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INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) in Jammu & Kashmir

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Abstract

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 State of Jammu and Kashmir is situated between 320 17' N and 37° 6' N latitude, and 73° 26' E and 80° 30' E longitude on the northern extremity of India. It occupies a position of strategic importance with its borders touching the neighboring countries of Afghanistan in the north-west, Pakistan in the west and China and Tibet in the north-east. To its south lie Punjab and Himachal Pradesh, the two other states of India. Female population of J&K State slashed down from 47.15% of the total population in 2001 to 46.88% (prov.) in 2011. As per details from Census 2011, Jammu and Kashmir has population of 1.25 Crore souls over the figure of 1.01 Crore in 2001 census. Total population of Jammu and Kashmir as per 2011 census is 12,548,926 of which male and female are 6,665,561 and 5,883,365 respectively indicating a reduced sex ratio of 883. The corresponding figures of male and female as per Census 2001 were 5,360,926 and 4,782,774 respectively indicating sex ratio of 892. Finally the researcher concludes, all vacant positions of the CDPOs and ACDPOs should be filled up at the earliest so that the scheme does not suffer any more. This will help in proper planning, implementation, supervision and monitoring of the scheme. All the departments must regularly coordinate and meet the expectations from each other department. All vacant positions of the Supervisors should be

filled up at the earliest so that supervision and monitoring is strengthened both in the urban and rural areas. The Panchayats should be made functional in areas where these are non-functional. Further, Panchayats should be involved in planning, monitoring and supervision of the AWCs.

Keywords: *Integrated Child, Development, Jammu & Kashmir*

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.

The State of Jammu and Kashmir is situated between 320 17' N and 37° 6' N latitude, and 73° 26' E and 80° 30' E longitude on the northern extremity of India. It occupies a position of strategic importance with its borders touching the neighboring countries of Afghanistan in the north-west, Pakistan in the west and China and Tibet in the north-east. To its south lie Punjab and Himachal Pradesh, the two other states of India. The total geographical area of the State is 2, 22,236 square kilometers and presently comprising of three divisions namely Jammu, Kashmir and Ladakh and 22 districts. The Kashmir division comprises of the districts of Anantnag, Kulgam, Pulwama, Shopian, Srinagar, Ganderbal, Budgam, Baramulla, Bandi Pora and Kupwara. The Jammu division comprises of the districts of Doda, Ramban, Kishtwar, Udhampur, Reasi, Jammu, Samba, Kathua, Rajouri and Poonch. The Ladakh division consists of Kargil and Leh districts. Every region has distinct social, economic, linguistic and cultural characteristics.

Demography

Female population of J&K State slashed down from 47.15% of the total population in 2001 to 46.88% (prov.) in 2011. As per details from Census 2011, Jammu and Kashmir has population of 1.25 Crore souls over the figure of 1.01 Crore in 2001 census. Total population of Jammu and Kashmir as per 2011 census is 12,548,926 of which male and female are 6,665,561 and 5,883,365 respectively indicating a reduced sex ratio of 883. The corresponding figures of male and female as per Census 2001 were 5,360,926 and 4,782,774 respectively indicating sex ratio of 892. The population growth in this decade was 23.71 percent while in previous
decade it was 29.04 percent. The population of Jammu and Kashmir forms 1.04 percent of India in 2011. In 2001, the figure was 0.99 percent. This difference indicates a much higher

rate of growth in comparison to average All India growth rate. Demographic imbalance between men and women, however, continues to exist and has further deteriorated.

Sex Ratio

Sex ratio (females per thousand of males) is an important indicator of the social conditions particularly with respect to women's status in any society. Low sex ratio shows indulgence of artificial interventions, distorting the biological trend and natural balance in terms of number of females per thousand males. An important concern in the present status of Jammu and Kashmir's demographic transition relates to adverse sex ratio. The sex-ratio as per census 2001 is 892 which is very unfavorable to the women of the State. The sex-ratio as per census 2011 was 883 which is a matter of great concern and needs to be addressed on priority. The following Table sheds light on percentage change in the sex ratio over the period

OBJECTIVES

- To analyze socio-economic and demographic characteristics of the beneficiaries of the scheme, so as to assess the extent to which the guidelines for identifying the beneficiaries/villages have been followed.
- To identify the problems in the implementation of the scheme and reasons for tardy implementation, if any.

METHODOLOGY

Both primary and secondary data was collected through instruments structured at different levels. The secondary data was obtained through the State, District, Block and Village level questionnaires. Information was collected about financial and physical performance and adequacy of the implementation mechanism for the schemes. Detailed discussions were held with the officials at various levels to gather information on the implementation of the scheme. The primary data was collected through field surveys from beneficiaries as well as non-beneficiaries of the scheme.

INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS)

Introduction

For a child, family is the primary social institution where one seeks love and affection; care and protection; and the fulfilment of his basic physical, emotional and psychological needs. The transition from joint family system to nuclear family, the rising cost of daily necessities and various other economic and social compulsions are compelling reasons to take gainful employment, (part-time or full-time), to supplement the family income. A large number of families, both in rural and urban areas of the country, live below the poverty line. Some sections of the society, viz. i) urban slum dwellers, ii) marginal farmers and agricultural landless labourers, iii) tribals and iv) scheduled caste people are distinctly underprivileged. In spite of significant progress in the economic sphere, these sections of society are not in a position to provide due care and security needed for normal growth of their children even

today. Therefore, they require additional support through outside interventions to enable the family to fulfil its obligations towards proper health care, nutrition, education and social well-being of their children.

Governmental concern for the promotion of services for the growth and development of pre-school children is evident from the constitution of National Children's Board and also from the Resolution of National Policy for Children, 1974. Further, a number of expert bodies have been set up from time to time to frame policies for the welfare of children. These committees' collected valuable data related to the needs and problems of children, examined the effectiveness of existing programmes & services and suggested long-term measures to improve and strengthen them qualitatively and quantitatively.

The Scheme

In pursuance of the National Policy for Children, which laid emphasis on the integrated delivery of early childhood services and services for expectant and nursing women and based on the recommendations of the Inter-Ministerial Study Teams set up by the Planning Commission, the scheme of ***Integrated Child Development Services (ICDS)*** was evolved to make a coordinated effort for an integrated programme to deliver a package of such services. The blueprint for the scheme was drawn by the Ministry of Social Welfare, Government of India, in 1975. The scheme called for coordinated and collective effort by different Ministries, Departments and Voluntary Organisations. Considering the magnitude of the task, it was decided to set up 33 projects on an experimental basis in the year 1975-76. The Scheme was formally launched on October 2, 1975. Out of these 33 projects, 19 were rural, 10 were tribal and 4 were urban, spread over in all the States and the Union Territory of Delhi. On the basis of the evaluation report of its Programme Evaluation Organisation submitted in August, 1977, the Planning Commission sanctioned 67 additional projects, which started functioning during 1978-79. During the next two years, 100 additional projects were added raising the number of ICDS Projects in the country to a total of 200. Out of these 200 projects, 105 were rural, 67 were tribal and 28 were urban projects. During the Sixth Five year Plan (1980-85), 800 additional projects were sanctioned, raising the total number of projects to 1000 by the end of Sixth Five Year Plan. From the small beginning of 33 blocks in 1975, the ICDS has grown to become world's largest and most unique early childhood development programme. Today, the ICDS has a network of more than 7000 projects covering more than 75 percent of the Community Development Blocks and 273 Urban Slum pockets of the country.

The programme approaches a holistic child health comprising health, nutrition, and education components for pregnant women, lactating mothers, and children less than six years of age. The programme is implemented through a network of community-level A*nganwadi Centres*. The range of services targeted at young children and their mothers for growth Monitoring, immunization, health check-ups and supplementary feeding, as well as nutrition and health education to improve the childcare and feeding practices that mothers adopt. Pre-school education is provided to children between three and six years of age.

Objectives of the Scheme

The broad objectives of the ICDS Scheme are:

- To improve the nutritional and health status of children in the age group 0-6 years.
- To lay the foundations for proper psychological, physical and social development of children.
- To reduce the incidence of mortality, morbidity, malnutrition and school drop-out.
- To achieve effective coordinated policy and its implementation amongst the various departments to promote child development; and
- 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.

The Integrated Child Development Services (ICDS) Programme for the development of women and children was launched in Jammu and Kashmir in 1975 with the establishment of a project at Kangan in Srinagar district. By the year 2007, the coverage of scheme was extended to all the 140 Community Development Blocks of the state. At present, J&K State has 141 ICDS Projects (including one migrant project) and 28577 AWCs have been sanctioned by Government of India out of which 28467 are presently functional. All the AWCs in the state were established with the purpose to provide Supplementary Nutrition (SN), Nutrition and Health Education (NHE), Immunization, Health Check-ups, Referral Services and Non-formal Pre-School Education (PSE).

The objective of this study was to evaluate the functioning of the ICDS programme in Jammu and Kashmir. The findings of the study were based on the information collected from 40 AWCs, 10 each located in the districts of Anantnag, Kupwara, Doda and Rajouri. During the course of survey, information was also collected from 200 beneficiary mothers, whose children were enrolled in the AWCs. Besides, information was collected from four Programme Officers and eight Child Development Project Officers in the four selected districts.

Category	**2009-10**	**2010-11**	**2011-2012**	**2012-13 (Ending Oct-2013)**
0-3 Years	328838	330637	303354	379965
3-6 Years	276715	251572	237882	274237
Pregnant & Lactating Mothers	743736	880909	681297	771646
Child Populatio	**All India Level**		**J&K State**	

n	2001	2011	2001 2011	
Male	8,50,08,267	8,29,52,135	7,65,397	10,80,662
Female	7,88,29,128	7,58,37,152	7,20,409	9,27,980
Child Sex Ratio	927	914	941	859

Financial progress

The ICDS is a Centrally Sponsored Scheme. While the Central Government bears the full cost of meeting the operational requirements, the state government provides funds for Supplementary Nutrition (SN) component. In addition to mobilizing domestic resources, significant contribution also comes from UN Agencies, bilateral donors and the World Bank. The expenditure for running the ICDS programme is currently met from three broad sources: viz., (a) funds provided by the Centre under `general ICDS which used to meet expenses on account of infrastructure, salaries and honorarium for ICDS staff, training, basic medical equipment including medicines, play school learning kits etc. (b) allocations made by state governments to provide supplementary nutrition to beneficiaries and (c) funds provided under the Pradhan Mantri Gramodaya Yojana (PMGY) as additional central assistance, technically to be used to provide monthly take-home rations to children in the age group 0-3 years living below the poverty line and those who are in need of additional supplementary nutrition.

Supplementary Nutrition Programme (SNP)

As mentioned above, the ICDS covered all the Community Development Blocks of the state and as of March, 2007, there were 140 ICDS projects in operation in the state. The government has sanctioned a total number of 18772 AWCs in the state but only 18043 AWCs were functional. All the sanctioned AWCs in Anantnag, Kupwara and Doda were functional but only 60 percent of the sanctioned AWCs in Rajouri were functional. However, efforts were on to make the remaining AWCs functional in the district. According to Programme Officers almost all the villages were covered under ICDS scheme. But the scheme was not reaching to as many children and women as it could because of a ceiling of a target group of 20 children and 5 women per AWC for Supplementary Nutrition Programme (SNP). With this ceiling, the SNP scheme in 2008 was reaching out to 3,60,860 children and 90215 pregnant and lactating women. However, the total child population (0-6 age group) in Jammu and Kashmir as per 2001 Census was 14,31,132. Thus, the scheme was in a position to cover just 25 percent of the child population. The ceiling of targeting only 20 children and 5 women by each AWC could only be explained from the point of view of financial constraints because the available infrastructure in the AWCs could have supported more than this target

population. The programme provided single ration of 300 calories and 10 grams of protein to children. Pregnant and lactating mothers also received an equivalent quantity, whereas the provision was 500 calories and 20 grams of protein. It was mentioned by the Programme Officers that financial constraints were limiting the provision of SN to all eligible children and women. The norms of expenditure per child on SNP was fixed many years ago, whereas the cost of supplies increased over this time, but there was not corresponding increase in the allocation on SNP per beneficiary. Besides, AWCs were serving SNP for 210 days only against 300 days norm in other states.

Pre school education (PSE)

As per the provisions (in the ICDS guidelines), Rs. 500 is earmarked for the non-formal pre school material on an annual basis per AWC. The Programme Officer mentioned that such funds were not released regularly.

Infrastructure

An appropriate infrastructure is essential for effective delivery of services. The ICDS programme in Rajouri has one of the largest grass roots level networks amongst all the government departments in the district. The ICDS programme in the district was extended to all the community development blocks and covered a majority of the villages. As per the 2001 census, the total population of Jammu and Kashmir was little more than one crore and as such there was an AWC for every 545 persons. The comparable figures for Anantnag, Kupwara, Doda and Rajouri were 540, 444, 405 and 518 respectively. But Rajouri and Doda were among the most difficult terrain districts of the state and as such it was not possible for the children living in the remote and inaccessible areas to avail the ICDS services. Hence, there is a need to open more AWCs in the remote areas of these districts so that the ICDS services to the children living in the far-flung areas are made accessible at a walking distance.

Space

According to ICDS guidelines, the space for the AWCs was to be donated by the community at a central location, preferably near a primary school. The AWCs should provide sufficient space for indoor and outdoor activities and also separate space for kitchen, dinning and storage. However, in all the AWCs studied, it was noted that the space was provided by the AWHs. It was rather one of the criteria that whosoever rovide space would be considered for the work of AWH. Consequently, both the quality of space and the locational aspects of the AWCs were compromised. Besides, there was no provision of rent for AWC in the district. Without rent, one cannot expect an appropriate space. Usually, it was seen that AWHs devote those room to the AWCs which were in poor condition. Regarding the status of the building for running of AWC, it was observed that only 28 percent of the AWCs were housed in pucca buildings (Table 5.8) while 45 percent of the AWCs were housed in semi-pucca houses and another 28 percent were in katcha houses which constitute a perpetual apprehension of danger to the life of the children. In Rajouri and Anantnag district 40-50 percent of the selected AWCs were located in katcha buildings while in Kupwara 70 percent were located in semi-pacca houses.

Kitchen is an integral part of the AWCs. However, 82 percent AWCs covered under the study had no separate space for cooking purpose as cooking for AWCs was done in the AWHs personal kitchen. In Kupwara, none of the AWCs had a separate kitchen. Other issues such as separate storage space, dinning and sufficient space for indoor and outdoor activities were also compromised. This was established by the fact that only 38 percent of the AWCs had separate space for storage, 55 percent had separate outdoor space for recreation and 53 percent had some sort of space for indoor activity (Table 5.9).

Due to lack of separate storage facilities in about 38 percent of the AWCs covered under the study reveals that many a times storage of various items such as utensils and records in addition to the personal belongings of the AWH occupies the main room pushing beneficiaries to a corner. Most areas of the districts included in the study witness low temperature during the winter. Delivery of services requires the beneficiaries to sit in the Centre for up-to 4 hours a day. The study found that 25 percent of the AWCs had no arrangement for heating. Consequently, the children got exposed to sever cold and viral infections like fever, cold etc.

(b) Delivering the Services

Health check-ups

According to the mandate of the ICDS, the health check-ups should include health care of children less than six years of age, antenatal care of expectant mothers and postnatal care of nursing mothers. The health services provided for children by AWWs and PHC/SC staffs should include regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, de-worming and distribution of simple medicines etc. At the AWCs, children, adolescent girls, pregnant women and nursing mothers should be examined at regular intervals by the Lady Health Visitor (LHV) and Auxiliary Nurse Midwife (ANM). They should also diagnose minor ailments and distribute necessary medicines among them. They should act as a link between the villages and the PHC/SC. Maternal and child health facilities should be geared towards providing adequate medical care during pregnancy, at the time of childbirth and also post-partum care. These services should also aim at promoting safe motherhood, healthy child development – reducing maternal and infant mortality. Immunization of pregnant women and infant protects children from six vaccine preventable diseases viz., Poliomyelitis, diphtheria, pertuses, tetanus, tuberculosis and measles.

The primary role of AWW is to survey and identify women and children for these services and gather the identified people during the visits of the ANMs and LHVs for health check ups. AWWs are also expected to coordinate with the ANMs and LHVs of the PHCs and SCs. It was, however, observed that ANMs and LHVs, were not located in the vicinity of the AWCs and they did not visit the AWCs. Even if they visited, these visits were irregular. This was substantiated by the fact that health check ups were not conducted by the ANMs/LHVs in any of the AWCs under study. In fact, ANMs had not visited 68 percent of the AWCs for health check ups during the last three months. Similarly, Lady Health Visitors (LHVs) and Medical Officers (MOs) had not paid any visit to 85 percent of the AWCs (Table The situation was more alarming in Rajouri while none of these health officials had

visited 80 percent of the AWCs. Thus, the health check-up were not a regular feature of the AWCs primarily because of poor coordination between the ICDS functionaries and the Health Department. AWWs are also supposed to visit the households for health education and motivate them to utilize maternal and child health services. It was found that AWWs had visited only about three fourth (72 percent) of the households during the last three months with little variation among the districts (Table 5.16). It was mentioned by the respondents that AWWs generally visit them either at the time of special health campaigns like Pulse Polio Campaign, Family Health Awareness campaign or when to conduct household surveys.

An important objective of the this study was to provide information on the usage of safe motherhood services and the role played by the AWWs in facilitating these services to women. It was found that only 70 percent of the women had utilized Antenatal care services during their last pregnancy (Table 5.17). Percentage of women who had availed ANC service was very low in Rajouri and Kupwara. AWWs are supposed to motivate and register pregnant women for ANC services. It was found that majority of the women (32 percent) were motivated by the AWWs to avail ANC services at the time of last pregnancy, 14 percent were advised by ANM and 11 percent were advised by the family members to register for ANC services. Further 6 percent were not advised by anybody to utilize the ANC services but availed the facility on their own effort. AWWs had played an important role in motivating pregnant women to utilize ANC services during pregnancy in Doda district and had played a complimentary role in other districts (Table 5.17).

The effectiveness of antenatal check-ups in ensuring safe motherhood depends both the tests and measurements done and the advice given during the check-ups. During the survey information on this important aspect of antenatal care was collected by asking mothers (who availed ANC services) if they had received each of several components of antenatal check-ups during their last pregnancy. Table 5.17 presents the percentage of women, who received specific components of antenatal check-ups. Seventy seven percent of the women who availed ANC services had received tetanus toxoid injections during last pregnancy and blood pressure of women during pregnancy was checked in case of 66 percent of women. Similarly, iron folic tablets were supplied to 70 percent and weight was monitored in case of 55 percent of pregnant women. The utilization of each of these services was higher in Anantnag and Kupwara districts compared to Doda and Rajouri districts.

AWWs are also supposed to impart pregnancy care information to women during pregnancy. Only 43 percent of women during their last pregnancy were advised by the AWWs to take special care during pregnancy. Higher proportion of women in Doda (86 percent) and Anantnag district (58 percent) were given such advice. As far as the nature of advice was concerned, 37 percent of women were advised to eat more food than usual, 27 percent were advised to take green leafy vegetables and 10 percent each were advised to take more rest and avoid stress-full work. Surprisingly very few women were advised by the AWWs to deliver their babies in a health facility.

Women who had delivered during the last three years were further asked about the place of delivery of the last child. It was found that 58 percent of the women had delivered

their last child at home and the remaining 43 percent had delivered in a health institution. All the women who were advised by an AWW to deliver in a health facility had in fact delivered in a health institution. Proportion of women who had delivered in a health institution in Anantnag, Kupwara, Doda and Rajouri was 46 percent, 44 percent, 42 percent and 38 percent respectively.

Post partum care is an important component of post natal services and AWWs are supposed to visit the women at home and advise them to seek post partum care. But more than 50 percent of the women were not visited by any one for post partum services. In fact, 82 percent of women in Rajouri and 66 percent of women in Kupwara were not provided such services. It was found that only 28 percent of women were visited by the AWWs after the delivery, enquired about their health conditions and also advised them to visit a health facility to seek post partum care. ANM/LHVs had also visited 19 percent of the interviewed women for post partum services (Table 5.18). Thus, it was observed that AWWs had played some role in motivating women to visit a health facility for post partum care. AWWs are also supposed to motivate women to use family planning methods. Information regarding the current use of family planning methods was collected from the women and it was found that only 40 percent of the interviewed women were using any modern method of family planning in J&K. National Family Health Survey conducted in the State during 1999 had also shown that 40 percent of couples in the state are using a modern method of family planning. Thirteen percent were using female sterilization, 10 percent were using IUD, 11 percent oral pills and 6 percent condoms. So far as the use of family planning in the four selected districts is concerned, only 24 percent of the women in Rajouri were using a method of family planning as compared to 36 percent in Anantnag, 44 percent in Kupwara and 56 percent in Doda. Of the women who were using a method of contraception, one third were motivated both by the Health Workers and their husband to use family planning while another 20 percent were motivated by AWWs. Thus, it was observed that AWWs did complement the health department in motivating couples to accept family planning methods (Table 5.19). AWWs had played a limited role in motivating women to plan their families in the districts of Anantnag and Rajouri.

Immunization

National prophylaxis programme for prevention of blindness caused by deficiency of vitamin A, and control of nutritional anemia among mothers and children are two direct nutrition interventions integrated in ICDS. For dietary promotion the food rich in vitamin A, iron, folic acid and vitamin C should be an important part of nutrition and health education. At nine months of age, 100,000 IU of vitamin A solution should be administered to infants along with immunization against measles. Children in the age group of 1-5 years should 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 should be administered to expectant mothers for prophylaxis and treatment and to anemic children. The usage of only iodized salt should be promoted, especially in the food supplement provided towards preventing iodine deficiency disorders.

Immunization of pregnant women against tetanus reduces maternal and neonatal mortality. The PHC and its subordinate health infrastructure have to carry out immunization of infants and expectant mothers as per the national immunization schedule. Children are also to be given booster doses of various vaccinations. The AWWs are required to assist the health functionaries in the coverage of the target population for immunization. They are also required to help in the organization of fixed day immunization sessions, maintain immunization records of ICDS beneficiaries and resort to follow up action to ensure full coverage. In order to enhance the reach of these services, particularly to the disadvantaged groups and ensure their better utilization, AWWs have to mobilize support from the community. AWWs are also required to survey families in the community to identify pregnant and nursing mothers, adolescent girls and children below six years of age from the low income families and deprived sections of the society to ensure early registration of pregnant women leading to better utilization of key health services, as well as better care and counseling for improved maternal nutrition. It also promotes a healthy prenatal and postnatal environment of the young child, to reduce the incidence of low birth weight thereby promoting child survival and development. During the survey, it was found that AWCs did not provide immunisation to the children. On the contrary the AWW advise the parents of the children to get their children immunised from the nearest health centres. In some of the AWC, the local ANM/Health worker also visited the AWCs for immunisation.

Information regarding the immunization of children was collected both from the AWC records as well as from the beneficiary households. The immunization records maintained by the AWCs showed that almost all the children registered with the AWCs have received all the recommended doses of vaccination. On the contrary, the information collected from the beneficiary households revealed that 89 percent of the children had received BCG, 91 percent had received all the three doses of DPT and Polio (Table 5.20). Measles vaccine was received by 74 percent of the children. Except for 3 children, all other children were administered polio drops under pulse polio campaign. Hepatitis-B vaccine was not received by 90 percent of the children. Coverage pf immunization was comparatively less in Doda and Kupwara districts compared to Anantnag and Rajouri districts.

It was, therefore, observed that although immunization was taking place to a great extent, but there was still scope for more work that needs to be done to ensure universal immunization of children. The constraints in completing regular immunization for the entire target group include:

Less than satisfactory coordination between the ANMs and LHVs

Less efforts in educating the community about the importance of immunization and

Insufficient provisions of material resources such as immunization cards and registers at the AWCs.

Referral services

As per guidelines of the ICDS programme, AWWs are required to identify sick and malnourished children and refer them to appropriate Health Care Centre. Besides, children and women in need of prompt medical attention are to be provided referral services through

ICDS. Therefore, the AWWs are also required to detect disabilities in young children and pregnant & lactating women. They are supposed to enlist all such cases in a special register and refer them to the appropriate Health Centre. The effectiveness of these services depends on timely action, cooperation from health functionaries and willingness of families to avail such services.

AWWs mentioned that they did not refer the children to a nearby facility but advise the parents of the children to visit a health facility in case they detected any problem among the enrolled children. The AWWs also mentioned that they also lack sufficient skills in detecting disabilities among women and children. Other reasons for this situation were non-availability of referral forms and inefficient supervision.

Medical kit

As per the provision of the ICDS guidelines, each and every AWC should have a medical kit containing essential drugs and first aid items. But, it was found that the medical kits were generally provided once a year and the quantity of drugs and other items supplied to the AWCs was insufficient and lasted for one or two months only. Therefore, the AWCs had to function without the basic medicines and medical kits for most part of the year. All the mothers also mentioned that they had never received any medicines or first aid from the AWCs.

Supplementary nutrition Supplementary Nutrition includes supplementary feeding, growth monitoring and promotion, nutrition and health education, and prophylaxis against vitamin A deficiency and control of nutritional anemia. The observations on these services are given below:

Supplementary feeding

The primary objective of the ICDS is to provide supplementary nutrition to the beneficiary children. Supplementary nutrition means identifying and fulfilling the deficiencies of calories, proteins, minerals and vitamins in the existing diets, avoiding cut-backs in the family diet, and taking other measures for nutritional rehabilitation. As per the guidelines, the state government is supposed to provide funds for supplementary nutrition. As per norms under guidelines each AWC is required to cover 102 beneficiaries comprising of 80 children, 20 lactating and pregnant women and 2 adolescent girls. Each beneficiary should receive 300 calories, 8 to 10 gms of proteins for 300 days in a year. The Govt. of India under PMGY has also kept a mandatory provision of 15 percent of the total allocation for additional nutrition for the children in the age group of 0-3 years. The funds under PMGY are released through Planning and Development Department as additional central assistance. The supplementary nutrition component of ICDS and nutrition component of PMGY are too mutually exclusively components. One is meant to provide nutrition supplement to the children in the age group of 6 months to 6 years, lactating mothers and pregnant women, while the second is meant for additional dose of nutrition for the children in the age group of 0-3 years only.

The guidelines of the ICDS programme envisage that, all families of the community should be surveyed to identify low income families, deprived children below the age of six, pregnant and nursing mothers and adolescent girls. These identified groups should be provided supplementary feeding support for 300 days in a year. By providing supplementary

feeding, the AWCs attempt 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 opportunity for the AWWs to have interaction with pregnant women, mothers of children, infants and young children to promote improved behavioral actions for the care of pregnant women and young children. The type of food varies, but usually it should consist of a hot meal cooked at the AWCs, containing a varied combination of pulses, cereals, oil and sugar/ iodized salt. There should be some flexibility in the selection of food items to respond to local needs.

However, it was observed that there was a single ration for different target groups such as children, pregnant women and nursing mothers, which was not in accordance with the ICDS guidelines. Similarly, there should ideally be provisions of double ration for malnourished children, but it was observed that there was no such practice in the district as no child received double diet, despite of the fact that few AWWs mentioned that certain children were suffering from malnutrition.

The AWWs mentioned that they get supplies, which last for 3-4 months only. Once the supplies exhaust, the children stop coming to the AWCs and AWCs get virtually closed. The respondents were asked to report whether their children had received any SN from the AWCs in the last month. Since most of the AWCs had recently received supplies therefore, supplies were available in all the selected Centres. But only 83 percent children had received SN from the AWCs in the last month (Table 5.21). This percentage was very low (50 percent) in Rajouri district and almost universal in Anantnag and Doda districts.

All the mothers mentioned that SN was not provided to their children regularly. They however, mentioned that whenever supply of nutrition items were available at the AWCs, their children get SN. But the problem was that AWCs did not get enough nutrition to last for about 300 days. Mothers mentioned that on an average AWCs provided SN for 100 days a year. The AWWs also mentioned that due to inadequate supplies they were not in a position to provide SN for recommended 210 days. All the AWCs had a uniform weekly schedule for providing SN to the beneficiaries. The AWWs mentioned that they followed this schedule strictly when nutritional items were available. All the AWWs also mentioned that it is not only the inadequate nutrition that affects the provision of nutrition but inadequacy of other material resource such as utensils, functional stoves and cooking fuel also contribute to it. The AWWs mentioned that sometimes they were unable to prepare SN, either because the stove was not in working order or the fuel was not available. The supplementary nutrition was distributed in the utensils of the AWCs. SN was generally consumed at the AWCs. Only, the physically challenged and sick children were allowed to take home SN. Mothers were also asked to mention whether they were satisfied with the various nutritional items provided at the AWCs. It was a general perception among mothers that children did not like Nutri Pulaw. Further, Halwa was not appreciated during winters for reason of potential throat infection. Therefore, it was required that the SN provided should have sensitivity to local taste and seasons

Conclusion and Suggestions

It may be concluded that in the State of Jammu & Kashmir, the ICDS programme was not in a position to achieve its objectives to the desired level. Not only the coverage of the services was low, but the scheme was not in a position to provide Supplementary Nutrition (SN) to beneficiaries throughout the year. As such, the scheme was not in a position to improve the nutritional status of the children. Due to lack of nutrition items in the ICDS Centres, pre-schooling has become a casualty, because many parents send their children to AWCs mainly for Supplementary Nutrition. The scheme was not in a position to help majority of the women to receive ante-natal care services and health education, as only a limited number of women were informed by AWWs about ante-natal care services, child immunization, management of diahorrea, methods of family planning, etc. The study also found that there was lack of coordination between various Departments engaged in implementation of the Scheme viz., Health, Rural Development, Education and Social Welfare. It was observed that lack of coordination was one of the major reasons for under performance of the ICDS. Another important reason for tardy implementation of ICDS was non-availability of adequate supervisory staff. Based on the findings of the study, the following recommendations are made for improving the implementation of the programme: -

1. All vacant positions of the CDPOs and ACDPOs should be filled up at the earliest so that the scheme does not suffer any more. This will help in proper planning, implementation, supervision and monitoring of the scheme. All the departments must regularly coordinate and meet the expectations from each other department.

2. All vacant positions of the Supervisors should be filled up at the earliest so that supervision and monitoring is strengthened both in the urban and rural areas.

3. The Panchayats should be made functional in areas where these are non-functional. Further, Panchayats should be involved in planning, monitoring and supervision of the AWCs.

4. The AWWs should be selected on the basis of their merit and educational competence which will go a long way in delivering the AWCs services in effective and constructive manner. Further the AWWs should be relocated to the AWCs in their own areas of residence, which will help AWWs to do full justice with their occupational commitments as well as to their inevitable domestic commitments.
5. Nutrition and health education is very important component of the ICDS in educating and involving communities and hence it should gain a focus for interventions at the AWCs. The AWCs should be supported by supervisors and others in organizing and educating mothers.
6. So far as early childhood care and pre-school education is concerned, there is a need to improve the skills of the AWWs on the concepts and approaches of the joyful learning (play-way methods). Adequate provisions should be made for procuring of relevant teaching and learning aids. Provisions should also be made for suitable accommodation along with matting and heating provisions at each AWC. There is also a need to develop and strengthen coordination with the local primary schools to seek their support and especially with the primary wing of the ZEO for monitoring purposes.

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