UNIT 4 INTEGRATED CHILD DEVELOPMENT SERVICES PROGRAMME

Contents

4.0 OBJECTIVES

This unit aims at acquainting you with ICDS (Integrated Child Development Services) Programme. It is the world's widest children's programme, which offers an integrated package of service to mothers and children. The package comprises mutually reinforcing

components of health, nutrition and preschool education. On completion of reading through this unit, you will be able to :

- enumerate the objectives of ICDS programme;
- understand the strategy services provided under the programme;
- describe the administrative structure of ICDS programme;
- state the importance of additional thrusts like
    - Adolescent girl's scheme,
    - Balika Mandal, etc.
- understand the concept of community participation in the programme;
- enhance your knowledge on the innovative concept like 'udisha' and
- review the functioning of the programme at the field level.

5.1 INTRODUCTION

Integrated Child Development Services (ICDS), globally considered as one of the world's largest and most unique community based outreach systems for promoting early childhood care for survival, growth and development, has covered many milestones since its inception in the year 1975. India is home to 21 percent of the developing world's young children - more than 170 million children under six years of age, constituting 17.5 percent of India's population.

2. The constitution of India , Directive Principles of State Policy, and the National Policy for Children 1974, have recognized this priority, and are addressing the holistic

needs of young children, as the foundation of the national human resource development effort. The National Policy for Children 1974, acknowledged that since a majority of India's children live in economic and social environments, which can impede their physical, social and mental development, special interventions are required to provide equality of opportunity to these children. The policy stressed that while poverty alleviation and community development programmes must continue, focussed child centered interventions were required to address the interrelated needs of children and women from disadvantaged community groups. Based on this conviction, the Integrated Child Development Services (ICDS) programme was launched on 2nd October, 1975, in 33 blocks 28 years ago.

4.2 ICDS: OBJECTIVES AND TARGET GROUPS

The ICDS Programme provides an integrated approach for covering basic services for improved child care, early stimulation and learning , health and nutrition, water and environmental sanitation, targeting young children, expectant and nursing mothers and women's /adolescent girl's groups. The programme offers a powerful community based outreach system that functions as the convergent interface between disadvantaged communities and government programmes, such as primary health care and education. It contributes to the achievement of major nutrition and health goals embodied in the National plan of action for children in 1992 and national plan of action on nutrition 1995.

The Major objectives of the programme are as under:

- Lay the foundation for the proper psychological , physical and social development of the child;
- Improve the nutritional and health status of children below the age of six years;
- Reduce the incidence of mortality, morbidity, malnutrition and school dropouts;
- Achieve effective coordination of policy and implementation among various departments to promote child development;
- Enhance the capability of the mother to look after the normal health, nutritional and development needs of the child through proper community education.

Services and Target Beneficiaries

The target beneficiaries in the scheme are women and children. The principal participants of the scheme, i.e., children below six years, expectant and nursing mothers and women in the age group of 15 to 45 years receive supplementary feeding, growth monitoring and promotion , immunization , health checkup, referral services, nutrition and health education and early childhood care and preschool education. In addition, there is coverage of other important supportive services like safe drinking water, environmental sanitation , women's development and education programme. Different target groups are provided a different package of services.

Beneficiaries are selected after a comprehensive survey of all families in the area to ensure that the most deprived are covered under the programme.

Beneficiaries	**Services**
1. Children below three years	supplementary nutrition immunization health checkups referral services
2. Children between three and six years	supplementary nutrition immunization health checkups referral services Non formal preschool education
2. Expectant and nursing mothers	supplementary nutrition immunization health checkups referral services nutrition and health education

4. women between 15 and 45 years Nutrition and health education

4.3 DELIVERY OF SERVICES

The focal point in the village for delivery of these services is the Anganwadi center, which runs with the help of the Anganwadi worker, educated up to tenth standard and preferably to be selected from the same village. Depending on the nature of the project as rural/urban or tribal, the Anganwadi Centre is based on a population of 1000 for rural/urban and 750 for tribal population. Therefore, in a block of one lakh population, there would be 100 Anganwadi centers. For location of rural and tribal projects under the ICDS programme, priority is given to areas predominantly inhabited by scheduled castes/scheduled tribes, backward areas, drought prone areas, nutritionally deficient areas and areas poor in development of social services. In case of urban areas, priority is given to slums. The Anganwadi worker is assisted by a helper in the implementation of the prograamme. The activities at the center is supervised by a supervisor who reports to the Child Development Project Officer who is the overall in-charge of the implementation of the progrmme in the community development block.

The six services provided in an Anganwadi Centre are as under

1. Health checkups

This includes health care of children under 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 PHC staff include regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, deworming and distribution of simple medicines, etc.

At the Anganwadi, children, adolescent girls, pregnant women and nursing mothers are examined at regular intervals by the Lady Health Visitor (LHV) and Auxilliary Nurse Midwife (ANM) who also diagnose minor ailments and distribute simple medicines. They provide a link between the village and the Primary Health Care Sub-centre. Maternal and child health facilities are geared towards providing adequate medical care during pregnancy, at the time of childbirth and subsequently. It is aimed at promoting safe motherhood and healthy child development, thereby reducing maternal and infant mortality.

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.

PHC and its subordinate health infrastructure carry out immunization of infants and expectant mothers as per the national immunization schedule. Children are also given booster doses. The Anganwadi worker assists the health functionaries in the coverage of the target population for immunization. She helps in the organization of fixed day immunization sessions, which now have become "Mother-Child Protection Days". She maintains immunization records of ICDS beneficiaries and follows up to ensure full coverage.

3. Referral Services

During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are provided referral services through ICDS. 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. The effectiveness of this service depends on timely action, cooperation from health functionaries and willingness of families to avail of these services. Health departments in states/UTs identify one hospital at the district level, which attends to the referral cases coming from ICDS areas.

4. Supplementary Feeding

All families in the community are surveyed to identify low-income families and deprived children below the age of six, pregnant and nursing mothers and adolescent girls. 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. This pattern of feeding aims only at supplementing and not substituting for family food. It also provides an important contact opportunity with pregnant women and mothers of infants and young children to promote improved behavioral actions for care of pregnant women and young children.

The type of food varies from state to state, but usually consists of a hot meal cooked at the Anganwadi, containing a varied combination of pulses, cereals, oil, vegetables and sugar/iodized salt. Some states provide a ready-to-eat meal, containing the same basic ingredients. There is flexibility in the selection of food items to respond to local needs. The expenditure towards supplementary feeding is met by the State under the plan budget, available for the Minimum Needs Programme.

Food supplements are provided to pregnant women and nursing mothers (up to six months of nursing) to help to meet the increased requirements during this period. This provides a crucial opportunity to counsel pregnant women thereby enabling utilization of key services, i.e., antenatal care, immunization, iron folic acid supplementation and improved care, adequate extra family food and rest during pregnancy. Pregnant women and nursing mothers are also counselled to promote exclusive breastfeeding of infants up

to about six months of age. They are encouraged to seek timely immunization and commence appropriate and timely complementary feeding when their infants are around six-months of age, so that by the time the baby is one year old, she or he receives a complete wholesome diet daily. This is accompanied by continued breastfeeding up to two years.

Special care is also taken to reach children below the age of two years, and to encourage parents and siblings to either take ration home or to bring them to the Anganwadi for supplementary feeding. This provides a contact opportunity for growth monitoring of children under two years of age and nutrition counselling of mothers for improved childcare and development practices.

National Prophylaxis Programme for prevention of blindness caused by vitamin A deficiency, and control of nutritional anaemia among mothers and children, are two direct nutrition interventions integrated in ICDS. Dietary promotion of food rich in vitamin A, iron, folic acid and vitamin C is an important part of nutrition and health education and targeted supplementation is also provided. At nine months of age, 1,00,000 IU of vitamin A solution is administered to infants, along with immunization against measles. Children in the age group of 1-5 years receive 200,000 IU of vitamin A solution every six months, with priority given to children under three years of age. Tablets of iron and folic acid are administered to expectant mothers for prophylaxis and treatment and to children with anaemia. The Anganwadi worker/auxiliary nurse, midwife dispenses these supplements

and they monitor their utilisation. The usage of only iodized salt is promoted, especially in the food supplement provided, towards preventing iodine deficiency disorders.

5. Nutrition and Health Education

Nutrition, Health and Education (NHED) is a key element of the work of the Anganwadi worker. 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. All women in this age group are expected to be covered by this component. NHED comprises basic health, nutrition and development information related to childcare and development, infant feeding practices, utilisation of health services, family planning and environmental sanitation. Community education is imparted through counselling sessions, home visits and demonstration.

Anganwadi workers use fixed day immunization sessions, mother-child protection days, growth monitoring days, small group meeting of mothers/Mahila Mandals, community and home visits, village contact drives and other women's groups meeting (DWCRA, Mahila Samakhya, etc.) local festivals/gatherings for nutrition, health and development education. Presently, there are nearly 100,000 Mahila Mandals, which are actively involved in extending community education activities.

All efforts are made to reach out to women, including pregnant women and nursing mothers to promote improved behavioural actions for care of pregnant women, young children and adolescent girls at household and community levels, and to improve service utilisation. Sustained support and guidance has to be provided in the period spanning pregnancy and early childhood to mothers/families of young children, building upon local knowledge, attitude and practices. This helps promote early childhood care for survival, growth, development and protection.

6. Early Childhood Care And Preschool Education

The Early Childhood Care and Preschool Education (ECCE) component of the ICDS may well be considered the backbone of the ICDS programme, since all its services essentially converge at the Anganwadi. This is also the most joyful playway 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. ECCE, as envisaged in the ICDS, focuses on total development of the child, in the age range of up to six years from the underprivileged groups. It includes promotion of early stimulation of the under-three years olds through interventions with mothers/caregivers. 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. Child-centred playway activities, which build on local culture and practices, using local support materials developed by Anganwadi workers through enrichment training, are promoted. The early childhood preschool education

programme, conducted through the medium of play, aims at providing a learning environment for the promotion of social, emotional, cognitive, physical and aesthetic development of the child. Through ICDS, 12.5 million children (three to six years of age), from disadvantaged groups, are participating in centre-based early learning activities.

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 universalisation 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.

For this, improved local level coordination between the Anganwadi worker and primary school teacher--are being promoted.

Growth Monitoring and Promotion

Growth Monitoring and nutrition surveillance are two important activities that are in operation at the field level in ICDS. Both are important for assessing the impact of health and nutrition related services and enabling communities to improve the same. Children below the age of three years of age are weighed once a month and children in the age group of 3-6 years are weighed quarterly. Fixed day immunization sessions or days when mothers of children under two years collect take-home ration, are opportunities for

growth monitoring and promotion of younger children. Weight-for-age growth cards are maintained for all children below six years. This helps to detect both growth faltering and also in assessing nutritional status.

Growth monitoring and promotion helps the mother/family and Anganwadi worker/auxiliary nurse, midwife in taking timely cost-effective preventive action, to arrest any stagnancy or slipping down in weight through early detection of growth faltering. Through discussion and counselling, growth monitoring also increases the participation and capability of mothers in understanding and improving childcare and feeding practices for promoting child growth and development. It helps families understand better the linkage between dietary intake, health care, safe drinking water and environmental sanitation and child growth. Growth monitoring and promotion can also be an effective entry point for primary health care.

Identified severely malnourished children (those placed in grade III and IV) are given special supplementary feeding, which may be therapeutic in nature, or just double ration, and are also referred to medical services.

The concept of community-based nutrition surveillance has also been introduced in ICDS. A community chart for nutrition status monitoring is maintained at each Anganwadi. This chart reflects the nutritional status of all children registered with the Anganwadi at any given point of time. This helps the community in understanding what the nutrition status of its children is, why it is so, and what can be done to improve the

same. This helps mobilise community support in promoting and enabling better childcare practices, in contributing local resources and improving service delivery and utilisation.

4.4 ADDITIONAL THRUST AREAS

Adolescent Girls' Scheme

ICDS, with its opportunities for early childhood development, seeks to reduce both soio-economic and gender inequities. In order to address concerns for women and the girl child, it was necessary to design interventions for adolescent girls. This is aimed at breaking the intergenerational life cycle of nutritional disadvantage, and providing a supportive environment for self-development.

For the first time in India, a special intervention has been devised for adolescent girls, using the ICDS infrastructure. This intervention focuses on school drop-outs, girls in the age group of 11-18 years, with a view to meet their needs of self development, nutrition, health, education, literacy, recreation and skill formation. Special emphasis is also placed on reducing nutritional anaemia among this group. This scheme has been sanctioned in 507 blocks covering all States and UTs.

The Adolescent Girls Scheme was launched as part of the lCDS programme, comprising an additional thrust area of the programme. This has been done following the recognition of the fact that:

- Any programme, in terms of their basic needs, does not cover girls in the crucial age group of 11-18 years.
- The adolescent girl is a crucial human resource and a potential bridge between the community and the changes that the ICDS philosophy intends to bring about in the lives of children and women, and through them, the entire community.

The objectives of these schemes for 11-18 years old girls include the following:

I. To improve the nutritional and health status of girls in this age group.

ii. To provide them the required literacy and numerical skills through the non-formal stream of education.

iii. To stimulate a desire for more social exposure and knowledge and to help them improve their decision-making capabilities to train the girls and help them improve and upgrade home-based skills and;

iv. To promote awareness of health, hygiene, nutrition, home management, child care and family welfare.

The task of organising the adolescent girls and educating them in these various areas has been assigned to the A*nganwadi* worker. It is envisaged that these girls will play an active role in the actual running of the A*nganwadi, s*haring work and involving themselves in the decision making process with the worker and helper.

These initiatives are covered in 507 ICDS Projects of the country. An unmarried adolescent girl in the age group of 11-18 years belonging to families falling below poverty line in rural areas will be eligible to receive these services. In the selected Blocks, the State-Governments provide health services like immunization, general health check-up every six months, treatment of minor ailments, de-worming, prophylaxis measures against anaemia, goitre, vitamin deficiencies, etc., referral in case of acute need. These services will be provided to all adolescent girls in the age group of 11-18 years. The programme is run in coordination with the State Government and state Health and Family Welfare Departments. Besides the above mentioned educational and health services, additional services under two schemes will be provided to girls between 11 and 15 years, and 15 and 18 years, respectively.

Scheme I : Girl-to-Girl Approach

This scheme is for the age group of 11 to 15 years. Three girls will be identified from each selected *anganwadi.* Preference will be given to those from families below the poverty line. In addition to the services mentioned earlier, these girls will receive:

i. A meal that will provide 500 calories and 20g proteins, on all six working days of the week.

ii. In--service training from the *anganwadi* worker and supervisor over a period of six months.

Scheme II : Balika Mandal

This scheme has been initiated for girls in the age group of 15 to 18 years. The objectives include involving and motivating these girls in non-formal education and up--gradation of home-based skills and educating them about personal hygiene, environmental sanitation, first aid, nutrition and child care. In addition, facilities for recreation and entertainment will be provided.

It is expected that 10 per cent anganwadi in the selected ICDS Blocks will act as a centre for Balika Mandal. Timings of Balika Mandal will be other than those of the anganwadi and will be decided as per the convenience of the participating adolescent girls.

To achieve its objectives, the scheme provides for appointment of honorary instructors. The anganwadi worker, serving as a regular honorary instructor for Balika Mandal, will be paid an additional honorarium of Rs. 150/- per month.

Training of functionaries

Training is the most crucial element in ICDS, since the achievement of programme goals depends upon the effectiveness of frontline workers in empowering communities for improved childcare practices as well as effective intersectoral service delivery. Recognising this, from the inception of the programme itself, the Government of India formulated a comprehensive training strategy. The National Institute of Public Cooperation and Child Development (NIPCCD), New Delhi, is the apex body for the training of ICDS functionaries. The Institute is responsible for planning, Coordinating and monitoring the training of ICDS functionaries; revision, standardization and updating

of training syllabi; development of effective training methods; preparation, procurement and development of training materials; and organising the training of trainers.

A number of training programmes have been designed for ICDS personnel. These include initial job training and refresher training of CDPOs, supervisors and anganwadi workers; orientation courses for helpers; and workshops for senior officers dealing with the ICDS programme in states and Union Territories. NIPCCD also formulates modules and assists in imparting skill training programme for instructors of middle level training centers and anganwadi training centers all over the country.

While the training of CDPOs is the direct responsibility of NIPCCD, the training of supervisors is conducted by about 30 training centers located in each of the state, depending on the training targets. These training centres are known as Middle Level Training Centres (ML TCs). The training centers have a full fledged staffing pattern with three instructors in the areas of social work, child development and nutrition, respectively with a coordinator. The centers are run under the direct supervision and guidance of State Governments. NIPCCD provides the technical input in issues related to module and implementation of training programme, etc. The training of Anganwadi workers is entrusted to Non Governmental oranisations as well as to Schools of Social Work, Colleges of Home Science and training institutions run by the state governments. There are about 300 Anganwadi Training Centres all over the country.

Community Participation

ICDS is development-oriented and its ultimate success depends, to a large extent, on the participation of the local community in the programme. In the context of ICDS, community participation would imply acceptance of the programme, utilisation of services, contribution of material and other resources, assisting in the delivery of services, and supervising and providing feedback on the functioning of the programme.

The participation of the people could be on individual as well as on collective basis. While involvement of individuals is important, participation, in order to be meaningful and sustained, must be institutionalized. Local level organisations have a better potential for influencing decisions. These organisations can provide a forum for people to discuss issues and problems relating to implementation of the ICDS programme and to work out alternative ways and means of tackling them. In addition, such organisations can help in filling gaps in the services and also in acting as watch dogs on behalf of the community.

Local organisations like panchayats, Mahila Mandals, youth organisations, and voluntary social service organisations could be effectively mobilised to provide help in the planning and implementation of the programme. Their participation would also greatly reduce mismanagement and wastage of resources. It would also help in making the services suited to the requirements of beneficiaries and in reducing the administrative and operational costs of the programme. In addition, it would help ensure that the intended beneficiaries are not left out in the delivery of the package of services.

Strengthening process for women' empowerment (Swayamsidha)

Mobilizing women for promoting their own health, nutritional well being and self development, as well as that of their children, is an underlying principle of ICDS. This was furthered by introduction of ICDS adolescent girls' scheme in 507 blocks during 1991 – 92. Indira mahila yojana (IMY), fostered new possibilities for ICDS to promote processes for women's empowerment. The scheme was started in 200 blocks of the country in the year 1992 wherein three major components like convergence of intersectoral services, awareness creation and income generation activities. Homogenous women's groups have been constituted, forming a registered society, known as Indira Mahila Kendra at village /anganwadi level. The anganwadi worker is the secretary of IMK, which has an elected executive body. At the block level, there is an Indira mahila block, society (with CDPO as the secretary) linked to the district zila parishad. IMY provided for activities based on the felt needs of women's groups. The IMY programm provides the umbrella cover for all sectoral programmes, including non formal education, training, family welfare and minimum needs programme. IMY also helps create a supportive environment for greater participation of adolescent girls in balika mandals in ICDS areas.

Swayamsidha

It was envisaged to recast Indira Mahila Yojana (IMY) into an integrated programme for women's empowerment, renamed Swayamsidha (IWEP) and to expand it from the existing 238 blocks to 650 blocks by the end of IXth plan. The programme is

likely to be expanded to all the ICDS blocks. The objective of swayamsidha is the all round empowerment of women, especially socially and economically, by ensuring their direct access to, and control over resources through a sustained process of mobilization and convergence of all the ongoing sectoral programmes. The immediate objectives of the programme are:

- Establishment of self reliant women's self help group.
- Creation of confidence and awareness among members of SHGs regarding women's status, health, nutrition, education, sanitation and hygiene, legal rights, economic upliftment and other social, economic and political issues.
- Strengthening and institutionalizing the saving habit in rural women and their control over economic resources.
- Improving access of women to micro credit.
- Involvement of women in local level planning.
- Convergence of services of DWCD and other departments.

In every block, Project implementing agency will be involved in the formation of 100 SHgs at the sub village/village level at a remuneration of Rs. 2750/- for successful formation of each group. Each group will have 15 – 20 members, with one leader/key person with attempts being made to have homogenous groups of the same socio economic status. All groups at the sub village level will federate by sending one representative each at the village level to form village societies (VSs). Women groups formed under the government sponsored programme like DWCRA, mahila Samakhya, Mahila Swastha Sangh, Yuvati Kendras, etc will also participate in such federations.

The village level societies, then is federated to the block level by sending one representative each to form block societies (BSs).

4.5 ADMINISTRATIVE STRUCTURE

The ICDS team

The ICDS team comprises the Anganwadi helpers Anganwadi workers, Supervisors and the Child Development Project Officers (CDPOs). In larger sized rural tribal projects, Additional Child Development Project Officers (ACDPOs) are also a part of the team.

The medical officers (MOs), the lady health visitors (LHVs) and female health workers (FHW) from nearby primary health centres (PHCs) and sub-centers form a team with functionaries of the social welfare/women and child development departments in the implementation of ICDS.

The Anganwadi worker is a community-based, frontline voluntary worker of the ICDS programme. Selected from the community, she assumes a pivotal role due to her close and continuous contact with the people, especially women she works with. As a crucial link between village population and the Government administration, she becomes a central figure in helping the community identify and meet the needs of their children and women. As a caregiver looking after children at the Anganwadi centre, she plays a crucial role in promoting child growth and development. She is also an agent of social

change, mobilising community support for better care of young children, girls and women.

The anganwadi worker is expected to monitor and promote the growth of children, with the active participation of communities/families. She enhances their capability for preventive and promotive actions for child growth and development. She also enables them to prevent diseases/infections. The Anganwadi worker organises supplementary feeding, helps organise immunization sessions, distributes vitamin A supplement and iron and folic acid tablets, treats minor injuries and ailments, and refers cases to medical services.

The more visible aspect of her role is in making the Anganwadi literally a courtyard play centre-nurturing and joyful--with playway activities, attracting and sustaining the participation of children and families. She strengthens the capacity of caregivers--the mother, family and the community for childcare and development by building upon local knowledge and practices. This creates a nurturing physical and social environment for the child, not only at the Anganwadi centre, but also in the family and the community.

The Supervisor (Mukhya Sevika) is responsible for 17-25 Anganwadi, depending upon the nature of the project. She supports and guides the Anganwadi worker and assists in recording home visits, organising community meetings and visits of health personnel, and providing on-the-job orientation to Anganwadi workers.

The CDPO provides the link between ICDS functionaries and the Government administration. This officer is also responsible for securing Anganwadi premises, identifying participants, and ensuring supply of food to centers and flow of health services, conduct of playway activities, monitoring of the programme and reporting to the State government. The CDPO also ensures convergence of services by networking with other government departments and voluntary agencies.

At the community level, other frontline workers including the Gram Sevika, primary school teachers, also link with the Anganwadi worker. Local women's groups, Mahila Mandals, youth clubs, local organizations, panchayat samitis, Bal Vikas Mahila Samiti members also provide support to the Anganwadi worker. Examples include DWCRA/Mahila Samakhya groups, and total literacy campaign volunteers.

The ICDS team can help create partnerships between frontline workers and community/ women's groups, facilitating an integrated approach for improved childcare, health, nutritional well being and women's development. Training is the most crucial element in ICDS, since the achievement of progamme goals depends upon the effectiveness of frontline workers in empowering communities for improved childcare practices as well as effective intersectoral service delivery. Recognizing this, from the inception of the programme itself, the Government of India formulated a comprehensive training strategy.

The ICDS is a centrally sponsored programme. The expenditure on the project is borne by the Central Government except for that of supplementary nutrition, which is borne by

the state government. Department of women and child development, government of India has the overall responsibility of monitoring the programme, which is implemented by the state government. It coordinates with the Ministry of Health at the Centre for facilitating the delivery of the health components of the programme.

At the state level, the responsibility for implementation and monitoring lies with the nodal department designated by the State government, like Department of Social Welfare/women and child development/health. Separate directorate of ICDS has been established in several states.

With the expansion of the programme, covering a large number of blocks and districts in the states and Union territories, provision has been made for the establishment of district level ICDS cells. These are established in districts, which have five or more ICDS projects.

4.6 UDISHA

Udisha, the national initiative for quality improvement in training of child-care functionaries and care-givers is fundamental to the improvement in the quality of early childhood care for survival, growth and development. Udisha recognizes parents and communities as the ultimate link in the training chain, where behavioural change must take place to promote care, development and active learning of the young child.

It envisages a key transformation in approaches to training of child-care functionaries and care-giver education. This is through a holistic approach to the young child, reflected in a new child centred curriculum that is structured along the life cycle and development continuum of the child. This pulls together different sectoral interventions in a right perspective. Greater emphasis is placed on addressing the development needs of the prenatal – under three years period. The emphasis is on locally responsive participatory learning and action processes.

Udisha seeks to address the physical, social, emotional and intellectual development of children by promoting a convergence of actions in the areas of health, nutrition, early learning and better parenting. It also promotes affirmative action to raise the status of women and support improved care of women and girls (not only by them) as well as enhanced involvement of men and families in child care.

Udisha is seen as an important element in empowering child-care workers, parents and communities for a continuous process of assessment, analysis and informed action – to promote the fulfillment of young children's rights in the communities in which children live, grow and develop.

Main features of Udisha

a. Revision of syllabus

The syllabus is being reviewed, so that it responds to the changing needs of the community and the AWW, thus contributing towards the ownership of the AWC. The

revised syllabus is modular where each module is self-contained, yet reflects the necessary link. All modules will follow the life cycle approach in terms of philosophy and content. The syllabus and materials, therefore, focus on age-specific holistic interventions across the life cycle to promote early childhood care for survival, growth and development. This includes a focus on the critical prenatal stage, and the under three years period of early childhood, where early care for survival, growth and development is especially important.

The revised syllabus focuses on the AWW as a communicator, a facilitator and a mobiliser. The Foundation focuses on the importance of childcare, communication skill, personality development, self-assessment and evaluation. The syllabus focuses on practical ways of carrying out activities, participatory methodologies and experiential learning. The AWW is encouraged to carry out self-assessment and self-evaluation, so that she can enhance her capability, and know where she is going right and where she is going wrong, where she needs assistance and to seek guidance for the same.

Each self-contained module of the syllabus comprises practical learning. For example, **Udisha** explains that nutrition is more than the supplementary food distributed at the AWC. The entire issue of food, its production and distribution within the family, health and caring practices also has to be considered. AWWs are, thus, enabled to promote health, caring practices and also household food resources. The CDPOs are responsible for providing the linkage with other programmes. Each module also contains training/learning materials for the AWC, such as flip boards, animated booklets, etc.

b. Integration and coordination of training

To deal with the problems of heterogeneous groups of trainees in different training situations, every State has been asked to prepare its own training action plan and training calendar. This process of planning and training involves issues like who is to be trained, what they need to be trained on , where and by whom they need to be trained, how they need to be trained and when the training will take place, etc.

c. Refresher training for AWWs by training teams.

Each state is encouraged to develop innovative training strategies and curriculum in response to area specific needs like women's empowerment, early learning, community based monitoring, disability prevention and management, monitoring and progamme planning, etc.

d. Technical support and institution building

The scheme also encourages the apex body like NIPCCD to develop into a center of excellence and premier institute of child development. It encourages a dynamic collaboration with India's leading institutes like National Institute of Nutrition, NCERT, National Institute of Urban Affairs, and NIHFW.

e. **Monitoring**

Emphasis is being paid into rationalizing reporting system in ICDS. In the programme Udisha, the anganwadi worker is supported in community based monitoring, in promoting assessment, analysis and action, closest to the level at which data is generated i.e. the community.

4.7 CRITICAL REVIEW

Started on an experimental basis in 33 projects, the programme, by march 1999, covered 4,200 projects in the country, including 273 projects covering urban poor pockets. There were 3177 rural ICDS Projects and 750 tribal ICDS projects as per the statistics available in the year 2000. Some State governments have sanctioned ICDS projects from their own resources, so that the services could be extended to cover a larger area. When reading about the services provided under the ICDS programme, you must have noticed that ICDS is unique in several respects. It is a programme, which encompasses within itself the three major components of integrated human resource development, viz. health, nutrition and education. It is a coordinated endeavour of several departments with the health directorates providing the health inputs and services. It is a preventive and developmental programme beamed to the poorest, and among them, the most vulnerable segments, namely, children and women. It is uniquely Indian in the sense that it will be difficult to find another massive national level integrated programme, with as broad an

agenda as that of ICDS. Moreover, ICDS is a programme, which is almost entirely funded from national resources.

An important feature of the ICDS programme is that it employs community level female workers at the grassroots level as anganwadi workers and helpers. This facilitates the acceptance of the worker and the programme. Also, as you know, the programme follows an integrated approach, providing a package of mutually, supportive services, which is more cost-effective than individual services delivered separately.

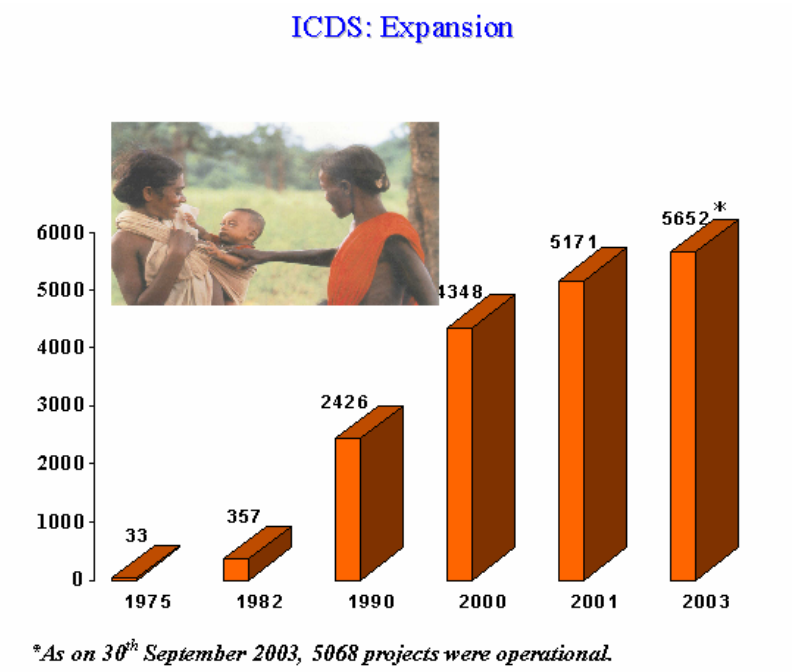
Let us now study the efficacy of the ICDS programme at the field level. Before proceeding further, we would like to draw your attention to the fact that i) not enough studies have been carried out in this area ii) the studies done show marked variation in performance at the state, block and anganwadi levels, and iii) it is difficult to compare findings of different studies because of small sample sizes, lack of control groups, differences in operational definitions, differences in focus and so on. Some general observations, however, are common with regard to most of the studies, which have been carried out. Let us take a look at them.

It has been observed that ICDS bas brought about reduction in the incidences of protein-energy malnutrition. Several research studies have reported that nutritional status of children in ICDS areas is better than in comparable non-I CDS areas. Further, their health and nutritional status has improved in the project area after the programme has been in operation for some years.

A longitudinal study (Tandon, Ramachandran & Bhatnagar, 1981), using a stratified random sample of about 18,000 preschool children, found that after about two years of utilization of ICDS package of services, there was a significant decrease in the proportion of children with severe malnutrition (Grades III and IV) in rural, tribal and urban projects. At the same time, the proportion of children with normal and near-normal nutritional status (Grade I) increased on follow up study from 46 to 58 per cent in both rural and tribal project areas, and from 43 to 75 per cent in the urban project areas.

The system of nutrition intervention has been found to be helpful in the management of severe malnutrition at the village level by the anganwadi workers. A study (B.N. Tandon, 1981) on the prognosis of more than 4,000 severely malnourished children in ICDS projects showed that 80 per cent children had improved. A very low mortality rate of three per cent was observed during the course of study compared to the general estimate of 35 per cent in this group. The study observed progressive improvement in the delivery and utilization of the health and nutrition services.

According to the Report of the Central Technical Committee ICDS Evaluation and Research 1975-1988, "Various approaches adopted to assess the impact of ICDS on nutritional status of 0-3 and 0-6 years old children confirm a decline in moderate and severe under nutrition and increase in the proportion of normal children and children with normal grade I under nutrition. The longitudinal study showed that severe under nutrition amongst the preschool children in the population where ICDS was started as pilot project in 1975, had declined from 19.1 to 6.3 per cent in eight years follow up study. Corresponding decline for moderate under nutrition was from 27.0 to 19.7 percent".



A national level evaluation was conducted by the NIPCCD, covering 98 districts in 25 states and one union territory. The studies were aimed at ascertaining the impact of the scheme on children and women, identifying problems and bottlenecks in the

implementation of the programme, and evolving strategies for further improvement. The data was collected from ICDS projects spread over 98 districts, 25 states and one union territory. The findings indicated the positive impact of health nutrition and preschool education services and led to several recommendations to further improve the implementation of ICDS.

Highlights of the National Evaluation of ICDS 1992 were as under:

- The profile of households was in line with the guidelines prescribed in ICDS scheme for selection of beneficiaries.
- There was a definite improvements in the educational qualifications of women appointed as anganwadi workers.
- Higher percentage of babies had low birth weight in non ICDS areas as compared to ICDS areas. In tribal areas, the difference was even more marked.
- The coverage of children for immunization was found to be higher in ICDS areas as compared to non ICDS areas.
- The utilization of health services was also better, indicating the effective role played by ICDS in mobilizing the health system and linking the community and health system.
- The nutritional status of children in ICDS areas was better than that of children in non ICDS areas. A decline in percentage of severely malnourished children was reported.

- Twenty five per cent nursing mothers in ICDS areas had introduced semi solid food to their infants at around six months of age; indicating a positive effect on complementary feeding practices.
- Fifty per cent mothers in ICDS areas got their children (below three years) medically examined as against 38 percent of their counterparts in non ICDS areas.
- Infant mortality rate (IMR) recorded for ICDS samples were 81.4; 74.0 and 66.6 for urban, tribal and rural projects, respectively. These figures were lower than the national SRS estimates for the year 1989.
- The findings clearly indicated the positive role played by early childcare and preschool education in promoting enrolment in primary schools, reduction in dropout rate and greater retention.

Several other research studies show that the ICDS programme has resulted in:

- Decline in the incidences of nutritional anaemia - Decline in the incidences of vitamin A deficiency.
- Improvement in the nutritional status of children (0-6 years) and expectant and nursing mothers. Increase in birth weight.
- Decrease in infant mortality rate - Decrease in morbidity rate.
- Immunization coverage also has been found to be significantly more in ICDS than in non-I CDS areas.

4.8 LET US SUM UP

ICDS programme adopts a holistic approach towards child development and comprises an integrated package of services viz. (i) supplementary nutrition, (ii) immunization, (iii) health check up, (iv) referral services, (v) nutrition and health education, and (vi) non-formal preschool education. Providing a package of mutually supportive services has been found to be more beneficial and cost-effective than delivering individual services separately.

These services are provided to children in 0-6 year age-group, to expectant and nursing mothers and to women between 15-45 years from the disadvantaged segments of society. The focal point for the delivery of services under the ICDS programme is the anganwadi, which caters to a population of about 1,000 and is staffed by an anganwadi worker and a helper.

ICDS, which was initiated on an experienmental basis in 33 blocks in 1975, has developed into a major national programme for the development of children. It is a unique programme with a sound concept and strategy. However, several deficiencies in its functioning at the grass-roots level have come to light. The implementation of the programme, therefore, has to be closely monitored and supervised, so that the deficiencies can be removed.

4.9 SUGGESTED READINGS

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