TRAINING OF TRAINERS OF SIRDs ON COMMUNITISATION OF ICDS AND VILLAGE CONVERGENCE & FACILITATION SERVICE (VCFS)

A COMPENDIUM

NATIONAL INSTITUTE OF PUBLIC COOPERATION AND CHILD DEVELOPMENT

PROGRAMME SCHEDULE
Training of Trainers on Village Convergence Facilitation Services (VCFS) and Communitization of ICDS in High Burden Districts

Date: **Venue:**

DAY 1	
Time	**Programme Sessions**
9.00 a.m. – 10.15 a.m.	Registration and Inaugural Session
10.15 a.m. – 10.30 a.m.	Tea Break
10.30 a.m. – 11.30 a.m.	Situational Analysis of Health & Nutritional Status of Women and Children especially Girl Child
11.30 a.m. – 1.00 p.m.	ICDS Strengthening and Restructuring with special emphasis on High Burden Districts
1.00 p.m. – 2.00 p.m.	Lunch Break
2.00 p.m. – 3.30 p.m.	Beti Bachao Beti Padhao (BBBP), Gender Concerns and Introduction to Village Convergence Facilitation Services (VCFS) in 161 Gender Critical Districts
3.30 p.m. – 4.45 p.m.	Role of Gram Panchayat, PRIs and Various Monitoring Committees in ICDS & VCFS • *Jan Sunvai* • Public Disclosure • Community Owned Accreditation Services • Social Audit
4.45 p.m – 5.00 p.m.	Tea Break
5.00 p.m – 6.00 p.m	Accessing Public Services for Community Facilitation • Government Departments • Right to Information • Police • Hospital • Bank etc.
DAY 2	

9.00 a.m. – 9.30 a.m.	Review of Previous Day's Activities
9.30 a.m. – 2:00 p.m.	Field Visit to observe the functioning of Village Convergence Facilitation Services (VCFS) and ICDS, Panchayat etc.
2.00 p.m – 3.00 p.m	Lunch Break
3.00 p.m – 4.45 p.m	Convergence of Multi Sectoral Interventions from ICDS, NHM and *Swachh Bharat Abhiyan* in High Burden Districts • IGMSY • RGSEAGs - SABLA • VHND • VHSNC • ALMSC • Village Contact Drives
4.45 p.m – 5.00 p.m	Tea Break
5.00 p.m – 6.00 p.m	Early Childhood Care Education (ECCE) in ICDS
DAY 3	
9.00 a.m. – 9.30 a.m.	Review of Previous Day's Activities
9.30 a.m – 10.45 a.m	Reaching the Under Threes, Pregnant Women & Lactating Mother - Use of Mother & Child Protection Card & New WHO Child Growth Standards in ICDS
10.45 a.m. 11.00 a.m.	Tea Break
11.00 a.m. – 1.00 p.m.	Identification and Community Based Management of Moderate and Severe Underweight Children: Concept and Organisation of *Sneha Shivir*
1.00 p.m. – 2.00 p.m.	Lunch Break
2:00 p.m. – 4:00 p.m.	Planning an Advocacy Campaign for Creating Awareness on Issues related to Nutrition and Health of Women and Children
4:00 p.m – 6.00 p.m	Way Forward and Preparation of Action Plan for State Level Training (Group Work)

DAY 1

Day 1 Session 1

Situational Analysis of Health and Nutrition Status of Women and Children in India

Health & Nutrition: Status of Girl Child

Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity.

- Infant mortality rate (IMR) is the number of deaths of children less than one year of age per 1000 live births.
- IMR for a given region is the number of children dying under one year of age, divided by the number of live births during the year, multiplied by 1,000.

Figure 6: Causes of IMR

Table 4: Health Status of Children in India

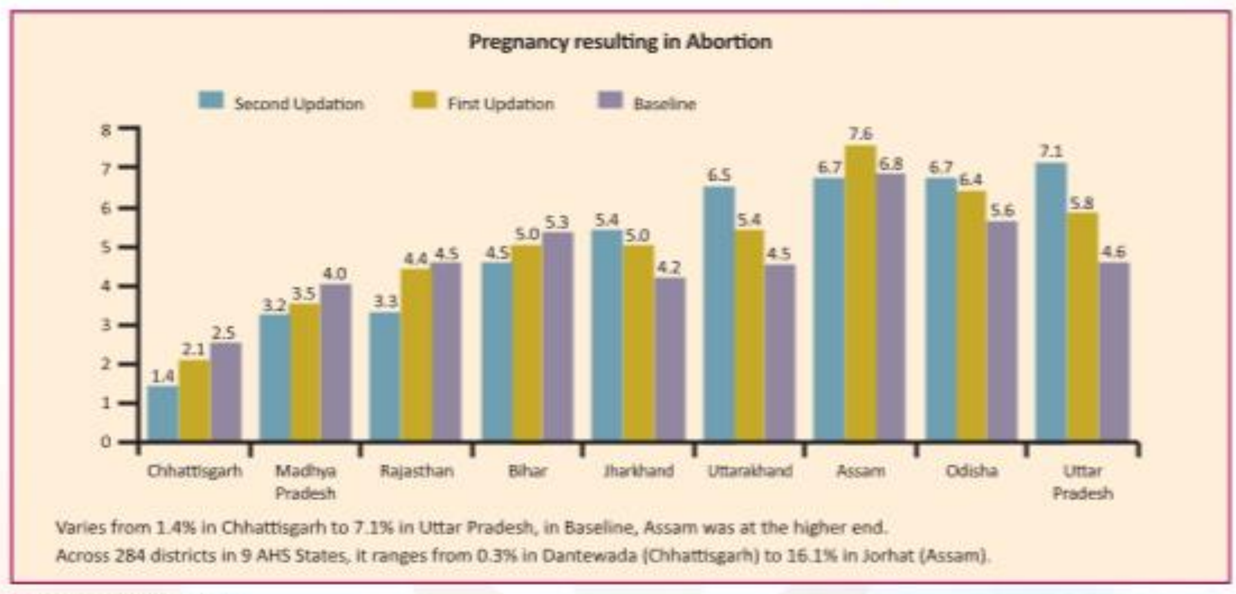
S.No.	INDICATORS	Data (%)			Source
		Total	Rural	Urban	
1.	Infant Mortality Rate	40 M: 39 F: 42	44	27	2013, SRS
2.	USMR	Total:49 M: 47 F: 53	55	29	2013, SRS
3.	Child Mortality	11	12.3	6.4	2013, SRS
4.	Post-neonatal Mortality	12	13	12	2013, SRS
5.	Low Birth Weight	22	--	--	NFHS-3
6.	Neo Natal Mortality Rate	28	31	15	2013, SRS
7.	Any Anaemia (6-59 months)	69.5 M: 69 F: 69.9	--	--	NFHS-3

Maternal Mortality Rate

- MMR has declined from 400 maternal deaths per 100,000 live births in 1997-98 to 212 in 2007-09 and finally to 178 in 2010-2012 (SRS, 2013).
- The decline has been most significant in Empowered Action Group (EAG) states & Assam.

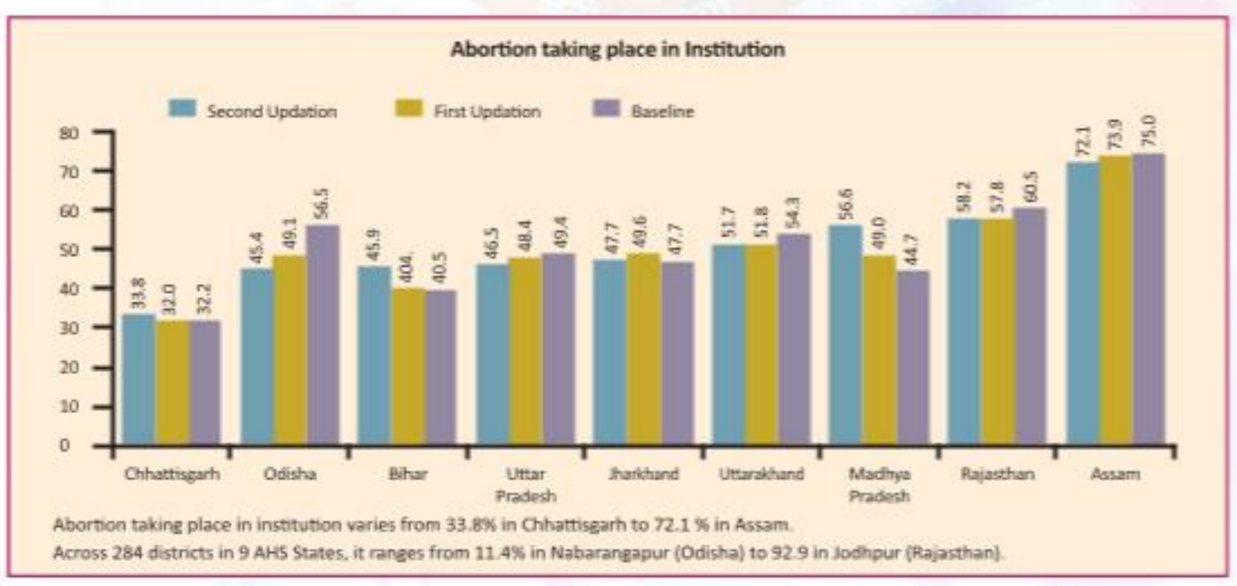
Medical Termination of Pregnancy

According to the AHS (2012-2013) second round of updating statistics, one of the indicators used is abortion for assessing the status of MTP. Seven out of every 10 deliveries are `safe' in Madhya Pradesh, Rajasthan, Odisha and Assam, the same in baseline. The few abortion related statistics are depicted below.



Source: AHS (2012-2013)

Figure 7: Pregnancy Resulting in Abortion



Source: AHS (2012-2013)

Figure 8: Abortion Taking Place in Institution

Source: AHS (2012-2013)

Figure 9: Abortion Performed by Skilled Health Personnel

Registration of Births

- In India, the registration of births and deaths is compulsory under the Registration of Births and Deaths (RBD) Act of 1969. Under this act, institutional heads like Municipality or *Gram Panchayats* who are responsible for registering all births that take place within their institution within 21 days of their occurrence. Heads of households are responsible for registering any births that take place within their homes. After registration, the birth certificate is obtained by applying to the registrar or sub-registrar of the area, either on plain paper or by filling in a form.
- Nationally, 41 percent of children under age five years have had their births registered with the civil authorities. However, only 27 percent of children under age five years have a birth certificate. Girls and boys are equally likely to have their births registered and to have birth certificates **(Table 5).** It is the children with more educated mothers and fathers and children from the higher wealth quintiles who are more likely to have their births registered and to have birth certificates.

Table 5: Birth Registration of Children Under Age Five

	Registered, have a birth certificate	Registered, does not have a birth certificate	Total Registered
Male	27.1 %	13.9 %	41.0 %
Female	26.7 %	14.6 %	41.3 %

Source: NFHS-3

Access to Health Services

- **Ante-natal check-up (ANC):** As per DLHS 3, around 55 percent of women received ANC check up from a government health facility as compared to 36 percent from private health facility and around 10 percent from community based services like non-government hospital/trust hospital or clinic, own home, parents home, other home and others. The ANC check-up services received from government health facilities are higher than private and community based services.

The timing of the first visit and number of ANC visits are the important factors for the health of mother and outcome of the pregnancy. 24 percent of women in India had 1-2 ANC visits and around 50 percent of women had three or more visits. A higher proportion of urban women (around 68 percent) had at least three ANC visits, compared to 43 percent among rural women. Seventy-nine percent of women educated for 10 years and above had at least three ANC visits, while it was just 29 percent for non-literate women.

- **Full ANC:** The DLHS-3 defines full ANC as "at least three visits for ANC check-up, at least one TT injection received and 100 IFA tablets/syrup consumed". The full ANC has increased from DLHS-2 (16.4 percent) to DLHS-3 (18.8 percent).
- **IFA Tablet/Syrup:** 16 percent of women who had still/live birth in the three years preceeding the survey received no IFA supplements. Only 47 percent of women consumed 100 IFA tablets. Thus, the coverage of IFA supplement is below average. The utilisation of full ANC across different states is shown in **Figure 10**.
- **Place of Delivery:** Around 47 percent of the deliveries took place in government health institutions and 52 percent at home. At least 70 percent of the deliveries in urban areas and only 38 percent of deliveries in rural areas took place in the health institutions. Only around 6 percent of home deliveries were assisted by skilled persons.
- **Immunization:** Universal Immunization Programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. It is one of the largest immunization programmes in the world and a major public health intervention in the country averting between 2 and 3 million deaths each year. Immunization is the process whereby a child is made immune or resistant to an infectious disease, typically by the administration of a vaccine.
    - It is one of the most cost-effective health investments, with proven strategies that make it accessible to even the most hard-to-reach and vulnerable population.

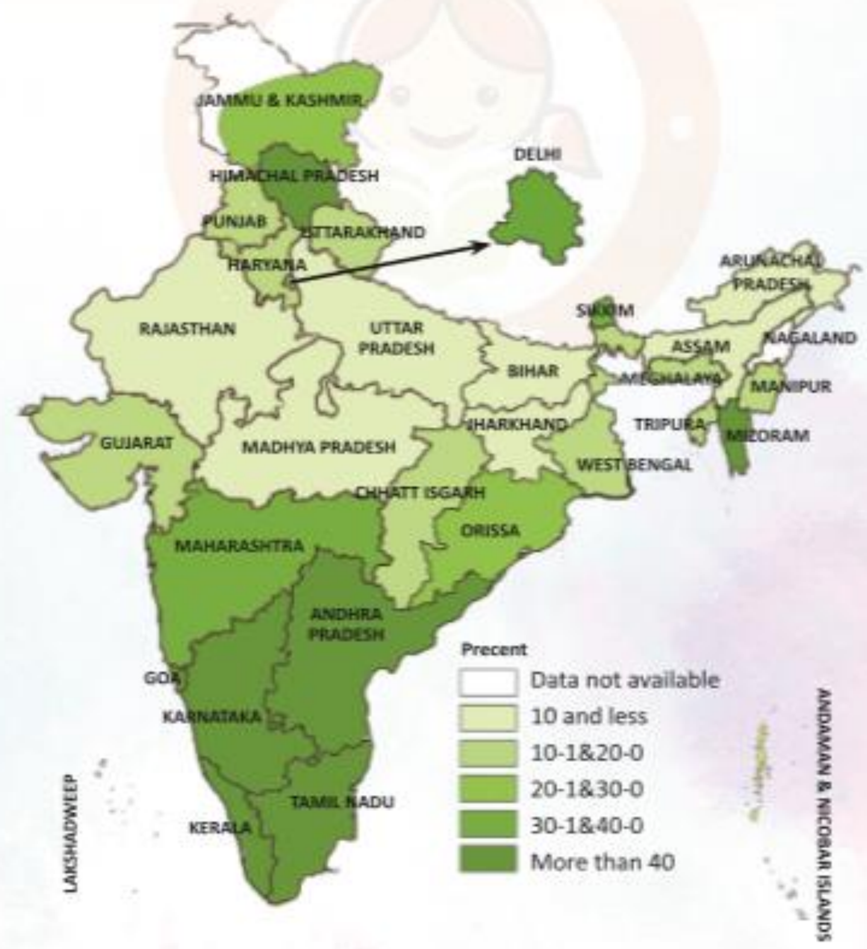


Figure 10: Percentage of Women who Received Full ANC by States

- Despite a long standing national programme for universal immunization in India, poor coverage and multiple inequalities in immunization continue to exist. At the national level, the Universal Immunization Programme (UIP) targets approximately 2.7 crore infants and 3 crores pregnant women. Children are immunized against six vaccine preventable diseases which are Tuberculosis, Polio, Tetanus, Measles, Pertussis and Diphtheria. As per Coverage Evaluation Survey (CES) - 2009, 61 percent children (12-23 months) received full immunization.
- The proportion of children receiving full vaccination was 54 percent as per NFHS-3. The full vaccination includes one dose of BCG, three injections against DPT, three doses of Polio (excluding polio 0) and one vaccine against measles. About 5 percent of the children at the national level had not received single vaccine. The trends in immunization coverage at the national level are not at all encouraging. According to DLHS-1 (1998-99), it was 54 percent. It declined to 46 percent in DLHS-2 (2002-04). It has shown some improvement as per DLHS-3 (2007-08) with coverage of 54 percent. 55 percent of boys were fully immunized as against 52 percent of girls. The **Table-6** below reveals the vaccination of children by sex of the child.

Table 6: Immunization Status

	BCG	DPT-All 3 doses	Polio- All 3 doses (includes dose 0)*	Measles	Full Vaccination	No Vaccination
Male	87.3	64.6	66.7	70.1	54.6	4.5
Female	86.0	62.0	64.4	67.9	52.3	4.7

**At Birth*

Source: DLHS 3

- **Source of Immunization:** Nearly 16 percent of the children received vaccination from Sub-Centres, 15 percent from Primary Health Centres and 67 percent from the other government health facilities. The contribution of the private sector in the immunization programme was about 10 percent only.
- **Vitamin A Supplementation:** At the national level, 57 percent of the children received at least one dosage of vitamin A. However, the proportion who received three to five dosages of vitamin A was only 19 percent. However, no major difference was found about the Vitamin A supplementation among boys (18.4 percent) and girls (18.7 percent).

Mortality

- Around 9 million children die every year before reaching their fifth birthday.
- Most deaths among under-five are still attributable to conditions like acute lower respiratory infections, like pneumonia (17 percent), diarrhoea (16 percent), malaria (7 percent), measles (4 percent), HIV/AIDS (2 percent).
- Other neo-natal conditions mainly pre-term births, asphyxia and infections account for 37 percent of all deaths in under-five.
- The causes of neo-natal deaths are shown in **Figure-11** below.
- Poor and delayed care seeking contributes to 70 percent of child deaths.

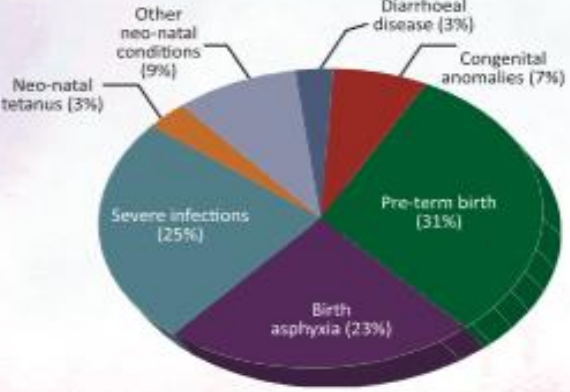
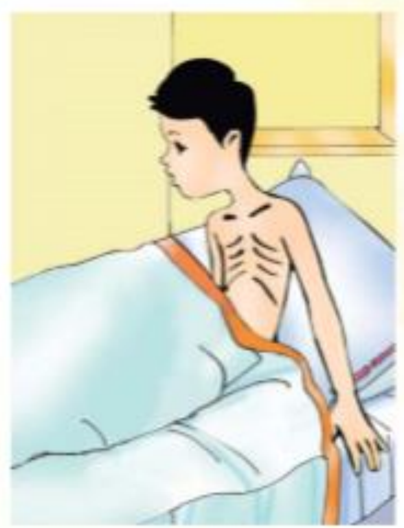


Figure 11: Causes of Neo-natal Death

Nutrition



- India is undergoing nutrition and socio-economic transition and is facing the dual burden of malnutrition i.e., problem of under-nutrition and micronutrient deficiencies along with emerging problems of over nutrition and obesity within the same population which presents threat to human health and economic progress and development of the nation as a whole.
- The nutritional status of children is presented in **Table-7.**
- Child malnutrition is the single biggest contributor to under-five mortality due to greater susceptibility to infections and slow recovery from illness.
- Children do not reach their optimum size as adults (and so may have less physical capacity for work), their brains are affected (resulting in lower IQs) and they are at greater risk of infection (which kills many children during their early years).
- Child malnutrition has an impact on education attainment. The degree of cognitive impairments is directly related to the severity of stunting and Iron Deficiency Anaemia.
- Child malnutrition has major implications on economic productivity as well.

Table 7: Nutritional Status of Children

Indicators (0-5 Years)	Male	Female	India
Stunting			
(% Below -3 SD)	23.9	23.4	23.7
(% Below -2 SD)	48.1	48.0	48.0
Wasting			
(% Below -3 SD)	6.8	6.1	6.4
(% Below -2 SD)	20.5	19.1	19.8
Underweight			
(% Below -3 SD)	15.3	16.4	15.8
(% Below -2 SD)	41.9	43.1	42.5

Source: NFHS-3

- **Stunted:** Stunted growth refers to low height-for-age, when a child is short for his/her age but not necessarily thin. It reflects failure to receive adequate nutrition over a long period of time and is also affected by recurrent and chronic illness.
- **Wasting:** Refers to low weight for height. The weight-for-height index measures body mass in relation to body length and describes current nutritional status.
- **Under-Weight:** Under-weight refers to low weight-for-age, when a child can be either thin or short for his/her age. This reflects a combination of chronic and acute malnutrition.

Food, health and care along with the degree of an individual's or a household's access to them affects how well they are nourished. The main conditions to determine this are as under:

- Food quantity and quality.
- Health and sanitation environment.
- Social and care environment.

Nutritional Status of Women & Adolescent Girls

Nutritional status of adolescent girls and women is critical as this affects the reproductive age of the women. Following table highlights some of the major statistics on health and nutrition of adolescent girls and women:

Table 8: Nutritional Status of Children, Women & Adolescents of India

Nutritional Challenges In India: Some Facts		
Children	**Women**	**Adolescent Girls**
• LBW 22 %	• Women with BMI below 18.5 (Chronic Energy Deficiency) 36%	• 11-18 years Approx. 8.32 Crore (16.75 % of female population)
• IMR 40	• Anaemia (15-49 years) 56.2%	• BMI below 18.5 - 47 %
• 42.5% (0-5 years) underweight	• Overweight- % of ever-married women (15-49 years) 15%	• Anaemia 56 %
• 79% (6-35 months) anaemic	• Under nutrition declines and over nutrition increases with age of women	• 58 % women married and 30% gave first birth before age of 18 years
• Bitot Spots (preschool children) 0.6%	• Dropout rate (I-X) 63.5%	

Source: DLHS 3, NFHS 3, NNMB, SRS 2013

Micronutrient Intake among Children

- **Vitamin A:** NFHS-3 collected information on the consumption of vitamin A rich foods. For the youngest child aged (6-35 months) living with the mother, 47 percent consumed foods rich in vitamin A in the day or night preceeding the survey. These foods include meat, liver, fish, poultry, eggs, pumpkin, carrots, sweet potatoes, vegetables & fruits that are yellow or orange inside, dark green leafy vegetables, ripe mango, papaya, cantaloupe, and jack fruit. No difference was found in male (46.8 percent) and female (47.3 percent) children in the intake of vitamin A rich food.
- **Iron:** The consumption of iron rich foods (such as meat, liver, fish, poultry, eggs, green leafy vegetables, lotus stem, anar etc.) is considerably lower than the consumption of foods rich in vitamin A. Overall, only 15 percent of children ate foods rich in iron during the day or night before the survey. Girls and boys are about equally likely to receive these items.
- **Salt iodization:** Iodine is an important micronutrient. Lack of iodine in the diet can lead to Iodine Deficiency Disorder (IDD), which can cause miscarriages, still births, brain disorders, and retarded psychomotor development, speech and hearing impairments, and depleted levels of energy in children. Iodine deficiency is the single most important and preventable cause of mental retardation worldwide. Among the households that had their salt tested, just over half (51 percent) were using salt that was adequately iodized.

Note: The details about micronutrient deficiencies and information about their related preventive programmes may be referred from Day 1, Session 5-Health & Nutrition of Girl Child

Time Trends in Nutrient Intakes

- **1-3 year children:** The average intake of protein, energy, calcium and iron decreased over the period. The extent of decrease in the intake of energy was 67 Kcal and that of protein was about 2 g from 1975-79 to 2011-12. The intake of vitamin A increased from 136 µg to 151 µg and iron decreased from 10.2 mg to 5.8 mg during the same period.
- **4-6 year children:** The average daily intake of energy has declined by about 36 Kcal over 4 decades. The intake of micronutrients such as vitamin A and niacin increased from 159 µg to 177 µg and 7 mg to 8 mg respectively, while the intake of thiamine and riboflavin were comparable.
- **7-9 year children:** The average daily intake of all the nutrients except thiamine, vitamin C and niacin declined from 1996-97 to 2011-12.

- **10-12 year girls & boys:** Among girls, the mean intake of energy (1635 Kcal to 1401 Kcal), protein (42.6 g to 38.6 g), calcium (422 mg to 293 mg), iron (20.3 mg to 11.4 mg) and vitamin A (241 μg to 198 μg) declined during the period from 1996-97 to 2011-12, and the intake of rest of the nutrients remained similar. On the other hand, among boys, the average daily intake of all the nutrients decreased except for thiamine, niacin and vitamin C which either remained same or marginally increased. The extent of decrease with respect to energy was 276 Kcal while that of protein was 5.4 g during 1996-97 to 2011-12.
- **13-15 years girls & boys:** The intake of all the nutrients declined considerably from 1996-97 to 2011-12. The extent of decline was 294 Kcal of energy, 5.6 g of protein and 144 mg of calcium for girls and 45 Kcal of energy, 6.4 g of protein, and 121 μg of Vitamin A for boys.
- **16-17 year girls & boys:** The intake of all the nutrients except thiamine and niacin declined considerably from 1996-97 to 2011-12 among both girls and boys. The intake of energy declined by 374 Kcal, protein by about 6 g iron by 10 mg and calcium by 188 mg for girls and among boys the energy declined by 530 Kcal, protein by about 12 g and Vitamin A by 112 μg.

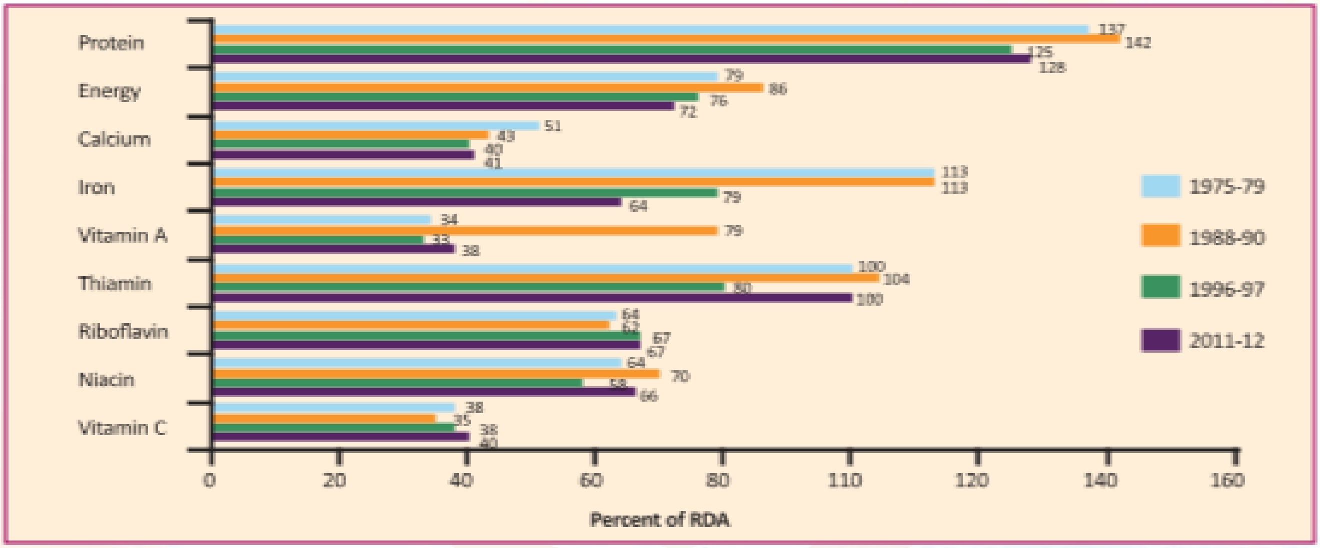


Figure 12: Mean Intake of Nutrients Among 1-3 Year Children as % RDA: TIME TRENDS

Infant and Young Child Feeding

Optimal infant and young child feeding (IYCF) practices are crucial for growth, development, health, and ultimately the survival of children. Brief look at the statistics of IYCF are provided for situation analysis.

Table 9: Data on IYCF

INDICATORS	DLHS-3 (2007-08)	NFHS-3 (2005-06)
Children received colostrum	80.1% (15-49 months)	---
Mothers fed water/pre-lacteals to their infants before 6 months	---	57.2% (pre-lacteals)
Initiation of breastfeeding within one hour of birth	40.5%	24.5%
Initiation of breastfeeding within one day	70.9%	55.3%
Initiation of breastfeeding after 24 hrs of birth	29.1%	---
Initiation of breastfeeding after three days	---	---
Exclusive breastfeeding of children under 6 months	46.8%	28% (4-5 months)
Introduction of complementary feeding upon completion of 6 months, along with continued breastfeeding for 2 years	23.9 % in the age group of 6-9 months	53% (6-8 months)

Rapid Survey on Children
2013-2014

INDIA Fact Sheet

The results of **Rapid Survey on Children (RSOC)** are intended to strengthen the data system on children and women, based on a nationwide household cum facility based survey in 28 states and Delhi. This survey provides level of selected indicators at national and state level. The indicators mainly focus on the wellbeing of children below 6 years and their mothers covering aspects of child development, maternal care, school /college attendance among persons aged 5-24 years. Early childhood care and the enabling environment, like access to drinking water and use of toilet facilities are also covered in the survey. The survey maps the ICDS programme in terms of its infrastructural facilities, awareness and utilization of the six services by the target groups.

Respondents: Head of the selected household, all ever married women (EMW) aged 15-49 years; currently married women aged 15-49 pregnant at the time of survey in the selected households and Anganwadi workers (AWW) in the selected AWC.

Selection of Primary Sampling Unit (PSU), Household and AWC: Selection of PSUs was similar to the National Family Health Survey 2005-06. PSUs were selected using Probability Proportional to Size (PPS) with replacement and from each PSU, selection of 26 households was done by circular systematic random sampling in a manner that 20 households from households having at least one child below 6 years of age and 6 households from other households. All AWC in the selected PSU / Segmented PSUs were selected in the sample. Overall 2655 rural PSUs and 1497 urban PSUs were covered.

RSOC covered 105,483 households and 5630 *Anganwadi* centres (AWC) leading to more than 210,000 interviews. For compiling nutritional status, measurement of height and weight of over 90,000 children aged 0-4 and over 28,000 adolescent girls aged 10-18 have been collected across all states. The anthropometric equipment used for the measurement are of international specifications. More than 167 exclusive health investigators were trained and engaged for taking anthropometric measurements in this survey.

RSOC fieldwork was completed in 23 weeks (3rd week of November 2013 to 2nd week of May 2014), by 188 listing teams and 167 survey teams. The survey was conducted on CAPI mode.

	Key Indicators	Residence			Gender		Social category				Wealth index	
		Total	Rural	Urban	Male	Female	SC	ST	OBC	Other	WI-Lowest	WI-Highest
A	Women who had live-birth in 35 months prior to survey by specific maternal health care (Percentage)											
1	**Prenatal Care**[1]											
1.1	Registered pregnancy	84.1	82.7	87.4			82.0	86.1	82.4	87.1	75.9	89.1
1.2	Received Mother and Child Protection (MCP) card at the time of pregnancy registration	73.0	72.0	75.4			71.8	71.2	70.8	77.6	62.0	78.2
1.3	Received at least one ante-natal check-up (ANC)	85.2	83.0	90.3			83.8	81.8	84.2	88.8	74.7	94.0
1.4	Received first ANC in first trimester	61.8	58.5	69.7			59.6	54.7	62.8	65.1	47.0	77.0
1.5	Received three or more ANCs	63.4	58.5	74.9			58.9	56.4	60.9	72.9	43.7	80.1
1.6	Received four or more ANCs	45.4	39.6	58.9			41.8	37.0	43.3	54.4	24.5	64.4
1.7	Received two or more Tetanus Toxoid (TT) injections	89.8	88.8	92.2			89.2	86.1	89.4	92.3	84.4	94.8
1.8	Received/purchased 100 or more IFA tablets /syrup during pregnancy	31.2	29.1	36.1			29.3	30.5	30.3	34.3	20.7	41.8
1.9	Consumed 100 or more IFA tablets /syrup during pregnancy	23.6	21.4	28.8			21.6	20.6	23.6	26.6	13.8	35.0
1.10	Received full ANC[2]	19.7	17.3	25.2			18.0	15.0	19.6	23.2	9.5	31.3
1.11	Visited at least once during pregnancy[3] by											
	ANM	13.9	14.9	11.4			14.3	13.8	14.3	13.1	10.5	11.1
	AWW	34.8	38.7	25.7			36.1	42.5	33.6	32.5	33.5	27.2
	ASHA	31.6	39.4	13.3			33.3	37.4	29.4	30.6	36.8	19.7
1.12	Received ANC at											
	Anganwadi centre	22.4	27.4	10.6			24.3	36.5	23.0	14.4	32.4	12.3
	Government health facility	43.3	42.7	44.6			48.8	43.1	38.0	46.1	37.8	36.1
	Private health facility	38.1	33.1	49.7			30.3	22.8	41.1	45.7	19.3	63.9
2	**Natal Care**											
2.1	Institutional delivery	78.7	74.6	88.5			76.0	70.1	79.2	84.2	60.8	93.0
2.2	Delivered by skilled health provider	81.1	77.2	90.2			78.8	72.7	81.6	86.1	64.1	94.5
2.3	Stay at health facility after delivery											
	Less than 12 hours	20.6	25.1	11.7			25.4	17.0	22.0	16.8	32.9	12.6

[1] It is based on births taken place during the last three years

[2] Full ANC- receipt of 3 + ANC, atleast 1 dose of TT and consumption of 100 IFA tablets/ syrup

[3] Out of those that have AWC in their area

	Key Indicators	Residence			Gender		Social category				Wealth index	
		Total	Rural	Urban	Male	Female	SC	ST	OBC	Other	WI-Lowest	WI-Highest
	48 hours or more	57.8	51.5	70.2			54.1	55.1	58.8	60.1	39.1	70.1
3	**Post Natal Check-up (PNC)**											
3.1	Received PNC within 48 hours of discharge/delivery											
	All	39.3	34.2	51.1			35.3	36.6	43.3	38.0	23.0	48.8
	Home delivery (after birth)	13.0	12.4	15.9			12.8	12.1	15.4	9.5	9.9	23.6
	Institutional delivery (after discharge)	46.3	41.6	55.7			42.4	47.0	50.6	43.3	31.5	50.8
3.2	New born who received first check up within 24 hours of birth/discharge											
	All	33.6	31.0	39.8			31.2	34.0	35.8	32.6	22.9	37.6
	Home delivery (after birth)	13.0	12.6	15.0			13.2	11.6	15.4	9.6	10.0	22.9
	Institutional birth (after discharge)	39.2	37.2	43.1			36.9	43.5	41.1	36.9	31.2	38.7
3.3	Visited by primary health worker (AWW/ ANM/ ASHA) at home within one week of delivery/ discharge from health Institution	51.0	49.4	54.7			49.0	53.5	53.5	48.3	40.9	53.2
3.4	Availed benefit from national programme for safe motherhood[4]											
	Janani Suraksha Yojana (JSY)	47.7	51.8	36.6			54.5	54.7	47.7	39.4	54.3	31.9
	Janani Shishu Suraksha Karyakrama (JSSK)	14.0	14.2	13.6			15.2	16.1	12.8	14.2	11.6	11.0
	Both JSY and JSSK	7.8	8.3	6.5			9.6	8.4	7.3	7.0	7.1	5.8
B	**Birth Weight (Percentage of children aged 0 –35 months)**											
1	Weighed with 24 hours of birth	68.7	64.1	79.7			65.3	63.7	67.4	75.5	49.9	83.0
2	With birth weight less than 2500 grams (out of those weighed)	18.6	18.7	18.4			19.6	21.6	18.0	17.6	22.3	15.6
C	**Immunization (Percentage of children aged 12 –23 months)**											
1	**Percentage of children aged 12-23 months**											
1.1	Having MCP/ immunization card	84.3	82.8	87.8	84.4	84.2	83.5	79.3	82.9	89.0	75.6	90.9
1.2	Fully immunized[5]	65.3	62.4	72.0	65.0	65.7	61.6	55.7	65.4	71.6	50.6	80.0
1.3	Received DPT 3 injection	74.8	72.2	80.7	74.3	75.3	72.0	65.0	74.9	80.5	62.4	87.2
1.4	Received first dose of Measles vaccine	78.9	77.0	83.1	79.4	78.3	76.7	75.4	77.5	83.8	66.5	88.5
1.5	Received no vaccination	6.6	7.6	4.5	6.6	6.7	8.8	7.4	7.1	4.1	12.6	2.0
2	Drop out in vaccination											

[4] Out of mothers who are aware JSY / JSSK schemes

[5] Full Immunization- BCG, Measles, 3 doses each of DPT and Polio vaccine (excluding polio vaccine given at birth)

Key Indicators		Residence			Gender		Social category				Wealth index	
		Total	Rural	Urban	Male	Female	SC	ST	OBC	Other	WI-Lowest	WI-Highest
	DPT 2 to DPT 3	11.1	12.6	8.0	11.7	10.5	12.4	17.3	10.6	8.7	16.9	6.0
	OPV 2 to OPV 3	11.9	12.8	9.9	12.4	11.4	13.6	16.9	11.7	9.1	17.4	6.7
3	Place of the vaccination											
	Anganwadi centre	49.3	59.7	26.3			55.1	63.1	52.4	36.2	69.7	25.8
	Government health facility	35.3	29.9	47.2			36.3	27.7	29.6	44.7	23.1	40.5
	Private health facility	11.7	5.8	24.6			5.5	6.3	13.3	16.0	2.1	30.7
D	**IYCF (Infant and Young Child Feeding Practices) (Percentage)[6]**											
1	Children aged 0-23 months breastfed immediately/ within an hour of birth	44.6	44.2	45.6	43.8	45.4	43.1	54.7	42.3	44.8	42.5	42.3
2	Children aged 0-5 months who were exclusively breastfed[7]	64.9	65.1	64.2	65.0	64.8	67.1	64.3	64.0	64.5	70.0	61.7
3	Children aged 6-8 months who were fed complementary foods	50.5	47.1	58.1	52.9	47.8	45.2	45.5	50.8	55.6	41.2	62.1
4	**Breastfed children (6 -23 months)**											
4.1	Fed a minimum number of times[8]	36.3	35.7	37.7	36.8	35.8	35.8	37.8	36.8	34.7	35.9	40.1
4.2	Had a minimum dietary diversity[9]	19.9	18.6	23.0	20.7	19.0	17.9	16.6	19.1	24.1	14.2	26.5
E	**Nutritional Status of Children (Percentage)[10]**											
1	**Percentage of children aged 0-59 months**											
1.1	Stunted (Height for age below -2SD)	38.7	41.6	32.0	39.5	37.8	42.4	42.3	38.9	33.9	50.7	26.7
1.2	Severely stunted (Height for age below -3SD)	17.3	19.1	13.2	17.6	16.9	19.3	19.5	17.8	14.2	25.8	10.7
1.3	Wasted (Weight for height below -2SD)	15.1	15.1	15.0	15.6	14.5	15.5	18.7	14.8	13.6	17.0	13.0
1.4	Severely wasted (Weight for height below -3SD)	4.6	4.5	4.8	4.8	4.4	4.9	5.3	4.4	4.4	5.0	4.4
1.5	Underweight (Weight for age below -2SD)	29.4	31.6	24.3	30.0	28.7	32.7	36.7	29.3	23.6	42.1	18.6
1.6	Severely underweight (Weight for age below -3SD)	9.4	10.6	6.9	10.0	8.9	10.8	13.0	9.3	7.0	16.3	5.1
F	**Micronutrient and Deworming (Percentage)**											

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[6] Based on standard set of questions as given in 'Indicators for Assessing IYCF practices part 2 Measurement' 2010 by USAID, WHO, UNICEF etc.

[7] Exclusive breastfeeding- children who are fed breast milk exclusively for first six months (excluding pre-lacteals given at birth) and including ORS/medicine during sickness;

[8] At least twice a day for breastfed infants 6-8 months old; at least three times a day for breastfed children 9-23 months old;

[9] Minimum Dietary Diversity refers to four or more food groups to children age 6-23 months.

[10] Based on WHO Growth Standards

Key Indicators		Residence			Gender		Social category				Wealth index	
		Total	Rural	Urban	Male	Female	SC	ST	OBC	Other	WI-Lowest	WI-Highest
1	**Percentage of children aged 6-59 months received in six months prior to survey**											
1.1	Vitamin A dose	45.2	43.8	48.3			43.4	46.0	45.5	46.4	37.5	48.8
1.2	Iron and Folic Acid supplement	13.4	12.7	15.2			12.3	15.4	13.7	13.5	8.7	15.1
1.3	Deworming medication	27.6	26.6	30.0			24.4	28.2	25.5	32.8	23.0	31.2
G	**Morbidity - Percentage of children aged 0-59 months (Percentage)**											
1	**Diarrhoea**											
1.1	Had diarrhoea in 15 days prior to survey	6.5	6.5	6.3	6.5	6.4	6.7	6.3	7.0	5.7	6.8	5.8
1.2	For whom advice or treatment was sought	77.9	78.5	76.4	79.8	75.7	78.9	73.0	77.3	79.8	77.2	77.6
1.3	Children with diarrhoea given											
	Oral Re-hydration Solution (ORS) including Home Available Fluids (HAF)	54.4	51.7	60.9	56.3	52.4	56.2	51.4	52.9	56.8	48.1	61.8
	ORS and Zinc	12.6	11.2	16.1	12.4	12.8	12.8	13.2	12.3	13.0	9.2	14.8
2	**Fever**											
2.1	Had fever in 15 days prior to survey	13.6	13.8	13.2	13.8	13.5	14.4	11.6	13.8	13.5	14.8	12.4
2.2	Given anti-malarial drug during fever	18.4	19.2	16.4	19.2	17.5	18.9	22.6	19.8	15.1	19.0	17.5
3	**Prevalence of symptoms of ARI**											
3.1	Had symptoms of ARI in 15 days prior to survey	8.6	9.1	7.6	8.9	8.3	9.0	7.9	8.8	8.3	10.6	7.0
3.2	For whom advice or treatment was sought	76.9	75.8	79.9	78.1	75.4	78.0	66.4	78.1	78.1	73.9	83.2
H	**Pre-School Education and Literacy (Percentage)**											
1	**Percent of children aged 3-6 years currently attending pre-school education (PSE) at[11]**											
	Anganwadi centre	37.9	45.1	21.6	36.6	39.3	41.6	50.9	34.8	33.9	51.4	15.4
	Privately run institution (Play school, nursery etc.)	30.7	22.0	50.3	31.7	29.6	25.0	17.3	32.1	39.1	8.6	61.5
	Not attending	26.9	28.0	24.5	27.3	26.6	29.1	27.3	28.3	22.9	34.7	19.9
2	Pre-School Education (PSE)											
	Percentage of children aged 36-71 months attended PSE in AWC for 16 or more days in the month prior to survey (among	58.1	58.6	55.5	57.2	58.9	57.2	58.0	58.4	58.9	56.6	56.6

[11] Out of those households which are covered by an AWC

	Key Indicators	Residence			Gender		Social category				Wealth index	
		Total	Rural	Urban	Male	Female	SC	ST	OBC	Other	WI-Lowest	WI-Highest
	children attending PSE at AWC)											
3	Literacy Rate 5 Years & above	71.9	67.0	82.2	79.0	64.6	65.9	61.9	72.2	79.3	52.1	88.6
4	Literacy Rate 6 Year & above											
5	Literacy Rate 7 Year & above	73.4	68.5	83.7	81.0	65.8	67.4	63.2	73.9	80.7	53.5	90.0
6	Youth Literacy rate (Aged 15-24)	88.7	87.0	92.5	91.9	85.6	86.2	81.5	89.1	92.8	74.3	97.5
I	**Birth Registration and Marriage (percentage)**											
1	**Children aged below 5 Years whose birth is registered**											
1.1	Birth registered	72.0	67.1	83.2	71.3	72.7	67.5	70.5	68.4	80.8	56.8	86.2
1.2	Have birth certificate	37.2	32.6	47.5	36.3	38.1	36.5	32.2	34.2	43.7	21.7	48.9
2	**Mean age at marriage**											
	Female	21.1	20.5	22.2			20.5	21.4	20.9	21.6	20.2	22.8
	Male	25.0	24.3	26.3			24.5	24.7	24.8	25.9	23.5	26.9
3	Women aged 20-24 married before age 18	30.3	33.5	22.4			34.9	31.0	30.5	25.7	44.1	15.4
4	Men aged 25-29 married before age 21	30.2	34.3	21.1			33.8	37.1	30.3	24.1	47.3	17.6
J	**Adolescent Girls (10-19 years) (Percentage)**											
1	**Adolescent girls ever married**											
	Age 10-19	6.4	7.2	4.5			7.5	6.4	6.0	5.8	6.7	3.2
1.1	Aged 10-14	0.3	0.4	0.1			0.5	0.6	0.3	0.1	0.4	0.2
1.2	Aged 15-19	12.8	14.4	8.9			15.1	12.7	12.0	11.5	15.3	5.9
2	**Girls aged 15 -18 whose Body Mass Index (BMI) was (Height/Weight)[12]**											
2.1	Less than 18.5 (low weight)	44.7	44.9	44.2			46.7	49.2	44.7	40.7	45.9	41.1
2.2	More than 25 (over weight)	4.5	3.1	7.9			3.2	4.4	4.3	5.9	2.9	6.0
K	**Awareness and use of ICDS services (Percentage)**											
1	**Mothers of children aged 0-35 months aware of services at AWC**											
	Supplementary food	85.1	87.2	79.3			86.5	89.2	84.0	83.6	86.0	79.1
	Immunization	57.4	59.2	52.5			56.0	62.8	61.8	50.9	55.3	58.3
	Health check-up	29.4	28.8	31.0			27.6	29.8	28.7	32.0	21.0	33.3
	Referral service	12.2	11.8	13.3			11.6	11.9	13.5	11.2	7.1	14.8
	Nutrition and health education	17.2	16.7	18.4			15.6	17.6	17.9	17.6	10.5	20.7

[12] BMI in kg/m^2

	Key Indicators	Residence			Gender		Social category				Wealth index	
		Total	Rural	Urban	Male	Female	SC	ST	OBC	Other	WI-Lowest	WI-Highest
	All Services[13]	9.3	9.0	10.3			8.6	9.4	10.2	8.8	4.4	11.6
2	**Mothers of children aged 36-71 months aware of services at AWC**											
	Supplementary food	91.0	91.5	89.5			91.5	93.1	89.5	91.7	90.7	89.5
	Immunization	59.8	60.1	59.0			56.3	64.7	64.5	54.3	55.8	65.5
	Pre-School Education	49.9	49.3	51.6			46.3	50.1	49.4	54.0	42.1	56.3
	Health check-up	30.5	28.9	35.2			27.6	31.6	29.8	34.1	21.6	37.1
	Referral service	13.4	12.3	16.4			12.2	12.6	14.1	13.9	7.4	17.8
	Nutrition and health education	18.6	17.3	22.3			16.4	18.1	19.2	20.1	10.8	24.5
	All Services[14]	9.7	8.8	12.2			8.4	9.1	10.1	10.6	4.2	13.7
3	**Currently pregnant women aware of services at AWC**											
	Supplementary food	87.7	88.3	85.8			88.4	91.0	86.2	87.6	86.4	87.3
	Immunization	59.6	59.9	58.6			59.1	62.5	62.7	55.4	53.5	62.5
	Health check-up	29.9	28.6	34.3			33.1	27.7	27.2	33.7	20.8	34.0
	Referral service	11.0	9.8	14.9			11.4	11.9	11.2	10.2	5.6	16.3
	Nutrition and health education	16.5	15.7	19.3			19.0	14.2	16.2	16.9	10.2	18.3
	All Services[15]	8.3	7.2	11.9			9.5	9.0	7.8	8.0	2.6	10.8
4	**Percentage availing various *Anganwadi* services**											
4.1	Supplementary food											
	Children aged 6-35 months	49.2	53.8	36.7			53.0	62.8	45.1	45.8	57.0	32.0
	Children aged 36-71 months	44.2	48.7	31.1			46.6	57.9	39.1	43.0	53.7	24.0
	Pregnant women	40.7	44.0	29.8			43.9	55.6	36.7	36.7	43.7	27.1
	Lactating mothers	42.4	46.7	28.7			46.7	53.8	40.4	35.9	53.1	26.8
4.2	Percentage who received supplementary nutrition for 21 or more days in the month prior to survey[16]											
	Children aged 6-35 months	21.3	20.5	24.3			20.8	24.8	23.7	16.7	16.8	28.0
	Children aged 36-71 months	31.0	30.9	31.7			31.6	33.1	29.8	31.3	29.9	33.9

[13] All ICDS services as applicable for the mothers of children aged 0-35 months
[14] All ICDS services as applicable for the mothers of children aged 36-71 months
15 All ICDS services as applicable for the currently pregnant women
16 Calendar month prior to survey refers to September, 2013

Key Indicators		Residence			Gender		Social category				Wealth index	
		Total	Rural	Urban	Male	Female	SC	ST	OBC	Other	WI-Lowest	WI-Highest
	Pregnant women	27.8	27.0	31.4			37.1	26.8	23.3	25.4	26.6	29.3
	Lactating mothers	20.3	20.5	18.9			22.3	26.0	19.9	15.8	16.5	26.4
L	**Household characteristics (Percentage)**											
1	Access to any improved source of drinking water	91.0	90.2	92.8			92.7	85.3	90.3	93.1	88.7	91.2
2	Using improved sanitation facility[17]	41.8	29.9	66.0			29.8	22.2	43.3	55.4	4.5	84.5
3	Households practicing open defecation	45.5	61.6	12.8			58.1	68.9	45.7	28.0	91.1	2.3
4	Households using adequately iodized salt (> =15 ppm)	67.4	61.3	79.7			61.1	62.1	65.6	75.8	49.6	86.6

Key Indicators on Anganwadi Centre

	Key Indicators	Total	Rural	Urban
	CHARACTERISTICS			
A	General Information about *Anganwadi* worker (AWW) and AWC (Percentage)			
1	AWWs living in the AWC village/ward	74.1	75.5	60.9
2	AWW having 10 or more years of schooling	84.8	83.8	94.4
3	AWW below 45 years	78.4	78.9	74.7
4	Median age of AWW	38.0	37.0	39.0
5	AWCs serving to population more than the stipulated norm	56.9	54.5	78.0
6	AWW Received Flexi fund	43.9	43.5	48.2
B	Infrastructure Facilities at AWC (Percentage of AWC)			
1	AWC functioning in			
	Own ICDS building	40.5	42.8	19.6
	Rented building	21.3	17.1	60.9
	Out of those not functioning from ICDS or rented building			
	School building	49.8	50.9	26.4
	Panchayat Building		12.8	
	Anganwadi worker or Anganwadi helper's house	11.1	10.1	32.8
2	**Various infrastructure facilities in AWCs**			
2.1	Separate kitchen (among those centres that are cooking supplementary food in the AWC)	52.7	52.6	54.5
2.2	Cooking supplementary food in the same room where PSE sessions are conducted[18]	15.9	15.4	21.9
2.3	Cooking supplementary food in open space	19.9	20.5	13.0
2.4	Barrier free access for physically challenged children	25.3	25.6	22.3
2.5	Having toilet facility	43.4	42.0	56.7
2.6	Access to drinking water			
	Within the premises of AWC	44.7	43.5	56.1
	Outside the premises of AWC but within 50 meters of AWC	62.9	61.9	74.2
2.7	Having electricity connection	32.4	28.6	68.0
3	Percentage of AWCs open for at least for 4 hours per day	93.1	92.8	96.2
4	AWCs functioning in rooms (other than kitchen space)			
	one room	65.6	64.5	75.0
	Two or more rooms	25.5	26.1	20.2
5	**AWCs providing services**			
	Supplementary nutrition	96.7	96.5	98.0

[18] Out of those AWCs where Supplementary food is cooked in the AWC

	Key Indicators	Total	Rural	Urban
	Pre-School Education	90.6	90.3	92.9
	Immunization	82.1	82.2	81.1
	Nutrition and health education	64.7	63.4	77.2
	Health check-up	60.8	60.1	66.9
	Referral	43.1	42.3	50.4
	Four or more services	71.5	70.6	80.2
	All six services	29.3	28.8	34.7
6	Percentage of AWCs functioned for 25 or more days in the calendar month prior to survey	62.6	63.1	57.4
C	**Supplementary Nutrition (Percentage)**			
1	Coverage of Beneficiaries (Supplementary Food)			
	Children aged 6-35 months	78.3	80.2	76.4
	Children aged 36-71 months	73.6	74.4	67.0
	Pregnant women	83.1	83.4	82.8
	Lactating mothers	81.7	82.7	80.7
2	Beneficiaries received supplementary food for at least 21 days in the month[19] prior to survey			
	Children aged 6 -35 months	28.6	24.2	33.1
	Children aged 36-71 months	86.8	90.1	83.6
	Pregnant women	34.8	28.8	40.7
	Lactating mothers	33.8	28.7	38.9
D	**Growth Monitoring (Percentage of AWCs)**			
1	**AWCs having functional weighing scale**			
	Baby weighing scale	72.4	72.4	72.1
	Adult weighing scale	51.6	51.3	53.8
2	Availability of WHO growth chart at AWC[20]	89.7	89.9	88.1
3	Children for whom Growth chart was prepared			
	0 -35 months	43.8	43.1	49.5
E	**Pre-School Education**			
1	Average number of days spent on PSE sessions in the month prior to survey[21] (Days)	23.7	23.7	23.4

[19] Month prior to survey refers to September, 2013
[20] Includes both- shown and not shown
[21] Month prior to survey refers to September, 2013

	Key Indicators	Total	Rural	Urban
2	Percentage of AWCs conducted PSE sessions in one calendar month prior to survey			
2.1	One or more hours a day	86.4	86.4	86.4
2.2	Sixteen or more days	95.2	95.3	94.4
3	Percentage of children aged 36-71 months attended PSE for 16 or more days in one calendar month prior to survey			
	Boys	55.9	57.1	46.8
	Girls	57.2	58.3	48.5
4	Average number of activities per day conducted in the week prior to survey	4.8	4.8	5.0
F	**Convergence with health (Percentage of AWCs)**			
1	AWCs that organized three Village Health and Nutrition Day (VHND) meetings during three calendar months prior to survey[22]	65.2	65.2	
2	AWCs reporting three visits by ANM during the three months prior to survey	83.6	83.6	
3	AWCs having Anganwadi level Management Committee (ALMC)	50.7	52.1	37.8
4	AWW reporting support from Panchayat/ward member	43.2	44.2	33.5
G	**Training & Comprehensive Knowledge (Percentage of Anganwadi workers)**			
1	Trainings received by AWWs			
1.1	Refresher training in two years prior to survey	42.5	42.5	41.8
	Special Training			
	IMNCI	50.5	50.2	52.8
	IYCF	55.1	54.8	58.7
	PSE	69.5	69.5	69.9
	Growth monitoring	59.6	59.3	62.2
	Early childhood care and development	49.1	48.6	53.6
	Joint ICDS-Health Training	44.4	43.9	48.3
	Revised ICDS MIS training	30.8	30.4	34.4
2	AWW having correct knowledge of			
2.1	Intake of food by Pregnant women	91.4	91.1	94.1
2.2	Normal Birth weight of a child	80.4	80.1	82.8
2.3	Initiation of breast feeding within one hour	96.0	96.1	95.3
2.4	Exclusive breast feeding for the first six months	92.9	92.7	94.9
2.5	Appropriate age of child for complementary food	63.8	63.6	65.8

[22] Three Calendar month prior to survey refers to July, August, September, 2013

Population, sample coverage on key parameters and survey duration RSOC, 2013-14	
Population (Census 2011)	1,210,854,977
Sample coverage	
Number of primary sampling units (PSUs) covered	4,162
Households interviewed	105,483
Number of ever married women aged 15-49 years interviewed	111,636
Number of children 0-59 months for whom anthropometric measurements done	90,665
Number of Adolescent girls aged 10-18 years for whom anthropometric measurements done	28,522
Number of children aged 12-23 months	17,311
Month and year of field work	
From	11/2013
To	5/2014

Sampling errors of selected indicators, RSOC 20013-14

Key Indicators	Value (R)	Standard error (SE)	Design effect (DEFT)	Relative standard error (SE/R)	Confidence limits	
					R-2SE	R+2SE
Received at least one ante-natal check-up (ANC)	0.852	0.002	1.312	0.002	0.848	0.856
Received three or more ANCs	0.634	0.003	1.347	0.004	0.628	0.639
Consumed 100 or more IFA tablets /syrup during pregnancy	0.236	0.002	1.355	0.011	0.231	0.241
Institutional delivery	0.787	0.002	1.331	0.003	0.783	0.792
Delivered by skilled health provider	0.811	0.002	1.352	0.003	0.807	0.816
Fully immunized (children age 12-23 months)	0.653	0.005	1.395	0.008	0.643	0.663
Received BCG (children age 12-23 months)	0.911	0.003	1.455	0.003	0.905	0.917
Received DPT 3 injection (children age 12-23 months)	0.748	0.005	1.398	0.006	0.739	0.757
Received first dose of Measles vaccine (children age 12-23 months)	0.789	0.004	1.397	0.005	0.780	0.797
Children aged 0-5 months who were exclusively breastfed	0.649	0.007	1.417	0.011	0.635	0.663
Stunted (Height for age below -2SD) (children age 0-59 months)	0.387	0.002	1.460	0.006	0.382	0.392
Severely stunted (Height for age below -3SD) (children age 0-59 months)	0.173	0.002	1.448	0.011	0.170	0.177
Wasted (Weight for height below -2SD) (children age 0-59 months)	0.150	0.002	1.473	0.012	0.147	0.154
Severely wasted (Weight for height below -3SD) (children age 0-59 months)	0.046	0.001	1.474	0.023	0.044	0.048
Underweight (Weight for age below -2SD) (children age 0-59 months)	0.294	0.002	1.434	0.007	0.290	0.298
Severely underweight (Weight for age below -3SD) (children age 0-59 months)	0.094	0.001	1.454	0.015	0.092	0.097
Given vitamin A supplement in last 6 months (children age 6-59 months)	0.452	0.002	1.331	0.005	0.447	0.456
Had diarrhoea in 15 days prior to survey (children age 0-59 months)	0.065	0.001	1.464	0.018	0.062	0.067
Children with diarrhoea given ORS (children age 0-59 months)	0.393	0.009	1.343	0.023	0.376	0.411
Children with diarrhoea given ORS and HAF* (children age 0-59 months)	0.544	0.009	1.385	0.017	0.526	0.563
Households access to any improved source of drinking water	0.910	0.002	1.813	0.002	0.907	0.914
Households using improved sanitation facility	0.418	0.003	1.933	0.007	0.412	0.424
Households practicing open defecation	0.455	0.003	1.852	0.006	0.450	0.461

*Oral Re-hydration Solution (ORS) including Home Available Fluids (HAF)

Day 1 Session 2

ICDS Strengthening and Restructuring in High Burden Districts

Integrated Child Development Services (ICDS) Scheme

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 was launched on 2nd October 1975. ICDS provides pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other hand.

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 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 on the idea that the overall impact will be much larger if the different services are given 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.

Three of the six services namely Immunisation, Health Check-up and Referral Services delivered by using Anganwadi Centre as the platform by the health personnel under the Ministry of Health & Family Welfare.

Supplementary Nutrition: All families in the community catchment area thoroughly surveyed for identification of children below six years and pregnant & nursing mothers. They avail supplementary feeding support for 300 days in a year. By providing supplementary feeding, the ICDS attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities.

<u>Nutritional Norms</u>:- 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

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.

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.

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.

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.

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.

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.

ICDS in Mssion Mode

In order to realize this vision implementation of ICDS in the **Mission Mode** with flexibility in implementation on the lines of NRHM and SSA is the utmost priority at this stage. The consensus of transforming ICDS in Mission Mode has emerged after a series of consultations and deliberations held with State Governments, line Ministries, Planning Commission and other stakeholders including members of the civil society and voluntary organisations across the country. The learning from recently initiated Annual Programme Implementation Plans (APIPs) and related discussion have also highlighted the need for transforming the implementation of ICDS in flexible Society / Mission Mode. The experience

and lessons learned from the implementation of NRHM and SSA in Mission Mode have shown the advantages of implementing the programme in Mission Mode. These include:

- Improved focus on programme planning, management, monitoring and supervision;
- Improved operational efficiency and accountability at all levels;
- Decentralized, streamlined and accountable financial management systems – improved fund flow mechanism;
- Result based monitoring indicators at different levels;
- Time bound goals, outcomes;
- States' ownership and local solutions;
- Greater engagement with States with clearly laid down MOUs linked with performance based funding;
- Decentralised planning -State, district, block, village habitation;
- Convergent actions by bringing together different sectors;
- Clear and flexible implementation framework;
- Sustainable financing, beyond 5 year plans – greater commitments from States / UTs;
- Induction of professionals and voluntary action groups;
- Normative approach as well as defined service standards;
- Address of gaps as per standards-entitlements;
- Empowerment for local action - Greater participation of women's SHGs, mothers committees in delivery and decision making;
- Centrality of PRIs, partnerships with community based organisations and voluntary agencies;

Comprehensive guidelines and tools for planning, management, monitoring and supervision at all levels

ICDS Mission Goals

(i) **Preventing and reducing undernutrition as early as possible**, in a life cycle approach, recognising that growth and development deficits are cumulative and irreversible.

(ii) **Focusing on reaching children under three years of age**, pregnant and breastfeeding mothers, for enhanced child survival, nutrition, development and learning outcomes.

(iii) **An integrated approach to early child development**- addressing physical/motor, cognitive, emotional and social development holistically, enabling children to realise full development potential and active learning capacity -without discrimination.

(iv) **Extending from the centre to family and community** based approaches, recognising that service providers and community volunteers need to reach out to the most vulnerable age groups and the most excluded community groups

(v) **Fostering decentralization**, **flexibility** and community based locally responsive child care approaches, relevant to diverse local contexts, and building upon local innovation and capacities.

(vi) **Ensuring equity** - inclusive approaches to reach the most vulnerable & disadvantaged community groups– Scheduled Castes, Scheduled Tribes, Minorities, etc.

(vii) **Strengthening convergence** to address the inter-related needs of young children, girls and women, in a gender sensitive life cycle approach.

(viii) **Promoting rights based approach, with women's empowerment** as the mover of social change.

(ix) **Moving from outlays to child related outcomes** and ensuring ICDS Universalisation with Quality.

(x) **Ensuring good governance**, accountability and enhanced community participation.

ICDS Mission Objectives

(i) To institutionalize essential services and strengthen structures at all levels by:

- Implementing ICDS in Mission Mode to prevent undernutrition and assure children of the best possible start to life;
- Strengthening ICDS - AWC Platform as the first village post for health, nutrition and early learning – as transformed Early Childhood Development Centre (Anganwadi – Bal Vikas Kendra);
- Focusing on children under-3 years;
- Focussing on early child care and learning environment;
- Moving from outlays to child-related outcomes
- Fostering decentralization and community-based locally responsive childcare approaches;

(ii) To enhance capacities at all levels:

- Vertical integration of training of all functionaries / staff to strengthen field based joint action and teamwork to achieve desired results and laid down objectives
- Establish national training resource centers at central & state levels

(iii) To ensure appropriate inter-sectoral response at all levels:

- Ensure convergence at the grassroots level by strengthening partnerships with the panchayati raj institutions (PRIs), communities and civil societies to improve outreach and quality of child development services;
- Coordinate and network with all allied systems i.e. Government departments and Non-Government agencies providing services for children for effective implementation of the scheme.

(iv) To raise public awareness and participation:

- Strengthen maternal and child care, nutrition and health education;
- Raise public awareness at all levels on situation and vulnerabilities of children and families
- Inform the beneficiary group and public on the availability of the six core child development services under ICDS
- Promote social mobilization and voluntary action.

(v)To create database and knowledge base for child development services:

- Strengthen ICDS Management Information System (MIS);
- Use Information, Communication Technology (ICT) to strengthen the information base and facilitate sharing and dissemination of information;
- Undertake research and documentation.

Achievement Indicators of ICDS Mission

Key indicators to achieve the goals and objectives are as follows:

- Reduction in underweight prevalence
- Improved IYCF
- Contribute to reduction in anaemia, IMR and MMR in collaboration with health
- Reduction in incidence of low birth weight babies
- Improved early learning outcomes

LIST OF RESULT INDICATORS

Indicators	*Current Status*	*Target (End 12th Plan)*	*Means of verification*
A. Impact Level			
i. Reduction in percentage of underweight (<-2SD) children below 3 and 5 years *(separately)*	42.5 % (NFHS-3) for below 5 yrs	10 percentage point	NFHS/AHS/ Periodic Surveys
	40.4 % (NFHS-3) for below 3 yrs		Do
ii. Reduction in percentage of severely underweight (<-3SD) children below 3 years	16.0 %(NFHS-3)	50%	Do
iii. Reduction in prevalence of anaemia in under-5 children	78.9 % (NFHS-3)	20 %	Do
iv. Reduction in prevalence of anaemia in pregnant women	57.9 % (NFHS-3)	20%	Do
v. Reduction in incidence of low birth weight babies	22% (NFHS-3)	10%	Do
vi. Percentage of 5-6 yrs children at the AWCs who are school-ready	NA	60%	Periodic survey
B. Outcome Level			
ICDS Core:			
i. Percentage of children weighed at birth within 24 hours	46.5% (NCAER, 2009)	90%	AHS/ Independent surveys
ii. Percentage of children initiated breastfeeding within one hour of birth	40.5% (DLHS-3)	75%	NFHS/ DLHS/ AHS
iii. Percentage of children exclusively breastfed till 6 months of age	46% (NFHS-3)	75%	NFHS/ DLHS/ AHS
iv. Percentage of children 9-23 months who have been given complementary feeding after 6 months in addition to breastfeeding	57.1% (DLHS-3)	90%	NFHS/ DLHS/ AHS
v. Percentage of mothers receiving counseling on post weighing of their children	48.9 (NFHS-3)	100%	NFHS/AHS Independent survey
vi. Percentage of mothers of 0-3 yrs children who are using MCP card and are aware of early stimulation practices as outlined in MCP Card	NA	70%	
vii. Percentage of families using child progress card for tracking children in 3-6 years age achieving age appropriate developmental milestone	NA	50% of those attending ICDS PSE	Independent Survey
Common with Health: [3]			
i. Percentage of children 12-23 months received full immunization	20 % (NFHS-3)	(85 %)	NFHS / AHS /DLHS
ii. Percentage of children who received Vitamin A dose in last 6 months	24.9% (NFHS-3)	(75%)	NFHS/AHS
iii. Percentage of children below 3 years with diarrhoea treated with ORS	34.2 (DLHS-3)	(70%)	NFHS/ DLHS/ AHS
iv. Percentage of pregnant women receiving at least 3 or more ANC checkups	50.7 (NFHS-3)	(80%)	NFHS/ DLHS/ AHS
v. Percentage pregnant women who consumed at least 100 IFA tablets	46.6 (DLHS-3)	(80%)	NFHS/ DLHS/ AHS
C. Process Level			
i. Percentage of registered children 6 to 71 months who received supplementary		100%	ICDS MIS

nutrition for at least 21 days/month *during the last 3 months*			
ii. Percentage of registered pregnant and lactating women receiving supplementary nutrition for at least 21 days per month *during the last 3 months*		100%	Do
iii. Percentage of eligible children below 3 yrs who are weighed every month *during the last three months*		100%	Do
iv. Percentage of AWCs organized VHNDs every month *during the last 3 months*		80%	Do
v. Percentage of AWWs who conducted at least one session on health and nutrition issues per month *during the last 3 months*		70%	Do
vi. Percentage of AWCs that have regular health check-ups		70%	Do
vii. Percentage of AWWs who have been imparted job/refresher training (separately)		90%	Do
viii. Percentage of AWCs that are open for at least 6 hrs per day during the reporting month		90%	Do
ix. Percentage of AWCs that have conducted at least 4 activities on PSE *(as per new MIS)*		70%	Do
x. Percentage of AWCs that have conducted fixed monthly ECCE Day		50%	ICDS MIS/Periodic survey/assessment
xi. Percentage of AWWs who have conducted *Sneha Shivirs*		50%	Do
xii. Percentage of AWWs reporting at least 15 home visits in a month		70%	Do
xiii. Percentage of AWCs conducting one ALMC per month		80%	Do
xiv. Percentage of AWCs conducting PSE and ECCE activities for at least 21 days in a month		70%	Do
xv. Percentage of AWWs who are able to identify growth faltering and provide counselling support		70%	Do
D. Input Level			
Percentage of AWCs equipped with: a. Adequate indoor and outdoor space b. Adult & baby weighing scales c. WHO new growth charts d. Joint MCP Cards e. PSE kits and graded curriculum f. Medicine kits g. Revised MIS Registers		100%	ICDS MIS

ICDS Mission - Core Strategies

The core strategies of the ICDS Mission are largely derives from the programmatic, management and institutional reforms discussed under ICDS restructuring section above. In particular, the core strategies of ICDS Mission would include:

(i) **Strengthening ICDS as a programme with clear focus on accelerating achievement of maternal and child outcomes, repositioning early child development centrally.** This mission will

contribute to accelerated reduction in maternal and young child undernutrition and related mortality, and enhanced early child development and learning outcomes, in a nurturing and protective environment for the young child.

(ii) **Developing an implementation framework with programmatic, management and institutional reform**s, **in Mission Mode with a clear time frame** for achieving stated monitorable outcomes for integrated early child development, using a life cycle approach.

(iii) **Strengthening partnership between the Central, State, PRIs /urban local bodies and communities** that recognizes and builds on local initiative and innovation, fostering convergent action with NRHM, SSA, TSC, MGNREGA and others.

(iv) **Facilitating States, districts and communities** to develop specific locally relevant strategies, based on a menu of innovative models/ pilots through decentralised, flexible, locally relevant plans first at state-level and gradually extending to the district plans of action capturing the samples and needs of block and village based pointers for plan of action, designed to achieve mission goals, maternal and child related outcomes, within a defined normative framework through the APIP route.

(v) **Transforming the ICDS system into a learning organization, backed by a strong monitoring and evaluation function, accountability and transparency** through community owned accreditation processes, building on best practices and lessons learnt from implementation experience.

(vi) **Involving PRIs and urban local bodies, community/women's groups/SHGs, mother's committees** in the planning, management and monitoring of AWCs. Strengthened partnerships with parents, families, mothers' committees, Women's SHGs, Mahila Samakhya, VHSNCs, VECs (village education committees), and other grass roots level structures are a key element of the same.

(vii) **Strengthening community and family empowerment approach that promotes nurturing family care behaviours** and a caring community environment for young children, girls and women-especially the most vulnerable and crucial younger child under three years.

(vii) Functioning as instrument of social change for "more inclusive growth" that ensures equality of opportunity in the crucial early years of life for fair inclusion and non-discrimination of children belonging to marginalized and /or vulnerable community groups such as SCs, STs, minorities, migrants, children with disabilities, children in need of care & protection.

(ix) **Strengthening capacity development and putting in place a resource network for young children** - networking across different sectors, professionals and institutions of excellence, voluntary agencies and action groups, programme functionaries, community based organizations, and Nutrition and Child Resource Platforms / Centres. National ICDS Mission Resource Centre and collateral strengthening of the NIPCCD, its regional centres and Food & Nutrition Board (FNB).

(x) **Improving basic infrastructure and service delivery through Anganwadi Centres (AWCs)** to progressively make all AWCs the first village post for women and children with community ownership and a child friendly environment.

(xi) **Institutionalising improved delivery of essential services and strengthening and up-scaling innovations in service delivery -** ICDS beyond Anganwadi Centres to fulfill the commitment to reach every young child.

(xii) **Initiating commensurate strategies** to achieve the objectives, goals and vision of the ICDS

Mission.

Launched in 1975, ICDS is a unique early childhood development programme aimed at addressing health, nutrition and the development needs of young children, pregnant and nursing mothers. Over 35 years of its operation, ICDS has expanded from 33 community development blocks selected in 1975 to cover almost all habitations (14 lakh) across the country .

However, the larger part of expansion (more than 50%) has taken place post 2005. Recognizing that early childhood development constitutes the foundation of human development, ICDS is designed to promote holistic development of children under six years, through the strengthened capacity of caregivers and communities and improved access to basic services, at the community level. Within this group, priority is accorded to addressing the critical prenatal-under three years age group, the period of most rapid growth and development and also of greatest vulnerability.

The programme is specifically designed to reach disadvantaged and low income groups, for effective disparity reduction. ICDS provides the convergent interface / platform between communities and other systems such as primary healthcare, education, water and sanitation among others. The programme has the potential to break an intergenerational cycle of undernutrition as well as address The multiple disadvantages faced by girls and women but with adequate investment and enabling environment

2. ICDS STRENGTHENING AND RESTRUCTURING

The ICDS Scheme has been a well conceived Scheme. But the real problem lies in its implementation which arises out of inadequate funding, lack of convergence, accountability of those managing and implementing the programme, specially, at the level of anganwadi centres and supervisory level, lack of community ownership and the general perception about this being a feeding programme and not an Early Childhood Development programme. If these inadequacies are addressed appropriately, the Scheme has the potential to give satisfactory nutritional and child development outcomes. The strengthening and restructuring of the Scheme will then have to address these concerns. Conceivably then, this would need to be undertaken as a necessity. But the issue of management of anganwadi centres and their supervision, capacity building and focus on under 3 (<3) will require putting in place the system of controls which are decentralized and which are closer to the scene of operation. The experience, so far, has been that any amount of guidelines/instructions issued by the Government of India or by the State Governments, do not percolate evenly and with the same seriousness down to the last level, the States/UTs. As a result, the accountability becomes a casualty and, thus, the delivery under the programme suffers.

ICDS strengthening and restructuring addresses the above issues and provides framework for implementation of ICDS Scheme in the Mission Mode.

1.3 Emerging Issues and Gaps

Over the years, ICDS has evolved with difference across the States in regard to modalities of delivery, convergence, community and NGO participation, duration in service hours, available infrastructure and facilities, incentives to honorary workers, selection processes etc. The diversity is also linked to levels of governance in States / UTs. There are examples of innovative and successful models under ICDS implemented by the State Governments of Tamil Nadu, Gujarat, Karnataka, Andhra Pradesh, Kerala, Rajasthan, Orissa etc., in respect of one or more components or interventions that have shown good results and have the potential of being replicated. The programme as a whole has potential for delivering on the nutritional and early childhood outcomes, if invested, supported and managed well.

(i) **Challenges of Universalisation:** In 2008-09, the programme was universalized, this meant rapid expansion from a 8.44 lakh AWCs in 2007 to 13.19 lakh operational AWCs in August 2012 and target of 14 lakh AWCs by the end of 2012 without the corresponding augmentation of resources, both human and financial resulting in a series of operational challenges at all levels. Some of the challenges that have accompanied the universalisation and third phase of expansion are summarized below:

ICDS UNIVERSALISATION AND THIRD PHASE OF EXPANSION: CURRENT CHALLENGES

The universalisation of ICDS Scheme has not been an unmixed blessing. While adding the number of AWCs and taking them to the door steps of children in smaller clusters has been a welcome step, it (universalization) concomitantly has brought in its wake, huge challenges in terms of resources as well as challenges of management, delivery of services with quality and standards. These are briefly as under:-

- **Delay in universalisation**:
  - Approved for Universalization in 2008-09; 6722 projects Operational (March 2011); 7005 projects (Aug 2012)
  - 7076 projects in 14 lakh habitations: 12.62 lakh AWCs Operational (Mar 2011); 13.19 lakh AWCs (Aug 2012)
  - Cost of Supplementary nutrition: Rs.1 (1991 to 2004); Rs.2 – 2.70 (2004 – 09); Rs. 4 – 6 (2009 – 10)
  - Adherence to revised population norms not conformed.
  - Mapping (GIS) and Ground verification yet to be completed to ensure saturation of coverage.
- **SNP management and administrative challenges:**
  - Adoption of and adherence to revised nutritional and cost norms still underway and not achieved fully.
  - Optimization of coverage and improved quality of delivery an issue.
  - Improved supply chain and commodity management and uninterrupted distribution at AWC for 25 days in a month.
- **Financial management and SOE:**
  - Timely submission of component-wise expenditure in SOE along with Utilization Certificate (UC)
  - Fund utilizations as per norms under SNP and ICDS(G) including expenditure on components like PSE, Medical kits, POL, utilization of flexi funds etc.
- **Inadequate Availability of space for Anganwadi Centres**
- **Availability of Human resource:** Large scale vacancies (August 2012) - CDPO/ ACDPO (32%), Supervisors (34%), AWW (8%)/ AWH (8%), need for a dedicated cadre &team for ICDS functionaries & tenure stability and disengagement of ICDS functionaries from non- ICDS related activities. Mode of engagement needs to be worked out.
- **Increased challenge for Inter Sectoral Convergence:** Provision of safe drinking water and child friendly toilet, Joint arrangement of delivery of 3 services: Immunization, Health Check-up and Referral, Joint Home Visits, management and treatment of undernourished children, the linkage with NRC and MTC
- **Low focus on Growth monitoring, ECCE and PSE kits:** Roll out new WHO Growth Standards and Joint MCP cards and ensure availability of PSE kits
- **Low focus on Early childhood Education:** need for policy, curriculum framework and guidelines
- **Challenges of strengthening Training, Monitoring, MIS and ICT:** Focus on cross sectoral, horizontal and vertical integration, in content and participation of training component,timely transfer of funds to AWTCs & MLTCs, implementation of monitoring Guidelines

(ii) **Programmatic and Operational Gaps:** Based on the learning from various studies and inputs received from States through series of consultations as well as from Annual Programme Implementation Plans (APIPs) key gaps in the implementation, management, supervision and monitoring of present ICDS programme have been identified. Major gap areas in effective implementation of ICDS can be categorised in two broad categories i.e., programmatic gaps and operational issues, as discussed below:

- **Programmatic Gaps:** The implementation of ICDS Scheme has been uneven across the States/UTs in the country. The programmatic gaps have been many. While some of them are faced universally across the States/UTs, there are others which are State-specific. The universalisation has, in a way, aggravated the position in respect of some of them. These include: (a) absence of physical space (building) and facilities to operate efficiently and effectively; (b) constraints of quality and number of human resources for meeting diverse needs for service provision with improved quality; (c) inadequate focus on under 3s; (d) inadequate focus on Early Childhood Education (ECE) as large part of time of AWW's spent in AWC related work; (e)perceived as feeding center operated through an overburdened and underpaid AWW; (f) low investment on child development in terms of provision of adequate resources, both human and financial; (g) inadequate convergence of programmes / services – weak linkages with public health system; (h) implementation of programme largely left to States - low intensity engagement with States in planning, implementation, monitoring and supervision; (i) community engagement and participation virtually non-existent often leading to lower demand for services; (j) poor data management, information system (MIS), analysis and reporting; (k) inadequate and inappropriate training; (l) programme implementation guided by periodic revisions of norms and Office Order / Circulars; (m) lack of comprehensive programme implementation guidelines; and (n) little or no attention paid to the needs of working women – availability and accessibility of crèche and day care services (not part of the current programme).

- **Operational Issues:** Besides, the programmatic gaps ICDS implementation is marked with many operational issues such as: (a) inadequate operational efficiency and accountability at national, state, district and grassroots levels in absence of infrastructure, human resource (large vacancies, educational qualification and inadequate numbers), mobility, etc.; (b) delivery of supplementary nutrition due to non-sharing of cost on SNP prior to 2005 – 06, followed by issues in management of SNP arising out of the requirement to supply morning snack and hot cooked meal; (c) non revision & indexation of cost to rising prices of food, fuel and transportation etc.; (d) program envisaged as community driven but in reality has evolved as State run programme; (e) regularity of AWC functioning in terms of prescribed working hours, number of days and service provision; (f) slow pace of universalisation due to a variety of problems faced by the States/UTs; (g) fund transfer mechanism marked with delays at all levels often resulting in delays in release of funds and payments to AWWs and for SNP; (h) Concurrent monitoring a continuing weak point –inadequacy and non-usage of data, poor management information system (MIS); and (i) Single AWW at each AWC & ICDS functionaries burdened with non- ICDS functions.

Sl. No	Components	Services	Core Interventions	Target Group	Service Provider
1.	Early Childhood Care Education & Development (ECCED)	Early Childhood Care and Education (ECCE) / Pre-school Non-formal Education	• Home based guidance for parents • Early stimulation • Early screening and referral • Optimal IYCF Practices • Monthly Monitoring & Promotion of Child Growth & Developmental Milestones. • Fixed Monthly Village ECCE Days	0-3years Parents/caregivers	AWW /Second AWW cum Child Care & Nutrition Counsellor
			• Non formal preschool education: a) activity based b) semi-structured play and learning method • Quarterly Monitoring & Promotion of Child Growth & Developmental Milestones. • Fixed Monthly Village ECCE Days	3-6 years Parents / caregivers	AWW
		Supplementary Nutrition	• Morning snack, Hot Cooked Meal and THR as per norms	6 m – 3 yrs 3-6 years P&L Mothers	AWW / Second AWW/ AWH / SHGs / others
2.	Care & Nutrition Counselling	Infant & Young Child Feeding (IYCF) Promotion &Counselling	• One to one counselling for optimal breastfeeding practices linked to growth monitoring • One to one counselling on Complementary feeding • Counselling to ensure food intake • Home visit and follow up	P&L mothers. Mothers of children under 3 yrs	AWW / Second AWW cum nutrition counsellor/ supervisors ASHA / ANM
		Maternal Care and Counselling	• Early registration of pregnancy, 3 or more ANC, Institutional delivery and PNC • Counselling on diet ,rest and IFA compliance during Home visit • Monitoring weight gain • Examination for pallor and oedema and any danger signs • Home based counselling for essential newborn care • Counselling and lactational support • Counselling on spacing	P&L women	ASHA / ANM / MO/Second AWW cum nutrition counsellor
		Care, Nutrition, Health & Hygiene Education	• Monthly health and nutrition education sessions • Education on Improved caring practices-- feeding, health and hygiene and psychosocial. • Knowledge sharing for care during Pregnancy, lactation and adolescence • Promotion of local foods and family feeding. • Appropriate food demonstration • Celebration of nutrition week, Breastfeeding week , ICDS day etc	P&L Mother and other caregivers , community and families	AWW / Second AWW cum nutrition counsellor/supervisors

		Community based care and Management of underweight children	• 100% weighing of all eligible children and Identification of underweight children • Referral to NRCs/MTCs for children requiring medical attention • 12 day Nutritional counselling and care sessions for moderately and severely underweight children (SNEHA SHIVIRs) • 18 day home care and follow up during home visit • Monitoring of weight gain after 12 days and 18 days	Moderately and Severely under-weight children &their mothers/careg iver	AWWs/ AWH/ supervisors/ Mothers' Group/PRIs / SHGs /MO ASHA and ANM as facilitator
3.	Health Services	Immunization and micronutrient supplementation	• Regular Fixed Monthly VHNDs • Primary Immunization • Boosters • TT for Pregnant women • Vitamin A supplementation (9 months – 5 years) • IFA supplementation (infants after 6 months of age) • Deworming as per guidelines • Counselling	0-3 years 3-6 years P&PL Mothers	ANM / MO / ASHA/ AWWs as facilitator
		Health Check Up	• ANC / PNC / JSY • Support for IMNCI / JSSK • Identification of severely underweight children requiring medical attention • Support to Community based care of underweight children	0-3 years 3-6 years P&L Mothers	ANM / MO / ASHA /AWWs as facilitator
		Referral Services	• Referral of severely underweight to health facility/NRCs • Referral for complications during pregnancy • Referral of sick newborns • Referral of sick children	0-3 years 3-6 years P&L Mothers	ANM / MO / ASHA/ AWWs
4.	Community Mobilization, Awareness, Advocacy & IEC	IEC, Campaigns and Drives etc.	• Information dissemination & awareness generation on entitlements, programmes behaviours and practices • Sharing of nutritional status of children at gram sabha meetings • Linkage with VHSNC • Voluntary Action Groups • Village contact drives	Families & Community	AWW / Second AWW/ supervisors / FNB / Dist. & Block Resource Centres / ICDS Management

Steps Initiated for Strengthening

- **Annual Programme Implementation Plans (APIPs)** in at least 10 States in 2011-12.
- **IDA assisted ISSNIP** programme in eight selected States in 162 plus districts to address greater governance and programmatic deficits by providing catalytic support for system strengthening, conducting various pilots, innovations and experimentation of various good practices, development of protocols / standards / guidelines.
- **Adoption of WHO Child Growth Standards and joint Mother & Child Protection Card**
- Introduction of the **five-tier monitoring system** including supervision guidelines
- Draft Guidelines for **grading and accreditation of AWCs and awards** for service providers and other stakeholder issued
- Pilot Testing of **revised Management Information System (MIS) completed**
- **Core Group on ECCE Policy Formulation** – draft ECCE Policy, Curriculum Framework and Standards prepared; shared in public domain for comments and suggestions; expected to be approved by the end of current financial year
- **Enhancement of honoraria** of AWW & AWH
- **Establishment of Nutrition Resource Platform –** Process initiated for establishment of single e-platform for sharing knowledge related to nutrition by different stakeholders and sectors having a Digital/physical Library, web-based knowledge management e-forum for discussion and exchange of ideas and a package of services for end-users through mobile telephony services (ongoing).

Steps Ahead for Strengthening

- Universalization with quality with focus on operationalizing approved projects and 14 lakhs AWCs across the country
- Cluster approach – on a cluster of 17 - 25 AWCs, a Cluster Office in a selected AWC to be set up by placing one Supervisor;
- Focus on under 3s – Growth monitoring & IYCF;
- Training & capacity building at all levels; rolling out revised MIS; use of ICT;
- Health & Nutrition Education and caring practices;
- Preliminary actions for strengthening ECCE by formulation of policy, curriculum etc.; addressing issues pertaining to human resource and Grading and accreditation of AWCs Revision in cost norms for Supplementary Nutrition and providing scope for flexibility to states and in implementation and provision for untied funds to address innovations, pilots and local needs are also envisaged for expediting the processes.
- There will be additional funds required both for construction of anganwadi buildings and for providing facilities as well as for increased rentals for hiring buildings, wherever, construction is not a viable option.
- The replacement of weighing scales and other equipment's will be a periodic requirement and shall have to be provided for.
- The current cost norms of IEC, pre-school education and medicine kits are on the lower side and need revision.
- Additional resources will also be required for mobility of Supervisors and for IYCF activities. The IYCF activities would focus on under 3 (<3) and will require experimentation with different set of options including that of having additional nutritional coordinators at the block level.

ICDS Restructuring

ICDS is now implemented in Mission Mode to ensure holistic - physical, psychosocial, cognitive and emotional development of young children under 6 years of age in a nurturing, protective, child friendly and gender sensitive environment.

To enhance its impact on child related outcomes programmatic, management and institutional reforms would be undertaken.

Programmatic Reforms

The programmatic reforms include a range of reformative actions related to programme planning and implementation. It focuses on:

1. Repositioning the AWC as a "vibrant ECD centre"

- AWCs as a child friendly centre with adequate infrastructure, facilities (kitchen, safe drinking water& child-friendly toilets), play space and joyful learning environment.
- The activities of AWC would be expanded to include extended hours (minimum of 6 hours).
- The provision of day care crèches for care and development of children whose mothers go for work.
- 5% of the AWCs would be converted to AWC cum Crèche on 75:25 cost sharing basis between centre and state.

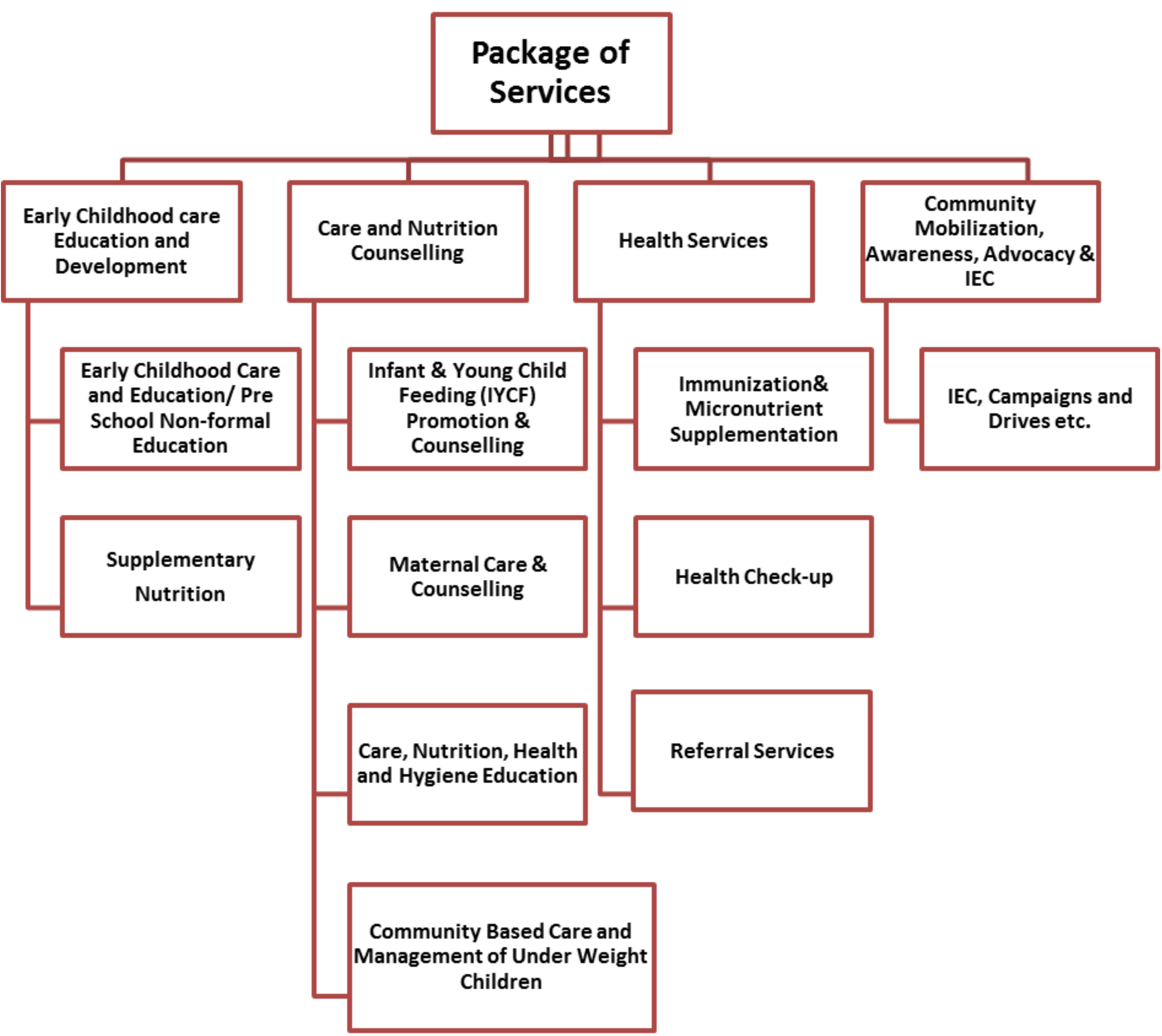
2. Appropriate AWC Building and Infrastructure

- ***Construction of AWC Buildings:*** Providing *pakka* building for anganwadi at a cost sharing ratio of 75:25 except NER where it would continue to be 90:10 between centre and state.

(**AWCs as per the guidelines should be child friendly with all relevant infrastructures and the space should be at least 600 sq. ft.)**

- ***Up-gradation and Maintenance:*** Funds for up-gradation on 75:25 cost sharing basis.
- ***Enhancement of Rent: I***ncrease in monthly rent of the AWCs
  - Upto Rs.750 for AWCs / Mini-AWCs in rural and tribal areas.
  - Upto Rs.3000 for AWCs / Mini-AWCs in urban areas depending upon the tier / class of the town/city
  - Upto Rs.5000 for AWCs / Mini-AWCs in metropolitan cities.
- ***Enhancement of Rent for CDPO building:*** Rent for CDPO buildings enhanced @Rs. 79200/- per project per annum with centre – state cost sharing ratio being 75:25.

3. Strengthening Package of Services: The core of package of six services to be continued after reorganization and reformation. Anganwadi centre to be transformed as Early Childhood Care and Development Centre from the perception of being a feeding centre.



Package of Services under Restructured & Re-strengthened ICDS

4. **Focusing on the under-3s and early child care and learning environment:** Facility based management of severe undernutrition at Nutrition Rehabilitation Centres (NRCs) and *Sneha Shivir*.

5. **Strengthening Early Childhood Care and Education (ECCE)**
   - Developing and implementing activity based child centres and age appropriate curricula
   - Ensure school readiness interventions for 5 + year olds
   - Ensure availability of motivated, trained and quality personnel

- Availability of child friendly, low cost and culture specific infrastructure
- Supervision and monitoring to ensure quality improvement
- Setting up National / State ECD Council
- Developing special modules of training in ECCE with emphasis on hands on training
- Revision of cost norm of PSE kits @Rs.3000 per kit for AWCs and Rs.1500 per kit for mini AWCs, with Centre-State cost sharing being 90:10.
- Monthly fixed Village ECCE day on the lines of VHND

6. **Improving Supplementary Nutrition Programme:** Anganwadi Centres would continue to provide morning snacks, hot-cooked meal and Take Home Rations (THR) to children and pregnant and lactating women on cost sharing of 50:50 basis and 90:10 for states/UTs and NER respectively.
7. **Care and Nutrition Counselling Service:** This is a core service for mothers of children under three years and includes monitoring and promotion of young child using WHO growth charts and mother & child protection card.

8. **Management of severely and moderately underweight children**
    - Identification and management of severely and moderately underweight children through community based intervention and *SNEHA SHIVIRs*.
    - Referring cases of severe underweight to rehabilitation centres.

9. **Focusing on Children with special needs:** Provision of Rs.2000/- per child (as untied fund) has been made under the ICDS Mission for ensuring need based interventions, some of the major ones include:
    - Identification of children with special needs
    - Linking children with special needs with existing service provisions

- Training and sensitization of AWWs, Link Workers and Families
- Assistive devices / special education kit / books
- Improved Accessibility
- Referral Services

10. **Strengthening Human Resource:** For better human resource management and to motivate the existing functionaries, following actions would be undertaken:

- Evolving a transparent appointment and selection policy for AWW and AWH
- Separate cadre for ICDS would be introduced in States (wherever not existing). Provisions in the guidelines would be introduced to ensure that the ICDS cadre cannot be transferred to any other cadre, except as per the rules.
- Permitting the States to fill up vacant posts through temporary job contract to avoid interruption in the services.
- Prescribing minimum educational qualifications and age limit (Matriculation and age limit- 18 to 35 years) for appointment as AWW/AWH
- Relieving AWWs / AWHs on completion of 65 years of age
- Opening a Cluster Office for supervising and managing a cluster of 17 – 25 AWCs. Engagement of Additional Nutrition Coordinator and ECCE Coordinators in projects to act as master trainers.
- Enhancing the honorarium of AWWs of Mini-AWCs from Rs. 1500/- to Rs. 2250/-, subject to the educational qualifications on a cost sharing of 90:10.
- About 25% posts of Supervisors reserved for AWWs to be filled by the method of induction under the ICDS.
- The cost of uniform for the AWW and AWH has been revised from the Rs.400/- p.a. (for two sarees /suits) to Rs.600/- (for two sarees /suits), while the cost of badge would remain the same, i.e., Rs.25/- per badge.
- Provision for appointment of both regular and contractual workers at all levels.

11. **Capacity Development to ensure professional child development services:** Regular training and capacity building of service providers and functionaries would be ensured at all levels. NIPCCD, MLTCs and AWTCs would be engaged in carrying out training and capacity to equip and enhance their skills and knowledge on child care and development standards.

12. **Promoting Community ownership:** The focus would be on mobilizing and engaging the community, especially parents and families, in ensuring maternal and child health, nutrition and development.

Management Reforms

In order to support the programmatic reforms envisaged above, a range of reformative actions related to programme management, monitoring and supervision from the central to the AWC level. The focus would be on:

1. **Decentralized planning, management and flexible architecture:**

Decentralized planning would involve

- Carrying out need assessment and local mapping for preparation of APIPs catering to the specific needs at the State, District, Project and local level.
- Timely delivery of services, expeditious / timely availability of funds and human resource.

Flexibility in implementation would involve

- Developing innovative models for effectively delivering the core ICDS services.
- Piloting targeted interventions based on local needs.
- Undertaking modifications on all matters such as human resource, travel and transport, programme implementation, revision in population norms considering local situations etc.

2. **Ensuring convergence**

- Strengthening partnerships with PRIs, communities and civil societies to improve outreach and quality.
- Ensuring intersectoral convergence (health, education, employment).

- Organizing VHNDs, ECCE Day and other ceremonies for convergence of health and nutrition services at grass root level.

3. **Strengthening Governance**
    - Involvement of PRIs and ULBs and giving them prime positions in five tier monitoring system.
    - Promoting civil society partnerships by involving civil society, networks, Non-Governmental Organisations (NGOs) / Community Based Organisations (CBOs), institutions and voluntary action groups at different levels of planning, management and service delivery of ICDS for advocacy and capacity building activities.

4. **Strengthening of ICDS Management Information System (MIS)**
    - Revising the MIS to focus on collecting and providing data on a real time basis to support the programmatic actions and timely interventions.
5. **Using Information, Communication Technology (ICT)**
    - To promote use of ICT in order to strengthen the information base and facilitate sharing and dissemination of information.
    - Linking ICDS with mobile phone infrastructure for better service delivery.

6. **Allocating Adequate Financial Resources** for implementation of strengthened and restructured ICDS i.e. Adapting to PIP mode, enhancing cost of SNP, additional human resources, construction of AWCs and developing and implementing flexi models.

Institutional Reforms

The programmatic and management reforms envisaged above would require strong institution structures and mechanism at different levels, including:

1. **ICDS in Mission Mode:** In order to carry out the functions of the mission, State Child Development Societies will be established with powers to establish district units.
2. **Guidance and Supervisory Bodies:** ICDS at an overall level will be guided by the National Mission Steering Group headed by the Hon'ble

Minister (I/C) MWCD. The ICDS operations will be supervised and monitored at different levels

- **National level** - by Empowered Programme Committee under the Chairpersonship of the Secretary MWCD.
- **State level** – guided by State Mission Steering Group headed by the State Chief Minister, monitored by State Empowered Programme Committee headed by Chief Secretary
- **District and Block levels** - Advisory Bodies

3. Greater Involvement of PRIs

States are urged to promote leadership and steering role at grass root level. States are encouraged to:

- Support facilitative and supportive supervision
- Ensure an enabling and assuring environment free from discrimination, violence and biases to work towards removal of social barriers with knowledge, sense of duty and purpose;
- Give greater roles, responsibilities to PRIs and ULBs with measures for ensuring their involvement, participation and accountability.

The restructured ICDS has identified certain additional roles if nutrition counselor (additional AWW). These roles are given below-

Role and Responsibility of Additional AWW cum- Nutrition Counsellor-

- ❖ Prime worker for Pregnant and lactating mothers and children under three years
- ❖ Ensuring the promotion, protection and support of optimal infant and young child feeding practices, especially early and exclusive breastfeeding for the first six months of life
- ❖ Contributing to the operationalisation of the National Guidelines on Infant and Young Child Feeding (MWCD 2006) and effective implementation of the Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003 (IMS Act), IMNCI
- ❖ Ensuring services at family level for nutrition counseling
- ❖ Monitoring and promotion of young child growth and development
- ❖ Ensuring full usage and compliance of new joint Mother and Child Protection Card
- ❖ Supporting community based child care arrangements and linkages with child care provisions

- ❖ Coordinate with ASHA and ANM for health related services for under 3 children
- ❖ Organisation of SNEHA SHIVIRS at the AWC, jointly with the AWW and ASHAs
- ❖ Facilitating linkage of mothers with IGMSY, a scheme addressing the inter-generational cycle of undernutrition and anaemia
- ❖ Promoting early stimulation and care package of ECD
- ❖ Early screening / interpersonal communication
- ❖ Interaction with community /family in respect of under twos and pregnant and lactating mothers

The Multi-sectoral Nutrition Programme to Address the Maternal and Child Undernutrition will be implemented as a special intervention in 200 High Burden Districts across the country in a phased manner. The first phase will begin in 100 districts during the year 2013-14, while in the second phase, it will be scaled up to cover 200 districts during the year 2014-15. The National Mission Steering Group (NMSG) and Empowered Programme Committee (M-EPC) constituted for ICDS Mission would be the highest administrative and technical bodies for ensuring effective planning, implementation, monitoring and supervision.

The goal is to bring inter-sectoral convergence and coherence in policy, planning and action with core focus on nutrition by including specific pro-nutrition and nutrition sensitive actions in different programmes/ schemes through intensified and sustainable direct targeted interventions.

Objectives of the Multi-sectoral Nutrition Programme

(i)Ensuring strong nutrition focus through institutional and programmatic convergence by integrating it in the planning, implementation and supervision process in all relevant direct and in-direct interventions / programmes;
(ii)Increasing availability and accessibility of key maternal and child health & nutrition services at all levels through convergence of sectoral programmes;
(iii)Bridging critical gaps in inter-sectoral programmatic and institutional arrangements for addressing maternal and child undernutrition at National, State, District, Block and Village levels leading to harmonized nutrition action plan;
(iv)Enhancing the capacities and skills of service providers, care givers, voluntary action group, mothers' groups and communities; and
(v)Ensuring convergent multi-sectoral actions for empowering families and communities for improved care behaviours such as early and exclusive breastfeeding for the first six months and optimal IYCF,health, hygiene, psychosocial and early learning and care for girls and women.The proposed Multi-sectoral Nutrition Programme would provide a platform at all levels to facilitate convergence of all the key services and stakeholders for holistically addressing the maternal and child undernutrition.

(viii) **Management of severely and moderately underweight children:** Special and prompt actions would be taken for identification and management of severely and moderately underweight children through community based intervention and SNEHA SHIVIRs. Cases of severe underweight requiring medical attention would be referred to NRCs / MTCs set up under NRHM. Already, some states with high undernutrition prevalence are effectively providing care and treatment to undernourished children at health facilities through strong coordination between ICDS and NRHM.

Village Nutrition Counselling & Child Care Sessions (SNEHA SHIVIR) under the ICDS Mission would be designed to be a community based approach for the prevention and management of moderate and severe undernutrition. These SNEHA SHIVIRs would be held at an Anganwadi Centre selected from amongst the cluster of 4-5 Anganwadi Centres. SNEHA SHIVIR would be organised in the selected areas where numbers of moderately and severely underweight children are high. The overall goals of the SNEHA SHIVIRs would be to ensure quick rehabilitation of undernourished children; enable families to sustain rehabilitation; and prevent future undernutrition in community by changing behaviours in childcare, feeding and health seeking. The key strategies would include: (i) orientation of Anganwadi workers and Supervisors on the approach; (ii) 100% per cent weight monitoring and tracking using growth charts and the Mother and Child Protection Card; (iii) community orientation / sharing of the magnitude of the problem; (iv) showcasing the positive practices in the homes of well-nourished children in poorer households; and (v) setting up Nutritional care and counselling sessions. Each SNEHA SHIVIR would comprise 12 day monthly sessions followed by 18 days home based practices. During the 12-day monthly sessions, the best practices prevalent in the community would be learnt by caregivers of moderately and severely underweight children through a process of "Learning by Doing". This initiative is need based and wherever required additional funds can be sourced from normal SNP provisions.

The ANM / doctor under the NRHM would be responsible for health check up of all the underweight children reporting to SNEHA SHIVIRs. For those children who are attending the SNEHA SHIVIR and still not showing signs of improvement, the ANM or a doctor assigned by the NRHM would be responsible for deciding on type of referral or treatment facilities required as well as linking the child to the appropriate health care / treatment facility Outline for setting up SNEHA SHIVIRs in selected areas and modalities under this scheme are given at

3. Role of ICDS in Prevention and Reduction of Undernutrition

Integrated Child Development Services (ICDS) is the largest national programme committed to the welfare of children under 6 years of age, and pregnant and lactating women. It caters to the most vulnerable and critical age group of under threes, a period marked by rapid growth, development and requiring immense care and support to pregnant and lactating mothers. ICDS is one such platform which can apply universally a set of well-targeted core interventions such as promotion of exclusive breastfeeding, Oral rehydration therapy and appropriate and adequate complementary feeding and growth monitoring it can help take timely action and prevent undernutrition. Along with NRHM it offers integrated packages of essential health interventions like Immunization, micronutrient supplementation, ANC and home based care and counselling for benefit of mother and child, thus averting growth retardation before and after delivery. It also serves as a platform to orient and provide life skill education to adolescent girls thus making a crucial entry point for breaking the intergenerational cycle of undernutrition and enhancing the chances of survival of children.

It has also been recognized as the intervention to address undernutrition in India, however with poor access to health, drinking water and sanitation facilities the undernutrition rates have shown extremely slow pace of decline. Further ICDS has been largely criticized for its relative lack of focus on both the 0 to 6 month child and the children in 6 month to 3 year period, both of which are the most vulnerable to slip into malnutrition. Conception to two years is a period of rapid growth and lack of care during this narrow period of opportunity could lead to early onset of undernutrition. Most ICDS activity occurs at the centre itself, where children above three are brought and by the time the child comes there, a crucial period to control undernutrition has elapsed.

During the 12th Plan period ICDS will implemented in a Mission mode with clear defined outcomes and results. ICDS in the Mission mode envisages major programmatic reforms supported by appropriate managerial and institutional reforms to address the gaps in scheme. There will be greater focus on under threes, and thrust on prevention of undernutrition, through rigorous counselling and follow up of pregnant mothers, emphasis on early initiation of breastfeeding, exclusive breastfeeding and timely introduction of age appropriate complementary feeding, and strengthening of routine growth monitoring of children and early identification of growth faltering. Provision of additional human resources is made in 200 high burden districts, to specially reach out to under threes through intensified home visits and village level contacts.

It will also focus on continuum of care from prenatal period to adulthood with adequate resource investment and optimal implementation. Interventions to ensure young child survival and development will be prioritized, with primary focus on the acceleration of progress in reducing maternal infant, and child mortality. This will include preventing maternal and child undernutrition and promoting early childhood care, along with empowerment of families and communities, caregiver education, capacity development and locally responsive child care interventions.

The scheme will forge strong convergence with all relevant programmes and service providers at the grassroots levels like Anganwadi Workers of ICDS, Auxiliary Nurse Midwife (ANMs) and Accredited Social Health Activists (ASHAs) of National Rural Health Mission (NRHM) with stronger partnerships with Panchayati Raj Institutions, Village Health Sanitation and Nutrition Committees, parents/mothers' committees etc.

To address the undernutrition and growth faltering in children a new component (Sneha Shivir), - a community based care and nutrition counselling initiative especially for mothers/ care givers has been introduced. Intensive and diligent hands on training of mothers on child care will be conducted along with close monitoring of growth of the child. Sustained child care practices will not only rehabilitate children but also prevent undernutrition in later born siblings.

The ensuing section will elaborate the processes involved in operationalizing Sneha Shivirs in the 200 high burden districts.

Day 1 Session 3

Beti Bachao Beti Padhao (BBBP), Gender Concerns and Introduction to Village Convergence Facilitation Services (VCFS) in 100 Gender Critical Districts

I. Women & Girls in India – Key Issues

SOCIAL ISSUES CONCERNING WOMEN /ADOLESCENT GIRLS

Socio-cultural landscape for women is diverse, where on one hand a liberalised economy has offered better education, jobs, decision making powers and opportunities for women. On the other, women and girls have been targets of a strong backlash with increased violence in and outside the home, acute wage differentials and discrimination and continuing commodification in society. Migration, skewed sex ratio, environmental degradation are other issues which have added to the women's vulnerability.

Discriminatory practices such as child marriages, dowry, honour killing, witch hunting and gender biased sex selection indicate profound vulnerability of and inequality towards girls and women in Indian society. Child marriage is a denial of childhood, with irreversible consequences, especially for girls. Dowry devalues women. Witch hunting is a way to control women who do not conform. Gender biased sex selection eliminates girls from the families and societies, altering the social fabric and causing further vulnerability to abuse and violence for those alive. Honour killing is a barbaric violation and humiliation girls and women. All these factors have contributed to low child sex ratio (CSR) which is at an all-time low of 914 according to the 2011 census. Changes in CSR at the district level are more pronounced. Of the total 640 districts in the country, 429 districts have experienced decline in CSR. The 2011 Census points to the spread of this phenomenon from largely urban and prosperous areas to rural, remote and tribal areas.

Creating a protective and safe environment for girls and women in public consciousness and public places in order to ensure gender equality for more inclusive growth has emerged as a priority area. Safety and security are important underlying parameters to ensure a violence free environment. Several Departments/ Ministries like Home Affairs, Transport, Education, MCD, Home Affairs, Law and Justice, WCD, etc. are primary stakeholders responsible for the

issues concerning safety of women. In areas of public transport, civic awareness and partnership building, education, urban planning and design of public spaces, provision and maintenance of public infrastructure and services, legislation, justice, and support to victims; policing etc one has to renegotiate their roles to ensure violence free spaces for women and girls. Hence, any initiative to address the issue has to adopt a multi-pronged strategy and focus on convergent approach.

In the past two decades many laws were passed, however, despite these laws, gender based violence and discrimination against women continue to feature of our society and women are yet to positively gain from the legislations. Legislative changes have faced resistance in their implementation due to social, cultural and religious mores. It is important for women to understand and know the laws pertaining to their rights.

The need to change social norms and mind-sets towards girls and women starts from the family, the community, religious and educational institutions. The state can bring changes in the objective circumstances that perpetuate discrimination and neglect towards a girls and women by strengthening and implementing its economic, social policies for gender equality, which will further impact the subjective changes in perceptions and expectations towards girls and women.

Government of India has recognised these paradoxes and steps have been taken to address these concerns through policies, legislation and programmes. In this context, awareness generation and convergence among various programmes/schemes of the government both at the Central and State/UT level remains crucial.

BBBP Scheme:

1. Background and Context

1.1 The trend of decline in the Child Sex Ratio (CSR), defined as number of girls per 1000 of boys between 0-6 years of age, has been unabated since 1961. The decline from 945 in 1991 to 927 in 2001 and further to 918 in 2011 is alarming. The decline in the CSR is a major indicator of women disempowerment. It reflects both, pre-birth discrimination manifested through gender biased sex selection, and post

birth discrimination against girls. Social construct discriminating against girls on the one hand, easy availability, affordability and subsequent misuse of diagnostic tools on the other hand, have been critical in increasing Sex Selective Elimination of girls leading to low Child Sex Ratio.

1.2 There are wide variations seen in ratios across different regions of the country. The CSR remains adverse in 21 States and Union Territories, the fall ranging from 3 to 79 points. 11 states and 2 UTs have shown an increase in CSR during the last decade. The district level changes in CSR are much more pronounced as may be seen that out of 640 districts in the country, 429 districts have experienced decline in CSR. The decline is widespread across the country ranging from urban to rural, remote as well as tribal areas.

1.3 Coordinated & convergent efforts are needed to ensure survival, protection and education of girl child to help realize her full potential. Recognizing the need for urgent action, Government has announced in the Budget Speech, 2014-15, *Beti Bachao, Beti Padhao* (BBBP) Scheme to empower the girl child and enable her education. It was decided in the meeting held on 7th July, 2014 in Prime Minister�much Office that the Ministry of Women and Child Development will be the Nodal Ministry for launching a mass campaign under the slogan of BBBP and that it would be supported by the Ministry of Health and Family Welfare and Department of School Education and Literacy. The issue was highlighted in the Prime Minister's Independence Day address to the nation on 15th August, 2014.

1.4 The Beti Bachao Beti Padhao (BBBP) Scheme will be implemented through a national campaign and focussed multi sectoral action in 100 selected districts, covering all States and UTs. This is a joint initiative of Ministry of Women and Child Development, Ministry of Health and Family Welfare and Ministry of Human Resource Development.

2. Overall Goal:

Celebrate the Girl Child & Enable her Education

3. Objectives:

3.1 The objectives of the Scheme are as under :

i) To prevent Gender biased sex selective elimination: Focussed intervention targeting enforcement of all existing Legislations and Acts, especially to Strengthen the implementation of Pre-Conception & Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PC&PNDT Act) with stringent punishments for violations of the law.

ii) To ensure survival & protection of the girl child: Article 21 of the Constitution defines „protection of life and liberty" as a legitimate right of its citizens. The difference in mortality rates of girls and boys indicates the difference in access to various health care and nutrition services as well as the preferential care and treatment given to boys. The access to various entitlements, changes in patriarchal mind-set etc. are to be addressed in order to ensure equal value, care for and survival of the infant and young girl child. Further implementation of various legislative provisions for the protection of the girl child and women has to be ensured to create a nurturing and safe environment for the girl child.

iii)To ensure education & participation of the girl child: The access and availability of services and entitlements during the various phases of the life cycle of the Girl Child has a bearing on her development. Essential requirements related to Nutrition, Health Care, Education and Protection have to be fulfilled to enable every girl child to develop to her full potential- especially the rightto quality early childhood care, elementary and secondary education. Right To Education (RTE) Act, 2010 provides children the right to free and compulsory education till completion of elementary education in a neighbourhood school. Further, Sarva Shiksha Abhiyan (SSA) is a flagship programme for achievement of Universalization of Elementary Education (UEE) in a time bound manner, as mandated by 86th amendment to the Constitution of India making free and compulsory Education to the Children of 6-14 years age group, a Fundamental Right. Denial of these

entitlements is a violation of childrens rights, which will have a lasting lifelong negative impact. This will also adversely impact upon future human development.

3.2 Discrimination and neglect of girl child can lead to low self-esteem, lifelong deprivation and exclusion from the social mainstream. Appropriate initiatives will be taken to encourage girls to express their views and to be heard, to participate actively, effectively and equally at all levels of social, economic, and political leadership.

3.3 Long term interventions for gender equality would focus on creating enabling environment including employable opportunities, safety & security, mobility & speedy justice.

3.4 The Objectives stated above will be achieved through Convergence and Coordination with concerned Ministries/Departments/District Administration.

4. Monitorable targets:

i) Improve the Sex Ratio at Birth (SRB) in 100 gender critical districts by 10 points in a year.
ii) Reduce Gender differentials in Under Five Child Mortality Rate from 8 points in 2011 to 4 points by 2017.
iii) Improve the Nutrition status of girls - by reducing number of underweight and anaemic girls under 5 years of age (from NFHS 3 levels).
iv) Ensure universalization of ICDS, girls‟ attendance and equal care monitored, using joint ICDS NRHM Mother Child Protection Cards.
v) Increase the girl‟s enrolment in secondary education from 76% in 2013-14 to 79% by 2017.
vi) Provide girl's toilet in every school in 100 CSR districts by 2017.
vii) Promote a protective environment for Girl Children through implementation of Protection of Children from Sexual Offences (POCSO) Act 2012.
viii) Train Elected Representatives/ Grassroot functionaries as Community Champions to mobilize communities to improve CSR & promote Girl‟s education.

The scheme is envisaged for focused interventions to improve the CSR, within an overall National Strategy for Beti Bachao, Beti Padhao. Recognizing that the issue of decline in Child Sex Ratio is complex and multi-dimensional, it shall be addressed within the broad framework of survival, protection and

education of girl children. A multi- sectoral strategy which is governed by the core principles of respecting, protecting and fulfilling the rights of girls and women, including the ending of gender based violence will be adopted. The core strategies will be as follows:

i) **Evolving a sustained Social Mobilization and Communication Campaign** to change societal norms, to create equal value for the girl child.
ii) **Positioning improvement in the Child Sex Ratio as a lead development indicator** for good governance.
iii) **Focusing on very low Child Sex Ratio or gender critical districts and cities** for accelerated impact.
iv) **Mobilizing and empowering frontline worker teams** as catalysts for social change,in partnership with local community/women‟s/youth groups (Ahimsa Messengers).
v) **Developing capacity of Panchayati Raj Institutions/Urban local bodies** - especially women panchayat /urban local body members, to create community and peer support for making panchayats / urban wards girl child friendly.
vi) **Engendering development and essential services**: to ensure that service delivery structures are sufficiently responsive to issues of gender and children‟s rights.
vii) **Enabling Inter-Ministerial and inter-institutional convergence** at different levels.

6. Components:

i) Mass Communication Campaign on Beti Bachao-Beti Padhao : A nation-wide campaign will be initiated with the launch of "Beti Bachao, Beti Padhao" to increase awareness on celebrating Girl Child & enabling her education. The campaign will be aimed to ensure that girls are born, nurtured and educated without discrimination to become empowered citizens of this country with equal rights. Ministry of Information& Broadcasting (DAVP) has been entrusted with the responsibility of developing a Media Campaign in consultation with Ministry of Health & Family Welfare (M/o H&FW), Ministry of Human Resource Development (M/o HRD) & Ministry of Women & Child Development (M/o WCD).

ii) Multi-Sectoral intervention in 100 Gender Critical Districts worse on CSR: MWCD will initiate a Multi-Sectoral Action in selected 100 districts covering all States/UTs for schematic intervention. Sectoral actions are drawn in

consultation with M/o H&FW & M/o HRD. Measurable outcomes and indicators will bring together concerned sectors, states and districts for urgent concerted Multi-Sectoral Action to improve the CSR. A flexible framework for Multi-Sectoral Action will be adapted and contextualised by State Task Forces for developing, implementing and monitoring State/ District Plans of Action to achieve the State Specific Monitorable Targets. State/ Districts will similarly develop their plans responsive to different State/District contexts.

7. Linkage

7.1 At the Centre, linkages under the proposal shall be established with concerned line ministries/departments namely Ministry of Health & Family Welfare (MoHFW) and Ministry of Human Resource Development (MoHRD) & Ministry of Women & Child Development (MoWCD). At the States/UTs level, Dept. of WCD will work in close coordination with these concerned departments for inclusion of issue of Child Sex ratio as a priority agenda. Further, Linkages will also be strengthened with the existing government training institutions and Autonomous Training Institutes at national and State Levels to provide training on matters related to CSR. Sharing of good practices with line departments/states for encouraging adoption of good practices would be done.

7.2 At the District level, appropriate linkages with Panchayats, Anganwadi Centres, PHCs will also be strengthened. Grassroot functionaries of different departments shall be sensitized & trained on the issue of CSR, value of girl child & promote her education and will in turn facilitate community ownership and participation on creating an enabling environment for survival, protection & education of girl child.

8. **Poject Implementation**

8.1 The Ministry of Women and Child Development would be responsible for budgetary control and administration of the scheme from the Centre. At the

State level, the Secretary, Department of Women and Child Development will be responsible for overall direction and implementation of the scheme. The Structure of the proposed Scheme may be seen as follows:

8.2 **At the National level**, a National Task Force for Beti Bachao, Beti Padhao headed by Secretary, WCD with representation from concerned ministries namely Ministry of Health & Family Welfare, Ministry of Human Resource Development, National Legal Services Authority, Department of Disability Affairs and Ministry of Information & Broadcasting; Gender Experts and Civil Society representatives. The Task Force will provide guidance and support; finalize training content; review state plans and monitor effective implementation. A sub group would be constituted for a Joint Communication Action Committee (JCAC) with representatives from relevant ministries to work out the joint and comprehensive National Communication and Media Campaign. This would be convened every quarter.

8.3 The Scheme would be anchored by the Ministry of Women and Child Development, with the critical task of coordinating and monitoring Multi-Sectoral interventions. Concerned ministries would be responsible for ensuring relevant sectoral inputs for the effective implementation. MWCD will have the responsibility of coordinating the implementation of the scheme through the Women‟s Welfare Bureau. Technical inputs for the implementation and coordination would be extended by the Project Management Unit (PMU) supported by National Resource Centre for Women (NRCW), National Mission for Empowerment of Women (NMEW).

8.4 **At the State level**, the States shall form a State Task Force (STF) with representation of concerned Departments (Health & Family Welfare; Education; Panchayati Raj/ Rural Development) including State Level Services Authority and Department of Disability Affairs for Beti Bachao, Beti Padhao to coordinate the implementation of the Scheme. As the issue requires convergence & coordination between Departments, the Task Force would be headed by the Chief Secretary. In UTs the Task Force would be headed by Administrator, UT Administration. Some States/UTs have their own mechanism at the State/UT

level for Women‟s Empowerment, Gender and Child related issues which may be considered and/or strengthened as State/UT Task Force. Principal Secretary, WCD/Social Welfare will be the convenor of this body. Department of Women & Child Development will have the responsibility of coordinating all the activities related to implementation of the Plan in the State/UTs through the Directorate of ICDS. State Resource Centre for Women (SRCWs) will act as a Secretariat to provide technical and coordination support for implementation of the state action plan. A Gender expert/CSO member may also be included in the Task Force

8.5 **At the District level**, a District Task Force (DTF) led by the District Collector/Deputy Commissioner with representation of concerned departments (Health & Family Welfare; Appropriate Authority (PC&PNDT); Education; Panchayati Raj/ Rural Development, Police) including District legal Services Authority (DLSA) will be responsible for effective implementation, monitoring & supervision of the District Action Plan. Technical support and guidance for the implementation of Action Plan in the district would be provided by District Programme Officer (DPO) in the District ICDS Office for formulation of District Action Plan using the Block level Action Plans. A Gender expert/CSO member may also be included in the task force.

8.6 **At the Block level**, a Block level Committee would be set up under the Chairpersonship of the Sub Divisional Magistrate/Sub Divisional Officer/Block Development Officer (as may be decided by the concerned State Governments) to provide support in effective implementation, monitoring & supervision of the Block Action Plan.

8.7 **At the Gram Panchayat/Ward level**, the respective Panchayat Samiti/Ward Samiti (as may be decided by concerned State Governments) having jurisdiction over the concerned Gram Panchayat/Ward would be responsible for the overall coordination & supervision for effectively carrying out activities under the Plan.

8.8 **At Village level**, Village Health Sanitation and Nutrition Committees, (recognised as sub committees of panchayats) will guide and support village level implementation and monitoring of the plan. Frontline workers

(AWWs, ASHAs & ANMs) will catalyze action on ground by creating awareness on the issue of CSR, collecting data, dissemination of information about schemes/programmes related to girl child & their families etc.

8.9 **In identified cities/ urban areas**, the plan shall be implemented under the overall guidance & leadership of Municipal Corporations.

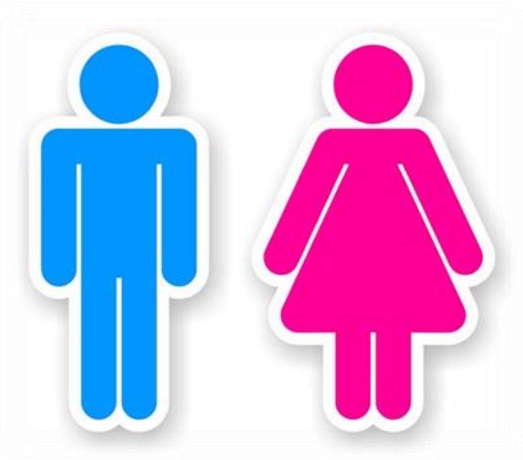
8.10 The Guidelines for District Collectors/Deputy Commissioners along-with suggestive template for district action plan are enclosed for reference.

9. Evaluation

The Scheme would be evaluated at the end of the 12th Five Year Plan to assess its impact and take corrective measures. Mapping of Ultra-sonography machines, baseline survey of concurrent assessment of % age of births of male & female child, reporting of complaints under PC& PNDT act will also help in assessing the impact or outcome.

GENDER

- Refers to the socially constructed roles and status of women and men, girls and boys. It is a set of culturally specific characteristics defining the social behaviour of women and men, boys and girls, and the relationships between them.



- Gender roles, status and relations vary according to place (countries, regions, and villages), groups (class, ethnic, religious, and caste), generations and stages of the lifecycle of individuals.

- Gender is, thus, not about women but about the relationship between women and men.

- Gender identities and associated expectations of roles and responsibilities are therefore changeable between and within cultures.

GENDER RELATIONS

- Refers to social relations between men and women. Major issues are power and hierarchy. How these relations are formed and supported by family, culture, state and market is an important consideration.
- Gender relations are *not static*; they vary across cultures and time. They are dynamic and *recreate* new ways in which masculinity and femininity are constructed and communicated in a particular context or period.

SEXUAL/GENDER DIVISION OF LABOR

- Societal pattern where women are allotted one set of gender roles and men another. This division is not based on skill, but on the basis of sex.
- The socially determined ideas and practices which define what roles and activities are deemed appropriate for women and men.
- *"Who does what work?"* is an entry point to understanding gender as a social construct.

GENDER ROLES AND RESPONSIBILITIES

- Gender roles and responsibilities are extensions of the division of labor, the key issue is the concept of "gender" (the social, not biological concept) and how different roles and responsibilities are assigned to men and women.
- The intersection of these gender roles and responsibilities with a development project's goals and activities is the focal point of a gender analysis.

GENDER-SPECIFIC NEEDS, INTERESTS AND PRIORITIES

- Refer to the fact that women and men have different roles and responsibilities, they also have different needs in order to fulfil them and they accord differing priorities to their needs.
- Shared and prioritised needs identified by women/men that arise from their common experiences as a gender.

GENDER EQUALITY

- Entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices.
- Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally.
- It does not mean that women and men have to become the same, but that their rights, responsibilities and opportunities will not depend on whether they are born male or female.
- In the Education Sector it is fairness and justice in girls' and boys' access to and benefits from education, and to include important qualitative as well as quantitative dimensions.

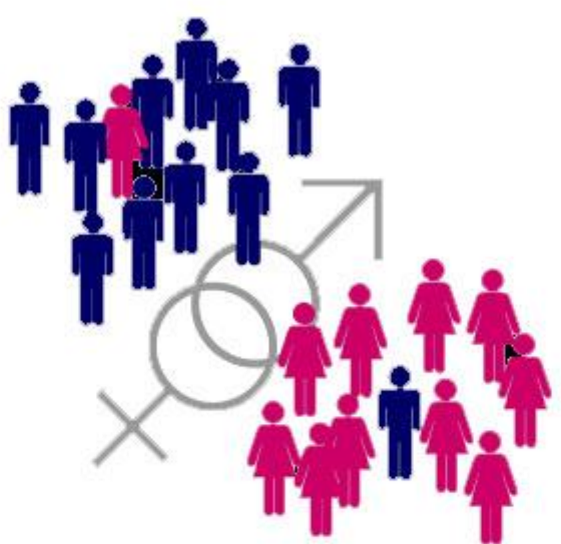
GENDER EQUITY

- Gender equity denotes the equivalence in life outcomes for women and men, recognising their different needs and interests, and requiring a redistribution of power and resources.

GENDER ANALYSIS

- Is a tool /set of tools to assist in strengthening development planning, implementation, monitoring and evaluation, and to make programmes and projects more efficient and relevant.
- The aim of such analysis is to formulate development interventions that are better targeted to meet both women's and men's needs and constraints.

- It takes into account important social and economic differences between men and women at all stages of the planning and implementation processes and makes it possible to identify potential differential effects before they are put into place.



- GBA challenges decision-makers to question the assumption that policies and programmes affect everyone in the same way.
- It is a basis for gender mainstreaming.

GENDER PLANNING

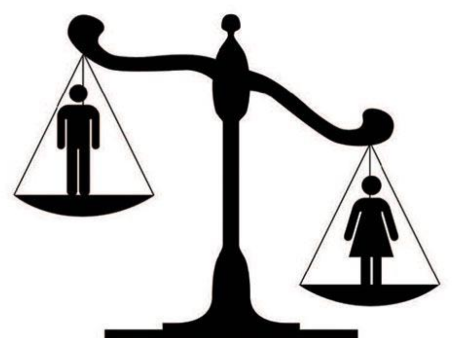
- The formulation of specific strategies, which aim to provide equal opportunities and benefits for both men and women.

GENDER MAINSTREAMING

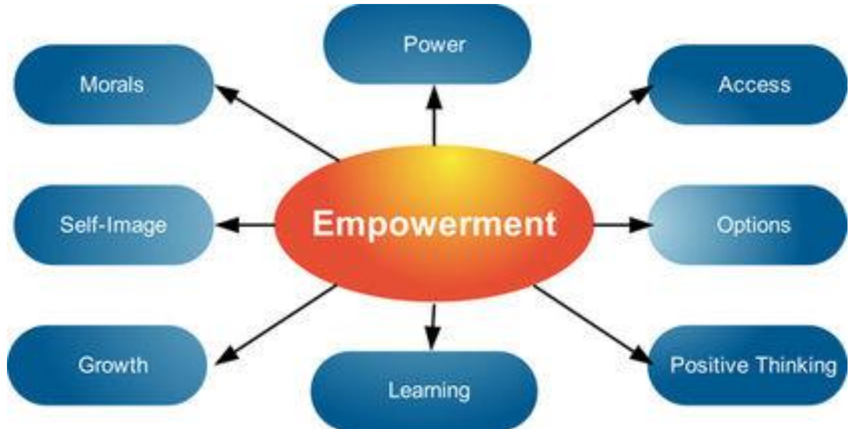
- Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels.
- It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.
- The ultimate goal is to achieve gender equality.
- This approach recognizes the need to take social and economic differences between men and women into account to ensure that proposed policies and programmes have intended and fair results for women and men, boys and girls.

GENDER DISCRIMINATION

- The systematic, unfavourable treatment of individuals on the basis of their gender, which denies them rights, opportunities or resources
- This involves systematic and structural discrimination against women in the distribution of income, access to resources, and participation in decision making.



EMPOWERMENT



- Implies people – both women and men – taking control over their lives by setting their own agendas, gaining skills (or having their own skills and knowledge recognized), increasing their self- confidence, solving problems, and developing self-reliance.
- It is both a process and an outcome.
- Empowerment implies an expansion in women's ability to make strategic life choices in a context where this ability was previously denied to them.

i. Village Convergence Facilitation Service (VCFS)

- Village Convergence and Facilitation Service (VCFS) is being implemented in selected districts to create awareness on issues affecting women and girls also linking women in need with the schemes/programs being implemented by the Central/State Government such as BBBP, Sabla, Jan Dhan Yojana, Swach Bharat etc. The activities in the select Gram Panchayats (GP) will be undertaken by Village Coordinators (volunteers) who will work in close coordination with the Gram Panchayats and

other sub-committees to address issues pertaining to education, health, nutritional needs, legal rights, safety and security of women. VCFS is being implemented in 100 BBBP districts.

- For the first year the service will be provided in 20 Gram Panchayats (GPs) in each of the selected 100 BBBP districts. The service will then cover another 20 GPs (in the same district) in the next year and another set of GPs during the following year. Thus, the services under VCFS will not be static in nature and is conceived to cover the entire district in a phased manner during the 12th Plan period.

II. **Village Convergence and Facilitation Service (VCFS) -**Step-by-step guide

Scheme: Facilitation services under VCFS are aimed to linking women in need with the schemes/programs being implemented by the Central/State Government impacting the lives of women such as BBBP, Sabla, Jan DhanYojana, Swach Bharat etc. Ground level services will specially focus on the activities at the GP level as listed under BBBP Scheme. Under BBBP Scheme Multi-Sectoral interventions in 100 gender critical districts with low CSR has been envisaged and activities under VCFS (NMEW) will converge directly with the structures and activities at the GP level.

- ***Identification of districts/Gram Panchayats/wards:***VCFS will be provided in 20 Gram Panchayats (GPs)/ wardsin each selected district (currently implemented in 100 BBBP distrcits). The identification of locations for the coverage under this service will be done in consultation with State Govt. /District Collector (DC/DM)/District Task Force under BBBP Scheme of the respective district.The service will then cover another 20 GPs (in the same district) in the next year and another set of GPs during the following year. Thus, the services under VCFS will not be static in nature and is conceived to cover the entire district in a phased manner during the 12th Plan period.
- ***Selection of Village coordinators/Volunteers under VCFS*:** The Village coordinators/Volunteers engaged under VCFS will be the focal point for activities. At the GP level Village coordinators /volunteers may be engaged who would be educated women from the local community. The primary role will be to facilitate convergence & coordination on ground and work in close coordination with the Gram Panchayats and other sub-committees to address issues pertaining to education, health, nutritional needs, legal rights, safety and security of women and will be focal convergence point for activities under BBBP Scheme.
- **Role & Responsibilities of the Village Coordinators:**

- Collection, compilation of databases from different sources related with resource mapping of the villages being covered by them and the target group of women.
- Mobilize women into joining collectives, strengthen existing collectives at village level.
- *Provide easy access to* informational and other resources to *the* community members for effective participation in Gram Sabhas and PRIs
- Organize community meetings through "*NaarikiChaupal*" to engage with community to build awareness about social issues, facilitate discussions on issues concerning women. The existing platform of Gram Sabha/Mahila Sabha/VHSNC/VHND may be used. Mobilize women to participate in Gram Sabha meetings.
- Undertake household visits to spread awareness about government schemes, programmes and services, motivate to join various programs meant for their development and help in improving access.
- Grievance redressal through articulation and follow-up cases in right forums such as Panchayats, OSCC, VHSNC/VHND. Bring issues affecting women as agenda before Gram Panchayats for suitable redressal.
- Coordinate with other field level functionaries of different Government programmes like Anganwadiworkers, ASHA's, ANM's for various activities.
- Facilitate convergence & access to women centric programmes through SHGs platforms
- Coordinate with other local Civil Society Organizations (CSOs)/Non-Governmental Organizations (NGOs) and their staff working in the same region to utilize opportunities for collaboration.

- *Situation Analysis/Baseline survey of Women & Adolescent Girls in Districts/GPs:* A format for conducting baseline survey will be developed/shared during the training program.

  A reporting format for VCFS will be shared during the training programme based on the following design:

Monthly Progress Report for the month of _ _ _ _ _ _ _ _		
Information on Convergence Forums (District, Block, Village level)		
1.	No. of Meetings of Convergence Forums held during last one month: i) District ii) Block iii) Gram Panchayat	
2.	Participation of Stakeholders in Convergence forum meetings at various levels i) Convergence Forum Members ii) Govt. Officials iii) NGO functionaries iv) District Officials v) Gram Panchayat (GP) members vi) Self Help Group (SHG) members vii) Any other	
3.	What were the Issues taken up at Convergence Forum meetings? Please elaborate as per the focus areas annexed below.	
4.	List the follow-up actions taken on the last Convergence Forum meetings.	
Information on Activities (District, block, village level)*		
5.	**Capacity-building/Training/ Sensitisation sessions held** 1) No. of sessions held: 2) Theme: 3) Nature of Participants/functionaries:	
6.	**Linkages and Network-building** 1) Stakeholder's meetings held: 2) Issues identified: 3) Follow-up actions:	
7.	**Community Engagement (** Community Meetings/ Focus Group Discussions/ Door-to-door approach) 1) No. of sessions held: 2) Theme: 3) Nature of Participants/functionaries	
8.	**Information, Education & Communication** 1) Scheme facilitation through Information desk -No. of people who visited information desk -No. of application forms filled-up for various schemes.	

	List the schemes -Status of forms filled 2) Other IEC activities undertaken. Pls. illustrate.	
9.	**Grievances redressal** 1) No. of cases reported: 2) No. of cases resolved: 3) No. of cases in process: 4) No. of cases pending:	
10.	Any other activities undertaken, pls. illustrate	
Enclose activity plan for the subsequent month		

III. Case Studies:

Step by Step Process to Guide - Village Convergence Facilitators to Strengthen Linkages of Women and Girls to All Schemes and Programmes

DEFINING AND ASSESSING INCLUSION THROUGH CONVERGENCE

The first essential step is to strengthen the participants understanding about "inclusion".

Ask the participants to reflect on one illustrative example of how 'inclusion' is fostered and enabled

You can share the following case study:

This is a narrative of exclusion
Lakmavva, 55 years, lost her husband 12 years ago in Meeraj. After the death of her husband she moved to Ramadurga Taluk of Belagavi District. Since he died in Meeraj, she was not able to apply for widow pension scheme as she needed to submit the death certificate to avail the scheme. She paid 500 rupees to a middleman when he assured to help her to get the death certificate from Meeraj. After the payment was done, he stopped attending Lakmavva's calls. When she pleaded, he started threatening as he knew that she could not do anything because there was nobody to support her.

Discussion points with the participants:

- Have we experienced or seen or heard about a similar situation?
- What are the reasons for Lakmavva's exclusion?
- Is exclusion the rule?

Let participants list down the various factors that propel exclusion. (poverty, illiteracy, disability, culture, identities) .

Classify the Exclusion as:
- Political
- Economic
- Social
- Cultural
- Any other

Initiate Group Work

Divide the participants into smaller groups of 3-4 each.

Task-Trace the Collective Journey of Inclusion
Let participants share their experience of facilitating "inclusion" or "access to schemes"
Let them re-cap the following steps::
1. Providing information to their peers or beneficiaries
2. Filling the application
3. Forwarding it to the department
4. Doing the necessary follow up
5. Scheme and its benefit reaches the applicant

Ask the participants to do the following
- Explore opportunities and challenges
- Learn from each other about tactics or processes that worked or did not work
- List out Tips on what should be done and what should be avoided

Present a Success Story to illustrate what worked

Problem

Mangal Hebbe, 55, residing in Tembhurni taluka, Solapur was told by the doctors that her 4 month old grandson had a congenital heart disease. He required immediate surgery otherwise his life would be danger. She met the Community facilitators and sought their help. The team of facilitators documented her case and started looking at options of getting her grandson treated. The most feasible option was to extend to her the benefit of the Rajeev Gandhi Jeevan Arogyadayi Yojana which meets all expenses for such critical surgeries. However, a further study of the scheme made the team realise that the surgery for a congenital heart disease was not covered under the scheme.

The team of facilitators started reviewing other schemes and finally located the not so well known scheme of Construction Labour Welfare Card. This was a scheme started by the Central Government to provide financial aid to children of construction labourers so that they could meet some of their immediate educational needs. Besides, it also provided medical insurance for critical illness and surgeries. The team of facilitators got to know that congenital heart disease was covered under it.

Once the scheme was identified, the next step was to get all documents of Mangal and her grandson ready. The most critical document was the yellow ration card meant for BPL families who were entitled for the said scheme. However, the challenge was that the surgery had to be performed within a few days time and processing all formalities for the ration card could take anything between one to four months.

Problem Solving

The team of fcailitators met the Food Distribution Officer (FDO), Solapur and shared Mangal's case with him. Jointly with the FDO and the team, a plan was chalked out to expedite the process of providing ration card to Mangal. As a provider, the FDO and his team had to ensure all formalities and compliances including the due diligence is in order and nothing gets compromised. As scheme facilitators, the team had to ensure that the ration card is done, Mangal is enrolled as a beneficiary and the benefits reach her in time.

The following steps were undertaken:

- It was decided that the form for ration card and construction labourers welfare card would be filled immediately for her. The form was filled within an hour's time after meeting the FDO
- Next came the task of arranging the documents. She had the voter's card for identity. A lease agreement for her rented house was done immediately that day with her landlord.
- The most critical document was the income certificate as a BPL beneficiary. The tehsildar was roped in and the income certificate was made the very next day.
- On the same day, the Zonal Officer and his colleague went to conduct the house verification visit. There they realised that her house actually fell into a different zone. Immediately, the FDO summoned the concerned zonal officer and he was asked to do the home visit immediately.
- The concerned zonal officer executed this task that day and submitted his report.
- With all formalities over within two days, the ration card was issued on Day three.
- On Day three the form for Construction Labours Welfare Card was submitted to the Revenue Department who enrolled Mangal as a beneficiary and extended the scheme to her.
- Her grandson is now admitted in the hospital and will be operated upon soon.

Open Discussion

- ❖ What did you learn from this case study?
- ❖ What is it that really mattered here - the immediate response by the team? Or the response of the FDO?

- Who do you think played a critical role? List down the role played by the provider and the team
- What was the turning point and who made it happen?

Explain: In the above incident, everything mattered. The immediacy with which the team of facilitators swung into action to the sense of leadership and responsibility to fast track the delivery of the ration card shown by the government officers, every process was significant. However, all actions were founded on the principle of how best to catalyse a Partnership and Convergence.

To effectuate social inclusion, a foundational aspect is create Partnership - between community and government and Convergence between all government departments.

ACHIEVING CONVERGENCE THROUGH COMMUNITY FACILITATORS

Explain: Key Features

The entire process comprises of many small steps that starts with applying leading up to the provider learning about or realizing the extent of demand for the scheme, understanding the needs and concerns of the applicant, processing the demand to its final delivery to the applicant

Through the team of Community Facilitators, CFAR ensure that the process is grounded in the community and made user-friendly.

We can use many ways to find out the demand such as surveys to list out beneficiaries and focus group discussion to identify specific needs

Strengthen the information and understanding of the community members on various schemes

Hold scheme education camps where all providers from the government and field come together to inform and enroll the community members

After this facilitate community member to apply conforming to all the necessary prerequisites of the scheme.

Each and every application that gets submitted gets systematically verified

The applications are sent to the concerned departments.

Follow up on the applications

Conduct review meetings (once in a month with the nodal agency - WCD and quarterly along with the District Collector) are done to take stock, address any gaps and fast track the process.

Day 1 Session 4

Role of Gram panchayat, PRIs and various monitoring committes in ICDS and VCFS

The success of any community based programme depends on active community participation.

Community participation is voluntary and democratic involvement of elders, local and religious leaders, institutions and organizations. It includes community action and decision - making in planning, implementation and monitoring of the programme which leads to self-reliance, ownership and sustainability of the programme.

Community refers to a village or a group of villages with families inhabiting them, who are dependent on one another in their day to day transactions of mutual advantages.

Community Participation is active involvement of people in planning, implementation and monitoring of any programme which is for their well-being. Community participation is not just utilization of services and being passive users.

Community Mobilization is the process of bringing together or empowering members of the community from various sectors to raise awareness on and demand for a particular development programme. It facilitates change and development taking into account the felt needs of the community and leads to community organization.

Community Organization is the process of organizing the community in such a way that they can identify and prioritize their needs and objectives, develop confidence and will to achieve them by finding resources through cooperative and collaborative attitude, practices and community participation.

WHO CAN BE INVOLVED

1. Panchayati Raj Members
2. Sarpanch
3. Religious & Local Leaders
4. Mahila Mandal
5. Youth Club Members
6. Self Help Groups

Community members have an important role to play in Govt. Programmes

TABLE: ROLE OF COMMUNITY MEMBERS

COMMUNITY MEMBER	MAJOR ROLE
Gram Panchayat	• Planning and Promote delivery of services and advocacy • Monitoring and Implementation
Adolescent Girls	Assist Govt. functionaries in delivery of services, and other advocacy and BCC/IEC material preparation
Mahila Mandal Pradhan	Encourage women to participate in the activities of the programme and utilise services
Primary School Teacher	Encourage community, children and their parents to participate and avail services of the programme
Religious and Local Leaders	Mobilize and organise community participate in Programme
NGOs	Support services to run the programme effectively

India is one of the largest and most vibrant democracies in the world enjoy a unique place in the world. The world famous definition of democracy, "Government of the people, by the people, for the people" becomes meaningful when democratic practices actually percolate to the grass roots level. The emergence and evolution of Panachayati Raj system in India has in fact paved the way for further strengthening our democratic roots. After the 73rd amendment of Indian Constitution, made effective from April, 1993 has institutionalized the Panchayats as the unit of local self-government. The two decades of Panchayati Raj system has brought about tangible improvements at the grass root level. The PRIs have emerged as the institutions of self-governments which enabled people's participation for vulnerable section of the people. PRIs in order to function as institutions of local self-government, the panchayats have to fulfill basic conditions namely (a) institutional existence in the sense that the decisions are taken by the people's representatives; (b) institutional capacity that these institutions have clearly defined functions, functionaries and finances. The effort of the Ministry has been to strengthen the capacity of the Panchayats in delivering services and support States to devolve powers and promote transparency and accountability. The Panchayats are critical in preparation of context specific plans to address poverty, local infrastructure, and other socio- economic needs.

The involvement of the people in their development through grass-root democratic institutions like Panchayat Raj institutions (PRIs) ensure good governance. Good governance fosters the foundation of people's participation and empowerment of poor. ICDS is a community based programme and its success depends on active participation of the people. ICDS strives to improve the capabilities of the parents to look after their children by encouraging the community for improving the quality of life and wellbeing of the child and family. ICDS being a community

based programme which calls for community participation in its implementation through utilization of local resources. ICDS lays great emphasis for bringing about social change in the community by increasing awareness, change in attitude, beliefs and practices of the community members through proper utilization of services.

- Panchayati Raj Institutions bring changes in the socio-economic aspects of life in rural India. Effective functioning of the PRIs depends on active involvement, contribution and participation of its member both male and female.
- Panchayats at all levels help in promoting integrated community-based monitoring of all developmental programmes. They help ICDS functionaries in forming & strengthening Mahila Mandals.
- Panchayats are capable of playing a major role by promoting the participation of communities, in understanding the needs of children and women and finding local ways to respond to the same.
- Three tiers of Panchayati Raj System- **Gram Sabha, Gram Panchayat and Nyaya Panchayat (village level setting)** are active at different levels for ensuring planning, designing, implementing and monitoring of any developmental programmes**.**
- **Gram Panchayat**: facilitates activities like sanitation; conservancy; water supply; construction and maintenance of roads, bridges and drains, establishment and maintenance of hospitals and dispensaries; promotion of agriculture, cooperation, cottage industries, etc.; maintenance of markets cattle pounds; provision of schools and libraries; preparation of village plans; and identification of 'agency' for functions assigned by higher tiers and few regulatory functions.
- **Panchayat Samiti (Block level):** Planning and execution of developmental programmes concerning agricultural, animal husbandry, irrigation, cooperation, cottage-industries, education and social education, public health and rural sanitation, inter village communication and social welfare; functions assigned by zila parishad and state government.
- **Zilla parishad (District level):** Advise government on development schemes, classify markets, roads, etc.; advise, supervise and coordinate functions of samitis and approves samiti budgets.
- The Gram Panchayat can help create a supportive environment for childcare, by enlisting better teamwork from frontline workers (ANMs, AWWs, school teachers), to ensure convergence of services
- Gram Sabha has the responsibility of mobilising voluntary labour and contribute in kind and cash for the community welfare programmes and also identify beneficiaries for the implementation of development schemes pertaining to the villages.
- Rural people need to ensure that the Panchayati Raj bodies are able to mobilize resources from different sources so that these bodies can work for the socio economic development of the areas.

- Panchayati Raj Institutes should ensure that all the sections of the society particularly weaker section including women and girl child & particularly SC/ST get adequate opportunity for availing services.
- Panchayats need to maintain good communication channels with the hospitals and provide facilities to available referral services.
- Voluntary groups, Community Based Organizations, NGOs, Religious Organizations and other agencies should be encouraged by PRIs for effective implementation of development programmes.
- PRI provides for one-third reservation of women at all three tiers. This indicates active participation of women would be of a great opportunity for rooting more developmental programmes in the community.

Challenges faced by the Functionaries in involving PRI Members

One of the ways adopted by the government has been seeking the help of Panchayats in acquiring village land so that a sub centre or PHC or AWC can be built there. The selection and appointment of the AWWs at village level was also done with participation of Panchayat. Besides that many challenges confronted by the AWWs in getting support of PRI includes-

- ✓ Lack of awareness among PRI members about different services rendered by AWWs at the AWCs.
- ✓ Majority of the Panchayat leaders don't participate in meetings convened by the AWWs due to lack of time, not informed, lack of knowledge, other engagement and may be low priority accorded to ICDS.
- ✓ Political interferences in AWC's activities jeopardize ICDS activities.

❖ **Roles of PRI members in the Anganwadi Level Monitoring and Supervision Committee**

The Ministry of Women & Child Development vide its circular dated 31st March, 2011 cited about the constitution of various monitoring committees for monitoring of different activities of AWCs at the village level. The committee will review and take / suggest delivery of services at the AWC. The Committee is authorized and expected to play the following roles:

- ➢ Check regularity of functioning of AWC; ensure coverage of all eligible beneficiaries as against the surveyed population;
- ➢ Review status of supply of supplementary food to all beneficiaries for at least 21 days in a month;
- ➢ Review nutritional status of children 0-3 years and 3-6 years, weighment, availability of WHO New Growth Charts and joint mother and child protection card; and number of moderate and severely undernourished children and steps taken;

- Review functioning of non-formal PSE – activities per day, development / use of local learning and play materials; organisation of parents meet; etc.

- Ensure participation of AWWs at VHSC meetings;

- Ensure participation of at least one of the members (other than AWW, ASHA and ANM) on the monthly Village Health and Nutrition Day at each AWC and to ensure that it is well-organized and well attended, and that all due services are rendered on that day;

- Review facilities available at the AWC in the light of established norms (Infrastructure including clean water, functioning toilet, play area, PSE / medicine kits, cooking utensils, etc); [The Committee may consider ways of locally strengthening the AWC infrastructure mobilizing resources from the community / other schemes]

- Review receipt and utilization of consumables such as food supplements and medicines as well as physical stocks; find reasons for any shortfall from expected norms, or discrepancies in stocks; document and report such shortfalls and discrepancies to the Block level Monitoring Committee and CDPO; attend to any local disputes related to the AWC or AWW, and resolve such disputes amicably; flag unresolved disputes to the Gram Panchayat or Block level Monitoring Committees;

- Interact with the AWW / ICDS Supervisor to understand reasons for any short falls in services provided at the AWC, and find ways to locally strengthen services or correct shortfalls; formally document and report unresolved issues to the Block Level Monitoring Committee with a copy to CDPO, MO /PHC and Gram Panchayat as appropriate and concerned.

- Any other matter as may be relevant for improving service delivery.

- **Strategies to strengthen PRI support in ICDS**

  - Involvement of NGOs, CBOs, social workers and other influential members such as religious leaders, youth groups, and local mahila representatives etc., for organizing awareness camps for the community and invite the PRI members to attend the same.

  - Women should also be encouraged to participate in the activities of ICDS, Mahila Mandals can play a role in the proper implementation of ICDS programme.

  - The guidelines issued by the departments must be shared with the Panchayat members for gaining of knowlge so that implementation of any development programme should not suffer. PRI members should avoid political favoritism and nepotism so that the common man should not suffer.

- ICDS functionaries should approach panchayat representatives for material help and resolve the issues confronted at the village level amicably.

- Panchayat representatives should be consulted at the initial stages of project planning for decisions regarding selection of site, identification of AWWs and helpers, etc.

- The services of ICDS should be regular and meet the demands of the community.

- The services of ICDS and other matters relating to AWCs must be discussed in the Gram Sabha Meeting so that Panchayat members should have broader understanding of the issues.

The restructured and strengthen ICDS has reiterated to strengthen governance by involving PRIs and Urban Local Bodies (ULBs) through its 73 and 74 Constitutional Amendments. The ICDS Mission has also envisaged an important role for civil society network, NGOs/ CBOs, institutions and voluntary action groups. A norm of implementing up to 10 per cent Projects in every State would be recommended for implementation by the above organization through MOU route. The ICDS Mission has emphasized the greater involvement of PRIs for effective implementation of ICDS programme. In this regard States are encouraged to –

- ✓ Support facilitative and supportive supervision for ensuring entitlements and services and bridge local gaps in meeting the essential needs of AWCs.

- ✓ Acknowledge and understand critical needs of early childhood and maternal care and support systems and ensure providing an enabling environment free from discrimination, violence and biases to work towards removal of social barriers with knowledge, sense of duty and purposes.

- ✓ Give greater roles, responsibilities to PRIs and ULBs with measures for ensuring their greater involvement, participation and accountability for effective implementation of ICDS programme at village level.

Inter-departmental convergence:

The implementation of IGMSY requires close coordination with the following Departments for:

a) Health Department:

i. Ensuring services and counseling is given during VHND and women are motivated to avail benefits of this Scheme.

ii. Promoting early initiation of breastfeeding, colostrum feeding and exclusive breastfeeding for first six months as part of the JSY package.

iii. Ensuring availability of IFA tablets and vaccine supply to meet the increased demand.

iv. Ensuring MCP cards are available and used.

v. Organizing sensitization and training programs for IGMSY for all concerned staff.

vi. Organizing joint community mobilization activities, especially during Breastfeeding Week (1-7 August), National Nutrition Week (1-7 September), etc besides any other such events.

Panchayati Raj Institutions:

i. Organizing community awareness events.
ii. Providing additional incentives to mothers through their own funds.
iii. Conducting social audits/addressing grievances.

c) Information / Public Relations Department: Publicity and mass reach through- All India Radio, Song and Drama Division, Directorate of Audio Visual Publicity (DAVP), Division of Field Publicity, State IEC Bureau, Print Media, Regional TV channels, etc.

d) Lead State and District Post Office/Banks: for opening of no frill accounts with zero balance for IGMSY beneficiaries and devising appropriate cash transfer mechanism for smooth transactions in 52 selected districts.

e) State Training Institutes/Medical Colleges for ensuring their training curriculum includes training on IGMSY.

Role of Mahila Mandals in ICDS Programme

Mahila Mandal is a community based rural organization consists of group of women (around 20) joined together to form a mandal where they share common set of interest and abide by the group ideology and norms. Since the women were from the same socio economic backgrounds, it is obvious that they develop a sense of "**we**" feeling and try to address the social challenges or issues confronted by the women folk in the locality in an effective manner. Mahila Mandal being the influential women group most often strives for economic, social and political up-liftment of rural women.

Mahila Mandal is a village level forum for women to discuss their personal, social, political, and economic concerns. The Mahila Mandal continues to be the hub where women play a crucial role in strengthening these groups. Women members try to strengthen themselves and families and finally develop their own communities and villages. Many women become empowered by this process; inculcate new strengths not only to help themselves, but those around them. The true asset of the Mahila Mandals has been their ability to think together and be together. The Mahila Mandals always meet at least once a month in order to analyze their problems and find applicable solutions within their limited resources. Such solutions often contribute to the betterment of the lives of the Mahila Mandals' members and the community in which they live.

Objectives of Mahila Mandal

- Enable rural women to realize their innate potential individually and work collectively.

- Provide a forum for rural women to discuss their personal, family, social, economic as well as political aspects of their lives.
- Thoroughly addresses issues such as social justice, poverty, health, education, protection, etc., through empowerment of rural women.
- Empower women to make transition from the sense of insecurity to security.
- Creating awareness among rural women about local problems, challenges faced by them and try to prioritize these challenges as per their felt needs.
- Develop strategies to networking with other local institutions for attainment of optimal rural development.
- Explore possibilities to make the rural women economically stable through creation of opportunities and market their products for better economic growth by linking with Self Help Groups for micro-credit.

Role of Mahila Mandal in ICDS has been important in many ways -

- Mahila Mandals play a key role in consolidating and strengthening rural women's movement, for creation of pressure groups to avail services at AWC.
- Involvement of Mahila Mandal in the activities of Anganwadi would facilitate its smooth functioning.
- Mahila Mandal can be involved in construction and maintenance of Aanganwadis, contribution to supplementary nutrition, supervision at Anganwadi activities.
- Mahila Mandals can create a message chain to spread news about risk conditions to vulnerable groups.
- The Mahila Mandals will create awareness and helping to identify community needs & mobilize resources for support mechanisms to AWC.
- Mahila Mandal Pradhan can also help in encouraging women to utilize ICDS services and participate in activities at AWC.
- ICDS functionaries can also guide the activities of Mahila Mandals at the village level and spread awareness on social evils like dowry and female foeticide and promote women education in the rural areas to combat the same.
- Many project functionaries share the view that village panchayat and Mahila Mandals can give meaningful support to the Anganwadis and must have greater ownership of ICDS activities for which special drive can be launched to raise resources and mobilize support for ICDS at the village and block levels.

- To participate in programme of income generation for women & adolescent girls & credit & thrift activities.

- To help in up gradation of skills of women & adolescent girls & marketing the products of SHGs.

- To coordinate with Block Level Officers for better convergence of services on women & child related issues in the community

SOCIAL AUDITS/ ADDRESSING GRIEVANCES

i. A grievance can be defined as any sort of discontent/dissatisfaction, which needs to be redressed in order to bring about the smooth functioning of the Scheme. Some indicative examples of grievances could be:

- No services provided by the AWW/AWH/ANM
- Irregular (delayed or short) payments of the installments to the beneficiaries
- Exclusion of some beneficiaries owing to caste/class/personal bias
- Victimization
- Corruption

ii. The States may consider setting up a formal grievance redressal mechanism at project and district level for handling complaints, determining the time limits and responsible units for addressing complaints and taking necessary action. Existing grievance redressal units, e.g., Collector's grievance redressal unit / Zilla Parishad Council at district-level, may be considered for addressing grievances related to this Scheme.

iii. Issues and grievances related to the Scheme should be discussed in the meeting of the Village Health and Sanitation Committee (VHSC) or Village-level IGMSY Steering and Monitoring Committee and forwarded to the project-level steering and monitoring committee for necessary action.

iv. Entitlements under the Scheme, eligibility criteria and list of beneficiaries should be pasted at the AWC to maintain transparency. Further for Social Audits, IGMSY should be an agenda point during the Gram Sabhas. Wherever possible, special Women Gram Sabhas (Mahila Sabhas) may be convened by the Women Sarpanch/Panchayat member. During the Mahila Sabhas, names of IGMSY beneficiaries should be informed to the community members by the Anganwadi Worker/member secretary of Village-level IGMSY Steering and Monitoring Committee. Representatives of Bank, Post office and District IGMSY cell may also be invited to these meetings. Mahila Sabha meetings may be held twice a year.

v. In areas where Mahila Sabhas are not in existence, the IGMSY Steering and Monitoring Committee at village-level may hold such a meeting by inviting community members.

- Social Audit is a process that collects information on the resources of an organization. The information is analyzed and shared publicly in a participatory fashion. Although the term "Audit" is used, Social Auditing does not merely consist in examining finance. The central concern of a social audit is how resources are used for social objectives.
- The underlying idea of a social audit is directly linked to the concept of people's participation in the developmental activities. Social Audit examines the impact of government activities – policies, programmes or services on certain section of the society.

- A social audit is a process by which the people or the beneficiaries of any scheme or developmental programme, policy or law, are empowered to audit such schemes, programmes, policies and laws. A social audit is an ongoing process by which the potential beneficiaries and other stakeholders of an activity or project are involved from the planning to the monitoring and evaluation of that activity or project. It thereby tries to ensure that the activity or project is designed and implemented in a manner that is most suited for the prevailing (local) conditions, appropriately reflects the priorities and preferences of those affected by it, and most effectively serves public interest.

- A Social Audit is a process conducted by the people in coordination with local administrations to enable the people to have the details on resources (finance and non-finance) are being used by public agencies for developmental initiatives. Social audit is usually done in the form of a public platform (forum).

- To put it in a simpler way, social audit can be described as checking and verification of a programme/ scheme implementation and its results by the community with the active involvement of the primary stakeholders.

- Social audit covers the quantity and quality of works in relation to the expenses incurred/ disbursement made, number of works/ materials used and also selection of works and location of works. The aim is effective implementation and control of irregularities. Administrative machinery should extend full support in carrying out a social audit by the community.

- Social audit is a community driven tool for enhancing transparency and accountability. It explores misappropriation, corruptions and exposes the perpetrators of wrong deeds and makes them accountable in the public forum.

- The social audit can be used to manage a project in the village at a given time. The social audits carry out the following activities like-

- produce information that is perceived to be evidence-based, accurate and impartial,
- create awareness among beneficiaries and about local services providers,
- improve access to information concerning government activities to the community members,
- valuable tool for exposing corruption and mismanagement,
- permit stakeholders to influence the behavior of the government, and
- Monitor progress and help to prevent fraud.
- It helps in raising voices by the public and provide opportunity for good governance

Objectives of Social Audit

The objectives of social audit are as follows-

- Accurate identification of requirements
- Prioritization of developmental activities
- Proper utilization of funds
- Conformity of the developmental activities with the stated goals
- Quality of services

Principles of Social Audit

The basic principles of social audit are -

- **Transparency**: Complete transparency in the process of administration and decision-making, with an obligation on the government to (voluntary disclosure of information) give the people full access to all relevant information.

- **Participation:** A right based entitlement for all the affected persons (and not just their representatives) to participate in the process of decision making and validation.

- **Accountability**: Immediate and public answerability of elected representatives and government functionaries, to all the concerned and affected people, on relevant actions or inactions.

- Social Audits can be both monitoring and evaluation tools- **A monitoring tool:** A social audit is a critical monitoring tool and it can be taken during the implementation and also after the implementation to assess the end results. **An evaluation tool:** A social audit is carried out jointly with government functionaries/external agencies and by local communities could be termed as participatory evaluation. Social Audits bring integrity to stakeholders.

Who would conduct Social Audit

Social Audit is conducted by the community of stakeholders. The stakeholders include beneficiaries / participants, implementing agency, Gram Panchayat representatives etc. The entire Gram Sabha is expected to participate in Social Audit. It is not always possible to voluntarily form a group with encouragement by panchayats, representatives from beneficiaries, SHGs, village level organizations etc., the respected local/ community leaders, youth clubs, marginalised sections (SC/ST/Women) etc., would form the part of social audit and present their findings in the Gram Sabha.

The benefits of conducting social audits are – generating awareness among beneficiaries about the programme; monitor the programme implementation and suggest corrective measures; assess the impact of the programme to achieve the goal; and constitute grievances redressals and follow up of the corrective actions.

Monitoring, Review and Evaluation under ICDS Mission

Community Based Monitoring of ICDS services is a key strategy to ensure that the services reach to those for whom they are meant. CBM would address the gaps in the implementation of services and enhance transparency at the grass root level. It is also being seen as an important aspect for promoting community-led action. Under ICDS mission monitoring would be carried out at all levels like AWCs/ village, block, district, state and national level through standardized format by clearly defining input, output and outcome indicators. To improve public accountability and transparency in ICDS programme, in consistence with sevottam compliance and citizen's charters four major community based mechanisms have been introduced for monitoring of child related outcomes.

(a) Introduction of Common Review Mission (CRM) – It would be conducted on the lines of National Health Mission as three core services such as immunization, health checkups and referral of ICDS being provided by health department through AWCs. The recommendations of the joint CRM would provide mid course correction in the programme design and provide feedback to the National and concerned State ICDS Mission.

(b) Jan Sunvai- The monitoring group comprise of a mix group of National, State and District level (different districts) officials and members of Voluntary Action Group would visit a defined sample of hot- spots/areas repeatedly reporting higher numbers of moderate and severely underweight cases. These team members would conduct quantitative and qualitative analysis of planned intervention, gaps and further measures required improving the child development outcomes and impact. In this regard the team members would carry out public interaction and focus group discussion with members of families and communities. The team would prepare and submit an analytical report with recommendations to the district, state and National ICDS mission.

(c) A Community Owned Accreditation System- In order to ensure quality standards in child care service delivery at different levels, ICDS mission has envisaged to do rating/ grading

of the service delivery points such as AWCs, health sub centre at village, block, districts based on health, nutrition and development outcomes. These service points would be awarded or given community recognition in line with Nirmal Gram Puraskar (TSC) for high performing Panchayat, Blocks, Districts and States. The high performing districts would be "living Universities" for learning by other districts/states.

(d) ***Community Disclosure and Public Information***- The community level indicators of ICDS – attendance of children, moderate & severely underweight, eligible beneficiaries, core services would be tracked at the village level and prominently displayed at the outside of the AWCs, health sub centre and Gram Panchayats. The community chart would be updated on fixed monthly Village Health & Nutrition Days (VHNDs) and should be based on Mother and Child Protection Card.

Village Convergence Facilitation Service (VCFS)

- Village Convergence and Facilitation Service (VCFS) is being implemented in selected districts to create awareness on issues affecting women and girls also linking women in need with the schemes/programs being implemented by the Central/State Government such as BBBP, Sabla, Jan Dhan Yojana, Swach Bharat etc. The activities in the select Gram Panchayats (GP) will be undertaken by Village Coordinators (volunteers) who will work in close coordination with the Gram Panchayats and other sub-committees to address issues pertaining to education, health, nutritional needs, legal rights, safety and security of women. VCFS is being implemented in 100 BBBP districts.
- For the first year the service will be provided in 20 Gram Panchayats (GPs) in each of the selected 100 BBBP districts. The service will then cover another 20 GPs (in the same district) in the next year and another set of GPs during the following year. Thus, the services under VCFS will not be static in nature and is conceived to cover the entire district in a phased manner during the 12th Plan period.

Thematic Projects

- 46 Thematic Pilots across the country on diverse women's issues have been operational and are undertaking activities in collaboration with NGOs, Academic Institutes. In the mode of convergence, NMEW has also taken forward research projects on themes such as social inclusion and economic empowerment of women.

DAY 2

VISIT TO OBSERVE FUNCTIONING OF VILLAGE CONVERGENCE FACILITATION SERVICES (VCFS), PALI, RAJASTHAN- A REPORT

15 December 2015

National Institute of Public Cooperation and Child Development

BRIEF REPORT OF VILLAGE CONVERGENCE FACILITATION SERVICES (VCFS), PALI, RAJASTHAN

A team from NIPCCD visited Pali District of Rajasthan on 15th December 2015 to get a detailed insight on the functioning of Village Convergence Facilitation Services at Pali district of Rajasthan.

Setting up the context

National Mission for Empowerment of Women (NMEW) aims to strengthen inter-sectoral convergence and facilitate the process of coordination of all the women's welfare and socio-economic development programmes across ministries and departments. The NMEW is piloting the 'convergence model' across the country with the aim to bridge the gap between demand and supply of women-related services by creating greater awareness about women based schemes and programmes of the Government, augment the demand for various services/schemes for women and connect them with the service providers. Under this scheme government has initiated the first contact point for woman at the village level which is known as the Poorna Shakti Kendra (PSK) or Village Convergence Facilitation Services Centre (VCFS).

PSK is the focal point of action on ground through which the services to grassroots women would be facilitated. Each VCFs comprise village coordinators to listen the problems and difficulties of local women and try to solve the problems through establishing coordination with other departments. Village coordinators at the Kendras reach out to the women with the motto "HUM SUNENGE NAARI KI BAAT". The model includes introduction of convergence-cum-facilitation centres for women at district, tehsil/block and village levels. The first such pilot convergence project was launched in Pali district in Rajasthan on 16 September 2011 with the opening of 150 village-level centres.The PSK is the focal point at grassroots level through which the services to women would be facilitated by the Village Coordinators with the motto **Hum Sunenge Naari ki Baat!**

Pali District, Rajasthan

The Pali district of Rajasthan comprises 11 community development blocks and 320 Gram Panchayats. There are 1829 operational AWCs catering the needs of women and children of 1012 villages of Pali district. The VCFS are not operational in all Gram Panchayats. There are only 150 VCFS centre in the Pali district and the Village Coordinators of each VCFS covers on an average 3 - 4 village for providing different services to the women through different government programme. It is evident that the VCFS are not operational all GPs of Pali district. The table given below shows the number of VCFS centres distributed across Pali district.

Name of the Block	Number of VCFS
Pali (Rural)	23
Bali	14
Sojat	13
Jaitaran	12
Rohat	11
Marwar junction	12
Sumerpur	29
Raipur	13
Rani	11
Desuri	12
Total	**150**

Functions of PSK

- To provide information to women about all government programmes/schemes/ services and help them utilizing those benefits provided by the Government. Further, it facilitates the extending benefits to women related to health, education and livelihoods at the village level.
- To enhance capacity building of women on various issues like leadership qualities, crisis management, stress management, life skills development, legal rights & entitlements etc., in order to create awareness and increase their knowledge & skills.
- To maintain a database of target population (women) on various issues and programmes related to women
- To coordinate with the outreach service providers of various departments.
- To organize women into clusters to access various services and to strengthen SHGs.

In order to have a deeper understanding about the convergence model being implemented in Pali district of Rajasthan, a team of Faculty Members of NIPCCD visited various VCFS centre on 15th December, 2015. The centres visited by them and the name of the village coordinators are given below-

Sl. No	Name of VCFS	Name of Village Coordinators
1	Giradarha	1. Ms. Bali Sen 2. Ms. Meenakshi
2	Rupawas	1. Ms. Sugna Devi 2. Ms. Gundi Devi
3.	Dayal Pura	1. Ms. Neema Garg
4.	Bhanwari	1. Ms. KushumLata
5.	Singari	1. Ms. Son Kanwar 2. Ms. Manju Patel

During the visit, care was also taken to interact with more village coordinators of different VCFS to understand the concept of PSK model, its mechanisms, roles and responsibilities and strategies to generate awareness about different schemes run by the government. The details of village coordinators who are contacted for group discussion are given

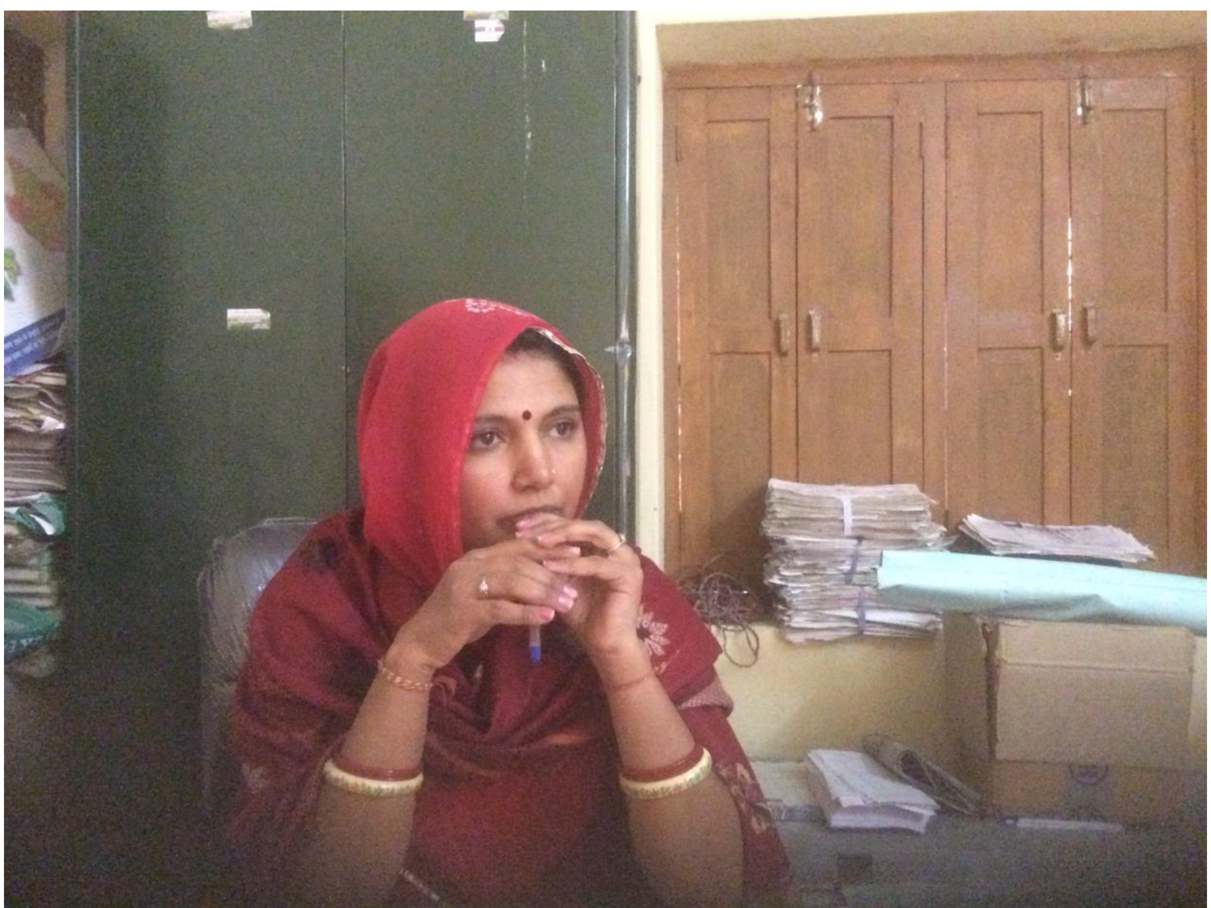
at annexure- I. During the day of visit, the team interacted with the Village Coordinators, women beneficiaries and the Programme Officer (Women Empowerment) to understand the salient features of VCFS, works undertaken by them, constraints or difficulties faced while conducting Mahila Sabha, Nari ki Chaupal and rendering different services.

Village Coordinators:

The village coordinators are the local women selected by the District Magistrate through Interview and they are given an honorarium of Rs. 4,000/- to carry out different activities for empowerment of women through mechanism of convergence. The Village Coordinators are expected to -

- Generate awareness about Central and State Government programmes or schemes in the context of women empowerment.
- Mobilise the community to create demand and avail such services.
- Conduct household visits to spread awareness about government schemes, programmes and services.
- Motivate people to extend their cooperation in accessing, availing various programmes meant for their welfare and help them in improving access and availability of services.
- Coordinate with other field level functionaries like Anganwadi Workers, Accredited Social Health Activists (ASHA) and ANM for various activities and establish contacts with other civil society bodies, non-government organisations and their staff to utilise opportunities for collaboration.

In Pali district, there are 150 VCFS and out of which only 140 are functional. In each VCFS, two Village Coordinators/ Gram Samanwayaks have been appointed to carry out different activities at the village level. It was further stated by the Programme Officer that some VCFS are being managed by only one Village Coordinator because of getting better employment opportunities in School or other services.



Educational Qualification& Selection Criteria:

The village coordinators are the women members residing in the same or nearby village to provide assistance to the women with regard to awareness generation about different schemes, services or programmes being implemented by the governments. The basic minimum qualification for the selection of village coordinators is Intermediate. During the visit to the visited VCFS, it was found that majority of them were Graduates and Post Graduate with B. Ed. The vacancy positions for Village Coordinators are advertised in the local newspapers and the selection is based on interview under the Chairmanship of District Magistrate.

Training of VCs

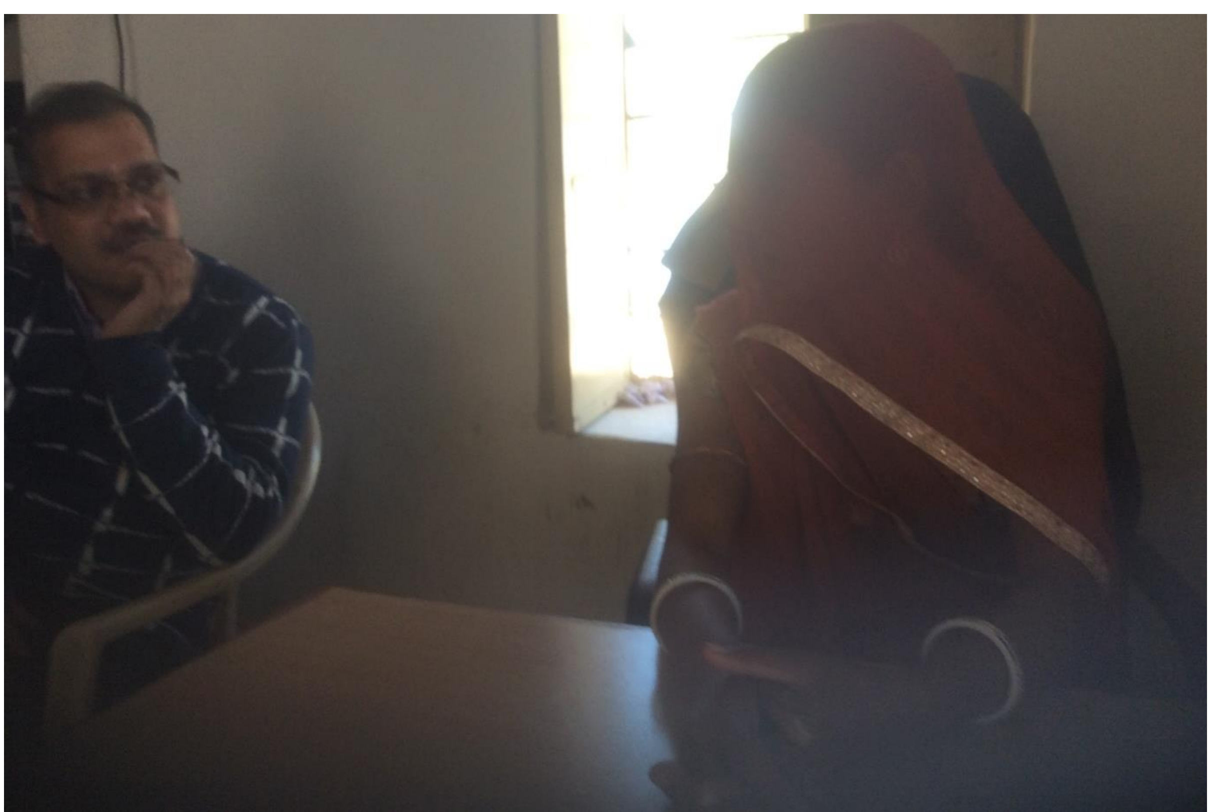
All Village Coordinators have received orientation training for seven days at Hingabas, Pali. The Shani Dham Trust organised the orientation training for the Village Coordinators. The major issues discussed in the training were - *Yoga, use of computer, BetiBachao, Janani Suraksha Yojana (JSY), Subhalaxmi Scheme, BPL Putri Vivah, Beti Janmostava, Pradhan*

Mantri Arogya Yojana, Arogya Rajasthan, mainstreaming dropout children in school education, PWDV Act, SHGs, Child Marriage, Pt. Deen Dayal Kaushal Yojana etc.

The training was imparted mainly through lecture cum discussion method. The VCs reported that they lack detail knowledge regarding issues or schemes being discussed in the training. They don't have requisite circulars, guidelines and other materials for further references.

Strategies for Implementation

The VCFS centre is mainly located in the Gram Panchayat Office adjacent to Atal Sewa Kenda. The village coordinators have been allotted a room in which they keep their essential records and registers and conduct different activities pertaining to the schemes or programmes being implemented from time to time by the State Governments. The village coordinators also establish linkages with other field functionaries like – Sarpanch, Upa Sarpanch, Ward Panch, AWWs, ANM, ASHA and Teachers. They keep liason with field level Institutions like Gram Panchayat, AWCs, Sub centre, Schools, SHGs etc. for generating awareness and facilitate linkages.



Mahila Sabha

The Village Coordinators organize different meetings with the women groups comprising of elderly, pregnant & lactating women, adolescent girls of the village. In the Mahila Sabha, discussions are focused on different social issues and various government programmes with the view to create awareness among women to enable them for attaining better livelihood and sustain empowerment. The meeting empowers the women members to generate demand for the services and how these demands to be fulfilled through provision of supply mechanism at the field. During the visit, the team members got the opportunity to attend one Mahila Sabha, where issues of “Swachhata” were discussed in detail. It was observed that the village coordinators were able to communicate the contents and address the questions raised by the women members during the meeting.

The interaction with the women members of Mahila Sabha revealed that they got benefited from the meeting. The benefits included - increasing knowledge, understanding the social issues, various provisions about government schemes, raising voice to fulfil the needs etc.

Nari Ki Chaupal

It is a form of meeting organized once in every month in the villages where the village coordinators along with other field functionaries listen to the problems confronted by the women groups with regard to their fulfilment of their basic needs and create awareness about different services of government programmes. The dates for meeting have been fixed on 5th, 12th, 20th and 27th of every month. The village coordinators organize Nari ki Chaupal meeting in given dates in villages covered under the Gram Panchyat. In Nari ki Chaupal, field functionaries like AWWs, ANM, ASHA and peoples representatives like Sarpanch, Upa-Sarpanch, Ward Panch, Teachers etc., remain present to resolve the grievances raised by the villagers. The month wise topics have been assigned by the departments to generate discussion in the meetings. The details are given below-

Months	**Issues to be Discussed**
First	Beti Bachao
Second	Nirmal Bharat Abhiyan
Third	Vaccination and Malnutrition
Fourth	Mainstreaming the Dropout Children in School
Fifth	Social issues (Child Marriage)
Sixth	Female Foeticide
Seventh	New admission for children in school
Eighth	Balika Mahostava/ Beti Janmostava
Ninth	Beti Bachao
Tenth	Swachhata Abhiyan (Construction of Toilets)
Eleventh	Bhamasha Card
Twelfth	Opening bank accounts and SHGs credit linkages

Advocacy Campaign

The roles of VCs being generating awareness among village women about different services and programmes of government, but the mechanisms of generating awareness is only limited to conduct meetings only. The Village Coordinators have been given flex banner of Nari Ki Chaupal by the department. The VCs reported that they conduct rallies in the village to generate awareness. It was further apprised that due to non- availability of IEC funds, they don't prepare charts, posters, banners and other audio- visual aids for awareness generation. Therefore, the impacts of the programme does not sustain long. The VCs also reported that those families who don't turn up for meeting, in this regard intense home visits are carried out to mobilize them to come for meeting.

Involvement of NGOs/ CSOs

The VCs get good support from **Shanidham Trust**, Pali and Hand in Hand India for providing services to the women beneficiaries at the village level. The Shanidham trust organizes training programme for VCs and provide charitable services like celebration of Beti Janmostava, distribution of blankets, organize marriage for BPL Putri Vivah etc.

The **Hand in Hand India** organization conducts Village Up-liftment Programmes (VUP) to improve the village livelihood in Pali district. The organization has adopted some AWCs and decorated AWCs with various child friendly painting of effective use in conducting Preschool Education.

Matru Suraksha Dal (Women Protection Group)

The Matru Suraksha Dal comprises 10 elderly women (50 yrs and above) of the village to help the village coordinators in facilitating the process of awareness generation and capacity building and resolve any grievances if any among village women. The members of this group are mainly women who are influential, good communicator, having earned respect in the village. These women have been providing constant support to the village coordinators for creating awareness; generate understanding about different programmes/ services being implemented by the governments. The women members do home visits and mobilize women beneficiaries for availing services at the AWCs or at GP. The women group is not given any financial assistance for conducting such activities; it is purely voluntary in nature.

KishoriBalikaDal (Adolescent Groups)

The Kishori Balika Dal comprises of 10 adolescent girls of the village who are considered the catalyst for generating awareness about nutrition and health related matters. The Adolescent groups are grossly involved in supply of IFA tablets to the AGs in the village and mobilise other women and Kishori Balikas to attend mahila sabha and nari ki chaupal.

Convergence and Coordination

The PSK convergence model has been initiated to promote access and demand for services meant for rural women. The village coordinators establish linkages with AWCs, sub centre, School and Gram Panchayat to facilitate services accessibility and availability. The VCs are merely confined to filling up of the forms and construction of toilets to declare the village as Open Defecation Free (ODF). The convergence with regard to ICDS is limited to distribution of IFA tablets, mobilize women for immunization and sending severely underweight children to Malnutrition Treatment Centre (MTC) at Pali.

Management Information System (MIS)

The village coordinators have been given MIS register for submitting their monthly progress report. The Monthly Progress Report contains- Name of the scheme, application forwarded during the reporting month, total application forwarded, name of women beneficiaries in the current month and total number of women beneficiaries.

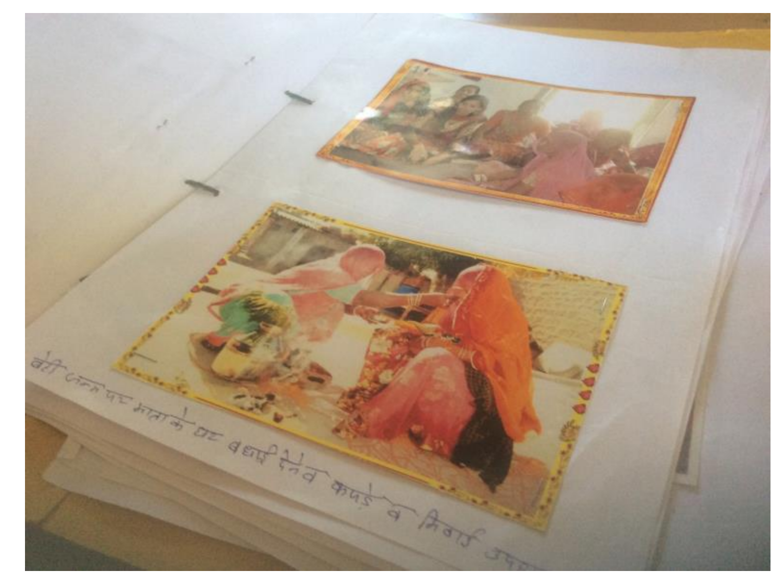
In order to facilitate the field visits during the proposed training period, the checklist has been developed keeping in view the field experiences. The checklist is enclosed in the field visit compendium.

Best Practices

Beti Janmostava

The beti janmostav is a grand celebration for birth of a girl child in the village with the initiative to promote survival, development and protection of girl child. The Shanidham Trust, Pali organises the function and in which the families of girl child are given a certificate, clothes, sweets and other gift so that the birth of girl child be valued in the society. The phenomena is so encouraging that other family members of the village approach to the village coordinators and register the birth of girls child so that their children may experience the same rewards.

BPL Putri Vivah



Many a times the expenses accrued for the girls' marriage is very high so that the parents of a poor household face various difficulties to manage the ceremony. In order to facilitate the process of marriage for BPL families, the Shanidham Trust conducts marriage ceremony. It contributes sarees, other materials for marriages and gives cash amount of Rs.50, 000/- for conducting marriages.

Gaps and Challenges in Implementation of VCFS

- The Village Coordinators are highly educated and paid Rs. 4,000/- as monthly honorarium to conduct various activities under VCFS. The salaries are not regularly paid to them.
- The VCFS centre lack IEC materials and funds are not provided to them for purchasing charts and posters for conducting awareness generation activities at the village level for women groups.
- Most of the times officials of Gram Panchayat and other officials give verbal instruction to conduct different activities and filling up of the forms for different government programmes. Due to lack of detailed guidelines or circulars they face difficulty in convincing the rural women especially the matters related to cash transaction.
- The VCs had received orientation training programme for seven days. They received only brief ideas of various Acts, Programmes and services provided by the government during training duration. They lack detailed information about different Acts like PWDV, PCPNDT and others.
- The working hours for VCs have been fixed from 10. 00 a.m. to 3.00 p.m. in every day. The majority of time is being spent on filling up of the forms only and they find very less time to do home visits and create awareness programme at the village level.

- The Post of Assistant District Coordinator and Block Coordinators have not been filled in. It leads to difficulty in monitoring the VCFS by the staff.
- There is inadequate convergence with ICDS. It is confined only to Immunization and Supplementary Nutrition

Annexure- I

The interaction meeting with VCs at the office of BDO at Rohat

Sl. No	Name of VCFS	Name of the Village Coordinators
1	Shawnta Kala	1. Ms. Sangeeta Mali
2	khundawas	1. Ms. VandanaSreemali 2. Ms. ShyamKunwar
3	Kulthana	1. Ms. Sushilakunwar 2. Ms. Maya Devi
4	Kalali	1. Ms. Champa Devi 2. Ms. JashparaMadhuben
5.	Rohat	1. Ms. Vandana Banjara
6.	Diwandi	1. Ms. Pushpa Banjara
7.	Garhbara	1. Ms. VidyaCharan 2. Ms. DayaCharan

CHECKLIST FOR DEVELOPING STATE TRAINING ACTION PLAN

Sl. No	Dimension of Training action Plan	Responses by the State
1.	Number of High Burden Districts	
2.	Number of Blocks covered under high burden districts	
3.	Number of BBBP Districts	
4.	Number of districts under Village Convergence & Facilitation Service (VCFS)	
5.	Number of Village Coordinators under each VCFS	
6.	Total number of Village Coordinators in the State	
7.	Number of DPO in the District	
8.	Number of ICDS projects under the High burden district	
9.	Number of State Institute of Rural Development (SIRD) in the State	
10.	Number of Extension Training Centre (ETCs) functional in your State	
11.	Number of State Institute of Health &Family Welfare (SIHFW) in your Satte	
12.	Number of Middle Level Training Centres (MLTCs) in your State	
13.	Number of Anganwadi Workers Training Centres (AWTCs) in your State	
14.	Number of Training Programme to be conducted for ICDS functionaries by SIRDs	
15.	Number of Training to be conducted for Village Coordinators under VCFS by SIRDs	
16.	Duration of Training for ICDS Functionaries	
17.	Duration of Training for Village Coordinators of VCFS	
18.	Training Venue • State Head Quarters • District Head Quarters • SIRD • Extension Training Centre	

	• Any other	
19.	**Training Curriculum**	
	Programme Schedule: Programme schedule developed by NIPCCD would be followed exclusively with inclusion of state specific issues or challenges	
	Contents : *Situational analysis of women and children, ICDS strengthening and restructuring, Beti Bachao Beti Padhao (BBBP)scheme and gender concerns, Inter sectoral convergence, VHND, VHSNC, ECCE Day, Role of PRIs in Communitisation of ICDS, Concept of Village Convergence Facilitation Service (VCFS), Use of MCP card and New WHO Child Growth Standards, Community Based Management of Underweight Children – Sneha Shivir, Early Childhood Care and Education, Planning advocacy campaign on nutrition & health issues relating to women and children, IGMSY and SABLA scheme, Accessing different government services (Centre and State), panel discussion with grass root level workers on community development programme etc.*	
	Methodology The methodology of training would include- lecture cum discussion, group discussion, role play, demonstration, screening of videos on different sessions etc.	
	Reading Materials The training modules developed and provided by NIPPCD during the training of master trainers would be followed while conducting the training programme for ICDS and VCFS. NIPCCD has provided two sets of training module covering all sessions of training; field visits comprising of checklists and extra reading materials for training.	

	Field Visits The participants would be given field exposure regarding process involved in creating awareness about different government programmes, strengthening convergence with Gram Sabha, VHND, and VHSNC etc. The NGOs or CBOs working in the field of women Empowerment, AWCs, health facilities and educational institutions etc., would also be visited during the training. Exposure visit to see some best practices at the ground level shall be the important aspects of training.	
20.	Faculty Support for conducting training • Master Trainer of SIRD • ICDS • Health • PRIs • Others	
21.	**Budget** The budget head would comprise of Board and lodging charges, TA to participants, kit materials, Stationary & Xeroxing, Transportation for field visits, Honorarium to Resource person, audio- visual charges, Contingencies etc. The budget would be provided by MWCD to SIRDs for organization of training at SITRDs or ETCs.	

DAY 3

Day 3 Session 1

Convergence of Multi Sectoral Interventions from ICDS, NHM and Swachh Bharat Abhiyan in High Burden Districts

OBJECTIVES OF CONVERGENCE:

The basic objective of convergence of different Government initiatives is to establish synergy among different programmes in planning and implementation to optimize the benefits. Secondly, appropriate convergence strategies will bring enhanced economic and social opportunities for the target mass in the project locations which will strengthen the capacity and behavior change option of the people. It is expected that through convergence, there would be additional resource support to project from different other schematic provisions of Government which will contribute to realise the project outputs.

The ICDS scheme since its inception has committed to promote community ownership through mobilizing and engaging parents and families for attaining better maternal and child health and nutrition outcome. In this regard, the Village Health, Sanitation and Nutrition Committees (VHSNCs) would be actively engaged in the management and supervision of ICDS programme at village and local level. According to the guidelines issued by the Ministry of Health and Family Welfare, Government of India dated 25th July 2011, a sub – committee of VHSNC (maternal and Child Nutrition Committee) consisting of community representatives, members of PRIs and village level functionaries would be constituted at each village. The sub-committee would oversee the functioning of all AWCs at the village. The function of VHSNC are given below-

Village Contact Drives

The main focus of the project activities is on strengthening, promoting and making the practices sustainable for community members at the GP level who will manage community the community activities. The project will also provide specific components for the inclusion of extreme poor, vulnerable, disabled and tribal groups to enable them to participate effectively in social institutions as well as overcoming the barriers they face in social and economic spheres.

Guideline of Village Contact Drive

The communication activities through Village Contact Drive carried out in the vulnerable/ unreached and media dark areas where penetration of Television and Radio is poor. With poor penetration of modern mass media tools, folk dance, folk shows, magic shows etc. are still the most preferred medium for information dissemination. In those media dark and hard to reach areas we can organize social mobilization campaign as a day long activity and the shows should be organised around the areas. This may also be organised in the advantageous locations nearing Swasthya Kantha through different traditional / folk media activities like puppet show/magic show, Street theatre/ jatra/palla, pada yatra/rally, Video Show/ and exhibition with enough pre-publicity.

- The communication activities carried out for each thematic issue is the part of supplementary programme in the Swasthya Kantha Campaign "Kantha Kahe Kahani".
- Every quarter one drive to be carried out at the block level with clear supervision by district level Officials. The thematic area are given below;

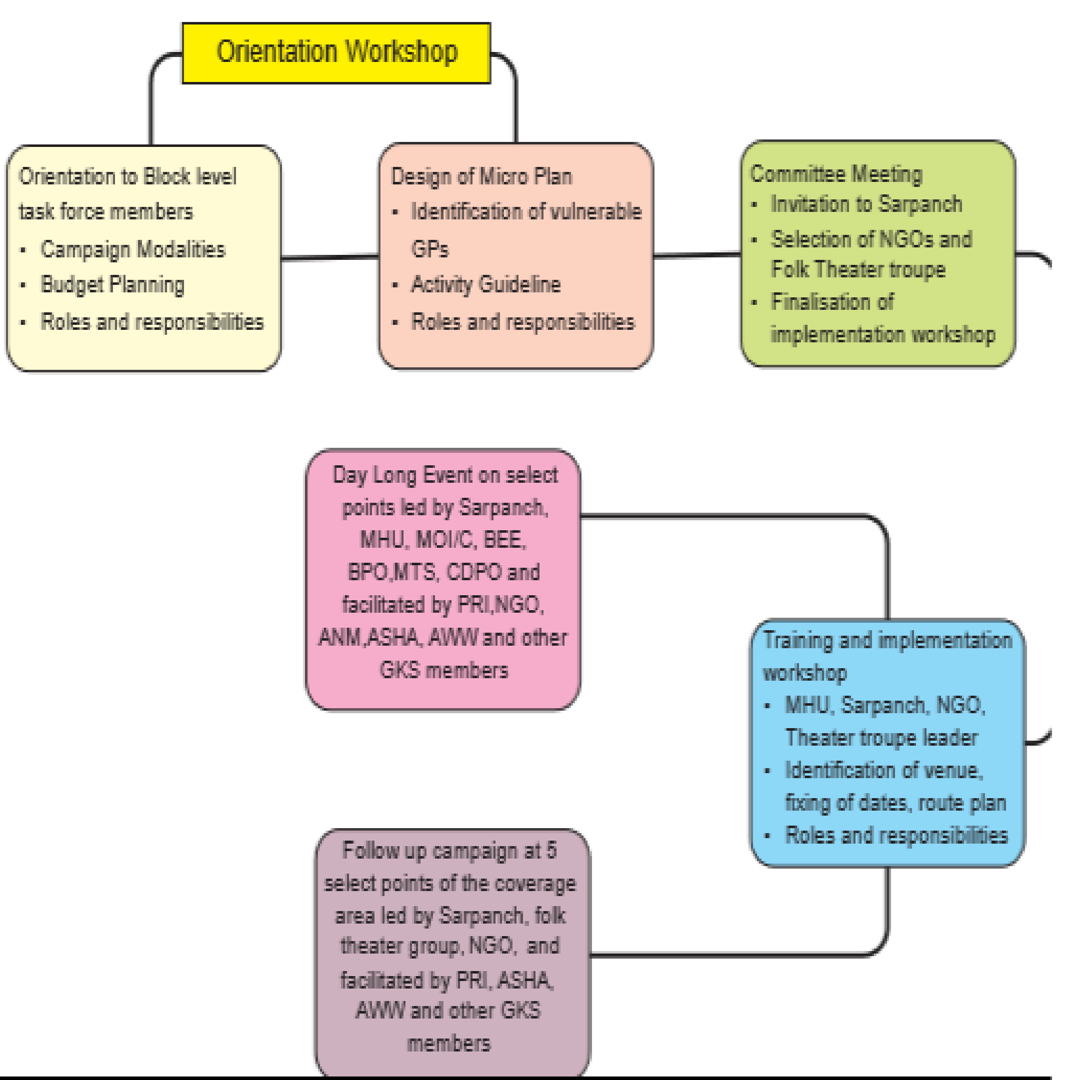
Thematic Components: (RCH-II)

- Maternal Health : Focus on postnatal care and 48 hour stay and promotion of schemes like JSY and Janani Sisu Surakshya Karyakram
- Child Health : Neonatal care and HH level diarrhea management
- Family Planning : Fixed day Approach and promotion of sterilization
- Tribal Health : Contextual and need based campaign
- Adolescent Health : RTI/STI and counseling
- Immunization : Hepatitis B and bundling of Vitamin A+ Albendazole
- PC & PNDT : Save girl child

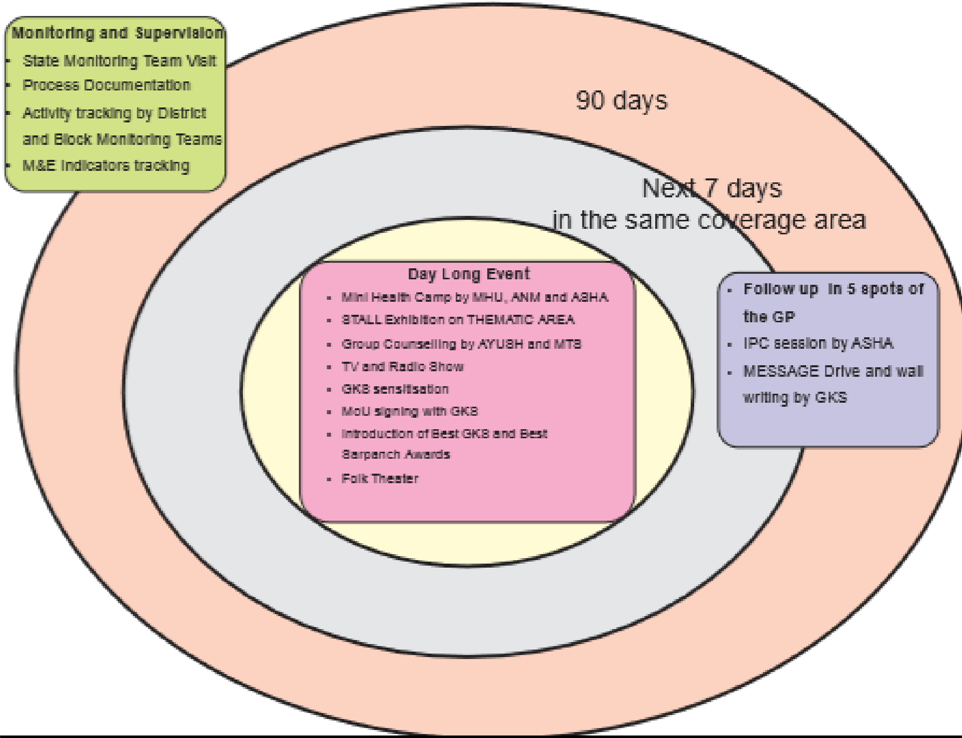
Salient features

- 5 most vulnerable patches to be identified in each block for organization of village contact drive.
- The communication activities is a combination such as;
  - A day long event comprising of an exhibition on given thematic area, health camp, Folk/Video show, focus group discussion* with facilitated by MHU Doctor and other health functionaries etc.
  - Pre-publicity of the event through miking, poster in swasthya kantha, banners, orientation to GKS members and village leaders and any other medium suitable to the condition.
  - Play the radio / video episodes of Kantha kahe Kahani during the event

BLOCK LEVEL ACTIVITY MODEL



VILLAGE/GKS LEVEL ACTIVITY MODEL



Execution level

- The block is the unit for the execution of the communication activities on each issue and MO I/C will be the overall in charge of the programme.
- The Child health with immunisation programme will be continued for three months from March to May 2011 as part of the Swasthya Kantha Campaign and in that supplementary Village Contact Drive carried out in the RCH high focus blocks on 1st quarter 2011.
- The communication activities carried out in the last 3 quarter in the year of 2011-12. The flexi pool budget given to the district @ Rs. 45,000/- each block on RCH high focus districts and @ Rs. 30,000/- each block in the other districts. The details list of RCH high focus districts are given at annexure-I for your reference.
- The Public Health Extension Officer will be primarily responsible for effective implementation of the programme taking support from BPMSU and selected NGO/CBO.
- A block level committee will be formed under the chairmanship of MOI/C, CDPO, PHEO, BPO, MHU Doctor and AYUSH Doctor (Head quarter) for the finalization of the entire activities. The suitable venue of the campaign may be selected by clubbing 2-3 Sub-centres. The selection should be done in the Block level committee with prioritization of area vulnerability and media dark area.
- The block level committee will identify the 5 most vulnerable areas in their block based on the vulnerability as hard to reach factor and will plan accordingly for the campaign integrating health camp with village contact drive. Identification of locations for events giving the coverage of the catchment area and target group.
- The entire events may be organized through PPP Mode or involvement of NGO/CBO partner.

- Selection of NGO by the Committee, if the activity carried out through the PPP mode or involvement of NGO/CBO
  - How to select the NGO: The Social Mobilisation programme will be carried out through a partner NGO, preferably FNGO working at block level. If the FNGO is not available in the block, the block may prefer other PPP NGO which is involved in the Health/ NRHM programme at block level. Where the FNGO/PPP NGO are not available in the district, the block may prefer the NGOs those who are involved in the any other programme of health department like Malaria, RNTCP and GKS training programme etc. at block level. Where as the above mentioned NGO are not available in the block, a formed block level committee will decide any other NGO at their level. NGO/ Voluntary Organisation/CBO should have adequate credibility and having substantial experience in implementing RCH & other Health & Family Welfare programs with strong presence in the area.

The PHEOs at block level will be responsible for preparing a micro-plan with support of NGO for their respective block and submit it to the district through MO I/C. Micro plan should contain;

1. Finalise the route plan for publicity in the catchment area
2. Population details
3. Date, Venue and other materials
4. Activity plan with budget
5. Co-ordination and planning with MHU for location and date of events
6. Monitoring and Supervision plan
7. Documentation

- Two types of services i.e. Curative and preventive services should be delivered in the entire campaign process.

Curative Services

- A Health Camp will be organized in the identified spot with provision of MHU/AROGYA Plus, if MHU/ AROGYA Plus is not available in the block MOI/C arrange a doctor for this purpose.

- As per the Health Camp, the MOI/C will be responsible for the details arrangement like doctor, medicine, para medical staff etc. in the camp.

- **Role of Village Health Sanitation & Nutrition Committee**

Besides the above, the Ministry of Health and Family Welfare vide its circular dated 25th July, 2011 has expanded the role of VHSC by adding Nutrition component within its ambit

with the active participation of ASHA, ANM and AWWs. The committee would hence forth be known as VHSNC. The role of VHSNC would be broadly mandated as follows-

- Create awareness about nutritional issues and significant of nutrition as a major determinants of health

- Carry out survey on nutritional status and nutrition deficiencies among women &children in the village

- Identify locally available food stuff having high nutrient values and disseminate and promote best practices as per the local cultures

- Inclusion of Nutritional needs in the Village Health Plan- the committee will do an in-depth analysis of causes of malnutrition at the community and household level by involving ASHA, ANM, ICDS supervisor and AWW.

- Monitoring and supervision of Village Health & Nutrition Days (VHNDs) to ensure that it is organized in every month in the village with the active participation of the whole villages.

- Facilitate early detection of malnourished children in the community and tie up referral to the nearest Nutrition Rehabilitation Centre (NRC) as well as follow up for sustained outcome.
- Supervise the functioning of the AWCs in the village and facilitate its working in improving the nutritional status of women and children.

- Act as a grievance redressal forum on nutrition and health issues at the village.

Role of Adolescent girls/ SABLA girls in implementation of ICDS

The Ministry of Women and Child Development (MWCD) has launched a new scheme called Rajiv Gandhi Scheme for Empowerment of Adolescent Girls- SABLA in 205 districts all across the country in pilot basis. The Kishori Shakti Yojana (KSY) is also being operational in non SABLA districts with the objectives to improve nutrition and health status, upgrade the life skills, vocational skills and home based skills, promote awareness about reproductive and sexual health etc. The roles of adolescent girls in ICDS are as follows-

- Motivate and assist all AGs to fill up and maintain their kishori health card.
- Assist the AWW in maintaining the registers.
- Assist AWW in distribution of THR.
- They may accompany AWW on home visits.

- They will work as peer educators for Kishori Samooh and create awareness among adolescent girls about reproductive and sexual health, life skill education etc.
- Take lead role in motivating the AGs to join the Scheme supported by AWW.
- Facilitate activities to be conducted at AWC on day to day basis and on Kishori Diwas.
- AGs in the AWCs may help in conducting preschool education, development of teaching learning materials.
- AGs may mobilize mothers and other beneficiaries to participate in the NHEd session.

VILLAGE HEALTH NUTRITION DAYS

The Government of India and State Governments have taken various initiatives to create awareness among community members in general and mothers in particular about different services available at health and ICDS. It has been decided that Village Health and Nutrition Day (VHND) is to be organized once every month at the AWC in the village. The VHND would be a platform for sharing the service benefits available to the beneficiaries and knowledge regarding maternal and child health.

The Village Health Nutrition Day popularly known as (VHND) is organized once in every month at the AWC. It is jointly carried out by both Health and ICDS functionaries to assess the nutrition and health issues of women and children. On village health and nutrition days (VHND), ASHAs, AWWs, and other will mobilize the villagers, especially women and children, to assemble at the nearest AWC. The ANM and other health personnel should be present on time; otherwise the villagers will be reluctant to attend the following monthly VHND. It allows the villagers to interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, other facilities. Since the VHND will be held at a site very close to their habitation, the villagers will not have to spend money or time on travel. Health services will be provided at their doorstep. The Village Health Sanitation Committee comprising of ASHA, the AWW, the ANM, and the PRI representatives should be fully involved in organizing the day to bring significant changes in peoples' perception of health and health care practices.

Why do we Organize VHND?

- It is a platform for providing first contact primary health care to women & children.
- VHND is seen as a platform for interfacing between the community and the health system.
- ASHAs, AWWs, and others will mobilize the villagers, especially women and children, to assemble at the nearest AWC.
- The ANM and other health personnel should be present on this day so that the villagers can interact freely with the health personnel and obtain basic services and information.
- They can learn about the preventive and promotive aspects of health care and know about basic facilities.

- Since the VHND will be held very close to their habitation, the villagers will not have to spend money or time on travel.
- VHND ensures providing health services at their doorstep.
- The VHSNC comprises ASHA, AWW, ANM, and the PRI representatives, if they are fully involved in organizing the VHND, can bring dramatic changes in the health care practices among the people.

1. Services provided during VHND

- All pregnant women are to be registered.
- Registered pregnant women are to be given ANC.
- Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them.
- All eligible children below one year are to be given vaccines against six Vaccine-preventable diseases.
- All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.
- Vitamin A solution is to be administered to children.
- All children are to be weighed, with the weight being plotted on a growth chart and managed appropriately in order to combat malnutrition.
- Anti-TB drugs are to be given to patients of TB.
- All eligible couples are to be given condoms and Oral Contraceptive Pills as per their choice and referrals are to be made for other contraceptive services.
- Supplementary nutrition is to be provided to underweight children.

2. Issues to be discussed with the community Members during VHND

- Danger signs during pregnancy
- Importance of institutional delivery and where to go for delivery
- Importance of seeking post-natal care
- Counselling on NBC
- Registration for the JSY/ IGMSY?SABLA
- Counselling for better nutrition
- Exclusive Breastfeeding
- Weaning and complementary feeding
- Care during diarrhoea and home management
- Care during acute respiratory infections
- Prevention of malaria, TB, and other communicable diseases
- Prevention of HIV/AIDS
- Prevention of STIs
- Importance of safe drinking water
- Personal hygiene

- Household sanitation
- Education of children
- Dangers of sex selection
- Age at marriage
- Information on RTIs, STIs, HIV and AIDS
- Disease outbreak
- Disaster management

3. Identification of Cases that need Special Attention

- Identify children with disabilities.
- Identify children with moderate and severely underweight for referral
- Identify severe cases of anaemia.
- Identify pregnant women who need hospitalization.
- Identify cases of malaria, TB, leprosy, and Kala Azar.
- Identify problems of the old and the destitute.
- Pay special attention to the SC, ST, the minorities, and the weaker sections of society.

On VHND, the functionaries should -

- Prepare the list of women and children come for services.
- Discussion with ANM and malnourished children.
- Provide supplementary nutrition to children with special needs..
- Assist the ANM and the AWW.
- Arrangement of cleaning of AWC, clean drinking water during the VHND.
- Select a place with privacy at the AWC for ANC.
- Availability of adequate number of MCH cards.
- Coordinate activities with the ASHA and the ANM.

MONITORING COMMITTEES

Community-based Monitoring involves activating, motivating, building capacity and allowing the members of community and its representatives to give feedback directly about the functioning of ICDS scheme. Community-based monitoring (CBM) is one of the key strategies to ensure accountability. Looking at the quantum of the activities undertaken by ICDS, the existing monitoring systems are inadequate to achieve optimal performance indicators; therefore, monitoring through involvement of local beneficiaries would be of paramount significance. The 73rd and 74th amendments to the Constitution of India (April 1993) reiterates Government attempts to institutionalize CBM on a larger scale in the developmental programmes.

Monitoring of any developmental programmes is of high necessity for development partners, programme implementer, policy makers, educationists, social scientists, civil societies and others to understand the effectiveness of the programmes. It is a better means to learn from

past experiences; improving service delivery, allocation of resources and meeting the desired objectives. Monitoring is a continuing function which takes place throughout the programme implementation of the programme.

Strengthening Monitoring Mechanisms under ICDS

- Ministry of Women and Child Development (MWCD), GOI has taken several measures to strengthen monitoring & supervision mechanisms in ICDS. In past, GOI [F. No. NI/12-11/93 CD-1 dated 20.1.1994] developed guidelines for Community Based Monitoring Mechanisms to ensure monitoring of the scheme at grass root level by the community themselves envisaging the constitution of Bal Vikash Mahila Samitis at village, block and district level.
- MWCD vide its circular [F.No. 16-3/2004 ME (Pt.) dated 22.10.2010] devised supervision & monitoring visits to AWCs by the officials at all levels and also the involvement of PRIs in monitoring the activities of AWCs.
- In order to strengthen quality delivery of services at AWCs, MWCD,GOI vide its circular [F.No. 16-8/2010- ME dated 31.3.2011] constituted five tier monitoring & review mechanisms from central level up to AWC level to strengthen coordination & convergence with the line departments. Its objective is to review the progress made in implementation of ICDS.

Five Tier Monitoring and Review Mechanisms

- National Level Monitoring & Review Committee (NLMRC) on ICDS
- State Level Monitoring & Review Committee (SLMRC) on ICDS
- District Level Monitoring & Review Committee (DLMRC) on ICDS
- Block Level Monitoring Committee (BLMRC) on ICDS
- Anganwadi Level Monitoring & Support Committee (ALMSC) on ICDS

For the present chapter, we would discuss only about the Anganwadi Level Monitoring & Support Committee (ALMSC).

Composition of ALMSC

Gram Panchayat/Ward Member (preferably women member)	**Chair Person**
Mahila Mandal (2 members on rotation)	Member
ASHA	Member
Representative of Community Based organization (2)	Member
Community (Parents of children attending AW/Teachers/Retd. Government officials) (3)	Member
Sakhi under SABLA Programme if any	Member

AWW	**Convener**

(*The committee will regularly organize monthly meetings to discuss various issues at the AW area/ward/slum and record minutes of the meeting. A copy of the meeting may be sent to CDPO and we may invite LHV/ANM/supervisors to attend the meeting)*

Role of ALMSC

- The committee should conduct monthly meeting to discuss about issues of AW areas
- Check regularity of functioning of AWCs
- Ensure coverage of all eligible beneficiaries as against the survey
- Review the supply of SN for at least 21 days in a month
- Review nutritional status of children (0-3 years & 3-6 yrs), weighing of children, availability of growth chart, weighing machines, MCP card, number of moderate & severely underweight children and steps taken
- Monitor the PSE activities per day, use of local TLM and involvement of parents, organization of parents meet and fixed monthly ECCE day
- Ensure participation of AWWs in VHSNC Meeting
- Ensure participation of at least one member-AWW, ASHA, ANM on VHND
- Review facilities available at each AWCs
- Review and receipt of all consumable food items
- Visit AWCs periodically and interact with other members of community to enquire about the functioning of AWCs
- Attend to any local disputes related to AWW/AWC and try to resolve it amicably
- Interact with AWW and Supervisors to understand local problems and gaps if any and report the same to CDPOs

IGMSY Scheme

- Undernutrition continues to adversely affect majority of women in India. In India, every third woman is undernourished and every second woman is anemic1. An undernourished mother almost inevitably gives birth to a low birth weight baby. When poor nutrition starts in-utero, it extends throughout the life cycle, particularly in women. Owing to economic and social distress many women continue to work to earn a living for their family right up to the last days of their pregnancy. Furthermore, they resume working soon after childbirth, even though their bodies might not permit it, thus preventing their bodies from fully recovering on one hand, and also impeding their ability to exclusively breastfeed their young infant in the first six months. Janani Suraksha Yojana (JSY) was launched in 2005 by Ministry of Health and Family Welfare. It provides a differential one-time cash incentive to pregnant women for institutional/home births through skilled assistance. JSY however, does not address the issues regarding a woman's socio-economic compulsions to work right up to the last stage of pregnancy and resuming work soon after child birth. Hence, a need for

introducing a modest maternity benefit to partly compensate for their wage loss was recommended by the Planning Commission in the XIth Five Year Plan.

- IGMSY is a Centrally Sponsored Scheme under which full grant-in-aid would be provided to State Government (SGs)/Union Territories (UTs). It has been approved by the Government on pilot basis in 52 selected districts across the country. It will be implemented using the platform of ICDS. The focal point of implementation will be the Anganwadi Centre (AWC).

Objectives of IGMSY:

- To improve the health and nutrition status of Pregnant and Lactating (P & L) women and their young infants by:
- i. Promoting appropriate practices, care and service utilization during pregnancy, safe delivery and lactation.
- ii. Encouraging women to follow (optimal) Infant and Young Child Feeding (IYCF) practices including early and exclusive breastfeeding for the first six months.
- iii. Contributing to better enabling environment by providing cash incentives for improved health and nutrition to pregnant and lactating women.

- *Note: The Scheme aims to provide partial compensation for the wage loss so that the woman is not under compulsion to work till the last stage of pregnancy and can take adequate rest before and after delivery.*

Target beneficiaries:

P & L women of 19 years of age and above for their first 2 live births.

- *Why 19 years of age and above?* The legal age of marriage in India for women is 18 years and hence the age criterion for child birth has been taken as 19 years. This is to encourage marriage and child birth at the right age.

- *Why only first two live births?* To ensure that the health of the woman is not compromised due to repeated pregnancies and to promote family planning.

Cash Transfer	Conditions	Amount (Rs)	Means of Verification
First Installment (In Third Trimester)	• Registration of Pregnancy at AWCs/ Health Centre within 4 months of Pregnancy • At least two ANCs with IFA Tablets and TT	3,000/-	MCPC certified by AWW
Second Installment (6 months after delivery)	• The Birth of the child is registered • The Child has received BCG, DPT- I, II & III and three OPV doses • Attended at least three Growth Monitoring and IYCF Counseling Sessions within three months of delivery • Exclusive Breast feeding for six months and introduction of complementary feeding as certified by the mother	3,000/-	Self certification and MCP Card

IGMSY linkage with Janani Suraksha Yojana (JSY):

- AWWs should encourage the IGMSY beneficiaries to avail the JSY package for institutional delivery. All delivery attendants should be sensitized to motivate mothers to initiate breastfeeding within an hour of birth, colostrum feeding and for exclusively breastfeeding their infant for the first six months.

Incentive to AWW and AWH:

- i. AWW will receive a cash incentive of `**200 per beneficiary** after all the **due** cash transfers to the beneficiary are completed.
- ii. AWH will receive a cash incentive of `**100 per beneficiary** after all the **due** cash transfers to the beneficiary are completed.

- ***Note:*** *Even if the beneficiary migrates in or out of the AWC area, the AWW and AWH would be entitled to the complete cash incentive amount if **all due cash transfers** to the beneficiary arecompleted. E.g., in some cases it might be the first two installments after which the beneficiarymigrates out of the area, in other cases it might be that the beneficiary is eligible for the last two installments only, since as a result of migration she registered herself at the AWC for this Scheme after delivery.*

RAJIV GANDHI SCHEME FOR EMPOWERMENT OF ADOLESCENT GIRLS (RGSEAG) – SABLA SCHEME

The term “adolescence” literally means “to emerge”, “to mature” or “achieve identity”. It is a significant phase of transition from childhood to adulthood, which is marked by physical

changes accompanied by psychological changes. This is the time to make adolescents aware of and informed about various facets of life in order to promote a healthy way of living. Awareness of health, nutrition, lifestyle related behaviour and adolescent reproductive & sexual health (ARSH) needs to be positioned in this phase of life in order to improve the health of adolescent girls and facilitate an easier transition to womanhood. During this period, nutritional problems originating earlier in life as well as those occurring during the period itself can be addressed. Going beyond this, AGs need to be viewed not just in terms of their needs but even as individuals who would become productive members of society in future.

The Ministry of Women and Child Development, Government of India, in the year 2000, came up with a scheme called *Kishori Shakti Yojana (KSY),* which was implemented using the infrastructure of the Integrated Child Development Services Scheme (ICDS). The objective of this scheme was to improve the nutrition and health status of girls in the age-group of 11 to 18 years, to equip them to improve and upgrade their home-based and vocational skills, and to promote their overall development, including awareness about their health, personal hygiene, nutrition and family welfare and management. Thereafter, the Nutrition Programme for Adolescent Girls (NPAG) was initiated as a pilot project in the year 2002-03 in 51 identified districts across the country to address the problem of under-nutrition among AGs. Under this programme, 6 kg of free food grain per beneficiary per month was given to undernourished AGs.

Both these schemes have influenced the lives of AGs to an extent, but have not shown the desired impact. Moreover, the extent of financial assistance and coverage under them has been limited and they both had similar interventions and catered to more or less similar target groups. Therefore, a new comprehensive scheme, called **Rajiv Gandhi Scheme for Empowerment of Adolescent Girls** or **SABLA,** merging the erstwhile KSY and NPAG schemes has been formulated to address the multidimensional problems of AGs. **SABLA will be implemented initially in 205 districts selected across the country, using the platform of ICDS. In these districts, RGSEAG will replace KSY and NPAG. In rest of the districts, KSY would continue as before.**

OBJECTIVES OF THE SCHEME

The objectives of the scheme are to:

(i) enable self-development and empowerment of AGs;

(ii) improve their nutrition and health status;

(iii) spread awareness among them about health, hygiene, nutrition, Adolescent Reproductive and Sexual Health (ARSH), and family and child care;

(iv) upgrade their home-based skills, life skills and vocational skills;

(v) Mainstream out-of-school AGs into formal/non formal-education; and

(vi) inform and guide them about existing public services, such as PHC, CHC, Post Office, Bank, Police Station, etc.

TARGET GROUP

The scheme aims at covering AGs in the age group of 11 to 18 years under all ICDS projects in selected 200 districts across India on pilot basis Keeping in view the need of different ages and in order to give age appropriate attention for certain components of ARSH and family matters, the target group may be subdivided into two categories, *viz.*, 11-14 and 15-18 years. Interventions on health and personal hygiene, etc. would have to be planned accordingly.

MODALITIES OF THE SCHEME

Formation of Kishori Samooh will be a group of average 15 to 25 AGs from the village/area of the AWC and will be formed at the AWC level. In case there are less than 15 AGs, Kishori Samooh can still be formed. Kishori Samooh will not be formed if there are less than 7 AGs in the area of the AWC in which case, the benefits of the Scheme may be given to these AGs without nominating sakhi and saheli. The AGs will select three leaders of their choice for a year from within the KS. In this selection, they may be guided by the AWW and, wherever possible, a school-teacher from the village. Selection may be based on age, education level, maturity, willingness of the girl and her acceptability within the group. These girls will be called 'Sakhi' (one girl) and 'Saheli'(two girls), which in English mean 'friend'. As far as possible, the Sakhi and Sahelis may be selected from among the out of school girls. One of these girls will be Sakhi, *i.e.*, peer-monitor. Each of the three selected girl will have a term of four months as Sakhi.

Kishori Diwas will be a special health day, celebrated **once in three months on a fixed day, as decided by the State Governments /UTs**. On this day, the AWWs with the help of health functionaries, including Medical Officer, Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA), will mobilize AGs and their families, especially mothers, to assemble at the AWC. For better coordination, the State Governments /UTs may choose to combine Kishori Diwas with the corresponding month's Village Health and Nutrition Day (VHND). However, care should be taken that the overall aim of the Kishori Diwas is not lost and that it is not overshadowed by the VHND.

On Kishori Diwas, the following services are to be provided:

(a) General health check-up, including recording of height, weight, Body-Mass Index (BMI) for all AGs, by the Medical Officer / ANM

(b) Filling up of Kishori Cards for every AG, marking major milestones

(c) Referral to specialized healthcare facilities, as required specially for conditions like malnutrition (BMI < 18.5), menstrual problems, frequent headaches, prolonged acne, worm infestation, etc.

(d) Organising of special health camps

(e) Providing nutrition and health education

(f) Demonstration of preparing nutritious recipes(FNB may be involved for these)

(g) Holding counselling / behaviour change communication (BCC) sessions with

AGs and their families for promoting good practices

(h) Imparting information, education and communication (IEC) to community, parents, siblings etc.

(i) Mobile Health Units (where existing) may be utilised.

Services under the Scheme: There are two major components under the Scheme - Nutrition Component and Non Nutrition Component as under:

i) Nutrition Component:

11-14 years AGs : Out of school girls

14 -18 years AGs : All girls

ii) Non Nutrition Component

For Out of school AGs :

a)11-18 years

- Nutrition provision,
- IFA supplementation,
- Health check-up and Referral services,
- Nutrition & Health Education (NHE),
- Counseling/Guidance on family welfare, ARSH, child care practices,
- Life Skill Education and accessing public services

b)16-18Years

- Vocational training under National Skill Development Program (NSDP)

For school going AGs of 11-18 years, the services at ii) a) will be provided twice a month in school days and four times a month in vacations.

SERVICE	SERVICE PROVIDER
Nutrition Provision Rs.5 per day(600 calories and 18-20 gram of protein)	AWW /AWH/Peer Leader
IFA supplementation *	ANM/AWW/Health System
Health check-up and Referral services*.	ANM/ MO/AWW
Nutrition & Health Education *	AWW/ANM/ASHA/MNGO
Counseling/Guidance on family welfare, ARSH*, child care practices and home management	MNGO/ANM/NRHM setup/AWW
Life Skill Education and accessing public services (also includes efforts to mainstream into formal/non formal education	MNGO/Education setup/Youth Affairs/AWW/Supervisor
Vocational training (for girls aged 16 and above) using existing infrastructure of other Ministries /Departments: NSDP	Through NSDP of Ministry of Labor, Supervisor/CDPO: to coordinate

* Health services are to be provided by establishing convergence with M/H&FW

- Other Services in coordination / convergence with related sectors/department

* Health services are to be provided by establishing convergence with M/H&FW

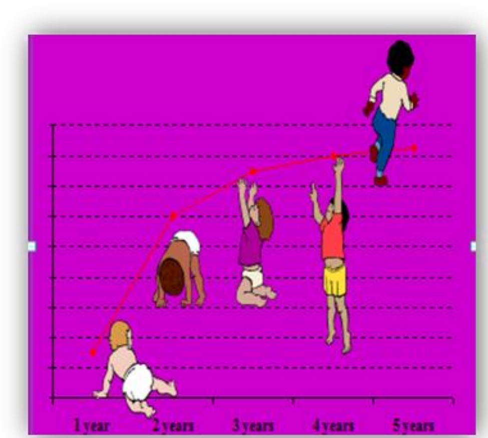
• Other Services in coordination / convergence with related sectors/department

Day 3 Session 2

Reaching Under threes, pregnant women and lactating mothers – use of MCPC and New Who growth standards.

Growth

- Growth is the periodic increase in size or weight of any living being.
- It is a continuous process that starts from conception and continues till adulthood.
- Growth is different from development, which implies change in shape, form or structure resulting in improved functioning (leading to maturity).
- Regular and continuous growth is the essence of health and development in early life of living.
- For optimal child growth adequate food, a caring, nurturing social environment and absence of illness is essential.



How to Measure Growth

- Growth of a child is seen in many ways: increase in size, height and weight.
- These are all signs of growth but they cannot tell us if the child is growing well enough for its age.
- There are many ways of measuring the growth of a child. One of the accurate and sensitive measures of growth is weight gain.

What is Growth Monitoring

- Growth monitoring involves weighing of the child at regular intervals (i.e. weekly, monthly, or once in 3 months), the plotting of that weight on a graph (called a Growth Chart) to see changes in weight.

- Monitoring helps to track the growth of a child. The change in weight of a child over a period of time is one of the ways to assess the growth and provide counselling to the mother to ensure optimal growth.
- Growth monitoring emphasizes that the change in weight over a period of time is more important than the weight itself.
- Each time a child is weighed, the weight is recorded by marking a point on the chart. These points are joined by a line. This line is called a Growth Curve.
- The Growth Curve, thus, provides the direction to the observer (Anganwadi worker in Integrated Child Development Scheme (ICDS)) and the mother.
    - If a child is growing normally and there is regular weight gain, the line should move in an upward direction.
    - If the weight does not increase as expected, the line on the growth chart stays flat.
    - If the child loses weight, the line on the growth chart may go in a downward direction.

Remember:

The purpose of Growth Monitoring is to detect Growth Faltering (inadequate growth, no growth or weight loss) in children at its early stages and take immediate action so as to restore health and proper growth.

Growth Monitoring: When to Start and Frequency

- Growth Monitoring should start from the birth of the child. The Anganwadi Worker (AWW) must explain to the mother and other older persons in the house, the importance of weighing a new born baby preferably, same day of birth.
- All newborns and children should be weighed from
    - Birth- one month : **every week**
    - One month- 3 years : **every month**
    - 3-5 years : **every three months**

- However, children who are severely underweight or who have not gained weight for 2 months or who are "at risk" of undernutrition, should be weighed frequently preferably every month.
- Day of weighing of each child should be determined keeping in view her/his date of birth in order to ensure that every child is weighed on completed month.
- However, every time it may not be feasible to weigh every child on her/his completed month therefore, efforts should be made to fix the days of weekly weighing in such a way so that maximum number of children who complete and those who have already completed their months are accommodated on that day for proper growth monitoring.

How Children Should Grow

- The child grows most rapidly during the first year of life called infancy.
- The pattern of weight gain in a healthy child is presented in Table.

Table : Normal Weight Gain of Children from Birth to 3 Years

Age (years)	Average Weight Gain per Month (grams)
Birth to 2 months	800
3 months to 4 months	600
5 months to 6 months	400
7 months to 3 years	200

- Factors like inadequate nutrition or illness, interfere with the pattern of child's growth and may slow or stop the process of growth.
- Growth faltering is a sign that something is wrong with the child and must be discovered at the earliest and necessary action to restore growth must be taken.

Factors Affecting Growth

Nutrition, environment and healthcare are stronger factors in determining growth and development than regional or ethnic background.

Details of these three factors are:

Optimal Nutrition

- Exclusive breastfeeding up to six months
- Appropriate complementary feeding

Optimal Environment

- No microbiological contamination
- No smoking

Optimal Health Care

- Immunisation
- Paediatric routines

Steps of Growth Monitoring

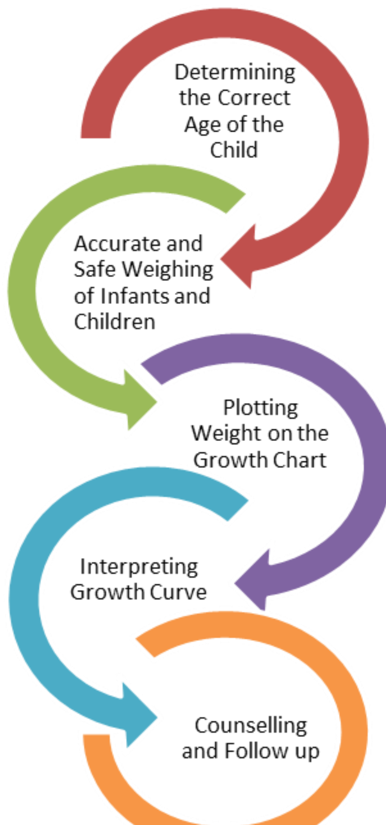


Figure : Steps in Growth Monitoring

Step 1: Determining the Correct Age of the Child

- The first step of Growth Monitoring is determining correct age of the child.
- In the ICDS programme, Growth Monitoring is done by weight for age method that involves comparing the weight of the child with her/his age.
- It is important to know the correct age of the child up to nearest month because without the correct age it is not possible to assess the growth of the child and have an accurate growth chart.
- An under or over estimate of even two or three months could result in the child being considered either healthy or undernourished than what she/he actually is. Therefore, knowing the correct age of the child is necessary to do accurate growth monitoring.
- The AWW can track the age of children by tracking of Pregnant Women and contact with Trained Birth Attendant.
- However, if the mother comes to her present place of residence a few months or years after the child's birth, she may not remember the month of birth of the child. For these children-
    - The AWW can consult the local official register of births with the village *panchayat* and/ or hospital card (in case of urban or rural projects close to city).
    - In case of unavailability of such records of births in a given area, AWWs can assess the age of a child by following ways:
        - with the help of Mother and Child Protection Card (MCPC)
        - with the help of birth certificate
        - from the mother, if she remembers the exact date of birth
        - using a local events calendar.

Activity: Calculating child's age using event local calendar

The trainer may give the trainees some situations and ask them to calculate the age of the child using local event calendar .

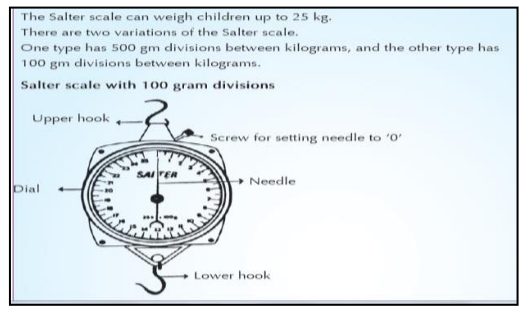
Situation: Rosy had recently shifted with her family to Badarpur, Delhi. She is a mother to a very young girl. Since her daughter was born in village and they had to shift immediately, so she could not get her birth certificate made. She is confused between 2 dates, but she vaguely remembers that her daughter was born in year 2015 after *Holi* but before Good Friday. She also remembers that 2 days after her birth there was a huge celebration at the Hindu temples and people offered food.

Discuss:
Local event calendar is a useful tool and can provide accurate estimate of the age of the child if prepared carefully.
Care should be taken while preparing these calendars and locally celebrated festivals of a particular area must be included for greater accuracy. For e.g. while making an event calendar for Odisha festivals like *Nuakhai, Rasa Purnima, Laxmi Puja* etc. must be included.

Step 2: Accurate and Safe Weighing of Infants and Children

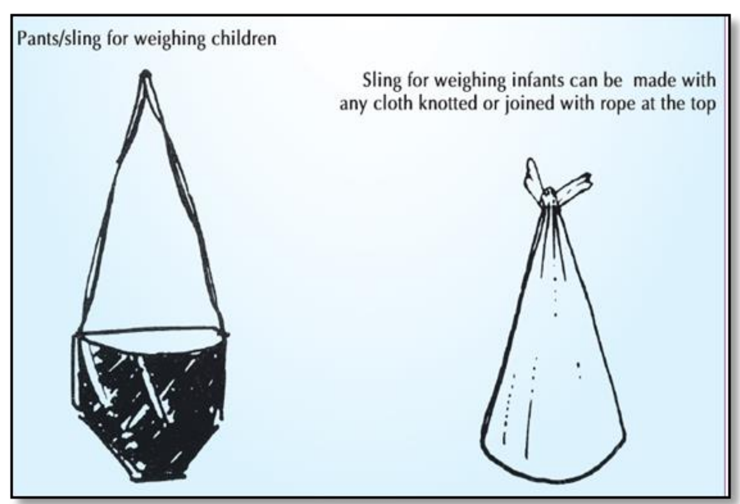
Regular weighing of the child is necessary for monitoring her/his growth. The two types of scales being used in ICDS for weighing children are the 'Salter or Dial type scale' & 'Digital

Salter Weighing Scale



- The Salter Weighing Scale is a reliable, light and portable scale, which can weigh children weighing up to 25 kg. It is round in shape, with the needle in the centre.
- Weights are marked in kilograms around the dial.
- The Salter scale with 100 gm as well as 500 gm markings between kilograms provides accurate measurement and is most commonly used.

- The Scale has a screw on top to make the zero adjustment so that the needle points to zero before the child is weighed.



The scale has two hooks. One on the top is used to hang the scale on a beam or branch of a tree with a rope. The other one is below the dial and is used to hang the sling or pants in which the child is placed for weighing.

Activity: Weighing using Salter Scale

The trainer may use the flip cards to explain the process of weighing using Salter Scale.

After explaining the process the trainer may demonstrate the use of Salter Scale emphasizing the important points.

- *Hang the scale securely. The scale should not touch a wall or doorway.*
- *Scale should be at the worker's eye level.*
- *Adjust the scale to zero with the basket, pants or sling on the lower hook, at the beginning of each weighing session.*
- *Take the child's weight with the minimum of clothing, without shoes.*
- *Read the weight to the nearest 100 gm*
- *Check the accuracy of the Salter (dial) weighing scale every month with a standard weight (5 kg weight is recommended), which are easily available.*

The trainer may divide the trainees in groups and allow them to practice this technique on children.

Note: The trainer must allocate adequate time for this activity so that the trainees are given an opportunity to practice weight measurement technique using Salter Scale and get hands on training.

Digital Scale (Taring Scale)

- "Tared weighing" means that the scale can be re-set to zero ("tared") with the person (mother) just weighed still on it.
- In this technique, a mother is made to stand on the scale, weighed and the scale is tared while the mother still standing on the scale, if now she is given her child to hold, the child's weight alone appears on the scale.
- Tared weighing has few clear advantages:
  - There is no need to subtract weights to determine the child's weight alone (reducing the risk of error).
  - The child is likely to remain calm when held in the mother's arms while being weighed.
  - A taring scale is easy to use and reliable.

Preparation for Weighing the Children by Digital Scale

a) **If the child is less than 2 years old or is unable to stand,** tared weighing is used.

b) **If the child is 2 years or older** and can stand still on the scale without support the weighing can be done directly.

For detailed procedure of tared weighing using Digital Scale .

Points to be kept in mind while weighing using digital scale

- While weighing the child less than 2 years, it is important that the mother should stay on the scale until her child has been weighed in her arms.
- An older child should step on the scale alone and stand very still.

- A child should be weighed with minimum clothes.
- A wet diaper, shoes, jeans or any other clothing that can weigh more than 0.5 kg must be removed.
- If it is too cold to undress a child or if the child resists being undressed and becomes agitated, one may weigh the clothed child, but note in the *Growth Record* that the child was clothed. It is important to avoid upsetting the child so that the length/height measurements can also be taken if needed. If it is socially unacceptable to undress the child, remove as much of the clothing as possible.
- If a mother is very heavy (more than 100 kg) and the child's weight is relatively low (less than 2.5 kg), the child's weight may not register on the scale. In such cases, have a lighter person hold the child on the scale.
- While getting weighed, the child/ mother holding child should not look down but straight.

NOTE:

The trainer may conduct both the demonstration and the practice session for Tared Weighing using Digital Scale in same manner as that of Salter Scale.

If the trainer wants she/he may club the two activities as practice session.

Step 3: Plotting Weight on the Growth Chart

- The third step in Growth Monitoring is plotting the recorded weight of the child to her/his Growth Chart.
- As per the new Standards, there are separate Growth Charts for girls and boys, as they have different weights and lengths at birth and grow to different sizes as they age .
- A Growth Curve is formed by joining the plotted points on a Growth Chart.
- Direction of the Growth Curve indicates whether the child is growing or not and is more important than the actual weight of the child at a given point of weighing.

Growth Chart

- Observe the Growth Charts carefully. On the extreme top left there is an information box where the child's name, father's and mother's name, family survey register number and weight at the time of birth are to be filled.
- Each Growth Chart has two axes. The horizontal line at the bottom of the chart is the X axis. This is for recording the age of the child for five years and is called 'month axis'. The vertical line at the far left of the chart is the Y axis. This is for recording the weight of the child from birth onwards and is called 'weight axis".
- The horizontal lines from bottom to top of the Growth Chart reflect the weights from 0 to 21 kg at 100 gm interval.
- The vertical lines from left to right of the chart reflect age from 0 to 5 years at one month interval. Look at the vertical line on the extreme left of the growth chart. Along this line are weights written in kilograms, 1, 2, 3… 21 kg. The bold line in between the kilograms indicates 500 grams and the thin line 100 grams.
- At the bottom of the Growth Chart are five steps, each of which represents one year in the child's life. Each step has been further subdivided into boxes to write the twelve months of the year. The first box on the extreme left has a thick dark outline. This is for the birth month and year of the child.
- On the whole, 'month axis' of each growth chart has 60 squares and can be used for a child up to 5 years or 60 months.
- Age is recorded in completed weeks/months/ years. It is recorded in completed weeks only for a child below 1 month.
- Small lines dividing the first month into four weeks has been drawn in the first square which need to be drawn upward while plotting weight depending on the completed week and weight of the child.
- White rectangles below the 'month axis' are for writing month and years as per the date of birth of the child. On each visit, weight of the child taken is plotted, corresponding to the relevant rectangle.

Plotting on the Growth Chart

Let us now learn how to plot a Growth Chart. In the ICDS programme, the Growth Charts have been provided in the form of a register which has an index at the end of the Growth Chart register. Pink Growth Charts are to be used for girls and the blue ones for boys.

Described below are steps for plotting a Growth Chart.

A. Index of Growth Charts

In the index of the Growth Chart register (as mentioned below), write down the name of the child and other relevant information such as Serial No, Name of the Child, Date, Month and Year of Birth D/M/Y, Birth Registration No. Father's Name, Mother's Name, Family Survey Registration No, and Page No. of Growth Chart in GM Register.

Index of Growth Charts							
Serial No	Name of the Child	Date, Month and Year of Birth D/M/Y	Birth Registration No.	Father's Name	Mother's Name	Family Survey Registration No	Page No. of Growth Chart in GM Register

Now, turn to an empty growth chart and choose appropriate growth chart (Pink or Blue) according to sex of the child.

B. Information Box

Write down the required information in the information box on the growth chart i.e., name of the child, father's name, mother's name, family survey registration number and weight at the time of birth.

C. Filling up the month and year column

Write the month and year during which the child was born in the first white rectangle at the bottom of the first column from the left hand side.

Note:

The child's birth month and year will be written in the first thickly outlined Box and date of birth on the margin.

Points of Consideration for Plotting Weight on the Growth Chart

- Use pink border chart for girls and blue border chart for boys.
- Fill up the 'Information Box' on the left hand side of each Growth Chart before using it.
- Do the plotting with help of a HB pencil.
- Write the month and year during which the child was born in the first white rectangle at the bottom of the first column from the left hand side.
- Identify the 'month box', which identifies the present age of the child in completed weeks or months.
- Plotting has to be made at the junction of vertical line (not between vertical lines) of the identified 'month box', and line corresponding to weight.
- Plotting has to be done on the lines for completed weeks/months. Weekly plotting will be restricted to only initial 1st month from the birth and thereafter plotting will be done on completed months.
- The child born on 1st of any month would complete her month on the last day of respective month and so on during all the years.
- For plotting on completed weeks, small lines drawn in the birth month need to be followed/extended upward vertically till the plotting of actual weight of the child.
- Identify the horizontal line which indicates the present weight of the child to the nearest 0.1 kg e.g. 6.2 kg.
- Follow this horizontal line on the 'weight axis' towards right to the point where it intersects with the line which is extended from the vertical line from the 'month box' indicating the present age of the child.
- Write the weight taken to the nearest 100 grams below the 'month box', which indicates the present age of the child.
- Put a dot on the line where the two lines intersect. Draw a circle around the dot, so as to know the position of the plotted point for weight-for-age.

- Do not plot any point in the space between the two vertical lines on a Growth Chart.
- Record weight-for-age of the child by plotting a point on the Growth Chart, each time she/he is weighed.
- Connect the points plotted for two or more months/weight, with a straight line to form the Growth Curve and observe trends.
- Whenever there is a gap in monthly weighing or no information available about weight then that gap in growth chart needs to be joined with a dotted line.

Remember:

The weight should be plotted at the intersection of two lines (weight line and age line) against the month and year in which the weight was taken. Write the weight below the box of that month. Join the plotted weights to make the growth curve.

Advantages of Plotting Weight on the Growth Chart

- Provides a visual record of the growth pattern of a child.
- Acts as a tool/aid for health and nutrition education to mothers.
- Detects growth faltering and weight loss in its early stages.
- Determines the grade of weight of child.
- Identifies beneficiaries for supplementary nutrition.

Activity: Plotting weight on Growth Chart

For this activity the trainer may provide trainees with a weight record of a child and ask them to plot the readings on the chart.

Case:

On 26th of February 2009, Jenny gave birth to a baby girl Jancy. AWW goes to Jenny's house same day and weighed the child. She was 2.5 kg. Jancy's weight was monitored thereafter regularly. Plot her growth on the suitable growth chart.

Date of Weighing	Weight	Age of Child
4.3.2009	2.6 Kg	1 Wk
10.3.2009	2.7Kg	2 Wk
16.3.2009	2.9Kg	3 Wk
22.3.2009	3.1Kg	4 Wk
21.4.2009	-	1 Mo
20.5.2009	4.1 kg	2 Mo

Discuss :

- Which growth chart will you use?
- How will you plot the missing value on the growth chart?

Step 4: Interpreting Growth Curve

- After plotting weight and joining dots (points) on the Growth Chart to form a Growth Curve, interpreting or reading the Growth Curve is the fourth step in Growth Monitoring.

- Depending on the pattern of monthly growth of a child, the direction of the Growth Curve may be upward, flat or downward. An upward Growth Curve indicates that the child is healthy, gaining weight and is growing. However, when the weight gain is not sufficient as per the age of the child, then the Growth Curve is either flat or downward.

Table: Interpretation of Growth Curve

Position of the Plotted Point	Growth Curve	Nutritional Status
Plotted point is • **Exactly on or just above the 1st curve(or)** • **Between the 1st & 2nd curve** • **Exactly on the 2nd curve**	**Green band**	**Child's growth is normal**
Plotted point is: • **Between 2nd & 3rd curve** • **Exactly on the 3rd curve**	**Yellow band**	**Child is moderately underweight**
Plotted point is below the 3rd curve	**Orange band**	**Child is severely underweight**

The trainer must explain that if the Growth Curve of a child falls in the yellow and orange band, it means that the child is suffering from one of the forms of undernutrition and adequate nutritional care must be provided to the child in order to protect and rehabilitate the child.

Step 5: Counselling and follow up

Points to Keep in Mind While Counselling & Follow-Up

- Explain to the mother the growth and development of the child using Mother & Child Protection Card.
- Show the Growth Chart of the child to the mother and explain the direction of the Growth Curve/ position of the plotted point.
- Discuss 'developmental milestones' of the child with the mother and the family. If there is a delay in reaching a particular milestone or the child seems slow, advice to increase feeding, talking and playing. If the child is still slow, refer the child to a doctor/health facility.

- Prioritize and list children who are not growing well.
- Follow up severely underweight children. Make home visits.
- Convince the mother to bring the child regularly to AWC on monthly Village Mother Child Health Day for key services.
- Keep the discussion positive and it should be in a soft and familiar language.

Tips for counselling the mother

- Ask the mother questions about caring practices, especially feeding, current or previous illness and about immunization.
- Counsel mothers on improved child care practices for ensuring optimal growth and development.
- Praise the mother if the child is growing well and encourage her to follow good caring practices.
- Build confidence in the mother and encourage family support
- Listen to the mother and try to ascertain the cause of the problem
- Advise the mother, as per the problem, about nutrition care and feeding the child.
- Keep the discussion positive and use soft and familiar language.
- Explain to the mother and the family that feeding, playing and communicating with children helps them grow and develop well
- Check understanding of the advice given to the mother
- Reinforce messages.

Mother and Child Protection Card

India's major initiative to reduce maternal, neonatal and infant mortality and child undernutrition has been the adoption of WHO Child Growth Standards, (w.e.f 15 August 2008 in convergence with MoHFW/NRHM & MWCD/ICDS). This initiative has been enhanced and complemented by another decision of both the ministries by introducing a common Mother and Child Protection Card for both ICDS and NRHM, to strengthen the continuum care for pregnant mothers and children under-three years of age thereby integrating the new WHO Child Growth Standards.

The family based Mother Child Protection Card (MCPC) is an important tool for families to learn understand and adopt better care practices. It enables pregnant and lactating women to monitor their health status during this crucial period and helps families, care givers and community to monitor on their own the growth and development of children up to 3 years and take timely and appropriate measures.

The MCP focuses on the child holistically by integrating health, nutrition and development. It links critical contact points for strengthening the continuum of care and improving utilisation of key ICDS, NRHM services, including immunisation and Janani Suraksha Yojna. Also, it is meant to promote key family care behaviours, highlights danger signs and links families to the referral system. The MCP Card enable gender disaggregated tracking, to ensure optimal care of the girl child.

MCP Card as Package:

- MCP Package is a comprehensive package of services addressing the needs of pregnant women, lactating mothers and children up to 3 years of age

Importance of the card:

• The card is developed as a tool to monitor the health and nutrition status of the pregnant woman and there are of the child till three years.

• The card helps families to know about various types of services which they should access and utilise to ensure the overall health and well-being of women and children.

• The Mother and Child Protec on Card has been developed to help families learn, understand and follow positive practices for achieving good health of all pregnant women, mothers and children.

• The card empowers families to make decisions for improved health and nutritional status, outcomes during pregnancy, and development of healthy young children on a continuous basis.

Who uses the card?

The card can be used by different individuals or groups which include:

A. Family Members (Mothers, Fathers, Mother and Father-in-laws, Adolescent Girls and Others)

1. For gaining knowledge related to the pregnant woman's health, nutrition and optimum foetal development.
2. To counsel the woman about danger signs in pregnancy and when and where to seek help.
3. For gaining knowledge related to children's health, nutrition and development.
4. For using all available health and nutrition services.
5. For practicing op mum care behaviour(s).
6. For monitoring and promo ng growth and development of children.

B. Village Groups/VHSNC/Women's Group

1. As a discussion tool in the meetings.
2. Monitoring effective service delivery in the area.

C. ANM/AWW/ASHA

1. For educating families about op mal health, nutrition and child care practices for mothers and young children.
2. For recording information on utilization of health and ICDS services.
3. For appropriate home visits referrals and follow up.
4. For promo ng birth preparedness and seeking appropriate care for the mother and baby.

D. Health and ICDS Supervisors

For ensuring that:

1. The card is introduced to the target families;
2. Its use is properly explained to the families with support materials; and
3. There is effective and efficient delivery of services to the target families.

Who are the specific target groups for the card?

1. Pregnant women
2. Lactating women
3. Families with children under 3 years of age
4. IGMSY, JSY, NRC and JSSK beneficiaries

Who keeps the card?

1. Pregnant woman/her family
2. Mothers of children under 3 years of age
3. Duplicate card may be kept at sub-centre or AWC by ANM/AWW

4 Families should be advised to keep the card safely in plastic covers to prevent it from wear and tear

5. Families should be advised to bring the card along whenever they visit AWC, Sub centre, health centre, private doctor and/or a hospital

How to Use Growth Chart in MCP Card:

- Child is taken to the AWC every month (as per the day/date fixed by Anganwadi Worker depending on the child's birth date) for weighing.
- Weight of the child is plotted on the growth chart by the worker in front of the family.
- The direction of the growth curve is understood by the family.
- Care of the child is discussed with the worker.
- The worker is informed about any previous/current illnesses.
- Advice of AWW is sought and followed regarding feeding, care and care during illness for the child.

Implications for New Child Growth Standards & Improved Counselling through MCP Card:

- Correct assessment of child under nutrition
- Gender Specific – link to improved care of the girl child
- Greater attention to Pregnant Mother's Health & Early infancy - timely interventions
- Promote early and exclusive breastfeeding for the first six months of life & optimal Infant and Young Child Feeding
- Respond to improve care, feeding, health referrals – 40% underweight and 15.8 % severely underweight children
- Comparable with other national and international data

How to Use the Card?

- Information on the cover page on Family Identification and Birth Record should be filled in before the card is given.
- Families should be advised to bring the card along when they visit AWC, sub-centre, health centre, private doctor and a hospital.
- Families should be advised to keep the card in a safe place to prevent it from wear and tear.

Yellow colour has advice/information that the ANM/AWW/ASHA must explain to the mother and family members. The reasons/details are given below the yellow box.

Red denotes danger and requires immediate contact with health care provider. Danger signs/information is in red boxes or written in red letters.

Blue boxes and writing in blue is important information for the ANM/AWW/ASHA. She must understand these messages before counselling the mothers.

Green boxes have instructions/advice that the family must follow/ensure. Pink boxes require ANM/AWW to record/fill the information in the card. This

Different Sections of the MCP Card

Maternal Care

The various components included under the maternal care in the card are:

- **Essential obstetric care:** Essential obstetric care include three antenatal check-ups, recording of blood pressure and weight, administering 2 doses of TT injection and consumption of IFA tablets, one tablet a day for at least three months (100 days)

- **Care during pregnancy:** Care during pregnancy depicts message and illustrations related to nutritional needs and taking at least two hours of rest during the day;

- **Danger signs during pregnancy, child birth and after delivery:** Danger signs during pregnancy, child birth and after delivery includes bleeding during pregnancy, excessive bleeding during delivery or after delivery severe anemia with or without breathlessness, high fever during pregnancy or within one month of delivery, convulsions or fits, blurring of vision, headache, vomiting, sudden swelling of feet, labour pain for more than 12 hours and bursting of water bag without labour pain;

- **Preparation for delivery:** Preparation for home delivery depicts the 5Cs i.e. clean hands, clean surface and surroundings, clean blade, clean umbilical cord, clean thread to tie the cord; after delivery, adoption of family planning; and dealing with an emergency, arranging for transport, and identifying hospital in advance, for taking the mother in case of an emergency.

Child Care

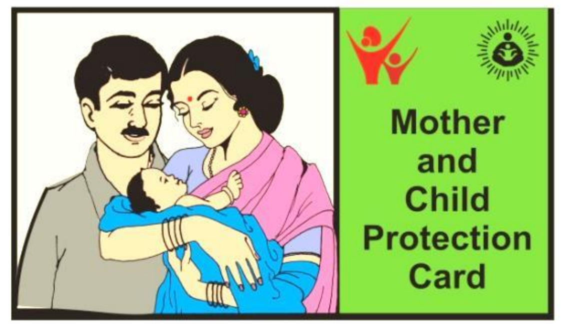
In the Child Care Section MCP Card focus on:

- **New born care:** Messages on new born care include; keeping the baby warm, starting breastfeeding immediately after birth and ensuring exclusive breastfeeding, not to bathe the child for 7 days, keeping the child away from people who are sick, weighing child at birth, and need for special care if the child is less than 2.5kg.
- **Care during illness:** Care during illness covers illnesses like diarrhea, fever and Acute Respiratory Infection.
- **Danger signs in a child:** Danger signs in a child that need immediate attention of health workers such as weak suck or refusal to breastfed; baby unable to cry/ difficult breathing; yellow palm and soles; cold to touch and convulsions.
- **Immunisation schedule:** Immunisation schedule of Bacillus Calmette Guerin, Diphtheria Pertussis and Tetanus, polio, measles and hepatitis B vaccine and administration of vitamin A solution.
- **Growth chart:** Growth chart of boy and girl child.

Development Milestones and Care Practices

- The 'care aspect' is a new addition in this card, compared to the other existing cards in the health and ICDS system. The card focus on the behaviour and practices of caregivers (mothers, siblings, fathers and family members); besides focussing on food, health care, stimulation, and emotional support necessary for children's health growth and development.
- The illustration and messages on developmental milestones and care practices have been classified age-wise i.e. 0-6 months (0-3 months, 3-6 months); 6-12 months, 1-2 years and 2-3 years. It has messages on 'feeding behaviour', 'what mothers can do to

Integrated Child Development Services



Photograph of Mother & Child

Family Identification
Mother's Name ____________ Age
Father's Name ____________
Address ____________
Mother's Education: illiterate/primary/middle/high school/graduate
Birth Record
Child's Name ____________
Date of Birth / / Birth Weight kgs gms
Girl Boy Birth Registration No:
Pregnancy Record
Date of the last menstrual period / /
Expected date of delivery / /
No of pregnancies/ previous live births /
Last delivery conducted at: Institution Home
Current delivery: Institution Home
JSY Registration No. ____________
Institutional Identification
AWW ____________ AWC/Block ____________
ASHA ____________ ANM ____________
SHC / Clinic ____________
PHC / Town ____________ Hospital Address ____________
Transport Arrangement ____________
Anganwadi Reg. No Sub-centre Reg. No Date
Referral
Food & Nutrition Board
Ministry of Women & Child Development, Government of India

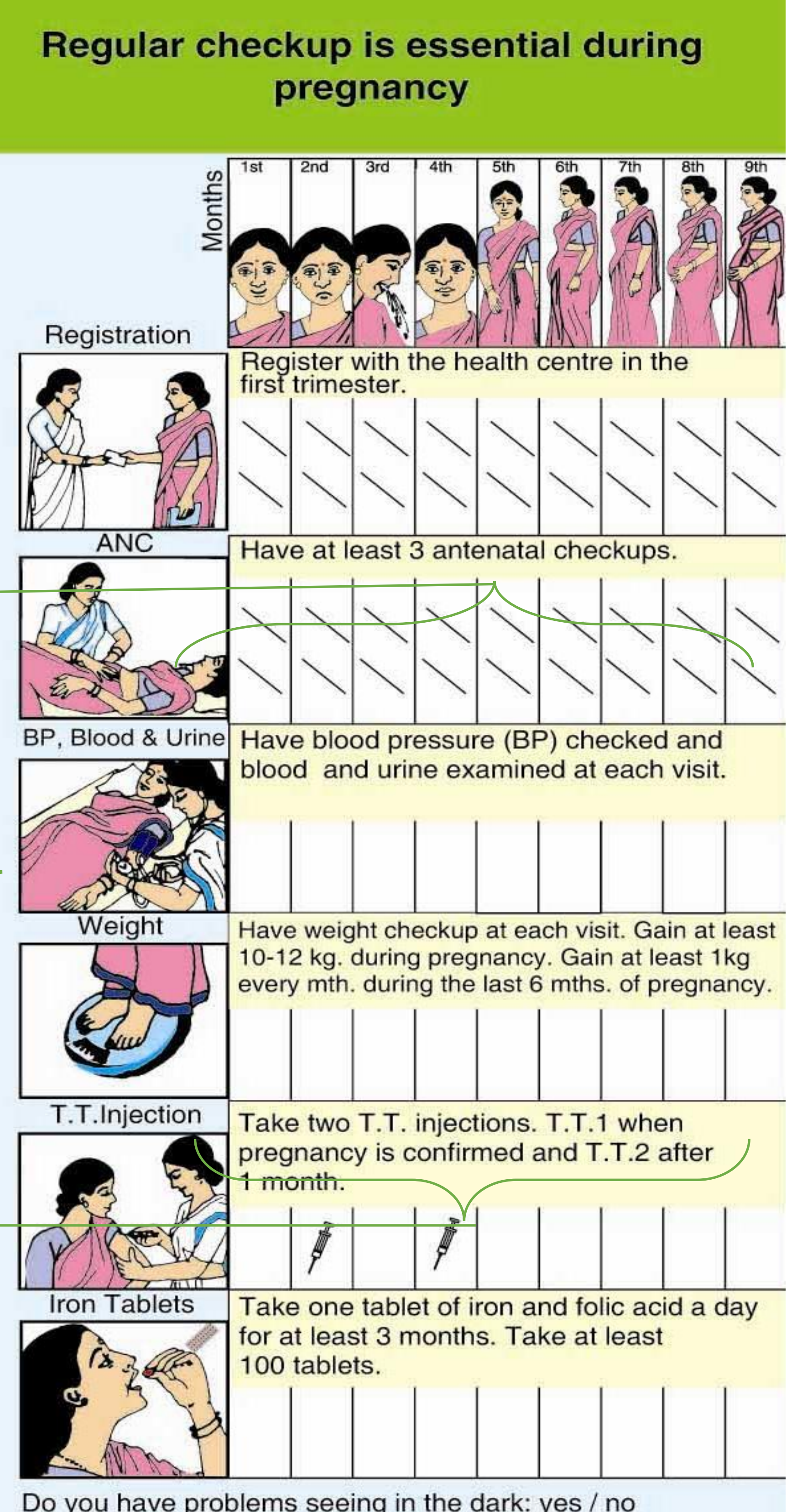
promote growth and development in their child to develop to his/her full potential and what most children can do tells, what milestones children reach in that particular age.

Details of different sections of card

Front Cover

It has space for recording the details of family, pregnancy record, birth record of the child and institutional identification.

1. **Family identification**
   - Name of father/ mother& address
   - Age of mother
   - Mother's education
   - Photograph of Mother & child
2. **Pregnancy Record**
   - Mothers ID no.
   - Date of last menstrual period
   - Expected date of delivery
   - No. of pregnancies/ previous live births
   - Last delivery conducted at
   - Current delivery conducted at
   - JSY registration No.
   - JSY payment amount
3. **Birth Record**
   - Child's name
   - Date of birth



- Birth weight
- Select the Gender of the child
- Birth Registration No.

4. **Institutional Identification**

- Names and address
- Anganwadi worker
- Angandiwadi block
- ASHA
- ANM
- SHC / Clinic
- PHC town
- Hospital FRU
- Contact no. of ANM
- Hospital
- Transport Arrangement
- AWC registration No.
- Sub centre registration No.

Details of Antenatal Check-up (ANC)

How to read this Section:

- Nine columns in the Regular Check- up section across the MCP Card depict nine months of pregnancy with pictures of pregnant women.

- Six picture boxes depicted vertically, i.e. Registration, ANC etc. depict six services that a woman must seek during a pregnancy.

- The columns alongside each picture are for recording the appropriate information.

Regular Check-up : is essential during pregnancy

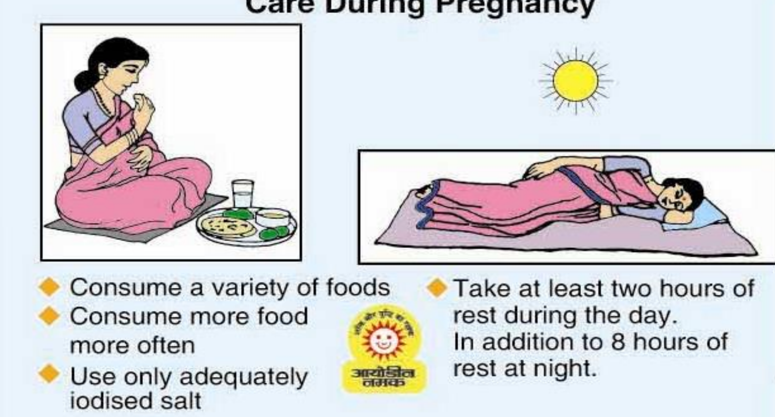
- ❖ Help to improve the health of mother & baby
- ❖ Early detection of complications
- ❖ Ensuring good maternal & foetal outcomes
- ❖ Early Registration in health centre : (first trimester)
- ❖ Antenatal care: Atleast have antenatal checkups
- ❖ Blood pressure & urine : Blood pressure and urine should be regular check up .If Bpis above 130/90 , doctor should be contacted
- ❖ Weight: Regular weight checkup at each visit. Weight gain atleast 10-12 kg during pregnancy. 1kg every month during the last 6 months

- ❖ TT injection : Take 2 TT injections at an interval of one month
- ❖ IFA tablets : Take one iron & folic acid tablet for at least 3mths

CARE DURING PREGNANCY

1. Nutritional Care during Pregnancy

- A pregnant woman should consume more food, more often during the day.
- She should consume a variety of foods like cereals and whole grains, pulses, dark green leafy vegetables like spinach, amaranth, cholai, red & yellow fruits like papaya, mango and melon, lentils & beans, milk & milk products and fish, meat and eggs if acceptable and affordable.



- Take more food around 1/4th times extra than the normal diet
- She should use only iodised salt.
- Consume SNP from the AWC regularly

Iodised salt is important for the proper brain development for the unborn child and it prevents abortion, still and pre-term births.

2. Rest:

- Take at least two hours of rest during the day, in addition to 8 hours of rest at night.
- Routine activities should be interspersed with short periods of rest throughout the day

What Family should ensure?

- The pregnant woman eats along with her family. She should not be the last one to eat/eat leftover.
- She does not avoid any food during pregnancy and also does not observe fast during pregnancy.
- Alcohol and tobacco are not be used during pregnancy.
- Medicines are taken only when prescribed by the doctor.
- The pregnant woman avails supplementary food and nutrition counselling services at the AWC every month.

- The pregnant woman avoids doing strainuous work in the home. Family members offer help in doing household chores.

Obstetric Complication in Previous Pregnancy, Past History and Examination

- It is essential for the ANM to take the history of the pregnant woman.
- It is essential to ask a woman about her previous pregnancies or obstetric history.
- This is important especially if she had any complications in the previous pregnancies, as some complications may recur during the present pregnancy.

Key question in history taking include:

1. The date of last menstrual period
2. Her age
3. The order of pregnancy
4. No. of living children
5. Date of last delivery/abortion
6. Menstrual history and LMP
7. Any problem during the previous pregnancy/ delivery
8. History of any systemic illness, significant family history
9. Complication in the current pregnancy

• Be particular about asking for records to validate the history given of the previous pregnancy

ANTENATAL CARE

Take the history of mother includes:

- o Date of last menstrual period
- o Age
- o Order of pregnancy
- o No. of living pregnancy
- o Date of last delivery
- o Problem in previous pregnancy
- o History of systemic illness
- o Complications in previous pregnancy

ANTENATAL CARE

OBSTETRIC COMPLICATION IN PREVIOUS PREGNANCY
(Please tick (✓) the relevant history)

A. APH	☐	B. Eclampsia	☐	C. PIH	☐
D. Anaemia	☐	E. Obstructed labor	☐	F. PPH	☐
G. LSCS	☐	H. Congenital anomaly in baby	☐	I. Others	☐

Obtain information about any obstetric complications in previous pregnancy:

- o APH :Ante partum hemorrhage
- o Eclampsia

- PIH : Pregnancy induced hypertension
- Anaemia
- Obstructed labour
- PPH :Post partum hemorrhage
- Abdominal surgery
- Congenital anomaly

PAST HISTORY

(Please tick (✓) the box of the appropriate response/s)

A. Tuberculosis ☐ B.Hypertension ☐ C.Heart Disease ☐

D. Diabetes ☐ E.Asthma ☐ F. Others ☐

EXAMINATION

General Condition	Heart	Lungs	Breasts

Past history of the mother includes

- Tuberculosis
- Hypertension
- Heart Disease
- Diabetes
- Asthma
- Others

ANTENATAL VISITS

	1	2	3	4
Date				
Any complaints				
POG (Weeks)				
Weight (Kg)				
Pulse rate				
Blood pressure				
Pallor				
Oedema				
Jaundice				

Antenatal visit

The 4 antenatal visit are mandatory for each pregnant women to find the complications and managed within the time

- 1st visit within 12 weeks
- 2nd visit between 14-26weeks
- 3rd visit between 28-34 weeks
- 4th visit after 36 weeks

ABDOMINAL EXAMINATION

Fundal height Weeks/cm				
Lie/Presentation				
Fetal movements	Normal/Reduced/ Absent	Normal/Reduced/ Absent	Normal/Reduced/ Absent	Normal/Reduced/ Absent
Fetal heart rate per minute				
P/V if done				

Abdominal Examination

- Abdominal examination tells about foetal lie and presenting parts of foetus
- It should be assessed whether the fundal height corresponds to the period gestation

ESSENTIAL INVESTIGATIONS

Hemoglobin				

Blood Group & Rh Typing. ☐ Date / /

OPTIONAL INVESTIGATIONS

1. Urine pregnancy test. ☐ Date / /
2. Hbs Ag. ☐ Date / /
3. Blood sugar. ☐ Date / /

Participate in monthly fixed village Mother Child Health & Nutrition Day

Essential Investigations

- Hemoglobin
- Urine albumin
- Urine sugar

- Blood group & RH typing

Optional Investigations

- Urine pregnancy test
- Hbs Ags.
- Blood Sugar

Put a tick mark in the box. It is important to refer the pregnant woman to a higher health facility where appropriate management of the condition can be done during the antenatal period. Examination for general condition, heart, lungs and breasts should be done and any complaint should be recorded in the box.

What family should ensure?

- They comply with the referral made by the ANM in case of complications during previous pregnancies, bad obstetric history or chronic/systemic disease or any abnormal finding during the examination.
- Pregnant woman comes for the antenatal visits within the stipulated period. MCP card is carried along for each visit and is produced at the time of delivery.
- Referral made by the ANM should be complied. Not doing so can prove to be harmful for the pregnant woman and/or foetus.

Why ANC is Important?

- Each pregnant woman should get at least 4 antenatal check-ups including registration during pregnancy. It is important as many of the complications can be detected and managed on time.
- 4 antenatal visits are mandatory (including registration) for each pregnant woman.
- 1st visit within 12 weeks, 2nd visit between 14-26 weeks, 3rd visit between 28-34 weeks and 4th visit after 36 weeks
- During each antenatal visit, all the parameters need to be checked and recorded. The check-ups may be conducted as under:

What happen at ANC Visits?

1st Visit (within before 12 weeks)

1. Registration
2. History taking
3. Give tetanus toxoid (1st dose)

2nd Visit (14 - 26 weeks)

1. Screen for risk factors and medical conditions
2. Record BP, weight and height
3. Haemoglobin estimation/Screen for anaemia
4. Urine examination for albumin
5. Breast examination
6. Give tetanus toxoid first/second dose
7. Provide health and nutrition education
8. Develop individualized birth plan

3rd Visit (28 - 34 weeks)

1. Record BP, weight
2. Abdominal examination to asses for intrauterine growth retardation (IUGR), twins etc.
3. Haemoglobin estimation
4. Urine for albumin
5. Give tetanus toxoid (2nd dose)
6. Anaemia prophylaxis /treatment
7. Health education
8. Nutrition counselling
9. Danger signs during pregnancy

If you or anyone in your family sees any of these danger signs, take the pregnant woman to the hospital immediately

Bleeding during pregnancy, excessive bleeding during delivery or after delivery

Severe Anaemia with or without breathlessness

High fever during pregnancy or within one month of delivery

Convulsions or fits, blurring o vision, headaches, vomiting, sudden swelling of feet

Labour pain for more than 12 hours

Bursting of water bag without labour pains

4th Visit (after 36 weeks)

1. Record BP, weight
2. Detect - Pregnancy induced hypertension
3. Abdominal examination to identify foetal lie / presentation to detect IUGR
4. Check for pelvic adequacy to rule out if head is bigger than pelvis in primigravida (first pregnancy) after 37 weeks.
5. Update individualized birth plan with the trained birth attendant and family.
6. Health and nutrition counselling, diet, rest, IFA tablet consumption, danger signs and where to go when any complication arises.

• **A properly maintained MCP card helps in tracking progress of the baby and mothers condition.**

• **During VHND, special effort should be made to do a complete antenatal check-up for all the pregnant women who are due for it.**

DANGER SIGNS

- Bleeding during pregnancy or delivery
- Severe anaemia with or without breathlessness
- High fever during pregnancy or within one month of delivery
- Convulsions or fits, blurring of vision, headache, sudden swelling of feet
- Labor pain for more than 12 hours
- Bursting of water bag without labor pain

POST NATAL CARE

Date of delivery ☐☐☐☐☐☐ Place of delivery ____________ Type of Delivery N.☐ Instr.☐ CS☐

Term/Preterm ________ If at institution period of stay post delivery ______________

Complications, if any (Specify) ______________________

Sex of baby M F *Weight of baby ☐ kg. ☐☐☐ gms

Cried immediately after birth Y N

Initiated exclusive breast feeding within 1 hour of birth Y N

* (Three extra visits if birth weight < 2.5kg)

Postnatal Care

The first 42days after the delivery are postnatal period. The first week are the most crucial for the health and survival of the mother and newborn. During the postnatal period, visits on stipulated time helps in detecting complications.

Care of Mother

• First postnatal visit is on Day 1, second on Day 3, third on Day 7 and fourth at 6th week.

• In case of institutional delivery, first and second visit should ideally happen at the facility.

• ANM should take help of AWW and ASHA to carry out stipulated visits to the mother and baby.

What Family should ensure?
• Danger signs in mother and baby are given immediate attention.
• Nutritious diet is provided to the mother.
• Clean sanitary pad are made available.

POST PARTUM CARE

	1st Day	3rd Day	7th Day	6th Week
Any complaints				
Pallor				
Pulse rate				
Blood pressure				
Temperature				
Breasts Soft/engorged				
Nipples Cracked/normal				
Uterus Tenderness Present/absent				
Bleeding P/V Excessive/normal				
Lochia Healthy/foul smelling				
Episiotomy/Tear Healthy/infected				
Family planning Counselling				
Any other complications and referral				

Care of Baby

- Baby may be examined on 1,3,7 days and 6weeks
- Low birth baby should visit additionally
- Weight should be regular monitored Baby must be breastfed exclusively and frequently.
- Difficulty in suckling needs immediate attention
- Hands and breasts should be cleaned before feeding the baby.
- Any abnormal/danger signs must be reported to the ANM/MO and care

CARE OF BABY

	1st Day	3rd Day	7th Day	6th Week
Urine passed				
Stool passed				
Diarrhea				
Vomiting				
Convulsions				
Activity (good /lethargic)				
Sucking (good/ poor)				
Breathing (fast/difficult)				
Chest indrawing Present/absent				
Temperature				
Jaundice				
Condition of umbilical stump				
Skin pustules Present/absent				
Any other complications				

should be sought.

- During each visit, weight of the child should be monitored.
- The baby must be examined on 1,3,7,days and at 6 weeks
- Low birth weight babies should be visited additionally on Day 14, 21 and 28.
- During each visit, weight should be monitored and recorded on growth chart.
- At birth the child is given BCG, OPV + Hepatitis B vaccine. At birth or upto 14 days polio drops (called the zero dose which is given before the first dose).
- Any deviation from the normal must be noted and acted upon as per the protocols.
- ANM should take help of AWW and ASHA to provide care to the newborn.

New born care starts soon after the baby has been delivered

- After delivery newborn should be cleaned
- Keep the baby warm
- Do not bathe the baby for the first seven days
- Start breastfeeding immediately after the birth not be given any other liquid or foods such as water, honey ghutti etc.
- For the first six months feed the baby only mothers milk
- Keep the baby away from people who are sick
- Keep the cord dry
- Weigh your child at birth
- Give special care if child is less than 2.5 kg at birth

NEWBORN CARE

- Keep the child warm
- Start breastfeeding within 1 hour after birth.
- For the first 6 months, feed the baby only mother's milk
- Do not bathe the child for the first 48 hours
- Keep the cord dry
- Keep the child away from people who are sick
- Weigh your child at birth
- Give special care if child weighs less than 2.5 kg. at birth

Danger Signs in Newborn

DANGER SIGNS – SEE HEALTH WORKER

- Weak sucking or refuses to breastfeed
- Baby unable to cry/difficult breathing
- Yellow palms and soles
- Fever or cold to touch
- Blood in stools
- Convulsions
- Lethargic or unconscious

What Family should ensure?
- Newborn is handled by only few people.
- Baby is not given anything by mouth except breast milk.
- Routine Immunisation is started as per schedule.
- Babies with low birth weight are given additional care.
- Baby is kept warm and cord is kept dry & clean.

Details of Immunization

❖ At birth the child is given BCG, OPV + Hepatitis B vaccine

❖ At birth or upto 14 days polio drops (called the zero dose which is given before the first dose)

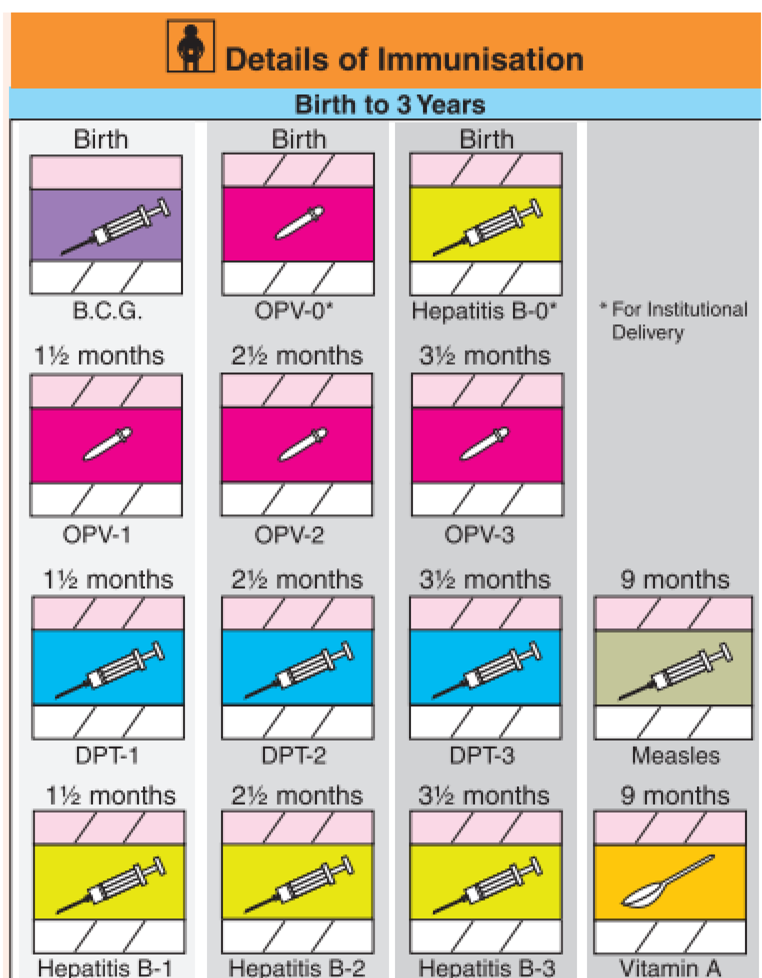
❖ At 1½ months for first dose of DPT, polio and Hepatitis B

❖ At 2½ months for second dose of DPT, polio and Hepatitis B

❖ At 3½ months for third dose of DPT and polio

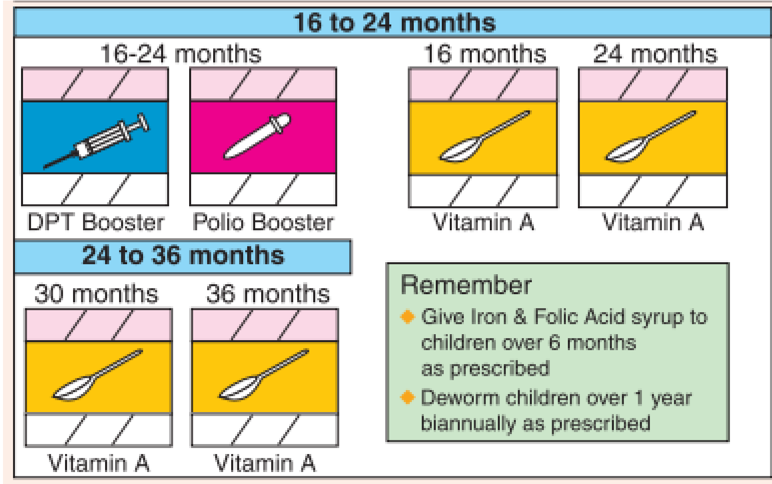
❖ At 9 months for measles, third dose of Hepatitis B and Vitamin A supplement

❖ Full course is completed for each vaccination



Child is taken for immunisation four times in the first year of life apart from immunization given at birth.

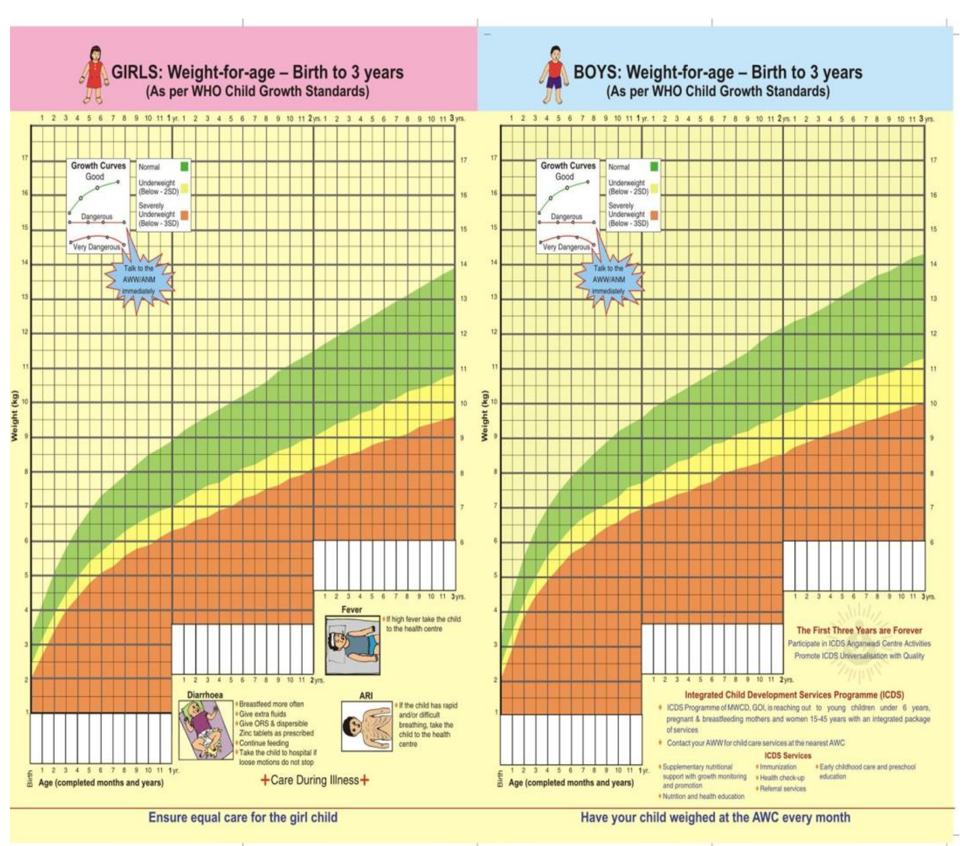
❖ Child is taken for immunisation even if there is mild fever, cough, cold and diarrhoea
❖ Deworm children over 1 yr biannually as prescribed.
❖ Give iron and folic acid syrup to children over 6 months.
❖ Child to be given OPV or pulse polio drops in addition to routine Immunisation



Weighing the Newborn (May refer to the Module on Growth Monitoring and Promotion for details)

GROWTH CHART

- Child is taken to the AWC every month (as per the day/date fixed by Anganwadi Worker depending on the child's birth date) for weighing.
- Weight of the child is plotted on the growth chart by the worker in front of the family.
- The direction of the growth curve is understood by the family.
- Care of the child is discussed with the worker.
- The worker is informed about any previous/current illnesses.
- Advice of AWW is sought and followed regarding feeding, care and care during illness for the child.

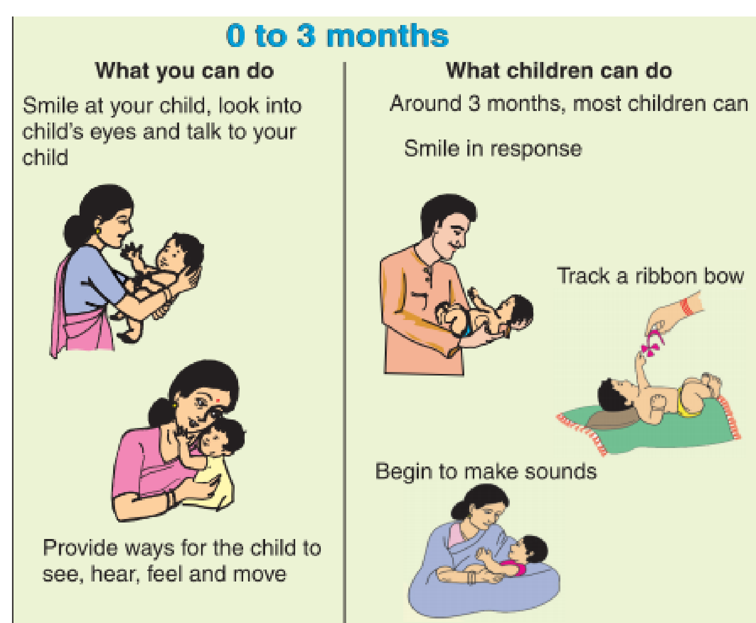


Feeding, Playing & Communication with Children

Feeding: Birth- 6 Months

- Start breastfeeding immediately after birth and exclusively
- Exclusively breastfeed for 6 months – this means do not give any other foods, drinks, not even water
- Breastfeed as many times as the child wants
- Breastfeed as often as the child wants, day and night, atleast eight times in 24 hours.
- Continue breastfeeding during illness. The child needs extra food after illness
- Caregiver should wash hands with soap and water before feeding the child.
- Caregiver should wash hand with soap or ash after washing baby who has defecated, and after baby's excreta has been disposed.

Development: Birth to 3 Months



- Smile and laugh at your child, look into child's eyes and talk to your child
- Provide ways for the child to see, hear, feel and move
- Around 3 months what most children can do
- Smile in response
- Track a ribbon bow
- Begin to make sounds
- If the child seems slow, increase feeding, talking and playing.If the child is still slow, take the child to a doctor.
- Mother has adequate time to breastfeed the baby and play with her/ him.
- While breastfeeding, mother looks into the baby's eyes and talks to her/him.

- Make available safe, clean and colourful objects (e.g. a rattle, plastic bowl, small doll)
- The father spends time with the child and gently cuddles and talks to her/ him.

Development Milestones: 3 to 6 Months

- Have large colorful objects for your child to see and to reach for
- Talk and respond to your child. Get a conversation going by copying your child's sounds or gestures
- Hold head steady when held upright
- Reach out for objects
- Turn to a voice
- All family members can smile, laugh, and talk to the child, and "coo" in response to the child's sounds

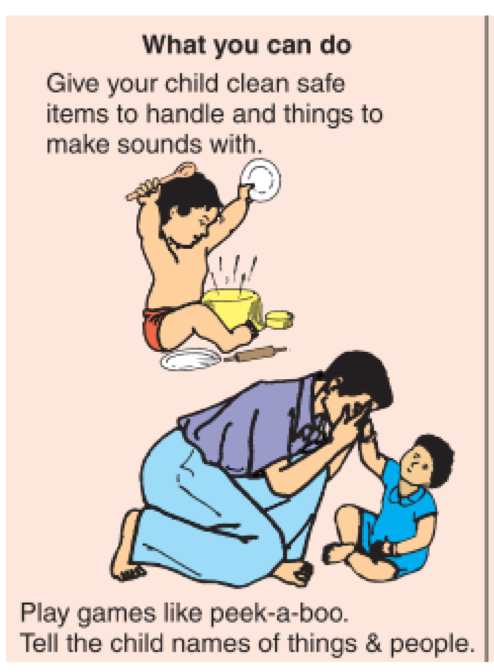
Feeding: 6 - 12 Months

- At 6 months, the child should be given small amounts of soft mashed cereal, dal, vegetables and seasonal fruits.
- Offer a variety of foods as after 6 months of age
- Introduce one type of food at a time.
- Increase the quantity, frequency and thickness of food gradually
- Breastfeed as often as the child wants
- Offer foods rich in micronutrients especially iron and Vitamin A

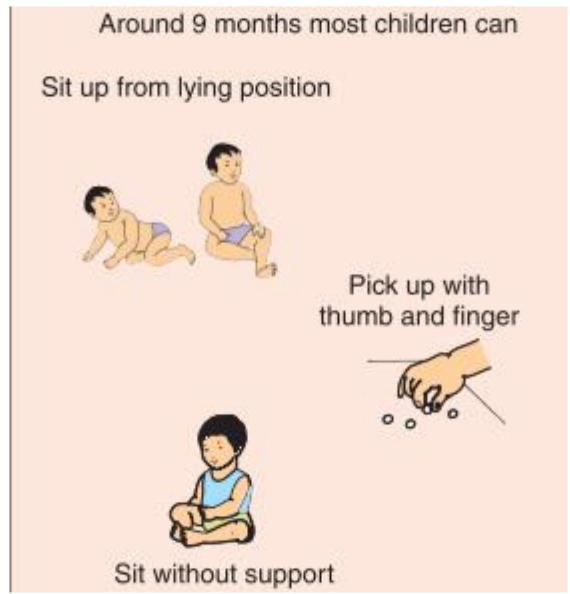
- On completion of 6 months, start with small amounts of soft mashed cereal, dal, vegetables and fruits
- Increase the quantity, frequency and thickness of the food gradually
- Understand child's signals for hunger and respond accordingly
- Feed the child 4-5 times a day and continue breastfeeding

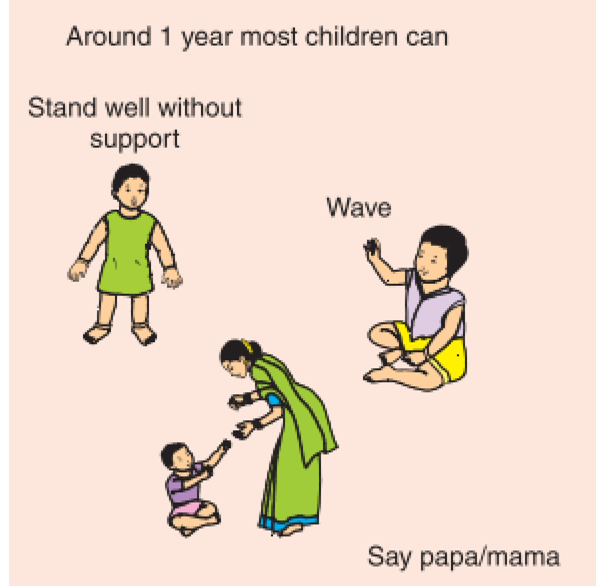
- Understand child's signals for hunger and respond accordingly
- Sit with the child and feed the child by showing interest, smiling or offering an extra bite.

Development milestones: 6 - 12 Months



- Give your child clean, safe household items to handle, bang & drop and things to make sounds with
- Play games like peek-a-boo and bye bye.
- Tell the child names of things and people.
- Stand well without support
- Says papa/mama
- Waves bye bye
- They should use every opportunity to make conversation with the child, when feeding and bathing the child, and when working near the child.





- Encourage the child when s/he tries to walk, play new games and learn new skills.
- Ask simple questions: "Where is your nose?", or "Where is the cat?" Together they can look at pictures and talk about what they see.

Feeding: 1 – 2 YEARS

- Continue to offer a wide variety of foods such as rice/chapatti, pulses, green leafy and other vegetables, yellow and other fruits, and milk and milk products, meat, fish and eggs should be given.
- Feed the child about five times a day (3 meals + 2 extra feedings/day)
- Feeding the child from a separate bowl and mother/caregiver should watch how much food the child actually eats.

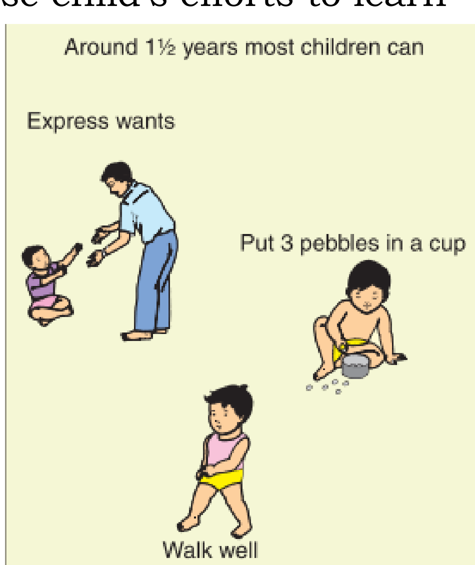
1 to 2 years

Feeding

- Continue to offer a wide variety of foods including family foods, such as rice/ chappati, dark green leafy vegetables, orange & yellow fruits, pulses and milk products
- Feed the child about 5 times a day
- Feed from a separate bowl and monitor how much the child eats
- Sit with the child and help her finish the serving
- Continue breastfeeding upto 2 years or beyond

Development milestones: 1 – 2 YEARS

- Give your child things to stack up and put into containers and take out
- Uses all opportunity to make conversation with the child, when feeding and bathing the child, and when working near the child. Play simple word games, and ask simple questions; "Where is your nose?, or "Where is the bird?"
- Make available simple home-made toys for the child to play with
- Use kind words to soothe an upset child
- Respond to and praise child's efforts to learn a skill. Do not force her to do an activity



Feeding: 2-3 years

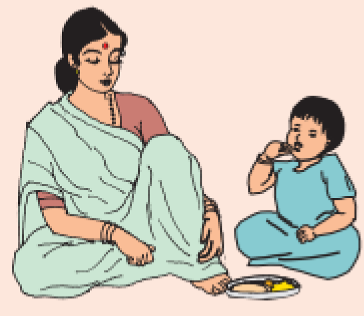
- Continue to feed family food 5 times a day (3 meals + 2 extra feeding/day)
- Help the child feed herself/himself
- Supervise the child's feeding and encourage the child to eat enough
- child's hands are washed before s/he eats on her/his own.
- The child's eating supervised by the mother/caregiver.

Development milestones: 2 - 3 years

- Help your child count and compare things; make simple toys for your child
- Encourage your child to talk and respond to your child's questions.
- Teach your child stories, songs, and games.
- Provides affection and expresses love for the child.
- Responds to child's interests and answers child's many questions.
- Praises child for her/ his efforts to learn a new skill.
- Make available simple home-made toys for the child to learn colours, shapes, size and numbers

2 to 3 years

Feeding



- Continue to feed family foods 5 times a day
- Help the child feed herself / himself
- Supervise feeding
- Ensure hand washing with soap before feeding

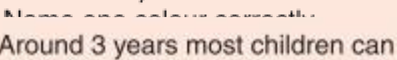
Help your child count and compare things; make simple toys for your child.

Encourage your child to talk & respond to your child's questions. Teach your child stories, songs, and games.

Around 2½ years most children can

Point to 4 body parts

Feed self spilling little



Around 3 years most children can

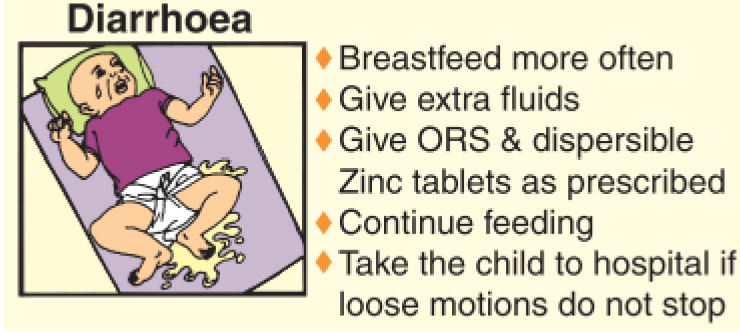
Copy & draw straight line

- Ensures safe environment for the child to play
- Utilize opportunity to gently tell the child what is correct.

CARE DURING ILLNESS

Diarrhoea

- Breast feed more frequently and for longer time at each feed
- Give increased amounts of fluids during diarrhoea.
- If the child is less than 6 months old and exclusively breast fed, give ORS in addition to breast milk.
- If the child is over 6 months of age, give ORS as well as home available fluids like rice kanji (mand), Buttermilk (lassi), lemon water with sugar and salt (shikanji), dal soup, vegetable soup, fresh fruit juice (unsweetened) plain clean water or other locally available fluids.



- Continue to give normal diet to the child
- In case the child is not able to take the normal quantities of food, s/he should be given small quantities of food at frequent intervals.
- Child can also be given foods of thicker consistency such as Khichari, Dalia, suji or rice in milk, idli etc.
- If loose motions do not stop, take the child to the health centre

Acute Respiratory Infection

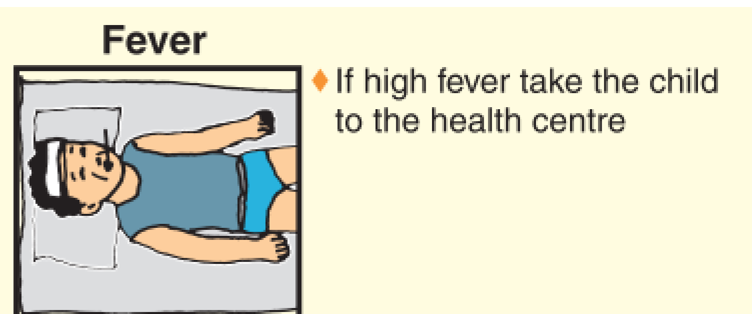
- Keep the young child warm and away from the draught
- If the child's nose is blocked and interferes with feeding, clean the nose by putting in nose drops
- Breastfeed frequently and for longer period at each feed. Exclusively breastfeed for six months.
- Continue to give normal diet to the child.
- Child can also be given foods of thicker consistency such as Khichari, Dalia, sooji or rice in milk, idli etc.)
- Small quantities of oil/ghee should be added to the food to provide extra energy.
- Give increased amounts of fluids.

ARI

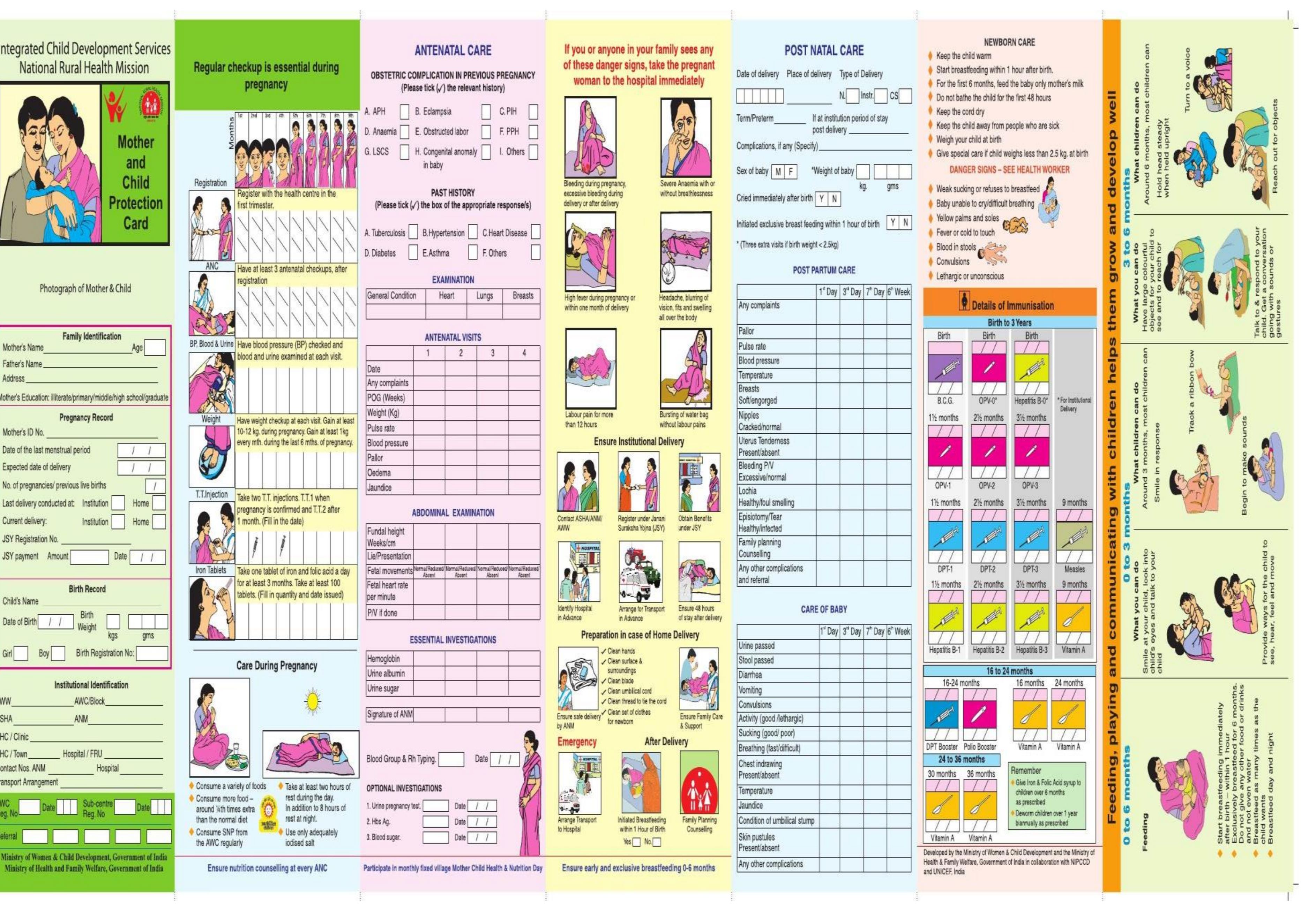
If the child has rapid and/or difficult breathing, take the child to the health centre

- Give extra fluids such as: dal soup, vegetable soup, plain clean water
- Contact a doctor if no improvement is seen within 1-2 days.

Fever



- If the fever is very high cold, wet sponging must be started.
- The child should be taken to the hospital if the fever does not come down in one day.
- Child should be breastfed more frequently and for longer time each feed. Child under 6 months should be exclusively breastfed.
- In addition to breast milk a child over 6 months should be given extra fluids and normal diet during fever.



Integrated Child Development Services
National Rural Health Mission

Mother and Child Protection Card

Photograph of Mother & Child

Family Identification

Mother's Name ____________ Age ___
Father's Name ____________
Address ____________
Mother's Education: illiterate/primary/middle/high school/graduate

Pregnancy Record

Mother's ID No. ____________
Date of the last menstrual period __ / __ /
Expected date of delivery __ / __ /
No. of pregnancies/ previous live births __ /
Last delivery conducted at: Institution ☐ Home ☐
Current delivery: Institution ☐ Home ☐
JSY Registration No. ____________
JSY payment Amount ____ Date __ / __ /

Birth Record

Child's Name ____________
Date of Birth __ / __ / Birth Weight ___ kgs ___ gms
Girl ☐ Boy ☐ Birth Registration No: ____

Institutional Identification

AWW ____________ AWC/Block ____________
ASHA ____________ ANM ____________
SHC / Clinic ____________
PHC / Town ________ Hospital / FRU ________
Contact Nos. ANM ________ Hospital ________
Transport Arrangement ____________

AWC Reg. No ☐ Date ☐ Sub-centre Reg. No ☐ Date ☐
Referral ☐ ☐ ☐ ☐ ☐

Ministry of Women & Child Development, Government of India
Ministry of Health and Family Welfare, Government of India

Regular checkup is essential during pregnancy

Months: 1st 2nd 3rd 4th 5th 6th 7th 8th 9th

- Registration — Register with the health centre in the first trimester.
- ANC — Have at least 3 antenatal checkups, after registration
- BP, Blood & Urine — Have blood pressure (BP) checked and blood and urine examined at each visit.
- Weight — Have weight checkup at each visit. Gain at least 10-12 kg. during pregnancy. Gain at least 1kg every mth. during the last 6 mths. of pregnancy.
- T.T.Injection — Take two T.T. injections. T.T.1 when pregnancy is confirmed and T.T.2 after 1 month. (Fill in the date)
- Iron Tablets — Take one tablet of iron and folic acid a day for at least 3 months. Take at least 100 tablets. (Fill in quantity and date issued)

Care During Pregnancy

- Consume a variety of foods
- Consume more food – around ¼th times extra than the normal diet
- Consume SNP from the AWC regularly
- Take at least two hours of rest during the day. In addition to 8 hours of rest at night.
- Use only adequately iodised salt

Ensure nutrition counselling at every ANC

ANTENATAL CARE

OBSTETRIC COMPLICATION IN PREVIOUS PREGNANCY
(Please tick (✓) the relevant history)

A. APH ☐ B. Eclampsia ☐ C. PIH ☐
D. Anaemia ☐ E. Obstructed labor ☐ F. PPH ☐
G. LSCS ☐ H. Congenital anomaly in baby ☐ I. Others ☐

PAST HISTORY
(Please tick (✓) the box of the appropriate response/s)

A. Tuberculosis ☐ B.Hypertension ☐ C.Heart Disease ☐
D. Diabetes ☐ E.Asthma ☐ F. Others ☐

EXAMINATION

General Condition	Heart	Lungs	Breasts

ANTENATAL VISITS

	1	2	3	4
Date				
Any complaints				
POG (Weeks)				
Weight (Kg)				
Pulse rate				
Blood pressure				
Pallor				
Oedema				
Jaundice				

ABDOMINAL EXAMINATION

Fundal height Weeks/cm				
Lie/Presentation				
Fetal movements	Normal/Reduced/Absent	Normal/Reduced/Absent	Normal/Reduced/Absent	Normal/Reduced/Absent
Fetal heart rate per minute				
P/V if done				

ESSENTIAL INVESTIGATIONS

Hemoglobin				
Urine albumin				
Urine sugar				
Signature of ANM				

Blood Group & Rh Typing ____ Date __ / __ /

OPTIONAL INVESTIGATIONS

1. Urine pregnancy test ____ Date __ / __ /
2. Hbs Ag. ____ Date __ / __ /
3. Blood sugar. ____ Date __ / __ /

Participate in monthly fixed village Mother Child Health & Nutrition Day

If you or anyone in your family sees any of these danger signs, take the pregnant woman to the hospital immediately

- Bleeding during pregnancy, excessive bleeding during delivery or after delivery
- Severe Anaemia with or without breathlessness
- High fever during pregnancy or within one month of delivery
- Headache, blurring of vision, fits and swelling all over the body
- Labour pain for more than 12 hours
- Bursting of water bag without labour pains

Ensure Institutional Delivery

- Contact ASHA/ANM/AWW
- Register under Janani Suraksha Yojna (JSY)
- Obtain Benefits under JSY
- Identify Hospital in Advance
- Arrange for Transport in Advance
- Ensure 48 hours of stay after delivery

Preparation in case of Home Delivery

- Ensure safe delivery by ANM
- ✓ Clean hands
- ✓ Clean surface & surroundings
- ✓ Clean blade
- ✓ Clean umbilical cord
- ✓ Clean thread to tie the cord
- ✓ Clean set of clothes for newborn
- Ensure Family Care & Support

Emergency

- Arrange Transport to Hospital

After Delivery

- Initiated Breastfeeding within 1 Hour of Birth Yes ☐ No ☐
- Family Planning Counselling

Ensure early and exclusive breastfeeding 0-6 months

POST NATAL CARE

Date of delivery ____ Place of delivery ____ Type of Delivery N. ☐ Instr. ☐ CS ☐
Term/Preterm ____ If at institution period of stay post delivery ____
Complications, if any (Specify) ____
Sex of baby M ☐ F ☐ *Weight of baby ___ kg. ___ gms
Cried immediately after birth Y ☐ N ☐
Initiated exclusive breast feeding within 1 hour of birth Y ☐ N ☐
* (Three extra visits if birth weight < 2.5kg)

POST PARTUM CARE

	1st Day	3rd Day	7th Day	6th Week
Any complaints				
Pallor				
Pulse rate				
Blood pressure				
Temperature				
Breasts Soft/engorged				
Nipples Cracked/normal				
Uterus Tenderness Present/absent				
Bleeding P/V Excessive/normal				
Lochia Healthy/foul smelling				
Episiotomy/Tear Healthy/infected				
Family planning Counselling				
Any other complications and referral				

CARE OF BABY

	1st Day	3rd Day	7th Day	6th Week
Urine passed				
Stool passed				
Diarrhea				
Vomiting				
Convulsions				
Activity (good /lethargic)				
Sucking (good/ poor)				
Breathing (fast/difficult)				
Chest indrawing Present/absent				
Temperature				
Jaundice				
Condition of umbilical stump				
Skin pustules Present/absent				
Any other complications				

NEWBORN CARE

- Keep the child warm
- Start breastfeeding within 1 hour after birth.
- For the first 6 months, feed the baby only mother's milk
- Do not bathe the child for the first 48 hours
- Keep the cord dry
- Keep the child away from people who are sick
- Weigh your child at birth
- Give special care if child weighs less than 2.5 kg. at birth

DANGER SIGNS – SEE HEALTH WORKER

- Weak sucking or refuses to breastfeed
- Baby unable to cry/difficult breathing
- Yellow palms and soles
- Fever or cold to touch
- Blood in stools
- Convulsions
- Lethargic or unconscious

Details of Immunisation

Birth to 3 Years

Birth	Birth	Birth	
B.C.G.	OPV-0*	Hepatitis B-0*	*For Institutional Delivery
1½ months	2½ months	3½ months	
OPV-1	OPV-2	OPV-3	
1½ months	2½ months	3½ months	9 months
DPT-1	DPT-2	DPT-3	Measles
1½ months	2½ months	3½ months	9 months
Hepatitis B-1	Hepatitis B-2	Hepatitis B-3	Vitamin A

16 to 24 months

16-24 months		16 months	24 months
DPT Booster	Polio Booster	Vitamin A	Vitamin A

24 to 36 months

30 months	36 months
Vitamin A	Vitamin A

Remember
- Give Iron & Folic Acid syrup to children over 6 months as prescribed
- Deworm children over 1 year biannually as prescribed

Developed by the Ministry of Women & Child Development and the Ministry of Health & Family Welfare, Government of India in collaboration with NIPCCD and UNICEF, India

Feeding, playing and communicating with children helps them grow and develop well

0 to 6 months

Feeding
- Start breastfeeding immediately after birth – within 1 hour
- Exclusively breastfeed for 6 months. Do not give any other food or drinks and not even water
- Breastfeed as many times as the child wants
- Breastfeed day and night

0 to 3 months

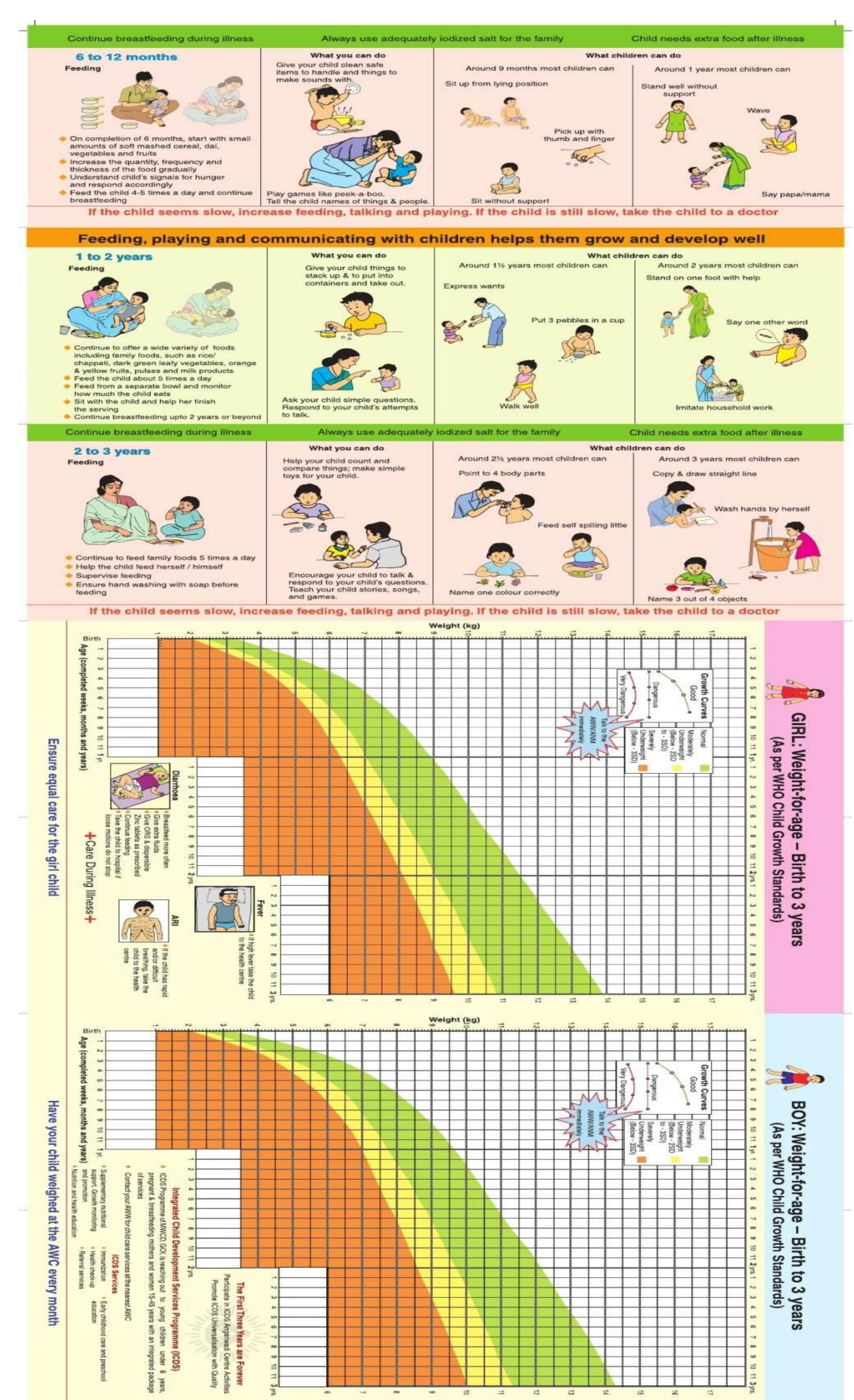
What you can do
Smile at your child, look into child's eyes and talk to your child
Provide ways for the child to see, hear, feel and move

What children can do
Around 3 months, most children can
Smile in response
Begin to make sounds
Track a ribbon bow

3 to 6 months

What you can do
Have large colourful objects for your child to see and to reach for
Talk to & respond to your child. Get a conversation going with sounds or gestures

What children can do
Around 6 months, most children can
Hold head steady when held upright
Turn to a voice
Reach out for objects



Continue breastfeeding during illness
Always use adequately iodized salt for the family
Child needs extra food after illness
6 to 12 months
Feeding
On completion of 6 months, start with small amounts of soft mashed cereal, dal, vegetables and fruits
Increase the quantity, frequency and thickness of the food gradually
Understand child's signals for hunger and respond accordingly
Feed the child 4-5 times a day and continue breastfeeding
What you can do
Give your child clean safe items to handle and things to make sounds with.
Play games like peek-a-boo.
Tell the child names of things & people.
What children can do
Around 9 months most children can
Sit up from lying position
Pick up with thumb and finger
Sit without support
Around 1 year most children can
Stand well without support
Wave
Say papa/mama
If the child seems slow, increase feeding, talking and playing. If the child is still slow, take the child to a doctor
Feeding, playing and communicating with children helps them grow and develop well
1 to 2 years
Feeding
Continue to offer a wide variety of foods including family foods, such as rice/ chappati, dark green leafy vegetables, orange & yellow fruits, pulses and milk products
Feed the child about 5 times a day
Feed from a separate bowl and monitor how much the child eats
Sit with the child and help her finish the serving
Continue breastfeeding upto 2 years or beyond
What you can do
Give your child things to stack up & to put into containers and take out.
Ask your child simple questions. Respond to your child's attempts to talk.
What children can do
Around 1½ years most children can
Express wants
Put 3 pebbles in a cup
Walk well
Around 2 years most children can
Stand on one foot with help
Say one other word
Imitate household work
Continue breastfeeding during illness
Always use adequately iodized salt for the family
Child needs extra food after illness
2 to 3 years
Feeding
Continue to feed family foods 5 times a day
Help the child feed herself / himself
Supervise feeding
Ensure hand washing with soap before feeding
What you can do
Help your child count and compare things; make simple toys for your child.
Encourage your child to talk & respond to your child's questions. Teach your child stories, songs, and games.
What children can do
Around 2½ years most children can
Point to 4 body parts
Feed self spilling little
Name one colour correctly
Around 3 years most children can
Copy & draw straight line
Wash hands by herself
Name 3 out of 4 objects
If the child seems slow, increase feeding, talking and playing. If the child is still slow, take the child to a doctor
GIRL: Weight-for-age – Birth to 3 years
(As per WHO Child Growth Standards)
Weight (kg)
Age (completed weeks, months and years)
Growth Curves
Good
Dangerous
Very Dangerous
Normal
Moderately Underweight (Below -2SD)
Severely Underweight (Below -3SD)
Talk to the AWW/ANM immediately
Diarrhoea
Fever
ARI
Care During Illness
Ensure equal care for the girl child
BOY: Weight-for-age – Birth to 3 years
(As per WHO Child Growth Standards)
Weight (kg)
Age (completed weeks, months and years)
Growth Curves
Good
Dangerous
Very Dangerous
Normal
Moderately Underweight (Below -2SD)
Severely Underweight (Below -3SD)
Talk to the AWW/ANM immediately
The First Three Years are Forever
Integrated Child Development Services Programme (ICDS)
ICDS Services
Have your child weighed at the AWC every month

Day 3 Session 3

Identification and community based management of moderate and severe underweight children, concept and organization of sneh shivir

To address the undernutrition and growth faltering in children a new component, *Sneha Shivir* has been introduced. *Sneha Shivir* a community based care and nutrition counselling initiative especially for mothers/care givers. In intensive and diligent hands on training of mothers on child care will be conducted along with close monitoring of growth of the child. Sustained child care practices will not only rehabilitate children but also prevent undernutrition in later born siblings. The ensuing section will elaborate the processes involved in operationalizing *Sneha Shivir*s in the 200 high burden districts.

Concept of *Sneha Shivir*

Sneha Shivir has been conceptualized as a community based programme for accelerated reduction in moderate and severe under nutrition in children. It is adapted from the globally acknowledged Positive Deviance Approach, for reduction of moderate and severe under nutrition. Intervention is time bound, outcome oriented and result focused. Blocks/clusters/sectors having undernutrition > 20% would be targeted for intervention.

Positive Deviance Approach is based on the principle that some solutions to community problems for example childhood undernutrition exist within the community and just need to be discovered. It has been found that in the same socio economic condition some children possess a normal nutritional status while most suffer from compromised growth. Why does this difference occur in similar socio economic condition? Positive Deviance approach provides an answer to this difference. The approach is based on the belief that in every community there are certain individuals or families who are special or uncommon practices and behaviours enable them to find better ways to prevent under nutrition than their neighbours who share the same resources and face the same risks. These families are the Positive Deviant families.

The identified positive behaviours followed by the positive deviant families are reinforced during **Nutrition Counselling and Childcare Sessions (NCCS**) organised for 12 days where mothers / father or caregivers of under nourished children come for supervised feeding and learning positive practices through participatory learning and Nutrition and Health sessions followed by 18 days of home practice where12 days is the minimum number of days required for weight change.

Appropriate regime of care provided needs to be ascertained for each child weighed based on the degree of growth faltering.

Medical attention will be provided to all children who are sick and thereafter enrolled in *Sneha Shivir*. For chronic growth faltering (severe underweight) double ration, medical attention will be provided along with care and counselling sessions. It is important to also counsel and encourage caregivers of children who are normal. Sector supervisors will monitor and verify selection of the AWCs and children for Sneha Shivir. `

The Approach

Sneha Shivir's focuses on

- Rehabilitation of malnourished children
- To sustain the rehabilitation
- To prevent other siblings and future generation from being undernourished
- Best practices of the community are learnt by the caregiver through "learning by doing" during 12 days session.

Strategies of *Sneha Shivir*

- Community mobilization through participatory processes
- Promoting convergence and partnership
- Building capacity of frontline functionaries and the community on caring practices
- Developing community-based Feeding and childcare counselling sessions.
- Promoting gender sensitive childcare practices in families and community.

Components of *Sneha Shivir*

*Sneha Shivir*s consists of two major components:

a) Nutrition and Child Care Sessions (NCCS) imbibing positive care practices through participatory learning by doing approach
b) Community Mobilization to create visibility and awareness on undernutrition and evoke participation of people for its reduction and prevention

Steps for *Sneha Shivir*

1. Identification of pockets of high under nutrition
2. Sensitisation of functionaries of ICDS, Health, members of Panchayati Raj Institutions (PRI) and members of VHSNC and NGOs at district and sub district levels
3. Training of community facilitators/ Childcare functionaries
4. Community Mobilization

5. Facilitating the development of village based Feeding and Child Care Counselling sessions and follow up
6. Nutrition and Health Education to provide a continuum of care
7. Phase out Strategy

Nutrition and Child Care Counselling Sessions (NCCS)

The NCCS is a twelve days rehabilitation programme, with the selected mothers of the undernourished children, at the cluster level. The process involves supervised feeding sessions by mothers/ caregivers demonstrated initially by AWWs/ additional AWWs. Mothers/ caregivers gradually actively participate and learn correct feeding methods, cooking nutritious meal appropriate for children. They also learn important practices like hand washing before feeding, feeding in clean environment and psychosocial practices and active feeding

Key Processes for Initiating Nutrition and Child Care Counselling Sessions (NCCS)

Screening of Children and Selection for admission in NCCS

- The Anganwadi worker will weigh all eligible children at the routine growth monitoring session or monthly weighing sessions. All severe underweight and moderate underweight should be identified. There may be children who are severely undernourished with visible signs of medical complication like bipedal pitting oedema, loss of appetite etc. Anganwadi workers should be able to recognize these complications and refer to health facility taking the help of ASHA.
- ANM/ASHA/MO should further screen all severe underweight children for case finding of severe acute malnutrition (SAM or severely wasted measured by weight for height) both with medical complications and those without. This could easily be done at the

monthly weighing session, VHND, Health check-ups or any other health camps organized in the village/ Sub centre / PHC level.

- ASHA will accompany children with complication to health facilities for treatment. Those identified without medical complications will receive treatment at Sub health centre (SHC) with appropriate medical and nutritional therapy along with counselling. Second AWWs will provide necessary support for monitoring each case through home visit, monitoring of weight gain at follow up sessions at AWCs.
- The children who do not fall in the category of SAM or severely wasted but are severe underweight should be brought to NCCS.

Severe acute malnutrition is defined by very low weight-for-height/length (-3 SD). Children suffering from undernutrition begin their lives with a significant disadvantage. Child malnutrition significantly contributes to under-five mortality as undernourished children have increased susceptibility to infections and hence frequent episodes of illness and longer recovery period. Besides increasing risk of mortality, undernutrition leads to growth retardation and impaired psychosocial and cognitive development.

Nutrition Rehabilitation Center (NRC)

Nutrition Rehabilitation Center (NRC) is a unit in a health facility where children with Severe Acute Malnutrition (SAM) are admitted and managed. Children are admitted and provided with medical and nutritional therapeutic care. Once discharged from the NRC, the child continues to be in the Nutrition Rehabilitation program till she/he attains the discharge criteria. In addition to curative care, special focus is given on timely, adequate and appropriate feeding for children; and on improving the skills of

mothers and caregivers on complete age appropriate caring and feeding practices. In addition, efforts are made to build the capacity of mothers/caregivers through counselling and support to identify the nutrition and health problems in their child.

Objectives of NRC

1. To provide clinical management and reduce mortality among children with SAM
2. To promote physical and psychological growth
3. To build the capacity of mother and other care giver in appropriate feeding and caring practices for infant and young children
4. To identify child who might fall into SAM category by assessing the "shipping factor".

Services at NCR

The services and care provided for the in-patient management of SAM children include:

1. 24 hour care and monitoring of the child.
2. Treatment of medical complications.
3. Therapeutic feeding.
4. Providing sensory stimulation and emotional care.
5. Social assessment of the family to identify and address contributing factors.
6. Counselling on appropriate feeding, care and hygiene.
7. Demonstration and practice- by -doing on the preparation of energy dense child foods using locally available, culturally acceptable and affordable food items.

5. Follow up of children discharged from the facility

Children who are discharged from NRCs will be enrolled for medical nutrition therapy at the sub health centres (SHC), once discharged and if

required will be enrolled in *Sneha Shivir*s, this will ensure seamless and complete rehabilitation and follow up of children.

Sequence of Activities and Services in N.C.C.S

i. Weight Recording (Entry weight & Exit Weight)
ii. Deworming and administration of IFA
iii. Learning by doing feeding sessions to adopt correct feeding, hygiene health and psychosocial practices, Sharing of positive practices by Positive deviant mothers
iv. Counselling on Care Practices
v. Case Management and Assessment of adequate weight gain
vi. Medical Support and Referral
    a) Routine services – Immunization, Vitamin A and IFA
    b) Health check-ups by ANM/MO and any appropriate treatment
    c) Referral service for medical complication by ANM /ASHA / MO
vii. Follow up action in 18 days home care
viii. Graduation of children

Activity: Positive care practices

The trainer may divide the trainees into 4 or 5 groups and assign one topic each group to make a list of relevant positive care practices

- Hygiene and sanitation
- Food preparation and storage
- Health practices
- Feeding practices
- Psychosocial behaviors
- Feeding behaviors

Ask them to display their list and discuss.

COMMUNITY MOBILIZATION

The approach actively involves the community throughout the process.

Community leaders and village health sanitation and nutrition committees can provide support in organizing the weighing of all children in the target age group, identifying village level volunteers, contributing materials, utensils, and food for the sessions, assuring that eligible caregivers attend the sessions regularly, and encouraging other community members to support the families with undernourished children in adopting new practices. The community can participate in monitoring program implementation and results. It raises the consciousness of community members and empowers them to prevent under nutrition within their own community.

Key Processes of Community Mobilization

Sneha Shivir is a community-based approach therefore it is important to actively involve the community at all stages. The following steps are planned to foster community involvement:

1. Mobilization and engagement of community
    - Engaging community using techniques and activities like role play, demonstration, group discussions etc. this will convince the community as they will see things for themselves in practical. People learn through mutual interaction as they get an opportunity to express their ideas, opinions and views. Other techniques include: community meetings, door-to-door campaigns, electronic and print media, person to person discussion, rallies such as cycle rallies, puppet shows, film and video shows, posters etc.

All these tools can be utilized to mobilize the community effectively and help in the awareness generation and participation of the community.

Activity: Role-Play

Divide the trainees into groups and ask them to develop a role play on any one child care practice related problem which they think is important to address. The trainer may ask the trainees to role-play scenarios they are scripting.

2. Linking of ALMSC and VHSNC
    - Village Health Sanitation and Nutrition Committees, Anganwadi level Support and Monitoring Committees should be sensitized about *Sneha Shivir*. ALMSC should oversee the activities at the *Shivirs* and ensure the participation of caregivers and children while VHSNC should review the improvement of nutritional status of children in the village.

3. Orientation of PRI members and opinion leaders on the concept and need for *Sneha Shivir* in the village.

4. Active engagement in management and supervision of ICDS

- Orientation of the community (not mothers alone) on Nutritional status of children, scale of the problem in the village and consequences of under nutrition and obtaining their agreement to initiate NCCS. Simple tools always used and known to ICDS such as Community growth chart, resource map and Mother Child protection cards should be used to illustrate and develop an understanding of undernutrition, and encourage community based analysis of the problem. Community growth monitoring is an effective and beneficial collaborative practice, the community mobilization tools evoke response and empower community to collectively take action for reduction of under nutrition. Community orientation should involve entire community (elders-grandfathers, grandmothers, ever married women and men, youths, adolescents etc). Consensus emerges best with involvement and sensitization of all.

5. Pre NCCS meeting held two – three days before NCCS for Mothers/ caregivers of selected undernourished children They are oriented on:
   - Nutritional status of their children, with help of Mother Child Protection card.
   - MCPC as a self- monitoring tool for growth trajectory of children
   - NCCS and its requisites.
   - Involvement of maternal and child nutrition committees and mahila mandals.

Role of different functionaries in Sneha Shivir

Different functionaries have different roles to play in effective organisation of *Sneha Shivir*. Some of the roles and responsibilities of facility providers are mentioned in the figure below.

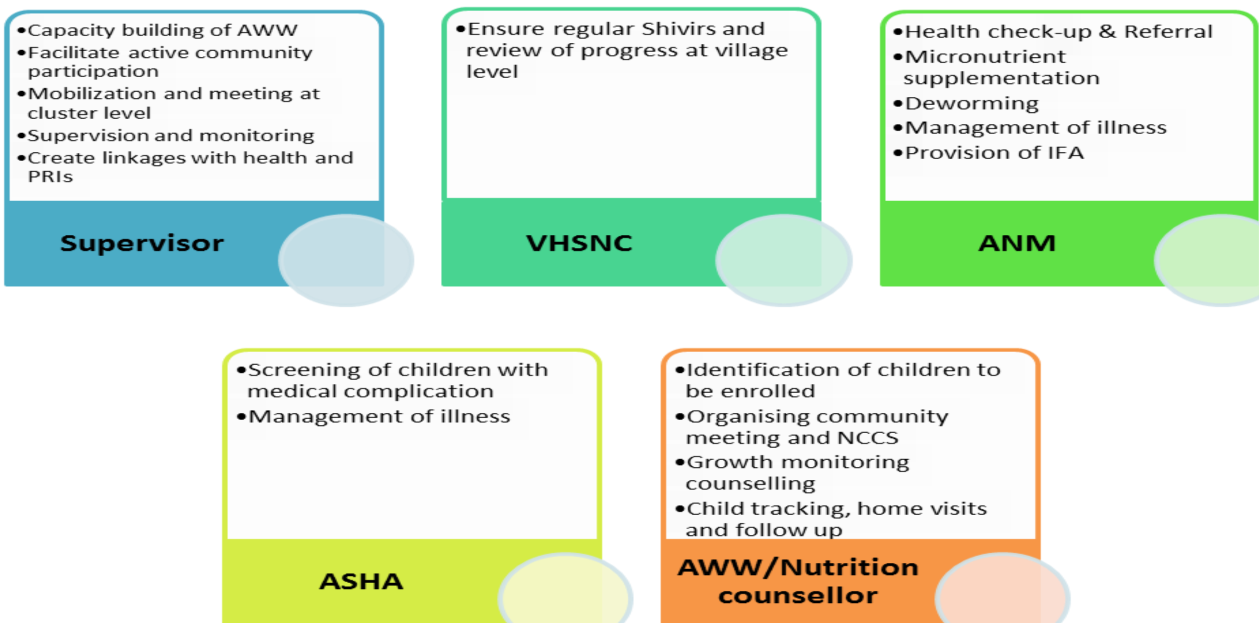


Figure: Role of different functionaries in *Sneha Shivir*

Day 3 Session 4

Early Childhood Care Education (ECCE) in ICDS

CORE PACKAGE OF SERVICES UNDER ICDS MISSION

1. Early Childhood Care Education and Development (ECCED)

Early Childhood Care and Development (ECCD) under the ICDS Mission is defined as holistic and integrated provisions / environment for children below 6 years, that would enable and ensure their care, protection, learning and all round development, through family, community and center based interventions. Within the framework of ECCD, the Early Childhood Care & Education (ECCE) refers to the informal early psychosocial stimulation for children below 3 years and more planned Non-formal Preschool Education for children between 3 to 6 years, which is child friendly, focused around play and individuality of the child and aimed towards the child's holistic development and readiness for school.

Non-formal Pre-school Education / Early Childhood Care & Education (ECCE):

The Preschool Education (PSE) is one of the most important components of the ICDS and in many ways can be considered to be the backbone of the programme. The purpose of PSE is to provide sustained activities through joyful play-way method that helps to prepare the child for regular schooling. PSE, as envisaged in the ICDS, focuses on holistic development of children up to six years. The Anganwadi strives to satisfy the curiosity of the child and channel the child's creative energy by providing a learning environment for promotion of social, emotional, cognitive, motor, physical and aesthetic development of the child. The early learning component of the ICDS Mission would ensure a significant input for providing a sound foundation for cumulative lifelong learning and development. It would also contribute 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.

With the aim to strengthen the early child care and learning environment, ICDS in Mission Mode would invest resources on proper quality improvement in ECCE through the AWC platform, with joyful early learning initiatives that would increase the demand for ICDS services and participation in the same, by the local communities and other stakeholders such as mothers' groups. The focus would be on making AWCs as the ECCE child friendly centre equipped with the

locally appropriate play / learning materials, aids, and facilities for teaching by trained AWWs.

In order to strengthen the existing ECCE services, ICDS would focus on providing a broad range of services to children both at the Anganwadi Centre and beyond Anganwadi Centre. These services would be broadly provided through the following main interventions:

(i) ECCE Services at Anganwadi Centres: The focus would be on strengthening early childhood care and education as a core service of the Anganwadi Centres with dedicated four (4) hours of early childhood education sessions followed by supplementary nutrition, growth monitoring and other related interventions. In particular, the ECCE Services at the Anganwadi Centres would largely be delivered through:

(a) Anganwadi Worker-led Intervention: In order to improve the quality of the ECCE service delivery under ICDS, the Anganwadi Worker would be trained. She would be responsible for the education and care of all children upto the age of 6 years with focus on the holistic development of the child. The AWW would provide home based guidance to care givers and mothers and early stimulation of the under-threes. She will also undertake early screening for delayed development and referral. For children in the age group of three to six years effort would be on ensuring a natural, joyful and stimulating environment, with emphasis on necessary inputs for optimal growth and development. Developmentally appropriate curriculum would be designed in order to foster holistic development in all domains. Starting from planned play based programme for 3-4 year olds with more of free play, and thereafter, moving towards an increasing ratio of adult guided large group activities focused more on specific school readiness for 5-6 year olds. In order to ensure a joyful learning process and child friendly environment, Provisions of adequate space for a play based programme / activities and age specific developmentally appropriate play and learning materials would be made. In order to strengthen the Pre-school Education component, the ICDS Mission would encourage tapping existing resources at district level for additional inputs wherever required. Assistance of SSA would be sought for need based training of AWW, provision of learning materials, building advocacy on the importance of early childhood care & development, organizing training programmes for community leaders, providing for intensive planning for ECCE & promoting convergence between school system & ECCE.

(b) Parent-led AWC – based Intervention: As a pilot initiative, the parents would be encouraged to come forward to provide education and care for their children at AWC. The Mother's Groups and Parents' Groups (wherever available) would be involved in taking care of this

intervention. The focus would be on parents as first educators, learning through play and the child's individual interests. Initially, the parents may be made responsible for supporting the management of the early childhood care and education services twice a week, with the support and guidance of the AWW. The number of days of parent-led ECCE intervention may be increased or decreased on the basis of the success of this pilot initiative. Monthly Fixed ECCE day will be organised at the AWCs for advocacy and capacity building of the parents including Grand Parents and elderly citizens.

(ii) ECCE Services beyond Anganwadi Centres: The focus would be on strengthening early childhood care and education as a core service with dedicated four (4) hours of early childhood education sessions followed by supplementary nutrition, growth monitoring and other related interventions. In particular, the ECCE Services beyond the Anganwadi Centres would largely be delivered through:

(a) <u>Parent-led home-based Intervention</u>: As a pilot initiative, the parents would also be encouraged to hold ECCE interventions in their home settings. Regular training and capacity building to parents would be ensured by the ICDS Mission to carry out this responsibility.

(b) <u>NGO-led Interventions</u>: In order to strengthen the ECCE services beyond Anganwadi Centres, voluntary organizations / NGOs would be involved to implement interventions. They would provide education and care services to young children either in the child's own home or centre based. This may be all-day or part-day education and care. The aim of this service would be to provide learning opportunities for children in small groups within homelike surroundings. Voluntary organization implementing this component would operate playgroups, so that educators and children can have regular social and educational contact. Voluntary organizations engaged for carrying out this activity would engage qualified and registered teachers as "ECCE Coordinators" to support the educators / caregivers. Behaviour change communication between parents and educators / caregiver would be an important feature of this service. Regular training and capacity building of educators / caregiver would be carried out to improve their understanding and knowledge of how children learn. The ECCE Coordinators would regularly visit the community / families to check on children's safety, well-being and learning process.

(c) <u>Private sector schools (pre-primary & nursery etc.) led interventions:</u> Although there are no accurate figures available, according to some estimates, the number of children enrolled in private-sector initiatives (including day-care centres, nurseries, kindergartens, and pre-primary classes) was about 1 crore (2001), or about as many children as the number under ICDS at that time. Today the initiatives of the private sector may be as large as the programmes undertaken by the government sector, which caters to different classes.

The first six of life are critical years of human life since the rate of development in these years is more rapid than at any other stage of development. Global brain research also informs us about the significance of early years for brain development.

Early Childhood Care and Education (ECCE) makes a positive contribution to children's long term development and learning by facilitating an enabling and stimulating environment in these foundation stages of lifelong learning.

3. The Policy

3.1 The National ECCE Policy conforms to the vision of holistic and integrated development of the child, with **focus on care and early learning** at each sub-stage of the developmental continuum, in order to support children's all round and holistic development. This is envisaged to be provided by several care providers such as parents, families, communities, and other institutional mechanisms like public, private and non-governmental service providers.

3.2 The sub stages with their age-specific needs are as follows:

(i) Conceptions to birth – ante and post natal health and nutritional care of mother, maternal counselling, safe childbirth, maternity entitlements, child protection and non-discrimination.

(ii) Birth to three years – survival, safety, protective environment, health care, nutrition including infant and young child feeding practices for the first six months, attachment to an adult, opportunity for psycho-social stimulation and early interaction in safe, nurturing and stimulating environments within the home and appropriate child care centres.

(iii) Three to six years – protection from hazards, health care, nutrition, attachment to an adult, developmentally appropriate play-based preschool

education with a structured and planned school readiness component for 5 to 6 year olds.

3.3 These age-specific needs are the basis for providing ECCE services in accordance with appropriate technical norms and standards. The various needs of the children will be taken care of by the National ECCE Policy in convergence with related programmes and policies of other sectors such as health, nutrition, education etc.

3.4 The policy recognizes that young children are best cared for in their family environment; however in a country of widespread diversity and stratification, many families need supportive measures for the optimal development of the child. The Policy thus acknowledges multiple models of ECCE service delivery and would be applicable to all ECCE programmes that are offered by public, private and non-governmental service providers in all settings which could go by the nomenclature of AWCs, crèches, play groups, play schools, pre-schools, nursery schools, kindergartens, preparatory schools, balwadis, home-based care *etc.*

4. Vision of the Policy

4.1 The vision of the policy is to achieve holistic development and active learning capacity of all children below 6 years of age by promoting free, universal, inclusive, equitable, joyful and contextualised opportunities for laying foundation and attaining full potential.

It envisages to improve pathways for a successful and smooth transition from care and education provided at home to centre based ECCE and thereafter to

5. Key Areas of the Policy

The Policy focuses on the following key areas to achieve the objectives:

a. Access with equity and inclusion in programmes and interventions across service providers

b. Improving quality (minimum specifications, quality standards, regulation, curriculum, play and learning material, programme assessment and child assessment)

c. Strengthening Capacity (institutions, personnel, families and communities)

d. Monitoring and Supervision (MIS, National ECCE Council, etc.)

e. Research and Documentation

f. Advocacy and awareness generation

g. Convergence and Coordination among policies and programmes

h. Institutional and Implementation Arrangements (ECCE Cell, National ECCE Council, Plans of Action)

i. Partnerships

j. Increased investment towards ECCE

k. Periodic Review

2. Objectives of Early Childhood Care and Education (ECCE)

The aim of Early Childhood Care and Education is to facilitate optimum development of the child's full potential and lay the foundation for all round development and lifelong learning. While parents and home have the main responsibility of the welfare of the child, a strong partnership between the community and the ECCE centres is important for the well being of the child and in achieving the following objectives.

Broad objectives of the Early Childhood Care and Education programme are to:

- Ensure each child is valued, respected, feels safe and secure and develops a positive self concept
- Enable a sound foundation for physical and motor development of each child- as per each child's potential
- Imbibe good nutrition routines, health habits, hygiene practices and self help skills
- Enable children for effective communication and foster both receptive and expressive language
- Promote development and integration of the senses
- Stimulate intellectual curiosity and develop conceptual understanding of the world around by providing opportunities to explore, investigate and experiment
- Enhance development of pro-social skills, social competence and emotional well being
- Develop sense of aesthetic appreciation and stimulate creative learning processes.
- Imbibe culturally and developmentally appropriate behaviour and core human values of respect and love for fellow human beings.
- Enable a smooth transition from home to ECCE centre to formal schooling
- Enhance scope for overall personality development

Families and communities represent vast geographic, social, cultural, linguistic, and economic diversity within the country. Children also differ in their physical, emotional, social, and cognitive capacities. Urban and rural communities offer different types of opportunities and face distinct challenges in providing good quality early care and learning experiences to children. Socio –economic status as well as social and cultural diversity characterize the nature of family life and the context for growing up in India.

Each child requires a safe and nurturing environment to develop optimally. Children with special needs and their families need assistance and information regarding prognosis and early intervention in order to support optimal development of children. Other families may also, face stresses that can compromise their ability to support their children's early learning and need support services to assist families in their critical role as primary caregivers.

Discrimination and inequities based on gender, social identity, disability and other exclusionary factors is prevalent in the society that adds to the above problem. The issues need to be addressed proactively to ensure universal access to integrated services towards fulfilment of right to free, universal pre-primary education. Regardless of income, social status, geographic isolation, and other potential barriers, all children deserve and have a right to inclusive and equitable opportunities to build on their unique strengths.

In recent times many children are receiving early education and care outside the home in child care centres, preschool programs, and other community-based early learning settings. Whether children receive early education and care in the home or the community, it is important that their early learning experiences draw on the unique strengths of their

FIXED MONTHLY ECCE DAY

The Fixed Monthly ECCE Day is to be organized once every month at the AWC.

The Fixed Monthly ECCE Day will be a platform for interface between the Anganwadi Worker and the parents/community. The ICDS functionaries would organize activities for advocacy, awareness generation and involvement of parents and community.

The Fixed Monthly ECCE Day would facilitate involvement of parents and community in the early childhood care and education of children and establish the partnerships for optimum development of the young child.

All the children attending the Anganwadi Centre, and preferably all other children in the age group of 0-6 years in the community and their parents would participate in the Fixed Monthly ECCE Day.

Purpose of the Fixed Monthly ECCE Day

- To enlighten the parents and community about age and developmentally appropriate early child care and education practices
- Facilitate active participation of parents and community by creating opportunities for parents to contribute human and material support to the AWC.
- Inform parents and community to get them well versed with the non-formal play and activity based method of learning.
- Inform parents about the progress of their child on growth, development and learning milestones.

Activity to be Organized on Fixed Monthly ECCE Day		
A. Monthly	**B. Bi-Monthly**	**C. Half- Yearly**
Display of work of all the children from the daily activities of the curriculum (Art and craft work, models, worksheets etc.).	Presentations such as dance, drama, rhyme recitation, role play etc. by groups of children. (Ensure participation of all children attending the AWC).	Sports Day. (Ensure participation of all children attending the AWC).
Demonstration of activities of children for parents and community and explaining the rationale for conducting the activities.	Group activities for parents and children availing home based ECCE services.	Participation of all young children and parents/ community in fun activities such as Bal Mela/ Diwali/ Local Festival Fairs, exhibits etc.
Parent –AWW interaction and sharing of child assessment and taking feedback.	Development of play and learning material through parent and community participation.	Child friendly paintings on AWC walls.
Display of Advocacy Material on ECCE (Charts/Audio- Visual).	Development of play material through participation of local artisans/ crafts persons	
Talks for the parents on topics listed in the "Issues to be Discussed with Parents"		
Involve Community for awards and incentives to children/AWW/AWH		
Toy Bank/ Activity Bank/ Book Bank: Creating a corner where parents can donate toys, games, books, puppets and other play and learning material		
Collation of local cultural stories. rhymes, songs, games, drawings, art forms for activity bank		

Who will be involved in the organisation of the Fixed Monthly ECCE Day

- AWW
- AWH
- Crèche Worker, Additional AWW and link Worker (if they are working in AWC) and any teacher/ worker for other programmes for PSE/ ECCE
- PRI Members/ members of ALMSC
- Members of Community Based Organisation (Village education committee, Mother's (Parent's) committee, Village resource Groups)
- Local NGOs working in relevant field
- Primary school teachers, Preraks of Literacy Mission, nursery teacher/ trained ECCE persons of the community
- Grand Parents, especially Grand Mothers , Elderly Citizens etc
- Local artisans, Craft persons and folk artists
- Traditional/ community leaders
- Office-bearers of Mahila Mandals
- Office bearers of Youth Clubs/ Nehru Yuva Kendras
- Health functionaries (ANM/LHV)/ ASHA (as considered/ necessary)
- Sakhi/ Saheli of 'Sabla'/ Kishori Shakti Yojana
  Any other as appropriate

Issues to be discussed with parents on Fixed Monthly ECCE Day

Orientation sessions and workshops may be organized to build the capacities of parents and community as they are the prime caregivers during early childhood. A topic from the following suggested list may be identified respectively for each Fixed Monthly ECCE Day.

- Importance of early childhood
- Significance of non- formal preschool education and ECCE
- Growth and developmental milestones during early years; developmental delays; early signs of disability
- Early Stimulation
- Care giving at home
- Importance of play
- Good habit formation
- Role of community and parents in ECCE
- Preparing children for school
- Developing a mechanism in consultation with community for involving mothers and the older girls in performing various tasks at the Anganwadi (such as, preparation and distribution of food, organizing outdoor activities for children, etc.)

Role of AWWs/AWHs in holding Fixed Monthly ECCE Day

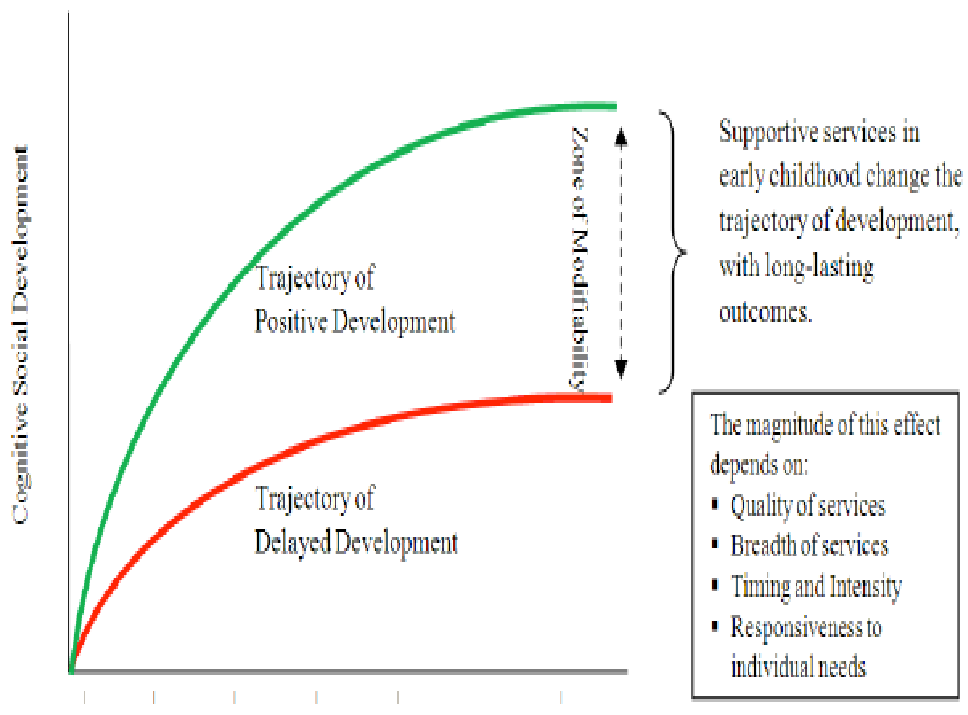
- Arrangement of venue (preferably Panchayat Ghar) if space at AWC is not adequate.
- Providing advance information to the locality about venue and timings of ECCE Day.
- Make a list of all children below 6 years of age, preferably also record the number of children receiving pre-school education from other sources in the community
- Provide supplementary nutrition to the children.
- Prepare a list of activities identified for Fixed Monthly ECCE Day.
- Decide and organise thematic events for children and conduct activities.
- Arrange and display PSE material.
- Form positive rapport with parents/caregivers/guardian and to convince them.
- Coordinate with CDPO and Supervisor.
- Demonstrate through role model (a child of that AWC) to motivate parents.
- Use Mother and Child Protection Card, IPC Tool Kit and other relevant tools.
- Prepare a report on the celebration so that further improvements can be done.
- Ensure that all the children participate in the Fixed Monthly ECCE Day activities.
- Invite the parents of children attending the AWC, parents of other young children in the community and other community members.
- Encourage grandparents especially grandmother to attend and participate in the ECCE Day.
- Invite teachers from nearby primary school to be part of celebration to facilitate smooth transition of children from AWC to primary school.
- Cross learn from best practices in the cluster/ project.
- Maintain record.

3. Principles of Early Learning and Development and its Implications for Practice

The principles and practices relevant for learning and development in the early years are based on the insights and observations of thinkers and evidences from researches. Each of the principle elaborates specific ideas and at the same time they are all interconnected like the domains of development. The practical implications for each of the principle will also be influenced by the culture and individual prerequisites.

The first six years of life are critical since the rate of development in these years is more rapid than at any other stage of development. Research in neuro-science confirms the importance of the early years in a child's life particularly since 90% of brain development has already taken place by the time a child is six years of age. Research also indicates that the development of brain is influenced not only by health, nutrition and quality of care but also the quality of psycho-social environment the child is exposed to in these early years. (Figure 1). A psycho-socially deficit environment or emotional neglect can lead to negative consequences for a child's development, which may even be irreversible. This places a very large percentage of children from poorer or marginalised families, 'at risk', in terms of their life chances and opportunities. Supportive ECCE services enable to bridge the gap that can lead to more positive long-term outcomes for individuals and society than later interventions.

Figure 1: Trajectory of Development



3.1 Development and learning takes place in all domains, development in one domain influences the other domain: Children are thinking, feeling and interacting human beings and it is important to address all domains for their development. Changes or development in one domain facilitates or hinders the development of another domain.

3.2 Children's development and learning follows a sequence in which later acquired abilities (skills and concepts) build upon what children already know and apply. In the first few years of life the growth, change and development mostly follow a predictable pattern; however the way these changes are demonstrated varies in different context and culture. Knowledge of known sequence of development enables in developing early stimulation activities and curricular planning for children.

3.3 Child Development and Learning are characterized by individual variation: While learning and development follows a predictable pattern there may be individual variation in the normative course of development as well as uniqueness of each child as an individual. No two children, even within the same family are the same. Each child has an individual pattern and timing of growth and development as well as individual styles of learning. Each individual child has his/her own strengths.

3.4 Children develop holistically and benefit from experiential learning: This simply means that children learn best through active exploration using the senses such as touch, taste, smell and manipulation to build perceptual skills. Children should be actively interested and engaged in their learning with a high sense of motivation and positive disposition to explore and build skills across various domains.

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3.5 Learning begins from birth: From birth onwards children are mentally and physically active. They learn through all their senses and stimulations. Early care and stimulations whether positive or negative have a cumulative impact on children's development. Since care and early stimulation promotes brain development and leads to the forming neural connections, it is imperative that children are provided with optimal stimulation in the early years and prevent cumulative deficit in the long run.

3.6 Development and learning result from a continuous interaction of biological maturation and experience. A child has genetic endowments which may predict healthy growth, but inadequate nutrition in the early years of life will keep this potential from being fulfilled. On the other hand if the child is suffering from an inherent condition, then the detrimental impact learning and development can be minimized through systematic, individualized intervention. With this perspective in mind, it is important for early childhood educators to maintain high expectations and employ all their knowledge, ingenuity, and persistence to find ways to help every child succeed.

Our young children strive to be:

- Happy and healthy
- Inquirer
- Confident
- Communicative
- Creative
- Caring
- Open-minded
- Resilient
- Sensitive to diversity
- Respectful
- Mindful
- Life-long learner

Day 3 Session 5

Planning an advocacy campaign for creating awareness on issues related to nutrition and health of women and children.

Information, Education & Communication, (IEC) in ICDS Programme

- o The major objectives of IEC are to create awareness and build up image of ICDS programme; stimulate demand for ICDS services; affect and sustain behavioural and attitudinal changes in child rearing, nutrition and health care practices; and elicit sustained community participation and principles of social marketing may be followed to formulate need based, area-specific and target-oriented IEC strategy.

- **Information** means telling something to an individual about a person or a thing or a subject.

- **Education** is a gradual process of learning through which a person gains knowledge and understanding of a subject. Communication is a two way process of giving information or sharing ideas between two or more than two persons.

Why IEC required?

- ❖ Strengthening Interpersonal Communication and supportive Counselling by field functionaries
- ❖ Improving the knowledge and skill and sustaining the support of community groups (viz. Women Working Groups, Adolescent Girls Working Groups and Children Working Groups) in communication activities.
- ❖ Involving formal and informal leaders in maintenance and upkeep of Anganwadi centers.
- ❖ Use of traditional folk media
- ❖ Mobilizing community resources and support for successful implementation of all services.
- ❖ Decentralized, need based area specific and target oriented educational approaches.
- ❖ Strengthening mass media support for Interpersonal communication and Group communication activities
- ❖ Sensitizing and involving influencing groups like a) in-laws and elders in the family b) Panchayat Raj members c) traditional medical practitioners d) other opinion leaders, Self Help Groups and NGOs
- ❖ Organising exhibitions in fairs and festivals.

- ❖ Developing IEC materials and training support materials like modules and manuals
- ❖ Updating information and improving knowledge and skill of field functionaries

- In order to improve the knowledge and attitude of people, specially, women to bring about change in their behaviour and living pattern, the role of communication has neither been fully realized nor defined so far by Government.
- To meet the above challenges there is a need to make planned and conscious efforts through IEC in achieving the objective of ICDS.
- IEC activities should be undertaken to sensitise people about the various services provided through ICDS.
- Activities under IEC should be aimed at sensitising and creating awareness about certain issues.
- IEC should be through the process of community participation, which helps individuals to modify their behaviour and change in attitude for holistic development of children and women.
- IEC should involve the people, who are the ultimate beneficiaries so that they can effectively participate in the implementation of ICDS services thereof.
- IEC helps in realizing the objectives of ICDS and for bringing about change in knowledge, attitude, beliefs and behavior pattern of the people in the community.
- Certain activities such as distribution and use of slides, flash cards, flip charts/books, flannel graphs etc. Publication of periodical newsletters, posters, handbills, hoardings, newspaper advertisement etc, folk media, puppet shows, folksong, rally, prabhat pheri, yatra, audio visual media etc can be taken up to create awareness.

In order to create awareness among community and popularize the ICDS, the MWCD has made provisions of Rs 1,000/- per annum per AWC.

It is well evident that research and proper planning form the foundation of an effective communication campaign. Knowing the needs of the population are crucial in achieving the goal of raising awareness and ultimately, changing attitudes and behaviours of target audience. The essential feature of communication paradigm is to find the needs and desires of

the audience, then deliver messages and the messages would bring real benefits for changing behaviours. It is commonly believed that many social change campaigns fail because the message is not meaningful or relevant and consequently not motivating to members of the target audience. Therefore, understanding the needs of the community members through their local contexts and designing the messages according to their situation would bring desirable results. All these communication materials are effectively utilized it would enable the members of the community for bringing behavior change.

ADVOCACY

Advocacy is a set of organised activities designed to influence the policies and actions of others to achieve positive changes for children's and women's lives based on the experience and knowledge of working directly with them, their families and communities.

Definition

Advocacy is an action directed at changing the policies, position, or programmes of any type of institution. It also includes:

- Building support for an issue or cause and influencing others to take action.
- Making sure that the necessary financial resources are provided for programmes and services.
- Persuading government officials to prioritise particular programme approaches or services.
- Informing the general public and opinion leaders about a particular issue or problem and mobilising them to apply pressure to those in the position to take action.
- Creating support among community members and generating demand for the implementation of particular programme approaches or services.

ESSENTIAL POINTS FOR DISCUSSION:

Advocacy and BCC or IEC initiatives are similar in that they all are focused on raising awareness about a particular issue. However, BCC or IEC initiatives are aimed at changing behaviour at the individual level, whereas advocacy activities are aimed at mobilising collective action and promoting social or legislative changes at the community, district, national, or global levels.

STEPS/STAGES IN ADVOCACY CYCLE

SELECTING AN ADVOCACY ISSUE

Advocacy begins with an issue or problem that the organisation agrees to support in order to promote a policy change. A situation analysis forms the foundation for any programme or advocacy plan. It provides the analysis of the problem that you are trying to address, and looks at the ways in which it can be solved.

Exercise

Problem Tree Analysis

One way to understand your issue and problem more fully is to create a visual representation of your problem, its root causes and its consequences in a problem tree.

DRAW A PROBLEM TREE SHOWING CAUSES AND EFFECTS OF THE PROBLEM

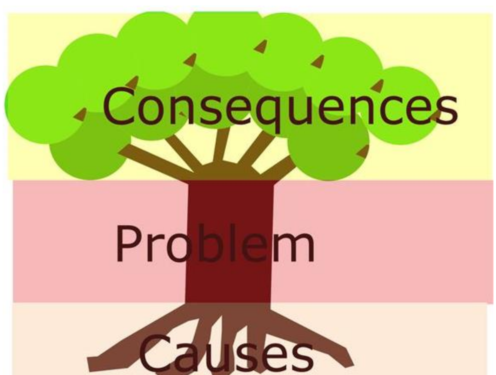
- **Identify the central problem** – for example, Improving girl child nutrition, improving child sex ratio, promoting education of girls, prevention of child marriage, prevention of sex selection and abortion, creating value of girl child etc.

- **Brainstorm** to produce a list of its causes and consequences.
- **Rank** the list of causes and consequences in terms of importance.

- Identify the **most direct causes** of the problem.

- **Arrange causes and effects** into a problem tree, with causes as the 'roots' and effects as the 'branches'. Discuss the links between them.

- It will become clear that which of the causes can be addressed through advocacy.



USE THE PROBLEM TREE TO HELP SET YOUR GOALS AND OBJECTIVES

Your objectives should be SMART – Specific, Measurable, Achievable, Realistic and resourced, and Time-bound. They should also be change-oriented rather than activity-oriented.

They should describe the change you intend to bring about, not what you intend to do. The change should be quantified and the objective should state who will do it and when.

For example, consider the difference between these two objectives:

ORIGINAL OBJECTIVE:

To educate community about child sex ratio.

SMART objective:

By 2015, all women of the North East district will be educated about child sex ratio and its ill-effects by AWWs.

IDENTIFYING TARGET AUDIENCES

- ✓ Tell participants that before choosing advocacy activities and materials for the advocacy campaign, they need to identify who should be targeted to achieve the advocacy objectives.
- ✓ Ask participants to explain the difference between primary and secondary audiences.
- ✓ Record their comments on the blackboard/paper.

There is a need to decide where to focus your advocacy efforts, and identify targets – people who can make the decisions to bring about the changes you want.

- ✓ The **primary audience** is the individuals and/or institutions with authority to change or ensure the implementation of the policy commitment.
- ✓ The **secondary audience** is the individuals or and/or institutions that can influence the primary audience.

Target Audiences for an Advocacy Campaig

Exercise

Stakeholder mapping exercise

This exercise will help you map all the relevant stakeholders and the links, power dynamics and relationships between them. Start with your targets and then include other stakeholders (both allies and opponents).

- On a flip chart draw two axes (see below) showing support/opposition for the change you seek, and their power.
- Brainstorm possible key advocacy targets and place each name on one card/ board (this should be done for each change objective).
- Then place your targets according to your perception of their support or opposition to your advocacy objectives, and their power to make a change.

+ Power
Opposition
Support
- Power

- Those with the most power are your main targets and should be prioritised.
- The hardest targets to influence will be those with the most power who oppose the change.
- Then do the same, but use different colour pens, to identify possible influential allies (those who support your advocacy objectives) as well as opponent

DEVELOPING MESSAGES

- You need to develop clear, consistent and effective messages. To do this you need to think about what you want to say, and how you should say it.

GENERAL GUIDANCE ON DEVELOPING MESSAGES:

- ✓ Make messages clear, compelling and engaging. Avoid jargon.
- ✓ Put your ‘frame’ around the issue – highlight your perspective.
- ✓ Use clear facts and numbers creatively.
- ✓ If possible include information that is local so that it is relevant for people.
- ✓ Allow your audience to reach their own conclusions.
- ✓ Present a solution if possible.
- ✓ Remember: concise and consistent messages are critical for advocacy.
- ✓ Content is only one part of a message. Other factors such as who delivers the message, where a meeting takes place or the timing of the message can be as, or more, important than the content alone. Sometimes what is not said delivers a louder message than what is said.

Note: Example of the type of message to be given to the community is highlighted in the case study in the last of this chapter.

Discuss:
Ask participants to brainstorm reasons why it is important to have an implementation or action plan before starting their advocacy activities. Record comments.

ACTION PLANNING

DRAWING UP AN ACTION PLAN

In developing the action plan, there is a now need to put together something that shows practically who will do what, and when.

Action Plan Performa				
What do we need to do?		By When?	Who will do it?	What resources are needed?
Output	Activities			

MONITORING & EVALUATION

MONITORING

The purpose of monitoring is to track activities during every step of the advocacy campaign in order to ensure that activities are being implemented as planned and to compare what has been done against what was planned or expected.

EVALUATION

An evaluation assesses whether the activities were effective in contributing to progress in meeting the advocacy objectives. Evaluation of advocacy activities primarily measures outcomes—the achievements or results. In an advocacy initiative, outcomes are measured at two levels—at the level of each advocacy activity, and at the level of the overall advocacy initiative or campaign.

WHAT IS CAPACITY BUILDING?

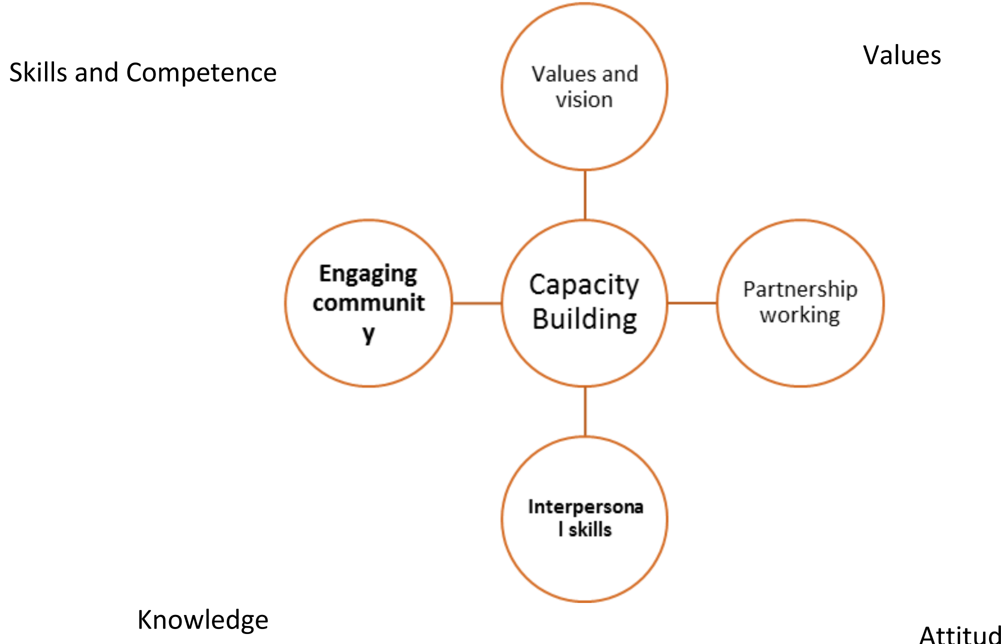
- Capacity building is recognised as one of the essential component in order to empower the community.

- Capacity building is an enduring development through which individuals, groups, organizations and societies augment their capability to recognize and congregate development challenges.

- Capacity and capability building is defined as enabling involves the proficiency, motivation and aptitude to commence, design, accomplish, start, organise, budget, monitor/supervise and evaluate project activities.

- Thus capacity and capability building are related to the organizational and functional levels as well as to individuals, groups and institutions.

- Capacity building is one of the ways in which women in the community can be empowered and provide them with the knowledge to deal with their issues and problems of the community and their household.



STRATEGIES FOR CAPACITY BUILDING

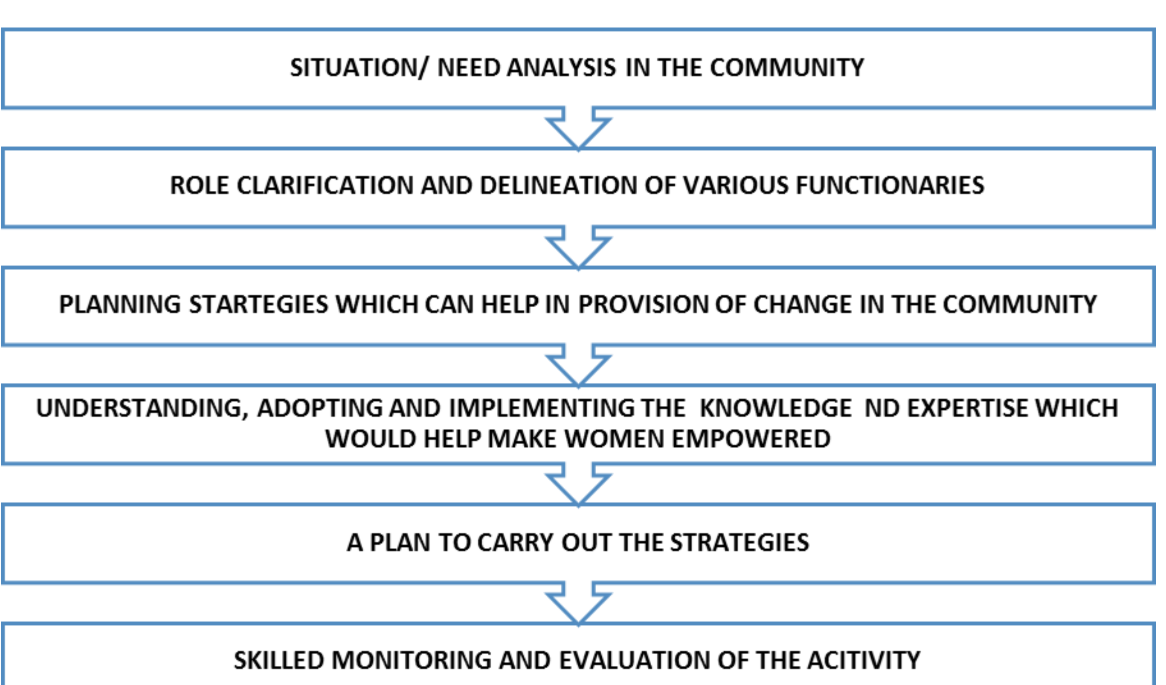
- Capacity building is a gradual process which requires in-depth knowledge and analysis so that reflective results can be seen in the community.

- The strategies that need to be prepared for capacity building can either be short term or long term.

- Situation Analysis is a process which involves certain steps and processes. It requires dedicated and decentralised approach, an action plan for the capacity building, pool of resource people,

- The steps involved for capacity building are a guided process which provides long term solutions for the community.

- The process typically would involve steps like



Group Activity:

- The trainers may ask the trainees to assemble in groups and discuss about the various problems that they face in their community.
- The groups may then highlight the key problems and prioritize them as the problem which needs urgent attention.
- The group may then formulate their future activities based on the problems identified.

Capacity Building & Information Education and Communication (IEC) activities:

i. An amount of 3 percent of total annual expenditure under the Scheme is available for each SG/UT for Capacity Building and IEC activities.
ii. All cadres of ICDS staff from SG/UT level up to grassroot workers need to be sensitized on IGMSY. Wherever possible, these sensitization workshops should be organized in coordination/jointly with the Health Department as health services provision is a significant part of IGMSY.
iii. NIPCCD along with its Regional Centres would organize trainings, either through cascade model, vertical training or as the SGs/UTs deem appropriate. NIPCCD would also include IGMSY training in its regular job and refresher training courses of ICDS functionaries.
iv. State ICDS and Health Departments through their training Institutes should ensure all concerned personnel are trained in IGMSY in selected districts.
v. Capacity building should include training of PRI members.
vi. IEC activities at sector/project/district level and State/UT level should be organized for spreading awareness about the Scheme and sensitizing all concerned. A one-page pamphlet informing the intended beneficiaries about the Scheme, criterion to be met to receive the financial benefits and mechanisms to receive the money and from whom and when may be considered to be distributed to the service providers and beneficiaries.
vii. Advertisements as IEC may be used to spread mass awareness about the Scheme.

Day 3 Session 6

Accessing Public Services for community facilitation

Right to Information Act, 2005

Democracy is the Govt. of people. People pays tax for running the Govt. so they have right to seek any information. In India this act was implemented on 12 October, 2005.

Objective of the Right to Information Act

The basic objective of Right to Information Act is to empower the citizens, promote transparency and accountability in the working of the Govt. contain corruption, make our democracy work for the people in real sense. The act has created practical regime through which the citizens of the country may have access to information under the control of the public authorities.

What is Information

Information is any material in any form. It includes records, documents, memos, e-mails, opinions, advices, press releases, circulars, orders, logbooks, contracts, reports, papers, samples, models, data materials held in any electronic form. It also includes information related to any private body which can be assessed by the public authority under any law for the time being in force.

Right to Information Under The Act

- A citizen has a right to seek such information from a public authority which is held by the public authority or which is held under its control.
- A citizen has a right to obtain information in the form of diskettes, floppies, tapes, video cassettes or in any other electronic mode or through printouts provided information is already stored in a computer or in any other device from which the information may be transferred to diskettes etc.
- The information to the applicant shall ordinarily be provided in the form in which it is sought. However if the supply of the information causes any harm to the safety or preservation of the records, supply of information in that form may be denied.
- The act gives the Right to Information only to the citizens of India.

Central Public Information Officer

Application for seeking information should be made to an officer of the public authority who is designated as Central Public Information Officer (CPIO). All the Public Authorities have designated their central public information officer and have posted their particulars on their respective websites. This information is also available on the RTI portal www.rti.gov.in.

Persons seeking information are advised to refer to the website of the concerned public authority of the RTI portal for ascertaining the name of the concerned CPIO. If it is found difficult to identify or locate the concerned Central Public Information Officer of a public authority, application may sent to the Central Public Information Officer without specifying the name of the CPIO at the address of the public authority.

Assistance Available From Central Public Information Officer

The Central Public Information Officer shall render reasonable assistance to the person seeking information, if a person is enable to make a request in writing, he may seek the help of the CPIO to write his application. Where a decision is taken to give access to a sensorily disable person to any document, the Central Public Information Officer shall provide such assistance to enable access to information, including providing such assistance to the person as may be appropriate for the inspection.

Method of Seeking Information

- A citizen desires to obtain any information under the act should make an application to the Central Public Information Officer of the concerned public authority in writing in english or in hindi or in official language of the area in which the application is made.
- The applicant can send the application by post or through electronic means or can deliver personally in the office of the Public Authority.
- The application can also be sent through a Central Assistant Public Information Officer appointed by the department of post at sub divisional level or other sub district level.

Fee for Seeking Information

- The applicant, along with the application, should sent a demand draft or a banker's cheque or an indian postal order of rate of Rs. 10, payable to the accounts officer of the public authority as fee prescribed for seeking information.

- The applicant may also be required to pay further fee as prescribed in the rules as given below:
  - Rupees two (Rs. 2/-) for each page (in A-4 size or A-3 size paper) created or copied;
  - Actual charge or cost price of a copy in larger size paper;
  - Actual cost or price for samples or models;
  - For inspection of records, no fee for the first half; and a fee of rupees five (Rs.5/-) for each subsequent hours (fractions there of);
  - For information provided in diskettes or in floppy Rs. Fifty (Rs. 50/-) per diskette of floppy;
  - For information provided in printed form at the price fixed for such publication or Rupees two per page of photocopy for extract from the publication.
  - If the applicant belongs to Below Poverty Line (BPL) category, he is not required to pay any fee. However, he should submit a proof in support of his claim to belong to the Below Poverty Line.

Disposal of the Request

The CPIO is required to provide information to the applicant within 30 days of the receipt of a valid application. If the information sought for concerns the life or liberty of a person, the information shall be provided with in forty-eight hours of the receipt of the request.

First Appeal

If an applicant is not supplied information within the prescribed time of 30 days or 48 hours, as the case may be, or is not satisfied with the information furnished to him, he may prefer an appeal to the first appellate authority who is an officer senior in rank to the CPIO.

Second Appeal

If the appellate authority fails to pass an order on the appeal within the prescribed period or if the appellant is not satisfied with the order of the first appellate authority, he may prefer a second appeal with the central information commission with in 90 days from the date on which

the decision should have been made by the first appellate authority or was actually received by the appellate.

Format of Applicantion

- There is no prescribed form of application for seeking information. The application can be made on plain paper. The application should, however, have the name and complete postal address of the applicant. Even in case where the information sought electronically, the application should contain name and postal address of the applicant.
- The information seeker is not required to give reasons for seeking information.

How to Write an RTI Application

The basic requirement needed to write an RTI application consists of:

- Information about Public Information officer, name and address etc.
- Locate central Government PIO's.
- Incase you have problems locating your PIO/APIO you can address your RTI application to the PIO C/o Head of department and send it to the concerned public authority with the requisite application fee.
- The head of depavwrtment will have to forward your application to the concerned PIO.
- It is always advisable not to address your RTI application to the PIO by his name, just in case if he gets transferred or a new PIO is designated in his place.

Public Distribution System (PDS)

- PDS means distribution of essential commodities to a large number of people through a network of Fair Price Shop on regular interval.

- The commodities distributed generally include- wheat, rice, sugar, kerosene.

- PDS is a major instrument of the Government's economic policy for ensuring availability of food grains to the poor at affordable prices and for enhancing food security for the poorest of the poor.

Ration Card

A Ration Card is a document issued under an order or authority of the State Government, as per the Public Distribution System, for the purchase of essential commodities from Fair Price Shops.

How to Obtain a Ration Card

- An Indian citizen may obtain the application form for making a new Consumer (Ration) Card from obtain Office.

- He will require (a) a photograph of the head of the family attested by a gazetted officer/MLA/MP/Municipal Councilor, (b) proof of residence, and (c) the Surrender/Deletion Certificate of the previous Ration Card, if there was any.

- In case anyone is not able to provide proof of his/her residence,

the Circle FSO conducts spot inquiries by recording the statements of two independent witnesses in the neighbourhood.

- The standard prescribed time schedule for the preparation of a Ration Card is generally 15 days. However, the procedure and time limit may vary.

Fair Price Shops

- There are at present 28,995 fair price shops serving 1.90 crore families in the country.

- The problem of providing greater access of the public to the fair price shops has been solved to some extent by simplifying the norms for opening the shops.

- Out of the families with rice cards, 18.38 lakh poorest of the poor families have been identified as beneficiaries under the Antyodaya Anna Yojana (AAY) Scheme sponsored by the Government of India and the letters "AAY" have been stamped on their family cards so as to enable them to draw food grains at the special scale specified by the Government of India.

- The AAY beneficiaries are now supplied with 35 kg of rice per card per month at the rate of Rs.2/- per kg through Fair Price Shops.

Accessing Public Services Using Internet and Mobile

Ration Card

- A *ration* card is a very useful document issued under public distribution system for the purchase big of essential commodities from fair price shops.

Steps involved in online application are:

1. Registration as New User using a valid mobile number.
2. Log – In using registered mobile number and password.
3. Going through the ration card checklist to fill application form.
4. Filling the online application form which consists of 6 steps-
   Step 1: Bank Account Details
   Step 2: Basic Details
   Step 3: Address Details
   Step 4: Family Details
   Step 5: Attachment (photograph, ID proof, address proof)
   Step 6: NFSA Criteria
5. A draft acknowledgement receipt will be generated after the successful completion.
6. Check the receipt for any errors and finally "lock" the application.

After the successful online submission, the application will be automatically forwarded to the concerned authority for verification and *ration* card will be issued.

Issuing *Ration* Card is the responsibility of the State Government; therefore the application format may vary slightly from one state to another.

Voter ID Card/ Electors Photo Identity Card (EPIC)

- A Voter ID card is a very important document for Indian citizens. It is essential for casting vote and also used as a legal document (proof of identification) for many purposes.
- A Voter ID card can be issued to any person who is:
  - A citizen of India.
  - 18 years of age or above.
- To become a voter one needs to fill in the application Form- 6.
- Once this Form is accepted, the applicant's name will be included in the Electoral Roll as a voter.

Online Application

Step I: Go to Enroll Online on the home page of Chief Electoral Officer of the respective state.

Step II: A new user must sign up to obtain a user name and password.

Step III: Upload one passport size colour photograph in the space mentioned in the Form.

Step IV: Upload the following documents in the space mentioned in the Form and submit.

a) Proof of the residence (such as driving license, passport, bank pass book, any postal letter received in the name on specified address etc).

b) Proof of the age, such as birth certificate, school leaving certificate etc. However, this is only required if the age is between 18 and 21 years.

- In case there is a problem in uploading the documents, then the Booth Level Officer (BLO) will verify the information and will collect both the documents from the applicant's residence.
- After the completion of verification process, the voter ID card is delivered through speed post.

AADHAAR

- *AADHAAR* is a 12 digit individual identification number issued by the Unique Identification Authority of India on behalf of the Government of India which serves as a proof of identity and address, anywhere in India.
- *AADHAAR* number helps provide access to services like banking, LPG connections and other government schemes for direct benefit transfer.

AADHAAR Status

This application enables the citizen to check the *AADHAAR* status at any point of time.

Aadhaar Status
mGovernance Team

My AADHAAR (Mobile Application)

My Aadhaar
mGovernance Team

The initiative to issue an *AADHAAR* to every resident in India has an ambitious objective to enable residents identify themselves anytime anywhere. The *AADHAAR* platform helps service providers authenticate identity of residents electronically, in a safe and quick manner, making service delivery more effective and efficient.

Through this mobile application *AADHAAR* applicants can directly download the *AADHAAR* card.

AADHAAR Linking

This application allows citizens to register request for linking 12 digit unique *AADHAAR* number to their personal identification documents or benefit cards such as:

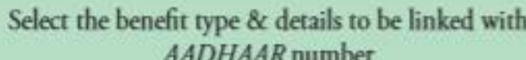
AADHAAR Linking
mGovernance Team

- Scholarships
- Pension ID
- MGNREGA Job Card
- LPG Consumer ID

Process of linking AADHAR to Personal IDs

Enter location details (Location details - State and District name)

↓



Select the benefit type & details to be linked with *AADHAAR* number

↓

Enter 12-digit *AADHAAR* number & contact details

↓

Enter the OTP (One Time Password), sent to the mobile and the security code displayed and Submit

↓

Request Registered

Permanent Account Number (PAN)

- PAN is a code that acts as identification, especially for those who pay Income Tax.
- It is a unique, 10-character alpha-numeric identifier, issued by the Indian Income Tax Department under the supervision of the Central Board for Direct Taxes (CBDT) and it also serves as an important proof of identification.

Process for Online Application of Permanent Account Number

Apply online for PAN on https://tin.tin.nsdl.com/pan/form49A.html or http://www.utitsl.co.in/utitsl/uti/newapp/newpanapplication.jsp

Fill details of ward, area code and other number related information, mention your office/personal address

Submit the filled form after checking whether entered information is correct

As submission is confirmed, a unique reference number (acknowledgement number) for PAN application will appear which can be used for tracking the status of PAN application

Save and print the acknowledgement form, paste recent colour photograph and sign the acknowledgement

Note: For online application for PAN, one must have DD/Cheque of ₹ 105 or you must have credit card to pay the application fee online.

Passport

- Passport *Seva* Project was launched with the objective of delivering Passport services to the citizens in a comfortable environment with wider accessibility and reliability.
- Under Passport *Seva*, new measures and procedures have been introduced in order to improve governance in Passport Offices by ensuring citizens comfort, improvement in delivery of passport services, transparency and enhanced security.
- For issue of fresh passport and reissue of passport, one needs to fill the application form online via e-Form Submission (preferred) or via Online Form Submission.

Online Application and Appointment

The online appointment system avoids congestion at the Passport *Seva Kendras* (PSKs) and cutting down the waiting time for applicants. Appointment date/ time will be automatically allotted by the system as per the availability of appointment slots at the desired PSK.

Online Application Process for Passport

- Register 'user name' and assign a 'password' at passportindia.gov.in
- Log in using your 'user name' and 'password'

- Fill online application form and submit online
- Take an appointment to visit the nearest Passport *Seva Kendra* by clicking "Schedule Appointment" link

- Select the Mode of Payment or pay using *challan* link (submit *challan* along with indicated application fee at nearest SBI branch)

- Take a printout of the Application Receipt and carry it along while visiting the Passport *Seva Kendra* on the given appointment date/time

Note: It is mandatory for all applicants, including infants, to be physically present at the Passport *Seva Kendra* to give their biometrics (fingerprints) and photographs.

mPassport Seva (Mobile Application)

- Passport *Seva* Project, of the Ministry of External Affairs (MEA), aims at providing all the Passport related services to the Indian Citizens in a speedy, convenient and transparent manner.
- MEA with a view to provide mobile enablement of public services, has launched a Mobile Application 'mPassport *Seva*' to offer a wide variety of services to smartphone users such as:
  - Passport application status tracking.
  - Locating the Passport *Seva Kendra*.
  - General information on various steps involved in obtaining a Passport.

mPassport Seva
Consular, Passport and

e-Transportation

Under the National e-Governance Programme (NeGP) e-Transport services includes air, train and road transport which helps in:

- ➢ Booking train tickets online.
- ➢ Online status check of running trains.
- ➢ Tour to the National Museum.
- ➢ Book Air India tickets.

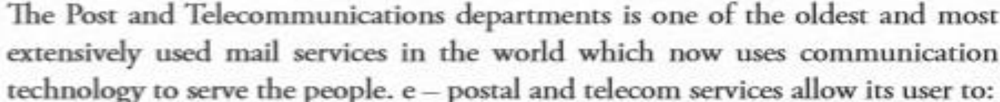
IRCTC Connect (Mobile Application)

It is an application of Indian Railways allowing m-reservation of railway tickets from anywhere in India.

Features:

- ➢ One step login to existing users.
- ➢ Search and Book train tickets.
- ➢ View and Cancel tickets.
- ➢ Retains recently added passenger details.
- ➢ New Users, register from App directly.
- ➢ Upcoming Journey Alerts.

e - Postal & Telecom Services



The Post and Telecommunications departments is one of the oldest and most extensively used mail services in the world which now uses communication technology to serve the people. e – postal and telecom services allow its user to:

- ➢ Send message through e-post.
- ➢ Send money through Instant Money Order (iMO).
- ➢ Track speed post status online.
- ➢ Search ISD code online.
- ➢ Calculate the postal charges online.
- ➢ Find numbers on 'Online Telephone Directory'.

India Post Tracker (Mobile Application)

India Post's online tracking allows one to access tracking information and confirm the delivery of item by using the tracking number assigned at the time of booking.

What can be tracked?

- ➢ Speed post (Domestic EMS)

- International EMS
- Electronic Money Order (eMO)
- Registered Mail
- Express Parcel
- Electronic Value Payable Parcel (eVPP)

India Post Tracker
mGovernance Team

How it works?

The tracking system is updated periodically to provide the most current information available about the location and status of the item. Other information provided includes:

- Date and time of booking.
- Dispatched and receiving date and time at various locations during its journey.
- Date and time of delivery.
- Date and time of issue of delivery intimation notice, to notify the recipient that the item is available for delivery.

India Speed Post Tracker (Mobile Application)

- India Post's online tracking for Speed Post allows one to access tracking information and confirms the delivery of the item sent by speed post by using the tracking number assigned at the time of booking.

India Speed Post T
mGovernance Team

e - Educational Services

- Online learning is a method of delivering educational information through the internet.
- It is flexible and self-paced and suited for distance learning.
- The use of ICT in education has made it possible to reach learners who want to pursue education from far-off places.

Employment Exchange

Employment Exchange is an organisation that provides employment assistance on the basis of qualification and experience. The Departments of Employment in various states of India allow unemployed educated youth residing in the respective states to pre-register for impending job vacancies occurring in different sectors of that state.

Online Registration Process for Employment Exchange

Visit State Employment Exchange website for online registration, create an account and log into State Employment exchange website with the credentials.

Submit filled form and print the acknowledgement containing the registration number, registration date and name of the employment for future reference.

Produce relevant certificates in support of education, experience, caste, sports, handicapped, ex-serviceman, widow, freedom fighter and proof of residence to the Employment Exchange within 15 days from the date of registration.

Employment Exchange will issue a registration card carrying Registration No. with date of renewal of that registration.

Note: Apart from the above documents one needs to submit documents as residence proof (*Ration* Card, Voter ID Card, Certificate from Municipal Councilor/*Sarpanch*, Proof of job in the state of either of the parents, Certificate of Education in the state, Letter from Gazetted Officer or School Head, Certificate issued by an MLA/MP, Domicile Certificate).

e-Grievance Redressal

- During the course of public-government interface or interaction, the citizen may feel wronged which may be real or supposed. This forms valid grounds of complaint.
- To redress grievances, the Central Government has set up a portal for public grievances. A list of Uniform Resource Locators (URLs) which link citizens directly to the concern department.

Online Banking (OLB)

- Online banking is an electronic payment system that enables customers of a bank to conduct financial transactions on a website operated by the bank.
- Online banking is also referred as Internet banking, e-banking and virtual banking.
- Online banking services includes:
  - **Account Details:** View bank account details, account balance, download statements and more. Also view demat, loan & credit card account details, all in one place.

- **Funds Transfer:** Transfer fund to own accounts, other accounts in same bank or accounts in other banks.
- **Request Services:** Give a request for cheque book, demand draft etc.
- **Investment Services:** View complete portfolio with the bank, create fixed deposit.
- **Value Added Services:** Pay bills, recharge mobile, register for e-statement and SMS banking etc.

Steps for Accessing Internet Banking

1. The customer has to register with the bank for internet banking.
2. Once registered the customer is provided with a customer name and is required to set a password.
3. To access online banking, a customer would go to the Bank's secured website and enter the online banking facility using the customer name and password previously setup.
4. The customer can now use the bank services as required.

Mobile Banking

Banking can also be done by using mobile applications of the banks.

Mobile Banking Services

Account Information	Transaction	Support
• Mini-statements and checking of account history • Alerts on account activity • Monitoring of term deposits • Access to loan statements • Access to card statements • Mutual funds / equity statements • Insurance policy management	• Mini-Funds transfers between the customer's linked accounts • Paying third parties, including bill payments and third party fund transfers	• Mini-Status of requests for credit, including mortgage approval and insurance coverage • Check (cheque) book and card requests • Exchange of data messages and email, including complaint submission and tracking • ATM locator

Right to Information (RTI)

As per RTI every citizen has freedom of speech and expression and has the right to know how the government works, what role does it play, what are its functions and so on.

Online Application Process for Right to Information

Fill the form and attach required document at http://rti.india.gov.in/rti_direct_complaint_lodging.php

Click on "Save as Draft/ Submit", once the form is saved, an unique complaint ID is provided

After submitting the application one can also check the status of application using unique complaint ID on http://rti.india.gov.in/rti_check_request_status.php?cat=compl

Other Important Mobile Applications

Electricity Bill Details

It is a pull service that provides details of electricity consumer bill such as due amount and due date on specifying consumer number.

Vikaspedia

- Vikaspedia portal is a multilingual knowledge repository dedicated for providing information/ knowledge and ICT based knowledge products and services in the domain of social development.
- Vikaspedia browser app allows the users to have easy access to the Vikaspedia portal in the language of their choice (presently five languages) without having to remember the URL.

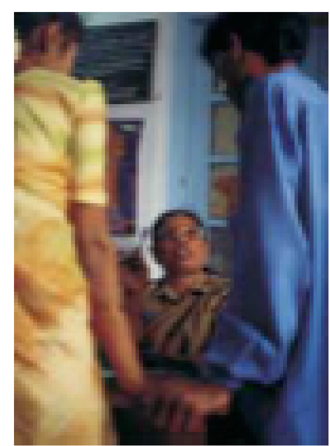
mkisan

This mobile app enables farmers and all other stakeholders to obtain advisories and information being sent by experts and government officials at different levels through *mkisan* portal without registering on the portal.

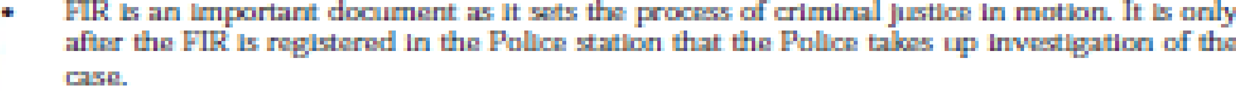
Session- Lodging an First Information Report or FIR

Objective	By the end of the session, the participants will be
	• Aware of the importance of FIR
	• If required, be able to file an FIR
	• Be aware that if the FIR is not registered, what can be done against it.
Training Content	• Introduction about FIR and its importance.
	• Details like who can lodge an FIR, procedure of filing an FIR
	• Things to keep in mind while filing an FIR.
Training Method:	Lecture cum group discussion and activity
Class Activity	The whole group will be divided in pairs and one person will act as Police Officer, who will file the FIR and one person will act as the person who files the FIR.
	One by one all the pairs will be given different situations by the trainer and they will file the FIR.
	By using different situations, participants will be able to know the difference between cognizable and non-cognizable offences, situations in which the Police Officer may not investigate a complaint even after filing an FIR, the procedure for filing an FIR, and what all should be mentioned in the FIR.

Salient Points



- FIR is a report that reaches the Police first in point of time and that is why it is called so. It is a written document prepared by the Police when they receive information about the commission of a cognizable offence (a cognizable offence is one wherein the Police may arrest a person without warrant. They are authorized to start investigation into a cognizable case on their own and do not require orders from the court to do so. On the other hand, in a non- cognizable offence, the Police has no authority to arrest without warrant. The Police cannot investigate such an offence without the Court's permission).
- It is generally lodged with the Police by the victim of a cognizable offence or by someone on his/her behalf. It can be reported either orally or in writing to the police. Even a telephonic message can be treated as FIR.



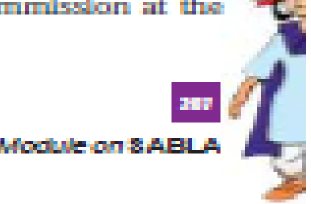
- FIR is an important document as it sets the process of criminal justice in motion. It is only after the FIR is registered in the Police station that the Police takes up investigation of the case.

- Anyone who knows about the commission of a cognizable offence can file an FIR. It is not necessary that only the victim of the crime should file an FIR. A Police Officer who comes to know about a cognizable offence can file an FIR himself/herself.
- One can file an FIR if:
  - One is the person against whom the offence has been committed.
  - One has seen the offence being committed.
- The procedure of filing an FIR as prescribed in Section 154, of the criminal procedure code, 1973, is as follows:
  - When information about the commission of a cognizable offence is given orally, the Police must write it down.
  - It is your right as a person giving information or making a complaint to demand that the information recorded by the Police is read over to you.
  - Once the information has been recorded by the police, it must be signed by the person giving the information.
  - One should sign the report only after verifying that the information recorded by the Police is as per the details given.
  - People who cannot read or write must put their left thumb impression on the document after being satisfied that it is a correct record.
  - Always ask for a copy of the FIR, if the Police does not give it. It is one's right to get it free of cost.
- It is given in section 157, criminal procedure code, 1973, that the Police may not investigate a complaint even if an FIR is filed if;
  - They find the case is not serious in nature.
  - They feel that there is not enough ground to investigate.

However, the Police must record the reasons for not conducting an investigation and in the latter case must inform the person filing the FIR.

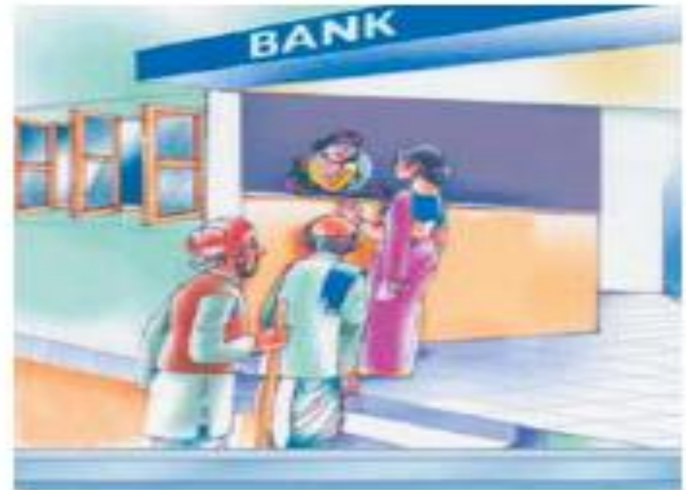
- Things to be mentioned in FIR;
  - Name and address of the person filing the FIR.
  - Date, time and location of the incident being reported;
  - True facts of the incident as they occurred;
  - Names and descriptions of the persons involved in the incidents;
  - Witnesses, if any.
- One should never file a false complaint or give wrong information to the police; one can be prosecuted under law for giving wrong information or for misleading the police.
- Never make vague or unclear statements and never exaggerate or distort facts.
- If one's FIR is not registered, one can meet the Superintendent of Police or other higher officers like Deputy Inspector General of Police and Inspector General of Police and bring one's complaint to their notice, one can also send the complaint in writing and by post to the Superintendent of Police concerned.

In case the FIR is not registered a private complaint before the court having jurisdiction may also be complained, or the complaint may be made to the Human Rights Commission at the State or National level.



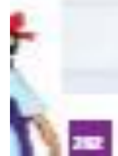
Session- Opening and Managing Bank Accounts

Objectives	At the end of the session trainees will:
	• Know the importance of opening a bank account
	• Know about the steps and documentation involved in opening a bank account
Contents	• Introduction about various types of bank accounts
	• Documents required for opening a bank account
	• The procedure for opening and managing a bank account
Training Methods	• Lecture-cum-discussion
	• Demonstration
Class Activity	Sample of account opening forms will be given to each participant, and they will be asked to fill in the complete form and give their forms to the trainer. Then the trainer will check those forms for any mistake. At the end, queries will be taken up by the trainer.
Training Aids/materials	Sample of bank account opening forms, flash cards, etc.



Salient Points

- Bank account is not only a safe way of keeping your money but it also provides easy access to money
- These days carrying a lot of cash is not advisable. Therefore it is best to keep one's money in the bank, which will provide access to services like debit cards and ATMs, so that one may carry one's money in the form of a debit card all the time, without fear of losing the money.
- Various types of bank accounts are available. One needs to collect information about these various kinds of accounts that are available, and then decide which one is best suited to one's needs.
- To open bank account, one should do a brief survey of all the banks available and the schemes that they are offering. While choosing a bank, one should keep in mind the feasibility of commuting to the bank from one's home or place of work.
- After choosing the bank, one should gather information about various types of services provided by it and choose the account / services, keeping needs in mind.
- In order to open an account, one has to provide some basic information to the bank, like name, date of birth, address and some identification details.
- The account holder has to agree to abide by certain rules and accept responsibility for certain actions. While opening a bank account, one forms a relationship based on a very sensitive subject- money. Therefore one should know very well what one is getting into.
- After the account is open, one can easily deposit or withdraw money with ease. With an ATM, it becomes even simpler.
- Opening and managing a bank account is really easy as long as one knows what to expect.



Session- Opening and operating an Account in the Post Office

Duration	40 minutes
Objectives	At the end of the session trainees will:
	• Know the importance of opening an account in the Post Office.
	• Know about various schemes available in the Post Office for saving money.
Contents	• Introduction about various types of Post Office accounts
	• Documents required for opening an account in the Post Office
	• The procedure for opening and managing one's account in the Post Office
Training Method	Lecture-cum-discussion
Class Activity	Sample of account opening forms will be given to each participant, and they will be asked to fill in the complete form and give it to the trainer. The trainer will check the forms for mistakes. At the end, queries will be taken up by the trainer.
Training Aids/material	Sample of account opening forms, flash cards, etc.

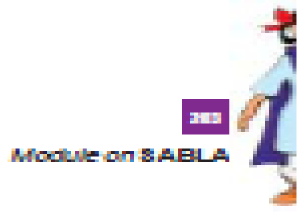
Salient Points

Post Offices have the largest service network in India. Postal personnel provide services even in remote regions of the country. There are places where one may see an old postman riding a bicycle, distributing letters, awaited eagerly by the kith and kin of the people who are far from their families and friends. The reach of Post Offices is greater than that of banks and this is the reason why the Government has introduced monthly income accounts and savings accounts through Post Offices. These take the benefit of having a savings account right to the people who need them the most. If one is living in a remote corner, sometimes it is better to have a savings account in a Post Office rather than a bank, since the Post Office and postman are nearerby.

There are two types of Post Office accounts –

(1) Post Office Monthly Income Account

(2) Post Office Savings Account



- ## Post Office Monthly Income Account

This is meant for those who want to invest a lump sum and earn interest on a monthly basis for their livelihood. The scheme is, therefore, a boon for retired or handicapped persons. They can just deposit an amount and rest assured of a regular flow of money. They would get an amount every month and can live on it. A fair number of people opt for this scheme on reaching retirement age. They put their savings in a Post Office under this head and enjoy their life with family and friends, while the Post Office, takes care of their monthly income with their deposited money.

How to Invest

One can invest in any Head Post Office/Sub- Post Office by cash, demand draft or local cheque. One will need to fill up a prescribed form and submit it with the amount. It would entitle one to withdraw an amount every month.

Who can Invest

- An adult
- 2 - 3 adults jointly
- A minor of minimum ten years
- A guardian on behalf of a minor or a person of unstable mind

Maturity and Rate of Interest

- It is a six year account with 8 % interest per annum payable monthly.
- Premature encashment facility is available after one year.
- There is a facility of premature closure of the account after 1 year uptil 3 years @2 % discount.
- There is deduction of 1 % if account is closed prematurely at any time after 3 years.
- Facility of reinvestment on maturity of account.
- Maturity proceeds that have not been withdrawn are eligible for earning savings interest rate for a maximum period of two years.
- Minor's investment is not clubbed with the guardian.
- Account is transferable to any Post Office in India, free of cost.
- Nomination facility is available.
- Monthly interest can be credited to the savings bank account in the same Post Office.
- 5 % maturity bonus is also given.

Amount of Investment

Minimum invested amount has to be Rs. 1500. Maximum amount can be Rs. 4.5 lakh for a single account and Rs. 9 lakh for a joint account. Minors have a separate limit of investment of Rs. 3 lakh and the same is not clubbed with the limit of guardian.

Tax benefits

- Deposits are not eligible for rebate under section 80 c.
- Deposits are exempt from wealth tax.
- No Tax Deduction at Source (TDS) is applicable.
- **Post Office Saving Account**

Post Office saving account is similar to a person's savings account in a bank. It is a safe instrument to park one's funds, which one might need to liquidate fully or partially at a very short notice. Post Office savings accounts are more suited for people living in rural and semi rural areas where the reach of the banks is limited.

How to open Account

The account can be opened at any Post Office with a minimum balance of Rs. 20. Maximum of Rs. 1 lakh for single account holder and Rs. 2 lakh for joint account holders can be deposited. There is no lock-in or maturity period. One can just go to a Post Office, meet the clerk, complete the formalities and open the account.

Who can open Account

Single account can be opened by an adult, a minor with minimum age of 10 years, or a guardian on behalf of a minor or person of unsound mind. Joint account can be opened by two or three adults.

Withdrawal of money

The amount can be withdrawn anytime, subject to keeping a minimum balance of Rs. 50 in simple account and Rs. 500 for cheque facility accounts.

Interest Paid

Rate of interest is decided by the Reserve Bank of India from time to time. Interest is calculated on monthly balances and credited annually. It is typically around between four percent.

The account also has other facilities like nomination, tax benefits, etc.

NOTES