Summer Training at

Yahwantrao Chavan Academy of Development Maharashtra (YASHADA)
Pune

April 9th to 31st May 2012

Study on Intersectoral Convergence of Department of Health & Family Welfare and Department of Woman & Child Development in ICDS Scheme in Beed District of Maharashtra

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CERTIFICATE

This is to certify that Dr. Vinodkumar Damodhar Gaikwad from Institute of Health Management Research, Jaipur has undergone Summer Training at Yawhwantrao Academy of Development Administration,Pune from April 9th to 31st May 2012.

The candidate himself carried out all the studies related to her Summer Training. His approach to the studies has been sincere, scientific and analytical. This summer training is partial fulfillment of the course requirement and is recommended for the award of Post Graduate Diploma in Hospital and Health Management.

I wish him success for future endeavor.

Dr. P.R Sodani
Dean, Academic & Student Affairs
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ACKNOWLEDGEMENT

I would like to sincerely thank Mr.Ravindra Chavan, Director,Centre for Social Justice and Equity(CJEC),YASHADA for giving this project to me and hence giving an opportunity to understand the system, functioning and available convergence in ICDS scheme in the state of Maharashtra.

I would also like to thank Dr. P.R. Sodani, Dean(Health stream), IIHMR, Jaipur, for being a continuous guiding source throughout the project.

I am thankful to my team at YASHADA for their timely course corrections and friendly guidance throughout the course of my project study. I express my gratitude to all the staff of sub centre and anganwadi for giving me micro level details about the ICDS scheme working in Maharashtra state.

List of abbreviation:

- DWCD = Department of woman and child development
- DHFW = Department of health and family welfare
- ISC = Intersectoral convergence
- MIS = Management information system
- IMR = Infant mortality rate
- BCC = Behavior change communication
- MMR = Maternal mortality ratio
- AW = Anganwadi
- SC = Sub center
- ANC = Antenatal care
- PNC = Postnatal care
- AWW = Anganwadi worker
- CDPO = Child development project officer

PURPOSE OF SUMMER INTERNSHIP:

Practical exposure is an integral part of postgraduate diploma in health and hospital management. As a part of curriculum, I had a privilege to get hands on experience in YASHADA, Pune where I learnt the functioning of Government and various health programmes at district, block, CHC , PHC and sub centre level. During my internship I visited DHS, PHC, CHC where I learnt functioning of health system and worked in a project Intersectoral convergence of Department of Health & Family welfare and Department of Women & Child development in ICDS in Maharashtra.

1. To understand functioning of CHC, PHC, SC, Anganwadi, district hospital and tertiary care centre etc and learn various managerial inputs required in an organization.
2. To understand the ongoing activities and my responsibility so as to contribute in the best possible manner to the organization and project given to me.
3. Develop skills in collection of primary data, operations and managing task also managerial issues of the program me.
4. The above objective required extensive reading and interaction with the staff to get brief idea of the STATE HEALTH SYSTEM and its functioning style.

Section – 1

About Organization:

Yahwantrao Chavan Academy of Development Maharashtra (YASHADA),Pune:

Yashwantrao Chavan Academy of Development Administration (YASHADA) is the Administrative Training Institute of the Government of Maharashtra, and meets the training needs of government departments and rural and urban non-official and stakeholders.

Human Resource Development has traditionally been one of Maharashtra's major strengths. The importance of evolving sound and responsive administrative systems was realized as far back as 1963 when the Administrative Staff College (ASC) was established in Mumbai. The ASC was relocated at Pune in 1984 and renamed "Maharashtra Institute of Development Administration" (MIDA). MIDA, constituted as an autonomous society under the Societies Registrations Act, 1860, was to serve as the apex body for promoting and developing modern management practices and was to function as the nodal state level training institute in the field of development administration. Aptly enough, it was renamed, "Yashwantrao Chavan Academy of Development Administration" (YASHADA) in 1990, as a tribute to the pioneering spirit of the late Shri Y. B. Chavan, former Chief Minister of Maharashtra & Deputy Prime Minister of India, who had inspired the setting up of the ASC.

OBJECTIVES-

YASHADA is a composite training institute having a dual role as an ATI and a SIRD.

The objectives of YASHADA are :

- To promote modern management science as a major instrument for development of economic and social activities of the State Government, Zilla Parishads and other institutions and organizations of the State Government.
- To develop managerial skills, organizational capability, leadership and decision-making ability for development planning and efficiency in implementation of policies, programmes and projects.
- To carry on operational and policy-oriented research, to evolve ideas and concepts appropriate to the local, state and national environment and to formulate policy alternatives.
- To serve as the apex institute for the collection and dissemination of information regarding development administration.
- To foster, assist and support individuals, organizations and institutions in the use of management science.
- To provide consultancy services in development and public administration.
- To function as the nodal State-level training institute in the field of development administration.

Department of woman and child development (DWCD): The Department of Women and Children (DWCD) is the repository of national programmes for the holistic development of women and children. It includes: the Integrated Child

Development Services (ICDS), to provide supplementary nutrition for pregnant and lactating mothers and children under six, and non-formal preschool education; programmes to ensure social and economic empowerment of women through collectivization, welfare and support services, training for employment and income generation, and gender sensitization. At the village level, the DWCD is represented by a village level honorary worker, the Anganwadi Worker (AWW) and her assistant, an Anganwadi helper. DWCD norms stipulate one Anganwadi Center (AWC) for a population of 1000 in plains and 700 in tribal areas. Supervision of AWW is by the Mukhiya Sevika, who is in charge of about 15-20 AWC. At the block Level, the Child Development project Officer is the functionary in charge of DWCD schemes.

Department of health and family welfare (DHFW): The goal of the Department of Health and Family Welfare (DHFW) is to ensure universal access to quality health care. All programmes of the DHFW are channeled through a three-tier system. The unit closest to the community is the sub center. It is staffed by an Auxiliary Nurse Midwife, covers a population of 5000 (about 3-5 villages) and offers a mix of center based and field outreach. The sub center is expected to provide services for a range of primary health care interventions, but is substantially focused on maternal and child health.

SECTION -2

Project Work:

Convergence: Convergence is a Process that facilitates different functionaries and community to work together for efficient service delivery. Intersectoral convergence means convergence between two department here two departments are department of health & family welfare and department of woman & child development.

Integrated Child Development Services (ICDS) Scheme

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**.**

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.

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.

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 includes regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, de-worming and distribution of simple medicines etc.

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 (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.

Nutrition and Health Education: Nutrition, Health and Education (NHED) are 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.

RESARCH QUESTION:

To understand the extent of intersectoral convergence between DHFW & DWCD in ICDS schemes.

OBJECTIVES:

(1) To find out the present extent of convergence between DWCD & DHFW in the following area

- Immunization
- Health checkups services
- Referral services
- Village health & nutrition education

(2) To find out the gap in the ICDS scheme services.

(3) To make recommendation to bridge this gap.

STUDY DESIGN

Type of study: Descriptive cross sectional study.

Study Period: 9th April 2012 to 31st may 2012.

Study Area: Beed district of Maharashtra state

Study unit: Sub centre for DHFW and Anganwadi for DWCD,

SAMPLING:

Study unit for DHFW is sub centre and study unit for DWCD is anganwadi. Sub centre was selected by cluster random sampling and Anganwadi was selected by simple random sampling from each selected sub centre.

Cluster random sampling: Total cluster or sub centre taken for study were 20 because 20 are more than 10 % of 172 subcentres in beed district of Maharashtra. .In this sampling method all 172 sub centre of Beed district were arranged in descending order of their population. Next cumulative population was calculated. First cluster was selected by dividing total population of all 172 sub centre by 20. So first sub centre selected was cumulative population having less than this value. After that another 19 sub centre was selected by subsequently adding this value to cumulative population of first selected sub centre.

Simple random sampling: Anganwadi under each sub canter was selected by simple random sampling. In this method. For this list of aw under each sub centre was taken and one aw from each centre was selected by chit system.

METHODOLOGY

The following tools were used for carrying out the study; some of the tools were purely used for exploratory research.

Secondary Research/survey: ICDS scheme document, some already publish paper on intersectoral convergence from internet were studied in great depth for a better understanding of the topic.

Primary Research/survey: Primary Research has been the most crucial tool used in the form of interviews with ANM, AW to understand the extent of convergence. Finally Director of DWCD & DHFW was interviewed for recommendations.

Questionnaire: Interview guides and questionnaires formed the backbone of most primary surveys and interviews.

Finding and Analysis:

(1) Immunization :

Table 1- Convergence between DWCD & DHFW in immunization services:

Convergence	Number of health centre	Percentage
Yes	20	100 %

Convergence between DWCD & DHFW in Immunization services is 100 %. The anganwadi worker helps health department in identification of target group. They also motivate community people for immunization.

Immunization coverage of beed district is more than 80 %. Rest 20 % people who are not getting immunized are seasonal migrant people. Near about 30 % population of Beed district is migrant. Out of this 30 % migrant population, about 10% population is covered for immunization because of proper coordination of ANM and AWW. An outreach camp is arranged by Health department with the support of AWW for immunization of migrant people.

In some area where migrant population is more, example in Naigaon SC under the PHC of Patoda immunization coverage is less (almost 50 %) as compare to rest of the Beed district.

(2) Health checkups services :

Graph -1 Convergence between DWCD & DHFW in health checkups services like ANC, PNC.

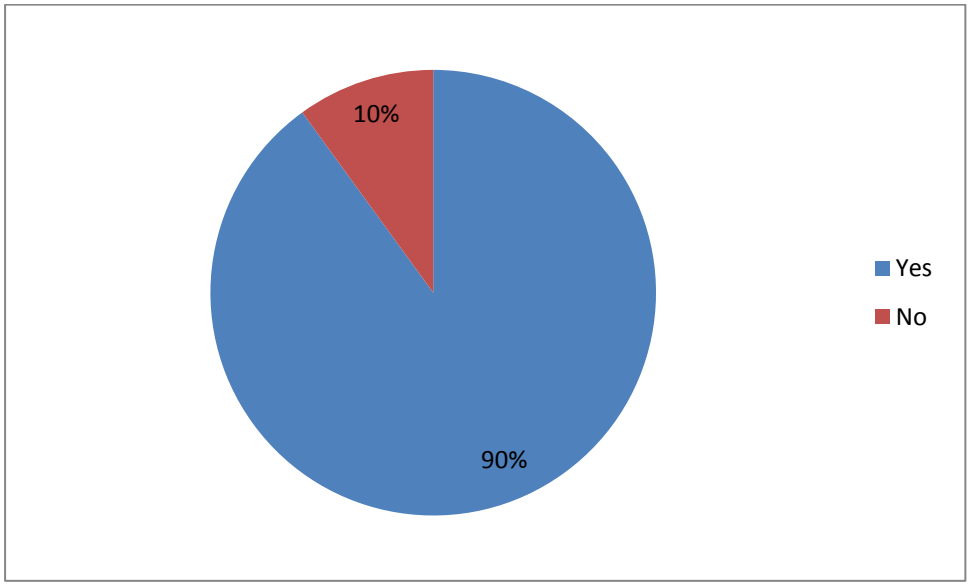


Table 2-After how much time MO visit the AW:

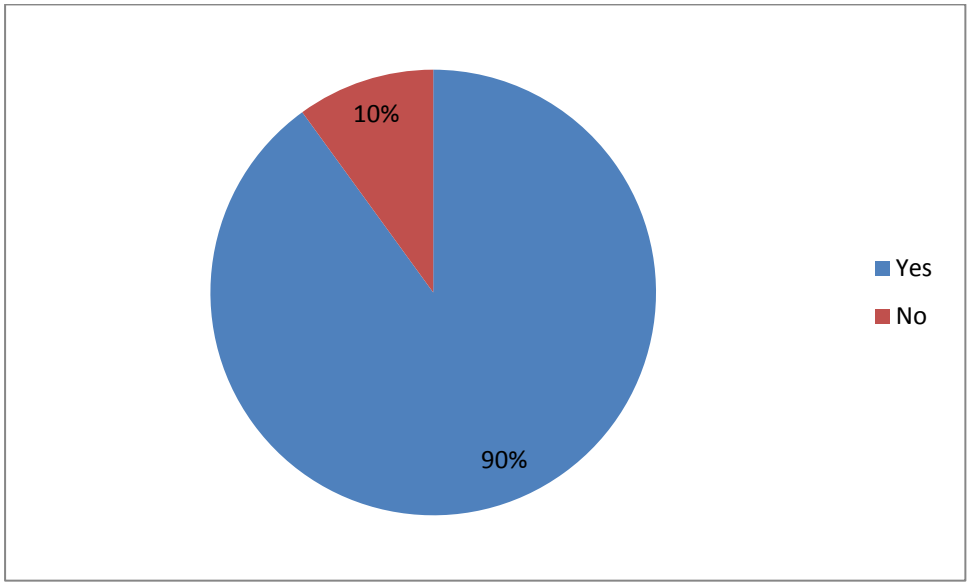
Duration in months for MO visit at AW	Number of AW	Percentage
3	16	80%
4	2	10%
6	2	10%

Convergence between DWCD & DHFW in Health checkup services like ANC, PNC etc. is 90 %. In this when ANM visit the area AWW mainly help in identification of target group which are mainly pregnant and lacting woman, children below the age group of six. And at these 90 % places all the maternal and child health services are reaching to target group on time.

At 10 % AW there is coordination gap between AWW and ANM. AWW does not inform the ANM about ANC, PNC case in their area to ANM .Only difficulty found by ANM is that she has to find the case herself and it may take some time but still all the services are reaching to target group.

(3) Referral services :

Graph 2- Convergence between DWCD & DHFW in referral services:



Convergence between DWCD & DHFW is 90 % in referral services. Whenever a child is found malnourished, mentally disabled or with any disabilities is referred by AW to health centre for further treatment. Some examples are like

(a) Some dental carries cases were referred by AWW at Savarkhed health centre (from Kaij SC area)
(b) Some dysentery cases were referred by AWW at CHC Georai and PHC jategaoni.
(c) One mental disability case was referred by Aher Wadgaon AW at Kaij health centre.

Only at 10% places there is gap because distance between AW & Health centre is more and there is also no coordination between both department employees.

(4) Health and Nutrition education :

Table 4 Convergence between DHFW and DWCD in VHND:

Duration in months for VHND at AW	Number of AW	Percentage
1	14	70%
2	5	25%
6	1	5%

At 70 % anganwadi village health and nutrition day conducted within a month so there is full coordination between ANM and AWW.

At 25 % anganwadi VHND is conducted once in a two month so there is a partial convergence. It is because of following reason –

(a) Number of AW under sub centre is more and number of ANM at SC is one so it is not possible for ANM to cover all the AW in a month.
(b) Distance between AW and SC is more and also area is remote.
(c) Transportation problem

At 5 % anganwadi VHND is conducted within a 6 months so there is no convergence between ANM and SC it is because both AW and ANM are not coordinating with each other

RECOMMENDATION:

(1) For Immunization :

(a) To increase immunization coverage of migrant population frequency of out reach camp can be increased with proper planning, specially in that area where migrant population is more.

(b) Tracking ID for migrant people: a tracking id for migrant people can be introduced. For this three main things are required :

(i) A health card for each migrant should be compulsory. This card will design in a way that it should contain information of each family member, a unique tracking id and medical history of each family member.

(ii) A joint MIS by which all the health centre's of Maharashtra are connected.

(iii) It should mandatory for floating migrant that whenever they migrant within a state, they must inform the near by health centre.

So by this way at new health centre all the past medical history of migrant family can be track by this unique ID.

(2) For Health checkups and Referral services :

(a) Joint Training: Joint training of AWW and ANM is required. So both of them can be aware about their responsibilities.

(b) Department level suggestion: In this if grass root level worker AWW or ANM are having problem in coordination than AWW or ANM must inform to their department senior like Health officer for health department CDPO for Woman and child development department. Than coordination gap can be filled interfere of both departments senior. If problem is not solved at this level than problem can be solved at department level means by the interfere of DHFW and DWCD.

(3) For Village Health and Nutrition Day :

Number of ANM must increase specially at those SC which cover more population and larger area.

(4) Providing sufficient medicines / medical apparatus

Medical Officer responsible for health check up

Monthly Meetings of Medical Officers and CDPOs

ANNEXURE:

(1) Questionnaire for sub centre :

QUESTIONNAIRE FOR SC

Name of SC: Population covered by SC:

PHC under which SC comes: No. of AW under SC-

Q.1 Does in immunization services AWW supports ANM?

(Yes =1, No=2)

Q.2 If yes than how –

Q.3 If no than specify the problem –

Q.4 Does in health checkups services like ANC, PNC AWW supports ANM –

(Yes=1, no=2)

Q.5 After how much time medical officer visit the AW -

Q.6 If MO visit duration is more than 3 months than specify the problem -

Q.7 Does in Referral services AWW supports ANM –

(Yes=1, no=2)

Q.8 If yes than some examples of refer cases-

Q.9 If no than specify the problem-

Q.10 After how much time VHND is conducted at AW –

Q.11 If duration is more than one month than specify the problem-

Q.12 Any other issue with AWW or any activity in which AWW are not supporting-

Q.13 Any other suggestion to improve coordination between AWW & ANM-

(2)Questionnaire for AW:

QUESTIONNAIRE FOR AW

Name of AW: Population covered by AW:

SC under which AW comes:

Q.1 Does in immunization services you supports ANM?

(Yes =1, No=2)

Q.2 If yes than how –

Q.3 If no than specify the problem –

Q.4 Does in health checkups services like ANC, PNC you supports ANM –

(Yes=1, no=2)

Q.5 After how much time medical officer visit the AW -

Q.6 If MO visit duration is more than 3 months than specify the problem -

Q.7 Does in Referral services you supports ANM –

(Yes=1, no=2)

Q.8 If yes than some examples of refer cases-

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Q.12 Any other issue with ANM or any activity in which ANM are not supporting-

Q.13 Any other suggestion to improve coordination between AWW & ANM-

References:

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