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## Antenatal and Perinatal Care in an ICDS Area: Progress Made in 19 Years

ICDS program has made significant improvement in availability and utilization of antenatal and natal care including IFA supplementation, TT administration and delivery by trained personnel. However, postnatal care and promotion and initiation of breastfeeding within 2 hours of birth still remain deficit areas.

**Key words:** Integrated Child Development Services

The Integrated Child Development Services (ICDS) scheme was initiated in the year 1975 and later it became the largest Governmental programme for mother care and child development. The beneficiaries included children (0-6 yr), expectant & lactating mothers, and women aged 15-45 years. Facilities provided were supplementary nutrition, immunization, non-formal education of preschool children, functional literacy of the women, and essential health care and health surveillance [1]. We had studied the utilization and availability of antenatal and perinatal care in 1991 [2]. To evaluate the progress made in availability and change in utilization patterns of the services over a period of about 2 decades, we conducted this study during 2009-2010. We visited the same ICDS block (Chaksu, District Jaipur, Rajasthan) as in previous study and door to door survey of all lactating mothers was done using similar questionnaire [2]. Lactating woman was defined as one who had delivered a child (living or dead) within the last 12 months and was not pregnant again during the same period.

**Table I** shows the comparative data in year 1991 and 2009-2010. Overall, significant improvement in delivery and coverage of services in ICDS scheme were observed in terms of coverage of antenatal care (72.8% vs 97.8%), Tetanus Toxoid (TT) administration (68.4% vs 97.8%) and Iron Folic acid (IFA) supplementation (50% vs 87%) during pregnancy, institutional deliveries (4.4% vs 57.7%) and breastfeeding practices (initiation of breastfeeding within 6 hours of child birth, 17.25 vs 81.9%). However,

**TABLE COMPARISON OF THE DATA FROM 1991 AND 2009-10**

	1991 N=136 (%)	2009-10 N=182, (%)
Age <18 yr	3 (2.2)	3 (1.7)
Age 18-35 yr	127 (93.4)	175 (96.2)
Age >35 yr	6 (4.4)	4 (2.2)
ANC received	99 (72.8)	178 (97.8)
<i>First ANC</i>		
First trimester	15 (11)	103 (56.6)
Second trimester	54 (39.7)	64 (35.2)
Third trimester	30 (22.1)	11 (6.0)
<i>Number of ANCs</i>		
1-3 times	84 (61.8)	124 (69.7)
4-5 times	02 (1.5)	42 (23.6)
≥6 times	13 (9.6)	12 (6.7)
<i>Receipt of Tetanus Toxoid</i>		
Two doses	90 (66.2)	178 (97.8)
One dose	3 (2.2)	0
Not received	43 (31.6)	04 (2.2%)
<i>Antenatal supplementation</i>		
Regularly	46 (33.8)	140 (76.9)
Irregularly	22 (16.2)	19 (10.4)
Nil	136 (50)	23 (12.6)
<i>Place of delivery</i>		
Sub center	2 (1.5)	30 (16.5)
PHC	4 (2.9)	12 (6.6)
Private Hosp	16 (11.8)	26 (14.3)
<i>Hosp</i>	6 (4.4)	105 (57.7)
Other	1 (0.7)	0
<i>Home</i>	107 (78.6)	09 (4.9)
<i>Postnatal care*</i>		
Untrained dai	0	0
Trained dai	0	0
ANM	3 (2.2)	02 (1.1)
LHV	0	0
Medical officer	12 (8.8)	117 (64.3)
Other	1 (0.7)	0
Total received care	16 (11.7)	119 (65.4)
<i>Initiation of breastfeeding</i>		
Within 6 hours	23 (17.2)	149 (81.9)
6-48 hours	74 (54.5)	21 (11.5)
>48 hours	39 (28.3)	05 (2.7)
Died		7 (3.8)

\*0-10 days after birth

early marriage and child birth were still a problem as 2.2% mothers were younger than 18 years in 1992 as well as 2010. The norm of having two children is not yet established as 29% mothers were having 3 or more children in year 2009-10, which also suggests inadequacy of birth control measures.

There are many other areas where improvement was suboptimal like first ANC visit in first trimester, >3 ANC visits, ANC as well as TT at all, and not receiving IFA supplementation. However, these data were better as compared to national figures reported by Government of India where 11.5% pregnant mother did not receive ANC and 26.5% did not receive TT [1] and also in the report from Rajasthan (2010) only 55% pregnant women received TT [3]. Postnatal care was a relatively weak area of ICDS project as only 65.4% mothers received postnatal care as compared to national data where 87% received PNC [3,4]. Postnatal home visits in initial 2 days after delivery has been shown to reduce neonatal mortality rate; hence, it is very important to improvise this [4]. There was increasing trend to have antenatal, natal and postnatal services from medical officers and home deliveries were significantly reduced from 78.6% in 1992 to 4.9% in 2010. However, the progress made in many areas were also due to additional efforts made as part of Janai Suraksha Yojna in National Rural Health Mission, which has its primary focus on institutional deliveries.

To conclude, ICDS program has made significant improvement in many areas but a lot need to be done for improvement in postnatal care, promotion and initiation of breastfeeding within 2 hours of birth.

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## Non-alcoholic Fatty Liver Disease in Children

A cross sectional study was conducted in 100 children, aged 5 to 12 years, to find the prevalence of non-alcoholic fatty liver diseases (NAFLD), at New Delhi. Those with fatty liver on ultrasonography with no apparent etiology, were labeled as NAFLD. Three (3%) children had evidence of fatty liver on ultrasonography.

**Key Words:** *Non alcoholic fatty liver disease (NAFLD), Prevalence, Ultrasound.*

**N**on-alcoholic fatty liver disease (NAFLD) is characterized by hepatic fat accumulation (steatosis) with no apparent etiology [1]. The risk factors for NAFLD are obesity, insulin resistance and genetics. In adults, 15-20% of obese and 2-

3% of lean individuals have steatohepatitis [2]. We intended to find out the prevalence of NAFLD in children visiting Holy Family Hospital, New Delhi, between June 2007 to December 2008.

One hundred children aged 5 to 12 years were included. Children with malnutrition, acute or chronic liver disease, history of hepatotoxic drug intake and those receiving total parenteral nutrition were excluded. All children underwent anthropometry (height, weight, body mass index (BMI) and waist to hip ratio) and an ultrasound of the abdomen. The diagnosis of fatty liver was based on ultrasonographic findings of hepatorenal echo contrast, bright liver, deep attenuation, and vessel blurring [3]. Further evaluation of these children included liver transaminases, lipid profile, hepatitis B surface antigen, anti-Hepatitis C antibodies, fasting blood sugar, serum ceruloplasmin, and urine for reducing substances. The