Internship
at
ICDS, Gujarat

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Contents

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Abbreviations

AG's	Adolescent Girls
AWC	Anganwadi Centres
ANM	Auxiliary Nurse & Midwifery
ANC	Ante-Natal Check-up
AWW	Anganwadi Worker
CDPO	Children Development Project Officer
DWCD	Department of Women and Child Development
ECE	Early Childhood Education
EBF	Exclusive Breast Feeding
ICDS	Integrated Child Development Services
IEC	Information, Education & Communication
INCC	Intensive Nutrition Care Campaign
IFA	Iron & folic acid
GM	Growth Monitoring
MCH	Maternal and Child Health
NFHS	National Family Health Survey
NM	Nursing Mothers
PHC	Primary Health Centre
PNC	Post- Natal Care
PSE	Pre-School Education
SES	Socio-economic Status
SF	Supplementary Food

Chapter 1

Introduction

Internship is a part of the second year program, where we have to observe and learn the work culture of organization. Also it will be necessary to participate in various department/activities so we could orient our self with different departments that gives us first hand exposure.

Internship is the process, through which we can understand process of work and thereafter be able to involve in decision making.

I was appointed as District Programme Coordinator at Integrated Child Development Services, Valsad, Gujarat.

Chapter 2

Objectives of the Internship

1. To understand the work pattern of ICDS Valsad and Gujarat and its organizational structure.
2. To understand the structure and operations of the organization.
3. To learn various managerial and administrative skills needed to work in a government system.
4. To ensure effectively implementation of child health programmes in the State.
5. To identify existing gaps in human resource, service delivery quality, analysis and implementation of child health programmes in the State.

Chapter 3

State Profile

Figure 3.1 Figure 1 **Map of Gujarat State**

Gujarat state, 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. About 24 percent (1997-98) of Gujarat's population is estimated to be BPL, while 7 lpercent and 15 percent (2001) are classified as SC and ST respectively. 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.

The state of Gujarat is characterized by sea-coastal, tribal, desert and geographically hostile terrain having sparse and scattered population at the

periphery. Communities living in the remote and disadvantaged areas especially BPL population, tribal and women, are generally unable to access reliable and cost effective health care services. The state has 12 districts having population of 89, 96,744 accommodate 70 percent of tribal population (Census 2001). Approximately 18% (89, 96,744) of the total population of the state is living in these Tribal districts. The coastline of the state is about 1600 Kms. About 4487752 persons live in 36 coastal talukas.

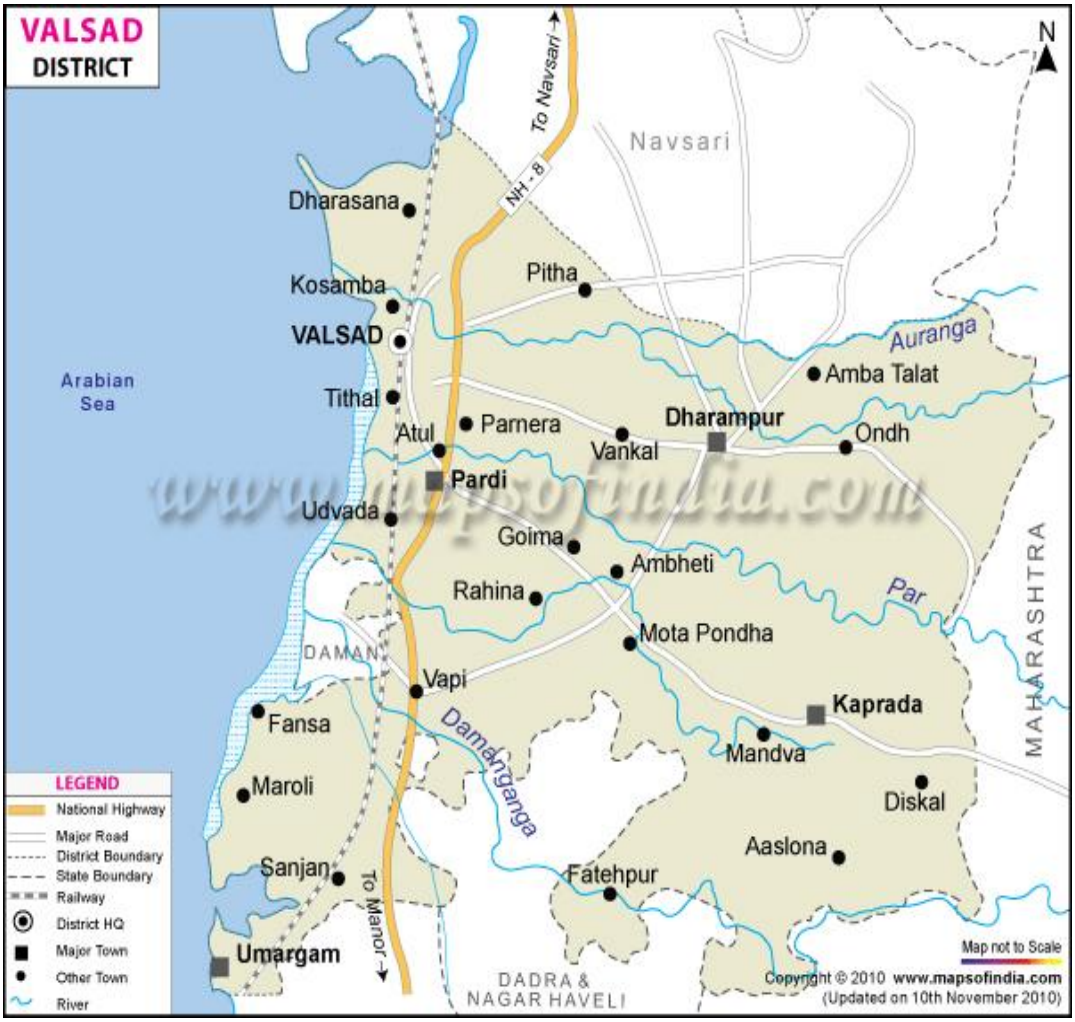
Administratively, the state has been divided into 26 districts, sub-divided into 225 Blocks, having 18618 villages and 242 towns. It has a large three-tier health infrastructure comprising 24 district hospitals, 273 Community Health Centre (CHCs), 1158 Primary Health Centre (PHCs) and 7274 Sub-Centres (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-centres.

The word **Anganwadi** means "courtyard shelter" in Hindi. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition. A typical *Anganwadi centre* also provides basic health care in Indian villages. It is a part of the Indian public health-care system. Basic health-care activities include contraceptive counselling and supply, nutrition education and supplementation, as well as pre-school activities. The centres may also be used as depots for oral rehydration salts, basic medicines and contraceptives. As many as 13.3 lakh Anganwadi and mini-Anganwadi Centres (AWCs/ mini-AWCs) are operational out of 13.7 lakh sanctioned AWCs/ mini-AWCs, as on 31.01.2013. These centres provide supplementary nutrition, non-formal pre-school education, nutrition and health

education, immunization, health check-up and referral services of which later three services are provided in convergence with public health systems.

3.1 District Profile

Figure 3.1.1 Figure 2 **Map of Valsad District**



According to the 2011 census Valsad district has a population of 1,703,068. The district covers 5,244 square kilometres. The district has a population density of 561 inhabitants per square kilometre (1,450/sq mi). Its population growth rate over the decade 2001-2011 was 20.74% Males constitute 51% of the population and females 49%. Valsad has a sex ratio of 926 females for every 1000 males.

Valsad has literacy rate of 80.94% higher than the national average of 59.5%: male literacy is 84%, and female literacy is 77%. Gujarati and Hindi are the

main languages of Valsad. Valsad district is divided into five talukas: Valsad, Pardi, Umargam, Kaparada and Dharampur. The name 'Valsad' derivesfrom *vad-saal*, a Gujarati language compound meaning "hampered (*saal*) by banyan trees (*vad*)" (the area was naturally rich in banyan trees).

Chapter 4

Integrated Child Development Services (ICDS) Mission, Gujarat

4.1 Introduction

India is the nation with high-level of regional inequality, social hierarchy and multicultural society. With high level of economic and social inequality, health and nutrition inequalities are also pervasive and persistent. According to WHO classification of 14 sub regions, India comes in the region of South East Asian Region (SEAR D), which is characterized as high child and adult mortality (WHO, 2000). In India, mortality for children less than 5 years of age is currently around 74 per 1000 live births (NFHS-3, 2005-06). Poor status of health and nutrition among the children of deprived group challenging to achieve Millennium Development Goals (MDGs) set forth by United Nation. To combat this situation, the Government of India initiated the Integrated Child Development Service (ICDS) scheme on experimental basis from 2nd October 1975 to reduce the level of infant and child mortality rates. Today ICDS represents one of the world's largest programmes for early childhood development (GOI, 2010).

The main objective of this programme is **to cater to the needs of the development of children in the age group of 0-6 years.** Pre-school education aims at ensuring holistic development of the children and to provide learning environment to children, which is helpful for promotion of social, emotional, cognitive development among children. Universalization of the ICDS was originally considered to be achieved by the end of 1995-96, through the development of services all over the country. It is one of the largest child care programmes in the world aiming at child health, hunger, malnutrition and its related issues.

ICDS services are provided a vast network of ICDS centres, it is known as **"Anganwadi".** The word Anganwadi is developed from the Hindi word "Angan" which refers to the courtyard of a house. In rural areas an Angan is where people get together to discuss, meet, and socialize. The Angan is also used occasionally to cook food or for household members to sleep in the open air. This part of the house is seen as the 'heart of the house'. A network of "Anganwadi Centre (AWC)" literally it is a courtyard play centre, provides integrated services comprising supplementary nutrition, immunization, health check-up, referral services, pre-school education and health and nutrition education. It is a childcare centre located within the village or the slum area itself. It is the central point for the delivery of services at community levels to children below six years of age, pregnant women, nursing mothers and adolescent girls.

Under the ICDS scheme, one trained person is selected to focus on the health and educational needs of children age 0-6 years. This person is the **Anganwadi worker (AWW).** The Anganwadi worker is the most important functionary of the ICDS scheme. The Anganwadi worker is a community based front line voluntary worker of the ICDS programme. This service will help the children to get into the right from the pre-school age. The Integrated Child Development Service (ICDS) scheme is utilized to help the family especially mothers to ensure effective health and nutrition care, early recognition and timely treatment of ailments.

In spite of the on-going direct nutrition interventions like ICDS, India still contributes to about 21% of the global burden of child deaths before their fifth birthday (UNICEF 2007). They also found little evidence of

programme impact on child nutrition in villages with ICDS centre. ICDS is the 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.

World Bank has also highlighted certain key shortcomings of the programme including inability to target the girl child improvements, participation of wealthier children more than the poorer children and lowest level of funding for the poorest and the most undernourished states of India (World Bank, 2011).

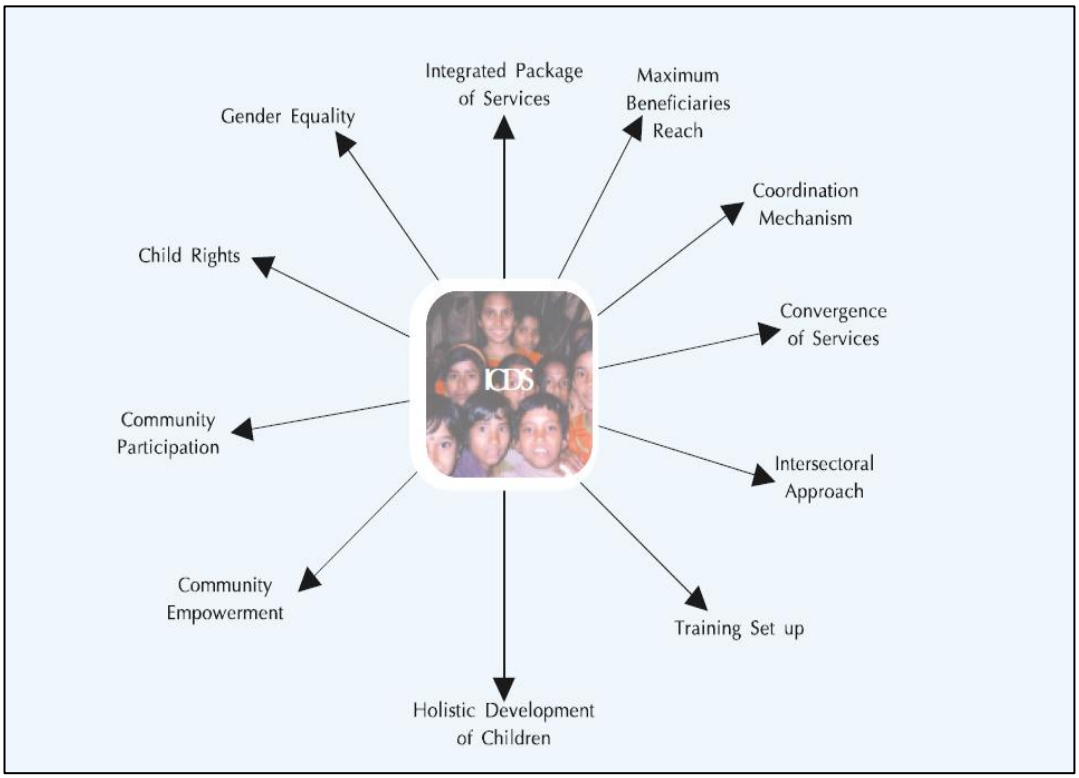
4.2 The main objectives of the Integrated Child Development Services (ICDS):

The basic purpose of the ICDS scheme is to meet the health, nutritional and educational needs of the poor and vulnerable infants, pre-school-aged children, and women in their child-bearing years. Its specific objectives are:

- To develop the nutritional and health status of children in the age-group 0-6 years.
- To put the groundwork for proper psychological, physical and social development of the child.
- To reduce the prevalence of mortality, morbidity, malnutrition and school dropout.
- To achieve effective co-ordination of policy and functioning along with the various departments to promote child development.

- To improve the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

Figure 4.2.1. Figure 3 **Special Features of ICDS**

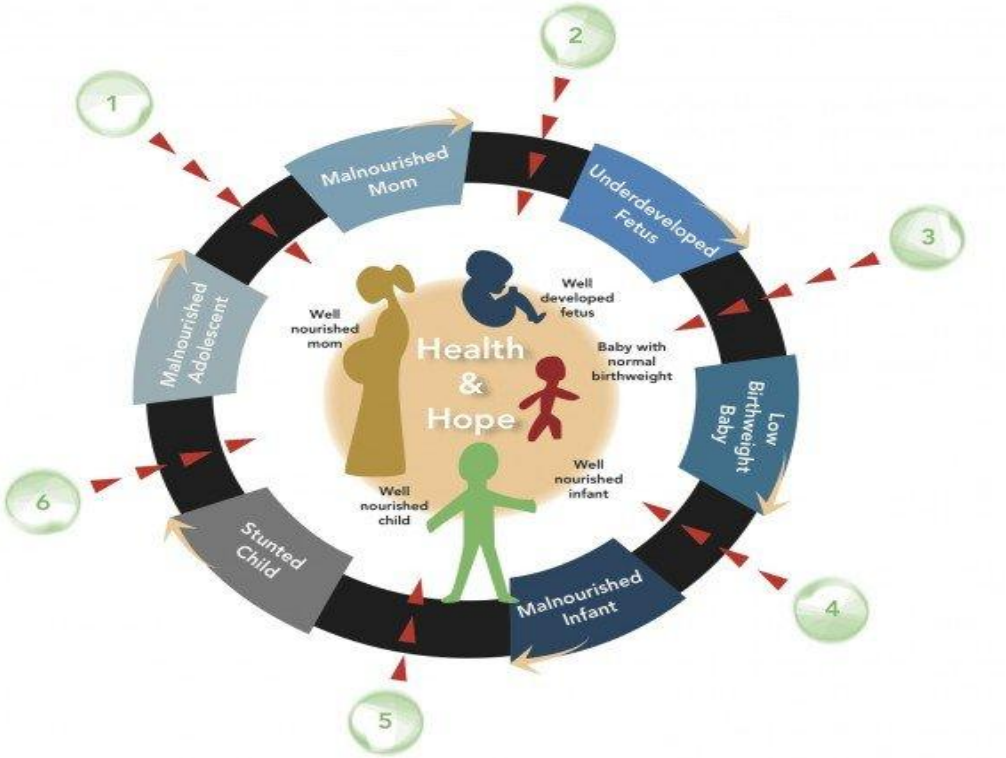


4.3 Services provided by Anganwadi Centres

The above objectives are necessary to be achieved through a package of services. Delivery of services under ICDS scheme is managed in an integrated way through Anganwadi centres, its workers and helpers. The services of Immunization, Health Check-up and Referral Services delivered through Public Health Infrastructure under the Ministry of Health and Family and Welfare UNICEF has provided necessary equipment for the ICDS scheme since 1975. World Bank has also assisted with the financial and technical support for the programme. The cost of ICDS programme averages $10–$22 per child a year. The scheme is centrally sponsored with the state governments contributing up to 1.00 (US$ 0.02) per day per child.

Furthermore, the (GOI 2008) adopted the World Health Organization (WHO) standards for measuring and monitoring the child growth and development, both for the ICDS and the National Rural Health Mission (NHRM). These standards were developed by WHO through an intensive study of six developing countries since 1997. They are known as New WHO Child Growth Standard and measure of physical growth, nutritional status and motor development of children from birth to 5 years

Figure4.3.1. Figure 4 **Intergenerational Cycle of Malnutrition**



ICDS intervenes across the life cycle as early as possible to fulfil the needs and rights of the girl child.

ICDS through its package of services creates an environment to reduce gender discrimination at all stages.

There are six dimensions or services of ICDS scheme which are provided by AWCs.

1. Supplementary Nutrition

2. Immunization

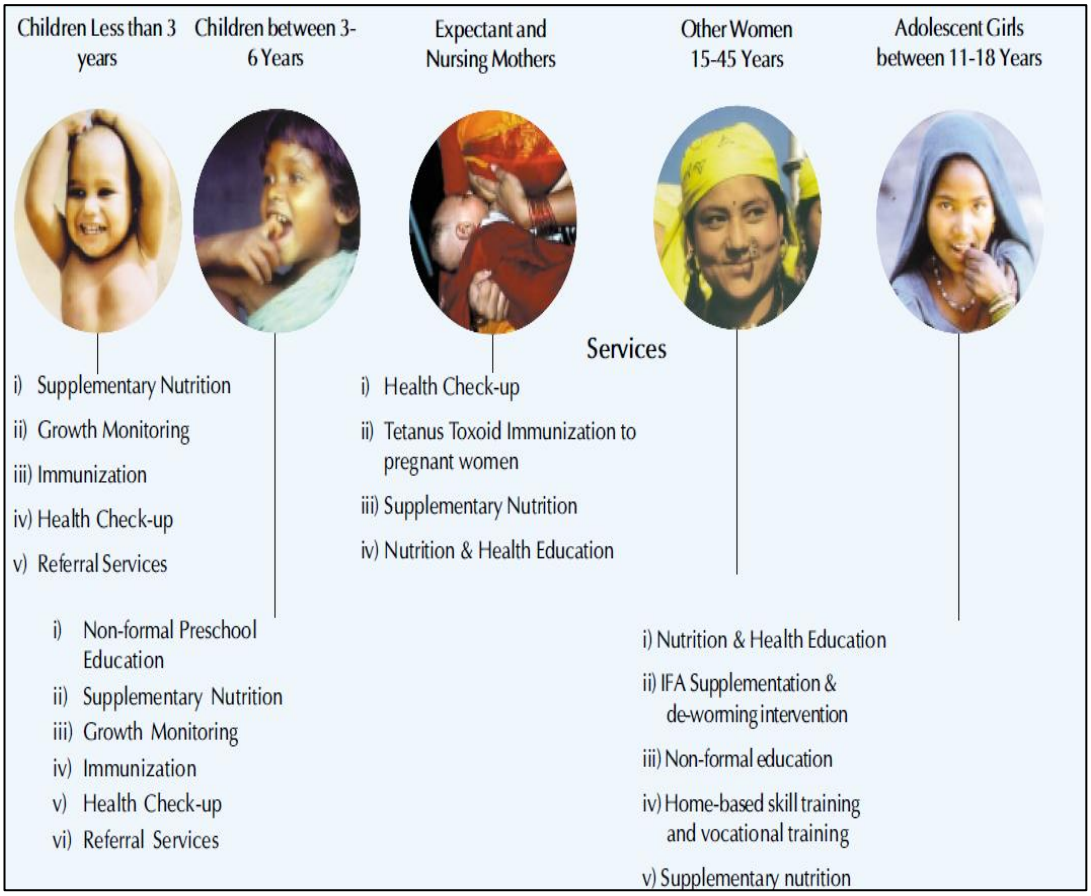
3. Health check-up

4. Referral services

5. Non-formal Preschool education

6. Nutrition and health education

Figure 4.3.2. ICDS Beneficiaries and Services



4.3.1Supplementary Nutrition

Supplementary Nutrition is one of the important factors for balancing the nutrition status of the children. This includes supplementary feeding and growth monitoring; and against vitamin A shortage and control of nutritional

anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. Anganwadi workers are advantage of 4 supplementary feeding supports for 300 days in a year. For nutritional purposes ICDS provides 300 calories (with 8-10 grams of protein) every day to every child below 6 years of age. For adolescent girls it is up to 500 calories with up to 25 grams of protein every day.

By providing supplementary feeding, the Anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities. Growth Monitoring and nutrition are two important actions 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 find out the growth flattering and helps in assessing their nutritional status. In addition, highly malnourished children are focused with special supplementary feeding and referred to medical services for the betterment.

4.3.2Immunization

To prevent the child from health related problem, immunization is utmost necessary. Immunization of pregnant women and infants protects children from six vaccine preventable diseases, tetanus, tuberculosis and measles. These are major preventable that helps in preventing the child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus also reduces the risk of maternal and neonatal mortality.

4.3.3 Health Check-Up

The health check-up includes children less than six years of age, antenatal care of mothers and postnatal care of nursing mothers. The different health services provided by Anganwadi workers for those children and Primary Health Centre (PHC) staff includes regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, and distribution of simple medicines etc

4.3.4 Referral Services

During health check-ups of malnourished children and timely medical attention are referred to the Primary Health Centre (PHC) or its sub-centre. The Anganwadi workers have also been oriented that the young children are not capable. She enlists all such cases in a special register and refers them to the medical officer of the PHC.

4.3.5 Non-formal Pre-School Education

Non-Formal Pre-School Education (NFPSE) is a part of the ICDS and it is mostly considered as its backbone, because its services basically cover the Anganwadi. Anganwadi Centre (AWC) – a village courtyard is the main platform for delivering of the services. These AWCs have been set up in every village of the country. In its functioning, the commitment to the cause of India's children, present government has decided to set up an AWC in every human occupation / settlement. As a result, total number of AWC would go up to almost 1.4 million. This is also the most joyful play-way daily activity, visibly sustained for three hours a day. It brings and keeps young children at the Anganwadi centre- an activity that motivates parents and communities. Pre-school education (PSE), as considered in the ICDS, focuses on total development of children chiefly six year olds, mainly from the poor groups or

those who are mostly needy. **Its programme for the three-to six years old children in the Anganwadi is directed towards providing and ensuring a natural, joyful and motivating environment, with importance on necessary inputs for most advantageous growth and development.** The early learning component of the ICDS is a significant contribution for providing a sound foundation for increasing lifelong learning and development. It also contributes to the universalization of primary education, by providing the necessary preparation for primary schooling and offering alternative care to younger siblings, thus freeing the older ones especially girls to attend school.

4.3.6 Nutrition and Health Education

Nutrition, Health and Education (NHED) is a key element of the the Anganwadi worker. This is a part of the BCC (Behaviour 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.

4.4 Duties and Responsibility of Anganwadi Worker (AWW)

The Anganwadi Workers and helpers are the basic functionaries of the ICDS who run the Anganwadi Centre and implement the ICDS scheme. The following are the key duties and responsibility of AWWs.

- To maintain files and records as prescribed.
- Accompany ASHA on spreading awareness for healthcare issues such as importance of nutritious food, personal hygiene, pregnancy care and importance of immunization.

- Co-ordination with block and district healthcare establishments to benefit medical schemes.
- Helping to mobilise pregnant or lactating women and infants for nutrition supplements.
- Discover immunization and health check-ups for all.
- To keep a record of pregnant mothers, childbirths and diseases or infections of any kind.
- Maintaining referral card for referring cases of mothers and children to the sub-centres, PHC.
- Conducting health related survey of all the families and visiting them on monthly basis.
- Conducting pre-school activities for children of up to 5 years.
- Organising supplementary nutrition for feeding infants, nursing mothers.
- Organising counselling or workshops along with Auxiliary Nurse Midwife (ANM) and block health officers to spread education on topics like correct breastfeeding, family planning, immunization, health check-up, ante natal and post natal check.
- To visit nursing mothers in order to be on course with child's education and development.
- To ensure that health components of various schemes is availed by villagers.
- Informing supervisors for villages' health progression, or issues needing attention and intervention.
- To ensure that Kishori Shakti Yojana (KSY), SABLA, Nutrition Programme for Adolescent Girls (NPAG) and other such programmes are executed as per guidelines.

- To determine any disability, infections among children and referring cases to PHC or District Disability Rehabilitation Centre if needed.
- Immediately reporting diarrhoea and cholera cases to health care division of blocks and districts.

4.5 Key Features of ICDS in Mission Mode

- *Programmatic Management and Institutional reforms*
- *Anganwadi as "Vibrant ECD centre" through revised packages of services*
    - *Greater focus on under three years children*
    - *Strengthening early childhood education*
    - *Care and counseling of mothers and family*
- *More than 2 lakh Anganwadi to be constructed*
- *More than 2700 new technical human resources*
- *More than 4.5 lakhs additional Anganwadi workers/nutrition counsellors/link workers*
- *Improved Supplementary nutrition*
- *70,000 Anganwadi cum crèches*
- *Intensive monitoring, training and capacity building*
- *Greater convergence and linkages with other sectors health, education PRIs and Rural Development*
- *Flexibility to states and flexibility in programme implementation*

4.6 Indicators of Achievement under ICDS Mission

- Reduction in underweight prevalence
- Improved IYCF
- Contribute to reduction in anaemia, IMR and MMR in collaboration with health

- Reduction in incidence of low birth weight babies
- Improved early learning outcomes

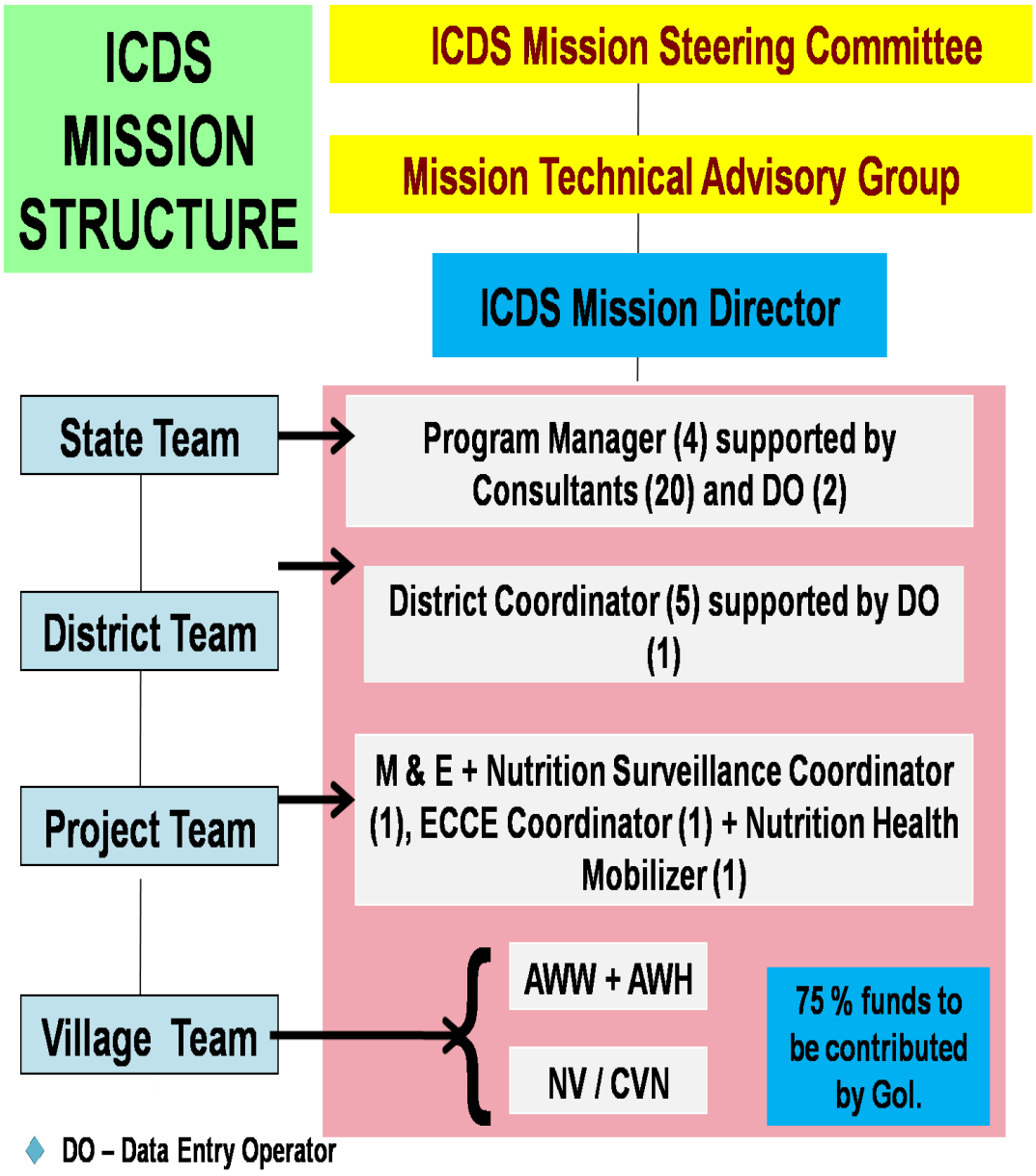
Chapter 5
ICDS in Valsad

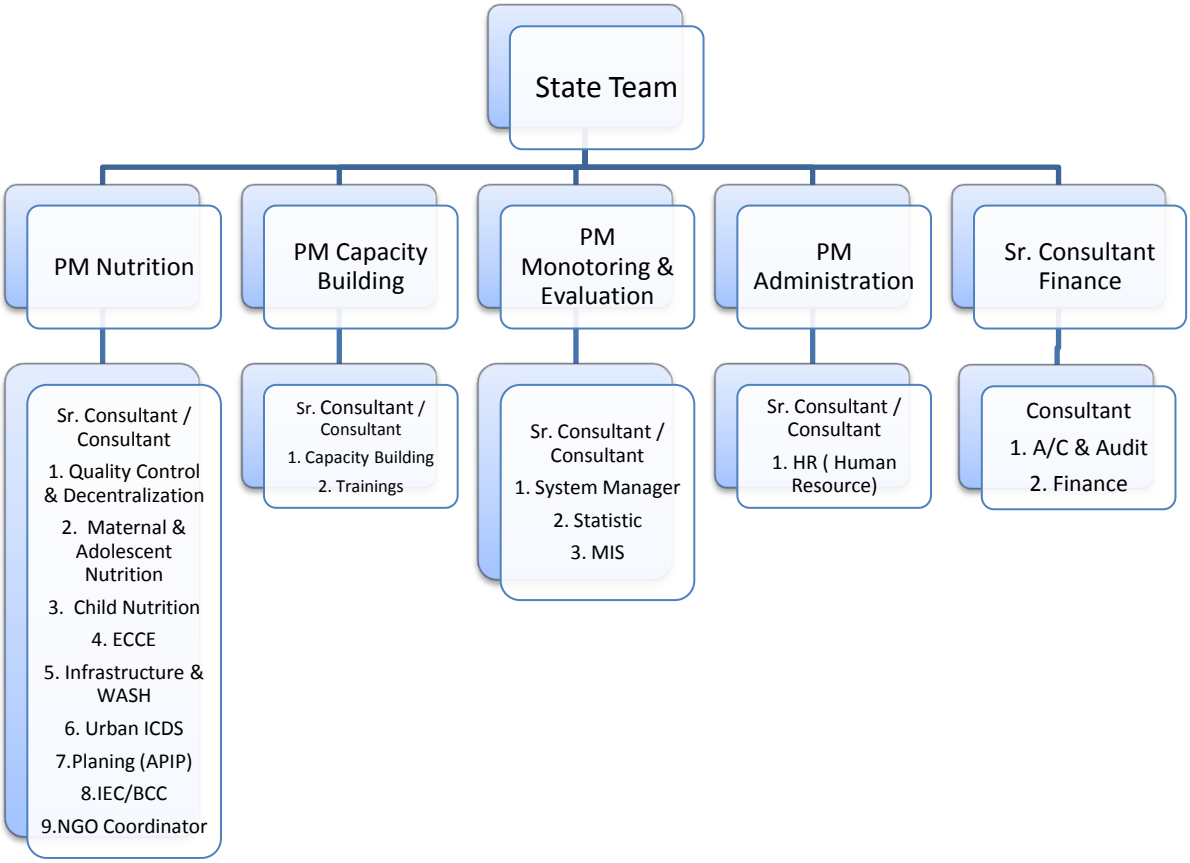
In the year 1960 when Gujarat state was formed after it for children's all-round development and mainly social and financial development for poor people many targets are decided and for it many effective steps have been taken. Due to these steps combined (overall) child development scheme's 33 components were started all over the country in 1975-76 at an experimental level. Among it in Gujarat, it was first experimented in Vadodra District's chhota udaipur taluka. It known from evaluation these components that due to this scheme children's health/nutrition standard has improved back class, divas, and poor children have benefited considerably. Encouraged by the results of scheme government has decided to increase the area where it is used this scheme. At present, in Gujarat state, work is done in total 260 blocks. **Anganwadi's number is 41484. Similarly in Valsad district 12 blocks (components) and 1860 Anganwadi centres are working at present. In which service are given as under.**

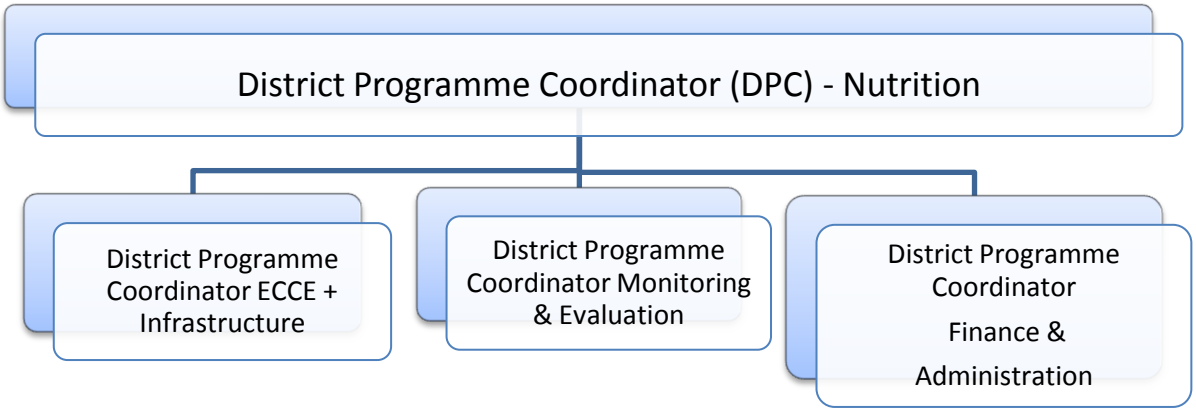
- 6 months to 6 years children, pregnant ladies, feeding mothers, and young girls are given supplementary Nutrition.
- Pre-primary education to children in the age group of 3-6 years.
- Health and nutrition education to pregnant women, feeding mothers and other women in the age group of 15-45.
- 0-6 years children, pregnant ladies disease ingraining vaccines.
- Medicinal check-up of 0-6 years children, pregnant ladies and feeding mothers.

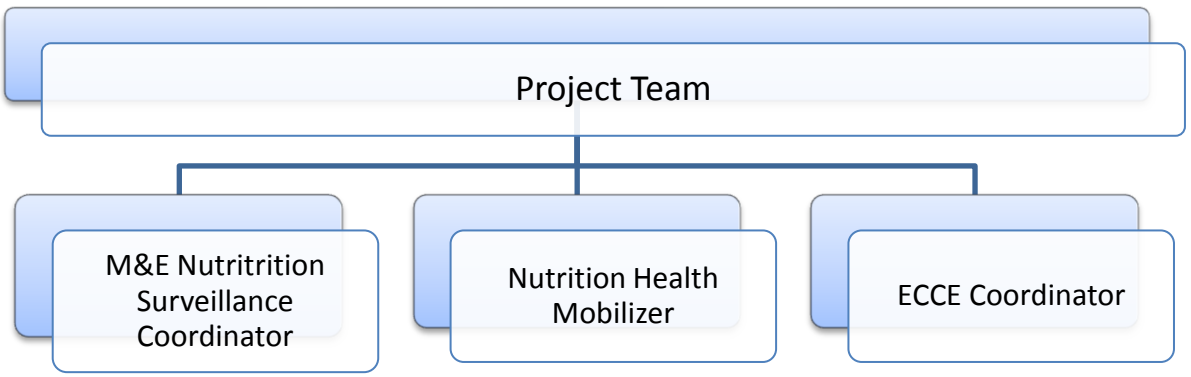
- Services related to 0-6 years children, pregnant ladies and feeding mothers.
- Girls born after, Balika Samruddhi scheme (15-8-97) of BPL family for each family having 2 girls will be given help at birth scheme, "Shishya Vrulti".
- Under SABLA - supplementary nutrition to young girls, living education training, iron tables distribution.
- Doodh Sanjivani Yojana in Dharampur and Kapradad block.

Figure 5.1 Figure 5 **Organogram of ICDS Mission Structure**




State Team
PM Nutrition
PM Capacity Building
PM Monotoring & Evaluation
PM Administration
Sr. Consultant Finance
Sr. Consultant / Consultant
1. Quality Control & Decentralization
2. Maternal & Adolescent Nutrition
3. Child Nutrition
4. ECCE
5. Infrastructure & WASH
6. Urban ICDS
7.Planing (APIP)
8.IEC/BCC
9.NGO Coordinator
Sr. Consultant / Consultant
1. Capacity Building
2. Trainings
Sr. Consultant / Consultant
1. System Manager
2. Statistic
3. MIS
Sr. Consultant / Consultant
1. HR (Human Resource)
Consultant
1. A/C & Audit
2. Finance


District Programme Coordinator (DPC) - Nutrition
District Programme Coordinator ECCE + Infrastructure
District Programme Coordinator Monitoring & Evaluation
District Programme Coordinator Finance & Administration


Project Team
M&E Nutritrition Surveillance Coordinator
Nutrition Health Mobilizer
ECCE Coordinator

5.1 Key learning during internship

- Understanding of various PPP initiatives running in Gujarat for Child and Maternal health
- Meeting key resource persons from different developmental partners
- Attending review meetings, workshops and seminars related to Child Health in Gujarat.
- Screening and line listing of moderately and severally malnourished children.
- Attending Two days TOT programme at state level.
- Micro planning of implementation of Intensive Nutrition Care Campaign INCC at AWC.

5.2 Observations of the field visit:

- During the situational analysis it was observed that the coverage of registered children of 0 to 6 years is decreasing in few blocks.
- During my visits to Anganwadi Centre, in general all of them were maintained properly and many need to be maintain properly. Having spent lot of money and providing flexi funds and contingency fund to improve the facility and daily requirement of AWC , Proper orientation of AWW require to utilize them for benefits of beneficiaries, unfortunately the kitchen, toilets were not maintained properly.
- Medicine Kits are provided to some AWC but AWW not having proper knowledge of using the medicine provided in Medicine kits.
- Proper Hand Washing and washing of Utensils of Beneficiaries are not present in most of the AWC.
- SABLA kits are not implemented in most of the AWC and the scheduled meeting of Adolescent girls are not organised by AWW.

- Mamta divas sessions held are an example of intersectoral convergence of Health and ICDS.
- Only children were attended during the morning session. ANC is taken up in the afternoon, along with Adolescent girls.
- Height is measured but proper marking not present at AWC.
- Quantity and Quality of food is not maintained which are provided to children.
- Counselling is not observed.
- ECCE activities are not present at all AWC.
- AWW are not receiving the incentives of MAMTA DIVAS on time or not received from few years
- Supervisors (Mukiya Sevika) are not visiting to the field frequently.
- Only AWW and AWH are active during Mamta Divas ,ASHA just sitting at AWC along with FHW.
- Only Immunization is done no proper health check-up at AWC of Children.
- No 24 hours stay at CMTC centre and children admitted in CMTC not gaining recommended 15 % weight gain.l
- Nutri Candy not available from last one month.
- Doodh Sanjivani yojana was started for one year (From Sep 2013 to 2014)
- AWW found difficulties in filling new eleven registers at AWC.
- Growth charts are not maintained properly at AWC.
- After the implementation of INCC in AWC there is reduction in malnutrition amongst children.
- New 11 registers need to be maintain by AWW, but they are facing problems to maintain them.