector and consisting of district level officers of the concerned departments, would implement and monitor the progress of implementation every month.

A Programme Management Unit (PMU) at State level headed by Secretary WCD and assisted by a Consultancy firm will have the responsibility of management of the project.

It is very important to mention here that the project will require strengthening, initiation and coordination activities including DWCD, Health and Family Welfare, PRI, Rural Development, Food and Civil Supplies, Education, Horticulture, Agriculture and Forestry.. This can be handled best at District Level. This project can also very well complement the Border District Cluster Strategy in Gulbarga and Raichur districts in terms of nutrition and childcare at family level.

6.0 Project Interventions

6.1 Information, Education and Communication

6.1.1 Support Women's Self Help Groups (SHGs)

Experiences have shown that when a community is fully involved in design, implementation and monitoring of nutrition and other development projects, using a triple-A process (assessment-analysis-action), these are likely to be more effective and sustainable. Such participatory efforts more often meet the real needs of the people and achieve results that can be continued with minimum external inputs. The present project also envisages organizing SHGs of women from the community and improving their knowledge and practices regarding health, nutrition and infant care and reduce the load of AWWs. These women will play a critical role in carrying out the main nutrition activities including:

- (a) Setting up self-sustainable nutritious food production units and production of fortified supplementary food. Food produced in these units will be distributed amongst beneficiaries of ICDS scheme.
- (b) Educating community about raising vegetables and fruits even in landless households and the methods of home based preservation and drying of vegetables and fruits.
- (c) Nutrition and health education. Acquired knowledge and skills related to nutrition and infant care will empower them to solve the local problems and provide support to women and families. They will be able to identify and optimize existing resources and solutions within the community to solve community problems.
- (d) Supervision of regular GMP sessions. These groups will also regularly monitor the nutrition situation of the community. This will include home visits for monitoring G-I and II malnourished children and counselling care givers to prevent G-III and IV malnutrition.

Karnataka government has declared a programme called *stree shakti* for rural women with a view to give special impetus to the empowerment of rural women through SHGs. Under the programme each AWW will form three SHGs in the limits of her centre. Each AWW will be given an incentive of Rs 50/- p.m. for each group formation and supervisors an FTA of Rs 200/- pm under the project. For production of supplementary food and nursery development women can be selected from these SHGs. The

4.0 Summary Project Description

Concerned about the grim malnutrition situation in Karnataka amongst all the southern states and to ameliorate the nutritional level of population, the Govt of Karnataka has planned to initiate an Integrated Nutrition Project (INP) in four districts namely, *Raichur, Gulbarga, Tumkur and Chikmagalur*. The project will address the problems of malnutrition including micronutrient malnutrition by adopting intergenerational life cycle approach to reduce morbidity and mortality due to malnutrition amongst the most vulnerable groups of the population namely: children 0-2 years, adolescent girls and pregnant and lactating women.

An analysis of the causes of malnutrition reveals that the problem is the result of multiple factors and no single sectoral programme input can address it effectively. The programme, therefore envisages bringing in better intersectoral coordination of various ongoing activities at all levels.

The total cost of the project will be Rs. 565 crores (approx) over five years. The project will consist of seven components, organized as follows:

a) Information, Education and Communication(IEC)

- support to women's SHGs who will be educated and trained on (a) promotion of child care at family level; (b) preparation of supplementary food for infants, pre school children, adolescent girls, pregnant and nursing mothers; nutrition and health education; (c) growing fruits and vegetable plants;(d) preservation and drying of fruits and vegetables in peak season; and (e) monitoring of nutrition situation in the village.
- IEC and nutrition counseling, including nutrition-related topics in school curricula
- joint training of local Government and non-governmental functionaries

b) Food Fortification

- distribution of fortified supplementary food to vulnerable groups
- fortification of local cereals

c) Supplementation

- distribution of Iron Folic Acid supplements to under-threes, adolescent girls, pregnant and lactating mothers
- Vitamin A supplementation to children from 9 months to the age of 6 years

d) Dietary Diversification

- intervention on micronutrient-rich horticulture produces

e) Health Services

- strengthening linkages with the health sector
- establishing Nutrition Rehabilitation Units in each district for management of severely malnourished cases

f) Project Management

- establishment of a Project Management Unit and its efficient operation
- establishment of a Project Steering Committee and support for its activities

g) Monitoring and Evaluation

- on-going performance monitoring and feedback, and periodic external evaluation
- community-based monitoring and feedback, using the triple-A approach

5.0 Project Strategy

The strategies of the project will be on the lines of National Nutrition Mission, that is,

- a) Vigorous awareness campaign on malnutrition to reach all sections of the society
- b) Direct interventions for preventing onset of malnutrition among 0 – 2 years, adolescent girls, and reduce LBW and micronutrient malnutrition
- c) Nutrition Mapping and Surveillance for monitoring the nutrition situation regularly.

The project has been designed based on assumption that it will support and strengthen government's ongoing programmes for improving nutritional status of the community. Local women of the Self Help Groups will be the key players in the project. Technical support will be provided to SHGs to build up their own capacity to perform the required tasks. The project also envisages to strengthen abilities of ICDS and health functionaries working at field level as well as their trainers to actively support and assist SHGs.

An individual's nutrition is determined by a number of factors acting directly or indirectly. The causes of malnutrition are complex and include

- Inadequate child caring practices, often governed by cultural and religious beliefs and status of women in the families
- Poverty and household food insecurity
- Inadequate access to health care services and poor sanitation
- Constraints to the physical and social development of the girl during childhood and adolescence
- Heavy workloads, social and economic barriers compounded by gender discrimination in the community and within the family that influence access to healthcare, intra-household food distribution and access to information.

Malnutrition is transmitted across generations. LBW infants born to severely malnourished women, remain malnourished in the childhood and adolescence. These effects are especially devastating in the case of girls who are neglected during infancy and childhood. Chronically malnourished girls are therefore, even more likely to remain malnourished during adolescence and adulthood, and when pregnant, to deliver low birth weight babies. Early marriage and teenage pregnancy further deteriorate her nutritional and health status.

Household food insecurity also perpetuates across generations. Diminished work capacity and work output result in low family income and household food insecurity, thus perpetuating the cycle of household food insecurity and malnutrition. Therefore, protection and promotion of health and nutrition of women can be achieved through a combination of strategies involving concerted actions by various sectors at different levels.

A depressing child nutrition and health scenario is common feature for most of the states in the country. In Karnataka, it is estimated that 54 % of children below 4 years of age are underweight and 48 % are stunted or short for their age. Wasting, which is the most serious nutritional problem, affects 19% of the children in Karnataka. According to NFHS I (92-93) about 22 % of the children in the state were low birth, weighing less than 2500 grams at the time of birth. This clearly indicates the poor nutritional status of mothers. Over 40 % of women suffer from

anaemia due to iron deficiency and close to 30 % women are suffering from severe and moderate grades of CED. The degree of iron deficiency anaemia is highest in 12 – 23 months old children (78 %) in Karnataka (NFHS II)

Some of the contributing practices to this dismal-situation in Karnataka are:

- Intake of dietary energy, proteins, calcium, iron, vitamin A by children are well below the Recommended Dietary Allowances (RDA).
- Cereals constitute the bulk of diets of women and children. Type of cereal or millet varies with the region.
- Diets of women and adolescent girls are also deficient in most of nutrients – especially iron and vitamin A. This is mainly due to the reason that average intake of GLV by women (15 grams) is far below the RDA, which is 100 grams.
- Only 27 % of rural women in Karnataka initiate breastfeeding on the first day. About 60 % of mothers discard colostrum and 85 % women give prelactael feeds to infants. This practice which deprives the newborns from getting benefits of colostrum, exposing them to dangers of infection.
- 22% of urban women introduce complementary food before 2 months of age and 84% introduce it above 6 months of age.

Integrated Child Development services (ICDS) Scheme is implemented in all of the States of India including Karnataka to improve nutrition, health and psychosocial status of young children and women. Services provided to local population under ICDS are: distribution of supplementary nutrition to vulnerable groups, immunization, health check ups, pre-school education and referral services. The focal point of delivery of services is the Anganwadi Centre (AWC) – childcare center in the village or urban slum. The centers are run by local community based women childcare workers – the Anganwadi workers.

Child health is also addressed by Reproductive and Child Health Programme which aim to reduce IMR, CMR & MMR. This programme is an extension of earlier Maternal and Child Health (MCH) and Child Survival and Safe Motherhood (CSSM) Programme. However, the improvement is not of the intended level, which is quite apparent from the data discussed earlier.

Integrated Nutrition Project – Karnataka

1.0 Purpose

The purpose of this project is to support and strengthen the Government of Karnataka's on-going programs for improving the nutritional status of the community by reducing all forms of micronutrient malnutrition among vulnerable population.

2.0 Objectives

The objectives of the project are:

- To improve the quality, coverage and use of nutrition related services namely, provision of supplementary nutrition and nutrition education at AWCs in collaboration with and support from the health sub-centre
- To create awareness education to the community for development of proper nutrition habits with the use of low cost locally available resources.
- To empower women through participation in Self-Help Groups. This is intended to increase ownership of the project, and improve knowledge and practices regarding health, nutrition and infant care.
- To establish Nutrition Rehabilitation Units for management of severe malnutrition

3.0 Background

Malnutrition and morbidity are twin problems affecting a major part of the country's population - especially women and children. They are undoubtedly the most crucial segment of the population, due not only to their sheer numbers, but also their special physiological demands. Malnutrition is often associated with morbidity and mortality thus adversely affecting life expectancy. Additionally, it causes growth retardation and leads to functional impairment, disability, diminished productivity and reduced resistance to diseases.

An individual's nutrition is determined by a number of factors acting directly or indirectly. The causes of malnutrition are complex and include

- Inadequate child caring practices, often governed by cultural and religious beliefs and status of women in the families
- Poverty and household food insecurity
- Inadequate access to health care services and poor sanitation
- Constraints to the physical and social development of the girl during childhood and adolescence
- Heavy workloads, social and economic barriers compounded by gender discrimination in the community and within the family that influence access to healthcare, intra-household food distribution and access to information.

Malnutrition is transmitted across generations. LBW infants born to severely malnourished women, remain malnourished in the childhood and adolescence. These effects are especially devastating in the case of girls who are neglected during infancy and childhood. Chronically malnourished girls are therefore, even more likely to remain malnourished during adolescence and adulthood, and when pregnant, to deliver low birth weight babies. Early marriage and teenage pregnancy further deteriorate her nutritional and health status.

Household food insecurity also perpetuates across generations. Diminished work capacity and work output result in low family income and household food insecurity, thus perpetuating the cycle of household food insecurity and malnutrition. Therefore, protection and promotion of health and nutrition of women can be achieved through a combination of strategies involving concerted actions by various sectors at different levels.

A depressing child nutrition and health scenario is common feature for most of the states in the country. In Karnataka, it is estimated that 54 % of children below 4 years of age are underweight and 48 % are stunted or short for their age. Wasting, which is the most serious nutritional problem, affects 19% of the children in Karnataka. According to NFHS I (92-93) about 22 % of the children in the state were low birth, weighing less than 2500 grams at the time of birth. This clearly indicates the poor nutritional status of mothers. Over 40 % of women suffer from

STATEMENT SHOWING THE PERFORMANCE REPORT IN % OF SCHOOL HEALTH PROGRAMME FROM JULY 2000 TO JANUARY 2001 & REVIEWED IN FEBRUARY 2001.

Sl. No.	Name of the District	Med. Exam. of Students	D & T	T. T.		Teacher Training	Remarks "Marks / Grade"	
				1st dose	2nd dose		Marks	Grade
01	Bangalore(U)	95.83	91.92	95.50	100.78	11.13	84	A
02	Bangalore(R)	82.13	81.26	76.88	59.91	46.97	80	B
03	Kolar	97.74	99.02	63.75	106.26	10.72	80	B
04	Shimoga	93.60	64.83	97.56	150.50	60.07	92	A
05	Chitradurga	95.10	71.12	94.40	147.00	03.35	80	B
06	Davanagere	94.00	44.91	63.52	30.23	01.56	70	B
07	Tumkur	78.21	85.31	85.85	91.33	85.02	96	A
BANGALORE DIVISION		89.82	80.85	80.30	87.80	31.41	88	A
08	Mysore	90.05	85.72	101.18	67.00	00.93	80	B
09	Chamarajnaragar	75.26	85.58	73.68	107.15	62.83	88	A
10	Mangalore(DK)	93.74	104.74	80.55	68.55	84.35	96	A
11	Udupi	86.77	64.54	80.23	69.26	43.98	84	A
12	Mandya	93.80	78.64	93.21	88.06	00.00	76	B
13	Kodagu	429.64	120.58	384.28	223.69	97.28	100	A
14	Hassan	128.40	83.33	91.30	136.47	28.40	88	A
15	Chikkamagalur	88.53	68.47	82.38	112.42	64.27	92	A
MYSORE DIVISION		110.96	84.90	101.80	91.95	38.01	88	A
16	Belgaum	98.98	73.62	81.20	102.97	15.05	80	B
17	Karawar(UK)	61.48	41.20	65.00	99.54	33.84	82	A
18	Dharwar	86.60	66.08	74.59	126.87	35.65	80	B
19	Gadag	98.60	86.43	80.13	93.14	14.42	84	A
20	Haveri	125.55	73.65	91.62	263.55	67.70	92	A
21	Bijapur	89.00	61.10	60.09	113.62	03.95	76	B
22	Bagalakote	132.46	61.45	82.71	206.66	38.00	84	A
BELGAUM DIVISION		98.94	66.25	76.42	128.80	26.52	80	B
23	Gulburga	116.82	76.20	98.22	240.98	05.71	80	B
24	Bidar	40.72	65.15	84.62	200.67	00.00	78	B
25	Bellary	78.93	77.92	93.70	134.84	216.58	92	A
26	Raichur	84.44	62.55	63.28	145.31	64.59	88	A
27	Koppal	89.55	73.80	74.70	159.78	24.27	80	B
GULBURGA DIVISION		82.13	71.95	86.32	185.10	37.34	84	A
GRAND TOTAL		95.23	74.76	84.72	112.37	32.57	84	A

- > Note : 'A' - Good , 'B' - Poor , 'C' - Very poor , 'D' - Extremely poor , 'E' - Bad performance,
 > Note : 'A' - Marks- 81-100 , 'B' - Marks- 61-80 , 'C' - Marks- 41-60, 'D' - Marks- 21- 40,
 'E' - Marks- 10-20 & less

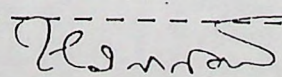
(Dr S.B.Kurtakoti)
 Addl. Director(HET)

ಅನುಬಂಧ - 1

ರಾಜ್ಯದ ಪರಿಷತ್‌ಗಳಿಗೆ ಹಂಚಿಕೆ ಮಾಡಲಾದ ಐಷ್ಠ್ಯ ವೆಚ್ಚಗಳ ನಿಯಮ

ಕ್ರ.ಸಂ.	ಪರಿಷತ್‌ಗಳ ಹೆಸರು	ಐಷ್ಠ್ಯ ವೆಚ್ಚಗಳ ನಿಯಮ
01.	ಬೆಂಗಳೂರು ನಗರ	—
02.	ಬೆಂಗಳೂರು ಗ್ರಾಮಾಂತರ	790
03.	ಕೋಲಾರ	1040
04.	ಶಿವಮೊಗ್ಗ	590
05.	ಚಿತ್ರದುರ್ಗ	505
06.	ದಾಕುಣಿ	480
07.	ತುಮಕೂರು	1025
08.	ಮೈಸೂರು	615
09.	ಜಾಮರಾಜನಗರ	335
10.	ಮಂಗಳೂರು (ದ.ಕ.)	525
11.	ಉಡುಪಿ	165
12.	ಮಂಡ್ಯ	590
13.	ಕೊಡಗು	240
14.	ಹಾಸನ	755
15.	ಚಿಕ್ಕಮಗಳೂರು	450
16.	ಬೆಳಗಾವಿ	735
17.	ಕಾರವಾರ (ಉ.ಕ.)	615
18.	ಧಾರವಾಡ	370
19.	ಗದಗ	300
20.	ಹಾವೇರಿ	450
21.	ಬಿಜಾಪುರ	450
22.	ಬಾಗಲಕೋಟೆ	480
23.	ಗುಲ್ಬರ್ಗಾ	700
24.	ಬೀದರ	450
25.	ಬಳ್ಳಾರಿ	420
26.	ರಾಯಚೂರು	450
27.	ಕೊಪ್ಪಳ	425

ಒಟ್ಟು: 14000


 ಸರ್ಕಾರದ ಅಧಿಕಾರಿ
 ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ
 ಸಚಿವರು, ಬೆಂಗಳೂರು.

16/11/2000

GOVERNMENT OF KARNATAKA

No:HET/SHP/ 30 /2000-2001

Directorate of Health & F.W.Services,
Bangalore-9, Dated: 02-03-2001.

TO:

The District Health & F.W.Officer,
.....

District R.C.H. Officers/D.N.O. may please be instructed to contact the Deputy Director of Public Instruction of their District to collect the following information as per the format given below.

1. No.of Schools in Urban & Rural areas
2. No.of Students in Urban & Rural areas

These collected information should be sent to this Directorate by 3rd week of March 2001.

Statement showing the Schools and School Children in Urban & Rural areas of the District.....for the year 2000-2001.

Sl. No.	Name of the Taluk	No. of Schools from 1st Std. to 7th Std.			No. of School Children from 1st Std. to 7th Std.														Re marks
					Urban							Rural							
		Urban	Rural	Total	1	2	3	4	5	6	7	1	2	3	4	5	6	7	
	District Total:																		

- Note:-** 1)Urban area means District Headquarter & Taluk Headquarter
 2)Rural area means other than above.
 3)Students from 1st Std. to 7th Std.
 4)Schools : 1st Std. to 7th Std.

Additional Director(HET)
 Directorate of Health & F.W.Services,
 Bangalore-9.

1. Copy with best compliment to the Deputy Director Public Instruction,District.
2. Office copy.

DIRECTORATE OF HEALTH AND F. W. SERVICES, BANGALORE-9

REVISED FORMAT

The Progress Report of the School Health Programme for the month of _____

Note * Medical Officers should examine, ** Health Assistant should examine, *** % to the yearly target, **** Target should be fixed depending on the budget allotted by ZP of respective Districts.

SL.No.	Name of the District / Taluk / PHC / SC	Total of No. of primary / higher primary schools	No. of students enrolled during the period of 2000-2001 (This is the annual target to be covered for the year under report)			Monthly target fixed for the Medical examination of students.		No. of students examined medically			
			4			5		6			
			During the month								
1	2	3	1st, 4th. & 7th. Std. Students *	2nd, 3rd, 5th, & 6th Std. students **	Total	1st, 4th. & 7th. Std. Students *	2nd, 3rd, & 5th, & 6th Std. students **	1st, 4th. & 7th. Std. Students *	2nd, 3rd, 5th, & 6th Std. students **	Total	

No. of students medically examined			No. of students found medically defectives/ having the medical problems									
6		Total	% ***	Dental Carries	Worm Infestation	URI	Anaemia	Vitamina- A deficiency	Scabies	Defective Vision	Otitis media	Defective Hearing
1st, 4th. & 7th. Std. Students *	2nd, 3rd, 5th. & 6th Std. students **			(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	

No. of students found medically defectives/ having the medical problems					No. of students treated for minor ailments	No. of students referred to Taluk or referral Hospitals	Training conducted for the school teachers @ rate of at least one or two teachers in each school		
7							10		
Leprosy (i)	TB (j)	Rheumatic heart Diseases (h)	Goutre (k)	Others (l)	8	9	Annual Target ****	During month	Cumulative achievement

Health education activities								Environmental sanitation in the school & school Premises				Drinking water facilities			
11								12				13			
No. of health education talks given in the school		No. of health education materials distributed to the schools		No. of mndi exhibition / films shows arranged in the schools		No. of PTA meetings conducted by the health personnel		Maintenance of School premises in & around the school building Mention yes or No	Urinals & latrines in the schools and their maintenance Please mention the number.		Available / Not -available / Available but not sufficient / Not suitable for drinking				
DM	CT	DM	CT	DM	CT	DM	CT		Having	Maintained cleanliness or not					
DM	CT	DM	CT	DM	CT	DM	CT	M	F	M	F				

To PRAKAS

for Translation.

16.3.01.

ಕರ್ನಾಟಕ ಸರ್ಕಾರ

ಆಯುಕ್ತರ ಕಛೇರಿ, ಸಾರ್ವಜನಿಕ ಶಿಕ್ಷಣ ಇಲಾಖೆ, ನೃಪತುಂಗ ರಸ್ತೆ, ಬೆಂಗಳೂರು

ಜನವರಿ ೨೦೦೧ ರಲ್ಲಿ ನಡೆಸಿದ ೦-೧೪ ವಯೋಮಾನದ ಮಕ್ಕಳ

ಸಮೀಕ್ಷೆಯಿಂದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ

(out of school) ಮಕ್ಕಳ ಕುರಿತಾಗಿ ಹೊರಬಂದ ಅಂಶಗಳು.

ದಿನಾಂಕ: 18-01-2001 ರಿಂದ 20-02-2001 ರ ವರೆಗೆ 0-14 ವಯೋಮಾನದ ಮಕ್ಕಳ ಸಮೀಕ್ಷೆಯನ್ನು ನಡೆಸಲಾಯಿತು. ಈ ಸಮೀಕ್ಷೆಯ ಮುಖ್ಯ ಉದ್ದೇಶ ಕುಟುಂಬವಾರು ಮಕ್ಕಳ ಮಾಹಿತಿಯನ್ನು ಅಂದರೆ ಶಾಲೆಗೆ ಹಾಜರಾಗುತ್ತಿರುವ ಮಕ್ಕಳು, ಶಾಲೆಗೆ ಸೇರಿಲ್ಲದ ಮಕ್ಕಳು ಹಾಗೂ ಶಾಲೆಯನ್ನು ಬಿಟ್ಟಿರುವ ಮಕ್ಕಳ ಮಾಹಿತಿಯನ್ನು ಪಡೆಯುವುದಾಗಿತ್ತು. ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಮಕ್ಕಳ ಪಟ್ಟಿಯನ್ನು ಜನವಸತಿ ಪ್ರದೇಶದ ಹಂತದಿಂದ ತಾಲ್ಲೂಕು ಹಂತದ ವರೆಗೆ ಪಡೆಯುವುದು ಮತ್ತು ವಿವಿಧ ಹಂತಗಳಲ್ಲಿ ಈ ಮಕ್ಕಳ ದಾಖಲಾತಿಗೆ ಕ್ರಮ ಕೈಗೊಳ್ಳುವ ಉದ್ದೇಶ ಹೊಂದಲಾಗಿತ್ತು.

ಎಲ್ಲಾ ಜನವಸತಿ ಪ್ರದೇಶದ ಮಾಹಿತಿಯನ್ನು ಗಣಕೀಕರಣ ಮಾಡಲು ಕ್ರಮ ಕೈಗೊಂಡಿದೆ. ಸದ್ಯದಲ್ಲಿ ಕ್ರೋಢೀಕರಣ ನಮೂನೆಗಳ ಮಾಹಿತಿ ಆಧಾರದ ಮೇಲೆ ತಾತ್ಕಾಲಿಕ ಅಂಕಿಅಂಶಗಳನ್ನು ಪಡೆದಿದ್ದು ಈ ಅಂಕಿಅಂಶಗಳಿಂದ ಕೆಳಕಂಡಂತೆ ಮುಖ್ಯಾಂಶಗಳನ್ನು ಗಮನಿಸಲಾಗಿದೆ.

ರಾಜ್ಯದ ಅಂಕಿಅಂಶಗಳ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ

ರಾಜ್ಯದ ಅಂಕಿಅಂಶಗಳ ವಿವರ :- ಎಲ್ಲಾ ವರ್ಗಗಳ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಮಕ್ಕಳ ಅಂಕಿಅಂಶಗಳನ್ನು ಗಮನಿಸಿದಾಗ ರಾಜ್ಯದಲ್ಲಿ ಒಟ್ಟು 10,53,744, ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದು ಶೇಕಡ. 11.72 ರಷ್ಟಿದೆ. ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಹೆಣ್ಣು ಮಕ್ಕಳ ಪ್ರಮಾಣವು ಶೇಕಡ. 11.12 ಆಗಿದ್ದು ಗಂಡು ಮಕ್ಕಳ ಪ್ರಮಾಣವು ಶೇಕಡ. 11.53 ಇದೆ.

13
 ಪರಿಶಿಷ್ಟ ಜಾತಿ - ಜಿಲ್ಲಾವಾರು ಅಂಕಿಅಂಶ:- 6 ರಿಂದ 14 ವಯೋಮಾನದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಪರಿಶಿಷ್ಟ ಜಾತಿಯ ಮಕ್ಕಳ ಅಂಕಿಅಂಶಗಳನ್ನು ಗಮನಿಸಿದಾಗ ಕೊಡಗು ಜಿಲ್ಲೆಯಲ್ಲಿ 38.68 ರಷ್ಟು (4558), ರಾಯಚೂರು ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 32.60 ರಷ್ಟು (30961), ಗುಲ್ಬರ್ಗ ಜಿಲ್ಲೆಯಲ್ಲಿ 30.11 ರಷ್ಟು (60473), ಕೊಪ್ಪಳ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 28.95 ರಷ್ಟು (13291), ಬಳ್ಳಾರಿ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 24.41 ರಷ್ಟು (21143), ಬಿಜಾಪುರ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 24.26 ರಷ್ಟು (23750). ಬಾಗಲಕೋಟೆ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 22.72 ರಷ್ಟು (14359), ಗದಗ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 21.93 ರಷ್ಟು(7032) ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿರುವುದು ಕಂಡು ಬಂದಿದೆ. ಈ 8 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಒಟ್ಟು 175567 ಪರಿಶಿಷ್ಟ ಜಾತಿಯ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದು ರಾಜ್ಯದ ಶೇಕಡ 56.67 ರಷ್ಟು ಈ ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಇರುವುದು ಕಂಡು ಬರುತ್ತಿದೆ.

ಉಡುಪಿ ಜಿಲ್ಲೆಯು ಅತೀ ಕಡಿಮೆ ಪರಿಶಿಷ್ಟ ವರ್ಗದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿರುವ ಮಕ್ಕಳ ಪ್ರಮಾಣವನ್ನು ಹೊಂದಿರುವ ಜಿಲ್ಲೆಯಾಗಿದ್ದು ಶೇಕಡ 2.06 ರಷ್ಟು (242) ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗಿದ್ದಾರೆ.

6 ರಿಂದ 14 ವಯೋಮಾನದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಪರಿಶಿಷ್ಟ ಜಾತಿಯ ಹೆಣ್ಣು ಮಕ್ಕಳ ಜಿಲ್ಲಾವಾರು ಅಂತರವನ್ನು ಗಮನಿಸಿದಾಗ ಶೇಕಡ 37.22 ರಷ್ಟು ಹೆಣ್ಣು ಮಕ್ಕಳು ಕೊಡಗು ಜಿಲ್ಲೆಯಲ್ಲಿವರೆ, ಶೇಕಡ 2.07 ರಷ್ಟು ಹೆಣ್ಣು ಮಕ್ಕಳು ಉಡುಪಿ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶಾಲೆಯಿಂದ ಹೊರಗಿದ್ದಾರೆ.

ಪರಿಶಿಷ್ಟ ವರ್ಗ - ಜಿಲ್ಲಾವಾರು ಅಂಕಿಅಂಶ:- 6 ರಿಂದ 14 ವಯೋಮಾನದ ಪರಿಶಿಷ್ಟ ವರ್ಗದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಮಕ್ಕಳ ಅಂಕಿಅಂಶಗಳನ್ನು ಗಮನಿಸಿದಾಗ ಗುಲ್ಬರ್ಗ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 41.31 ರಷ್ಟು (15577), ರಾಯಚೂರು ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 39.36 ರಷ್ಟು (33990), ಕೊಪ್ಪಳ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 30.45 ರಷ್ಟು (10343), ಕೊಡಗು ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 24.26 ರಷ್ಟು (1603), ಬಳ್ಳಾರಿ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 24.27 ರಷ್ಟು (19991), ಬಾಗಲಕೋಟೆ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 21.12 ರಷ್ಟು (4029), ಬಿಜಾಪುರ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 19.70 ರಷ್ಟು (2044), ಬದರ್ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 18.81 ರಷ್ಟು (7375), ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗಿದ್ದಾರೆ.

ಉಡುಪಿ ಜಿಲ್ಲೆಯು ಅತೀ ಕಡಿಮೆ ಪರಿಶಿಷ್ಟ ವರ್ಗದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿರುವ ಮಕ್ಕಳನ್ನು ಹೊಂದಿರುವ ಜಿಲ್ಲೆಯಾಗಿದೆ. ಅಂದರೆ ಶೇಕಡ 2.01 ರಷ್ಟು (179), ಮಕ್ಕಳು ಈ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶಾಲೆಯಿಂದ ಹೊರಗಿದ್ದಾರೆ.

ಪರಿಶಿಷ್ಟ ವರ್ಗದ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿರುವ ಹೆಣ್ಣು ಮಕ್ಕಳ ಜಿಲ್ಲಾವಾರು ತಾರತಮ್ಯವನ್ನು ಗಮನಿಸಿದಾಗ ಗುಲ್ಬರ್ಗ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 44.31 ರಷ್ಟು ಹೆಣ್ಣು ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದರೆ, ಉಡುಪಿ ಜಿಲ್ಲೆಯಲ್ಲಿ ಶೇಕಡ 1.77 ರಷ್ಟು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿರುವುದು.

ಪರಿಶಿಷ್ಟ ಜಾತಿಯ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಮಕ್ಕಳ ಶೇಕಡು ಪ್ರಮಾಣವು 15.55 ರಷ್ಟಿದೆ. ಪರಿಶಿಷ್ಟ ಜಾತಿಯ ಮಕ್ಕಳಲ್ಲಿ ಶೇಕಡ. 16.79 ಹೆಣ್ಣು ಮಕ್ಕಳು ಶೇಕಡ. 14.36 ಗಂಡು ಮಕ್ಕಳೂ ಅಂದರೆ ಒಟ್ಟು 3097763 ರಷ್ಟು ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದಾರೆ.

ಪರಿಶಿಷ್ಟ ವರ್ಗದ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಮಕ್ಕಳ ಅಂಕಿಅಂಶಗಳನ್ನು ಗಮನಿಸಿದಾಗ ಒಟ್ಟು 144142 ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗಿದ್ದು ಶೇಕಡ 19.18 ರಷ್ಟಿದ್ದಾರೆ. ಇವರಲ್ಲಿ ಶೇಕಡ 20.71 ರಷ್ಟು ಹೆಣ್ಣು ಮಕ್ಕಳು ಮತ್ತು ಶೇಕಡ. 17.69 ರಷ್ಟು ಗಂಡು ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದಾರೆ.

ಹೆಣ್ಣು ಮತ್ತು ಗಂಡು ಮಕ್ಕಳ ಅಂತರವನ್ನು ಗಮನಿಸಿದಾಗ ಈ ಅಂತರವು ಶೇಕಡ 3 ರಷ್ಟಿದ್ದು ಹೆಣ್ಣು ಮಕ್ಕಳು ಹೆಚ್ಚು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿರುವುದು ಕಂಡು ಬರುತ್ತದೆ.

ಎಲ್ಲಾ ವರ್ಗಗಳ ಜಿಲ್ಲಾವಾರು ಅಂಕಿಅಂಶಗಳ ವಿವರ:- ಎಲ್ಲಾ ವರ್ಗಗಳ ಜಿಲ್ಲಾವಾರು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ 6 ರಿಂದ 14 ವರ್ಷದ ಮಕ್ಕಳ ಮಾಹಿತಿಯನ್ನು ಗಮನಿಸಿದಾಗ ರಾಯಚೂರು ಜಿಲ್ಲೆಯು ಅತೀ ಹೆಚ್ಚು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಮಕ್ಕಳನ್ನು ಹೊಂದಿರುವ

ಜಿಲ್ಲೆಯಾಗಿದ್ದು ಶೇಕಡ. 26.73ರಷ್ಟು (ಮಕ್ಕಳ ಸಂಖ್ಯೆ 1,16,8) ಗುಲ್ಬರ್ಗ ಜಿಲ್ಲೆಯು ಶೇಕಡ. 25.76 (185997) , ಕೊಪ್ಪಳ ಜಿಲ್ಲೆಯು ಶೇಕಡ 22.18 ರಷ್ಟು (58136), ಬಿಜಾಪುರ ಜಿಲ್ಲೆಯು ಶೇಕಡ. 18.53 ರಷ್ಟು (813330), ಬಳ್ಳಾರಿ ಜಿಲ್ಲೆಯು ಶೇಕಡ 17.90 ರಷ್ಟು(73575), ಬಾಗಲಕೋಟೆ ಜಿಲ್ಲೆಯು ಶೇಕಡ. 15.13 ರಷ್ಟು (50263), ಬದರ್ ಜಿಲ್ಲೆಯು ಶೇಕಡ 12.45 ರಷ್ಟು (42799), ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದ ಮಕ್ಕಳನ್ನು ಹೊಂದಿರುವ ಜಿಲ್ಲೆಗಳಾಗಿವೆ. ಈ 7 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಒಟ್ಟು 608995 ರಷ್ಟು 6 ರಿಂದ 14 ವಯೋಮಾನದ ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದು ರಾಜ್ಯದ ಶೇಕಡ 57.79 ರಷ್ಟು ಈ 7 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಇರುವುದು ಕಂಡು ಬರುತ್ತಿದೆ.

ಮೈಸೂರು ಮತ್ತು ಬೆಂಗಳೂರು ವಿಭಾಗಗಳಲ್ಲಿನ ಜಿಲ್ಲೆಗಳನ್ನು ಗಮನಿಸಿದಾಗ ಚಾಮರಾಜನಗರ ಜಿಲ್ಲೆಯಲ್ಲಿ ಅತೀ ಹೆಚ್ಚು 6 ರಿಂದ 14 ವಯೋಮಾನದ ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದಾರೆ. ಅಂದರೆ ಶೇಕಡ 12.08 (17101), ರಷ್ಟಿದೆ.

ರಾಜ್ಯದ ಅಂಕಿಅಂಶಕ್ಕೆ ಜಿಲ್ಲಾವಾರು ಪಾಲನ್ನು ಗಮನಿಸಿದಾಗ ಗುಲ್ಬರ್ಗ ಜಿಲ್ಲೆಯು ಶೇಕಡ 17.65 ರಷ್ಟು ಇರುವುದು ಕಂಡು ಬಂದಿದೆ.

ಉಮಖಿ ಜಿಲ್ಲೆಯಲ್ಲಿ 6 ರಿಂದ 14 ವಯೋಮಾನದ ಮಕ್ಕಳಲ್ಲಿ ಶೇಕಡ 1.14 ರಷ್ಟು (2060) ಮಕ್ಕಳು ಶಾಲೆಯಿಂದ ಹೊರಗುಳಿದಿದ್ದು ರಾಜ್ಯದಲ್ಲಿ ಅತಿ ಕಡಿಮೆ ಪ್ರಮಾಣದಲ್ಲಿದೆ.

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ತಾಲೂಕು ವಸುಲಿ

ಶಾಲಾ ಆಯೋಗಕ್ಕಾಗಿ- ಕಡಿ ಅಥವಾ ಸುಬ್ಬಂದಿ ಮತ್ತು ಮಕ್ಕಳ ಮನೆ	40 X 30 (ಅಳತೆಯು ನಿರೀಕ್ಷಿಸಲ್ಪಟ್ಟ 8 ಬದಲಿನಲ್ಲಿ ನಿರೀಕ್ಷಿಸಲ್ಪಟ್ಟ (ಪ್ರತಿ ತಾಲೂಕುಗಾಗಿ)	-	(178 ತಾಲೂಕು- 4,80,000 X 178 ಕುಗಾಗಿ)	8,54,40,000-00
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ಮರುಕಳಿಸುವ ಒಟ್ಟು ಮೊತ್ತ :- 48,11,34,612-00

ಮರುಕಳಿಸದ ಒಟ್ಟು ಮೊತ್ತ :- 17,99,10,000-00

ಪ್ರಧಾನ ಮೊತ್ತ :- 66,10,44,612-00

ಅನುಬಂಧ-೨

ರಾಜ್ಯದ ಜಿಲ್ಲಾವಾರು ಮಂಜೂರಾದ ಶಿಕ್ಷಕರ ಅಂಕಿ ಅಂಶಗಳು - 1999-2000

District wise sanctioned teachers

ಜಿಲ್ಲೆ	ಕಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು L.P.s (1-4)				ಹಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು H.P.S (5-7)				ಪ್ರೌಢ ಶಾಲೆಗಳು High School (8-10)				ಒಟ್ಟು Total			
	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು
ಬೆಂಗಳೂರು ನಗರ	520	104	122	746	2137	2016	3481	7634	559	1205	3971	5735	3216	3325	7574	14115
ಬೆಂಗಳೂರು ಗ್ರಾಮಾಂತರ	2783	11	101	2895	6277	228	987	7492	1236	867	678	2781	10296	1106	1766	13168
ಬೆಂಗಳೂರು ದಕ್ಷಿಣ	1079	187	228	1489	3027	1869	4799	9695	766	1386	2718	4870	4872	3437	7745	16054
ಬಳ್ಳಾರಿ	1729	13	131	1873	4878	261	477	5616	821	1168	614	2603	7428	1442	1222	10092
ಬಾಗಲಕೋಟೆ	1279	20	116	1415	5372	556	870	6798	1232	758	262	2252	7883	1334	1248	10465
ಬೀದರ	3831	62	240	4133	7308	539	2192	10039	1728	618	1027	3373	12867	1219	3459	17545
ಶಿವಮೊಗ್ಗ	1913	33	195	2141	5081	337	1147	6565	1288	709	797	2794	8282	1079	2139	11500
ತುಮಕೂರು	3673	5	152	3830	8354	363	1357	10074	1684	2220	1036	4940	13711	2588	2545	18844
ಬಾಗಲಕೋಟೆ	1058	11	220	1289	4829	287	697	5813	712	821	536	2069	6599	1119	1453	9171
ಬೆಳಗಾವಿ	2579	37	433	3049	12434	146	1503	14083	1307	3028	1324	5659	16320	3211	3260	22791
ಬಿಜಾಪುರ	1310	25	445	1780	5868	800	431	7099	635	1411	729	2775	7813	2236	1605	11654
ಧಾರವಾಡ	485	28	138	651	4143	247	342	4732	395	518	441	1354	5023	793	921	6737
ಗದಗ	516	4	73	593	3216	71	295	3582	487	730	345	1562	4219	805	713	5737
ಹಾವೇರಿ	799	7	28	834	5082	130	452	5664	660	864	534	2058	6541	1001	1014	8556

ರಾಜ್ಯದ ಜಿಲ್ಲಾವಾರು ಮಂಜೂರಾದ ಶಿಕ್ಷಕರ ಅಂಕಿ ಅಂಶಗಳು - 1999-2000

ಜಿಲ್ಲೆ	ಕಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು				ಹಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು				ಪ್ರೌಢ ಶಾಲೆಗಳು				ಒಟ್ಟು			
	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು
ಉತ್ತರ ಕನ್ನಡ	2068	18	49	2135	5315	105	413	5833	711	1031	473	2215	8094	1154	935	10183
ಬಳ್ಳಾರಿ	786	0	331	1117	5965	558	839	7362	915	609	432	1956	7666	1167	1602	10435
ದೀದರ	508	40	111	659	4797	887	261	5945	1145	676	732	2553	6450	1603	1104	9157
ಗುಲ್ಬರ್ಗ	2226	112	214	2552	7873	1205	1277	10355	2188	590	976	3754	12287	1907	2467	16661
ಕೊಪ್ಪಳ	804	15	118	937	2970	42	287	3299	725	221	199	1145	4499	278	604	5381
ರಾಯಚೂರು	1358	31	190	1579	3666	153	637	4456	831	203	411	1445	5855	387	1238	7480
ಚಾಮರಾಜನಗರ	822	10	104	936	2457	206	224	2887	436	251	300	987	3715	467	628	4810
ಚಿಕ್ಕಮಗಳೂರು	1657	12	123	1792	4306	89	266	4661	899	687	358	1944	6862	788	747	8397
ದಕ್ಷಿಣ ಕನ್ನಡ	626	23	82	731	4397	1780	743	6920	1181	1223	502	2906	6204	3026	1327	10557
ಹಾಸನ	3049	4	105	3158	5699	208	1096	7003	1787	873	765	3425	10535	1085	1966	13586
ಹೊಸಗು	353	0	40	393	1716	131	336	2183	363	389	207	959	2432	520	583	3535
ಮಂಡ್ಯ	1770	16	89	1875	5724	236	612	6572	1388	664	595	2647	8882	916	1296	11094
ಮೈಸೂರು	2081	91	157	2329	6370	744	1747	8861	1459	918	1165	3542	9910	1753	3069	14732
ಉಡುಪಿ	533	4	56	593	2697	2336	340	5373	748	719	191	1658	3978	3059	587	7624
ರಾಜ್ಯದ ಒಟ್ಟು:	42195	918	4391	47504	141958	16530	28108	186596	28286	25357	22318	75961	212439	42805	54817	310061

ರಾಜ್ಯದ ಜಿಲ್ಲಾವಾರು ದಾಖಲಾತಿ ಅಂಕಿ ಅಂಶಗಳು - 1999-2000
Districtwise Enrollment

ಜಿಲ್ಲೆ	ಹಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು L.P.S				ಹಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು H.P.S				ಪ್ರೌಢ ಶಾಲೆಗಳು (Jr. High School)				ಒಟ್ಟು Total			
	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು
ಬೆಂಗಳೂರು ಉತ್ತರ	59946	56161	99026	215133	31564	40129	70532	142225	11450	36657	51427	99534	102960	132947	220985	456892
ಬೆಂಗಳೂರು ಗ್ರಾಮಾಂತರ	135832	6531	19768	162131	94046	5839	11572	111457	27375	29350	12616	69341	257253	41720	43956	342929
ಬೆಂಗಳೂರು ದಕ್ಷಿಣ	90489	47327	103874	241690	48135	33983	70835	152953	15471	47868	55763	119102	154095	129178	230472	513745
ಚಿತ್ರದುರ್ಗ	134067	10620	15627	160314	76064	8867	9286	94217	14951	31863	9643	56457	225082	51350	34556	310988
ದಾವಣಗೆರೆ	143551	20347	21873	185771	79429	15259	13758	108446	24786	18550	3634	46970	247766	54156	39265	341187
ಕೋಲಾರ	191296	12201	44333	247830	112395	10156	26690	149241	43108	19135	14684	76927	346799	41492	85707	473998
ಕಿವಿಮೊಗ್ಗ	115119	9128	24389	148636	72721	7900	15124	95745	25241	21113	11887	58241	213081	38141	51400	302622
ಕುಮಟಾ	200475	6168	18795	225438	134144	8821	13059	156024	34179	59598	14325	108102	368798	74587	46179	489564
ದಾಗಲಾಕೋಟೆ	169757	9401	23960	203118	73190	6560	10568	90318	12183	26324	9440	47947	255130	42285	43968	341383
ದಲಭಾಂ	383019	6713	50823	440555	192636	13875	25917	232428	18157	91861	21162	131180	593812	112449	97902	804163
ದಿಬಾಳೂರು	207193	21559	22612	251364	84851	12066	8168	105085	7758	35450	10792	54000	299802	69075	41572	410449
ಧಾರವಾಡ	121257	12309	25843	159409	62144	12970	14295	89409	6727	30904	11992	49623	190128	56183	52130	298441
ಗದಗ	94542	2816	10701	108059	48403	4007	5099	57509	7045	21598	5180	33823	149990	28421	20980	199391
ಹಾವೇರಿ	141525	3091	9909	154525	75827	3198	6685	85710	9207	23871	9649	42727	226559	30160	26243	282962

ರಾಜ್ಯದ ಜಿಲ್ಲಾವಾರು ದಾಖಲಾತಿ ಅಂಕಿ ಅಂಶಗಳು - 1999-2000

ಕಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು					ಹಿರಿಯ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳು				ವೃದ್ಧ ಶಾಲೆಗಳು				ಒಟ್ಟು			
ಜಿಲ್ಲೆ	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು	ಸರ್ಕಾರಿ	ಅನುದಾನ ಸಹಿತ	ಅನುದಾನ ರಹಿತ	ಒಟ್ಟು
ಉತ್ತರ ಕನ್ನಡ	111171	4321	10606	126098	62865	3863	5555	72283	9594	26943	5645	42182	183630	35127	21806	240563
ಬಳ್ಳಾರಿ	198481	19614	24535	242630	88057	12121	11051	111229	22651	19333	9236	51220	309189	51068	44822	405079
ಬೀದರ	160854	40009	15321	216184	65941	26830	8024	100795	17051	13319	11605	41975	243846	80158	34950	358954
ಗುಲ್ಬರ್ಗ	339000	42474	36999	418473	105998	26233	20448	152679	37615	16952	20170	74737	482613	85659	77617	645889
ಕೊಪ್ಪಳ	128787	2207	10821	141815	45601	1851	4847	52299	15268	6566	3562	25396	189656	10624	19230	219510
ರಾಯಚೂರು	169159	7119	19509	195787	52015	5490	10539	68044	19897	6347	7781	34025	241071	18956	37829	297856
ಬಾಮರಾಜನಗರ	70415	7734	6453	84602	39512	5348	4204	49064	12954	7572	5853	26379	122881	20654	16510	160045
ಚಿಕ್ಕಮಗಳೂರು	85111	4055	6930	96096	55972	4073	5102	65147	16560	15242	4720	36522	157643	23370	16752	197765
ದಕ್ಷಿಣ ಕನ್ನಡ	97493	49979	19537	167009	67472	44948	12233	124653	21946	40552	9197	71695	186911	135479	40967	363357
ಹಾವೇರಿ	125931	7232	18789	151952	88763	6263	11542	106568	31545	24241	10825	66611	246239	37736	41156	325131
ಕೊಡಗು	28045	2076	6993	37114	21951	2009	3929	27889	4865	11278	2660	18803	54861	15363	13582	83806
ಮಂಡ್ಯ	119576	7992	20200	147768	86524	6136	12524	105184	37194	20883	13056	71133	243294	35011	45780	324085
ಮೈಸೂರು	170966	27468	43085	241519	105394	19163	31396	155953	37951	31063	22455	91469	314311	77694	96936	488941
ಉಡುಪಿ	57043	38410	7910	103363	44687	36649	4798	86134	17306	20909	5296	43511	119036	95968	18004	233008
ರಾಜ್ಯದ ಒಟ್ಟು:	4050100	485062	739221	5274383	2116301	384607	447780	2948688	560035	755342	374255	1689632	6726436	1625011	1561256	9912703

ಶಾಲಾ ಆಯೋಗಗಳ ವಿಭಾಗದ ಪುನರ್ ರಚನೆಯಲ್ಲಿ ಅವಶ್ಯಕ ವಾಹನಗಳ ಸಾಲಭ್ಯ

ಕ್ರ. ಸಂಖ್ಯೆ	ಯಾವ ಹಂತದಲ್ಲಿ	ಹುದ್ದೆ	ವಾಹನದ ಮಾದರಿ	ಬೇಕಾಗಿರುವ ವಾಹನಗಳ ಸಂಖ್ಯೆ	ವಾಹನದ ಅಂದಾಜು ಮೊತ್ತ	ವಾಹನಗಳ ಒಟ್ಟು ಮೊತ್ತ	ಇಂದಿನಕ್ಕೆ ತಗಲುವ ಅಂದಾಜು ವೆಚ್ಚ (ವಾರ್ಷಿಕವಾಗಿ)	ಒಟ್ಟು ಮೊತ್ತ
1)	ನಿರ್ದೇಶನಾಲಯದ ಹಂತ	ಸಹ ನಿರ್ದೇಶಕರು	ಅಂಬೇಡ್ಕರ್ ಕಾರು	1	3,50,000-00	3,50,000-00	1,18,000-00	5,30,000-00
2)	ಜಿಲ್ಲಾ ಹಂತ	ಜಿಲ್ಲಾ ಶಾಲಾ ಆಯೋಗಾಧಿಕಾರಿ	ಜೀಪು	27	3,25,000-00	8,77,50,00-00	4,86,000-00	1,36,35,000-00
3)	ತಾಲೂಕು ಹಂತ	ತಾಲೂಕು ಶಾಲಾ ಆಯೋಗಾಧಿಕಾರಿ	ಟ್ರಾಕ್ಟರ್ ಜೀಪು	178	3,50,000-00	6,23,00,000-00	1,60,20,000-00	7,85,20,000-00
					ಒಟ್ಟು:	7,14,25,000-00	2,10,60,000-00	9,26,85,000-00

1	2	3	4	5	6	7	8	9	10	11	12	13
18)	ಶಿಕ್ಷಣ ನಿರ್ದೇಶನಾಲಯದಲ್ಲೇ (ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ)	ಶಿಕ್ಷಣ ಇಲಾಖೆಯ ಅಧೀನದಲ್ಲಿ	1	3850 ರಿಂದ 7050	3850	1579-00	424-00	150-00	25-00	6028-00	72336-00	72,336-00
19)	- ಡಿಪಾರ್ಟ್‌ಮೆಂಟ್	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ (ನಿರ್ದೇಶಕರ ಅಧೀನದಲ್ಲಿ)	1	3000 ರಿಂದ 5450	3000	1230-00	330-00	150-00	25-00	4735-00	56820-00	56,820-00
20)	- ಡಿಪಾರ್ಟ್‌ಮೆಂಟ್	ಗ್ರಾಮೀಣ ಮಟ್ಟದಲ್ಲಿ (ನಿರ್ದೇಶಕರ ಅಧೀನದಲ್ಲಿ)	2	2500 ರಿಂದ 3850	2500	1025-00	275-00	100-00	25-00	3925-00	47100-00	94,200-00
											ಒಟ್ಟು:	12,47,30,412-00

ಕ್ರ. ಸಂಖ್ಯೆ.	ನಿರೀಕ್ಷಿಸಲಾಗುವ ಸಂಬಳ ವರ್ಗ.	ಮೂಲಕಳಿಸಿ ಬರುವ ಆಯವ್ಯಯ.	ಮೂಲಕಳಿಸಬೇಕಾದ ಆಯವ್ಯಯ.	ಒಟ್ಟು ಆಯವ್ಯಯ.
I				
1)	ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ	8,02,680-00	-	8,02,680-00
2)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ	81,80,028-00	-	81,80,028-00
3)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	11,57,47,704-00	-	11,57,47,704-00
II ಇಂಧನ ವರ್ಗ				
1)	ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ	1,80,000-00	-	1,80,000-00
2)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ	48,60,000-00	-	48,60,000-00
3)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	7,85,20,000-00	-	7,85,20,000-00
III ಆಕಸ್ಮಿಕ ನಿಧಿ				
1) ಲೇಖನ ಸಾಮಗ್ರಿಗಳು				
2) ಕಛೇರಿಗೆ ಅವಶ್ಯಕವಾಗಿ ಬೇಕಾಗುವ ಸಾಮಗ್ರಿಗಳು ಹಾಗೂ ಇತರ ದುರಸ್ತಿ				
1)	ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ	2,50,000-00	-	66,80,000-00
2)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ (ಪ್ರತಿ ಜಿಲ್ಲೆಗೆ)	1,50,000-00 x 27		
3)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ (ಪ್ರತಿ ತಾಲೂಕುಗೆ)	60,000-00 x 178		
IV ವಾಹನಗಳು				
1)	ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ	3,50,000-00	-	7,14,25,000-00
2)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ	87,75,000-00		
3)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	6,23,00,000-00		
V ಮನೆತಿ, ಶಿಕ್ಷಣ ಮತ್ತು ಸಂಪರ್ಕದ ಸಾಮಗ್ರಿಗಳು				
1)	ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ	30,00,000-00	-	30,00,000-00
2)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ (ಪ್ರತಿ ಜಿಲ್ಲೆಗೆ)	1,00,000-00 x 27	-	27,00,000-00
3)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ (ಪ್ರತಿ ತಾಲೂಕುಗೆ)	12,000-00 x 178	-	21,36,000-00
VI ಔಷಧಿಗಳು				
1)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ (ಪ್ರತಿ ಜಿಲ್ಲೆಗೆ)	8,10,000-00 x 27	-	2,18,70,000-00
2)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ (ಪ್ರತಿ ತಾಲೂಕುಗೆ)	4,50,000-00 x 178	-	8,01,00,000-00
3)	ಶಾಲಾ ಮಟ್ಟದಲ್ಲಿ (ಪ್ರತಿ ಪ್ರಾಥಮಿಕ ಮತ್ತು ಮಾಧ್ಯಮಿಕ ಶಾಲೆಗಳಿಗೆ) ಪ್ರಥಮ ಚಿಕ್ಕತನದ ವಿದ್ಯಾರ್ಥಿ ಮತ್ತು ಅವಶ್ಯಕವಾದ ಚಿಕ್ಕತನ ಸಲಹೆ ಮತ್ತು ಔಷಧಿ ಇತ್ಯಾದಿಗಳಿಗೆ.	1,000-00 x 50000	-	5,00,00,000-00
ಒಟ್ಟು:				45,42,11,412-00

ಶಾಲಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದಡಿ ಯಲ್ಲಿ ನಿರೂಪಿಸಲ್ಪಡುವ ಹುದ್ದೆಗಳು - ವೇತನ ಶ್ರೇಣಿ - ವೇತನ ಮತು ಭತ್ಯೆಗಳು

ಕ್ರ.ಸಂಖ್ಯೆ	ಯಾವ ಹಂತದಲ್ಲಿ	ಹುದ್ದೆಗಳು	ಹುದ್ದೆಗಳ ಸಂಖ್ಯೆ	ವೇತನ ಶ್ರೇಣಿ	ಪ್ರಾರಂಭದ ಮೂಲ ವೇತನ	ತುಟ್ಟ ಭತ್ಯೆ	ಮನಬಾಡಿಗೆ ಭತ್ಯೆ	ನಗರ ಭತ್ಯೆ	ವೈದ್ಯಕೀಯ ಭತ್ಯೆ	ಒಟ್ಟು ಮಾತ್ರ	ಪಾರ್ಷ್ವಪಾಗಿ ತಗಲುವ ಬೆಡ್ಡು ಒಬ್ಬರಿಗೆ	ಪಾರ್ಷ್ವಪಾಗಿ ತಗಲುವ ಒಟ್ಟು ವೆಚ್ಚ
1)	ನಿರ್ದೇಶನಾಲಯದಲ್ಲಿ (ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ)	ಸಹ ನಿರ್ದೇಶಕರು ಶಾಲಾ ಆರೋಗ್ಯ	1	10620 ರಿಂದ 14960	10620-00	4350-00	1168-00	200-00	-	16338-00	196056-00	1,96,056-00
2)	ನಿರ್ದೇಶನಾಲಯದಲ್ಲಿ (ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ)	ಸಹಾಯಕ ಸಾರವ್ಯಕ್ತಿ ಅಧಿಕಾರಿ	1	4575 ರಿಂದ 8400	4575-00	1876-00	503-00	150-00	25-00	7179-00	85548-00	85,548-00
3)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ	ಶಾಲಾ ಆರೋಗ್ಯ ಅಧಿಕಾರಿ	27	8000 ರಿಂದ 13440	8000-00	3280-00	600-00	-	-	11880-00	142560-00	38,49,120-00
4)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ	ಪ್ರಥಮ ದರ್ಜೆ ಸಹಾಯಕ	27	3850 ರಿಂದ 7050	3850-00	1579-00	289-00	-	25-00	5743-00	68916-00	18,60,732-00
5)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ	ಬಾಲಕರು	27	2600 ರಿಂದ 4350	2600-00	1066-00	195-00	-	25-00	3886-00	46632-00	12,59,064-00
6)	ಜಿಲ್ಲಾ ಮಟ್ಟದಲ್ಲಿ	'ಡಿ' ವರ್ಗದ ನೌಕರರು	27	2500 ರಿಂದ 3850	2500-00	1025-00	188-00	-	25-00	3738-00	44856-00	12,11,112-00
7)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	ವೈದ್ಯಾಧಿಕಾರಿಗಳು, ಶಾಲಾ ಆರೋಗ್ಯ	178	7400 ರಿಂದ 13120	7400-00	3034-00	222-00	-	-	10656-00	127872-00	2,27,61,216-00
8)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	ಶಾಲಾ ಆರೋಗ್ಯ ಶಿಕ್ಷಕರು	178	4150 ರಿಂದ 7800	4150-00	1701-00	125-00	-	25-00	6001-00	72012-00	1,28,18,136-00
9)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	ಶಾಲಾ ಆರೋಗ್ಯ ಸಂದರ್ಶಕಿ (ಮಹಿಳಾ)	178	4575 ರಿಂದ 8400	4575-00	1876-00	137-00	-	25-00	6613-00	79356-00	1,41,25,366-00
10)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	ಶಾಲಾ ಆರೋಗ್ಯ ಪರಿವೀಕ್ಷಕರು	178	4150 ರಿಂದ 7800	4150-00	1701-00	125-00	-	25-00	6001-00	72012-00	1,28,18,136-00
11)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	ಶಾಲಾ ಆರೋಗ್ಯ ಸಹಾಯಕಿ (ಮಹಿಳಾ)	356	3300 ರಿಂದ 6300	3300-00	1353-00	99-00	-	25-00	4777-00	57324-00	2,04,07,344-00
12)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	ದ್ವಿತೀಯ ದರ್ಜೆ ಸಹಾಯಕರು	178	3000 ರಿಂದ 5450	3000-00	1230-00	90-00	-	25-00	4345-00	51780-00	92,80,920-00
13)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	ಬಾಲಕರು	178	2600 ರಿಂದ 4350	2600-00	1066-00	78-00	-	25-00	3769-00	45228-00	80,50,584-00
14)	ತಾಲೂಕು ಮಟ್ಟದಲ್ಲಿ	'ಡಿ' ವರ್ಗದ ನೌಕರರು	356	2500 ರಿಂದ 3850	2500-00	1025-00	75-00	-	25-00	3625-00	43500-00	1,54,86,000-00
15)	ನಿರ್ದೇಶನಾಲಯದಲ್ಲಿ (ರಾಜ್ಯ ಮಟ್ಟದಲ್ಲಿ)	ಕಛೇರಿ ಅಧೀಕ್ಷಕರು (ಸಹ ನಿರ್ದೇಶಕರ ಅಧೀನದಲ್ಲಿ)	1	5200 ರಿಂದ 9580	5200-00	2072-00	572-00	150-00	25-00	8019-00	96228-00	96,228-00
16)	- ಡಿಜಿಟಲ್ -	ಪ್ರಥಮ ದರ್ಜೆ ಸಹಾಯಕರು (ಸಹ ನಿರ್ದೇಶಕರ ಅಧೀನದಲ್ಲಿ)	2	3850 ರಿಂದ 7050	3850-00	1579-00	424-00	150-00	25-00	6028-00	72336-00	1,44,672-00
17)	- ಡಿಜಿಟಲ್ -	ದ್ವಿತೀಯ ದರ್ಜೆ ಸಹಾಯಕರು (ಸಹ ನಿರ್ದೇಶಕರ ಅಧೀನದಲ್ಲಿ)	1	3000 ರಿಂದ 5450	3000-00	1230-00	330-00	150-00	25-00	4735-00	56820-00	56,820-00

TRANSLATION OF SCHOOL HEALTH.

Govt of Karnataka

Commissioner's office, Dept of Public Instructions,
Nrupathunga Rd.

Information came out of study carried out
abt drop-out (out of school) children - (0-14 age
group)

Survey was conducted on above mentioned topic
btw 18/1/01 & 20/2/01. Major objective of the study
was to find out no of school going children,
no of children not at all joined school &
out of school children. Information abt out of school
children was collected lowest level of habitation to
Taluk level & to encourage these children to enrol
themselves in school.

These info is getting compiled. Tentative
findings of study are as follows:-

Findings abt out of school children (6-14 yr of age)
This no stands @ 10,53,744 which is 11.72%.
Among the girls it stands @ 11.12 & with boys
it is 11.53%.

S.C.s - District wise details:- Out of school child
Kodagu (4558, 38.68%), Rai Chur (30,961, 32.6%),
Gulbarga (60,473, 30.11%), Koppal (13,291, 28.95%),
Bellary (21,143, 24.44%), Bijapur (23,750, 24.26%),
Basalkot (14,359, 22.72%), Gadag (7032, 21.93%).
In these districts, total no of S.C out of school
child are 17,55,67 which is 56.67%. Least
among on this category is Udupi (242, 2.06%).
Among S.C girls (6-14 age group) Kodagu
(37.22%) & Udupi (2.07%).

Schedule Tribe - (6-14 age group)

Gulbarga (15577, 41.31%), Raichur (33990, 39.36%)

Koppal (10,343, 30.45%) Kodagu (1603, 24.26%)

Bellary (19991, 24.27%), Bagalkot (4029, 21.12%),

Bijapur (2044, 19.70%) & Bidar (7375, 18.81%)

In this category also Udipi is least, (179, 2.01%)

↳ District wise differences show if in Gulbarga statistics is at 44.31%, in Udipi it is 1.77%.

In this age group, among S.C's (Out of School) is 15.55%. Among girls 16.79%, among boys 14.36.

Total no 30,99763.

S.T's - boys 17.69%.

girls 20.71%.

Total No - 144142.

District statistics (General)

~~Gov~~ Raichur (11687 - 26.73%)

Gulbarga (185997, 25.76%) Koppal (58136,

22.18%), Bagalkot (50,263, 15.13%), Bidar

(42799, 12.45%). These 7 districts -

No - 608995 - Percentage - 57.79%

In B'lore / Mysore division -

Chamarayanagar - (17,101 - 12.08%).

In State statistics - ↑ Gulbarga - ~~17.65%~~ 17.65%.

In Udipi - ↓ - 2060 (1.14%)

ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳ ನಿರ್ದೇಶನಾಲಯ

ನಿರ್ದೇಶಕರು

ಆರೋಗ್ಯ ಶಿಕ್ಷಣ ಮತ್ತು, ತರಬೇತಿ ಹಾಗೂ ಶಾಲಾ ಆರೋಗ್ಯ ಸೇವೆಗಳ ಸಿಬ್ಬಂದಿ ವ್ಯವಸ್ಥಾಪನೆ.

ಅವರ ನಿರ್ದೇಶಕರು (ಅ.ಶಿ.ತ)

ಸಹ ನಿರ್ದೇಶಕರು (ಅ.ಶಿ.ತ) (ಪ್ರ.ನು.ತ ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ)

- ತರಬೇತಿ ಅಧಿಕಾರಿಗಳು (ಅಸ್ತಿತ್ವ)
- ಸಹಾಯಕ ನಿರ್ದೇಶಕರು (ಅಸ್ತಿತ್ವ)
- ವಸ್ತು ಪ್ರದರ್ಶನ ಅಧಿಕಾರಿ (ಅಸ್ತಿತ್ವ)
- ತಾಂತ್ರಿಕ ಅಧಿಕಾರಿ (ಎ.ವಿ) (ಅಸ್ತಿತ್ವ)
- ತಾಂತ್ರಿಕ ಅಧಿಕಾರಿ ವಹಿ-ವಹಿ.ಡಿ.ಸಿ. (ಅಸ್ತಿತ್ವ)
- ಕಛೇರಿ ಸಿಬ್ಬಂದಿ (ಅಸ್ತಿತ್ವ)

ಸಹ ನಿರ್ದೇಶಕರು - (ವೈದ್ಯಕೀತರ - ನಿರೂಪಿಸಬೇಕಾಗಿದೆ)

- ಉಪನಿರ್ದೇಶಕರು (ವಿ.ಅ.ಶಿ) (ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ)
 -
 - ಜಿಲ್ಲಾ ಶುಶ್ರೂಷಣಾ ಅಧಿಕಾರಿಗಳು (ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ)
- ಸಹಾಯಕ ಸಾಂವ್ಯಕ್ತ ಅಧಿಕಾರಿ (ನಿರೂಪಿಸಬೇಕು)

ಜಿಲ್ಲಾ ಮಟ್ಟ

ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಅಧಿಕಾರಿಗಳು (ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ - ವೈದ್ಯರು)

ಜಿಲ್ಲಾ ಶುಶ್ರೂಷಣಾ ಅಧಿಕಾರಿ (ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ)

ಜಿಲ್ಲಾ ಆರೋಗ್ಯ ಶಿಕ್ಷಣಾಧಿಕಾರಿ (ಸಾಮಾನ್ಯ-ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ)

ಶಾಲಾ ಆರೋಗ್ಯಾಧಿಕಾರಿ (ನಿರೂಪಿಸಬೇಕಾಗಿದೆ)

- ಪ್ರಥಮ ದರ್ಜೆ ಸಹಾಯಕರು-(1) (ನಿರೂಪಿಸಬೇಕು)
- ಪಾಹನ ಚಾಲಕರು -(1) (ನಿರೂಪಿಸಬೇಕು)
- 'ಡಿ' ವರ್ಗದ ನೌಕರರು-(1) (ನಿರೂಪಿಸಬೇಕು)

ತಾಲ್ಲೂಕು ಆರೋಗ್ಯ ಅಧಿಕಾರಿ (ವೈದ್ಯ) (ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ)

ಅಧೀನ ವೈದ್ಯಾಧಿಕಾರಿಗಳ ತಂಡ (ಅಸ್ತಿತ್ವದಲ್ಲಿದೆ)

ವೈದ್ಯಾಧಿಕಾರಿ ಶಾಲಾ ಆರೋಗ್ಯ (ನಿರೂಪಿಸಬೇಕಾಗಿದೆ)

- ಶಾಲಾ ಆರೋಗ್ಯ ಶಿಕ್ಷಕರು-(1) (ನಿರೂಪಿಸಬೇಕು)
- ಶಾಲಾ ಆರೋಗ್ಯ ಪರಿವೀಕ್ಷಕರು-(1) (ನಿರೂಪಿಸಬೇಕಾಗಿದೆ)
- ಮಹಿಳಾ ಶಾಲಾ ಆರೋಗ್ಯ ಸಂದರ್ಶಕಿ-(1) (ನಿರೂಪಿಸಬೇಕು)
- ಮಹಿಳಾ ಶಾಲಾ ಆರೋಗ್ಯ ಸಹಾಯಕಿ-(2) (ನಿರೂಪಿಸಬೇಕು)
- ದ್ವಿತೀಯ ದರ್ಜೆ ಸಹಾಯಕ-(1) (ನಿರೂಪಿಸಬೇಕು)
- ಚಾಲಕ-(1) (ನಿರೂಪಿಸಬೇಕು)
- 'ಡಿ' ವರ್ಗದ ನೌಕರರು-(2) (ನಿರೂಪಿಸಬೇಕಾಗಿದೆ)

ಹೆಚ್.ಎನ್. ಪಿ. ಕಾರ್ಯಕರ್ಮಿಗಳ ಅಧಿಕಾರವಹಿಷ್ಕಾರದ ಪರಿಹಾರದ ವ್ಯವಸ್ಥೆಗಳು

1) ಮೂಲ ಸೌಲಭ್ಯಗಳ ಅಭಿವೃದ್ಧಿ :	
1) ಹುದ್ದೆಗಳ ಸೃಷ್ಟಿಕರಣ (ವಿವಿಧವರ್ಗದ ಹುದ್ದೆಗಳೂ 187)	ರೂ. 12,47,30,412-00
2) ಸಾಗರೀಕ ಕಾಮಗಾರಿ(ಸಿವಿಲ್ ವರ್ಕ್)	ರೂ. 14,20,60,000-00
3) ಸಂಚಾರ ವ್ಯವಸ್ಥೆಗಾಗಿ	ರೂ. 7,14,25,000-00
4) ಗಣಕಯಂತ್ರ : ಔದ್ಯೋಗಿಕವರ್ಗಗಳ ವ್ಯವಸ್ಥೆಗಾಗಿ.	ರೂ. 3,43,30,000-00
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	ರೂ. 36,25,45,412-00
2) ಹೆಚ್ಚುವರಿಗಾಗಿ	ರೂ. 15,19,00,000-00
3) ಮಾಹಿತಿ ವಿಷಯ ಸಂಪರ್ಕ	ರೂ. 58,36,000-00
4) ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಕ್ಕಾಗಿ:	ರೂ. 2,69,23,200-00
1) ಉಪನ್ಯಾಸಕರರೂ.	
2) ಶಾಲಾ ಮಕ್ಕಳೂ	
3) ತರಬೇತಿಮಾಹಿತಿಗೆ ತರಬೇತಿ	
5) ನಾಡಿಯಾರರ ವೆಚ್ಚ	ರೂ. 66,80,000-00
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	ರೂ. 17,07,38,200-00
ಅನಾವರತಕ ಹಣ	ರೂ. 36,25,45,412-00
ಆವರತಕ ಹಣ	ರೂ. 17,07,39,200-00
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	ರೂ. 55,32,84,412-00
	<hr/>

ಹೆನ್. ಎನ್. ಪಿ. ಕಾರ್ಯಕ್ರಮದಡಿ ಯಶಸ್ವಿ ಶಾಲಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮ

1. ವೈದ್ಯಕೀಯ ಸೇವೆಗಳು

1. ಶಾಲಾ ಮಕ್ಕಳ ವೈದ್ಯಕೀಯ ಫಿಲ್ಡ್. 1ನೇ ತರಗತಿಯಿಂದ 7ನೇ ತರಗತಿಯ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ.
2. ಡಿ. ಎಸ್. ಟಿ., ಟಿ. ಪಿ., ಇನ್ಯುನ್ಯುಟಿವ್ ಕಡ್ಡಾಯವಾಗಿ 1ನೇ ತರಗತಿ, 4ನೇ ತರಗತಿ 7ನೇ ತರಗತಿ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ಕಡ್ಡಾಯವಾಗಿ.
3. ಜ್ವರ, ಕಾಲುಜ್ವರ, ಉಸಿರುಗಿ ಸೂಜಿದ ವಿದ್ಯಾರ್ಥಿಗಳ (ಸ್ಪಾಟಿಯಸ್ ಕಾರ್ಡ್) ಅನ್ನು ಅಳವಡಿಸುವುದು.

2. ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮ:

- 1) ಶಿಕ್ಷಕರ ತರಬೇತಿ.
- 2) ಹೋಲಾಪದ ತರಬೇತಿ
- 3) ಶಾಲಾ ವಿದ್ಯಾರ್ಥಿಗಳ ತರಬೇತಿ.
 - 1) ವೈಯಕ್ತಿಕ ಸ್ವಚ್ಛತೆ. ಹಾಗೂ ನೈರ್ಮಲ್ಯ
 - 2) ಪಿಸು ನೈರ್ಮಲ್ಯ
 - 3) ನೀರು, ಫಲಿ, ಆರೋಗ್ಯ ಹೋಲಾಪ ನಿಂದ ಪಡೆಯಬೇಕಾದ ಲೋಕಗಳು
 - 4) ಸುರಕ್ಷಿತ ಕುಡಿಯುವ ನೀರು
 - 5) ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮ.
 - 6) ಪಿ.ಪಿ.ವಿ. ಎಸ್.ಪಿ.ಡಿ.

3. ಮಾಹಿತಿ ಶಿಕ್ಷಣ ಸಂಪರ್ಕ - ಪರಿಷ್ಕರಣೆಗಳು

ಶಾಲಾ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ, ಉಪಾಧ್ಯಾಯರಿಗೆ: ಹೋಲಾಪದ ಮಾಹಿತಿ ಶಿಕ್ಷಣ ಸಂಪರ್ಕ ಸಮಗ್ರಗಳನ್ನು ಒದಗಿಸುವುದು.

2) ಶಾಲಾ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ಚರ್ಚಾಟಕ, ಪ್ರಬಂಧ ಸ್ಪರ್ಧೆಗಳನ್ನು ಒದಗಿಸುವುದು.

4. ಸಾಮಾಜಿಕ ಸೇವೆಗಳು (ಸಮಾಜ ಸೇವೆಗಳು)

- 1) ಶಾಲಾ ಆವರಣದಲ್ಲಿ ತೋಟಗಾರಿಕೆ ಹಾಗೂ ಸಸಿಗಳನ್ನು ಶಾಲಾ ಮಕ್ಕಳಿಂದ ನೆಡಿಸಿ ಅಭಿವೃದ್ಧಿ ಪಡಿಸುವುದು.
- 2) ಶಾಲಾ ಆವರಣವನ್ನು ಸ್ವಚ್ಛವಾಗಿಡುವುದು ಹಾಗೂ ಶಾಲಾ ಅನುಪಯೋಗಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಕೆಲಸಗಳನ್ನು ಒದಗಿಸುವುದು.
- 3) ಶಾಲಾ ಆವರಣವನ್ನು ಶುದ್ಧವಾಗಿ ಹಾಗೂ ಸ್ವಚ್ಛವಾಗಿಡುವುದು ಯಾವಾಗಲೂ.
- 4) ಶಾಲಾ ಆವರಣವನ್ನು ನೋಡು ಹಾಗೂ ನೋಡುಗಳಿಂದ ಮುಕ್ತಗೊಳಿಸುವುದು.
- 5) ಸಮತೋಲನ ಆಹಾರದ ತಯಾರಿಕೆಯ ಬಗ್ಗೆ.

5. ಮುದ್ರಣ ಮತ್ತು ಸರಬರಾಜು:

- 1) ಶಾಲಾ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ಆರೋಗ್ಯದ ನೋಂದಣಿ ಪುಸ್ತಕಗಳು (ಕಾರ್ಡ್‌ಗಳು)
- 2) ರಿಪನ್ಟರಗಳು
- 3) ಫಾರ್ಮ್‌ಗಳು.
- 4) ಉಪಾಧ್ಯಾಯರಿಗೆ ಶಾಲಾ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ಕೈಪಿಡಿಗಳು.
- 5) ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದ ಬಗ್ಗೆ ಕೈಪಿಡಿಗಳು.

ಆರೋಗ್ಯ ಶಿಕ್ಷಣ ಮತ್ತು ಶಾಲಾ ಆರೋಗ್ಯ ಸೇವೆಗಳ ಕಾರ್ಯಕ್ರಮದ ಕ್ರಿಯಾ ಯೋಜನೆ ಹಾಗೂ ಸಿಬ್ಬಂದಿ ನೌಲ್ಯವನ್ನು ಒದಗಿಸುವ ಬಗ್ಗೆ.

ಇಲ್ಲವೆಂದು ತನಕ ಶಾಲಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮದಡಿಯಲ್ಲಿ ರಾಜ್ಯದ 1,4 ಮತ್ತು 7ನೇ ತರಗತಿಯಲ್ಲಿ ವ್ಯಾಸಂಗ ಮಾಡುತ್ತಿರುವ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ವೈದ್ಯಕೀಯ ತಪಾಸಣೆ ನಡೆಸಲಾಗುತ್ತಿದ್ದು, ಅದರಲ್ಲಿ 1 ಮತ್ತು 4ನೇ ತರಗತಿಯ ಮಕ್ಕಳಿಗೆ ಕ್ರಮವಾಗಿ ಡಿ.ಟಿ. ಮತ್ತು ಟಿ.ಟಿ. ಚುಚ್ಚುಮದ್ದುಗಳನ್ನು ಕೊಡಲಾಗುತ್ತಿದೆ.

ಇದೇ ರೀತಿ ಆರೋಗ್ಯ ಶಿಕ್ಷಣದ ಸಂಬಂಧದಲ್ಲಿ ಪ್ರಸ್ತುತ ಕೆಲಸ ನಿರ್ವಹಿಸುತ್ತಿರುವ ಎಲ್ಲಾ ಆರೋಗ್ಯ ಸಹಾಯಕರು (ಕಿರಿಯ ಮತ್ತು ಹಿರಿಯ) ಅವರು ವ್ಯಾಪ್ತಿಯಲ್ಲಿ ಬರುವ ಶಾಲೆಗಳಿಗೆ ತಿಂಗಳೊಂದಕ್ಕೆ 3-4 ಬಾರಿ ಭೇಟಿ ನೀಡಿ ಆರೋಗ್ಯ ಶಿಕ್ಷಣವನ್ನು ನೀಡುತ್ತಿದ್ದಾರೆ. ಅಷ್ಟೇ ಅಲ್ಲದೆ, ಅಲ್ಲಲ್ಲಿ ಸುರಕ್ಷಾ ಸಭೆಗಳಲ್ಲಿ ಅಧಿಕ ಮೆಚ್ಚುವಿರಿ ಅಥವಾ ಇಲ್ಲದಿರಲಿ ಶಾಲಾ ಶಿಕ್ಷಕರುಗಳಿಗೆ 1 ರಿಂದ 3 ದಿನಗಳವರೆಗೆ ಆರೋಗ್ಯ ಶಿಕ್ಷಣದ ಬಗ್ಗೆ ತರಬೇತಿ ನೀಡುತ್ತಿದ್ದಾರೆ.

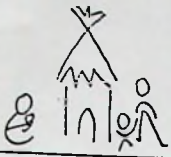
ಇತ್ತೀಚೆಗೆ ಫಿನ ಸರ್ಕಾರವು ರೂಪಿಸಿರುವ ಆರೋಗ್ಯ ಕ್ರಿಯಾ ತಂಡ ಸಮಿತಿಯ ಶಿಫಾರಸ್ಸಿನ ಪ್ರಕಾರ, ಆರೋಗ್ಯ ತಪಾಸಣೆಯನ್ನು ಇನ್ನೂ 2,3,5 ಮತ್ತು 6ನೇ ತರಗತಿಯಲ್ಲಿ ವ್ಯಾಸಂಗ ಮಾಡುವ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ವಿಸ್ತರಿಸಬೇಕಾಗಿದೆ. ರಾಜ್ಯದ ಎಲ್ಲಾ ಪ್ರಾಥಮಿಕ ಶಾಲಾ ಶಿಕ್ಷಕರು, ಶಿಕ್ಷಕ ತರಬೇತಿ ಸಂಸ್ಥೆಗಳಲ್ಲಿ ಕೆಲಸ ನಿರ್ವಹಿಸುವ ಭೀಷಣಕರು ಮತ್ತು ಶಿಕ್ಷಕ ಪದವಿ ಮಹಾವಿದ್ಯಾಲಯಗಳಲ್ಲಿರುವ ಗುಪ್ತಾಧಿಕಾರಿಗಳಿಗೆ ಆರೋಗ್ಯ ಶಿಕ್ಷಣದ ಬಗ್ಗೆ ಸುರಕ್ಷಾ ತರಬೇತಿ ನೀಡಿದರೆ ಆರೋಗ್ಯ ಶಿಕ್ಷಣವನ್ನು ಪರಿಣಾಮಕಾರಿಯಾಗಿ ಅನುಷ್ಠಾನಗೊಳಿಸಲು ಸಾಧ್ಯವಾಗುತ್ತದೆ.

ಪ್ರಸ್ತುತವಾಗಿ ರಾಜ್ಯದಲ್ಲಿ ಹಲವಾರು ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಹಮ್ಮಿಕೊಂಡು ಇಲಾಖಾ ಸಿಬ್ಬಂದಿಯವರು ವ್ಯವಸ್ಥಿತವಾಗಿ ಕಾರ್ಯನಿರ್ವಹಿಸುತ್ತಿದ್ದಾರೆ. ಇದು ಮಧ್ಯೆ ಬಹುಗುಪ್ತವಾಗಿರುವ ಶಾಲಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವನ್ನು ಅಧ್ಯತೆಯ ಮೇಲೆ ಸಂಪೂರ್ಣವಾಗಿ ಕಾರ್ಯಗತಗೊಳಿಸಲು ಕ್ಷೇತ್ರ ಸಿಬ್ಬಂದಿಯವರಿಗೆ ತುಂಬಾ ಕಷ್ಟಕರವಾಗಿ ಕಾಣುತ್ತಿದೆ. ಇಂತಹ ಪರಿಸ್ಥಿತಿಯಿಂದ ಸಮಾಜಕ್ಕೆ ಪೂರ್ಣ ಆರೋಗ್ಯವನ್ನು ಒದಗಿಸಲು ಸಾಧ್ಯವಿಲ್ಲದ ಕಾರಣ ಹೆಚ್ಚಿನ ಸಿಬ್ಬಂದಿ ನೌಲ್ಯವನ್ನು ಕೇಳಲು ಸರ್ಕಾರಕ್ಕೆ ಒಂದು ಪ್ರಸ್ತಾವನೆಯನ್ನು ಕಳುಹಿಸಿಕೊಡಲು ಯಾವುದೇ ಆಯ್ಕೆತರಾತಿ ಕಂಡುಬರುವುದಿಲ್ಲ. ಏಕೆಂದರೆ ಶಾಲಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವು ಇತರ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮಗಳಿಗಿಂತ ಸಾಮಾಜಿಕ ಆರೋಗ್ಯಕ್ಕೆ ಹೆಚ್ಚಿನ ಪ್ರಾಧಾನ್ಯತೆಯನ್ನು ಪಡೆದಿರುತ್ತದೆ.

ಗುಡಾ:- ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮಗಳು ಸುಮಾರು 20 ಕ್ಕಿಂತ ಹೆಚ್ಚಾಗಿದ್ದು, ಇವುಗಳೆಲ್ಲದರ ಬಗ್ಗೆ ವಿವರವಾಗಿ ಆರೋಗ್ಯ ಶಿಕ್ಷಣದ ಮೂಲಕ ಶಾಲಾ ಮಕ್ಕಳು ಮತ್ತು ಶಿಕ್ಷಕರಿಂದ ಸಾರ್ವಜನಿಕರಿಗೆ ಆರೋಗ್ಯ ನೀಡಲು ಅನುವು ಮಾಡಿಕೊಟ್ಟಂತಾಗುತ್ತದೆ. " ಇಂದಿನ ಶಾಲಾ ಮಕ್ಕಳ ಮುಂದಿನ ಆರೋಗ್ಯವಂತ ಮತ್ತು ಪ್ರಜ್ಞಾವಂತ ಪ್ರಜೆಗಳಾಗಿ ಸಾಮಾಜಿಕ ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತನಿಸಿಕೊಳ್ಳಬಹುದು "

ಪ್ರಸಕ್ತವಾಗಿ ಲಭ್ಯವಿರುವ ಅಂಕಿ ಅಂಶಗಳ ಪ್ರಕಾರ ಕರ್ನಾಟಕ ರಾಜ್ಯದಲ್ಲಿ ಸುಮಾರು 50 ಸಾವಿರ ಪ್ರಾಥಮಿಕ ಶಾಲೆಗಳಿವೆ. (1 ರಿಂದ 7ನೇ ತರಗತಿಗಳು). ಈ ಎಲ್ಲಾ ಶಾಲೆಗಳಲ್ಲೂ ಕಾರ್ಯನಿರ್ವಹಿಸುವ ಮಕ್ಕಳ ಸಂಖ್ಯೆ ಸುಮಾರು 80 ಲಕ್ಷಗಳಷ್ಟಿದೆ. ಇದೇ ಪ್ರಕಾರ ಶಾಲಾ ಶಿಕ್ಷಕರ ಸಂಖ್ಯೆಯು 2,06,516 ಇರುತ್ತದೆ.

ಶಾಲಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮವನ್ನು ಹೆಚ್ಚುಪಡಿಸಿ ಈಗಿಡಾರಿಯಲ್ಲಿರುವ
ವಿವಿಧ ಎಲ್ಲಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮಗಳೂ ಮೂನವನಿಗೆ ಲೋಗ ಬಂದ ಮೇಲೆ
ಚಿಕಿತ್ಸಾ ನೇವೆಯನ್ನು ನೀಡಲು ಅವಕಾಶವನ್ನು ಒದಗಿಸುತ್ತವೆ. ಚಿಕಿತ್ಸೆಗಿಂತ ತಿಳುವಳಿಕೆಯು
ಮೂಲಕ ಲೋಗಗಳನ್ನು ದುರವಿಡುವ ಆರೋಗ್ಯ ಶಿಕ್ಷಣಕ್ಕೆ ಎಲ್ಲಾ ಮುಖ್ಯದಲ್ಲೂ
ಆದ್ಯತೆ ಕೊಡಬೇಕೆಂದಾಗ ಇಲಾಖೆಯಲ್ಲಿ ತಜ್ಞ ಸಿಬ್ಬಂದಿ ವರ್ಗದವರ ನೇಮಕಾತಿ ಅತ್ಯಗತ್ಯವಾಗಿ
ಬೇಕಾಗಿದೆ. ಅಷ್ಟೇ ಅಲ್ಲದೆ, 80 ಲಕ್ಷ ವಿದ್ಯಾರ್ಥಿಗಳ ಸಂಖ್ಯೆಗನುಗುಣವಾಗಿ ಪ್ರತಿವರ್ಷ ಅವರ
ಆರೋಗ್ಯ ಪರೀಕ್ಷೆ ಮುಂದುವರಿಸಿಕೊಂಡು ಹೋಗಬೇಕಾಗಿರುವುದರಿಂದ ಈ ಕೆಳಗೆ
ನಮೂದಿಸಿರುವ ಹೆಚ್ಚುವರಿ ಸಿಬ್ಬಂದಿ ವರ್ಗದ ಸಾಲಭ್ಯಾಗಳನ್ನು ಪಡೆದುಕೊಳ್ಳಲು ಸರ್ಕಾರಕ್ಕೆ
ಪ್ರಸ್ತಾವನೆಯನ್ನು ಕಳುಹಿಸಬಹುದು.



ಸಮುದಾಯ ಆರೋಗ್ಯ ಕೋಶ
COMMUNITY HEALTH CELL - CHC

Phone : 0091-80-5531518 / 5525372
Fax : 0091-80-5525372
email : sochara@vsnl.com

No. 367, Srinivasa Nilaya, Jakkasandra I Main, I Block, Koramangala, Bangalore - 560 034.

REF: CHC/ /2001

17TH March, 2001

To;
Mr. T.M. Vijay Bhaskar, IAS
Commissioner Public Instruction,
Ambedkar Veedhi,
Bangalore.

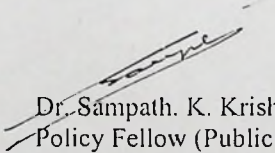
Sub: Forwarding the minutes of Integrated HNP meeting held on 7th March 2001.

Dear Sir,

Enclosed herewith please find copies of the 'Minutes of the Integrated HNP Meeting' held on 7th March 2001 at your conference hall. We are in the process of integrating the points, which came up for discussion during the meeting, into the project implementation plan (PIP) of HNP on school health programme. This would be discussed in detail with you and your officers before finalization.

Thanking you,

Yours sincerely,


Dr. Sampath. K. Krishnan,
Policy Fellow (Public Health)
For Coordinator
Community Health Cel

Internal copy to Thelma Narayan - Coordinator.

GOVERNMENT OF KARNATAKA

AW 21

DEPARTMENT OF HEALTH & FAMILY WELFARE SERVICES,
ANANDA RAO CIRCLE, BANGALORE - 560 009.

**THE FOLLOWING ARE THE IMPORTANT SALIENT FEATURES
TO BE STRICTLY ADOPTED BY SCHOOL AUTHORITY**

STATISTICS

1. No. of schools : 49,537
2. School children : 93, 48,666 (girls and boys 50 : 50 %)

SCHOOL SANITATION

1. Provision of sufficient lavatories @ one per 60 students (separate for girls and boys)
 - 1,55,820 (77,910 for girls and 77,910 for boys)
2. Provision of sufficient ^{Urinals} lavatories @ one per 40 students.
 - 2,33,716 (1,16,858 for girls and 1,16,858 for boys)
3. Provision of water (safe drinking and other purpose) @ 5 litres per student
 - 46,88,940 litres (18,69,733 Ltr. for drinking and 28,19,207 Ltr. for other purposes)

4. PROVISION OF HEALTHY ENVIRONMENT (IN AND AROUND THE SCHOOL BUILDING)

- Development of school garden by the students
- Keeping the school premises clean by disposing school waste in compost pits.
- Keeping the school premises clean and tidy always
- Keeping the school premises free from the flies and mosquitoes.



MINUTES OF THE HNP DISCUSSION WITH DHO's HELD ON 25TH JANUARY, 2001
AT NEW CONFERENCE HALL, HEALTH COMMISSIONERS OFFICE.

The **Commissioner H & FW** briefly described the salient features of the HNP project. He emphasized that the project covered the important aspects of Integration, Women's health (not just reproductive health), equity, Regional Disparities, Nutrition (which had long been neglected) and other issues. He then asked the DHO's (starting from the category 'C' Districts) to give their suggestions/ views on the project proposal (which had been distributed to all the 27 DHO's the previous day itself). All the DHO's expressed that the Project proposal was well prepared and covered a large range of issues.

DHO's of Koppal, Raichur and Gulbarga felt that in their districts there was no requirement of new PHC's.

DHO's of Bagalkot and Bijapur felt that a few new PHC's would be required as some of their PHC's were covering a population of above 45,000. **Health Commissioner** advised them that they should review the distribution of population with all their PHC's and see if by re-distribution of area of responsibility could they avoid asking for new PHC's. (He felt that asking for new PHC's posed a problem as Government, may sanction PHC's on political lines).

DHO, Bidar stated that 11 PHU's in his district needed to be upgraded to PHC's.

DHO Gulbarga stated that out of his 11 PHCs there was management problems and also large number of vacancies in staff still required to be filled. He felt that government should provide accommodation for health staff and staff should stay at their Headquarters. **Health Commissioner** emphasized that it was left to the DHO to ensure that staff resided wherever staff quarters existed.

DHO Koppal also emphasized the shortage of staff due to vacancies not being filled up especially Lab Technicians and staff nurses and also the problem of having only 3 jeeps for 43 PHC's. **Health Commissioner** clarified that though some of those issues were important they did not require a project to tackle them. He urged the DHO's to come out with concrete suggestions for the HNP project.

Dr. Krishnan stated that not having adequate vehicles definitely affected supervision of health activities, but if vehicles were provided then MOs should ensure that these were not taken over / misused by Zilla Panchayat staff.

DHO Raichur also reiterated that vehicles could definitely influence health indicators positively. He pointed out that about 86 SC's in his districts had no buildings, large number of vacancies and the requirement of same funds for day-to-day maintenance of PHC's. **Commissioner Health** stated that under the **PMJY** for infrastructure these SC's could be tackled in a phased manner. He agreed that an annual maintenance fund of Rs. 20,000/- per PHC could be worked out for simple repairs but the exact modalities needed to be worked out. Some of the **DHO's** were in favour of a Junior Engineer under DHO's to carry out such works. (as ZP's were busy with large projects more than Rs. 5 lacs).

HNP file
for
5/2/2001

Some **DHO's** felt that Disposable Dai Kits needed to be provided to Dais so that aseptic home deliveries could be conducted. Many felt that ANM's found it difficult to perform deliveries without an assistant. It was felt that the Dais from the village should be encouraged (through Health Education, IEC etc.) to bring cases to the SC and assist the ANM in conducting the deliveries. An incentive of about Rs. 50/- per case could be given to the Dai and ANM for every delivery conducted in the SC's. This would not only bring down the incidence of home deliveries (with likely complications) as well as give on the job skill based training to the Dais in the villages.

One of the **DHO's** agreed with the project proposal statement that the under 2's were not being reached in the Nutrition programme. It was stated that earlier under CARE ANM's were distributing tinned milk / powder to the under 2's. Some felt that Nutrition Education to mothers was adequate, others that SHG's in villages could be involved in preparation and distribution of weaning foods. PHC doctors and ANM should conduct well-baby clinics during immunization days and actively monitor the nutritional status of children. Also during these clinics once in a while nutrition demonstrations could be conducted.

Regarding partnering with the private sector a lot of discussion was generated. Some **DHO's** felt that it would result in encouraging quacks to practice. **Health Commissioner** stated that whether the medical fraternity accepted it or not, 75% of the patients in rural areas accessed private practitioners first. Some felt that Health Societies could be formed at the village level with PP's, NGO representatives, etc. and meet regularly. PHC MO's should have linkage / liaison with local PP's (atleast once a month) and they could be briefed about the National Health Programmes as well as inform about disease outbreaks (surveillance).

There being shortage of time the discussion was concluded. The participants were asked to read the project proposal in detail and submit written suggestion / strategies within a week.

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MINUTES OF THE MEETING HELD ON 07 MARCH 2001
AT THE OFFICE OF
THE COMMISSIONERATE OF PUBLIC INSTRUCTION ON
INTEGRATED HNP PROJECT

Mr. Vijay Bhaskar initiated the meeting by congratulating Dr Kurtakoti for the excellent performance in the School Health Programme during the previous year.

Mr. Sanjay Kaul briefly touched upon the HNP project and CHC's role in preparation of the project proposal. He stated that the project was for about Rs 800 crores from the World Bank and that a Project Preparation Grant had also been sanctioned. The main focus was on Primary Health Care that should provide integrated services, and converge initiatives especially in collaboration with other sectors on nutrition, health of children and women and other related issues. He mentioned about the responsibility of the Dept of Health in provision of Nutrition through the ICDS scheme of WCD Dept and similar commitment to the health of the children in schools. While accepting the good efforts of the Chief Medical Inspector of schools and Dr Kurtakoti in the School Health programme, especially where documentation is concerned, he still felt that the school health programme was neglected. He commented that though the education dept. had printed beautiful and useful health cards for the school children, these were not being filled up while conducting the medical check up of children. Also the school registers were not being updated. The components of Health Education and Education of Adolescents, especially girls, (Life skills/ Sex education) was not being linked to the school health programme. Coordination between the Health Dept and Education Dept had been initiated through joint circulars. but this needed to be improved. He emphasized that counselling of adolescents (or even post-pubertal girls) needed to be intensified. He felt that the health gains of the ICDS programme, which covered children upto 6 years, should continue for the children in schools also.

Dr Kurtakoti briefly described the school health programme achievements and gave handouts. He stated that in 1998-99 only 25% children had been medically examined and this has steadily increased from more than 80% in 1999-2000 to 95.23% in 2000-2001. He stated that he was convinced of the validity of the data as they were reflected by the DHOs. The medical examination was carried out for children of I, IV and VII standards (once every 4 years), as per the guidelines of the Government of India. He also stated that DT was given for I Std students and booster dose of TT was given to Std IV and VII students and almost 79% coverage had been achieved. About 22% of children have defects of which majority were dental and malnutrition- (5%). He felt that most of these could be avoided by simple health education alone. He also submitted a proposal for about Rs 55 crores for improving the implementation of the School Health Programme. Regarding training of teachers, he stated that this depended on the budget received by each district, which varied from Rs 80,000/- to one lakh per year.

Mr. T.M. Kumar was skeptical that such a large number of school children had been medically examined and expressed doubts regarding the validity of the statistics presented. He was of the view that only a campaign mode was suited for carrying out medical check ups. He also stated that ideally 3 days of training for teachers was required but only about one day training was being given. Also modality for referral of school children to Taluk and District hospital needs to be worked out.

Mr. Vijay Bhaskar briefed about the UNICEF project in Mysore District where schools were being provided water supply, toilets, sanitation and training of school teachers on Health and Environment. He also stated that the department has approached NABARD for assistance for toilets and water supply to schools in all districts.

Mr. Sanjay Kaul stated that life skills training (including sex education) was required for adolescents and felt that NCERT had a good booklet on life skills with practical tips.

Dr. Kurtakoti commented that students in the schools could take up tree plantation and the other batches could maintain the trees. He also felt that this would help in Nutrition education. He said that all schools would be provided first aid kits.

Ms. Jalaja stated that more than 80% of girls in schools suffer from anaemia. Since there were roughly 4 million school girls, mechanism should be worked out to deworm them once a year and provide elemental Iron weekly to them, as well as out of school girls. She also felt that small doses of Vitamin A could also be administered rather than the mega doses being given by ICDS.

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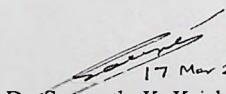
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For Coordinator,
Community Health Cell
Bangalore.

Date: 07 March 2001

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2.	Mr. Sanjay Kaul, IAS	Commissioner Health & FW
3.	Mr. G.S. Hegde	DPI (Primary Edn.)
4.	Mr. T.M. Kumar	Jt. Director, DSERT
5.	Dr. S.B. Kurtakoti	Addl. Director (HET)
6.	Mr. Kiran Kamal Prasad	Jeevika, Bangalore
7.	Dr. Sabu George	CHC, Bangalore
8.	Dr. Jalaja Sundaram	Jt. Director (Nutrition)
9.	Dr. Thelma Narayan	CHC, Bangalore
10.	Dr. Pushpa Madjani	CMI
11.	Dr. Sampath K. Krishnan	CHC, Bangalore
12.	Ms. S.N. Meera Devi	Principal, Bangalore Urban DIET
13.	Ms. B. Sushila	DDPI (Textbooks)
14.	Ms. Veena Naik	Sr. Lecturer Urban
15.	Mr. M.R. Jagannatha	Sr. Jt. Dtr. DHERT
16.	Mr. H.S. Jayshankarmurthy	Sr Program Officer DPEP
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MINUTES OF THE MEETING HELD ON 07 MARCH 2001
AT THE OFFICE OF
THE COMMISSIONERATE OF PUBLIC INSTRUCTION ON
INTEGRATED HNP PROJECT

Mr. Vijay Bhaskar initiated the meeting by congratulating Dr Kurtakoti for the excellent performance in the School Health Programme during the previous year.

Mr. Sanjay Kaul briefly touched upon the HNP project and CHC's role in preparation of the project proposal. He stated that the project was for about Rs 800 crores from the World Bank and that a Project Preparation Grant had also been sanctioned. The main focus was on Primary Health Care that should provide integrated services, and converge initiatives especially in collaboration with other sectors on nutrition, health of children and women and other related issues. He mentioned about the responsibility of the Dept of Health in provision of Nutrition through the ICDS scheme of WCD Dept and similar commitment to the health of the children in schools. While accepting the good efforts of the Chief Medical Inspector of schools and Dr Kurtakoti in the School Health programme, especially where documentation is concerned, he still felt that the school health programme was neglected. He commented that though the education dept. had printed beautiful and useful health cards for the school children, these were not being filled up while conducting the medical check up of children. Also the school registers were not being updated. The components of Health Education and Education of Adolescents, especially girls, (Life skills/ Sex education) was not being linked to the school health programme. Coordination between the Health Dept and Education Dept had been initiated through joint circulars, but this needed to be improved. He emphasized that counselling of adolescents (or even post-pubertal girls) needed to be intensified. He felt that the health gains of the ICDS programme, which covered children upto 6 years, should continue for the children in schools also.

Dr Kurtakoti briefly described the school health programme achievements and gave handouts. He stated that in 1998-99 only 25% children had been medically examined and this has steadily increased from more than 80% in 1999-2000 to 95.23% in 2000-2001. He stated that he was convinced of the validity of the data as they were reflected by the DHOs. The medical examination was carried out for children of I, IV and VII standards (once every 4 years), as per the guidelines of the Government of India. He also stated that DT was given for I Std students and booster dose of TT was given to Std IV and VII students and almost 79% coverage had been achieved. About 22% of children have defects of which majority were dental and malnutrition- (5%). He felt that most of these could be avoided by simple health education alone. He also submitted a proposal for about Rs 55 crores for improving the implementation of the School Health Programme. Regarding training of teachers, he stated that this depended on the budget received by each district, which varied from Rs 80,000/- to one lakh per year.

Mr. T.M. Kumar was skeptical that such a large number of school children had been medically examined and expressed doubts regarding the validity of the statistics presented. He was of the view that only a campaign mode was suited for carrying out medical check ups. He also stated that ideally 3 days of training for teachers was required but only about one day training was being given. Also modality for referral of school children to Taluk and District hospital needs to be worked out.

Mr. Vijay Bhaskar briefed about the UNICEF project in Mysore District where schools were being provided water supply, toilets, sanitation and training of school teachers on Health and Environment. He also stated that the department has approached NABARD for assistance for toilets and water supply to schools in all districts.

Mr. Sanjay Kaul stated that life skills training (including sex education) was required for adolescents and felt that NCERT had a good booklet on life skills with practical tips.

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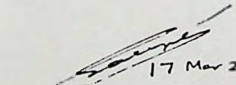
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