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HOW AWW, ANM AND ASHA HELP IN DEVELOPMENT OF THE ICDS TO TACKLE MALNUTITION AND HEALTH ISSUE FOR A BETTER INDIA

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Abstract: *Integrated Child Development Services, popularly known as ICDS was evolved in 1975 by Government of India with the major objectives of: Improving the nutritional and health status of children in the age group 0-6 years. Laying the foundation for proper psychological, physical and social development of the child. Reducing the incidence of mortality, morbidity, malnutrition, and school dropout. Achieving effective coordination of policy and implementation amongst the various departments to promote child development, and enhancing the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education. The basic premise of the programme revolves around the common consensus among educationists, researchers and practitioners that early childhood education and care are inseparable issues and must be considered as one. Based upon this fundamental assumption, the basic inputs under ICDS programme include delivery of integrated package of minimum basic services - health care (immunisation, referrals, health check-ups, nutrition and health education), nutritional supplementation and early childhood education (stimulation activities for children of 0-3 years and non-formal pre-school activities for children 3-6 years) so as to benefit the children from pre-natal stage to the age of six years and to pregnant and lactating mothers. The concept of providing a package of services is based primarily on the consideration that the overall impact would be much larger if the different services are provided in an integrated manner.*

ICDS, therefore, takes a holistic view of the development of the child and attempts to improve his/her both pre- and post-natal environment. Accordingly, besides children in the formative years (0-6 years) , women between 15-45 years of age are also covered by the programme, as these are child-bearing years in the life of a women and her nutritional and health status has a bearing on the development of the child. Further, in order to better address the concern for women and for girl child, interventions have also been designed for adolescent girls seeking to break the inter-generational cycle of nutritional disadvantage. The adolescent girls therefore have also been brought under the ambit of ICDS services

A total of 170 icds projects were selected and the data were collected on the visit and on analyzing the data on the spread sheet we could see that out of 13 lacks38 thousand anganwari we could study only a very small of these numbers of On analysis of the data collected .The study of children with normal as well as malnourished children in whole of India according to new who growth chart. The immunisations study done by 432 awc were shown how the health centers are taking care of the children and pregnant women. The data after analysis we see that the aww, anm, and asha help in these work and we able to achieve a good result. We are able to be declared polio free nation.

Keywords: *AWW, ANM, ASHA, ICDS, Malnutrition*

INTRODUCTION

Integrated Child Development Services, popularly known as ICDS was evolved in 1975 by Government of India. After traversing a momentous path from its launching in 1975 with 33 projects on experimental basis, the ICDS scheme over the time has now been extended to 7025 operational (sanctioned 7076) ICDS Projects with 13.38 lakh AWCs (as on March 2013) located across all 35 States/ Union Territories in the country. The significance of this nationally run initiative of ICDS may also be judged on many counts. ICDS, which is more than 40 years old now, is primarily based on the philosophy of convergence as ICDS functionaries are tuned to seeking and obtaining services from other government programmes implemented at the field level. Like out of six ICDS services, three health-related services namely Immunisation, Health Check-Up and Referral Services are being delivered through public health infrastructure i.e. through sub centers, Primary and Community Health Centres under the Ministry of Health and Family Welfare. It has been the endeavour of the Government of India to ensure that delivery of these health-related services is made through effective convergence with the Reproductive and Child Health component of National Rural Health Mission (NRHM) being administered by Union Ministry of Health and Family Welfare. Similarly, under Multi sectoral Development Programme .

The study was done by the central monitoring unit of NIPCCD and based on this report this paper was presented. The data collected from the reports from CMU and ministry of women and child development to see the number of children who have been weight under new WHO growth chart in the different states and union territory

A total of 170 icds projects were selected and the data were presented in this study. On analyzing the data we could see that out of 13 lacks38 thousand anganwari we could study . The study of children with normal as well as malnourished children in whole of India according to new who growth chart.

States/UTs	No. of ICDS Projects	Total Registered Children	No. of Children weighed	
			N	%
Andhra pradesh	9	70068	67805	96.77
Arunachal pradesh	5	6213	5983	96.30
Assam	5	32851	30075	91.55
Chhartisgarh	14	92442	89432	96.74
Delhi	1	0	0	0.00
Gujarat	14	118185	109401	92.57
Haryana	2	19923	17660	88.64
Himachal Pradesh	8	34979	33115	94.67
Karnataka	7	63981	61985	96.88
Kerala	14	66534	65942	99.11
Madhya pradesh	3	26653	15714	58.96
Meghalaya	3	19032	13745	72.22
Mizoram	1	3145	3145	100
Odisha	1	6607	6138	92.90
Punjab	15	77959	76539	98.18
Pudducherry	4	24290	23630	97.28
Rajasthan	10	78899	69414	87.98
Sikkim	11	14372	13787	95.93
Telangana	4	75891	73216	96.48
Tripura	3	3827	3557	92.94
Uttar Pradesh	18	231995	227764	98.18
Uttarakhand	15	73832	70318	95.24
West Bengal	3	39110	36307	92.83
Total	170	1180788	1114672	94.40

The children were classified as normal, moderately underweight and severely underweight

Normal		Moderately Underweight		Severely underweight	
N	%	N	%	N	%
53880	79.46	13518	19.94	407	0.60
5948	99.42	29	0.48	6	0.10
24581	81.73	5298	17.62	196	0.65
70345	78.66	16115	18.02	2972	3.32

0	0.00	0	0.00	0	0.00
87498	79.98	21023	19.22	880	0.80
14160	80.18	3415	19.34	85	0.48
30476	92.03	2599	7.85	40	0.12
52694	85.01	8896	14.35	395	0.64
51815	78.58	13846	21.00	281	0.43
13252	84.33	2355	14.99	107	0.68
11742	85.43	1977	14.38	26	0.19
2977	94.66	168	5.34	0	0.00
5647	92.00	465	7.58	26	0.42
61525	80.38	14952	19.54	62	0.08
19242	81.43	4388	18.57	0	0.00
62670	90.28	6693	9.64	51	0.07
13675	99.19	105	0.76	7	0.05
65579	89.57	7275	9.94	362	0.49
3173	89.20	363	10.21	21	0.59
166737	73.21	46976	20.62	14051	6.17
66307	94.30	3370	4.79	641	0.91
28813	79.36	6801	18.73	693	1.91
912736	81.88	180627	16.20	21309	1.91

36384	97.01	31090	85.45	5132	14.11	162	0.45
56255	97.67	44549	79.19	10581	18.81	1125	2.00
0	0.00	0	0.00	0	0.00	0	0.00
61837	99.60	58650	94.85	2787	4.51	400	0.65
13049	84.32	11040	84.60	1969	15.09	40	0.31
20555	74.30	18497	89.99	2033	9.89	25	0.12
46702	98.32	38613	82.68	7753	16.60	336	0.72
43767	95.89	33149	75.74	10443	23.86	175	0.40
10832	78.71	8357	77.15	2365	21.83	110	1.02
8351	71.01	7232	86.60	1111	13.30	8	0.10
2288	100.00	2130	93.09	158	6.91	0	0.00
3950	91.35	3560	90.13	377	9.54	13	0.33
60938	83.75	47500	77.95	13400	21.99	38	0.06
1039	99.52	894	86.04	145	13.96	0	0.00
51680	97.90	47384	91.69	4254	8.23	42	0.08
10252	93.25	10137	98.88	98	0.96	17	0.17
161659	99.81	156295	96.68	5040	3.12	324	0.20
3173	97.15	2740	86.35	416	13.11	17	0.54
161257	97.20	122158	75.75	30893	19.16	8206	5.09
35264	90.45	31341	88.88	3679	10.43	244	0.69
21092	94.16	15770	74.77	4933	23.39	389	1.84

865015	94.75	733589	84.81	119318	13.79	12108	1.40

Why we should provide the SUPPLEMENTARY NUTRITION

Supplementary nutrition has to be given to all children below six years of age and to nursing and expectant mothers. **Promoting Optimal Infant and Young Child Feeding Practices** - In view of the fact that sustained improvement in maternal and child nutrition is possible through behavior change and improved care practices and prevailing sub optimal infant and young child feeding practices (IYCF), accelerated implementation and monitoring of the national guidelines on the Young Child Feeding needs to be ensured (copy of the guidelines are available on www.wcd.nic.in).

Children in the Age Group of 0- 6 months – For the children of this age group, the States/UTs are required to ensure continuation of current guidelines of early initiation of breast feeding (within one hour of birth) and exclusive breast feeding for children for first six months of life.

Children in the age group of 6 months – 3 years – For the children of this age group, the compliance of Infant Milk Substitutes , Feeding Bottles and Infant foods (regulation of Production ,Supply and Distribution) Amendment act, 2003 that specifies continued breastfeeding for two years and beyond needs to be ensured. It has also to be ensured that along with breast feeding, complementary feeding to children from age of 6 months must be started. In order to bridge the gap between RDA and ADI amongst children of this age group, food supplement of 500 calorie of energy and 12-15 grams of protein per child per day in Supplementary Nutrition Programme (SNP) should be provided. For the children of this age group, the existing pattern of Take Home Ration (THR) under the ICDS scheme shall continue. However, in addition to the current mixed practice of giving either dry or raw ration (wheat or rice) which is often consumed by the entire family and not the child alone, the THR should be given in the form that is palatable to the child and is seen as food to be exclusively consumed by the child instead of the entire family. The THR could be given in the form of Micronutrient Fortified Food and /or Energy Dense Food that may be marked as ICDS food supplement. Since a child under 3 years is not capable of consuming a meal of 500 calories in one sitting, AWW needs to advise mothers to give THR in small frequent meals to the child. The severely underweight children needs to be provided food supplement of 800 K calories of energy and 20-25 grams of protein in the form of Micronutrient Fortified food

and /or Energy dense food as THR. Considering the inability of under 3 old child (6 months to 3 years) to consume a meal of 800 K calories in one sitting, AWW needs to advise mothers to give THR in small frequent meals to the child. Severely underweight children requiring medical intervention may be given locally appropriate feeding and care under medical advice.

Children in the age group of 3 to 6 years – For the children of this age group, food supplement of 500 K calories of energy and 12-15 grams of protein per child per day has to be provided at the AWCs to supplement home feeding. Arrangements should be made for serving Hot Cooked Meal (HCM) at the AWCs and Mini AWCs under the ICDS Scheme. Since a child of this age group is not capable of consuming a meal of 500 K calories in one sitting, children who come to AWCs needs to be served more than one meal. Since the process of cooking and serving hot cooked meal takes time, and in most of the cases, the food served around noon, these children may be provided 500 K calories over more than one meal. Arrangements may be made to provide a morning snack in the form of milk/banana/egg/seasonal fruits/Micronutrient fortified food etc. For severely underweight children in the age group of 3- 6 years, additional 300 K calories of energy and 8-10 grams of protein (in addition to 500 K calories of energy and 12-15 grams of protein given at AWC) should be given in the form of Micronutrient – fortified food and /or Energy dense Food as THR. Severely underweight children requiring medical intervention may be given locally appropriate feeding and care under medical advice. **Pregnant Women and Lactating Mothers** – Food supplement of 600 K calories and 18-20 grams of protein per beneficiary per day in the form of Micronutrient – fortified food and /or Energy dense Food needs to be provided as THR. However, in addition to the current mixed practice of giving either dry or raw ration (wheat and rice) , which is often consumed by the entire family and not the mother alone, it should be given in the form of Micronutrient – fortified food or Food that may be consumed by the pregnant and lactating mothers rather than the whole family.

The significance of maternal nutrition to the pregnant mother and the development of the child during pregnancy has been considered carefully in the context of the low birth weight of babies common in the country and it is felt that provision of supplementary nutrition to a pregnant women only in the third trimester will not have the effect desired by us in the child development programmes in terms of the mother's safety at the time of delivery, her

capability to breastfeed the baby subsequently and other allied capabilities we aim to build for the mother. There is need for the mother to start receiving appropriate and adequate nutrition from the earliest stages of her pregnancy, in this context. Unless the mother has access to supplementary nutrition in the ICDS and other supplementary nutrition programme from the earliest point of pregnancy, it will be difficult for her to put on the right amount of weight, which she is expected to during her pregnancy to avoid the birth of a low birth weight baby

Under the revised Nutritional and Feeding norms for Supplementary Nutrition, the States/UTs are required to serve more than one meal to children who come to AWC which includes providing a morning snack to be followed by Hot Cooked Meal (HCM). The P &L Women and children below the age of three years are to be provided Take Home Ration (THR). Besides, for severely underweight children below 6 years, States/UTs are required to give additional locally appropriate care and feeding/ THR. These instructions have the approval of the Apex Court vide their order dated 22.4.2009 in CWP No. 196/2001-PUCL Vs. GOI&Ors. The States will need to ensure that all three forms of SNP are provided as per norms without interruption. The delivery systems will need to be put in place and monitored closely to ensure that the quantity and quality of SNP is not compromised. Measures to check pilferage, wastage and spoilage will need to be devised so that the resources are used optimally. Evaluations reveal that there is a significant difference in the number of beneficiaries actually attending the AWCs and those reported for giving SNP. The existing supervisory mechanism will need to be so improvised and strengthened as to capture the actual numbers for preparation of SNP and for reporting accordingly. Pilots may be initiated to establish and adopt normative approach to provide SNP based on average daily attendance.

Micro Nutrient Fortification – The supplementary food may be fortified with essential micronutrients (energy and protein excluded) with 50% of RDA level per beneficiary per day, as indicated in the table below;

Table

	RECOMMENDED DIETARY ALLOWANCES, NUTRIENT INTAKES AND GAPS											
	Age Group 1-3 Years			Age Group 4-6 Years			Pregnant Women			Lactating Women		
	RDA	Intake	Gap	RDA	Intake	Gap	RDA	Intake	Gap	RDA	Intake	Gap
Energy(K cal)	1240	687	553	1690	978	712	2175	1654	521	2425	1857	573
Protein (g)	22	18.6	3.4	30	26.5	3.5	65	45	20	75	46.7	28.3

Iron(mg)	12	4.3	7.7	18	6.8	11.2	38	12	26	30	11.8	18.2
Vitamin A (mg)	400	56	344	400	66	334	600	111	489	950	107	843
Calcium(mg)	400	161	239	400	66	334	1000	352	648	1000	320	680
Thiamin(mg)	0.6	0.4	0.2	0.9	0.6	0.3	1.1	1.0	0.1	1.2	1.2	0
Riboflavin(mg)	0.7	0.3	0.4	1.0	0.3	0.7	1.3	0.5	0.8	1.4	0.6	0.8
Niacin(mg)	8.0	4.7	3.3	11	7.4	3.6	14	12.4	1.6	16	14.4	1.6
Vitamin C(mg)	30	9	21	40	15	25	40	26	14	80	28	52
FreeFolic Acid (µg.)	30	18	12	40	26	14	400	48	352	150	53	97

Food Safety and Nutrient Composition – The State Governments /UT Administration with the support of Food and Nutrition Board (FNB) needs to ensure the quality of supplementary nutrition being provided under SNP with reference to the norms of food safety as well as nutrient composition. The supplementary nutrition should confirm to the prescribed standards laid down under the Prevention of Food Adulteration Act and the Integrated Food Law to ensure consistent quality and nutritive value of the intervention per serving (as per Nutritional Norms). FNB in collaboration with State Governments/UT administration have to carry out periodical checks to ensure that prescribed standards are adhered to and quality and nutritive value of the supplementary nutrition is maintained. In case of Hot Cooked Meal, it needs to be ensured that it is prepared in proper kitchen sheds having adequate sanitation and safe drinking water so as to maintain hygienic conditions. AWWs and AWHs are also expected to sensitize children in the hygienic practices like washing hands before eating and after visiting the toilets. Similarly, it also needs to be ensured that the Micronutrient – fortified food and /or Energy dense Food also meets the norms as per Recommended Daily Allowance (RDA) and the quality and nutritive value of such food is maintained.

The question of extending the benefit of supplementary nutrition in the ICDS Scheme to anganwadi workers and helpers has been considered, especially in the context of the following factors:-Anganwadi Workers and helpers should be fully involved with the supplementary nutrition programme. A large number of them come from modest backgrounds and should therefore get the benefit of supplementary nutrition. Sharing of supplementary nutrition would also bring the field level workers closer to the programme beneficiaries namely the pregnant women, nursing mothers and children. Anganwadi Workers and helpers, being aware that they too are part of taking of the food, would be more careful in its preparation, in terms of quality, cleanliness and hygiene

The AWW should be aware of all births taking place in her area. She can do this by keeping in constant touch with the pregnant women, who are her beneficiaries. She should note down the date of birth of a child as soon as the women delivers the baby. Keeping in touch with the local trained birth attendant (TBA) can also help her knowing the births of new babies. The AWW should immediately record the date of birth (day, month and year) of the child in her register .She should also start monitoring the growth of these children.

However, if the mother comes to the present place of residence a few months or years after the child's birth, she may not remember the month of birth of the child. For these children, the AWW can consult the local official register of births with the village panchayat , and or hospital card .Keeping in view the implementation of JananiSurakshayajana(JSY) , number of institutional deliveries has been increased in our country. Therefore, the date of birth in case of large number of children would be available from the health centre. If, however, there are no such records of births in a given area, the AWW can assess the age of the child from other sources. Some of these includes with the help of Mother and Child protection Card (MCPC), with the help of the birth certificate, from the mother, if she remembers the exact date of birth, or using a local event calendar.

Prophylaxis against Blindness in Children Caused by Vitamin 'A' Deficiency

Vitamin A supplements are given to protect the child against blindness due to Vitamin A deficiency. Vitamin A also reduces illness and deaths in children. Child should be given total five doses of Vitamin A drops starting from 9 months through 3 years of age, every six months. First Vitamin A dose of 1, 00,000 IU is to be given at 9-12 months of an age along with measles vaccination. For children older than 12 months of age, Vitamin A dose of 2, 00,000 IU needs to be given once in 6 months till the child is 5 years of age at health centre/AWC. During 24 to 36 months, child needs 2 doses of Vitamin A supplements.

Prophylaxis against Nutritional Anemia among Mothers and Children

Anemia is one of the major health problems affecting women of child bearing age and children in the country. Anemia in pregnant women is an important cause of maternal mortality. Apart from affecting the health of the pregnant women, it also affects the new born babies adversely. Anemic women is more prone to pre mature delivery, still birth, and low birth weight babies. Symptoms of anemia includes general fatigue, breathlessness on routine and somewhat strenuous work, palpitation, loss of appetite, sensation of tingling

and pins and needles in the fingers and toes, giddiness, dizziness, diminishing vision and headache, paleness of eyes, nails and insides of eyelids etc.

In order to prevent nutritional anemia among mothers, a pregnant women must be given one iron tablet a day for at least three months. She has to take at least 100 tablets during her pregnancy to prevent anemia. . If a pregnant woman suffers from mild anemia (<11g/dL to 10.9 g/dL) she must be given a daily prophylactic dose of IFA tablets starting from 4^{th} month of pregnancy for 100 days. Those who are moderate anemic (10g/dLHb to > 7 g/dLHb) would need to be given two tablets of IFA – one in the morning and one in the evening for 100 days. Severe anemia can lead to increase in complications during pregnancy ,delivery and in the post natal period ,including death. Hence ,pregnant women with severe anemia (<7g/dLHb) need treatment and blood transfusion. Such women should be referred to a FRU for appropriate medical treatment. The AWW/ANN has to record the date and number of Iron and Folic Acid tablets given to the pregnant women in MCP card. Intake of iron tablets may cause stool to become either loose or hard. The colour of the stool may also become black. This should not be a cause of worry. Intake of iron tablets may also cause nausea. To avoid this, it should not be taken in empty stomach. It is estimated that on an average each beneficiary would have to receive the tablets continuously for a period of 100 days. For children, one tablet containing 20 mg of iron and 0.1 mg of folic acid is to be given daily. The tablets are sugar coated. For smaller children who cannot swallow tablets, limited quantity of liquid preparation will also be supplied. The daily dose would be 2 ml which is equivalent to one tablet. Children should be given iron and folic acid syrup over 6 months However, the exact period would depend upon the progress of the individual woman or child. For the convenience of the beneficiaries as well as for administrative purpose, it has been suggested that the drugs may be dispensed for a fortnight or even a month at a time. Anganwadi workers and ANMs should, however, check on the proper utilization of the tablets during their home visit

Management and Delivery of Supplementary Nutrition

The ICDS scheme envisages the delivery of supplementary nutrition to the child and mother as one of the most important components of the package of ICDS services. Anganwadis which are meant to feed children and pregnant and nursing mothers provides an excellent potential base for reaching out those sections of the target group population which have

hitherto remained inaccessible. Certain guidelines and norms have been set down by the Ministry of Women and Child Development in order to facilitate the attainment of those objectives. The more important elements are as follows;

Educational efforts should be continued, with the help of local leading citizens and women of the area to educate the community that the supplementary food is required to be given to only those children who are identified in accordance with the given criteria. Supplementary nutrition is an important component of the ICDS programme and constitutes a major part of the cost of the projects.

There should be clear understandings of the food audit, food accounting and food management at the project level, the CDPO, who is responsible for the management of the nutrition component under ICDS, should estimate the number of beneficiaries for supplementary feeding in the project area. He should then ensure that the funds for the required quantity of food, transportation and administrative overheads are committed in time by the State Governments/UT Administration. The CDPO in consultation with the BDO should plan for adequate storage of the food commodity at the project headquarters and at the Anganwadi. He should arrange for periodic fumigation of bulk food commodities. The flow of food supplies from the project level to the Anganwadi level should also be smooth on an uninterrupted delivery of food supplies, its sustained shelf life and proper distribution. One should not take comfort in the reassuring statistics of 'numbers fed' as these may generally relate to more mobile, less nutritionally vulnerable and less deserving sections of population.

There is also an urgent need to evolve a delivery system for reaching the inaccessible and 'hut-bound' below threes and tradition and superstition bound pregnant women. Alternative delivery mechanisms such as 'take home food' system should be explored for reaching out such cases. In the interest of wider coverage of the target group a combination of both 'on the spot feeding' and 'take home food system' should be tried out to gain experience in the more effective delivery of nutrition services to malnourished children.

A food supplement can have little impact unless the various health factors working adversely such as insanitary conditions, gastro intestinal infections etc. in the vulnerable groups are first taken care of the PHC supported and aided by the local indigenous health practitioners, TBAs and opinion leaders can play a significant role in prescribing and

distributing locally produced, low-cost, ready-to-eat cereal pulse mixes to the nutritionally deficient children.

Mothers should be involved in the nutritional rehabilitation of their children in their own homes and not necessarily in clinics or Anganwadi centers. The food mixes should be simple and within the economic means of the family so that they can continue the supplementation without much outside support.

The prescribed project technology for tackling child malnutrition is that every child below 6 years should be weighed for ascertaining his nutritional status on the basis of weight related to age. Many mothers may object to their children being weighed. The mothers interested in the treatment of the sick children may not, however, object to their children being weighed. If such children are treated successfully, the weighing procedure can be used for educating the mothers in the project area. Besides other nutritional intervention

The programmes, like protection against Vitamin 'A' deficiency and nutritional anemia to the total child population through administration of oral Vitamin 'A' solution, and iron and folic acid tablets, indirect intervention programmes such as protected water supply, periodic Deworming drives with the help of health staff, simple oral rehydration therapy, mass immunization programme, and greater investment in basic drugs and medicines at the PHCs and sub-centres would be needed to have a much greater spread-effect.

The immunisations study done by 432 awc were shown how the health centers are taking care of the children and pregnant women

Immunisations

States/UTs	Total No. of AWCs	Health Centres at Which Beneficiaries received Immunisations							
		Sub Centres	%	PHC	%	AWC	%	Other	%
Andhra pradesh	15	2	13.33	0	0	9	60	5	33.33
Arunachal pradesh	20	2	10	2	10	1	5	0	0.00
Assam	25	5	20	4	16	10	40	2	8
Chhartisgarh	65	11	16.92	5	7.69	38	58.46	11	16.92
Delhi	5	1	20	3	60	5	100	0	0.00
Gujarat	55	19	34.55	2	3.64	26	47.27	8	14.55
Haryana	10	0	0.00	1	10	8	80	1	10
Himachal Pradesh	5	1	20	1	20	1	20	2	40
Karnataka	30	12	40	8	26.67	9	30	4	13.33

Madhya pradesh	15	0	0.00	0	0	13	86.67	2	13.33
Meghalaya	15	8	53.33	2	13.33	2	13.33	3	20
Punjab	67	19	28.36	9	13.43	30	44.78	10	14.93
Rajasthan	10	0	0.00	1	10	9	90	0	0.00
Telangana	20	7	35	6	30	6	30	6	30
Uttar Pradesh	70	8	11.43	6	8.57	52	74.29	5	7.14
Uttarakhand	5	0	0.00	0	0	4	80	0	0.00
Total	432	95	21.99	50	11.57	223	51.62	59	13.66

PHC	%	AWC	%	Other	%
0	0	9	60	5	33.33
2	10	1	5	0	0.00
4	16	10	40	2	8
5	7.69	38	58.46	11	16.92
3	60	5	100	0	0.00
2	3.64	26	47.27	8	14.55
1	10	8	80	1	10
1	20	1	20	2	40
8	26.67	9	30	4	13.33
0	0	13	86.67	2	13.33
2	13.33	2	13.33	3	20
9	13.43	30	44.78	10	14.93
1	10	9	90	0	0.00
6	30	6	30	6	30
6	8.57	52	74.29	5	7.14
0	0	4	80	0	0.00
50	11.57	223	51.62	59	13.66

The AWW and ASHA are in contestant touch with the society .The pregnant mothers and children from birth, children are exposed to various health hazards including communicable diseases. The natural resistance of the body of children to fight diseases is in low order with the result that children fall an easy prey to diseases. In order to protect the children against these diseases immunization is done. *Immunization increases the fighting power of the body. It is a process of production of immunity (i.e. resistance) to an infectious disease by artificial means i.e. other than by an attack of disease itself.* In this immunizing agents like either antigens or **immunoglobulins** are administered. When vaccine (a preparation of an antigen) is administered it stimulates specific antibody formation in the body and is known as Active immunization. Whereas administration of immunoglobulins does not stimulate antibody formation in the body but it itself act against disease and is known as passive

immunization. Active immunization (i.e. administration of vaccine) is the most effective means of controlling communicable disease. Immunizations against certain infections have to be repeated over a period of time. These repeated doses are known as “booster doses”. They further strengthen the resistance of the body against the particular disease for which the body has been immunized. Immunization should be done early in life and repeated periodically. Active immunization by live vaccines (e.g. oral polio) killed vaccine (e.g. whooping cough) and toxoid (e.g. tetanus) prove better resistance to the respective diseases than by passive immunization e.g. with anti-toxins or gamma globulins.

Immunization prevents the child from developing six fatal diseases and one disabling disease. These diseases can cause death and disability in the children. Vaccines that are administered to prevent these diseases are as under;

BCG : Tuberculosis

Hepatitis B : Hepatitis B

OPV : Polio

DPT : Diphtheria, Pertussis (Whooping Cough) and Tetanus

Measles : Measles

The immunization is to be carried out by the PHC/Urban Health Unit and its subordinate health infrastructure.

Immunization Schedule

A baby should be taken to sub centre /AWC at 1½, 2½, 3½ and 9 months of age for immunization. The following national schedule of immunization will be followed in ICDS project areas:

Age of Children	Vaccination
At the time of Birth	• BCG • OPV-0* • Hepatitis-B*
1and half months	• OPV-1 • DPT-1 • Hepatitis-B1
2 and half months	• OPV-2 • DPT-2 • Hepatitis-B2
3 and half months	• OPV-3 • DPT-3 • Hepatitis-B3

9 months	• Measles • Vitamin A
16 – 24 Months	
16 months	• Vitamin A
24 months	• Vitamin A
16-24 months	• DPT Booster • Polio Booster
• **24 - 36 months**	
30 months	• Vitamin A
36 months	• Vitamin A
• IFA syrup to children every six months • Deworming over one year biannually as prescribed	

The AWW has to ensure that every child is taken for immunization four times in the first year of life apart from immunization given at birth. The AWW has to advice the family to ensure that full course is completed for each vaccine. However, if for any reason, a date is missed for any vaccination, child has to be brought as soon as possible after that for vaccination. A child may be taken for immunization even if there is mild fever, cough, cold and diarrhea. Every child has to be deworm over 1 year or 2 years biannually.

A pregnant woman must take at least 2 Tetanus Toxoid (T.T.) injections. The TT Immunization protects the mother and the baby against tetanus which is a life threatening disease. The first T.T. injection should be taken during the first visit, even if it is the first trimester, and the second T.T. injection should be taken at least one month later. If the woman has been previously immunized with two doses during a previous pregnancy within the past three years, then give her only one booster dose as early as possible in this pregnancy. If the woman skips one antenatal visit, give the TT injection whenever she comes back for the next visit. If the woman receives the first dose after 38 weeks of pregnancy, then the second dose may be given in the postnatal period, after a gap of four weeks. The dosage of the TT injection to be given is 0.5 ml. Tetanus toxoid is to be administered by deep intramuscular injection. It should be given in the upper arm, and not in the buttocks as this might injure the sciatic nerve. It has to be informed to the woman that there may be a slight swelling, pain and/or redness at the site of the injection for a day or two.

Guidelines for use of Live Oral Polio Vaccine

To prevent the inactivation of the vaccine before administration to the children it is recommended that it should be stored at subzero temperature. In case a deep freeze is not

available it might be stored in the freezing chamber of the refrigerator. During transport the vaccine must be kept either on dry or freezing mixture. Remove the required quantity of the vaccine from the vial with a sterilized syringe and needle. Do not freeze and throw the vaccine container repeatedly. Vaccine not handled in an aseptic manner may develop turbidity due to bacterial or fungal contamination. Such vaccine should not be used. The vaccine is given by mouth to children .First dose is given at birth, other doses are given at the age of one and half month, two and half month, three and half month and the booster dose is given at the age of 16-24 months. Three doses of the vaccine at intervals of one to two months are necessary for adequate protection against polio-myelitis. One dose of the vaccine contains 0.5 ml. The vaccine should not be diluted with water, milk or syrup.

Storage and Transportation of Vaccine

All vaccines must be handled and stored carefully as these may deteriorate and lose their potency if not kept at the recommended temperature, for this purpose the cold chain has to be maintained. Liquid vaccines are readily damaged whereas freeze-dried vaccines and toxoids are relatively stable. The potency of each vaccine is guaranteed for a specific period only. The vaccine must therefore be used before the date of expiry. During transportation the vaccine must be kept in a thermos or thermocol box or vaccine carrier packed with cold pack or ice for carrying it to remote areas so that it does not lose its potency

Plan for Immunization

The annual plan for immunization should be drawn up keeping in view the number of new-born and other eligible population for vaccination. While in urban project areas routine immunization through mothers and children's clinics and attached hospitals may be conducted, for rural project areas a *campaign approach* may be adopted. The eligible children and mothers in the project villages may be collected at convenient places (say market days) according to a predetermined schedule and immunization may be carried out involving all the qualified persons, namely the LHVs. Basic Health Workers, Family Planning Assistants, BCG vaccinators, Health Inspectors and ANMs All such workers should be involved in the immunization campaign. The Anganwadi workers and ANMs should jointly educate and prepare the local community for total coverage of the target group population under various immunization and prophylaxis programmes. Local groups, village committees, Panchayat and MahilaMandals can play a very useful supportive role in this programme. The

visit has to be repeated till three doses of DPT and polio are administered as per schedule. Incomplete immunization and lesser than the required number of doses is not an effective immunization. It may be worthwhile to consider working out specific project by project priorities and differential sequence of immunization schedule depending on the local situation of severity and incidence of childhood and maternal diseases.

Health Check-up

This service includes ante-natal care of expectant mothers, post-natal care of nursing mothers and care of newborns and care of children under 6 years of age. The entire population of expectant and nursing women and of children under 6 years of age of the project area is required to be covered under this service. It is therefore to be ensured that this service is not limited to or monopolized by children who are present at the Anganwadi at the time of the visits of the ANMs/LHVs and MOs. It is also to be seen that the more needy mothers and children of poor and marginal families who mostly remain in homes and re generally deprived of the service of health check-up and medical care are covered under this service in the ICDS project areas. The health check-up and medical care has to be rendered by the ANMs and LHVs under the guidance of the PHC, MOs during the Village health and Nutrition day (VHND). Primary health care of a simple nature is also supposed to be rendered by the Anganwadi worker. For this purpose, Anganwadi workers have been given a medicine kit which needs to be replenished at regular intervals after checking the expenditure register.

Ante-Natal Care of Expectant Mothers

Each pregnant woman should get at least 4 antenatal check-ups (1st visit within 12 weeks, 2nd visit between 14-26 weeks, 3rd visit between 28-34 weeks and 4th visit after 36 weeks) including registration during pregnancy. It is important as many of the complications can be detected and managed on time. During each antenatal visit, all the parameters need to be checked and recorded. The check-ups may be conducted as under:

1st Visit (within before 12 weeks) Registration History taking Give tetanus toxoid (1st dose)

2nd Visit (14 - 26 weeks) Screen for risk factors and medical conditions Record BP, weight and height Haemoglobin estimation/Screen for anaemia Urine examination for albumin Breast examination Give tetanus toxoid first/second dose provide health and nutrition education develop individualized birth plan

3rd Visit (28 – 34 weeks) Record BP, weight Abdominal examination to asses for intrauterine growth retardation (IUGR), twins etc. Haemoglobin estimation Urine for albumin Give tetanus toxoid (2nd dose)Anaemia prophylaxis /treatment Health education Nutrition counselling Danger signs during pregnancy

4th Visit (after 36 weeks) Record BP, weight Detect –Pregnancy induced hypertension Abdominal examination to identify foetal lie / presentation to detect IUGR Check for pelvic adequacy to rule out if head is bigger than pelvis in primigravida (first pregnancy) after 37 weeks. Update individualized birth plan with the trained birth attendant and family. Health and nutrition counselling, diet, rest, IFA tablet consumption, danger signs and where to go when any complication arises.

A properly maintained MCP card helps in tracking progress of the baby and mothers condition. During VHND, special effort should be made to do a complete antenatal check-up for all the pregnant women who are due for it. The observation on the fundal height, presentation of foetus, foetal movement, foetal heart rate has to be taken on each visit. The AWW has to take record of the date and observation during each antenatal visit. ANM also records observations in her register. All pregnant women should be asked to produce MCP card during their antenatal visits. While conducting ante natal check ups, the risk factors during pregnancy may be kept in mind. These risk factors includes Short statured women (less than 145 cm or 4 feet 10 inches), age less than 18 years or more than 35 years, history of any medical problem such as heart disease, diabetes, T.B., Malaria, anaemia and another medical problem, weight less than 38 kgs at first trimester, problems in previous pregnancy (bad obstetric history or previous caesarean section), Operative delivery-Still birth/ neonatal death in previous pregnancy, complicated delivery such as prolonged labour, retained placenta, antepartum and post-partum haemorrhage and sepsis. History of more than four deliveries, History of repeated abortions, Problems in present pregnancy like: Bleeding anytime during pregnancy, Abnormal presentation, Pregnancy induced hypertension, Severe anaemia, Twins, over-distended uterus, Floating head in primigravida at 38th week or later, very big or very small baby, Pre-term labour (earlier than 37 weeks), Height of uterus not corresponding to period of gestation, Sluggish/loss of foetal movement, Malaria in pregnancy

In order to take care of pregnant women, the AWW has to identify all pregnant women of the village. She has to ensure that all pregnant women are registered at the AWC. She has to facilitate in getting their four ante-natal check-ups. The AWW has to assist the ANM/ ASHA in the ANC check-ups.She has to ensure that all the women are registered under IGMSY to avail all ANC services. The AWW has to provide NHE to all pregnant women. She has to ensure that all pregnant women receive supplementary nutrition from AWC. The AWW has to ensure immunization of all pregnant women in coordination with ANM/ASHA. She has to mobillize all pregnant for the Village Nutrition and Health Day through SHGs, Mothers Committee, beneficiaries of the ICDS Scheme. She has to make home visits during pregnancy. The AWW has to counsel/advise the pregnant women and their families for institutional delivery and for promoting breastfeeding and Infant & Young Child Feeding Practices.

If there is no functioning health centre or hospital within reach, or the family prefers a home delivery, the AWW has to advise the pregnant woman and her family to have the delivery conducted at home by a skilled birth attendant (SBA) such as ANM, staff nurse or doctor. However, in case a skilled birth attendant is not available, the delivery can be conducted by a trained TBA. In case of home delivery, it has to be ensured that that five cleans are practiced during delivery i.e. clean hands, clean surface, clean new blade, clean cord tie and clean cord stump (do not apply anything on the stump) and place of delivery to be kept warm and free from dust. The mother has to initiate breastfeeding within one hour of birth

The ASHA has many roles and responsibilities to take care of pregnant women. She has to identify all pregnant women of the village and to help them in getting registered before 12 weeks of pregnancy and in getting the next three ante-natal check-ups. The ASHA has to ensure all requisite examinations/investigations are done for all pregnant women. She should know the date and time of availability of ANM in Anganwadi Centre (AWC) in the village during VHNDs and inform all pregnant women about the same. The ASHA has to advise all pregnant women regarding importance of balanced diet and ensure that all pregnant women receive supplementary food from AWC. The ASHA has to track the drop-out pregnant women especially those who live in remote areas, are below poverty line, schedule caste/schedule tribe/migrants etc. and help them in accessing health services. She has to help eligible pregnant women to get benefits under JananiSurakshaYojana. The ASHS

should know the location of nearest FRU/hospital with obstetrician, anesthetist, paediatrician, nursery, Operation Theatre (OT) and blood bank, the mode of transport to reach facility should there in emergency and the approximate cost for caesarean section, blood transfusion and hospital stay, if it is a private hospital. In case, it is second pregnancy, when a couple already has a daughter, ASHA needs to be alert on the possibility that the family may reject another daughter and counsel accordingly. The ASHA has to counsel/advise the pregnant women and their families for institutional delivery and she has to escort/accompany the pregnant woman to the hospital for institutional delivery. If there is no functioning health centre or hospital within reach, or the family prefers a home delivery, she should advise the pregnant woman and her family to have the delivery conducted at home by a skilled birth attendant (SBA) such as ANM, staff nurse or doctor. In case a skilled birth attendant is not available, the delivery can be conducted by a trained TBA. In case of home delivery, the ASHA has to ensure that five cleans are practiced during delivery i.e. clean hands, clean surface, clean new blade, clean cord tie and clean cord stump (do not apply anything on the stump), place of delivery to be kept warm and free from dust. She has to help the mother initiate breastfeeding within one hour of birth Pregnant women should be advised to register themselves for IGMSY benefits, if she resides in IGMSY districts. All pregnant women are at risk of developing complications. In some women these complications can occur without warning. It is important that the pregnant woman and her family be aware of the danger signs and be able to recognize these signs. Pregnant woman must also bring it to the notice of the family members, in case she develops any of the danger signs. If timely treatment is not sought, it can result in death or disability of the woman or child or both. A pregnant woman with danger signs should be taken to the FRU/hospital immediately. The identified first referral unit (FRU)/hospital means that it must have A gynecologist, facilities for blood transfusion, operation theatre and anesthetist, oxygen and life-saving medicines, X-Ray and laboratory diagnosis. One of the danger sign is any bleeding during pregnancy or excessive bleeding during/after delivery. Other danger sign is anemia during pregnancy , which leads to many other complications like heart failure at the time of childbirth, pre-term labour and infections during pregnancy).Women with severe anemia have pale eyelids, nails and palms. They may or may not have breathlessness. High fever is an indication of some infection in the woman. It can

be harmful for the growing baby. Convulsions or fits, blurring of vision, severe headache, sudden swelling of feet can occur during pregnancy, delivery or after delivery. A woman with these symptoms should be immediately taken to the hospital. If the woman has been in labour pain for more than 12 hours, she should immediately be taken to the hospital and should deliver in the presence of a doctor. In case the pregnant woman has bursting of water bag without labour pain, she should be immediately taken to the hospital and the delivery should be conducted in the presence of a doctor.

In order to prevent any complication, the pregnant women should be advised to contact ASHA/ANM/AWW, register under JananiSurakshaYojna (JSY), obtain benefits under JSY and IGMSY., identify a nearest functional PHC, CHC, or a District Hospital in advance which has all the necessary facilities for safe delivery, take support from the ASHA/ANM/AWW and the community resources to identify fastest means of transportation to the health facility. Make the necessary arrangements in advance. For the safety of the Mother and Child ensure that the mother stays in hospital for 48 hrs after giving birth As far as possible, delivery should be conducted in a hospital. If delivery is conducted at home, it should only be conducted by a skilled birth attendant (SBA) or an ANM. Women and newborn child can easily get infected during and after delivery. Pregnant woman/family should also try to get a disposable delivery kit (DDK) before delivery. DDK is available at all Government hospitals and health centres. If DDK is available, then it would contain clean blade and thread. The ANM has to follow five cleans. These are **Clean Hands** (Hands must be thoroughly washed with soap and water by the person before conducting the delivery. After washing, hands should be air dried and not wiped to avoid infection. Nails must be cut and bangles, rings etc. must be removed before washing hands), **Clean surface and surroundings** (**Clean Sheet-**The sheet on which woman plans to deliver must be washed with soap and water and dried in sun and **Clean Room**-The room in which delivery is planned should be freshly white-washed and cleaned thoroughly. Shoes/chappals should not be allowed inside) **Clean Blade** (The blade for cutting the cord must be new and unopened) **Clean umbilical cord -** Nothing should be applied to the cord to avoid risk of infection. And **Clean thread** (This must be washed with soap and water, then boiled for 20 minutes and dried in sun).

The family members of the pregnant women should be advised to ensure that the phone no. and contact details of the ANM are readily available with them. They have to contact

the ANM as soon as possible to ensure safe delivery. The family members have to ensure that the hands of the ANM and helper are clean and washed with the soap and water. They have to ensure that the place where the delivery is to be carried out and its surrounding areas are clean. The family members of the pregnant women that the blade for cutting the cord should be new/clean (preferably wiped with a disinfectant) and the umbilical cord is clean , A clean, new thread should be tied to the cord before cutting it. The newborn should be wrapped in a clean (washed with soap and water and sundried) set of soft cotton clothes. Women will have vaginal discharge (bleeding) for few days after the delivery. Only clean pieces of cloth/sanitary pads (washed and dried in sun) should be used. The family members should be asked by AWW to ensure that the delivery is conducted by a skilled birth attendant/ ANM.

Just after delivery, the AWW/ANM /ASHA has to ensure that breastfeeding is initiated within one hour of delivery/birth in both hospital and home delivery. She has to take necessary steps for family planning counseling - planning to the mother at the time of discharge to ensure adequate birth spacing. She should made aware the mother about the contraceptive alternatives.

Post-Natal Care of Nursing Mothers

A very high rate of infant mortality in India is further characterized by the fact that maximum infant deaths take place in the first week of life. It is, therefore, obvious that post-natal care is also an important aspect of health care system particularly in rural and tribal areas.

The first 42 days (6 weeks) after the delivery are considered the postnatal period. However, the first 48 hours, followed by the first week are the most crucial for the health and survival of the mother and new-born. Evidence show that more than 60% of maternal deaths take place during the postpartum period.

In case of institutional delivery, the hospital stay should be at least 48 hours, which provides a chance for postnatal care on 1st and 3rd day. First postnatal visit has to be made on Day 1, second on Day 3, third on Day 7 and fourth at 6th week. In case of institutional delivery, first and second visit should ideally happen at the facility. All postnatal visits to be recorded as per the columns of the MCP card and appearance of danger signs in mother are mentioned in the relevant column. Baby must be kept warm and breastfeeding initiated with one hour

of delivery. Proper cord care and perinatal hygiene is important to prevent infections in the mother and the baby. No diet restriction should be done for the mother. She should be provided with full and nutritious diet. Mother may need support for breast feeding; she should not hesitate to ask for it. Where and how to get benefits of the government scheme related to mother and child. If the child is less than 2.5 kg (low birth weight) three extra visits must be made as per protocol i.e., on 14^{th}, 21^{st} and 25^{th} day. Danger signs for both mother and baby have to be explained to the mother and the family. In case of any abnormality/appearance of danger signs, ANM/MO must be consulted. Nutritious diet and IFA supplementation should be continued throughout the postnatal period. MCP card should be produced during each PNC visit for the ANM to help in recording the parameters each time. Mother must use clean sanitary pad to prevent infection.

Besides undertaking post-natal home visits, efforts are to be made to persuade the mother to come to the clinic for post-natal examination of herself as well as of her infant 6 to 8 weeks after the delivery. The post-natal clinic provides the following services: general physical examination of the mother with special reference to the conditions of her breast, abdomen, perineum and pelvic organs to ensure that she has regained her general health and is fit to resume her normal work; physical examination of the child and advice on his health and nutrition requirements e.g. importance of breast feeding, infant care, immunization etc.; advice on family planning and motivating mothers to adopt suitable methods for spacing the next birth or for birth control if the size of the family is within norms; and Recording the findings of the post-natal examination and the acceptance of the family planning method on the ante-natal card of the mother.

Newborn Care Newborn care starts soon after the baby has been delivered. AWW has to explain it to the family to weigh the newborn baby at birth and start breast feeding within one hour after birth. AWW/ANM has to tell the mother to keep the new born baby warm. Do not bathe the new born baby for first 24 hours and low birth weight newborn babies for first 7 days because bathing can expose the baby to cold which can be fatal. Keep the cord of new born baby dry. AWW has to explain the importance of breast feeding for the first six months of life, the baby should be fed only mother's milk and nothing else, not even water. Do not give the baby prelacteals i.e., honey, gripe water, jaggery water, tea, cow's/goat's milk etc. to protect the new born from infections. Mother should keep away the baby from

people who are sick and give special care if the baby weighs less than 2.5 kg. AWW/ANM must explain that immediately after delivery, newborn should be cleaned with a soft, moist cloth and then wiped with a soft dry cloth. The baby must be kept close to mother's chest and abdomen. Baby should be wrapped in clothing depending on the season. The room should be warm enough and should be free from strong wind as the newborn has lived in a warm and protected environment in the womb and needs to be protected from cold after delivery. AWW has to explain to the mother that if she see any danger signs like weak sucking or refuses to breastfeed, baby unable to cry/difficult breathing, yellow palms and soles, fever/cold to touch, blood in stools, convulsions and if the baby is lethargic or unconscious, then the mother should seek help of health worker. The AWW has to tell the mother that after Immunization the reaction of vaccination like mild rash, fever or redness and swelling at the local site may develop. If it does not subside in 24-48 hours and keep increasing, see the health worker.

Children 0-6 Months

ANM/AWW has to explain to the mother to start breast feeding within one hour of birth. Do not discard the 'first milk' from the breast because it is very important and feeding first milk (colostrum) is rich in nutrients and protective factors that protect the baby from diseases. It is good for both baby and mother. The early skin to skin contact with the mother gives warmth to the baby and it helps in early secretion of breast milk. Breastfeed has to be done as often as the child wants, day and night, at least eight times in 24 hours. The baby should be held in correct position and be put to breast correctly to ensure optimal breast feeding and avoid feeding problems for the baby and the mother. ANM/AWW must tell the benefits of breast feeding to the mother that it helps womb to contract and the placenta is expelled easily and reduces the risk of excessive bleeding after delivery. AWW/ANM explains the family if the child seems slow, increase feeding, talking and playing. If the child is still slow, take the child to a doctor. AWW should educate the father to spend time with the child and plays with her/him and show his love. Feeding, playing and communicating with the children helps them grow and develop well.

Children 6 - 12 Months AWW/ANM has to describe the family about the importance of complementary feeding, which has to be started at the age of 6 months (180 days). The

child should be given small amounts of soft mashed cereal, dal, vegetables and seasonal fruits, as breast milk alone is not enough to meet the nutritional needs of the child for growth and development. The complementary feeding has to be started with the small amount of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding. Give variety of complementary foods in addition to breast milk, initially 2-3 times a day between the ages of 6-8 months, increasing the frequency to 3-4 times daily between 9-24 months with additional nutritious snacks offered 1-2 times per day as desired. Increase the amount of food gradually with 2-3 tablespoon of food at one time, increasing it to ½ katori (125 ml) at a time by 9-11 months and to 1 katori (250ml) by the end of 24 months. AWW/ANM must explain about feeding the child a variety of foods after 6 months of age for eg: Gruels made from roasted whole wheat flour, or flour of other cereals, or suji and milk., mashed potatoes, soft fruits like banana, mango and papaya and Soft cooked and mashed rice and dal etc. Tell the mother of the baby to Introduce one type of food at a time to allow the baby to develop taste for it. If the child develops an allergic reaction to a specific type of food, it can be stopped. She has to educate the mother or family about Good complementary foods that are: rich in nutrients food which are not too spicy or salty, easy for child to eat, liked by the child and locally available and affordable .Increase the quantity, frequency and thickness of food gradually. Foods rich in micronutrients especially iron and Vitamin A must be given to the child. AWW/ANM describe that how to feed the baby safe food: by cleaning the food before cooking and feeding ,cooking the food thoroughly, Use safe water & fresh ingredients ,feed freshly prepared food and Store food in cool temperature. Mother should understand child's signals for hunger and respond accordingly Mother must continue breastfeeding during illness. The child needs extra food after illness so feed enough to the recovering baby .Always use iodised salt for the family and in baby's food.

Children 1 – 2 Years AWW and ANM has to explain to the mothers that they should continue to offer a wide variety of foods such as rice/chapatti, pulses, green leafy and other vegetables, yellow and other foods, milk and milk products, meat, fish and eggs. The child needs be given Iron rich foods and Vitamin A rich foods. The child should be given complementary nutritious foods that s/he can hold and eat. This helps the child remain interested in food. Good complementary foods are Nutritious, rich in energy, proteins,

vitamins & minerals, not spicy, not salty, easy for child to eat, liked by the child, locally available and affordable. The Anganwadi worker has to explain to the mothers that they should feed the child about five times a day (3-4 meals + 1-2 extra snacks/day). Feeding the child from a separate bowl should be advised so that mother/caregiver can watch how much food the child actually eats. The child should be offered food from the family pot. Mothers need to give at least 1 katori (250 ml) at each serving (5-7 times per day) of: Mashed roti/rice/bread mixed in thick dal with added ghee/oil or khichdi with added oil/ghee. Add cooked vegetables also in the serving Or Mashed roti/rice/bread/biscuit mixed in sweetened undiluted milk Or Sevian/dalia/halwa/kheer prepared in milk or any cereal porridge cooked in milk Or Mashed boiled/vegetables like pumpkins, green leafy vegetables etc. Fruits like banana/ chikoo/mango/papaya, which can be easily mashed.

The AWW must explain to the mothers that the child should also be allowed by the mother/caregiver to feed himself/herself using a spoon. However, children at this age still need help to eat. They eat slowly and easily get distracted. Caregiver should continue to sit with the child and actively feed the child. The child should be continued to be breast fed as long as s/he wants. Breastfeeding should be continued during illness. The child needs extra food after illness. It should be suggested to always use iodized salt for the family. If the child is given animal milk or any other drinks including water, it should only be given by cup, not by bottle. The AWW and ANM should also give tips about hygienic practices that mother/Caregiver should wash the hands before handling and serving child's food. The child's hands should also be thoroughly washed with soap and water before meals. Caregiver should wash hands with soap or ash after washing the baby who has defecated, and after the baby's excreta has been disposed. Caregiver should keep the floor and play area of children clean by keeping it free of urine and excrement of farm animals and humans.

AWW/ANM should explain to the mother or caregiver that feeding, playing, and communicating with the children helps them grow and develop well and should encourage activities that they can do for the development of their child . Like Give your child things to stack up and put into containers and take out. The child likes to put things into cans and boxes, and then take them out. S/he also likes to stack things up until they fall down. Mothers can give the child safe things to play with and encourage him/her to learn new

skills by playing with the child and offering help. Give your child things to stack up, and to put into containers and take out: Sample toys: Nesting and stacking objects, container and cloth clips. Mothers/caregivers should use every opportunity (e.g. while feeding or bathing the child) to make conversations with the child.

Children 2 - 3 Years

AWW/ANM should tell mother/caregiver to give family foods at 3 meals each day. Also, twice daily, give nutritious food between meals, such as: Banana/ biscuit/ chikoo/ mango/papaya/kheer/pakora as snacks. Give 3/4 to 1 katori (250 ml) in each meal. It has to be explained that children at this age like some foods and dislike others. This may be a problem because children need a variety of foods for good nutrition. Caregiver should encourage the child to try new foods by showing that s/he likes the food. If a new food is refused, small amounts as "tastes" should be repeatedly offered over several days. The child may eventually start accepting the new food. Forcing a child to eat is never a good idea. Mother should be encouraged to supervise the child's feeding. The child should be encouraged to eat at the same time every day as it helps the child have a good appetite and eat more, eat in the same place to avoid distractions and eat herself/himself. AWW and ANM should also give tips about hygienic practices to mother/Caregiver that the child's hands should also be thoroughly washed with soap and water before meals before s/he sits to eat, caregiver should guide the baby to defecate in one place, preferably in a safe latrine or in a small dug pit and the excreta is covered with ash or soil to prevent odor and flies. Caregiver should wash hands with soap or ash after washing the baby who has defecated, and after the baby's excreta has been disposed and caregiver should keep the floor and play area of children clean by keeping it free of urine and excrement of farm animals and humans. AWW/ANM should explain to the mother or caregiver that feeding, playing, and communicating with the children helps them grow and develop well and should encourage activities that they can do for the development of their child.

Diarrhoea

AWW/ANM has to explain to mothers that during diarrhea they should breast feed more frequently and for longer time at each feed, give increased amounts of fluids during diarrhea. If the child is less than 6 months old, exclusively breast fed, give ORS in addition to breast milk. If the child is over 6 months of age, give ORS as well as home available fluids like

rice kanji (mand), Buttermilk (lassi), lemon water with sugar and salt (shikanji), dal soup, vegetable soup, fresh fruit juice (unsweetened) plain clean water or other locally available fluids. Give as much fluids as the child can take. Extra fluids prevent dehydration due to diarrhoea. Always feed from a cup or spoon. Never use a bottle. Child should be given an extra amount of fluid each time s/he passes stools, in addition to the usual fluid intake. Continue to give normal diet to the child**.** In case the child is not able to take the normal quantities of food, s/he should be given small quantities of food at frequent intervals. Child can also be given foods of thicker consistency such as Khichdi, Dalia, suji or rice in milk, idlietc. If loose motions do not stop, take the child to the health centre.

Acute Respiratory Infection

AWW/ANM has to explain to mothers that during respiratory infection they should keep the young child warm and away from the dust, If the child's nose is blocked and interferes with feeding, clean the nose by putting in nose drops (boiled and cooled water mixed with salt) and by cleaning the nose with a soft cotton wick. Breastfeed frequently and for longer period, at each feed, exclusively breastfeed for six months Continue to give normal diet to the child. In case the child is not able to take the normal quantities of food, s/he should be given small quantities of foods frequently. Child can also be given foods of thicker consistency such as Khichdi, Dalia, sooji or rice in milk, idli etc.)Small quantities of oil/ghee should be added to the food to provide extra energy. After the illness, at least one extra meal should be given to the child for at least a week to help the child in speedy recovery. Give increased amounts of fluids. Give extra fluids (as much as the child will take) such as: dal soup, vegetable soup, plain clean water or other locally available fluids. Always feed from a cup or spoon. Never use a bottle. For babies over six months of age, soothe the throat and relieve the cough with a safe homemade cough remedy (made into a tea) such as- Sugar, ginger, lemon, tulsi leaves- Sugar, ginger, lemon, mint- Saunf, elaichi, ginger

Pregnant mothers and children with problems requiring specialized treatment has to be referred by the Anganwadi worker, ANM or LHV to the PHC/upgraded referral hospitals. A bad obstetric history in previous pregnancy is an indication for referral to a higher health facility, where further antenatal check-ups and the delivery can be conducted. The cases needing further attention or treatment have to be referred by the Medical Officer of PHC/Referral Hospitals to the Taluk/City/District Hospital as the case may be. The MO

Incharge PHC will refer such cases with a referral card prescribed for the purpose. In case of an urban project the MO Incharge of project health unit has to refer cases to the appropriate health clinic/hospital. The hospital after completing the treatment has to refer the mother/child back to the PHC/Urban Health Unit with notes of the treatment given and further treatment/advice to be followed. The flow of referral thus, , therefore, be both up and down the hierarchical ladder consisting of the Anganwadi Centre, ANM Sub-centre, PHC/Urban Health Clinic, District/City Hospital. Depending on seriousness of the disease or sickness the referral may jump over intermediate steps in the ladder.

During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are referred to the Primary Health Centre or its sub-centre. The anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer of the Primary Health Centre/ Sub-centre. For example, need for referral might arise when: a child develops severe diarrhea, passes more than 10 stools a day, does not pass urine for 6 hours and pulse is rapid and breathing rate is more than 50 per minute; a patient has high fever (104°F) for more than 4 hours inspite of treatment or has fever with fits; a patient has skin infections or scabies and starts getting fever or when boil starts growing big with spreading of fed area around it and forming of pus; a patient has malaria and is not responding to treatment;

a child has whooping cough with fever and loss of weight continues inspite of the treatment; a child is severely malnourished and refuses to eat; and a child with severely wrinkled eyes and other manifestation of Vitamin 'A' deficiency. when a woman is identified as a case of high risk pregnancy and develops complication like toxemia characterized by swelling of legs and feet and high blood pressure; pain in abdomen continues with vomiting; a woman or a child has met with a serious accident; a child discovered with congenital defect or residual chronic disabilities. if child has sore eyes and the eyes do not start getting better in 2 days of treatment.

The scheme of referral has to function effectively to be purposeful. The State / Union Territory Health Department has to identify the district/Taluk's city hospital which has to function as the first referral hospital for the ICDS project area. At the PHC level it is suggested that the day and time for attending to referral cases should be fixed and

communicated to the staff. It is also necessary that sufficient stock of therapeutic food is available with the PHC / Urban Health Centres to treat cases of severely underweight children. There should also be an adequate follow up of cases given specific treatment. Referral services should be so developed as to elicit good response from the community. The difficulties, procedural or otherwise, faced in referring the cases should be listed so that these are brought to the notice of higher level authorities and resolved.

For availing referral services the funds available with NRHM may be utilized. It is suggested that where the family is indigent and not in a position to meet the expenses for taking the patient to the PHC or referral hospital, the Panchayats or other local bodies or local organizations may bear the cost of transportation and such other expenditure. At the same time efforts should be made to motivate concerned parents to take children or pregnant women to such centers despite difficulties faced by them.

All pregnant women are at risk of developing complications. In some women these complications can occur without warning. It is important that the pregnant woman and her family be aware of the danger signs and be able to recognize these signs. Pregnant woman must also bring it to the notice of the family members, in case she develops any of the danger signs. If timely treatment is not sought, it can result in death or disability of the woman or child or both. A pregnant woman with danger signs should be taken to the FRU/hospital immediately. The identified first referral unit (FRU)/hospital means that it must have A gynecologist, facilities for blood transfusion, operation theatre and anesthetist, oxygen and life-saving medicines, X-Ray and laboratory diagnosis.

One of the danger sign is any bleeding during pregnancy or excessive bleeding during/after delivery. Other danger sign is anemia during pregnancy , which leads to many other complications like heart failure at the time of childbirth, pre-term labour and infections during pregnancy).Women with severe anemia have pale eyelids, nails and palms. They may or may not have breathlessness. High fever is an indication of some infection in the woman. It can be harmful for the growing baby. convulsions or fits, blurring of vision, severe headache, sudden swelling of feet can occur during pregnancy, delivery or after delivery. A woman with these symptoms should be immediately taken to the hospital. If the woman has been in labour pain for more than 12 hours, she should immediately be taken to the hospital and should deliver in the presence of a doctor. In case the pregnant woman has

bursting of water bag without labour pain, she should be immediately taken to the hospital and the delivery should be conducted in the presence of a doctor.

NUTRITION AND HEALTH EDUCATION: Their Importance

The Nutrition and health education component of the ICDS scheme aims at effective communication of certain basic health and nutrition messages with a view to enhancing the mother's awareness of the child's needs and her capacity to look after these within the family environment. Nutrition and health education is required to be given to all women in the age group 15-45 years and other members of the family. A special follow up has to be made of mothers whose children suffer from malnutrition and from frequent illness.

The Nutrition and health education is of crucial importance as the problems of ignorance, ill-health and malnutrition go hand-in-hand. The need for such education is greatest and most urgent for poorer and vulnerable sections of the community. Successful health and nutrition programme can bring greater and lasting returns in terms of improved health and nutritional status of women and children. Further, a relatively small investment in this vital service can lead to saving much larger investment in supplementary feeding and health services.

Need for Child Care Education

In the context of ICDS, child care education is the core of health and nutrition education, and the objective of such education is not to impart knowledge but to reinforce or change behavior and practices related to child and maternal care. As such the education has to be relevant to the social, economic and cultural conditions of the people, their perceptions and needs and the opportunities they have for meeting them. Poverty, ignorance and unhygienic environment often compounded with superstition about the nature and amount of food to be given to young children lead to malnutrition and disease. Large families, and especially closely spaced families, further aggravate the problem. Health and Nutrition education to be imparted in the project area must be relevant to this context. It must be concerned with the nature and amount of food to be given to young children both in sickness and in normal condition; simple means of preventing and coping with infectious diseases. The messages for nutrition and health education should be simple and straight forward, relevant i.e. based on the felt needs of the people, easily understood practicable and easy to adopt.

Guidelines on Child Care Education

:Breast feed as long as possible. Introduce semi-solid food from 6 months. Feed young children 5 or 6 times a day. Do not reduce food in illness. Use the health services available. Get children immunized. Keep yourself and your surroundings clean, drink clean water. Have no more than two or three children, two to three years apart: *PregnantMother e*ats more than usual amount of cereal and pulse, plenty of dark green and yellow vegetables, milk; and Visit PHC doctor / ANM during last three months of pregnancy.

*New Baby*Mother's milk is best – don't discard colostrum. If you feed additional liquid, use traditional feeding vessel instead of a bottle ensuring that it is cleaned properly. *Keep Breast feeding* the child as long as possible, but breast milk is not sufficient by itself from the age of 6 months. *Mothers breast feeding the child* Mother should eat more than usual amount of cereal, pulse, and plenty of dark green and yellow vegetables and fruits and milk; Visit the doctor / ANM for check-up. Start semi-solid food (local staple or mashed up ready food) from 6 months, and also undiluted milk, if you can. Food must be prepared carefully. Give what you would normally give later much earlier as raw vegetables and fruit. A child grows the amount and variety of food should be increased. By the time he/ she is one year old he/ she should be given similar food as are given to the rest of the family-cereals, pulse, green vegetables. He/ She should be fed these solid food 3 or 4 times a day without spices. Do not use excessive water for cooking rice and vegetables; if you drain the water after cooking do not discard it; it is good for you and should be consumed. To prevent the child getting some diseases, he/she should be immunized. To prevent him/ her from getting other diseases he/ she should be clean and his/ her surrounding should be as clean as possible. Do not spit or cough at or near him/ her. Do not let excreta lie around where your baby may be playing. Remove it quickly. After he defecates, wash him clean with soap and wash your hands. Your child may get sick if he/she puts dirty hands in his/ her mouth. Hands should be washed before eating and before preparing food, and before holding and feeding the baby. Kitchen and feeding utensils should be kept clean and should be washed with clean water. Flies mean dirt means disease. Food should be covered from flies and dust. A Child needs plenty of water. Only the safest available water should be drunk. Learn to recognize signs of common diseases: cough, dehydration, fever, running ear, skin diseases, sore eye, poor sight. Learn their management and how to deal with accidents in the house, and when to

need advice from ANM. When the child is ill with fever or diarrhea continue feeding him/ her as before, but you may have to prepare the food more appetizingly. You may have to force him/ her a little. He/ She will get better quickly if he/ she eats plenty of cereal, pulse and vegetables (Give examples of particular cereals, pulses, vegetables and methods of their preparation).

Encourage the child to play with simple household article and things he/ she can gather in the neighborhood. Children cared for in this way are likely to be alert, and would grow well.

Children cared for in this way are likely to survive than those who are not. You may not then want so many children; family planning can show you how to achieve this as also to space children.

So we see that the asha, aww, anm plays a very important role in this society. This helps in the development of the modern society which can tackle the health issue and we can march to the goals set by our PM.

For a better tomorrow we must all work towards the ideas given by our Prime Minister

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