Internship
at
ICDS (Integrated Child Development Scheme, Patan

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2013-2015

Institute of Health Management Research, Jaipur
2015

Contents

1. DISTRICT PROFILE

Patan district has nine talukas, out of which three talukas Sami, Shankheshwar Radhanpur and Santalpur talukas has been allotted with high priority status and rest six talukas like Patan, Sarashvati, Siddhpur, Chanasma and Harij have been allotted non high priority status. District health action plan has been prepared considering the health related matter of this talukas.

Patan district is situated at north of Gujarat. It was newly created on 2nd October 1998. This is the district where there is a lack of resources as well as manpower. Geographically it has 7 talukas which distributed in 6 blocks. It has 517 revenue villages. Main business of people from Patan is labour, agriculture and animal husbandry. Patan, Sidhpur and Radhanpur are well known cities of the District. Patan city is a main city having population of approx. 1,35,000. All kind of higher education is available and Patan city is the head quarter of local University. This is a center of medical specialist and well sophistications in medical field are available in Patan City. District do not have any Municipal corporation, it has 2 Nagarpalika i.e. Patan & Siddahpur and 3 Muni. Bureau i.e. Radhanpur, Chanasma and Harij.

Patan District Population Growth Rate:

There was change of 13.61 percent in the population compared to population as per 2001. In the previous census of India 2001, Patan District recorded increase of 14.16 percent to its population compared to 1991.

Patan District Density 2011

The initial provisional data released by census India 2011, shows that density of Patan district for 2011 is 232 people per sq. km. In 2001, Patan district density was at 206 people per sq. km. Patan district administers 5,792 square kilometers of areas.

Patan Literacy Rate 2011

Average literacy rate of Patan in 2011 were 72.30 compared to 60.36 of 2001. If things are looked out at gender wise, male and female literacy were 82.90 and 61.05 respectively. For 2001 census, same figures stood at 73.63 and 46.33 in Patan District. Total literate in Patan District were 837,913 of which male and female were 494,631 and 343,282 respectively. In 2001, Patan District had 599,082 in its district.

Patan Sex Ratio 2011

With regards to Sex Ratio in Patan, it stood at 935 per 1000 male compared to 2001 census figure of 932. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate. In 2011 census, child sex ratio is 890 girls per 1000 boys compared to figure of 865 girls per 1000 boys of 2001 census data.

Patan Child Population 2011

In census enumeration, data regarding child under 0-6 age were also collected for all districts including Patan. There were total 184,779 children under age of 0-6 against 190,192 of 2001 census. Of total 184,779 male and female were 97,762 and 87,017 respectively. Child Sex Ratio as per census 2011 was 890 compared to 865 of census 2001. In 2011, Children under 0-6 formed 13.75 percent of Patan District compared to 16.08 percent of 2001. There was net change of -2.33 percent in this compared to previous census of India

Growth Rate

The district has a population of 1343734. The district has experienced an annual exponential growth rate of 1.20 %. (Census 2011)

Literacy Rate

The literacy rate of the district is 72.30 percent, with 82.90 Percent for males and 61.05 percent for females, which are comparable to the respective rates in the state. Thus, in terms of urbanization, Patan district is at a disadvantageous Position as compared to the state as a whole.

Vital Rates

The Crude Birth rate & crude death rate of the district is 21 & 6.2 respectively. The infant mortality rate of the district is 33. Neonatal mortality rate is 40.2 & the post neonatal mortality rate 17.07. (MIS 2013).

Population Distribution & Sex Ratio

Table 1: Taluka wise population percentage distribution of Total population and Sex Ratio

Sr. No.	Name of Taluka	Population	% of Total Population	Male	Female	Sex Ratio
1	Patan	449480	33.45	233211	216269	927
2	Sidhpur	213087	15.86	109587	103500	944
3	Chanasma	130743	9.73	67752	62991	930
4	Harij	94562	7.04	48994	45568	930
5	Sami	182805	13.60	94050	88755	944
6	Radhanpur	144266	10.74	74083	70183	947
7	Santalpur	128791	9.58	66720	62071	930
	Total	**1343734**	**100.00**	**694397**	**649337**	**935**

Source: census 2011

2. INTRODUCTION

2.1 ABOUT THE ORGANIZATION

INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME

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). 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 programs for early childhood development [13].

The main objective of this program 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. It is one of the largest child care program 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 devloped 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 ongoing 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 program 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.

2.2 Objectives of 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.

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

2.3 Supplementary Nutrition

Supplementary Nutrition is one of the important factor 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 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.

2.4 Immunization

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.

2.5 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 diarrhea, and distribution of simple medicines etc.

2.6 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 refer them to the medical officer of the PHC.

2.7 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.

2.8 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.

3.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.
- Assisting 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 mobilize 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-centre's, 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
- Organizing supplementary nutrition for feeding infants, nursing mothers.
- Organizing counseling 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), 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 diarrhea and cholera cases to health care division of blocks and districts

4. OBSERVATIONS AND LEARNINGS

- Almost all AWC were proper in terms of cleanliness and maintenance of hygiene.
- registers were seen incomplete at most of AWCs
- Recently time for AWC have changed , now it is 8:30 am to 2 pm , but usually they dont open till 10 am and gets closed around 1pm
- 8:30 to 9:30 am was usually time for children of 1-3years, they have to come along with their mothers for Baal Bhog , but this practice was also not followed.
- Proper training to AWW was given . Orientation training was given to AWW and AWH before joining AWC , Apart from this , timely refresher trainings were given to them . Also, Rasoi Shows were organized for AWW and AWH so they can cook nutritious food for children.
- Proper ECCE activities were seen to be followed at AWCs.
- Children of 3-6 years were weighed on solter scale and marked on growth chart (pink for girls and blue for boys. Also , medical checkups were undertaken on Mamta diwas (every wednesday).
- Once in a month , AWW distributes premixed packets to adolescent girls and pregnant women.
- Children from 3-6 years were given flavored milk (100ml) by sumul and ICDS twice a week i.e. Tuesday and Friday.
- According to Growth Chart , children were graded into green(normal) , yellow(moderately malnourished) , and red (Severely malnourished) zone.
- Mukhya Sevika was not going to visits timely.
- Immunization of children was done on mamta diwas, for which incentive was given.

4.1 WORK WITH ORGANIZATION

- Made presentations and presented same for Gatisheel Gujarat under which milk was given to children of 3 to 6 years for reducing malnutrition.
- Part of Beti Bachao Abhiyaan i.e for saving girl child.
- Also, active member of Dhoodh sanjeevani Yojna .
- Done all the documentation for Intensive Nutrition Care Centres for Severely malnourished children.