Internship
at
Integrated Child Development Services (ICDS)
Women and Child Department, Gujarat
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Submitted By

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INTRODUCTION

Amreli District is situated on south of Saurashtra area. According to the 2011 census, Amreli has a population of 15,13,614. The district head quarters are located at Amreli. The district head quarters are located at Amreli. The district head quarters are located at Amreli. The district occupies an area of 6760 km square.

DIVISIONS:-

The District comprises of 11 Talukas
(1)Amreli-1 and Amreli-2
(2)Bagasara
(3)Babra
(4)Lathi
(5)Lilia
(6)Savarkundla-1 and Savarkundla-2
(7)Dhari
(8)Khambha
(9)Kunkavav
(10)Rajula
(11)Jafrabad

The District has a population density of 205 inhabitants per square killometre, its population growth rate over the decade 2001 to 2011 was 8.59 percent. It has 642 villages .The literacy levels are 77.55 %.

Table 1.1 : Socioeconomic and demographic indicators in the district, 2011 Census

INDICATORS	STATUS

POPULATION*	MALE	FEMALE	TOTAL
Total	771049	743141	1514190
Urban	198495	188140	386635
Rural	572554	555001	1127555
Tribal			
LITERACY FOR			
Total	558180	437279	995459
Urban	153242	127174	280416
Rural	404938	310105	715043
Tribal	-	-	-
SEX RATIO			
Over All			964
0 – 6 Years			886
POPULATION			
Overall 2011	KM^2		205
Overall 2001	KM^2		

I have been employed as the District Program Coordinator, ICDS Amreli.

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.

1. 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.

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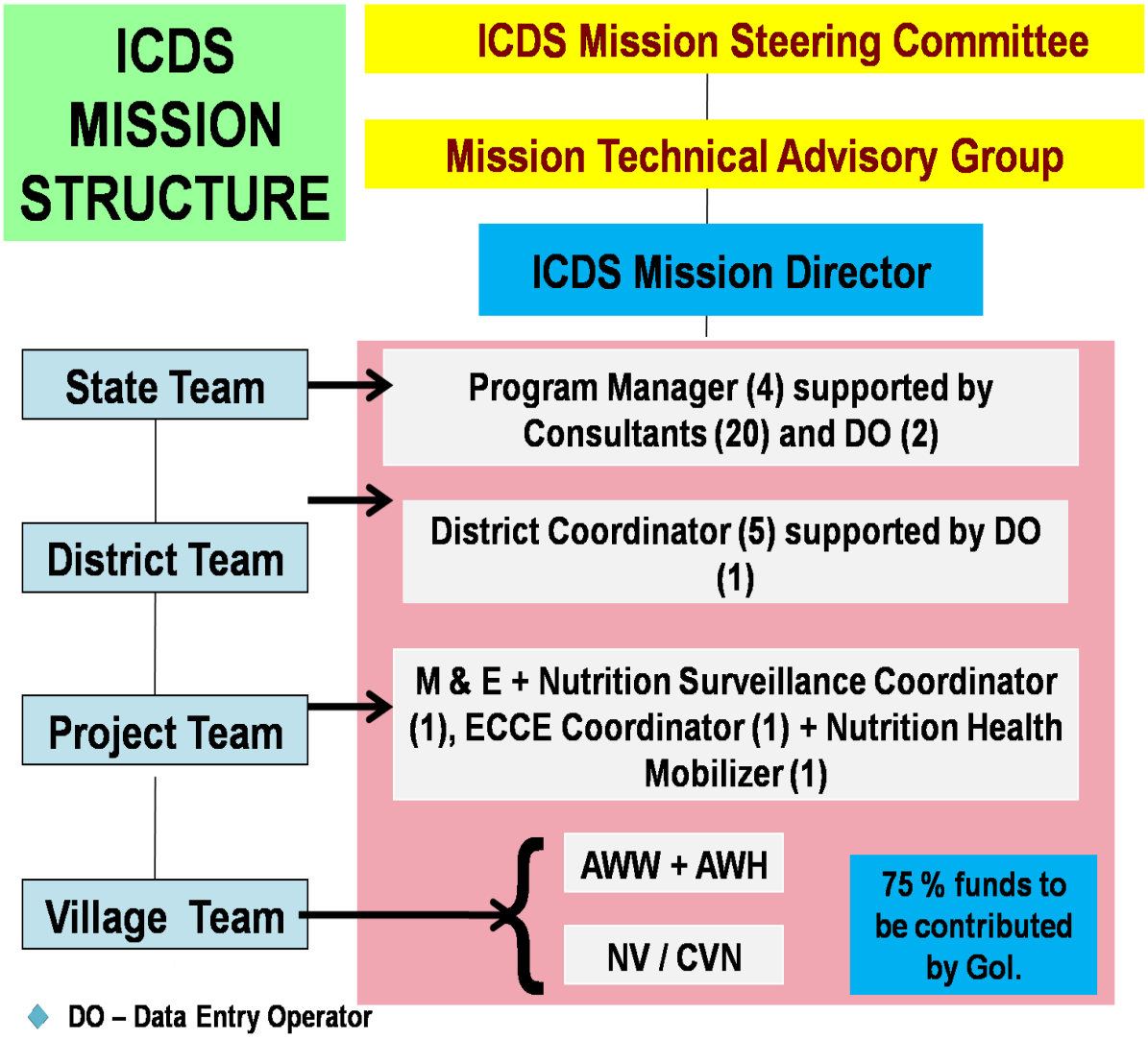
ORGANIZATIONAL PROFILE

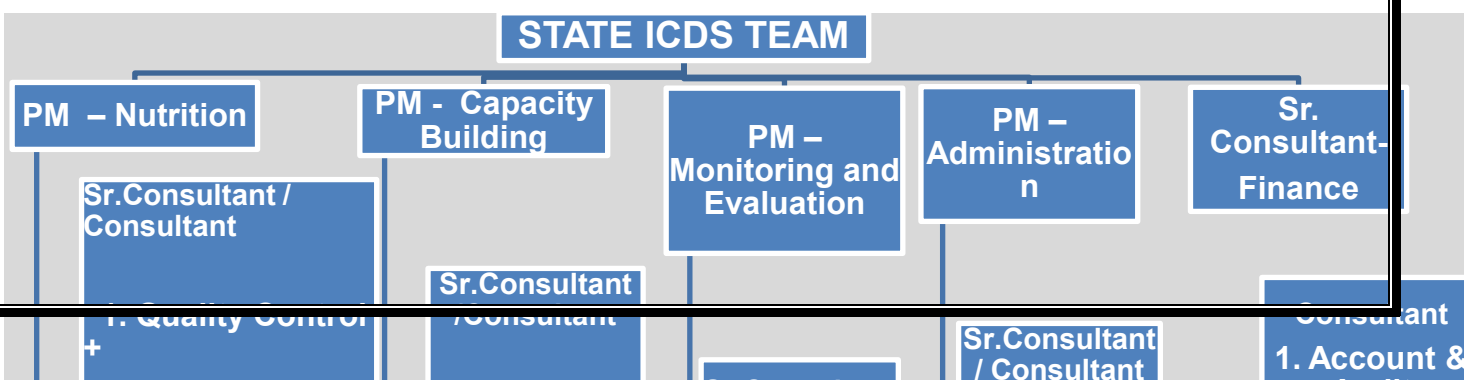
The structure of ICDS is that it is currently funded scheme implemented through the States and Union Territories. Originally,financially it was 100% backed by the Central government, except the supplementary nutrition, which must be provided by the States resources. But in 2005 -06, it was noted that many of the States were not capable of providing adequately supplementary nutrition in view drought, economic slowdown,etc. Hence it was decided to support the States up to 50 percent of their economic norms or to support 50 percent of expenses acquired by them on supplementary nutrition, whichever is less. The reason for Ceentral assistance for Supplementary nutrition is to ensure all beneficiaries are receiving the supplements for 300 days of the year as has been laid out in the norms of the scheme.

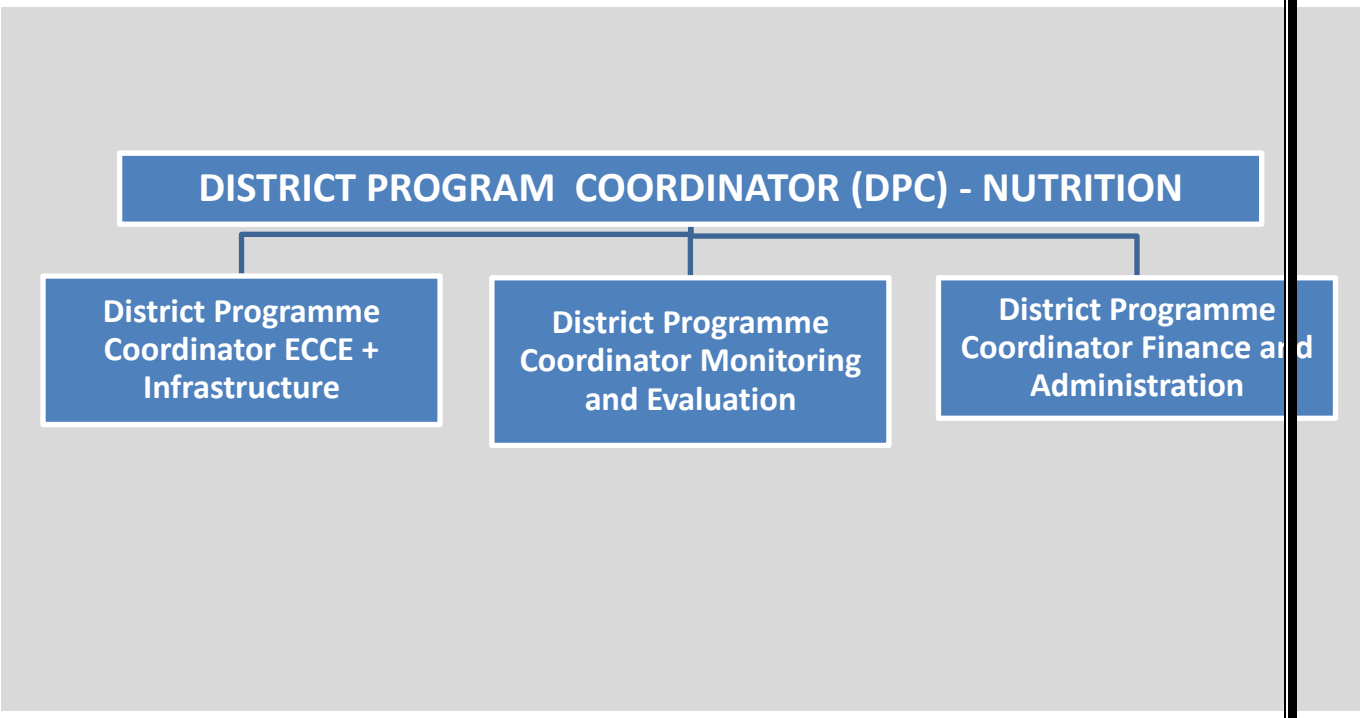
Anganwadis are set up as per the population of a village. The norms for which are

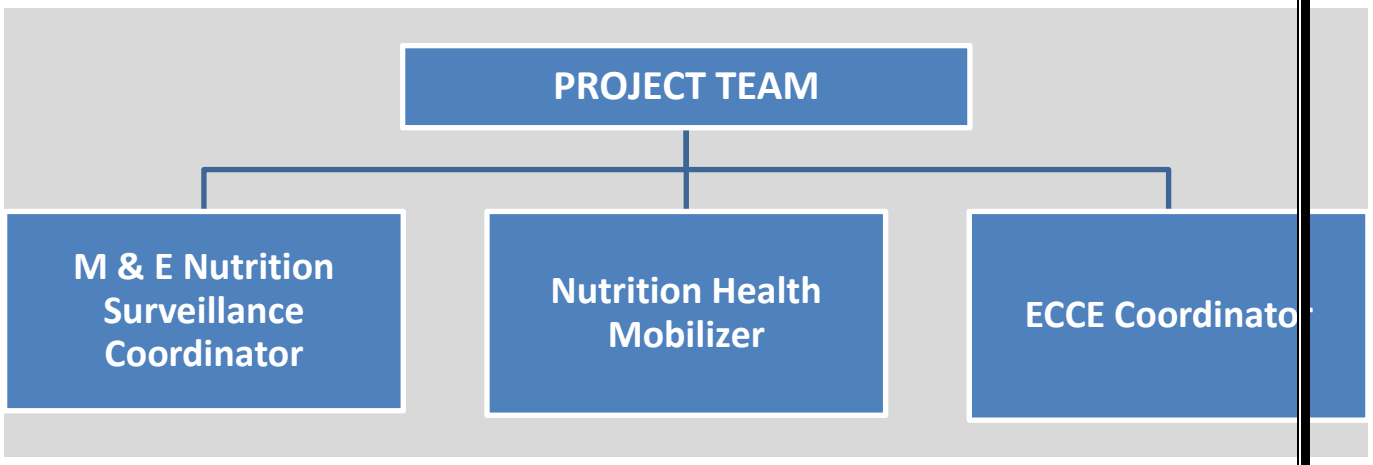
For Rural/Urban Projects	
400 - 800	1 AWC
800 - 1600	2 AWC
1600 - 2400	3 AWC
For Mini AWC	
150 – 400	1 Mini AWC
For Tribal/Riverine/Desert, Hilly and other difficult areas/ Projects	
300 -800	1 Mini AWC

Organizational Structure Of ICDS






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

SERVICES PROVIDED

Services Provided by ICDS Scheme

a) Supplementary Nutrition to 6 months to 6 years aged children, Pregnant and Lactating mothers

b) Non Formal Pre School education to 3 -6 years children

c) Immunization to children and pregnant women

d) Health check ups to children and women

e) Referral services to children and women

f) Health and Nutrition Education to Children, Women and adolescent girls.

Mandate, Goals and Policy frame work

- To reduce Malnutrition in 0-6 year Children.
- Reduction of Children with low Birth Weight.
- To reduce Infant Mortality Rate.
- To reduce Maternal Mortality Rate.
- To educate Mothers about Nutrition & Health.
- To reduce anemia, Vitamin A deficiency and Iodine deficiency among the Children below 6 years and Mothers.
- To improve the Feeding Practices.
- To achieve the above goals Supplementary Nutrition Programme is provided to the Children 0-6 years, Pregnant and Lactating Mothers.

DEPARTMENTS VISITED

The convergence with the Health department for efficacious implementation of health related ICDS activities at the AWCs has not been well established. Organizing effective Mamta Divas through coordination between the FHW and Anganwadi worker requires immense effort. Working with PA nutrition on malnutrition issues is a major step taken up for improving the nutritional status of the district. Further, the Adolescent training is being implemented by effective tie-ups with NGOs ,Kaunshalya

Vardhak Kendra and ITI .Coordination with Gujarat Livelihood Promoter Contributor for set up of Take Home Ration Plant.

STEPS INITIATED FOR STRENGTHENING

- Annual Programme Implementation Plans (APIPs) to have a plan of action for the smooth functioning of the anganwadis. I
- ICDS program in Mission Mode
- Adoption of WHO Child Growth Standards and joint Mother & Child Protection Card 41
- Introduction of the five-tier monitoring system (March 2011) including supervision guidelines (Oct. 2010)
- Draft Guidelines for grading and accreditation of AWCs and awards for service providers and other stakeholder issued
- Revised Management Information System (MIS) completed, Revised MIS Guidelines issued, roll out during current year and spill over next year
- Strengthen the infrastructure at Anganwadi level
- Introduction of skilled human resource for managerial assistance
- Greater involvement of the community and PRI

Problems and Issues

In the duration of 4 months, I have visited 45 Anganwadis and attended 8 block meetings.
During the field visits the following has been observed:

1. ICDS has been restructured on the lines of NRHM and started on a mission mode.

2. ICDS, Gujarat has not taken ground realities into account while designing the new structure instead has copied the NRHM guidelines blindly and rather than converging with the Health

Department in the new structure, ICDS mission also created a parallel structure with the already existing ICDS cell. These two structures many a times give rise to the conflicts and delay the decision making and also mask the transparent reporting and hinder the management information system. There are no clear distinctions of roles and responsibilities in the system. The State consultants unaware of the ground situations fail to make effective guidelines

3. The Anganwadi worker is the one who has to bear the burden of almost 20 registers as Well as providing supplementary nutrition and preschool education. However the salary paid to them is still minimal at the rate of Rs. 4250 per month.

95 percent AWW are highly de-motivated to do the job because of the high pressure, so many people to supervise (supervisors, ANMs,CDPO, MOs) and corruption and exploitation by their Supervisors and CDPOS.

4. It has also been observed that during Mamta Divas that FHW is not able to coordinate with the Anganwadi worker and hence most of the time the AWC remains closed on these days or children are not called to the Anganwadi centre. Also in the Anganwadis located in the urban areas, Mamta sessions are irregular and hence the beneficiaries often visit the district hospital or nearest PHC for the services. Lack of human resource has been cited as one of the main reasons for this.

5. Water and sanitation is the major issue of any AWC in Amreli. Proper hand washing and other sanitation practices have not been followed and children end up using space outside AWC for urinating or sometimes defecating too. No water supply inspite of presence of a toilet is another major reason for bad sanitation practices.

6. It has also been observed that inadequate supply of materials at the AWC is another major reason for inefficient running of the AWC.

7. In the urban areas, mushrooming of the English medium play-schools equipped with high end facilities for children such as Audio-video aids for education and connivance facilities; affect the enrollment in the anganwadis . There is high pressure from the state government on the figures (high enrollment should be visible in the monthly reporting figures); however government fails to take into account the lack of facilities at the anganwadis.

8. The official working language is Gujarati whereas new formats introduced for monthly reporting are in English. Largely, the people working in ICDS system do not understand english which results into wrong and incomplete reporting at the end of the month.

9. Even the number of malnourished children was faked to show the decrease in malnutrition. Because of this, many malnourished children have been devoid of the supplementary nutrition (Third meal or Triju Bhojan- which is provided to severely malnourished children). This trend has set in deep into the system and thus prevents the program to be effective in real time.

10. There is hardly any IEC material available for behavior change communication and education of the community. IEC activities are least focused at the district level, block level, and anganwadi level. Anganwadi workers are not aware as to how and where to use IEC funds.

11. There are no clear guidelines on Kishori Shakti Yojana. Though vocational for adolescent girls have started in many Talukas of Amreli district but again there is an issue of no travel allowance to adolescent girls living farther from the training center.

12. There is no provision for mobility in the district , neither for CDPO ‘s or for district officials and hence regular monitoring and supervision has not been possible all this time. The visits that I have made have been informed ones, so there is a chance of that the true picture has not been shown.

KEY LEARNINGS

1. Prepared the district action plan 2014 -2015 with the help of block action plans and with reports from Health.

2. Providing managerial support to the district and peripheral level Programme Support and Grassroots functionaries.

3. Providing technical inputs in planning, implementation and documentation of child health and nutrition programs.

4. Coordinating and liasoning with various departments and officials at the district level.

5. Analyzing monthly progress report and suggest corrective measures for improving output.

6. Conducted training for Electronic weighing machines at block level.

7. Attend block and sector meetings for information dissemination to Anganwadi workers

8. Hand holding of AWW to help them provide services and document them as well.