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Original Article:

Evaluation of functioning of ICDS project areas under Indore and Ujjain divisions of the state of Madhya Pradesh

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Abstract:
Background: Integrated Child Development Services (ICDS) is recognized worldwide as one of the most efficient community based programmes promoting early childhood care. Regular evaluations of the programme have been conducted to make it more effective and adequate for the beneficiaries. **Objectives:** To evaluate the functioning of the Anganwadi Centers under different project areas of Indore and Ujjain Divisions. **Methods:** Under the present evaluation system one ICDS project and five Anganwadi Centers under the project area (AWCs) were visited on a monthly basis and services provided reviewed. Findings reported are from nine project areas under Indore and Ujjain Divisions in the state of Madhya Pradesh from October 2008 – June 2009. **Results:** A total of 45 centers were evaluated. 29 centers were operating from rented buildings and storage facilities were lacking at 19 of the centers. Though the quality of food was acceptable to the beneficiaries shortage of food was a problem at the centers. Absence of Pre-School Education (PSE) and Nutrition and Health Education (NHED) Kits compromised PSE and NHED activities at the centers. Unavailability of medicine kits, lack of regular visits by the ANMs to the centers and absence of routine health check up of beneficiaries were other problems encountered under the project areas surveyed. Availability of a doctor under each project area was stated as a major need by the workers. **Conclusion:** Coordinated steps catering to different services provided at the centers are needed to optimize the functioning of the ICDS scheme.

Key Words: Anganwadi Centers, Anganwadi Workers, Integrated Child Development Scheme

Introduction:

Children are the first call on agenda of human resources development not because young children are the most vulnerable, but because the foundation for life long learning and human development is laid in the crucial early years of life. The view has been envisaged by the Government of India which in August 1974 proclaimed a national policy for children and declared children as "supremely important assets".[1]

This led to the birth of the Integrated Child Development Services (ICDS) in 1975, which is no doubt recognized as the world's largest early child health programme: which approaches child health holistically and comprises health, nutrition and education component for pregnant women, lactating mother and children less than 6 years of age.[2]The ICDS programme functions through a network of Anganwadis Centers (AWCs) which are the focal points for the delivery of services attached to the scheme and are managed by the Anganwadi Workers (AWWs). As on 30th September 2007, 6284 ICDS project areas have been sanctioned in the country out of which 5929 with 9.3 lakh AWCs are operational.[3] The scheme has been subjected to a number of evaluation and appraisals since its inception in order to optimize the services delivered. The findings here are a part of a present appraisal of the project areas, being conducted by the National Institute of Public Cooperation and Child Development (NIPCCD) across the country in order to evaluate the quality of services provided at AWCs, identify the gaps and thereby suggest appropriate rectifications.

Materials and Methods:

The evaluation of ICDS project areas has been subjected to numbers of changes since its inception. Till 1992, the social components of the scheme were being monitored by NIPCCD and the health component through a Central Technical Committee at the All India Institute of Medical Sciences (AIIMS). Since 1999 the Monitoring and Evaluation Unit in the Department of Women and Child Development (DWCD) serves as the nodal agency and receives monthly and annual reports from the state DWCDs. To make the monitoring of the scheme more effective a Central Monitoring Unit (CMU) has presently been set up at NIPCCD in addition to the existing system.[4] Results reported here are from the evaluation of the ICDS project areas from Indore and Ujjain Divisions in the state of Madhya Pradesh over a period of nine months from October 2008- June 2009. Under one ICDS project five AWCs were visited on a monthly basis. Stratified sampling was employed to select the ICDS project areas and the AWCs under them. The ICDS project areas surveyed include: Mhow urban (Indore district), Indore urban (Indore district), Jhabua Rural (Jhabua district), Khandwa Rural (Khandwa district), Ujjain Urban (Ujjain district) and Dewas Urban (Dewas district), Dewas rural (Dewas district), Ratlam urban (Ratlam district) and Sailana (Ratlam district). (Table 1) (Figure 1)

Figure 1: Map showing Districts in which Project areas were surveyed

Table 1: ICDS project areas evaluated till date:	
Project area visited	**Operational for**
Mhow urban (Indore district)	2 years 4 months
Indore urban (Indore district)	11 years
Jhabua rural (Jhabua district)	20 years
Khandwa rural (Khandwa district)	12 years
Ujjain urban (Ujjain district)	20 years
Dewas urban (Dewas district)	2 years
Dewas rural (Dewas district)	13 years
Ratlam urban (Ratlam district)	13 years
Sailiana (Ratlam district)	20 years

Pre designed questionnaires developed by NIPCCD were utilized for the survey. The AWCs visited have been evaluated pertaining to the qualification and training status of the AWWs, infrastructure at the AWCs and the services provided at the centers namely:

1. Supplementary nutrition
2. Growth Monitoring
3. Pre- school education
4. Nutrition and health education
5. Health check-up and immunization
6. Community support
7. Services to Adolescent girls.

Results:

The results pertain to the nine ICDS project areas and the forty five AWCs visited till date

Educational Qualification and Training Status of Anganwadi Workers:

The educational qualification of the workers was as follows: illiterate 1, primary school 3, secondary school 6, higher secondary 23 and graduates 12 (Table 2).

Table 2: Educational Qualifications of AWWs in the ICDS projects surveyed					
Project area	**Illiterate**	**Primary School**	**Secondary school**	**Higher secondary**	**Graduate**
Mhow urban	----	----	----	2	3
Indore urban	----	----	----	4	1
Jhabua rural	1	----	1	2	1
Khandwa rural	----	1	1	1	2
Ujjain urban	----	----	----	2	3
Dewas urban	----	----	----	4	1
Dewas rural	----	1	3	1	----
Ratlam urban	----	----	----	4	1
Sailana	----	1	1	3	----

Eighteen workers were employed under the ICDS scheme for the last 1-5 years, 13 for 6-10 years and the remaining 14 for more than 10 years (Table 3).

Table 3: Employment duration of AWWs in the ICDS projects surveyed				
Project area visited	**< 1 year**	**1-5 years**	**6-10 years**	**> 10 years**
Mhow urban	----	5	----	----
Indore urban	----	----	5	----
Jhabua rural	----	2	1	2
Khandwa rural	----	2	1	2
Ujjain urban	----	----	----	5
Dewas urban	----	5	----	----
Dewas rural	----	----	2	3
Ratlam urban	----	2	2	1
Sailana	----	2	2	1

The training provided to the AWW consists of a 7 day induction training course and a detailed 30 day job training course with periodical refresher training courses. The Induction training is provided to the AWCs as soon as possible following their appointments and provides the workers with a brief overview of the functioning of the ICDS scheme. The detailed job training course is to be provided within a year of their appointments. All the workers interviewed had received induction training while job training had been received by 36 workers. 28 AWWs had undergone at least one refresher training course since being employed. Though Mhow (urban) and Dewas (urban) had been operational for around two years, regular training was deficient in the two project areas, 3 workers at Mhow (urban) and 1 at Dewas (urban) had undergone job training and none had received refresher training. Similarly though the Ratlam (urban) project area had been operational for 12 years only one AWW had received Refresher training. (Table 4)

Table 4: Training status of AWWs in the ICDS projects surveyed			
Project area visited	**Induction**	**Job**	**Refresher**
Mhow urban	5	3	----
Indore urban	5	5	5
Jhabua rural	5	4	3
Khandwa rural	5	5	5
Ujjain urban	5	5	5
Dewas urban	5	1	----
Dewas rural	5	4	5
Ratlam urban	5	4	1
Sailana	5	5	4

Physical Infrastructure at the Anganwadi Centers:

All but 2 AWCs (one in Ratlam (urban) and Sailana each) operated from pucca or semi-pucca buildings, 29 of the buildings were rented (all the centers under Mhow, Ujjain, Dewas (urban) and Ratlam (urban) project areas). There was an apparent shortage of space at 19 of the centers, separate room for cooking was unavailable at 19 centers, toilet facilities were absent at 13 centers. Drinking water facilities were available at all the centers.

Services provided at the Anganwadi Centers:

Supplementary Nutrition (SN):

Under the present system operational under ICDS SN provided to the beneficiaries is in two forms. The food is either prepared at the center itself or distributed through a central distribution system on a daily basis. This is referred to as "Hot Cooked Food". Pre-prepared food is also provided to the beneficiaries. This food is provided to the centers on a monthly basis and subsequently distributed to the beneficiaries, referred to as the "Ready to Eat Food (RTE)". Four of the project areas visited with the exception of Jhabua (rural) and Ujjain (urban) provided both types of SN while the two centers provided only Hot Cooked Food to the beneficiaries. The Hot Cooked food was currently being provided to the centers through the Central Distribution System.

Food was provided according to a fixed weekly menu at the centers and standard measures for distributing SN were available at 40 of the centers. Though rates of SN under the scheme for the beneficiaries have been revised under the 11th Five year plan at none of the project areas SN was being provided as per the new rates [5]. Problems encountered were an inadequacy of utensils at 11 centers and a shortage of SN to all the enrolled beneficiaries in almost all the centers. Hot Cooked Food through the Central Distribution System was being provided for a fixed number of beneficiaries, thus creating a problem of adequate food distribution amongst them.

Growth Monitoring, Health check up and Immunization:

Except for one center in the Dewas (rural) project area Salter's scale was available at all the centers and children were weighed on a periodical basis, as per guidelines the weight has to be monitored once a month. Regular counseling sessions with mothers focusing on Child Growth and Nutrition and adolescent girls focusing on personal hygiene and reproductive and physical well being were conducted at all the centers. Though Mother to Child Protection (MCP) Cards were available at the centers visited, yet the plotting of growth curves on the cards was inadequate at almost all the centers.

Routine health check ups are provided to the child beneficiaries at the centers by visiting Auxiliary Nurse Midwives (ANMs). The ANM visits the centers on a fixed day every week. At only one of the project area (Jhabua rural) was routine health check up being conducted. Routine immunization is performed at the centers by the visiting ANM but the facilities were compromised at Dewas (urban and rural project areas) and Ratlam (urban) project areas where immunization was performed at the nearest Health Care Facility area due to lack of regular visits by the ANMs. Immunization records were incomplete and ill maintained at 13 of the centers.

There was a severe shortage of medicine kits across the centers. The only medicines presently available at the AWCs were Iron and Folic Acid tablets at 32 centers and Deworming tablets at 25 centers. The centers received medicine kits on an irregular basis and the kits were very near their expiry dates. Referral slips were present at 10 centers, which created problems while referring patients to health care settings.

Other services:

There was shortage of Pre-School Education (PSE) kits at 28 centers This compromised the PSE activities at the centers with all child beneficiaries not participating in PSE activities. Nutrition and Health Education (NHED) kits were available at 34 centers.

Local Self Help groups (SHGs) were functional at 19 centers and regular coordination meetings with ANM and Village Health Committees (VHCs) were conducted at 11 centers.

Discussion:

The study findings reflect a gap in the training needs of the AWWs, though all the workers had received induction training, job and refresher trainings were specifically lacking. An evaluation of the scheme by the National Council of Applied Economic Research (NCAER) in 60,000 AWCs during 1996-2001 reported that though 84% of the functionaries had received training; it was largely pre-service in nature and in-service training remained largely neglected.[6] Regular refresher training courses are extremely essential as they keep the AWWs abreast with the recent trends and changes in their field. The UDISHA training

programme addressed the issue to a great deal[7] and the ICDS IV project too tries to effectively meet the training needs of the ICDS functionaries.[8] Evolving a package of coordinated and joint training program for various health functionaries with provision of practical field oriented training is needed.

The AWCs visited had problems of inadequate space, lack of cooking facilities, toilets and majority of them operated from rented buildings. At just one project area (Jhabua) AWCs operated from Panchayati Raj Institution (PRI) bhawans and all of them had adequate cooking and storage facilities. AWCs should operate from Government buildings, housing AWCs in PRI bhawans, Sub centers and Primary Schools in the localities are viable options, if centers are to be rented guidelines should be formulated for the type of buildings to be rented. AWCs serve as centers for health education for the community and lack of basic provisions like toilet facilities results in loss of effective service delivery making people unreceptive to the health measures imparted at the center.

Cooking was not presently being performed at any of the centers as SN was being provided to them. This practice of SN changes frequently under the scheme and often the food is prepared at the center itself. Most AWCs operated from single rooms and cooking is performed in the room itself which is hazardous to the children. Moreover storage of RTE is also done in the center which leads to overcrowding with less space for other Anganwadi activities. Beneficiaries at all the project areas used to receive SNP in the form of Hot Cooked Food; RTE was available at seven project areas. The Hot Cooked Food at the centers was provided for a fixed number of beneficiaries which ultimately resulted in inadequate distribution of SNP among the beneficiaries. Under the scheme provision should be made to provide SNP to all the enrolled beneficiaries at every center. Whatever the type of SNP provided, it should be acceptable to all the beneficiaries. During the survey there were instances of beneficiaries not liking a particular recipe, formulating SN recipes after consultation with beneficiaries or local community leaders can be initiated. A fixed weekly menu for Hot Cooked Food was followed in all the project areas, frequent changes or alteration in the recipes will improve the response rates among the beneficiaries. The AWWs raised concern pertaining to the quality of RTE being provided, this is a major issue and adequate quality maintenance should be done by regular monitoring of the food production and processing sites. Provision of SNP according to the revised rates and provision of logistics for SNP is also desirable.

Growth monitoring, routine health check-ups and immunization comprise an important function of the ICDS scheme. Though the weight of the children was being recorded on a regular basis, the plotting of growth curve on MCP cards was inadequate. At most of the centers the AWWs were not conversant with the plotting of growth curves. An assessment of the scheme stated that growth charts were maintained in only 51% of the AWCs and though all the AWWs had received the necessary training only 32.2 % workers were competent to correctly plot and interpret the growth charts.[9] Growth curves provide the earliest indication of growth failure, hence AWWs must be adequately trained to plot growth curves and they can specifically be monitored on this by the supervisors and the CDPOs of the project areas. It is also imperative to introduce the new WHO Growth standards in the ICDS scheme as early as possible which will help in a more effective monitoring of growth pattern and can be used to compare data on national and international levels. Routine health check-up of enrolled beneficiaries and, immunization services were inadequate in the surveyed AWCs. In a review of AWCs, by NCAER in 2004 it was observed that only 64% of the centers provided health check-up for children and 53% check-up for women.[10] In addition there was also shortage of medicine kits and referral slips at the centers. ANMs are required to visit the AWCs once every week to provide for routine immunization services and health check-up for beneficiaries. Monthly health check-up for all the beneficiaries was being practiced in just one project area while in other health check-up was either provided to sick children or none at all. Routine immunization was hampered because of infrequent visit of ANMs to the centers. ANMs are over burdened with different jobs so appointing ANMs or other health workers specifically catering to ICDS can be taken up, similarly attaching a qualified doctor to a group of project areas with provision of in-house medical facilities at the center may be initiated. Regular supply of essential medicines and referral slips will also improve the functioning of the scheme.

Under the scheme two adolescent girls are enrolled for six months and are provided with SNP during the time period, they are replaced by two other after the stipulated time period. The number of girls enrolled under the scheme at one time should be increased, also the overall involvement of beneficiary women and adolescent girls in AWCs has been reported to be low.[6] These two sections of the population are central to tackling the problem of underweight and malnutrition in the country. Hence it is essential to optimize their involvement in the scheme, formation of social networking groups and providing a comprehensive package of health services to the women and adolescent girls is required. The AWCs can serve as effective outpost to implement ARSH strategies (Adolescent and Reproductive Sexual Health) for out of school adolescent girls. Involvement of father/parents in the counseling session at the center can provide better result in the health aspects of the children.

There was a shortage of PSE kits and NHED kits at the AWCs, which adversely impacted the PSE and NHED services. PSE activities have not been given much importance under the scheme as only 19% of Anganwadi worker training hours have been set aside for Pre School Education activities.[11] Studies have reported poor skills development of Anganwadi children as against the private nursery school children, which could be attributed to poor stimulating environment including lack of play materials, hence there is need to improve the pre school environment of the Anganwadis.[12,13] PSE activities need to be streamlined at the AWCs and performance appraisals of the children attending AWCs should be undertaken at regular interval to check on the quality of services provided.

Self health groups were operational at 19 centers, it is essential that community participation in the scheme be optimized. Self health groups can function as independent monitoring bodies for the scheme and provide valuable input for effective delivery of services.

Conclusions:

Though the findings are restricted to a few ICDS project areas and AWCs, they help in providing some insight into the existing situation. A holistic approach is needed to optimize the functioning of the scheme, identifying various issues concerning the scheme as a whole will help in reworking the policies related to women and child development. Still it is important that appropriate measures to strengthen the services provided under the scheme be taken with immediate effect so that the scheme realizes its full potential.

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