Internship
at
ICDS, Gujarat

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MBA Hospital & Health Management
2013-2015

Institute of Health Management Research,
Jaipur
2015

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1.1 Introduction:

Internship training is an integral part of the MBA (Hospital and Health Management) second year program, where we have to observe and learn the work culture of the organization. Also it will be necessary to participate in various department/activities so that we get first hand exposure of the different departments and work done in the organization and through which we can understand process of work and thereafter be able to involve in decision making.

I am appointed as District Programme Coordinator, by Integrated Child Development Scheme (ICDS) at Tapi District of Gujarat, INDIA. The focus of the organization is to reduce child malnutrition by providing supplementary nutrition and health-checkup.

1.2 Objective of Internship

a) To understand the work pattern of ICDS Tapi, Gujarat and its organizational structure.
b) To understand the structure and operations of the organization.
c) To learn various managerial and administrative skills needed to work in a government system
d) To ensure effectively implementation and coordinate proper functioning of child health programmes in the State.
e) To identify existing gaps in human resource, service delivery, quality, data collection, analysis and implementation of child health programmes in the district and to propose probable solutions to them.

The key responsibilities assigned by the organization are:

- Assist the program officer-ICDS matters related to overall management of human and financial resources
- Provide managerial support to district and peripheral level programme and grassroot functionaries
- Provide expert technical inputs in planning, implementation and documentation of child health and nutrition programmes
- Coordinate and liaise with other consultants at State/District level, various department of the state government, Ministry of women and child development.
- Provide necessary support to technical consultants appointed at state level and field level during their filed visits.

- Analyze physical and financial progress report and take corrective measures for improving output.
- Monitoring of district specific interventions for prevention of malnutrition in the district
- Carry out need assessment of nutrition related training and plan training activities in association with training institutes.
- Undertake visits to district for providing technical support and suggest measures for improvement

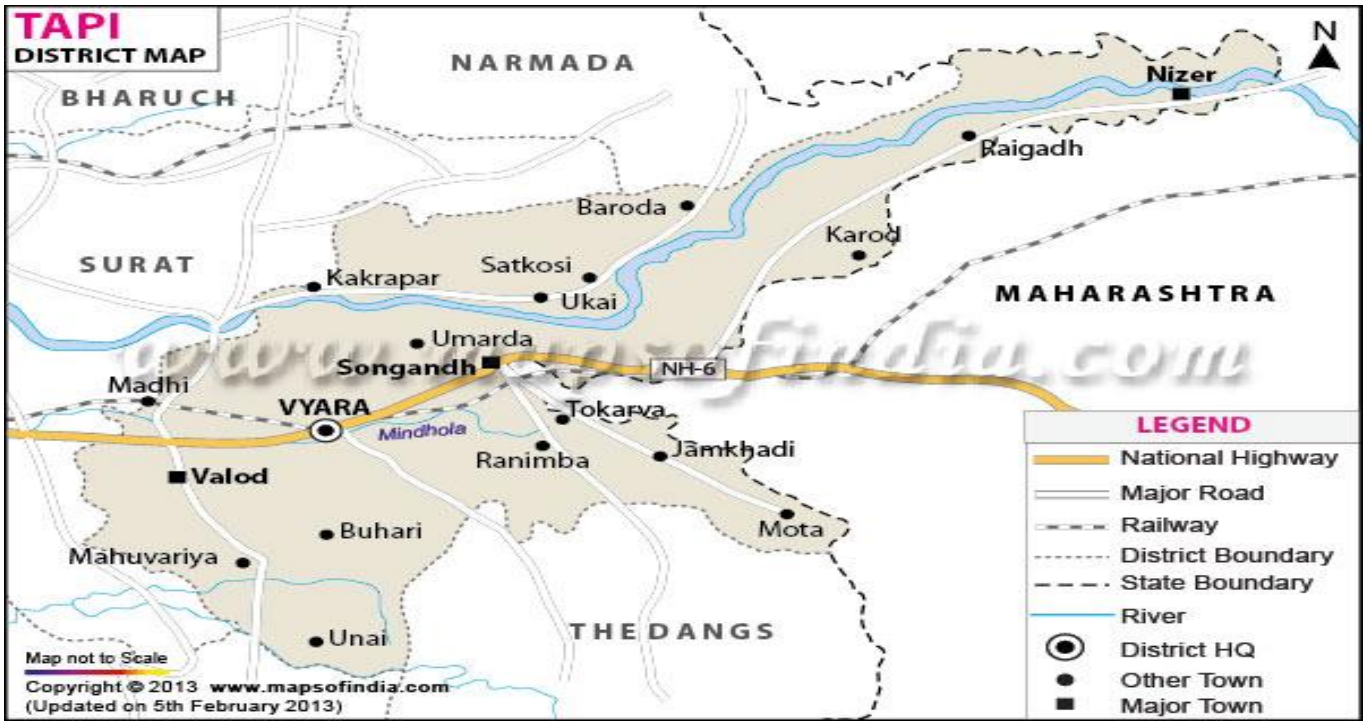
Provide technical support for preparation of IEC material and review implantation if IEC material

1.3 State Profile: Gujarat

Gujarat is located in the western part of India has an area of 196, 022 sq. km, representing about 6.19 percent of the total area of the country. The state has a population of 6.03 crore (2011 Census), which is nearly 5 percent of the total population of the country. About 43% of the State's population resides in urban areas, compared to the India average of 28 percent. The population density of the state is 258 as compared to the national average of 324. Socio-economic indicators are, in general somewhat better than the India average: 70 percent and 59 percent of its total and female population respectively are literate, the corresponding figures for India being 65 percent and 54 percent respectively. The state has a relatively large (40% of its population) work force.

Communities living in the remote and disadvantaged areas especially BPL population, tribal communities and women, are generally unable to access reliable and cost effective health care services. Approximately 18% (89, 96,744) of the total population of the state is living in these Tribal districts. Administratively, the state has been divided into 26 districts, sub-divided into 225 Blocks, having 18618 villages and 242 towns. It has a large three-tier health infrastructure comprising 24 district hospitals, 273 Community Health Centre (CHCs), 1158 Primary Health Centre (PHCs) and 7274 Sub-Centers (SCs). As per RHS 2006, 907 doctors at PHC's, 84 specialists at CHCs, 616 male and 862 female health (LHV) assistants are positioned in these facilities in addition to 2773 male and 6508 female health workers at sub-centers.

District Profile: Tapi



Tapi is Located in the southern part of Gujarat formerly part of Surat district. On 27 September 2007, the district of Surat was bifurcated into two new districts by Government, viz. Surat district with its headquarters at Surat and Tapi district with its headquarters at Vyara. It consists of five talukas viz. Valod, Vyara, Songadh, Uchchal, Nizar. According to the 2011 census, Tapi district has a population of 807,022; with population density of 234 inhabitants per square kilometer (610/sq mi). Its population growth rate over the decade 2001-2011 was 12.07%. It has a sex ratio of 1007 females for every 1000 males. It had a literacy rate of 67.7% in 2001 which increased to a literacy rate of 75.80% in 2011 (Source: Census, 2011)

Socioeconomic and demographic indicators in the district, 2011 Census

INDICATORS	STATUS		
POPULATION	**MALE**	**FEMALE**	**TOTAL**
Total	402188	404834	807022
Urban	40640	38847	79487
Rural	361548	365987	727535
LITERACY FOR:-+ 7	61.16%	75.44%	
SEX RATIO			
Over All			1007
0 – 6 Years			953
POPULATION DENSITY			
Overall 2011	257 KM^2	-	-
Overall 2001	222 KM^2	-	-

1.4 About the Organization

Integrated Child Development Scheme was launched on 2nd October, 1975. It is a centrally sponsored scheme of the Ministry of Women and Child Development. It is one of the world's largest and most unique programme for Early Childhood Development .It aims to reduce malnutrition rates, morbidity and mortality among children as well as to provide pre-school education and health education.

ICDS is foremost symbol of India's commitment to her children – India's response to the challenge of providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality on the other.

Its basic objectives are:

- To improve the nutritional and health status of children(0-6 years)
- To lay the foundation for proper psychological, physical and social development of the child.
- To reduce the incidence of mortality, morbidity, malnutrition and school dropout.
- To achieve effective co-ordination of policy and implementation amongst the various departments to promote child development.
- To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

1.5 Services provided by ICDS

ICDS scheme provides an integrated package of services to its beneficiaries namely children below six years of age, adolescent girls and pregnant and lactating mothers.

There are six services of ICDS scheme which are provided by Anganwadi centers:

1. Supplementary Nutrition
2. Immunization
3. Health check-up
4. Referral services
5. Non-formal Preschool education
6. Nutrition and health education

Supplementary Nutrition

This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. They avail supplementary feeding support for 300 days in a year. By providing supplementary nutrition, Anganwadi centres attempts to bridge the caloric gap between the recommended daily allowance and average intake of children and women in low income and disadvantaged communities. Growth Monitoring and nutrition surveillance are two important activities that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to detect growth faltering and helps in assessing nutritional status. Besides, severely malnourished children are given special supplementary feeding and referred to medical services.

Immunization

Immunization of pregnant women and infants protects children from six vaccine preventable diseases-poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles.

Health Check-Up:

- Record of weight and height of children at periodical intervals
- Watch over milestones
- Immunization
- General check up for detection of disease
- Treatment of diseases like diarrhea, ARI
- Deworming
- Prophylaxis against vitamin A deficiency and anemia

Referral Services

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.

Non-formal Pre-School Education

Program for the three-to six years old children in the anganwadi is directed towards providing and ensuring a natural, joyful and stimulating environment, with emphasis on necessary inputs for optimal growth and development. The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. It also contributes to the universalization of primary education, by providing to the child the necessary preparation for primary schooling and offering substitute care to younger siblings, thus freeing the older ones – especially girls – to attend school.

Nutrition and Health Education

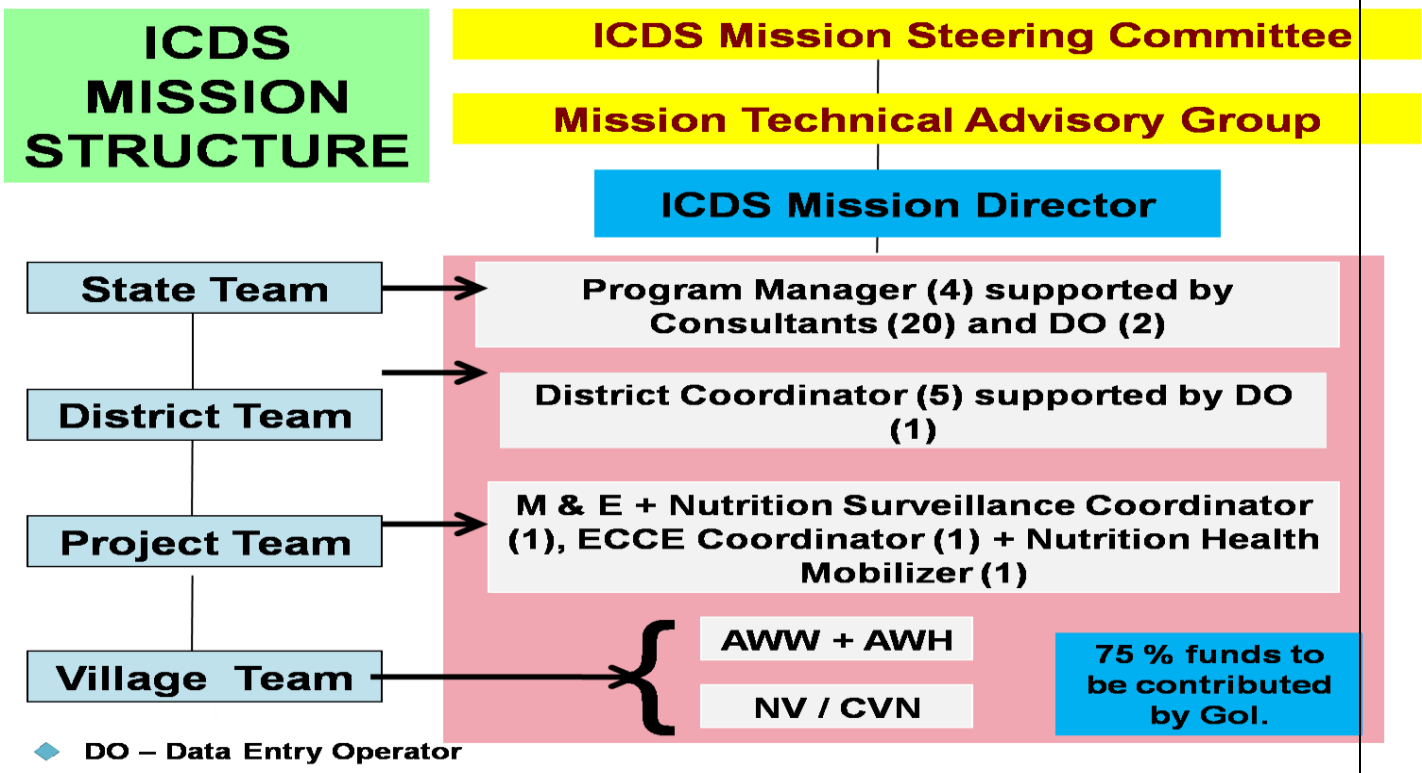
Nutrition and Health Education (NHED) is a key element of the Anganwadi worker. This is a part of the BCC (Behavior Change Communication) strategy. This has the long term goal of capacity-building of women particularly in the age group of 15-45 years so that they can look after their own health, nutrition and development needs as well as that of their children and families.

ICDS in Tapi District:

ICDS department works through a network of 1049 Anganwadi centres (44 mini anganwadi centres) in 7 blocks of the district.

Tapi has successfully reduced malnutrition status with the help of various programmes in convergence with various departments like health and educational department. In compare to last four year result from 2011-12 to 2014-2015, number of normal weight children has increased from 59 % to 85 %. The number of moderately malnourished and severely malnourished children has decreased from 38 % to 13 % and 3% to 2% respectively.

1.7 Organizational structure



1.8 Field visits undertaken:

- Visits to various Anganwadi centers to observe their overall functioning and to identify gaps so that corrective measures could be taken.
- Visits to blocks for block level review meetings and suggesting improvements.
- Visits to state headquarter to participate in orientation meeting, sickle cell anemia workshop and review meeting.
- Visits to Nutritional Rehabilitation Centers /Child Malnutrition Treatment Centre to observe the availability and quality of services for children with Severe Acute Malnutrition.

1.9 Observations of the field visit

During field visits, I observed that some Anganwadi centers were functioning efficiently and some had gaps. Gaps found during visits to Anganwadi centers:

1) Coverage of Beneficiaries: in some of the Anganwadi centers, only half the enrolled beneficiaries were present at the time of visit. When home visits were being made, it was found that Tapi being a tribal district, people live in far and isolated places and have poor access to anganwadi centers and poor health seeking behavior.
2) Supplementary nutrition: Quantity and Quality of food is not maintained which are provided to children
3) Infrastructure: Some of the Anganwadi centers had inadequate infrastructure. Buildings and toilets were in a bad state. Kitchens were also in unhygienic condition.
4) Equipment: there was shortage of utensils in some centers and washing of utensils was not done properly. Weighing scales was being shared by one or more angawadis in some cases.
5) Knowledge of Anganwadi workers: Some workers and helpers did not know the basics of malnutrition and were not giving counseling to parents effectively as they themselves lacked the knowledge.
6) Growth monitoring charts: one of the important tasks of anganwadi workers is to take the weights of all enrolled children and to plot it on growth monitoring charts. It was found that they face difficulty in filling the charts and interpreting them.
7) Monitoring visits: monitoring visits by anganwadi supervisors and block coordinators to some centers was an issue as they were located in far isolated areas and it was difficult to reach them.
8) Bill clearances: a major issue faced by anganwadi workers and helpers was that they get were not getting their bills cleared on a regular basis.

Nutritional rehabilitation centers and child malnutrition centers are working very efficiently in the district. The staff had good knowledge and is highly motivated.