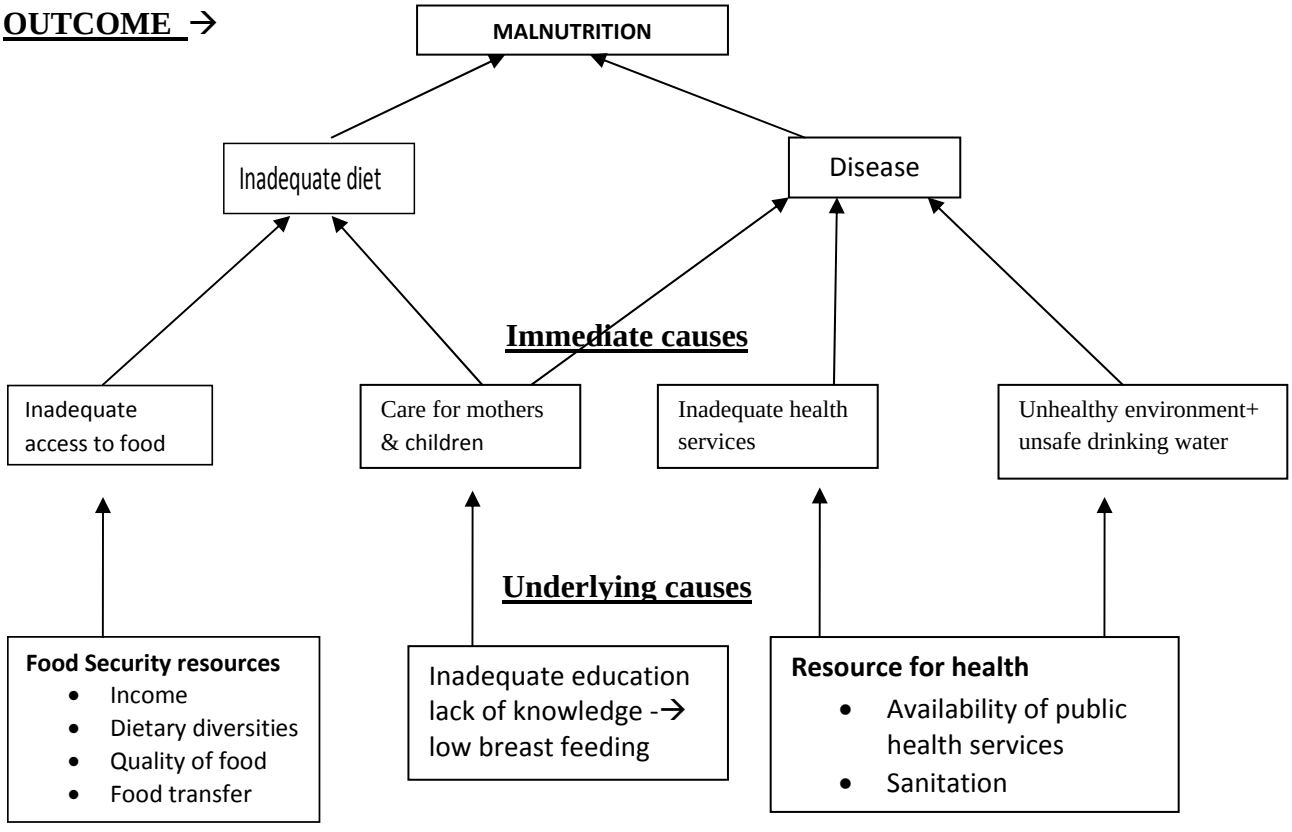
NUTRITION- the basis of holistic development of children

Introduction:--

Malnutrition permeates all aspects of health, growth, cognition, motor and social development of young children in developing countries. More than 50% of deaths in these children can be attributed to malnutrition, most often in conjunction with serious infection. Child survival initiatives and programs have accomplished much to save the lives of children from common and preventable illnesses, but the quality of the survivors' health needs to be improved, with much more attention paid to nutrition of the preschool and school child. Promotion of nutritional health must become an integral part of primary health services, especially for infants, preschoolers, schoolchildren, and women. Promotion of exclusive breastfeeding and appropriate complementary feeding and weaning are essential inputs. A daunting challenge is to improve diet quality through the raising and consumption of small animals by rural subsistence households to enhance maternal and child nutrition. School feeding from preschool onward must be an integral part of education so children are in a condition to learn. An excellent example of such programs is the WHO initiated Integrated Management of Childhood Illness, which integrates nutrition into the care of both sick and well children. The Early Child Development Program initiated by the World Bank and UNICEF has taken hold in many countries. Nutrition outcomes are closely linked with health and education activities starting in the preconception period through pregnancy, lactation, and childhood. Investment in human capital early in life will optimize the growth and social and economic development of children, families, and communities.



Determinants of malnutrition

Malnutrition affects one out of every three preschool-age children living in developing countries. This disturbing, yet preventable, state of affairs causes untold suffering and, given its wide scale, presents a major obstacle to the development process. Volumes have been written about the causes of child malnutrition and the means of reducing it. But the role of women's social status in determining their children's nutritional health has gone largely unnoticed.

Types of malnutrition

Malnutrition is a group of conditions in children and adults generally related to poor quality or insufficient quantity of nutrient intake, absorption, or utilization.

There are two major types of malnutrition:

- **Protein-energy malnutrition** - resulting from deficiencies in any or all nutrients
- **Micronutrient deficiency diseases** - resulting from a deficiency of specific micronutrients

Protein-energy malnutrition

There are three types of protein-energy malnutrition in children:

Type	Appearance	Cause
Acute malnutrition	Wasting or thinness	Acute inadequate nutrition leading to rapid weight loss or failure to gain weight normally
Chronic malnutrition	Stunting or shortness	Inadequate nutrition over long period of time leading to failure of linear growth
Acute and chronic malnutrition	Underweight	A combination measure, therefore, it could occur as a result of wasting, stunting, or both

Wasting and stunting are very different forms of malnutrition. Stunting is chronic and its causative factors are poorly understood. Stunting usually does not pose an immediate threat to life and is relatively common in many populations in less-developed countries. This is not to say that it is unimportant, just less important than wasting in humanitarian emergencies. Wasting results from an acute shortage of food, is reversible with refeeding, and has a relatively high mortality rate. For these reasons, wasting is the highest priority form of malnutrition in humanitarian emergencies.

Status of Protein-energy malnutrition in West Bengal :

In West Bengal generally protein-energy malnutrition is more prevalent because the state is not self sufficient in production of protein rich foods like milk, egg, fish and meat and imports those articles from other states. Even vegetable proteins like pulses are beyond the rich of the poor because of their high prices.

Micronutrient deficiencies

Micronutrient deficiencies may also be important in an emergency-affected population. In fact, they can cause a large proportion of deaths in children and adults in populations after the acute phase of the emergency when infectious diseases and acute malnutrition are under relative control.

Relief food supplied to food-aid dependent population is almost always deficient in several micronutrients, including the three which cause the most common deficiencies, that is iron, vitamin A, and iodine. Many outbreaks of otherwise rare micronutrient deficiencies, such as scurvy (vitamin C deficiency), pellagra (niacin deficiency), beriberi (thiamine deficiency), and others, have occurred in such populations.

Survey Report: National Nutrition Monitoring Bureau (NNMB)

During the year 2000-2001, the NNMB carried out surveys in a sub-sample of Central quota of NSSO sample of 54th round Consumer Expenditure survey, in the States of Andhra Pradesh, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu and West Bengal, to assess diet and nutritional status of individuals and prevalence of morbidity in the rural populations.

About 51,300 individuals of different ages from 14,288 HHs in 715 villages were surveyed for anthropometry, clinical examination and prevalence of morbidity. Information on food and nutrient intake was collected from 30,968 individuals from 7,131 households.

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At the aggregate level, about 37% of the males and 39% of the females had chronic energy deficiency (BMI: <18.5). The prevalence of overweight was marginally higher among females (8.2%) than males (5.7%). The most common forms of morbidities among different age groups were fever, diarrhoea, dysentery and acute respiratory infections, the prevalence of which ranged from 1 to 2%.

India's overall performance in nutritional aspects and right to food:-

1. 21.5% of babies in India are born with low birth weight.
2. Nearly half of the India's children are malnourished.
3. There are wide gaps between states and rural and urban areas with respect to cereal consumption.

4. Child malnutrition is higher in rural areas than in urban areas.
5. The prevalence of anaemia among adolescent girls are very high with severe anaemia being more prevalent among them than the pre-school going children.

Why intervention:--

Children suffering from malnutrition have an extremely compromised immune system and are 10 times more likely to die of treatable illnesses like chest infections or diarrhoea. If malnutrition is left untreated, a child's physical growth and mental development can become permanently impaired, and in severe cases they can lose their lives.

Earlier interventions:

Need of special attention and care for women & children have been recognized in Indian Constitution. The 1st systematic attempt framed for the welfare of children was made in 1954 through Welfare Extension Projects administered by Central Social Welfare Board which offered a package consisting of:

(i)Pre-primary school called Balwadi, ii) limited supplementary nutrition, (iii) Health services for children & mothers (iv) first aid (v) recreational facilities (vi) adult education and training of arts & crafts.

Each project covered 25 villages and services were provided at the village through gram sevikas.

Thereafter was launched another Scheme in 1967 called Family & Child welfare project which has a Child Development Centre and Women's welfare Centre at the block level and Sub-centres at the key villages.

Apart from these programmes, special programme **for health and nutrition** have been taken up by the GOI since the early seventies v.i.z.

(a) Balwadi nutrition Program in 1970-71 through Voluntary organizations where the pre-schooling and Supplementary Nutrition were provided through Child care centres called Balwadis.
(b) Special Nutrition program in 1970-71 provided supplementary nutrition to children upto 6 years of age as well as expecting and nursing mothers living in urban slums, tribal and backward areas.
(c) Applied Nutrition program in 1973 with a view to raising the nutritional status of children and women by spreading the concept of kitchen gardens and promoting consumption of protective foods.
(d) The Health department administered the Health Care Programs for women and children which was concerned with immunization, supply of drugs, vitamins, iodised salt and iron.

Major Programme to address the problem of malnutrition:

It was realised by the GOI that although the various services essential for the welfare of children were being delivered under different programs , the basic problems affecting the

children remained to a great extent intractable. One serious lacuna at these child welfare programs was that each was administered in isolation. It was felt that if the delivery of essential services was integrated it would not only be cost effective but the impact would also be greater than the aggregate of impact of each of the programs. **The Integrated Child Development Services (ICDS) scheme was thus conceived to remedy these defects and started its journey from 2nd October 1975 in all over the country.**

In West Bengal also it was started on 2nd October -1975 with two projects, one in Calcutta – **Khidirpur ICDS** Project and other in Purulia – **Manbazar ICDS** Project which has now been expanded to all over the state covering all the Blocks, Municipalities and Municipal Corporation of state through 416 number of ICDS Projects.

Initially the beneficiaries were selective i.e. those who belonged to any one of the following category of families:-

(i) Families of landless agricultural labourers,
(ii) families of marginal farmers,
(iii) families of SCs,
(iv) Families of STs and
(v) Families of other poor sections of the community i.e. with total monthly income of all the members of the family not exceeding Rs.300/-.

But from the early nineties these criteria of selecting the ICDS beneficiaries have been totally abolished covering all the sections of people.

As far as supplementary nutrition component was concerned the food for ICDS projects was provided by two agencies (1) CARE and (2) WFP assistance in the form of Vulgare Wheat and salad Oil. In terms of calories the quantity was 300 calories & 10 gms of protein for the children from 6 months to 6 years of children, 600 calories and 20 gms of protein for severely malnourished children and 500 calories & 20 gms of protein for the pregnant & lactating mothers. Then CSM (Corn soya Milk) with Soya bin Salad oil (SSO) entirely provided by CARE and from early nineties came CSB (Corn Soya Blend) with Refined vegetable Oil(RVO) entirely provided by CARE. From 2000 and onwards khichri with boiled rice and Musur dal are being provided from all the AWCs throughout the state.

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.

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

anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. They avail of supplementary feeding support for 300 days in a year. By providing supplementary feeding, the Anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities.

Growth Monitoring and nutrition surveillance are two important activities that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to detect growth faltering and helps in assessing nutritional status. Besides, severely malnourished children are given special supplementary feeding and referred to medical services.

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

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

4. Referral Services: During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are referred to the Primary Health Centre or its sub-centre. The anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer of the Primary Health Centre/ Sub-centre.

5. Non-formal Pre-School Education (PSE)

The Non-formal Pre-school Education (PSE) component of the ICDS may well be considered the backbone of the ICDS programme, since all its services essentially converge at the anganwadi – a village courtyard. Anganwadi Centre (AWC) – a village courtyard – is the main platform for delivering of these services. These AWCs have been set up in every village in the country. In pursuance of its commitment to the cause of India's Children, present government has decided to set up an AWC in every human habitation/ settlement. As a result, total number of AWC would go up to almost 1.4 million. This is also the most joyful play-way daily activity, visibly sustained for three hours a day. It brings and keeps young children at the anganwadi centre - an activity that motivates parents and communities. PSE, as envisaged in the ICDS, focuses on total development of the child, in the age up to six years, mainly from the underprivileged groups. **Its programme for the three-to six years old children in the anganwadi is directed towards providing and ensuring a natural, joyful and stimulating**

environment, with emphasis on necessary inputs for optimal growth and development. The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. It also contributes to the universalization of primary education, by providing to the child the necessary preparation for primary schooling and offering substitute care to younger siblings, thus freeing the older ones – especially girls – to attend school.

6. **Nutrition and Health Education:**

Nutrition, Health and Education (NHED) is a key element of the work of the anganwadi worker. This forms part of BCC (Behaviour Change Communication) strategy. This has the long term goal of capacity-building of women – especially in the age group of 15-45 years – so that they can look after their own health, nutrition and development needs as well as that of their children and families

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 provided 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).

Population Norms:-

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

Projects:

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

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

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

for blocks with population of less than 1 lac or so, staffing pattern of CDPO office could be less than that of a normal block.

Anganwadi Centres

For Rural/Urban Projects

400-800 1 AWC

800-1600 - 2 AWCs

1600-2400 - 3 AWCs

Thereafter in multiples of 800 1 AWC

For Mini-AWC

150-400 1 Mini-AWC

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

300-800 - 1 AWC

For Mini- AWC

150-300 1 Mini AWC

Supplementary Nutrition Norms:

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

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

Nutritional Norms:- Revised vide letter No. 5-9/2005-ND-Tech Vol. II dated 24.2.2009

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

Type of Supplementary Nutrition :

Children in the age group 0 – 6 months : For Children in this age group, States/ UTs may ensure continuation of current guidelines of early initiation (within one hour of birth) and exclusive breast-feeding for children for the first 6 months of life.

Children in the age group 6 months to 3 years : For children in this age group, the existing pattern of Take Home Ration (THR) under the ICDS Scheme will continue. However, in addition to the current mixed practice of giving either dry or raw ration (wheat and rice) which is often consumed by the entire family and not the child alone, THR should be given in the form that is palatable to the child instead of the entire family.

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

Registration of beneficiaries: Since BPL is no longer a criterion under ICDS, States have to ensure registration of all eligible beneficiaries.

Expansion of the ICDs Scheme in India:

Number of Sanctioned Projects/ AWCs	**EXISTING**	**ADDITIONAL(sanctioned in 2008-09)***	**TOTAL**
PROJECTS	6284	789	7073
ANGANWADI CENTRES (AWCs)	10.53 lakh	1.89 lakh	12.42 lakh
MINI-AWCs	36,829	77,102	1,13,931
Total AWCs			13.56 lakh#

THE ICDS TEAM:

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

Role & responsibilities of AWW, ANM and ASHA:

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

STATUS OF ANGANWADI WORKERS AND HELPERS:

Anganwadi Workers (AWWs) & Anganwadi Helpers (AWHs), being honorary workers, are paid a monthly honoraria as decided by the Government from time to time. **Government of India has enhanced the honoraria of these Workers, w.e.f. 1.4.2008 by Rs.500 above the last honorarium drawn by Anganwadi Workers (AWWs) and by Rs.250 of the last honorarium drawn by Helpers of AWCs and Workers of Mini-AWCs**. Prior to enhancement, AWWs were being paid a monthly honoraria ranging from Rs. 938/ to Rs. 1063/- per month depending on their educational qualifications and experience. Similarly, AWHs were being paid monthly honoraria of Rs. 500/-

In addition to the honoraria paid by the Government of India, many States/UTs are also giving monetary incentives to these workers out of their own resources for additional functions assigned under other Schemes.

FACILITIES/BENEFITS EXTENDED TO AWWs &AWHs:-

By the Govt. of India

- **Honorarium:** At the beginning of the Scheme in 1975, the Anganwadi Worker was paid honorarium of Rs.100/- per month (Non-Matriculate) and Rs.150/- per month (Matriculate) and Helper was paid Rs.35/- per month. Govt. has increased their honorarium from time to time, as indicated below:

Qualification/Year	**1975-76**	**1.4.78**	**1.7.86**	**2.10.92**	**16.5.97**	**1.04.02**	**1.04.08**
Non-Matriculate	100	125	225	350	438	938	1438
Matriculate	150	175	275	400	500	1000	1500
Non-Matriculate With 5 year exp	-	-	250	375	469	969	1469
Matriculate With 5 year exp	-	-	300	425	531	1031	1531
Non-Matriculate With 10 year exp	-	-	275	400	500	1000	1500
Matriculate With 10 year exp	-	-	325	450	563	1063	1563
Mini-Anganwadi Workers	-	-	-	-	-	500 (w.ef. 1.1.2007)	750

Honorarium of Helper:

Helper	35	50	110	200	260	500	750

Leave: They have been allowed paid absence of 135 days of maternity leave.

Insurance cover: The Govt. of India introduced `Anganwadi Karyakartri Bima Yojana' to Anganwadi Workers/Anganwadi Helpers w.e.f.1.4.2004 under Life Insurance Corporation's

Social Security Scheme. The amount of premium of Rs. 80/- payable by AWWs and AWHs has also been waived of w.e.f. 1.4.2007 for a period of two years.

Under this Bima Yojana, a free add on scholarship is available for the children of the members who are covered under the scheme. Scholarship of Rs.300/- per quarter for students of 9th to 12th standard [including ITI courses] would be provided. Scholarship is limited to two children per family.

- **Award:** In order to motivate the Anganwadi Workers and give recognition to good voluntary work, a Scheme of Award for Anganwadi Workers has been introduced, both at the National and State Level. The Award comprises Rs.25,000/- cash and a Citation at Central level and Rs.5000/- cash and a Citation at State level.
- **Uniform:** Government has made a provision for a Uniform (saree/suit @ Rs. 200/- per saree per annum) and a name badge to Anganwadi Workers and Helpers;

By State Governments/UT Administartions:-

- To consider the services rendered as AWWs as additional qualification for being recruitment of Primary School Teachers, ANMS and other such village based posts;
- To recruit at least 25% of Supervisors under ICDS Scheme from **AWWs** with 10 years' experience of satisfactory service;
- To Engage 25% of AWWs from amongst the **Anganwadi Helpers** who have put in minimum 10 years of satisfactory service and also possess the requisite qualifications (age, education etc.) as laid down by the concerned States for selection of AWWs.
- To set up Anganwadi Workers and Helpers Welfare Fund at the State/UT level out of the contribution from Workers/Helpers and State/ UT Governments;
- To set up Grievances Redressal Machinery at the State/UT and Districts level for prompt redressal of their grievances.

ICDS Training Programme:

Training and capacity building is the most crucial element in the ICDS Scheme, as the achievement of the programme goals largely depends upon the effectiveness of frontline workers in improving service delivery under the programme. Since inception of the ICDS scheme, the Government of India has formulated a comprehensive training strategy for the ICDS functionaries. Training under ICDS scheme is a continuous programme and is implemented through 35 States/UTs and National Institute of Public Cooperation and Child Development (NIPCCD) and its four regional centres.

During the 11th Five Year Plan, the Government of India has laid much emphasis on strengthening the training component of ICDS in order to improve the service delivery mechanism and accelerate better programme outcomes. An allocation of Rs. 500 crore has been kept for the ICDS Training Programme during the 11th Five Year Plan.

Financial norms relating to training of various ICDS functionaries and trainers have been revised upwardly with effect from 1 April 2009.

Types of Training Courses: Three types of regular training are imparted to AWWs, AWHs, Supervisors, CDPOs/ACDPOs and Instructors of AWTCs and MLTCs, viz.:

- Induction Training (*on initial engagement/appointment*) mainly to AWWs
- Job/Orientation Training (*once during service period*)
- Refresher Training (*in-service, once in every two years)*

Also, specific need based training programmes are organized under the 'Other Training' component, whereby the States/UTs are given flexibility to identify state specific problems that need specialized issue based training and take up such training activities.

Training Infrastructure: There is a countrywide infrastructure for the training of ICDS functionaries, *viz.*

Anganwadi Workers Training Centres (AWTCs) for the training of Anganwadi Workers and Helpers.

Middle Level Training Centres (MLTCs) for the training of Supervisors and Trainers of AWTCs;

National Institute of Public Cooperation and Child Development (NIPCCD) and its Regional Centres for training of CDPOs/ACDPOs and Trainers of MLTCs. NIPCCD also conducts several skill development training programmes.

Based on the needs, State Governments identify and open up AWTCs and MLTCs after due approval by the Government of India. As on 31.3.2009, 490 AWTCs and 31 MLTCs were operational across the country. About 80% of the AWTCs and 70% MLTCs are run by State/District based NGOs.

Monitoring & Supervision of Training Programme: A separate ICDS Training Unit within the Ministry of Women and Child Development headed by a Director/Dy. Secretary level officer is responsible for overall monitoring, supervision and evaluation of the training programme. The following measures are undertaken for monitoring and supervision:

- *Physical and financial progress are captured through Quarterly Progress Reports (QPRs) in a standardized format, that are submitted by the States/UTs to GoI at the end of every quarter;*

- *A detailed analysis of the QPRs is carried out by the ICDS Training Unit and based on the same, quarterly review meetings are organized with the States at the central level;*
- *Monthly/quarterly review meeting with the Training Centres at the state level;*
- *Necessary feedback and guidelines are issued to the States after each of the review meetings;*
- *Field visits to AWTCs/MLTCs by Nodal Officer or the District Programme Officers (DPOs)/CDPOs; and also by the officials from the Ministry of WCD and NIPCCD.*
- *Annual meeting of State Training Task Force (STTF) for the approval of STRAP and review of past performance and chalking out future actions.*

Recent Initiatives: The Ministry has recently initiated a process of consultations with the States and other stakeholders to review and identify gaps in the existing training system and make suggestions to strengthen the ICDS Training programme including its contents/syllabi, training methodology and the existing monitoring mechanism under ICDS training programme. Three regional workshops have since been organized in collaboration with NIPCCD and with technical support from USAID/CARE INDIA during July-August 2009 at three Regional centres of NIPCCD at Bangalore, Lucknow and Guwahati.

Existing Monitoring System under ICDS Scheme:

Central Level

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

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

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

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

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

(iv) Nutrition and Health Education

This service is not monitored at the Central Level. State Governments are required to monitor up to State level in the existing MIS System.

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

Analysis & Action

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

State Level

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

Block Level

At block level, Child Development Project Officer (CDPO) is the in-charge of an ICDS Project. CDPO's MPR and HPR have been prescribed at block level,. These CDPO's MPR/ HPR formats have one-to-one correspondence with AWW's MPR/ HPR. CDPO's MPR consists vacancy position of ICDS functionaries at block and AWC levels. At block level, no technical post of officials have been sanctioned under the scheme for monitoring. However, one post of statistical Assistant./ Assistant is sanctioned at block level to consolidate the MPR/ HPR data.

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

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

Village Level (Anganwadi Level)

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

In the existing Management Information System, records and registers are prescribed at the Anganwadi level i.e. at village level. The Monthly and Half-yearly Progress Reports of Anganwadi Worker have also been prescribed. The monthly progress report of AWW capture information on population details, births and deaths of children, maternal deaths, no. of children attended AWC for supplementary nutrition and pre-school education, nutritional status of

children by weight for age, information on nutrition and health education and home visits by AWW. Similarly, AWW's Half yearly Progress Report capture data on literacy standard of AWW, training details of AWW, increase/ decrease in weight of children, details on space for storing ration at AWC, availability of health cards, availability of registers, availability of growth charts etc.

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

Evaluation of ICDS Scheme: A number of evaluation studies on implementation of ICDS Scheme have been conducted in the past viz., Programme Evaluation Organisation of the Planning Commission in 1982, National Evaluation of ICDS Scheme conducted by National Institute of Public Cooperation and Child Development (NIPCCD) in 1992, Evaluation Results of Annual Survey during 1975-1995, published by Central Technical Committee on Integrated Mother and Child Development on completion of 20 years of ICDS and Nationwide Evaluation of ICDS by National Council of Applied Economic Research (NCAER) 1998-1999. Main findings of study conducted by NCAER (1996-2001) are as follows:-

i. Most of the AWCs across the country were located within accessible distance (100-200 meters) from beneficiary households. A majority of the beneficiary households was within 100 metres of the AWC. Another 10 per cent were about 150-200 meters away. The rest were beyond 200 meters. Thus, the factor of distance of beneficiary households from the AWC was unlikely to affect attendance at the AWC during inclement weather;
ii. Most of the AWCs in the country, except those in Tamil Nadu, Kerala, Karnataka and Orissa were functioning from community buildings. The type of building plays an important role in safeguarding against any natural hazards. Of those sampled, about 40 per cent were functioning from pucca buildings.
iii. Nearly 50 per cent AWCs reported adequate space, especially for cooking.
iv. One out of two AWWs was found to be educated at least up to matriculate level across the country. In all central and southern states, less than 50 per cent of the AWWs were 'at least matriculate'; more than 75 per cent of AWWs were matriculates in the northern and eastern states of the country. Gujarat and Rajasthan reported lowest percentage of matriculate functionaries.
v. Though about 84 per cent of the functionaries reported to have received training, the training was largely pre-service training. In-service training remained largely neglected.
vi. The day to day functioning of the AWC is a critical indicator of the effectiveness of the ICDS programme. An assessment of on-going activities of sample AWCs through observations, record reviews and personal interviews with the AWWs revealed that, on average, an AWC functioned for 24 of 30 days in a month. On a given day, the AWC functioned for about 4 hours. By and large, environmental factors did not affect the functioning of the AWC.

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

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

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

Rapid facility Survey by NCAER: The National Council of Applied Economic Research (NCAER) conducted a Rapid Facility Survey on ICDS infrastructure in 2004. The report submitted by NCAER in February, 2005 has, inter-alia, brought out that;

i. More than 40 per cent AWCs (Anganwadi Centres) across the country are neither housed in ICDS building nor in rented buildings. One-third of the Anganwadis are housed in ICDS building and another one-fourth are housed in rented buildings;
ii. As regards the status of Anganwadi building, irrespective of own or rented, more than 46 per cent of the Anganwadis were running from pucca building, 21 per cent from semi-pucca building, 15 per cent from kutcha building and more than 9% running from open space;
iii. It is quite encouraging to observe that average number of children registered at the Anganwadi centre is 52 for boys and 75 for girls;
iv. The survey data reveal that more than 45 per cent Anganwadis have no toilet facility and 40 per cent have reported the availability of only urinal;
v. Of the 39 per cent Anganwadis reporting availability of handpumps, half of the handpumps were provided by the Gram Panchayat and 12 per cent provided by the ICDS;
vi. Regarding the provision of services at the Anganwadi centres, more than 90 per cent Centres provided supplementary food, 90 per cent provided pre-school education and 76 per cent weighed children for growth monitoring;
vii. Only 50 per cent Anganwadis reported providing referral services, 65 per cent health check-up of children, 53 per cent for health check-up of women and more than 75 for nutrition and health education;
viii. Average number of days in a month in which services are provided at the Anganwadi centres are 24 for supplementary food, 28 for pre-school education and 13 for Nutrition and health education;
ix. More than 57 per cent of Anganwadi centres reported availability of ready-to-eat food and 46 per cent availability of uncooked food at the Anganwadi centres;

x. Nearly three-fourth of the Anganwadis have reported the availability of medical kits and baby weighing scale. On the other hand adult weighing scale has been reported only by 49 per cent of the Anganwadis.

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

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

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

ii) Around 75% of AWCs have pucca buildings;

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

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

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

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

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

Wheat Based Nutrition Programme (WBNP) The Government of India allocates food grains (wheat and rice) at BPL rates to the States, on their demand, for meeting their requirement for supplementary nutrition to beneficiaries under the ICDS Scheme. Total quantity of food grains allotted during last 3 years is as under:-

2006-07 23095 MTs

1.544000 MTs

2008-09 716745 MTs

Presently, 23 States are availing the allocation of wheat/rice under the WBNP.

INTERNATIONAL PARTNERS

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

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

UNICEF supports the ICDS by providing technical support for the development of training plans, organizing of regional workshops and dissemination of best practices of ICDS. It also assists in service delivery and accreditation system where the capacity of ICDS functionary is strengthened. Impact assessment is also done in selected States on early childhood nutrition and development, micro-nutrient and anemia control through Vitamin. 'A' supplementations and de-worming interventions for children in the age group of 9-59 months is also conducted by UNICEF from time to time.

CARE is primarily implementing some non-food projects in areas of maternal and child health, girl primary education, micro-credit etc. Integrated Nutrition and Health Project (INHP)-III, which is a phase-out programme of INHP series, would come to an end on 31.12.2009.

WFP has been extending assistance to enhance the effectiveness and outreach of the ICDS Scheme in selected districts (Tikamgarh & Chhattarpur in Madhya Pradesh, Koraput, Malkangir & Nabrangpur in Orissa, Banswara in Rajasthan and Dantewada in Chhattisgarh), notably, by assisting the State Governments to start and expand production of low cost micronutrient fortified food known as 'Indiamix'. Under this the concerned State Government are required to contribute to the cost of Indiamix by matching the WFP wheat contribution at a 1:1 cost sharing ratio.

Recent Initiatives

Revision in **Population norms** for setting up of AWCs/Mini-AWCs

Universalisation and 3rd phase of expansion of the Scheme of ICDS for 792 additional Projects, 2.13 lakh additional Anganwadi Centres (AWCs) and 77102 Mini-AWCs, as per the revised population norms, with **special focus on coverage of SC/ST and Minority population**.

Introduction of **cost sharing** between Centre & States, with effect from the financial year 2009-10, in the following ratio:

a. 90:10 for all components including SNP for North East;
b. 50:50 for SNP and 90:10 for all other components for all States other than North East.

Budgetary allocation for ICDS Scheme **increased** from **Rs.10391.75 crore** in 10th Five Year Plan to **Rs.44,400 crore** in the 11th Plan Period

Revision in **financial norms of supplementary nutrition enhancing the unit cost per beneficiary per day as follows:-**

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

Revision of feeding and nutrition norms as under (vide letter No. 5-9/2005-ND-Tech Vol. II dated 24.2.2009)

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

- Revision in **financial norms of other existing interventions** to improve the service delivery. Details are given in the statement at **Annex-XI**.
- **Enhancement of honoraria** by Rs.500 above the last honorarium drawn by Anganwadi Workers (AWWs) and by Rs.250 of the last honorarium drawn by Helpers of AWCs and Workers of Mini-AWCs;
- Introduction of **World Health Organisations (WHO) Growth Standards for** monitoring the growth of children.
- **Provision of Uniform** for Anganwadi Workers and Helpers;
- **Provision of flexi funds** at Anganwadi level;
- Strengthening of **Management Information System** (MIS) and
- Revision in cost norms of **Training component** of ICDS Scheme.

INTRODUCTION OF WHO GROWTH STANDARDS IN ICDS -

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

Implications

- Change in current estimates
- Increase in total of normal weight children
- Increase in severely underweight children
- Increase in underweight children (mild/moderate and severe) in age group of 0-6 months.
- The requirement of funds for SNP; Centre and State contribution would be almost double.

The Anganwadi Worker with the help of New Growth Chart would be able to assess correctly severely underweight children and number of such children would increase in each Anganwadi Centres. The number of normal children would also increase in all the Anganwadi Centres.

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

Achievements: There has been significant progress in the implementation of ICDS Scheme during X Plan both and during XI Plan (up to 31.12.2010), in terms of increase in number of operational projects and Anganwadi Centres (AWCs) and coverage of beneficiaries as indicated below:-

Year ending	No. of operational projects	No. of operational AWCs	No. of Supplementary nutrition beneficiaries	No. of pre-school education beneficiaries
31.03.2002	4608	545714	375.10 lakh	166.56 lakh
31.03.2003	4903	600391	387.84 lakh	188.02 lakh
31.03.2004	5267	649307	415.08 lakh	204.38 lakh
31.03.2005	5422	706872	484.42 lakh	218.41 lakh
31.03.2006	5659	748229	562.18 lakh	244.92 lakh
31.03.2007	5829	844743	705.43 lakh	300.81 lakh
31.03.2008	6070	1013337	843.26 lakh	339.11 lakh
31.03.2009	6120	1044269	873.43 lakh	340.60 lakh
31.03.2010	6509	1142029	884.34 lakh	354.93 lakh
31.12.2010	6719	1241749	918.65 lakh	355.02 lakh

Infrastructure of Anganwadi centres in West Bengal:

There is no data available about the infrastructural facilities of AWCs in West Bengal. But is generally observed that many of the centres are run either in primary school buildings or even clubs or private houses.

Visit to ICDS centres:-

While visiting any ICDS the following things can be seen:--

1. Attendance register of AWW and helper needs to be checked. The attendance register of pre-school children (three to six years) should be also checked and actual number present should be tallied with the names of the attendance register.
2. SNP register should also be checked. It contains the names of children from six months to six years along with the number of pregnant and lactating mothers.
3. Growth chart: it shows the number and status of malnourishment among the children. If there is any severely malnourished child/children (red zone) then the following things to be checked additionally:

a) Whether they are getting enhanced ration.
b) Whether counseling of parents of the severely malnourished children are done or not.

4. In counseling the following aspects should be mentioned: exclusive breast feeding for children upto six month. For children above six months it needs to be examined whether semi-solid food in addition to breast milk is being given or not. Further for the children above two years it also to be verified whether there is any worm infection or any chronic disease causing the malnutrition.
5. Mothers' meeting: whether these are held regularly. It should also be examined where the meetings are held at the centre itself or at other places within the area of the centre.
6. Immunization: immunization status of pregnant mothers and the children as per age need to be checked also.
7. Quality of SNP: whether vegetables, soya bean, egg and dal and rice as per prescribed ration size are being distributed or not.
8. Book verification and physical verification of food grains.
9. How many five years plus children have been admitted to primary school from the centre?