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ROLE OF ICDS IN INDIAN

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Abstract

The programme provides an integrated approach for converging basic ices through community-based Anganwadi Workers and helpers, supportive community structures/women's group - through the Anganwadi centre, the health system and in the community. Besides this, the AW is a meeting ground where women's/mother's group can come together, with other frontline workers, to promote awareness and joint action for child development and women's empowerment
***Keywords**: NFHS I, NFHS II, ICDS, women's empowerment, child development, Community*

ICDS in India's Main Early Child Development

India's main early child development and nutrition intervention is the Integrated Child Development Services (ICDS) programme, which has expanded steadily across the country during the last 30 years of its existence. It is well-designed and well-placed to address many of the underlying causes of under nutrition in India. However, it faces a range of implementation difficulties that prevent it from fully realizing if's potential. This presents some key findings of a World Bank discussion paper2 which evaluates the performance and potential of the ICDS prograrmne. To do so, it uses -data from the two National Family Health Surveys (NFHS I and NFHS II), a 2000-02 world Bank-funded ICDS survey of women and children 3 a number of qualitative studies, and the experiences of technical experts, NGO partners and policy- makers in India.

ICDS at Meickilarpatti

ICDS at Meickilarpatti was started in the year 1982 this centrally implemented ICDS schemes, which covers 7 others villages such as, M. puthoor, M puthupatti, ChikkamPatti, Kumararcovil, Mayannagaer, ImayaNagar, Kattalai Mayanpatti, Hence there Hamlet village under Meickilarpatti also being the benedictory of this scheme. ICDS targets two sections namely 1. Pregnant women 2. New born babies and children Nutrition's flour and lunch has been provides to the babies, and vegetables, nutrition, tables has been provided, As the pregnant women on daily buries. In addition to that vaccination like DPT, BLG, oral polio etc, are given to children and tetanus taxied does are provided to pregnant women as early as possible during pregnancy after 1st trimester health case staff including secretary cook and once nurse, and one assistant and are working under ICDS the total population of Meickilarpatti panchayat is 3067 with the break up male 1,680 and female 1,439. In ICDS at Meickilarpatti village the following number of babies and children an being benefiter

Male	1630
Female	1437

Total Population	3067
0 to 5	16
6-24	28
25-36	13

Total Number of Children below 3 year	- 57
Total number of weight calculated children Below 3 year	- 57
Total number of Children get nutrition Flour and lunch	- 25
Total (ANC) - Pregnancy and (PNC) - Feeding Mother, Nutrition Flour get (ANC) pregnancy And (PNC) mother feeding	-4+16

ANC -Pregnancy	- 4
PNC -Feeding mother	- 16
37 Months Babies	11
60 Months Babies	19
37 to 60 month children	30

After birth the new born babies are weighted and get nutrition's food regular monitoring has been provided to both babies and children and pregnant women says the secretary of ICDS.

Other Programmes Related with ICDS

National Children's Fund

The National Children's Fund was reacted during the International Year of the child in 1979 under the Charitable Endowment Fund Act, 1890. The Fund provides financial assistance to voluntary agencies for implementing programmes for the welfare of children including rehabilitation of destitute children

National Plan of Action for Children

India is a signatory to the 27 survivals and development gold laid down by the world summit on children 1990. In order to implement these goals, the Department of women & child Development has formulated a national Plan of Action on Children. Each concerned Central Ministries/Department, State Governments/ Union Territories. These goals have been integrated into National Development Plans.

Balwadi Nutrition Programme (BNP)

The programme is being implemented since 1971. There are around 5641 Balwadi throughout the country benefiting 2.25 lakhs children. The program me extends supplementary nutrition consisting of 300 calories and 12.15 Gms. Of protein every day per child in the age group of 3-5 years.

The Early Childs Education (ECE)

The scheme being implemented since 1982 has been visualized as a strategy to reduce the dropout rate and to improve the rate of retention of children: in schools. The scheme is being run by voluntary organizations through 4365 Early Child Education centres in nine educationally backward states of Andhra Pradesh, Assam, Bihar, Jammu & Kashmir, Madha Pradesh, Orissa, Rajasihan-Uttar Pradesh and West Bengal.

The Impact of ICDS on Adult Women

The adult women, micronutrient supplementation, -health referrals and preschool education for 3-6 year olds. As the programme has developed, it has expanded its range of interventions to include components focused on adolescent girls nutrition, health awareness and skills development, as well as income generation schemes for adult women.

Capacisity Mobilization of ICDS

Undoubtedly, the skills of the Anganwadi worker (AWW), her capacity to mobilize the community to support ICDS and her ability to recruit eligible children stand central to quality service delivery and ICDS effectiveness. TOO often, though, performance is constrained by poor: quality training and the pressure of a large and disparate workload's While AWWa tend to be well-educated, they are sometimes poorly trained for ICDS tasks. Survey data show that preserves training is scarce with most women undergoing short-term in service training (Bredenkamp and Akin 2004). To provide high quality support and training to functionaries of ICDS programmes. IN 2002, a new training programme, "Udisha", was initiated with funding from the World Bank and attempts to shift the focus of training from the mere transfer of knowledge towards the strengthening of AWW competencies. (Bredenkamp and JS Akin (2004) 'India's integrated child Development services scheme.)

Anganwadi Worker

AWW must engage in Economic and Political Weekly March 25, 2006 1199 supplementary nutrition-related activities, preschool education, growth-promotion, health and nutrition education, home visits, referral services and meeting with the community. In addition, AWWs must maintain at least 12 different type of records.

The frequent delays in payment of honoraria to AWWs are excusable: in Uttar Pradesh in 2000, for example, as many as 67 percent of urban AWWs reported that they dit not receives their honoraria regularly (Bredenkamp and Akin 2004).

Promote collaboration between ICDS and the Reproductive and child Health Programme the objectives of the Reproductive and Child Health (RCH) programme and ICDS are intertwined and" so the promotion of linkages between the activities of the two would be mutually beneficial. Already some of these linkages are recognized in the job descriptions of the Angan wadi workers and auxiliary nurse' midwives (ANMs). A WWs are

supposed to promoted awareness of national immunization days (NIDs) and maintain immunization records.

Lower Levels of LCDS Programme

ICDS policy stipulates that there should be one Anganwadi centre in place per 1000 populations, with more intensive placement of one per 7100 populations in tribal areas, where poverty tends to be more prevalent. While this policy aims to promote a quit able distribution of centres, in reality, the ICDS programme is rather poorly targeted. The poorest states and those states with the highest levels of under nutrition tend to have the lowest coverage by IDCDS activities and the smallest government budgetary allocations per malnourished child. The overage of villages by ICDS is much more pronounced in Wealthier states, as can be seen by the steep slope of the curve in Figure 1. States with lower per capita net state domestic product (NSDP) have a smaller percentage of villages covered by the ICDS programme than those with higher per capita NSDP

The States with the Worst Malnutrition have the Lowest Levels of ICDS Programme Coverage

Regardless of the indicated of ICDS coverage used, whether it be (a) the percentage of village with an Anganwadi centre, (b) the number of ICDS beneficiaries or (c) public expenditure of ICDS, access to the Icds programme is poorest in the states with the worst nutrition indicators: (a) Examining the percentage of village with an Anganwadi centre, it can be seen that the face states with the highest underweight prevalence, namely, Rajasthan, Uttar Pradesh, Bihar, Orissa and Madhya Pradesh, all rank in the bottom 10 in terms of ICDS coverage. Wealthier communities are also more likely to have the ICDS programme than poorer communities. In 1998, while only half of the village from the lowest two deciles of the all-India wealth covered about .8Q per cent of the richest (Das Gupta 2005). (b) Also, in terms of beneficiary numbers, states with a greater percentage of underweight children tend to have a smaller percentage of children enrolled in the ICDS programme. Worst in Bihar Where, despite an under weight prevalence of 55% only 1.5% of children benefits.

Most Vulnerable Groups of Children

Since most growth faltering occurs during two years of life, and continues to negatively affect children's development all though their lives (ACC/SCN 20o_4 initial that children under the age of three are effectively reached with IGDS interventions. In addition, according to ICDS policy, a "special effort". should be made to reach children from lower income families or scheduled tribe and scheduled caste groups (DWCD 2003). There is also supposed to be explicit targeting of severely malnourished children who should receive double food rations.

Effectively Reach Children under Three

Because of the type of services provided and the focus on centre- based activities. ICDS does not attract as large a share of the youngest children as it could. Consequently, monthly growth monitoring of under three is not regularly performed and the supplemental feeding programme is not effectively targeted at children during the early childhood years, i.e during the optimal window for influencing growth (ALLEN and Gillespie 20012) instead, the centre tends to attract more four to six year olds. Partly because of the preschool activities that are offered concurrently. Thus, interventions miss the most critical age group, and the prevalence of stunting and underweight remains very high. A more concerted effort needs to be made to recruit young children into the programme, perhaps through reaching out to women effectively while they are still pregnant or when their children are born. Succeeding in this effort would produce a shift towards preventing malnutrition instead of just treating it, when it is often already too late to recover the growth trajectory. One possibility is to explore the use of conditional cash-transfers which have been very successful in other countries. In Mexico (Skoufias 2001), Honduras (Rawlings and Rubio 2003) and Colombia, they have been used to increase the demand for healthcare among young children, educate parents .about adequate caring and feeding practices and, Ultimately, appear to have improved child nutritional and health status quite rapidly.

Free Ding and Caring Practices

Failure to exclusively breastfeed children during the first size months of life, along with delayed introduction of semisolid foods, is an important trigger of malnutrition. In 2003, it was found that less than 40 per cent of infants in India were exclusively breastfed during the first sic months (BPNI 2003), the quality of complementary foods is often poor, due to local customs and beliefs (Roy 1997) and, according to the NFHD II, only one- third of children in India were fed semi-solid foods between the ages of six and nine months. ICDS appears to have little success in encouraging mothers to adopt appropriate child care and feeding behaviours (including practices related to breastfeeding, weaning and diet) that have the potential to improve child growth health outcomes. Data from Kerala, Maharashtra, Rajasthan and Uttar Pradesh yield very little evidence that these healthy behaviours are more common in Village with A WCs than without A WCs (Bredenkamp and Akin 2004). The AWW should devote much more of her time and energy to communicating the importance of exclusive breastfeeding and, later, adding semi-solid complementary food three to four times a day in appropriate quantities thereafter (Ghosh 2004). Also important is to show women hoe to use their own resources to feed their children more effectively. This approach has been used in many settings including the Republic of Korea.

ICDS Better Target Children of Low Economic Status

In states included in the ICDS III baseline/ICDS II end line survey, remarkably little variation was found in children's participation rates across wealth quintiles- not much more

than a 10 per cent age point difference. On the one hand, this implies that a poor economic background does not present too formidable an obstacle to ICDS attendance. On the other hand, since poorer children are more likely to be malnourished, it is desirable that ICDS attracts a larger population.

References

- Jelliffe, b. the asssessment of the nutritional status of the commonly World health organization , Geneva 1966
- Gopalan, c., et, al. Nutritive value of Indian foods, National institute of nutrition, Hyderabad , 1971
- Davidson stanely and passmore. k, Human nutrition and dietetics, liingston London, 1965.
- World health organization , hand book of human nutrition requirement geneva, 1974
- Dutt, p. R. Rual health services in Indian, primary health centre central health education bureau directorate general of health services, New Delhi, 1962.
- Jaggi, o. p Indian system of medicine, Atma ram & sons, Delhi, 6, 1978