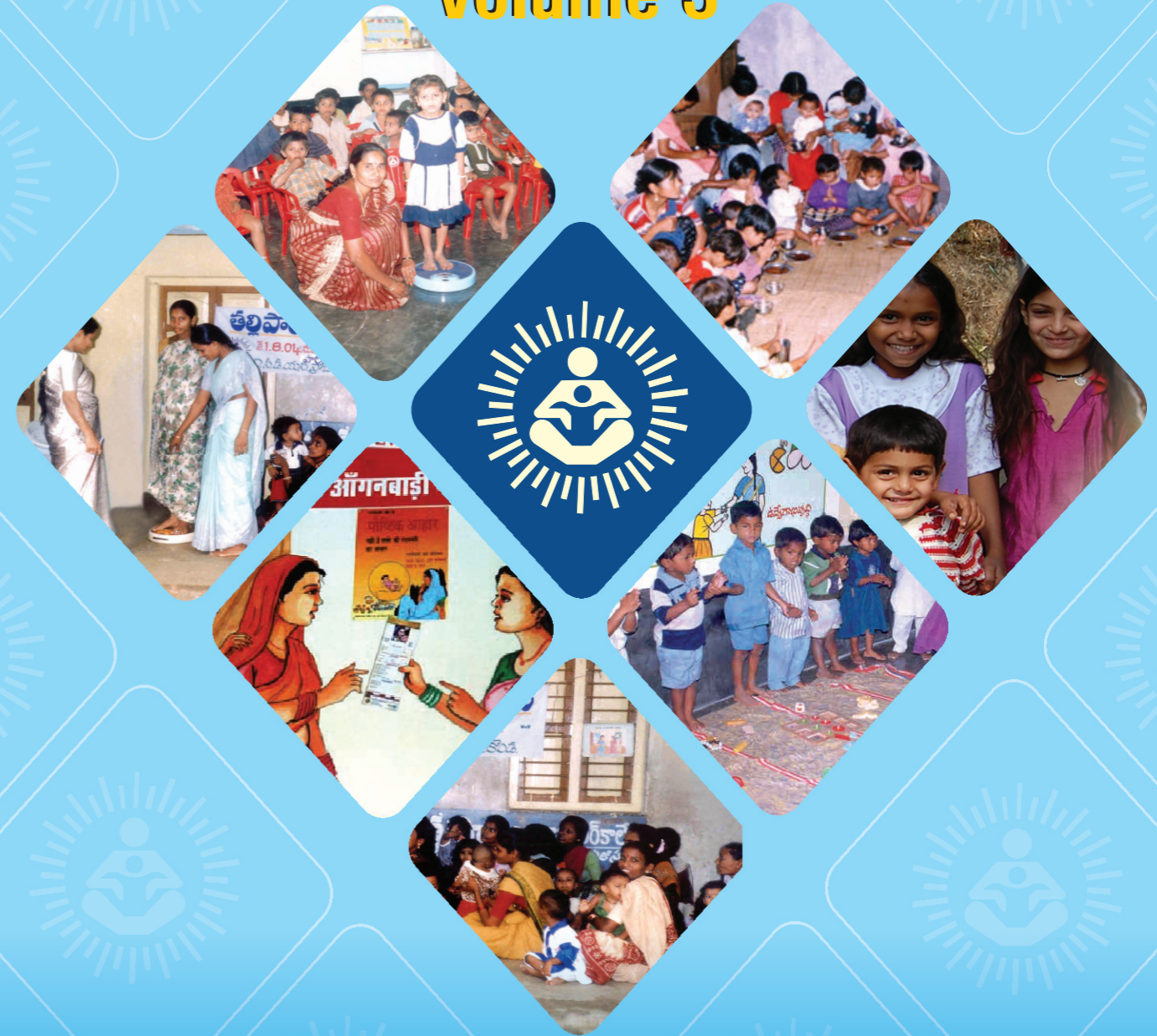


Research on ICDS An Overview Volume 3



National Institute of Public Cooperation and Child Development
5, Siri Institutional Area, Hauz Khas
New Delhi - 110 016



National Institute of Public Cooperation and Child Development
5, Siri Institutional Area, Hauz Khas, New Delhi - 110 016

Research on ICDS: An Overview
(1996-2008)
Volume 3



National Institute of Public Cooperation and Child Development
5, Siri Institutional Area, Hauz Khas, New Delhi - 110016

Number of Copies: 500



सत्यमेव जयते

कृष्णा तीरथ
Krishna Tirath



राज्य मंत्री (स्वतंत्र प्रभार)
महिला एवं बाल विकास मंत्रालय
भारत सरकार
नई दिल्ली-110001
Minister of State (Independent Charge)
Ministry of Women & Child Development
Government of India
New Delhi-110001

Message

Investing in children is a decision a nation makes for improving the quality of life of its future citizens, and embarking on a path of planned development. Keeping this in view, the Government of India launched ICDS in 33 projects on 2nd October 1975. ICDS has expanded over the years, and now is one of the world's largest programmes working for the holistic development of young children. It is instrumental in enabling mothers to care for their young children, by providing them services and appropriate information support and guidance. The services provided under ICDS have had a positive impact on the health and nutritional status of children, helped in reducing infant mortality, and created awareness in the community on many issues. These achievements were revealed by the many research studies undertaken on ICDS.

To collate the findings of scattered research studies on ICDS, NIPCCD undertook the task of compiling the research studies conducted on various aspects so that the programme could be further strengthened. This would lead to further improvement in the situation of women and children from weaker sections of society, which is the goal of all social development programmes.

I hope this document would be useful to all persons and institutions working for the empowerment of vulnerable sections of society.

(Krishna Tirath)



अनिल कुमार
Anil Kumar



सचिव
महिला एवं बाल विकास मंत्रालय
भारत सरकार
नई दिल्ली-110 001
Secretary
Ministry of Women & Child Development
Government of India
New Delhi-110 001

Foreword

The future of a country is shaped by the investment it makes in its children, especially those from vulnerable sections of society. Recognizing the importance of early childhood in the life of an individual, Government of India launched ICDS in 1975 to provide young children with the inputs necessary for their survival, growth and holistic development.

ICDS has had considerable positive impact on the health and nutritional status of children, and has, therefore, been the subject of many research studies. In order to disseminate the findings of research to users, NIPCCD brought out a document titled "**Research on ICDS: An Overview: 1975-1985: Volume I**", which covered research done during the decade, and included over 200 research studies. Subsequently, another document was brought out titled "**Research on ICDS: An Overview: 1986-1995: Volume 2**" which covered about 80 studies conducted during the decade. It also included important studies which could not be included in Volume I due to various reasons.

The document titled "**Research on ICDS: An Overview: 1996-2008: Volume 3**" is the third in the series, and includes about 70 research studies. It covers areas such as administration of ICDS, adolescent girls, anaemia, anganwadi workers training centres, community participation in ICDS, evaluation of ICDS, functioning of AWCs, health status, nutrition and malnutrition, preschool education, time management, training of functionaries and World Bank assisted ICDS Projects. The major findings of research and recommendations have been compiled in one document for the benefit of researchers, planners, administrators, trainers, and all other persons involved in assessing the outcome of this programme.

It is hoped that this document would be useful to all stakeholders working in the field of ICDS. It would not have been possible to bring out this document without the cooperation of various organizations who have shared their research studies with NIPCCD. Their contribution is gratefully acknowledged, and it is hoped that this document would be of immense use to all those working for women and children.

Anil Kumar

(Anil Kumar)

Acknowledgement

ICDS, being the world's largest programme for development of young children, has had many researchers investigate various aspects of it. This document has summarised the salient findings and recommendations of the research studies received by NIPCCD during 1996-2008. I wish to express my gratitude to the various Government departments, medical colleges, home science colleges, social work departments of universities, research institutes, voluntary and autonomous organisations, UN agencies and international organisations who willingly shared their research studies with NIPCCD. Without their cooperation and support it would not have been possible to bring out this compilation.

I would specially like to thank Dr. Dinesh Paul, Additional Director and Dr. Sulochana Vasudevan, Joint Director for the help, guidance and support extended. I would like to thank Ms. Meenakshi Sood, Deputy Director and her Project Team at Documentation Centre for Women and Children for painstakingly compiling the research findings. Special thanks are due to Shri A.K. Goyal, Senior Programmer in Ministry of Women and Child Development for providing information on the ICDS Scheme. I would also like to thank Shri A.J. Kaul, Publication Officer and Smt. Jyoti Sethi, Proof Reader for ensuring timely publication of the document.

I hope this document would be useful to all users working for the empowerment of vulnerable groups of society.



(A.K. Gopal)
Director

Project Team

Project In-charge	: Meenakshi Sood
Text	: Abhilasha Mishra Punita Mathur
Computer Assistance	: Pawan Kumar Sundara Prabha Varun Kumar
Institutional Cooperation	: Government Ministries and Departments Autonomous Organizations United Nations Organizations International Organizations Research Institutions Voluntary Organizations Home Science Colleges Social Work Colleges/Departments
Layout and Production	: A. J. Kaul Jyoti Sethi

Contents

Introduction	xix
I. Administration and Management of ICDS	
1. ICDS Project Implementation in Pooh Block (Kinnaur Block) Himachal Pradesh - NIPCCD, Regional Centre Lucknow, Uttar Pradesh. (2003).	3
II. Adolescent Girls in ICDS	
2. Adolescent Girls Scheme: An Evaluation in Kerala - Solidarity among Women, Thiruvananthapuram, Kerala. (2002).	9
3. Kishori Shakti Yojana (KSY) under the Ambit of ICDS in Uttar Pradesh and Rajasthan - Formative Research and Development Services, New Delhi, Delhi. (2008).	13
4. Report of Evaluation of National Programme for Adolescent Girls - Nutrition Foundation of India, New Delhi, Delhi. (2007).	18
5. Report on Survey and Evaluation of the Adolescent Girls Scheme - Juthika Sen Voluntary Health Association, Delhi (VHA), New Delhi, Delhi. (2004).	24
III. Anaemia Prevention	
6. Community Level Micronutrient Fortification of a Food Supplement in India: A Controlled Trial in Pre-School Children Aged 36-66 Months - Jessica L. Verma, Soumita Das, Rajan Sankar, Marthi G. Venkatesh Mannar, - F. James Levinson and Davison H. Hamer Child in Need Institute, Kolkata, West Bengal. (2007).	29
7. Process Documentation of Gumla Anaemia Project - AMS Consulting, Ranchi, Jharkhand. (2007).	32
IV. Anganwadi Workers Training Centres	
8. Anganwadi Workers Training Centres in Uttar Pradesh: A Case Study - NIPCCD, Regional Centre Lucknow, Uttar Pradesh. (2005).	37
9. A Quick Appraisal of AWTCs in Bihar - NIPCCD, Regional Centre Lucknow, Uttar Pradesh. (2004).	41
10. Situational Analysis of Anganwadi Workers Training Centres in Jharkhand - V. D. Gadkar NIPCCD, Regional Centre Lucknow, Uttar Pradesh. (2006).	46

V.	Baseline Survey	
11.	Baseline Survey for World Bank Assisted ICDS-III Project in Rajasthan - Indian Institute of Health Management Research, Jaipur, Rajasthan. (2000).	53
VI.	Community Participation in ICDS	
12.	A Study on Community Participation in ICDS in North Kolkata - Sangita Banarjee Vidya Sagar School of Social Work, Kolkata, West Bengal. (1999).	61
13.	A Study on Community Participation in ICDS in Chennai - T. Sampath Loyola College, Department of Social Work, Chennai, Tamil Nadu. (2008).	64
VII.	Enrollment of Children	
14.	A Study on Factors Influencing Non-Enrollment of Children in the ICDS Anganwadi Centres at Chennai Corporation - A. Vinnarasan Loyola College, Department of Social Work, Chennai, Tamil Nadu. (2007).	69
VIII.	Evaluation of ICDS	
15.	Child Welfare and Community Participation: A Case Study of the ICDS Programme in Thiruvananthapuram District, Kerala - Ameya Balsekar, Ashish Thomas George, Chloe Puett and Preeti Dhingra Institute of Social Sciences, Thiruvananthapuram, Kerala. (2005).	75
16.	Concurrent Evaluation of Integrated Child Development Services: National Report - Devendra B. Gupta and Anil Gumber National Council of Applied Economic Research (NCAER), New Delhi, Delhi. (2001).	78
17.	Consultancy for Continuous Social Assessment (CSA) - World Bank, Navi Mumbai, Maharashtra. (2005).	81
18.	Evaluation of Integrated Child Development Services (ICDS) Volume A: Haryana - Socio-Economic and Educational Development Society (SEEDS), New Delhi, Delhi. (2005).	85
19.	Evaluation of Integrated Child Development Services (ICDS) Volume B: Himachal Pradesh - Socio-Economic and Educational Development Society (SEEDS), New Delhi, Delhi. (2005).	88

20.	Evaluation Study of ICDS in Haryana - R. C. Sharma Haryana, Department of Economics and Statistics, Chandigarh, Haryana. (2004).	91
21.	Focus on Children under Six - Citizen's Initiatives for the Rights of Children under Six (CIRCUS), New Delhi, Delhi. (2006).	95
22.	ICDS in Delhi: A Reality Check - FORCES Delhi (NEENV), New Delhi, Delhi. (2007).	99
23.	Impact Assessment/ Evaluation of ICDS Programme in the State of Orissa - N. C. Dash et al. Centre for Rural Development, Institute of Media Studies, Bhubaneswar, Orissa. (2006).	103
24.	The Micro Status of ICDS in Hayatnagar, Andhra Pradesh: A Study by FORCES - FORCES (Forum for Creche and Child Care Services), New Delhi, Delhi. (2005).	108
25.	A Micro Study of the Status of the Young Child: A Block Level Study in Chandauli District of Uttar Pradesh - FORCES (Forum for Creche and Child Care Services), New Delhi, Delhi. (2005).	111
26.	Nutritional, Health and PSE Status of Children Covered under the ICDS Scheme in Orissa - Indian Institute for Social Development (IISD), Bhubaneswar, Orissa, (2001).	114
27.	Performance Appraisal of ICDS and Non-ICDS Districts with Reference to Holistic Development of Child and Mothers in the Light of Social Organization Participation: An Impact cum Comparative Study in the States of Maharashtra and Madhya Pradesh - Midstream Marketing and Research Pvt. Ltd., (MMR), New Delhi, Delhi. (2005).	117
28.	Quick Review of Working of ICDS in Rajasthan - Society for Economic Development and Environmental Management (SEDEM), New Delhi, Delhi. (2005).	122
29.	Social Assessment of ICDS in Karnataka - Indian Institute of Management (IIM), Bangalore, Karnataka. (2005).	125
30.	A Social Audit of ICDS in the State of Bihar : A Study by FORCES - FORCES (Forum for Creche and Child Care Services), New Delhi, Delhi. (2005).	129

31.	A Social Audit of ICDS in the State of Uttar Pradesh: A Study by FORCES - FORCES (Forum for Creche and Child Care Services), New Delhi, Delhi. (2005).	132
32.	The Status of the Young Child in Rajasthan: A Study by FORCES - FORCES (Forum for Creche and Child Care Services), New Delhi, Delhi. (2005).	135
33.	Three Decades of ICDS: An Appraisal - NIPCCD, New Delhi, Delhi. (2006).	138
34.	Welfare Services for Women and Children - I. Sobha Sri S. P. Mahila Vishvavidyalayam, Department of Women Studies, Tirupati, Andhra Pradesh. (2003).	142
35.	Women and Child Development/Integrated Child Development Services (WCD/ICDS) III Project - World Bank, New Delhi, Delhi. (2002).	146
IX. Fortified Candy		
36.	Distribution of Fortified Candy in ICDS : A Pilot Project Howrah, West Bengal - Child in Need Institute, Daulatpur, South 24 Parganas, West Bengal. (2005).	151
X. Functioning of Anganwadi Centres		
37.	Functioning of Anganwadi Centres in Assam and Meghalaya - Centre for North East Studies and Policy Research, Guwahati, Assam. (2006).	157
38.	Functioning of Anganwadi Centres under ICDS Scheme: An Evaluative Study - Nibha Rani Burman Assam Agricultural University, Faculty of Home Science, Department of Child Development and Family Relations, Jorhat, Assam. (2001).	162
39.	Integrated Child Development Service Scheme: Presenting Innovative Panorama - D. D. Pandey NIPCCD, New Delhi, Delhi. (2004).	164

XI.	Health Status in ICDS	
40.	Mortality and Morbidity Pattern in Children 0 to 6 Years Attending Anganwadi Extent to Primary Health Care through Awareness and Community Health Problem, Follow-Up Case of Grade III and IV of Malnutrition Children under ICDS - Probodh Kumar Bhowmik and Samita Manna West Bengal Council for Child Welfare, Kolkata, West Bengal. (2001).	169
XII.	Infant Mortality	
41.	Infant Death Audit - AMS Consulting Pvt. Ltd., Dehradun, Uttarakhand. (2007).	175
XIII.	Low Birth Weight	
42.	Prevention of Low Birth Weight Babies in the State - AMS Consulting Pvt. Ltd., Dehradun, Uttarakhand. (2007).	183
XIV.	Medicine Kit in ICDS	
43.	Evaluation of Medicine Kit Provided to Anganwadi Workers - Dinesh Paul NIPCCD, New Delhi, Delhi. (2003).	189
XV.	Monitoring ICDS	
44.	Community Based Monitoring System - AMS Consulting Pvt. Ltd., Dehradun, Uttarakhand. (2007).	197
XVI.	Mother and Child Protection Card	
45.	Report of Pre-Test Study: Mother and Child Protection Card - NIPCCD, New Delhi, Delhi. (2005).	203
XVII.	Nutritional Status/Malnutrition/Malnutrition Deaths	
46.	A Cross Sectional Study to Determine Extent, Pattern and Gender Differences in Malnutrition of 30-71 Months Children in Urban, Rural and Tribal Blocks of ICDS, Vadodara District - Samir J. Shah Medical College Baroda, Department of Preventive and Social Medicine, Baroda, Gujarat. (1998).	209
47.	Evaluation of Malnutrition (Grade III and IV) among ICDS Children in ICDS States of Uttar Pradesh, Orissa and Rajasthan - The OASES (Organization for Applied Socio-Economic Systems) Society, New Delhi, Delhi. (2002).	212

48.	Nutritional Status of Beneficiaries of ICDS in Mysore District: A Situational Analysis	215
	- C. Anitha and Khyrunissa Begum Mysore University, Department of Studies in Food Science and Nutrition, Mysore, Karnataka. (2007).	
49.	Nutritional Status of Rural Preschool Children in Southern Rajasthan	218
	- Sharad D. Iyengar and Pavitra Mohan Action Research and Training for Health (ARTH), Udaipur, Rajasthan. (2000).	
50.	Nutritional Status of Women and Children and Working of ICDS in Flood Prone Districts of Bihar	222
	- Society for Economic Development and Environmental Management (SEDEM), New Delhi, Delhi. (2005).	
51.	Quick Appraisal of Supplementary Nutrition Component of ICDS - 9th and 10th January 2008: Report on ICDS Projects, Udupi and Karkala, Udupi District, Karnataka	225
	- Pawan Kumar and Meenakshi Garg Kasturba Medical College, Department of Community Medicine, Manipal, Karnataka. (2008).	
52.	Sheopur Disaster: An Alert Note on Death of Children in Patalgarh	228
	- Right to Food Campaign, Bhopal, Madhya Pradesh. (2006).	
XVIII.	Nutrition and Health Education	
53.	A Comparative Study of Urban, Rural and Tribal Anganwadi Workers and Beneficiary Mothers Regarding Their Knowledge, Attitude and Practices of Nutrition	233
	- Anita Joshi Bal Niketan Sangh, Indore, Madhya Pradesh. (2001).	
54.	Effectiveness of Health and Nutrition Education through Home Visit as a Strategy: A Study	236
	- NIPCCD, Regional Centre Bangalore, Bangalore, Karnataka. (1996).	
XIX.	Preschool Education in ICDS	
55.	Quality of Pre-Schooling under Different Programmes including ICDS: A Study	241
	- D. D. Pandey NIPCCD, New Delhi, Delhi. (2008).	
56.	A Study on the Perception of Anganwadi Workers towards Non-Formal Pre-School Education Programme of Anganwadi Centres	245
	- Debashish Mitra Vidya Sagar School of Social Work, Kolkata, West Bengal. (2004).	

XX.	Supervisors	
57.	Analysis of Role Effectiveness of ICDS Supervisors of Gujarat: A Study Report - S. G. Gangur NIPCCD, Western Regional Centre Indore, Indore, Madhya Pradesh. (2007).	249
58.	Integrated Child Development Services: A Study of Job Performance of Supervisors - Pasupuleti Usha Rani and A. Laxmi Devi Acharya N.G. Ranga Agricultural University, College of Home Science, Hyderabad, Andhra Pradesh. (2004).	253
XXI.	Supplementary Nutrition in ICDS	
59.	Supplementary Feeding in ICDS: Present System of Food Purchase, Distribution and Satisfaction of Beneficiaries - K. Jose Boban Loyola College of Social Sciences, Thiruvananthapuram, Kerala. (2006).	259
XXII.	Time Management in ICDS	
60.	A Study on Redesigning the Anganwadis in Kerala - Antony Kariyil and Celine Sunny Rajagiri College of Social Sciences, The Research Institute, Kalamassery, Kochi, Kerala. (2001).	265
61.	Time and Work Study of Anganwadi Workers - D. D. Pandey NIPCCD, New Delhi, Delhi. (2008).	268
62.	Time Management by Anganwadi Workers of ICDS - Renu Khosla and Manorama Kaul NIPCCD, New Delhi, Delhi. (1997).	275
XXIII.	Training of Anganwadi Workers	
63.	Impact of ICDS Training on Service Delivery by Anganwadi Workers: A Study - Adarsh Sharma and D.D. Pandey NIPCCD, New Delhi, Delhi. (2005).	281
XXIV.	Udisha Training	
64.	Evaluation of Project Udisha: The National Training Component of World Bank Assisted Women and Child Development Project - Operations Research Group, New Delhi, Delhi. (2005).	287

65. Factors Affecting Job Performance of Anganwadi Workers: A Study of Three Districts of Maharashtra 294
- Vrinda Datta
Tata Institute of Social Sciences (TISS), Mumbai, Maharashtra. (2001).

XXV. World Bank Assisted ICDS Projects

66. Andhra Pradesh Economic Restructuring Project (APERP) (Credit 3103-IN): Nutrition/ Integrated Child Development Services (ICDS) Component 399
- World Bank, New Delhi, Delhi. (2003).
67. Implementation Completion Report of World Bank Assisted ICDS – III/ WCD Project 301
- India, Ministry of Women and Child Development, New Delhi, Delhi. (2007).
68. Presentation of Nutrition Survey End-line Survey of World Bank Assisted ICDS II Projects in Chhattisgarh 306
- Indian Institute of Development Management (IIDM), Bhopal, Madhya Pradesh. (2003).

Introduction

The first six years of a child's life are most crucial as the foundations for cognitive, social, emotional, physical, motor and psychological development are laid at this stage. As per Census of India 2001, there are 157.86 million children below six years of age, and many of them have inadequate access to health care, nutrition, sanitation, child care, early stimulation, etc. To ensure that all young children, even those from vulnerable sections of society have access to their basic rights, ICDS was launched in 1975 to provide a package of services to ensure their holistic development. ICDS provides health, nutrition, immunization, preschool education, health and nutrition education, and referral services to young children and their mothers. ICDS also empowers mothers to take better care of their children.

During the Eighth, Ninth and Tenth Five Year Plan periods, the outreach of ICDS services increased enormously, and several initiatives were taken to improve the quality of services, the goal being universalization with quality. Government of India increased the budgetary allocations for ICDS so that more Projects could be started in hitherto unreached areas, and World Bank, UNICEF, CARE India, USAID and other international agencies provided support in many ways. Training of ICDS functionaries was strengthened under the Udisha Project, and Mobile Training Teams provided skills training at the field level.

However, in spite of the expansion of ICDS, evaluation studies done by FORCES indicate that ICDS reaches out to only 30% of the children. Children from remote scattered hamlets, and children living in new slum clusters are often out of the ambit of ICDS services. Malnutrition has decreased only marginally from 47% in 1998-99 to 46% in 2005-06, as was revealed in the National Family Health Survey III (2006).

Clearly, new innovations are required to actually make a dent on the problem of malnutrition among children. The Supreme Court, in its order dated 29.04.2004, directed the Government of India to increase the number of AWCs to cover 14 lakh habitations. Efforts are being made to universalize ICDS so that a functional AWC exists in every settlement and full coverage of children is ensured. Mini-Anganwadi Centres are already functioning in rural/ tribal projects with population between 150-300. States have to submit their special requirements for setting up AWCs in habitations with less than 150 population, which have to be cleared by Government of India.

During the Eleventh Five Year Plan (2007-2012), nutritionally backward states would be the focus of special attention, and micronutrient supplementation/ fortification would be used as a strategy to combat specific micronutrient deficiencies. The involvement of Panchayats, women's self help groups (SHGs), NGOs, corporates and business houses, and other civil society organizations usher in public-private partnership in the true spirit of the concept.

In spite of the many lacunae in the functioning of the scheme, the achievements under ICDS are many. Notable among them is the progressive decline in infant and child mortality, and the spread of awareness about immunization, and health and nutrition education.

Research reveals the true ground realities and field situation, and serves as a pointer to the path which needs to be taken to achieve desired results.

This compilation covers the research studies on ICDS conducted during 1996-2008. It includes studies on Administration of ICDS, Adolescent Girls, Anaemia, Anganwadi Workers Training Centres, Community Participation in ICDS, Evaluation of ICDS, Functioning of AWCs, Health Status, Nutrition and Malnutrition, Preschool Education, Time Management, Training of Functionaries and World Bank Assisted ICDS Projects.

It is hoped that the compilation would be useful to all persons and organizations working for the betterment of vulnerable sections of society.

Administration and Management of ICDS

Administration and Management of ICDS

ICDS Project Implementation in Pooh Block (Kinnaur Block) Himachal Pradesh

*National Institute of Public Cooperation and Child Development,
Regional Centre Lucknow*

Introduction

ICDS Scheme in Pooh tribal block started as an experimental project first in the state of Himachal Pradesh in 1975-76. This programme was implemented through 55 AWCs and 13 Mobile Centres. These centres operate in a difficult mountaineous inaccessible inhabitable terrain, and the AWW of the main nearby AWC visits the left out children and women in inaccessible areas to provide supplementary nutrition and monitor the growth of children.

Aims and Objectives

The main objectives of the study were to:

1. Assess the functioning of ICDS project in Pooh Block in Himachal Pradesh.
2. Assess the felt needs of the community.
3. Suggest possible measures for improving the ICDS service delivery system in Pooh Project.

Methodology

This study was conducted in Kinnaur district of Himachal Pradesh. Out of the total 55 AWCs, 4 were selected namely Solan, Una, Kullu and Kinnaur. A total of 456 beneficiaries comprised the sample, of whom 59 were lactating mothers, 56 were expectant mothers, 38 were children 0-6 months, 162 were children aged 6 months to 3 years, 141 were children aged 3-6 years, and there were 59 other persons. Data was collected through interviews and observations.

Findings and Conclusions

1. All the AWWs in the Project were literate. All had received job training except two. No AWH had been provided orientation training. However, the State has developed a short orientation course for AWHs, which is implemented all over the State, and the same would be implemented in ICDS project in Kinnaur also.
2. AWWs mentioned that fewer children come to AWCs in winter, however elder family members collect supplementary nutrition (SN) for small children.

3. The State Government of Himachal Pradesh has started Mobile AWCs since 1999 for unapproachable areas/ villages to provide SN and health and nutrition education (HNE) by AWWs. Anganwadi workers informed that they visited the houses of the beneficiaries of Mobile Centres regularly and provided the required ICDS services.
4. Pre-school education (PSE) component was very weak and needed proper attention for improvement. AWWs realized that they need training for improving their skills on PSE. In four AWCs, the AWWs were not able to demonstrate any stimulating PSE activities. Very few children were able to name some colours, sing songs, or perform action songs.
5. NIPCCD kit on PSE was supplied by the State Government but was not used in maximum AWCs.
6. The food storage facility was very poor, and storage bins/ other equipments supplied under the project were in bad condition. No adequate utensils were there to serve supplementary food.
7. AWWs were not able to properly monitor the growth of children. One AWW demonstrated perfect weighing skills in terms of fixing weighing machine setting to zero, keeping the child on the machine, and reading the weight correctly. 12 AWWs expressed the need for more information and skill training on growth monitoring.
8. Of all the children weighed between April 2002 and May 2003, 81.98% were in normal grade, 13.62% were in Grade I and 4.40% children were in Grade II malnutrition. The average number of children weighed per month was 1007 with 826 children in normal Grade, 137 in Grade I and 44 children in Grade II malnutrition. There was no child who was in Grade III or Grade IV malnutrition in the project.
9. Health and Nutrition Education (HNE) was very weak in the project area. Beneficiaries were not aware of HNE except immunization. AWWs mentioned that they provide HNE but the knowledge did not reflect in the community. They also needed knowledge and skills to address HNE needs of the local community, environmental sanitation, etc., and personal hygiene in AWCs was also not up to the mark.
10. All the children and pregnant women went to health centres for immunization on fixed days. Iron, folic acid and Vitamin A tablets were also provided at health centres. AWWs had knowledge about the immunization schedule.
11. AWWs mentioned that there was no health check-up in the four villages. According to the Block Medical Officer, health check-up was not done properly due to lack of funds for petrol/ transport available to the sector doctor. Therefore, health check up was done only in villages near CHCs, where health infrastructure was present. There were 2 community health centres (CHC), 6 primary health centres (PHC) and 13 sub-centres in Pooh.
12. Referral services as envisaged under ICDS were not implemented in the project.
13. Out of four AWWs, three showed their medicine kit, but one had no kit. All AWWs had knowledge about diseases and doses of medicine, but they were not confident to provide medicines to beneficiaries. Almost every medicine had not been used.

14. Activities of AWCs were not properly monitored and supervised due to non-availability of supervisors since July 1998. The project had been sanctioned five supervisory circles but due to non-availability of any supervisors, the five circles were assigned to one statistical assistant and one clerk.
15. The major objective of ICDS is to develop the capacity of mothers to take care of the health and nutritional needs of their children. This depends on involvement of the community in ICDS programme, but it was observed that the community was not well conversant with ICDS services provided at AWCs.

Recommendations

1. The present felt need of communities is that buildings for AWCs should be constructed with toilet facilities, and these centres should be provided with utensils like plates, spoons, soap, etc.
2. Dry supplementary food should be provided during winter, and yearly supply of food materials should be given in place of half yearly rations.
3. Technical assistance should be provided to project functionaries for taking up income generation activities (IGA) by SHGs for women.
4. AWWs should take interest in all activities of the project.
5. There is need for repair or replacement of bins and other storing equipments.
6. Filling up posts of supervisors and CDPOs should be done on a priority basis.
7. The performance of the project may not be compared with any other general/ normal project of the State because the project functions in a very difficult area.

Adolescent Girls in ICDS

Adolescent Girls in ICDS

Adolescent Girls Scheme: An Evaluation in Kerala

Solidarity among Women

Introduction

Adolescent girls (AGs) have been recognised as a group requiring special care and attention. A special intervention has been devised for adolescent girls, using the ICDS infrastructure, which focuses on school drop-out girls in the age group of 11-18 years, and meets their needs of self development, nutrition, health, education, literacy, recreation and skill formation. Many studies have identified gaps in the empowerment of women in Kerala, as the number of atrocities against women is on the increase. Adolescent girls also have to bear the brunt of this trend. This scheme faces a special challenge in Kerala where the status of women is comparatively better than in that of women in other states. The AGs scheme in Kerala covers the less developed Northern districts of Palakkad, Malappuram, Wayanad and Kasargode, and this study reviewed the efficacy of the 'Adolescent Girls Scheme' in these four districts.

Aims and Objectives

The study aimed to:

1. Evaluate the status of services rendered under the Adolescent Girls Scheme.
2. Ascertain the benefits of the scheme selecting specific indicators related to various services provided to adolescent girls.
3. Identify the factors contributing to the success/ failure of the scheme.
4. Suggest an action plan for improving and extending the scheme.

Methodology

The study was conducted in 4 districts of Kerala namely Palakkad, Malappuram, Wayanad and Kasargode. A total of 1530 respondents were selected, including 500 beneficiary AGs, 500 mothers of beneficiaries, 150 non-beneficiaries, 150 local leaders, 150 AWWs, 50 Supervisors and 30 CDPOs. Data was gathered through questionnaire method, dialogue method and case studies.

Findings and Conclusions

1. It was found that 30.20% of the adolescent girls (AGs) in the sample were in the age group of 14-15 years, followed by 29.20% in the 11-13 years age group, 28.60% in the 16-17 years age group, and 12% were 18 years old. Nearly 16% of the girls were married at age 18 years

- or less. Mostly tribal girls were married off early, even before 18 years, and had one or two children also.
2. 3.57% of the AGs were illiterate, 46.34% had studied less than SSLC, 32.23% had SSLC or equivalent education, and 17.86% had education up to SSLC or +2 Classes.
 3. Nearly 69.64% girls knew about the scheme from the AWC or AWWs. 92% of the girls felt that the scheme made them want to return to studies. However, only 25% to 30% had done so, that too not regular formal studies, but local parallel schools or private tuition, homes or they had enrolled in correspondence studies. 8% of them had completely stopped studies.
 4. Life skills oriented training was found satisfactory by 88% of the adolescent girls (AGs); 6.24% gave a negative reply, and about 5.76% were not able to give any opinion.
 5. It was found that AGs clubs were as effective as self help groups in Kerala, which have done much to empower women economically and build self confidence.
 6. About 42% of the AGs shared an equal status with the men folk in their family, 55% gave negative response, and 4% of the AGs were not forthcoming with a reply.
 7. It was found that the greatest problems AGs were faced were lack of support from parents and the timings of the scheme. During training itself AGs were able to indicate subjects that could be incorporated in the training. Nearly 58% of the girls wanted to study more about health related issues like growing up, AIDS, pregnancy, etc. Nearly 40% AGs wanted to know more about job oriented programmes. Only 2% were non-committal.
 8. It was found that the mothers of AGs were not aware about the programme. Even when their daughter was a beneficiary the mother had not taken any interest to understand the scheme. Mothers who were aware of the scheme felt that the scheme was good. Some mothers felt that the time spent by their daughters on anganwadi work was taking them away from doing household chores. 38% of the mothers who were part of self help groups were more accommodative and were conscious that the AG scheme could help their daughter prepare for a life in future.
 9. Nearly 38% of the mothers wanted training under the scheme to be job oriented. They were unaware that the scheme would not give a certificate for their daughters to get a job.
 10. Local leaders mentioned that health and nutrition education given to mothers ranked first in importance because a mother has the greatest responsibility in forming a girl child's character.
 11. It was found that Palakkad district ranked first for providing information about job oriented issues and health. In Wayanad, awareness about the scheme was greater as there were many activists and NGOs functioning in this district. Kasargode district ranks first in skill development issues through the scheme, as DWCRAs, SHGs and self employment endeavours were greater there. Malappuram district had lagged behind in achievement and perception in many of the concerns taken up.
 12. The AG scheme in Kalpetta was outstanding on many aspects and ICDS was functioning best there. The overall performance of AGs in Attappady block in Palakkad was found to be lacking on many indicators of performance.

13. Lack of monetary assistance was the greatest problem hampering the success of the scheme. Job oriented training was inadequate in Malappuram. Problems related to networking with other agencies were the main problem in Palakkad district.
14. All AGs were interested in the scheme and were cooperating well. They wanted the training to be job oriented and also employment opportunities to be provided under the scheme. Tribal girls were the real beneficiaries of the scheme. However, they were not active in the scheme, they were hesitant to participate and the workers were not very keen on their participation.
15. All mothers were found to be active in participating in the programmes of AWCs. Non-beneficiaries had very little idea about the scheme in most cases.
16. Almost all the local leaders did not know anything about the scheme. They never participated in planning/ implementation or monitoring aspects of various programmes. They mentioned that the implementing officials never consulted them.
17. All the AWWs faced shortage of funds and of trained resource persons. They were overburdened with the amount of work. Supervisors did not have any direct role in implementation of the scheme. Project Officers were trying to implement the scheme efficiently but they had to face hurdles like lack of sufficient funds under the scheme. Therefore they had not achieve their targets in many cases.

Recommendations

1. Classes should be conducted only by learned people, they should be able, not only to impart knowledge, but also to motivate the girls to participate in the scheme and its activities.
2. Timings of the classes should be decided by the girls, their parents and the implementing staff.
3. Tribal girls should be induced to join the scheme by informing them of the benefits to be gained from the scheme.
4. The training team should have at least one female member to help the girls overcome their anxiety when raise they questions on personal issues.
5. Adolescent girls should be encouraged to take up training in fields that ensure employment. Training should be conducted to suit the convenience of girls and should be of their interest. At a later stage, training and sessions can be conducted at the panchayat level.
6. Awareness training should be conducted for officials and local leaders which would ensure their cooperation and participation.
7. Cultural programmes, art and sports competitions should be held to encourage the talent of AGs and also to attract them to the scheme. This would also provide a platform for socialization and networking among girls who have no social contacts.
8. Resource persons who are able to conduct training and classes efficiently should be identified. The services of Supervisors also need to be efficiently utilized. Supervisors could also be used as resource persons for training.

9. 'High risk' AGs require and should be given extra attention for SN. Separate literacy classes should be conducted for those girls who are lagging behind in studies.
10. AWCs, as nodal centres, must facilitate and encourage the formation of adolescent groups. These would help the girls and women to come together and promote the creation of multifarious activities for women and child development. This would enable them to be recipients of services and also serve as agents of Government run schemes in local areas.
11. A Resource Centre for a cluster of villages would be ideal for disseminating information, counselling, and organizing skill training for girls, especially drop-outs. Such a Centre would largely help in identifying the real beneficiaries. Sensitive issues pertaining to girls' development can be handled tactfully, ensuring them the necessary privacy.

Kishori Shakti Yojana (KSY) under the Ambit of ICDS in Uttar Pradesh and Rajasthan

Formative Research and Development Services

Introduction

This study seeks to document the details (approach, components, technicalities, community response and participation, etc.) of the Adolescent Girls' Scheme added on to the ICDS projects in the state of Rajasthan (blocks of Abu Road and Revdar in Sirohi district, and Jhadol and Khaiwara in Udaipur district) and Uttar Pradesh (blocks of Jasrana and Khairagarh in Firozabad district, and Babaganj and Patti in Pratapgarh district). It also proposes to evaluate the outcome of this specifically designed scheme, as an add on under the ambit of only very few ICDS projects in the country, drawn up to address the need of AGs in focussed manner. The evaluation covers all aspects/ components of the scheme and makes an objective assessment about its benefits and overall impact on the target group.

Aims and Objectives

The study aimed to:

1. Assess the activities and services, programme initiation and implementation strategies of AGs scheme.
2. Assess the coverage of AGs under different services initiated under the scheme in each AWC of the ICDS blocks/ projects selected for the study.
3. Make a critical review of programme (scheme) design and assess its strength and weakness vis-à-vis its relevance/ competence to address the micro issues and problems faced by AGs in the particular area/ community.
4. Identify gaps, if any, in the programme services and suggest changes needed to strengthen the AGs scheme.
5. Assess capabilities of ICDS (AWC) staff members vis-à-vis proper implementation of AGs scheme.

Methodology

This study was conducted in ICDS projects in the states of Rajasthan (blocks of Abu Road and Ravdar in Sirohi district, and Jhadol and Khaiwara in Udaipur district) and Uttar Pradesh (blocks of Jasrana and Khairagarh in Firozabad district, and Babaganj and Patti in Pratapgarh district). In Rajasthan, 826 AGs beneficiaries, 48 parents of AGs, 81 AWWs and 3 CDPOs were taken; in Uttar Pradesh, 622 AGs beneficiaries, 48 parents of AGs, 99 AWWs and 3 CDPOs were selected. Data was collected through interviews and focus group discussions (FGD).

Findings and Conclusions

1. 90% of the girl respondents belonged to the age group 12-18 years while only 5% were of age 11 years and 4% above 18 years.
2. It was found that 49.2% girls had dropped out from school while 16.2% were illiterates.
3. Approximately one third (35.5%) girls belonged to BPL families while the remaining 64.5% belonged to non-BPL families.
4. Approximately three fourth (73.5%) of the girls were aware about the Adolescent Girls (AG) Scheme while the remaining (26.5%) mentioned that they were not aware about the services. Awareness was found to be much better in the state of Uttar Pradesh (94.5%) compared to Rajasthan (57.6%).
5. About 47.7% girls mentioned that they visited AWCs daily, followed by once in a week (31.6%), and once in a month (10.5%) approximately. 9% mentioned that they went to AWCs when called by the AWW, and a very small number of girls (1.4%) mentioned that they never visited any AWC.
6. Adolescent girls mentioned the purpose of visiting AWCs. The major activities under KSY in Rajasthan were stitching and weaving courses, while in the case of Uttar Pradesh, the major focus of the scheme was to provide knowledge related to health and hygiene to AGs.
7. Among the girls who were aware about the services provided at AWCs, majority of them thought that the AWC programmes and services were basically meant for pregnant women. Around half the AGs mentioned that the main beneficiary of AWC services were pregnant women, followed by AGs (4.3%), children below 5 years (2.3%), and lactating mothers (1.7%). Approximately 15% girls were not aware about the target beneficiaries of the ICDS scheme.
8. About 45.7% girls were aware about KSY scheme. Awareness in Uttar Pradesh was found to be better (73%) than in Rajasthan (25.2%). AWWs were found to be the most effective functionary in spreading awareness about KSY among girls, and 38.7% of the girls mentioned that they came to know about the scheme from AWWs. Around 8% of the girls came to know about KSY from TV/ radio, family members, friends, newspapers, sector supervisors, etc.
9. Around 90% girls were registered at AWCs. More girls were registered in Uttar Pradesh (96.8%) than in Rajasthan (83.5%). The remaining 10% were not aware about their registration status at the AWC. 73.9% girls mentioned that AWWs were the main person who motivated them to join KSY. 87% girls mentioned that their parents and family members did not oppose their joining the scheme.
10. Majority of the girls (43.1%) mentioned that new learning had been in the area of health, followed by education (29.7%), reproductive health (10.5%), vocational training (6.2%) and art and painting (6.1%). Some of the girls also mentioned that they learnt about nutrition (1.8%) and received education on environmental issues (0.6%).

11. AGs were asked whether they had ever participated in any of the exposure visits organized under KSY. There had been no such programme in Uttar Pradesh. In Rajasthan, about 65.6% girl respondents reported that they had participated in exposure visits organized under KSY. Most of the girls (63%) had gone for the exposure visit only for one day, while only a very small fraction (3.1%) reported that they had gone for the exposure visit for two days.
12. In the state of Rajasthan, it was found that some activities related to skill development had also been undertaken under KSY. 40% girls mentioned that there had been some skill development programmes organized at the AWC.
13. Approximately 50.7% of the girls mentioned that sports activities were carried out at AWCs for AGs. In Uttar Pradesh, about 64% girls mentioned about sports activities at the AWC, while in Rajasthan, 40.7% AGs mentioned about sports.
14. Around 49% of the girls mentioned that they had benefited from KSY, while the remaining AGs did not feel so. In Rajasthan, 58.1% girls admitted that they had benefited from KSY, while in Uttar Pradesh, only 37% girls felt so. Around 80% girls were satisfied with the work done by AWWs. Satisfaction was much higher in the state of Uttar Pradesh (98.7%) compared to Rajasthan (65.9%).
15. Majority of the girls (43.8%) mentioned that they wanted to receive more knowledge related to health, followed by more vocational training (30.8%). One-fourth (25.4%) respondents also desired that the raw material for vocational learning should also be available at AWCs. In Rajasthan the stress was on the availability of raw materials (40.4%), while in Uttar Pradesh majority of the girls desired training in vocational courses (52.4%).
16. More than half the girls (56.8%) desired to learn about stitching, followed by craft activities (23.2%), and to make home made items (20.2%) such as papad, pickles, etc. In the state of Rajasthan, the emphasis was on stitching courses, while in Uttar Pradesh, craft and preparation of home made items was given much emphasis.
17. Around 70% girls were able to read newspapers and could write a letter. Reading and writing skills in Uttar Pradesh were found to be better (85%) than in Rajasthan (60%). Around 78% girls mentioned that they were able to do simple calculations even before joining KSY, and of the remaining 22% who were not able to perform simple calculations, 9% mentioned that they could do it now after attending the KSY scheme.
18. Around 72.8% girls mentioned that they learnt about gender equality during KSY training. In Uttar Pradesh, 94.9% girls mentioned that they learnt about gender equality from KSY, only 56% girls in Rajasthan stated the same.
19. About 67% AGs had started menstruation, 80% AGs in Uttar Pradesh and 57% in Rajasthan. Certain restrictions were imposed on AGs during the menstrual period, 17% avoided going to the kitchen, 12.6% avoided spicy food, and 11.2% avoided going to temples. In Uttar Pradesh, 19.9% AGs avoided going to the temple, 17.4% AGs avoided spicy food, and 6.4% did not

enter the kitchen. In Rajasthan, maximum response was for not going to the kitchen (24.9%), followed by care for hygiene (15%), not going to the temple (4.6%), and 9% avoided spicy food.

20. 50% girls were aware of diarrhoea. This awareness was much higher in Uttar Pradesh (59.2%) than in Rajasthan (45.3%). 40% girls were aware of anaemia. 15.6% girls were aware that anaemia could be reduced by taking IFA tablets, eating green vegetables (14.9%), use of pulses (5.7%), and eating eggs (2.9%). In Uttar Pradesh 18.6% girls stated that IFA tablets help reduce anaemia, while in the state of Rajasthan use of green vegetables was stated by 16% girls.
21. All girls were aware of child immunization. Four out of five girls (81%) mentioned that child immunization was essential. In Uttar Pradesh around 97% girls were aware of the need for immunization, while in Rajasthan only 70% stated so.
22. 63% girls were aware of at least one method of delaying pregnancy. Awareness was more in Uttar Pradesh (68.8%) than in Rajasthan (59.3%). Most of the girls were aware of oral pills (24.3%), followed by condoms (18.5%), tubectomy (15.1%) and IUDs (Intra Uterine Devices) (5%). A few girls also mentioned about vasectomy and safe period method. In Uttar Pradesh, most of the girls were aware of condoms (26.7%) and oral pills (24.8%); in Rajasthan, many girls (24%) were aware of oral pills and only 12% girls were aware of condoms.
23. Only 8% girls were aware of the symptoms of RTI (Reproductive Tract Infections). In Uttar Pradesh about 15% girls were aware of RTIs, but in Rajasthan the awareness was much lower. Only 3% girls in Rajasthan were aware of the symptoms of RTI. About 11% girls mentioned that they were aware of STI (Sexually Transmitted Infection). In Uttar Pradesh 22% girls were aware of STI, while in Rajasthan only 2% AGs were aware of the same.
24. Overall, 56% girls were aware of HIV/ AIDS. In Uttar Pradesh 67.5% girls and in Rajasthan 47.2% girls were aware of HIV/ AIDS. AWWs were the main source providing awareness among girls (24.3%), followed by television (18.5%). Television as a source of HIV/ AIDS awareness was more in Uttar Pradesh (30.2%) than in Rajasthan (9.7%).
25. More than 98% AWCs had attendance register, immunization register, supplementary food register, birth death register, and stock register. About 53.4% AWCs had medicine kit and 66.7% AWCs had weighing machine.
26. All the AWWs had received general training in both the states. Only 41% AWW had received training under KSY. 85% AWWs received training in Rajasthan while in Uttar Pradesh only 4% AWWs received training under KSY.
27. AWWs mentioned that around 55% AGs visited AWCs for IFA tablets. 47% AWWs mentioned that girls visit AWCs daily, followed by a fixed day (29.4%), alternate day (19.4%), and no regularity (4.4%).

28. 46% girls came to the AWC for one to two hours, followed by more than two hours (28%), and less than one hour (10%); 16% respondents mentioned that there was no fixed timing for visiting the centre.
29. AWWs mentioned that nutrition and hygiene were the most important issues that girls came to learn at AWCs, followed by reproductive health issues (9.4%), and work related to the household (8.3%). Some girls also liked to learn about social issues such as child labour, etc.
30. 71% AWWs mentioned that girls did not come to the centre, and if they came to the centre, they did not stay for long. The other problem was that they did not pay attention to what AWWs told them.
31. AWWs mentioned that the training imparted to them was not sufficient for implementation of KSY. In Uttar Pradesh, most of the AWWs reported that they were not aware what exactly the KSY is for. AWWs felt they were overburdened with responsibilities which made them inefficient in delivering the services. Parents of AGs did not allow their daughters to come to AWCs as the girls were not able to perform household chores.

Recommendations

1. There should be master trainers in each project for the vocational training programme, hired by project personnel.
2. Normally, five days training is organized at the block level. It was suggested that this training programme should be organized at the Panchayat level, where 4-5 AWWs can be provided with the training together. This will help in better participation of girls.
3. Timing for girls under KSY should be separated from the other activities at AWC.
4. Raw material and necessary equipment should be made available at AWCs.
5. Most of the girls who came for training were working. Their participation under KSY, visiting AWCs, reduced their income. Hence, it is suggested that some money should be given to these girls.
6. The quality of training given to AWWs should be more extensive and help them to understand KSY scheme better.
7. Honorarium to AWWs under the scheme is not sufficient and should be increased.
8. Community should be sensitized on reproductive health issues to ensure better coordination from the community.
9. Many of the AWWs themselves are not literate. Hence, it is difficult for them to understand and explain the scheme to the girls. Another educated female should be attached with the AWW to undertake specific jobs under KSY at such centres.

Report of Evaluation of National Programme for Adolescent Girls

Nutrition Foundation of India

Introduction

Adolescent girls are also one of the nutritionally vulnerable groups but they have not got any benefit from the on-going ICDS programme to improve their nutritional status. Government had launched a project named as National Programme for Adolescent Girls (NPAG) in 51 districts. Ten districts were selected for evaluation to assess the performance of NPAG under existing conditions.

Aims and Objectives

The study aimed to:

1. Evaluate the performance of NPAG under existing conditions in ten vulnerable districts of ten states.
2. Assess the awareness level of service providers and community regarding NPAG.

Methodology

This study was conducted in ten states, namely Rajasthan, Delhi, Uttaranchal, Orissa, Mizoram, Kerala, Gujarat, Uttar Pradesh, Chhattisgarh and Tamil Nadu. In each selected district, 40 primary sampling units (PSUs – villages/ UFs) were chosen. The sample size in each district was set at 1000 complete residential households from 40 selected PSUs. The data was gathered from AWCs, ration shop and households. Under the NPAG, AWWs identify AGs with body weight less than 35 kg and they give a signed note (chit) requesting the Public Distribution System (PDS) shopkeeper to provide the family of the identified undernourished person 6 kg of food grains (wheat/ rice based on habitual consumption pattern of the state) totally free of cost for a period of three months.

Findings and Conclusions

Banswara (Rajasthan)

1. It was found that all AWWs received training to weigh and provide nutrition and health education. They were able to communicate to the population the paradigm shift in the programme. AWWs received support from PRIs (97%), ANMs (100%) and from the families of the girls (97%) in identifying AGs, weighing them, etc. Those weighing less than 35 kg were provided chits for collecting food grains from ration shops.
2. 32 AWWs mentioned that NPAG could improve participation of girls in KSY and improve the nutritional status of AGs.

3. Out of 1853 AGs, 1732 were weighed. 66.7% girls weighed less than 35 kg. 763 new AGs weighed less than 35 kg. AWWs gave NHE to 1020 AGs. Chits were distributed to 1044 AGs by 30 AWWs. All 1044 girls of 30 AWWs collected rations for 3 months, 310 girls showed no weight gain, 579 girls gained weight but did not cross 35 kg, and 46 girls had crossed 35 kg. Under KSY scheme, 58 girls were taking food supplements from 16 AWWs.

North West Delhi (Rural)

1. 6 rural AWWs were taken for NPAG. 5 AWWs received training to weigh and all 6 AWWs provided NHE. The community accepted the concept of NPAG.
2. Current data was available in 5 AWWs. 346 AGs were identified and all were weighed, 38.4% girls weighed less than 35 kg. All AWWs gave NHE to 61 AGs. Chits were not distributed to the identified AGs and no rations were given. Under KSY scheme 13 girls collected food supplements from AWWs.

North West Delhi (Urban)

1. The NPAG evaluation was done in 26 AWWs. 24 AWWs (92.3%) received training to weigh AGs, and 25 provided NHE. The community accepted the concept of NPAG.
2. All AWWs had weighing scales but they were not working properly. Only 16 AWWs weighed AGs correctly. Nine AWWs provided NHE to identified AGs. 17 AWWs had maintained records of NPAG beneficiaries.
3. It was found that weighing had been done repeatedly every year but food grains were not distributed even once. This had reduced the support of families of AGs for the programme, and they did not want the girls to be weighed repeatedly as no benefits were forthcoming.
4. In 22 AWWs, out of total 1225 AGs around 1181 (96.4%) were weighed, 48.3% girls were less than 35 kg. AWWs provided NHE to 30 AGs. Chits were not distributed and no rations were given to AGs. Under KSY scheme, 33 girls collected food supplements from AWWs.
5. In North West Delhi AWWs were requested to weigh AGs and prepare a list of AGs weighing less than 35 kg. As food grains were distributed only once since 2002-2003, families were reluctant to get AGs weighed. Very few adolescent girls knew about KSY (17%) and NPAG (14.9%).
6. The families mentioned that 8.5% AGs visited AWCs for KSY, 14.9% received NHE, 8.5% had received iron/ folic acid tablets, 9.1% took food supplements from AWCs, and 6.4% AGs took rations from PDS shops under NPAG.

Haridwar Rural (Uttaranchal)

1. In all, 29 AWCs were covered, and all had weighing scales. 270 AGs were identified of whom 242 were weighed and 161 were less than 35 kg. The families were reluctant to weigh the girls again, because food grains were not distributed.

Haridwar Urban (Uttaranchal)

1. Out of 7 AWWs, 5 had weighed AGs and identified the number of girls below 35 kg. Only one AWW had kept records of NPAG. Out of 204 AGs, 201 were weighed and 107 were below 35 kg. One AWW gave NHE to 20 AGs. Under KSY scheme 29 girls were taking food supplements from 4 AWWs.

Kalahandi Rural (Orissa)

1. All AWWs received training to weigh AGs. The community accepted the concept of NPAG. The AWWs received support from PRIs (100%), ANMs (100%) and from families of girls (96.6%) in identifying AGs.
2. In 25 AWWs out of 2522 AGs around 2471 were weighed, and 54.7% girls weighed less than 35 kg. In the current round of NPAG 163 new AGs weighed less than 35 kg. 27 AWWs gave NHE to 1533 AGs, 529 (39.1%) AGs collected food grains from 11 AWWs. Repeated measurement of weight after three months showed that 40 girls did not show any change in weight, 5 girls lost weight, 75 girls gained weight but did not cross the 35 kg mark, and 19 girls had crossed 35 kg.

Kalahandi Urban (Orissa)

1. All AWWs (11) received training to weigh AGs and provided NHE. They were able to communicate with the population about NPAG. They received support from PRIs (90.9%), ANMs (100%) and from families of AGs (100%).
2. In 11 AWWs out of 904 AGs, 873 were weighed, 55.4% girls weighed less than 35 kg. All AWWs gave NHE to 476 AGs; and 386 undernourished girls collected rations from 8 AWWs. Repeated weighing of 78 AGs after three months showed that three girls did not show any change in weight, 4 girls lost weight, 69 girls gained weight but did not cross 35 kg, and 2 girls crossed 35 kg.

Lunglei Rural (Mizoram)

1. A total of 18 AWWs were taken. All AWWs had received training to weigh AGs. They were able to communicate with the people about the programme. They had received support from ANMs (50%), and from families of adolescent girls (55.6%). 55.6% ration shop workers were willing to take the chits and provide food grains to the families of AGs.
2. Six AWWs had records of NPAG beneficiaries. Out of 449 AGs, 433 were weighed and 43.2% girls weighed less than 35 kg. AWW gave NHE to 293 AGs. Chits were distributed to 187 AGs by 18 AWWs. Only 2 girls received ration for 1 month and 185 girls took ration for 3 months. Under KSY scheme 264 girls collected food supplements from 15 AWWs. Repeated weighing after three months showed that 12 girls did not gain weight, 20 girls lost weight, 119 girls gained weight but did not cross 35 kg and 36 girls crossed 35 kg.

Lunglei Urban (Mizoram)

The data of NPAG was available in 17 AWWs. Out of total 485 AGs around 443 girls were weighed. 30.5% girls weighed less than 35 kg. 34 new AGs were less than 35 kg. AWWs gave

NHE to 274 AGs. Chits were given to all undernourished AGs, and all collected food grains. Under KSY scheme, 199 girls collected food supplement from 9 AWCs. Repeated weighing showed that most (89) of the girls gained weight, but they did not cross 35 kg. Even though they had received food grains in both the rounds, only one fourth of the girls crossed 35 kg on receiving food grains for 3 months.

Palakkad Rural (Kerala)

1. A total of 41 AWCs were taken for evaluation. 39 AWWs received training to weigh AGs. 22 AWWs provided information pertaining to NPAG. They were able to communicate with the community. All AWWs provided NHE. Only 27 AWWs had records of NPAG.
2. Out of total 934 AGs, around 558 were weighed in 8 AWCs, 33% girls were below 35 kg. Chits were not distributed to undernourished girls.

Palakkad Urban (Kerala)

1. All 17 AWWs received training to weigh AGs, and provided NHE. 16 AWWs had distributed chits to identified undernourished girls. Data was available in 8 AWCs. Out of 700 AGs, 598 AGs were weighed, and 27.1% were below 35 kg. 2 AWWs gave NHE to 15 AGs, chits were distributed to 106 undernourished girls, 12 girls in 2 AWCs collected ration for two months and 59 girls in 3 AWCs collected ration for three months. Under KSY 14 girls collected food supplements from 2 AWCs.

Panchmahal Rural (Gujarat)

1. A total of 28 AWCs were covered for NPAG evaluation. 25 AWWs received training to weigh AGs and 23 providing NHE. AWWs received support from ANMs (82.1%) and from families of girls (78.6%).
2. 92.9% ration shop workers wanted to take chits and provide food grains. AWWs mentioned that very little of the ration went to the undernourished girls. Joint families disagreed with this because if a daughter of one family got free ration all members of the joint family wanted to share the food. The ration shopkeepers mentioned that free ration helped in improving household food security but not the dietary intake or nutritional status of undernourished girls.
3. The data was available in 20 AWCs. 1141 AGs were weighed, 81.3% girls were less than 35 kg. 6 AWWs gave NHE to 119 AGs. Chits were distributed to 110 AGs by 3 AWWs, 54 girls belonging to one AWC collected ration for 2 months, and 57 girls belonging to one AWC collected rations for 3 months. Under KSY scheme 50 girls collected food supplement from 6 AWCs.

Panchmahal Urban (Gujarat)

1. 16 AWCs were covered to evaluate NPAG. 14 AWWs had received training to weigh AGs. 15 AWWs provided NHE. AWWs received support from ANMs (81.3%) and families of girls (87.5%). 11 AWWs provided NHE to 68.8% AGs. 11 AWWs had records of NPAG beneficiaries.

2. 68.8% AWWs mentioned that NPAG could improve the nutritional status of AGs and could improve the participation of girls in KSY.
3. In 7 AWCs out of 1325 AGs, 817 were weighed and 60% girls were below 35 kg. No chits were distributed to AGs to receive rations.

Sonbhadra Rural (Uttar Pradesh)

1. A total of 31 AWCs were covered for evaluation. 21 AWWs had received training to weigh AGs and 23 AWWs had received training to provide NHE. AWWs received support from PRIs (25.8%), ANMs (58.1%) and from families of girls (77.4%).
2. A total of 30 AWWs provided NHE. 8 AWWs had given chits. Only one AWW had records of NPAG. Out of 2807 AGs in 25 AWCs, 2011 were weighed in 22 AWCs. 55.5% girls weighed less than 35 kg. AWWs gave NHE to 763 AGs. In the current round 131 new AGs weighed less than 35 kg. Chits were distributed to 392 AGs by 8 AWWs. Only 316 girls of 5 AWCs collected ration for 2 months. Under KSY scheme, 75 girls were taking food supplements from AWCs. There was an improvement in weighing and identification of undernourished AGs by AWWs, therefore more girls were able to get benefit from the programme in the current round.

Sonbhadra Urban (Uttar Pradesh)

1. Out of 3 AWWs only one AWW received training to weigh AGs. AWWs received support from PRIs, ANMs and families of girls. The ration shopkeepers were willing to take the chits and provide food grains. However all 3 AWWs mentioned that there was no ration available in ration shops during March to April 2006. Higher authorities had been informed about the situation.
2. All 3 AWWs gave NHE to AGs. Previously all AWWs had given chits to undernourished girls, and they had collected food grains from the ration shop (2004). AWWs stated that NPAG could improve nutritional status of AGs and their participation in KSY.
3. Out of 247 AGs, 65 girls were weighed in 1 AWC, and 73.8% girls were less than 35 kg. 121 AGs received NHE. Under KSY scheme, 9 girls received food supplements. Chits were not distributed.

Surguja (Chhattisgarh)

1. A total of 28 AWCs were covered. All AWWs were trained to weigh AGs, and provide NHE pertaining to NPAG. They were able to communicate with the people and community accepted the concept of the programme. AWWs received support from PRIs (75.9%), ANMs (100%) and from the families of girls' (96.6%) in identifying all AGs.
2. Out of a total of 1565 AGs around 1533 girls were weighed. 71.8% were less than 35 kg. AWWs gave NHE to 1274 AGs. 1099 girls collected ration for 1 month from ration shops under NPAG (April – May 2006).

Thiruvanamalai (Tamil Nadu)

1. A total of 66 rural AWCs were covered for evaluation. All AWWs received training to weigh AGs and provide NHE. Community accepted the concept of the programme due to the effective

communication of AWWs. They received support from PRIs, ANMs and families of AGs. The ration shop workers were willing to take the chits and provide food grains to families of AGs.

2. The data of current round was available in all 66 AWWs. Out of 7702 AGs, 5583 (72.5%) were weighed, 41.9% weighed less than 35 kg. AWWs gave NHE to 2211 AGs, the chits were distributed to 2302 AGs by all AWWs. 202 girls from 6 AWWs collected rations for 3 months, 87 girls from 4 AWWs collected rations for 1 month, and 612 girls from 17 AWWs collected rations for 2 months. Under KSY scheme 25 girls were taking food supplements from 7 AWWs. 783 (33.4%) AGs showed no weight gain, 1183 (50.5%) girls gained weight but did not cross 35 kg, and 257 girls (11%) crossed 35 kg.

Lacunae in the Programme

1. Project Director mentioned that the selection of AGs was not always accurate. There were many discrepancies in weight as well as age of AGs recorded. Adolescent daughters-in-law were generally not perceived as beneficiaries of the programme.
2. It was found that far spread out houses in villages and AWCs not being located in the centre of the village emerged as obstacles in access to NPAG and other services.
3. Many AWWs depended on friends or male relatives for record keeping which contributed to inaccuracies in records.
4. Project Officers mentioned that due to long procedures of financial and administrative sanctions, there was delay in reaching the programme to the beneficiaries.

Recommendations

1. Sufficient and timely release of the central budget is needed to ensure continuous supply of food grains through out the year.
2. In Surguja there were no AWCs in urban areas, therefore urban poor families were not benefited by the scheme. Hence AWCs should be established in poor urban areas as well.
3. AWWs should be trained to determine the nutritional grade of beneficiaries.
4. The cut-off weight of 35 kg for all girls (10-19 years) does not seem to be rational. It should be changed to the use of BMI and all those below a BMI of 18.5 should be covered. Normograms can be made available. In addition, we can use the criteria for under nutrition to be below 35 kg for 10-13 year old girls and below 40 kg for 14-19 years old AGs.
5. With operationalization of NPAG, the provision of supplementary nutrition under KSY has become redundant. The daily participation of AGs in AWWs was found to be non-existent. The state level Women and Child Development (WCD) officials should seriously consider merging KSY and NPAG in NPAG operationalized areas.
6. All eligible AGs of a family should get benefits under the scheme unlike only one as is currently the practice.

Report on Survey and Evaluation of the Adolescent Girls Scheme

Juthika Sen

Introduction

The Government of India launched a scheme for adolescent girls (AGs) and has invested huge resources for training and upliftment of AGs besides providing nutrition, and health services. It was felt that there was need for a systematic assessment of the scheme for its continuation in future, as also to introduce remedial measures and improve its functioning. With plans for universalization of ICDS programme under way, there was need for a quick appraisal/ evaluation of the AGs scheme, and for taking follow-up measures in order to extend it further. This study attempted to identify the factors which would help or hinder the success of the programme.

Aims and Objectives

The study aimed to:

1. Evaluate the nutritional and health status of AGs.
2. Evaluate their literacy and decision making capabilities.
3. Assess their vocational skills.
4. Evaluate their awareness regarding health, hygiene, nutrition, family welfare, home management, child care and age at marriage.
5. Evaluate their awareness regarding environment related social issues.

Methodology

The study was conducted in four blocks of Delhi, namely Mehrauli, Kanjhawala, and Alipur. A total of 872 respondents were selected of whom 200 were beneficiary AGs, 200 were mothers of AGs, 200 were non-beneficiary AGs, 200 were mothers of non-beneficiary AGs, 15 local leaders, 40 AWWs, 14 Supervisors, and 3 CDPOs. Data was collected through interviews and focus group discussions.

Findings and Conclusions

1. 53% AGs in Mehrauli, 28% in Khanjawala and 62% in Alipur were in Standard VI-VIII; 37 out of 200 AGs were in Standard IX-X; and 32 out of 200 AGs were in Standard XI and above. Only 3 AGs out of 200 were illiterate (2 in Mehrauli and 1 in Alipur), which indicated that there was a positive attitude towards education of the girl child.

2. 6 AGs out of 200 were employed as casual workers, 5 in Khanjhwala and 1 in Mehrauli.
3. It was found that most of the activities of AWCs were strengthened due to the involvement of AGs. Project level functionaries and beneficiaries mentioned growth monitoring as one of the activities which had been greatly strengthened due to the involvement of AGs.
4. Beneficiaries mentioned that they did nothing for preparing the community for implementation of ICDS. 10.5% beneficiaries came to AWCs only for SN. AGs go to school and the timings of the AWC were the same as school timings therefore they had little time to spend in AWCs.
5. The attendance of children in AWCs had increased along with the participation of mothers in the nutrition and health education (NHED) activities.
6. None of the Supervisors and the CDPOs thought that there was increased awareness about services of AWCs through the contribution of AGs.
7. Mothers of beneficiaries mentioned that the food provided in the blocks was of the ready-to-eat (RTE) variety. 75% of them were satisfied with the food served at the AWC, while 24% were not satisfied.
8. 57% AWWs mentioned that the place and time of imparting NHED by them was convenient for AGs. 25% AWWs mentioned that they conducted NHED prior to the arrival of children at AWC. Only 5% stated that they conducted NHED at the time of collecting SN by the AGs and after the children departed from the AWC.
9. In NHED sessions maximum emphasis was given to breastfeeding (100%); followed by immunization (97%); diet during pregnancy and lactation; diarrhoea management (93%); nutrition during adolescence (62%); and health services (60%). Aspects on growth monitoring (62.5%) were also stressed upon during NHED, but the coverage on kitchen gardening and conservation of nutrients remained poor.
10. 37% AWWs mentioned that it was convenient to conduct NHED sessions on a fortnightly basis and for four days a week. While 12% of the AWWs conducted it once a week, 7% conducted NHED everyday, and 5% AWWs conducted it on a monthly basis.
11. Supervisors and CDPOs mentioned that AGs had gained adequate knowledge and information related to various important aspects from the NHED sessions.
12. It was revealed that out of 200 AG beneficiaries, 142 beneficiaries had the knowledge regarding the initiating of breastfeeding on the first day. 170 out of 200 AG non-beneficiaries had the same knowledge. 145 of the beneficiaries were aware of growth monitoring of children where as only 111 of the non-beneficiaries related themselves to this area. The awareness level of both beneficiaries and non-beneficiaries was almost at par, as awareness was also generated by Health Department, mass media and Education Department.
13. It was found that activities like nutrition and health education sessions conducted in the AWCs were open to all. AWWs mentioned that the non-beneficiaries too attend the sessions, as and when they wish.

14. It was found that beneficiaries from all the blocks put into practice the knowledge gained during NHed sessions to improve Nutrition and Health Practices. Most of the non-beneficiaries were also utilizing the knowledge gained through NHed sessions in their day to day life.
15. All the Supervisors and 92% AWWs mentioned that the scheme was useful in promoting better motherhood, promoting better child care practices, and contributed towards generating awareness in the areas of health and hygiene. 62% AWWs felt that the scheme had also helped in enhancing the status of the AGs in their families.
16. Non-beneficiaries mentioned that immunization helped in improving the health status of AGs. They found some other services very useful like referral services, getting deworming tablets, health check-up, etc.
17. All the local leaders, Supervisors, CDPOs and 95% of the AWWs mentioned that the scheme should provide immunization to all. Provision of deworming tablets, iron and folic acid tablets, treatment for minor ailments, etc. were appreciated, but these services were subject to the availability of stocks at the AWC, as the supply was very irregular.
18. All the Supervisors, CDPOs, 60% of the local leaders, and AWWs stressed that the most beneficial and effective part of the scheme was providing NHed.
19. 2 of the CDPOs, all the Supervisors and 18% of the AWWs had no problems and faced no constraints in involving AGs in the activities of the AWC. They were satisfied with the scheme. However, 82% of the AWWs felt that there were some gaps in the scheme.
20. Almost all the functionaries were of the view that the scheme did not recognize the work of the AGs, which made the scheme less attractive to the AGs. Project level functionaries believed that if some incentive, in the form of recognition, is given to the work of AGs, the attendance would increase further and the scheme would receive a more positive response from the people.
21. AWWs mentioned that the quality of food served to AGs needs to be improved. The duration of involvement of AGs, which at present is only six months, should be increased.
22. It was found that the mothers of non-beneficiary AGs felt that the SNP supplied was not adequately nutritious for AGs.
23. The drawback of the scheme, as revealed by the project level functionaries, was the lack of training which forms an essential part of the AG scheme.

Recommendations

1. The role of AGs must be well recognized.
2. Some incentives should be given to AGs - may be a credit certificate or preference in job recruitment of AWWs.
3. AGs should be given vocational training.
4. The enrollment of adolescents should be increased.
5. Quality of food given to AGs should be improved, and quantity increased.

Anaemia Prevention

Anaemia Prevention

Community Level Micronutrient Fortification of a Food Supplement in India: A Controlled Trial in Pre-School Children Aged 36-66 Months

Child in Need Institute

Introduction

Children participating in the ICDS programme in India have high rates of iron and Vitamin A deficiency. The addition of a fortified premix to the ICDS supplementary nutrition (SNP) programme would be unique because the fortification would occur at the community level in AWCs, to improve the health and nutritional status of children. The food supplied in anganwadis, *khichdi* (a mix of boiled rice and pulses), was locally fortified with encapsulated ferrous fumarate and Vitamin A. This study examined the effect of fortified *khichdi* on haemoglobin, serum ferritin, and serum retinol concentrations, and on prevalence rates of anaemia, iron deficiency, Vitamin A deficiency, and low Vitamin A status in children aged 3-6 years.

Aims and Objectives

The study aimed to:

1. Assess the acceptance of a premix fortified with iron and Vitamin A at the community level.
2. Assess the efficacy of including iron and Vitamin A to prepare *khichdi*, a rice and dal mixture, in increasing iron and Vitamin A stores in the body, and decreasing the prevalence of iron deficiency, anaemia and Vitamin A deficiency among children attending ICDS centres.

Methodology

This study was conducted in AWCs through out Mahestala block in South 24 Parganas, West Bengal. Mahestala is a semi-urban area. There was an average of 1 AWC per 1000 persons in the general population and an average of 20-30 children per centre. This was a double blind, cluster, randomized trial initiated in 30 AWCs (day care centres) in the block. Children aged 36-66 months (n=516) attending village based ICDS centres were randomly assigned to receive either a fortified or a non-fortified premix for 24 weeks. Data was gathered through measurement of height and weight at 0 week and 24 weeks by using standardized techniques. At 0 and 24 weeks, 5 ml whole blood was collected from the enrolled children by venipuncture for the measurement of Hb, serum ferritin, serum retinol, and C reactive protein (CRP). Blood was collected by finger prick for the analysis of haemoglobin at 12 weeks.

Findings and Conclusions

1. It was found that during training, AWWs were taught proper storage procedures for the fortified premix and proper preparation techniques. They were instructed to thoroughly mix the premix with the *khichdi* after the *khichdi* had cooled for 10 minutes to ensure a homogenous mixture.
2. It was found that the Panchayat monitors collected weekly monitoring forms from 2 AWCs for the preparation of *khichdi*, storage of the premix, and the amount of *khichdi* consumed by each enrolled child. All monitoring forms were collected by ICDS Supervisors and reviewed by ICDS CDPOs.
3. The monitoring forms indicated that 85% of the AWWs experienced minor problems with the packaging of the premix, including breakage of the polythene bag and failure of the bag to seal properly.
4. A total of 684 children were screened and enrolled in 30 AWCs. Around 168 children (24.5%) were lost to follow-up before the 24 week assessment; thus 516 completed the 24 week trial. Reasons for loss to follow-up were refusal of further venipuncture (n = 161), change of location (n = 5), and low attendance at the AWC (n = 2). Most of the characteristics of children who dropped out of the study did not differ significantly from those of the children who completed the trial, including age, sex, iron status, and mean Hb concentration. However, the prevalence of anaemia was significantly greater in the children lost to follow-up (35.1%) than in those who completed the trial (26.2%) ($p < 0.05$).
5. It was found that children in the non-fortified *khichdi* group had a lower Hb concentration ($p = 0.003$) and a higher prevalence of anaemia ($p < 0.001$) than did children in the fortified *khichdi* group. The serum retinol concentration was greater in the non-fortified *khichdi* group ($p = 0.003$); however, the prevalence of Vitamin A deficiency and low Vitamin A status were not significantly different.
6. It was found that there were significant differences in the prevalence of elevated CRP ($p = 0.008$) and the CRP (C-reactive protein) concentration ($p = 0.001$) between the two groups (non-fortified and fortified). Children with an elevated CRP concentration did not have a higher prevalence of recent fever, abdominal pain, bloody stool, or cough, and no significant difference in these factors was found between the fortified and non-fortified *khichdi* groups.
7. It was found that compliance was high among enrolled children. Children in the fortified and non-fortified groups, on an average, received the *khichdi* 90.2% and 89.3% of the days respectively, during the study period.
8. Around 98.9% of the enrolled children consumed 100% of the *khichdi* at each sitting. Monitoring forms collected weekly showed that AWWs had no difficulties with the preparation or storage of the *khichdi* at the AWCs once the initial packaging problems were resolved. The workers strictly followed training instructions on the preparation and storage of the fortified premix.

9. It was found that there was no significant difference in the mean haemoglobin concentration of the participants in the 2 groups between baseline and end of the study. Because of a significant interaction between anaemia, treatment group, and time ($p < 0.01$) Haemoglobin concentrations in the anaemic children increased significantly in the fortified group when compared with the non-fortified group from weeks 0-24 ($p = 0.04$). After 24 weeks, serum ferritin significantly increased in all participants in the fortified group, and the change in serum ferritin was different from that of the non-fortified group ($p < 0.001$).

Recommendations

1. The addition of a fortified premix to *khichdi* in ICDS AWCs could be an excellent opportunity to provide the needed micronutrients to children with or at risk of micronutrient deficiencies throughout India.
2. It is suggested that fortified premix could be an effective means of meeting the micronutrient needs of pregnant and lactating women and of younger children who are consuming solid food.
3. The provision of proper packaging is needed for the fortified premix to increase the fortified premix's ability to increase serum retinol concentrations and decrease Vitamin A deficiency and low Vitamin A status.

Process Documentation of Gumla Anaemia Project

AMS Consulting

Introduction

Gumla district was identified by the Government of Jharkhand as a priority area for anaemia eradication project. Multiple interventions were taken up to reduce anaemia which involved increased intake of IFA tablets by pregnant and lactating women and AGs; consumption of de-worming tablets by pregnant women (after 1st trimester), lactating women and AGs through the bi-annual catch-up rounds; improved treatment of malaria with tablets; improved reporting mechanism; and imparting nutrition education. These interventions were taken up by the Government of Jharkhand in partnership with MOST (India), the USAID Micronutrient Programme, along with Vikas Bharti, a local NGO, as the implementing partner.

Aims and Objectives

The study aimed to:

1. Understand the process by which health workers and the community could be motivated to understand the barriers to reducing anaemia, and then to provide the tools that would enable them to take the action needed to address the problem.
2. Increasing access to anaemia related services among the target group - pregnant and lactating women and adolescent girls.
3. Enabling families and the community to support IFA supplementation.

Methodology

In Gumla, the proportion of pregnant and lactating women who were anaemic was very high (90%), hence this district was selected as a high priority area for anaemia eradication project. This study was conducted in 5 blocks (424 villages) of Gumla district, namely Bishunpur, Ghaghra, Palkot, Raidih and Sisai. Each of these blocks had different characteristics which was the reason for their selection. Bishunpur had very high primitive tribal population; Ghaghra had hilly and difficult terrain; Palkot had active and well organized self help groups; Raidih was a very small block; and Sisai had high Muslim population. Data was collected through interviews and observations.

Findings and Conclusions

1. It was found that the training modules prepared for various levels were very comprehensive and easy to comprehend. They covered in detail the project processes and issues on awareness and knowledge on anaemia and also its causes and consequences.

2. It was found that the training given to project functionaries was very comprehensive. The enthused functionaries evolved innovative linkages between the mother, the child in the womb and consequences of iron deficiency to motivate the women to consume IFA.
3. Village health workers (VHWs) were not given any regular honoraria under the project, hence they were discouraged by their family members to perform their duties under the project. Also, since no refresher training or orientation training of the VHWs was organized after the initial training at Vikas Bharti, they became complacent and less motivated.
4. It was revealed that 'community influences' were respected people of the village, and people of the village followed their advice sincerely. Their involvement in community meetings had a very positive impact on the villagers, but in the later stages of the project, they took very little interest and had a minimal role in the project.
5. Pregnant women mentioned that the visit/ meetings with the ANM and the AWW were the greatest motivation for them, and women had tremendous faith on them.
6. AWWs mentioned that due to their regular interaction with the women/ girls, they were more affable and candid in their discussions with them.
7. The regular meetings of the VHWs and the Social Support Group members to share the outcome of their visits to pregnant women were very useful. In these meetings, they discussed and prepared an action plan as per the requirement of each case in the village.
8. At several places all adolescent girls were given IFA tablets to consume in the presence of everybody to make IFA popular and to ensure that it is consumed. This was a novel method to remind the women as well.
9. It was found that *Nukkad nataks* (street plays) received tremendous response from the women as well as AGs. They were seen by all the villagers, including men and other household members, educated and uneducated persons. That helped in garnering the support of household members of women and girls, and motivated them to consume IFA tablets regularly.
10. Not being able to meet the growing demand for IFA tablets in their area was the most common woe of ANMs. When supplies were exhausted at the sub-centre, ANMs would collect it from the PHC. ANMs also stocked some IFA tablets with AWWs. When there was a gap of some days, women mentioned that they realized the use of consuming IFA tablets, and also that the effect would not be optimum if there was a break in continuity. AGs of Ghaghra mentioned that they never got any IFA tablets.
11. The women confessed that earlier when they used to receive IFA tablets, they would throw them away and not consume them. The best friend and mentor of pregnant women was the ANM and then the AWW, when they suffered from the side effects of consuming IFA tablets. Consultations with the ANM/ AWW of their area increased as now many more women had started consuming IFA.
12. Most of the women said that now their husband and other family members encouraged them to regularly consume IFA tablets, and supported them when they suffered side effects. Earlier

their husband/ family members would suggest that they discontinue IFA consumption for some days, but now they suggest consultation with the ANM/ AWW.

13. AGs mentioned that they were encouraged by their family members to consume IFA.
14. It was found that Vikas Bharti had been working for the people of the area on various fronts and people had developed faith on that organization. The Village Health Workers (VHWs) posted by Vikas Bharti had been instrumented in making the presence of Vikas Bharti stronger in the village.

Recommendations

1. Some tests on women should be done in hospitals to check what changes had occurred in their haemoglobin levels due to consumption of IFA.
2. There should be some method to help women keep a track of the number of IFA tablets consumed by them.
3. Healthy Mother Competition should be organized in villages.
4. Video vans should be used to propagate the importance of consuming IFA tablets, and IEC (Information Education Communication) should be in local language.
5. At least once a month an educated woman of the village should talk to other women about anaemia and its aspects with the help of pictures/ photographs in a meeting, which is attended only by women and AGs. The importance of consuming IFA tablets should also be highlighted.
6. Male members need to be educated about anaemia, as the women were ready to consume IFA but the men resisted when the women fell ill and were unable to work.
7. Sometimes IFA tablets were out of stock in AWCs which resulted in discontinuation of consumption. Regular supply of IFA tablets should be ensured.

Anganwadi Workers Training Centres

Anganwadi Workers Training Centres

Anganwadi Workers Training Centres in Uttar Pradesh: A Case Study

*National Institute of Public Cooperation and Child Development (NIPCCD),
Regional Centre Lucknow*

Introduction

The Government of India had sanctioned 66 AWTCs in 1999 for training AWWs in Uttar Pradesh. These AWTCs were spread over 48 districts of the state to provide maximum accessibility to grass root level workers and meet the requirements of the local population. The main task of AWTCs is organization of the job training and refresher training courses for AWWs. The inputs given in job training courses are very intensive in the areas of child development, health and nutrition and community participation etc. Monitoring and other field visit reports about these training centres in the state were not encouraging. Physical infrastructure, training equipment and material were inadequate in these centres. Methods used in transaction of the training were didactic. To have a better understanding about the functioning and problems of these very significant training institutions, NIPCCD undertook an in-depth qualitative study of AWTCs in Uttar Pradesh.

Aims and Objectives

The study aimed to:

1. Assess the existing infrastructure and training facilities available in AWTCs.
2. Identify gaps in the transaction of training to ensure quality.
3. Assess the human resources in terms of their specialization, training and experience in AWTCs.
4. Find out the problems and hurdles faced by the centres in organization of training programmes.
5. Suggest measures to strengthen the overall functioning of AWTCs to ensure effective training.

Methodology

The study was conducted in Uttar Pradesh. Only six AWTCs had been selected out of the 66 AWTCs. These were in Bareilly, Allahabad, Bulandshahar, Lalitpur, Chitrakoot, and Firozabad. Data was collected through interview schedules and an observational checklist.

Findings and Conclusions

1. The centres selected for this study started in 1982 and 1986. It was found that there was wide variation in the infrastructure facilities available and experience of staff, their orientation to early childhood care and development, and teaching methodologies. Over all transaction of training and management of training centres varied widely between new and old AWTCs.
2. It was found that out of 18 instructors in 6 centres only 4 were untrained. These included two in AWTC Lalitpur and one each in AWTC Chitrakoot and AWTC in Firozabad. In contrast, the instructors at AWTCs run by UPCCW and Bharat Scouts and Guides had attended innumerable training programmes organized by NIPCCD, UNICEF, etc. on various issues from time to time.
3. Principals were organizing, coordinating and monitoring training programmes, besides taking sessions in the courses. They liaised between the parent body and the training centre on the one hand and between the training centre and Directorate of Child Development and Nutrition (ICDS) in the state on the other. They ensured that the expenditure incurred by the centre was in accordance with the budgetary provisions. They looked after the overall administrative work related to staff and trainees, and preparation of monthly progress reports, course reports and annual reports.
4. It was found that in a majority of the AWTCs surveyed the honorarium to staff was paid as per the guidelines, particularly by UPCCW, Uttar Pradesh Bharat Scouts and Guides, and Nehru Yuvak Kendras (NYK). In one AWTC run by Prayag Manav Kalyan Evam Vikas Samiti, Chitrakoot, the instructors mentioned that they were not getting the full amount, but they did not come out openly to reveal this. This could be due to fear of losing their job and further there was no documentary evidence available to prove this practice.
5. It was observed in all surveyed centres that the material given to the trainee AWWs was negligible. Unless the worker was provided with basic material it is difficult for them to carry on their assigned functions effectively.
6. All the trainers made adequate preparations before taking any session. They prepared lecture notes from subject books available in the centres. Only blackboards were used extensively.
7. It was found that the educational background of instructors did not match with the subjects they taught. Lack of good training facilities at AWTCs such as AV aids, subject matter books particularly on child development and preschool education, separate room for demonstration and practicals, and provision of raw material for preparing teaching and training aids had been identified by trainers as major difficulties in organizing training effectively.
8. It was found that all AWTC trainers evaluated the performance of trainees at the end of the training programme. Evaluation was done on various aspects including theory, practicals, fieldwork, assignments and viva. However, the allocation of marks for each of the above varied from centre to centre. There were no guidelines issued to the training centres on evaluation, and as a result there was no uniformity and the centres themselves adopted a system of evaluating their trainees arbitrarily.

9. It was found that majority of the trainees (88%) were 23 years and above, and only 12% were very young. Most of these young trainees were freshers. About 68% trainees who were undergoing job training had already worked for more than 4 years as AWWs without having any orientation to ICDS.
10. Trainees mentioned that physical facilities like board and lodging, entertainment facilities and arrangements in the training centres should be improved. According to them they were not provided with basic reading materials, which could also be carried to their respective AWCs. But in almost 50% centres no kit was provided to the trainees. The reasons given by the principals for this lacunae was lack of funds and non-availability of reading materials related to ICDS scheme, nutrition, preschool education etc.
11. A few trainees mentioned that the duration of training was too long, and it became extremely difficult for them to leave their children and family behind and concentrate on training. For those workers who had small children it was impossible to undergo such a long duration training programme.
12. The ICDS budget provided Rs.3,24,615/- for payment of stipend to trainees, and Rs.1000/- as stipend was to be paid to the trainee AWWs at the training centre. Each training centre had been provided with Rs.26,250/- for payment of travelling allowance (TA) at Rs.150/- per trainee. It was found that even this amount was not paid due to non-release of grants to the training centres.
13. Rs.2,94,000/- was given to the training centres annually to meet the expenses on boarding at Rs.30/- per trainee per day. In a majority of the centres, caterers and the organizations were providing food, hence the non release of grants did not affect this aspect as much as it did other aspects. The principals and head of the organizations had to pacify and convince the caterers over and over again that bills would be paid as soon as the grants were received.
14. It was found that an amount of Rs.5000/- per annum and at Rs.1000/- per batch was allocated in the budget for training materials. This amount was being utilized for preparation of preschool and teaching aids provided to trainees. There was no provision of kit in the present budget. Whatever the training centres decided to give the trainees as a part of kit, they has to manage within the amount. Approximately Rs.28/- was worked out for each trainee.
15. The principals and heads of organizations mentioned that due to non-availability of funds they were not able to manage training centres smoothly, and the training was not being organized as effectively as it should be. They were not even able to organize field visits to AWCs, hospitals and community, but could only conduct institutional training due to lack of funds.
16. The principals and heads of NGOs and NYK expressed that their training centres did not have the required training equipment such as over-head projector, TV, VCR/VCD and tape recorder, etc. to organize training effectively. They mentioned that they have been organizing training for 3-4 years but these basic AV aids were not provided.

17. The principals mentioned that they were not able to provide any simple supportive reading material like booklets, pamphlets, leaflets, fliers on issues concerning nutrition, health, pre-school education or information related to new programmes to the people or community.

Recommendations

1. The physical facilities available at centres like classrooms, seating facilities, furniture in the classrooms, provision of bedding and *almirahs*/ cupboards, training equipment and A.V. aids, etc. needed some attention.
2. For effective and smooth organisation of training grants should be released on time. Both, the State Directorate and DWCD (GOI), need to work out a strategy to ease out procedures for releasing grants for training purposes.
3. The trainees were not getting proper food as the food allowance of Rs.30/- per day was insufficient and needed to be enhanced as early as possible. The heads of the organisations suggested it should be increased to Rs.60/- per day per trainee.
4. The allowance for training material, which was Rs.1000/- per batch, should be increased, and it could be Rs.50/- per participant and the total for 35 participants would be Rs.1750/-. Alternatively, the provision of a kit for the trainee AWW could be reintroduced. An amount of Rs.75/- per participant would work out to be Rs.2625/- per batch. This amount was necessary because right now reference materials are not given to AWWs as the required number of copies were not available with the AWTCs. At least these materials could be photocopied and given to the trainees for ready reference at their work place.
5. A few centres were not able to invite guest speakers for taking sessions due to lack of separate provision in the budget. It was recommended that a separate head 'Honorarium to Guest Speakers' should be created in the budget to enrich the training imparted.
6. There is a need for provision of library funds in the budget. It was found that particularly in new centres subject books on child development, pre-school education, nutrition, health, community participation, communication, etc. were not available.
7. There is need to develop a training module for the job training of AWWs in order to conduct the training sessions systematically and to send precise and uniform messages to the AWWs.
8. It was recommended that AWTCs should be provided with basic A.V. aids, i.e. VCR/VCD, T.V. set, tape recorder, overhead projector, video films, etc. particularly on subjects like girl child, breastfeeding, infant stimulation and care, community participation, self help groups and many other areas.
9. There is need to constitute a core team of experts from State Directorate of ICDS and technical institutions which could monitor the training centres.
10. There is an urgent need for upward revision of financial norms under various budgetary provisions to strengthen the training as well as facilitating the organizers for smooth conduct of the training of AWWs.

A Quick Appraisal of AWTCs in Bihar: A Report

***National Institute of Public Cooperation and Child Development (NIPCCD),
Regional Centre Lucknow***

Introduction

The main task of Anganwadi Workers Training Centres (AWTCs) is the organization of job training and refresher training courses for AWWs and AWHs. The monitoring and survey reports of AWTCs in the state of Bihar are not encouraging. Their physical infrastructure, training equipment and materials were inadequate. The methods used in transaction of the training were didactic. The poor social indicators of this state in terms of infant mortality, incidence of low birth weight babies, malnutrition in children and the maternal mortality rates indicate that the field level functionaries are not able to translate the training inputs into action. NIPCCD, Lucknow was asked to conduct a quick study of the existing AWTCs for further strengthening and for developing minimum norms/ requirements of infrastructure/ facilities/ staff, etc. to be used for commissioning new AWTCs.

Aims and Objectives

This study aimed to:

1. Assess the existing infrastructure and training facilities available in AWTCs.
2. Assess the human resources in terms of their specialization, training and experience in AWTCs.
3. Identify gaps in the transaction of training.
4. Assess the knowledge, understanding and skills of trained AWWs in work situations.
5. Assess the problems and hurdles faced by AWTCs in organizing training programmes.
6. Suggest measures to strengthen the overall functioning of AWTCs and effectiveness of training and suggest common minimum standard for AWTCs.

Methodology

This study was conducted in Bihar. Of the total 15 operational AWTCs in Bihar (10 run by BCCW and 5 run by VOs), 8 (50%) were selected for the study. Those run by Bihar Council for Child Welfare (BCCW) were Purvi Champaran (Motihari); Hajipur (Vaishali); Patna; Bodhgaya (Gaya); and Barari (Bhagalpur). The 3 AWTCs run by Voluntary Organisations (VOs) were Madhubani, Bhagalpur and Kadamkuan. Data was gathered through interviews, observation and field survey.

Findings and Conclusions

1. Out of 8 AWTCs, 4 operated from their own buildings (Kumrahar of BCCW and Kadamkuan, Nathnagar and Madhubani of NGOs); two were on rent (Motihari and Barari); and two AWTCs (Hajipur and Bodhgaya) operated in Government buildings.
2. All AWTCs had adequate toilets/ bathroom facilities except Barari, where these facilities were inadequate. But proper maintenance of these facilities was lacking. All AWTCs had safe drinking water facilities.
3. All AWTCs managed to meet the expenditure on food for trainers except one AWTC (Kadamkuan), where trainees paid for their food at Rs.30/- per day because that AWTC had not received funds from the ICDS Directorate.
4. Quality of food differed from centre to centre and it was found that there was scope for improvement of food quality within the budgetary provision of AWTCs.
5. Six AWTCs (Kumrahar, Kadamkuan, Hajipur, Madhubani, Nathnagar and Bodhgaya) had spacious classrooms, while two AWTCs (Motihari and Barari) had small classrooms, and it became difficult to accommodate trainees.
6. It was found that the books and other training and communication material available at AWTCs were quite old editions/ versions, and from the way these materials were kept/ stored it appeared that they were rarely used.
7. No AWTC had a medicine kit.
8. During visit of the study team, two Instructors of AWTCs (Kumrahar and Bodhgaya) were untrained, two of them were deputed for training to NIPCCD, Regional Centre, Lucknow, one of them had received training, and one Instructor at Bodhgaya was still untrained. One post of Instructor was vacant due to transfer, and the training status of instructor was not known in the ICDS Directorate.
9. Instructors of AWTCs run by BCCW were getting honorarium regularly, but there was delay of around 8-12 months in payment of honorarium in the case of AWTCs run by NGOs. This was due to the late release of funds from the ICDS Directorate.
10. All AWTCs of BCCW and Kadamkuan (NGO) applied for increment of honorarium for Instructors regularly, and they were getting enhanced honorarium as per the financial guidelines. However, the increment of honorarium after completion of 5 years and 10 years of service had not been implemented in AWTCs run by NGOs in the case of 3 Instructors (one from Madhubani and two from Nathnagar, Bhagalpur).
11. Audio-visual/ other aids were not used by AWTCs in training sessions in induction training due to lack of time.
12. All AWTCs (except Kadamkuan) were following the NIPCCD syllabus for organizing Induction Training, whereas AWTC at Kadamkuan had developed its own syllabus. These 7 AWTCs

- had translated the English version of Induction Training Syllabus into Hindi for use in training programmes.
13. It was found that field visit/ supervised practice were not done as prescribed in the Induction Training Module.
 14. Seven AWTCs evaluated the performance of trainees at the end of the training programme verbally in the classroom, and trainees clarify their doubts. The AWTC at Madhubani was doing this in writing through a set of questions. This AWTC also used to get written feedback from trainees about the facilities in hostel, classroom, cleanliness in toilet/ bathroom and library, etc.
 15. It was found that in the duration of one year (January – December 2003) 4 AWTCs were visited once by ICDS officials, 2 AWTCs were visited twice, and one AWTC (Hajipur) was visited five times.
 16. There was delay in release of funds to AWTCs. In the absence of funds, AWTCs used to manage training materials on credit, and sometimes Principals/ Instructors managed by spending their own money. AWTCs had to pay more, in comparison to the approved budgetary provision, towards rent of building, electricity and water charges.
 17. All AWTCs (15) in Bihar were utilized for conducting Induction Training Programmes (12 working days) for AWWs since April 2003. Very few Orientation Training Programmes were conducted for AWHs (Anganwadi Helpers). As per the guidelines, Induction Training was conducted by the Training Team at project level but not by AWTCs. In some cases, it was found that a break of even one day was not given to AWTCs between two training courses to make preparations for the next course.
 18. Only one AWTC (Kadamkuan) had got academic staff with prescribed qualifications. In 3 AWTCs (Kumrahar, Motihari and Bodhgaya) there were no Instructors with Home Science/ Nutrition background to take care of Nutrition component of ICDS training.
 19. Apart from growth charts and survey forms (which were photocopied and provided to trainees), no other relevant material for conducting various activities at AWC were provided to trainee AWWs.
 20. AWTCs reported that material for preparation of PSE aids was provided to trainees, and aids prepared by trainees during the course were given to them at the end of the training courses.
 21. Trainees mentioned that small living rooms, cooking of food, less height of boundary wall and inadequate supply of electricity were the major problems they faced.
 22. State Training Officer/ District Welfare Officer mentioned that deputation orders of trainees were issued mostly 16-30 days before the course. But it was found that orders were issued around 15 days before the course and sometimes been less than 15 days prior to the course.
 23. DD (W) (Deputy Director, Welfare)/ District Welfare Officer visited one to two AWTCs twice in the last one year, while the minimum visits to each AWTC should have been at least four to send quarterly reports for smooth release of funds.

24. Out of 30 AWWs, 20 had received 21 days Induction Training and 10 had undergone Sandwich Job Training.
25. All AWWs were residing in the AWC villages. The distance between residence and AWC of 24 AWWs was around 5-500 meters, and in the case of 6 AWWs, AWCs were run at their residence.
26. Out of 30 AWCs, 12 AWCs had displayed the time table, whereas 18 had no time table. These time tables were developed during March 2001 to April 2004.
27. In one AWC, all the registered children; in 17 AWCs, less than half of the registered children, and in 12 AWCs, half the registered children attended AWCs for pre-school education activities.
28. Out of 150 AWC children aged 4-6 years, 84 were able to identify round shape, 46 identified triangle and 50 identified square shape.
29. Out of 150 children aged 3-4 years, 110 children had understanding of the concept of small and big.
30. Out of 150 children aged 4-5 years at AWCs, 27 children identified red colour, 29 yellow colour, 22 blue colour and 19 children identified green colour.
31. Out of 30 AWWs, 8 had skills required for telling a story to children, and fulfilled the objectives of story telling.
32. AWWs mentioned that health check-up of children was conducted at 13 AWCs out of 30. However, there was no structured health check-up programme at AWCs. Mostly, AWWs perceived immunization as health check-up.
33. Out of 30 AWCs, more than 50% registered children in 5 AWCs, 50% children in 1 AWC and less than 50% registered children in 14 AWCs attended anganwadis for supplementary nutrition. However, supplementary nutrition was not available in 10 AWCs.
34. Growth monitoring was done in 21 AWCs. 8 AWWs out of 30 were able to fill the child's name and age in the growth chart.
35. More than 50% AWWs had the required skills for weighing children. Around 70% AWWs were able to read the weight of children correctly.
36. Around 43% AWWs were able to interpret growth chart and demonstrated skills to advise/counsel mothers.
37. Almost all AWWs conducted HNE sessions; and six AWWs out of 30 provided referral services to beneficiaries. Immunization of children was done in all AWCs.
38. Out of 150 women (including pregnant and lactating mothers) from 30 AWCs, 124 (83%) women were aware that PSE services were provided at AWCs.
39. Community participation was limited to providing a building for the AWC in case of 2 AWCs and space for play in the case of one AWC.

40. Out of 30 AWCs, Village Coordination Committee was formed in 29 AWCs.
41. More than 50% AWWs made between 1-5 home visits per day. However, there was no fixed interval for home visits.
42. Village surveys were conducted by 26 AWWs.

Recommendations

1. AWTCs should have physical infrastructure like hostel, kitchen, toilet, bathrooms, classroom, library, office, etc.
2. Every AWTCs should have white board/ black board and display board for the classroom.
3. Cooking of food by trainee AWWs for children and staff of orphanage run by NGO at Nathnagar should be stopped immediately.
4. ICDS Directorate may make alternative arrangements so that trainee AWWs do not pay cost of their food at Rs.30/- per day at Kadamkuan AWTC.
5. Every AWTC should rearrange training/ communication materials available with them, and keep them in a specified place where there is some space, so that these are used by trainers and trainees.
6. AWTCs run by BCCW/ NGOs need to send to ICDS Directorate course-wise utilization certificate and course reports indicating list of trainees, programme schedule, method of training, details of field work, details of training materials and training kit provided, use of audio visual aids, feed back of trainees about the course, etc. and annual audit certificate to facilitate early release of funds for organization of training programmes.
7. Payment of less honorarium to Instructors of AWTCs run by NGO at Madhubani and Nathnagar may be investigated by the ICDS Directorate, in order to ensure that the right amount is paid to AWTC staff.
8. Deputation order may be issued 30 days in advance in order to ensure that all trainee AWWs/ AWHs report to AWTCs for training in time.
9. NIPCCD syllabus for organizing Induction Training Programme should be followed in *toto*.
10. AWTCs should be provided with component-wise training material, weighing scales, medicine kit and sample SN. Refresher courses for Instructors of AWTCs need to be organized.
11. Government of India and the State Government have to ensure that funds are made available to AWTCs for conducting training programmes.

Situational Analysis of Anganwadi Workers Training Centres in Jharkhand

V. D. Gadkar

Introduction

NIPCCD is the training resource centre in the Government of India. It is responsible for developing syllabi, preparing training materials for ICDS training, and provides training to State/District level officials, CDPOs and trainers of MLTCs/ AWTCs. It was decided to conduct a quick study and undertake a situational analysis of existing AWTCs by NIPCCD, Lucknow for further strengthening training centres and to develop minimum norms/ requirements to be used for commissioning new AWTCs. Hence two separate studies for Bihar and Jharkhand were commissioned. This study covered AWTCs in state of Jharkhand.

Aims and Objectives

The study aimed to :

1. Assess the existing infrastructure and training facilities available in AWTCs.
2. Assess the human resources in terms of their specialization, training and experiences in AWTCs.
3. Identify gaps in the transaction of training.
4. Assess the knowledge, understanding and skill of trained AWWs in work situations.
5. Find out the problems and hurdles faced by trainers in AWTCs in organizing training programmes.
6. Suggest measures to strengthen the overall functioning of AWTCs and impart effective training.
7. Recommend common minimum standards for AWTCs.

Methodology

This study was conducted in the state of Jharkhand. There were five AWTCs functioning for the last many years, and the State was in the process of commissioning another 23 AWTCs to clear the backlog of training of ICDS functionaries. The Government had started 7 additional AWTCs to clear the backlog of untrained AWWs of the above mentioned five old AWTCs, four were selected for assessment. These were Holy Cross AWTC, Burdwan Compound, Ranchi; Mahila Dastkari Vidyalaya AWTC, Shamimabad, Itki; Adinyati Seva Mandal AWTC, Khunti; and Institute of Labour Studies AWTC, Jamshedpur. 4 principals of AWTCs, 8 Instructors, 20 trainee AWWs undergoing training,

10 AWWs trained within the past one year who had work experience, 10 AWWs trained 2 years prior to the study, and 10 AWWs trained 3 years prior to the study who also had work experience at AWCs were selected as the sample. Data was gathered through interviews and field survey.

Findings and Conclusions

1. It was found that all the AWTCs were running in rented buildings and had hostel facilities. All had spacious halls and separate rooms for trainees, but half of the AWTCs were in a dilapidated condition. All had the facility of safe drinking water.
2. Kitchen was available in all the centres. Three AWTCs had proper dining facility, but one did not have this facility.
3. All the AWTCs managed to meet the expenditure for board of trainees. The quality of food differed from centre to centre according to their location. The quality of food was better in urban and rural located AWTCs than tribal located AWTC.
4. The AWTCs in urban areas had spacious classrooms. In one centre there was only one small classroom, and it was difficult to accommodate trainees. Though two AWTCs in urban areas had spacious classrooms, but only *durries* (mats) were available to seat the trainees. There were no desks or writing facilities.
5. None of the centres had separate rooms for demonstration and preparation of extension aids.
6. All the centres had blackboards in their classrooms. Three of them also had display boards. White board was available only in one AWTC, but displayed at a distance from where trainees could not see it properly.
7. A Library was available in all the centres, but there was no seating arrangement for reading books. Centres in urban areas had a rich collection of books and maintained a good library. All the centres had a good collection of books and journals, etc. in the areas of Child Development and PSE, Health and Nutrition, Community Participation, Management, etc. Regional language newspapers and magazines were also available for the trainees. The total number of books were 1275; Institute of Labour Studies, Jamshedpur had the highest number (584), and Adimjati Seva Mandal, Khunti had the lowest number of books (55), but the books were rarely referred.
8. All the AWTCs had a Recreation Room with musical instruments/ games, etc. but only one centre had a television set for the trainees.
9. The Principal of Holy Cross, Ranchi was herself an Ayurvedic Doctor so medical check-up was organized once in every course. In the other centres, trainees were referred to near by doctors when they fell sick.
10. It was found that all the centres had full academic staff consisting of two Instructors and one Principal. They were not qualified according to the criteria set by NIPCCD. All were trained except one, who was newly appointed.
11. The honorarium of Principals/ Instructors was given once in a year in all the centres on the basis of courses conducted.

12. It was found that the condition of training equipment in the centres was poor, and essential equipment was not available. Audio-visual aids were not available.
13. All AWTCs followed the syllabus prescribed by NIPCCD, and in one centre about one fourth of the syllabus was changed, which was as prescribed by State Head Quarters according to their requirement.
14. AWTCs were giving training to freshly recruited AWWs in both previous and present batches. Only one centre had trainee AWWs with experience of more than three years and all had attended induction training also.
15. The schedules were prepared daily for training sessions in three AWTCs, whereas in one centre the schedules were made component-wise. Additional topics were also incorporated in the programme schedule in three centres, while no additional topics were covered in Adimjati Seva Mandal, Khunti. Guest speakers were invited to deliver sessions on different topics in all the AWTCs.
16. No transport facility was available in any centre so all of them hired buses for both observational and supervised visits except one centre, which was located close to the AWC.
17. It was found that discussions were held between Instructors of AWTCs and the trainees before and after their field work about the tasks to be performed in the field.
18. All the centres evaluated the performance of trainees at the end of the training course, and various Government officials visited the centres from time to time.
19. It was found that no funds/ grants were released regularly in any centre. The existing budget provisions were inadequate for all the AWTCs.
20. All centres had organized maximum number of induction courses, and only one centre had organized refresher courses in the past one year. Orientation programmes were conducted by all the centres except Institute of Labour Studies, Jamshedpur. Job training courses were running in all the centres.
21. Half of the AWTCs did not provide any reference material to trainees. The raw materials for preparing PSE aids were provided to trainees, and aids prepared by them were returned to them after the course.
22. No complaints were mentioned by the trainees of Mahila Dastkari Vidyalaya AWTC, Shamimabad, Itki. On the other hand, most trainees of the other AWTCs faced transport problems and sometimes when they visited AWCs, they found them either closed or the AWW or children were not available. Other problems faced were very small rooms, food, water, lack of electricity, toilets and insecurity.
23. A coordinator was appointed for monitoring the AWTCs in half of the parent organizations (NGOs), while in the other half, the Executive Head acted as the coordinator for supervision.
24. It was found that all the AWWs had attended job training course, and 16 of them had undergone induction training as well.

25. Out of 30 AWWs only nine of them were using a timetable for daily activities. None of the AWWs with two years experience used any timetable, resulting in disorganized conduct of activities in the AWCs. The timetable was very old and needed proper revision.
26. Health check-ups were conducted in eight out of ten AWCs from each category (i.e. AWWs with one, two and three years of experience). More than 75% of the total AWWs organized health check-ups every month.
27. The growth of all children was monitored by all 10 AWWs with 3 years of experience, while growth monitoring of all children was done by seven and eight AWWs with one and two years experience respectively. Only 17 AWWs out of 30 monitored the growth of children once in a month, two AWWs monitored growth quarterly, and in the rest growth monitoring was rarely done. The performance of AWWs with two years of experience was unsatisfactory. 17 AWWs were able to fill the growth chart and 7 could not fill it. Only 18 out of 30 AWWs could give correct interpretation of growth chart and advice to mothers for improving the child's nutritional status.
28. All the AWWs with one and three years of experience conducted health and nutrition education sessions once in a month. While three AWWs with two years of experience conducted the session either weekly or twice a month, and the rest conducted the NHE session monthly.
29. It was found that only eight of the 30 surveyed AWWs provided referral services.
30. It was found that five AWCs of the 1st category, four AWCs of the 2nd category and eight AWCs of the 3rd category did not have any record of immunization. Thus dropouts increased and sometimes children received vaccination twice.
31. Out of 150 women beneficiaries (lactating and pregnant women) from 30 AWCs, 120 of them knew about SN and 100 were aware of health check-up, but only 16 knew about referral services.
32. It was found that community participation was very poor and only 7 out of 30 AWCs received support from the community. In 26 AWCs the Village Coordination Committee was operational.
33. No specific time frame was reported for home visits by almost all the AWWs of the 1st category. One AWW of this category did not conduct any home visit, while the rest visited 1-2 homes in a day.

Recommendations

1. The reading material should be provided to trainees preferably in Hindi (local language). Library should have proper seating arrangement.
2. Orientation of new Instructors of AWTCs should be organized soon after their selection. Skill training programmes should be organized for Instructors on all subjects on a regular basis.
3. There should be Coordination Committees to monitor training programmes and to ensure release of funds on time.

4. The budget for AWTCs needs revision, as it is not adequate to meet the expenditure of boarding, rent, electricity bills and transport.
5. To make the training process interesting and lively, more and more training methods and audio-visual aids need to be used to facilitate adult learning.
6. Instructors should develop a standard evaluation sheet (oral and written) for proper and unbiased evaluation of trainees after a course.
7. There is a need to invite guest speakers like ANMs/ Doctors from Primary Health Centres for taking sessions related to health and nutrition component.
8. There is need to constitute a Monitoring and Supervision Committee. The Committee should include DPO, CDPOs and Head of the Organisation of AWTCs. The Committee should visit AWTCs during training programmes to study the situation and supervise the activities on the spot.
9. The deputation order of trainee AWWs for job training should be issued at least one month in advance from the date of commencement of the training course so that AWWs can prepare themselves and report to AWTCs in time for the training.

Baseline Survey

Baseline Survey

Baseline Survey for World Bank Assisted ICDS – III Project in Rajasthan

Indian Institute of Health Management Research

Introduction

The Government of India approved the World Bank assisted ICDS III project in the state of Rajasthan to make substantial contribution to the qualitative improvement of the ICDS programme. It aimed to reorient the programme to become promotive of behaviour change for adoption of improved health and nutrition practices; to augment capacities and capabilities within the state; to improve access to ICDS services in the project area; and strengthen monitoring, evaluation and operational research components.

Aims and Objectives

The study aimed to:

1. Collect baseline information about the nutritional and health status of children aged 0-6 years, pregnant and lactating women and adolescent girls.
2. Assess the knowledge, attitude and practices among AGs with regard to nutrition.
3. Create a database and establish baseline indicators for assessing and monitoring progress of the project in terms of health and nutritional status of the target groups and programme input, management processes and outcomes.

Methodology

This study was conducted in 20 districts in Rajasthan. A total of 94 AWCs, 21,013 children in the age group of 0-6 years, 1223 pregnant women, 7253 lactating mothers, 4190 non pregnant non lactating (NPNL) women and 3410 adolescent girls (AGs) were covered. Among the 21,013 children, 12,775 children were 0-3 years old and 8238 children were 3-6 years of age. Data was gathered through interviews and field survey.

Findings and Conclusions

1. In the 26 ICDS blocks surveyed, nearly 14% children in the age group 0-3 years, and about 13% children aged 3-6 years were severely malnourished. About 23% children aged 0-3 years were underweight and in the age group 3-6 years 24% children were underweight.
2. Among the surveyed women, no woman was participating in any income generation activities under the ICDS programme, whereas 42 (0.3%) were reported to be participating in other income generation programmes. 15 women were found to be an elected member of the panchayat/ ward.

3. In the old ICDS blocks of Rajasthan around 24% pregnant women reported receiving IFA tablets and TT injections both, whereas 29% pregnant women had received TT injections alone. 44% pregnant women mentioned that neither TT injections nor IFA tablets were given.
4. In the new ICDS blocks of Rajasthan, around 25% pregnant women reported having received IFA tablets and TT injections both, whereas 42% pregnant women had received TT injections alone, and 2% reported intake of IFA tablets alone. 31% pregnant women mentioned that neither TT injections nor IFA tablets were given.
5. Around 25% of all deliveries in Rajasthan were institutional deliveries. Out of these, 17% were in government health facilities (district hospitals/ SC/ PHC/ CHC). The extent of institutional deliveries was reported to be highest among women of other general castes (25.2%). The extent of institutional deliveries also increased with the level of women's education (25.9%).
6. Among the old ICDS projects, the coverage of TT was found to be highest in Jaipur (87.5%) and lowest in Barmer (46.4%). Nearly 45% women in Banswara reported intake of IFA tablets against around 20% women in Barmer. Complicated deliveries were reported to be highest in Jaipur (10%) and lowest in Barmer (0.8%). Complications during delivery were reported to be highest in Dholpur (12.2%) and lowest in Barmer (1.5%). The extent of institutional deliveries was found to be highest in Jaipur (52.9%) and lowest in Barmer (5.3%).
7. In new ICDS projects, the intake of IFA varied from a high of around 52% in Chittorgarh to a low of about 20% in Kota. Nearly 8% women in Sri Ganganagar reported complicated delivery against 0.5% women in Rajsamand. In Kota district, the incidence of complications during delivery was reported to be the highest (7.8%) while in Ajmer (3.1%) and Rajsamand (3.1%) it was lowest. Institutional deliveries were found to be the highest in Sikar (47.4%) and lowest in Alwar (6.8%). TT coverage was highest in Sri Ganganagar (92.6%) and lowest in Alwar (50.2%).
8. Out of 3502 children weighed at birth, the record of their birth weight was available in nearly 89% cases. The percentage for recording birth weight was found to be higher for children of literate (89.6%) and schedule tribe women (97.6%). In a majority of cases the record of birth weight was reported on the discharge card (88.5%). In 6 cases the record of birth weight was reported at the AWC.
9. Among the old ICDS projects, the proportion of children weighed at birth was found to be highest in Jaipur (40.9%) and lowest in Barmer (4.1%), whereas this proportion was reported to be highest in Sri Ganganagar (40%) and lowest in Alwar (6%) among the new ICDS project.
10. Among the children who were weighed at birth, Banswara district reported the highest proportion of low birth weight babies (40%) and the lowest number of LBW babies was in Dungerpur district (20%). Among the new ICDS projects, the proportion of low birth weight babies was found to be highest in Udaipur (52.6%) and lowest in Jhunjhunu (8.8%).
11. Among the old ICDS projects, colostrum feeding was reported to be highest in Jaipur (41.7%) and in districts like Dholpur, Chittorgarh, Barmer and Banswara; this proportion varied between

- 7.4% to 8%. 41% children in Sikar received colostrum. This proportion was found to be the lowest in Udaipur (3.7%) among the new ICDS projects.
12. In old ICDS blocks around 42% children aged 0-6 years receiving supplementary nutrition (SN) from ICDS were found to be under weight, including nearly 11% who were severely malnourished. Around 39% of the children who were not enrolled at AWC, and enrolled at AWC but not attending AWC, were found to be under weight, including nearly 18% who were severely malnourished.
 13. In new ICDS blocks, around 38% children in the age group 0-6 years who received SN from ICDS, were found to be underweight. Around 38% children, who were not allowed at AWC, and enrolled at AWC but not attending AWC, were found to be underweight.
 14. Among children receiving SN from ICDS, more male (43.8%) than female (40.4%) children were found to be underweight. Among children not receiving SN also more male (40.8%) than female children (37.4%) were found to be underweight.
 15. Among children receiving SN from ICDS, children who were ST (38.7%) were more underweight than others. Among children who were not enrolled at AWC, and enrolled at AWC but not attending AWC, the proportion of underweight children was found to be higher among ST children (41.5%).
 16. Among the old ICDS projects in Dungarpur, around 48% children in the age group of 0-6 years, who received SN from ICDS were found to be under weight, including nearly 18% who were severely malnourished. Around 45% children in Chittorgarh, who were not enrolled at AWC, and enrolled at AWC but not attending AWC, were found to be underweight, including nearly 5% who were severely malnourished.
 17. Among the new ICDS projects, the proportion of under weight children was found to be highest in Rajsamand (45.9%), including nearly 7% children who were severely malnourished. This proportion was found to be the lowest for children in Hanumangarh (25.1%), including nearly 14% who were severely malnourished.
 18. In old ICDS blocks, around 41% children in the age group of 0-3 years received SN from ICDS. The proportion was found to be higher for female children (42%), children of literate (42.1%) mothers and ST women (43.2%). The proportion of children in the age group of 3-6 years who received SN from ICDS was reported to be around 60%. More children of literate women (62.2%) and general caste women (61.2%) received SN from ICDS. The distribution of male (60%) and female children (59.7%) followed a similar pattern.
 19. The proportion of children who received complementary food varied between 92% to 98% across all the surveyed districts. Among the old ICDS projects, the proportion of children in the age group 0-36 months receiving SN from ICDS was found to be highest in Banswara (25.2%) and lowest in Jaipur (7.5%). The proportion of children in the age group of 37-72 months receiving SN was highest in Banswara (42.5%) and lowest in Dholpur (11.9%).

20. The consumption of Vitamin A rich food was highest in Jaipur (44.5%) among the old ICDS projects, while Dholpur (17.6%) reported the lowest percentage consumption of Vitamin A rich food. Churu had the highest percentage of children (42.1%) consuming Vitamin A rich food among the new ICDS projects, and it was found to be lowest in Udaipur (14.7%) and Rajsamand (14.7%).
21. The proportion of children who had undergone de-worming was highest in Jaipur (8.2%) and lowest in Dungarpur (1%) among the old ICDS projects. Rajsamand had the highest proportion of children (6.8%) who had undergone de-worming and Udaipur (0.6%) the lowest, among the new ICDS blocks.
22. The incidence of illness was highest in Dholpur (37.7%) and Tonk (37.1%) districts and lowest in Barmer (22.5%) among the old ICDS projects. Udaipur (38%) reported the highest proportion of children suffering from diarrhoea, cough, fever or pneumonia among the new ICDS projects, whereas this proportion was found to be lowest in Jhunjhunu (21.2%).
23. Around 49% mothers of children in the age group of 0-3 years were found to be aware of AWC in the area.
24. Among the old ICDS blocks, the enrollment of children at AWC was reported in around 36% of cases; while among the new ICDS blocks, wherever the AWCs had become functional, the enrollment of children at AWC was reported to be around 34%.
25. About 55% children in the age group 0-3 years attend the AWC daily/ weekly/ monthly. The younger children were accompanied to AWC either by their mother or any elder to collect SN. This frequency was higher in case of female children (56.8%), children of literate (56.7%) and ST women (62.2%).
26. Around 51% mothers of children in the age group 3-6 years were aware of the AWC in the area.
27. In old ICDS projects, around 14% of the children aged 3-6 years attended pre-school classes at AWC, while 50% children attended pre-schools other than AWC (private/ government). More female children (15.2%) received PSE at AWC than males.
28. About 36% children in the pre-school age group (3-6 years) were found to be attending no school. More female children (38.5%) and children of women belonging to other castes 36.2% were reported to be attending no school.
29. In the old ICDS blocks, among children enrolled at AWC, around 66% children attended pre-school classes at AWC. In the new ICDS blocks, wherever the AWCs had become functional, around 55% children, among the children enrolled at AWC, attended pre-school classes at AWC.
30. Among the old ICDS blocks, 86 pregnant women and 324 lactating women collected SN from ICDS. No SN had been provided at new AWCs, therefore, no pregnant and lactating women collected SN from ICDS centres.

31. In old AWCs around 59% AWWs made home visits at least once a week, followed by home visits at least once a month (28.1%). Nearly 11% AWWs reported daily home visits. About 2% AWW had never made a home visit. AWWs in new AWCs had not started discharging their duties in a full-fledged manner.
32. Around 88% AWWs in old ICDS blocks reported monthly visits by the supervisors. Majority of AWWs mentioned that they received help and guidance from the supervisors in checking registers/ records (74.5%), followed by checking of food stocks (54.3%), talking to/ examining beneficiaries (31.9%), and making home visits (19.1%). Support in the form of holding community meetings (Mahila Mandal, Bal Sabha), weighing of children, imparting health education and filling growth charts were reported by nearly 31% AWWs.
33. Out of 3410 adolescent girls, 121 (3.5%) went to AWCs. The literacy level among AGs was 69%. AGs scheme was not operational at any of the new ICDS projects, but it was operational in 9 old AWCs. About 4% AGs had taken nutritional supplements such as Vitamin tablets, syrups, etc. (2.9%), or food supplements (1.5%) at AWCs. Nutritional supplements were received by maximum number of AGs in Barmer (8.1%) and lowest in Chittorgarh (1%). Regular intake of nutritional supplements was highest in Jaipur (8%), and lowest in Barmer (0.7%) and Dholpur (1.4%) among old ICDS projects. About 23% AGs were aware about health, nutrition and family life, and 50% AGs were aware of AIDS.
34. Salter weighing machines were available in 92% old AWCs, but only 88% of the weighing machines were in working condition. Salter weighing scales had not been provided at any of the new AWCs.
35. Weighing of children aged 0-3 years was done in the week preceding the survey in 44% AWCs, while 38% AWWs reported that this was done last month. Last weighing of children done two months ago was reported by nearly 11% AWWs. In 8% AWCs, the children had never been weighed.
36. In the age group 3-6 years, last weighing of children in the week preceding the survey was reported in around 42% AWCs. In 38% AWCs children were weighed in the previous month, followed by 13% AWCs where children were weighed two months ago. Children were never weighed in about 8% AWCs.
37. Adequate number of growth charts were available in 89% of the old AWCs, while nearly 3% AWCs reported inadequate availability of growth charts. In 8% old AWCs, growth charts were not available. No growth charts had been provided at any of the new AWCs.
38. It was found that 31-40 growth charts were filled by around 35% AWWs, followed by 21-30 growth charts (21.1% AWWs), 10-20 growth charts (12.2% AWWs), 51-60 growth charts (5.3% AWWs), 41-50 growth charts and above 60 growth charts (3.5% AWWs each). Not even a single growth chart was filled by nearly 19% AWWs.

39. About 27% old AWCs reported irregularities in supplying of foods stocks in the 3 months preceding the survey. The duration of irregularity was found to be for 15 days in around 16% AWCs, followed by for a month in 13% AWCs, for more than a month in 7.8% AWCs and for week in 6.3% AWCs. No irregularity in supplying of food stocks was reported in 58% AWCs.
40. About 19% AWCs reported inadequate availability of PSE kit. No kit was found in 76% AWCs. Only 5% AWCs reported adequate availability of PSE kit. In 94% of the old AWCs, PSE was imparted for 3-6 days per week, whereas in the remaining 6% AWCs PSE had never been imparted. 1731 children attended PSE at AWCs regularly.
41. Drug/ medicine kit was available in 84% of the old AWCs. The reason for non-availability of drug kit was reported as “drug kit not provided” by 85% of the AWWs followed by finished and “not replaced” by nearly 13% of the AWWs. One AWW reported that the kit was at her home.
42. The Immunization Survey Register was available in 72% AWCs. It had not been provided in any of the new AWCs. In 48% AWCs, the Register was updated in the last one month preceding the survey, but nearly 30% AWWs had not updated the Register since more than one month. Around 20% AWWs had updated the Register in the week preceding the survey, whereas at one old AWC, the worker had never updated the Register.

Recommendations

There were no recommendations in the study.

Community Participation in ICDS

Community Participation in ICDS

A Study on Community Participation in ICDS at North Kolkata

Ms. Sangita Banerjee

Introduction

Care and development of children is a primary responsibility of the family, neighbourhood and community. It was felt that in the project area of North Calcutta there was very little involvement of those who were not getting benefits from the ICDS scheme, and they did not have complete knowledge about the scheme, its services and benefits provided by the staff. It was observed that there was a good possibility of securing community participation. This study was conducted to find out the areas where and how better community participation can be ensured to run the ICDS programme smoothly.

Aims and Objectives

The study aimed to:

1. Assess the actual extent of community participation and involvement in this programme.
2. Evaluate the involvement of local clubs/ local bodies/ mahila mandals in smooth running of the programme.
3. Identify whether the workers/ staff of AWCs can mobilize the unused enthusiasm and energy of youth and women for community action.
4. Find out the areas in which help and co-operation is not forthcoming at all, and reasons for the same.
5. Identify and mobilize local resources for generating self-reliance among the community.
6. Identify local leaders who can further educate and mobilize the people in that area.

Methodology

This study was conducted in North Kolkata. Only one centre of ICDS was selected, which was run by Ramkrishna Mission Loka Shiksha Parishad. It covered a total population of 854, among them 421 were males and 433 were females. 30 cases were taken for in-depth study, and among them there were 14 mothers and one father of beneficiary children, 10 were non-beneficiary parents or representatives of local organizations and 5 were functionaries of different centres. Data was collected on the monthly income of the beneficiary family to determine their economic status, and information was gathered through interviews, observations and from secondary sources.

Findings and Conclusions

1. It was found that the respondents were living in slum areas and they took up various occupations yielding low income.

2. The fathers of beneficiary children mentioned that they used to work outside the home, otherwise they could not earn any money. When they went out for work the other adult family members looked after their children.
3. It was found that 13 respondents families had a monthly income of Rs.1000-2000, one family earned between Rs.2000-3000, i.e. was not below the poverty line, and one family had income below Rs.1000 per month.
4. Out of 15 respondent mothers, 7 reported correctly about the services rendered under the programme for their children. Mothers' awareness was higher than that of fathers as the mothers were closely related with their children.
5. Out of 15 respondents 7 mentioned that they came to know from adult family members that they could send their children to anganwadi centres. 5 respondent mothers of the beneficiary children were encouraged by family members to send their child to the centre, while 4 were motivated by the AWW.
6. 3 respondent mothers reported that slum children did not get adequate food, proper education, etc. 9 respondent mothers out of 15 said that Government had started the programme in their area because poor people lived there. This revealed that most of the respondent mothers more or less knew about the reasons for starting the programme in their area.
7. Most of the respondents knew about the services provided to their children from the centres. Out of 15 respondents 13 reported that they knew all about the services as they visited the centres frequently and attended the Mothers' Day meetings. 2 respondent fathers did not know anything about the services provided at AWCs, they knew only that their children were provided food at the centre. Only one respondent stated that their family members played a vital role to find out an appropriate place to start the centre in their locality.
8. Out of 15 respondents 9 mentioned that the AWW visited their homes once or twice every three months, while 4 respondents reported that AWW visited their homes every month, and 2 respondents were not happy with the AWW because they did not have any fixed time and they were not delivering services satisfactorily.
9. It was found that 10 respondents (66%) would send vegetables, whatever were available, or they would hand it over to the AWW directly. They would provide whatever their capacity permitted.
10. Out of 15 respondents 13 were involved in and participate in Jeevandeep programme, a programme meant to promote the savings habit among the mothers of beneficiary children. They were contributing regularly, and only 3 respondents were not associated with this programme, and their names were not entered in the list also. Most of them had no idea about how many families were associated or involved with this programme.
11. Respondents mentioned that they were not aware about the facilities pregnant women could avail from the centre. They said if the AWW could visit them more often, at least twice/ thrice in a week, they (community) would develop more interest, and if AWWs help them in solving not only child care problems, but also other problems which they are facing daily, more people would get involved in this programme.

12. The non-beneficiary respondent mentioned that there was no relation, linkage or co-ordination between the local clubs, youth organization and Mahila Mandal with the AWC, which is a vital weakness and should be overcome to strengthen the process of community participation.
13. It was found that out of 10 non-beneficiary respondents, 9 had not played any important role for the betterment of the AWC, only one father (respondent) had helped in searching for space for the AWC. This showed that AWWs have no links with people who were not getting benefits from their centre.
14. Out of 10 non-beneficiary respondents, 3 mentioned that the behaviour of AWW was not good, they favoured healthy, good looking and well dressed children. 2 respondents mentioned that the quality of food served caused stomach trouble in children, therefore they were not sending their children to the AWC.
15. Respondents knew about the services provided by the centre, but they did not have much linkage with the centre, and their organization (other clubs, youth organizations, Mahila Mandals, etc.) were not playing any supportive role for the AWC. They did not know about services provided to mothers, but they saw mothers gathering at the centre.
16. Beneficiary respondents urged that uniforms should be provided to beneficiary children, as was done in schools; and non-beneficiaries mentioned that AWWs should contact them also while visiting beneficiaries, there should be a programme for them also, and more effort should be put in on motivational work for the residents of that area.
17. There was no adequate study material in the anganwadi centre.

Recommendations

1. There is need to have a short duration preparation phase to raise awareness of the community regarding ICDS services, and the benefits that the community could derive from the programme before launching the scheme in that area.
2. The ICDS package should be made flexible to meet needs of the community.
3. Self help should be encouraged as per the capability status of the community.
4. The training of project functionaries should be strengthened to impart them specific skills to elicit community participation.
5. Provision of incentive/ award should be made for better functioning of centres which would help raise the interest of the functionaries.
6. Considering the opinion of beneficiaries, non-beneficiary respondents and functionaries asking for uniforms, the authorities should provide uniforms to the beneficiary children.
7. The authorities should supply good quality food grains and adequate medicines for the community and may ask for a small contribution from them.
8. The functionaries should not have any bias or partiality towards any child, and the Supervisor should look into the matter whether AWWs are carrying out their responsibilities effectively or not.

A Study on Community Participation in Integrated Child Development Scheme (ICDS) in Chennai

T. Sampath

Introduction

The Government and its officers concentrated on nutritional and health status of mothers and children and implemented the ICDS programme as a Government programme rather than making the community feel that it is their programme, and till now there is no exclusive study on community participation (CP) in ICDS programme at national, state, district or block level. This study was conducted to evaluate the status of CP and obstacles to community participation, and offer suggestions to enhance community participation in ICDS programme.

Aims and Objectives

The study aimed to:

1. Assess personal details about the AWWs.
2. Assess the knowledge about ICDS among ICDS staff and community.
3. Assess the knowledge about community participation in ICDS among ICDS staff and community.
4. Assess the status of community participation in ICDS.
5. Identify the obstacles that hinder community participation in ICDS.
6. Recommend strategies to enhance community participation in ICDS.

Methodology

This study was conducted in Chennai. A total of 180 respondents including 40 anganwadi workers (AWWs), 26 anganwadi helpers (AWHs), 36 mothers, 24 members of self help groups (SHGs) and 26 AGs were selected for the study. Data was gathered through focus group discussions, interviews and questionnaires. Secondary data was collected from published books, daily newspapers, internet, magazines, unpublished research reports, and minutes of conference meetings and workshops on early childhood care and development (ECCD).

Findings and Conclusions

1. It was found that ICDS staff had inadequate knowledge about the basic concept of community participation, and the community also lacked knowledge on community participation.
2. Only 16% mothers and 2% members of self help groups participated to the extent of 80-100% in the ICDS programme.

3. About 26% mothers, 16% SHGs members, 14% youth, 36% AGs and 10% councillors participated in the range of 20-40% in the ICDS programme.
4. Nearly 30% of the community helped in the range of 40-60% in the day to day activities and functioning of ICDS centres.
5. About 22% of the community participated in the range of 40-60% in the form of material contribution.
6. Nearly 34% of the community participated in the range of 40-60% in special programmes of ICDS, and 24% of the community participated in the range of 40-60% in monitoring ICDS centres and their functioning.
7. It was found that mothers were contributing mats, plastic chairs, plastic pots and old toys for ICDS children. Self help group members were contributing plastic baby chairs, vessels, fans and gas stove. Councillors were contributing wall paintings, plates and tumblers, and other materials were contributed by Lions Club, Rotary Club, banks and people with humanitarian concern.
8. Around 48% respondents were satisfied with the level of community participation.
9. It was gathered that 60% AWWs were satisfied; 20% had low satisfaction; 10% had very low satisfaction; 6% were very highly satisfied; and 4% respondents were highly satisfied with their job performance.
10. It was found that the majority of ICDS buildings were in poor condition, without basic facilities. They were not located within community areas and mothers had difficulty in sending and bringing back their children from ICDS centres.
11. Parents were interested in sending their children to private crèches and schools because they thought that 'private' meant quality, and it was also a status symbol.
12. The level of job satisfaction was very poor among AWWs due to their heavy work load and poor monetary benefits.
13. Sometimes the quality of supplementary nutrition supplied was poor, which led to a poor image and developed a negative attitude among mothers towards ICDS and its services.
14. AWWs were maintaining 20-26 or a greater number of registers. In some centres they had clubbed the contents and maintained a single register.
15. There was lack of co-ordination and co-operation between government departments while implementing the ICDS programme in Chennai city.
16. In a few places the Corporation was running pre-primary schools, and it created confusion among the community about where they could send their children. They were sending their children to ICDS centres due to rapport with the ICDS functionaries and services provided by AWWs and AWHs. Sometimes there was unnecessary internal conflict between anganwadi workers and Corporation teacher, and this created confusion among the community members, and also hindered their participation.

Recommendations

1. The State Government should motivate and give guidelines to all local body representatives to spend 15% of their area welfare allotment fund for the ICDS programme, to improve infrastructure and maintenance of the centres.
2. The State Government should recognize ICDS as an administrative unit, and give power to its functionaries to issue certificates to preschool children.
3. It should be made an official government procedure to get preschool certificates from ICDS for enrolling the children in first standard at all Government schools and government aided schools.
4. The State Government, Social Welfare Department can issue identity cards to all ICDS staff. This would motivate the staff and avoid unnecessary identity crisis problems among ICDS staff.
5. The State Government should pass a resolution to separate “Dr. MGR Sathu Unavu Scheme” for preschool children and school children. It should be given the name “Dr. MGR Upgraded Preschool or Nursery School ICDS” for all preschools for the benefit of administration, and to enhance community participation.

Enrollment of Children

Enrollment of Children

A Study on Factors Influencing Non-Enrollment of Children in the ICDS Anganwadi Centres at Chennai Corporation

A. Vinnarasan

Introduction

When eligible children are not enrolled under ICDS, they are deprived of services which are their due right. Several evaluation studies have been done earlier to study the functioning, placement, impact and effectiveness of the ICDS programme, but there have been few or no studies which analysed the factors for non-enrollment of children in the ICDS Anganwadi centres. This study was conducted to evaluate the factors influencing non-enrollment of children in AWCs functioning under Chennai Corporation.

Aims and Objectives

The study aimed to:

1. Assess the profile of non-enrolled children and their families.
2. Assess the knowledge and awareness level among the community about the ICDS programme.
3. Assess the various factors that influence the non-enrollment of children.
4. Assess the satisfaction level of non-ICDS child care services.
5. Recommend strategies for better enrollment in ICDS.

Methodology

This study was carried out in the eleventh project of ICDS, which consists of 88 AWCs situated in Adyar, Besant Nagar, Mandaiveli, Santhome, Kotturpuram and Pattinapakkam. A total of 150 non-enrolled children aged 2 1/2 years to 5 years residing in ICDS area were selected for the study and information was gathered from their mothers. Primary data (both quantitative and qualitative) was obtained directly from the respondents. Secondary data was gathered by using different sources such as books, journals, reports and Internet.

Findings and Conclusions

1. It was found that 40% respondents were not availing any kind of child care services (formal institutional services) and they were simply staying at home.
2. Among the participants who were availing non-ICDS child care services, 84.4% were receiving services from private players.

3. More than 75% of the respondents (76.7%) had chosen English as their medium of instruction for ECE (Early Childhood Education).
4. Security of the child was the main concern for parents, hence 78.9% were attending ECD (Early Childhood Development) services within 1 km from their home.
5. Majority of the respondents (98%) were aware about the existence of ICDS centres in their locality.
6. More than 30% participants (34.7%) perceived the AWC in their habitation as a place that provided preschool education.
7. Nearly half of the respondents (47.3%) believed that the purpose of existence of the AWC was to look after the children.
8. Majority of the respondents were of the opinion that supplementary nutrition was provided in the AWC for the growth (47.3%) and nutritional development (32.7%) of children. Respondents were quite aware of the provision of supplementary nutrition, but not aware of the special care given to malnourished children under the supplementary nutrition programme (SNP).
9. On an average 40% of the respondents mentioned that they were not fully aware that ECE contributes to the child's holistic development.
10. Respondents felt that the significance of preschool education was to learn the basics (41.3%) and for school preparedness (36%).
11. Nearly one-third respondents (31.33%) agreed that there had been some kind of learning or play activity taking place in AWCs.
12. About 77.3% respondents were approached by either anganwadi worker or helper for enrollment in the ICDS centre.
13. Only 34% respondents agreed that AWW had visited their house for some type of counselling or advice.
14. It was found that only 17.3% respondents had made any attempt to enroll in ICDS.
15. There were multiple factors influencing parents for non-enrollment of their children. Except 11.3% of the respondents, the others were not convinced that ICDS had been offering good quality services to the beneficiaries.
16. 95.3% respondents felt that good infrastructure was very much needed to stimulate a child's learning in a better way. Only 8.7% respondents said that AWCs were well equipped with physical infrastructure. Many respondents (29.3%) said that poor physical infrastructure was the reason for their child's non-enrollment in the AWC.
17. Every second respondent (50.7%) mentioned that AWC in their habitation was not a friendly place.
18. 100% respondents mentioned that providing preschool education in the mother tongue was good for the child, but an overwhelming majority (91.3%) felt that teaching in English was also mandatory for the child's future.

19. More than 1/3 respondents (34%) felt pride in sending their child to English medium preschools. More than half the respondents (60%) had attributed medium of instruction in Tamil in the AWC as the reason for their child's non-enrollment in ICDS centres.
20. About 25.3% respondents mentioned that the AWW's attitude was also the reason for not sending their children to the AWC.
21. Nearly 22.7% respondents felt that community participation in children's enrollment was high in their habitation.

Recommendations

1. Respondents suggested that child friendly environment (30.7%), adequate space with proper ventilation (26%), separate space for children and kitchen (17.3%), maintenance of hygienic centre (16.7%), and the provision of safe drinking water and hygienic toilet facility (9.3%) could improve the physical infrastructure of the AWC.
2. AWWs should build good rapport with the people (23.3%), she should visit people's houses (18%), involve the community in service delivery (44%) and adopt some other measures to improve community participation.
3. 49.3% respondents suggested that regular functioning of preschool activity would increase the enrollment of children in the AWC.
4. Government should emphasize on and strongly enforce the convergence of services to children through different departments.
5. Adequate funds should be allotted for the capacity building of AWWs. Training for the staff should emphasize the value of their work, impart skills to mobilize community support, and also sensitize them about the Right to Participation of Children in the AWCs.
6. The appointment of an additional AWW in each AWC was recommended to strengthen "community based intervention" for children below 3 years and to carry out administrative responsibilities.
7. CDPOs should motivate and encourage AWWs through individual counselling and words of appreciation.

Evaluation of ICDS

Evaluation of ICDS

Child Welfare and Community Participation: A Case Study of the ICDS Programme in Trivandrum District, Kerala

Ameya Balsekar, Ashish Thomas George, Chloe Puett and Preeti Dhingra

Introduction

UNICEF enlisted a corps of international interns to examine the performance of programmes it sponsors across India and to develop case studies around central development themes. This is a short evaluation action study of the ICDS programme in two blocks in Thiruvananthapuram district of Kerala.

Aims and Objectives

The study aimed to:

1. Assess the relevance of ICDS in Kerala today.
2. Take a closer look at the State Government and Local Government's successful official track record regarding underweight children in Kerala through implementation of the ICDS programme.

Methodology

Five AWCs were selected from each block, based on the grades given to them by the ICDS office. Four of the AWCs were selected from Perumkadavila panchayat, one was from Amboori, a tribal panchayat, and five AWCs of Kazhakuttom block were from Mangalapuram panchayat. Total population was 41,788, out of which total child population 0-3 years was 2368, children aged 3-6 years were 2265, total pregnant women numbered 181, total lactating women were 271, and total number of adolescent girls 10-19 years of age were 3000 in the area. Data was collected from monthly progress reports of AWCs and consolidated at the block/ CDPO project office level. Secondary data gathered from the AWCs was supplemented by field observations in order to ascertain the relevance of the ICDS grading system to the health outcomes of the children attending each AWC. To monitor and assess the functioning of AWCs, the ICDS Department of Government of Kerala designed a grading system. The maximum marks that could be obtained by any AWC were 100. The highest marks were given to the availability of infrastructure (15), preschool education (15), supplementary feeding programme (10), growth monitoring (10), people's involvement (10), coverage of beneficiaries (5), maintenance of registers (5), health activities (5), adolescent programme (5), women's empowerment (5), convergence with other departments (5), IEC and innovative activities (5), and motivation of AWWs/ Helpers (5). Grades accorded, namely A, B, C, D and E, depended on the marks awarded to

the AWC. Grade A ranged from 75-100, Grade B was 50-74, Grade C was 35-49, Grade D 20-34, and Grade E was below 19.

Findings and Conclusions

1. It was found that the percentage of children in the normal category in terms of current weight showed wide variation across the different AWCs. 62% of the weighed children in Perumkadavila project fell under the normal weight category. The percentage of those in normal category varied from 68% in case of Grade A AWCs to 53% in case of B Grade AWCs.
2. The Chakaparra AWC had nutritional status of children assessed in terms of child weight, comparable with and in some cases, better than that of children of the Perumkadavila panchayat. This was the only AWC among those studied that had a near 100% coverage of child population in the 3-6 years age group (pre-school children). This AWC, located in one of the most remote areas of an ICDS project, could function successfully and obtain satisfactory health outcomes for children in the area.
3. In Kazhakuttom ICDS project 78% of the children were in normal category in terms of current weight status, which varied from 56% in the case of Grade C AWCs to 93% for Grade D. Comparing the weights of children at the time of enrollment and current weights, Grade D AWCs had shown remarkable improvement. The Grade A AWCs showed no change in terms of percentage of children in normal, Grade 1 and Grade 2, when comparing the current weight and weight of children at the time of enrollment to anganwadi pre-schools. In terms of weight at enrollment and current weight, Grade D had shown the best nutritional status and progress.
4. It was found that better performance was recorded by Grade B and Grade C AWCs. In almost all AWCs children had 100% immunization coverage. Children in Grade D AWCs had better nutritional status among the target group.
5. It was found that in Grade A Mangalapuram panchayat, 82.1% children coming to the AWC belonged to Above Poverty Line (APL) families. However the trend is that children stay in the AWC only till the age of four and then go to private schools because of English education and their families can afford it. Similar facts can be stated for Grade B AWC of Perumkadavila project.
6. It was found that Grade A AWC of Amboori panchayat, which is a tribal area, had 96.7% enrollment of children from Below Poverty Line (BPL) families. This was completely a BPL area and was also highly inaccessible because of which there were no private schools.
7. In Grade C AWC at Perumkadavila, community participation in terms of contribution of funds by the local people was low because the area mainly comprised BPL families. Only 29.4% of the BPL children were coming to the AWC, and a large proportion was going to private nurseries. But for immunization and other health related activities, they were brought to the AWC.
8. It was found that Grade A AWC at Mangalapuram panchayat was a good case of high community participation. Being a part of the World Bank (WB) assisted ICDS project, it had excellent infrastructure. In this project, land was bought by the community and the centre was then able to get WB funds for the building. There was 46.6% enrollment of eligible children for PSE and 82.1% children coming to the AWC belonged to Above Poverty Line (APL) families.

9. It was found that in Grade B AWC of Perumkadavila the Welfare Committee actively contributed when funds, in excess of the amount allotted, were required. In the case of Grade E Mangalapuram panchayat AWC, the community comprised mainly of uneducated migrants, and AWW mentioned that community people had no interest in the activities of their children, and they were only interested in food. This AWC functioned in a rented building and had still not been able to get land for its own building.
10. In Grade D AWC at Kazhakuttom, caste affected the functioning of the AWC. The AWW belonged to the scheduled caste and forward caste parents hesitated to send their children to the AWC. Most families could afford to send their children to private schools and neither group took interest in the working of the centre.
11. In Grade C AWC at Mangalapuram, beneficiaries mentioned about the inefficiency of the anganwadi worker. In fact, the Supervisor reprimanded her and pointed out her mistakes. This took its toll on the PSE enrollment, which was merely 16% of the total children in the area in the 3-6 years age group, and had only 26.8% of the BPL children. Supervisor had been not able to cover this area in the past three months. Teacher was not self motivated and needed control from Supervisors. Thus ICDS has still not reached the stage where complete devolution of authority to manage the affairs of the AWC can be given to the AWW.
12. The CDPO at Perumkadavila mentioned that besides the Supervisor, sometimes the initiatives of CDPO can also make a difference for the overall growth of the programme. In this project CDPO took the initiative to boost participation by organizing enrollment drives and giving away sweets at such functions to attract more and more people. The enrollment drive was also organized with a view to counter the threat from private nurseries, which offered many such concessions as a marketing strategy to increase their enrollment. He had also started a scholarship programme for the education of poor and disadvantaged children.

Recommendations

1. Active community participation from the panchayat and the local community supervisor and support from the CDPO, improves the efficiency of the AWC, and coordination among them becomes a crucial determinant in making an AWC a pro-active institution.
2. By making the programme more responsive to the needs and demands of parents, particularly teaching English language, the enrollment of larger sections of the community can be ensured for pre-school education.
3. By extending the SNP to cover all pregnant and nursing women and all 0-3 year olds, the problem of low birth weights and persistent under nourishment in the high-risk 0-3 years age group could be better addressed.
4. By specifically targeting poorer, marginal and vulnerable groups, the programme will be able to benefit those people who need its services the most.
5. Child nutritional indicators should be included as a criteria in the AWCs grading system, and ICDS needs to have the potential not only to improve health outcomes, but also to equip children with the necessary capabilities to help secure their future.

Concurrent Evaluation of Integrated Child Development Services: National Report (Volume - I)

Devender B. Gupta and Anil Gumber

Introduction

India's first nation wide evaluation of ICDS was conducted by NIPCCD in 1990-92. The Ministry of Women and Child Development entrusted the National Council of Applied Economic Research (NCAER) to carry out a nation wide evaluation of ICDS projects. This study was conducted to help the Government in initiating corrective measures to make the programme more effective.

Aims and Objectives

The study aimed to:

1. Assess the performance of the ICDS scheme on the ground.
2. Assess the capabilities of the functionaries to meet the objectives of the programme.
3. Recommend policy measures for its further improvement.

Methodology

This study covered almost 90% of the country's population in all the States and Union Territories. It covered not only households but also Child Development Project Officers, Supervisors, AWWs and Community Leaders. Nearly 4000 projects, 60,000 AWCs, 4000 Mukhya Sevikas and 1.80 lakhs beneficiary households with children in the age group of 0-1 year, 1-3 years and 3-6 years were selected. Data was collected through field survey.

Findings and Conclusions

1. Most of the AWCs across the country were located within an accessible distance from beneficiary households. A majority of the beneficiary households were within 100 metres of the AWC. Another 10% were about 150 to 200 metres away, and the rest were beyond 200 metres. The factor of distance affected attendance at the AWC during inclement weather.
2. Most of the AWCs in Tamil Nadu, Kerala, Karnataka and Orissa were functioning from community buildings. About 40% were functioning from 'pucca' (permanent) buildings. Nearly 50% AWCs reported adequate space, especially for cooking. Toilet facilities were available in only 17% AWCs across the country.
3. Most of the functionaries were residing within the village, giving them adequate time for dispensing services and for building rapport with the community.
4. One out of two AWWs was found to be educated at least up to matriculate level across the country. In all central and southern states, less than 50% of the AWWs were matriculate. More

- than 75% AWWs were matriculates in the northern and eastern region of the country. Gujarat and Rajasthan had the lowest percentage of matriculate functionaries.
5. About 84% of the functionaries had received training, and the training was mainly pre-service training. In-service training remained largely neglected.
 6. On an average, an AWC functioned for 24 out of 30 days in a month for about 4 hours each day. Environmental factors did not affect the functioning of the AWC.
 7. It was found that in a majority of the states the weight register, health and referral register received less attention. Orissa, Arunachal Pradesh and Punjab scored over the other states in record maintenance, but performance of Sikkim was poor.
 8. It was found that co-ordination between various departments at the micro level had been weak. The main problem appeared to be lack of interest of the supervisory staff. Very few AWWs and community leaders expressed their willingness to work under panchayats.
 9. On an average, nearly 66% of the eligible children and 75% of the eligible women were registered at AWCs.
 10. In India, severe malnutrition (Grade III and Grade IV) was 1.3% among children aged 6-12 months, 3.6% among children aged 13-36 months, and 1.4 % among children aged 37-72 months. Bihar had the highest number of severely malnourished children. In Bihar, severe malnourishment among children 13-36 months was 28%, in 6-12 months age group severe malnutrition among children was 6%, and in 37-72 months aged group severe malnutrition was 5%. Most states indicated low levels of severe malnourishment. About 11.3% of the children were moderately malnourished. Children in the age group 37-72 months reported relatively higher incidence of moderate malnourishment. Except a few states, incidence of moderately malnourished children was evenly spread.
 11. The ICDS package of services combines early childhood services in the areas of nutrition, health and education. Though the importance of supplementary nutrition (SN) and pre-school education (PSE) had been widely recognized, inadequate availability of inventories, supply of poor quality food items and inadequate space were major obstacles in the smooth delivery of services.
 12. It was found that more than 80% children were immunized against all major diseases. In most states more than 90% of the women mentioned that they had received Tetanus Toxoid vaccination. The referral system was found to be quite weak in many states.
 13. Most of the AWWs and community leaders were not in favour of functioning under the panchayats, either due to their lack of interest or inadequate knowledge and awareness of the importance of women and child development. Both community and panchayats provided space and other infrastructural support to AWCs, and helped in identifying beneficiaries for the programme. A high percentage of beneficiary mothers provided support to AWCs but this was restricted to immunization and SNP. Community participation was mainly from mothers and family members of beneficiary children who derived benefits from the programme.

14. More than 80% community leaders were generally positive about the functioning of the AWCs, while more than 70% found the programme to be beneficial to the community.
15. The participation of beneficiary women and adolescent girls in AWC activities was very low.
16. A majority of the households reported that they needed SN, PSE, immunization and NHE services provided under ICDS and were satisfied with the delivery of these components.
17. Of the 26 states in the country, Mizoram, Meghalaya, Orissa, Gujarat and Goa were among the top 5 states. Adequate infrastructure and inventories, better profile of functionaries and well functioning AWCs were responsible for their better performance. Arunachal Pradesh, Bihar, Jammu and Kashmir, Nagaland and Uttar Pradesh were ranked low due to inadequate infrastructure facilities and poor functioning of the AWCs. The performance of the states was more or less comparable with the performance rated by the beneficiary households. There was lack of one to one correspondence between the overall performance and the household perception of the benefits received from the programme in Arunachal Pradesh, Assam, Goa, Gujarat, Himachal Pradesh, Punjab, Tamil Nadu and Uttar Pradesh.

Recommendations

1. Training given to functionaries should focus more on reaching mothers and children below 36 months, not only for maintaining growth charts (GC) but also for hands-on training for understanding the complications involved in growth monitoring. Special skills and training are also required to identify children having disability.
2. There is need for strengthening both inter and intra departmental coordination for smooth delivery of the programme. CDPOs, Supervisors, Medical Officers (MOs) and other officials can play a major role in improving ICDS services.
3. Adequate attention needs to be directed towards proper building and housing of AWCs for their smooth functioning, especially in states/ districts where the situation is bad.
4. Only 17% of the AWCs had toilet facilities. Adequate measures should be taken to ensure provision of toilet facilities at all AWCs.
5. There is need to have a regular update on the developments in the area of women and children so that appropriate and timely interventions can be devised.
6. To implement ICDS services effectively, certain issues and problems need to be understood which occur in people's interpersonal relationships and pose social, psychological and cultural obstacles.
7. There is need to build in flexibility in the delivery of the package of services, which should be based on local socio-economic and cultural needs of the population.
8. This survey has identified lacunae in the programme and also the data gaps for making a complete evaluation. It is suggested that the second phase of the study should cover all regions in phases to understand the delivery of the programme.

Consultancy for “Continuous Social Assessment” (CSA)

World Bank

Introduction

To improve service quality at project level, concurrent social assessment (CSA) forms an important part of the quality improvement efforts under ICDS III Project. ICDS aims to ensure that socially disadvantaged groups, i.e. poor women and children, tribal people, landless families, etc. get benefits from the Project, particularly in terms of nutrition, health, preschool education, etc. As a part of the ICDS III Project in Maharashtra, a concurrent social assessment was carried out to ascertain needs, problems, potential and preferences of different groups in the Project.

Aims and Objectives

The study aimed to:

1. Understand the community’s perception of anganwadi centres (AWCs), whether they are seen as a Government programmes/ institution or a programme required to be supported by the community.
2. Assess awareness of the community about the morbidity condition in the area by which children, mothers and adolescent girls are generally afflicted, action taken in such cases, sources of treatment and referrals.
3. Assess the role of ‘Mahila Mandals’ (women’s groups) or SHGs in augmenting the activities of AWCs.
4. Assess the perceived importance and efficacy of pre-school activities being organized at AWCs, extent of compliance, and whether attendance in AWCs translates into higher admissions and attendance in primary schools.
5. Assess the impact of health activities and community perception with regard to adolescent girls, child marriages, etc.
6. Understand the role of Gram Panchayats in maintenance and functioning of anganwadi centres.
7. Assess child rearing and care practices, whether there is any impact of the programme on breastfeeding and colostrum intake.
8. Assess the perception of the anganwadi worker and her cultural barriers that impinge on bringing behavioural change among the target groups.

Methodology

The study was conducted in 10 project areas of Maharashtra, namely Thane, Nandurbar, Gadchiroli, Amravati, Kolhapur, Jalna, Mumbai, Nagpur and Pune. In Mumbai, almost 86% of the targeted pregnant women were registered within 4 months of pregnancy. About 12% of the adolescent girls were interviewed, highest in Amravati (40%), and 25-30% in Nandurbar. Almost 60% of the eligible pregnant and lactating women were covered who were receiving supplementary food regularly. Data was collected through rapid assessment survey and observation of the selected AWCs. Information was obtained from ANMs, AWWs, CDPOs and beneficiaries.

150 households were visited in each of the 10 project areas, and the average household size was 6 persons.

Findings and Conclusions

Health

1. Women across the 10 project districts generally suffered from gynaecological problems along with some other illnesses. According to ANMs, AWWs and CDPOs, diarrhoea and anaemia were the most common illnesses among women.
2. The health status of pregnant women appeared to be better in urban areas as compared to rural and tribal areas. Health status of pregnant women was better in urban centres of Mumbai and Nagpur as well as in rural centres of Kolhapur and Pune (Mawal).
3. Most private practitioners knew that children were beneficiaries at AWCs, but only two of them could tell the age group, i.e. 0-6 years old. Only one knew that pregnant and nursing mothers could avail services at the AWCs. Private practitioners in Mumbai had no awareness regarding beneficiaries of the ICDS programme.
4. In Pune urban ICDS projects, AWWs mentioned that the health status of adolescent girls improved due to IFA tablets. Pregnant women faced problems earlier during delivery, but after the provision of supplementary food, their health status had improved.
5. Due to superstitions, sick children were not taken to a clinic, but were given treatment by traditional healers, or delayed treatment in Amravati, which were some of the causes contributing to malnutrition.
6. It was found that local health functionaries in tribal areas helped to improve the health of pregnant and lactating mothers.
7. In Nagpur, AWWs mentioned that the 'anganwadis' were not involved in any of the preventive vaccination camps. They did convey the knowledge about vaccinations that should be given to children through home visits. One AWW mentioned that percentage of beneficiaries undergoing immunization had increased to 100% due to identification of beneficiaries through home visits and surveys. In Pune also 100% immunization has been achieved due to the conscious efforts of AWWs, ANMs and beneficiaries who come on their own for immunization.

Nutrition

1. The district level Government officials mentioned that pregnant women were suffering from both malnutrition and anaemia. In tribal areas, especially Gadchiroli and Nandurbar, health status of women was mentioned to be deteriorating due to strenuous labour and lack of nutrition.
2. ANMs and AWWs in Kolhapur district mentioned that supplementary nutrition and protovita was provided to mothers and children respectively. Nutritious recipes like curry, *halwa*, *shakarpara* and *ladoos* were taught to mothers and adolescent girls. In Amravati, meals were provided 4 times a day. Quantity of meals was doubled for children with Grade IV malnutrition.
3. Lack of adequate and nutritious food was the main reason for malnutrition across all the districts. In Jalna, Nagpur, Amravati, Nandurbar and Gadchiroli, poverty was the main cause of malnutrition.
4. Effectiveness of the nutrition service was not very evident because children and mothers took their food home along with them. There was no space to sit and eat in AWCs so it was not possible to monitor whether the food was consumed or not. They mentioned that IFA consumption was negligible hence prevalence of malnutrition was high and newborns had low birth weight.
5. Almost 60% of the eligible pregnant and lactating women mentioned that they received supplementary food regularly, and the highest percentage (96%) was in Amravati. A negligible percentage reported receiving supplementary food in Nagpur and Pune centres. None of the women in Mumbai received supplementary food from AWCs.

Adolescent Girls

1. ANMs mentioned that adolescent girls suffered from anaemia and T.B. in Nagpur. In Kolhapur and Pune urban adolescent girls were suffering from malnutrition due to negligence in taking nutritional supplements like prescribed vitamins.
2. It was found that early age at marriage and frequent pregnancies among the tribal population were the most commonly mentioned reasons for malnutrition.
3. Only 12% adolescent girls were covered under the awareness programme and almost all had heard about AWCs. Majority of the girls were more aware of services offered to children like supplementary nutrition, preschool education, and immunization to children. They were not very aware about services for adolescent girls.

Community Involvement

1. Almost all local and district level functionaries knew that children (0-6 years), and pregnant and lactating mothers were the beneficiaries in AWCs across the ten districts. Malnourished children were given special attention in most places.
2. In Nandurbar, AWW mentioned that children missed school because they had to take care of their younger siblings at home. In Nagpur, people could afford to send their children to formal schools, therefore the need or importance of AWCs became less.

3. In Thane, help was extended by SHGs to monitor children's attendance and find out the reasons for absenteeism. The savings group in Jalna worked towards creating awareness about saving in the village.

Women Beneficiaries

1. In almost all centres, AWWs regularly visited pregnant women, particularly those who were nearing delivery. Health education for antenatal mothers included counselling on regular medical check up, immunization caution during pregnancy, and advice on place of delivery.
2. In Pune (Mawal), Deputy CEO mentioned that only 40-50% pregnant and lactating mothers were availing the nutrition facility. People's understanding of free food as not being good to eat was the reason for this.

Pre-School Education

1. In Mumbai, AWWs mentioned that the muslim community did not send their children to pre-schools. An NGO in Pune (Mawal) informed that there were certain attitudinal barriers due to social practices that came into play while sending children to school, and pregnant and lactating mothers to AWCs for supplementary nutrition. There was very low attendance in these places. It was believed that only those who wanted 'free food' went to AWCs.

Recommendations

1. The main factor responsible for maximum health problems among mothers and children was early marriage. ICDS needs to work in this area along with the education sector to inform people about the ill effects of early marriage.
2. There is need for active participation of community members. Community should come forth to organize appropriate seating facilities for women and children.
3. There is need to orient and sensitize private practitioners towards the ICDS programme and make them more accessible to rural and tribal populations.
4. During any illness, or while dealing with malnutrition, mainstream doctors should also be regarded as a resource that can be tapped.
5. Benefits of preschool education should be conveyed clearly to parents. Accolades should be given to children and a social/ financial one-time benefit to families for regular attendance and good performance in preschool. Girls should be encouraged to attend preschool education.
6. Regular growth monitoring should be done to detect malnutrition at an early stage.
7. AWWs should keep a watch on the women who do not approach any source for regular check-ups and guide them accordingly, specially during pregnancy.
8. Remuneration of AWWs should be improved, which may result in better motivational levels.
9. AWWs should build personal rapport with community members. Parents should be informed about children's weight and the grade of malnutrition, if any.
10. There is need for better training of AWWs. ICDS functionaries should come across as knowledgeable workers, with high confidence levels and efficiency to handle local issues and problems.

Evaluation of Integrated Child Development Services (ICDS)

Volume A: Haryana

SEEDS

Introduction

In various research reports it was felt that evaluation of ICDS programme should be carried out to assess its benefit to the community in general and beneficiaries specifically. It has been reported that impact on beneficiaries, selection of beneficiaries to cover all the needy ones, and its delivery mechanism need to be assessed against the set objectives of the ICDS programme. In this regard, Socio-Economic and Educational Development Society (SEEDS) evaluated the implementation of the ICDS programme in Haryana.

Aims and Objectives

The study aimed to:

1. Evaluate implementation of the ICDS programme with a focus on the delivery aspect of the programme.
2. Assess effectiveness of the existing supplementary nutrition (SN) supply chain.
3. Evaluate the impact of ICDS on beneficiaries, specifically against the set objectives.
4. Carry out a SWOT analysis of the scheme and recommend suitable strategies.
5. Assess the level of participation of various village level institutions.

Methodology

This study was conducted in Haryana. Two blocks from each of the four districts were selected, namely Ambala, Fatehabad, Rohtak and Gurgaon. 32 AWCs were covered and a total of 725 beneficiaries were sampled, in which 131 lactating mothers, 127 expectant mothers, 65 children 0-6 months, 241 children 6 months to 3 years, 161 children 3-6 years, and 131 others were covered. Data was collected through field survey, and qualitative data was gathered from secondary sources.

Findings and Conclusions

1. It was found that the number of beneficiaries per household was slightly higher in Ambala and Fatehabad districts than in Gurgaon and Rohtak. 64.4% were children up to 6 years of age while the remaining 35.6% were lactating and pregnant women. There were no adolescent girl beneficiaries in the sampled districts.
2. SN was the major benefit received by beneficiaries from AWCs.

3. It was revealed that 83% of the families were getting SN. 77% of them mentioned that SN supplied was good, 11% felt it was satisfactory and 7% said the quality was poor. In Gurgaon district the maximum number of respondents felt that the quality of SN was poor. They felt that the quality was good when they used to get biscuits but presently the quality of items got affected while it was in storage.
4. 43% respondents mentioned that AWWs made home visits thrice a week, followed by 24% who mentioned once a week, 30% once in a month and 4% said AWW never made home visits.
5. It was found that in Haryana the awareness level for immunization was not very high. 25% of the population mentioned that the AWW made home visits for immunization. Maximum number of people knew about immunization programme in Fatehabad, and very few knew about it in Gurgaon district. Majority of the beneficiaries mentioned that AWW helped in the immunization programme by informing them about it from time to time. It was revealed that all the children below 6 years of age had been immunized against BCG, measles and polio.
6. 15% respondents mentioned that health check-up camps were organized once a week. In Ambala district, maximum number of villages had health check-up camps. 17.63% respondents depended on traditional *dais* (birth attendants) and quacks for ante-natal check-up, 58.67% sought ante-natal check-up from ANM and 13.87% went to nearby Health Centres/ Sub-Centres. 93.63% beneficiaries went for child delivery to the ANMs or trained *dais*, but 2.31% still depended on traditional *dais* and a few on elderly women in the locality.
7. 34.4% respondents mentioned about the role of AWWs in supplying medicines for minor ailments. 36.8% respondents recognized the AWW's role in providing medicines during pregnancy.
8. It was found that the majority of expectant mothers in ICDS areas received regular health check-up during pregnancy and most of them were referred to PHCs/ hospitals by ANM/ AWW. Various stakeholders mentioned that due to lack of budgetary provision and motivation, AWWs felt handicapped in providing referral services on regular basis.
9. Majority of the mothers mentioned that most of children stayed in the AWC for the full duration and participated in all activities, but a lower percentage of girl children participated in PSE activities.
10. It was found that due to lack of proper advocacy for the AWW, the villagers did not give much importance to the work of AWW and considered her as a "Nutritious Food Dispenser", and the ANM faced problems in carrying out the immunization programme in the village.
11. Most of the PRI representatives were not contributing towards ICDS. They mentioned lack of awareness about ways and means by which they could contribute to the programme, and AWWs did not approach them for any help.
12. Voluntary organizations were also providing health services by organizing health check-up camps, awareness activities, free distribution of medicines, free referral services, etc. The major

threats to NGOs in Haryana are lack of long term commitment from funding organizations and non-recognition from the State Government.

13. It was found that Mahila Mandals were operational in a few of the AWC areas. In a few villages Mahila Mandals rendered help in the preparation of food, collecting children for immunization, organizing camps, etc.
14. AWWs mentioned some problems in eliciting community participation like lack of time on the part of the beneficiaries and AWWs, and indifferent attitude of the community. However, adolescent girls in the village were being involved in activities of the AWCs like preparation/ distribution of food, pre-school activities, collecting children for immunization, etc.

Recommendations

1. The State Government, with active participation of the private sector or PRIs, should make efforts to upgrade the physical infrastructural facilities of AWCs.
2. Regular supply of food items should be ensured by the State Government so that the disruption in distribution of SN can be minimized.
3. The regular interaction of community representatives with CDPOs/ Supervisors is mandatory to motivate them for effective participation.
4. Regular capacity building programmes should be organized for AWWs, Helpers, and Supervisors with an objective to update them about the latest trends of community mobilization.
5. Efforts should be made to motivate the Supervisors to make regular visits, and proper support like transportation facilities, etc. should be provided to them. The supervision schedule should be prepared in consultation with and agreed upon by the CDPO.
6. There is need to improve the interpersonal relationships between CDPOs, Supervisors and AWWs for effective implementation of the ICDS programme.
7. Various activities like home visits, street plays, door to door visits, etc. should be organized on regular basis with active participation of local NGOs or Mahila Mandals in the village.
8. The State Government should ensure active convergence of Health and ICDS Departments to regularize NHE by holding formal meetings.
9. To improve the PSE component active participation of teachers should be sought, and PTA involvement should be ensured. Every AWC should be provided with appropriate educational aids and material.
10. The Central and State Governments should take appropriate measures to streamline ICDS supplies for smooth implementation of the programme.

Evaluation of Integrated Child Development Services (ICDS): Himachal Pradesh

SEEDS

Introduction

In various research reports it was suggested that evaluation of the ICDS programme should be carried out to assess its benefits to the community and beneficiaries. Its impact on beneficiaries, selection of beneficiaries to cover all the needy, and its delivery mechanism need to be assessed against the set objectives of the ICDS programme. In this regard, Socio-Economic and Educational Development Society (SEEDS) conducted this study to evaluate the implementation of the ICDS programme in Himachal Pradesh.

Aims and Objectives

The study aimed to:

1. Evaluate the implementation of the ICDS programme with a focus on the delivery of services.
2. Assess the effectiveness of the existing supplementary nutrition supply chain.
3. Evaluate the impact on the beneficiaries, specifically against the set objectives of the programme.
4. Do a SWOT analysis of the scheme and recommend suitable strategies to improve the working of the programme.
5. Assess the level of participation of various village level institutions like PRIs in this programme.

Methodology

This study was conducted in 4 districts of Himachal Pradesh namely Kinnaur, Kullu, Solan and Una. 32 AWCs were covered and 59 lactating mothers, 56 expectant mothers, 38 children 0-6 months, 162 children 6 months to 3 years, 141 children 3-6 years who were beneficiaries were selected, thus the total number of beneficiaries was 456. Data was collected through field survey. Qualitative data was gathered mostly from secondary sources.

Findings and Conclusions

1. It was found that children formed the major part of the beneficiaries as children in the age group of 6 months to 3 years constituted 35.53% of the total beneficiaries, followed by children in the age group of 3-6 years (30.92%), and children below 6 months (8.33%). Lactating and expectant mothers were about 25% of the total beneficiaries.

2. It was found that in a majority of the villages (91.44%) the AWWs stayed in the village, 5.85% did not stay in the same village but went to the AWC daily, and in the remaining villages villagers said that the AWW came to the village thrice a week or less often.
3. 68% of the beneficiaries mentioned that the quality of SN was good, and 31% rated it as satisfactory. The quality of SN was rated highest (97%) in Solan district, followed by Una (86%) and Kullu (60%). Only 42% surveyed persons mentioned that quality of SN was good in Kinnaur district.
4. It was found that majority of AWWs were not able to monitor the growth of children. The reasons they mentioned were non-availability of growth charts, non-cooperation of parents, and weighing scales not in working condition.
5. Due to lack of utensils and fuel, there were gaps in supplementary nutrition (SN) services. AWWs mentioned that 55% women (15-45 years) were registered with AWCs under nutrition and health education (NHE), and they were conducting NHE sessions at least once in three months. A large majority of women mentioned that they had been imparted NHE by ICDS staff. The problems faced by AWWs in organizing NHE sessions were lack of time and interest of women, timings unsuitable to women, lack of resources, etc.
6. AWWs faced problems in conducting health check-up such as unwillingness of medical staff to visit AWCs, reluctance of people to come for check-up, lack of awareness, belief in traditional system of medicine, etc.
7. AWWs mentioned that non-achievement of immunization target was due to non-cooperation of health staff, non-cooperation of parents, superstition of parents, etc. Immunizing of expectant mothers against tetanus was found to be moderate due to lack of awareness and unwillingness of mothers to get immunized.
8. It was found that majority of the cases were referred by health staff. Most of the expectant mothers received regular health check-ups during pregnancy, and in case of complication, they were referred to PHCs/ hospitals. Most of the birth attendants were trained *Dais*.
9. Mothers mentioned that a large majority of children stayed in AWCs for the full duration and participated in all activities.
10. AWWs mentioned that it was mainly women, followed by adolescent girls and community leaders who offered help in conducting AWC activities. Contribution was restricted to participation in AWC activities and providing firewood/ fuel, drinking water and site/ building for AWC.
11. It was found that Mahila Mandals were operational in a few of the AWCs. They rendered help in preparation of food, collecting children for immunization, organizing camps, etc.

Recommendations

1. It is imperative that community representatives should be involved right from the preparatory stage of initiating a project. CDPOs and Supervisors should take appropriate initiatives for promoting community participation.

2. Adequate indoor and outdoor space for activities and separate storage space should be made available.
3. For better implementation of the programme, training workshops should be organized frequently for Supervisors, AWWs and Helpers.
4. Supervisors need to provide support and make supervision more supportive in terms of providing guidance to AWWs. All the posts of Supervisors should be filled up. No Supervisor should have more than 20 AWCs under her charge. Double charge and too many AWCs under supervisory control of a Supervisor imposed constraints in performing a supportive role effectively.
5. Participation of ANMs in providing referral services, health check-ups, home visits and NHE sessions needs to be worked out systematically to make them join hands with AWWs in taking care of the health needs of women and children.
6. Regular supply of food items should be ensured by the State Government so that the disruption in distribution of supplementary nutrition can be minimized.
7. There is a need to increase the frequency of visits to AWCs by CDPOs. During their visits to AWCs, CDPOs should not limit themselves to verification of stocks and checking records only, but they should participate in AWC activities.
8. Coverage of expectant mothers and children below three years of age under SN should be improved through exhaustive door to door surveys, and by enhancing awareness of mothers about the role of nutrition in improving health status.
9. There is scope for improving the implementation of PSE component. Efforts should be made to provide a minimum set of appropriate educational aids and material at every AWC.
10. Irregular supply of weighing scales, growth charts, play material, medicine kits, etc. is one of the major problems in implementation of ICDS. The Central and State Government should take appropriate measures to streamline supplies for smoother implementation of the programme.
11. There is an urgent need for improvement in health services. Health check-up and immunization of women and children revealed a poor link of the programme in the State. Categorical instructions to the District/ Project level health functionaries may be issued by the Central or State Government regarding health and immunization services. Joint visits should be undertaken to AWCs by CDPOs with MOs, and joint meetings of ICDS and health functionaries at different levels may be held regularly for better coordination between the two departments to provide better quality health services.

Evaluation of ICDS in Haryana

Chandigarh, Department of Economics and Statistics

Introduction

Integrated Child Development Services (ICDS) was adopted in the state of Haryana to improve the nutritional and health status of children in the age group of 0-6 years and enhance the capabilities of mothers to look after the normal health and nutritional needs of children. Department of Women and Child Development, Government of Haryana had adopted various innovative measures under ICDS. 'Ready to Eat' foods were supplied as supplementary nutrition in Mahendragarh district, which were prepared by women under the Integrated Women's Empowerment and Development Programme (IWEDP). The 'Ankur Manual' was introduced in order to make non-formal pre-school education more interesting and attractive, with supply of aids and equipments in AWCs, and training of ICDS functionaries in DPEP (District Primary Education Programme) districts by Prathmik Shiksha Pariyojana Parishad. Hence Planning Department of the Government of Haryana assigned the task of evaluating the impact of these innovations to the Economics and Statistics Department.

Aims and Objectives

The study aimed to:

1. Assess the impact of supplementary nutrition (SN) in improving the health of children and level/ quality of knowledge among 14-45 years women about health and nutrition of children and women.
2. Assess the role of ICDS regarding enrollment of children in primary schools with special reference to girl child.
3. Assess the retention of children in the 3-6 years age group in AWCs, i.e., at what age they leave the AWC to join primary school.
4. Assess the availability and use of service delivery equipment in AWCs with special reference to 'Ankur Manual'.
5. Evaluate and role played by Coordination Committees at various levels.
6. Assess the community's involvement and its participation in ICDS programme.

Methodology

This study was conducted in 8 districts of Haryana, namely Kaithal, Kurukshetra, Mahendragarh, Rewari, Bhiwani, Hisar, Karnal and Panipat. A total of 48 AWCs and 576 beneficiariers were selected. Data was collected through interviews, and secondary data was gathered from the Director, Women and Child Development Department, Haryana, Programme Officers of selected districts and CDPOs of the concerned blocks.

Findings and Conclusions

1. It was found that there were 2040 sanctioned AWCs in the 16 sampled ICDS projects, and as many as 2038 (99.90%) AWCs were functioning. 46% AWCs were functioning either in rented or privately owned buildings.
2. It was found that the expenditure on ICDS was more than SNP; it was 57% on ICDS and 43% on SNP.
3. It was found that the trend of availing SNP by expectant women/ nursing mothers during the years 1999-2000 to 2001-02 was decreasing against the allotted target. The percentage increase of child beneficiaries in the age group of 3 years – 6 years was more as compared to children in the age group of 6 months to 3 years during the three years 1999-2000 to 2001-02.
4. All AWWs were fully trained while 33 (69%) helpers were not trained. Only 15 (31%) helpers received training from Haryana Government. Refresher courses were attended by 42 (88%) AWWs.
5. Out of 3189 child beneficiaries, only 12 children received double ration while the rest received single ration. Maximum number of malnourished children 10 (77%) were found in Bhiwani district, while there were 2 (15%) in Karnal district (in 1st, 2nd and 3rd month), and 1 (8%) in Kurukshetra district (during 1st month). In Hisar district grading data was not available.
6. A total of 16,324 children were weighed, and it was found that 6583 (40%) children were normal, 6105 (37%) were in Grade I, 3502 (21%) were in Grade II, 127 (1%) were in Grade III besides 7 (0.42%) in Grade IV malnutrition. All children in Grade IV malnutrition were in Rewari district.
7. It was found that only 2% of the total children were weighed. No proper record of SC children was maintained by AWWs for Grades I to IV malnutrition. Out of 134 malnourished children only 37 (28%) children had received double ration.
8. It was found that highest number of women referred to PHCs/ CHCs were in Panipat and Karnal districts in the 2nd and 3rd month, and in these districts more attention needs to be given to the health and nutritional requirements of women.
9. Awareness about AWC facilities was provided through home visits. 1345 pregnant and nursing mothers' health was checked up, out of whom 909 were checked by ANMs, 359 by LHVs and 77 were checked by MOs.
10. Immunization was 82%, 98% and 99% in the case of measles, polio and BCG respectively for children in the age group 0-1 year. But TT immunization of expectant women was only 68% for the 1st dose and 64% for the 2nd dose.
11. It was found that out of 144 expectant women beneficiaries, 127 (88%) women were motivated for medical check up by AWWs, 14 (10%) by ANMs, while 3 (2%) had self knowledge. Around 126 (88%) pregnant women received Folic Acid tablets from AWCs.

12. Majority of the women were taking care of their children's health as 141 (98%) mothers' children were found to be in good health. Out of 144 sampled beneficiaries, 127 (88%) women adopted family planning norms.
13. It was found that SN was distributed on an average for 25 days in a month. Out of 288 child beneficiaries, 179 (62%) children took SN to their homes, and 109 (38%) consumed it in the AWC itself. Around 62% children shared their SN items with their family members.
14. It was found that all child beneficiaries received SN at appropriate time and 251 (87%) children took SN regularly. Out of 288 children, 276 (96%) children's mothers mentioned that SN was of good quality and only 12 mentioned about the inferior quality of SN.
15. It was found that only 29 (10%) children came to AWCs for SN items only, but the remaining 90% children came to AWCs for other reasons like non formal education, health care and to learn other things like cleanliness habits, etc.
16. Out of 288 beneficiaries, 268 (93%) were in favour of the prevailing system of SN.
17. Out of 48 AWCs, in 46 (96%) AWCs there were no complaints about the quality and quantity of SN supplied.
18. It was revealed that 18 Gram Panchayats extended help to AWWs in organizing cultural functions in AWCs to attract public participation. Members of Mahila Mandals also took active part in AWC activities.
19. Out of 48 AWCs, in 42 (88%) AWCs education kits supplied by the Government were found intact. 26 AWWs (54%) mentioned that all children leaving AWCs had joined primary schools, but 22 AWWs had no idea about children who left the AWC. It was also found that some children attend the AWCs even after their discharge in the allurements of getting SN or due to the penury condition of their parents who were unable to get them admitted in regular schools.
20. In 47 (98%) out of 48 AWCs, attendance registers were maintained properly. In all the sampled AWCs BPL beneficiaries were covered. Out of 288 beneficiary children, 283 (98%) accepted that weight record was maintained in AWCs using register/ card system.

Recommendations

1. Ministry of Women and Child Development should construct AWC buildings to ensure 100% coverage of the functioning AWCs.
2. Prescribed posts of health staff such as ANM, LHV, MO in all PHCs/ CHCs should be filled up by Health Department immediately to provide intended benefits of the scheme to beneficiaries.
3. All anganwadi helpers must be trained to get better results from the scheme.
4. Honorarium of both AWWs and Helpers should be increased because the entire functions envisaged under the scheme are being done by them.

5. AWWs and Helpers should make more efforts to achieve the targets of enrollment of children, expectant women and nursing mothers.
6. Inspections by POs and CDPOs should be increased.
7. The record of Special Component Plan for SC beneficiaries should be maintained properly.
8. Meetings of coordination committees should be held as per prescribed norms.
9. Facilities like drinking water, electricity and sanitation should be provided in every AWC.

Focus on Children under Six

Citizen's Initiative for the Rights of Children under Six (CIRCUS)

Introduction

In the Indian context, the safe delivery of a healthy child and the survival of both mother and child in poor families cannot be taken for granted. Survival of the child and mother is an indicator of the level of human development of India. Integrated child development services (ICDS) has lofty goals and is based on fairly sound thinking, however, as is with many other development programmes, there is a wide gap between theory and practice.

Aims and Objectives

This study aimed to:

1. Find out how ICDS is doing on the ground.
2. Assess how Anganwadi Centres (AWCs) were functioning and whether they were really doing what they ought to do for the welfare of rural people.

Methodology

This focus survey was conducted in six states, namely Chhattisgarh, Himachal Pradesh, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. In each state, 3 districts and 12 villages were selected by random sampling, but of the target number of 216 sample villages, only 203 were covered. Data was collected through detailed interviews with anganwadi workers (AWWs) and anganwadi helpers, and a random sample of about 500 women who had at least one child below the age of 6 years.

Findings and Conclusions

Administration and Functioning of ICDS/ AWCs

1. The FOCUS survey found startling contrasts in the effectiveness of ICDS between different states. It was found that Tamil Nadu was doing very well, anganwadis were open throughout the year, nutritious food was available every day, regular health services were provided, and the pre-school education programme was in good shape. On the other hand, the daily routine of AWCs in Uttar Pradesh was little more than a brief ritual, involving the distribution of ready-to-eat mixture (Panjiri) or filling up registers. There was rampant corruption from top to bottom and no signs of any significant impact of ICDS.
2. The six FOCUS States could be divided into two broad groups. Three of them (Himachal Pradesh, Maharashtra and Tamil Nadu) had relatively active social policies, good indicators of social development, and effective public services. The other three states (Chhattisgarh, Rajasthan and Uttar Pradesh) had been relatively passive as far as ICDS was concerned.

3. FOCUS investigators found that in Chhattisgarh and Uttar Pradesh most of the AWCs were located in the home of the AWW or Helper. That was a highly unsatisfactory arrangement which entailed frequent disruptions in ICDS activities and restricted access for some communities of the village.
4. FOCUS survey found that in Varanasi district of Uttar Pradesh, supervision turns into extortion. AWWs are apparently expected to bribe the Supervisor to the tune of Rs.200 – 300 each time he or she visits or face the risk of harassment.
5. In Rajasthan, most of the trainers were men, many of them were untrained, and it is difficult for them to provide effective guidance to AWWs in a patriarchal environment. In Tamil Nadu, ICDS was managed almost entirely by women, not only at the level of training and supervision, but also at higher levels.

Health

6. It was found that in a typical anganwadi in both states (Himachal Pradesh and Tamil Nadu), growth charts were well maintained, immunization services were fairly regular and health checkups took place from time to time.
7. In some respects, Himachal Pradesh was doing even better than Maharashtra or Tamil Nadu. 84% of the sampled children in Himachal Pradesh had a vaccination card, and 76% were fully immunized.
8. In Chhattisgarh, Rajasthan and Uttar Pradesh, the sample mothers were not aware of ante-natal care and maternal health care. They mentioned that nobody came to tell them about those services.
9. In Maharashtra, immunization services were well integrated with ICDS. Children were regularly weighed, growth charts were well maintained, and children with low or faltering weight were often given food supplements.
10. In Tamil Nadu, immunization, health check-ups and weight measurements were done each month on a pre-designated day in the joint presence of health department and ICDS staff.
11. In Chhattisgarh, Rajasthan and Uttar Pradesh, growth charts were missing, fudged, poorly maintained or had outdated data in most cases, and even basic immunization services left much to be desired in many places.

Health and Nutrition Education

12. Nutrition counselling was yet to be developed as an active component of ICDS, and in many states AWWs rarely visited pregnant or nursing women at home, or counselled them.
13. In the three states of Himachal Pradesh, Maharashtra and Tamil Nadu, with relatively well functioning ICDS services and better indicators of child well being, women had much higher levels of awareness of nutrition and health issues.

Nutrition

14. In Rajasthan parents mentioned that children got the same '*murmura*' (puffed rice) everyday, and lack of variety was the main reason for poor child attendance.
15. It was found that in Himachal Pradesh three items *khichri* (rice and lentils), *dalia* (porridge) and chana (roasted gram) were served on different days of the week, and supply was quite regular.
16. FOCUS found that in Tamil Nadu the diversity and nutritious content of the food was even higher. There were a fortified, pre-cooked "health powder" for children below two years, a hot lunch of rice, dal and vegetables freshly cooked with oil, spices and condiments (with occasional variants such as weekly egg) for children in the 3-6 years age group.

Pre-school Education

17. Pre-school education was in great demand, especially in areas where parents were relatively well educated. However, the development needs of young children are poorly understood by communities, and therefore the monitoring of PSE is limited. This led to some casualness about pre-school education in many AWCs. Lack of space, infrastructure and basic facilities were common hurdles, and many AWWs were inadequately trained for this purpose.

Recommendations

1. The core objective for ICDS in the 11th Plan should be "universalization with quality". This would involve ensuring that every hamlet has a functional anganwadi, and ensuring that all children under six and all eligible women have access to all ICDS services.
2. Every child under six should be eligible for enrollment at the local anganwadi. There should be no eligibility criteria other than age, and no ceiling on the number of children to be enrolled in a particular anganwadi.
3. A major effort should be made to extend ICDS services to all children under the age of three years without affecting the entitlements of children in the 3-6 years age group.
4. AWWs should be recognized as regular, skilled workers and their concerns should be addressed, particularly those relating to work overload, inadequate remuneration, delayed salary payments and poor working conditions.
5. For children aged 3-6 years, SN should consist of a cooked meal prepared at the anganwadi, based on local foods, with some variation in the menu on different days of the week.
6. In each AWC a pre-fixed day of the month should be reserved for specific activities such as distribution of take-home rations to pregnant and nursing mothers, immunization sessions, NHE sessions, weighing of children under three, identification of severely malnourished children.
7. Every anganwadi should have a medicine kit with basic drugs, to be distributed by AWWs with appropriate training as well as guidance from the ANM.

8. Pre-school education, suitable for implementation through ICDS, should be developed under Sarva Shiksha Abhiyan (SSA). SSA funds should also be made available to strengthen existing PSE activities under ICDS.
9. Each AWC should have basic PSE facilities including adequate space for indoor and outdoor activities (with clean and hygienic surroundings), appropriate charts and toys, etc. PSE should receive higher priority in AWW training programmes, and also in the support activities of ICDS Supervisors and CDPOs.
10. New AWC buildings should generally be situated on or near the premises of the local primary school, unless the latter is at some distance from the children's home.
11. An 'outreach model' should be developed under ICDS to extend essential services to hitherto excluded groups through designated outreach workers.
12. All ICDS related information should be in the public domain. Provisions of the Right to Information (RTI) Act, including pro-active disclosure of essential information (Section 4), should be implemented in letter and spirit in the context of ICDS. Social audits of ICDS should be conducted at regular intervals in *Gram Sabhas* (village meetings) and/ or on "Health and Nutrition Day".
13. The burden of record maintenance at the anganwadi level should be reduced.
14. Each child under six should have a '*Bal Adhikar Patra* (Child Rights Certificate) combining birth certificate with immunization details, weight at various ages, AWC registration, health check-up and sickness records, etc.
15. Steps should be taken to promote more active involvement of PRIs in the management and monitoring of ICDS, bearing in mind that 'women and child development' is listed in the Eleventh Schedule of the Constitution. In particular, PRIs should be actively involved in the monthly 'Health and Nutrition Day' at the AWC, and in the selection of ICDS functionaries.

ICDS in Delhi : A Reality Check

FORCES (Forum for Creches Child Care Services)

Introduction

This study was conducted to assess the status of the performance of ICDS services in the city of Delhi with respect to infrastructure, coverage, distribution of supplementary nutrition, health and PSE services, and to understand the linkages of health, drinking water and sanitation facilities from the perspective of the functionaries.

Methodology

This study was conducted in 242 AWCs in Delhi. Out of the total 28 ICDS projects in Delhi 27 were covered. About 2970 beneficiaries and functionaries were selected. Data was collected through interviews, focus group discussions and field survey.

Aims and Objectives

The study aimed to :

1. Assess the performance of ICDS in the city of Delhi with respect to its service delivery components.
2. Understand the challenges faced by functionaries like AWWs, Supervisors and CDPOs, and see how their roles and responsibilities impact the effectiveness of the programme.
3. Find out the level of participation of the community in this major government programme.
4. Understand whether resource allocation is adequate in the context of the programme objectives.
5. Identify the major challenges to achieve universalization with quality.

Findings and Conclusions

1. It was found that 96% centres were on rent. Only 57% centres had toilets and 58% centres had access to clean drinking water. Sometimes the neighbours provided drinking water to the centres.
2. 82.23% AWWs mentioned that there was scarcity of equipment like weighing machines, education kits, toys, even jugs and buckets for water storage.
3. It was found that in summer food became rotten as it was cooked early in the morning. Dry ration was preferred to cooked food as it can be stored and also shared within the family. Beneficiaries of 39% centres complained of poor quality of food. Najafgarh area had specifically complained of insects and dirt found in the food material.

4. The children followed over six months had been receiving food from the AWC regularly. Some beneficiaries mentioned that the quantity of food given was one *katori* (bowl) or two *karchhi* (ladle). Only one mother specifically mentioned 200 gms. The number of beneficiaries were more, but less quantity of food was distributed.
5. In 26% AWCs, AWWs complained about irregular food supply.
6. In one AWC 17 women, pregnant women and lactating mothers, were registered. In Delhi, on an average, 3 to 4 pregnant women and lactating mothers were found to be attending the anganwadi centre.
7. Only 82 out of 2861 (2.87%) beneficiaries were taking food in the centre, 76% beneficiaries were sharing SN with their family members, and the rest of them (21%) were taking SN to their home and consuming it themselves.
8. The data on weighing was not encouraging. In most centres AWWs either did not have weighing machines or the place to keep them. Beneficiaries mentioned that they were not weighed due to the non-availability of weighing machine or the weighing machine not being in working condition.
9. Only 4 centres had data on Grade III and Grade IV malnutrition. 17% centres had data on Grade I and 17% on Grade II malnutrition. Only one centre had offered medical intervention and around 9% offered double SN ration to malnourished children. In 55% of the 27 projects, AWWs could not provide any data on malnutrition. This raises doubts about the accuracy of the number of malnourished children quoted by Delhi Government.
10. The training programme was also found to be inadequate. Out of the 242 AWWs interviewed, 27% had special training on AIDS but only 18% had special training on nutrition. The mothers who participated in focus group discussions (FGDs) were largely unaware of the issue of malnutrition.
11. The immunization coverage in Delhi was good. Among children aged 0-3 years, 98% children had received BCG vaccination, 88% had received Polio drops; 98%, 98% and 97% children had received DPT I, DPT II, DPT III doses respectively; 94% children had received measles vaccination; and 68% children had received MMR vaccination. TT injections were received by 88% pregnant women. About 25% children aged 0-3 years had received Vitamin A doses.
12. 85% of the immunization in Delhi was done by ANMs in PHCs and dispensaries. 87% AWCs had data on immunization for children below 3 years and only 67% had data for children 3-6 years old.
13. As per AWWs' data, 46% reported TT immunization of pregnant women whereas the data collected from beneficiaries showed 88% pregnant women were immunized.
14. 88% beneficiaries mentioned that they had received iron tablets from PHCs. AWWs' records had no data on iron tablets distributed, which indicated that the AWC records were not updated on this aspect.

15. Data on Vitamin A distribution was available in 9% of the centres but the survey on beneficiaries revealed that 25% of the children below 6 years had received Vitamin A doses.
16. 84% AWWs mentioned that the MO (Medical Officer) had not visited the centre for more than six months. ANMs were more regular visitors, and 51% of them visited AWCs once a month. But as per the AWWs' experience only 28.5% ANMs had been supportive.
17. Preschool activities were irregular. There was inadequate space for PSE activities and inadequate teaching aids. Children in the 0-3 years age group were left out, and mothers of children below three years did not receive any input on learning needs of children in this age group.
18. In 44% centres no children were found attending preschools. 45.62% AWCs had an average of 14 children and in the remaining 11% centres no children were found.
19. 57.83% AWWs reported that they had no space for PSE activities. Most of the AWCs did not have space to seat 40 children. None of the AWWs were providing (early childhood care and education) ECCE inputs to children below 3 years of age.
20. 93% AWWs had received job training and 82% AWWs had attended the week long refresher training course. Apart from that, 10% AWWs were trained on RCH, 27% on AIDS and 18% on nutrition.
21. 96% AWWs mentioned that they did not receive payment on time. The worker does not feel motivated to come to the centre every day since the Government is not regular in paying their honorarium every month. AWWs even have to purchase registers, earthen pots and water containers with their own money. Sometimes they have even paid the rent in order to get rid of the landlords' harassment.
22. 14% AWWs mentioned that they had received support from CDPOs, 40% AWWs had received support from beneficiary families, 12% had received support from Mahila Mandals, 6% from local MLAs, and all AWWs mentioned that they had received support from Supervisors and ANMs.
23. The survey team could not come across even one AWC that had a child with disability. Only 2.89% AWWs had special training on disability. Inclusion of children with disabilities is a national mandate. The system in ICDS did not stress on the importance of fulfilling this mandate.

Recommendations

1. It is suggested that minimum area should be prescribed for an AWC, with demarcation of space for activities, storage and kitchen, and an independent toilet and drinking water facilities must be available.
2. Growth charts should be maintained for all children and weight of children below two years should be taken on a monthly basis and for the rest on a three monthly basis, as per norms.

3. No attention is given to disability. Disability should be specified in the guidelines of the scheme. The training programme for AWWs must have comprehensive inputs on disability.
4. AWCs should have enough space for conducting PSE activities so that at least 40 to 50 children can be registered, and learning activities can be carried out every day for 3-4 hours. Early childhood care and development for children aged 0-6 years must be brought under the ambit of the Fundamental Right to Education.
5. There should be regular monitoring and supervision of health records. AWWs need to receive regular feedback from CDPOs and Supervisors on their work, and their problems need to be listened to.
6. Awareness, sensitization and community participation needs to be addressed. Mahila Mandals, AWWs and ANMs need to work on developing active participation of mothers, pregnant women and AGs so that they are all sensitized on the importance of nutrition and on the issues of malnutrition and anaemia.
7. The State needs to review its policy on handing over AWCs to NGOs. NGOs' role as community mobilizers, trainers, etc. will be of benefit to ICDS beneficiaries. State systems need to be responsible for the implementation of services, and accountable to the people.

Impact Assessment/ Evaluation of ICDS Programme in the State of Orissa

N. C. Dash et al

Introduction

This study was the outcome of the impact evaluation of ICDS programme in the state of Orissa sponsored by the Ministry of Women and Child Development. The objective was to see whether ICDS had succeeded in delivering services to the target groups as envisaged under the scheme. It also aimed to assess the lacunae and bottlenecks, if any, and suggest measures to overcome them.

Aims and Objectives

The study was aimed to:

1. Analyse the degree of success of the six basic services delivered under ICDS.
2. Identify the gaps/ bottlenecks in service delivery at different levels.
3. Assess the present level of convergence of ICDS with other on-going schemes of other departments.
4. Evaluate the efficiency of AWCs by testing the level of knowledge and awareness of AWWs.
5. Analyse the extent of community participation and the scope for improvement.
6. Recommend ways for improving efficiency and effectiveness of the programme in the state.

Methodology

This study was conducted in the state of Orissa. It covered 250 villages/ AWCs, in each of the 25 blocks spread over 20 districts of Orissa. A total of 12,621 children under 3 years, 12,468 children between 3 and 6 years, 2221 pregnant women, 2686 lactating mothers and 13,908 adolescent girls were selected for the study. Qualitative data was gathered through interviews and secondary data was collected from the Ministry of Women and Child Development and Panchayati Raj Department.

Findings and Conclusions

1. It was found that supplementary feeding was usually given for 25 days in a month and was considered adequate by over 96% of the mothers of beneficiary children. 92% of the mothers mentioned that the quality of food given was good.
2. About 60% mothers of non-beneficiary children considered supplementary feeding to be useful to improve health and nutritional status of children.
3. The immunization coverage for BCG of children of lactating mothers was found to be 82%. The place of immunization had largely been the AWC (73%), followed by PHC (11%) and health Sub-Centre (8%).

4. The immunization coverage for DPT was estimated to be 41%, 22% and 38% for the first, second and third dose respectively. With respect to immunization against polio, 32%, 26% and 43% children had been administered the first, second and third dose of OPV respectively.
5. Over 92% of the beneficiary children had received 3 doses of immunization against DPT/POLIO. The immunization coverage for measles was around 96%. Over 96% of the beneficiary children had received BCG immunization. Around 26.32% children aged 9-12 months had received complete immunization.
6. Almost 9 out of every 10 mothers of beneficiary children mentioned that their children had been administered Vitamin A supplement as against 77% of non-beneficiary children.
7. About 80% mothers mentioned that AWWs were capable of treating minor diseases. Nearly 73% of the mothers of beneficiary children had received treatment from AWWs.
8. Nearly 60% of the mothers of non-beneficiary children mentioned that they had been visited at home by the AWW, mostly within 1-3 months. Over 28% of the mothers of non-beneficiary children who fell ill during the last 6 months consulted the AWW for treatment of diseases.
9. 17% of the lactating mothers mentioned that their children had been referred for treatment to PHCs (64%), followed by Health Sub-Centre (21%), and CHC/ DH (Community Health Centre)/ (Department of Health).
10. Around 5% mothers of beneficiary children also mentioned that their children had been referred predominantly to PHCs (79%). All the mothers of the beneficiary children referred had received referral services and were satisfied with the services provided.
11. Over 99% mothers of the beneficiary children aged 3-6 years mentioned that they were sending their children for PSE. Among the preschool children, the proportion of female children (53%) was more than that of males (47%).
12. Over 98% of the mothers of children attending PSE mentioned that classes were usually held for 3-4 days a week. The timings of PSE were convenient to over 99% of the mothers, and 99.6% mothers considered that PSE was beneficial to children.
13. About half the mothers of non-beneficiary children also felt that PSE was beneficial to children.
14. About 99% of the mothers of beneficiary children mentioned that their children were weighed regularly by the AWW. The growth of all children 0-3 years was monitored monthly. About 75% of the mothers were aware of the nutritional grade of their children.
15. Around 48% of the children were found to be having normal nutritional grade, followed by 17% in Grade I, 9% in Grade II, 0.4% in Grade III and 0.2% in Grade IV malnutrition.
16. It was found that 88% of the mothers of non-beneficiary children considered weighing useful because it apprised the mother about the nutritional grade of the child.
17. It was found that 8 out of every 10 lactating mothers had not received any IFA tablets.

18. About 93% of the pregnant women mentioned that they had received at least 1 antenatal health check-up. Only about 22% of the pregnant women received 3 health check-ups. Doctors at PHCs (45.5%), followed by the paramedical workers (ANM) at Sub-Centres (35%) conducted the antenatal check-up.
19. Around 76% of the pregnant women mentioned that they had received supplementary food from the AWW. The Take Home Ration (THR) was usually shared with other members of the family (49%) and children (29%).
20. About 90% of the pregnant women reported that they had received IFA tablets supplied mainly by AWWs (75%), followed by ANMs (14%).
21. It was found that the distribution of IFA tablets was primarily on monthly basis (44%) or in a single lot (30%). About 44% of the women received tablets, and they consumed all of them, but 50% reported that they consumed less than what was received.
22. Around 27.67% pregnant women received complete antenatal care (3 check-ups + 2TT + 100 IFA tablets).
23. It was revealed that home (58%) had been the common place of delivery, followed by hospital (39%), and family members had assisted in 21% cases. Traditional Birth Attendants (22%) and ANMs (7%) had been the birth attendants at home.
24. It was found that 57% of the women faced obstetric complications during delivery and they were referred to FRUs (First Referral Units) such as PHC (34%), District Hospital (30%) and Sub-Centres (7%).
25. It was found that pregnant women and nursing mothers were provided counselling by AWWs for ante-natal care, post natal care, iron supplementation, timely immunization, and special care for children in the age group 0-3 years for improved child care and feeding practices.
26. About 96% of the pregnant women mentioned that they were visited at home by AWWs, and more than half of them had been visited more than six times.
27. As many as 99% of the adolescent girls (AGs) mentioned that vocational training was hardly addressed by AWWs.
28. Over 75% of the AGs were aware of the causes of anaemia. Lack of iron rich food being the most common cause was known to the majority. About 70% of the AGs were familiar with the symptoms of anaemia. Over 70% of the AGs knew that girls were more vulnerable to anaemia.
29. Around 88% of the AGs reported that there was no Balika Mandal (Adolescent Girls Group) in their village.
30. About 60% of the children were found to be malnourished. 40% children were mildly malnourished, 18% were moderately malnourished and 0.6% children were severely malnourished. Female children (64%) were found to be more malnourished than male children (54%).

31. It was found that the percentage of malnourished girls was higher in all grades than that of boys. 43%, 19.7% and 1.2% of the girls had mild (Grade I), moderate (Grade II) and severe (Grade III and Grade IV) malnutrition as against 37.5%, 16.7% and 0% for boys. Less than 1% of the children showed signs of protein energy malnutrition (PEM).
32. The nutritional status of beneficiary children was better than that of non-beneficiary children. 59% of the beneficiary children were malnourished as compared to 69.9% of the non-beneficiary children.
33. 92% of the AWWs were capable of taking the weight of children correctly and 90% were capable of maintaining growth charts.
34. Almost all AWWs (96%) provided health and nutrition education (NHE) to target groups like pregnant women, lactating mothers and women in the reproductive age group, either through home visits or through group sessions. Education session was usually held fortnightly (58%). However, 26% and 16% AWWs reported that they conducted the session monthly and weekly respectively.
35. AWWs mentioned that they faced the problem of irregular supply of food (12%), irregular supply of drugs (12%), and extraneous work assignments such as formation and grading of Self Help Groups, survey work, preparation and distribution of emergency feeding, etc.
36. It was found that the Referral Units suffered due to non-availability of funds. The funds earmarked for the purpose (Rs.10,000 per annum) was considered too small an amount and was found largely unspent.
37. The AWW was provided with a medicine kit consisting of easy to use and dispensable medicines to remedy common ailments like cough and common cold, skin infections etc., but the kit was hardly replenished in a regular manner.
38. The travel bills of the field staff were reportedly not settled for years together, creating resentment and indifference among them. The funds for maintenance of vehicles were insufficient, restricting the mobility of the staff for frequent interaction with the AWWs and community.
39. The Lady Village Level Workers, particularly in Balasore district, had been deputed to the post of Sector Supervisors, and they were neither conversant with the programme nor motivated enough.
40. Maintenance of records and registers, updating them every month and compiling for reporting progress was found to be an uphill task for the less educated AWWs, mostly in tribal areas.

Recommendations

1. Convergence between the ICDS and Health Department was visible in respect of immunization only. Such convergence for antenatal and postnatal care and referral should be strengthened.
2. Special campaigns should be launched to enroll children with disability in PSE classes.

3. Health workers were not properly oriented to the concept of ICDS scheme. Joint orientation of Health workers and ICDS workers is required, which would ensure mutual reciprocity and accountability.
4. The AWW should be encouraged to promote institutional delivery, which is at present very low. Their knowledge on anaemia was very limited, and most of the AWWs were confused about the concept of exclusive breastfeeding. A special course to orient them on the subjects is felt necessary.
5. Panchayati Raj Institutions (PRIs) were found to be least involved in the implementation of the ICDS programme. Their involvement can be hardened to promote enrolment of students in PSE, referral of emergency obstetric cases, etc.
6. The health functionaries, at or below the block level, were least motivated and orientation to ICDS was lacking. Orientation of health functionaries is needed to strengthen functional linkages of the ICDS scheme with Health Institutions.
7. The supervisory staff of ICDS were constrained to have infrequent interaction with the AWW and the community as well, in view of the limited funds available for petrol, oil and lubricants (POL), and maintenance of vehicle. The funds earmarked on this account need to be enhanced.
8. In the absence of health care provider in remote rural areas, poor people, especially the disadvantaged tribals and dalits, depend on the AWW for treatment of diseases. The medicine kits provided to the AWWs need to be replenished regularly.
9. AWWs with low education found it difficult to weigh children accurately, hence digital scales may be provided to AWWs. This will enable the AWW to take the birth weight of newborn babies as well.
10. The funds earmarked for IEC are too small an amount to embark upon proper IEC activities for effective behaviour change for reduction of malnutrition. The allocation may be enhanced from Rs. 10,000 to Rs. 50,000. The travelling allowance (TA) of functionaries should be increased.

The Micro Status of ICDS in Hayatnagar, Andhra Pradesh: A Study by FORCES

FORCES (Forum for Creche and Child Care Services)

Introduction

ICDS has not managed to bring all children under its coverage. The programme, which was visualized as a progressive step in providing strong, qualitative support to working mothers from the underprivileged sections, has not really taken on. In Andhra Pradesh, majority of the children were of women working and living below the poverty line. There had been some persistent circumstances that had a serious impact on the delivery and status of services. FORCES undertook this study to ascertain the status of ICDS services in the district.

Aims and Objectives

The study aimed to:

1. Assess the status of services in the Hayatnagar and Ranga Reddy districts of Andhra Pradesh.
2. Recommend strategies to bridge the gaps in implementation of the programme with full effectiveness.

Methodology

This study was conducted in Hayatnagar district of Andhra Pradesh. A total of 154 AWCs, 17,073 children below the age of 6 years, and 2983 pregnant and lactating mothers were covered. Data was collected through interviews and field survey.

Findings and Conclusions

1. It was found that a majority of the centres covered around 58 beneficiaries, out of which 30 were children in the age group 3-6 years.
2. It was found that mother beneficiaries were aware of their rights, and the functionaries were knowledgeable and responsible for their tasks.
3. Functionaries mentioned that 100% immunization was taking place in the district/ mandal. 99% deliveries had been conducted by ANMs.
4. Almost 100% of the children were going to pre-schools that were private and 95% of them were helped in their studies by relatives. Only 5% children were taught at home by their parents. In the absence of their mothers, 83% children were taken care of by elderly relatives and 8% were taken care of by siblings.

5. Around 154 AWCs in Hayatnagar catered to 17,073 children below the age of 6 years, 2983 pregnant and lactating mothers, and 148 AWCs had supplied SN for 21 days to 901 pregnant and lactating mothers.
6. During the month of June 2005 Hayatnagar catered to 4858 beneficiaries eligible for SN in the age group of 3 to 6 years. 4673 children were registered but the actual number of beneficiaries receiving SN was 3820. Children below the age of 3 years who received SN were 4813. 100% growth monitoring and 99% SN coverage was achieved in this district.
7. Project Director mentioned that the concept of 'Change Agents' among women and adolescent girls had been introduced by the Department. 3 AGs in the age group 15-19 years were identified and they were provided SN from the centre. They were initiated into spreading awareness on nutrition, health and social issues among other AGs in the village. Each AG was weighed and if found to be less than 35 kgs, they were given SN intervention.
8. Around 8 mothers within the age group of 15-45 years were also identified as 'Change Agents' to spread awareness among other mothers in the village. They were weighed and if less than 45 kgs, they also received SN intervention. They were volunteers for the day to day activities of the AWC and helped in facilitating women to women approach.
9. It was found that malnutrition was not an important issue in Ranga Reddy district. 50% children belonged to normal category, 49% belonged to Grade I and II only, and 1% were in Grade 3 or 4 categories.
10. Three types of foods were distributed in Ranga Reddy district. Children between the age group of 6 months to 3 years were given Pradhan Mantri Gramodaya Yojana (PMGY) food, children 3 to 6 years and pregnant and lactating mothers were provided ready to cook food in 60% projects and 40% of them procured locally made food. Project Director mentioned around 15-20% of the population belonged to BPL category and they were given first preference.
11. Beneficiaries of Peddambarpet village mentioned that they were all satisfied with the working of the centre. There was good coordination among Supervisors, AWWs and community members. PRIs were also proactive. They welcomed the idea of a crèche as most of them left their children at home with their elderly relatives. Both the functionaries and beneficiaries mentioned that there was almost no corruption in the ICDS.
12. AWWs mentioned that PSE activities were conducted regularly, but the parents preferred to send their children to private schools. Private doctors were also preferred over Pre-Natal Clinics (PNCs). For deliveries, the mothers depended on *dais*. The AWWs had only some first aid facilities. IMR and MMR record was very low in the area.

Recommendations

1. Only 12 beneficiaries below three years received ready mix food. The number of beneficiaries should be 40 so that more children can benefit from this scheme.

2. PSE should be extended to 40 children. Strengthening its linkage with the primary school can stop beneficiaries going to private schools.
3. Pregnant women and lactating mothers should be encouraged to take food at the centre instead of taking away the monthly ration.
4. ANMs and doctors should be available in PHCs everyday so that the beneficiaries do not have to depend on private doctors. ANMs should also be involved in deliveries.
5. As the AWCs were running from 9 am to 3.30 pm, they can easily be converted into a crèche by adding another human resource for the children below 3 years. This would be really beneficial for mothers working in the unorganized sector.

A Micro Study of the Status of the Young Child: A Block Level Study in Chandauli District of Uttar Pradesh

FORCES (Forum for Creche and Child Care Services)

Introduction

FORCES believes in the survival and development of the young child and mothers working in the unorganized sector. This study, supported by 'Plan International', is an outcome of the collective endeavour and allegiance to a single agenda, that of ensuring early childhood care and development to all children in the country.

Aims and Objectives

The study aimed to:

1. Assess the status of child care services at block level.
2. Find out the persisting gaps in services provided and take appropriate measures to overcome them.

Methodology

This study was conducted in Chandauli district of Uttar Pradesh. A total of 80 beneficiaries and 20 AWW from 20 AWCs were taken for the study. Data was collected through interviews, field survey and observation.

Findings and Conclusions

1. It was found that there were less beneficiaries from BPL families and more beneficiaries from APL (above poverty line) families.
2. Most of the AWCs had no space for medicine storage. Health check-up was carried out on a weekly basis by ANMs outside the centres, mainly from PHCs.
3. It was found that all the AWCs had drinking water and sanitation facility. Nine out of ten anganwadi centres were running in the premises of primary schools, and these centres lacked both indoor and outdoor space and storage facility; ten centres that had their own premises also lacked both indoor and outdoor space and storage facility. Learning kits were available in all centres and weighing scales were also available in nine out of 10 centres. Only 45% of the centres had toilet facility.
4. It was found that there were 186, 165 and 170 children below six years in three AWCs and 28, 25 and 26 AGs. AWWs were providing SNP and PSE to 80 beneficiaries below six years of age.

5. It was found that teaching aids were available at the AWCs in the form of charts and posters.
6. 80% of the AWWs were highly educated, but 90% of them did not receive any training.
7. There was low rate of malnutrition and the level of awareness about nutrition was also found to be low. It was observed that the supply of SN was irregular.
8. In Hetampur village the AWWs counselled the families with children suffering from malnutrition Grade I and II, but the awareness about malnutrition and its gradation was not clear to most of the AWWs. Grade I and Grade II malnourished children were not receiving any intervention. Although, a significant number of children were suffering from malnutrition of Grades I and II, the prevalence of Grade III and Grade IV malnutrition was quite low.
9. It was found that disability was neglected in this region and people were not aware about the causes of disability. In every house there were physically challenged members, but they did not know the cause of disability or its prevention. In Hetampur, all the three AWWs mentioned that they had received no training on disability.
10. It was found that 33% of the deliveries were conducted at home by untrained *dais* in all villages.
11. It was found that 80% of the AGs had not received any immunization. The immunization records of children were quite impressive but Vitamin A distribution was not satisfactory.
12. It was found that AWWs did not have any medical stock, or medicines to treat general ailments and diarrhoea.
13. It was found that infrastructure was inadequate in the PHC. There were beds without mattresses, and an unclean delivery room which spread infections to women and children. The local people preferred private medical assistance due to easy accessibility. Only immunization was a regular activity carried out by ANMs.
14. Medical Officer mentioned that the facilities offered by the PHC were immunization, family planning, pre-natal and post-natal care, treatment for malaria and TB, etc., but no information or data was given on the general ailments treated. Also, no data was provided on treatment of children.
15. Private practitioners mentioned that most mothers were aware about breast-feeding, but they were not aware of the Pre-Natal Diagnostic Techniques (PNDT) Act.
16. It was found that in 90% AWCs PSE was a regular activity.
17. Community representatives mentioned that AWC services had a positive impact on health, nutrition and education.
18. It was found that sex selective abortions did take place in this district. The MOs, private practitioners, Neem-Hakims and *Dais* mentioned that they were not aware of PNDT Act.

Recommendations

1. The problem of dearth of space in AWCs should be addressed, and all AWWs must have enough space for storage and for conducting activities.

2. Supply of SNP should be regularized. The beneficiaries should be encouraged to take food at the centre.
3. Torn kits should be replaced to make PSE more attractive to children.
4. CDPOs and Supervisors should monitor the number of beneficiaries suggested as per norms of the scheme, and ensure regular monitoring and on-going improvement in the services provided.
5. The linkage with PHCs should be strengthened, because the non-availability of medical staff at the PHC was forcing people to go to private practitioners.
6. The needs of children below three years should be addressed by AWWs as a part of their activities. They can work as facilitators of best practices of child care.
7. AWCs can be expanded to become crèches to provide relief to mothers working in the unorganized sector.
8. The Gram Pradhan and Panchayat Pradhan should be proactive and they should get involved in the activities of the AWC. Their financial and other involvement should be solicited for child rights related issues. For this they should be sensitized by the Government and NGOs.

Nutritional Health and Pre-School Education Status of Children Covered under the ICDS Scheme in Orissa: An Evaluation Study

Indian Institute for Social Development

Introduction

In Orissa, endemic poverty, combined with poor education, health and physical infrastructure, has made the position of children and women vulnerable. In view of the persisting severe malnutrition and alarming infant mortality rate (IMR), the Government of Orissa had evolved a strategy to improve the nutritional status of children through ICDS projects. This nutrition campaign had the objective of eradicating Grade III and Grade IV levels of severe malnutrition. The Government had put in place a network of around 22,000 AWCs in 279 ICDS projects, covering around 1.3 million children under six years of age and 0.2 million pregnant and lactating mothers from disadvantaged and vulnerable community groups.

Aims and Objectives

The study aimed to:

1. Measure the benefits of the scheme on identified criteria related to Nutrition, Health and Pre-School Education status of children and women.
2. Find out the difference, if any, between the stated objectives and their implementation, along with an assessment of the accessibility of these services to beneficiaries in rural, urban and tribal areas.
3. Ascertain the constraints, if any, in the implementation of the programme, as perceived by functionaries and beneficiaries.
4. Survey the perception of the community about ICDS and assess the extent of community participation in the implementation of the programme.

Methodology

The study was conducted in six districts of Orissa namely, Khurda, Cuttack, Nayagarh, Puri, Kandhamal and Rayagada. 43 AWCs comprising 12 rural, 14 urban and 17 tribal were selected. The sample consisted of 1200 beneficiaries, 61 ICDS functionaries, 30 health functionaries, and 108 representatives of the concerned communities. Data was gathered through interviews and observation methods.

Findings and Conclusions

1. It was found that 56.08% of the respondents were illiterate, and only 3.67% had educational qualifications above high school level. 79% illiteracy was observed in case of the tribal sample. In the scale of educational achievement, tribals lag far behind the rural and urban samples.

2. About 51% families had adopted the nuclear family system and the rest lived in joint family system. The number of persons in a family was highest in rural areas as compared to urban and tribal areas. Majority of the respondents were landless.
3. It was found that a majority of the AWCs had clean and hygienic surroundings, but most of the AWCs did not have proper toilet facilities and proper drainage system.
4. It was found that the children residing in rural areas had better nutritional status than children in tribal and urban slums. Grade III malnutrition among boys was more prominent in urban slums, followed by tribal and rural areas. Among girls in the age group 0-3 years, Grade III malnutrition was more among the urban slum population.
5. To assess the PSE component, a total of 455 children were observed, covering 147 rural, 144 tribal and 164 urban slum children. The rote memory in counting was found to be 47.62%, 41.67% and 49.39% for rural, tribal and urban children. For counting up to five objects, the tribal children performed better (56.94%), followed by urban (55.60%) and rural children (55.10%) respectively.
6. It was found that majority of the respondents in all areas did not adopt weaning practices at the appropriate time. In the study area, semi-solids were introduced to children as late as two years. This contributed towards poor nutritional status of children.
7. Nearly 48% of the pregnant women were not regular in the consumption of iron and folic acid tablets. They perceived that consumption of IFA tablets caused constipation, and had bad smell, and some women forget to take tablets.
8. AWWs mentioned that they faced a number of problems in organizing NHE. The timings for NHE sessions were found unsuitable to the women, because they were busy in their household work during that time. Sometimes the health functionaries did not help the AWWs in organizing NHE session.
9. AWWs mentioned that there was paucity of funds for transportation of food from block office to AWC, irregular distribution of the SN, and the quality and taste of the food supplied in rural and urban slum areas was very poor.
10. A majority of the pregnant mothers mentioned that the delivery was usually assisted by self, relatives or experienced women from the community. AWWs mentioned that hospitals were far off and without adequate transport facilities it was not possible to go there.
11. CDPOs mentioned that the constraints in implementing the programme were lack of transport and too much administrative work. Trainers were not satisfied with the transport facilities for training, infrastructural facilities and the funds allotted for training. They mentioned that the coordination with health functionaries was satisfactory with respect to immunization.
12. It was found that participation of ANMs in referral services/ home visits/ health check-up and NHE was not satisfactory.

13. Medical officers mentioned that lack of conveyance facilities, distance and the scattered location of AWCs were the major problems they faced.
14. It was found that community members had low awareness about ICDS programme, and marginal support was provided by youth clubs and Mahila Mandals.
15. It was found that 46.66% members of Mahila Mandals were relatively more active in immunization programmes, 36.66% in feeding programmes, 26.66% in motivating the community to take part, and 20% in organizing health check-up camps in rural, tribal and urban areas.
16. It was found that 36.66% members of youth clubs were more active in immunization, 26.66% in taking sick children to hospital, 10% in providing drinking water at village area, and 6.67% in supplying fuel for cooking at AWCs.

Recommendations

1. There is need to upgrade the physical infrastructural facilities at AWCs. A separate storage space for food rations should be made available.
2. It is suggested that iodized salt fortified with iron may be added to supplementary food to combat goitre and anaemia.
3. Supervisors should be given the responsibility to hold formal NHE sessions regularly in AWCs. Rigorous monitoring by CDPOs and active participation of health functionaries can further improve the implementation of these programme components.
4. For group learning sessions such as NHE, women should be collected at one place by organizing locally popular social/ recreational events.
5. The State Government should take appropriate measures to streamline delivery of supplies for smoother implementation of the programme.
6. Marginal support was provided by youth clubs and Mahila Mandal members in the implementation of the programme. Effective ways of augmenting community participation need to be evolved. AWWs have to be equipped with the requisite skills for promoting community participation. CDPOs and Supervisors should take appropriate initiatives in this regard.
7. Efforts should be made to provide a minimum set of materials, appropriate for play and learning activities, at every AWC.

Performance Appraisal of ICDS and Non-ICDS Districts with Reference to Holistic Development of Child and Mothers in the Light of Social Organization Participation: An Impact cum Comparative Study in the States of Maharashtra and Madhya Pradesh

Midstream Marketing and Research Pvt. Ltd.

Introduction

This study was conducted to assess the performance of ICDS with focus on health and nutritional status of children and mothers in the light of role of social organizations. On this issue the study was to make a comparative study in two states namely Maharashtra and Madhya Pradesh. The specific objectives of the study were to study the extent of coverage of the scheme, its functioning, and the impact on beneficiaries.

Aims and Objectives

The study aimed to:

1. Study the extent and magnitude of ICDS coverage and non-coverage in the states.
2. Study the functioning of ICDS centres based on stipulated government norms.
3. Study the accessibility of ICDS centres for community people/ stakeholders.
4. Assess the well being of beneficiaries through ICDS centres in the light of SNP, immunization, health check-up, referral services, PSE, nutrition and health education.
5. Assess the impact of the programme on socio-economic indicators – school dropout, school retention, IMR/ MMR, health education, adolescent related, fertility regulation, nutrition, RCH services, etc.
6. Make a comparative performance appraisal between ICDS and non-ICDS blocks, and a state-wise comparison on the impact of the ICDS programme.

Methodology

This study was conducted in 8 districts of Maharashtra and 11 districts of Madhya Pradesh on a 25% sample basis, out of a total of 32 and 44 ICDS districts. Four blocks were selected from each district, and 15 beneficiaries were interviewed from each sampled block. A total of 480 sampled beneficiaries in Maharashtra and 660 sampled beneficiaries in Madhya Pradesh were selected. Qualitative data was collected through interviews, and secondary data, pertaining to coverage of the scheme in terms of number of beneficiaries, type of services rendered under the scheme, details of indicators such as level of malnutrition, school attendance, enrollment, SNP availability, etc., was gathered by scanning records and through discussions with officials.

Findings and Conclusions

1. It was found that a majority (44%) of the sampled children belonged to OBC category, and the remaining were from SC, ST and general category. A small proportion of them also belonged to muslim and other categories.
2. Among the women beneficiaries, expectant and nursing mothers, and others were selected in the ratio of 40:40:20 in both the states. In Maharashtra most women beneficiaries were in the age group 20-24 years, followed by 28% in the 25-29 years age group. In Madhya Pradesh, 65% were less than 30 years of age and 25% were less than 40 years of age.
3. 52% CDPOs in Maharashtra and 61% CDPOs in Madhya Pradesh had started the AIDS awareness campaign. Awareness was created through meetings, *mela* (fairs), street plays, home visits and pamphlets.
4. According to CDPOs, AWWs were implementing the scheme properly, but there were lacunae such as lack of additional training and educational qualification of AWWs. AWWs were unable to give sufficient time individually to beneficiaries.
5. It was found that Supervisors could make only monthly visits to the centre. In addition to the visit to AWCs they had to prepare reports, undertake counselling and make personal visits to beneficiaries, etc. There were also non-ICDS responsibilities such as Census operations, election duties, AIDS campaigns, SHG activities, etc.
6. In both states PRIs provided building infrastructure for AWCs. In Maharashtra, PRIs facilitated CDPOs in setting up Welfare Committees to help in the functioning of AWCs. In Madhya Pradesh, PRIs facilitated self help groups in catering and they provided supplementary food in AWCs.
7. It was found that 3 Mahila Mandals in Maharashtra and 8 in Madhya Pradesh were engaged in AIDS awareness, child education, awareness about malnutrition, and women's development.
8. It was found that one NGO in Maharashtra and 7 NGOs in Madhya Pradesh were engaged in immunization and providing vocational education to children. The number of beneficiaries covered under their programmes varied from less than 100 in Maharashtra, to 100-200 members in Madhya Pradesh. The NGO in Madhya Pradesh mainly helped in the reduction of handicapped children through pulse polio programme. The sampled NGOs in both states mentioned that they were useful to society as they provided legal help to victims, helped children of AIDS affected parents, etc.
9. In the ICDS centres of Maharashtra and Madhya Pradesh about 66.6% centres had less than 150 children, and the rest had more than 150 children. 100-200 children were registered in 82% centres in Maharashtra and 60% centres in Madhya Pradesh. About 66% centres in Maharashtra and 82% centres in Madhya Pradesh had less than 75 adolescent girls in the catchment area, the remaining 34% and 18% centres had 76-150 girls. The number of pregnant women surveyed by the AWCs was less than 75, and all of them were registered.

10. It was found that there were few referral cases for children. Adolescent girls in both states were not given referral services. Tetanus immunization of pregnant women was quite low, and less than 40 women in about 90% centres were immunized in both the states. Less than 40 persons including children, women and girls in both the states were referred to hospitals.
11. It was found that the AWWs visited homes for routine check-up of beneficiaries. In 56% cases in Maharashtra and 80% cases in Madhya Pradesh the visit was monthly. In 10 to 15% cases the visit was made fortnightly.
12. In both states 90% of the children had access to health check-up, but 10% did not have access. The frequency of health check-up was not regular but as per requirement. Immunization against tetanus was regular in both the states.
13. It was found that the number of days food was provided to beneficiaries in a month varied from 21 to 31 days in more than 80% cases in both the states. 85% of the AWCs in Maharashtra and 90% in Madhya Pradesh had taken steps to reduce malnutrition through proper monitoring and supply of additional nutritional supplement.
14. It was found that the number of children enrolled in the age group of 3-6 years was less than 40 in 48% centres in Maharashtra and 33% centres in Madhya Pradesh. The attendance of children was quite satisfactory in both states with more than 80% AWCs having 275-300 working days per year.
15. It was found that AWWs made visits to adolescent girls, pregnant women, and Mahila Mandals. The counselling varied from daily to once a month depending on the requirement. They also made social visits to beneficiaries.
16. A comparison was made among beneficiaries and non-beneficiaries in both states regarding health, nutrition and PSE. There was consistent decline in the number of children in Grade 3 and Grade 4 malnutrition, and increase in the number of normal children, and those in Grade 1 and Grade 2 malnutrition. The overall nutritional status of children improved. There was substantial improvement in the learning ability of children attending preschool/ crèches.
17. Comparing beneficiaries and non-beneficiaries the overall health of beneficiaries was good as they had access to health check-up and nutritious food supplement. Children in non-ICDS areas did not have access to PSE, and their abilities were observed to be less compared to children in ICDS areas. Children in both areas had access to primary education.
18. 60% non-beneficiary expectant and nursing mothers knew about AIDS from ANMs and friends. About 96% expectant and nursing mothers had access to health check-up, and 70% had access to nutrition and health education. 60% had no access to referral services.
19. The supply of food items to ICDS centres was more regular in Maharashtra. Regularity in supply of food items was not satisfactory in 22% cases in Maharashtra and 30% cases in Madhya Pradesh. The main problems in both states were that food items sent were either less than the amount demanded or not sent on time. In about 60% cases in Maharashtra and Madhya

Pradesh medicines were not received regularly, and in more than 50% cases they were not sufficient also.

20. AWWs mentioned that they had to purchase many of the items personally due to lack of supplies. They also expressed problems of time availability for non-ICDS work and extra work load of keeping records, registers and submitting various reports.
21. CDPOs mentioned that in 13% cases in Maharashtra and 35% cases in Madhya Pradesh AWWs were not technically qualified for the job.
22. CDPOs mentioned that they were involved in non-ICDS activities to a large extent. There was shortage of staff at CDPO level as well as Supervisor level. In certain blocks, the CDPO had more than one block to supervise. High illiteracy and economic backwardness of the region also added to the difficulty in proper implementation of the scheme.
23. Beneficiaries mentioned that problems were mainly related to their inclusion as beneficiaries. In 3% cases in Maharashtra and 16% cases in Madhya Pradesh, the selection procedure of children took more than one month. About 3% children in Maharashtra and 2% children in Madhya Pradesh had problems in being included as beneficiaries. The problems faced were repeat visits to the AWC and payment of bribe.

Recommendations

1. It was recommended that proper equipment should be made available in all AWCs. The ANM should be available more frequently at the AWC, at least twice a month on a regular basis. A full fledged medical kit should be made available at the AWC.
2. Supplementary nutrition should be provided to all needy beneficiaries as per the norms. AWWs suggested that items such as milk, green vegetables and fruits should also be included in the list of food items to be supplied to AWCs.
3. Educational and recreational items and space for interaction of children in the age group 3-6 years should be increased from the present level. There should be a dress code for the children.
4. Antenatal check-ups of mothers should be better and more regular. Mothers must be made more aware of nutritional aspects and problems of malnutrition during pregnancy in order to avoid complications during pregnancy or at the time of child birth.
5. AWWs recruited should be more qualified with minimum of higher secondary education.
6. The Supervisor must be given a maximum of 20 AWCs to supervise, and they must also be given better transport facility so that they are able to cover all AWCs. The educational level of Supervisors must be at least graduate level.
7. CDPOs need to be provided with proper facilities for mobility within the block, and they should have a minimum educational qualification of post graduation. They should also attend additional courses related to general health, nutrition, community health, child health, family, etc.

8. The local community must be facilitated to elicit better participation. Local organizations such as Mahila Mandals, Yuvak Mandals, NGOs, etc. must be motivated to participate through frequent interactions with them.
9. Panchayati Raj institutions (PRIs) should have a bigger role in the functioning of AWCs in terms of providing necessary facilities in the centre.

Quick Review of Working of ICDS in Rajasthan

Society for Economic Development and Environmental Management

Introduction

Nearly every developing country faces a severe crisis of malnutrition. In India, Rajasthan, Uttar Pradesh, Bihar and Madhya Pradesh are recorded as states with high malnutrition. The Government of India implemented ICDS, a critical intervention programme to break the inter-generational cycle of malnutrition through specific interventions. And these states are the focus of a major effort of ICDS programmes comprising (i) supplementary nutrition (SN), (ii) pre-school service, (iii) dissemination of health and nutrition awareness (HNA), (iv) health check-up, (v) immunization, and (vi) referral services which are to be provided jointly through coordinated efforts of Health Department and ICDS functionaries.

Aims and Objectives

The study aimed to:

1. Make a detailed system analysis of the working of ICDS programme including analysis of distribution of supplies, and documenting key problems, including the reasons thereof.
2. Document the quality of coordination between AWWs and ANMs at AWC, and participation of beneficiary women in Monthly Health Day (MHD)/ National Health Day (NHD).
3. Document the role of Gram Panchayat and Gram Pradhans as key stakeholders.
4. Suggest measures for strengthening the programme.

Methodology

The study was conducted in Rajasthan in five districts, namely Alwar, Ajmer, Nagpur, Sikar and Jaisalmer. The total number of respondents was 466, which included 5 Regional Deputy Directors (RDDs), 10 CDPOs, 10 Supervisors, 43 ANMs, 250 users and 47 Pradhans. 50 anganwadi centres (AWCs) were covered and data was collected through interviews.

Findings and Conclusions

1. It was found that nearly 92% women were getting SN benefits from AWCs. Storage of SN was a problem. Beneficiaries did not like SN because it was stale. Women shared SN with family members. Children enjoyed *murmure* (puffed rice), and even non-beneficiary children came for it. Data on supplies from CDPOs to AWWs was not made available; therefore average quantities supplied per AWC or per beneficiary could not be calculated.
2. It was found that children were coming to the creche. In a majority of AWCs, children were present at the time of survey between 9 a.m. to 12 a.m. There were some officially designated

- '*adarsh*' (model) AWCs. There were provisions for 40 children per creche, but in none of the centres was a register of enrolled children maintained. SN register was available, but not a separate register for creche attendance.
3. Over 90% women mentioned that NHD/ MHD was held in their AWC every month. Yet awareness was below 50% of the facts contained in National Health Education Day (NHED) books. Literacy and awareness had weak positive correlation, meaning thereby that literacy level was generally not a determinant of awareness. Majority of the respondents had made use of health facility for treatment of various illnesses, and all the sampled women did not take IFA tablets. Generally they did not go to AWCs on their own. 99% did wash their hands before eating, but 100% Exclusive Breastfeeding (EBF) is yet to be achieved.
 4. It was found that 38% AWCs had records of immunization of children and 40% had records on children. There was 100% achievement of DPT 1 and 2 vaccination, but on all other vaccinations records showed less than 100% coverage. Even OPV ranged from 97.7% (OPV-O) to 93% (OPV-3).
 5. Only 6% AWWs had maintained records of referred cases, and only 14% AWWs had given health check-up to women and children.
 6. It was found that over 90% ANMs regularly met the Sarpanch and other elected members of Panchayats. The main concerns of Gram Panchayat (GP) members were provision of hospital facilities, need for health and general awareness, need for medical personnel, etc. 76% ANMs discuss health problems with GP members, especially concerning sanitation, family planning, etc. Gram Panchayat members do take action when concerns are raised.
 7. Only 17.2% women visited AWCs to help with various tasks/ activities. 3.24% actively participated in centre level activities and performed tasks such as cleaning the centre. 25% beneficiary women were involved in preparation of SN meal, 28.75% in distribution of SN, 13.75% sent adolescent girls to the centres, and 1.25% were getting community support for nursing mothers.

Recommendations

1. Rajasthan Government's ICDS/ Women and Child Development Department should develop parameters to measure the performance of AWWs, Supervisors and CDPOs.
2. They should appraise the performance of each level of functionary immediately in a transparent manner.
3. High performing AWWs should be promoted to supervisory level and the 28% vacancies that currently existed should be filled up.
4. High performing Supervisors should be promoted to the level of CDPOs, with a clear instruction that their job is to continuously build the capacity of lower level functionaries.
5. Additional charge should be removed from all CDPOs, except those who have expertise in areas of convergence like agriculture, health care, or natural resource management.

6. If ANMs want to join at Supervisor's level, they should be encouraged, provided they have the minimum qualifications for being ANMs and have demonstrated the ability to coordinate with AWWs.
7. All Regional Deputy Directors (RDDs), CDPOs, Supervisors and AWWs must have a shared concern to break the inter-generational cycle of malnutrition. AWWs and ANMs should jointly ensure 100% immunization. There should be a shared concern from the Directorate level to the AWC level to break the inter-generational cycle of malnutrition through ICDS.

Social Assessment of ICDS in Karnataka

Indian Institute of Management Bangalore

Introduction

There has been a growing concern to know as to how ICDS services have been accepted by the community. Besides, there is a need to find out the extent to which institutions of ICDS are able to implement the projects successfully. Several efforts are made through training of functionaries to increase participation of the community in ICDS activities. UNICEF has provided appropriate interventions and support in the implementation of ICDS activities. UNICEF commissioned a number of social assessment studies in some states of India in order to identify the areas of improvement. Hence the current social assessment of ICDS in Karnataka was initiated by UNICEF to improve service delivery.

Aims and Objectives

The study aimed to:

1. Review the social infrastructure consisting of cultural, educational and political conditions prevailing in the chosen districts for effective delivery of services.
2. Study attitudes, values and beliefs of stakeholders including mothers about nutrition, pre-schooling and other services.
3. To obtain information about the existing practices and accessibility/ adequacy/ quality of services/ interventions.
4. Explore the current capacity of ICDS projects, including institutional capacity, to serve the targeted beneficiaries or stakeholders to increase utilization.

Methodology

This study was conducted in four districts of Karnataka namely Kolar, Dharwad, Gulbarga and Mysore. A total of 240 AWCs were selected for the study. Primary data was collected through questionnaires and checklists, personal interaction with the Deputy/ Assistant Directors and Programme Officers, and observational recording. Secondary data was gathered through reports of NIPCCD.

Findings and Conclusions

1. Out of 8 CDPOs, 4 CDPOs mentioned that the pre-school aspect of training programme was highly relevant, 3 CDPOs mentioned it to be some what relevant, and 1 CDPOs said that 50% AWWs of the taluk were effectively imparting PSE, while for the other 50% AWWs the training on PSE had no impact.

2. A large number of respondents mentioned that pre-school was the weakest link in the ICDS programme, because the AWWs spent a lot of time on added responsibilities outside the core ICDS programme. This left them with insufficient time to concentrate on pre-school activities. Another reason was the presence of Kannada or English medium private schools which motivated some parents to send their children to these schools. This was because the kindergarten programme of these schools laid emphasis on reading and writing, whereas the pre-school of ICDS limited itself to oral knowledge.
3. Around 91% respondents mentioned that meticulous and judicious selection of AWWs was an important consideration for better performance of AWWs.
4. It was found that a number of centres did not have proper storage facilities to keep SNF/ ARF (Amylase Rich Food). Sometimes the ARF powder was infected and some items were distributed without proper cleaning. Some centres supplied ARF balls made with cold water and children did not relish it.
5. When pregnant women moved to another village to their parents place during delivery, there was no provision in the ICDS programme to shift her to the other village than the village where she was currently registered. These women were denied SNF in the most critical period of their pregnancy.
6. It was found that children were not getting timely immunization due to lack of proper coordination from the Health Department and absence of mission mode in providing immunization services.
7. A number of AWCs did not have proper buildings. The problem was more acute in urban projects of Hubli-Dharwar. In this project area a number of AWCs were located in temples and mosques. This created problems of space and lack of kitchen and storage facilities. The centres located in places of worship suffered from another problem such as animal sacrifice. This caused an unhealthy atmosphere for children.
8. It was found the anganwadi helper (AWH) had to fetch drinking water from places which were quite far away, especially in the backward taluks. Even the water brought from tanks was not clean and it was not safe for children to drink. AWHs mentioned that fetching water took away quite a bit of their time and they were not able to attend to other activities.
9. It was found that lack of proper transportation facilities had been a major limitation for timely monitoring of the programme. A number of projects at the taluk level either did not have a jeep, or it was not in working condition.
10. All the CDPOs mentioned that monitoring such a large number of centres was unmanageable. However, in some large projects ACDPOs were appointed. They were deputed to perform other duties and many times did not have any delegation of powers to take decisions regarding monitoring and implementation. They did not have proper job description and their services were not well streamlined in the ICDS programme.

11. It was found that the panchayat raj institutions (PRI) namely ZP (Zila Panchayat), TP (Taluk Panchayat) and GP (Gram Panchayat) were not fully participating in ICDS activities. One major problem had been ownership and commitment. TPs did not own the ICDS programme as desired. There was total lack of any information system at the taluk level regarding the ICDS programme. Their positive role in construction of buildings for AWCs was also not very encouraging.
12. It was found that the Anganwadi Workers Training Centres (AWTCs) and Middle Level Training Centres (MLTCs), which were conducting training for AWWs and Supervisors respectively, had good physical infrastructure, but more full-time faculty were needed for enriching the training programme. Some AWTCs did not have adequate physical infrastructure, but the instructors seem to be competent and well motivated. In both these training centres UDISHA package was implemented.
13. It was found that AWWs were not well paid compared to the tasks carried out by them. Both, Supervisors and CDPOs felt that they were unable to punish the AWWs and AWHs who were violating the norms of their work. One of the CDPOs found the SNF illegally stored at the residence of an AWW but could not initiate action against her.
14. Supervisors did not have proper transport facilities to make frequent and surprise visits to AWCs. They did not have a small room and a desk to sit and work in the CDPOs office.
15. Doctors had to attend to their assigned OPD work in the mornings and could only visit AWCs in the afternoon. Health officials mentioned that non-availability of transport was a major cause for infrequent visits.
16. Most of the home visits were carried out either by AWWs alone or with AWHs. Many times ANMs did not accompany them when they made home visits.
17. Children who left AWCs were expected to join regular schools when they completed 5 years of age, and AWWs were also involved in educational census. However, when these children did not enroll in school or dropped out very early, school authorities did not seek any support from AWWs. ICDS functionaries had fairly good knowledge of the family background of these children and hence were in a position to guide the education authorities in preventing school dropouts. Besides, children who were supposed to be in the AWCs (children in the age group of 4 and 5 years) were taken away from the AWCs and enrolled in schools prematurely as parents and children were attracted to mid day meals. As there was no reading and writing in the pre-school component of ICDS, this also motivated parents to admit them even at the early age of 4 years either to Government Schools or nearby private schools.

Recommendations

1. There is a need to improve the building and other infrastructure facilities at the village level for every AWC.

2. It is desirable to house the AWCs in the school premises in future.
3. Every AWC building should be built with proper toilet facilities for children, clean drinking water and proper sanitation.
4. AWCs should have proper storage facilities and kitchen.
5. Necessary toys, charts, play materials, etc. should be supplied to all AWCs to strengthen the pre-school component.
6. Zila Parishads should work closely with CDPOs to ensure good quality of construction of buildings for AWCs.
7. Transfer of land in the name of ZP or ICDS should be ensured before constructing the building.
8. Proper measuring scales for SNF and standing scales to measure pregnant women and adolescent girls should be supplied urgently.
9. Modernization of offices of ICDS at the taluk and district levels should be given utmost importance. Computerization should be done and the administrative staff, CDPOs and DDs should be trained to make them computer literate.
10. Better vehicles and budget for diesel should be provided at the taluk and district level. Supervisors should be provided telephone facilities.
11. The post of ACDPOs should be abolished. Instead, CDPOs should be posted in every project with a maximum of 150 centres.
12. The Management Information System (MIS) should not be confined to stating the numbers of PHCs, PHUs, SC schools, enrollment, etc. It should, at any given point of time, be able to provide information on the status of a number of facilities in terms of how it is supporting the ICDS programme and its current status.

A Social Audit of ICDS in the State of Bihar: A Study by FORCES

FORCES (Forum for Crèches Child Care Services)

Introduction

This study, conducted in Bihar by FORCES (Forum for Creche and Child Care Services), revealed that in this state there was denial of survival, protection, development and participation rights of the young child. The poor implementation of health care services provided by ICDS violates the rights to survival and protection, and the rights to development and participation are denied by non-implementation of PSE. The quality of early childhood care and development (ECCD) programme can help break the poverty and deprivation cycle and benefit the child.

Methodology

This study was conducted in 12 districts of Bihar, namely Begusarai, Bhojpur, Kaimur, Katihar, Khagaria, Nalanda, Nawada, Patna, Purnea, Rohtas, Saran and Vaishali. A total of 120 AWCs were covered. 12 CDPOs, 24 Supervisors, 120 AWWs, 120 beneficiaries 0-3 years/ lactating mothers, 120 beneficiaries 3-6 years, 120 pregnant women and 120 adolescent girls were selected. Data was collected through interviews and field survey.

Aims and Objectives

The study aimed to:

1. Assess the financial and physical performance of ICDS in the state of Bihar and identify the gaps.
2. Assess the quality of monitoring in ICDS programme and recommend improvements in the delivery of services within the resources of the Government.
3. Assess the training methodology and quality of training of AWWs and identify existing gaps.
4. Assess the practicality of merging AWCs and crèches as suggested by the Government.
5. Assess the extent of transition of children from AWCs to primary schools and readiness of the primary school.

Findings and Conclusions

1. Bihar had 60,813 sanctioned AWCs out of which only 24,871 were operational. Only 37 out of 248 projects were functional which implied that only 14% AWCs were functional.
2. Around 26% of the children below 3 years in Bihar suffered from severe malnutrition, 29.9% had moderate malnutrition, 26.2% suffered from mild malnutrition, and only 17.7% children below 3 years were in normal grade of nutrition. 81.3% children below 3 years of age had anaemia. Around 26% of the children in Bihar suffered from severe malnutrition.

3. The survey showed a wide coverage of SCs, OBCs, and minorities (78% for children below 6 years and 74% for pregnant and lactating women). The dismal implementation of the scheme had adverse effects on the beneficiaries who belonged to socially and economically disadvantaged groups.
4. It was found that only 42% AWCs had 'pucca' (permanent) infrastructure. 22% of the AWCs operated from the AWW's residence, and only 8% had their own infrastructure. Only 40% had space for indoor and outdoor activities.
5. It was found that SNP in Bihar was in a state of disarray. There was no standardization regarding the type or quantity of food. In some AWCs, no SNP was distributed to children below 3 years of age, and they had no facilities for pregnant women.
6. About 75% of the centres recorded supply constraints and that was the reason for a 'hartal' (strike). Due to this, no SNP was being provided to Khagaria and Begusarai for two months.
7. The positive aspect was that cooked food was being distributed at all the centres. Some of the centres were distributing only lozenges/ chocolates, which were IFA tablets. These tablets were not supposed to be food items distributed as SNP through AWCs, but they were a part of the medicines distributed through AWCs.
8. Bihar had the highest number of children with malnutrition. It was found that more than 1 AWC had a similar number of malnourished children in mild, moderate and severe category.
9. Although most centres had weighing scales, less than 50% pregnant mothers and around 35% children were weighed at the centre.
10. Referral services were also dismal. Only 7 out of 120 AWCs had children with disability and none of the AWWs were trained on disability. Only 6% AWCs had children with disability and none of them had availed referral services.
11. It was found that 43% of the deliveries were at home attended by untrained *dais*. Only 2% of the births were attended by ANMs and 6% by doctors.
12. Only 60% AWWs were using teaching kits. Majority of the children were functionally literate, 67% could count 1-50, and 81% could read simple words.
13. Around 73% AWWs were not receiving their salary on time, and Bihar had not received any grant in 2003-04 under Udisha.
14. Only 44% community representatives had shown awareness and interest in the programme. Only PSE had received importance. PSE got 88% positive responses when the impact of ICDS was assessed by community representatives.
15. Under Kishori Shakti Yojana (Scheme), AGs were not provided with any services. Only in some centres, IFA tablets had been given to them.
16. Nutrition and Health Education, which should be conducted at least once in three months with the help of Mahila Mandals, was hardly ever conducted. AGs were denied all services, some of them received IFA tablets, but none of them were provided with *khichdi* or immunization.

17. The condition of day care centres/ crèches was very poor. In Bihar only 8,825 children were covered by 253 government crèches, whereas the child population was 16,234,539.

Recommendations

1. AWCs must be provided independent infrastructure with adequate space for activities and storage.
2. There is a need to introduce one trained person at the AWC to take care of pre-school activities and the AWW can take care of the stimulation and learning activities of children below three years.
3. All primary schools should have data on children coming from AWCs. Strengthening the link between PSE and primary school education can fill the gap.
4. Kishori Shakti Yojana should be made mandatory for all AGs. The duration of receiving services from the AWC should not be for six months only, AGs should receive SN from 12 years to 18 years of age.
5. AGs should attend regular NHE sessions and adult literacy programmes (for illiterate girls). This intervention of 5-6 years by providing them health and nutrition education can actually guarantee the right to survival, development and protection.
6. The number of crèches should be increased according to requirement.
7. Regularized salaries should be provided to all AWWs. Training on disability should be mandatory for all AWWs.
8. It is important to implement the scheme by extending the facilities to all AGs and ensure regular NHE programmes.
9. The quality of Early Childhood Care and Development (ECCD) programme can help break the poverty and deprivation cycle and benefit the child. A community-based programme can help to break the vicious cycle of poverty and malnutrition.
10. Bihar needs overhauling of all services under the ICDS scheme and this requires finance, strong political will and community support. The State Government, NGOs and panchayats need to expedite implementation of ICDS as per the norms defined in the scheme and guarantee the survival, protection, growth and participation rights of the young child.

A Social Audit of ICDS in the State of Uttar Pradesh: A Study by FORCES

FORCES (Forum for Creche and Child Care Services)

Introduction

This study was supported by Forum for Creche and Child Care Services (FORCES), a national network of organizations and individuals concerned with issues relating to women working in the unorganized sector and care of their children. This survey on ICDS was carried out in 12 districts of Uttar Pradesh. It is the outcome of a collective endeavour and allegiance to a single agenda of ensuring early childhood care and development to all children in the country.

Aims and Objectives

The study aimed to:

1. Assess the financial and physical performance of ICDS in the state of Uttar Pradesh and identify the gaps.
2. Assess the quality of monitoring of the programme and recommend improvements in the delivery of ICDS and the resources of the Government.
3. Assess the training methodology and quality of training of AWWs and identify existing gaps.
4. Assess the practicality of merging AWCs and crèches as suggested by the Government.
5. Assess the extent of transition of children from anganwadis to primary schools and readiness of the primary school.
6. Recommend strategies to bridge gaps in implementation of the programme to achieve full effectiveness.

Methodology

The study was conducted in 12 districts of Uttar Pradesh namely Aligarh, Allahabad, Azamgarh, Bahraich, Barabanki, Basti, Chandauli, Lucknow, Maharajganj, Mirzapur, Pilibhit and Deoria. In each district, one block was chosen. From each block 1 CDPO, 2 Supervisors, 10 AWWs, 10 mothers of children in the age group 3-6 years, 10 mothers of children below 3 years, 10 lactating mothers, 10 pregnant mothers, 10 adolescent girls, 10 panchayat pradhans, and 10 primary school teachers were selected for the study. The primary data was collected through interviews, and secondary data was gathered from concerned government departments.

Findings and Conclusions

1. 62% of the eligible beneficiaries in the age group of 0-6 years were registered in AWCs, while 64% pregnant and lactating mothers were registered, and 7% AGs were covered (3 adolescents girls were covered every 6 months).

2. Majority of the beneficiaries were from the BPL category.
3. The proportion of Muslim beneficiaries was between 8-9%, while Scheduled Caste and OBC category were 35% to 39% respectively. About 48% of the pregnant and lactating SC/ ST/ OBC women were covered under the programme.
4. The low percentage of housewives was also noticeable, 8% mothers of child beneficiaries and 10.8% pregnant women and lactating mothers were housewives. They mentioned the requirement of day care centres. In Uttar Pradesh under National Creche Fund Scheme there were only 368 creches and under Day Care Centres Scheme there were 740 creches. These centres benefit only 23,800 children in the whole of Uttar Pradesh, where the child population is over 3 crores.
5. It was found that 64% AWCs were operating from the premises of primary schools. This has its advantages and disadvantages. Children grow up with the habit of going to school, their transition from AWC to the primary school is quite smooth, and it is easy for parents to send the children attending primary school and AWC together when the venue is the same. Some disadvantages noticed are listed below. These are related to inadequate space, food supplements and logistic arrangements. A little over 50% AWCs had adequate space for indoor and outdoor activities, and only 31% had space for storage. AWWs were exploited as a resource to teach Class I along with pre-school children. The pre-school children were given the same mid-day meal as were primary school students, and there was no data on their share of "Sattu" (powdered roasted grains).
6. ICDS is expected to train AWWs on early detection of disability, and through referral services AWWs are expected to make early interventions. But in Uttar Pradesh only 14% AWWs recorded children with disabilities and only 6% of them had availed of referral services. Only 25% AWWs were trained on disability. In Pilibhit, disabled beneficiaries mentioned that they had not received any medical intervention.
7. It was found that in both urban and rural Uttar Pradesh, most births took place without any trained person in attendance. The percentage of births without trained assistance was above 50% in rural Uttar Pradesh and around 40% in urban Uttar Pradesh. Maximum deliveries took place at home attended by untrained *dais* (43%), 15% of the births were attended by ANMs, and 18% by doctors.
8. It was found that poor immunization was recorded in Maharajganj and Bahraich. No immunization was recorded in Pilibhit. No immunization was given to pregnant women beneficiaries at Mirzapur, and only 20% mothers were immunized at Azamgarh. Vitamin A was not available in Deoria, Maharajganj, Allahabad, five AWCs of Basti, Chandauli, and Azamgarh. There was no distribution of Iron and Folic Acid tablets to pregnant mothers in Deoria, Maharajganj, Pilibhit, Basti, Mirzapur, Azamgarh and Allahabad.
9. It was found that there was poor linkage between primary schools and AWCs. While it was mandatory for all primary schools to keep information about all AWC children who graduated

to primary schools, only 42% of the primary schools could provide information on AWC children who had joined primary schools.

10. It was found that out of 120 AWCs, 62 had toilet facilities. In Barabanki, 20% AWCs had toilets, AWCs in Allahabad had none and in Lucknow 20% centres had toilets. The situation was best in Chandauli (100% availability of toilet facilities), Basti (80%) and Aligarh (90%).

Recommendations

1. In Uttar Pradesh 25000 AWCs out of the sanctioned ones are not operational. The financial and human resources needed to make these centres operational should be treated as a priority as these have the potential to reach out to 25,000,000 people who are in need of these services.
2. The AWC must have a separate and *pucca* (permanent) infrastructure with adequate space for indoor and outdoor activities.
3. The AWC functions for 4 hours a day and the services to be provided in these four hours by the AWW are many. The AWW should ensure that within these hours various services are given like health services, PSE, home visits, record keeping, etc. and linkages with health and environment staff are maintained.
4. All AWCs should have proper drinking water and toilet facilities.
5. Training should be given to all *Dais* in the community to minimize the number of deliveries taking place without trained birth attendants.
6. Alternative monitoring system should be set up through social audits and frequent surveys to ensure accessibility to immunization, distribution of Vitamin A and IFA tablets at the AWC to all beneficiaries.
7. Standardization of PSE can only be attained through formalization of the PSE system which is yet to become a part of the education policy. Advocacy could be taken up about this issue so that PSE becomes compulsory and formalized, and comes under the purview of the Department of Education.
8. There is need to introduce one trained person at the AWC to take care of preschool activities while the AWW could take care of the stimulation and learning activities of children below three years.
9. The coverage of eligible population should be increased from 50% to 100% so that all children below six years join and participate in a common preschool system.
10. Kishori Shakti Yojana should be expanded to cover all adolescent girls, and the duration of receiving services from the AWC should be increased. At present they are eligible to receive services for only six months. They should attend regular NHE programmes and adult literacy programmes (for the girls who are not literate). This intervention for AGs should be for 5-6 years duration, and they should be provided health and education, which can actually bring in the desired impact on their lives as well as on the lives of the future generation.
11. There is urgent requirement for setting up crèches. SHGs can be mobilized to start crèches for the children of the women working in the unorganized sector.

The Status of the Young Child in Rajasthan: A Study by FORCES

FORCES (Forum for Creche and Child Care Services)

Introduction

Early childhood is the period during which critical physical and mental development takes place. This study, supported by AUSAID and Plan International, was done to evaluate the status of the young child in Rajasthan and gauge the extent, depth and outreach of ECCD (Early Childhood Care and Development) services in the context of CRC (Convention on the Rights of the Child). This study assessed the nutrition, health, education and child care services in twelve districts of Rajasthan.

Aims and Objectives

The study aimed to:

1. Study the status of young children in the context of early childhood care and development (ECCD) services in the state of Rajasthan.
2. Suggest macro and micro level recommendation to fill the gaps in implementation of ECCD services.
3. Explore the reach of ECCD services to the last child in remote locations, non-revenue paying villages, *dhanies*, tribals and nomadic groups, etc.
4. Ensure survival rights of the girl child with special focus on declining sex ratio.
5. Appraise the governments' role in protecting the young child in difficult circumstances.

Methodology

This study was conducted in twelve districts of Rajasthan namely Jaipur, Dausa, Hanumangarh, Jodhpur, Ajmer, Tonk, Alwar, Ganganagar, Jaisalmer, Karauli, Bhilwara and Udaipur. A total of 10,600 beneficiaries were taken. Data was collected through interviews and field survey.

Findings and Conclusions

1. It was found that the ANMs, visited AWCs regularly for immunization and health check-ups. Monthly immunization was done regularly in 77% AWCs, and NHE activities were carried out in 75% AWCs.
2. It was found that 53% AWCs had clean drinking water facilities, but only 29% had toilet facilities.
3. About 75% of the AWCs registered beneficiaries with disability. The centres did not provided any special services to special children and AWWs had only preliminary training on disability.

4. All PHCs had facilities for immunization, distribution of Vitamin A, ORS, testing facility for TB, free medicines for BPL patients, etc.
5. Private practitioners mentioned that 3% beneficiaries had received immunization services from them, and they also treated cases of malnutrition and disability.
6. Community was aware of the importance of breastfeeding. 55% children received breastfeeding within two hours of birth and 37% within a day.
7. In this survey of 12 districts, there was only one Government run crèche, which was functioning in Rajwas AWC in Tonk district. Child care services were not within the reach of every working mother. 60% to 70% of working women were leaving their children in the care of elderly relatives.
8. The average number of children for PSE in India was 33.69 per AWC and in Rajasthan the number was 38.13 children per AWC.
9. In Ajmer, the AWCs were more popular for SN, but for PSE parents preferred to send their children to NGO run schools, and those who could afford it preferred private schools. They mentioned that around 30% of the AWWs were illiterate.
10. Neem Hakims were found to be popular as they were available throughout the day and were easily available in this state.
11. Malnutrition among children was evenly prevalent all over Rajasthan. There was not even one district that had less than 30% prevalence of malnutrition. Malnutrition among children in various districts ranged between 30% to 59.4%.
12. It was found that certain remote locations in Jaisalmer were not covered by ICDS, as there was a very small population of children and the location was difficult to access.
13. Stakeholders mentioned that immunization and health check-ups were the only health related activities in villages. Distribution of Vitamin A, TT injections and distribution of IFA tablets to pregnant women and anaemic children were activities that took place occasionally.
14. Anaemia among adolescent girls and women increased the risk of premature delivery and incidence of low birth weight babies. Vitamin A deficiency continues to be a major public health problem.
15. Rajasthan has over one crore children (10 million) but only 26% were covered by SN programme of AWCs. This raises a deep concern for the coverage of all children belonging to economically weak groups and those lacking opportunities. There was a short fall of about 75,000 to 100,000 beneficiaries.
16. It was found that girls were provided adult education through adult literacy programmes. In Rajasthan two girls were chosen from BPL families per centre under Kishori Shakti Yojana (KSY scheme), and that was a very low figure. Efforts were made by the State Government through CDPOs to provide adult literacy to AGs under Sarva Shiksha Abhiyan, vocational training, and improve the health and nutritional status of AGs through provision of IFA tablets.

Recommendations

1. Coverage of all BPL beneficiaries should be prioritized and the right target groups need to be identified.
2. Disability needs immediate attention. Early identification and intervention is required for children with special needs. Referral services may be utilized for this.
3. Child care centres should be established in those urban areas where AWCs do not exist.
4. The proposal for merging AWCs with crèches should be implemented right away. To make them operational necessary functionaries should also be appointed.
5. In AWCs where the teachers (AWWs) are illiterate, trained staff should be appointed, and illiterate AWWs can be made literate through SSA.
6. It should be made mandatory for AWCs to provide PSE at least for two hours per day. Capacity building of AWWs for giving home based or centre based support on traditional and modern child care should be provided.
7. The implementation of Pilot Project of National Nutrition Mission should be speeded up so that beneficiaries can start enjoying the benefits of the programme.

Three Decades of ICDS: An Appraisal

National Institute of Public Cooperation and Child Development

Introduction

Integrated Child Development Services (ICDS) programme continues to be the world's most unique early childhood programme, which has been operating satisfactorily since three decades of its existence. The programme provides a package of services, comprising supplementary nutrition, immunization, preschool education, health check-ups, nutrition and health education, and referral services to children below six years of age and expectant and nursing mothers. The concept of providing a package of services is based on the consideration that the overall impact would be much larger if different services are delivered in an integrated manner, as the efficiency of a particular service depends on the support it receives from related services. There are presently 5652 ICDS projects functioning in the country comprising 4533 in rural areas, 759 in tribal and 360 in urban areas (as on December 2004).

Methodology

The study covered 150 ICDS projects from all 35 States and Union Territories (UTs) covering rural, urban and tribal projects. The universe of the study was restricted to those projects which were functional for a minimum period of 5 years. Sample was drawn only from blocks which were operational as on 1 April 2000 i.e. 4200 projects (3177 rural, 273 urban and 750 tribal) and the total sample comprised 750 anganwadis.

Aims and Objectives

The objectives of the study were to:

1. Assess the existing status of implementation of ICDS programme in terms of coverage, outreach, coordination, convergence and innovations introduced by States and NGOs.
2. Compare the differences in implementation of the ICDS program in rural, urban and tribal areas and NGO run projects, and also identify gaps and problems in the implementation of ICDS.
3. Find out the perception of community and local bodies about ICDS and the extent of support provided by them in implementation of the programmes.
4. Explore the inter-linkages of ICDS with other development programmes and their role in improving the quality of services.

Findings and Conclusions

Infrastructure

1. Data from the study showed that only 31% of the households had toilet facilities. Sewage / drainage system was reported in 30% villages under regular ICDS projects.
2. About 97% anganwadi centres (AWCs) in urban areas, 93% in rural areas and 74% in tribal areas were connected by roads. Primary Health Centres (PHCs) and Sub-Centres were available in 29% and 43% areas respectively, where anganwadi centres were located. Data thus revealed that accessibility to important health services was limited.
3. About 49% AWCs had inadequate space for outdoor and indoor activities, and 50% had no separate space for storage of various materials.
4. Weighing scales were available in 97% anganwadis of World Bank assisted ICDS projects, followed closely by NGO run projects (95.3%), and 85% regular ICDS projects. Around 89% of them were in working condition also.
5. The study revealed that cooking utensils were available in 61.8% rural, 49.2% urban and 65.9% tribal projects.

Profile of Functionaries

6. It was gathered that 15% positions of Child Development Project Officers (CDPOs), 48% of Assistant Child Development Project Officers (ACDPOs) and about 18% of Supervisors were vacant in the surveyed projects. However, the position with regard to the appointment and availability of AWWs and Helpers has been quite satisfactory.
7. Majority of the AWWs (43.2%) were matriculate, 23% were higher secondary and about 10% were graduates.

Disability

8. Data indicated that 0.83% of children in households covered under the study were handicapped. Out of these children, 55.56% have been receiving benefits from ICDS programme.

Community Participation

9. Around 32% women (15-45 years) extended a supportive role in anganwadis like assistance in cooking food, providing fuel, collecting children to bring them to anganwadis for immunization, fetching drinking water, etc. In tribal projects (39.6%) this type of support was found to be maximum.
10. Majority of community leaders (69.7%) extended their contribution to AWCs in the form of supervision, solving personal problems of AWWs, and protecting them from undesirable elements. Almost 45% also cooperated with and supported AWWs as and when it was necessary.
11. Around 42% anganwadis received raw food items which were cooked / prepared at AWCs and served to children. In some states like Gujarat, Rajasthan, Maharashtra and Madhya Pradesh, all children below 6 years identified as severely/ moderately malnourished on the basis of

weight were given therapeutic diet cooked in soft form (pulverized) or tinned milk donated by benevolent organizations/ individuals. This was an indication of significant efforts made by ICDS functionaries to mobilize resources at the grassroots level to make the programme effective and meaningful.

12. **Pregnant Women**

The study found that maximum coverage of pregnant women was found in tribal AWCs of regular ICDS projects (61.8%) and NGO run ICDS projects (58.3%).

13. **Nursing Mothers**

On the whole the study found that a little more than 50% nursing mothers were registered for supplementary nutrition. More than 80% nursing mothers had been registered for supplementary nutrition in the states of Arunachal Pradesh (82.9%), Mizoram (80.3%), Nagaland (81.8%) and UTs of Dadra and Nagar Haveli (85.5%) and Lakshadweep (87.7%).

Supplementary Nutrition

14. The study showed that in all categories of ICDS projects, percentage of female children (82%) who availed supplementary nutrition was quite high in all the areas as compared to male children (75%) in the age group 6 months to 3 years.
15. Among children of 3-6 years, despite the fact that more girls were registered (57.8%) than boys (51.1%), the share of benefits went more to boys (75.9%) than girls (74.6%).
16. Around 79.8% anganwadi workers (AWWs) reported that food was totally acceptable to children and mothers. They found it well prepared, tasty and enjoyed its consumption.

Growth Monitoring

17. The study found that AWWs weighed around 63.5% newborn children and mothers in all the areas. However, weighing of children in the age group 3-5 years was slightly better as majority of AWWs (83.3%) were able to do so.

Preschool Education

18. On an average, 37 children were registered for preschool education at anganwadis, and 75% of the registered children attended the AWCs.
19. In almost all the anganwadis preschool activities were going on like singing songs (95.1%), story telling, counting (91%), indoor activities (78%), etc.

Anaemia

20. Data obtained from mothers revealed that around 59.6% children between 6 months and 3 years were given Iron Folic Acid (IFA) tablets from AWCs, while IFA tablets were consumed by 68.9% pregnant women regularly.

Immunization

21. About 66.1% children were immunized, the highest being in rural projects (71.6%), followed by urban (65.7%) and tribal (51.5%) projects. It was also found that records of vaccination were correctly maintained by health functionaries/ AWWs.

22. The major reasons found for inadequate immunization were indifferent attitude of parents towards immunization, age old beliefs, customs, superstitions, stigma attached to castes/ creeds, and inadequate awareness about the advantages of immunization.
23. Around 76.2% pregnant mothers received tetanus toxoid immunization and coverage of immunization in rural projects was the highest (79%).

Low Birth Weight

24. Data showed that birth weight of 7% children was below 2 kg and around 75% children were above 2.5 kg in tribal ICDS projects.

Health Check-Up

25. According to AWWs (75.1%), health functionaries conducted health check-ups of children and the highest percentage was prevalent in urban projects (80.8%).

Nutrition and Health Education (NHED)

26. Around 69% AWWs mentioned that they organized NHE (Nutrition and Health Education) sessions once a month on topics related to mothers and children. On an average the attendance of mothers in urban, rural and tribal areas was 18.68%.

Adolescent Girls

27. In the sample of ICDS projects taken, 44% AWWs were also rendering services under the Adolescent Girls Scheme (Kishori Shakti Yojana) started during the year 1992. Around 32.2% AWWs provided Iron and Folic Acid tablets to adolescent girls daily and also organized health and educational programmes for adolescent girls in AWCs.

Recommendations

1. It was suggested that efforts should be made to coordinate with Health Department to make health services available in anganwadi areas as near as possible so that maximum benefits of nutrition and health services can be availed by the needy and poor, who otherwise have no other alternative to avail these services.
2. The Government and NGOs should start education programmes and campaigns related to ICDS to make the community aware about the importance of ICDS in the development of children and women.
3. Efforts to enhance immunization coverage need to be strengthened so as to cover all the children for full immunization. Community also needs to be sensitized adequately about the need and importance of immunization.
4. A special provision should be made in ICDS scheme to involve and train adolescent girls in anganwadi activities as they have the potential to extend all out support to AWWs and Helpers in all the spheres of anganwadi centre activities.

Welfare Services for Women and Children

I. Sobha

Introduction

ICDS is a centrally sponsored programme. Its projects are located in rural, urban and tribal areas. The scheme provides supplementary nutrition to needy children and to expectant and nursing mothers from low income families for 300 days in a year. The aim is to supplement nutritional intake by providing 300 calories and 20 gm of protein for malnourished children and 500 calories and 20-25 gm of protein for expectant and nursing mothers. The programme is also assisted by a few International Organizations like UNICEF, WFP, CARE, NORAD, etc.

Aims and Objectives

The study aimed to:

1. Study the organizational structure and management of social services with respect to ICDS programme.
2. Assess the health and nutritional status of women and children, and study the extent of utilization of health services under ICDS.
3. Evaluate the impact of ICDS services on the health and nutritional status of expectant and nursing mothers and children; and
4. Analyse the perception of beneficiaries and the extent of their participation in utilization and implementation of ICDS programme in the sample projects.

Methodology

The study was conducted in Chittoor district in Rayalaseema region of Andhra Pradesh. It covered five ICDS projects in Chittoor district, namely Chinnagottigallu, Srikalahasthi, Palamaneru, Thamballapalle and Tirupati. Data was collected from both primary and secondary sources. Secondary data was collected from books, journals and various institutional records relating to ICDS projects. One non-World Bank project, one NGO project and three World Bank projects were selected, and from each centre, ten beneficiaries were selected making a total sample of 500 beneficiaries. Information was also gathered from Child Development Project Officers (CDPOs) (4), Assistant Child Development Project Officer (ACDPO) (1), Supervisors (23), and Anganwadi Workers (AWWs) (50).

Findings and Conclusions

1. About 45.3% of the pregnant women were between 18-23 years. And the majority of lactating mothers (76%) were between 18-28 years of age.

2. Among lactating mothers, half of the beneficiaries were housewives, some were engaged in some economic activity, and 30% were labourers. 49.6% mothers, 45.3% pregnant women and 44% lactating mothers were illiterate.
3. AWWs created awareness about the ICDS programme and AWC for beneficiaries. Around 12% women availed the benefits after a few months or years, when the need arose. 1.6% of them mentioned that they knew about the AWC since their childhood and were going to the AWC.
4. Nearly 38.4% beneficiaries mentioned that they went to AWCs to avail the combined benefits of pre-school education, vaccination and supplementary nutrition food and 42.8% went to collect SN food and for immunization.
5. From 7th month onwards the child (infant) gets 80 gms of SN food daily. If the child is in 3rd and 4th Grade malnutrition, they get double the share of food i.e. 135 gms every day, and if the child is normal or in Grade I they may not get SN food of even 80 gms daily. When the child enters pre-school, all the children get 80 gms SN food daily. In case the pre-school child is malnourished he/ she gets 135 gms daily.
6. About 93.6% beneficiaries were satisfied with SN food in Srikalahasti and Tirupati; 97.4% beneficiaries did not give any suggestions about SN food due to ignorance and illiteracy. But 2.6% were not satisfied with SN food and they gave some suggestions as the weaning food (wheat, soya powder, sugar or jaggery) caused indigestion or diarrhoea among children. They suggested that Bengal gram powder, soyabeans, oil, salt and chilli powder should be given instead of the weaning food being given.
7. All the beneficiaries were aware of the various services rendered by the AWC, and AWC was mostly known as nutritional noon meal centre for pre-school children.
8. According to the NIPCCD Manual on ICDS, the required age limit for an AWW is between 25-41 years. But 30% of the respondents were above 40 years of age. Majority of them mentioned that they have learned a lot about immunization and ICDS programmes, 12.8% of them said that they have learned how to mingle with or how to motivate parents to send their children for pre-school and immunization, conducting the pre-school programme and distributing SN, which were their major responsibilities.
9. As ICDS is a multi-sectoral programme and involves several government and non-governmental organizations, all the AWWs had interaction with other institutions like balwadis, primary schools, PHCs, Mahila Mandals, adult education centres, educational institutions and nursery schools.
10. About 60% AWWs were facing problems like irregular supply of SNF and lack of toys for the children to play with, lack of proper building for the AWC; half of the respondents of Thamballapalli said that they were not getting honorarium and TA and DA properly, and 3% of the AWWs from Tirupati expressed that they were being called as a worker only, though they educated women and children.

11. 73% of the respondents mentioned that when there was no AWC, their villagers were unaware of vaccinations, getting the benefit of immunization at their doorsteps, pre-school education, SN food, etc. All the respondents felt that the lifestyles of their people have changed due to the scheme. 34.5% of the respondents felt that village women and children's health had improved, and 21.4% women changed their cooking practices and also food habits. Due to regular consumption of SN food their health had improved. 15.5% of the respondents learned about keeping the surroundings clean, recognizing the small family norm, etc., all of which reduced the mortality and morbidity rates and improved their health status.
12. 7% AWWs suggested that school dropouts can be prevented by offering different types of eatables, instead of giving the same type of powdered food daily. All mentioned that there was no CDPO in Tirupati project and a CDPO should be appointed to monitor the centre regularly for effective implementation of the programme.
13. Outdoor play equipment was not available at any of the centres. The reason could be that outdoor games can be conducted without any equipment.
14. The CDPO/ACDPO checks the MPRs comparing them with previous monthly reports, and consolidates project reports to be sent to the Project Director at district level. All respondents mentioned that the officials of various departments like health, social welfare, women welfare and rural development have specific roles to play in promoting co-operation and co-ordination for improving the nutritional and health status, and in improving the economic status by giving loans through self help groups, etc. It was found that there was effective co-ordination between various departments.

Recommendations

1. Proper accommodation for AWCs is a necessity for successful implementation of the programme. Lack of a proper room creates problems for safe keeping of equipment, utensils, teaching aids, etc. Hence every AWC should have a proper building.
2. Periodic supervision and effective monitoring of the work of each and every employee by their higher official is needed which would improve responsibility. Efforts should be made to enhance professional growth of AWWs by giving them assistance in carrying out administrative tasks to reduce their work load. This will enable them to spend more time on pre-school education activities and to fulfill a major objective of the scheme.
3. Improvement in service conditions of AWWs like frequent in-service training, incentives for better work, etc. may help in achieving better results. AWWs could be taken to various institutions to obtain knowledge regarding disabled children, methods of rehabilitation and other welfare activities.
4. As part of the immunization programme efforts should be made to concentrate on booster doses of vaccines and TT which is to be given to pregnant women. The supply of essential medicines should be ensured along with adequate support and an in-built referral system.

5. As immunization and health check-ups are being implemented with the coordination of Health Department, the effort of AWWs are not being appreciated by the community.
6. The health and nutrition education component needs to be strengthened as the present education imparted by AWW has a limited impact on the health of children.
7. Supply of teaching aids and toys for play can be increased in number which are essential requirements to attract children to AWCs. More emphasis should be laid to utilize nearby outdoor space for organizing programmes for children.
8. Community participation is not only for accommodation to run the AWC, but their co-operation should be sought to implement other services effectively.
9. Effort should be made to improve the quality of food, and instead of giving the same food every day, various recipes should be evolved based on low cost local food items.
10. There should be regular contracts among the staff to review and monitor the functioning of the centres.
11. Wide publicity about the scheme should be given through personal contacts and mass media to create awareness among the community.

Women and Child Development/ Integrated Child Development Services (WCD)/ (ICDS) III Project

World Bank

Introduction

The World Bank assisted ICDS programme innovations to improve service quality and increase effectiveness in achieving survival, growth and development outcomes for young children. The Bank had funded project activities in 5 selected States namely Rajasthan, Kerala, Tamil Nadu, Maharashtra and Uttar Pradesh.

Aims and Objectives

The study aimed to:

1. Evaluate the functioning of ICDS programme in the 5 States funded by World Bank.
2. Assess the service quality improvement of adolescent girls' empowerment, staffing and infrastructure development.
3. Identify the programme support provided and analyze the national training component (NTC)/ UDISHA.

Methodology

This study was conducted in five States, i.e. Rajasthan, Kerala, Tamil Nadu, Maharashtra and Uttar Pradesh, and it evaluated 1003 blocks and 118,460 AWCs. It covered approximately 30.72 lakh children aged 6 months to 3 years, 43.88 lakh children 3 – 6 years, and 16.45 lakh expectant and nursing mothers. Data was collected through observation and discussions during field visits.

Findings and Conclusions

1. The components that were strengthened with World Bank assistance were the following:
 - i. Implementation of the 'Kishori Shakti Yojana' for adolescent girls to address the life cycle approach to child development.
 - ii. Provision of enhanced honoraria to AWWs and Helpers.
2. Project implementation improved in Rajasthan, and Vitamin A and IFA supplies were made available to the beneficiaries. Growth monitoring of children and monitoring of pregnant women was regular, and satisfactory pre-school activities were conducted in the centres.
3. In Kerala the project had been transferred to the Panchayati Raj system and it was implemented at district, block and village levels.

4. The main problem that Kerala faced in project implementation was due to the treasury ban, which imposed several restrictions on the withdrawal of project funds at the local treasure level. This led to lack of utilization of funds. There was also a ban on purchase of new vehicles.
5. All eligible children in the age group 0-6 years and pregnant and lactating women were covered by the supplementary feeding programme. Children in the age group 6 months to 3 years also got 200 ml of milk under the Prime Minister's Gramin Yojana. There was strong community demand for pre-school at the Anganwadi Centres, and the AWWs and the local panchayats evinced a lot of interest in this component of the programme.
6. In Tamil Nadu, almost 90% of the centres still have 2 workers, one to take care of the 0 to 3 year olds and the other one to take care of the 3 to 6 year olds, and this arrangement has improved the quality of pre-school education in the centres. There was no proper supply of IFA for women under the project, and so far the provision was only for adolescent girls.
7. In the State of Maharashtra even though the overall operationalization of the new ICDS blocks was 66.8%, the corresponding figure for rural blocks was 86.1%. Supplementary food is provided to all eligible children and women. Medicine kits, deworming tablets, IFA tablets and medicine boxes had been procured.
8. In Uttar Pradesh, 108 of the 110 newly sanctioned blocks had been operationalized. Supplementary food was being provided. Growth monitoring is regular, and Vitamin A and IFA supplies are now being made available.
9. In most cases the AWWs do not have a complete household survey of a corresponding village. Apart from this, the indicators for selecting beneficiary households are different from state to state. There is the concept of a service area in Tamil Nadu whereby remote hamlets remain un-reached.
10. In most states there were fixed numbers for feeding that restricted participation and needy people were left out of the ambit of services. Feeding guidelines were used to deliver most other services as well in the programme, and therefore, the out reach of services such as referral, antenatal care, and counselling for household feeding of under-threes had not been addressed adequately in the programme.
11. Growth monitoring, although regular for attending beneficiaries, remains weak in the absence of counselling for home based infant feeding. The participation of underthrees remains very weak in the programme.
12. There was improvement in the implementation of activities for adolescent girls in all the states.
13. In Rajasthan, of a total number of 3333 AWC buildings proposed under infrastructure development, only 1510 buildings (45%) had been completed, and 800 (24%) were under construction. Out of 66 CDPO office-cum-godown buildings proposed, only 4 had been completed, and out of 1417 hand pumps targeted, 1077 (76%) had been commissioned.

14. In Tamil Nadu, the merger of the two streams of ICDS (that is TINP, ICDS III and the General ICDS) has been done. The entire program now comes under the direct control of the project coordinator of ICDS III. The procurement of vehicles for new projects is still pending sanction of the State Government. The Bank has recommended that this item should be dropped from the procurement plan for the State.
15. In Uttar Pradesh, there is a high level of vacancies - 67% in the posts of Supervisors (488 out of 729), followed by AWWs (30%) with 4400 posts out of 14,698 being filled, and Helpers (30%) with 4480 posts out of 14,698 being filled. As for civic works, the construction of CDPO office-cum-godowns had recorded 9.75% completion (113 out of 150), but the construction of AWCs was low with only 29% reporting completion (1311 out of 4548). The performance regarding installation of hand pumps was even lower, with only 22% achievement (447 out of 2015).
16. Training of adolescent girls had been taken up in all the states.

Recommendations

1. For project development outcomes to be achieved in less than two years from now, all states need to focus particularly on software components such as improved workers' training, communications for behaviour change and adolescent girls' activities.
2. Field observations indicated the need for closer monitoring of infant deaths for possible lapses in the provision of antenatal care as well as girl child discrimination at the household level.
3. Innovations of the Rajasthan and Uttar Pradesh Governments in creating decentralized training teams are worth mentioning. However, there is need to further improve and scale up adolescent girls training in all the states.
4. Use of the Indian Academy of Pediatrics Standards and Classification Scheme in ICDS does not allow for international comparisons. It was agreed that there is need for a national consultation on this issue, particularly as revision of the nutrition surveillance system is now underway in some states.
5. All states need to focus particularly on activities to improve targeting under threes, improving the access of ICDS to poorest households, improving workers' training, communications for behaviour change, and the adolescent girls programme.
6. The Mission recommended that institutional arrangements and approval procedures need to be reviewed by the Secretary, Department of Women and Child Development (DWCD), and a report prepared to be discussed at the mid-term review consultation proposed in April 2003.

Fortified Candy

Fortified Candy

Distribution of Fortified Candy in ICDS: A Pilot Project Howrah, West Bengal

Child in Need Institute

Introduction

In Howrah district of West Bengal, there is high prevalence of anaemia. Iron and Vitamin A supplementation programmes have been in operation in this area, but it has not produced the desired impact. The State Project of Micronutrient Initiative, in collaboration with the Government of West Bengal, implemented the Pilot Project in Howrah district to test the effectiveness of fortified candies in improving the iron status of ICDS beneficiaries.

Aims and Objectives

The study aimed to:

1. Determine the effectiveness of fortified candies in improving the iron and Vitamin A status in preschool children, adolescent girls (AGs) and pregnant and lactating women.
2. Demonstrate the feasibility of using fortified candies as add-on to the supplementary nutrition that is provided in ICDS centres.
3. Recommend ways for improving efficiency and effectiveness of the programme.

Methodology

This study was conducted in Howrah and North 24 Parganas. Three different groups were studied: pregnant and lactating women, preschool children (36-72 months), and AGs (12-19 years). Number of clusters per district was 30, number of individuals within clusters examined for night blindness was 50, number of individuals from each of the target groups within clusters for biological sample was 10. Data was collected through interviews and field survey.

Findings and Conclusions

1. The intervention used in this project was micronutrient fortified candy, which was given as a supplement. ICDS beneficiaries were given one candy fortified with micronutrient for a duration of 18 months, after which the post test was conducted. The composition of micronutrients per 3 gm of fortified candy were Vitamin A – 500 IU, Vitamin C – 10 mg, Folic acid – 50 mcg, and Iron – 7 mg.

2. It was found that more than 60% of the respondents had not heard about Vitamin A. Less than 50% of the respondents could associate Vitamin A with eyes/ vision. However, very few of the respondents knew anything about the other beneficial effects of Vitamin A. Less than 25% of the mothers could correctly identify that dark green leafy vegetables (DGLV), fruits and vegetables are good sources of Vitamin A.
3. Nearly 65% of the mothers had not heard any message on iron, but those who had heard had the right information. Most women had taken iron supplements during pregnancy; nearly 63% in Howrah and about 68% in North 24 Parganas, but many could not recollect the number of days they had taken supplements during pregnancy. Majority of those who had taken supplements mentioned that they had taken it for more than a month.
4. More than 60% of the population in both the districts claimed to use iodised salt. The knowledge level on iodine deficiency and iodised salt was much better than other micronutrients. 74% households in Howrah and 82% households in North 24 Parganas said that they were using branded salt.
5. It was found that there was no significant decrease in anaemia prevalence in the target groups in the intervention and control districts. However there is 5% reduction in the prevalence of moderate anaemia in the intervention district, whereas the proportion of different grades of anaemia was nearly the same in the control district at baseline and endline. The mean haemoglobin in Howrah at baseline was 11.66 (SD 1.55) gm/ dl and at end line it was 11.53 (SD 1.72) gm/ dl and this showed no significant change in mean haemoglobin.
6. There was significant reduction in anaemia prevalence in AGs before and after the intervention in Howrah and North 24 Parganas. However, the magnitude of change was much more in the area that received the intervention. The prevalence of anaemia decreased by 16.7% and 4.3% in Darjeeling and Kalimpong respectively. In Darjeeling, a significant proportion of people had moved from mild and moderate anaemia to the non-anaemic level. Prevalence of severe anaemia had also decreased by half.
7. It was found that there was no significant difference in the anaemia prevalence in AGs in both intervention and control districts. However, moderate anaemia decreased in the intervention district.
8. There were 79 AGs in whom the study had paired samples, that is, the same girls were studied at baseline and end line. In these girls there was an increase of 0.7 gm/ dl in the mean haemoglobin level. This increase had decreased the anaemia prevalence by nearly 10%.
9. It was found that the mean haemoglobin level in pre-school children showed a significant rise. The rise in mean haemoglobin in this group in Howrah district was 0.82 gm/ dl. This increase had decreased anaemia prevalence by 15.5%. There was no significant decrease in anaemia prevalence in North 24 Parganas district.

10. Blood spots were collected from different target groups at baseline and end line for estimation of serum retinol. From the dried blood spots retinol estimation was done using high precision liquid chromatography. The WHO (World Health Organization) and IV ACG (Associated Capsule Group) recommended cut-offs were used to define Vitamin A deficiency. In Howrah district, the prevalence of Vitamin A deficiency before and after the intervention in pregnant and lactating women was 22.5% at pre- and 18.3% at post intervention; in AGs it was 18.1% at pre- and 10.5% at post intervention; among preschool children it was 26.5% at pre- and 15.5% at post intervention. In North 24 Parganas, Vitamin A deficiency among pregnant and lactating women was 26.4% at pre- and 23.5% at post intervention; among AGs it was 22.5% at pre- and 20.5% at post intervention; and in preschool children it was 35.5% at pre- and 30.5% at post intervention.
11. It was found that Vitamin A deficiency (VAD) was a public health problem in all target groups in both the districts. There was significant decrease in the prevalence in all the target groups, and the decrease noticed in the intervention district in the three target groups was significant. The decrease noticed in pre-school children was more than 10% and in AGs it was about 8%.
12. It was found that improvement in the iron status in children was most likely due to the iron content of the candies. Although the candies also contained Vitamin A and Vitamin C, which were known to improve absorption of iron and also influence utilization of the absorbed iron, the content of these was small and it is unlikely that they contributed to the improvement in iron status.
13. During the period of intervention, the mothers of children expressed happiness about the intervention and requested for fortified candies to be given to other children.
14. AWWs mentioned that attendance and regularity of attendance improved in all AWCs that provided the intervention and compliance was one of the important reasons for the improvement in iron status.
15. It was found that under real life conditions the strategy of using candy as a vehicle to carry micronutrients had greatly improved compliance. Significant reduction in anaemia prevalence was found in school age children and AGs.

Recommendations

1. Fortified candies could be an attractive option to serve as a vehicle to carry essential vitamins and minerals to preschool children, AGs and pregnant and lactating women.
2. Technology to make centre-filled fortified candies and the capacity to scale up production exist in India. The vitamin and mineral premix required are available indigenously and production of fortified candies can be scaled up at short notice.
3. The Government could consider providing fortified candies to beneficiaries of ICDS and children covered by mid day meal scheme as an add-on to the food distributed.

Functioning of Anganwadi Centres

Functioning of Anganwadi Centres

Functioning of Anganwadi Centres in Assam and Meghalaya

Centre for North East Studies and Policy Research

Introduction

In the states of Assam and Meghalaya ICDS has been in operation since 1980. These two states have a total of 26,000 AWCs of which 2218 are located in seven districts of Meghalaya and the rest are in Assam. To assess the functioning of these AWCs, the Centre for North East Studies and Policy Research (C-NES), conducted a study.

Aims and Objectives

The study aimed to:

1. Assess the overall functioning and efficacy of anganwadis (AWs).
2. Find out if there are any gaps in implementation of the programme and recommend strategies for improvement.

Methodology

This study was conducted in the states of Assam and Meghalaya. 3 districts of Assam namely, Kamrup, Dhubri and Dibrugarh and 2 districts of Meghalaya namely East Khasi Hills and West Garo Hills were selected for the study. Data was collected through interviews, observation and browsing records of anganwadis.

Findings and Conclusions

Kamrup District

1. In this district about 35 (87.5%) centres out of 40 had 70-89 beneficiaries.
2. It was found that on an average every centre had 25-60 children in the age group 0-3 years. There was only one centre which had only 4 children.
3. In the age group 0-3 years it was found that male children out-numbered female children in almost every centre. Every centre had 13.38 male children and 12.23 female children. Most of the centres had 5-19 children and covered 82.5% of the eligible male and 90% of the eligible female children.
4. The average number of children in the age group 3-6 years was 39.88. 90% of the centres had 40 children enrolled, whereas 5% centres had 45 children. On an average, every centre had 21.00 male children and 21.48 female children.

5. In 35 centres (80%) ICDS services were provided to 0-9 pregnant mothers and in 60% centres these services were provided to 5-9 lactating mothers. In 1 centre (2.5%) AWW had not kept any records, either because she had not provided any service to lactating women or the women in this centre were not aware of the service provided. On an average, every centre provided services to nearly 6.33 pregnant mothers and 6.41 lactating mothers.
6. Out of the total 40 centres, only one centre could not provide any information about live births. 13 centres had recorded 6 live births every year, while one centre had recorded 12 live births in a year. The average value calculated was 6.10 live births per centre per year.
7. More than 66% of the 40 centres did not have any records of the deaths of children. Only 22.5% centres recorded the total number of deaths. On an average 1.22 deaths occurred per year.
8. Out of the total 40 centres, 34 centres (85%) provided services to beneficiaries. 6 of the centres did not keep the immunization record or they were not providing immunization services to beneficiaries. On an average, the centres provided immunization services to nearly 17.26 people.
9. It was found that only 31 AWCs provided PHC related services to the beneficiaries. But 9 centres did not keep records and they were not providing immunization services. On an average, AWCs provided these services to nearly 13.23 people which indicated very low performance of the PHCs in providing immunization services.

Dibrugarh

1. It was found that 50% of the centres in Dibrugarh had 80-89 beneficiaries. Every centre provided services to nearly 87 beneficiaries.
2. On an average, every centre had 16.7 male children and 15.6 female children in the age group 0-3 years. In the age group 3-6 years, there were more female children in AWCs than male children.
3. Nearly 68% of the centres provided services to 5-9 pregnant mothers in terms of nutritious food, immunization, etc., while one centre each provided these services to 15-19 and 20-24 mothers. Services were provided by these centres to an average of 6.7 pregnant mothers.
4. Around 23 centres, accounting for nearly 57.5% of the total centres, provided services to 5-9 lactating mothers. One centre provide services to more than 25 lactating mothers annually. On an average every centre provided services to nearly 8 lactating mothers.
5. On an average in the district, the centres had about 72.28 children. 12 centres of the total 40 centres had 70-74 children, while only 1 centre accommodated more than 85 children.
6. In nearly 67% of the centres AWWs did not keep any records of the nutritional status of children. The average number of children of normal status were 46.50 children per centre. Only 28% of the AWWs maintained records for Grade I and 15% maintained records for Grade II malnutrition status. On an average there were 2.36 and 1.33 children in Grade I and Grade II malnutrition respectively.

7. Nearly 73% of the centres had records that showed 5-9 live births took place annually, whereas in 10% of the centres AWWs did not maintain any record. The average number of live births for all the centres worked out to be 7.36.
8. Out of the total 40 centres in only 10 centres AWWs had maintained death records. On an average 1.10 deaths took place yearly in these 40 centres.
9. Only 13 centres (22.5%) provided immunization services to beneficiaries. Most of the AWWs did not keep any record of immunization.

Dhubri District

1. The maximum number of beneficiaries in Dhubri was 100-109 which was 57.5% of the total beneficiaries. On an average every centre had 97.16 beneficiaries.
2. Most of the centres catered to 85 children aged 0-6 years. It was found that every centre had 42.63 children in the age group of 0-3 years. Every centre had 22.16 male and 20.47 female children in the age group 0-3 years. The average number of children in the age group 3-6 years was 40.39. On an average, there were 20.50 male children and 19.89 female children in the age group 3-6 years. 5% centres had not maintained any records.
3. It was found that in 37 centres AWWs had maintained records, and every centre had 5 pregnant and 5 lactating mothers.
4. Adolescent population had been recorded and provided services only in Dhubri district. Most of the centres had 5 adolescent girls, but 15% centres had not maintained any record. On an average the centres had 4.91 adolescent girls who were beneficiaries.
5. It was found that on an average, in every centre, 24 students attended PSE activities. There were 5% centres which did not maintain any records of PSE activities and were not functioning properly.
6. It was found that in nearly 63% of the centres AWWs had not responded to the question on normal nutritional status of children. In most centres AWWs did not maintain proper records of the nutritional status of children.
7. It was found that in 62.5% centres records of live births in an year had not been kept. On an average, 6.4 live births took place in every centre each year.
8. It was found that in 85% of the centres deaths had not been recorded. 5% of the centres had recorded 2 deaths, and 10% AWWs mentioned only one death took place each year.
9. Only 10 centres (25%) provided immunization services to the beneficiaries. In most of the centres AWWs did not keep records. In only 12 centres immunization services were provided through PHCs.

East Khasi Hills

1. It was found that the maximum number of beneficiaries in a centre were 80-109. On an average, in the district, every centre had nearly 96 beneficiaries.

2. On an average every centre had 37.53 children in the age group 0-3 years. 18 centres (45%) had 20-29 children, 9 centres had 30-39 children. On an average, every centre had 18.00 male children and 19.53 female children aged 0-3 years. In every centre, on an average, there were 21.00 male children and 21.48 female children aged 3-6 years.
3. Nearly 52.5% of the centres provided services to 5-9 pregnant women, but 5% AWWs had not kept any record. Either they did not provided any service or the women were not aware.
4. Nearly 87.5% of the centres provided services to 0-14 lactating mothers but 5% AWWs had not kept any record. On an average every centre provided services to nearly 7 lactating mothers.
5. In 32.5% of the centres 30-39 children were enrolled while only 1 centre (2.5%) had enrolled more than 90 children. The average enrollment per centre was 34.63 children.
6. Normal nutritional status was found in 50-59 children of 14 centres. 35% of the children had average diet.
7. Nearly 90% AWCs had between 1-9 children in Grade I malnutrition. In 50% AWCs, AWWs had not maintained records of Grade II malnutrition; and in 92.5% AWCs, records of Grade III malnutrition were not maintained. On an average, in each AWC there were 4.52 children in Grade I, 3.21 children in Grade II, and 2.14 children in Grade III malnutrition.
8. On an average there were 9.94 live births in every centre per year. Out of 39 centres, in around 40% there were 10-14 live births yearly. In only one centre more than 25 live births were taking place yearly.
9. Out of the total centres, 31 centres (77.5%) provided services to beneficiaries. In 9 centres AWWs did not keep records or they did not provide immunization services to nearly 37.14 people. Only 32 centres provided immunization through PHCs, but in nearly 37% of the PHCs less than 9 persons were immunized.

West Garo Hills

1. On an average, every centre in West Garo Hills district had 85.13 beneficiaries. On an average, every centre had 30.15 children in the age group 0-3 years. The average number of children per AWC in the age group of 3-6 years was 49.90.
2. 20 centres, 53% of the total, provided services to 5-9 pregnant women, but 5% AWWs had not kept any records. Every centre provided services to nearly 9 pregnant women.
3. Nearly 87.5% of the centres provided services to 0-14 lactating mothers, but in 5% centres no record was kept. Either they were not providing any service or the women were not aware of the service. On an average every centre provided services to nearly 8 lactating mothers.
4. It was found that the average enrollment of children was 41.10 children per centre, which showed that enrollment of children was quite satisfactory.
5. The average number of children enrolled for preschool education was 22.33 in every centre.
6. All the centres had facilities for weighing children. It was found that children had average growth in 35% AWCs. Most of the centres had not reported or they did not maintain proper records

- of the nutritional status of children. On an average, in each centre there were 5.18 children in Grade I, 2.80 children in Grade II, and 2 children in Grade III malnutrition respectively.
7. In 16 centres, there were 10-14 live births annually. In 12 centres there were 5-9 live births. The average number of live births per centre was 10.31 annually.
 8. AWWs in 27 centres maintained death records, while in 13 centres they did not. 14 centres had recorded only 1 death annually, 2 centres had recorded 6 deaths annually. On an average, there were 2.07 deaths annually.
 9. Only 31 centres (77.5%) provided services to beneficiaries. 9 of the centres did not keep records or they were not providing immunization services to the local people. On an average the centres provided immunization services to nearly 28.77 people.
 10. Only 32 centres provided immunization services through PHCs. But 8 of the centres did not keep records or they were not providing services. On an average, the centre provided immunization services to nearly 19 people.

Recommendations

1. ICDS services should be need-based and culture sensitive. People must first be aware of the benefits of the AWCs as a primary support system, specially where other facilities are not available. Services should be available for every child under 6 years, not specifically only BPL families.
2. The food supplements provided under ICDS should be highly nutritious. The programme needs to consider take-home rations for children on a regular basis.
3. Every anganwadi should be housed in a well-designed building of its own and not in a make shift arrangement or a temporary hut.
4. There is urgent need to revamp the training capsule, supervision and monitoring arrangements. AWWs should have proper qualifications so that they command respect among the villagers. The duties and responsibilities of an AWW should be clearly marked out, and a chart outlining her duties should be kept at the centre.
5. Type of food given to children under 3 years of age should be different from that provided to older children.
6. CDPOs and Health Supervisors need more mobility and visibility.
7. AWWs should know how to detect malnutrition, under nutrition and severely malnourished children. They need to be in constant touch with health supervisors and report cases of children at risk to the nearest referral centre.

Functioning of Anganwadi Centres under ICDS Scheme: An Evaluative Study

Nibha Rani Burman

Introduction

Towards achieving the objectives of ICDS, a package of services is provided through the anganwadi worker (AWW), a crucial functionary at the village centre called AWC. Many reports have been published on ICDS which assessed its implementation and effectiveness. But there has been little discussion about the AWW, who carries the load of providing many integrated services. AWWs are so overburdened that they are not able to devote substantial time for appropriate tasks. This study was conducted to evaluate the impact of the programme on beneficiaries.

Aims and Objectives

The study aimed to:

1. Assess the performance of AWWs.
2. Assess the existing physical set-up of AWCs.
3. Assess the package of services provided by ICDS.

Methodology

This study was conducted in Jorhat district of Assam. There were five ICDS projects, out of which 'North-West Jorhat ICDS Project' which comprised Dhekeragora Block was selected. North-West Jorhat ICDS Project had 150 AWCs, out of which only 50 AWCs were covered. A total of 150 beneficiary women were selected for the study. Data was gathered through interviews and observations.

Findings and Conclusions

1. All AWWs were carrying out activities like organizing non-formal preschool education (PSE), making home visits, maintaining prescribed records and registers, assisting PHC staff, growth monitoring and sending reports to CDPOs/ Supervisors/ MOs. They accorded highest priority to their work. Community survey was also conducted very often by 86.67% AWWs.
2. Activities based on community participation and maintaining liaison with other institutions were put on medium level of priority by AWWs.
3. Formal sessions of NHE were conducted only in 26.67% AWCs, out of which only in 6.67% AWCs. NHE sessions were conducted once in 6 months, and in 13.33% of the AWCs they were conducted once in a year.
4. 77.33% beneficiaries expressed dissatisfaction due to irregularity of NHE programme, 65.33% mentioned that teaching was not satisfactory and 64% of them expressed that the content of classes and the timing of the classes was unsatisfactory.
5. The immunization status of children below 1 year of age for vaccination against BCG, measles, DPT and polio was 52.2%, 49.45%, 41.59% and 86.7% respectively. The coverage of children in the age group of 1-3 years for DPT booster and polio drops was 52.16% and 80.40%

- respectively. DT was given to only 26.12% of the total children aged 3-6 years. Of the total pregnant mothers in the AWCs studied only 54.25% received Tetanus Toxoid vaccination.
6. All the beneficiaries (100%) were aware of the health check-up service and about 60% were satisfied with the service. 60% AWWs mentioned that health check-up was carried out for both children and women at least once in 3 months.
 7. Medicine kit was available in all the AWCs and it was replenished regularly.
 8. Only 26.67% beneficiaries were aware of referral services and only 17.33% of them were satisfied with the service.
 9. Only 26.67% AWWs provided referral services at their centres but none of the AWWs reportedly filled referral slips with requisite details.
 10. All the AWWs organized activities for physical/ motor development, language development, social development and cognitive development, but none of them conducted activities for creative development.
 11. Only 26.67% AWWs arranged meetings for imparting NHE to mothers, and only 6.67% were using aids during meetings.
 12. Growth monitoring was done by all the AWWs who weighed the children and kept record of their weight, but only 46.67% of them could interpret the growth trends.
 13. All the AWCs were located within 3 km from the beneficiaries' habitat and more than 50% of them were located in clean, non-congested and non-hazardous surroundings.
 14. Out of the total AWCs, only 33.33% had adequate indoor space. Outdoor space and storage space was available only in 40% and 13.33% of the AWCs respectively.
 15. All beneficiaries were aware of supplementary nutrition provided by AWWs but none of them were satisfied with the programme. The main reasons were irregular supply of food, and poor quality and insufficient quantity of food.
 16. All beneficiaries (100%) were aware about the PSE component, but only 26.67% of them were satisfied with it. The main reason for dissatisfaction was informal character of PSE and unsatisfactory activities that were conducted under the preschool education programme.

Recommendations

1. Growth and nutritional status of preschool children should be monitored precisely and effectively to serve as an educational tool and for taking appropriate action.
2. Regular and effective nutrition and health education (NHE) sessions should be held in AWCs with the active participation of health functionaries.
3. Training of ICDS functionaries should emphasize more on important functions like growth monitoring, health and nutrition education, non-formal preschool education (PSE), and referral services.
4. The physical infrastructure facilities of AWCs should be improved.
5. Besides considering age, marital status and educational qualification in the selection of AWWs, consideration must also be given to her personal qualities such as resourcefulness, sincerity, diligence, etc.
6. The content of the training course for AWWs also needs thorough analysis.

Integrated Child Development Service Scheme: Presenting Innovative Panorama

D.D. Pandey

Introduction

ICDS, which is implemented through a network of about 7,00,000 AWCs, is the focal point for delivery of services. However, a number of input and process based functional problems operate in divergent ways for non-accomplishment of the desired objectives of the scheme. However, despite the prime importance of identification for taking corrective measures, there appears to be a scarcity of attempts, not only for their systematic exploration, but also to advance the understanding of their relative positioning in comparison to others. This study was conducted to address both these issues.

Aims and Objectives

The study aimed to:

- Decipher the inter-relations of various perceived problematic factors and their relative influential rankings in implementation of ICDS.
- Provide a powerful database for presenting a solid and cutting edge panorama of ICDS.
- Create a three tier classification system of factors affecting the implementation of ICDS.
- Accelerate a common understanding for analyzing the programme as a whole.

Methodology

Data was collected from 109 participants, 76 CDPOs/ ACDPOs and 33 trainers of ICDS. Five Point Rating Scale was used to collect the data. The scale had 39 perceived problematic areas spread over ten major dimensions namely Human Resource, Management (n=11); Convergence and Coordination (n=5); Community Ownership (n=2); Service Delivery Management (n=6); Hierarchy and Organizational Setup (n=4); Material Input (n=3); Beneficiaries Perception (n=1); Modus Operandi (n=4); Social Ills (n=1); and Budgetary Regulations (n=2). In order to eliminate acquiescence response set bias, the items were placed randomly and worded in both directions +ve and -ve. The scale was self administering in nature and allowed each subject to indicate his/ her level of agreement about the perceived problem on a potential range of 1 to 5, giving a score of 5 for Strong Agreement; 4 for Agreement; 3 for can't say; 2 for Disagreement; and 1 for Strong Disagreement.

Findings and Conclusions

Human Resource Management

1. Slow career progression of ICDS functionaries, lack of motivation among Supervisors, and AWWs wish to become regular Class III employees were identified as most important

factors adversely affecting the implementation of ICDS. Lack of commitment, interest and ineffectiveness of Supervisors were also found to be important factors. The burden of excessive and unmanageable larger system than what was envisaged in schematic pattern of ICDS melts the real spirit of supervision. Secondly, due to rapid expansion of the programme beyond the institutional capacity to manage it pushes these Supervisors towards adopting more pressure oriented mechanism, leaving no room for accommodating interpersonal authenticity, firm support and advice. Thirdly, Supervisors are generally recruited from two extremely different panels, promoted AWWs on one hand, and those possessing higher degrees of M. Sc, M.S.W and in some cases even M.Phil and Ph.Ds on the other. Both these extremely different groups find it difficult to manage the business of Supervision due to either their inferiority complex (as in the case of promotee AWWs) or superiority complex (as in the case of exceptionally qualified Supervisors). Fourthly, the absorption of surplus staff of other allied departments, with their lack of supervisory skills and basic context of ICDS, further adds fuel to the fire.

2. AWWs have started demanding their regularization at par with Group C employees of the government as they perform multifarious tasks. Besides this, the strangulation of the programme by Government machinery has taken the scheme miles away from its basic ideology of recognizing the programme as a vehicle for rendering social support to vulnerable sections of society.

Community Participation

3. Community participation is an essential ingredient of the programme. The input and process mechanism of ICDS is based on the technical aspect built into the operational design of the programme which relies heavily on optimal acceptability and utilization of services by the community, with its full support and cooperation.
4. There were two factors which were adversely affecting the implementation of ICDS. Firstly, community leaders stand away from the programme due to their non-involvement in the initial stages of the programme. Secondly, service providers mentioned their frustration with criticism of the ICDS programme management.

Material Input

5. Poorly equipped AWCs were found to be the second most important factor adversely affecting the implementation of ICDS. It is often seen that the programme functionaries fail to fully utilize the richness of the local surroundings due to inflexible nature and rigidity in the use of these locally available rich resources. They were always eager to use early childhood education aids supplied by state owned agencies. This deep rooted habit of dependency of the public, including functionaries, spoils the basic challenge emanating from the community.

Service Delivery

6. Carrying home the supplementary nutrition was identified one of the most important factors adversely affecting the implementation of ICDS. The manual of the scheme envisages on the spot feeding of vulnerable children and pregnant or lactating mothers. But sometimes the

beneficiaries are unable to get ration due to inaccessible AWCs and traditions or superstitions prevailing in the community.

Organization and Management

7. Large number of unfilled vacancies were also an important factor adversely affecting the implementation of ICDS. It is difficult for ICDS functionaries to elude the pressure exerted by local politicians.

Budgetary Regulations

8. One of the major hurdles identified for bringing improvement in the quality of ICDS services is inadequacy of financial resources. At times this is due to low utilization of funds by the implementing agencies. One of the impeding factors identified were only earmarking of funds for ICDS, this may not always guarantee their effective and full utilization in the absence of a well designed technical support service for its utilization. Due to inefficient work culture in the Government system, new ideas and practices are never welcomed. As a consequences of this, large amount of budgetary allocation is surrendered or remains unutilized.

Recommendations

1. The whole gamut of micro level management and control system of supervision requires serious reorganization. New managers are required for executing new processes in ICDS.
2. It is urgently needed to replace the concept of community participation with that of people's participation encompassing all those (technocrats, managers, middle level functionaries, socio-political system, community at large and beneficiaries) concerned with policy/ decision making processes, project formulation and implementation mechanisms.
3. The emphasis should be on improvisation of material from local resources. Local panchayats should also be responsible for providing help and support to the project by identifying land/ building for AWCs.
4. There is need to avoid high cost model of ICDS and preference should be given to a model that works to promote the provision of necessities. In-service education providers are required to take note of this while designing their courses for ICDS functionaries.
5. There should be flexibility for 'Take Home Ration'. The Policy designers and decision makers should take the view of beneficiaries, and before taking any decision, community views may also be solicited.
6. There is urgent need to fill up the large number of vacancies in posts.
7. Proper budgetary allocations should be made and effective utilization of financial resources could improve the quality of ICDS.

Health Status in ICDS

Health Status in ICDS

Mortality and Morbidity Pattern in Children 0 to 6 Years Attending Anganwadi Extent to Primary Health Care Through Awareness and Community Health Problem, Follow Up Case of Grade III and IV of Malnutrition Children Under ICDS

Probodh Kumar Bhowmik and Samita Manna

Introduction

In India, majority of the population suffers from large scale poverty, illiteracy, malnutrition and other allied problems, and the death rate among these children is very high. To check the Infant Mortality Rate (IMR) and to extend minimum health care services to children in the age group 0-6 years, the Government had launched Integrated Child Development Services Programme. This study was conducted to find out the mortality and morbidity pattern among children 0-6 years of age who regularly attend AWCs.

Aims and Objectives

The study aimed to:

1. Assess the socio-economic background of children attending ICDS centres.
2. Understand the major health problems of children belonging to higher and lower income categories.
3. Evaluate the health condition of mothers, particularly their reproductive health.
4. Assess the extent of immunization among children, which is one of the services provided by ICDS centres.
5. Assess the acceptance among mothers of maternity services provided by the Government.
6. Evaluate whether mothers are informed from time to time about the health situation of their children.
7. Evaluate the health education services provided to mothers by different functionaries.

Methodology

The study was conducted in three districts of West Bengal namely, North 24 Parganas, South 24 Parganas and Howrah. A total of 776 mothers and 1448 children were selected from various urban and rural areas. Data was collected through interviews and field survey.

Findings and Conclusions

1. It was found that in rural areas children lived in mud houses. Most rural houses had no drainage system, and the children in these houses lived in unhygienic conditions.
2. Positive awareness was found among rural and urban mothers regarding drinking water; they had realized that many diseases their children and they got were caused by drinking contaminated water.
3. It was found that there were no bathrooms even in the houses of the rural respondents who belonged to the Higher Income Category (HIC). In all three districts, most of the rural families did not have their own toilets/ latrines.
4. It was found in rural areas of the district 32 (42.11%) mothers in Lower Income Category (LIC) and 10 (37.04%) mothers in Higher Income Category (HIC) had their first child between 19 years to 21 years of age. But in rural areas of South 24 Parganas many mothers belonging to LIC and HIC had their first delivery when they were between 22 years to 25 years.
5. In South 24 Parganas, 74.14% rural mothers in LIC and 80.26% rural mothers in HIC had taken T.T. injections at health centres. Out of 18 rural mothers who belonged to LIC, 15 (25.86%) had not taken T.T. injections. In HIC, 15 (19.74%) rural mothers did not take such preventive measures regarding tetanus.
6. In Howrah, 42.67% rural mothers in LIC and 41.67% in HIC had not taken T.T. injections during pregnancy, but in urban areas of the district, in both LIC and HIC, majority of the mothers had taken preventive measures against tetanus. Out of 42 urban mothers in LIC, only 4 (9.52%), and out of 89 urban mothers in HIC, only 3 (3.37%) had not taken T.T. injections. In Howrah district, there was more health awareness among urban mothers than their rural counterparts.
7. About 72.41% rural mothers of LIC had given breast milk to their children just after delivery in 24 Parganas. In HIC, 36 (47.37%) out of 76 mothers had given breast milk to their children after delivery.
8. In rural South 24 Parganas, 65.52% mothers in LIC and 59.21% mothers in HIC provided their children with extra food along with breast feeding when their age was 6 months. A few rural mothers in North 24 Parganas also gave supplementary food to their children after 10 or 11 months of birth and no one in urban areas gave their children supplementary food before 4 months of age.
9. In Howrah district 61.80% rural mothers of LIC provided their children with extra food when their age was 6 months, and maximum mothers provided their children with extra food after 10 months of their birth.
10. In North 24 Parganas, it was found that four prenatal deaths of mothers took place in rural areas and three deaths of mothers took place in urban areas. Bleeding before delivery was an important cause of prenatal deaths of mothers. In urban areas, severe anaemia was the cause of prenatal deaths among mothers. Among the mothers of HIC in rural areas causes of prenatal

- deaths in most of the cases were not identified. 1 (33.33%) death of a mother in HIC of rural South 24 Parganas had been caused by anaemia and 1 (50.00%) mother in LIC of urban South 24 Parganas also suffered from anaemia.
11. Regarding the causes of still births it was found that 2 (50%) deaths were caused due to prenatal births. In HIC (urban), 2 (50%) male and 2 (50%) female still births had been recorded. Out of these, the causes of 3 (75%) incidents were unknown and 1 (25%) were caused by the illness of the mother.
 12. In North 24 Parganas the causes of infant mortality were malignant malaria, pre-maturity, high fever, tetanus, etc. In rural and urban South 24 Parganas infant mortality rate was higher than in North 24 Parganas. In HIC of rural South 24 Parganas 66.67% of child deaths were infant deaths among both males and females.
 13. It was found that pre-maturity and tetanus were important causes of infant mortality in South 24 Parganas. 60% children in LIC in rural areas had died due to prematurity, and 66.67% children had died due to tetanus in South 24 Parganas. In HIC of urban South 24 Parganas 33.33% cases of infant deaths had been due to tetanus.
 14. In Howrah district most incidents of child mortality had occurred within 1 year of age. In LIC of rural areas 1 (33.33%) male and 1 (50%) female child had died between 2-3 years of age. In HIC in rural areas all male children had died within 1 year of age. In HIC in urban areas 1 (50%) female child had died between 1-2 years of age.
 15. In urban areas of North 24 Parganas maximum number of children had shortage of Vitamin C in both LIC and HIC. 50.0% children in LIC and 46.67% children in HIC of rural areas suffered from skin problems.
 16. In South 24 Parganas, 10 (28.57%) children out of 35 in LIC of rural areas had been treated by private doctors, but in HIC of rural areas, more than 51.0% children were treated by private doctors.
 17. In Howrah district, most of the children did not need treatment during their illness. In LIC 20.32% children in rural and 38.89% children in urban areas and in HIC 22.14% children in rural and 40.28% children in urban areas needed treatment. The mothers of these children preferred allopathic treatment and brought their children to the nearest health centre or hospital in which free treatment was available.
 18. It was found that most of the respondents could not avail the facilities of health centres due to long distances and lack of communication facilities. They mentioned that these health centres could not provide them sufficient medicines. Even in urban areas, proper infrastructure was absent to extend required medical services to the people.
 19. In Howrah district, 52.81% mothers in LIC and 58.33% in HIC were informed of Vitamin deficiencies and their symptoms in children mostly by ICDS workers. In LIC of urban areas, 54.76% mothers mentioned that they were generally informed by the neighbours and not by the AWWs.

20. In rural areas of Howrah district, 82.02% mothers in LIC went to ICDS centres regularly. Among the rural mothers belonging to HIC also 81.94% sought the help of ICDS functionaries whenever necessary. Out of 161 rural mothers in Howrah, 29 (36.04%) did not go to ICDS centres regularly. In urban areas of the district, 90.48% in LIC and 95.51% in HIC took help from ICDS centres regularly.
21. In North 24 Parganas, 13.16% mothers in LIC and 11.11% mothers in HIC mentioned that there was no health check-up facility available under ICDS.
22. In South 24 Parganas, except 3 (5.17%) mothers in LIC and 1 (1.32%) mothers in HIC, all mentioned that they themselves and their children underwent health check-up regularly and got necessary advice from the AWWs. 94.83% mothers in LIC and 98.68% in HIC were satisfied with the health check-up function of ICDS centres in rural areas.
23. The percentage of children referred to hospitals for treatment of various diseases by ICDS workers was significantly high in HIC of urban areas of Howrah district. Out of 144 children in urban HIC of the district 81 (56.25%) children had been sent to hospitals by the ICDS worker, and in LIC (urban) 34.72% children had been referred to hospitals. In rural areas of Howrah district 20.86% children in LIC and 37.14% children in HIC had been referred by the ICDS worker to hospitals during serious illnesses.
24. In LIC (urban) 33.33% respondents and in HIC 15.33% respondents complained that the AWWs had no positive intention to contact them personally, but in urban areas of South 24 Parganas AWWs came to their houses and gave the necessary information or advice.
25. It was found that mothers nowadays started immunization for their children but sometimes they did not complete the course and the AWWs along with their Supervisors tried to convince them to complete the course. Pregnant mothers often did not complete the full course of tetanus injections due to lack of awareness.

Recommendations

1. In many urban and rural areas, the houses of respondents had no drainage system. AWWs should make them aware about the harmful effects of lack of drainage.
2. Remuneration of the AWWs should be increased as they devote themselves to welfare activities.
3. The infrastructural facilities in these ICDS centres should be increased so that the treatment of children for minor diseases would be possible.
4. For proper psychological, physical and social development of children there is need to reduce mortality and morbidity.
5. Many mothers were not aware of the necessity of a balanced diet for their children; they should be advised regarding the diet of their children.

Infant Mortality

Infant Mortality

Infant Death Audit

AMS Consulting Pvt. Ltd.

Introduction

Infant Mortality Rate (IMR) and Under-five Mortality Rate (U5MR) are the two universally recognized key indicators of child survival. In India, infant mortality constitutes more than 70% of all under-five child deaths in the country, highlighting the overwhelming importance of focusing on infant deaths. The various causes of infant deaths can be classified in two broad categories, (i) medical causes, and (ii) intermediate factors. Reduction in infant and child mortality and maternal mortality is the ultimate goal of the ICDS programme. Taking a serious note of the high IMR in rural areas, the Directorate of ICDS, Uttarakhand decided to probe the causes of infant deaths, so as to formulate appropriate remedial interventions. Accordingly, AMS Consulting was commissioned to conduct an Infant Death Audit in the rural areas of Uttarkashi and Pithoragarh districts of the state.

Aims and Objectives

The specific objectives of the Infant Mortality Audit were to:

1. Identify various causes of Infant Mortality in the project area.
2. Identify the practices, behaviours, mistaken beliefs and difficulties associated with high infant mortality.
3. Suggest suitable interventions at various levels to bring about behavioural changes to reduce infant mortality, and
4. Identify specific areas for interventions by ICDS and Health Department functionaries.

Methodology

A block-wise statement was made of the number of infant deaths in the last one year (April 2004 to March 2005) based on the monthly reports of both ICDS as well as Health functionaries. There was large scale under reporting of infant deaths by both the departments. The sample size for conducting infant death audits was fixed at 70, which was more than 50% of the total reported infant deaths in the area. To examine the impact of ICDS programme, it was planned to take equal number of ICDS and non-ICDS villages (7 each) in each sample block. Special efforts were made to select those cases where the death had occurred during the post neonatal period, particularly after 6 months. The 'verbal autopsy' method was used for determining the cause of death. Parents and caretakers of the deceased infant were interviewed using a structured questionnaire.

Findings

1. ARI/ pneumonia and diarrhoea emerged as the two major causes, accounting for half (47%) of the total infant deaths in the study area. In 14% cases, the deceased baby was reported to have had an inborn abnormality or malformation. The out break of measles accounted for 10% of the infant deaths in the area. In around 12% cases, the infant was assessed to have died due to asphyxia (birth as well as accidental), hypothermia or tetanus. Other causes accounted for 14% of the cases (tuberculosis, jaundice, epilepsy, etc.).
2. The overall incidence of low birth weight (LBW) babies in the study area was found to be around 41%. District-wise analysis revealed that the incidence of LBW was higher in Uttarkashi (45%) as compared to Pithoragarh (36%). The incidence of low birth weight babies was lower in ICDS villages as compared to non-ICDS ones.
3. During the interaction, parents and caretakers were asked whether the infant was ill at the time of his/ her death. In 66 cases, parents had recognized that the infant was ill.
4. Out of these 66 cases, in one-third of these cases, parents had not sought any medical treatment even after recognizing that the infant was ill. Almost all of them stated that they did not consider the illness to be so serious.
5. Only 66.7% parents had sought medical treatment after witnessing signs and symptoms of morbidity in the infant. Of these parents, only 55% had sought medical treatment from a government health facility, while the rest had approached private health providers, who were mostly unqualified medical practitioners. Even among those who had sought treatment from a government facility, one-third had first visited a private practitioner before coming there.
6. Information about the ANM's role during infant's illness was available for only 38 cases out of 70. It was distressing to note that in three-fourths of the infant death cases (28 out of 38), ANMs reported that they had come to know about the infant's illness only after his/ her death. Even in the remaining 10 cases, it was mostly during her out reach visits that she got to know about it.
7. Thus, in only 20% of the infant death cases (8 out of 38), the ANM was found to have played some role during the infant's illness. She had either offered verbal advice or had given primary treatment, such as giving septron/ cotrimoxzole tablets. In some cases, she had also advised the parents to take the infant to a medical facility. There was no formal referral mechanism to be seen anywhere.
8. In the 35 ICDS villages covered under the study, AWWs were also examined for their role during the infant's illness. Majority of the AWWs (21 out of 34) reported that they had visited the baby within 10 days of his/ her birth. In only 4 out of 34 cases of infant deaths, the AWWs had visited the baby on the day of the birth itself, while in 6 cases, the AWWs had never visited the baby at all.
9. The number of parents/ caretakers who had sought medical treatment was significantly higher in ICDS villages (79%) as compared to non-ICDS villages (50%). It indicated that majority of

the AWWs are indeed playing a definite role in advising parents to seek medical care for ailing infants.

10. Almost one-third (30%) of the mothers reported that they had not been registered at all for maternal care services when they were pregnant with the deceased infant. The overall proportion of the recommended early registration (within 4 months) of mother's pregnancy was found in only 34% of the infant death cases. Out of the total 49 registered cases, maximum 43% reported to have been registered by the ANM, while one-fifth (22%) had been registered at the Government Hospital. The remaining 35% reported to have been registered at the Anganwadi Centre.
11. During pregnancy, there is increased calorie requirement due to increased growth of maternal tissues, foetus, placenta and increased basal metabolic rate (BMR). The increased demand is to be met by taking extra diet during pregnancy. Contrary to the recommended extra diet, more than half (56%) of the mothers of deceased infants reported to have eaten less than their usual diet. Just 7% of the mothers reportedly increased their diet during pregnancy.
12. Most of the mothers (80%) reported that they had continued to do hard labour during pregnancy. The share of such mothers was observed to be as high as 93% in Uttarkashi as compared to 61% in Pithoragarh.
13. When mothers were asked about the role of Anganwadi Worker, one-third of these mothers mentioned that it was the AWW who had advised them to go in for TT vaccination. In most of these cases, she was also physically present when the ANM gave TT vaccination to the mother.
14. One-third of the mothers in ICDS villages, who had received IFA supplementation, reported that AWWs had impressed upon them to consume one tablet regularly.
15. In 7 (20%) cases, mothers reported to have been weighed during pregnancy. In all these cases weighing had been done either at the hospital or at the sub-centre. In none of these cases was the weighing done by the Anganwadi Worker. However, one of these mothers did mention that the AWW had advised her to get herself weighed.
16. Further, one-third mothers reported that the Anganwadi Worker had advised them to take extra diet during pregnancy.
17. In 12 cases, the baby was not breastfed at all due to one reason or the other. In the remaining 58 cases, in only 40% cases had breastfeeding been initiated within one hour. In another 48% cases, breastfeeding had been initiated on the same day, mostly within 2 to 3 hours. In most cases, delay had occurred mainly on account of delay in cutting the umbilical cord and cleaning/ bathing the baby. In 12% cases, breastfeeding was initiated after a considerable gap, ranging between 3 to 30 days.
18. The practice of giving colostrum was observed in only one-third cases. District-wise analysis revealed that the proportion of cases where colostrum was given to the deceased infant was significantly higher in Pithoragarh (39%) as compared to Uttarkashi (29%).

19. Immunization status of infants surviving beyond 6 months was only taken into consideration in the study. In 3 out of every 4 such cases, the baby was reported to have received BCG, although a gradual drop out from BCG onwards to measles was witnessed, which is the trend all over the country.
20. Mothers were found to be anaemic in nearly two-third cases of infant deaths.
21. About 36% mothers of the deceased infants reported that they had a history of infant death, prior to the birth of the infant taken up for the Infant Death Audit survey. In other words, they were mothers at risk.

Recommendations

1. ARI/ pneumonia emerged as a major cause of infant deaths in the study area. If the capacity of AWWs is built on their knowledge about the signs and symptoms of ARI/ pneumonia, she may properly counsel the parents on home based care in such cases, and also make referrals. This would, to a great extent, reduce the severity of ARI/ pneumonia and ensure the timely treatment of infants.
2. The practice of bathing the children twice daily was noticed to be quite prevalent in Uttarkashi district; there is a strong need for creating awareness in the community to discontinue this practice.
3. One of the important elements in diarrhoea management is the mother's knowledge to control dehydration by giving WHO-ORS and feeding more than the normal quantity of fluids during diarrhoea. The community needed to be oriented on diarrhoea management.
4. In ICDS villages, the practice of weighing children at birth was found to be almost non-existent. Similarly, weighing pregnant women for weight gain during pregnancy was also virtually non-existent. There is no denying the fact that the weight gained during pregnancy is an important indicator of the pregnancy outcome. Information about this must be propagated in the community.
5. The Directorate of ICDS has designed 'Referral Slips' for AWWs. However, the system was reported to be ineffective. While not all AWWs had received referral slips, the others who had received them did not know how to make the system actually functional.
6. Birth spacing of less than 24 months was also noticed to be one of the causes behind infant deaths. Sensitizing AWWs to identify 'eligible couples' and provide counselling to them with regard to the importance and need for birth spacing was required.
7. AWCs could be used as depots for making available Oral Contraceptive Pills (OCP), condoms, etc. to 'eligible couples'.
8. ICDS functionaries suggested that AWWs being community based workers, must be sensitized and oriented on various aspects associated with infant mortality by organizing a composite training programme specially designed for the purpose. As per the findings of this study, the aspects on which AWWs skills need to be enhanced include

- Identification of the warning signals during pregnancy.
 - Relationship of high parity with infant mortality.
 - Dealing with cases of low birth weight babies, particularly in the event of their inability to suckle mother's breast.
 - Pre-term milk and its essence for a low birth weight baby.
 - Signs and symptoms of ARI and pneumonia.
 - Need to improve care-seeking behaviour.
 - Home management of diarrhoea.
 - Dietary intake during pregnancy.
 - Strengthening referral mechanism and ensuring better convergence between Health and ICDS functionaries at community level for better treatment of ailing infants.
9. The Directorate of ICDS, Uttaranchal may send a team of its officials to Gadchiroli to study the Gadchiroli Model for Home Based Neonatal Care after taking into account the interventions suggested as well as those mentioned above; a special training programme for AWWs may be designed, so that they could effectively play their desired role in the community and help in reducing infant mortality to keep India's commitment under the Millennium Development Goals.

Low Birth Weight

Low Birth Weight

Prevention of Low Birth Weight Babies in the State

AMS Consulting Pvt. Ltd.

Introduction

The birth weight of an infant is the single most important determinant of its chances of survival, healthy growth and development. Irrespective of the primary causes of death, over two-thirds of neonatal deaths occur among infants who are born with low birth weight (LBW). Although the incidence of LBW babies in India has come down over the last few decades, the situation is still far from satisfactory when compared with other neighbouring countries. Reduction in the number of low birth weight babies, and reducing infant and child mortality is the ultimate goal of the ICDS programme. Taking a serious note of the high incidence of low birth weight babies in the state, the Directorate of ICDS, Uttarakhand decided to probe the causes of low birth weight babies so as to formulate appropriate remedial interventions. Accordingly, the study was conducted in rural areas of Uttarkashi and Pithoragarh districts of Uttarakhand.

Aims and Objectives

The study aimed to:

1. Conduct a thorough investigation of low birth weight babies in the State on a case to case basis in the project area.
2. To identify various causes leading to low birth weight babies in the project area.
3. To identify the practices, behaviour, wrong beliefs and difficulties associated with causes leading to low birth weight babies.
4. To identify specific areas of interventions that could be undertaken by ICDS and Health Departments jointly and separately to impact on the situation.

Methodology

The study was carried out in the hill state of Uttarakhand. The state of Uttarakhand comprises three distinct geographical regions – Garhwal, Kumaun and the Foothills. The study area was Uttarkashi (Garhwal region) and Pithoragarh (Kamaun region). Since low birth weight is one of the important factors contributing to infant mortality, therefore, in consultation with the ICDS Directorate, it was decided to conduct the study in five blocks, namely Dharchula, Munakot, Chinyalisaur, Mori and Dunda, as in the case of Infant Death Audit. A sample of 50 infants was selected after various calculations. Multi-stage sampling method was adopted, and 5 cases were taken up in 10 different

villages in each sample block. A structured questionnaire was developed for the study, and in-depth interviews were conducted.

Findings and Conclusions

1. It was observed that even in most cases of institutional deliveries, family members were unable to tell anything about the weight of the infant at birth. District-wise analysis reveals that according to the parents' perception, more than two-fifths (43%) of the babies born in Uttarkashi were much smaller than normal, while in Pithoragarh, none was much smaller than usual.
2. District-wise analysis reveals that in Pithoragarh, two-fifths of the low birth weight babies were found to be pre-term. In Uttarkashi, one fourth (27%) low birth weight babies were observed to be pre-term. Overall, it was found one-third (32%) of all low birth weight cases belonged to the pre-term category.
3. The factors influencing low birth weight of the baby, apart from the short gestational period, were maternal malnutrition and anaemia, intrauterine environment, and socio-economic causes such as hard physical labour during pregnancy and illness, specially infections, short maternal stature, very young age, high parity, smoking, close birth intervals, etc.
4. In an overwhelming majority (86%) of the low birth weight cases, mothers were found to be anaemic. In district Pithoragarh, mothers of all 20 low birth weight babies were anaemic. In only 24% cases, mothers of low birth weight babies received 100 or more tablets of IFA. One-third (36%) mothers reported that they had received no IFA tablets at all.
5. During the current study, mothers were probed about their diet during pregnancy. A great majority of mothers (70%) clearly stated that they had actually consumed less food during pregnancy as compared to their usual non-pregnancy intake.
6. During this study, two-thirds (66%) of them had continued to do hard labour during pregnancy.
7. More than one-fourth (28%) of the mothers reported that they had not been registered at all for maternal care services when they were pregnant with the low birth weight baby. Early registration of mothers was done in only 42% of low birth weight cases.
8. It was found that out of the total 36 mothers registered for antenatal care, maximum (64%) had been registered at the PHC/ Sub-Centre/ Army hospital, while one fourth (28%) had been registered at the anganwadi centre. The rest (8%) were registered with private doctors.
9. In around one-third (34%) of the cases, the mother of the low birth weight baby had not received even one general health check-up during pregnancy.
10. Overall, 70% of the mothers reported to have received at least one dose of TT vaccination. Out of these, 58% reported to have received 2 doses, while the remaining 12% had received only one dose.

11. As regards IFA supplementation, almost two-thirds (64%) of the mothers of low birth weight infants received IFA tablets during pregnancy. Two-thirds of the mothers who received IFA tablets, consumed less than half of the tablets received by them.
12. In ICDS villages, 72% of the mothers reportedly received TT vaccination.
13. About 31% of the mothers in ICDS villages who had received IFA supplementation reported that the AWW had impressed upon them to consume the tablets regularly.
14. In ICDS villages, 20% of the mothers had been weighed during pregnancy, at the PHC or at the Sub-Centre.
15. Further, 24% of the mothers reported that the anganwadi worker had advised them to take extra diet during pregnancy.
16. Out of 50 cases covered under the study, in 3 cases the baby was not breastfed at all due to one or the other reasons. Out of the remaining 47 cases, in only 38% cases, breastfeeding was initiated within one hour. In 45% cases, breastfeeding had been initiated on the same day, mostly within 2 to 3 hours. In the remaining 17% cases, breastfeeding had been initiated after a considerable gap, ranging between 2 to 11 days.
17. Among the low birth weight cases, the practice of giving colostrum was observed in 57% cases.
18. Mothers of low birth weight babies were also probed about the status of administration of OPV and BCG vaccines. In just 1 out of 7 (14%) low birth weight babies, the baby was reported to have received both the BCG vaccination and OPV drops.

Recommendations

1. The share of pre-term babies among those born with low birth weight (LBW) in the study area was about one-third (32%). The pre-disposing factors associated with pre-term birth were maternal malnutrition, infection, BP, diabetes, etc. If these factors are identified well in advance and properly managed the problem of low birth weight may be reduced to a great extent.
2. AWWs also need to understand the importance of pre-term milk, which is secreted naturally in case of pre-term delivery. This calls for the capacity building of AWWs as well as that of mothers on breastfeeding techniques. Hence, there is a need to orient the AWWs on pre-term milk, essence of pre-term milk for a low birth weight baby, and on breastfeeding a low birth weight baby.
3. Weight gain during pregnancy is a vital indicator of the growth and development of the foetus and health care needs of the mother. Considering the significance of this factor in relation to low birth weight, all the AWWs need to specifically disseminate information about weight gain during pregnancy among pregnant women during NHE sessions.
4. There is need for strongly enforcing the system of taking the weight of babies at birth. AWWs may be asked to submit details of the weight at birth of the newborns in her village on monthly basis to keep a check on them.

5. About 28% of the pregnant ladies were not registered at all. There is urgent need to sensitize AWWs with regard to registering pregnant women.
6. Lack of awareness among the community about the necessity and importance of registration of pregnancy was also seen to be a major hurdle. As such, there is a strong need to launch an awareness drive to create awareness in the community about the necessity and importance of registration of pregnant women.
7. Antenatal check-ups are crucial for saving the life of the mother as well as the baby, early detection of pregnancy complications and their timely treatment. Pregnant ladies should undergo at least 3 antenatal check-ups; and there is an urgent need to sensitize AWWs with regard to this.
8. There is a need to provide training to the AWWs on the use of referral slips, and sensitizing the health functionaries to give due cognizance to the referrals made by AWWs.
9. Almost four-fifths (79%) of the AWWs felt that there is a need for organizing special training for them on low birth weight, covering in detail various aspects related to this issue.
10. It is extremely necessary that AWWs should be given a two-day orientation course on the management of low birth weight, covering all important aspects related to low birth weight.

Medicine Kit in ICDS

Medicine Kit in ICDS

Evaluation of Medicine Kit Provided to Anganwadi Workers

Dinesh Paul

Introduction

Very limited studies have been conducted to assess the usage and efficacy of the medicine kit provided to the AWWs. Thus, no systematic feedback is available on the usefulness of medicine kit and its adequacy for the target group in terms of their needs. This study was conducted by NIPCCD to evaluate the extent of utilization of medicine kit provided to AWWs in ICDS projects.

Aims and Objectives

The study aimed to:

1. Assess the mechanism of procurement, quality control, storage and distribution of medicine kit given to AWWs by State Governments.
2. Assess the appropriateness and adequacy of different medicines supplied in the medicine kit.
3. Assess the extent of training provided to AWWs in usage of the medicine kit.
4. Assess the problems and bottlenecks faced by AWWs in the usage of medicine kit and suggest modifications.
5. Evaluate the relevance of medicine kit in the light of morbidity pattern of diseases in the region.

Methodology

This study was conducted by NIPCCD Headquarters located at New Delhi and through its Regional Centres at Bangalore, Guwahati and Lucknow. The ICDS projects covered were Uttar Pradesh in the northern region; Karnataka in the Southern region; Delhi in the Central region; and Meghalaya, Arunachal Pradesh, Assam and Nagaland in the North East. Total 640 AWCs, 150 ANMs, 16 CDPOs, 4-5 Supervisors, 1280 beneficiaries and 100 community leaders comprised the sample. Data was collected through interviews, observations and available records.

Findings and Conclusions

1. It was found that around 71.2% of the AWCs were housed in *pucca* (permanent) structures, and nearly 55.2% of the AWCs were in fairly good condition and had clean surroundings. 49.3% AWCs in the Southern region were very well maintained compared to AWCs of other regions.

2. The medicine kit had chlorine tablets for disinfecting water, 10 basic drugs such as Aspirin, sulphadiazine tablets, mebendazole tablets, Benzyl benzoate, Tetracycline eye ointment, Sulphacetamide eye drops, cotton wool, bandages and a pair of scissors. Some other useful items like mid upper arm circumference tape to measure the nutritional status, and plastic glasses with spoons for preparation of ORS were also there.
3. In all cases except one, the medicine kit was procured by the Directorate of Social Welfare/ Women and Child Welfare Department and handed over to the AWW.
4. 43.7% of the CDPOs mentioned that the order for replenishment of medicine kit was placed by them, whereas 56.2% CDPOs of eastern and central region reported that they did not place order for replenishment of medicine kit, but whenever they received replenishments from the Directorate, they handed it over to the AWWs.
5. The availability of medicine kit was found to be very poor in all the four regions. Almost 50% of the AWCs were without a medicine kit in all the regions. Medicine kits were available with only 36.3% AWCs in northeastern region as compared to 53.7% AWCs of the southern region.
6. About 78.1% of the AWCs in the northeastern region and more than 50% AWCs in the other three regions did not have medicines. Medicines were available in 48.7% northern, 48.1% southern, 17.5% northeastern and 42.5% central zone AWCs respectively.
7. In one of the projects in Delhi, the medicine kit was last received in the year 1995-96 only, thereafter it was not replenished. AWWs helped ANMs in distributing iron and folic acid tablets and Vitamin A solution to the children, which were supplied by the existing health infrastructure in the project area.
8. Around 265 AWWs received ORS packets from PHCs, followed by iron and folic acid tablets which were distributed to pregnant women and lactating mothers. The ORS packets were received by 66% of AWWs of northern region, followed by 55% of southern region, 24.6% of northeastern and 22% AWWs of central region. More than half the AWWs of northern and southern region mentioned that they received iron and folic acid tablets from ANMs in comparison to the AWWs of northeastern and central regions who did not received IFA tablets and contraceptive pills. The reason for not receiving IFA tablets could be that those were distributed to mothers through ANMs themselves.
9. Very few AWWs (30) of the southern region mentioned that they took eye or eardrops, chlorine tablets, Vitamin and mineral tablets from ANMs.
10. All the CDPOs and 96.8% Supervisors mentioned that they were very particular to check the date of expiry of medicines. All the CDPOs and 75% Supervisors of the southern region checked the date of manufacture before using the medicines.
11. All CDPOs of the northeastern region observed the colour of the medicine and leakage in the medicine tubes when they received the medicine kit, and also during their visit to the AWC.

12. 75% CDPOs of the northern region and 50% CDPOs of the northeastern region mentioned that they took the help of Medical Officers to check the medicines whenever the supply of medicine kit was received, but this practice was not prevalent among CDPOs of the southern and central region.
13. It was found that proper storage space was available only in 66.8% AWCs in northern region, 60.6% AWCs in southern region and 65.6% AWCs of central region.
14. In the central region 89.5% of the AWCs had cupboards to store medicines. Nearly half of the AWWs of southern region (47.6%) and central (46.6%) region mentioned that medicine kit was stored in an open shelf, which could be dangerous for the children attending the AWC. In northeastern region out of 37 AWCs where the storage space was available, only 14% AWWs stored medicines in a closed shelf. In the northeastern region, 63.5% AWWs stored medicine kits either on lofts/ card board boxes/ tin drums/ bench/ stool or kept it on the table in polythene bags.
15. It was found that 94.3% AWWs of the northern region and 92.4% of the southern region stored medicines in a cool place, as was specified on the medicines. 24% of the medicine kits were placed in sunlight, which could be harmful.
16. It was found that diarrhoea (72.5%) was the major illness among children, followed by cold (66.9%) and cough (45.1%). Least diarrhoea cases were reported by ANMs of southern region (44.1%) as compared to northeastern region where 88.2% ANMs had reported diarrhoea. Fever was not reported by ANMs of all other regions except of southern region where 88.3% ANMs reported fever as one of the major illnesses. Comparing the data of all the four regions it was found that people from the southern region had contacted ANMs for treatment of illnesses like jaundice/ measles (32.3%) and skin infection/ scabies (21.5%).
17. It was found that the incidence of diseases in general had reduced moderately (47.2%) in all the regions. In central and northern regions more than half of the AWWs reported moderate reduction in the incidence of diseases. 51.3% AWWs of the northeastern region and 34.3% AWWs of the central region mentioned slight reduction in morbidities, whereas the AWWs of northern region (39%) and southern region (33.7%) were of the view that provision of medicines at AWCs had tremendously reduced the incidence of some diseases.
18. Around 71.6% AWWs of northern region were satisfied with the medicines provided in the kit. However 68.1% AWWs of the central region felt that the medicines provided in the kit did not cover all the illnesses prevalent in their area. AWWs of southern (53.1%) and central regions (68.1%) reported that low reduction in the disease prevalence was due to non-availability of medicines in the kit. Parents treated sicknesses in their homes, consulted Sub-Centre ANMs, village practitioners, and utilized services of health centres.
19. Lack of transport facilities and dissatisfaction of the community towards the facilities available at Sub-Centres and Primary Health Centres (PHCs) were the main reason mentioned by AWWs for weak referral services in ICDS.

20. About 79.6% of the AWWs in all the regions had received training in identification of minor ailments and usage of medicine kit during their job training. 98.1% AWWs of central region and 93.1% AWWs of southern region had received training in diagnosis of illnesses and usage of medicines during their job training. About 55.1% AWWs of the northeastern region received specific training in the usage of medicine kit. Out of 504 AWWs who had received training, nearly 78.5% AWWs mentioned that they had received specific training on usage and distribution of medicines during continuing education sessions/ monthly review meetings.
21. Around 86.1%, 93.7% and 79.8% AWWs of the northern region were not able to tell the correct dosage of paracetamol tablets/ syrup and mebendazole tablets. AWWs of the central region were ahead of all the regions followed by AWWs of the southern region. They were more knowledgeable about the number of tablets to be given to adults and children.
22. It was found that both CDPOs and Supervisors of southern and northeastern region were a great support to AWWs in procurement, distribution and replenishment of medicines and also identification of medicines for various diseases.
23. AWWs of the northern region (98.1%), followed by southern region (90.6%) and northeastern region (88.3%) mentioned that the quantity of some commonly used medicines should be increased, especially ORS packets, which were always in short supply during the season. In some blocks all AWWs demanded syrup for cough and 20% of the workers demanded medicines for vomiting.
24. Although good functional linkages of ICDS and health functionaries were found, still a few AWWs (18.1%) suggested that there should be more coordination among the health and ICDS staff. 34.5% AWWs mentioned that medicines in the kit should be according to the diseases prevalent in the area.
25. CDPOs mentioned that AWWs were not educated enough to grasp the information instantly. They felt training and orientation should be a continuous process. They were satisfied with the fairly good functional linkages, which existed between ICDS and health functionaries. CDPOs as well as Supervisors stated that quantity of some common medicines were inadequate, there were financial constraints, lack of facilities for referrals, and irregular supply of medicines.
26. It was found that all ANMs of central, northeastern and southern regions were well aware of the availability of medicine kit. 58.8% ANMs mentioned that people preferred to take medicines from AWWs, as they were free of cost. The ANMs of northern (31.5%) and central (37.1%) regions mentioned that people thought that these medicines were not of good quality and did not care to use them because they were distributed free.
27. 62% ANMs mentioned that the quantity of medicines was quite inadequate compared to the requirements of the community.
28. It was found that all mothers were well aware of the existence of the AWC in their village, and a majority of them knew which services were provided by AWW. 63.4% mothers had availed the different services being provided at AWCs. The utilization of services for all regions ranged

from 28.7% to 84.9%. The utilization was highest for Supplementary Nutrition (84.9%) and PSE (84.8%), and lowest for Health and Nutrition Education (28.7%).

29. Mothers mentioned that there was lack of coordination among the functionaries. Almost 80% mothers from the northern region and 50.9% from the southern region suggested that the medicines should be available in time.
30. It was found that community leaders of the northern region (75%) and central region (63.6%) were not aware of the availability of medicine kit at AWCs. Almost all the community leaders (94%) suggested that medicines should be available at AWCs on time. Almost half (47.6%) of the community leaders suggested that the medicines supplied should be according to diseases prevalent in the area.

Recommendations

1. There is need for specific training of AWWs on the use of medicine kit during pre-service training.
2. There were vital gaps in the knowledge of AWWs in some areas as it was not possible to ensure the same standard of training everywhere. It is desirable to have Satellite Training Programmes all over the country. In addition, there was need to follow different training models to suit the basic educational qualifications of the trainees.
3. It was recommended that the replenishment of medicines in the kit must be prompt and regular.
4. There is need to increase the quantity of medicines provided in the kit.
5. Good functional linkages with the health system are required for better utilization of medicines and referrals in case of scarcity of medicines at the AWC.
6. There is urgent need to strengthen linkages at all levels, for which there must be an in-built arrangement for regular monthly meetings of health and ICDS staff for joint solution of problems.
7. The supervisory and monitoring visits of senior officials of both ICDS and health staff need to be supportive and full of guidance to the AWW.
8. The AWW should use Sub-Centres as much as possible to deal with sicknesses and give referrals whenever needed.

Monitoring ICDS

Monitoring ICDS

Community Based Monitoring System

AMS Consulting Pvt. Ltd.

Introduction

Community has multiple meanings and has been studied from varying perspectives. The aim of every community based intervention is community development, which is visible in the project objectives. Community based monitoring (CBM) makes the community aware of the services available and their accessibility to the beneficiaries. The major objective of community based monitoring system is to induce behaviour change among the community members in such a way that the on-going programme becomes more sustainable and feasible. This project seeks to integrate the ICDS programme at community level with the service delivery system in such a way that the community shares equal responsibility in delivery of the services under the programme and, in a way, owns it. The need for community based self-monitoring system can be categorized on following accounts.

1. To create awareness about the programme.
2. To develop community ownership.
3. To bring desirable outcome.
4. To develop sustainability of the programme.

Aims and Objectives

The basic objectives of the community based monitoring system is to induce behavioural change among community members to ensure sustainability of the ICDS programme. The specific objectives are to:

1. Induce behavioural change among the beneficiaries to reduce dependency on service providers.
2. Identify the various customs and traditions being followed across the identified villages related to children, women and adolescents that would help in developing a community based monitoring (CBM) system.
3. Develop a suitable tool based on traditional skills, art or folk art, which can be owned and managed by the community for monitoring the services available through Anganwadi Centres (AWCs).
4. Train and orient the village level ICDS functionary, that is AWW and ICDS beneficiaries about the importance of CBMS and methodology to use it.

Methodology

The study was carried out in districts of Uttarakhand. ICDS Directorate Officials at Dehradun helped in identifying 65 AWCs selected from 3 blocks, 1 tribal and 2 non-tribal. Since Thatyur is the only

tribal block, therefore it was selected to represent the tribal block. The other two blocks namely, Chamba and Bhilangana were chosen to represent non-tribal blocks. The blocks were selected by Swa Ankalan Pranali. These 65 villages were further divided into small groups of 2-4 villages based on their geographical location and proximity/ distance from each other. Twenty villages were selected from these 65 identified villages, giving due representation to each group for field visits to identify existing customs and traditions being followed so as to enable the researchers to develop a suitable monitoring tool for monitoring the services being rendered through ICDS. Focus Group Discussions (FGDs) were organized in each of the 20 villages visited during the field visit. The participants of the FGDs included Gram Pradhans, community influencers (PRI representatives, self help groups, teachers, social workers, etc.), community members, and Anganwadi Workers (AWWs) and Anganwadi Helpers (AWHs).

Findings and Conclusions

1. The respondents of most FGDs appeared generally satisfied with the frequency of distribution of supplementary nutrition. In two villages, namely Bangoli in Chamba and Indrola in Bhilangana, the respondents stated that supplementary nutrition was given weekly. However, in Titrana, Dauni and Maiti villages of Bhilangana, irregularity was reported in respect of SN.
2. In almost one-third of the villages, it was reported that pregnant women did not get themselves registered in AWCs.
3. In almost every village, importance of health check-up was least understood, and it was vehemently advocated by all during FGDs that the community must be made aware about health check-ups being provided at AWCs.
4. In Indrola village of Bhilangana block of Tehri district, it was reported that despite this village being very close to a health facility, very few people were visiting the health centre. This was due to lack of understanding about the importance of ICDS services.
5. Availability of ANM, lack of information about her outreach schedule and busy schedule of the women in villages were also stated to be closely linked to the poor status of health check-ups in the intervention blocks.
6. Overall, only in 33% of the villages, the status of TT vaccination to women during pregnancy was reported to be satisfactory.
7. Educated people in the community understood the importance of health services, and were making best possible use of the facilities available.
8. The beneficiaries were mainly getting IFA tablets from health centres/ANMs. Most of the pregnant women were not following the prescribed course of IFA tablets, and after consuming a few tablets (20-30) discontinued taking them on time. Not liking the taste of IFA tablets and some of its side effects were reported to be the major reasons why most of the pregnant women did not follow its full course.
9. The status of child immunization was reported to be better. In 50% villages of Bhilangana block, the status of child immunization was stated to be not good despite preparedness of the community

for child immunization. The feedback about availability of ANM and AWW were mixed. However, the way the community vehemently advocated for an active role to be played by Panchayati Raj Institutions in the service delivery system, is suggestive of the felt need that there is fair scope for their involvement in the delivery and monitoring of services at community level.

10. In about 40% of the villages, it was reported that colostrum was being fed to infants. In some of these villages this practice had been adopted only recently. In about 15% of the villages, it was reported that not all people fed colostrum to infants. In the remaining 45% villages, colostrum was thrown away as it was considered not good for the child.
11. In all the villages, the practice of administering 'gur' (jaggery) and 'honey' immediately after birth to a newborn was reported to be widely prevalent. The community in these villages has a feeling that administering *gur* and honey helps a child in suckling as well as keeps the digestive system of the newborn in order.
12. In about 50% of the villages, it was reported that children were exclusively breastfed for six months. They felt that administering *gur* or honey immediately after birth did not contravene the concept of exclusive breastfeeding.
13. In general, in all the villages the mother and her newborn child are kept isolated for a period of 11 to 21 days. The mother is considered untouchable for 11 days after the birth of the child.
14. In a majority of the villages, there was no system of institutional delivery, with the exception of Dikhhol in Chamba, where reportedly 95% of the deliveries were conducted in the hospital and Chopriyal Gaon in Chamba, where 90% of the deliveries were conducted at the Sub-Centres.
15. During FGDs the participants were probed for the self-monitoring system existing in the community, if any. It was observed that the community was solely dependent on service providers for the delivery of all maternal and child care health services.
16. Due to lack of awareness and various other constraints as mentioned earlier, availing health care services was not a priority for them. Hence, individuals or the community as a whole, have hardly done any exercise for developing a home based self-monitoring system to follow the service delivery schedule.

(i) Proposed Community Based Monitoring System

It is clear from the field findings that the community in the intervention blocks, values the ICDS programme highly. However, because of lack of understanding about the importance and role of each service under ICDS programme for the growth and development of children, there is passiveness in the community about availing the services. If the beneficiaries are made to understand the importance of the services being rendered through Anganwadi Centres (AWCs), they can well be mainstreamed into this programme. Therefore, active participation of PRIs, community influencers, teachers and adolescent girls is considered necessary for bringing about this change. Hence, the system envisages a concerted effort of all stakeholders to manage and own the programme. As the services under ICDS programme are many, diverse and inter-related, there is a need to develop a composite and integrated tool, based on group and home approach, for bringing behavioural change in the community. Since the literacy rate in the hills

is high and almost every household has one or more literate members, therefore, a printed tool was considered most appropriate. Even the community members were quite enthusiastic about the idea that a printed monitoring tool was being developed for them. Accordingly, Service Calendars and a Guidelines Based Monitoring Folder, mentioned below, have been developed. This Calendar has been developed to monitor the services applicable to pregnant women. The components that will be monitored through this Calendar include registration of pregnancy with AWC, supplementary nutrition, health check-ups, IFA supplementation, NHE at AWC, and observance of hygienic practices during delivery.

(ii) Service Calendar for Children and Adolescent Girls

The Calendar has the following five parts:

- a) care at birth
- b) care during first six months
- c) care during 6 months to 3 years
- d) care during 3-6 years
- e) care of adolescent girls

(iii) Guide Book Monitor

This book has been developed in the form of a Folder titled "*Samudaya Stariya Anushwaran*". This Guide Book contains the Schedule for obtaining various services by the beneficiary under ICDS programme, and instructions regarding various components of the services for ready reference of the Community Level Monitors. The proposed system would function through the following Committees:

1. Village Level Monitoring Committee, and
2. Cluster Level Monitoring Committee

Recommendations

1. In almost all FGDs the participants vehemently advocated for an active role to be played by Panchayati Raj Institutions (PRIs) in the delivery of services under the ICDS programme and monitoring thereof. Apart from PRIs the active involvement of Mahila Mandal Dals (Groups) in service delivery and monitoring was also strongly advocated. Participants were of the view that these institutions being village based, are readily available for addressing various problems that arise in the course of service delivery. They were of the view that service seekers as well as service providers are equally responsible for the not so effective functioning of ICDS services delivery system. Being based in the community, they can effectively exercise their influence, not only on service providers, but also on the service seekers. They were of the view that the AWW should attend the meetings of Village Panchayat and report the progress on various services during the meeting, and in turn, the Panchayat Committee should also help her in sorting out her problems with the Health Department and the community.
2. It was suggested that Self Help Groups (SHGs) should be given the task of monitoring the service delivery machinery and solve problems in the community relating to them.

Mother and Child Protection Card

Mother and Child Protection Card

Report of Pre-Test Study: Mother and Child Protection Card

NIPCCD

Introduction

Early Childhood Care for Survival, Growth and Development (ECCSGD) in collaboration with UNICEF and Ministry of Women and Child Development had developed Mother and Child Protection Card (MCPC). The key objective of the card is to promote adoption of key care practices by the families as well as utilization of services through the ICDS and Family Welfare System. The card was developed in close collaboration of UNICEF with NIPCCD. Ministry of Women and Child Development and Department of Family Welfare had supported the process of development of the Card, and both the Departments had accepted to operationalise the Card once it was field tested in several states. The Ministry of Women and Child Development and Department of Family Welfare planned to adopt MCPC in the major programmes namely Reproductive and Child Health (RCH) and ICDS. The purpose of the study was to assess the knowledge gain of mothers through use of this Card.

Aims and Objectives

The study aimed to:

1. Determine the format and content acceptability of Mother and Child Protection Card.
2. Establish the comprehension of the contents presented in the Card.
3. Expose the possible slips and errors in the Card.
4. Determine the feasibility of usage of Mother and Child Protection Card.
5. Assess the advantage of the Family Growth Card over the existing Growth Monitoring Card in ICDS and Health System.
6. Ascertain the usefulness of Guidebook for Mothers in understanding and using the Card.

Methodology

This study was conducted all over India including the National Capital Territory of Delhi. 100 Medical Practitioners from Government Hospitals and Private Hospitals, 100 Para Medical Health Workers, 280 mothers, 90 pregnant mothers, and 90 lactating mothers comprised the sample for the study. Data was collected through interviews and field survey.

Findings and Conclusions

1. It was found that majority of the respondents including doctors, functionaries and mothers appreciated the Mother and Child Protection Card (MCPC). They mentioned that the presentation

- and format of the Card was attractive, colourful, interesting, informative, organized, simple and easy to understand.
2. After having used the Card for two months the mothers' perception on various aspects of the Card had shown considerable improvement. The format of the Card was quite appealing. The comprehension and clarity of illustrations and messages as regards care during pregnancy, delivery and after delivery were elicited. The various components covered included essential obstetric care, care during pregnancy, danger signs during pregnancy, child birth and after delivery, and preparation for home delivery.
 3. It was found that almost all pregnant and lactating mothers could comprehend the illustrations and messages on all aspects of care during pregnancy and child birth, after having used the Card a couple of times in the last two months. The components that had been taken into consideration were newborn care, care during pregnancy, illness, danger signs in a child, immunization schedule and growth chart.
 4. Newborn care was rated to be lowest by mothers, followed by doctors and functionaries. The illustrations on care during illness were rated almost equally by doctors and mothers, but the clarity of messages were ranked lowest by mothers (85%) as compared to doctors (90%) and functionaries (92%).
 5. Clarity and comprehension of illustrations and messages on immunization and growth chart were found to be acceptable to majority of doctors, functionaries and mothers alike.
 6. Almost all the mothers could comprehend the illustrations and messages on all aspects of child care after having used the Card a couple of times. They found no problem in using the Card as well.
 7. Illustrations about practices to be adopted for children in the age group 0-6 months about feeding behaviour, care practices and developmental milestones were well received by doctors, functionaries and mothers alike.
 8. In the age group of 6-12 months the illustrations were comprehensible to all the groups of respondents. However the messages as regards feeding behaviour, care practices and to some extent developmental milestones need a re-look.
 9. In the age group of 1-2 years, the percentage of mothers who were satisfied with illustrations on care practices was 83%, followed by doctors (84%) and functionaries (89%). The percentage of respondents satisfied with messages related to developmental milestones was far less among doctors and mothers, as compared to the functionaries, which indicated a need to look at the messages given for the age group of 1-2 years.
 10. Doctors mentioned that mothers wanted to know how much her child should eat in a day. May be information about diet of children could be added in the card.
 11. Mothers felt that developmental activity they could do with their children could be listed, and the same should be illustrated well too.

12. The functionaries seemed fairly satisfied with the information and illustrations on developmental milestones and care behaviour. They mentioned that such useful information was lacking in the other cards that they had used so far, so they were happy about its inclusion in this card. On the other hand doctors had critically evaluated the messages and given suggestions. Mothers expressed their honest opinion based on their ability to comprehend whatever was given in the card.
13. It was found that 90% doctors, 81% functionaries and 88% mothers found that the Card would be very useful to mothers.
14. Around 93% doctors and 82% functionaries found that the language used in the Card was easy to understand. They mentioned that use of local words in the Card made it more acceptable than the other existing cards. They suggested that the Card and Guidebook should be translated in all national languages.
15. Majority of the respondents - doctors (70%), functionaries (20%) and mothers (62%) - mentioned that the Card should be priced at Rs. 1/-.
16. It was found that the gain in knowledge, after two months of usage of the Guidebook about early identification of danger signs in children for taking timely action in case of an emergency, had increased significantly.
17. There was significant gain in knowledge of mothers regarding early identification of danger signs during pregnancy and after delivery, and the gain was more so in the case of pregnant mothers.
18. It was found that knowledge gain regarding precautionary measures that they would take for dealing with cases of emergency among women and children increased from 14.4% to 32.2% for pregnant mothers, and from 12.2% to 38.9% in case of lactating mothers.
19. Considering parity of mothers, it was found that pregnant mothers with second baby and lactating mothers with first baby gained maximum knowledge about the correct age of developmental milestones in children.
20. It was found that the Card acted as a link between the health and ICDS systems. The Card facilitated in imparting uniform messages by both health and ICDS functionaries. Blue colour instructions helped ANMs and AWWs in counselling mothers uniformly. The green boxes had instructions/ advice for the family to follow (which helped in availing the service, including referral). The red colour messages indicated 'emergency' and a call to health and ICDS functionaries as well as beneficiaries to take immediate action.
21. This Card was used for keeping records of immunization of pregnant mothers, children and lactating mothers. About 80% of both pregnant and lactating mothers learnt about important aspects of child care, maternal care, developmental milestones and care behaviour after reviewing the Card. They did not face any problem while using the Card.
22. Primipara mothers found that information about care behaviour was rather low. Lactating mothers found information about developmental milestones and care practices very educative and useful.

23. It was found there was not much change in the knowledge of mothers of second and third birth order babies regarding developmental milestones and care behaviour. After using the Card a couple of times, pregnant mothers in comparison to lactating mothers found the Card to be more appealing, and they could comprehend and learn about various aspects of care behaviour much more readily and easily.

Recommendations

1. The use of local words in the Card made it more acceptable, so the Card and the Guide book should be translated in all languages.
2. Most of the health and ICDS functionaries suggested that information about colostrums feeding should be included in the Card to make it more comprehensive.
3. The age of the mother below 20 years and above 35 years should be enriched with red line to highlight the chances of low birth weight babies, still births and congenital anomalies.
4. The column in the Card does not indicated urine examination for sugar, haemoglobin estimation for anaemia detection, and blood pressure examination for detection of eclampsia. Some modifications should be made to include these in the Card.
5. The blood group and Rh typing may be added in the front portion of the Card under pregnancy record.
6. The Card acts as a link between health and ICDS functionaries, therefore all existing Cards in the health and ICDS sectors should be immediately replaced with the Mother and Child Protection Card in order to avoid any confusion in the minds of Health and ICDS functionaries.
7. Most of the respondents suggested that one rupee (Rs. 1/-) should be the price of the Mother and Child Protection Card.

Nutritional Status/ Malnutrition/ Malnutrition Deaths

Nutritional Status/ Malnutrition/ Malnutrition Deaths

A Cross Sectional Study to Determine Extent, Pattern and Gender Differences in Malnutrition of 30-71 months Children in Urban, Rural and Tribal Blocks of ICDS, Vadodara District.

Samir J. Shah

Introduction

The 1988-89 National Nutrition Monitoring Bureau Survey of rural children showed that only 10% were normal with weights above 90% of the standard. A majority of them exhibited mild or moderate malnutrition, while 8.7% were severely malnourished. Protein energy malnutrition (PEM) had also been identified as a major health and nutrition problem in India. It was observed that nearly 50% children had an inadequate intake in 1988-89, and distribution of children for malnutrition in Gujarat showed that 7.3% were normal, 33.9% were in mild degree, 45.8% were in moderate degree and 13% were having severe degree of malnutrition. The male to female ratio for normally nourished children was 2:1. Two out of every 3 severely malnourished children were female in India.

Aims and Objectives

The study aimed to:

1. Study the pattern and extent of malnutrition in urban, rural and tribal blocks of ICDS in Vadodara district.
2. Study the gender differences in malnutrition.
3. Study the association of the total number of days of supplementary nutrition availed with malnutrition.

Methodology

The study was conducted in Dabhoi Taluka (rural block) and Tilakwada Taluka (tribal block) in Baroda district. From each sector 30 anganwadis and 700 children were selected. A total sample of 2526 children in the age group of 30-71 months were gathered for the study. Malnutrition was detected by taking anthropometric measurements, and secondary data was obtained from the registers available at the Anganwadi Centres (AWCs).

Findings and Conclusions

1. The percentage of children having weight for age malnutrition based on National Centre of Health Statistics (NCHS) standards showed that on an average moderate and severe malnutrition was 66% for males and 68% for females. Severe malnutrition was on an average 14% for males and 17% for females.

2. Females were more malnourished than males in all blocks of ICDS, except in tribal blocks where females were a little less malnourished (1.5%) than males.
3. Using weight for age standards to measure malnutrition, it was found that males were more in normal and mildly malnourished category, whereas females were more in moderate and severe degrees of malnourishment.
4. Tribal males were more malnourished than rural males, and urban males were least affected. Urban females were least malnourished, while rural females and tribal females were more affected.
5. Percentage of children having moderate malnutrition among urban males was 64%, rural males 69% and among tribal males it was 61%, whereas the percentage of females with moderate malnutrition in urban areas was 65%, in rural area 64%, and in tribal area 63%.
6. Severe malnutrition among urban males was 31%, rural males 33% and among tribal males it was 25%. The percentage of severe malnutrition among urban females was 34%, rural females 30% and among tribal females it was 27%.
7. By using the Indian Academy of Pediatrics classification, the actual extent of malnutrition is grossly underestimated, and it is unable to show the actual problem of malnutrition. It was found that National Centre of Health Statistics standards use higher cut off point to assess malnutrition than Indian Academy of Pediatrics classification. Hence more malnourished children are able to get double ration if NCHS standards are used to assess malnutrition.
8. In different blocks of ICDS wasting of moderate and severe grade was seen, on an average in 18% males and 16% females, whereas severe grade of wasting was seen in 2% males and 3% females. On an average, 8% children were both wasted and stunted. These children were at highest risk of morbidity and mortality.
9. Supplementary nutrition in urban, rural and tribal blocks was availed by males and females to a similar extent. Urban females availed supplementary food for more days than males because male children of a little well to do families were sent to play schools in urban areas hence they did not avail the benefit of supplementary nutrition.
10. In anganwadis each child is to be supplemented with two doses of Vitamin A and 100 tablets of pediatric Iron tablets.
11. In the year 1997, 47.5% tribal, 53% rural, and 11.5% urban children did not receive Vitamin A doses. 17.8% tribal, 32% rural and 63.2% urban children received 2 doses of Vitamin A.
12. Nearly 43.6% urban, 31.5% rural and 11.1% tribal children received 90-100 tablets of Iron Folic Acid.
13. Among mildly malnourished (Grade I) children at baseline in January 1996, 17% males worsened as compared to 19% females, and 15% males improved their nutritional status as compared to 10% females on January 1997.

14. The majority of children remains stationary as they were before. The proportion of children who improved was almost the same as the proportion of children whose nutritional status worsened.

Recommendations

1. There is need to take sincere and accountable action like training and motivating the whole infrastructure of ICDS to combat malnutrition aggressively.
2. Use of Indian Academy of Pediatrics classification gives us a false sense of security hence time to time (if not routinely) the extent and pattern of malnutrition needs to be evaluated using National Centre of Health Statistics Standards and necessary corrective actions should be employed.
3. Every year some 12 million children die due to malnutrition, diarrhoea, pneumonia, measles, malaria, etc. Treating these children for a single cause in isolation is inappropriate, as multiple causes for illness exist and they are difficult to treat. Therefore it is suggested that child health programme should address the sick child as a whole by developing integrated case management for the same.

Evaluation of Malnutrition (Grade III and IV) among ICDS Children in States of Uttar Pradesh, Orissa and Rajasthan

The OASES Society

Introduction

Malnutrition is a social problem of staggering dimensions in South Asia. Around 35% of the developing world's low birth weight children are found in India, who are denied the best possible start in life. Today, ICDS (Integrated Child Development Services) represents one of the world's largest and unique programmes for early childhood development. ICDS is designed to promote holistic development of children under 6 years through the strengthened capacity of caregivers, communities and improved access to basic services, at community level. The present study was an attempt to evaluate malnutrition among ICDS children up to 6 years of age.

Aims and Objectives

The study aimed to:

1. Study the level of nutritional status and health care of children in terms of physical growth i.e. by age, weight and height and its effectiveness.
2. Study the awareness and perception among parents/ guardians of children about nutrition and health care
3. Identify the main constraints and suggest appropriate measures to improve the nutrition and health status of children.

Methodology

The study was conducted in 3 districts each from Uttar Pradesh (Rampur, Ambedkar Nagar and Badaun), Rajasthan (Dungarpur, Banswara and Jhalawara) and Orissa (Sundargarh, Gajapati and Rayagada). From each district, two blocks were selected and a total of 80 respondents were selected from ICDS centres in 18 blocks, making a total of 1440 respondents for the entire study. The break-up of the sample of 80 was 30 parents from each of 2 villages, 5 community leaders each from 2 villages, 5 medical doctors and 5 block officials. The sample size for beneficiary/ parents schedule alone was 1080 (564 ICDS children 0-3 years and 516 ICDS children 3 to 6 years). Data was collected through survey of anganwadis and by interviewing parents.

Findings and Conclusions

1. The highest percentage of babies with low birth weight (LBW) was found in Rajasthan (32.8%), followed by Uttar Pradesh (18.3%) and Orissa (16.4%).

2. Among the three states, maximum percentage of children (26.1%) in Grades III and IV malnutrition were from Uttar Pradesh.
3. The study revealed that overall about 36.8% of the children whose height measurements could be taken were short for their age or stunted.
4. In Rajasthan, 19% of the respondents affirmed the poor health status of their child. Around 90% respondents from Orissa affirmed the good health status of their child, and 10.6% mothers from Uttar Pradesh were certain of the poor health status of their child.
5. According to doctors and block officials, the main reasons for the poor health status of children were lack of education, poverty, unhygienic environment, and carelessness and avoidance of growth monitoring.
6. About 82% of the babies were breastfed immediately after birth and only 60.3% babies were breastfed upto 2 years.
7. Overall, 53.1% mothers received complementary food from anganwadi centres, both during pregnancy as well as up to 6 months after delivery.
8. Around 72% mothers mentioned that they took part in the growth monitoring activity at anganwadi centres.
9. It was found that 99.3% women in all the 3 states were given Tetanus Toxoid vaccination during pregnancy.
10. All the ICDS children were given the prescribed 6 vaccines for preventable diseases like Polio, Diphtheria, Pertussis, Tetanus, Tuberculosis and Measles.
11. About 95.2% of the mothers affirmed that the health check-up of the child was done after delivery.
12. Almost all the women sampled mentioned that they were aware of nutrition and health care programmes of ICDS.
13. The study found that only 5.7% women were informed about minor illnesses and their treatment, about 60.3% were told about ideal breastfeeding practices, only 24.4% were informed about required supplementary food/ diet, and only 23.4% knew about referral services provided by the centre.
14. Awareness about various facilities provided by the centres (AWCs) was not encouraging. About 39% of the women from Uttar Pradesh complained that no meetings were organized for women with children aged 0-6 years.
15. Around 82.5% of the doctors and 87% of the block officials mentioned that they were fairly well satisfied by the performance of the ICDS scheme.
16. Out of 1080 mother respondents, three women affirmed that favouritism for a male child was prevalent and 5% were silent on this issue.
17. About 27% of the 90 block officials mentioned that health status of girls was not favourable as compared to that of boys.

18. The literacy status of women in Rajasthan and Uttar Pradesh was at a dismally low level of about 14-15% only, which was associated with malnutrition, whereas in Orissa 37.5% women were illiterate.
19. The working of AWCs was found to be just satisfactory. The household survey was not updated in many cases. The recorded attendance of beneficiaries was usually found inflated. Children went to the centres only when supplementary nutrition was distributed. Full time attendance and engagement was a secondary consideration.
20. In some places there were complaints that centres did not open regularly. Growth charts were not found in Badayun and Ambedkar Nagar districts. The weighing machines at centres in Uttar Pradesh and Rajasthan were generally not in working order.
21. There were certain difficulties encountered in programme implementation. Irregular supply of commodities left AWCs without stocks for several days at a stretch. Irregularity in payment of honoraria to AWWs, insufficient budget allocation for expenditure on the transportation of supplementary nutrition, shortage of staff, inadequacy of funds, poor accommodation of AWCs, etc. were some of the problems voiced by the implementation agencies.

Recommendations

1. To improve nutrition and health status, strategies to impart comprehensive awareness on malnutrition should be given prime importance. Better medical amenities should be provided and the basic infrastructure facilities should be strengthened to exterminate diseases.
2. Males should be encouraged to share responsibility for women and children's health, and their involvement should be sought as they are the key decision makers for every household activity and expenditure.
3. It is most important that the issue of malnutrition should be moved from the 'Agenda of Welfare' to the 'Agenda of Rights'. It is the right of a child to have adequate care, and to grow to the maximum mental and physical potential.
4. A Programme of Nutritional Therapy for the Severely Malnourished should be implemented widely with immediate effect and administered properly through timely first hand primary reports to impact on the prevalent situation of malnutrition in the country.
5. Strategies which aim at ensuring that much needed information actually reaches rural women should emphasis inter-personal communication, and the ICDS programme should give priority to communication training for field workers.

Nutritional Status of Beneficiaries of ICDS in Mysore District: A Situational Analysis

C. Anitha and Khyrunissa Begum

Introduction

This study was conducted in Mysore to assess the nutritional status of child beneficiaries, and the impact of ICDS on nutrition and health status of child beneficiaries.

Aims and Objectives

The study aimed to:

1. Assess the impact of ICDS on the nutritional and health status of child beneficiaries.
2. Assess the competence of AWWs in conducting nutritional assessment.

Methodology

This study was conducted in 12 taluks of Mysore district namely Chamaraja Nagar, Yellandur, T. Narasipur, Periyapatna, Mysore rural, K.R. Nagar, Gundlepat, Hansur, Hegeda Devanakota, Kollegal, Mysore and Nanjangud. A total of 3425 child beneficiaries from 281 AWCs were covered under the study. Data was gathered through interviews and field survey.

Findings and Conclusions

1. The mean height of 3-6 years children in all the taluks ranged between 88.8 ± 4.6 cm to 100.5 ± 5.2 cm and 91.2 ± 3.6 cm to 99.3 ± 3.3 cm for boys and girls respectively. Boys were shorter by 10.2 – 12.5 cm while girls were shorter by 6.7 – 11.3 cm as compared to NCHS values.
2. The mean weight of children varied from 11.4 ± 1.1 kg to 13.4 ± 1.3 kg for boys and 11.1 ± 0.9 to 13.2 ± 1.0 kg for girls. The difference in weight as compared to the NCHS data was 4.3 – 6.3 kg for boys and 4.0 to 5.4 kg for girls, which indicated that the selected children were considerably lighter than their American counterparts. The mean height and weight obtained from different taluks were essentially similar.
3. The short stature found among children could be the consequence of the environment in which they exist. The quantitative and qualitative dietary deficiencies form the primary cause for growth faltering; secondly, high prevalence of morbidity drains out the nutrient reserves, which were already meagre resulting in growth retardation.
4. Prevalence of malnutrition was assessed using Gomez classification. Children in normal grades of nutritional status ranged from 6.4% to 31.8% among males and 14.0% to 36% among

females in different taluks. The remaining children were in various grades of under nutrition. Percentage of children in Grade III (severe malnutrition) were however small, varying from 0.7% to 6.5% among both males and females. Between 27.0% to 55.0% children were found to be Grade I and an equal percentage were in moderate malnutrition (Grade II).

5. It was found that there were some differences in distribution of children into various grades of malnutrition as assessed by the investigator and those recorded by AWWs. There was 3% to 7% difference between the observed and recorded values of normal and Grade I malnutrition in children. AW data showed a simultaneous decrease in Grade II and Grade III malnutrition among children, indicating a right side skew towards normalcy, as against the data recorded by investigators.
6. The differences between the two sets of data (investigators' observation and AWWs' record) raised doubts regarding the competence of AWWs in performing nutritional surveillance, and indicated some degree of ignorance among AWWs about the importance of the data. Insufficient practical exposure during the training programme, or lack of knowledge in management and use of the equipments could be the reasons for AWWs exhibiting lack of ability to classify the children into proper grades of malnutrition.
7. Classification according to IAP (Indian Academy of Pediatrics) for grading malnutrition seems to carry an inbuilt lacuna to exaggerate normalcy and Grade I malnutrition, hence cause a concomitant decrease in Grades II and III malnutrition, as against Gomez classification. A wide gap was evident in the percentage of male and female children graded as normal according to Gomez (20.3 and 20.6) and IAP (34.5 and 35.3) classification.
8. The assessment of functional competence related to malnutrition brought to light the failure of a variety of physiological capacities in children with body weights lower than 90th centiles of reference standard (14.15). Therefore 80% as the cut off level to classify children into normal grade, as followed in IAP classification, may not be appropriate, and such a classification fails to project the actual state of nutrition. Hence adoption of Gomez classification may be a better alternative at the AWC level for grading children into various grades of malnutrition.
9. Hair discolouration was seen in 0.7% to 12.0% boys and girls. Scabies was a common problem, and a relatively high percentage of children had these problems in Kollegal (6.0%, 10.3%), T. Narasipur (12.2%, 13.2%), K.R. Nagar (6.8%, 6.7%), Nanjangud (9.8%, 8.9%), H.D. Kote (6.2%, 7.4%) and Yellandur (8.2%, 26.7%). This was evidence of inadequate nutrition and poor personal hygiene practiced in these areas.
10. In some taluks where river water was used for washing and bathing purposes, skin infections were common. Pigmentation (10.4% to 38%) and decayed teeth (10-50%) were found to be prevalent in all the taluks. Pale and dull conjunctiva was fairly widely prevalent, ranging from 10-40%, and the incidence was higher among girls than boys.
11. Prevalence of conjunctival xerosis was found in all the taluks, and boys and girls were affected to a similar extent. Prevalence of flat nails was high among both the sexes.

12. In taluks like H.D. Kote, Periyapatna, Yellandur and K.R. Nagar, a small percentage of children had haemoglobin in normal range, while 80% exhibited mild, moderate and severe anaemia. However, in other taluks higher percentage of children had normal levels of haemoglobin. Children with moderate to severe anaemia ranged between 37-60%.

Recommendations

1. IAP classification failed to project the actual state of nutrition. Hence adoption of Gomez classification may be a better alternative to assess malnutrition correctly.
2. Competence of AWWs to undertake nutritional surveillance was doubtful, and that indicated a need for intensive training to improve their performance.

Nutritional Status of Rural Pre School Children in Southern Rajasthan

Sharad D. Iyengar and Pavitra Mohan

Introduction

This study was conducted in the five blocks of southern Rajasthan namely Salumber, Malvi, Kotra, Abu Road and Reodar. In these blocks Better Health and Nutrition Project (BHNP) had been in operation. This study was undertaken to assess the nutritional status of children younger than three years and to compare the nutritional status of children who were beneficiaries of the ICDS programme with those who were not. This study also attempted to identify the key programme as well as non-programme factors that were responsible for poor nutritional status of children in this region.

Aims and Objectives

The study aimed to:

1. Estimate the prevalence of stunting, wasting and underweight among rural pre-school children (0-35 months) of 5 blocks of Southern Rajasthan.
2. Compare the degree of stunting among beneficiaries and non-beneficiaries of ICDS supplementary nutrition.

Methodology

This study was conducted in two districts (Udaipur and Sirohi) of Southern Rajasthan. Five rural blocks namely Salumber, Malvi, Kotra, Abu Road and Reodar were selected. These five blocks had been divided by the ICDS system into 31 sectors. Each sector has an average of 21 AWCs, and from each sampled sector 2 AWCs were covered. Total number of beneficiary children was 3529, among whom 654 children were 6-11 months of age, 1365 were 12-23 months and 1510 were 24-35 months of age. The total number of pregnant women beneficiaries was 4450. Data was gathered through interviews and field survey.

Findings and Conclusions

1. It was found that 89.1% mothers had received no formal education, 6.2% had studied in primary school, 3.3% in middle school and 1.4% had been in higher secondary classes. Low levels of educational attainment were known to be associated with lack of exposure to media messages on health and nutrition.
2. It was revealed that families had a mean of 3.07 living children (range 1-13). Almost a fifth of all families had 5 or more living children. Around 28.9% (1301) mothers had at least one still birth or had given birth to a child that died subsequently.

3. In poor rural areas, women are known to have a heavy work burden while getting far less to eat. In Abu Road and Kotra more than half the women were able to get some rest during the day. In Reodar and Mavli, only 10% women consumed more food during pregnancy, while four times that number actually ate less during pregnancy. As many as 40% of all mothers ate less than during the index pregnancy.
4. It was found that as many as 1577 women (35.1%) did not know where the AWC of their village was located. A significant proportion of women resided more than 5 minutes away from the AWC but they did not know the location.
5. A total of 1061 women (23.1%) had received SN from the AWC during pregnancy. Most of these women received supplementary nutrition regularly, but most of them shared it with family members.
6. It was revealed that in each village, field supervisors had compiled lists of beneficiaries aged 0 to 35 months. In Mavli block it was difficult to obtain the records since the AWW was on leave. In Salumber block, ICDS records were found to be more complete, and the beneficiary coverage recorded was higher in this block.
7. If ICDS guidelines been followed, 44.8% children would have been listed as beneficiaries, but the targeted beneficiaries list covered only about 15.1% beneficiaries, and only 6.8% were in fact listed and covered as beneficiaries. Salumber block had highest programme effectiveness, and Kotra had the lowest inadequacy of both, targeting and the quality of record keeping by AWWs.
8. It was revealed that the children aged 6-35 months, irrespective of their beneficiaries status, had actually received supplementary food from the AWC in the past month. 16.7% children had received a food supplement at least once in the past month. Thus actual supplementary feeding (16.7%) reached over double the listed beneficiaries (6.8%). Coverage of supplementary feeding was higher than anticipated probably because several non-beneficiary children received food supplement. In terms of programme efficiency, SN had reached 37.3% of the children that could have been reached within the existing ICDS programme guidelines.
9. Some children were not seeking AWC food because they were still on breast milk, and their parents had not started them on top feeds.
10. On an average, 76% of the children were exclusively breastfed in the first six months. Another 13% children were receiving plain water in addition to breast milk. In the age group 6-11 months breast feeding continued to be the major source of nutrition for infants even beyond the age of 6 months. Almost a fifth of the infants (19.8%) were not being given any food at the end of 11 months of age. Only 49% had received any top feeds over the past 24 hours. Among children aged 6-11 months milk products were the most commonly consumed complementary foods. However, most of these children (64%) received milk diluted with water, thereby reducing its nutrient value. Cereals were consumed by less than 25% infants aged 6-11 months. 16.3% children had received supplementary nutrition from the AWC in the past month.

11. In the age group of 12-23 months it was revealed that most children were consuming 3-4 meals per day. Anganwadi food supplement had reached 21.4% children over the past month.
12. About 25% and 37-55% children in the age group of 24-35 months consumed pulses and vegetables while 25-30% received additional ghee. Anganwadi food supplement had been received by 21.4% children in this age group, over the past month.
13. There was high morbidity among the children of these 5 blocks. 48% of all children were mentioned to have had fever, cough or diarrhoea. The prevalence of illness was higher from 6-24 months, after which it reduced. An average of 65.4% children sought care for their illness, generally from locally available private or government sources.
14. Immunization levels were found to be extremely low in five blocks. Only 6.8% children in the age group 12 to 23 months had received all vaccines. Coverage for three doses of DPT and measles was especially low. About 26% of the children had not received three doses of OPV, despite the ongoing pulse polio campaign. Although several children received individual doses of vaccines, complete immunization was rare.
15. There had been wide administration of OPV through the pulse polio campaign during which immunization cards were not given out. It was found that 135 (16.2%) children had received one vaccine other than polio, and they were in possession of a card.
16. It was found that poor water supply and sanitation increased the burden of water borne diseases and thereby contributed to malnutrition. 97.3% of the respondent families had to defecate in open fields since they had no toilet facilities. Almost 60% families used a cloth to filter water. Since this method only filtered out particulate matter, it does not contribute to the microbiologic purity of drinking water.
17. Around 88.2% families had livestock that included cows, buffaloes, sheep, goats and occasionally camels.
18. It was found that around 48.1% children (49.4% boys and 46.5% girls) from birth to three years of age, suffered from stunting. Stunting among girls was significantly lower than among boys.
19. It was revealed that 19.4% children (21.4% boys and 17% girls) suffered from wasting. As with stunting, girls had significantly lower chances of suffering from wasting as compared to boys.
20. Almost half of all children who were stunted were severely stunted. Prevalence of severe malnutrition increased with age, except for a transient dip between 24-29 months. A continuing high level of severe stunting at the end of three years (39.6% were severely stunted in the age group of 30-35 months) reflects a serious situation of chronic persistent malnutrition among children under three years.
21. There was no significant difference in the prevalence of wasting or stunting between beneficiaries and non-beneficiaries of ICDS programme, since the number of beneficiaries defined as those whose name was listed in the AWWs register was extremely small and did not allow statistical testing of differences between the nutritional status of beneficiaries and non-beneficiaries.

22. In rural Rajasthan larger proportion of children belonging to scheduled caste and tribes were malnourished as compared to those from other castes. Children belonged to scheduled tribes were specially at higher risk.
23. It was found that stunting increased significantly with parity of mothers in this area. In these five blocks, high parity could have been partly responsible for high prevalence of malnutrition.
24. There was high prevalence of illness, particularly among children between 6-23 months. As many as 48% children had suffered from at least one illness in the last two weeks. Prevalence of stunting and wasting increased significantly with the number of illness episodes suffered by the child during this recall period.
25. Children between 6-23 months of age who additionally received top feeds were poorly nourished compared to those who were on near exclusive breastfeeding.
26. It was revealed that after around twelve months, mothers offered solid foods prepared for adults to their children in addition to diluted drinks. Children could not consume these foods because they were spicy and not easily chewable. Mothers invested far less time in actually feeding complementary foods as compared to breast feeding.

Recommendations

1. Contact with the primary health care system is limited if one goes by the levels of complete immunization. A low level of routine contact with health care providers makes it less likely that early malnutrition can be detected and treated by them.
2. Supplementary food from AWCs reached 16.8% of the children aged 6 to 35 months. More children in the age groups 6-35 months and 3-6 years should be covered.

Nutritional Status of Women and Children and Working of ICDS in Flood-Prone Districts of Bihar

Society for Economic Development and Environmental Management (SEDEM)

Introduction

In North Bihar, the Society for Economic Development and Environmental Management (SEDEM) had observed that the general health of women and children was extremely poor, and health facilities and anganwadi services were also poor. SEDEM conducted the study to evaluate the working of ICDS programme, including analysis of distribution of supplies, in 5 flood prone districts of Bihar namely Patna, Madhepura, Saharsa, Samastipur and Vaishali.

Aims and Objectives

The study aimed to:

1. Evaluate the working of ICDS programme in flood prone districts, including analysis of the distribution of supplies.
2. Assess the nutritional status of pregnant and nursing women and AGs based on anthropometric and biochemical measurements.
3. Assess the nutritional status of children in age groups 6 months to under 3 years and 3 to 6 years of age through biochemical and anthropometric methods.
4. Assess the working of AWWs against the given tasks and documenting key problems including the reasons thereof.
5. Assess the perception of users like nursing mothers and pregnant women.
6. Propose alternative sustainable strategies for health and nutrition through convergence of and synergy with other complementary programmes.

Methodology

This study was conducted in 5 flood prone districts of Bihar namely Patna, Vaishali, Samastipur, Madhepura and Saharsa. A total of 30 AWCs were covered and 557 women including 192 pregnant and 257 nursing mothers, 108 adolescent girls and 665 children under six, including 313 children aged 6 months to <3 years and 352 children aged 3-6 years (50% males and 50% females), were selected. Data was gathered through interviews and field survey.

Findings and Conclusions

1. Majority of females in flood prone districts of Bihar suffered below par health status from childhood to adolescent and motherhood. The inter-generational cycle of malnutrition

- continued in this area and the situation was far worse as compared to the State as a whole, and the situation calls for special focus on flood prone districts.
2. It was found that in the 6-36 months age group only 2.63% female children had normal weight for age, 6.58% had normal weight for height, and 13.16% had normal height for age. While female children 36-72 months gained on all indicators as compared to male children, the percentage gain was marginal. Overall 25.77% children had normal Hb count and 74.23% were anaemic; 36.54% had mild, 35.4% had moderate, and 2.28% had severe anaemia.
 3. The mean BMI of registered AGs was below par by 12.4% while that of non-registered AGs was below par by 9.61%, which was significantly below normal as compared to the estimated ICMR reference point of 18.98% for 14+ AGs. They also had mean Hb count below par (around 10.5g/ dl). 36% registered AGs had normal Hb count but 64% were anaemic. Among non-registered AGs 38% were normal and 62% were anaemic. None was observed to be severely anaemic.
 4. It was found that the health status of pregnant women (PW) was uniformly below par, with 84% being anaemic and having below normal BMI. 33.85% nursing mothers had normal Hb count, 66.15% were anaemic and the mean BMI was 7.88% below the ICMR reference point for women.
 5. It was found that the majority of females suffered from below par health status from childhood to adolescence and motherhood.
 6. It was observed that AWCs had not been maintained well. 56.67% AWCs got water logged during the rainy season and remained closed for a long duration. None of the Monthly Progress Reports (MPRs) were complete in terms of records at project level. 60% CDPO posts and 82% Supervisor posts were lying vacant. There were 4187 sanctioned posts of AWWs. 71.15% of the AWWs in position were trained. The quality of services of the six components of ICDS (SNP, pre-schooling, immunization, NHE, health check-up and growth monitoring and promotion, and referral services) was uniformly sub-standard. Physical facilities for pre-schooling were uniformly poor.
 7. Around 240 women and 60 AG beneficiaries gave their perception of AWC services; many did not even know that they were registered. Majority of the beneficiaries were from economically weaker sections, with low literacy and awareness levels.
 8. Around 19% mothers had reported premature death of a child. There were no specific social practices noticed that deprived mothers and children of proper diet. Certain constraints forced parents to remove an infant from exclusive breast feeding (EBF), and sometimes certain foods (milk, meat, eggs) were also prohibited to pregnant and nursing mothers. 72.7% women had never been invited to an AWC. 80% had never received any SN during pregnancy and about 80% had never received a course of IFA tablets.
 9. Although the mean educational level of AWWs in the sampled districts was at least high school, their awareness of nutrition and health facts was about 60% of what it should be. Nearly 70% of the AWCs were run by the husband of AWW.

10. It was found that the AWC facilities were poor on all counts: poor pre-school facilities, irregular SNP, irregular supplies, non-availability of ANMs, designated First Referral Units (FRUs) not known to AWWs, together with inadequate health facilities, etc. Majority of AWCs had no relevant records, indicating a very casual way of working and weak supervision.
11. It was found that training programmes were not conducted properly. ANMs do not realize that their own performance on Reproductive and Child Health (RCH) programme critically depends on coordination with AWWs. Coordination was observed to be very weak; at many centres it was non-existent.
12. It was found that there was widespread malnutrition among women and children in flood-prone districts. The programme benefits were not reaching the target population.
13. Delays in financial disbursement to CDPOs affected transfer of supplies to AWCs which in turn affected SN. There were certain practices, due to lack of awareness, that were compromising the health of infants. These were primarily delayed breast feeding and premature fluid supplementation.

Recommendations

1. Administrative action should be taken to improve financial flows and services especially during the rainy season.
2. Training of Supervisors and AWWs should focus on improving quality. Toilets should be provided in every AWC and children should be toilet trained in every AWC as a rule. It would have a wider impact on sanitation, and it would ensure that children grow into responsible and disciplined citizens.
3. There is need for coordination between Health Department and ICDS Department at strategic, tactical and operational levels.
4. There is need for computerization of all records at AWC and CDPO levels, and intensive training in record keeping is required.
5. Women should achieve food and nutritional security at household and community levels through women's self help groups to ensure intake of Recommended Daily Allowance (RDA) of essential nutrients.

Quick Appraisal of Supplementary Nutrition Component of ICDS – 9th and 10th January 2008: Report on ICDS Projects, Udupi and Karkala, Udupi District, Karnataka

Pawan Kumar and Meenakshi Garg

Introduction

India has a large population of hungry and undernourished children. ICDS is potentially an excellent programme which can address this problem. ICDS covers some vulnerable sections of the population like children 0-6 years, pregnant and lactating mothers, etc.; has an in-built food component; provides nutrition education to mothers and other caregivers; and has an in-built linkage with the public health system. Several international agencies have been involved in ICDS in various ways like World Food Programme, UNICEF, CARE, World Bank, and sometimes NGOs are also involved. They either provide funds or assist in delivery of some services directly in the day-to-day management of ICDS. This study was conducted to assess the effectiveness of the supplementary feeding programme in two projects of Karnataka, where hot cooked food is being served in AWCs. Need was felt for obtaining feedback about effectiveness of the nutrition component of ICDS.

Aims and Objectives

The study aimed to:

1. Assess the quality of supplementary nutrition distributed at AWCs.
2. Assess the efficacy of the supplementary feeding programme on the nutritional status of beneficiaries.
3. Suggest possible measures for bringing improvement in the supplementary nutrition component.

Methodology

This study was conducted to evaluate the efficacy of the supplementary feeding programme in two projects of Karnataka namely Udupi and Karkala. Data was gathered through observation and interviews.

Findings and Conclusions

1. There were a total of 19,092 children between 6 months to 3 years in both the projects, out of which 17,906 (93.73%) were registered and 17,787 (99.34%) were availing the benefits of supplementary nutrition.
2. Out of 18,640 children between 3-6 years of age in both the projects areas, 14,586 (78.25%) were registered and 13,953 (95.66%) were availing the benefits.

3. The number of pregnant women in these two projects were 3601, and out of them 3442 (95.59%) were registered and 3427 (99.56%) were availing benefits under the scheme. Out of 4262 nursing mothers, 4048 (94.98%) were registered and 4025 (99.43%) were availing benefits from ICDS projects.
4. Total number of AGs in both the projects were 41,909, of whom 1460 were registered and availing the benefits under ICDS.
5. Supplementary nutrition in both the projects was being supplied by the agency identified by the State Government. With regard to the number of days SN is given, HCF (High Calorie Food) was given for four days whereas semi-cooked Amylase Energy Rich Food (AERF) *Iaddus* (sweets) were given for two days in a week. Supplementary nutrition is given for 300 days in a year.
6. The quality of food stuff had been reported to be satisfactory by all the three categories of functionaries in both the projects, except for the AERF which was not liked by any of the beneficiaries.
7. It was found that in both projects less quantity of SN was being served to the beneficiaries. The food was monotonous in taste and sometimes unhygienically prepared in AWCs.
8. Hot cooked food was served at all the AWCs under SNP, but 70% of the AWCs had a common space for kitchen and storage together. 80% centres had adequate utensils for cooking hot food but in almost all the centres (100%) there were adequate utensils for serving the food. On an average, about one hour was devoted only for cooking food, which was not inclusive of washing utensils and house keeping, leaving little time for other activities. The food was usually cooked with the help of the Helper.
9. CDPOs mentioned that hot cooked food (HCF) was very well accepted in both ICDS projects. 100% Supervisors admitted that it was only partly acceptable to the beneficiaries, and 20% AWWs and community leaders had the same opinion about this. None of them had any specific idea about Ready to Eat Foods, and they could not give any strong reason for non-acceptance of RTE food.
10. All the beneficiaries mentioned that the hot cooked food was acceptable but it became very monotonous to have the same food over and over again, and it was tasteless on many occasions.
11. Most of the AWWs were very happy and satisfied over the cooking gas recently provided by the Gram Panchayat in the name of AWC, and it made their cooking simpler. But only one cylinder had been provided so there were still problems faced by AWWs.

Recommendations

1. There is need for infrastructure improvement, with separate storage space in the AWCs, and also ensuring supply of safe drinking water.

2. Utensils for cooking and serving food in AWCs should be made available in adequate quantity.
3. Better supervision and monitoring by the functionaries as well the community would ensure improvement in the quality of cooking and right amount of the food being distributed to beneficiaries.
4. There should be variety in the food served to avoid monotony and rejection of the food by beneficiaries.
5. Preparation of HCF food requires more time and is laborious. Also some innovative cooking demonstrations and training need to be arranged for bringing in variety in HCF.
6. Supervision of the AWCs by the Supervisor in particular needs to be made more regular and intensive.
7. There is urgent need to try out Ready to Eat (RTE) food with a variety of food stuffs, which would be much less expensive than the provision of High Calorie Food (HCF) and also much more logistically feasible to distribute and manage.

Sheopur Disaster: An Alert Note on Death of Children in Patalgarh

Right to Food Campaign

Introduction

Patalgarh is a village situated in Sheopur, a Sahariya dominated district of Madhya Pradesh. There were 13 children who had died due to malnutrition and measles. Natural factors and human neglect such as drought, vulnerability, exploitation and lacunae in systems of the state, etc. expose them to situations wherein they become victims of death. This study was conducted to find out the causes leading to mortality and assess whether there could be malnutrition deaths.

Aims and Objectives

This study aimed to:

1. Assess the causes of deaths and access whether any could be due to malnutrition.
2. Recommend strategies to bridge gaps in the implementation of programmes to make them fully effective.

Methodology

This study was conducted in Patalgarh village situated in Sheopur, a Sahariya tribe dominated district of Madhya Pradesh. The village has a population of 580 persons. As many deaths of children were reported from various sources, including newspapers, the study focused on this district. In all, 80 children were hospitalized, and 13 children passed away.

Findings and Conclusions

1. The village Patalgarh is situated in a remote interior, isolated area, and does not have even basic infrastructure facilities. The nearest hospital is situated at a distance of 35 kms. Drinking water was also not available to the villagers, and they fell ill frequently due to drinking contaminated water.
2. There was no AWC in Patalgarh village and the nearest AWC was situated in Hirapur village, 17 kms away. Perhaps, that was because the total population of the village was 580 and according to norms there has to be one AWC per 700 people.
3. Only 70 Antyodaya Anna Yojana Cards were issued though the total population of the village was about 580. The tribals who had cards had to travel a distance of 17 kms to bring ration, and when they went to the FPS (Fair Price Shop), they either found the shop closed or the shop owner said that their share of ration had not arrived. They had to go several times before they

- got their share of ration. They got 20-25 kgs of their share of ration instead of the 35 kgs they were entitled to.
4. It was found that none of the social security schemes had been implemented in the village. They had not received any help from Government sources. None of the widows in the village had received Widow Pension.
 5. According to Regional Medical Research Institute of Tribals in Jabalpur, 93% of Sahariya children were malnourished and 15% were almost on the verge of death, due to malnourishment. It was difficult to trace even a single child, youth or family that was not a victim of severe malnourishment and anaemia. However, the health and nutritional status of these children was not high on the priority list of the government agenda.
 6. The *Kuposhan Niwaran Abhiyan* (Malnutrition Elimination Campaign) was conducted in 5 phases. In the first, third and fourth phases more than 60% children were found to be malnourished, and in the second phase more than 58% children were malnourished.
 7. In the district where Sahariyas lived the supply of double amount of supplementary ration was not possible in AWCs because the supply from the Government itself was not in accordance with the increased demands. In Madhya Pradesh, out of the 10,618,323 children in the 0-6 years age group, only 2,334,789 were enrolled under the SNP – a mere 22%. While the norm for the average number of children to be enrolled per AWC was 80, only 57 was the actual enrollment. Similarly, the norm set for pregnant mothers was 20 per AWC, only 15 were actually enrolled.
 8. State officials mentioned that the inadequate allocation of funds was the major issue contributing to malnutrition. The Annual Report 2002-03 of the Planning Commission showed that funds needed for the SN programme for children aged 0-4 years and mothers in Madhya Pradesh was a total of Rs. 211 crores. However, only Rs. 59 crores had been made available by the State Government. The Centre had also set a norm of Rs. 1 per beneficiary per day, but the State only spent 49 paise (Rs. 0.49) on each child daily.
 9. It was found that post measles complications arose only among 120 children in the age group of 2-10 years among the Sahariya Adivasis in Patalgarh village. Out of them, 13 had died and 80 children were inflicted by post measles complications. All the children in the village were malnourished and their resistance capacity was not strong enough.
 10. It was found that after immunization children started vomiting and had diarrhoea because their resistance capacity was so weak.

Recommendations

1. There is need to improve the quality of immunization services.
2. Sick children should be segregated from healthy children. Vitamin A should be administered, and good antibiotic medicines should be given to sick children.

3. The Government should accept the reality that some deaths could be prevented if malnutrition is reduced, and make sincere efforts to force the Government departments and administration to work with the people, which would in turn, pressurize them to render effective services.
4. Generally the trend is when there are deaths each time, the lower level authorities (village level health worker, Panchayat Secretary, etc.) are suspended, but the higher level officials like the district Medical Officer, Collector etc, are not held liable, which they should also be. These incidents keep happening because of apathy, so immediate steps should be taken to make officials liable in their official capacity.
5. Adequate funds should be allotted to cover the most vulnerable groups, and the funds allotted should be fully utilized.

Nutrition and Health Education

Nutrition and Health Education

A Comparative Study of Urban, Rural and Tribal Anganwadi Workers and Beneficiary Mothers Regarding their Knowledge, Attitude and Practices of Nutrition

Anita Joshi

Introduction

The success of the ICDS programme depends on two persons, the mothers, who have a pivotal role in children's health and well-being, and AWWs who are key personnel of the programme to convey important messages to the target group. This study was conducted to assess the knowledge, attitude and practices regarding nutrition of rural, urban and tribal AWWs and beneficiary mothers.

Aims and Objectives

The study aimed to:

1. Assess the knowledge, attitude and practices (KAP) of AWWs and beneficiary mothers (BM) regarding basic nutrition; nutrition in pregnancy; nutrition in lactation; child nutrition; nutrition during illness; food preparation; hygiene; immunization and family welfare.
2. Observe whether there were any differences in the practices of AWWs and BMs in rural, urban and tribal areas.

Methodology

This study was conducted in three blocks of Madhya Pradesh namely Indore (urban), Sanwer (rural) and Nalcha (Dhar) (tribal). A total of 480 beneficiary mothers (BM) and 60 AWWs were selected for the study. From each urban, rural and tribal block, 20 AWWs and 8 mothers per AWW were taken. In this way 160 subjects from each area were covered. Data was gathered through interviews and observations.

Findings and Conclusions

1. AWWs and beneficiary mothers (BMs) of urban areas had maximum awareness about the nutritional requirements of growing children, that was 100% and 87.5% respectively. AWWs in both rural and tribal areas had 90% and 85% knowledge, and BMs of rural and tribal areas had 76.2% and 64.3% awareness regarding the same.
2. In general, all groups were not very aware of sources of energy rich foods in children's nutritious diet, as out of 20, only 15, 10 and 8 urban, rural and tribal AWWs knew rightly, whereas less than 40% BMs were aware about the same.

3. About 82.5%, 66.2% and 70.6% BMs and 95%, 80% and 95% AWWs of urban, rural and tribal areas respectively take food supplying haemopoietic substances like pulses, green leafy vegetables (GLV) and citrus fruit to prevent anaemia. Some others had partially right practices, 5 – 21% mothers and 11 – 20% AWWs were not taking the right kinds of foods to check anaemia.
4. It was found that 95% urban AWWs were giving and 94.3% mothers were taking iron tablets from AWCs. 95% AWWs of rural areas were giving iron tablets, but only 31.9% mothers of their group were taking iron tablets. 35% AWWs were getting IFA tablets but 75.6% mothers of that area were getting iron tablets from AWCs or health centres.
5. Urban groups of AWWs and BMs and tribal AWWs were moderately good in practices regarding consumption of additional food during pregnancy and the numbers were 65%, 56.3% and 60% respectively; while practices of rural and tribal mothers and rural AWWs were not so good, and the numbers were 23.8%, 41.8% and 40% of the total respectively. 14 to 27% mothers and 5 to 30% AWWs had partially right practices regarding having additional food during pregnancy.
6. About 95% urban AWWs weighed pregnant women correctly, while only 65% and 60% rural and tribal AWWs could weigh pregnant women correctly.
7. It was found that the practice of taking additional food during lactation was area-wise highly different. Only 75% and 48% urban AWWs and mothers, in comparison to 95% and 72% rural and 95% and 88% tribal AWWs and mothers consumed extra food during lactation. Tribal mothers had better practices during lactation and they took more milk, eggs, *dal* (pulses), *daliya* (porridge), ghee, etc. in comparison to urban and rural mothers. 32% and 13%, and 5% and 5% urban and rural mothers and AWWs respectively were adding only green leafy vegetables, fruits or *daliya* to their diet during lactation. 6 to 20% mothers and 5 to 20% AWWs were partially correct in addition of food during lactation.
8. All (100%) urban AWWs were having right practices regarding initiation of breastfeeding within 6 hours of delivery in comparison to 85% rural and 65% tribal AWWs. Similarly urban mothers had 90% right practices in comparison to other groups of mothers. 95%, 80% and 80% of urban, rural and tribal AWWs and 88.7%, 68.7% and 70% of mothers respectively had right practices and were using *katori* (bowl) for feeding milk to their children. Urban group had highest right practices among the three regions comparatively.
9. 100% urban AWWs and 87.5% urban BMs had correct knowledge regarding nutrition in diarrhoea. 85% rural AWWs and 71.2% rural BMs, 70% tribal AWWs and 82.5% tribal BMs had correct knowledge about nutrition in diarrhoea.
10. 95% urban AWWs and 100% urban BMs had good practices regarding anganwadi food for children. They encouraged children to consume the food. 75% rural AWWs and 72.9% rural BMs, 80% tribal AWWs and 88.7% tribal BMs encouraged children to consume the food provided at AWCs.
11. Correct method of washing grains was followed by 95% urban AWWs, 75% rural AWWs and 85% tribal AWWs. 67.5% urban mothers, 66.2% rural mothers and 59.3% tribal mothers washed

- grains correctly. The practice of washing hands before cooking and eating was 98% in urban areas among beneficiary mothers, but only 60% among rural BMs and 58.8% among tribal BMs.
12. About 75% urban AWWs, 35% rural AWWs, and 35% tribal AWWs had proper knowledge regarding cutting of vegetables (washing before cutting). However, only 51.8% urban BMs, 21.8% rural BMs and 28.2% tribal BMs knew about the proper method.
 13. It was found that urban AWWs had 100% knowledge of vaccination in childhood, whereas 70% AWWs in rural group and 85% in tribal group had good knowledge. Awareness of mothers was found to be 86.6% in rural areas, 82.5% in urban areas and 76.2% in tribal areas.
 14. It was found that urban AWWs (90%) were highly aware about BCG vaccination and so were urban mothers (63.7%). Rural AWWs showed moderate awareness, while tribal AWWs were the least aware. On the other hand, the group of rural and tribal mothers were not very different and were lagging far behind their urban counterparts in knowledge of BCG vaccination.
 15. It was found that urban AWWs and tribal AWWs had equal knowledge (100%) regarding advantages of birth spacing, while AWWs of rural areas had 85% awareness about the same. Tribal group of mothers were found to be lagging far behind with 41.2% having knowledge, 84.3% urban BMs and 62.5% rural BMs were aware and had knowledge about birth spacing.
 16. It was found that urban AWWs were 100% aware of the practices to be adopted for gaps in child birth, while 71.3% urban BMs were aware of the same. Rural and tribal groups of AWWs and BMs had moderate knowledge about practices to keep right gap between child births.

Recommendations

1. To improve the overall quality of Nutrition and Health Education (NHED), and develop the skills of AWWs, refresher training should be organized at the sector level, so that AWWs can easily participate in them.
2. ICDS Supervisors should be oriented to organize effective NHED sessions, so that they could guide AWWs. Kits should be provided to each AWC with charts, posters, flip books, various types of puppets, flannel graphs, etc. to make NHED sessions interesting and memorable.
3. Nutrition and Health Education (NHED) component was found to be very weak in tribal areas, and this should be strengthened. Self help groups comprising AGs could be initiated through ICDS. Training of AGs is needed to overcome the culture specific problems of the area. Their help could also be utilized for strengthening NHED.
4. Knowledge, attitudes and practices particularly regarding nutrition were found to be different in urban, rural and tribal areas. So special emphasis should be given to these aspects during training.
5. In general, ICDS personnel who deal with NHED are not always persons with nutrition background. So to strengthen NHED, nutrition educators should be posted in every project to plan, coordinate and implement NHED services. There is no provision to monitor the NHED programme, so an Expert Committee comprising officials, nutritionists and health personnel should be formed to plan, implement, monitor and evaluate the NHED service, which will certainly be helpful in giving feedbacks from the fields and upgrade the quality of services at grass roots level.

Effectiveness of Health and Nutrition Education through Home Visit as a Strategy: A Study

NIPCCD, Regional Centre Bangalore

Introduction

Children should be the focal point of any national policy that emphasizes human development. For the well being of children and mothers, both governmental and non-governmental agencies in India are making efforts and have launched programmes like ICDS for their protection and promotion. The ICDS programme recognizes maternal awareness as an important determinant of child health. The uniqueness of the programme lies in its attempt at transfer of the needed technology to the family through health and nutrition education (HNE). Two different strategies are suggested for providing health and nutrition education in ICDS, namely in a small group situation to mothers in the AWC, or by taking the HNE services to the door steps of the beneficiaries through 'home visits'. This study examined in depth the aspects of health and nutrition education with special reference to the contact with individuals during home visits.

Aims and Objectives

The study aimed to:

1. Study the effectiveness of delivery mechanisms of health and nutrition education (HNE) through 'home visits' as a strategy in the selected ICDS block.
2. Investigate the outcome of health and nutrition education.
3. Study the problems faced in delivery of HNE through home visits and suggest measures for improvement.

Methodology

The study was conducted in two selected ICDS projects of Karnataka state, i.e. Ankel rural ICDS project (in operation since 1978) and Bangalore urban ICDS project (operational since 1979), and from each of the five circles, five villages/ wards were selected. The total sample size from rural and urban projects were 50 AWWs, 2 CDPOs, 10 Supervisors, and 50 AWWs; 48 pregnant mothers and 102 lactating mothers from urban ICDS project, and 51 pregnant mothers and 99 lactating mothers from rural ICDS project. Data was collected from ICDS functionaries and beneficiaries, and some data was gathered from secondary sources such as registers and records available at the AWCs.

Findings and Conclusions

1. About 90% AWWs mentioned that planning and selection of the houses for home visits was done by ascertaining the needs of the target group.

2. The workers in rural areas spent more time on home visits as compared to workers of urban areas. In rural areas, 36% of the workers were spending more than 30 minutes in each house as compared to 16% of the workers in urban areas who spent more than 30 minutes in one house.
3. AWWs mentioned that the main educational messages discussed during home visits included immunization, personal hygiene and sanitation, management of diarrhoea, etc.
4. According to the data, only 30% of the AWWs surveyed had made home visits which could be considered as qualitative, 56% were rated as average, and only 14% AWWs came in the category of deficient.
5. Data showed that the utilization of teaching aids for HNE was highly qualitative during home visits among 20% of AWWs, 14% were on deficient level, but a large number of AWWs were in the average category.
6. It was found that the delivery mechanism and aids used were more deficient than content coverage. AWWs tried to communicate the important messages of HNE, however their manner of delivery was not so effective.
7. It was found that nearly 78% women were illiterate and nearly 17% of them had formal education. The percentage of literates was higher in urban areas as compared to rural areas. Rural mothers' participation was better in HNE activities, and a majority of mothers from rural areas were of the opinion that their skills had improved considerably as compared to mothers from urban areas.
8. It was found that only 9% AWWs always gave HNE during their home visits, 16% reported that HNE was given sometimes, and the remaining 75% respondents mentioned that AWWs visited their houses but HNE was not given at that point of time. It was mentioned that AWWs' visits were very casual in nature, and this indicated that perhaps 'home visits' were being done mechanically without giving due consideration to the needs of mothers.
9. It was found that relatives (57%), doctors (24%), AWWs (21%), auxiliary nurse midwives (10%), radio (95%) and others like neighbours, friends, television (6%) were the major source of information for mothers. Among the ICDS functionaries AWWs made some effort to impart knowledge to mothers. Rural mothers' information was mainly through AWWs, ANMs, relatives and doctors. Although urban mothers had more access to information through other sources, their total knowledge level was comparatively lower than that of rural mothers.
10. AWWs mentioned that they had no difficulty in imparting HNE during home visits. In urban areas AWWs faced problems in contacting mothers for HNE, since most of them left their houses early in the morning for gainful employment. Most AWWs were from outside the local community, and left the AWC before mothers returned from work, and no time was available for the AWWs to interact with mothers.

11. About 60% of the middle level functionaries mentioned that non-participation of mothers in urban areas was due to frequent migration. The other problems for conducting HNE were lack of funds (40%), teaching aids (60%), etc.
12. Project level officers mentioned the main problem to be non-utilization of the HNE component by the target group. The over-worked women hardly found time to attend the educational programme, and there was difficulty in follow up of the targeted beneficiaries. Non-involvement of health functionaries in HNE, lack of teaching aids, and inadequate funds for nutrition demonstration were some more problems which were mentioned by them.

Recommendations

1. Any approach towards effective HNE needs to focus on need based messages to cater to the specific needs of the target group. Prioritizing messages, based on the needs of target groups, should be a vital step in HNE.
2. The target groups should be presented with realistic information on the various health services provided.
3. The quality of HNE should be improved through provision of appropriate teaching aids. The materials for HNE need to be prepared and replenished constantly, and carried by AWWs during home visits. These aids can further contribute to the effective implementation of HNE.
4. HNE mechanism for making home visits should have an in-built monitoring mechanism that steers action towards fulfillment of the stated objectives, which is lacking in the present situation. There is an immediate need for developing indicators for effective monitoring system for HNE.
5. HNE should be planned and implemented as an integrated activity connecting all related services being provided under the umbrella of ICDS.

Preschool Education in ICDS

Preschool Education in ICDS

Quality of Pre-Schooling under Different Programmes Including ICDS: A Study

D. D. Pandey

Introduction

Many kinds of public pre-school initiatives exist in India, however, no attempt has been made to make a comparative analysis of such qualitative inputs (in terms of infrastructural, pedagogical concerns, training initiatives, structural dimensions, etc.) and desired outputs by way of developing and improving school readiness skills. No studies have been undertaken of the quality of the many early childhood education (ECE) centres going by different names like balwadis, crèches, day care centres, etc. The qualitative concerns of PSE under different programmatic options need to be studied in depth to facilitate not only understanding of how these initiatives impact children, but also to document the good practices in ECE. This study was conducted to assess the qualitative inputs being provided under different public initiatives of preschooling in India.

Aims and Objectives

The study aimed to:

1. Assess the status of preschool centres in terms of facilities provided and the local environment under which they operate.
2. Assess the quality of pre-schooling initiatives functioning under different programmes.
3. Evaluate the school outcomes of various pre-schooling programmes.
4. Assess the gaps that require further strengthening to improve the quality of PSE.

Methodology

This study was conducted in four states namely Uttar Pradesh, Haryana, Himachal Pradesh and Punjab. The selection of these four states was done purposively. Total eight districts were selected, two clusters (one each from rural and urban) were selected from each of these eight districts, bringing the number of clusters up to 16. In total 96 PSE centres were studied thoroughly. Data was gathered through interviews and observation.

Findings and Conclusions

1. It was found that except Himachal Pradesh, in all the remaining three states of Haryana (25%), Punjab (37.5%), and Uttar Pradesh (12.5%), ICDS centres were running in Panchayat buildings. Almost 25% of the PSE centres under Rajeev Gandhi National Creche Scheme (RGNCS) were running in NGOs' own buildings. Around 87.5% centres in HP and 62.5% centres in Uttar Pradesh were running in ECE workers' homes.

2. None of the states had well as a source of drinking water except in 12.5% centres under the Rajeev Gandhi National Creches Scheme (RNGCS) in the state of Himachal Pradesh.
3. Around 78.12% Sarva Shiksha Abhiyan/ National Programme of Education of Girls at Elementary Level (NPEGEL) centres had outdoor space, followed by 62.5% RGNCS centres and 53.12% ICDS centres.
4. Toilet facilities were found in 34.37% RGNCS centres. In nearly 50% PSE centres (ICDS 53.12%; RGNCS 46.87%; and SSA/ NPEGEL 56.25%) the condition of toilets was satisfactory.
5. In more than 50% ICDS and RGNCS centres, the PSE kit was found to be complete, whereas under SSA/ NPEGEL 40.67% centres had complete kits. Higher number of ICDS centres in Himachal Pradesh (87.5%) had complete kits, and the lowest number was in Haryana and Uttar Pradesh who had 37.5% complete kits each.
6. Charts were available in all the crèche centres (100%) and in a sizeable number of SSA/ NPEGEL centres (93.7%) and ICDS (81.2%) centres. However, their utilization for conducting PSE activities were not found up to the desired extent, as only 50% crèches, 43.7% SSA/ NPEGEL centres and 65% ICDS centres (anganwadis) were found using charts most of the time. The charts were available in all the ICDS, SSA/ NPEGEL centres and crèches in Haryana, but their utilization was only in 75% ICDS centres and 50% each in crèches and SSA/ NPEGEL centres.
7. Teaching learning material was found in only 46.8% SSA/ NPEGEL centres, 37.5% ICDS centres (AWCs) and 31.2% crèche centres under RGNCS. The utilization of blocks for organizing various activities was higher in ICDS centres (40.62%), followed by a low number of SSA/ NPEGEL centres (28.1%) and crèches (18.7%).
8. Highest availability of toys was found in creches (71.8%), followed by SSA/ NPEGEL (59.3%) and ICDS centres (50%). However, despite the higher availability of toys at RGNCS their utilization was as low as that in ICDS centres (43.75%).
9. In around 43.7% ICDS and an equal number of SSA/ NPEGEL centres, picture books were available, however they were available in a limited number of crèche centres (28.1%). The usage of picture books was highest in ICDS centres (43.7%) and lowest in crèches (28.1%).
10. Availability of indigenous material for early childhood education (ECE) centres was highest under SSA initiative (59.37%), followed by ICDS centres (46.8%) and RGNCS centres (21.87%). More ICDS centres (43.75%) used PSE material compared to the number of SSA centres (25%). Although SSA centres had indigenous material but their utilization was less, as around 15.62% of them did not use the material.
11. 34.37% of the AWWs were found to be graduates in comparison to 28.12% SSA functionaries and 12.5% crèche workers. 9.37% SSA functionaries were post graduates. Higher number of AWWs in Uttar Pradesh (75%) were found to be graduates compared to 25% graduate AWWs in each of the states of Haryana and Punjab, and Himachal Pradesh (12.5%).
12. Most of the functionaries who served under SSA and RGNCS had less than one year work experience. 43.75% ICDS functionaries had work experience between 10-15 years; 15.62%

- ICDS functionaries had 5-10 years work experience compared with 12.5% functionaries under SSA and RGNCS initiatives.
13. Around 87.5% AWWs and 70% SSA functionaries were trained. In case of crèche workers only 43.75% were trained. The highest number of trained AWWs were in Himachal Pradesh (100%), while the lowest percentage was in Uttar Pradesh (75%). AWWs and crèche workers (93%) each reported that the training provided was adequate while only 70% SSA workers thought so. All the crèche workers were found adequately trained in Haryana, Himachal Pradesh and Uttar Pradesh.
 14. Training inputs helped AWWs (56.25%) develop planning skills and skills for preparation of PSE aids. 78.12% AWWs also adopted play way method for teaching. The training inputs were used by crèche workers (62.5% in Haryana, and 37.5% in Punjab) for preparation of PSE aids, but impact of training was found to be negligible in the state of Uttar Pradesh and Himachal Pradesh.
 15. Knowledge about the importance of programme planning was good among all the workers. However, it was average among SSA workers in the states of Haryana and Uttar Pradesh and good in Himachal Pradesh and Punjab.
 16. The knowledge about role of parents' participation in PSE was very good among ICDS and RGNCS workers compared to good among SSA functionaries. The highest parent participation (75%) was reported in ICDS in Himachal Pradesh, and lowest 12.5% each in SSA in Uttar Pradesh and Punjab.
 17. AWWs received considerable help from Village Pradhans (25%), community leaders (37.5%) and women's groups (21.87%). The help extended to crèches and SSA/ NPEGEL was found to be lower.
 18. In most cases, the support was limited to providing space for PSE centres (31.5% in ICDS, and 46.87% in SSA), and for drinking water (43.75% in SSA and 25% in ICDS).
 19. PSE activities were organized for 3-4 hours a day in almost half the PSE centres. In 34.37% SSA centres and 31.25% centres under RGNCS workers organized PSE activities for 1-2 hours a day; in 6.25% SSA centres and 3.12% centres under ICDS and RGNCS workers organized PSE activities for less than one hour daily; and in around 15.62% crèches, workers were organizing PSE activities for more than four hours daily. In Punjab, 75% workers in crèches/ SSA centres were devoting 3-4 hours daily for PSE activities, however, it was much lower in Haryana, Himachal Pradesh and Uttar Pradesh.
 20. Indoor activities were conducted in most of the PSE centres (100% under SSA, 90.62% under ICDS AWCs, and 87.5% in crèches), however, outdoor activities were conducted only in 87.5% SSA centres, 78% AWCs and 71.8% crèche centres.
 21. Children's participation in various PSE activities was good in ICDS and SSA/ NPEGEL centres against average in RGNCS. The participation of children in RGNCS centres in Haryana and Himachal Pradesh was average; it was good in RGNCS of Punjab, but poor in Uttar Pradesh.
 22. Maintenance of records was found to be very good in RGNCS and SSA/ NPEGEL centres while it was good in ICDS anganwadis. In Haryana and Punjab records were found in very good condition, and in Uttar Pradesh records were in good condition.

23. The performance of children in all the four states and in all the three public initiatives (ICDS, SSA/ NPEGEL and RGNCS) was found to be excellent for the concepts of quantity, seriation categorization, and naming objects. The performance of children attending all the three public initiatives of PSE in the states of Uttar Pradesh and Punjab was good as against those of ICDS children in Himachal Pradesh and SSA/ NPEGEL children in Haryana, whose performance was very good. However, the performance of children attending SSA/ NPEGEL centres in Himachal Pradesh was average.
24. The performance of children enrolled in all the three public initiatives of ICDS, SSA/ NPEGEL and RGNCS crèches was good for concept of colours as well as concept of shapes.
25. The attendance of all enrolled children in the PSE centres was highest in RGNCS centres (90.62%), followed by ICDS (81.25%) and SSA (75%) centres.
26. Many children transitioned from preschools into schools. However, around 6.25% RGNCS centres had 0% transition rates, 3.12% ICDS centres, and 3.12% SSA/ NPEGEL centres also had 0% transition rates. Centres with 0% transition rates were found to be in Uttar Pradesh, and 25% of SSA centres with 0% transition rates were found to be in Himachal Pradesh.

Recommendations

1. There is a pressing need to design a similar kind of comprehensive Training Strategy as is in place for ICDS functionaries for functionaries of RGNCS centres also. The existing infrastructure and human resource inputs of AWTCs may be utilized for this purpose.
2. There is need to come out with locally relevant comprehensive training inputs for functionaries involved in SSA/ NPEGEL and RGNCS so as to make the training inputs more meaningful.
3. Institutions like NCERT and NIPCCD should evolve minimum specifications incorporating different pedagogical, infrastructure, administrative, staffing and training parameters of ECE centres, which can later on be applied to all categories of centres, using different instrumentalities appropriate to each sector.
4. Decentralised mode of training initiatives should be strengthened through respective BRCs (Block Resource Centres) and CRCs (Cluster Resource Centres). Documentation and case studies of best practices in ECE (Early Childhood Education) should be prepared for wide dissemination and replication. It is recommended that while NCERT may be assigned the task of doing work in pedagogical aspects for ECE initiatives under SSA/ NPEGEL, NIPCCD may be given the responsibility of continuing with training, research and resource material availability of ECE under ICDS and RGNCS.
5. Lack of physical infrastructure and individual space would affect the efficiency and effectiveness of AWWs, thus limiting the learning of children. This aspect needs to be properly looked into for improving the quality of inputs of ECE centres.
6. There is need to take immediate action to ensure availability of PSE kits in all centres of ICDS, SSA/ NPEGEL and RGNCS.
7. The funds under SSA for Early Childhood Care and Education (ECCE) activities need to be allocated in proportion to the child population living in the particular district.

A Study on the Perception of Anganwadi Workers Towards Non-Formal Pre-School Education Programme of Anganwadi Centres

Debashish Mitra

Introduction

The pre-school education (PSE) component of ICDS does not get as much time and attention as it requires as the AWW is loaded with many other tasks to perform. This study assessed the functioning of PSE component of ICDS in Bolpur-Sriniketan Block, Birbhum district of West Bengal.

Aims and Objectives

The study aimed to:

1. Assess the activities related to non-formal pre-school education.
2. Assess the role and responsibilities of AWWs in accomplishing the tasks related to non-formal pre-school education.
3. Assess the perception of AWWs towards implementation of the non-formal PSE component of the ICDS programme.
4. Find out the intricacies and problems faced by AWWs in implementing the non-formal PSE component of ICDS programme.

Methodology

This study was conducted in Birbhum district. In the first stage, 3 out of 9 Gram Panchayats under Bolpur Sriniketan Block ICDS project were selected, and in the second stage 40 AWWs, 13 functionaries each from two Gram Panchayats, and 14 functionaries from the remaining one Gram Panchayat were selected. Data was collected through interviews.

Findings and Conclusions

1. It was found that a majority of the AWWs were in the age group 30-40 years, and maximum respondents were educated up to secondary level, which was very essential for seriously performing their roles and responsibilities, and following the methods learnt during training in their practical day to day work.
2. After completing PSE sessions in the AWCs, both boys and girls were taking admission in primary schools, and parents gave equal importance to primary education, for both boys and girls.
3. A large number of parents were willing to send their children to the centre, because they gave more importance to free food and less importance to pre-school education.
4. It was found that a majority of the respondents were aware about the work instructions given to AWWs.

5. Most of the respondents gave more importance to a child's social, emotional and language development through pronunciation, symbolic identification, word power, and acquiring knowledge about various kinds of social behaviour.
6. Respondents mentioned that cooperation of the villagers was present but their active participation was missing.
7. It was found that some children were not taking admission in school after completing PSE in ICDS but were engaged in household work, and engaged in earning some money.
8. The material to conduct non-formal pre-school education was sufficient but there was lack of infrastructure and there were no rooms to take classes, to keep play material and supplementary nutrition food, etc.
9. Maximum respondents had completed the job training course, but they did not apply their knowledge properly in practice in the field situation, due to lack of infrastructure facilities, lack of interest in children and lack of interest among AWWs.
10. Respondents mentioned that if any child dropped out from the centre they always tried to get him/her back to the centre through home visits and by motivating their parents.
11. Respondents mentioned that children adjusted well with the new environment at AWCs. AWWs prepared children to learn other activities, which helped them to be ready for formal school.
12. In most centres PSE programme was very effective, the AWWs were enthusiastic and endeavoured to better their performance.

Recommendations

1. Proper infrastructure facilities should be provided in AWCs.
2. There should be good communication between Supervisors and AWWs.
3. Involvement of local people and their active participation is needed for success of the programme.
4. There is need to increase awareness among villagers about the benefits of ICDS, and channelling local resources in a more effective way.
5. There is urgent need to increase job satisfaction among the AWWs regarding wages, work place, etc. and to organize time to time training programmes for capacity building of AWWs because they have forgotten many things.
6. Some new changes in the learning procedure should be made.
7. Mothers' meetings should be conducted every month by AWWs, and AWWs should discuss with them measures for improving the educational quality of PSE and other services provided under ICDS.

Supervisors

Supervisors

Analysis of Role Effectiveness of ICDS Supervisors of Gujarat: A Study Report

S. G. Gangur

Introduction

Gujarat is considered to be one of the progressive states in the country. The State has entrusted the implementation of ICDS programme to some voluntary organizations in rural and urban/ municipal corporation areas of the State to ensure maximum community participation as also to support the Government to elicit better coordination and management for effective delivery of ICDS services. In addition, the State is constantly making efforts for capacity building activities of the ICDS functionaries, who play a crucial role in supervision and monitoring of the programme.

Aims and Objectives

The study aimed to:

1. Assess the role performance of ICDS Supervisors in the selected ICDS blocks.
2. Identify the problems encountered by Supervisors while performing their job.
3. Suggest measures to further improve the job performance of Supervisors.

Methodology

The study was conducted in 15 ICDS projects of Gujarat from central, western and southern zones of the state. The districts selected were Ahmedabad, Vadodara, Surendranagar, Valsad and Dangs (tribal). 15 CDPOs, 60 Supervisors and 240 AWWs from urban, rural and tribal areas were selected. Data was gathered through interviews and field survey. The data was analyzed separately for Supervisors, CDPOs and AWWs.

Findings and Conclusions

1. It was observed that age is one of the factors that determines the level of job performance of a functionary. 30% respondents were of the opinion that work output would be more at a younger age i.e. below 30 years. In urban blocks Supervisors (30%) were younger than those in other blocks. 48% Supervisors were in the age group of 41 years and above, and only 5% each were in the age group of 25 years and less, and 26-30 years.
2. 67% Supervisors were graduates, 23% were post graduates and 10% were matriculates.

3. 17% Supervisors had six months or less experience of being in ICDS, 3.33% had seven months experience, 1.7% had two to four years experience and 78% had experience of four years and more. 83.33% Supervisors in rural and tribal blocks had received job and refresher training, and remaining 20.66% had undergone orientation training long ago. Training status of Supervisors in Government run urban ICDS blocks was better than NGO run urban ICDS blocks.
4. 36% Supervisors mentioned that the distance travelled from the place of stay to the anganwadi centres was long. 12% of the Supervisors travelled a minimum distance of 5-10 km.
5. In urban, rural and tribal blocks, Supervisors (48.33%) were spending more time on supplementary nutrition (SN), maintaining records and registers, growth monitoring, and attending community and official meetings.
6. During field work, 35% Supervisors had devoted time to preschool activities, made efforts to improve attendance, and had undertaken health and other activities. 51.66% of them had utilized up to two hours time for supervision of immunization records of children and pregnant women, and administration of Vitamin A doses to children.
7. 51.66% Supervisors had spent up to half an hour time for undertaking home visits, especially for at risk women, children and disabled children. 3.33% of them had spent up to a maximum of three to four hours time for home visits.
8. 38.33% Supervisors had spent up to a maximum of three hours or more for planning and conducting community and official meetings.
9. The perception of Supervisors about their role and job responsibilities under ICDS was also considered important. Majority of the Supervisors (93.33%) were aware of their role and responsibilities.
10. Local NGOs like CHETNA, SEWA, etc. had oriented Supervisors briefly in NGO run ICDS projects about their job responsibilities.
11. Supervisors of urban blocks (in NGO run projects) stated that the management should ensure that Supervisors were fully engaged in ICDS programme. They wished that they could be paid a consolidated salary at par with permanent Supervisors of Government managed ICDS blocks.
12. Majority of CDPOs (40%) were in the age group of 35-40 years, followed by 27% in 45 years and above group, 13% were between 30-35 years and 40-45 years, and 7% were in the age group of 25-30 years.
13. 68% CDPOs were graduates and the remaining 32% were post graduates. None of them was below the graduation level.
14. 67% CDPOs had undergone job training and refresher training, but 33% were untrained when data collection was carried out.
15. 53% CDPOs had work experience of more than 10-15 years, and 40% CDPOs had experience of above 15 years in ICDS, which indicated that they had sufficient experience to build skills in functionaries working under them. 7% of them had work experience of less than five years.

16. 80% CDPOs informed that they had utilized Supervisors' time on anganwadi building related grievances, preparation and compilation of monthly statements for MPR/ APR reports, and other related statements.
17. 60% CDPOs mentioned that Supervisors had also spent time on other activities such as facilitating the process of recruitment of AWWs, deputation of AWWs and helpers for training, making alternative arrangements to ensure continuity of ICDS services at AWCs during the period of their deputation for training.
18. 70.33% CDPOs felt that their services were utilized at least one day in a month in the office, and sometimes two or more days in a month, depending on the urgency of workload of CDPOs.
19. Major problems faced by Supervisors were target oriented health/ educational programmes (87%), lack of conveyance facility (80%), staying outside the headquarters, personal problems (67%), difficulty in facing questions put in the Gram Sabha and other meetings (60%), scale upgradation (53%), and career oriented viz promotion related problems (33%).
20. 13.33% CDPOs had rated the sense of commitment in Supervisors as 'very high', whereas 33.33% had rated it as 'high'. This was followed by 'average' (20%), 'low' (20%), and 'very low' (13.33%).
21. Regarding 'problem solving skills' in Supervisors, 40% CDPOs had rated it as 'high', followed by average (27%), 'low' (7%) and 'very low' (7%).
22. The motivational level of Supervisors, which plays an important role in role effectiveness, showed that only 40% CDPOs had rated motivational level of Supervisors as 'average'.
23. Regarding 'altruistic quality' (selflessness/ sacrificial nature) in Supervisors, 80% CDPOs felt that Supervisors were selfless in discharging their tasks. Only 20% CDPOs said that some Supervisors were not sensitive and were self-centred.
24. During visits to AWCs, 81% AWWs mentioned that Supervisors utilized more of their time in verifying records and registers preferably relating to supplementary nutrition, growth monitoring, food stock registers, and targets and achievements on health.
25. By and large, 81% of the AWWs agreed that a Supervisor was an important link who facilitated them in attending to building related problems, organizing community meetings, follow up of referral cases, and building rapport with ANMs and community leaders. They regularly visited AWCs. They also felt that their senior officers should consider the above issues favourably and provide them all the support needed.

Recommendations

1. To enhance the job performance of Supervisors in the ICDS programme, there is a need to create suitable opportunities for improving their job performance.
2. The number of ICDS blocks managed by NGOs needs to be reduced, so that the monitoring mechanism could be easier and effective.

3. Initiating action on entrusting an entire ICDS block to one well sustained NGO would be beneficial.
4. It is desirable to allot 21 centres or less to one Supervisor (1:21 ratio). It may be also ensured that one circle only may be allotted to one Supervisor for easy and better monitoring of AWCs.
5. There is a need for imparting training to Supervisors.
6. Refresher/ orientation training could be imparted every year to update them with the latest developments in ICDS.
7. Government could develop training modules on management of ICDS for NGO executives. It may collaborate with or seek inputs from professional institutions like NIPCCD.
8. Present honorarium of Supervisors is insufficient. This needs to be enhanced in accordance with the standard norms of Government rather than based on number of AWCs fixed per year.

Integrated Child Development Services: A Study of Job Performance of Supervisors

Pasupuleti Usha Rani and A. Laxmi Devi

Introduction

Supervisors have a very important role in ICDS, and their job performance is a crucial element for the successful implementation of the programme. A number of studies have highlighted the impact of ICDS Scheme, but very few studies have analysed the performance of Supervisors. This study was conducted to evaluate the job performance and job expectations of Supervisors working in urban, rural and tribal ICDS projects.

Aims and Objectives

The study aimed to:

1. Assess the job performance and job expectations of Supervisors working in urban, rural and tribal ICDS projects.
2. Analyze the differences between the job performance and job expectations of Supervisors working in urban, rural and tribal ICDS projects.
3. Find out the differences among supervisors, their superiors and subordinates about the job performance and job expectations of Supervisors working in urban, rural and tribal projects.
4. Explore the relationship between the personal, socio-economic, psychological and organizational characteristics of Supervisors and their job performance and job expectations.
5. Determine the factors that predict the job performance of ICDS Supervisors.
6. Elucidate the problems of Supervisors and make suitable suggestions for effective implementation of the ICDS programme.

Methodology

This study was conducted in three districts of Andhra Pradesh, namely Hyderabad (urban), Anantpur (rural) and Visakhapatnam (tribal). A total of 72 Supervisors, 28 CDPOs and 144 AWWs were selected for the study. Data was collected through interviews and field survey.

Findings and Conclusions

1. Over all job performance of Supervisors was found to be low, medium and high in 20.8%, 65.3% and 13.9% cases respectively. In urban areas, 6.2% Supervisors had low job performance, 87.6% had medium job performance and 6.2% Supervisors had high job performance. In rural areas, low job performance was observed in the case of 12.5% Supervisors, medium job

performance was observed in the case of 71.9% Supervisors, and 15.6% Supervisors showed high job performance. In tribal areas, low and medium job performance was 41.7% each, and high job performance was observed in the case of 16.5% Supervisors.

2. In all projects, majority of Supervisors had medium job expectations. Supervisors with medium job expectations were most in urban projects (93.8%), followed by rural projects (71.9%) and tribal projects (50.0%). Supervisors with low job expectations were highest in tribal projects, which could be mainly due to inadequate knowledge about the ICDS programme and activities.
3. It was found that young Supervisors had better job performance as compared to aged ones, because the nature of the job involved extensive touring, and Supervisors need to put in a lot of physical exertion while doing the job. Young people had more enthusiasm and interest than aged people.
4. None of the respondents was found to be low in job experience. Majority of the Supervisors had medium job experience in urban (87.5%), rural (93.8%) and tribal (70.8%) projects. Relatively more Supervisors were rated as high in job experience in tribal projects (29.2%) as compared to urban (12.5%) and rural (6.2%) projects. In all the projects job experience of Supervisors was found to be medium (87.7%) and high (15.3%).
5. In urban projects, 25% of the Supervisors had low rural orientation, while 75% had medium rural orientation. In rural projects, the rural orientation was low, medium and high in 9.4%, 75% and 15.6% of the Supervisors respectively. The spectacular difference was that 33.3% of the Supervisors in tribal projects had high rural orientation compared to Supervisors in urban and rural projects. While 54.2% Supervisors had medium rural orientation, 12.5% had low rural orientation in tribal projects. Overall, majority of the Supervisors (68.0%) had medium rural orientation, while 13.9% and 18.1% had low and high rural orientation respectively. The mean job experience of respondents was around five years.
6. It was found that in urban projects, 62.5% Supervisors received training for 101 days, 37.5% for 102 to 112 days, and none received training for more than 112 days. In case of rural projects, 78.1%, 18.8% and 3.1% Supervisors received training for 101, 102-112 and more than 112 days. In tribal projects, 101, 102-112 and more than 112 days training was recorded for 8.3%, 66.7% and 25% Supervisors respectively. In all projects, urban, rural and tribal, 51.4% Supervisors had undergone training for 101 days; 38.9% Supervisors received training up to 112 days; and 9.7% Supervisors had training for more than 112 days.
7. In urban projects, facilities and resources available were medium in the case of 75% Supervisors, and high in the case of 25% Supervisors. In rural projects, 81.2% and 18.8% Supervisors had medium and high facilities respectively. 75% Supervisors in tribal projects had medium facilities and resources, while the remaining Supervisors had high category of facilities and resources. Overall 8.3%, 77.8% and 13.9% of the Supervisors had low, medium and high categories of facilities and resources.

8. It was found that 12.5% of the Supervisors in urban projects were not satisfied with the guidance and supervision received from their superiors. But majority (81.2%) of the Supervisors were moderately satisfied, and 6.3% were highly satisfied. The same trend was reported in rural projects with 12.5%, 84.4% and 3.1% of the Supervisors being not satisfied, moderately satisfied and highly satisfied. 20.9% Supervisors working in tribal projects were highly satisfied, 62.5% were moderately satisfied and 16.6% were not satisfied. On the whole, guidance and supervision from superiors was not satisfactory in 13.9% cases, moderately satisfactory in 76.4% cases and highly satisfactory in 9.7% cases.
9. It was found that job satisfaction was low of 6.2% Supervisors, medium of 75% Supervisors and high of 18.8% Supervisors who worked in urban projects. Rural projects had 12.5%, 65.6% and 21.9% Supervisors who had low, medium and high level of job satisfaction. Half of the tribal Supervisors (50%) had medium job satisfaction, 20.8% were highly satisfied with their job activities, and 29.2% had low job satisfaction. Overall 16.6%, 62.5% and 20.9% Supervisors had low, medium and high job satisfaction respectively.
10. In tribal projects, Supervisors mentioned that AWWs were facing the problem of attracting and holding the attention of children during PSE activities due to lack of proper play materials and teaching aids without which the children just took their food and ran away.
11. All the Supervisors of tribal projects mentioned that their major concern was the selection of uneducated women as AWWs. Due to non-availability of Standard X pass women in tribal areas, and due to various political and social reasons, most often women with primary education were being selected as AWWs. Therefore, they were not able to fill up records and registers.
12. Out of 16 urban Supervisors, 15 (93.8%) had medium job motivation, while one (6.2%) had low job motivation. There was none with high job motivation in urban projects. In rural projects, 12.5%, 71.9% and 15.6% Supervisors had low, medium and high job motivation. 29.2% Supervisors who worked in tribal projects, had low job motivation. The motivation was medium and high in 62.5% and 8.3% tribal Supervisors. Overall, from all three projects, 16.7%, 73.6% and 9.7% Supervisors had low, medium and high levels of job motivation.
13. In urban projects of Hyderabad district, majority of AWWs were muslims who could not write in Telugu language in spite of their ability to speak the language. Because of this, most AWWs in urban projects were unable to fill up records and registers.
14. A majority (81.2%) of the urban Supervisors had average knowledge while 6.2% and 12.6% had low and high knowledge levels. The knowledge level of 9.4%, 75% and 15.6% Supervisors who worked in rural projects was low, average and high respectively. In tribal projects, 41.7%, 45.8% and 12.5% Supervisors had low, average and high knowledge levels. On the whole, 19.4% Supervisors had low knowledge levels, while 66.7% and 13.9% Supervisors had average and high knowledge levels.

Recommendations

1. In tribal projects, the organizational environment was found to be low, so there is need to provide an environment where there is freedom to work, opportunities are there for personal growth, and there is room for Supervisors to improve their professional abilities.
2. All Supervisors should undergo the three types of training courses, namely job training, orientation training and refresher training, so that they can be more knowledgeable and skilled in their area of work, and also increase their abilities to transfer theoretical knowledge into practice at the field level.
3. There is need to improve the level of job performance of Supervisors in all projects. Hence suitable measures should be taken to increase their job satisfaction and knowledge which would ultimately improve the level of job performance.
4. AWWs in urban projects need to be trained intensively to be able to fill up the records and registers to be maintained by them. Lack of crèche and transport facilities were problems they faced, which needed attention.
5. Necessary training may be imparted to Supervisors and AWWs to utilize the locally available material for preparation of preschool education aids, toys and puppets, etc.
6. Ready to eat food items like *murkulu*, sweets, chocolates, etc. may also be provided.
7. Educated women should be selected as AWWs in tribal projects so that they can maintain records and registers.

Supplementary Nutrition in ICDS

Supplementary Nutrition in ICDS

Supplementary Feeding in ICDS: Present System of Food Purchases, Distribution and Satisfaction of Beneficiaries

K. Jose Boban

Introduction

Supplementary nutrition (SN) is a high cost input of the ICDS programme. It is imperative that it is delivered effectively to have the desired impact on the target population. This study was undertaken to understand the magnitude of feeding interruption and how it affects the beneficiaries; the reaction of the beneficiaries towards feeding interruption; and the challenges faced by ICDS functionaries in the implementation of feeding programme.

Aims and Objectives

The study aimed to:

1. Assess the opinion of beneficiaries regarding the present system of food distribution.
2. Understand the problems and difficulties faced by ICDS staff to ensure smooth functioning of the feeding programme.
3. Assess the constraints faced by the local self government in allocating adequate funds for the feeding programme.
4. Find out whether there is any reduction in the actual number of beneficiaries in the feeding programme on account of financial constraints.
5. Assess the problems related to access of different beneficiary groups.
6. Assess the efficacy of the present system of food distribution.

Methodology

This study was conducted in Kerala and covered 5 ICDS projects namely, Thiruvananthapuram (Urban-I) (WBS) (World Bank Strengthening); Kazhakuttam (WBS); Nedumangad (WBN) (World Bank New); Parassala (WBN); and Varkala (WBS). 5 CDPOs, 38 Supervisors, 200 AWWs, 200 beneficiaries and 150 elected representatives, 5 from each local self government institution, including Mayor of Corporation, Chairman of Municipality and President of Gram Panchayat were selected for the study. Primary data was gathered from AWWs and beneficiaries with the help of separate interview schedules. Secondary data was collected through documents available in the ICDS office.

Findings and Conclusions

1. It was found that about 92% of the respondents visit the AWC on all days either to receive food or to take pre-school children to class or for feeding their children in the 0-3 years age group.
2. 41% respondents mentioned that they were satisfied with the variety of food items. 95% beneficiaries of Thiruvananthapuram urban and 75% of Kazhakuttom were happy with the menu.
3. Respondents of all projects mentioned that the food being served is very nutritious. Beneficiaries of Varkala demanded that milk should be provided daily.
4. All beneficiaries mentioned that they were very punctual in attending the feeding programme. They mentioned that there is no wastage of cooked food.
5. 15% respondents mentioned that they preferred raw food. They were interested in getting raw food which they could cook according to their taste.
6. Respondents mentioned that they were not satisfied with the storage facilities. There was inadequacy of containers. This problem was felt more in AWCs functioning from rented buildings.
7. It was found that in Thiruvananthapuram urban I, Kazhakuttom rural areas of Nedumangad and Parassala projects, the condition of buildings was very poor, children did not have enough space to play, and beneficiaries did not have facilities to sit and eat food.
8. 84.2% CDPOs mentioned that through the feeding programme nutritious food was supplied to the most deserving beneficiaries in quite a regular manner.
9. Supervisors of Kazhakuttom mentioned that beneficiaries were satisfied with the variety in the food served. However a majority of Supervisors of Nedumangad revealed that beneficiaries were not satisfied with the variety in the menu.
10. 62% respondents were of the opinion that deserving people were selected as beneficiaries.
11. Members of Local Self Government Institutions (LSGI) were not fully confident that always deserving persons only were selected as beneficiaries. They felt that more strict procedures for the selection of beneficiaries should be adopted.
12. All ICDS officials explained that only deserving persons were selected as beneficiaries as their selection is made on the basis of objective criteria listed under the ICDS scheme.
13. 92.1% Supervisors mentioned that the members of LSGIs were very cooperative in implementing the feeding programme. 94.7% Supervisors reported that there was adequate consultation between them and members of local bodies for the feeding programme.
14. 55.3% Supervisors mentioned that there was good coordination between Gram Panchayat and Block Panchayat in the allocation of funds, but 31.6% said that there was no such coordination.
15. 89.3% people's representatives mentioned that their LSGIs were giving due priority to the supplementary feeding programme.

16. 75.5% respondents mentioned that there was no interruption in the feeding programme in their AWCs.
17. 56.5% of the AWWs mentioned that there was no interruption in the feeding programme while 41% AWWs said that there was occasional interruption.
18. More than half the respondents (51.7%) were not making any adhoc arrangements to overcome interruption in the SN programme as this problem was not very severe.
19. It was found that AWWs were not interested in approaching local people for getting assistance to handle any crisis.
20. It was found that shopkeepers refused to supply food material to AWCs when there was delay in the payment of money for a long period of time.
21. 97.7% AWWs mentioned that beneficiaries showed willingness to understand the situation when there was interruption in feeding.
22. 78.9% Supervisors had not observed any anxiety among the beneficiaries about interruption in feeding.
23. 74% respondents mentioned that there was no reduction in the number of beneficiaries due to interruption in feeding.
24. 76.5% AWWs mentioned that beneficiaries had no complaints regarding accessibility to AWCs, and there was no demand from beneficiaries for establishing new AWCs in their locality.
25. About 44% of the respondents accepted that the present feeding programme was effective.

Recommendations

1. There is need to improve the infrastructural facilities and construct their own building for each AWC.
2. AWWs should be aware of the quantity of food required for her AWC for a stipulated period of time.
3. There is need to increase the storage facilities for food materials in AWCs and the same food items should be supplied to all AWCs of a project.
4. There should be effective and timely communication between AWWs and Supervisors.
5. Funds of LSGIs must be made available to Supervisors without any delay.
6. There is need to increase awareness about the feeding programme among people who could be beneficiaries of the service.
7. Better coordination should be brought about between Gram Panchayat and Block Panchayats in the planning and implementation of the feeding programme.
8. ICDS officials must take strong corrective action when there are complaints against AWWs or Helpers with respect to the misappropriation of food materials.

Time Management in ICDS

Time Management in ICDS

A Study on Redesigning the Anganwadis in Kerala

Antony Kariyil and Celine Sunny

Introduction

Management of time is an integral component of any operational system. It is felt that the AWW, the key functionary of ICDS, is constrained to reduce the pre-school education (PSE) component as a result of the myriad functions she is entrusted with. This study aims at a realistic assessment of the time utilization by the AWWs, in relation to their multifarious tasks, and evolving appropriate strategies for improving the functioning of the AWCs in Kerala.

Aims and Objectives

The study aimed to:

1. Analyse the time spent by AWWs for each component of the six services.
2. Find out the interruption during pre-school activities.
3. Find out the problems faced by AWWs and Helpers in performing their tasks.
4. Assess the views of the respondents regarding the services of AWCs and the role played by the AWW.
5. Find out whether any of the duties performed by an AWW is redundant in the context of Kerala, and if so, whether they could be discontinued.
6. Suggest ways and means through which the pre-school component of ICDS in Kerala could be improved, so that a child coming out of an AWC could be effectively inducted to Standard I with the present curriculum and pedagogy.

Methodology

This study was conducted in rural, urban, semi-urban, coastal and tribal areas of 14 districts of Kerala. 400 AWCs were studied. Total 10,470 respondents were selected among whom there were 70 pre-primary experts, 1200 key persons, 6000 beneficiaries, 400 functionaries, 2000 community beneficiaries and 800 health personnel. Data was collected through interviews, observation and local level meetings.

Findings and Conclusions

1. It was found that more than 90% of the workers had an educational background of matric (Class 10) and above. 92% of the workers had undergone refresher training.

2. It was found that more than 60% of the AWWs spent less than 150 minutes for PSE as against the stipulated time of 180 minutes. There were also AWWs that assigned less than 60 minutes for PSE.
3. It was found that 88% AWWs spent less than 10 minutes for introductory activities. Regular attendance was marked in 95% of the centres, the time spent on attendance being 1-10 minutes. But majority of the AWWs (55.3%) spent less than 15 minutes for this. Checking the hygiene of children took less than 10 minutes. In 13.3% AWCs, AWWs neglected this responsibility. Tribal areas had more centres in which AWWs took 20-30 minutes for informal talks.
4. It was found that 76.7% of the AWWs assigned less than 20 minutes for motor activities, including organized games, nature walks and physical exercises, which required 30 minutes daily. 35% of the AWWs assigned less than 10 minutes and 23.3% of the AWWs never attended to this. No time was specified for free play, but in most of the centres (85%) time was given for it. Out of these, in 64% centres above 10 minutes had been assigned for free play.
5. It was found that while AWWs in 57.3% of the centres spent 10-20 minutes for action song, in only 25.5% AWCs the same time was used for story telling. In 33.8% centres AWWs assigned below 10 minutes for action song, 58.5% AWWs assigned the same time for story telling. 12.8% AWWs did not devote any time for these activities.
6. It was found that in 43% of the centres, time was not assigned for creative activities. Out of the 57% centres where creative activities were undertaken, 51.5% AWWs allowed less than 20 minutes. Tribal areas had more centres where creative activities were undertaken as compared to rural areas.
7. 37% AWWs spent less than the expected time of 60 minutes on supplementary nutrition and 48% AWWs spent above the expected time. Among the centres where AWWs assigned less than 60 minutes, tribal centres ranked on top (46.3%), followed by rural (42.4%) and coastal (40%) area centres. In 44% of the centres AWWs assigned more than 90 minutes for SN, and urban areas had the highest number of centres where 90 minutes were allocated.
8. The average time spent for each house visit was 19-20 minutes. Majority of the AWWs (69.8%) spent below 20 minutes for each home visit. Centres where AWWs spent above 20 minutes and above 60 minutes were 6% and 1.8% respectively. Records were regularly maintained in 90% centres, and 74.5% AWWs spent below 15 minutes on home visits.
9. Records maintained at AWCs included attendance of children attending pre-school education, food stock register and house visits register. Maintaining records took an average time of 27-30 minutes daily, which was equivalent to the expected time. However, in certain centres more than the average expected time was taken.
10. Almost 100% centres had weighing scales, and children were weighed regularly. In more than 75% centres morning hours were utilized for weighing the children. The AWWs discussed with parents the health status of the children. This activity took around 10 minutes in 75% of the centres.
11. Immunization was organized either at the primary health centre (PHC) or at the AWC. While 66.8% AWWs organized it at the AWC, the rest organized immunization camps at the primary

- health centre. 80.5% of the AWWs held immunization camps monthly. Some AWWs (17.9%) combined it with the Pulse Polio Programme.
12. It was revealed that AWWs had to spend one day each month for project level and sectoral meetings. Time was spent for informing the community, making arrangements, taking sessions and for reporting. An average time of 30 minutes each was spent both for informing the community and making arrangements, and more than 90% of them spent below 30 minutes for this.
 13. It was found that there was no perfect referral system in the centres. However, most of the centres provided the service, either partially or for namesake, and it was done mainly during home visits and as and when needed.
 14. AWWs mentioned that inadequate public cooperation hinders the smooth functioning of the centres. Exhaustive tasks and lack of time stagnated their creativity for discharging their duties in a better way.
 15. Helpers mentioned that absence of anganwadi workers normally doubled their workload.
 16. Most of the beneficiaries mentioned that they were satisfied with the on-going services of the centre, but they complained about the poor infrastructure facilities in a majority of the AWCs.
 17. Majority of the key personnel (community leaders) appreciated the activities carried out by AWWs, they were happy with the prevailing conditions and claimed that the AWC prepared the children for Standard I. They also expressed the need to discontinue certain tasks like providing health services, conducting surveys, organizing a number of meetings, maintaining a number of registers, undertaking house visits and panchayat related tasks.

Recommendations

1. Efforts should be made at the policy level, to exclude the AWW from health services. The worker should only be entrusted with the task of supplying IFA tablets and other medicines in the kit.
2. The number of records and registers maintained by anganwadi workers should be reduced.
3. The number of meetings, except sectoral/ project level meetings, should be reduced.
4. AWWs should not be burdened with too many Panchayat related activities, and AWWs should not be substituted by Helpers or vice versa.
5. A time frame should be fixed for specific activities/ services of the pre-school component of the ICDS programme.
6. AWWs training module should include aspects of time management like prioritization of tasks, planning the activities (daily, monthly and periodic).
7. Strict measures should be taken by the authorities to minimize interruptions during pre-school activities.
8. Indicators for monitoring allocation of time for various activities should be incorporated into the training module for Supervisors and Child Development Project Officers.

Time and Work Study of Anganwadi Workers

D. D. Pandey

Introduction

This study was conducted to understand the time allocation pattern of AWWs and to apprehend its various dimensions in terms of work load. So far studies have provided only piecemeal information about time dynamics vis-à-vis the work and functioning of AWWs. The need for a national level comprehensive investigation for assessing the variability of time allocation system and prioritization of tasks by AWWs was being felt for a long time. This study was initiated to fill the knowledge gaps in time allocation by AWWs, and to study their functioning.

Aims and Objectives

The study aimed to:

1. Assess the variability of time allocation by AWWs for carrying out the different tasks assigned to them.
2. Assess the actual amount of time spent by AWWs in performing the tasks directly connected with delivery of services as envisaged under ICDS.
3. Assess the prioritization of tasks by AWWs.
4. Explore the time being spent by AWWs for strengthening other developmental programmes.
5. Compare the time allocation and work pattern of AWWs for various services under different settings of rural, urban and tribal ICDS projects.
6. Suggest strategies for effective and efficient utilization of time by AWWs.

Methodology

This study was conducted in 24 ICDS projects of the country. 14 districts were covered in 4 states namely: Assam (Goalpara, Kamrup, Nalvari, Baska, Tinsukia); Maharashtra (Ahmednagar, Chandrapura); Tamil Nadu (Cuddalore, Erode, Namakkal); Uttar Pradesh (Lakhimpur, Kheri, Jhansi, Saharanpur). A total of 192 AWWs, 96 Supervisors, 24 CDPOs, and 384 stakeholders were selected. Data was gathered through interviews and field surveys.

Findings and Conclusions

1. It was found that all AWWs in tribal and urban projects had received some kind of training inputs. However, this trend was not found in the case of AWWs of rural areas. The untrained AWWs from rural projects were found only in the state of Uttar Pradesh. All AWWs working in urban projects were trained compared to 94% and 97% AWWs in rural and tribal projects respectively.

2. A sizeable number of AWWs in the states of Tamil Nadu and Maharashtra had received refresher training. The states of Assam and Uttar Pradesh, that had lagged behind in imparting job training inputs, were found to be moving ahead by imparting special training to AWWs. 71% of the AWWs in Assam and 50% of the AWWs from Uttar Pradesh had received special training compared to 43% and 30% of the AWWs working in the states of Tamil Nadu and Maharashtra.
3. It was found that some AWWs were engaged in personal encumbrances like agriculture, tuitions/ part time teaching, household business and heavy load of domestic work. Nine out of 10 AWWs were not engaged in any other activity apart from running the ICDS centre and they had no other personal encumbrances. The highest number of non-engaged AWWs were found in Tamil Nadu (98%), followed by Assam (92%), Maharashtra (88%) and Uttar Pradesh (85.5%). None of the AWWs working in urban projects across all the four states were engaged in other personal encumbrances. However, 15.4% rural AWWs and 12.3% tribal AWWs were found to be engaged in personal encumbrances.
4. In Assam, about 12.5% AWWs devoted upto 3 hours per day, and 87.5% AWWs spent 3-4 hours per day for ICDS activities. In Maharashtra 6.2% AWWs spent more than 3-4 hours, 87.4% AWWs spent 4-5 hours, 6.2% AWWs spent 5-6 hours. In Tamil Nadu 16.6% AWWs spent 6-7 hours, 83.3% AWWs spent 7-8 hours. In Uttar Pradesh 6.2% AWWs spent 3-4 hours, 89.5% AWWs spent 4-5 hours, and 4.1% AWWs spent 5-6 hours daily. Overall 3.1% AWWs devoted upto 3 hours, 24.9% AWWs devoted 3-4 hours, 44.2% AWWs devoted 4-5 hours, 2.5% AWWs devoted 5-6 hours, 4.1% AWWs spent 6-7 hours and 20.7% AWWs spent 7-8 hours daily for ICDS work at AWCs.
5. In Assam 60.4% AWWs took upto 10 minutes to reach the AWC, 29.1% AWWs took 10-15 minutes, 6.2% AWWs took 15-20 minutes and 10.4% AWWs took 20-30 minutes. In Maharashtra 72.9% AWWs took upto 10 minutes, 2.06% AWWs took 10-15 minutes, 2.06% AWWs took 15-20 minutes and 2.06% AWWs took 30-45 minutes. In Tamil Nadu 52.2% AWWs took upto 10 minutes, 16.6% AWWs took 10-15 minutes, 14.5% AWWs took 15-20 minutes, 6.2% AWWs took 20-30 minutes and 8.3% AWWs took 30-45 minutes. In Uttar Pradesh 68.7% AWWs took upto 10 minutes to reach the AWCs, 16.6% AWWs took 10-15 minutes, and 8.3% AWWs spent 15-20 minutes. In all 63.5% AWWs spent upto 10 minutes, 16.1% spent 10-15 minutes, 7.7% AWWs spent 15-20 minutes, 4.1% AWWs spent 20-30 minutes and 2.5% AWWs took 30-45 minutes to reach the AWCs.
6. About 29.1% AWWs of Assam spent upto 1 hour for PSE activities, and 70.8% AWWs spent 1-2 hours. In Maharashtra 12.4% spent upto 1 hour, 70.8% devoted 1-2 hours and 16.6% AWWs spent 2-3 hours. In Tamil Nadu 33.3% AWWs spent upto 1 hour, 64.5% spent 1-2 hours and 2.06% AWWs spent 2-3 hours. In Uttar Pradesh 6.2% AWWs devoted upto 1 hour, 52.06% AWWs devoted 1-2 hours, 25% AWWs spent 2-3 hours and 16.6% AWWs spent 3-4 hours. In all 20.2% AWWs devoted upto 1 hour, 65.1% devoted 1-2 hours, 10.9% AWWs devoted 2-3 hours and 4.1% AWWs devoted 3-4 hours per day for PSE activities.

7. In Assam 52.06% AWWs devoted 10-20 minutes for group activities, 39.5% AWWs devoted 20-30 minutes, and 4.1% AWWs devoted 30-40 minutes. In Maharashtra 29.1% AWWs spent 10-20 minutes, 18.8% AWWs spent 20-30 minutes, 25% AWWs spent 30-40 minutes, 16.7% AWWs spent 40-50 minutes and 6.3% AWWs spent 50-60 minutes. In Tamil Nadu 9.4% AWWs devoted 10-20 minutes, 25% AWWs devoted 20-30 minutes, 47.9% AWWs devoted 30-40 minutes, 8.3% AWWs devoted 40-50 minutes and 12.5% AWWs devoted 50-60 minutes. In Uttar Pradesh 8.3% AWWs spent 20-30 minutes, 12.5% AWWs spent 30-40 minutes, 8.3% AWWs spent 40-50 minutes and 45.8% AWWs spent 50-60 minutes. Overall, 21.8% AWWs spent 10-20 minutes, 22.8% AWWs spent 20-30 minutes, 22.3% AWWs spent 30-40 minutes, 8.3% AWWs spent 40-50 minutes and 16.1% AWWs spent 50-60 minutes for group activities.
8. Half of the AWWs (57%) were spending less than one hour for discharging all the functions related to organization of supplementary nutrition (SN) services including preparation and distribution of SN to beneficiaries of ICDS. Nearly, one-fourth of the AWWs from the states of Maharashtra (22%) and Uttar Pradesh (23%) spent 1-2 hours daily in organizing SN services.
9. One-third of the AWWs were found to be spending their time on preparation of SN food for children and women. Among those AWWs who were observed to be devoting time on preparation of food, maximum number of AWWs (11%) spent less than 45 minutes for the activity, followed by 7% of them who spent 20-25 minutes. In Tamil Nadu, 40% AWWs spent more than 45 minutes, which was in sharp contrast to the other two states of Maharashtra and Uttar Pradesh. In both these states, there was little involvement of AWWs in the preparation of SN. More than 46% AWWs spent more than 45 minutes on distribution of SN in Maharashtra. This is in sharp contrast to the involvement of AWWs in Tamil Nadu (17%) and Uttar Pradesh (3%). 30-45 minutes was spent by 25% AWWs from Maharashtra, compared to 8% AWWs in Tamil Nadu and 2% in Uttar Pradesh. Maximum number of AWWs from Uttar Pradesh (43%) and Tamil Nadu (37%) spent 15-20 minutes on SN activities.
10. 62% AWWs were involved in cleaning utensils and 44% AWWs were involved in cleaning the cooking area. This activity could be because there were many vacant posts of AWHs in all the four states.
11. Around 100% AWWs of Assam were organizing NHED sessions on monthly basis. In Maharashtra 2.06% AWWs organized NHED sessions twice a week, 2.06% AWWs organized NHED sessions fortnightly, and 95.8% AWWs organized NHED on monthly basis. In Tamil Nadu 8.3% AWWs organized NHED sessions daily, 60.4% AWWs organised sessions weekly, 14.5% AWWs twice a week, 4.1% AWWs fortnightly, 8.3% AWWs organised NHED sessions monthly, and 4.1% AWWs organized NHED sessions quarterly. In Uttar Pradesh 29.8% AWWs organized NHED sessions daily, 22.1% AWWs on weekly basis, and 45.3% AWWs organized NHED sessions monthly. Overall 9.5% AWWs organized NHED sessions daily, 20.6% AWWs organized NHED sessions weekly, 4.1% AWWs organized them twice a week, 1.5% AWWs were organizing them fortnightly, 62.3% AWWs monthly, and 1.03% AWWs were organizing NHED sessions quarterly.

12. The frequency of organizing health camps was found to be monthly and quarterly in 41% and 22% AWCs. In Assam, none of the AWWs had organized health camps. In 83% AWCs in Uttar Pradesh health camps were organized on monthly basis, while in Maharashtra 39% AWWs were organizing health camps on monthly basis. In Maharashtra 63% AWWs were organizing health camps on quarterly basis.
13. All AWWs (100%) in Maharashtra and 84% AWWs in Tamil Nadu spent 1-2 days in organizing health camps. Almost half of the AWWs in Tamil Nadu and 17% AWWs in Maharashtra spent up to one hour, compared to the state of Uttar Pradesh where none of the AWWs spent such time.
14. The frequency of organizing immunization camps across all the projects (rural, tribal and urban) in the states of Assam and Maharashtra was found to be monthly. The frequency was found to be weekly in 23% AWCs in Tamil Nadu and 17% AWCs in Uttar Pradesh. Overall, in 87% AWCs the frequency of organizing immunization camps was monthly.
15. In Assam, all the AWWs were found to be either devoting 4-6 days (65%) or more than six days (35%) to organization of immunization camps. However, in Maharashtra, 96% AWWs devoted only 1-2 days for immunization camps. In Tamil Nadu and Uttar Pradesh, nearly half the AWWs were devoting 1-2 days. On an average, 20% AWWs spent either 1-2 hours and 20% AWWs spent 3-4 hours. Only 5% AWWs spent 4-6 hours or more than 7 hours per day.
16. In Tamil Nadu almost 60% AWWs spent less than one hour per week followed by 24% of them devoting 1-2 hours weekly for referral services. About 62% AWWs from Uttar Pradesh spent about 5-6 hours per week on referral services. In Tamil Nadu 60% AWWs spent less than one hour per week on referrals, followed by 24% AWWs who devoted 1-2 hours for referral services.
17. Growth monitoring (GM) activities were organized on monthly basis in 77% AWCs and quarterly basis in less than 15% of the AWCs. In 47% AWCs the average time spent on undertaking GM activities was reported to be 1-2 hours, followed by 2-3 hours in 17% AWCs, and 3-4 hours in 15% AWCs. None of the AWWs from Assam reported spending more than two hours for GM activities, while in Maharashtra more than 50% AWWs spent 2-4 hours per month for undertaking tasks related to growth monitoring.
18. In Assam 100% AWWs spent upto 1 hour per day for maintenance of daily registers. In Maharashtra 83.3% AWWs spent upto 1 hour, 14.5% AWWs spent 1-2 hours and 2.06% AWWs spent 2-3 hours. In Tamil Nadu 60.3% AWWs spent upto 1 hour, 29.1% AWWs spent 1-2 hours, 6.2% AWWs spent 2-3 hours and 4.1% AWWs spent 3-4 hours per day. In Uttar Pradesh 91.6% AWWs devoted upto 1 hour, 2.06% AWWs devoted 1-2 hours per day, and the rest did not respond. Overall, 83.8% AWWs spent upto 1 hour, 11.4% AWWs spent 1-2 hours, 2.06% AWWs spent 2-3 hours and 1.03% AWWs devoted 3-4 hours per day for maintaining registers.
19. Close to one-fourth of the AWWs (23%) were not maintaining the daily diary. Among those who were observed to be doing so, about 14% AWWs were observed devoting 10-15 minutes,

- followed by one-fifth of them (19%) devoting 5-10 minutes to doing so. In Assam 33% AWWs devoted 15-20 minutes for updating the daily diary, however, in Uttar Pradesh only 2% AWWs were devoting 15-20 minutes.
20. 73% AWWs were maintaining health cards on monthly basis, followed by nearly one-fifth AWWs (19%) who maintained health cards on fortnightly basis.
 21. In Assam 54.1% AWWs devoted up to 1 hour, 33.3% AWWs spent 1-2 hours, 8.3% AWWs spent 2-3 hours and 4.2% AWWs devoted more than 4 hours for maintenance of immunization register. In Maharashtra 12.5% AWWs spent up to 1 hour, 56.2% AWWs spent 1-2 hours, 6.2% AWWs spent 2-3 hours, 20.8% AWWs spent 3-4 hours and 10.4% AWWs devoted more than 4 hours. In Tamil Nadu 31.2% AWWs spent up to 1 hour, 56.2% AWWs spent 1-2 hours, 8.3% AWWs spent 2-3 hours, and 4.1% AWWs devoted more than 4 hours. In Uttar Pradesh 4.2% AWWs spent up to 1 hour, 27.1% AWWs spent 1-2 hours, 8.3% AWWs spent 2-3 hours, 20.8% AWWs spent 3-4 hours and 37.5% AWWs devoted more than 4 hours. Overall, 24.5% AWWs devoted up to 1 hour, 43.2% AWWs spent 1-2 hours, 7.3% AWWs spent 2-3 hours, 10.4% AWWs spent 3-4 hours and 14% AWWs spent more than 4 hours to maintain the immunization registers.
 22. The frequency of updating the lactating mothers' register was monthly in all the AWCs (98%) in Assam, while the same was nearly half (44%) in Tamil Nadu. In Maharashtra the frequency of updating the register was found to be daily in nearly half of the AWCs, while in Uttar Pradesh the same was found to be weekly in many AWCs (81%). Average time spent on updating lactating mothers' register was reported by 77% AWWs to be up to 1 hour, followed by 1-2 hours time taken by 22% AWWs. Many AWWs from Assam (90%) and Uttar Pradesh (73%) spent 1 hour for updating the register. The register was updated monthly in Assam (98%) and almost weekly in Uttar Pradesh (81%).
 23. The frequency of updating the pregnant mothers' register was on monthly basis in Assam. 91.7% AWWs spent upto 1 hour, 6.2% AWWs spent 1-2 hours and 2.07% AWWs spent 2-3 hours. In Maharashtra 87.5% AWWs spent 1 hour, 6.2% AWWs spent 1-2 hours, and 6.2% AWWs spent 2-3 hours. In Tamil Nadu 85.4% AWWs spent 1 hour, 8.3% AWWs spent 1-2 hours and 6.2% AWWs spent 2-3 hours. In Uttar Pradesh 85.4% AWWs spent upto 1 hour, and 14.6% AWWs spent 1-2 hours. Overall, 87.5% AWWs spent upto 1 hour, 9.7% AWWs spent 1-2 hours, and 2.7% AWWs spent 2-3 hours for updating the pregnant mothers register.
 24. In Assam 77.06% AWWs spent upto 1 hour and 22.9% AWWs spent 1-2 hours in making home visits. In Maharashtra 79.1% AWWs spent upto 1 hour, and 20.8% AWWs spent 1-2 hours on home visits. In Tamil Nadu 70.8% AWWs spent upto 1 hour and 18.7% spent 1-2 hours on home visits. In Uttar Pradesh 85.4% AWWs spent upto 1 hour and 12.4% AWWs spent 1-2 hours on home visits.
 25. Three out of five AWWs (60%) reported that they had not undertaken any other activity or miscellaneous task other than ICDS activities. The maximum involvement of AWWs in other tasks was in the state of Uttar Pradesh, followed by Assam, Tamil Nadu and Maharashtra. More

AWWs working in rural projects were engaged in miscellaneous tasks compared with AWWs working in tribal and urban settings. Maximum number of AWWs (17%) had spent 3-6 hours per day, followed by 9% of them having spent 6-9 hours per day, 6% AWWs spent less than one hour per day, and 4% of them spent 1-3 hours per day in miscellaneous activities. The engagements in tribal projects were reported to be much less compared to urban and rural projects.

26. Maximum number of AWWs (67%) from Assam had utilized the help of AGs in preparation and distribution of SN, while their help was being utilized to minimum extent on this dimension (12.5%) in the state of Tamil Nadu.
27. Frequent visits of community leaders were reported by less than one-fifth AWWs from Assam (20%), Maharashtra (17%) and Tamil Nadu (20%), and an almost negligible number of AWWs (2%) from the state of Uttar Pradesh. Daily and fortnightly visits were found to be true in some AWCs in Assam and Tamil Nadu.
28. Lack of involvement of community leaders and lack of role clarity among AWWs were also identified as possible reasons of work pressure on AWWs as mentioned by 45% and 16% of CDPOs.
29. Low honorarium to AWWs was mentioned as a major concern by all CDPOs (100%) in Uttar Pradesh, and many of them from Assam and Tamil Nadu (83%). CDPOs mentioned that maintaining too many records and registers, assigning too many job responsibilities, and assigning too much additional work were other dimensions which affected the work of AWWs. On this matter the opinion of CDPOs from Maharashtra differed considerably from their counterparts working in the remaining three states of Tamil Nadu, Assam and Uttar Pradesh.
30. About 70% of the Supervisors mentioned that due to work pressure on AWWs, it was difficult for them to discharge their duties properly. 62% Supervisors of Assam, 67% from Tamil Nadu, 68% from Uttar Pradesh and 61% from Maharashtra expressed the opinion that AWWs faced difficulty in discharging their job responsibilities.
31. Four out of every five AWWs mentioned that they were overburdened with ICDS work. The concern for high workload was shown by maximum number of AWWs from Assam (96%), followed by AWWs of Tamil Nadu (90%), Uttar Pradesh (71%) and in Maharashtra (63%). The AWWs working in urban projects (89.05%) exhibited higher level of concern regarding workload compared to their counterparts working in rural (75%) and tribal (71%) ICDS projects.

Recommendations

1. On the basis of these findings, amalgamating state specific variations cannot be done. It may be concluded that it is difficult to draw a national picture about allocation of time by AWWs to run the AWCs. A need has been felt for conducting state specific studies on time allocation and work perspectives of AWWs.

2. The involvement of AWWs in holding elections and performing other miscellaneous tasks (like preparation of Identity Cards, photography, Municipality work, VIP movements, etc.) needs to be avoided. Categorical instructions are required to be issued by Government of India (GOI) regarding this. GOI may organize various regional workshops in which policy makers, ICDS practitioners and other stakeholders may be convinced about the importance of not deploying AWWs to perform various other tasks of these identified ministries/ departments.
3. The supportive help being provided by AWHs and AGs to run the day to day activities of AWCs needs to be considered while talking about work load and time management of AWWs.
4. There is a need to educate ICDS functionaries about the synergetic importance of deployment of AWWs tasks with those of various allied ministries/ departments. NIPCCD and Middle Level Training Centres (MLTCs) may like to take up this issue in the job and refresher training of CDPOs and Supervisors. Skill training workshops are also required to be organized in time management for all ICDS functionaries.
5. There is need to appoint a committee for prescribing minimum records and registers to be maintained at AWCs with a view to reducing the workload and time being consumed by AWWs in their maintenance.

Time Management by Anganwadi Workers of ICDS

Renu Khosla and Manorama Kaul

Introduction

The Department of Women and Child Development of the Government of India decided to sponsor a series of studies in selected ICDS blocks to understand the process of time management by AWWs to assess how much time is actually spent on the various tasks assigned to them, and how they apportion their time to meet the requirements of the programme. There was need to make a realistic estimate of the time an Anganwadi Worker (AWW) spent on different tasks under the ICDS programme.

Aims and Objectives

The study aimed to:

1. Find out the pattern of time allocation for different activities, daily, periodic and sporadic, by AWWs.
2. Assess the amount of time spent by AWWs in performing different tasks.
3. Study prioritization of tasks by AWWs.
4. Identify and analyze factors affecting efficient and effective time management.
5. Suggest ways/ strategies for effective and efficient utilization of time by AWWs in carrying out multifarious tasks assigned to them.

Methodology

The study was conducted in 1996-97 in Madhya Pradesh by National Institute of Public Cooperation and Child Development. Two ICDS projects namely Patan (rural), District Jabalpur and Gugri (tribal) District Mandla were selected. The study covered ten anganwadi centres (AWCs) and 20 anganwadi workers (AWWs). Data was gathered using observation sheets, interview schedules, records and registers.

Findings and Conclusions

1. In Madhya Pradesh, AWWs were expected to spend 4 hours daily for 300 days in an year at the AWC. On daily activities, AWWs were expected to spend a total of 240 minutes, 120 minutes on PSE, 60 minutes on SN, 30 minutes on record keeping, and 60 minutes on home visits. It was found that in a rural areas AWWs spent a total of 127 minutes daily, 43 minutes on PSE, 19 minutes on SN, 9 minutes on record keeping, and 56 minutes on home visits. In tribal areas AWWs spent a total of 111 minutes at the AWC daily, 44 minutes on PSE, 19 minutes on SN, 12 minutes on record keeping, and 36 minutes on home visits.

2. It was found that 36 hours per month were required to accomplish the monthly and periodic tasks assigned to AWWs. Although most centres opened at the appointed hour, majority of the children arrived closer to supplementary nutrition (SN) time; therefore pre-school activities commenced only about 45 minutes prior to distribution of SN. Most centres functioned in the residences of the AWWs so it was not possible to ascertain whether these actually opened on time. In tribal areas, distribution of SN took very little time and the children ate quickly or carried away the left over food. Home visits were the only tasks that actually utilized the time allocated for AWWs.
3. For monthly activities, time spent on collecting SN was significantly higher for tribal AWWs owing to distance and inadequate transportation, whereas rural workers spent more time on Mahila Mandal meetings or mothers' meetings, immunization, filling up MPRs and survey work. In rural areas 53.8% and in tribal areas 57.7% of the time was not utilized.
4. In both projects, none of the activities which required literacy skills, were found to be related to time management. Those projects had been functional for over 8 years and most AWWs had long standing experience in filling up records, etc, so their skills had been perfected over the years. Records were also reviewed systematically by Supervisors, and the relationship of AWWs and Supervisors between periodic tasks and literacy was weaker than for monthly activities and literacy implying that literacy does, to some extent, determine time spent on monthly activities.
5. In centres which were easily accessible, AWWs spent most time on daily routine work and least on monthly tasks. AWWs spent very little time on periodic tasks in the difficult-to-reach centres. Supervisors find on-road centres convenient to monitor.
6. In AWCs pre-school programme spanned between 70-130 minutes, however children were engaged for less than 50%, of the time. They either stayed huddled together quietly inside the centre or busied themselves in their own games. Presence of investigators appeared to have spurred workers into action. The attendance was very short at pre-school, and children were quickly gathered on day one of observation in many instances. AWWs hunting for activities to conduct or finding themselves at a loss was indicative that pre-school activities were not organized routinely.
7. It was found that there was no timetable for pre-school activities and they were arranged only in an adhoc manner. Children were not taking interest in learning activities. Alphabets and counting taught by the rote method was popular and organized daily in the tribal project and 2 to 3 times a week in the rural project.
8. It was found that checking of personal hygiene was not a routine daily chore. It was undertaken only once a week, and it took a lot of time. Dramatization of stories and going for nature walks were observed in only one AWC.
9. Attendance of children was more for SNP rather than PSE. For pre-school activities there were always fewer children than at the time of supplementary nutrition.

10. In the tribal project, due to scarcity of water, helpers spent more time in washing utensils. They avoided serving food to children in the dishes provided.
11. Rural workers collected rations once a month while tribal workers did so about 4-5 times a year, and they spent significantly more time in its collection. The frequency of their trips was less than half that of rural AWWs. In rural areas food supply was more regular with disruption reported once a year during rains for about 15 days. In tribal areas there could be interruptions for a continuous stretch of 4 to 5 months every year, adversely affecting the attendance of children. No extra time was spent on making alternate arrangements for feeding during the gap periods, further reducing the time spent by AWWs at the centre.
12. Organizing community meetings is a task which has not received adequate attention. Most AWWs do not organize any meetings for awareness building or mobilizing community participation, and most AWWs do not feel the need to organize formal mothers' meetings as they often met informally on their own. Frequency of Mahila Mandal meetings ranged from once a week in 2 centres to none in 4 centres in rural areas. In tribal areas meetings took place once a month in 1 centre and never in 5 centres.

Recommendations

1. The ICDS programme needs to be owned by people, which was not the case at present. Ownership would increase when people are made a part of the programme. Very little time of the AWWs is presently devoted to mobilizing people and involving them in the activities at AWCs.
2. ICDS must have an exit policy that would ensure that people learn to become self reliant, and AWWs do not continue to spend time in motivating/ informing people about immunization/ family planning, etc.
3. Although an AWW is an honorary functionary, it is imperative that along with her job responsibilities and tasks, a time frame is worked out for various activities. This would enable Supervisors and CDPOs to evaluate performance using time as an indicator, thereby improving the effectiveness of inputs/ monitoring by the supervisory staff.
4. The ICDS programme and its normative pattern is inflexible and applicable to all, irrespective of the conditions in which some of these projects/ AWWs operate. The situation in the tribal region and rural areas is different, and the programme must have the inbuilt flexibility to allow for such adaptations/ variations to improve the overall service delivery.

Training of Anganwadi Workers

Training of Anganwadi Workers

Impact of ICDS Training on Service Delivery by Anganwadi Workers: A Study

Adarsh Sharma and D. D. Pandey

Introduction

After inception of the ICDS programme, conscious and continuous efforts are being made to monitor the various aspects of training inputs (infrastructure and process mechanism) by Central Technical Agency, NIPCCD and a chain of MLTCs, but the output of training in terms of development of varied competencies (knowledge, attitude and skills) required for carrying out the job responsibilities of ICDS has not been evaluated comprehensively vis-à-vis their impact on the delivery of social components of the programme. In order to address both these issues concomitantly, NIPCCD undertook this study in two districts of Uttar Pradesh.

Aims and Objectives

The study aimed to:

1. Assess the impact of Job Training Course (JTC) of AWWs in terms of gain of knowledge, development of skills and attitudinal transformation among AWWs.
2. Assess the problem areas adversely affecting the impact of job training course.
3. Suggest strategies for strengthening the qualitative output of job training courses.

Methodology

This study was conducted in two districts of Uttar Pradesh, namely Muzaffarnagar and Saharanpur. 100 AWWs, 50 from Saharanpur AWTC and 50 from Muzaffarnagar AWTC were selected for the study. Data was gathered through Knowledge Gain and Awareness Schedule (KG & AS), Investigation Impressionistic Observation Schedule (IIOS), Attitudes and Practice Test (APT) and focus group discussions (FGD).

Findings and Conclusions

1. It was hypothesized that there was no significant difference due to intervention of Job Training Course (JTC) on the development of composite skills concerning PSE session, and its sub-skills of story telling, narrating children's song, organizing outdoor games, organizing creative activities, organizing number games, and organizing word games. It was found that the AWWs who received the job training (JT) were equipped in a better way with five skills (Story telling, Narrating children's song, Organizing creative activities, Number and Word Games) out of

the set of six skills (Story Telling, Narrating Children's Song, Organizing Outdoor Games, Creative Activities, Number and Word Games) required for organizing PSE sessions than their counterparts who did not attend the JTC. The insignificant difference between AWWs of both the groups on skill of organizing outdoor games might depend on the sizeable number of AWCs where these trainees performed the task but did not have sufficient outdoor space for practicing these skills.

2. The AWWs who attended the JTC had better composite skills for selection of proper teaching aids, innovative activities, maintaining teaching aids, and preparation of teaching aids. Thus JTC helped in developing the skills required for use of teaching aids to conduct PSE sessions more effectively.
3. It was found that AWWs who had attended the JTC had significantly better composite skills for communicating with children than those who had not. In the new syllabus of JTC, the practice of STTD (Simultaneous Training Technology Design) has been adopted in which the trainees not only use their skills in role play but also practice these skills in institutional settings. There has been a special session on skills for interacting with preschoolers. Thus JTC had a significant impact in developing the skills of AWWs to communicate with children more effectively. There was insignificant difference on the skills of softness in voice and appropriateness of communication at children's level in the field.
4. It was found that most of the time AWWs prepare different kinds of teaching aids for various purposes without keeping in mind that they are to be used for children. ICDS functionaries lack the basic directional philosophy of the scheme. They always seem to readily need early childhood education aids supplied by state owned agencies. This deep rooted dependence habit of AWWs spoils the basic challenge emanating from the non-formal preschool education component of the ICDS scheme.
5. AWWs who had undergone job training had better skills to enlist children's participation. AWWs of both groups were able to keep children happy, and allowed children to play with toys/ play material. Children of both the groups were seldom allowed to handle teaching aids due to the fear that they might either destroy or damage them.
6. The AWWs who received JT did not exhibit significant gain on the composite skill of delivery of supplementary nutrition and its constituent set of two skills of maintaining hygiene and distribution of supplementary nutrition according to norms as per schematic pattern of the scheme than their counterparts who did not attend JTC.
7. The AWWs who attended JTC had skills for preparation of a variety of foods because there were enough number of sessions during the JTC for preparing a variety of foods from locally available food stuffs and from ready to eat foods.
8. AWWs who had attended JTC had better composite skill for eliciting community participation than those AWWs who had not attended job training.

9. Both the groups of AWWs had similar attitude towards running the AWC efficiently, but the inner willingness of AWWs to go through the reading material was much more in the case of AWWs who had attended JTC.

Recommendations

1. The syllabus of JTC should be developed keeping in view the educational and professional background of AWWs, trainers of AWTCs and infrastructure and process based facilities available at AWTCs.
2. Trainers of AWTCs need to be fully oriented with the new concepts and *modus operandi* of supervised practice.
3. The language and writing style adopted in the textual material meant for AWWs and trainers should be easily intelligible to them. NIPCCD is required to develop the material in simple language. The concept of supervised practice is required to reinforce skills development, and in no case should pose additional problems of comprehension for trainers.
4. Intensive research is required by NIPCCD to ensure that the concepts introduced are compatible with the understanding of trainees as well as that of trainers of AWTCs.
5. Training strategies should be designed in such a way that trainees are adequately prepared to handle the revised syllabus. Trainers' guides or handbooks should be made available to all the trainees.
6. The formative and summative evaluation of JTC should be carried out continuously with a view to diagnose the trainee AWWs' weaknesses in the area of skills development, and subsequently remedial measures should be adopted for those AWWs who lag behind in some aspects of skills development. Time spent by trainees on remedial measures should be considered as part of their regular work load and task responsibilities.

Udisha Training

Udisha Training

Evaluation of Project Udisha: The National Training Component of World Bank Assisted Women and Child Development Project

Operations Research Group

Introduction

The training component of the World Bank Assisted Women and Child Development Project called Udisha envisages improved training of ICDS functionaries which is crucial to the success of ICDS. Besides improving the quality of the training system, Project Udisha also emphasizes on clearing the training backlog and providing training to every ICDS functionary. This study was conducted to analyse the physical and financial progress made under Project Udisha across various States and Union Territories (UTs) of the country.

Aims and Objectives

This study aimed to:

1. Assess the progress in implementation of Project Udisha, physical and financial state-wise.
2. Learn about the training needs of ICDS functionaries, trainers and others connected with implementation of the ICDS scheme; learn about their met and unmet needs; and the reasons for unmet needs.
3. Assess the quality of training with respect to training needs and field requirements.
4. Assess the impact of training on quality of service delivery.
5. Evaluate the areas of concern for mid-course intervention.

Methodology

This study was conducted in 15 states of India namely Delhi, Himachal Pradesh, Rajasthan, Gujarat, Uttar Pradesh, Chhattisgarh, Orissa, West Bengal, Assam, Andhra Pradesh, Tamil Nadu, Kerala, Jharkhand, Meghalaya and Maharashtra. A total of 90 Projects, 269 AWCs, 45 AWTCs, 15 MLTCs (Middle Level Training Centres), 45 District Programme Officers, 81 CDPOs/ACDPOs, 144 Supervisors, 269 AWWs/ AWHs (Anganwadi Helpers), 30 Focus Group Discussion beneficiaries/ women's group members, 30 state training task force/ SPMU members and 15 Nodal Officers were selected. Data was collected through in-depth interviews, Focus group discussions (FGDs) were held with concerned stakeholders, participant observation was done of the on-going training at training centres, and secondary sources from which data was collected included PIPs (Project Implementation Plan), STRAPs, minutes of STFF meetings, Government Orders, etc.

Findings and Conclusions

1. Almost all the functionaries had field based training. Overall 91% Supervisors mentioned that training helped in improving service delivery in the field. Over 50% of the Supervisors felt that there had been a change in the way PSE activities were organized post Udisha training. Other areas like knowledge about immunization, health and nutrition, growth chart, community participation, maintaining records and registers also improved after attending training.
2. It was found that 42% CDPOs/ACDPOs had undergone job training under Udisha. In Meghalaya, Andhra Pradesh, Kerala, Uttar Pradesh, Delhi and Jharkhand 50% or more CDPOs/ACDPOs had undergone job training. Frequent transfers to other departments and fresh recruitment were some of the reasons for this backlog of trained personnel.
3. It was found that the training performance for Supervisors was lower than that for CDPOs. Performance vis-a-vis target for Supervisors was 30% at all India level. State-wise performance was also not good. In the case of AWWs the performance had been just above average at all India level with 50% achievement. The achievement in Kerala, Chhattisgarh, Assam, Meghalaya and Delhi was over 70%, whereas from secondary sources it was found to be less than 10% in Uttarakhand and Manipur.
4. In the sample states of Himachal Pradesh, Chhattisgarh, Andhra Pradesh and Tamil Nadu, Supervisors had more experience than the average experience of Supervisors at the national level.
5. Only in Rajasthan, apart from the AWTCs, Mobile Training Teams were also involved in training. All the Supervisors were trained in MLTCs. NIPCCD was involved in imparting training in all the sample states till the year 2002. In Tamil Nadu, most of the training of AWWs was undertaken by Grade I Supervisors of the respective blocks through Communication, Navigation and Identification (CNI).
6. It was found that the achievement of refresher training was much lower than that of job training. Only 37% AWWs had received refresher training and only a few Supervisors had received refresher training.
7. Finding sufficient training institutions for conducting job training of AWWs was a major problem for most states. Out of the 571 sanctioned AWTCs only 445 (80%) were operational. Only 40 out of 52 sanctioned MLTCs were functional. Shortage of training infrastructure in Orissa, Andhra Pradesh, Rajasthan and Gujarat was quite high.
8. It was found that the trainees faced problems in relating the training programme to local needs. At times a batch of trainees had people with different backgrounds and levels of understanding. The trainer tends to treat them as a homogeneous group. Thus to deal with these issues each state is involved in the process of preparing a State Training Action Plan (STRAP). This is a participatory exercise and deals with identifying the training needs, trainees, venue of training, duration, kinds of training and training strategies. Further, to develop training strategies and plans, each State has constituted its State Training Task Force (STTF). This comprises members from various departments.

9. In most states STTF members were rarely involved in its preparation and approval. There was no clarity on the role of STTF members. They hardly provided any inputs to the curriculum.
10. AWWs mentioned that there had been an improvement in art and craft related skills and the training had helped them in bringing out the creativity skill inherent in them, and the same was being utilized for preparing charts/ toys with the help of local materials. They also felt more confident in interacting with community members, bringing improvement in day to day activities such as filling up registers/ records, weighing children and preparing growth charts, etc.
11. Various constraints were faced by AWWs. Due to lack of proper infrastructure facilities at AWCs, AWWs were not in a position to put some of the skills learnt during training into practice.
12. It was found that more than 1.5 lakh CDPOs/ ACDPOs and Supervisors had been trained under Udisha and overall around 50% of the target had been achieved. In most of the states the achievement was more than 50% whereas in Kerala, Bihar, Chhattisgarh, Assam, Meghalaya, Haryana, Punjab and Delhi, the achievement was more than 70%. On the other hand, from secondary sources it was found to be less than 10% in states like Manipur and Uttarakhand.
13. It was found that various states were not achieving the target for refresher training. However, some of the states had achieved moderate targets for refresher training. From secondary sources it was found that Haryana had achieved about 45% of the Project Implementation Plan (PIP) target of the AWWs refresher training, while Delhi had achieved 37%. In case of Supervisor refresher training, Punjab had achieved only 1.4% of the target according to secondary sources. In case of CDPOs, Haryana had achieved 33% of the PIP, while Rajasthan had achieved only 6%. Goa, Maharashtra, Orissa, Meghalaya and Karnataka had also performed well in the case of AWWs refresher training. In Jharkhand, Chhattisgarh and Uttarakhand, none of the CDPOs/ ACDPOs had undergone refresher training, while Uttar Pradesh had achieved a little above 4% of its Project Implementation Plan (PIP) target and Madhya Pradesh had achieved 11% of the same.
14. It was found that in states like Gujarat, Assam, Meghalaya, Delhi, Maharashtra, Himachal Pradesh and Rajasthan, the expected number of participants did not turn up for the training, and therefore the backlog did not get cleared. In Delhi, for instance, the AWTC instructors mentioned that there was under utilization of the capacities of the AWTCs because all the trainees did not come for training. In Uttar Pradesh, 40% to 50% attendance was reported because many of the participants did not turn up for training due to various personal reasons.
15. AWWs from Himachal Pradesh, Rajasthan, Gujarat, Meghalaya and West Bengal mentioned that training on pre-school activities had helped them to make PSE interesting and attractive. AWWs were also able to convince the community and mothers about the importance of immunization, growth monitoring and breast feeding.
16. Officials from some states said that the shortage of MLTCs and AWTCs was the reason for increase in the training backlog. In Gujarat, lack of accessibility to the training centres was

one of the constraints. The Nodal Officer mentioned that AWWs were reluctant to attend the training because AWTCs were located very far from their villages. In Assam, Jharkhand, Maharashtra and Rajasthan, shortage of MLTCs was the main reason for the increasing backlog of Supervisors training.

17. Under Udisha, all financial norms had been substantially revised with a view to enhancing quality. The outlay for the National Training Component was fixed at Rs. 600.55 crores, which was later revised to Rs. 409 crores. The outlay had been divided into eight major categories. These included job, joint and refresher training programmes for the functionaries of ICDS department, training of trainers (TOTs), implementation of innovative training ideas, institutional development of NIPCCD and upgradation of state training facilities.
18. It was found that each of the States prepared State Training Annual Plan (STRAP) and submitted them to CPMUs (Central Project Management Units) and Government of India for their approval.
19. It was found that about 88% of the total expenditure had been incurred on regular training, while 8% of the expenditure was incurred for the other types of training. In most states, expenditure under training component was more than 90% and States like Himachal Pradesh had utilized 100% of the expenditure on regular training. Uttar Pradesh, Gujarat, Goa, Delhi, Bihar and West Bengal had made use of most of their expenditure for the training component. Some States like Chhattisgarh, Rajasthan, Meghalaya, and Andhra Pradesh had also made significant expenditure for other kinds of training, namely Training of Trainers (TOTs) and IEC (Information, Education and Communication) components. The number of such states and proportion spent on other components was less.
20. For the overall training of AWWs, a total of 571 AWTCs had been sanctioned, but of these only 445 (80%) were operational. On the other hand, out of 52 sanctioned MLTCs, 40 were operational. Each of the States except North Eastern States were to identify State Training Institutes (STIs) that were supposed to hold TOT for MLTC/ AWTC instructors and Job/ Refresher training courses for CDPOs/ ACDPOs. All of them had earlier been trained by NIPCCD.
21. It was found that in some states the problem of shortage of infrastructure was very pronounced. In Rajasthan, only 14 AWTCs were operational. There was a short fall in Madhya Pradesh, Bihar, Orissa and Andhra Pradesh as well.
22. It was found that shortage of Middle Level Training Centres (MLTCs) also led to an increase in the backlog for training Supervisors. Rajasthan, Gujarat, Himachal Pradesh, Meghalaya and Assam had shortage of MLTCs.
23. In almost all the states NGOs were imparting training to ICDS functionaries. As far as the training is concerned, functionaries' training institutions and State Training Task Force (STTF) members were directly linked to the Department, but in practice, this horizontal link was missing. In Delhi, Orissa, West Bengal and Uttar Pradesh, AWTCs and MLTCs were training institutions linked to the Department, but the functional linkage among these two training centres was

- missing. STTF provided inputs to the Department, but their interaction with training centres was absent.
24. It was found that overall, across all the sample states, a total of 47,565 beneficiary households were registered. The average figures worked out to be 177 households per AWC, and on an average, 111 beneficiaries mentioned that they were availing services regularly from AWCs.
 25. It was found that the number of all groups of beneficiaries availing facilities was less than number registered with AWCs.
 26. It was revealed that both, cooked and ready-to-eat (RTE) food was served across the sampled states. In Gujarat, supplementary food was prepared at the AWC. In Orissa, uncooked pulses and jaggery was distributed to the beneficiaries. *Daliya* (porridge) and *khichri* (a mix of boiled rice and pulses) was served by almost all AWCs in Uttar Pradesh, Chhattisgarh, and Himachal Pradesh. In Delhi, Assam, Kerala and Rajasthan, mostly RTE food was served. Irregularity in supply of food items to AWCs was the common problem faced by them. 55% AWWs mentioned this problem, and they were mostly from Delhi, Uttar Pradesh, Chhattisgarh, Jharkhand, Orissa, Assam, West Bengal and Tamil Nadu.
 27. In some AWCs the food was prepared by Helpers, and sometimes that was wasted by the children because they did not relish the taste. Officials mentioned that the Government did not provided condiments and spices to AWCs located in tribal areas. There was no provision of storage facilities at 20% of the AWCs, while 27% did have the facility but the supply of condiments and spices was not adequate.
 28. It was found that only 67% children had been administered BCG inoculation. In some states none of the children were given Hepatitis B injection.
 29. Overall 80% of the AWWs had received Medicine Kit during the training programme. Those who had not received were from Maharashtra, Jharkhand, Tamil Nadu and Kerala. Around 40% AWWs who received medicine kits reported that the medicines were inadequate. Regular supply of medicines was mentioned by only 10% of the respondents. Around 68% of the kits had medicines, which were yet to reach their expiry dates, while in 10% cases some medicines had already crossed the expiry date. In the remaining cases medicines lasted for long and did not have expiry dates.
 30. About 33% AWWs stocked ORS packets. Many AWWs (45%) reported that they demonstrated the ORS preparation process to mothers, while 38% said that they did the same only sometimes or as and when required.
 31. Overall, only 58% and 48% AWWs filled Health and PSE Registers regularly. Other registers that were maintained by AWWs were Births and Deaths register (69%), Stock register (55%), Growth Chart register (46%), Mahila Mandals register (20%), and Family Planning (17%).
 32. On an average, CDPOs mentioned that they visited each AWC once a month. None of them reported that there was a formal monitoring format to be filled during their visit to the AWC.

The Supervisors also reported that they do not have to fill any formal monitoring format during their visit to the AWC. The functionaries acknowledged improvement in their professional relationship as a result of training. Supervisors showed satisfaction in playing the role of guide and teacher to AWWs on some areas such as health and nutrition, formation of groups and community participation.

33. AWWs mentioned that due to lack of support from the community and sometimes from seniors they were not in a position to put their learning into practice. Lack of proper infrastructure and learning and teaching material further aggravated the problem.
34. Functionaries were facing many problems in running AWCs in tribal areas of Rajasthan because the villagers were very superstitious and did not co-operate with them. Functionaries mentioned that they needed to organize many awareness campaigns for them in order to generate awareness regarding immunization and antenatal and post natal (ANC/ PNC) care.
35. CDPOs reported that there were several constraints faced by Supervisors and AWWs at the grass roots level. The common constraints faced by Supervisors and AWWs were infrastructure and rent problems of AWCs.

Recommendations

1. The States should be given more flexibility in planning and managing their affairs. They should have more independence and leverage in preparation of syllabus, and 25% of the syllabus may be state specific.
2. Proper mechanism should be evolved in deputing people for job/ TOT/ orientation training to avoid repetition of training to the same person and imparting training at the right/ appropriate time when needed.
3. In Delhi, AWCs were not perceived as important service delivery points and also the AWW was not given much importance in the area/ society. Hence the training should also address such problems which are more area specific.
4. Almost 70% functionaries have received job training in Delhi, but they were not applying their knowledge in the field. Therefore, some mechanism needs to be worked out to orient them to the new developments and knowledge incorporated in the training module, as refresher training is normally organized after 2-3 years of job training.
5. Besides cultural diversity, different languages or dialects are spoken in different districts, these differences also need to be emphasized. Resource persons may not be familiar with these different languages/dialects. Functionaries should be provided training in their own language.
6. Due to shortage of basic infrastructure and amenities at AWCs, translation of learning from training and other ICDS inputs to the field situation is difficult, hence this aspect should be given priority.

7. To make the States more accountable and decide on what is more important to them, financial flexibility in terms of expenditure should be given to them.
8. To make things move faster at the field level, communication and information flows should be improved from apex institutions like NIPCCD to the field, rather than being only Director-to-Director interaction.
9. Many times the services of AWWs are utilized for various other programmes, and this affects adversely the day to day functioning of AWCs. Thus norms should be prescribed on the utilization of services of AWWs by various departments and accordingly, incentives should be provided for their services.
10. There is need to orient the ICDS functionaries on their new roles and responsibilities. ICDS functionaries see themselves as “administrative agents” rather than “technical professional agents for social change”. There is need to change this perspective.

Factors Affecting Job Performance of Anganwadi Workers: A Study of Three Districts of Maharashtra

Vrinda Datta

Introduction

AWWs play a crucial role in promoting child growth and development, and their training has a direct impact on their job performance. With newer efforts in training through Udisha, this is an important point in time to look at the impact of training on job performance of workers. This study was conducted to understand the issue of job performance of AWWs by looking into the various determinants identified in the framework for the study.

Aims and Objectives

The study aimed to:

1. Assess the ICDS anganwadi workers' training programme.
2. Assess the knowledge, attitudes and skills of AWWs.
3. Assess the Supervisors role, inputs given to enhance the job performance of AWWs, and their appraisal of AWWs' performance.
4. Assess the AWWs' perception of problems and issues that affect her job performance.
5. Give suggestions and specific inputs to strengthen training and other aspects of enhancing job performance.

Methodology

This study was conducted in three districts of Maharashtra, namely Nagpur, Nasik and Amravati. In every district there were urban, rural and tribal blocks and 6 were covered. A total of 615 AWWs and 72 Supervisors were selected for the study. Data was gathered through interviews and observation.

Findings and Conclusions

1. It was found that the training centres were all about 18-20 years old and the infrastructure had not improved. There was generally one classroom and no additional classrooms or laboratories had been built, therefore the scope of taking small groups for intensive work or doing practicals for a long time was difficult.
2. No feedback was taken from training centres. CDPOs did not visit the centres to see how AWWs communicate with the community.
3. 70% of the Supervisors were graduates and post graduates. They had been trained a long time back and there had been no refresher training. 70% Supervisors had more than 10 years experience.

4. Out of the 72 Supervisors, around 52 of them visited AWCs only once a month, while 17 of them visited twice a month, and only 3 Supervisors visited AWCs more than twice a month. 50% Supervisors looked into the many registers and records that were maintained like attendance, growth chart, food record, Mahila Mandal meetings, etc. They also looked at the records of severely malnourished children.
5. 97% AWWs mentioned that training helped them to measure children's height and weight correctly. 98% said that training was essential for knowledge about immunization, distributing nutritious food, and providing parents with nutrition and health education. Only 74% AWWs mentioned that training was useful to create self help groups and conduct adult literacy classes for women.
6. About 46% AWWs mentioned that after training they would try and take special interest in children by telling them stories or singing songs, etc. 24% AWWs organized interesting activities like picnics or playing with toys. Some said that decorating the AWC well would induce children to come to AWCs, while others mentioned that parents need to be convinced first about the importance of preschool education.
7. Nearly 36% children were found to be neat, clean, hygienic and obedient, but 12% children were dirty and suffered from cough and cold.
8. In 76.5% AWCs, the environment was neat, clean and hygienic. 68% AWCs were described as colourful. However, there were 22 AWCs that were not safe for children. In 60% AWCs there was adequate equipment and material for work.
9. 89% Supervisors mentioned that the attendance of AWWs was regular. 56% Supervisors said that AWWs regularly participated in office work at the block level, and 13% participated only if there was some important work.
10. 81% AWWs were fully trained and had adequate information about measuring the height and weight of children.
11. 43% AWWs tried to teach by giving each child personal attention. 58% AWWs taught according to the syllabus prescribed, and 26% tried to give children personal attention while teaching from the syllabus.
12. AWWs mentioned that training prepared them for informal education, nutrition demonstration, home visits, plotting weight charts, and health related issues. All AWWs could weigh children and interpret growth charts correctly.
13. 90% Supervisors agreed that AWWs got average co-operation from villagers in their work.

Recommendations

1. There is need to improve the quality of training, and provide better board and lodging facilities.
2. The work environment of AWWs should provide basic amenities to carry on the ICDS programme in an effective manner.

3. The training curriculum should be reorganized and there is need to enhance AWWs' application of knowledge.
4. Better incentives should be given to enhance the motivation of AWWs.
5. There is need to revamp the Supervisor's role and their involvement should be sought in AWWs' training.
6. There is need for Mobile Training Units. Basic text books should be in regional languages.
7. A selection/ criteria should be evolved for selecting AWWs.

World Bank Assisted ICDS Projects

World Bank Assisted ICDS Projects

Andhra Pradesh Economic Restructuring Project (APERP) (Credit 3103 – IN) Nutrition/ Integrated Child Development Services (ICDS) Component

World Bank

Introduction

The World Bank assisted Andhra Pradesh Economic Restructuring Project (APERP), under which strengthening the ICDS component was the major initiative. The overall anaemia levels in adolescent girls (AGs) in the state of Andhra Pradesh is also unacceptably high. The NFHS II (National Family Health Survey 2, 1999) showed a high rate of moderately malnourished children in the state. Field observations have shown wide prevalence of stunting; and all these indicate the need for further fine tuning of the ICDS programme in order to address better the development objectives of this project.

Aims and Objectives

The study aimed to:

1. Evaluate the prevalence of anaemia in AGs.
2. Focus on universalization of the ICDS programme.
3. Recommend strategies to bridge the gaps in implementation of the programme.

Methodology

This study was conducted in Andhra Pradesh, and a total of 251 blocks, 108 old ICDS projects and 143 new blocks were covered. Data was gathered through field visits.

Findings and Conclusions

1. It was found that the base line data on adolescent girls for anaemia was 79% (overall), and the presence of a very high number of moderately malnourished children, as well as the wide prevalence of stunting in children in the state indicates the need for further fine tuning of the ICDS programme to address better the Development Objectives (DOs) of this project.
2. Universalization of ICDS has now been achieved in the State in terms of block outreach. However, there was an unfinished agenda of reaching the actual number of needy households/ young children within the limited resources under the programme, taking very focussed action for under-threes, and targeting poor households.
3. It was found that Service Quality Improvement has been good, where all 101 new blocks have received equipment and supplies such as basic equipment and standard medicine kits,

de-worming drugs for children, pre-school education kits, weighing scales, and outdoor play equipment. Similarly, all old blocks have been provided replenishment supplies.

4. It was found that Women's Empowerment Mothers' Committees were constituted in the newly expanded 101 blocks, and most of these women were actively participating in the management of the ICDS programme in activities such as village mapping as well as addressing advocacy issues like age at marriage of girls.
5. It was found that 167 hand pumps were installed, taking the total number to 4,866 against the proposed number of 5,137 hand pumps.
6. Only 1000 mini AWCs have been established against the needed 2700 mini AWCs.
7. "Mother and Child Protection Cards", known as "Sanjeevini Cards", that were launched in 61 projects during Phase I of the programme have been expanded to cover 150 plus 101 blocks.
8. It was found that under UDISHA, more than 30,000 AWWs and Helpers will require training.
9. The Primary Health Centres (PHCs) appeared to be well maintained with no cases of infant deaths or maternal deaths during the last one year.

Recommendations

1. It was recommended that the mid term evaluation of ICDS should be used to expand the information base for the whole state, including developing district-wise data.
2. It was also recommended that a rapid assessment of tribal blocks should be undertaken.
3. In order to clear the backlog of training and provide on-going refresher training at district level, there is need for non-institutional mobile training teams to be formed as has been done in Rajasthan.

Implementation Completion Report of World Bank ICDS – III/ WCD Project

India, Ministry of Women and Child Development

Introduction

Phase III of the World Bank assisted Integrated Child Development Services Project aimed at accelerating improvement of the nutrition and health status of children 0-6 years and women, by increasing the quality and impact of the ICDS programme. Originally the project was operational in the states of Uttar Pradesh, Rajasthan, Maharashtra and Tamil Nadu. The project was re-structured in 2003, to improve the progress and to utilize fully the allocations for Iodine Deficiency and Anaemia. The states of Madhya Pradesh, Bihar, Chhattisgarh, Jharkhand (from erstwhile Bihar ICDS – II Project), Orissa and Uttarakhand were included in the ICDS III Project.

Aims and Objectives

The study aimed to:

1. Improve the quality of service delivery to beneficiaries.
2. Expand ICDS to benefit uncovered communities.
3. Strengthen institutional framework for programme implementation.
4. Replicate successful innovations and initiatives from previous projects.
5. Introduce new activities in line with the latest paradigms of child development.

Methodology

The ICDS III Project was made effective for a period of five years originally in five states of India namely Uttar Pradesh and Rajasthan in the north, Maharashtra in the west, and Kerala and Tamil Nadu in the south. The project envisaged introduction of ICDS services in 318 new (uncovered) blocks, and strengthening and improving service quality and management in 685 existing (old) blocks in these states. The distinctive feature of the coverage in the project had been that of inclusion of 69 tribal blocks (in Rajasthan, Maharashtra and Kerala), 51 coastal blocks (in Kerala), 804 rural disadvantaged blocks (in 5 states), and 79 urban blocks with poor outreach of basic services (in Rajasthan, Maharashtra and Kerala).

Findings and Conclusions

1. IFA supplementation was provided to all adolescent girls (AGs) in both old and new AWCs in all five states as a new initiative and activity. AGs scheme was introduced in the states of Rajasthan and Tamil Nadu keeping in view the importance of adolescence in the life cycle of a female child, who needs care and attention for her proper physical and mental growth. AWWs

in these states provided training to AGs for basic reproductive and child health, HIV/ AIDS, legal and political rights of women, importance of education, and proper health and hygiene practices.

2. In some states, vocational training was also provided. AGs visit the AWCs and try to help AWWs in their work, like bringing children to the centres, weighing them, assist in feeding sessions, teaching children the basics of health and hygiene, and in imparting pre-school education. Training programme in Kerala focussed on the problem of high rates of suicide among AGs in the state by including counselling against such desperation. Members of AGs groups were also weighed regularly to monitor changes in their weight.
3. One of the major achievements in developing infrastructure under the project had been increased participation of the local self-government institutions and community. In Kerala, the responsibility for construction of AWC building was handed over to Local Self Government (LSG) institutions. This facilitated local planning, implementation and monitoring of civil works. Even though there had been instances of procedural delays, there was increased community ownership in implementing this particular scheme. Some LSGs even contributed their share over and above the funds provided by the World Bank for installation of hand pumps/digging of wells.
4. It was found that Information, Education and Communication (IEC) had been one of the major interventions in the project. The project laid special emphasis on IEC by focusing on communication for behaviour change (BCC or CBC) for appropriate child care and child rearing practices in households. A major shift in the IEC strategy had been addressing the needs of under three children through family based interventions instead of centre-based interventions. States adopted various methodologies for implementing IEC like inter-personal communication through home visits, nutrition and health education sessions, social mobilization through door to door contacts, rallies, video van, *gramin melas* (fairs), print/ electronic/ audio-visual media such as brochures, ICDS newsletter, booklets, and guidelines, pamphlets, calendars, hoardings and boards, etc. Many states did not limit the IEC interventions to the ICDS blocks under the project, but also covered the entire state. That was a good and positive aspect of the intervention. Overall, the project achieved 91% (Rs. 227.6 million) utilization of the allocations made under this component (Rs. 250 million). State-wise, Maharashtra topped the list with 118% utilization, followed by Rajasthan (96%), Tamil Nadu (94%), Uttar Pradesh (82%), and Kerala (64%).
5. Free Expression for Quality Improvement (FREQI) provided an opportunity for the formation of quality circles to encourage better interaction among AWWs so that they could exchange notes freely, bring them to the notice of supervisory staff, and with their support achieve higher quality of service delivery. FREQI process provided an opportunity for effective convergence of services from representatives of various departments such as Health, Education, Panchayati Raj, etc.

6. Under the FREQI process, meetings of ICDS functionaries were organized on a periodic basis (quarterly) at State, District, Block and Sector levels involving representatives from the community as well, using participatory approach. An effort had also been made to make these meetings process and output oriented, with focus on discussing quality contents, thereby facilitating preparation of action plans. Issues discussed in FREQI meetings are classified as resource based, based without resources, Government resource based, community cooperation based, and description of an innovative work plan.
7. Some of the major problems which were identified due to FREQI meetings were there was absence of growth monitoring charts and weighing scales, dislike of the supplementary food by the community, operational problems regarding shifting of AWCs to primary schools, absence of referral slips, etc.
8. It was found that the maximum number of FREQI meetings had used up the entire allocation; Tamil Nadu reported 98% utilization, Uttar Pradesh 97%, Rajasthan 88% and Maharashtra 74% utilization. The overall achievement was 88%.
9. The National Training Component of ICDS III project named Udisha, aimed at improving the quality of ICDS services in the country by providing improved training to ICDS functionaries all over the country; strengthening/ establishing training centres, and developing training materials, etc. The focus of Udisha has been on eliminating the heavy backlogs in job and refresher training of all functionaries.
10. It was found that overall the project has achieved its main objective of clearing the backlog of job training. A total of about 928,000 ICDS functionaries, 366,000 AWWs, and 759,000 other persons have been imparted on the job and refresher training under the project through a countrywide network of about 6000 AWTCs, 40 MLTCs and the National Institute of Public Cooperation and Child Development (NIPCCD) and its Regional Centres.
11. The performance under job training was 107.17% for AWWs and 83.13% as per revised target, 66.60% for Supervisors and 80.62% of revised target, 86.54% for CDPOs/ ACDPOs and 79.32% of revised target, 124.03% for AWHs (Anganwadi Helpers) and 84.56% of revised target. Under refresher training achievement was 102.42% for AWWs and 77.65% of revised target, 83.96% for Supervisors and 79.45% of revised target, 23.73% for CDPOs/ ACDPOs and 43.34% of revised target. PIP (Project Implementation Plan) target for AWHs was nil and revised target was 47.51%. The overall performance under job training for the different categories of functionaries was 115% of the PIP target, while such performance under refresher training had been reported as 129%. The performance as per revised targets was 84% for all categories of functionaries under job training and 68% under refresher training.
12. Some new initiatives started during the implementation of Project Udisha were training through Mobile Training Teams, which were provided at the project level/ block level by key trainers. The mobile training strategy has been in full operation in Tamil Nadu and partly in the states of Uttar Pradesh, Rajasthan, Madhya Pradesh, Nagaland, Sikkim and Jharkhand.

13. To operationalize the newly sanctioned AWCs and also to clear the backlogs of training of newly recruited AWWs, short duration induction training was introduced in several states.
14. Most states have undertaken such 'other training'. Kerala and Tamil Nadu have done the largest number of such 'other trainings'. Several joint training programmes have been organized with district level officials, panchayat members, community leaders, women's committees, and health and education officials. Special programmes are also held on issues like i. Immunization, ii. Breastfeeding, iii. Community mobilization, iv. Communication skills, v. Skills training on PSE, vi. Orientation training for mothers on food management at home, vii. Training of AGs, viii. Training of self help groups, ix. Training on personal hygiene and sanitation, etc.
15. It was revealed that significant progress was achieved in the proportion of children whose mothers did not squeeze out the first milk (59% in Base Line Survey to 64% in End Line Survey), proportion of children under 3 years who were breastfed within 2 hours of birth (37% in Base Line Survey to 51% in End Line Survey), proportion of children aged 6-9 months who received solid or semi- solid food and breast milk (complementary feeding) (38% in BLS to 64% in ELS), and proportion of children aged 6-36 months who consumed Vitamin A rich food (53% in BLS to 71% in ELS). However, breastfeeding exclusively up to six months remains a problem. It was found that only 21% children under six months reported to have been exclusively breastfed, which had come down from 28% in BLS. End Line Survey also revealed that about 37% children up to six months had been given plain water along with breast milk, which was a wrong practice.
16. It was found that significant progress was made in antenatal care of pregnant women, immunization, de-worming and treatment of diarrhoea. Monthly growth monitoring of under-three children had also improved overall, as mentioned by AWWs (from 67% in BLS to 82% in ELS). Practice of weighing at birth showed overall improvement from 40% in BLS to 46% in ELS. Impact of Information, Education and Communication and training also increased awareness of infant breastfeeding practices among the AWWs. But knowledge transfer from AWWs to AGs and women remains a matter of concern.
17. In Uttar Pradesh an innovative approach towards social mobilization and awareness campaign on nutrition and health education was adopted in the form of Anganwadi Kala Jattha. The idea was to develop a team of talented AWWs to form 'Anganwadi Kala Jathas'. After acquiring the required skills, AWWs have been able to run this awareness and social mobilization campaign in an effective and sustainable manner through rallies, door-to-door contact, wall writings, folk songs, group discussions, *nukkad nataks* (street plays) and quizzes. By performing live in front of a large audience, AWWs gained immense confidence, which was reflected in a positive improvement in their routine work of running AWCs.
18. Adolescent Girls Clubs constituted under each AWC in the state was an innovative initiative under the ICDS III project, considering the importance of adolescence in the life cycle.

19. In Kerala, another initiative undertaken was to convert the AWCs into Community Resource Centres to cater to the health and nutrition needs of community members. A total of 247 AWCs in 14 districts have been equipped with computers and accessories.
20. Overall, the performance of the ICDS III Project can be rated as satisfactory in comparison with the previous World Bank financed projects. The Project has achieved its development objectives of reducing malnutrition in under-three children. The significant change in household behaviour with respect to infant and young child feeding practices, increased awareness on nutrition and health issues and participation of other stakeholders in the programme is a pointer to the success of the Project.

Recommendations

1. There is need for preparation of a District Nutrition Profile of each district at periodic intervals to ensure appropriate special interventions in problem areas. This would help programme managers at the district and state levels to monitor the progress in achieving the objective of reduction of malnutrition more effectively.
2. There is need to further strengthen networking with the community at grass roots level to bring about quality improvement and accountability in the delivery of services at AWCs. Local initiatives like Anganwadi Kala Jattha Dal in Uttar Pradesh, involving in-house teams of AWWs, home visits, counselling, etc. have been very successful and could be replicated in other states. Local flexibility and local innovations should be an integral part of the overall programme.
3. There is an urgent need to establish a Nutritional Surveillance System up to the block level to monitor the nutritional status of severely and moderately malnourished children, and take appropriate actions for their management.
4. There is need to reinforce effective convergence with PRIs (Panchayati Raj Institutions) and other departments (health, education, drinking water supply, etc.) to strengthen the community base in effective implementation of the ICDS programme.
5. To ensure better services, AWCs should have their own buildings rather than function from primary school premises, AWWs own houses or other rented places.
6. State Project Management Units in the project states, and Central Project Unit at the central level should be established, and all necessary approvals for project processes should be completed before launch of the project, for effective take off of the project.

Presentation of Nutrition Survey: End Line Survey of World Bank Assisted ICDS-II Projects in Chhattisgarh

Indian Institute of Development Management

Introduction

World Bank has been assisting ICDS Projects in many states by providing inputs to bring about qualitative change in the lives of vulnerable groups. This study was undertaken to assess the working of World Bank assisted ICDS Projects in Chhattisgarh. The existing level of antenatal and post natal care, awareness about AWCs, nutritional status of children and growth monitoring, training of AWWs and their awareness about child feeding, maternal care and supplementary food were the main focus of this study. In this regard the Indian Institute of Development Management conducted this study in Chhattisgarh ICDS projects, and the findings of this study served as indicators for measuring the progress and planning for the future.

Aims and Objectives

The study aimed to:

1. Assess the impact of nutritional programme on target groups.
2. Assess the resource base of beneficiary groups and the manner in which they meet their nutritional needs.
3. Assess the significant knowledge, attitude and practices prevailing in relation to nutrition.

Methodology

This study was conducted in 96 AWCs covered by 11 ICDS projects in 8 districts of Chhattisgarh. The eight districts covered were Bilaspur, Sarguja, Raipur, Korba, Dantewara, Bhilai, Durg and Baloda. A total of 8699 households, 314 pregnant women, 321 lactating women, 2962 children aged 0-3 years, 1654 children aged 3-6 years, 877 adolescent girls (AGs) and 59 AWWs were selected. Data was collected through interviews and field survey.

Findings and Conclusions

1. It was found that TT injections were administered to 69% pregnant women, and out of them 64% had 2 injections. ANC check-up was done by doctors in 45% cases, and 89% pregnant women were aware of the existence of the AWC in the village. Around 71% pregnant women were registered in AWCs and the weight of 14% was recorded every month.
2. Advice on breastfeeding, child care, nutrition was given by elderly women in 64% cases and by ANMs/ AWWs in 10% cases.

3. Around 11% lactating women took 100 IFA tablets and 54% took any number of IFA tablets. 89% were administered TT injections. Out of them, 85% took 2 injections.
4. Breastfeeding was initiated within 2 hours of child birth in 44-45% cases. 51-54% lactating women squeezed their first milk and discarded it.
5. It was found that 52% lactating women collected supplementary food from AWCs. During home visits AWWs discussed about breastfeeding with 30% lactating women (LW), nutrition with 25% LW, and child care with 22% lactating women.
6. It was found that adolescent girls (AGs) intake of vitamins, IFA tablets and supplementary nutrition was 31%, 4% and 3% respectively. Out of them 11% girls took IFA tablets for more than 3 months. The main reason for not taking IFA tablets was lack of awareness in 64% cases. 80% of the total girls had never undergone blood tests.
7. It was revealed that 25% AGs had access to health/ nutrition education and family life education. Information was mostly provided by school teachers (31%), friend/ relatives/ neighbours (21%) and AWWs (13%). 19% of the girls were aware about AIDS. Participation in any women's group activities was 8%.
8. It was found that 72% children were not weighed at birth. Birth weight was recorded at AWCs in 52% cases. In 17% cases birth weight was below 2.5 kgs.
9. It was found that within 2 weeks preceding the survey 21% children were sick.
10. Under Kishori Shakti Yojana average enrollment was 2-3 girls. Weighing machine was available in 97% AWCs. Out of them 75% weighing machines were in working condition, and 88% children below 3 years were weighed once a month.
11. Family planning measures were available in 44% AWCs. Immunization register and survey register were maintained in 90% and 95% AWCs respectively.
12. It was found that advice by AWWs to lactating mothers to provide colostrum was given to 81% mothers, timely immunization to 68% mothers, exclusive breastfeeding to 66% mothers, keeping the child clothed to 41% mothers, and initiating breastfeeding within 1 hour to 73% mothers. 95% AWWs had correct knowledge about exclusive breastfeeding period.
13. In all the three areas people were aware that nutritive food was distributed at AWCs.
14. In rural and tribal areas availability of food stock at the AWC was irregular. In urban areas due to regular supply of supplementary food the physical and mental development of children was found to be better.
15. In urban areas AWWs gave proper attention to the health of children, but they were not aware about the causes and symptoms of malnutrition.
16. In rural areas people mentioned that if AWWs were not local, or they were relatives of the local leader, then they did not provide proper services.

17. In urban and rural areas food taboos for pregnant women were that sour food, *chapatis* (bread), potato and sago should not be given; and in tribal areas people thought that the more physical work a woman did during pregnancy, easier would be the delivery.
18. It was found that if ANC or immunization was not provided at the AWC, then people went to Government hospitals, PHCs or private clinics.
19. It was found that only a few educated mothers gave breast milk to their neonates between half an hour to 3 hours after delivery. In tribal areas first milk was squeezed out and offered to the river.
20. It was found that in most rural and tribal areas uneducated people did not allow their neonates to be weighed because of their belief that if they weighed neonates their Goddess would become angry, and it would lead to ill health and short life span of their child.
21. In some rural areas people mentioned that there was no pre-scheduled date for weighing at the AWC, and they were not aware of the advantages of weighing children.
22. It was found that Mahila Mandals were formed at all AWCs and health and nutrition education was imparted to women aged 15-45 years.

Recommendations

1. There is urgent need to bring people out of social taboos, superstitions and beliefs so that they can utilize the facilities provided under ICDS.
2. An attempt should be made to cover the entire population by suitably increasing the number of AWCs.
3. Strategies should aim at ensuring that much needed information reaches rural women. Interpersonal communication should be emphasized and the ICDS programme should give high priority to communication during training of field workers.
4. An awareness campaign needs to be launched on a massive scale. Women and their families should be taught to recognize the symptoms of malnutrition and to understand the importance of seeking medical attention.
5. Men should be encouraged to share responsibility for women and child health, as they are the key decision makers for every household activity and expenditure.
6. It was recommended that functional literacy for adult women (FLAW) should be revived as early as possible. Some sort of incentives, such as monetary reward, may be provided after they finish the required level of education.
7. The communities' own organizations should be involved in the process of assessing, analyzing, acting on and re-assessing the problem of poor child nutrition.