The Integrated Child Development Services

Introduction

Since Independence, the Government of India has launched a number of Central Schemes, Centrally Sponsored Schemes (CSS) and Community/Area Development Programmes in the areas of health & family welfare, education, employment & poverty eradication, agriculture, women & child development, sanitation, housing safe drinking water, irrigation, transport, tribal development, border area development, social welfare, etc. both in rural and urban areas of the Country, including Jammu & Kashmir. The main objectives of all these schemes are to generate employment, improve quality of life, remove poverty and economic inequality and human deprivation. Besides, these schemes are also aimed at creation of basic infrastructure and assets essential for economic development in rural areas. There is a general feeling that despite of huge allocations made by Government of India through Central Schemes/Centrally Sponsored Schemes in Jammu & Kashmir, the development in basic infrastructure and amenities/facilities are not perceptible, especially in rural areas of the State. Further, the standard of living of the people is still very poor and the employment opportunities to the young people are still considered to be very limited and inadequate.

Hence, it becomes imperative at this stage to know as to what extent these schemes have been in a position to achieve the stated objectives. Such an exercise will help to identify the problems/short comings in implementing these schemes. It will also help the policy makers and implementing agencies to introduce the necessary interventions to enhance the efficiency of the programme and to ensure better utilization of the resources.

Integrated Child Development Services (ICDS) Scheme

Integrated Child Development Services (ICDS) in India is the world's largest integrated early childhood programme, with over 40,000 centers nationwide. Since its inception in 1975, the programme has matured and expanded, despite difficulties in adapting to the vastly different local circumstances found on the Indian subcontinent. UNICEF helped to launch the ICDS programme and continues to provide financial and technical assistance along with the World Bank. The programme today covers over 4.8 million expectant and nursing mothers and over 23 million children under the age of six. Of these children, more than half participate in early learning activities. The purpose of ICDS is to improve the health, nutrition and development of children. The programme offers health, nutrition and hygiene education to mothers, non-formal preschool education to children aged three to six, supplementary feeding for all children and pregnant and nursing mothers, growth monitoring and promotion, and links to primary healthcare services such as immunization and vitamin A supplements. These services are delivered in an integrated manner at the Anganwadi, or childcare centre. Each centre is run by an Anganwadi worker and one helper, who undergo three months of institutional training and four months of community-based training. The cost of the ICDS programme averages $10-$22 per child a year.

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.

2. 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 and Lactating Mother (P&LM)	Anganwadi worker and Anganwadi Helper.
Immunization	Children Below 6 Years: Pregnant and Lactating Mother (P&LM)	ANM/MO
Health Check-up	Children Below 6 Years: Pregnant and Lactating Mother (P&LM)	ANM/MO/AWW
Referral Services	Children Below 6 Years: Pregnant and Lactating Mother (P&LM)	AWW/ANM/MO
Pre-school Education	Children 3-6 Years	AWW
Nutrition and Health Education	Women (15-45 years)	AWW/ANM/MO

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

2.1 Nutrition including Supplementary Nutrition: This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anemia. 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.

2.2 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.

5.2 Nutritional Norms: - Revised vide letter No. 52.3 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 diarrhea, de-worming and distribution of simple medicines etc.

2.4 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.

2.5 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 program 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.

2.6 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

1. Funding Pattern: ICDS is a Centrally-sponsored Scheme implemented through the State Governments/UT Administrations. Prior to 2005-06, 100% financial assistance for inputs other than supplementary nutrition, which the States were to provide out of their own resources, was being provided by the Government of India. Since many States were not providing adequately for supplementary nutrition in view of resource constraints, it was decided in 2005-06 to support to States up to 50% of the financial norms or to support 50% of expenditure incurred by them on supplementary nutrition, whichever is less.

2. From the financial year 2009-10, Government of India has modified the funding pattern of ICDS between Centre and States. The sharing pattern of supplementary nutrition in respect of North-eastern States between Centre and States has been changed from 50:50 to 90:10 ratio. So far as other States and UTs, the existing sharing pattern of 50:50 continues. However, for all other components of ICDS, the ratio has been modified to 90:10(100% Central Assistance earlier).

OBJECTIVES OF ICDS

Integrated Child Development Service has many objectives. Central published this scheme for those children who belongs from the rural areas. The scheme was started in 1975 and aims at the holistic development of children and empowerment of mother The scheme primarily runs through the Anganwadi Centre. The chief objectives of the Integrated Child Development Services scheme are as follows:

1. To improve the nutritional and health status of children in the age group of 0 to 6 years.
2. To lay the foundation for proper psychological, physical, and social development of the child.
3. To reduce the incidence of mortality. morbidity, malnutrition and school dropout
4. To achieve effective coordination of policy and implementation amongst the various developments to promote child development.
5. 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.
6. To improve the situation regarding nutrition and health of children upto the age of 6 years.

Method:

Introduction

Anthropometric measurements are noninvasive quantitative measurements of the body. According to the Centers for Disease Control and Prevention (CDC), anthropometry provides a valuable assessment of nutritional status in children and adults. Typically they are used in the pediatric population to evaluate the general health status, nutritional adequacy, and the growth and developmental pattern of the child. Growth measurements and normal growth patterns are the gold standards by which clinicians assess the health and well-being of a child. In adults, body measurements can help to assess health and dietary status and future disease risk. These measurements can also be used to determine body composition in adults to help determine underlying nutritional status and diagnose obesity.

The core elements of anthropometry are height, weight, head circumference, body mass index (BMI), body circumferences to assess for adiposity (waist, hip, and limbs), and skinfold thickness. According to the American Academy of Pediatrics and the Child Health and Disability Prevention (CHDP) Program Health Assessment Guidelines, accurate serial anthropometric measurements can help identify underlying medical, nutritional, or social problems in children. Abnormal anthropometric measurements, especially in the pediatric population, warrant further evaluation. Anthropometric measurements can also assess body composition in athletes; this has been shown to optimize the competitive performance of athletes and to help identify underlying medical problems, such as eating disorders. Anthropometry-driven fitness programs in athletes have been shown to improve cardiorespiratory fitness and strength. Anthropometric measurements are also used to assess nutritional status in pregnant women and to assess patients with obesity.

Equipment

Reliable and reproducible measurements are required to obtain meaningful data from anthropometric measurements. As such, clinicians should ensure the use of well-calibrated, quality equipment that is checked regularly for accuracy. Typical equipment list required to obtain anthropometric measurements includes:

- Weight scale
- Calibration weights
- Stadiometer
- Knee caliper
- Skinfold calipers
- Nonstretchable tape measure
- Infantometer to measure the recumbent length

Measurement	**Normal**	**PEM**
• Rao Index = Weight (kg)/Height $(cm)^2$ • Weight/age	>1.5 Normal	<0.15 80-60% Kwashiorkor Oedema <60% Marasmus without Oedema
• Skin Fold Thickness • Bangle test -4.0 cm diameter • Mid Arm Circumfarance	>10mm Does not pass 16cm	<6mm Passes above the elbow Mild -13.5 cm Moderate -12.5 cm Severe <12.5 cm
• Shakir tape (mid arm circumfarnces)		Normal green <13.5-16 cm Borderline Yellow <12.5-13.5 cm Wasted Red <12.5 cm
• Kanawati Index = Mid arm circumferences/ Head circumferences	>0.32	Mild = 0.28-0.32 Moderate = 0.25-0.28 Severe <0.02
• Chest circumferences/ Head circumferences	>1.0	<1.0

SURVEY

For our survey, we select an ICDS : Haldarpara . To create this survey, we really travel there and get the information.

- **Children in the ICDS by age group**

Age group includes :

- Infant age group: 1 month – 1 year
- Toddler age group: 1 year 1 month – 2 years
- Pre-school child age group: 2 year 1 month – 5 years

- **Comparison based on body weight**

Gomez's Rule: The youngster's weight is contrasted with that of an equivalent-aged child of normal weight. It is helpful for population screening and advancing public health.

%of reference weight for age= [(patient's weight) / (weight of normal child of same age)] x 100

Level of Malnutrition	%of reference weight for age
Overweight	>110%
Normal	90-110%
Mild	75-89%
Moderate	60-74%
Severe	<60%

[In this case, the National Centre for Health Statistics (NCHS), (USA), Standards were used to determine the weight of a typical kid of the same age. For (maximum) probable growth in Indian children, the average of mean value (or) 50% of NCHS is assumed as comparable to 100%.]

❑ Comparison based on the mid upper arm circumference (MUAC)

Definition: - Mid-Upper Arm Circumference (MUAC) is the circumference of the left upper arm, determined by taking a measurement at the point where the elbow and shoulder meet in the middle (olecranon process and the acromion).

Age group: - MUAC is advised for use in evaluating acute energy insufficiency in adults during famine and in children aged 6 to 59 months.

Condition	MUAC range (cm)
Normal	>13.5-16
Moderate	>12.5-13.5
Severe	<12.5

Interpretation of Mid-Upper Arm Circumference MUAC indicators: -

♦ Severe Acute Malnutrition (SAM) is indicated by MUAC less than 110mm (11.0cm), which is RED in colour. The youngster has to be treated right away.

♦ Moderate Acute Malnutrition (MAM) is indicated by a MUAC of 110mm (11.0cm) to 125mm (12.5cm), RED COLOR (3-

color Tape), or ORANGE COLOUR (4-color Tape) (MAM). The youngster needs to be referred for supplements right away.

♦ A child at risk for acute malnutrition with a MUAC between 125mm (12.5cm) and 135mm (13.5cm), YELLOW COLOR, should get counselling and follow-up for Growth Promotion and Monitoring (GPM).

♦ A MUAC over 135mm (13.5cm), GREEN COLOR, denotes a youngster who has received enough nutrition

❑ Comparison according to chest circumference/head circumference

Kanawati index = [chest circumference)/ (head circumference)]

Condition	Chest circumference / Head circumference
Normal	>1.0
P.E.M	<1.0

❑ Comparison according to Height

Waterloo classification: - The child's growth is hampered by persistent malnutrition, which finally causes diminished height (stunting). Malnutrition has an impact on the child's physical dimensions, ultimately leading to body wasting.

% Of height for age = [(height of patient)/ (height of normal child of same age)] × 100.

Condition	For age Stunting
Normal Height	>95
Mild Height	90-95
Moderate Height	85-90
Severe Height	<85

[In this case, the National Centre for Health Statistics (NCHS), (USA), Standards were used to determine the weight of a typical kid of the same age. For (maximum) probable growth in Indian children, the average of mean value (or) 50% of NCHS is assumed as comparable to 100%.]

❑ Comparison according to MUAC/ head circumference

Kanawati index = [(mid upper arm circumference)/ (head circumference)

Condition	MUAC / Head circumference
Normal	>0.32
Mild P.E.M	0.28-0.32
Moderate P.E.M	0.25-0.28
Severe P.E.M	<0.25

RESULT

NAME	AGE	SEX	CASTE	HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	CHEST CIRCUMFERENCE	MUAC
Binita das		f	obc	88	12.1	47	46	14.5
Muskan		f		99	14	47	48	14.5
Subham Basak		m		94	11.9	47	49	15.5
Abdul Mudassin		m		62	9.1	44	49	16
Ambia Khatun		f		99	15.2	49	52	17
Adrij Das	1yr	m		81	8.6	45	46	14
Dulal Das		f		104	15.1	47	50	15.5
Ruksana Khatun	3yr	f		89	12	47	48	15
Sadim Sk		m		64.5	5.1	40	39	11
Sadia Khatun		f		68	6.1	41	41	13
Naier Sk		m		97	13.7	50	50	18
Rizwan Sk		m		89	11.3	47	50	14.5
Umhali Khatun		f		95	12.2	48	50	14.5
Nabir Sk		m		98	11.9	47	49	15
Sizeratun Nisha		f		85	9.4	47	46	14
Anaz Sk		m		85	9.4	47	47	13
Ayushi Mandal		f		92	11.2	46	50	16.5
Sagnik Das		m		77	9.2	45	46	14.5
Ayush Sk		m		96	12	50	47	13
Abhro Das		m		85	10.1	47	47	13.7
Suhani Khatun		f		99	12.8	45	48	13
Ayushman Raut		m		73	6	42	37	13
Kharjana Khatun		f		83	9.3	44	45	13.8
Gourav Das	11mnth	m		76	8.9	47	45	13.5
Atif Sk		m		103	12.9	47	48	15
Mushkan Parvin	9mnth	f		75	7.8	43	45	14
Atika Khatun		f		82	9.8	44	44	14
Isham Sk	3mnth	m		66	4.8	39	40	13
Umme Kusum		f		82	8.5	45	46	13.5
Ahamad Sk		m		71	7.7	43	46	13
Firoz Sk		m		99	12.4	47	47	15
Aniz Sk		m		100	13.2	48	48	14
Alija Sultana		f		69	5.9	40	43	14
Ahil Sk		m		100	12.7	45	49	15.5
Afnan Khatun		f		101.2	14.4	48	50	16.5
Afhamad Rasul Sk		m		65	6.9	44	43	13
Atifa Khatun		f		87	9.9	47	44	13.5
Tousik Akhter		m		73	11.8	42	45	14
Ahaz Sk		m		92	11.4	48	50	14.5
Mehnaz Parvin		f		95	11.7	46	47	15
Rihan Sk		m		102	13.8	49	50	15
Fatema Khatun		f		80	9	46	44	14
Naira Khatun		f		75	8	45	47	14.5
Aliza Khatun		f		101	14.2	48	50	17
Sohagi Khatun		f		99	11.9	47	46	15
Afica Khatun		f		81	9	48	47	14.5
Adil Ahamed		m		74	6.6	44	45	15.5
Anjuma Khatun		f		91	10.9	46	48	14.5

Weight status of Children in ICDS

Category	Haldarpara ICDS	
	Male	Female
Severe Underweight	0	0
Moderate Underweight	2	0
Mild Underweight	3	5
Normal Weight	0	3
Overweight	1	1

Height status of Children in ICDS

Condition	Haldarpara ICDS	
	Male	Female
Normal height	3	4
Mild Height	2	3
Moderate Height	1	2
Severe Height	0	0

MUAC status of Children in ICDS

Condition	Haldarpara ICDS	
	Male	Female
Normal	6	12
Moderate	0	0
Severe	0	0

Status of Children in ICDS [Chest circumference / Head circumference]

Condition	Haldarpara ICDS	
	Male	Female
Normal	5	11
P.E.M	1	1

Status of Children in ICDS [MUAC / Head circumference]

Condition	Haldarpara ICDS	
	Male	Female
Normal	**3**	**8**
Mild PEM	**2**	**4**
Moderate PEM	**1**	**0**
Severe PEM	**0**	**0**


TOMMY

Conclusion

The integrated child development services programme with the six services namely Supplementary Nutrition, Immunization, Health Check-ups, Referral Services, Pre- School Education, and Nutrition & Health Education intends to ensure holistic development of children in the age group of 0 to 6 years and also to make necessary arrangements which will go on in ensuring better reproductive health for pregnant women through the Anganwadi centers established at the respective localities of the beneficiaries with the two persons operating the center known as Anganwadi worker and helper employed in the center in order to fulfill the above objectives. The programme also mentions a systematic mechanism to ensure all the objectives intended for the welfare of the beneficiaries however, the programme has not been able to deliver successfully because of the various lacunas and the imprudent avenues of corruption inherent in the programme itself which was testified in the present study also. The areas which need to be taken care of in order to make the programme effective in real terms have been mentioned in the above sections of the report.

It is to be said that governments' efforts are commendable; the complications arise in that people must first be aware of the problem before they can take advantage of the government services addressing it. Effective development and communication programmes can play a pivotal role in bridging these knowledge gaps by identifying barriers to behavior change, analyzing these barriers, and developing original techniques to overcome them.

The constraints which need to be taken care of are things such as dilapidated or absent physical infrastructure, absenteeism, timely reimbursement of salary and other remuneration, effective coordination between AWCs, health centers and schools, lack of paraphernalia, establishment of separate centers and effective monitory mechanism.