

preterms. One preterm infant (30 wk, HMD) had shown stage 1 ROP and the other two had retinal hemorrhages. All of them recovered without any residual lesions and the retina was reported to be normal at 12 weeks of corrected age. BAER done were normal in all infants.

Thus, most of the survivors of neonatal ventilation had a normal development between 6-12 months age. A better developmental outcome of inborn infants strongly suggests that until specialized neonatal transport services are developed, the aim must be to anticipate the neonatal problems and carry out intramural transfer. Infants must be followed up till at least six months of corrected age and preferably longer to evaluate their development. This pilot study would require a larger number of babies followed before our findings can be generalized in the Indian setting.

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Nutrient Intake and Consumption of Supplementary Nutrition by Pregnant Mothers in ICDS and Non-ICDS Areas - A Pilot Study

The Integrated Child Development Services (ICDS) scheme is being implemented in 3701 projects of the country(1). The scheme delivers a package of services to mothers and children. An important component of the package of services is delivery of supplementary nutrition (500 kcals and 18-20 g of protein) to the pregnant mothers during the second and third trimester of pregnancy.

Studies conducted under controlled

supervised trials have documented that the supplementary nutrition when being provided to the pregnant mothers (additional 500 Kcal) improves the birth weight of the newborn(2-6). On the other hand no significant differences have been observed in the birth weight of the newborn between the supplemented and the unsupplemented group of pregnant mothers(7). However, we do not have data on the actual consumption of supplementary nutrition provided to the pregnant mothers in the field conditions of a National Nutrition Programme.

We conducted a pilot study in which 174 pregnant mothers registered as beneficiaries for receiving supplementary nutrition in an ICDS project in the National

Capital Territory of Delhi and 51 pregnant mothers in a neighbouring Community Development Block (non - ICDS area) were included. The socio-economic status of the families was assessed according to the Kuppusswamy scale and it was found that 52.9% of the families belonged to the low socio-economic category. There were no significant differences among pregnant mothers in the two areas.

Data regarding dietary intake of the subjects was obtained by trained nutritionists utilizing the twenty four hour recall method. The raw amounts of food used for cooking for the family, the total volume of food cooked for the family, and the volume of food consumed by the pregnant mother was inquired by demonstrating standardized utensils. Raw equivalents of cooked food consumed by the pregnant mother were calculated from the above procedure[^]). Nutrient intake was calculated by using a database derived from Indian food composition tables⁽⁹⁾.

The nutrient intake of the pregnant mothers in ICDS and non-ICDS areas has been depicted in *Table I*. The caloric intake of the pregnant mothers in the ICDS areas in the first, second and third trimesters were 1046, 1330 and 1333 Kcals, respectively. In the non-ICDS areas the caloric intake was 1241, 1049, and 1240 Kcals in the first,

second and third trimesters, respectively. An earlier study also reported a caloric intake of 1400 Kcals of pregnant women of low income groups⁽¹⁰⁾. It was found that apart from energy intake during second trimester, there were no significant differences between the calories and protein intake of the pregnant mothers in the ICDS and non-ICDS areas.

It was found that only 24% of the pregnant mothers registered for supplementary nutrition, actually collected/received supplementary nutrition. Of those who collected only 11% consumed 75-100%, and 36% less than 50% of the supplementary nutrition. All the pregnant mothers shared the supplementary nutrition. About 42% of them shared more than 75% of the supplementary nutrition with their family members. The primary reasons for non-acceptance of supplementary nutrition monotonous of the supplements provided.

Earlier studies have made general observations that the supplementary nutrition provided to the beneficiaries usually becomes a replacement meal or is shared by other family members⁽¹¹⁻¹⁵⁾. However, the actual quantity of supplementary nutrition consumed has not been documented. The present study has assessed the same.

The pilot study highlights a need of un-

TABLE I—Energy and Protein Intake of Subjects in Different Trimesters of Pregnancy

Trimester	Energy intake (Mean ± SD) (kcal)		Protein intake (Mean ± SD) (g)	
	ICDS (n=174)	Non-ICDS (n=51)	ICDS (n=174)	Non-ICDS (n=51)
I	1406±337	1241±713	44.9±33.7	41.6±24.9
II	1330±549	1049±515*	42.3±19.2	34.4±19.9
III	1333±449	1240±487	43.8±15.6	40.7±20.5

* p < 0.05

dertaking a detailed study on the actual consumption of supplementary nutrition and identifying possible remedial measures to ensure that all the pregnant mothers consume supplementary nutrition so that it has a positive impact on the birth weight of the newborn.

Since food supplement is an expensive component of the ICDS scheme and because it is not being utilized adequately by beneficiaries, it may be better to target it only to the vulnerable areas with chronic food shortages.

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