Internship

at

Integrated Child Development Services (ICDS)
Government of Gujarat
(3rd February, 2014 – 30th April, 2014)

Submitted By

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ORGANISATION PROFILE – INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME (ICDS SCHEME)

INTRODUCTION

Launched on 2nd October 1975, today, ICDS Scheme represents one of the world's largest and most unique programmes for early childhood development. 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, on the other.

Objectives

The Integrated Child Development Services (ICDS) Scheme was launched in 1975 with the following objectives:

i. to improve the nutritional and health status of children in the age-group 0-6 years;
ii. to lay the foundation for proper psychological, physical and social development of the child;
iii. to reduce the incidence of mortality, morbidity, malnutrition and school dropout;
iv. to achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and
v. 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.

Services

The above objectives are sought to be achieved through a package of services comprising:

i. supplementary nutrition,
ii. immunization,
iii. health check-up,
iv. referral services,
v. pre-school non-formal education and

vi. nutrition & health education.

The concept of providing a package of services is based primarily on the consideration that the overall impact will be much larger if the different services develop in an integrated manner as the efficacy of a particular service depends upon the support it receives from related services.

Services	Target Group	Service Provided by
Supplementary Nutrition	Children below 6 years: Pregnant & Lactating Mother (P&LM)	Anganwadi Worker and Anganwadi Helper
Immunization*	Children below 6 years: Pregnant & Lactating Mother (P&LM)	ANM/MO
Health Check-up*	Children below 6 years: Pregnant & Lactating Mother (P&LM)	ANM/MO/AWW
Referral Services	Children below 6 years: Pregnant & Lactating Mother (P&LM)	AWW/ANM/MO
Pre-School Education	Children 3-6 years	AWW
Nutrition & Health Education	Women (15-45 years)	AWW/ANM/MO

*AWW assists ANM in identifying the target group.

Three of the six services namely Immunisation, Health Check-up and Referral Services delivered through Public Health Infrastructure under the Ministry of Health & Family Welfare.

1) Nutrition including Supplementary Nutrition: This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. They avail of supplementary feeding support for 300 days in a year. 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 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.

2) Immunization: Immunization of pregnant women and infants protects children from six vaccine preventable diseases-poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles. These are major preventable causes of child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus also reduces maternal and neonatal mortality.

3) Health Check-ups: This includes health care of children less than six years of age, antenatal care of expectant mothers and postnatal care of nursing mothers. The various health services provided for children by anganwadi workers and Primary Health Centre (PHC) staff, include regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, de-worming and distribution of simple medicines etc.

4) 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.

5) Non-formal Pre-School Education (PSE) : The Non-formal Pre-school Education (PSE) component of the ICDS may well be considered the backbone of the ICDS programme, since all its services essentially converge at the anganwadi – a village courtyard. Anganwadi Centre (AWC) – a village courtyard – is the main platform for delivering of these services. These AWCs have been set up in every village in the country. In pursuance of its commitment to the cause of India's Children, present government has decided to set up an AWC in every human habitation/ 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. PSE, as envisaged in the ICDS, focuses on total development of the child, in the age up to six years, mainly from the underprivileged groups.

Its programme 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.

6) Nutrition and Health Education: Nutrition, Health and Education (NHED) is a key element of the work of the anganwadi worker. This forms part of BCC (Behaviour Change Communication) strategy. This has the long term goal of capacity-building of women – especially 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.

Population Norms:-

The revised Population norms for setting up a Project, Anganwadi Centre and Mini-AWC are as under:

Projects:

(i) Community Development Block in a State should be the unit for sanction of an ICDS Project in rural/tribal areas, irrespective of number of villages/population in it.

(ii) The existing norm of 1 lakh population for sanction of urban project may continue.

Further to this, for blocks with more than two lac population, States could opt for more than one Project (@ one per one lac population) or could opt for one project only. In the latter case, staff could be suitably strengthened based on population or number of AWCs in the block. Similarly, for blocks with population of less than 1 lac or so, staffing pattern of CDPO office could be less than that of a normal block.

Anganwadi Centres

For Rural/Urban Projects

400-800	1 AWC
800-1600	2 AWCs
1600-2400	3 AWCs

Thereafter in multiples of 800 1 AWC

For Mini-AWC

150-400 1 Mini-AWC

For Tribal /Riverine/Desert, Hilly and other difficult areas/ Projects

300-800 - 1 AWC

For Mini- AWC

150-300 1 Mini AWC

Supplementary Nutrition Norms:

1) Financial norms:- The Government of India has recently, revised the cost of supplementary nutrition for different category of beneficiaries vide this Ministry's letter No. F.No. 4-2/2008-CD.II dated 07.11.2008, the details of which are as under:-

Sl.No.	**Category**	**Pre-revised rates**	**Revised rates (per beneficiary per day)**
	Children (6-72 months)	Rs.2.00	Rs.4.00
	Severely malnourished children (6-72 months)	Rs.2.70	Rs.6.00
	Pregnant women and Nursing mothers	Rs.2.30	Rs.5.00

2) <u>Nutritional Norms</u>:- Revised vide letter No. 5-9/2005-ND-Tech Vol. II dated 24.2.2009

Sl. No.	**Category**	**[Pr-revised]**		**[Revised]** **(per beneficiary per day)**	
		Calories (K Cal)	**Protein (g)**	**Calories (K Cal)**	**Protein (g)**
1.	Children (6-72 months)	300	8-10	500	12-15
2.	Severely malnourished children (6-72 months)	600	200	800	20-25
3.	Pregnant women and Nursing mothers	500	15-20	600	18-20

3) Type of Supplementary Nutrition :

- **Children in the age group 0 – 6 months :** For Children in this age group, States/ UTs may ensure continuation of current guidelines of early initiation (within one hour of birth) and exclusive breast-feeding for children for the first 6 months of life.
- **Children in the age group 6 months to 3 years** : For children in this age group, the existing pattern of Take Home Ration (THR) under the ICDS Scheme will continue. However, in addition to the current mixed practice of giving either dry or raw ration (wheat and rice) which is often consumed by the entire family and not the child alone, THR should be given in the form that is palatable to the child instead of the entire family.

- **Children in the age group 3 to 6 years** : For the children in this age group, State/ UTs have been requested to make arrangements to serve Hot Cooked Meal in AWCs and mini-AWCs under the ICDS Scheme. Since the child of this age group is not capable of consuming a meal of 500 calories in one sitting, the States/ UTs are advised to consider serving more than one meal to the children who come to AWCs. Since the process of cooking and serving hot cooked meal takes time, and in most of the cases, the food is served around noon, States/ UTs may provide 500 calories over more than one meal. States/ UTs may arrange to provide a morning snack in the form of milk/ banana/ egg/ seasonal fruits/ micronutrient fortified food etc.
- **Registration of beneficiaries:** States have to ensure registration of all eligible beneficiaries.

Expansion of the ICDS Scheme:

THE ICDS TEAM:

1) The ICDS team comprises the Anganwadi Workers, Anganwadi Helpers, Supervisors, Child Development Project Officers (CDPOs) and District Programme Officers (DPOs). Anganwadi Worker, a lady selected from the local community, is a community based frontline honorary worker of the ICDS Programme. She is also an agent of social change, mobilizing community support for better care of young children, girls and women. Besides, the medical officers, Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) form a team with the ICDS functionaries to achieve convergence of different services.

2) Role & responsibilities of AWW, ANM and ASHA:

Role and responsibilities of AWW, ANM & ASHA have been clearly delineated and circulated to States/UTs under the joint signature of Secretary, MWCD and Secretary, MHFW, vide D.O. No. R. 14011/9/2005-NRHM –I (pt) dated 20 January 2006**.**

3) STATUS OF ANGANWADI WORKERS AND HELPERS:

Anganwadi Workers (AWWs) & Anganwadi Helpers (AWHs), being honorary workers, are paid a monthly honoraria as decided by the Government from time to time.

Existing Monitoring System under ICDS Scheme:

1) Central Level

Ministry of Women and Child Development (MWCD) has the overall responsibility of monitoring the ICDS scheme. There exists a Central Level ICDS Monitoring Unit in the Ministry which is responsible for collection and analysis of the periodic work reports received from the States in the prescribed formats. States have been asked to send the State level consolidated reports by 17th day of the following month.

The existing status of monitoring of these six services is as under :

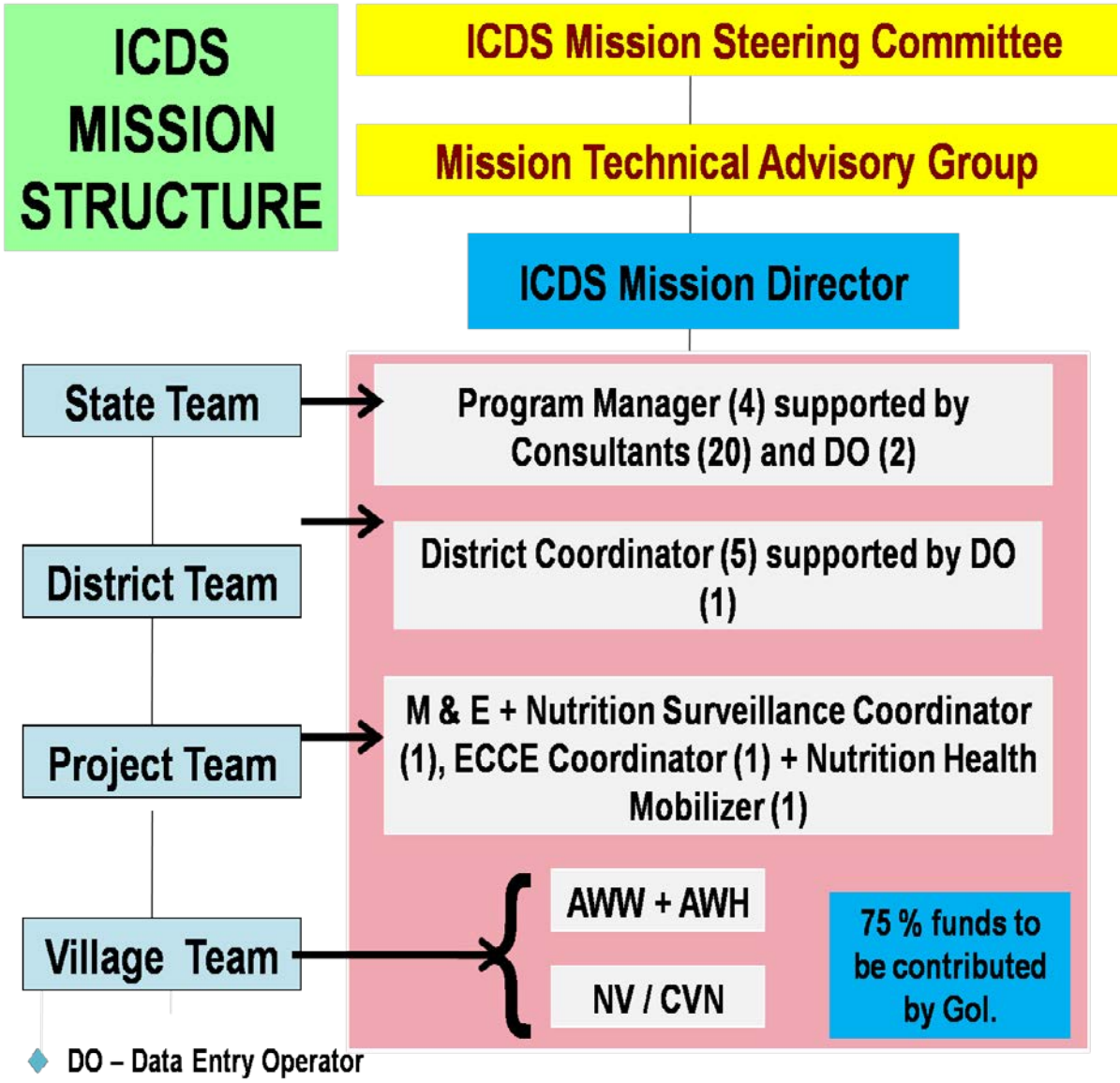
(i) Supplementary Nutrition : No. of Beneficiaries (Children 6 months to 6 years and pregnant & lactating mothers) for supplementary nutrition;

(ii) Pre-School Education : No. of Beneficiaries (Children 3-6 years) attending pre-school education;

(iii) Immunization, Health Check-up and Referral services : Ministry of Health and Family Welfare is responsible for monitoring on health indicators relating to immunization, health check-up and referrals services under the Scheme.

(iv) Nutrition and Health Education-This service is not monitored at the Central Level. State Governments are required to monitor up to State level in the existing MIS System.

(v) No. of ICDS Projects and Anganwadi Centres (AWCs) w.r.t. targeted no. of ICDS Projects and AWCs are taken into account for review purpose.



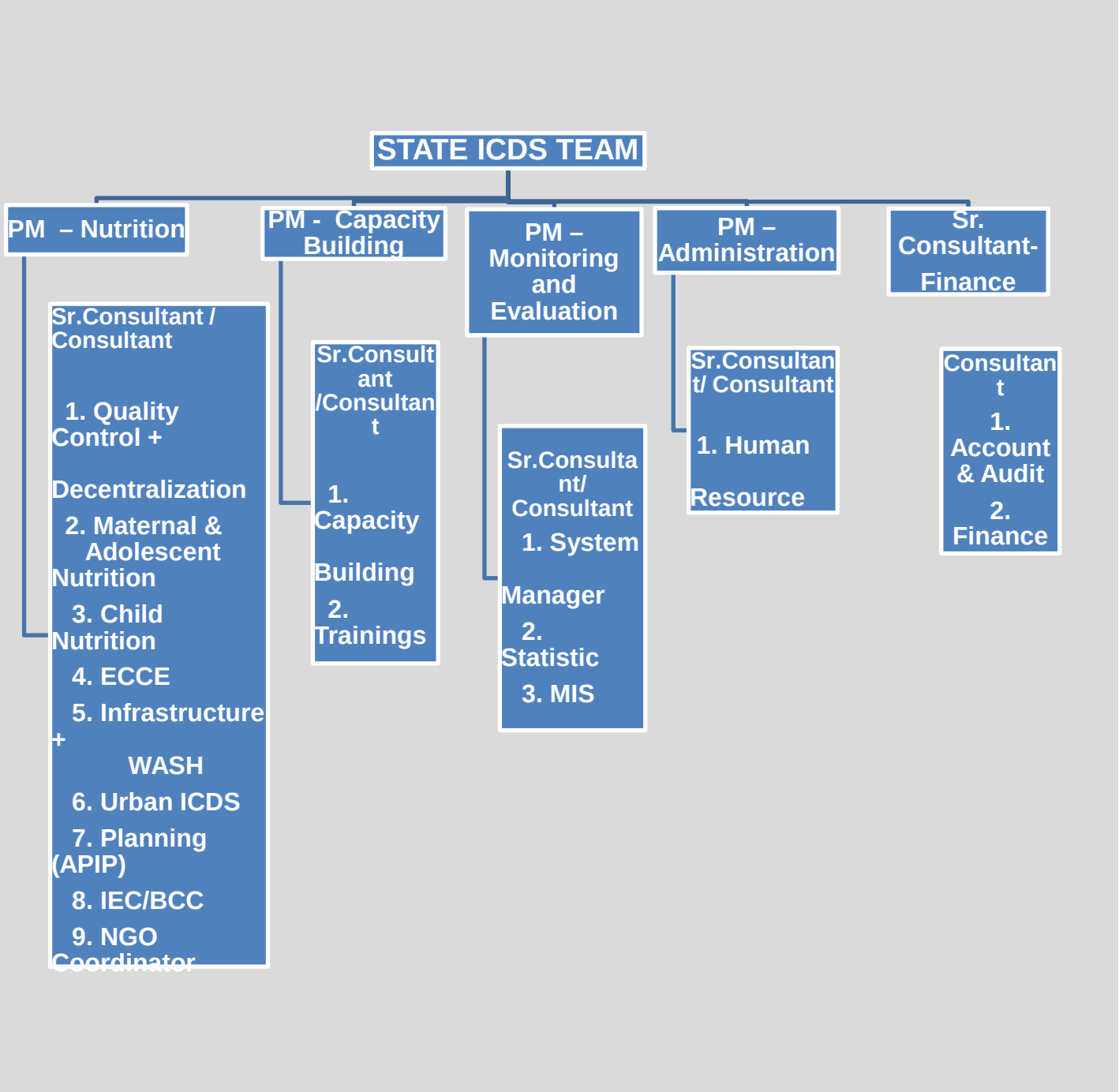
Analysis & Action

The information received in the prescribed formats is compiled, processed and analysed at the Central level on quarterly basis. The progress and shortfalls indicated in the reports on ICDS are reviewed by the Ministry with the State Governments regularly by review meetings/ letters.

2) State Level

Various quantitative inputs captured through CDPO's MPR/ HPR are compiled at the State level for all Projects in the State. No technical staff has been sanctioned for the state for programme monitoring. CDPO's MPR capture information on number of beneficiaries for supplementary nutrition, pre-school education, field visit to AWCs by ICDS functionaries

like Supervisors, CDPO/ ACDPO etc., information on number of meeting on nutrition and health education (NHED) and vacancy position of ICDS functionaries etc.



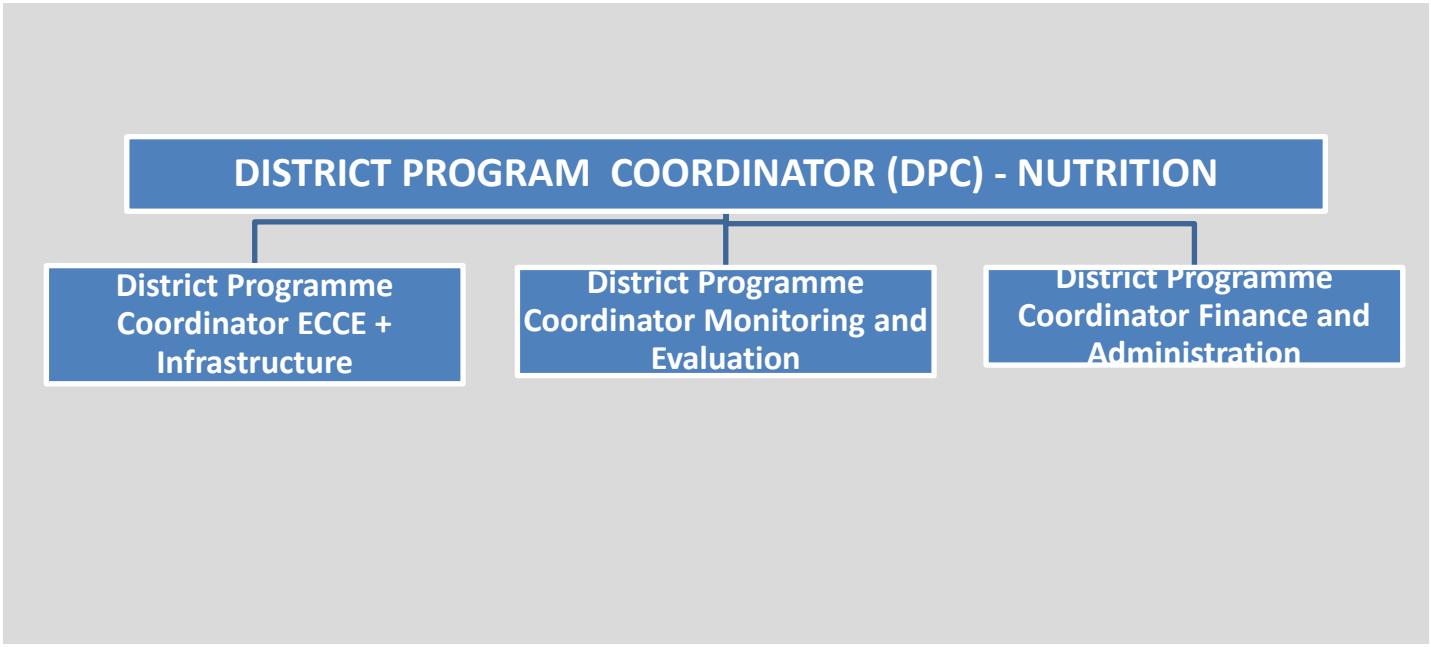
3) <u>Block Level</u>

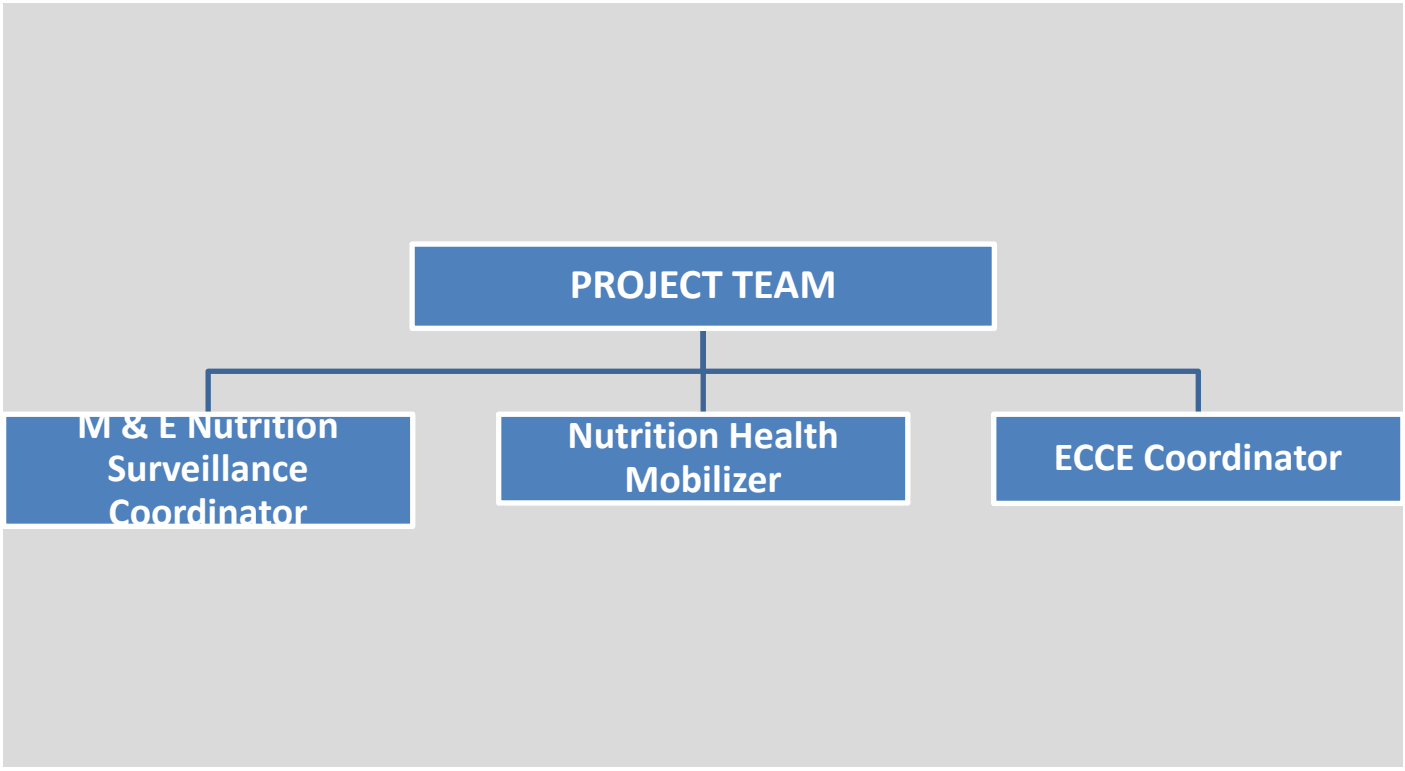
At block level, Child Development Project Officer (CDPO) is the in-charge of an ICDS Project. CDPO's MPR and HPR have been prescribed at block level,. These CDPO's MPR/ HPR formats have one-to-one correspondence with AWW's MPR/ HPR. CDPO's MPR consists vacancy position of ICDS functionaries at block and AWC levels. At block level, no

technical post of officials have been sanctioned under the scheme for monitoring. However, one post of statistical Assistant./ Assistant is sanctioned at block level to consolidate the MPR/ HPR data.

In between CDPO and AWW, there exist a supervisor who is required to supervise 25 AWC on an average.

CDPO is required to send the Monthly Progress Report (MPR) by 7th day of the following month to State Government. Similarly, CDPO is required to send Half-yearly Progress Report (HPR) to State by 7th April and 7th October every year.


DISTRICT PROGRAM COORDINATOR (DPC) - NUTRITION
District Programme Coordinator ECCE + Infrastructure
District Programme Coordinator Monitoring and Evaluation
District Programme Coordinator Finance and Administration


PROJECT TEAM
M & E Nutrition Surveillance Coordinator
Nutrition Health Mobilizer
ECCE Coordinator

4) Village Level (Anganwadi Level)

At the grass-root level, delivery of various services to target groups is given at the Anganwadi Centre (AWC). An AWC is managed by an honorary Anganwadi Worker (AWW) and an honorary Anganwadi Helper (AWH).

In the existing Management Information System, records and registers are prescribed at the Anganwadi level i.e. at village level. The Monthly and Half-yearly Progress Reports of Anganwadi Worker have also been prescribed. The monthly progress report of AWW capture information on population details, births and deaths of children, maternal deaths, no. of children attended AWC for supplementary nutrition and pre-school education, nutritional status of children by weight for age, information on nutrition and health education and home visits by AWW. Similarly, AWW's Half yearly Progress Report capture data on literacy standard of AWW, training details of AWW, increase/ decrease in weight of children, details on space for storing ration at AWC, availability of health cards, availability of registers, availability of growth charts etc.

AWW is required to send these Monthly Progress Report (MPR) by 5th day of following month to CDPO' In-charge of an ICDS Project. Similarly, AWW is required to send Half-yearly Progress Report (HPR) to CDPO by 5th April and 5th October every year.

Note : Details of various circulars/ orders on monitoring/ MIS issued from GOI and existing Management Information System (MIS) on ICDS are given at 'Child Development' portion of the web-site of the Ministry viz. www.wcd.nic.in

Evaluation of ICDS Scheme: A number of evaluation studies on implementation of ICDS Scheme have been conducted in the past viz., Programme Evaluation Organisation of the Planning Commission in 1982, National Evaluation of ICDS Scheme conducted by National Institute of Public Cooperation and Child Development (NIPCCD) in 1992, Evaluation Results of Annual Survey during 1975-1995, published by Central Technical Committee on Integrated Mother and Child Development on completion of 20 years of ICDS and Nationwide Evaluation of ICDS by National Council of Applied Economic Research

(NCAER) 1998-1999. Main findings of study conducted by NCAER (1996-2001) are as follows:-

i. Most of the AWCs across the country were located within accessible distance (100-200 meters) from beneficiary households. A majority of the beneficiary households was within 100 metres of the AWC. Another 10 per cent were about 150-200 meters away. The rest were beyond 200 meters. Thus, the factor of distance of beneficiary households from the AWC was unlikely to affect attendance at the AWC during inclement weather;

ii. Most of the AWCs in the country, except those in Tamil Nadu, Kerala, Karnataka and Orissa were functioning from community buildings. The type of building plays an important role in safeguarding against any natural hazards. Of those sampled, about 40 per cent were functioning from pucca buildings.

iii. Nearly 50 per cent AWCs reported adequate space, especially for cooking.

iv. One out of two AWWs was found to be educated at least up to matriculate level across the country. In all central and southern states, less than 50 per cent of the AWWs were 'at least matriculate'; more than 75 per cent of AWWs were matriculates in the northern and eastern states of the country. Gujarat and Rajasthan reported lowest percentage of matriculate functionaries.

v. Though about 84 per cent of the functionaries reported to have received training, the training was largely pre-service training. In-service training remained largely neglected.

vi. The day to day functioning of the AWC is a critical indicator of the effectiveness of the ICDS programme. An assessment of on-going activities of sample AWCs through observations, record reviews and personal interviews with the AWWs revealed that, on average, an AWC functioned for 24 of 30 days in a month. On a given day, the AWC functioned for about 4 hours. By and large, environmental factors did not affect the functioning of the AWC.

vii. On an average nearly 66 per cent of eligible children and 75 per cent of eligible women were registered at the AWCs. This indicates lack of motivation on the part of the AWW in identifying and registering the entire eligible population.

vii. Community leaders were generally positive about the functioning of the AWCs (more than 80 per cent in all states) while more than 70 per cent found the programme to be beneficial to the community

viii. Participation of beneficiary women and adolescent girls in AWC activities was reported to be low. These two segments of population form the foundation for any child care programme and their involvement is imperative for successful implementation of the ICDS Services.

Three Decades of ICDS – An appraisal by NIPCCD (2006)

The study covered 150 ICDS Projects from 35 States/UTs covering rural, urban and tribal projects. A total of five Anganwadi centres (AWCs) were randomly selected from each sample projects covering 750 AWCs. The main findings of the appraisal are as under:

i) Around 59 per cent AWCs studied have no toilet facility and in 17 AWCs this facility was found to be unsatisfactory.

ii) Around 75% of AWCs have pucca buildings;

iii) 44 per cent AWCs covered under the study were found to be lacking PSE kits;

iv) Disruption of supplementary nutrition was noticed on an average of 46.31 days at Anganwadi level. Major reasons causing disruption was reported as delay in supply of items of supplementary nutrition;

v) 36.5 per cent mothers did not report weighing of new born children;

vi) 29 per cent children were born with a low weight which was below normal (less than 2500 gm);

vii) 37 per cent AWWs reported non-availability of materials/aids for Nutrition and Health Education (NHED).

INTERNATIONAL PARTNERS

Government of India partners with the following international agencies to supplement interventions under the ICDS:

i. United Nations International Children' Emergency Fund (UNICEF)
ii. Cooperative for Assistance and Relief Everywhere (CARE)
iii. World Food Programme (WFP)

INTRODUCTION OF WHO GROWTH STANDARDS IN ICDS -

The World Health Organization (WHO) based on the results of an intensive study initiated in 1997 in six countries including India has developed New International Standards for assessing the physical growth, nutritional status and motor development of children from birth to 5 years age. The Ministry of Women and Child Development and Ministry of Health have adopted the New WHO Child Growth Standard in India on 15th of August, 2008 for monitoring the Growth of Children through ICDS and NRHM.

Implications

- Change in current estimates

- increase in total of normal weight children

- increase in severely underweight children

- increase in underweight children (mild/moderate and severe) in age group of 0-6 months.

ii. The requirement of funds for SNP; Centre and State contribution would be almost double.
iii. The Anganwadi Worker with the help of New Growth Chart would be able to assess correctly severely underweight children and number of such children would increase in each Anganwadi Centres. The number of normal children would also increase in all the Anganwadi Centres.

iv. The new charts would now help us in comparing growth of our children within projects, districts, states & also other countries.

Key learnings during internship

- Learning of implementation and monitoring of the different services provided under Integrated Child Development Services Scheme. (ICDS Scheme)
- In depth understanding of the core definitions of different grades of malnutrition.
- Understanding of the organizational culture and functions of ICDS Gujarat
- Meeting key resource persons from different developmental partners
- Attending review meetings, workshops and seminars related to Malnutrition and Supplementary nutrition in Gujarat

Observations during field visits:

- During visits to Anganwadi Centers, in general a majority of them were maintained 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 required to utilize them for benefits of beneficiaries.
- Mamta divas sessions held are an example of intersectoral convergence of Health and ICDS departments.
- Only children were attended during the morning session.ANC visits are taken up in the afternoon, along with consultations of Adolescent girls.
- Height is measured but proper marking not present at AWC.
- Quality of food is provided to children is not maintained.
- Improper and irregular maintenance of registers.
- ECCE and Pre School Education activities are present at AWC.
- Supervisors are not visiting to the field frequently.

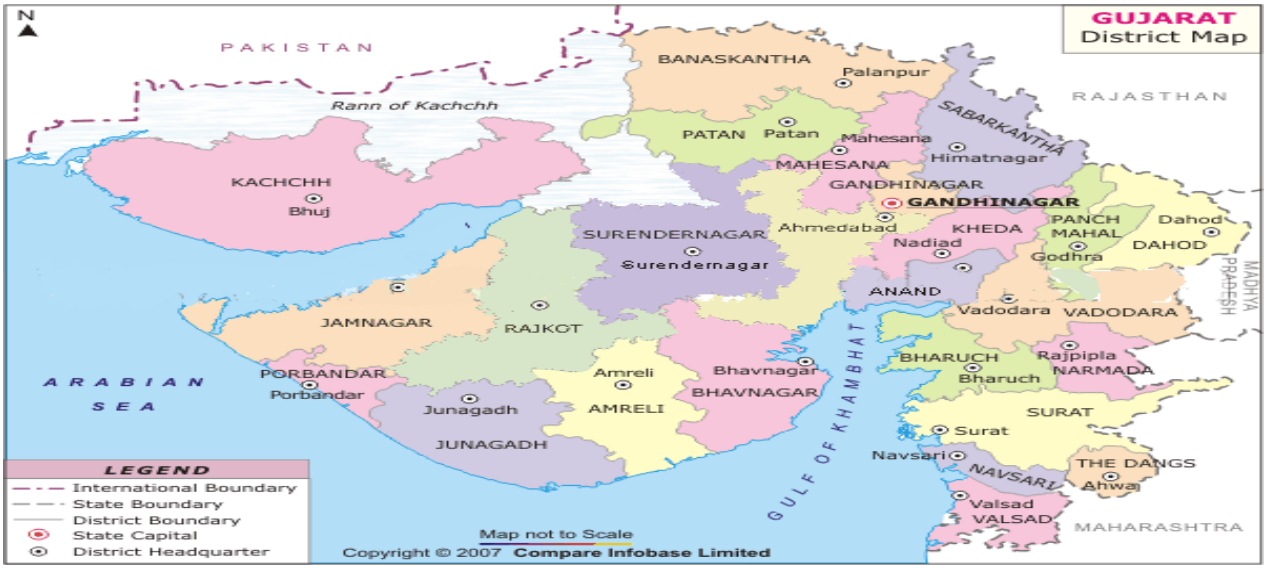
Specific Project –

1. Organising Committee member of Mata Yashoda Award (14th February, 2014) at district level.

Problems and Issues Faced-

1. Mobility issues due to unavailability of travel conveyance by District Programme Co-ordinators.
2. Accessibility to remote areas for field visit.
3. Many issues faced due to lack of training of co-ordinators.

State Profile



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 percent 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.

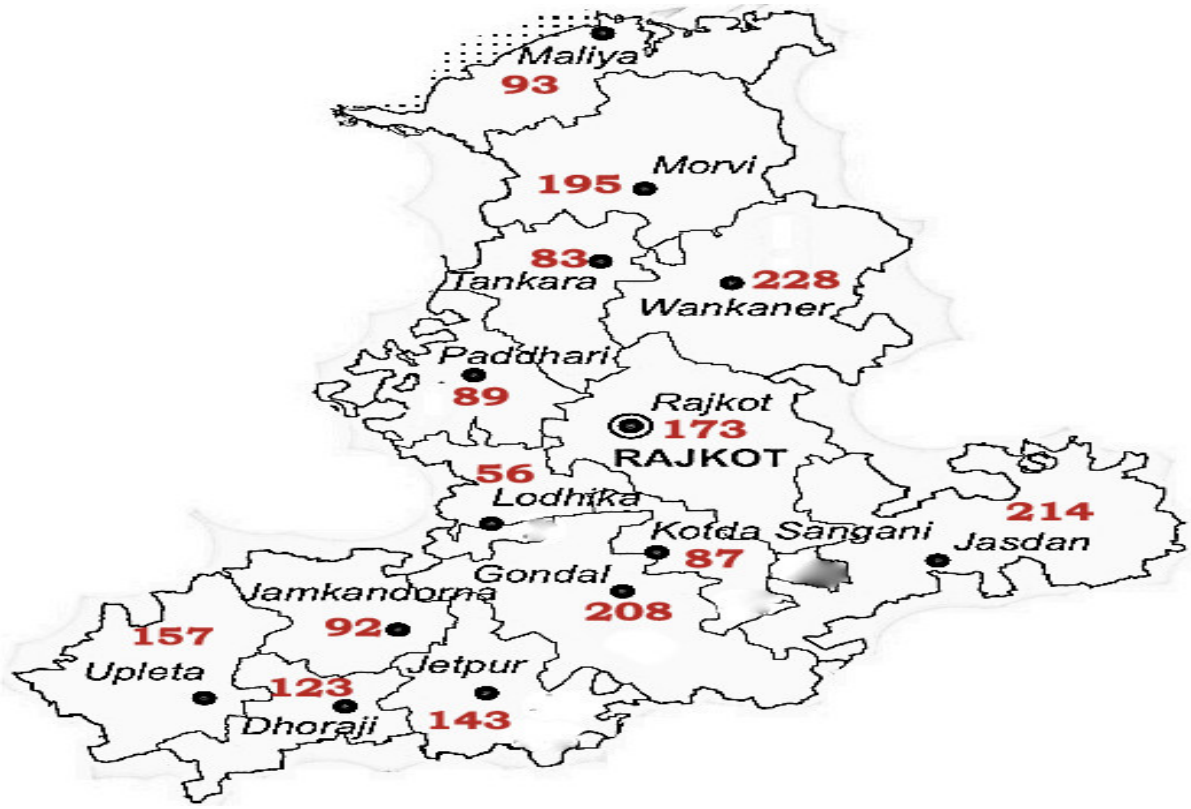
Administratively, the state has been divided into 26 districts, sub-divided into 225 Blocks, having 18,618 villages and 242 towns. It has a large three-tier health infrastructure comprising 24 district hospitals, 273 Community Health Centre (CHCs), 1158 Primary Health Centre (PHCs) and 7274 Sub-Centres (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 counseling 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.

Background of Rajkot

About the Study Area



Rajkot district is one of the 26 districts of the Indian state of Gujarat. Rajkot city is the administrative headquarters of the district. It is the third-most advanced district in Gujarat. This district is surrounded by Morbi district in North, Surendranagar and Botad districts in East, Amreli and Junagadh districts in south and Porbandar and Jamnagar district in West. The district occupies an area of 11,203 km². Rajkot District has 14 Talukas, 847 Villages. In Rajkot District 1940 Anganwadi + 5 Mini Anganwadi have been Sanctioned. Each Anganwadi Centre (AWC) covers a population of 1000 people. Also, the Rajkot City Area has 330 Anganwadi Centers. So Rajkot District consists of 2,270 AWCs in all.