Final Report

Evaluation of Nutrition Programme Run Through Anganwadi Centres

Submitted to:

Uttarakhand Planning Commission

Govt. of Uttarakhand.Dehradun.

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P R E F A C E

The Integrated Child Development Services (ICDS) scheme today is the world's largest programme aimed at enhancing the health, nutrition and learning opportunities of infants, young children (0-6) years and their mothers. It is the foremost symbol of India's commitment to its children – India's response to the challenge of providing pre-school education on one hand and breaking the viscous cycle of malnutrition, mortality and morbidity, on the other. The programme started in Uttarakhand in 1978-79 and spread to all districts of the state over the years. Uttarakhand Planning Commission wished to have an Evaluation of the Nutritional Programme run through Anganwadi Centres. Centre for Research, Planning & Action (CERPA) New Delhi, was selected as the best appropriate agency to carry out the Evaluation work.

We are extremely thankful to Secretary (Planning), Govt. of Uttarakhand; Director and Joint Director, Department of Planning Uttarakhand; Director ICDS, Uttarakhand; DPO and CDPO of ICDS (HQ) for their guidance.

We also express our deep sense of gratitude to District Programme Officers (DPOs) of Almora, Haridwar and Pauri Garhwal districts and Child Development Project Officers (CDPOs) of Tadikhet, Behadarabad I & II, and Duggada projects for their kind co-operation. We are also thankful to supervisors of all projects where field work was carried out.

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(T.S. Krishnan)
Project Director

C O N T E N T S

EXECUTIVE SUMMARY

Introduction

Uttarakhand, the 27th State of Republic of India came into being on 9th November 2000 with 13 districts. The state has an area of 53,484 sq.km, which is 1.7% of total land area of the country. The population of Uttarakhand is 1.01 crore as per 2011 census and it is less than 1% of total population of India. The demographic and topological peculiarities of the state have placed Uttarakhand in a unique socio-economic and geographical niche. Hence each intervention in the Health sector has tremendous potential to come up as innovation with a significant impact.

Improving the health and survival status of young children is an important humanitarian and economic investment. Low birth weight has been a matter of great concern for the state.

Children's nutritional status as assessed by weight-for-age, height-for-age, and weight for height shows that a large number of children in uttarakhand are under weight, malnourished and undernourished. Undernourishment is more prevalent in rural areas as well as among children belonging to household with low standard of living. Female children are more likely to be undernourished than male children.

The Integrated Child Development Services (ICDS) scheme today is the world's largest programme aimed at enhancing the health, nutrition and learning opportunities of infants, young children (0-6) years and their mothers, it is the foremost symbol of India's commitment to its children – India's response to the challenge of providing pre-school education on one hand and breaking the viscous cycle of malnutrition, mortality and morbidity, on the other.

The centrally sponsored scheme of ICDS has been implemented in the state of Uttarakhand since 1978-79 to achieve the desired objective.

Center for Research Planning & Action was commissioned the study "Evaluation of Nutritional Programme Run through Anganwadi Centers" in **Uttarakhand by the Department of Planning Uttarakhand**

Objectives

Objectives of the Evaluation are:

(i) To assess the Appropriateness of Spot selection to open Anganwadi Centres taking in to account;
   a. Population of the State(Men, Women and Children);
   b. Survey – Basis and appropriateness
   c. Malnutrition status of the village;
   d. Economic condition of the village;
   e. Procedures followed to open Anganwadi Centers.

(ii) To study with regard to valuable educational institutions with specific reference to
   a. Number of Primary schools & above;
   b. Enrolment Status of students in these schools;
   c. Quality of mid-day meals provided in these schools.

(iii) To study with regard to Availability of Health Care Facilities with specific reference to

a. Distance of Primary Health Centre/ Sub-centre from the village;
b. Timely availability of Medical Care;
c. Availability and Sufficiency of immunization facility and medicines.

(iv) To study the qualification and Knowledge of Anganwadi Workers of the various instructions/guidance's with specific reference to

a. Educational qualification;
b. Quality of training imparted by the Department;
c. Responsibility handled;
d. Cooperation of Anganwadi helper.

(v) To study the Details and specialties of Beneficiaries under the Nutritional Programme viz;

a. Total no. of pregnant/lactating mothers enrolled in the Centre;
b. Number of children between 06 months to 3 years;
c. Number of children between 3 years to 6 years.

(vi) To study the status of Malnutrition among

a. Pregnant women/lactating mother;
b. Among Children up to 6 years in Anganwadi Centers;

(vii) To study the Procedure followed to Open Anganwadi Centre with specific reference to:

a. Actual procedures followed
b. Community involvement

(viii) To study the Facilities made available under Nutrition Programme with specific reference to

a. Availability of the facilities
b. Quality of the facilities
c. Sufficiency of the facilities (ii) it's quality; (iii) whether the same is sufficient.

(ix) To study the Status of benefit of the nutrition Programme among pregnant women/lactating mothers ;(ii) among children up to 6 years of age.

(x) To study the difficulties faced is the implementation of the nutritional programme and to suggest ways and means for the successful implementation of the programme.

Methodology

CERPA has adopted both secondary and primary research methodology qualitative and quantitative methods as well. As part of secondary research we have studied available records, reports, literatures on the subject. So far as primary research method is concerned the study team had personal contact with beneficiaries (Pregnant women/ lactating mothers, adolescent girls and malnourished children, Anganwadi workers/Helper, ICDS supervisors, Child Development Projects Officers(CDPOs), District Programme Officers(DPOs) and officers at

the helm of affairs at Directorate.

Sampling

We have adopted multistage stratified sampling techniques for the purpose of sample selection.The state of Uttarakhand has been divided into three socio-economic regions Kumaun region, Garhwal Region and Tarai Region. One district from each of the region was selected having maximum number of Anganwadi Centre for the purpose of the study

Thus districts selected are as under:

S.No.	**Region**	**District**
1.	Tarai	Haridwar
2.	Kumaun	Almora
3.	Garhwal	Pauri Garhwal

Each district has a number of Projects and each project covers a number of Anganwadi Centers. Here we have selected one project from each district adopting purposive sampling method selecting that project having maximum number of Anganwadi centers.

Thus Projects selected are:

S.No.	District	Name of the project	No. of Anganwadi project on selected distance
1.	Haridwar	Bahaderabad	419
2.	Kumaun	Almora	106
3.	Pauri Garhwal	Duggada	131

10 percent Anganwadi centers were selected from each project. We have selected those centers having maximum number of beneficiaries. 30 beneficiaries were selected from each center comprising of (i) pregnant/lactating mothers, (ii) adolescent girls (iii) malnourished children. Although due care was taken to select 10 beneficiaries from each category, where a particular category of beneficiary were not available in required numbers the same was compensated by covering beneficiary from other categories.

Thus the distribution of complete samples is mentioned below:-

S.No.	District	Project	Anganwadi Centers	No. of selected Beneficiaries
1.	Haridwar	Bahaderabad	46	1375
2.	Almora	Tadikhet	11	330
3.	Pauri Garhwal	Duggada	13	390
Total			**70**	**2095**

Study Instrument

Study instruments were developed for different types of respondents: i.e.

(i) State Level Officers,
(ii) District level officers (DPOs),
(iii) Project Level officers (CDPOs), Anganwadi workers.

(iv) Beneficiaries

The members of study team interacted with offices of Directorate of ICDS, at Dehradun, to collect necessary information. The Director's office was kind enough to issue letter to DPOs/CDPOs of selected projects to extend necessary co-operation to the study team.

Members of study team also interacted with DPOs of Haridwar district, Pauri garhwal district and Almora district to have their considered opinions on the implementation of the project.

The study team also had extensive interaction with CDPOs and supervisors of Bahaderabad I & II Project (Haridwar district) Duggada Project (Pauri Garhwal district) and Tedikhet Project (Almora district) to have their opinion/views/suggestions regarding the implementation of the project.

It had also detailed discussion with workers/helpers of the Anganwadi centers which came under the sample of the study.

The study team had also established person to person contact with selected beneficiaries and collected information from them on the structured questionnaire developed for the purpose.

The study was conducted in Almora, Haridwar and Pauri Garhwal districts of the state covering one project from each of these districts. Thus projects selected were Tedikhet from Almora district, Dugada from Pauri Garhwal district and Bahadarbad from Haridwar district. The study team contacted/ interviewed expectant/lactating mothers and mothers of malnourished children (beneficiaries) of the selected projects to have their views on implementation/ functioning of the scheme.

Selection of Location for Anganwadi Centres

Most of the Anganwadi centres (98.1%) are located within one kilometer from the residence of beneficiaries.

Majority of the beneficiaries responded that total number of beneficiary population, status of malnutrition and economic condition of the village are taken into consideration while opening Anganwadi centres.

However 75.70 percent of respondents found to be unaware of procedure followed to open Anganwadi centres highest being in Almora and Pauri Garhwal districts. And those who know the procedure, a majority of them expressed the view that there was no need to bring about any change in the prevailing procedure.

Existence of Educational Institutions

89.68 percent of beneficiaries were aware of presence of educational institutions in their areas. 91.69 percent beneficiaries affirmed the existence of primary schools in their village while only 6.40 percent beneficiaries said their villages having middle schools and only 1.25 percent said about presence of secondary schools.

Regarding status of enrollment in schools 64.63 percent of the beneficiaries termed it as good while 22.19 percent said it to be average. 13.18 percent of beneficiaries expressed their ignorance about the enrollment status in schools.

More than 80 percent of beneficiaries confirmed that mid-day meal is provided in these schools (Primary). However 74 percent beneficiaries were of the opinion that mid-day meal provided in these schools are of good quality whereas around 8 percent termed it as average/less than average quality. 18 percent respondents declined to comment on the quality of mid-day meal as they have no idea about the same.

Timing

Almost all the beneficiaries appraised that Anganwadi centres open in all week days (except holidays) and the timing of opening is 8 A.M. and closing is 12 P.M.

Availability of Health Care Facilities

52 percent of beneficiaries confirmed about presence of sub-centre/primary health centre in their area. 41 percent of beneficiaries appraised that the location of sub-centre/PHC is within five kilometer radius and 7 percent said health care delivery institution is situated beyond five kilometer.

A large number of beneficiaries (48.45 percent) depend on PHCs/ CHCs for medical care while 25.82 percent depend on Anganwadi centres and almost an equal percent of beneficiaries (25.73 percent) opt for private institutions for medical treatment.

When asked about the time availability of Medical Care Facility in PHCs/CHCs/ Sub-Centres 71 percent beneficiaries replies in affirmation.

Fairly a large number of beneficiaries (47 percent) avail immunization facilities from PHCs/CHCs while 38 percent avail the same from anganwadi centres and 15 percent depend on private establishments for immunization.

Majority of beneficiaries (84 percent) expressed the view that available immunization facilities are quite sufficient.

Fairly a large number (48 percent) of beneficiaries depend on PHCs/CHCs for medicine, 26 percent depend on anganwadi centres and almost an equal number of beneficiaries prefer to get medicine from private sources.

81 percent considered the availability of medicines is sufficient as per the requirement.

Anganwadi Workers

The study team also wanted to know about anganwadi workers from the beneficiaries. When asked if anganwadi workers are well qualified 98 percent of beneficiaries replied with positivity and 97 percent expressed the opinion that they are properly trained and handle their duties and responsibilities in proper manner.

98 percent of beneficiaries replied that anganwadi helpers are quite co-operative and help anganwadi workers in discharge of duties.

Details and Specialties of Beneficiaries

94 percent of beneficiaries asserted the view that all pregnant women and lactating mothers of the area are enrolled in the programme.

Anganwadi workers takes due care to see that no eligible beneficiary is left out. 94 percent of beneficiaries appraised that all children in the age group of 6 months to 3 years and 3 years to 6 years are enrolled in the

anganwadi centres of the area.

Status of malnutrition

When asked about the nutrition status of pregnant women 81 percent of respondents considered it as good and 6 percent of respondents termed it as bad and 13 percent declined to comment as they do not have any idea of the same.

Regarding nutrition status of lactating mothers 81 percent respondents said it is quite good and 6 percent termed it as bad and 13 percent declined to comment.

Of the beneficiaries 77 percent of respondents agreed that the malnutrition status of children up to 6 years of age is quite good. However 9 percent of beneficiaries responded

Procedure

Of the beneficiaries 75.70 percent of respondents found to be unaware of the prescribed procedure followed to open Anganwadi centres. And those who were aware of the procedure, a majority of them (93 percent) expressed the view that due procedures were followed while opening new anganwadi centres in their respective areas.

Of the total respondents 49 percent beneficiaries opined that community participation was noticed while opening new anganwadi centres while 16 percent replied negativity and 35 percent could not say anything on the issue.

Facilities available through Nutrition Programme

Fairly a large number of beneficiaries (34 percent) are associated with anganwadi centres for 1 to 2 years whereas 31 percent beneficiaries are associated for a period of 3 or more years. 16 percent beneficiaries are attached with the centre for a period below 6 months and 19 percent beneficiaries for 6 months to 1 year.

By providing supplementary nutrition feeding the anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged population group. 98 percent of beneficiaries confirmed that supplementary nutrition is provided to pregnant/lactating mothers and children up to 6 years of age.

Health check-up is an important service provided by ICDS programme through anganwadi centres. It includes health care of children less than 6 years of age, antenatal care of expectant mothers and postnatal care of nursing mothers.

97 percent respondents admitted that health check-up facilities are available for expectant mothers and children up to 6 years of age. However 95 percent beneficiaries said the facility is available for lactating mothers.

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

Immunization is very important to prevent oneself from dreaded diseases. It is one of the important components of ICDS programme. 96 percent respondents confirmed that immunization facility is available for children up to 6 years of age and 93 percent

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

As regards referral services, 47 percent of respondents replied that referral service is available for children up to 6 years of age while only 6 percent of the respondents said it is available for pregnant/ lactating mothers. **Since 94 percent of beneficiaries replied referral service is not available for pregnant/lactating mothers, this component of ICDS programme needs urgent attention.**

The non formal pre-school education component of the ICDS is considered as the backbone of the programme. It is a programme for children of 3 to 6 years of age which provides a natural, joyful and stimulating environment which emphasis on necessary inputs for optimal growth and development. The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. It also contributes to the universalization of primary education, by providing to the child the necessary preparation for primary schooling.

Of the total respondents 80 percent appraised that non-formal pre-school education is available for children 3 to 6 years of age.

Pre- school education kit is provided to anganwadi centres worth of rupees one thousand and to mini anganwadi centres worth rupees five hundred.

In the opinion of 97 percent of respondents neither the provision of supplementary nutrition feeding nor Nutrition Health Education is available for women in the age group of 15 to 45 years of age.

Almost all the respondents informed that no other facilities are available apart from those mentioned above.

About Nutrition Food

Supplementary nutrition feeding is provided in two forms – Cooked Food and Take Home Ration.

Cooked food is provided to children between 3 to 6 years of age under the guidance/supervision of Mothers' Committee.

Take Home Ration is provided to pregnant/lactating mothers and children in the age group of 6 months to 3 years

Majority of the respondents (57 percent) appeared to be not satisfied with the supplementary nutrition provided maximum percentage being in Almora district. 12 percent respondents said they are very much satisfied while 31 percent said they are satisfied.

A large majority of respondents (78 percent) expressed their dissatisfaction over quality of cooked food and considered it as of ordinary quality. Only 4 percent respondents admitted that cooked food is of excellent

quality, 2 percent said it was very good and 12 percent termed the quality of cooked food as good and 4 percent respondents considered as bad.

As regards the quality of take home ration, 40 percent respondents appeared to be dissatisfied over the quality and in their opinion the quality of take home ration is of ordinary quality while 32 percent considered it as bad, 16 percent termed it as good and 5 percent said it was very good and 7 percent of respondents considered the same as excellent.

Majority of respondents expressed the desire that the take home ration which is being provided at present (Indiamix- what is called SATTU in local language) may be replaced by biscuits/seasonal fruits/gram etc.

When asked about availability of cooked food 82 percent informed that it was insufficient and regarding take home ration 56 percent respondents considered it insufficient.

Immunization Facilities

Immunization of pregnant women and infants protects them from various diseases. 92 percent of respondents confirmed that immunization facility is available against diseases like tetanus, BCG, measles, DPT, and polio.

88 percent of respondents expressed satisfaction over availability and quality of immunization facilities.

A large number of beneficiaries 86 percent appeared to be quite satisfied with the So far as availability and quality of referral services are concerned 77 percent respondents expressed their dissatisfaction.

Nutrition and Health Education

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

Unfortunately no regular NHED session are being organized in anganwadi centres. 58 percent of respondents subscribed to this view. Those who agreed that NHED is organized 72 percent of them found to be dissatisfied with its quality. There is a need to organize NHED sessions and to spread awareness about the same.

Mothers' Committee

2.15.1 Mothers' Committee looks after cooked food aspects of supplementary nutrition. It is under their guidance and supervision cooked food is prepared and distributed. However 62 percent of respondents found to be ignorant about mothers' committee. Those who knew about mothers' committee 81 percent of them were not satisfied with its working. There is a need to spread awareness about formation and working of mothers' committee and also improve its working so that its work is better appreciated.

Benefits

It has been confirmed from the respondents that pregnant/lactating mothers and children up to 6 years of age have immensely benefited from the ICDS programme. 68 percent of beneficiaries appraised that it has acted as a boon for children below 6 years of age whereas 69 percent of respondents have the opinion that the programme

has proved to be beneficial for expectant and lactating mothers.

Benefit for Adolescent Girls

Adolescent girls require special care and attention. Thus an intervention has been advised for adolescent girls using the ICDS infrastructure to meet their needs of self – development, nutrition health education and skill formation. They are provided with complementary nutrition and nutritional health education. They are encouraged and empowered which develop their self confidence to take care of themselves and their families in future.

When asked if formal education session is organized for them relating to health and nutrition 68 percent of respondents replied in negativity and those who informed that such camps has been arranged only 28 percent said they have participated in the camp.

To the question of as to why they have not participated in such sessions, they attributed the reason of non participation to non availability of nutrition food for adolescent girls from anganwadi centres.

It was found that at present no supplementary nutrition is being provided to adolescent girls through anganwadi centres.

Most of the anganwadi centres failed to produce records regarding organization of sessions for adolescent girls.

On enquiry, it was revealed that the provision of supplementary nutrition for adolescent girls has been discontinued for quite some time.

General

More than 66 percent of respondents described that getting facilities from anganwadi centres is not a smooth sailing.

Irregular supply and low quality of Take Home Ration, insufficient funds provision for cooked food, stands on the way of successful implementation of the project.

Observations and Major Findings

Observations

India’s primary policy response to child malnutrition the Integrated Child Development Services (ICDS) programme is well conceived and well placed to address major causes of child under -nutrition in India. However, more attention has been given to increased coverage rather than improving the quality of service and to distributing food rather than changing family based feeding and caring behavior.

The programme adopts a multi sectoral approach to child well being incorporating health education and nutrition interventions and is implemented through a network of Anganwadi centers at community level. The programme provides eight key services including supplementary nutrition, immunizations, health check-ups and referrals, health and nutrition education to adult women, and pre-school education to children of 3 to 6 years old.

The ICDS scheme has grown tremendously over 36 years of its operation to cover almost all development blocks in India offering a wide range of health, nutrition and education services to children women and adolescent girls.

However, the scheme has faced substantial operational challenges. In adequate skill of Anganwadi workers, shortage of equipment, poor supervision and weak monitoring system stand in the way of successful implementation of the programme.

The two immediate causes of malnutrition - poor dietary intake and infection - are closely linked to three underlying determinants of nutritional status: household level access to food, health resources including clean water & sanitation and appropriateness of the child care and feeding behavior of mothers/caretakers.

Central to the ICDS objective of reducing the prevalence of malnutrition is two services, i.e. growth monitoring and supplementary food.

Growth monitoring activities are hampered by poor access to appropriate equipment, such as weighing machine and growth cards. Needless to say, regular weighing – growth monitoring is effective only if accompanied by communication for behavior change that results in improved growth of the malnourished child. This needs to be strengthened.

Supplementary Nutrition

Beneficiaries contacted expressed the view that they (Pregnant Women/Lactating Mothers, Children below 6 years of age) have immensely benefitted from the programme. However the India Mix (Take Home Ration) being supplied at present is not up to their liking and they have suggested for replacement of India Mix (Home Ration by seasonal fruits/biscuits etc).

The supplementary nutrition is one of the most important components of ICDS interventions. Food is financed and procured by the state and provided to beneficiaries at the Anganwadi centers either in form of Take Home Ration or Cooked Food.

It has been noticed that home ration is available only for six to eight months in a year on an average. In some cases the gap in supply is as big as one year four months. That apart, sometimes funds are not available for cooked food throughout the year.

Due to irregularity in supply of food to Anganwadi centers, the very purpose of the project is defeated. It is needless to point out that ICDS needs to improve the regularity of food supply. There are some centers where the irregularity of food supply is for years together.

However, despite irregularity of food supply, the food is an effective incentive to attract children to the centers where they can get other health and nutrition related services .Without the provision of food, attendance in Anganwadi centers would have been very poor.

Infrastructure

The provision of supplementary food and other ICDS services are sometimes performed under adverse environment. Very few Anganwadi Centres are functioning in its own building. Most of the centres are functioning either in primary schools/Panchayat Bhawans, Community Halls or in rented premises making it vulnerable for external disturbances.

At present the admissible rent in rural areas is Rs.200/- and for Urban areas Rs.700/-.

ICDS staffs are of the opinion that it is very difficult to find out rented accommodation with this amount. Low budget allocation for rent ends with the consequence that Anganwadi centers are frequently found in small and unclean locations.

Non availability of toilets facility and clean drinking water is another problem with Anganwadi centers.

Training

Undoubtedly the skills of the Anganwadi workers and their capacity to mobilize the community to support ICDS and recruit eligible children are central to quality service delivery and ICDS effectiveness. However, during the course of the study, it was revealed that they are not much aware of various components of ICDS scheme. More refresher training programme may be organized for them.

As per the provision funds for cooked food is transferred to the bank account of Anganwadi workers. Anganwadi workers are expected to submit vouchers against the expenditure incurred.

Anganwadi workers are required to maintain cash book for funds received for cooked food. But they are not much aware about accounting procedure, they need training.

Administration

It has also been noticed that the Treasury insists on Pucca / Original Bill/voucher without which it does not pass the bill. So no funds become available for Cooked food as a result of which the beneficiaries suffer. But in a remote place where one has to walk miles together to reach the Anganwadi Centre such Pucca/ Printed bills may not be available. Due care may be taken to solve this problem.

In some places CDPO office is sandwiched between AG Audit and Treasury as both of them insist on original Bill/vouchers.

Selection of Centres

Earlier the criteria of opening Anganwadi centre were population of one thousand. This criterion has been revised and at present Anganwadi centre can be opened with a population of 300 to 500. And criteria for opening MINI Anganwadi centre are population of 150 to 300. The size of population has been reduced, not the targeted beneficiary per centre. In some cases, it becomes difficult to find out required number of beneficiaries per centre.

Most of the beneficiaries expressed the view that while deciding the location for opening the Anganwadi centres certain factor like total population (men,women,children), of the village, economic condition of the village, malnutrition status of the village were taken into account.

Majority of the Beneficiaries were not aware of procedure for opening the Anganwadi centres A large number of beneficiaries confirmed about the presence of primary schools in their respective villages in which enrolment status of students were quite good. Mid-day meals are provided in every school. However, they could not tell much about the quality of mid-day meal provided in these schools.

Human Resource

Shortage of manpower was clearly visible. In some cases one CDPO is in charge of two or more projects. One Supervisor is required to look after 50 to90 centres. This may be one of the reasons why supervisors do not know the exact location of the Anganwadi Centre as they do not have time to visit so many centres. The shortage of manpower stands in the way of successful implementation of the programme/ project.

Timing

It was observed that the opening time of Anganwadi centres is at 8 A.M. and closing time is at 12 P.M.

Availability of Health Care Facilities

Most of the Beneficiaries appraised about the presence of Primary Health Centres (PHC) Sub. Centres within the village or within a radius of 2 kilometer. Normally they depend on these health care delivery institutions for day to day treatment. To the question of timely availability of medical care they responded in affirmation. However although immunization facility was up to the mark, but sufficient medicine was not available in this Health Care Delivery Institutions.

Anganwadi Workers

In the opinion of Beneficiaries the Anganwadi workers are qualified and discharge their duties with sincerity. However they could not tell about quality of training imparted to them. Anganwadi Helpers were found to be cooperative.
All the pregnant/lactating mothers and Children in the age group of 6 months to 6 years were also registered in the Anganwadi centres.

Although the Beneficiaries could not tell if the prescribed procedures were followed to open Anganwadi centres, one thing they confirmed that there was community involvement in the process of opening of Centres.

Almost all the beneficiaries were of the opinion that Anganwadi centres provide nutritional food to pregnant women/lactating mothers, and children below 6 years of age (in form of take home ration/cooked food).

Facilities Available in Anganwadi Centre

Health Check-up facility is also available for pregnant women/lactating mothers and for children below the age of 6 years. Immunization facility is available for all the categories of beneficiaries mentioned above.

However the referral services available only for children below 6 years of age. (Malnourished Children)

The beneficiaries confirmed that pre-school education session is being organized at Anganwadi centres for children within the age group of 3 to 6 years of age.

No provision of nutritional food for women aged between 18 to 45 years.

The observation of Nutrition Health Education Day (NHED) is almost non- existent.

Majority of the Beneficiaries admitted about the presence of Mothers' Committee in their respective Anganwadi Centres which is comprised of 6 numbers. However only a few could tell about roles & responsibilities of Mothers Committee.

The Beneficiaries expressed their ignorance regarding availability of Mother and Child Protection Card.

Malnutrition

When asked about reason for malnutrition of the children most of the beneficiaries replied that poor economic condition and lack of purchasing power are the main reasons for this problem. However almost all of them are taking available help from the Anganwadi Centres / Health Care delivery Institutions to overcome this problem.

Majority of the Adolescent Girls (68 percent) appraised that no such non-formal educational sessions have been organized for them. No nutritional food is being provided to Adolescent Girls through Anganwadi Centres at present. This may be one of the reasons why majority of adolescent girls who were aware of such sessions did not attend the same.

The Anganwadi workers could not produce proper records of educational sessions organized for Adolescent Girls.

Recommendations

General

Integrated Child Development Service (ICDS) provides an integrated approach for converging all the basic services for improved child care ,early stimulation and learning, health and nutrition, water and environmental sanitation aimed at the young children , expectant and lactating mothers and adolescent girls in a community.

The first six years of a child's life are most crucial as the foundations for cognitive, social, emotional, physical, and psychological developments are laid down at this stage. To ensure that all young children even those from vulnerable sectors of society have access to the basic rights ICDS was launched in1975 to provide a package of services to ensure their holistic development

ICDS may be understood as a programme for child protection and child development.

The ICDS scheme has expanded tremendously over its 35 years of operations to cover almost all development blocks in India and offers a wide range of health nutrition and education services to children, women and adolescent girls and beneficiaries have immensely benefited from it

However the program has faced substantial operational challenges but stood the test of time.

Though there are certain shortcomings in ICDS still further thrust of the programme is necessary for the uplifttment of underprivileged section of the population.

Supplementary Nutrition

Due to irregularity in supply of nutritional food to Anganwadi centres, the very purpose of the project is defeated. Food is an effective incentive to attract children to Anganwadi centres. **It may be ensured that food is available for beneficiaries (both take home ration/cooked food) throughout the year.**

Infrastructure

Very few Anganwadi centres are functioning in its own building Most of the Centres are functioning either in Primary Schools, Panchayat Bhawans, and Community Halls or in rented premises making it vulnerable for external disturbances. **Steps may be taken to construct anganwadi centres in a phased manner.**

The rent for hiring accommodation for Anganwadi centres at present appears to be in lower side (Rs. 200/- for rural areas Rs.700/- for urban areas). Low budget allocation for rent ends with the consequence that Anganwadi centres are frequently found in small and unclean locations. **The rent structure may be revised**.

Administration

Since funds for cooked food is transferred to the Bank A/C of Anganwadi workers, they are expected to maintain cash book/accounts details and submit bill/vouchers against the expenditure. It has been observed that they do not know how to maintain accounts**. Some basic accounts training may be imparted to them.**

Treasury insists on original bill/voucher without which it does not pass the payment; so no funds available for cooked food as a result of which beneficiaries suffer. But there are some places where one has to walk miles together to reach the Anganwadi centre. And original/Printed bill/voucher may not be available in those places. **Steps may be taken to ensure that flow of funds is not disrupted due to this technical problem.**

Sometimes the CDPO office is sandwiched between AG Audit and Treasury as both of them insist for original/printed bill/voucher. Steps may be taken to solve the problem.

Criteria of Selection

Since the population criteria (size of population) for opening the Anganwadi centre is reduced over the period of time, the targeted beneficiary per centre may be reduced.

Mothers' Committee and NHED

Although Mother's committees are formed most of the beneficiaries are unaware about the functions of the Committee. **Some sort of awareness campaign is required.**

Observation of NHED (Nutrition Health Education Day) is almost non-existent. This is the right platform by which beneficiaries can be educated about what they are suppose to do and not to do with regards to health and hygiene. **Attention needs to be paid for regular NHED sessions in each and every Anganwadi Centre.**

In Anganwadi centres non-formal pre-school education for the moral, social, emotional, physical and mental development of children needs emphasis.

Services Available

It has been observed that referral service is available only for children below 6 years of age (malnourished children) which should be available for all other beneficiaries. **An effective system of referral from Anganwadi centres, for all categories of beneficiaries, should be developed through joint consultation with health and ICDS functionaries.**

Refresher Training courses and in-service training should be organized for Anganwadi Workers.

Anganwadi workers may be treated as valuable health care workers not a mere provider of childcare.

Monitoring & Supervision and Orientation

The system of supervision needs to be strengthened for improving the quality of ICDS service.

Supervisors should understand the job responsibility of field functionaries and should have the aptitude to guide, and motivate them for better job performance.

Refresher courses should be organized for CDPOs and Supervisors in regular intervals.

Required number of staff (CDPOs/Supervisors, /Anganwadi workers) may be appointed for the smooth implementation of the programme.

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Chapter-1
Prologue

1.1 INTRODUCTION

1.1.1 Uttarakhand, the 27th State of Republic of India came into being on 9th November 2000 with 13 districts. The state has an area of 53,484 sq.km, which is 1.7% of total land area of the country. The population of Uttarakhand is 1.01 crore as per 2011 census and it is less than 1% of total population of India. The demographic and topological peculiarities of the state have placed Uttarakhand in a unique socio-economic and geographical niche. Hence each intervention in the Health sector has tremendous potential to come up as innovation with a significant impact.

1.1.2 The demographic features of the State are unique. The population density is 189 per sq.km, while literacy rate among the male population is 88.33% and among the female population is 77.70%. The sex ratio is 963 women per 1000 men.

1.1.3 Uttarakhand is a place with great diversity of the region where snow clad mountains, green hills, fertile valleys, flowing rivers and thriving lakes add to the natural beauty.

1.1.4 Improving the health and survival status of young children is an important humanitarian and economic investment. Low birth weight has been a matter of great concern for the state.

1.1.5 Children's nutritional status as assessed by weight-for-age, height-for-age, and weight for height shows that a large number of children in uttarakhand are under weight, malnourished and undernourished. Undernourishment is more prevalent in rural areas as well as among children belonging to household with low standard of living. Female children are more likely to be undernourished than male children.

1.1.6 Children are a vulnerable group and susceptible to various infectious and parasitic diseases during childhood including diphtheria, whooping cough, tetanus, diarrhea, dysentery, skin infections etc.

1.1.7 The Integrated Child Development Services (ICDS) scheme today is the world's largest programme aimed at enhancing the health, nutrition and learning opportunities of infants, young children (0-6) years and their mothers, it is the foremost symbol of India's commitment to its children – India's response to the challenge of providing pre-school education on one hand and breaking the viscous cycle of malnutrition, mortality and morbidity, on the other.

1.1.8 The scheme provides an integrated approach for converging basic services through community based honorary workers viz- Anganwadi workers and helpers. The services are provided at a centre called the "Anganwadi" which literally means a courtyard play centre - a child care centre located within the village itself.

1.1.9 The services provided at Anganwadi Centre include supplementary nutrition, immunization, health check-up, referral services, pre- school non formal education and nutrition and health education.

1.1.10 The Government's emphasis has been on integrated and holistic development of children as far as the two basic elements of human resource development - health and education are concerned.

1.1.11 As development have several interrelated dimensions – physical, cognitive, social, emotional and psychological - therefore a synergetic scheme becomes inevitable

1.1.12 The ICDS scheme envisages inters sectoral convergence of various services like nutrition, health and education, through the Anganwadi centre. The services are delivered through different departments.

1.1.13 **ICDS aims at**

(i) Improving the nutritional and health status of children in the age-group 0-6 years;

(ii) Laying the foundation for proper psychological, physical and social development of the child;

(iii) Reducing the incidence of mortality, morbidity, malnutrition and school dropout;

(iv) Achieving effective co-ordination of policy and implementation amongst the various departments to promote child development; and

(v) Enhancing the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

Through

(i) Supplementary nutrition,

(ii) Immunization,

(iii) Health check-up,

(iv) Referral services,

(v) Pre-school non-formal education and

(vi) Nutrition & health education.

1.1.14 There has been widespread malnutrition among children, pregnant women and lactating mothers in Uttarakhand due to illiteracy and poor financial condition. In spite of the fact that the State has witnessed sharp rise in agricultural production and economic growth, malnutrition among adolescence girls, pregnant women and lactating mothers remains as a hindrance in public health programme.

1.1.15 The centrally sponsored scheme of ICDS has been implemented in the state of Uttarakhand since 1978-79 to achieve the desired objective.

1.1.16 There has been significant progress in the implementation of ICDS scheme both in terms of increase in number of operational projects and Anganwadi centers over the years.

1.1.17 In Uttarakhand 105 ICDS Projects and 14,327Anganwadi centers were in operation as on 31st march 2011.

1.1.18 Center for Research Planning & Action was commissioned the study "Evaluation of Nutritional Programme Run through Anganwadi Centers" in **Uttarakhand by the Department of Planning Uttarakhand**

1.2 OBJECTIVES

Objectives of the Evaluation are:

(i) To assess the Appropriateness of Spot selection to open Anganwadi Centres taking in to account;

a. Population of the State(Men, Women and Children);
b. Survey – Basis and appropriateness
c. Malnutrition status of the village;
d. Economic condition of the village;
e. Procedures followed to open Anganwadi Centers.

(ii) To study with regard to valuable educational institutions with specific reference to

a. Number of Primary schools & above;
b. Enrolment Status of students in these schools;
c. Quality of mid-day meals provided in these schools.

(iii) To study with regard to Availability of Health Care Facilities with specific reference to

a. Distance of Primary Health Centre/ Sub-centre from the village;
b. Timely availability of Medical Care;
c. Availability and Sufficiency of immunization facility and medicines.

(iv) To study the qualification and Knowledge of Anganwadi Workers of the various instructions/guidance's with specific reference to

a. Educational qualification;
b. Quality of training imparted by the Department;
c. Responsibility handled;

d. Cooperation of Anganwadi helper.

(v) To study the Details and specialties of Beneficiaries under the Nutritional Programme viz;

a. Total no. of pregnant/lactating mothers enrolled in the Centre;
b. Number of children between 06 months to 3 years;
c. Number of children between 3 years to 6 years.

(vi) To study the status of Malnutrition among

a. Pregnant women/lactating mother;
b. Among Children up to 6 years in Anganwadi Centers;

(vii) To study the Procedure followed to Open Anganwadi Centre with specific reference to:

a. Actual procedures followed
b. Community involvement

(viii) To study the Facilities made available under Nutrition Programme with specific reference to

a. Availability of the facilities
b. Quality of the facilities
c. Sufficiency of the facilities (ii) it's quality; (iii) whether the same is sufficient.

(ix) To study the Status of benefit of the nutrition Programme among pregnant women/lactating mothers ;(ii) among children up to 6 years of age.

(x) To study the difficulties faced is the implementation of the nutritional programme and to suggest ways and means for the successful implementation of the programme.

1.3 METHODOLOGY

1.3.1 CERPA has adopted both secondary and primary research methodology qualitative and quantitative methods as well. As part of secondary research we have studied available records, reports, literatures on the subject. So far as primary research method is concerned the study team had personal contact with beneficiaries (Pregnant women/ lactating mothers, adolescent girls and malnourished children, Anganwadi workers/Helper, ICDS supervisors, Child Development Projects Officers(CDPOs), District Programme Officers(DPOs) and officers at the helm of affairs at Directorate.

1.4 Sampling

1.4.1 We have adopted multistage stratified sampling techniques for the purpose of sample selection.The state of Uttarakhand has been divided into three socio-economic regions Kumaun region, Garhwal Region and Tarai Region. One district from each of the region was selected having maximum number of Anganwadi Centre for the purpose of the study

1.4.2 Thus districts selected are as under:

S.No.	Region	District
1.	Tarai	Haridwar
2.	Kumaun	Almora
3.	Garhwal	Pauri Garhwal

1.4.3 Each district has a number of Projects and each project covers a number of Anganwadi Centers. Here we have selected one project from each district adopting purposive sampling method selecting that project having maximum number of Anganwadi centers.

Thus Projects selected are:

S.No.	District	Name of the project	No. of Anganwadi project on selected distance
1.	Haridwar	Bahaderabad	419
2.	Kumaun	Almora	106
3.	Pauri Garhwal	Duggada	131

1.4.4 10 percent Anganwadi centers were selected from each project. We have selected those centers having maximum number of beneficiaries. 30 beneficiaries were selected from each center comprising of (i) pregnant/lactating mothers, (ii) adolescent girls (iii) malnourished children. Although due care was taken to select 10 beneficiaries from each category, where a particular category of beneficiary were not available in required numbers the same was compensated by covering beneficiary from other categories.

Thus the distribution of complete samples is mentioned below:-

S.No.	District	Project	Anganwadi Centers	No. of selected Beneficiaries
1.	Haridwar	Bahaderabad	46	1375
2.	Almora	Tadikhet	11	330
3.	Pauri Garhwal	Duggada	13	390
Total			**70**	**2095**

1.5 Study Instrument

1.5.1 Study instruments were developed for different types of respondents: i.e.

(i) State Level Officers,
(ii) District level officers (DPOs),
(iii) Project Level officers (CDPOs), Anganwadi workers.
(iv) Beneficiaries

1.5.2 The members of study team interacted with offices of Directorate of ICDS, at Dehradun, to collect necessary information. The Director's office was kind enough to issue letter to DPOs/CDPOs of selected projects to extend necessary co-operation to the study team. (copy of the letter provided at **Annexure – I**)

1.5.3 Members of study team also interacted with DPOs of Haridwar district, Pauri garhwal district and Almora district to have their considered opinions on the implementation of the project.

1.5.4 The study team also had extensive interaction with CDPOs and supervisors of Bahaderabad I & II Project (Haridwar district) Duggada Project (Pauri Garhwal district) and Tedikhet Project (Almora district) to have their opinion/views/suggestions regarding the implementation of the project.

1.5.5 It had also detailed discussion with workers/helpers of the Anganwadi centers which came under the sample of the study.

1.5.6 The study team had also established person to person contact with selected beneficiaries and collected information from them on the structured questionnaire developed for the purpose.

1.5.7 Copies of the questionnaires are provided at **Annexure – II.**

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Chapter-2

Assessment by Beneficiaries

2.1 Introduction

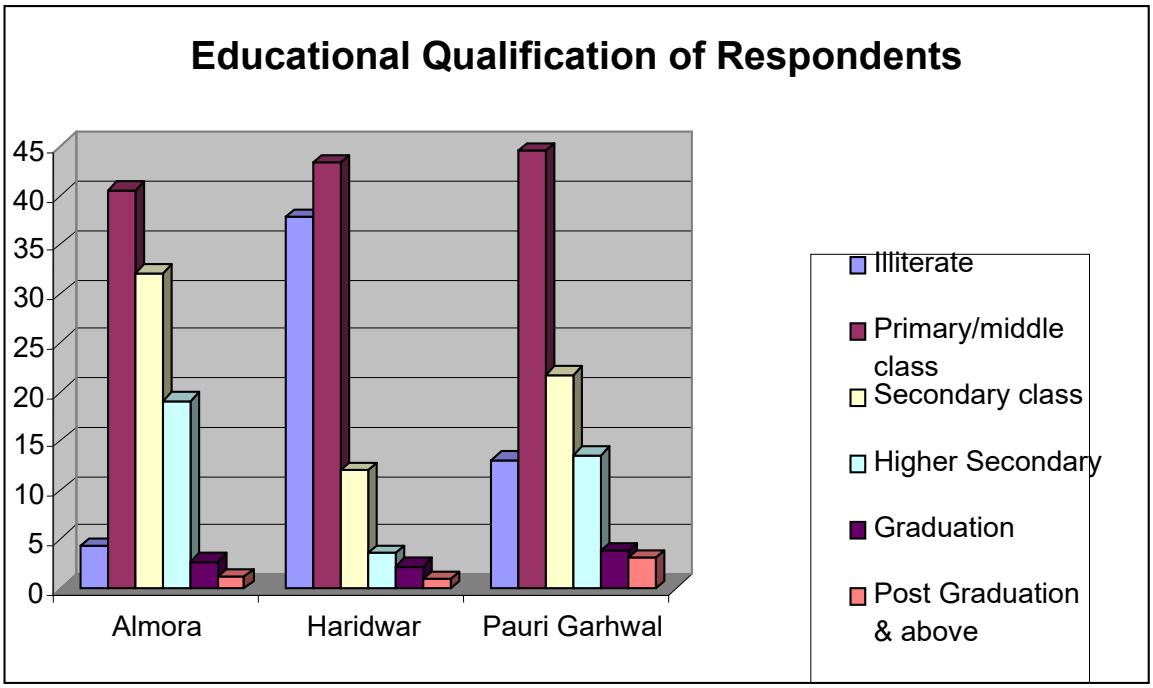
2.1.1 The study was conducted in Almora, Haridwar and Pauri Garhwal districts of the state covering one project from each of these districts. Thus projects selected were Tedikhet from Almora district, Dugada from Pauri Garhwal district and Bahadarbad from Haridwar district. The study team contacted/interviewed expectant/lactating mothers and mothers of malnourished children (beneficiaries) of the selected projects to have their views on implementation/ functioning of the scheme.

2.2 Distribution of Beneficiaries by Educational Qualification

2.2.1 Of the beneficiaries 27.88 percent were illiterates. 43.16 percent of beneficiaries have qualification up to middle level. The maximum numbers of such beneficiaries are from Pauri Garhwal district. Beneficiaries with secondary and higher secondary education accounted for 24.96 percent and this is largely in Almora district. Beneficiaries with graduation degree accounted only for 2.62 percent, maximum number being in Pauri Garhwal district. Those with Post graduation and above qualification accounted for 1.38 percent and most of them are located in Pauri Garhwal district.

Table 2.2.1 – Educational Qualification of Beneficiaries (in Percent)

Qualification	**Almora**	**Haridwar**	**Pauri Garhwal**	**Total**
Illiterate	4.24	37.75	13.07	27.88
Primary/middle class	40.60	43.35	44.62	43.16
Secondary class	32.12	12.07	21.80	17.04
Higher Secondary	19.09	3.64	13.58	7.92
Graduation	2.72	2.25	3.85	2.62
Post Graduation & above	1.23	0.94	3.08	1.38
Total	100.00	100.0	100.0	100.0
N	**330**	**1375**	**390**	**2095**



2.3 Selection of Location for Anganwadi Centres

2.3.1 Most of the Anganwadi centres (98.1%) are located within one kilometer from the residence of beneficiaries.

2.3.2 Majority of the beneficiaries responded that total number of beneficiary population, status of malnutrition and economic condition of the village are taken into consideration while opening Anganwadi centres.

2.3.3 However 75.70 percent of respondents found to be unaware of procedure followed to open Anganwadi centres highest being in Almora and Pauri Garhwal districts. And those who know the procedure, a majority of them expressed the view that there was no need to bring about any change in the prevailing procedure.

Table 2.3.3 - Level of Awareness Beneficiaries: (in Percent)

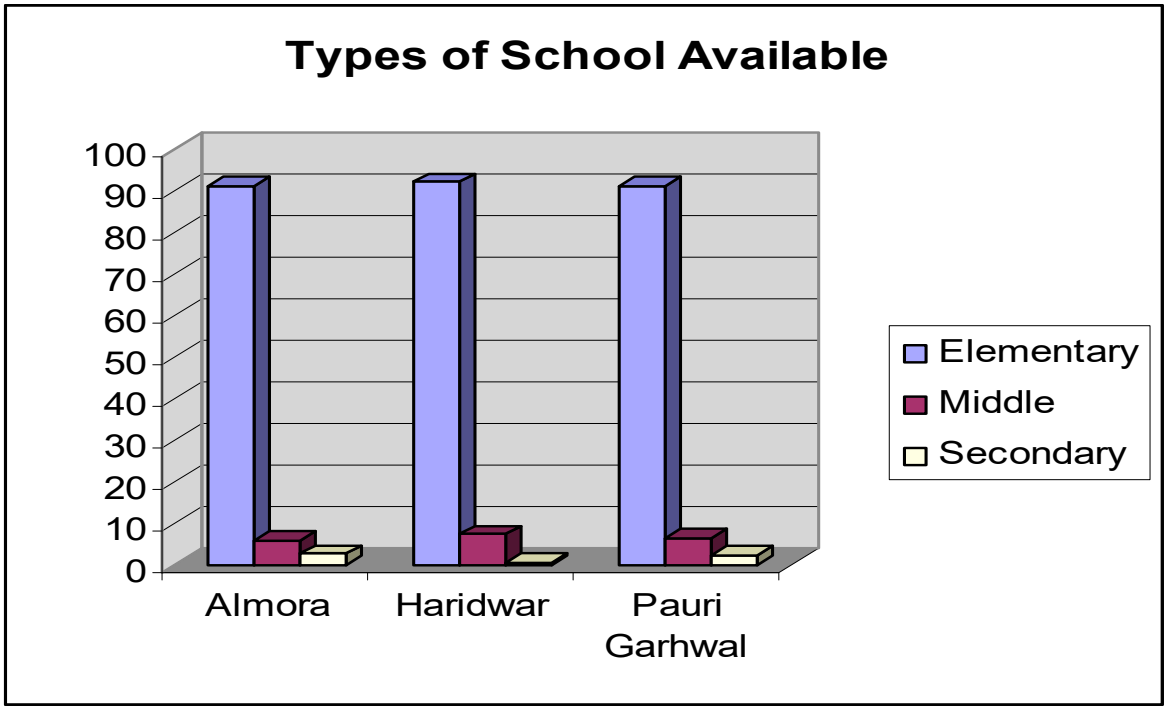
Awareness	**Almora**	**Haridwar**	**Pauri Garhwal**	**Total**
Aware	9.10	32.20	9.24	24.30
Not Aware	90.90	67.80	90.76	75.70
Total	100.0	100.0	100.0	100.0
N	**330**	**1375**	**390**	**2095**

2.4 Existence of Educational Institutions

2.4.1 89.68 percent of beneficiaries were aware of presence of educational institutions in their areas. 91.69 percent beneficiaries affirmed the existence of primary schools in their village while only 6.40 percent beneficiaries said their villages having middle schools and only 1.25 percent said about presence of secondary schools.

Table 2.4.1 - Types of Schools available (in Percent)

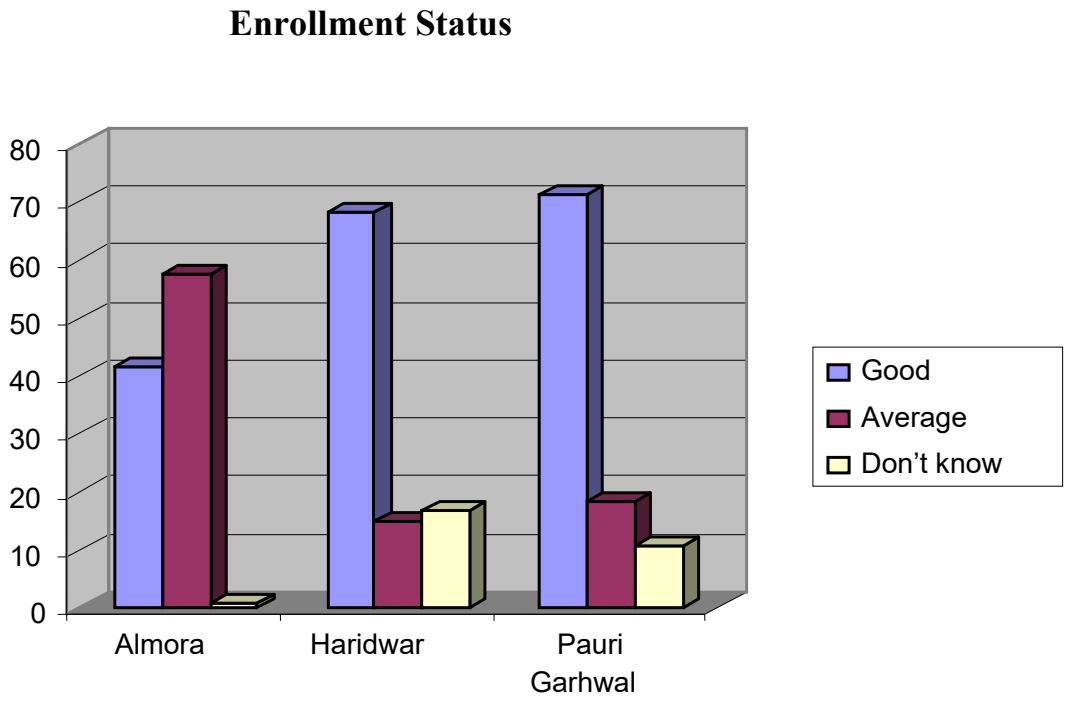
Type of School	Almora	Haridwar	Pauri Garhwal	Total
Elementary	91.22	92.00	91.02	91.69
Middle	6.06	7.42	6.67	7.06
Secondary	2.72	0.58	2.31	1.25
Total	100.0	100.0	100.0	100.0
N	**330**	**1375**	**390**	**2095**



2.4.2 Regarding status of enrollment in schools 64.63 percent of the beneficiaries termed it as good while 22.19 percent said it to be average. 13.18 percent of beneficiaries expressed their ignorance about the enrollment status in schools.

Table 2.4.2 – Enrollment Status (in Percent)

Enrollment status of School	**Almora**	**Haridwar**	**Pauri Garhwal**	**Total**
Good	41.50	68.30	71.28	64.63
Average	57.60	14.86	18.20	22.19
Don't know	0.90	16.84	10.52	13.18
Total	100.0	100.0	100.0	100.0
N	**330**	**1375**	**390**	**2095**



2.4.3 More than 80 percent of beneficiaries confirmed that mid-day meal is provided in these schools (Primary). However 74 percent beneficiaries were of the opinion that mid-day meal provided in these schools are of good quality whereas around 8 percent termed

it as average/less than average quality. 18 percent respondents declined to comment on the quality of mid-day meal as they have no idea about the same.

Table 2.4.3 – Quality of Mid-day Meal (in Percent)

Quality of the Mid-day Meal	**Almora**	**Haridwar**	**Pauri Garhwal**	**Total**
Good	94.80	69.60	72.05	74.03
Average	1.80	4.88	5.14	4.44
Less than Average	1.0	3.85	3.33	3.29
Don't know	2.40	21.67	19.48	18.24
Total	100.0	100.0	100.0	100.0
N	**330**	**1375**	**390**	**2095**

2.5 Timing

2.5.1 Almost all the beneficiaries appraised that Anganwadi centres open in all week days (except holidays) and the timing of opening is 8 A.M. and closing is 12 P.M.

2.6. Availability of Health Care Facilities

2.6.1 52 percent of beneficiaries confirmed about presence of sub-centre/primary health centre in their area. 41 percent of beneficiaries appraised that the location of sub-centre/PHC is within five kilometer radius and 7 percent said health care delivery institution is situated beyond five kilometer.

Table 2.6.1 - Health Care Facilities Available (in Percent)

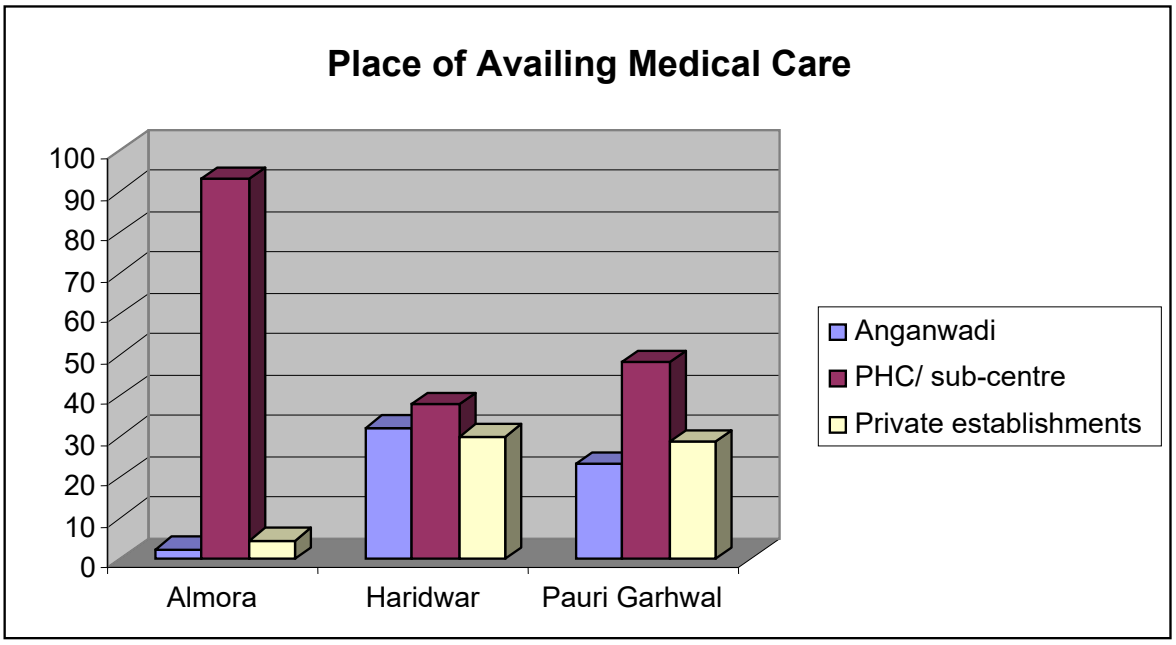
Districts	**Yes**	**No**	Total	**N**
Almora	43.00	57.00	100.00	330
Haridwar	56.10	43.90	100.00	1375
Pauri Garhwal	43.30	56.70	100.00	390
Total	51.64	48.36	100.00	2095

2.6.2 A large number of beneficiaries (48.45 percent) depend on PHCs/ CHCs for medical care while 25.82 percent depend on Anganwadi centres and almost an equal percent of beneficiaries (25.73 percent) opt for private institutions for medical treatment. **(It may be noted that a medical kit with some medicines is provided to Aganwadi workers. Though the local people do not go for detailed medical treatment in aganwadi centres they do go for immediate assistance and get basic Medicare / Firstaid).**

Table 2.6.2 – Place of Availing Medical Care

(in Percent)

Type	**Almora**	**Haridwar**	**Pauri Garhwal**	**Total**
Anganwadi	2.42	32.10	23.33	25.82
PHC sub-centre	93.04	37.90	47.95	48.45
Private establishments	4.54	30.00	28.72	25.73
Total	100.00	100.00	100.00	100.00
N	**330**	**1375**	**390**	**2095**



2.6.3 When asked about the time availability of Medical Care Facility in PHCs/CHCs/Sub-centres 71 percent beneficiaries replied in affirmation.

2.6.4 Fairly a large number of beneficiaries (47 percent) avail immunization facilities from PHCs/CHCs while 38 percent avail the same from anganwadi centres and 15 percent depend on private establishments for immunization.

Table 2.6.3 – Places from where immunization facilities availed

(in Percent)

Type	**Almora**	**Haridwar**	**Pauri Garhwal**	**Total**
Anganwadi	6.40	48.10	31.28	38.38
PHC /CHC	89.40	36.60	48.72	47.16
Private establishments	4.20	15.30	20.00	14.46
Total	100.00	100.00	100.00	100.00
N	**330**	**1375**	**390**	**2095**

2.6.5 Majority of beneficiaries (84 percent) expressed the view that available immunization facilities are quite sufficient.

2.6.6 Fairly a large number (48 percent) of beneficiaries depend on PHCs/CHCs for medicine, 26 percent depend on anganwadi centres and almost an equal number of beneficiaries prefer to get medicine from private sources.

2.6.7 81 percent considered the availability of medicines is sufficient as per the requirement.

2.7 Anganwadi Workers

2.7.1 The study team also wanted to know about anganwadi workers from the beneficiaries. When asked if anganwadi workers are well qualified 98 percent of beneficiaries replied with positivity and 97 percent expressed the opinion that they are properly trained and handle their duties and responsibilities in proper manner. **(Source:- Field Survey).**

Table 2.7.1 (a) District wise distribution of respondents whether Anganwadi workers are well qualified

District	Whether Well Qualified			
	Yes	**No**	**Do not know**	**Total**
Almora	99.40	.60	0.00	100
Haridwar	96.80	.90	2.30	100
Pauri Garhwal	99.2	.80	0.00	100
Total	**97.70**	**.80**	**1.50**	**100**
N				**2094**

Table- 2.7.1 (b) District wise distribution of respondents whether Anganwadi workers are well trained and discharge their duties properly.

District	Whether Well trained and discharge their duties properly			
	Yes	**No**	**Do not know**	**Total**
Almora	99.40	.60	0.00	100
Haridwar	96.10	.80	3.10	100
Pauri Garhwal	99.20	.80	0.00	100
Total	**97.20**	**.80**	**2.00**	**100**

2.7.2 98 percent of beneficiaries replied that anganwadi helpers are quite co-operative and help anganwadi workers in discharge of duties. (**The source of information is respondent's version to the query made in this regard, during the field survey).**

Table - 2.7.2. District wise distribution of respondents whether Anganwadi workers are cooperative

District	Whether Cooperative			
	Yes	No	Do not know	Total
Almora	99.40	.60	0.00	100
Haridwar	97.30	.60	2.10	100
Pauri Garhwal	99.20	.80	0.00	100
Total	**98.00**	**.60**	**1.40**	**100**

2.8 Details and Specialties of Beneficiaries

2.8.1 94 percent of beneficiaries asserted the view that all pregnant women and lactating mothers of the area are enrolled in the programme. (**In fact, as per the ICDS Scheme all expectant and lactating mothers were to be enrolled. However due to lack of awareness, some of them may not be aware on the same. The source of information is our field survey).**

Table 2.8.1 District wise distribution of respondents whether all pregnant/lactating Mothers of the area are enrolled in the programme.

District	Whether all pregnant/lactating mothers enrolled.			
	Yes	**No**	**Do not know**	**Total**
Almora	92.10	.60	7.30	100.0
Haridwar	93.50	1.30	5,20	100.0
Pauri Garhwal	98.20	.80	1.10	100.0
Total	**94.20**	**1.10**	**4.70**	**100.0**

2.8.2 Anganwadi workers takes due care to see that no eligible beneficiary is left out. 94 percent of beneficiaries appraised that all children in the age group of 6 months to 3 years

and 3 years to 6 years are enrolled in the anganwadi centres of the area. **(This is as per the findings of our field survey).**

Table 2.8.2 District wise distribution of respondents whether all Children in the Age group of 6 months to 3 years and 3 years to 6 years are enrolled in the Centre

District	Whether Enrolled			
	Yes	**No**	**Do not know**	**Total**
Almora	92.10	.60	7.30	100.0
Haridwar	93.50	1.30	5,20	100.0
Pauri Garhwal	98.20	.80	1.10	100.0
Total	**94.20**	**1.10**	**4.70**	**100.0**

2.9 Status of malnutrition

2.9.1 When asked about the nutrition status of pregnant women 81 percent of respondents considered it as good and 6 percent of respondents termed it as bad and 13 percent declined to comment as they do not have any idea of the same.

2.9.2 Regarding nutrition status of lactating mothers 81 percent respondents said it is quite good and 6 percent termed it as bad and 13 percent declined to comment.

2.9.3 Of the beneficiaries 77 percent of respondents agreed that the malnutrition status of children up to 6 years of age is quite good. However 9 percent of beneficiaries responded that it is quite bad and 14 percent beneficiaries chose not to comment

Table 2.9 – Malnutrition Status (in Percent)

Districts	Pregnant Women				Lactating Mothers				Children up to 6 years			
	Good	**Bad**	**Can't say**	**Total**	**Good**	**Bad**	**Can't say**	**Total**	**Good**	**Bad**	**Can't say**	**Total**
Almora	74.81	1.20	23.90	100.0	75.20	0.90	23.90	100.0	72.10	1.20	26.70	100.0
Haridwar	80.40	8.20	11.40	100.0	80.15	8.15	11.70	100.0	75.70	12.70	11.60	100.0
Pauri Garhwal	86.41	2.30	11.29	100.0	86.67	2.31	11.02	100.0	82.83	4.87	12.30	100.0
Total	80.62	6.01	13.36	100.0	80.57	5.92	13.51	100.0	76.46	9.41	14.13	100.0

2.10 Procedure

2.10.1 Of the beneficiaries 75.70 percent of respondents found to be unaware of the prescribed procedure followed to open Anganwadi centres. And those who were aware of the procedure, a majority of them (93 percent) expressed the view that due procedures were followed while opening new anganwadi centres in their respective areas.

2.10.2 Of the total respondents 49 percent beneficiaries opined that community participation was noticed while opening new anganwadi centres while 16 percent replied negativity and 35 percent could not say anything on the issue.

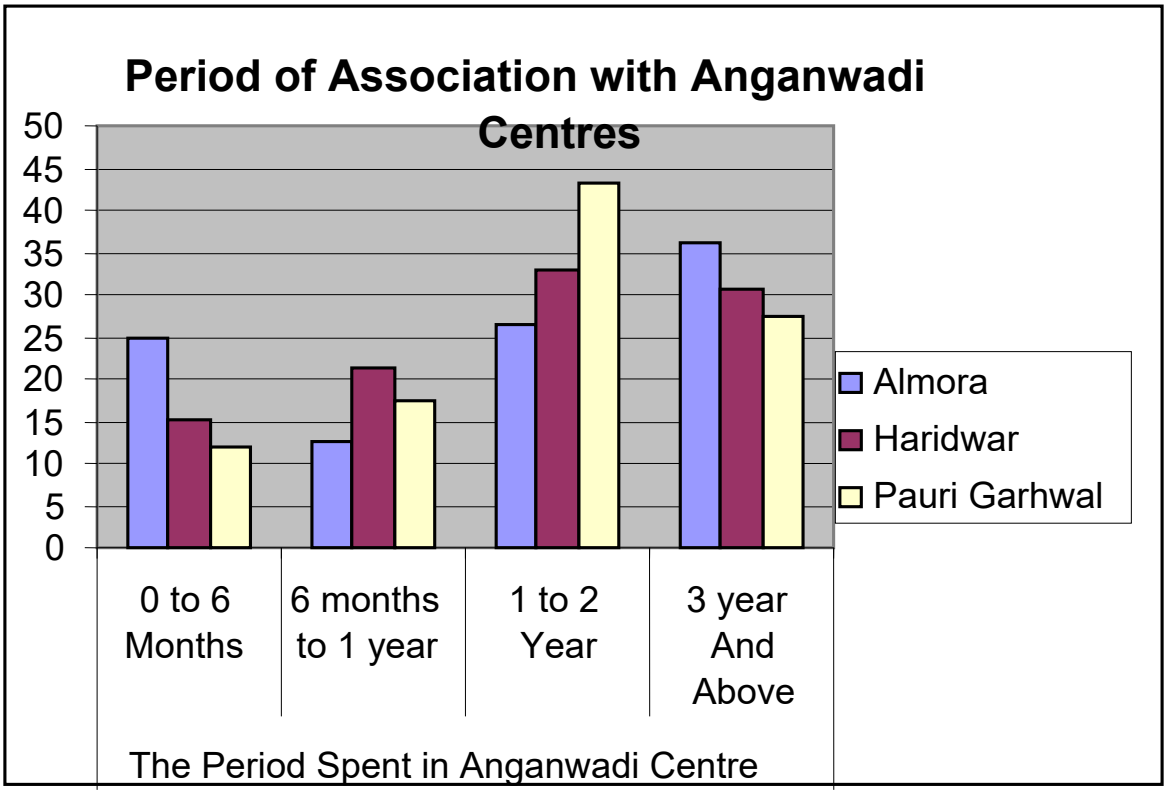
2.11 Facilities available through Nutrition Programme

2.11.1 Fairly a large number of beneficiaries (34 percent) are associated with anganwadi centres for 1 to 2 years whereas 31 percent beneficiaries are associated for a period of 3 or more years. 16 percent beneficiaries are attached with the centre for a period below 6 months and 19 percent beneficiaries for 6 months to 1 year.

Table 2.11.1 - Period of Association with Anganwadi Centre

(in Percent)

Districts	**The Period Spent in Anganwadi Centre**				**Total**	**N**
	0 to 6 months	**6 months to 1 year**	**1 to 2 year**	**3 year and above**		
Almora	24.80	12.70	26.40	36.10	100.0	330
Haridwar	15.20	21.20	33.00	30.60	100.0	1375
Pauri Garhwal	12.05	17.43	43.08	27.44	100.0	390
Total	16.13	19.14	33.84	30.89	100.0	2095



2.11.2 By providing supplementary nutrition feeding the anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged population group. 98 percent of beneficiaries confirmed that supplementary nutrition is provided to pregnant/lactating mothers and children up to 6 years of age. **(Source – The source of information is our field survey).**

2.11.2 District wise distribution of respondents whether supplementary nutrition is provided to Pregnant/lactating mothers and children up to 6 years of age.

District	Whether Supplementary nutrition provided		
	Yes	No	Total
Almora	99.40	.60	100
Haridwar	97.30	2.70	100
Pauri Garhwal	100	0.00	100

Total	**98.1**	**1.90**	**100**

2.11.3 Health check-up is an important service provided by ICDS programme through anganwadi centres. It includes health care of children less than 6 years of age, antenatal care of expectant mothers and postnatal care of nursing mothers. **(This is one of the inbuilt provisions of ICDS Scheme).**

Table 2.11.3 (a) District wise break-up of availability of health check-up facility for pregnant women and children up to 6 years of age.

District	**Availability of health check-up facility**		
	Available	**Not available**	**Total**
Almora	99.70	.30	100.0
Haridwar	94.90	5.10	100.0
Pauri Garhwal	99.50	.50	100.0
Total	**96.50**	**3.50**	**100.0**

Table 2.11.3 (b) District wise availability of health check-up facility for Lactating Mothers

District	**Availability of health check-up facility**		
	Available	**Not available**	**Total**
Almora	96.10	3.90	100.0
Haridwar	95.00	5.00	100.0
Pauri Garhwal	98.5	1.50	100.0
Total	**95.80**	**4.20**	**100.0**

Table 2.11.3 (c) District wise distribution of respondents by availability of immunization facility for children below 6 years of age.

District	Availability of immunization facility		
	Available	**Not available**	**Total**
Almora	96.10	3.90	100.0
Haridwar	95.70	4.30	100.0
Pauri Garhwal	98.50	1.50	100.0
Total	**96.30**	**3.70**	**100.0**

Table 2.11.3(d) District wise distribution of respondents by availability of immunization facility for pregnant women.

District	Availability of immunization facility		
	Available	**Not available**	**Total**
Almora	90.30	9.70	100.0
Haridwar	92.90	7.10	100.0
Pauri Garhwal	93,30	6.70	100.0
Total	**92.60**	**7.40**	**100.0**

2.11.4 97 percent respondents admitted that health check-up facilities are available for expectant mothers and children up to 6 years of age. However 95 percent beneficiaries said the facility is available for lactating mothers. **(This is the finding of our field Survey).**

2.11.5 Immunization of pregnant women and children protect them from six vaccine preventable diseases-polio, diphtheria, tetanus, pertussis, tuberculosis and measles. These

are major preventable causes of child mortality, disability, morbidity and related malnutrition. Immunization of pregnant women against tetanus also reduces maternal neonatal mortality. **(These are the facts as revealed by the medical personnel and well known to the people dealing with health issues).**

2.11.6 Immunization is very important to prevent oneself from dreaded diseases. It is one of the important components of ICDS programme. 96 percent respondents confirmed that immunization facility is available for children up to 6 years of age and 93 percent beneficiaries accepted that the facility is available for pregnant women.

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

2.11.8 As regards referral services, 47 percent of respondents replied that referral service is available for children up to 6 years of age while only 6 percent of the respondents said it is available for pregnant/ lactating mothers. **Since 94 percent of beneficiaries replied referral service is not available for pregnant/lactating mothers, this component of ICDS programme needs urgent attention.**

2.11.9 The non formal pre-school education component of the ICDS is considered as the backbone of the programme. It is a programme for children of 3 to 6 years of age which provides a natural, joyful and stimulating environment which emphasis on necessary inputs for optimal growth and development. The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. It also contributes to the universalization of primary education, by providing to the child the necessary preparation for primary schooling.

2.11.10 Of the total respondents 80 percent appraised that non-formal pre-school education is available for children 3 to 6 years of age.

2.11.11 Pre- school education kit is provided to anganwadi centres worth of rupees one thousand and to mini anganwadi centres worth rupees five hundred.

2.11.12 In the opinion of 97 percent of respondents neither the provision of supplementary nutrition feeding nor Nutrition Health Education is available for women in the age group of 15 to 45 years of age.

2.11.13 Almost all the respondents informed that no other facilities are available apart from those mentioned above.

2.12 About Nutrition Food

2.12.1 Supplementary nutrition feeding is provided in two forms – Cooked Food and Take Home Ration. Cooked food is provided to children between 3 to 6 years of age under the guidance/supervision of **Mothers' Committee.**

2.12.2 Take Home Ration is provided to pregnant/lactating mothers and children in the age group of 6 months to 3 years

2.12.3 Majority of the respondents (57 percent) appeared to be not satisfied with the supplementary nutrition provided maximum percentage being in Almora district. 12 percent respondents said they are very much satisfied while 31 percent said they are satisfied.

Table 2.12.3 – Level of Satisfaction on Available Nutrition

(in Percent)

Districts	**Very much Satisfied**	**Satisfied**	**Not Satisfied**	**Total**	**N**
Almora	3.60	16.70	79.70	100.0	330
Haridwar	13.96	35.42	50.62	100.0	1375
Pauri Garhwal	9.74	29.24	61.02	100.0	390
Total	11.55	31.31	57.14	100.0	2095

2.12.4 A large majority of respondents (78 percent) expressed their dissatisfaction over quality of cooked food and considered it as of ordinary quality. Only 4 percent respondents admitted that cooked food is of excellent quality, 2 percent said it was very good and 12 percent termed the quality of cooked food as good and 4 percent respondents considered as bad.

2.12.5 As regards the quality of take home ration, 40 percent respondents appeared to be dissatisfied over the quality and in their opinion the quality of take home ration is of ordinary quality while 32 percent considered it as bad, 16 percent termed it as good and 5 percent said it was very good and 7 percent of respondents considered the same as excellent.

2.12.6 Majority of respondents expressed the desire that the take home ration which is being provided at present (Indiamix- what is called SATTU in local language) may be replaced by biscuits/seasonal fruits/gram etc.

2.12.7 When asked about availability of cooked food 82 percent informed that it was insufficient and regarding take home ration 56 percent respondents considered it insufficient.

2.13 Immunization Facilities

2.13.1 Immunization of pregnant women and infants protects them from various diseases. 92 percent of respondents confirmed that immunization facility is available against diseases like tetanus, BCG, measles, DPT, and polio.

2.13.2 88 percent of respondents expressed satisfaction over availability and quality of immunization facilities.

2.13.3. A large number of beneficiaries 86 percent appeared to be quite satisfied with the availability and quality of health care facilities.

2.13.4. So far as availability and quality of referral services are concerned 77 percent respondents expressed their dissatisfaction.

2.14. Nutrition and Health Education

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

2.14.2 Unfortunately no regular NHED session are being organized in anganwadi centres. 58 percent of respondents subscribed to this view. Those who agreed that NHED is organized 72 percent of them found to be dissatisfied with its quality. There is a need to organize NHED sessions and to spread awareness about the same.

2.15 Mothers' Committee

2.15.1 Mothers' Committee looks after cooked food aspects of supplementary nutrition. It is under their guidance and supervision cooked food is prepared and distributed. However 62 percent of respondents found to be ignorant about mothers' committee. Those who knew about mothers' committee 81 percent of them were not satisfied with its working. There is a need to spread awareness about formation and working of mothers' committee and also improve its working so that its work is better appreciated.

2.16 Benefits

2.16.1 It has been confirmed from the respondents that pregnant/lactating mothers and children up to 6 years of age have immensely benefited from the ICDS programme. 68 percent of beneficiaries appraised that it has acted as a boon for children below 6 years of age whereas 69 percent of respondents have the opinion that the programme has proved to be beneficial for expectant and lactating mothers.

2.17 Benefit for Adolescent Girls

2.17.1 Adolescent girls require special care and attention. Thus an intervention has been advised for adolescent girls using the ICDS infrastructure to meet their needs of self – development, nutrition health education and skill formation. They are provided with complementary nutrition and nutritional health education. They are encouraged and empowered which develop their self confidence to take care of themselves and their families in future.

2.17.2 When asked if formal education session is organized for them relating to health and nutrition 68 percent of respondents replied in negativity and those who informed that such camps has been arranged only 28 percent said they have participated in the camp.

2.17.3 To the question of as to why they have not participated in such sessions, they attributed the reason of non participation to non availability of nutrition food for adolescent girls from anganwadi centres.

2.17.4 It was found that at present no supplementary nutrition is being provided to adolescent girls through anganwadi centres.

2.17.5 Most of the anganwadi centres failed to produce records regarding organization of sessions for adolescent girls.

2.17.6 On enquiry, it was revealed that the provision of supplementary nutrition for adolescent girls has been discontinued for quite some time.

2.18 General

2.18.1 More than 66 percent of respondents described that getting facilities from anganwadi centres is not a smooth sailing.

2.18.2 Irregular supply and low quality of Take Home Ration, insufficient funds provision for cooked food, stands on the way of successful implementation of the project.

Mr. P.K.Rout, Sr. Manager (CERPA)discussing with
Ms. D. Varma,CDPO, Tadikhet Project.(Dist. Almora)

Pre-School Education in Anganwadi Centres

Pre-School Education being imparted to children

CERPA investigator interacting with beneficiaries.

Investigator of CERPA interacting with lactating mothers

Children in playing mood in one of the anganwadi centres.

Interaction with beneficiaries.

Beneficiaries in one of the anganwadi centres.

Meeting with beneficiaries.

Interactiion with adolescent girls and others

Interaction with beneficiaries.

Fire wood stored in one of the anganwadi centre.

Chapter-3
Opinion of Officers

3.1 Opinion of the ICDS Directorate

3.1.1 The evaluation team had extensive interaction with officers of the ICDS Directorate at Dehradun. ICDS Directorate was kind enough to issue instructions to DPOs/CDPOs to extend necessary co-operation to the evaluation team during the course of the evaluation.

3.1.2 They appraised that six types of services like Supplementary Nutrition, Health Check-ups, Referral Services, Immunization, Nutrition & Health Education (NHED) and Pre-School Education are provided through anganwadi centres under ICDS.

3.1.3 As per the existing criteria a new ICDS project can be opened with a population of one lakh and above.

3.1.4 In urban areas one thousand population is the minimum requirement to open a new anganwadi centre and in rural areas population may vary from five hundred to seven hundred to open a new anganwadi centre. Around one hundred and fifty is the population to open mini anganwadi centres.

3.1.5 The anganwadi worker surveys the entire village to select beneficiaries (pregnant/lactating mothers, children in the age group of 0-3 years and 3-6 years of age) and adolescent girls in the age group of Eleven to eighteen.

3.1.6 Regarding duties and responsibilities of anganwadi workers, it was revealed that anganwadi workers role is very crucial in the successful implementation of the programme. They prepare list of beneficiaries by undertaking a detailed survey of the village.

3.1.7 Anganwadi workers play a very important role in providing Health Check-up Services, Referral Services and Supplementary Nutrition to children in the age group of

six months to six years, pregnant/lactating mothers; provide pre-school education to children three to six years of age; help in immunization; organize NHED; encourage married women about family planning; help health worker, refer malnourished and sick children to the doctor (PHC) for better treatment.

3.1.8 They also maintain records/registers relating to weight card, children health card, record of supplementary nutrition provided to beneficiaries, attendance registers etc.

3.1.9 Supplementary nutrition is provided (cooked food) to children in the age group of three to six years under their guidance. Take Home Ration is distributed among beneficiaries by them.

3.1.10 They also organized simple and creative games for all round development of children and looks after up-keep of materials supplied to the centre.

3.1.11 Anganwadi worker also attend joint sector meetings and help ANM to prepare strategy to tackle local health problems.

3.1.12 Anganwadi helpers looks after cleanliness premises of anganwadi centre, bring children from their residence to the centre and leave them in their respective houses once the session is over. She also arranges drinking water for the centre. The anganwadi helper also helps the anganwadi worker in the implementation of the programme and manages the centre in her absence.

3.1.13 Details of sanctioned posts/ filled in posts of anganwadi workers and helpers are annexed at **Annexure – III.**

3.2 Views of District Programme Officers

3.2.1 The members of the study team also interacted with District Programme Officers (DPOs) of Haridwar, Pauri Garhwal and Almora district and collected necessary information from them.

3.2.2 When asked about the procedure of opening anganwadi centres, they appraised the evaluation team that opening of new anganwadi centre is determined on the basis of population of the area (availability of beneficiaries – pregnant women/ lactating mothers/

malnourished children).Anganwadi worker of the nearest anganwadi centres surveys the area of proposed centre under the guidance and supervision of the anganwadi supervisor and identify beneficiaries. As per the guidelines the District Programme Officer, with the approval of the ICDS headquarters releases advertisement in News Papers for appointment of anganwadi Workers and Helpers. Anganwadi Workers and Helpers are selected through open interview. Once they are appointed the centre starts functioning.

3.2.3 To the question that how to identify malnourished children and lactating mothers they explain that the level of malnourishment is determined by taking the weight of the child. There is a provision of growth monitoring in anganwadi centres in every month. Accordingly children between 0 to 5 years of age are weighted in anganwadi centres and mothers of malnourished children are apprised about growth of their children and advised how to overcome the situation. Malnourished children falling in the category of Gr. - III & IV, get double ration from the centre and refer to the primary health centre of the area for onward treatment.

3.2.4 Mothers having children in the age group of 0 – 6 months of age are treated as lactating mothers. There is a provision of health check-up of lactating mothers in the immunization camp and those found in a critical condition are sent to the nearest PHC.

3.2.5 Anganwadi centre provides a number of facilities including pre- school education, supplementary nutrition, nutrition and health education, immunization, health check-up, referral services, cooked food (for children 3-6 years of age) and Take Home Ration.

3.2.6 The department provides free school kits and medicine kit once in a year besides toys; carpets (dari), almira etc. are supplied to certain centre which is adopted by Sarva Siksha Abhiyan (SSA). Places where the department has constructed anganwadi centres, carpets, chairs and bench- desks for children are provided by the village Pradhan (Sarpanch).

3.2.7 Details of district wise break- up of malnourished children & lactating mothers, district wise breakup of immunization status and district wise break- up of beneficiaries by availing health services are annexed at **Annexure– IV.**

Table 3.2.8 District wise break-up of Functioning of Anganwadi Centres

Category	Haridwar	Pauri Garhwal	Almora	Total
Functioning in own building	147	23	123	293
Functioning in panchayat building	190	201	125	516
Functioning in primary schools	371	78	417	866
Functioning in community halls		67	20	126
Rented accommodation	1207	272	169	1648
Others	533	433	59	1025
Total	**2487**	**1074**	**913**	**4474**

3.2.9 The above table shows that only 6.55 percent of anganwadi centres are functioning in its own building.

3.2.10 The department may construct buildings for all anganwadi centres in a phased manner so that the problem of accommodation may be overcome.

3.2.11 The district office of ICDS has experienced certain difficulties in the implementation of the programme. The officers to whom we contacted, they expressed the views that due to unapproachable and difficult geographical condition of hilly areas "it is difficult for supervisors to supervise required no. of anganwadi centres during the prescribed period". At present one supervisor is required to look after 50 to 60 centres which are very difficult. The shortage of manpower adds to the woe.

3.2.12 They have suggested that keeping in view the difficult geographical condition of the area one supervisor should be required to supervise maximum 17 to 18 anganwadi centres. Mini anganwadi centres, as per the parameter, may be upgraded to full-fledged anganwadi centres.

3.2.13 All sanctioned posts of CDPOs, supervisors, anganwadi Workers and Helpers should be filled-up for the successful implementation of the programme.

3.3 Views of CDPOs

3.3.1 The evaluation team also interacted with Child Development Project Officers (CDPOs) of the selected ICDS projects to have a first–hand assessment of the programme being implemented. When asked about the economic condition of their respective areas they appraised that economic condition of the people is not up to the mark. Mainly people depend on agriculture, animal husbandry, and work as daily wage laborers to sustain their livelihood.

3.3.2 The yardstick to open anganwadi centre is the total population of the area which may range from 400 to 1000. Mini anganwadi center can be opened with the population of 150.

3.3.3 CDPOs expressed their views at medical officers are available in the Primary Health Centres (PHCs) but the supply of the medicine needs to be improved. However there is lack of basic amenities.

Table 3.3.4 District wise breakup of Anganwadi Workers/Helpers

District	**No. of Sanctioned post**		**No. of posts filled-up**	
	Worker	Helper	Worker	Helper
Haridwar	238	238	235	197
Pauri Garhwal	188	188	155	157
Almora	106	106	106	106
Total	532	532	496	460

3.3.5 The mid-day meal scheme is being implemented in the primary schools of their area. However they could not tell about the quality of the mid day- meal being provided.

3.3.6 People have developed a good habit of sending their children to anganwadi centres. Women are fully aware of the facilities available in the anganwadi centres and interested to avail the same. Since cooked food is being prepared in anganwadi centres, women take much interest in what is being prepared and served to their children.

3.3.7 CDPO office was unable to provide information regarding number of training sessions conducted and number of participants attended the training.

3.3.8 When asked about the difficulties faced in the implementation of the programme, CDPOs apprised the evaluation team that shortage of staff stands in the way of successful implementation of the programme. Besides the reluctance of beneficiaries to accept India mix (Satu), shortage of proper accommodation to run anganwadi centers, disruption in supply of Take Home Ration and irregular supply of funds for cooked foods are other hindrances for successful implementation of the programme.

3.3.9 They have suggested that all sanctioned posts should be filled-up. The Take Home Ration (Satu) may be replaced by seasonal foods / dried gram / biscuits. It must be ensured that the supply of Take Home Ration is not disturbed and funds for cooked food is available throughout the year.

3.3.10 Details of Medical Facilities Available and break up of malnourished children are at **Annexure-V.**

Chapter-4
Assessment by Anganwadi Workers

4.1 Introduction

4.1.1 Every child must get opportunities to develop his/her full potential. It is imperative that families, societies and the state make it possible for every child to get this opportunity for optimum development. Anganwadi workers are the key frontline workers who play a crucial role in promoting child growth and development.

4.1.2 The ICDS is mainly a preventive and development project to improve the health and nutritional status of children below 6 years of age and expectant/lactating mothers.

4.1.3. Of all ICDS functionaries anganwadi workers are very crucial as the major responsibility of programme implementation lies on their shoulders.

4.1.4 The evaluation team members interacted with anganwadi workers of selected anganwadi centres to have a firsthand assessment of their views regarding the implementation of the project.

4.1.5 Of all the anganwadi workers contacted around 61 percent of them were below graduates, 32 percent were graduates and 7 percent were post graduates and above.

4.1.6 Most of the anganwadi workers (56 percent) are in service for more than 10 years.

4.2 Work Profile

4.2.1 When asked about their prescribed work, they appraised that, survey work, pre-school education to children enrolled at the centre, immunization, providing supplementary nutrition to beneficiaries (Take Home Ration/ Cooked Food), growth monitoring, health check- ups, referral services and Nutrition and Health Education (NHED) are the services prescribed for them.

4.2.3 In addition to the above works mentioned sometimes they are required to perform other duties like census duty.

4.3 Selection of Centre

4.3.1 Regarding appropriateness of selection of anganwadi centres majority of them admitted that while opening anganwadi centres factors like total number of beneficiaries in the project area, malnutrition status and economic condition of the village were taken into consideration.

4.3.2 Almost all of them appraised that there is no need to change the procedure being followed to open anganwadi centres at present.

4.4 Location of health care delivery institutions

4.4.1 Around 53 percent of anganwadi workers confirmed about the presence of Sub-Centre/Primary Health Centre (PHC) in their villages and 40 percent of anganwadi workers appraised that the Sub-Centre/PHC is located within 5 kilometers radius and 7 percent said that the distance of the health care delivery institutions mentioned above is beyond 5 kilometers.

4.5 Facilities available

4.5.1 When asked about the time availability of medical care facility in Sub-Centres/PHCs 70 percent of them replied in affirmation.

4.5.2 A large majority of anganwadi workers (86 percent) expressed the view that the immunization facility available in Sub-Centres/PHCs is quite sufficient.

4.5.3 Regarding availability of medicine 85 percent of respondents considered that it is sufficient as per the requirement.

4.5.4 All the anganwadi workers confirmed that health check-ups facility, immunization facility and supply of medicine free of cost (available in Medicine Kit provided to the centre) is available in anganwadi centres.

4.5.5 All the pregnant women, lactating mothers, children below 6 years of age are enrolled in the anganwadi centre of the village.

4.5.6 The malnourished status of children is ascertained through the survey of the village which is done once in a year.

4.5.7 All the anganwadi workers admitted that the provision of supplementary nutrition, facility of health check-up is available for pregnant women/lactating mothers and for children below 6 years of age. Immunization facility is available for pregnant women and children below 6 years of age.

4.5.8 During health check-up sick/malnourished children in the need of urgent medical attention are referred to the PHC or sub-centres. Majority of anganwadi workers (62 percent) said referral service is available for children below six years of age. However it was revealed that when they are referred to the PHC, the response is not encouraging from PHC side. The referral service is not available for pregnant/lactating mothers said majority of anganwadi workers.

4.5.9 The non formal pre-school education is one of the important components of ICDS programme. All the respondents admitted that pre-school education is available for children of 3 to 6 years of age.

4.5.10 No Nutrition and Health Education (NHED) sessions were organized for women in the age group of 15 to 45 years of age.

4.6 NHED Session

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

4.6.2 Unfortunately no regular NHED session are being organized in anganwadi centres. 52 percent of respondents subscribed to this view. Those who agreed that NHED session

is organized admitted that it is just nominal. The study team could not find a single case where NHED session was organized at least once in two months.

4.7 Mothers' Committee

4.7.1 Mothers' Committee looks after cooked food aspects of supplementary nutrition. It is under its guidance and supervision that cooked food is prepared and distributed.

4.7.2 More than 97 percent anganwadi workers confirmed about the presence of mothers' committee which helps in finalizing day wise menu for cooked food, authorized the anganwadi worker to draw money from the bank for cooked food as per the requirement and oversee the quality of food being prepared.

4.7.3 Members of mothers' committee meet on periodic intervals as per the requirement. Separate register is being maintained for mothers' committee in anganwadi centres in which proceedings of meeting/resolution are recorded.

4.7.4 When asked about what was the exact date of last meeting of mothers' committee, almost all responded said that the last meeting was held at least six months back. No cooked food is being given to children due to shortage of funds for last six months or so (the period varies from project to project)

4.8 General

4.8.1 In more than 98 percent of anganwadi centres, anganwadi helpers are posted. And all the workers informed that they are quite cooperative and helpful.

4.9 Benefits of Nutrition programme

4.9.1 All the anganwadi workers agreed to the point that all the beneficiaries – pregnant/lactating mothers and children below 6 years of age have immensely benefited out of the programme. However disruption in the supplementary nutrition defeats the purpose of the programme for which it was created.

4.10 Supplementary Nutrition

4.10.1 All the anganwadi workers informed that generally nutrition food (Take Home Ration/Cooked Food) is provided to beneficiaries for 25 days in a month which has been discontinued for last 6 months.

4.10.2 To the question if they are satisfied with the supplementary nutrition feeding provided to beneficiaries, 51 percent of them appeared to be dissatisfied for various reasons.

410.3 They expressed the desire that supply of Take Home Ration should be continuous and there should be sufficient funds provision for cooked food to maintain its continuity throughout the year.

4.10.4 Majority of the anganwadi centres are having weighing machine, storage container. They do not have mothers and child protection card.

4.11 Infrastructure

4.11.1 More than 90 percent of anganwadi centres are functioning either in Primary Schools/Panchayat Bhawans/Community Halls or in rented premises. Majority of them appeared to be Pucca Houses.

4.12 Pre-School Education

4.12.1 Almost all the anganwadi workers informed that pre-school education is provided to children between 3 to 6 years of age for 20 to 25 days in a month.

4.12.2 The enrollment status of children in anganwadi centres varies from centre to centre depending on the availability of beneficiaries.

4.13 Others

4.13.1 Every month weight of children is taken in anganwadi centres and weight for age is determined. Those found malnourished status of the children is determined by taking their weight.

4.13.2 Economic condition of the village, lack of purchasing power of parents, awareness deficit is some of the reason for malnutrition of the children in the area.

4.13.4 Majority of the anganwadi workers informed that mothers have become cautious about the benefits of breast feeding and no special awareness campaign is needed for the purpose. Majority of the women of the area go for breast feeding.

4.13.5 No supplementary nutrition is provided to adolescent girls. It may be one of the reasons why they are not attracted to attend non formal education session organized for them.

4.13.6 Anganwadi workers could not provide concrete evidence of having organized session for adolescent girls. This section of ICDS programme appears to be neglected.

4.14 Miscellaneous

4.14.1 More than 71 percent of anganwadi workers expressed dissatisfaction over difficulties faced by them in the successful implementation of the programme.

4.14.2 Irregular supply of Take Home Ration, scanty provision of funds for cooked food, non availability of appropriate place for anganwadi centres, problem of AG audit are some of the difficulties which haunt them very much.

4.14.3 In their opinion regular supply of supplementary nutrition (Take Home Ration/Cooked Food), increase in amount of rent for hiring space for anganwadi centre, accelerated pace for constructing building for anganwadi centres by the department, periodic refresher training, close co-operation from health care delivery institutions can help a lot in the successful implementation of the programme in the long run.

Sr. supervisor of CERPA interacting with one of the anganwadi workers.

Investigator of CERPA interacting with one of the anganwadi workers.

Chapter-5
Observations and Major Findings

5.1 Observations

5.1.1 India's primary policy response to child malnutrition the Integrated Child Development Services (ICDS) programme is well conceived and well placed to address major causes of child under -nutrition in India. However, more attention has been given to increased coverage rather than improving the quality of service and to distributing food rather than changing family based feeding and caring behavior.

5.1.2 The programme adopts a multi sectoral approach to child well being incorporating health education and nutrition interventions and is implemented through a network of Anganwadi centers at community level. The programme provides eight key services including supplementary nutrition, immunizations, health check-ups and referrals, health and nutrition education to adult women, and pre-school education to children of 3 to 6 years old.

5.1.3 The ICDS scheme has grown tremendously over 36 years of its operation to cover almost all development blocks in India offering a wide range of health, nutrition and education services to children women and adolescent girls.

5.1.4 However, the scheme has faced substantial operational challenges. In adequate skill of Anganwadi workers, shortage of equipment, poor supervision and weak monitoring system stand in the way of successful implementation of the programme.

5.1.5 The two immediate causes of malnutrition - poor dietary intake and infection - are closely linked to three underlying determinants of nutritional status: household level access to food, health resources including clean water & sanitation and appropriateness of the child care and feeding behavior of mothers/caretakers.

5.1.6 Central to the ICDS objective of reducing the prevalence of malnutrition is two services, i.e. growth monitoring and supplementary food.

5.1.7 Growth monitoring activities are hampered by poor access to appropriate equipment, such as weighing machine and growth cards. Needless to say, regular weighing – growth monitoring is effective only if accompanied by communication for behavior change that results in improved growth of the malnourished child. This needs to be strengthened.

5.2 Supplementary Nutrition

5.2.1 Beneficiaries contacted expressed the view that they (Pregnant Women/Lactating Mothers, Children below 6 years of age) have immensely benefitted from the programme. However the India Mix (Take Home Ration) being supplied at present is not up to their liking and they have suggested for replacement of India Mix (Home Ration by seasonal fruits/biscuits etc).

5.2.2 The supplementary nutrition is one of the most important components of ICDS interventions. Food is financed and procured by the state and provided to beneficiaries at the Anganwadi centers either in form of Take Home Ration or Cooked Food.

5.2.3 It has been noticed that home ration is available only for six to eight months in a year on an average. In some cases the gap in supply is as big as one year four months. That apart, sometimes funds are not available for cooked food throughout the year.

5.2.4 Due to irregularity in supply of food to Anganwadi centers, the very purpose of the project is defeated. It is needless to point out that ICDS needs to improve the regularity of food supply. There are some centers where the irregularity of food supply is for years together.

5.2.5 However, despite irregularity of food supply, the food is an effective incentive to attract children to the centers where they can get other health and nutrition related services .Without the provision of food, attendance in Anganwadi centers would have been very poor.

5.3 Infrastructure

5.3.1 The provision of supplementary food and other ICDS services are sometimes performed under adverse environment. Very few Anganwadi Centres are functioning in its own building. Most of the centres are functioning either in primary schools/Panchayat Bhawans, Community Halls or in rented premises making it vulnerable for external disturbances.

5.3.2 At present the admissible rent in rural areas is Rs.200/- and for Urban areas Rs.700/-.

ICDS staffs are of the opinion that it is very difficult to find out rented accommodation with this amount. Low budget allocation for rent ends with the consequence that Anganwadi centers are frequently found in small and unclean locations.

5.3.3 Non availability of toilets facility and clean drinking water is another problem with Anganwadi centers.

5.4 Training

5.4.1 Undoubtedly the skills of the Anganwadi workers and their capacity to mobilize the community to support ICDS and recruit eligible children are central to quality service delivery and ICDS effectiveness. However, during the course of the study, it was revealed that they are not much aware of various components of ICDS scheme. More refresher training programme may be organized for them.

5.4.2 As per the provision funds for cooked food is transferred to the bank account of Anganwadi workers. Anganwadi workers are expected to submit vouchers against the expenditure incurred.

5.4.3 Anganwadi workers are required to maintain cash book for funds received for cooked food. But they are not much aware about accounting procedure, they need training.

5.5 Administration

5.5.1 It has also been noticed that the Treasury insists on Pucca / Original Bill/voucher without which it does not pass the bill. So no funds become available for Cooked food as a result of which the beneficiaries suffer. But in a remote place where one has to walk miles together to reach the Anganwadi Centre such Pucca/Printed bills may not be available. Due care may be taken to solve this problem.

5.5.2 In some places CDPO office is sandwiched between AG Audit and Treasury as both of them insist on original Bill/vouchers.

5.6 Selection of Centres

5.6.1 Earlier the criteria of opening Anganwadi centre were population of one thousand. This criterion has been revised and at present Anganwadi centre can be opened with a population of 300 to 500. And criteria for opening MINI Anganwadi centre are population of 150 to 300. The size of population has been reduced, not the targeted beneficiary per centre. In some cases, it becomes difficult to find out required number of beneficiaries per centre.

5.6.2 Most of the beneficiaries expressed the view that while deciding the location for opening the Anganwadi centres certain factor like total population (men,women,children), of the village, economic condition of the village, malnutrition status of the village were taken into account.

5.6.3 Majority of the Beneficiaries were not aware of procedure for opening the Anganwadi centres A large number of beneficiaries confirmed about the presence of primary schools in their respective villages in which enrolment status of students were quite good. Mid-day meals are provided in every school. However, they could not tell much about the quality of mid-day meal provided in these schools.

5.7 Human Resource

5.7.1 Shortage of manpower was clearly visible. In some cases one CDPO is in charge of two or more projects. One Supervisor is required to look after 50 to90 centres. This may be one of the reasons why supervisors do not know the exact location of the Anganwadi Centre as they do not have time to visit so many centres. The shortage of manpower stands in the way of successful implementation of the programme/project.

5.8 Timing

5.8.1 It was observed that the opening time of Anganwadi centres is at 8 A.M. and closing time is at 12 P.M.

5.9 Availability of Health Care Facilities

5.9.1 Most of the Beneficiaries appraised about the presence of Primary Health Centres (PHC) Sub. Centres within the village or within a radius of 2 kilometer. Normally they depend on these health care delivery institutions for day to day treatment. To the question of timely availability of medical care they responded in affirmation. However although immunization facility was up to the mark, but sufficient medicine was not available in this Health Care Delivery Institutions.

5.10 Anganwadi Workers

5.10.1 In the opinion of Beneficiaries the Anganwadi workers are qualified and discharge their duties with sincerity. However they could not tell about quality of training imparted to them. Anganwadi Helpers were found to be cooperative.

5.10.2 All the pregnant/lactating mothers and Children in the age group of 6 months to 6 years were also registered in the Anganwadi centres.

5.10.3 Although the Beneficiaries could not tell if the prescribed procedures were followed to open Anganwadi centres, one thing they confirmed that there was community involvement in the process of opening of Centres.

5.10.4 Almost all the beneficiaries were of the opinion that Anganwadi centres provide nutritional food to pregnant women/lactating mothers, and children below 6 years of age (in form of take home ration/cooked food).

5.11 Facilities Available in Anganwadi Centre

5.11.1 Health Check-up facility is also available for pregnant women/lactating mothers and for children below the age of 6 years. Immunization facility is available for all the categories of beneficiaries mentioned above.

5.11.2 However the referral services available only for children below 6 years of age. (Malnourished Children)

5.11.3 The beneficiaries confirmed that pre-school education session is being organized at Anganwadi centres for children within the age group of 3 to 6 years of age.

5.11.4 No provision of nutritional food for women aged between 18 to 45 years.

5.11.5 The observation of Nutrition Health Education Day (NHED) is almost non-existent.

5.11.6 Majority of the Beneficiaries admitted about the presence of Mothers' Committee in their respective Anganwadi Centres which is comprised of 6 numbers. However only a few could tell about roles & responsibilities of Mothers Committee.

5.11.7 The Beneficiaries expressed their ignorance regarding availability of Mother and Child Protection Card.

5.12 Malnutrition

5.12.1 When asked about reason for malnutrition of the children most of the beneficiaries replied that poor economic condition and lack of purchasing power are the main reasons for this problem. However almost all of them are taking available help from the Anganwadi Centres / Health Care delivery Institutions to overcome this problem.

5.12.2 Majority of the Adolescent Girls (68 percent) appraised that no such non-formal educational sessions have been organized for them. No nutritional food is being provided to Adolescent Girls through Anganwadi Centres at present. This may be one of the reasons why majority of adolescent girls who were aware of such sessions did not attend the same.

5.12.3 The Anganwadi workers could not produce proper records of educational sessions organized for Adolescent Girls.

Chapter-6
Recommendations

6.1 General

6.1.1 Integrated Child Development Service (ICDS) provides an integrated approach for converging all the basic services for improved child care ,early stimulation and learning, health and nutrition, water and environmental sanitation aimed at the young children , expectant and lactating mothers and adolescent girls in a community.

6.1.2 The first six years of a child's life are most crucial as the foundations for cognitive, social, emotional, physical, and psychological developments are laid down at this stage. To ensure that all young children even those from vulnerable sectors of society have access to the basic rights ICDS was launched in1975 to provide a package of services to ensure their holistic development.

6.1.3 ICDS may be understood as a programme for child protection and child development.

6.1.4 The ICDS scheme has expanded tremendously over its 35 years of operations to cover almost all development blocks in India and offers a wide range of health nutrition and education services to children, women and adolescent girls and beneficiaries have immensely benefited from it

6.1.5 However the program has faced substantial operational challenges but stood the test of time.

6.1.6 Though there are certain shortcomings in ICDS still further thrust of the programme is necessary for the uplifttment of underprivileged section of the population.

6.2 Supplementary Nutrition

6.2.1 Due to irregularity in supply of nutritional food to Anganwadi centres, the very purpose of the project is defeated. Food is an effective incentive to attract children to

Anganwadi centres. **It may be ensured that food is available for beneficiaries (both take home ration/cooked food) throughout the year.**

6.3 Infrastructure

6.3.1 Very few Anganwadi centres are functioning in its own building Most of the Centres are functioning either in Primary Schools, Panchayat Bhawans, and Community Halls or in rented premises making it vulnerable for external disturbances. **Steps may be taken to construct anganwadi centres in a phased manner.**

6.3.2 The rent for hiring accommodation for Anganwadi centres at present appears to be in lower side (Rs. 200/- for rural areas Rs.700/- for urban areas). Low budget allocation for rent ends with the consequence that Anganwadi centres are frequently found in small and unclean locations. **The rent structure may be revised**.

6.4 Administration

6.4.1 Since funds for cooked food is transferred to the Bank A/C of Anganwadi workers, they are expected to maintain cash book/accounts details and submit bill/vouchers against the expenditure. It has been observed that they do not know how to maintain accounts**. Some basic accounts training may be imparted to them.**

6.4.2 Treasury insists on original bill/voucher without which it does not pass the payment; so no funds available for cooked food as a result of which beneficiaries suffer. But there are some places where one has to walk miles together to reach the Anganwadi centre. And original/Printed bill/voucher may not be available in those places. **Steps may be taken to ensure that flow of funds is not disrupted due to this technical problem.**

6.4.3 Sometimes the CDPO office is sandwiched between AG Audit and Treasury as both of them insist for original/printed bill/voucher. Steps may be taken to solve the problem.

6.5 Criteria of Selection

6.5.1 Since the population criteria (size of population) for opening the Anganwadi centre is reduced over the period of time, the targeted beneficiary per centre may be reduced.

6.6 Mothers' Committee and NHED

6.6.1 Although Mother's committees are formed most of the beneficiaries are unaware about the functions of the Committee. **Some sort of awareness campaign is required.**

6.6.2 Observation of NHED (Nutrition Health Education Day) is almost non-existent. This is the right platform by which beneficiaries can be educated about what they are suppose to do and not to do with regards to health and hygiene. **Attention needs to be paid for regular NHED sessions in each and every Anganwadi Centre.**

6.6.3 In Anganwadi centres non-formal pre-school education for the moral, social, emotional, physical and mental development of children needs emphasis.

6.7 Services Available

6.7.1 It has been observed that referral service is available only for children below 6 years of age (malnourished children) which should be available for all other beneficiaries. **An effective system of referral from Anganwadi centres, for all categories of beneficiaries, should be developed through joint consultation with health and ICDS functionaries.**

6.7.2 Refresher Training courses and in-service training should be organized for Anganwadi Workers.

6.7.3 Anganwadi workers may be treated as valuable health care workers not a mere provider of childcare.

6.8 Monitoring & Supervision and Orientation

6.8.1 The system of supervision needs to be strengthened for improving the quality of ICDS service.

6.8.2 Supervisors should understand the job responsibility of field functionaries and should have the aptitude to guide, and motivate them for better job performance.

6.8.3 Refresher courses should be organized for CDPOs and Supervisors in regular intervals.

6.8.4 Required number of staff (CDPOs/Supervisors, /Anganwadi workers) may be appointed for the smooth implementation of the programme.

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Abbreviations

1. **ANM**:- Auxiliary Nurse and Midwife
2. **AWW**:- Anganwadi Workers
3. **BCC**:- Behavior Change Communication
4. **CDPO**:- Child Development Project Officer
5. **CERPA**:- Centre for Research, Planning & Action
6. **CHC**:- Community Health Centre
7. **DPO**:- District Programme Officer
8. **ICDS**:- Integrated Child Development Services
9. **NHED**:- Nutrition and Health Education
10. **PHC**:- Primary Health Centre
11. **SSA**:- Sarva Shiksha Abhiyaan

Annexure –IV

District wise break- up of mal - nourished children and lactating mothers

Sl. No.	District	No. of mal-nourished children	No. of lactating mothers
1	Haridwar	2426	16956
2	Pauri Garhwal	752	4382
3	Almora	42	Not available

District wise break- up of status of immunization

Sl. No.	District	category	Year 2008-2009	Year 2009-2010	Year 2010-2011
1	Haridwar	Children	7606	6404	4702
		Pregnant women	14114	11248	8540
		Lactating mothers	-	-	-
2	Pauri Garhwal	Children	-	4797	3893
		Pregnant women	-	1031	948
		Lactating mothers	-	-	-
3	Almora	Children	-	-	7194
		Pregnant women	-	-	2188
		Lactating mothers	-	-	-

District wise break- up of beneficiaries by availing health services

Sr. no.	District	Category	Year 2008-2009	Year 2009-2010	Year 2010-2011
1	Haridwar	Health check-up of children below 6 years of age	-	-	2001
		Health check-up of pregnant women	-	-	1687
		Referral of mal-nourished children	-	-	24
		Referral of pregnant women	-	-	-
		Referral of lactating mothers	-	-	-
2	Pauri Garhwal	Health check-up of children below 6 years of age	-	6294	4336
		Health check-up of pregnant women	-	1243	1031
		Referral of mal-nourished children	-	01	36
		Referral of pregnant women	-	-	-
		Referral of lactating mothers	-	-	-
3	Almora	Health check-up of children below 6 years of age	54323	48457	42060
		Health check-up of pregnant women	14586	11560	9562
		Referral of mal-nourished children	376	501	470
		Referral of pregnant women	281	406	544
		Referral of lactating mothers	132	128	157

Annexure-V

Medical facilities available

Name of district	Name of the project	PHC	CHC	Sub-Centres
Haridwar	Bahadrabad	05	01	25
Pauri Garhwal	Duggadda	02	01	18
Almora	Tadi Khet	01	nil	20

Project wise breakup of mal nourished children;

Sl. No.	Project/District	Category	Year 2008-2009	Year 2009-2010	Year 2010-2011
1	Bahadrabad/(Haridwar)	Children	222	513	616
2	Duggadda(Pauri Garhwal)	Children	*	*	76
3	Tadikhet (Almora)	Children	4	14	8

* Information not available with CDPO office.