Mid Term Assessment of ICDS Program

My first School: My Anganwari Center

I play, eat, learn and get my Immunization

Rajasthan (2009-10)

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I. Introduction

The Government of India through its Department of Women and Child Development (DWCD) within the Ministry of Human Resource Development (MoHRD) is implementing one of the most critical programs to break the inter-generational cycle of malnutrition to reduce malnutrition among children and infant mortality through specific interventions. Rajasthan, Uttar Pradesh, Bihar, and Madhya Pradesh are the focus of a major effort of Integrated Child Development Services program comprising of –

i) supplementary nutrition,

ii) pre-school service,

iii) dissemination of health and nutrition awareness,

iv) health check-up,

v) immunization, and

vi) Referral services. Whilst services (i) to (iii) are key tasks of ICDS functionaries, services (iv) to (vi) are to be provided jointly through a coordinated effort of Health Department and ICDS.

ICDS program has the widest network to reach poor people and people living in harsh conditions in order to address their health and nutritional needs through AWC. The program is continuing since 1975. The challenges for effective implementation of the program in the state are many like geographically difficult terrain and environmental conditions like poor rain fall and repeated famines which gets further complicated with regional socio – cultural variations and poor literacy among rural poor women.

Government attempt to reduce poverty through different programs like Antodaya, JRY, DWARCA, and NEREGA are being implemented time to time could not result in addressing the poverty and in improving quality of life. People in rural areas and in urban slums are continuing living their lives below poverty line. Regardless of the above mentioned efforts or other efforts like public distribution system, distribution of green card and declaring right of food for everyone poverty and malnutrition is the continuing, and this remains the reality of our nation and state. ICDS is the specific designed intervention to provide supplementary nutrition every day to all enrolled children at Anganwari centers and increasing the availability of health services to break the inter-generational malnutrition cycle and reducing the IMR and MMR in the state and nation. Objectives of the program can be met by active community participation in the process of implementing the program that can only be achieved by taking them along and also through coordinated efforts

with ANM and Asha Sahyogini: without that it is not possible to make this program effective.

New strategic interventions have been planned in XIth five year plan (2007-2012) (Chapter 27.1: Empowerment of Women & Development of Child including the Food Security Support). These strategies are directing towards the inter department co-ordination, so Women and child development and Medical and Health Department need to function closely to meet the objectives of the project. To improve the co-ordination: Rajasthan state took the decision to entrust the responsibility of ASHA to the sahyogini and a detailed program was chalked out to enhance the coordination through mother and child health and nutrition day.

The attempt has been made to bring focus on life cycle approach by involving adolescent girls through Kishori Shakti Yozana and Suraj Yojana for pregnant and lactating women in ten urban project areas[1] i.e. in 1700 AWC. It was also recommended that children should be categorized only under two categories i.e. Malnourished and severely malnourished rather dividing them into four grades to simplify the operational procedures. In five districts data would be recorded as per revised category i.e. Tonk, Rajsamand, Dholpur, Baran and Jodhpur.

Following the decision of Government of India in the year 2005-06 the coverage of ICDS program has rapidly increased. The expansion has been planned in three phases in the state.

Phase	Child Development projects	AWC	Mini AWC
Ist	17	11041	
IInd	4 (New)	510	2681
IIIrd	26	6543	3523

In the year 2008-09 it is estimated that on average 100 / AWC would be the beneficiary. In order to understand the working of these programmes, a rapid assessment was undertaken in the state of Rajasthan.

II. Objectives of the study:

[1] *Udaipur, Bharatpur, Bikaner, Ajmer, Shrigangaagar, Bhilwara, Alwar, Kota, Jodhpur and Jaipur*

- To assess the reach and execution of Anganwadi functions in the state of Rajasthan
- To identify the gaps, problems in the way towards effective implementation.
- To recommend the strategies for improving the systems and functioning of AWC.

III. Selection of Area

State of Rajasthan has five administrative zones viz. – Bharatpur, Kota, Jaipur, Udaipur and Bikaner. To take the holistic picture and to assess the impact of the innovative strategies on the targeted population living in harsh and poor socio-economic conditions, it would be important to select one district from each zone i.e. five districts, showing higher SC / ST population

S. No	Regions or administrative zone	Name of the district	Name of the Block	
1.	Kota	Baran	Kishgarh	ST dominated (Sahariya), Rural
			Shahbad	
2.	Jaipur	Churu	Taranagar	Rural
			Sujangarh	
3.	Bikaner	Jaisalmer	Jaislamer	Rural and desert area
			Sam	
4.	Bharatpur	Karauli	Todaobhim	Rural
			Nandoti	
5.	Udaipur	Sirohi	Pindwara	ST
			Sirohi	

IV. Methodology

Assessment conducted in all the five administrative zones of Rajasthan to elicit the holistic picture. To create an in-depth understanding the following methods has been be used at different levels –

1. Observation.
2. Interviews of AWW, Anganwari helper, Asha Sahyogini and Lady Supervisor.
3. Discussion with beneficiaries (pregnant and lactating mothers).
4. Data recording and analysis.

Since the program is being implemented at the AWCs and lady supervisors are supporting at the cluster level and administrative units are located at the block and district level.

Data collection instruments

The following data collection instruments were used –

- **Village level information:**
  To gather the social category wise population, no. of children in the village, and health education and transportation facilities.

- **Observation Schedule:**
  This schedule was prepared to gather the information about the activities on the day of observation and to observe the processes of implementation of activities at the AWC.

- **About the AWC**:
  This was about Physical infrastructure, space, cleanliness, availability of Resource material etc.

- **AWW interview schedule:**
  To understand her perception, challenges and process of implementing important activities at the AWC. In this schedule the attempt has been made to understand her knowledge and her participation in trainings and collaborative efforts to accomplish important tasks.

- **Asha Sahyogini's interview schedule:**
  Sahyogini is also performing the role of Asha. As Sahyogini she has to collect the children and support in house hold contact and also in addressing the children 0-3 yrs of age. As Asha is supporting in immunization and care of pregnant women and supporting during delivery and promoting institutional delivery. Therefore her role becomes crucial and both AWW and Asha Sahyogini have to work in hand to hand. Interview schedule was prepared to understand their knowledge as well as her role in AW functioning.

- **Beneficiary schedule:**
  The schedule as prepared to understand the how the beneficiaries are enrolled in various activities of AWC. How they look at AWC and its functioning.

- **Lady Supervisor interview schedule:**
  To understand effectively of monitoring system and how and to what extent L.S is providing support to the AWW and constrains of Lady Supervisor.

In addition to this records were studied and entries checked for attendance, stocks, weighing events, immunization, mother and child health and nutrition days, and other activities carried out at AWCs.

Sampling

Sample districts:
Five districts and 10 blocks have been selected for the study: In each district 10 AWC were selected out of these 8 have been selected from the rural areas, 2 will be from urban areas. In each AWC beneficiaries pregnant and lactating mothers have been interviewed.

Overview of sample districts

Name of the district	Population	SC/ ST population	No. Of CDPO	Proposed AWC	No. Of AWC functional	AWW working	Proposed no. of LS	No. of LS deployed
Sirohi				790	755	729	34	23
Churu				1547	1445	1413		
Jaisalmer				655	484	484	23	8
Karauli				1194	1114	1081	48	34
Baran				1361	1179	1158	56	30

In the selected blocks of the 5 districts 50 AWC were visited, and 50 AWW were interviewed, at 9 places the Asha sahyogini has not been selected so far and in that situation 31 Asha sahyoginis and 8 Lady Supervisors were interviewed. The beneficiaries interviewed are 45 in numbers. The total covered population covered in this study was 58,105 across the 5 districts.

The district and block wise segregation of the key informants has been indicated in the table below.

S.No.	Name of the district	Name of the blocks	No. of AWCs	No. of AWWs	No. of Sayogini	No. of Beneficaries
1	Baran	Kisangani	5	5	4	5
		Shaba	5	5	2	5
2	Churu	Tara nagger	6	6	6	6
		Sujangarh	4	4	2	3
3	Sirohi	Pin Wada	4	4	1	4
		Sirohi	6	6	3	4
4	Jaisalmer	Jaisalmer	6	6	3	4
		Sum	4	4	2	4
5	Karauli	Nandoti	5	5	4	5
		Todabhim	5	5	4	5
Total			**50**	**50**	**31**	**45**

About the area

All villages covered in this study have the school facilities. In some villages private schools are also running. 78% villages have some or other health facility.

Most of the villages are well connected to the road few villages were 4-6 kms away from the main road. 4% villages does not have the transportation facilities, the villagers have to come on foot 4-6 kms to access the transport facility.

V. Analysis

Anganwari Centers (AWC)

The purpose of AWCs

The AWCs are being run by the AWW. The activities of the AWCs are focused on breaking the cycle of malnutrition and reducing IMR. Hence Anganwadies serve four groups: (a) pregnant women and nursing mothers (b) Infants (c) pre-school children and (d) adolescent girls.

Socialization of children begins here at the AWC when children of young age group start sharing the toys and food with other children belong to different communities. AWCs also act as distribution point for supplementary nutrition and essential micronutrients to registered beneficiaries in designated clusters.

Essentially, all the critical nutritional and health programmes converge at community level to be managed at AWCs through a coordinated effort of Anganwari worker, Asha sahyogani and Sub centre functionary i.e. ANM. It is their joint responsibility to create awareness about healthcare, sanitation, hygiene, childcare, and to provide the first point of contact to a villager. Mother Child Health and Nutrition (MCHN) days have been instrumental in collaboration efforts of nutrition and Health services.

The RCH programme of Health Ministry seeks to prepare village, block, district and state level participatory health plan through Community Needs Assessment tools. The AWC and Sub-centers are the bedrock for the entire planning exercise.

Physical Infrastructure

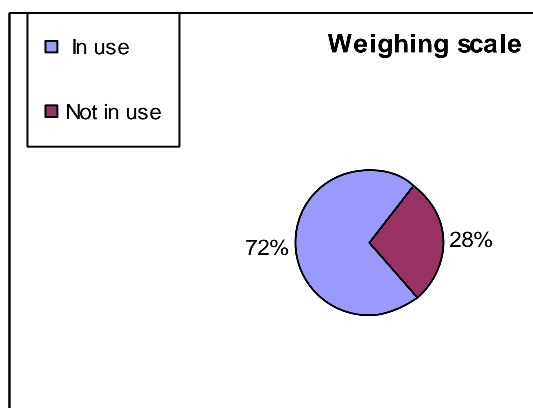
Improving physical infrastructure and construction of government buildings of AWC's was one of the tasks of XIth five year plans. It has been assumed that this would provide the conducive environment for effective functioning of AWC. In the present study 40 rural and 10 urban AWC were visited and out of those 30 in rural and 6 in urban area are running in the Govt. buildings and 14 (28%) AWC's are functioning in rented building. Out of these rented 28% AWCs 20% have appropriate & sufficient space for children to sit and function. 8% does not have the sufficient space to function. Few AWCs are still under construction which would complete very soon.

Cleanliness

On observation 17 out of 50 Anganwari centers demonstrated the cleanliness at satisfactory level. Tools, toys and charts were displayed properly and these were well arranged. Anganwari worker and helper were supporting and encouraging children to keep their toys and utensils at proper place. While in 50% anganwari centers the cleanliness was okay. These centers were swiped but outside area was not clean and the toys and other items were not kept properly. 16% AWC needs immediate attention to make their environment clean so the children get their food in clean utensils. In some places the main room was clean but toilets were left unattended and were very dirty.

Resources Material

The resource material for undertaking various activities at the AWC are: Weighing scales for children and for adult, toys, charts, medicine Kit and utensils for cooking and eating the food. To understand the functioning of the AWCs availability, present condition and utilization of the resource material was recorded.



Weighing scale for children is one of the basic tools to assess the nutritional status and monitoring growth of children. It was found that out of 50 AWC 41 have the proper weighing scale while at 9 AWC either don't have or they are not of order.

Only 72% (36) AWW are using the scale for monitoring the growth of children. In districts Karauli, Jaisalmer and churu in 7, 3 and 4 out of 10AWCs respectively weighing scale is not being used.

Adult weighing scale is being used to monitor the weight gain of the pregnant woman. In 42 AWC's adult weighing scale is available and functional. In two districts in Karauli and Jaisalmer adult weighing machine in 6 and 2 AWC's respectively is not functioning.

Charts: Charts are being used to **raise** awareness about health and nutrition issues among women and adolescent girls. Some of the charts are related to the preschool education like poster of alphabet or story telling. Charts are visual medium for showing and discussing the issues with and women and adolescent girls. The average number of charts available in rural and urban anganwari centers is 5 to8. In urban Anganwari centers it varied from 2-5 charts while in rural centers these were 4-8 in number. The picture given shows the charts related to different activities of AWC like educating pregnant women, teaching alphabets to the children, different body parts, story of tortoise etc. 78% of Anganwadi workers said that they are using these charts while doing preschool activities with children while display of posters does not indicate so indicates as these are placed too high or not properly categorized nor properly displayed. To

work effectively among the community and the target audience AWW need to use different mediums like flip books and small story, poem booklets and audio vedio films etc.

Toys

From the pictures taken it seems that cloured toys are the main attraction in the Anganwari center for children. Children from 2-6yrs of age would need two types of toys one which helps the children in bringing coordination among movements and balancing exercises and other toys are which are to promote pre-school learning. In 74% anganwari centers have sufficient number of toys coordinating muscular activities and anganwari workers were using them but other material to use the hands like colored pencils or other games are not there. 26% do not have toys in adequate number and same number of anganwari workers was not using the toys.

No other locally made toys were available as local resource material. This also shows lack of participation of community people that AWWs could not attract people towards its concern.

Anganwari Worker

Anganwadi Worker

Anganwari worker is the key functionary of the AWC. Anganwari worker is selected from the village itself to ensure the direct contact with the community and for ensuring regularity of the functioning of Agnawari centre. Anganwari worker is supposed to work with 0-6ys old children and the pregnant and lactating mothers and also with the adolescent girls. AWW keep the record of the no. of children 0-3, 3-6yrs of age and also register the pregnant and lactating mothers. AWC is the central place where supplementary nutrition is given to the children to prevent malnutrition in children and also to pregnant women & lactating women and adolescent girls..

Early and proper treatment to the sick child is central in preventing malnutrition. With this understanding AWW is supposed to co-ordinate with the health department functionaries ANM to accomplish immunization to children and pregnant women to supporting in early diagnosis and refer the child if needed to ensure early recovery from illness. It is expected that AWW and ANM would educate the parents regarding adopting practices which can help them in prevention from seasonal diseases.

Nutritional counseling is required for adopting proper feeding practices for the child. Many a times it is required to ensure the sufficient food intake by the pregnant women and also about the consumption of micro nutrients.

AWW execute pre school education activities with the objective that this would help the children to get enrolled in school and also to develop habits like washing hands before eating food.All these activities AWW accomplish with the support of Anganwari Helper and Sahyogini.

AWW's is entrusted to maintain records. She has to fulfill the registers and this takes substantial time. The main concern of AWW is to ensure that children, adolescent girls and women get proper SN, and information related to nutrition in order to break the cycle of malnutrition. She is supposed to co-ordinate with Asha and ANM. She is supposed to attend the Gram panchayt and gram Sabha meetings. At present she is also given the responsibility to make the self Help Groups of women. She also conducts and attends the self help group meetings every month.

However majority of AWWs express that their main function is distribute Supplementary Nutrition and keeping the records. It appears as other functions are not seen very important.

The effective functioning of Anganwari is dependant on the education qualification, training and motivation of AWW.

Literacy level of AWW's

Literary rate		Number	Total	%
Literate	Urban	0	7	14%
	Rural	7		
5th	Urban	0	3	6%
	Rural	3		
8th	Urban	3	23	46%
	Rural	20		
10th	Urban	3	9	18%
	Rural	6		
12th	Urban	4	4	8%
	Rural	0		
Graduate	Urban	0	3	6%
	Rural	3		
Post graduate	Urban	0	1	2%
	Rural	1		

On analyzing the educational qualification of the AWW it has been found that (46+18)% AWW are 8th and 10th pass and 8% are, higher secondary 6% graduate and 2% are post graduate too. 20% AWW's are either literate or primary level pass.

As a first impression the situation looks satisfactory but on the field it was felt that many AWW are unable to complete the registers and find difficulty in maintaining the records and also monitor the growth of the children by using growth charts. AWWs who are literate or 5th pass take the support of another person in completing the registers and in maintaining the stock registers. In spite of education qualification job training plays an important role to get acquainted with the functions assigned to them role and becoming a good communicator for the poor and illiterate women.

Age and caste composition of AWW's:

The majority of AWW are of younger age group. 70% are within 25-45 yrs of age 30% are above 45 yrs.

48% of AWW belong to General category and 52% are from SC, ST and OBC category. Here it important to mention that 82% of total children enrolled belong to SC, ST and OBC category and 18% belong to general category. The caste and class biases are the reality of our community and in some places this hampers the effective functioning of the center.

Experience

Angan wari workers have varied work experience and this varies from 1-to 20yrs. 56% of AWW have work experience more than 10yrs. 12 % have the experience more than 5yrs and 28% have experience between 1-5yrs. None of the AWW has less than one year experience. Long experience of working may bring the efficiency but on the other hand it becomes difficult to change the practices.

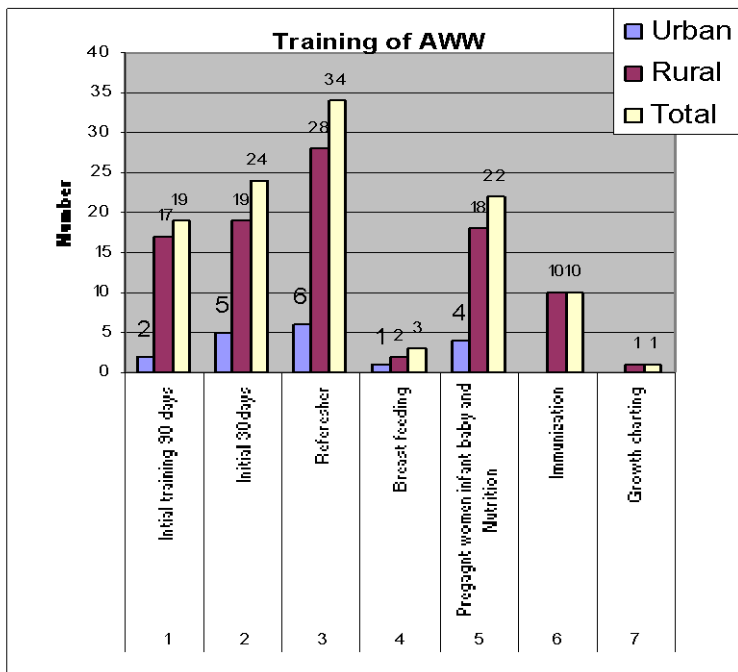
Training

Initial job training of Anganwari worker is very important

- To imbibing the objectives of the program
- To get technical information related to child care, nutrition malnutrition and pre school educational activities.
- To enhance communication skills in order to enroll the community members
- To understands the job functions like maintaining the records

- In this training they also need to acquire the skill for weighing the children, use of growth chart, planning the action as per the need of the child.

Since this training has huge task in front of them, the initial training has to be given to every worker for 90 days. In this regard the questions were asked from the every AWW and it was found that AWW's received the initial trainings are of varied duration i.e.30 days and 90 days. If we combine the data of the two trainings 90% (45 out of 50) AWWs have received the initial training. Out of this 50% of trained AWWs received full 3 months initial residential training while rest of 50% received only one month training. 33% of trained AWWs feel that they don't have sufficient information and they rate the training as okay (i.e. THIK – TAK).



Anganwari worker covered under the study have fairly long experience of working but still 52% AWWs have not undergone 3 months residential training. 10% AWWs have not received any training so far.

To address this gap some of the refresher trainings were organized and most of them mentioned that they have attended the refresher trainings on different themes related to their work like breast feeding, immunization and care of the pregnant women & infant baby. Only 2% AWWs received exclusively training on growth monitoring.

Understanding of AWW regarding their main functions

During the interview with AWW questions asked were to make out the level of understanding of Anganwari workers.

1. What the key objectives of the AWC?
2. What are the functions of the AWC?
3. How they know the status of child's nutrition? Explain each step.

4. How they decide the grade of malnutrition?
5. What is the course of action once they come to know the status of malnutrition?

On analyzing the question no. 1 and 2 it we found that it was difficult for the AWW to distinguish between the objectives and the functions of the AWC. They have narrated their functions in the objectives like distribution of food pre- school education, immunization, survey of the village and care of pregnant women.

Few AWW included issues like population control, stopping child marriage as part of the objectives of the ICDS program.

In answer to the questions 3, 4 & 5; 94% AWWs said that they identify the status of child nutrition by plotting the weight of the child on growth chart. Among these 38% included their observation, like activities of the child, color of the skin and only 4% mentioned about the mile stones and they also said they take the help of the ANM.

14% AWWs could explain the need to take weight repeatedly of the child and see that child is gaining the weight or not. 6% did not answer these questions at all.

On asking about the course of action they have taken that they would provide SN as per norms and discuss with the mother to give extra food to the child at home. If child is severely malnourished child would be referred to hospital for medical help.

Understanding about the gender issues

ICDS program was the part of the social welfare department and only in 1985 the separate department was created i.e. Women and child development with the understanding that women are not the object of welfare rather they need to empower. At the same time rights frame work was discussed every where and right to live was understood differently and it was felt we need to change the mind set of people working and process of implementation of this program.

In the state of Rajasthan Women's Development program also came in existence in 1984 to bring the shift in the position and status of women. In the conception of the WDP the shift in approach was from welfare to women participating in developmental process and to facilitate that they need to

empower to take participation and making the decisions in different spheres of life i.e. in family, in community and at public places like in Jati panchayt as well as in gram panchayts.

It was assumed that if WDP and ICDS would work under one roof they would bring the shift not only in understanding but also in processes of implementation. To gather the information it was asked from AWW that "how are you helping women in distress.

Since AWW is meeting pregnant and lactating mothers every week and also on monthly basis on during MCHN days and also while conducting self help group meetings. To understand that how AWW is supporting women who are facing gender discrimination; it was asked have they come across where women is facing the pressure of giving birth to the male child, or when women is not getting attention to take treatment or extra care when ever is needed or any other kind of violence at home. None of the AWW said that they have come across any such issue so far so no question arises of helping them.

Coordination with Asha Sahyogini & ANM

Co- ordination with health department and RCH activities is crucial for reducing the IMR and MMR. Enrolling pregnant women and counseling for birth preparedness & motivating women for institutional delivery, providing care to the mother and child during the post partum period and immunization of pregnant women and children all these functions can be effectively performed in co-ordination with Asha Sahyogini and health department functionaries i.e. ANM and PHC doctor incharge.

AWW mentioned that Asha sahyogini extend her support in the following activities –

i) Immunization,
ii) care of the pregnant women
iii) Household survey and registration of pregnant women.
iv) Distribution of SN.
v) MCHN days and
vi) Women's Self Help Group Meeting.

On asking from the AWW that which activity you feel is best conducted at your center? 60% of AWWs said "immunization" this is the activity which is

happening most appropriately. This is the monthly activity in which all workers join hands and accomplish the task.

Co-ordination is required in other important activities but some how in other activities like plotting the weight of each child and discussing the issue of nutrition with family members, discussion on the health issue of the child and mother co-ordination does not seems to happen properly. Only few AWWs are taking support of ANM in monitoring the growth of the child.

Participation in Panchayt meetings

Anganwari worker needs to co-ordinate with the panchayt members to bring the children's and women's health on the agenda of the panchayts while the earlier focus is on activities related to construction and the famine relief works or employment activities like NREGA. It is also supposed that they would motivate the panchayt members to extent the support in improving the functioning of center. AWW have been asked to participate in Gram Panchayt and Gram sabha meetings.

Participation				Issue raised				
G. Panchayt		Gram Sabha		No	Yes			
Y	N	Y	N		Physical infrastructure	Immunization	Increasing enrollment and attendance	Deployment of Assistant and Asha Sahyogini
27	23	33	17	34	5	3	7	1

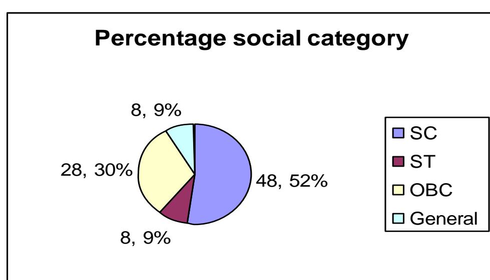
From the above table it is clear that 54% Anganwari workers are attending the Gram Panchayt meeting and in 66% AWW's are attending Gram Sabha meetings but 68% of the AWW's who are attending meetings are not raising any issue related to AWC and its' functioning.

32% AWW are raising the issue and issues were of physical infrastructure and increasing the enrollment and attendance of children and in Gram Sabha appealing the villagers to send their children to AWC to avail the services like immunization and nutrition. The data reflects that the role of anganwari worker at panchayt level is ineffective. 68% AWWs who attend the meeting but never raised the issue; One AWWs said that we raised the issue but we have not heard any response or re-address from the panchayt members. They feel that their presence could not bring any change.

Anganwari Helper

Anganwari Helper plays very important role in the functioning of AWC She collects children, maintains cleanliness and prepare & distribute food. Many a times when AWW is engaged in trainings program, meetings at the block & district level and other activities like house hold visits, immunization camps etc helper perform the main function.

She learns through observation and while assisting the AWW. 49 Anganwari helpers were interviewed and it was found that 66% are either literate or primary pass. 16% Anganwari helpers are illiterate in rural AWC's,



17% are either middle pass or secondary pass.

Majority of anganwari helpers belong to SC. ST and OBC category.

Asha Sahyogini

ASHA is the person which was conceived by National Rural Health Mission and she is being trained to function as interface between community and public health system. She has to provide assistance to the pregnant women and help in facilitating the institutional deliveries. She is also the first contact person in case of health problem. While sahyogini is the ICDS functionary who give counseling at the door step related to health and nutritional issues and also about the care of 0-3 yrs children and training mothers to adopt early child care practices like psychosomatic stimulation and exclusive breast feeding. Looking at the overlapping of roles and responsibilities of ASHA and Sahyogini it was decided to have one link person i.e. ASHA Sahyogini.

Asha sahyogini is selected in the Gram Sabha to ensure her linkage with the villagers. She is supposed to support the AWW and ANM on the Mother and child health and nutrition (MCHN) days and counsel and motivate women and family members to access health services and to adopt early child care practices. State has set the target to deploy Asha Sahyogini in all the AWC's (i.e. 48,372) by 2009.

In most of the villages Asha Sahyogini has been selected and trained. Asha sahyogini is working in co-ordination with AWW and ANM. In this study

interview of Asha Sahyoginis was taken and analyzed to understand their role and support to the women and children of the village and also to AWW in execution of her role.

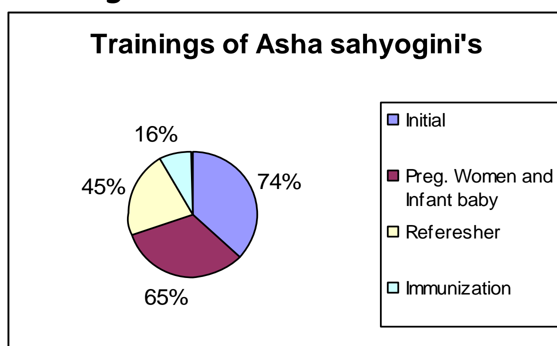
During the study 31 Asha Sahyogini's were interviewed

Literary level

S. No.	Educational level	Urban	Rural	Total
1	5th	1	1	2
2	8th	2	17	19
3	10th	0	7	7
4	12th	1	1	2
5	Graduate	1	0	1
	Total	5	26	31

For the above table it is clear that majority of Asha Sahyogini's are either 8th pass or above i.e. secondary, higher secondary and graduate. Only 6% are 5th pass. Training and refresher courses time to time would enhance their capacity to understand and performing their role.

Trainings



75% Asha Shayogini's covered under this study have received the initial training and 65% have attended the training about the care of pregnant women and infant baby. Trainings, refresher courses would help the Asha Sahyogini in building their capacities to communicate and support the women and children and also working in collaboration with ANM and AWW on day to basis. She is also supposed to support in co-ordination with near by referral hospitals in case of emergencies and delivery of the baby.

Understanding of Sahyogini's about the role of AWC:

It has been assumed AWW and Asha sahyogini both will work in close collaboration for improving the health of the women and children of the selected population. Their joint efforts with the help of ANM will reduce the maternal and child mortality and morbidity.

S.No	Functions of AWC	Urban	Rural	Total
1	Immunization	5	18	23
2	Care of pregnant woman	2	18	20
3	Distribution of SN	5	12	17
4	Reducing Maternal and child death	1	0	1
5	Care of malnourished child	0	3	3
6	Pre school education	3	12	15

From the table shown here indicates that majority of Asha Sahyogini's understand role of anganwari center as center for providing immunization and care to pregnant women and pre school education. Only few have said that it is the center to reduce malnutrition, care of malnourished child and only one could relate their work towards the larger objective i.e. to reduction of maternal and child mortality.

Knowledge of Asha Sahyogini

Asha Sahyogini is supporting the pregnant women with the help of ANM and AWW. She is supporting in household survey, care of pregnant women, immunization, referring cases to the hospital and increasing the awareness about health issues. Therefore in order to understand her knowledge about the issues related to pregnancy it was asked that what the conditions are during antenatal period, during pregnancy and after delivery in which she would refer the cases to the hospital and how many cases have been referred so far. Asha Sahyogini has referred the cases only during antenatal period and mainly in three conditions, Anemia, Swelling on the body and vomiting. In the last six months duration Asha Sahyogini's have referred 2-3 cases on average from each village from 50 AWC areas. In total 102 antenatal cases have been referred: 17 cases from 10 urban AWC and 85 from 40 rural AWC's. Based on this data we can say that ASHA Sahyogini can play an important role in increasing the access of women to the health system.

Knowledge level of Asha Sahyogini about the danger signs during and after delivery would be crucial to avoid delay at family level and saving lives of the

women. **None of the Asha Sahyogini could tell about the about conditions during and after delivery when women should be referred to hospital**.

Beneficiaries

Poverty, illiteracy, living in difficult areas, poor health facilities and lack of opportunity to learn and get correct information are the challenges which are faced by the communities and children get directly affected by the position and condition of her/his parents. 70% population is still living in rural areas 27% are living below poverty line. In the above situation providing supplementary nutrition and increasing the accessibility to health services and increasing awareness about the health and nutrition issues are important to reach to the beneficiaries.

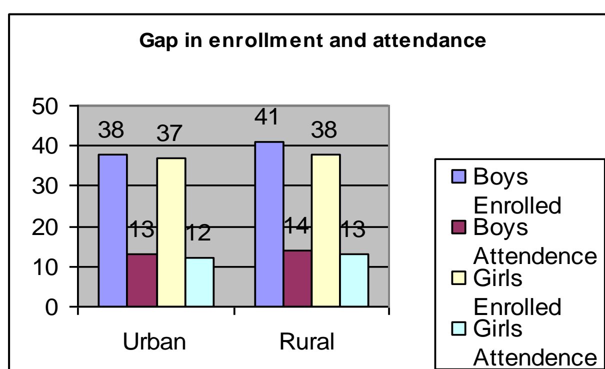
To prevent malnutrition among children and breaking the intergenerational cycle of malnutrition it is important to address the following:

- 0-3 yrs Children
- 3-6yrs children
- Pregnant women
- Lactating Women
- Adolescent Girls

Since multi-prone strategies important to address malnutrition therefore the planned strategies are to address the life cycle approach. AWC are within the reach of the community and it is expected that center would reach out the families and the children.

Enrolment attendance and presence of children in AWCenters

To understand the strength of children attending the AWC; data on the day of observation and average data of the month from the register was analyzed.



If we examine attendance it has been found that in 46% of AWCs children attending are less than 25 and lowest number ranges from 8-25 while in 54% AWCs children are more than 25 the maximum number are ranges from 39-70

across different districts. Children of 0-6yrs age group has been enrolled 75-80 in each Angan-wari but on average only 1/3rd children are attending the AWCs. Average attendance based on monthly attendance against enrolled children is reflected in the graph above.

Age wise distribution

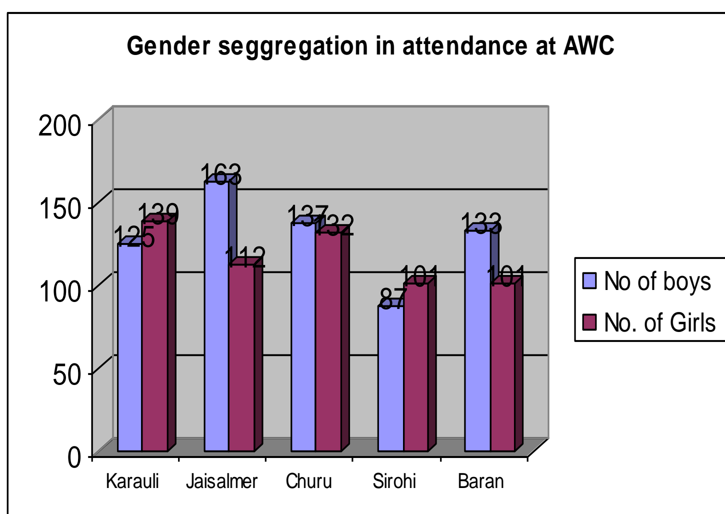
As compared to 3-6yrs age group the children who fall under the 0-3 yrs of attend more.

To understand the functioning of AWCs attendance of boys and girls of 0-3 yrs and 3-6yrs age group of all four social categories (SC, ST, OBC and General) has been analyzed.

Therefore the data reveals the concern of reaching services to children. This has been further substantiated during the interview of Anganwari workers. In response to the question i.e. what are the major challenges? Most of the AWW said that poor attendance of children or they also mentioned that parents don't send their children to AWC.

Gender and caste wise attendance of children

In all four social categories the children of younger age group i.e. 0-3yrs are more in number than 3-6yrs of age group. This is one of the welcoming shifts as in earlier review reports this has emerged as important concern as malnutrition sets-in in younger age group.

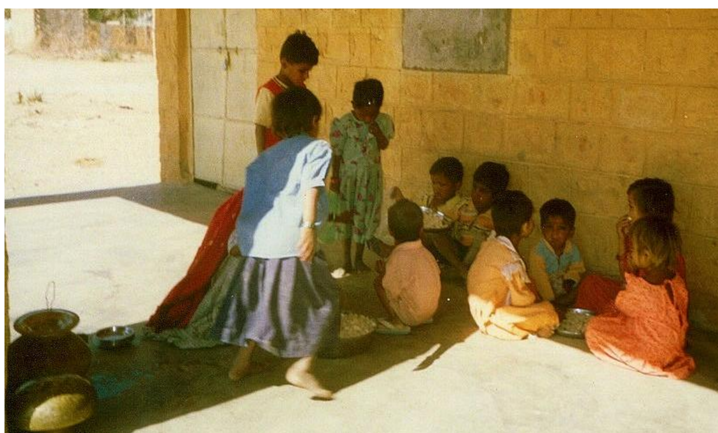


Boys are reaching to the AWC in more number than girls which needs to be given due attention. In different AWWs where 645 boys are attending the AWC girls are 585 in number. The district wise segregation has been given in the graph

The data indicated that only in 14% AWC AWCs malnourished children have been identified and are attending the services i.e. in three districts Sirohi, Baran and karauli. Rest of the 86% AWC either no malnourished child is attending or they have not been detected.

Name of the district	No. of children grade I (Malnutrition)	No. of children grade II (Malnutrition)	No. of children grade III (Malnutrition)	No. of children grade IV (Malnutrition)
Churu	Nil	Nil	Nil	Nil
Jaisalmer	Nil	Nil	Nil	Nil
Sirohi	34+21+1	26+8	03+1+1	1
Baran	2+2+2	2+1+2	0	3
Karauli	3	Nil	Nil	Nil
Total	**128**	**39**	**5**	**4**

The maximum number of malnourished children has been identified and categorized as per their nutritional status are in Sirohi district.



Children belong to BPL families are not availing the ICDS services as the children are not reaching to the AWCenters. Only 4% Children belong to BPL families from all categories are reaching to the Anganwari i.e. in two districts. Either the poor people who really need these services has not been registered as BPL families or children belong to BPL families has special constrains in reaching and accessing the facilities.

Growth Monitoring and action taken by AWWs

While on examining the record register it was found that in 16% Anganwari centers 3/10 in urban and 5/40 in rural have not recorded the weight of all children while in 18% centers either the weighing scale is out of order or it not available. And on data related to use of scale it was found that in 28% AWCs weighing scale is not in use. Therefore it is difficult to say that how many workers are conducting weighing sessions every month and assessing the growth of the child.

Theoretically all AWW said that to know the growth of the child we have to weigh the child and by plotting on the growth chart we can know the level of nutrition. Percentage of poor recording is higher in urban area than the rural angan wari centers.

Action taken by the AWW for the underweight children

District	No of AWC Children recorded underweight	No of children	Age group	Action taken
Sirohi	4/10	4 (1+2+1)	1.6yrs,1.3yrs, 4yrs and 1 yr	2 children were in grade III and IV both were referred for treatment but both of them died. One was sent for treatment, one was given Panjiri
Churu	Nil	Nil	Nil	Nil
Jaisalmer	Nil	Nil	Nil	Nil
Karauli	1/10	3	4,2,6 yrs	Informed the family members and discuss with them about the food intake and maintaining cleanliness to prevent any further illness, Informed the ANM and asked her to do the health checkup, started monitoring weight more regularly also started giving Panjiri.
Baran	2/10	4 (2+2)	2 children were of 1yr old and 2 were , 3yrs and 4yrs old	One was referred to the hospital and other was given baby mix.

Out of the total sample AWCs 13 children were recorded underweight out which 4 children were referred to hospital and 2 have died and nine were managed at the AWCs. As per NFHS-3 data 44 percentage children in 0-3 yrs of age are underweight but the underweight children addressed in the AWCs are very few in number.

Supplementary Nutrition

Providing Supplementary nutrition is the key function of the AWW. On the day of visit in 46 AWCs hot food Dalia, Khichari and Namkeen Chawal was served to the children. Preparation of food began after cleaning the center. Three angan wari centers were short of supply and no food was served on the day of observation; one in Jaisalmer (rural)

and two in Karauli (1 in rural and 1 in urban). The food is cooked and served by the anganwari helper.
Along with this Panjiri (prepared food) was also distributed to the malnourished children. In some AWC anganwari helper was helping the child in cleaning their hands before eating the food. She is inculcating the habit of washing hands among children from the very young age before eating food. Food was served in clean utensils and in 76% AWC's children were eating food happily while 18% AWC's children were having the food but not enjoying it and in 6% there was no food.

Quantity and quality

The amount served was sufficient in 95% of AWC; only in 5% the food was not sufficient. On asking about the norms of giving food to the children, it was observed that AWW described it differently in different districts. On asking about to describe the amount of food they give to the normal, malnourished child and extremely malnourished child. The amount which was described by the AWW for daily food and for panjiri varies across the district and within the district too leaving aside district karauli.

As per administrative and progress report of the WCD department Rajasthan page no. 8 says that:

"Rajasthan Nutrition Mission -RTE supplementary nutrition (Decentralized management):- from July 2010 on wards this system would be operational and baby mix would be produced by the women's groups. The baby mix would be distributed as per following norms –

Malnourished child 6 months to 3 years	125 gm baby mix
Extremely Malnourished 6months to 3 years	200 gm baby mix
Pregnant, Lactating and adolescent girls	150 gm per day

In 32 districts (except Banswara) there is provision for providing supplementary food from 3-6 years of age, like Namkeen Kichadi, Meeta Daliya and namkeen chawel. In Baran the meal would be served through *Axay Patra".*

In district Karauli all AWW's mentioned the same amount, and there was no variation within the district. The variation in amount in other districts is as follows. For the child falling in the normal category; some AWWs' mentioned

750gm while others mentioned 600 gms and 800 gms too. For the malnourished child it was said ranging from 750 gms, 900gms and 1500 gms. For the extremely malnourished they said 2250 and 3000gms.

The amount of Panjiri is also varying from 65, 85 and 125 gms and 160 for grade I and II and 200gms for grade III and few said it is 100 for normal category, 100 for malnourished and 200 for extremely malnourished children.

Pregnant women and lactating mothers collect the food every week.

It seems that AWW don't remember the amount in grams very well but they have bowl through which they measure and give to different children and pregnant and lactating women as per norms. It seems that they might be facing lot of difficulty in calculating the amount of poshhar maintaining the registers.

30% AWWs said that SN program in our center is the running appropriately. Out of this maximum number of AWW who mentioned that *Poshahar program is running good are from Baran* district. It is important here to mention that here the food is being served by *Axay patra*, 70% still feel that nutrition program is not running up to their satisfaction and this needs to be improved.

Diseases of Children

Asha Sahyoginis were asked: What are the diseases which causes children's death in their village in last six months?

S. No.	Name of the Disease	Urban area	Rural area	Total
1.	Jaundice	3	17	20 (70%)
3.	Pneumonia	3	15	18 (38%)
2.	Malaria	2	8	10 (30%)
4.	Anemia	0	4	4 (13%)
5.	Diarrhea	1	0	1 (3%)
6.	Chicken pox	0	1	1 (3%)

Asha Sahyogini mentioned the diseases.
Like Jaundice, pneumonia, Malaria, Anemia, Diarrhea and chicken pox.
Since the team visited in the winter season more cases of pneumonia has been identified & referred to the hospital for treatment and other important cause which is resulting in death of children mentioned by Asha Sahyogini's was jaundice.

Preschool educational activities

This has been one of the important functions of AWW and to facilitate the same the toys has been provided to the AWC.

76% AWC have sufficient number of toys while 78% are using those toys for preschool educational activities.

Anganwadi worker is telling story to the children and women are also sitting and observing the activities. Researchers observed the 46 running Anganwari centers and recorded the activities taking place during that period. It has been found that in Pre School educational activities were taking place in 50% anganwari centers. e.g. *In Nandoti block of Kararuli district researcher pradeep sharma recorded that Anganwari worker was playing the games by making a circle of children and after that she told the story of Lion and Rat. After that AW helper helped the children in washing their face and hands before eating the food.*

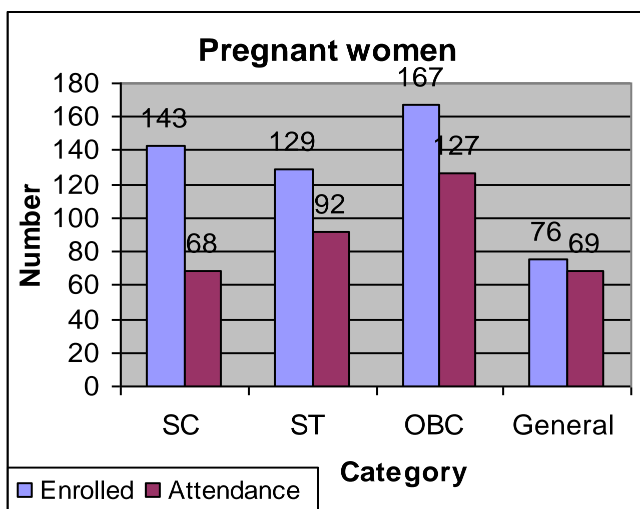
S. No.	Activity	Urban	Rural	Total
1.	Pre school educational and playing with toys	7	18	25
2.	Reciting poem and after serving food	3	11	14
3.	Health Check up	0	7	7
4.	Anganwari closed		4	4
Total		**10**	**40**	**50**

In 28% Anganwadi centers children were reciting poem before eating the food. Anganwari helper was preparing the food and helping the children in washing hands before eating the food.

Pre school educational activity and playing with toys is key activity to keep them busy for 2-3 hrs and anganwari worker plays important role in doing it. It was difficult for the AWW to comprehend that how the AWC are helping the child in school admission.

Pregnant women

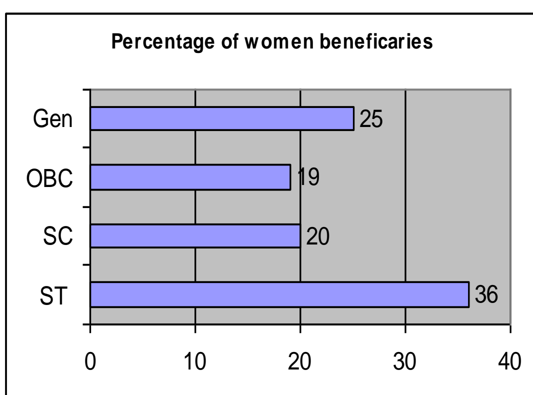
In 50 Anganwari Centers 396 pregnant women are using the services out of enrolled 515 pregnant women. On an average 11 pregnant women are enrolled and out of those only on average 7 pregnant women are accessing the services. The graph given is indicative that the number of pregnant women is higher among SC ST, and OBC categories but the gap between the enrolled and number of women who are coming and using the services is evident in the graph. On analyzing the social category of the women who are attending the AWC it is found that general and ST category are using the services better than women who belong to SC and OBC categories. These pregnant women get the poshhar as well as antenatal check ups during the health and nutrition day.



Beneficiaries

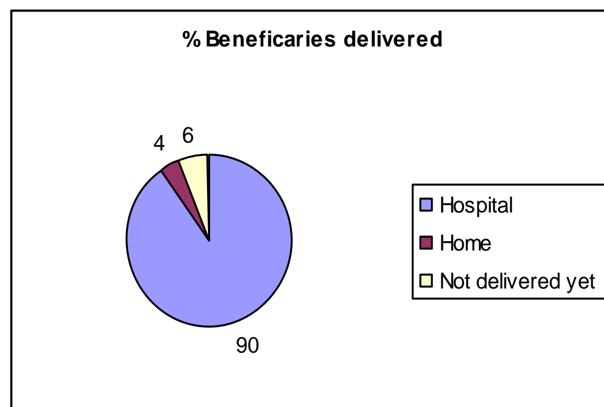
Interviews of women beneficiaries from each AWC were conducted to understand the views about functioning AWC and services being provided to them.

The table depicts that women from all categories ST, general, SC and OBC category are accessing the services through Anganwari Centers.



Out of the 47 beneficiaries interviewed 33 beneficiaries were lactating mothers and few of them were pregnant too. 14 beneficiaries who were linked to AWC were pregnant for the first time. On asking the place of immunization of their children out of the 33 lactating mothers 85% responded that their children received their immunization at AWC.

To understand the impact of discussions about the benefits of the institutional delivery it was asked place of delivery 90 % women who were linked to AWC delivered at hospital. This was one of the positive impacts on the women as they also got the information related to the benefits of Zanani Suraksha Yozana.



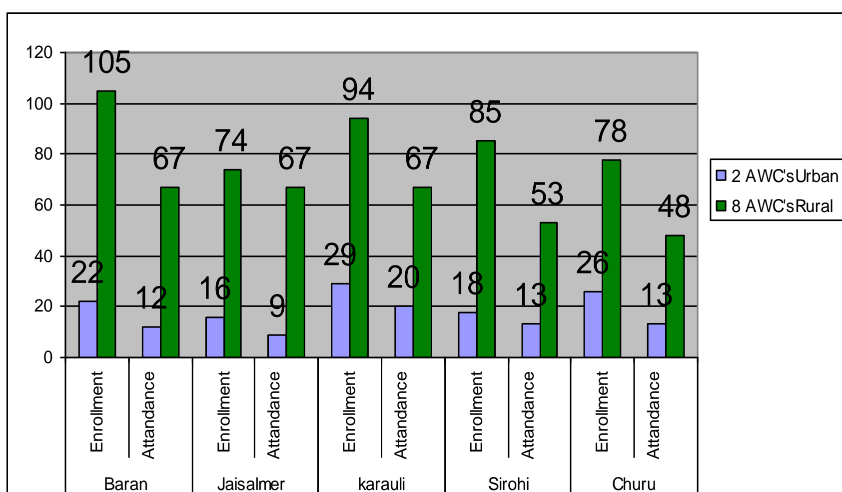
And 68 % women said that Asha Sahyogini accompanied them during the labor and they visited home after the delivery. She inquired about the welfare of the child and the mother and also told how to care the new born and explained the benefits of exclusive breast feeding.

Lactating as well as pregnant women said that they have received iron folic acid tablets, tetanus toxoid immunization and received poshahar. ANM examined them and their weight was monitored during pregnancy.

It was asked "if there was no AWC in your village how this would have been the impacted you and your village. "79% beneficiaries told that they would have not received immunization, nutrition and health facilities but 21% beneficiaries did not respond to the question.

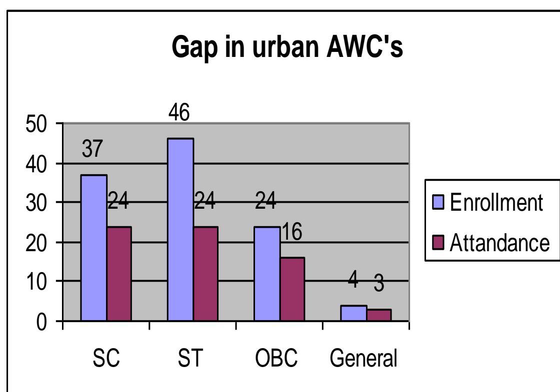
Women also said there visit of the ANM's at the AWC should be regular, few proposed to add activities like health and nutrition fair and few said that food which is distributed should include fruits.

Lactating Mothers

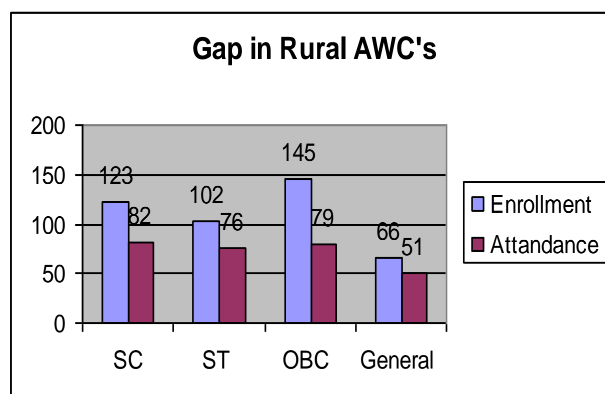


It is expected that 22 lactating mothers would be enrolled and receiving the service per Anganwari. The data of 50 AWCs was analyzed and it was found that

on average 11 lactating mothers (50% of the expected no.) are enrolled and 7 are showing their attendance. In Baran enrollment is high and the gap between the enrolled and attendance was also higher while in Jaisalmer enrollment was lowest and the gap between the enrolled women and women using the services was also lowest. Therefore we can say that lactating women attending is almost same in two districts where the enrollment is high or where the enrollment is low. The gap was further analyzed as per social categories and it was found that



The gap in accessing the services is higher among SC, STand OBC than the women belong to general category though the absolute number is higher. On comparing urban and rural area the situation is almost similar. Gap in urban and rural area across the social categories is almost similar except in attendance of ST and OBC category. In rural are more ST women are accessing the services as compared to urban area while in urban area more OBC women are accessing the services more in urban areas than the rural areas.



Frequency of visit of the beneficiary at AWC

To understand the interaction of the women with the AWW and their participation in various activities taking place at AWC; which they feel important, it was asked from the beneficiaries that when and how frequently they visit the AWC and what are the services they are availing.

S.No.	Frequency	% of respondents
1.	Once a week (to take nutrition supply)	32
2.	On Immunization day	24
3.	On MCHN day	20
4.	Health check up	14
5.	As per need	4

From the above mentioned table it is evident that 32% respondents go and take their nutrition from AWC every week. From the rest of the data we see that majority of women visit the AWC for specific days i.e. 24% go either for their immunization or for child's immunization, 20% said that they visit on the MCHN day and 14% on the day for health check up. Only 4% said that they feel free to go to AWC and to the AWW and they visit the center as per their need.

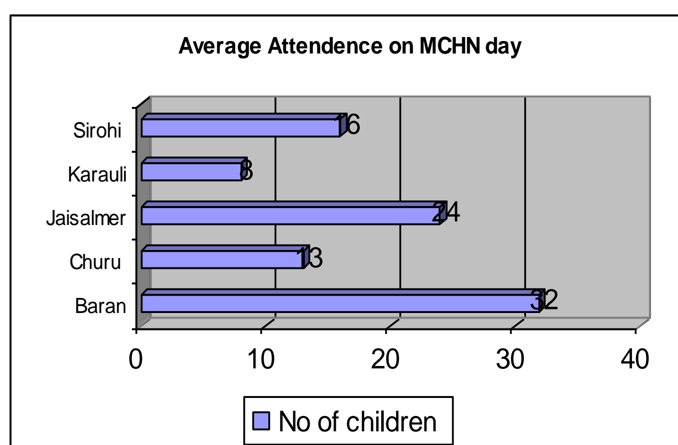
MCHN days

In 36% AWC the MCHN days are being organized regularly and in 24% anganwari centers MCHN days have not conducted in last six months; in 30% AWC the frequency of organizing MCHN days is poor. In difficult areas like and Jaisalmer and Baran the minimum no. MCHN days have been undertaken.

No. of AWC: MCHN days in last 6 months

Name of the District	Number of AWC (MCHN days organized)			
	5 days	4 days	2 or 1 day	0 day
Karauli	8	2	0	0
Sirohi	4	0	1+5	0
Churu	4		5	1
Jaisalmer	2	1	2	5
Baran	0	2	2	6
Total	**18**	**5**	**15**	**12**

MCHN day is one of the important activities which are being organized in every month on the scheduled days like second Thursday, Third Friday etc. Asha sahyogini support the AWWs in collecting the children and pregnant women on that day for immunization and health check up.

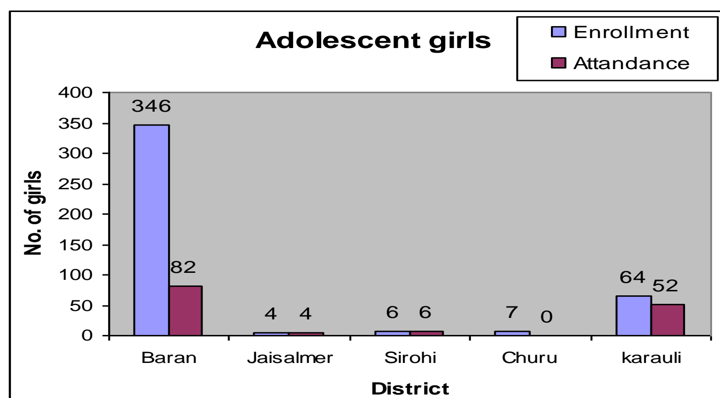


Here it would be important to analyze the average attendance of the children and pregnant women for immunization, health check up and to take nutrition supplement in the each district. If we see the average attendance in one MCHN day

in the state it is 19 children and 6 pregnant women who attend the MCHN day which ranges from 8-32 in number while the range for pregnant women attendance is 3-8 in number.

Adolescent Girls

Pubertal changes and growth spurts are the characteristics of the adolescent age and lack of nutrition results poor growth and in deficiency of iron and other micronutrients resulting in anemia. To provide supplementary nutrition and iron folic acid tablets and give the necessary information

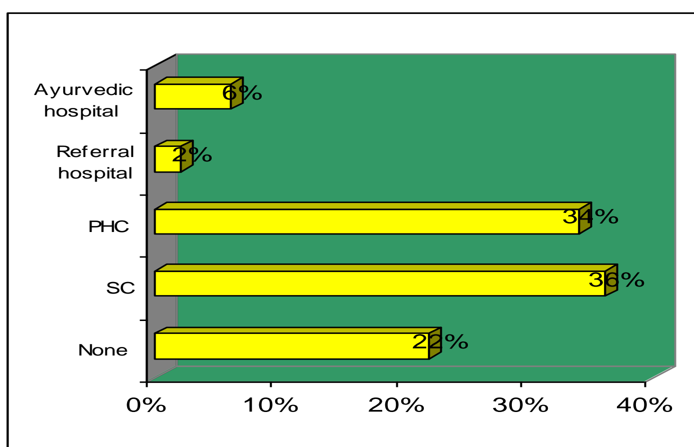


related to pubertal changes adolescents girls from the age group to 11-18 are enrolled at the AWC. Presence of adolescent girls at the AWC has been recorded by the researchers. Girls in district Baran are coming to the avail the services, other wise 2-4 girls on average re attending the AWCs.

And it has been found that on the day of observation in 24% AWC's adolescent girls were present and they stayed for more than 30 minutes at the AWC. During her stay she has been given the SN and iron folic acid tablet.

AWC is the place where she learns about the care of the pregnant women and care of the children through direct observation. She also receive guidance regarding maintaining the hygiene during menstruation. Since the attendance is very poor, and this requires different skill to attract them this is not being implemented properly.

Co-ordination with RCH



Health facility availability in the sample villages:
In 76% places some or other health facility is available and out of which 36% villages have the sub-center, 34% have the PHC and at 6% places there is an Aurvedic hospital.

For 22% villages where there is no health facility AWC and ASHA sahyogini is the first contact point for villagers in case of any health problem. In these situations the Asha and AWW has the key role in providing support in accessing these services.

AWW's were asked to rate different activities which are being accomplishing through AWC: the majority of AWWs i.e. 46% rated immunization at the top. 98% AWW's remember the name of the ANM visiting their center. In three AWC male nurse is visiting the center. All AWWs could tell about the last MCHN days happened in last four months.

Visit of ANM at AWC on MCH day

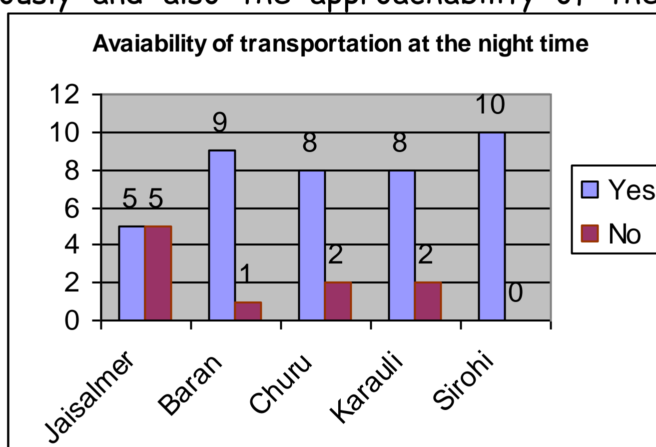
In the interview with AWW the question was put forth was that have they supported and counsel any pregnant women to take an extra care after antenatal check up by ANM in last 6 months. 10 AWWs 3 from urban and 7 from rural area have said that they have advised pregnant women to take and extra care and also advised few of them to go to doctor for check up and take her/his advise e.g. *anganwari worker Phool kanwar from village Khambal block and district Sirohi told the pregnant women who was suffering from Jaundice to for check up and take advise from the doctor. She said that I also advised her not to do much work at home.*

IT was asked Asha Sahyogini is supporting ANM in conducting the survey of pregnant women in the village, health check up by the ANM at the AWC and counsel and support women who need referral services.

Health check up: Health check-up events held at AWCs are difficult to collate because of variations in recording. At some places number of events is has been mentioned while at only number of boys and girls has been given. Thus it is difficult to say whether there is a consistent pattern of health check up or not. In fact the quality of coordination can only be commented upon from the number of events held in the past and number of beneficiaries used these services..

Referral Services

To understand the situation of referral services knowledge of danger signs of the workers was analyzed previously and also the approachability of the health services. The distance of referral services from the village varies from 3.5 km to 45 km. The villages are well connected to the road only few villages 6% are at a distance from 1-6km from the main road but still in the night if there is any emergency situation 20% villages don't get any transportation facility easily.



Some of the AWW in Sirohi district are aware and confident about the 108 ambulance services.

S. No.	District	Urban	Rural	Total
1	Baran	9	17	26
2	Jaisal mer	0	0	0
3	Sirohi	0	22	22
4	Churu	0	4	4
5	Karouli	8	42	50
6	Total	17	85	102

One AWW from Jaisalmer told that she referred 5 children who were suffering pneumonia, Diarrhea and excessive vomiting.

31 Asha Sahyogini were interviewed and it was asked that how many women they have referred to higher centers in last six months. The data is as follows: In total 102 cases have been referred to

the higher centers maximum in Karouli and minimum in Churu while no case has been referred in Jaisalmer to the higher center.

Support and Monitoring of AWCs

Lady Supervisors

The responsibility of supervisors is to physically visit each AWC under her/his charge at least once a month to ensure that all records are properly maintained, that medical kits and SN are supplied as per the needs to each AWC, and that all planned events are held accordingly. Supervisors are supposed to extend support the AWW in execution of her duties and also solve the problems coming at the village, block and district level.

Main concern

As per discussions with supervisors, the majority feels that their main concern is (i) to reduce infant mortality (ii) maternal mortality But majority feels that they have failed in addressing these concerns because the needy are not getting assistance and we are not reaching at the centers as per norms.

Under-staffing

Out of 219 sanctioned posts of supervisors in the sample districts 125 (57%) are placed while 94 posts are lying vacant, many for more than one year. Situation in districts in Jiasalmer, Churu and Baran needs immediate attention.

District	Sanction	Working
Baran	56	30
Jaisalmer	23	8
Karauli	48	34
Sirohi	34	23
Churu	58	30
Total	219	125 (57%)

District	Block	Sanction	Working
Baran	Kisanganj	10	6
	Shahbad	7	4
Jaisalmer	Jaisalmer	6	5
	Sam	7	2
Karauli	Nadoti	5	4
	Todabhim	NA	NA
Sirohi	Sirohi	5	5
	Pindwara	9	5
Churu	Sujangarh	12	5
	Taranagar	7	0
		68	36(52%)

In some of the selected blocks from these districts the situation is still grim and requires urgent attention to change the situation.

Due to understaffing lady supervisors have been entrusted the responsibility to supervise 40-102 anganwari centers. In such situation 50% lady supervisors admitted that they are not visiting all centers every month. The average number they said that they reach only in 20 AWC every month.

80% AWW said that they receive the support from the lady supervisor. She guides how to distribute the nutrition and check the stock of food and nutrition. Few AWWs mentioned that LS supports in conducting house-hold survey for increasing enrollment of the AWC. She also helps in organizing self help groups. On MCHN days she helps in discussing the health and nutritional issues some of them said she also helps in collecting children and women.

Visit of CDPO's

Support from NGO's

To understand the support and involvement of other agencies and civil society organizations, it was asked that:

Do they know any non Government organization working in their area Do they visit AWC and support you?

In all 50 AWC visited in five districts none of the NGO was linked to AWC's and no member from any NGO ever visited anganwari center.

Maintenance of information system

Different registers have been maintained by the AWW to keep the records. The overall stock and registration and attendance registers have been maintained in registers by 93% AWWs in 7% AWWs records have not been updated.

Records of the weight of the children; 84% AWW are keeping the records of the weight of the children. Data related to MCHN days was also available

showing the no. of children and pregnant women's attendance and their immunization

At the state level the data has been computerized and detailed information about the AWC is available on the department web site.

Conclusion

The persistence of malnutrition, especially among children and mothers, in this" World of plenty, is immoral. To live a life without malnutrition is a fundamental human right. But the commencement of ICDS program was through social welfare department and the understanding of the program was to do the welfare of the poor children and save them from hunger. Therefore the strategies & processes of implementation and its approach have no element of empowering the people and the women in particular. In mid eighties the program was shifted in the Women and child development department and it was assumed that this would bring the change without any change in the approach in its strategies and processes of implementation.

It is recognized by the academicians that the social and economic costs of poor nutrition are huge on the nation and social investment in nutrition will reduce health care costs, reduce the burden of non-communicable diseases, improve productivity and economic growth and promote education, intellectual capacity and social development. But some how this understanding has never reached to the implementers of the program, and the program has the image of welfare not as a right of the child and women to live life free from malnutrition.

The strength of the ICDS program has been recognized as this is one of largest network which has the reach to the poor people. But the assessment study has indicated that reach to the needy people especially the children belong to BPL families and women belong to SC and ST category is still very poor. This also indicated in the data of the malnourished children attending the center. Only in three districts and 7 AWCs malnourished children are attending the AWC and getting the poshahar.

Reach to the pregnant and lactating women is still has not improved from the assessment study done in 1991. But it is important to observe that greater no. of pregnant women and lactating mothers from SC, ST and OBC category has been registered and enrolled but their attendance remains poor. The

services are better availed by women belong general category. It is good to see that women from all social categories are attending the AWC

Initial 90 days residential training has been planned to build the capacity of human resource but all AWWs have not undergone this training. This has reflected in their work in recognizing the malnourished children, children who are risk of falling in the trap of malnutrition and taking action accordingly. 33% AWWs admitted that they do not have the required information. This is important to say that only 16% of AWWs have recognized the children with malnourishment and took some action.

The deployment of ASHA health worker was one of the key strategies of National Health Mission to increase the reach of the public health programs. Institutional structure which is available at the village level and near the marginalized communities is the Anganwari Centers. To strengthen the co-ordination and functioning of anganwari centers "ASHA Sahyoginis" have been appointed and it is proposed that by the end of 2012 all Asha Sahyoginis will be on board.

Appointing ASHA Sahyoginis has been instrumental in increasing institutional deliveries in the state. 68% Asha sahyoginis accompanied women during the labor in past six months. They also visited these women at home during the post partum period.

Planned immunization session through MCHN days has resulted in strengthening coordination between the ANM, Asha Sahyogini and AWW. This activity has been ranked on the top by 60%AWWs among the all other activities being implemented at AWC. But the coverage of full immunized children has not shown the substantial improvement. This has not resulted in increase in day to day attendance of the pregnant women and children at the AWC. Health check up has not been streamlined and there is no evidence of regular checkup.

In the observation of the AWC it has been found that majority of the AWWs are engaged in pre school educational activities. Playing with toys is best enjoyed by the children and this is necessary to bring the motor and sensory development and muscular coordination and balance in the action of the children. There are toys and charts through which the AWW undertake the pre school educational activities. This is the activity which keeps the

children engaged and bringing the quality in pre school education may be helpful and can motivate parents in sending their children more regularly.

Implementation of Kishori Shakti yozana and involvement of adolescent girls in the AWC is minimal. We can say that this is not functional neither the AWWs have the capacity to engage the adolescent girls and handle their issues and in rural areas most of adolescent girls are engaged in household and agricultural related works..

Lady supervisor is not reaching to all AWWs and the main reason which is evident is understaffing. Lack of trained human resource has resulted in the poor supportive supervision.

In the sampled areas it has been mentioned by the AWW's that none of NGO's members have ever visiting and supported any activity happening at the Anganwari center.

Enrolling the beneficiaries and communities with the objective of the AWC can help in improving the function of AWCs. But some how the strategies applied so far have not resulted in effective community involvement.

From the study we can say that health component of the program has geared up with the appointment of Asha Sahyogini and executing planned immunization sessions. But this would not suffice with the objective to reduce the incidences of low birth weight, reduction in malnutrition, anemia and reduction in mortality and morbidity of infants and children.

Suggestions

ICDS program is now 35yrs old and program has not demonstrated the impact as expected. This gives us a clear indication that we need to give attention to the program and to rethink about the approach (i.e. from welfare to empowering people) and bringing the shift so the benefits could reach to children and women and beneficiaries can play an active role in monitoring the program.

Political will

- The vision of the program should be put forth as "Making the state malnutrition free" and bringing the nutrition on the priority of political agenda is very important to bring the qualitative shift in the program.

- Right to get food is the individual's right and it is the obligation of the government to do so.
- With the 50% reservations for the women at the panchayt level; involvement of GP members can be increased through orientation and designing a planned intervention to increase the collaboration and bring this into thee agenda of each panchayt. This would also help to understand that how this would result in decrease in burden of the diseases and increase in productivity and social development.
- "Political will" would have direct impact on the monitoring of the program.

Strategies to improve the attendance

- Children pregnant women and lactating mothers who are not availing the services needs to be enrolled more specifically. This may need a pilot study to understand constrains and evolve the effective strategies to combat the same.
- Children living in BPL families should be targeted specifically. A special intervention needs to be designed for people living in difficult situation.
- Supportive innovative activities need to be planned for making the AWC popular and attractive.

Human resource

- At Key positions like CDPO who are supposed to provide leadership at the block level and to influence the process of implementation are on deputation from various departments may be good in carrying out the instructions but that is not sufficient They need to be trained to handle the soft issues.
- Immediate attention to drawn infilling the vacancies and completing the trainings back lock of the deployed human resource without which they are unable to perform qualitatively. E.g. Initial job training should be completed and all should receive the training within the stipulated time.
- Reorientation training needs of the AWW's should be assessed properly and should be completed in the stipulated time for effective functioning.
- Lady supervisors should be trained to accomplish their specific job.
- NGO's should be engaged in training and reorientation of the AWW AND Lady supervisors.

Monitoring the program

- It is important that how do we report and what we present about the status of the program. In the program like ICDS which is being implemented with special focus in reduction in malnutrition and to bring reduction in low birth weight of babies and reduction in mortality and morbidity of infants and children the data at each stage should reflect that how many children are being identified as malnourished and how they are being addressed.
- Reports say about number of children using the services and amount of distribution of the food and Supplementary Nutrition. This reduces the malnourished child as one of the beneficiaries and does not substantiate the real information about the children living in harsh conditions and in BPL families.
- Change in the reporting system and mechanisms needs to be established to get the correct information.
- Involving the community members and the beneficiaries in monitoring the program is important. As set aside fund has been given to ANM It would be important to give set aside fund to fill the gap in supply of food and repairing the weighing scale, holding small events at the village level etc

Research Studies

- Time to time survey on identification of malnourished children and households at nutrition risk can bring the rigor in the program.
- Number of reported malnourished children in the data is very poor, this needs to get reliability test. In the sampled AWC the most of AWWs only look for the weight as per age. They are not aware for other aspects which indicate about the child health and nutritional status. This also calls to build the capacity of the worker and supportive supervision so they can learn in their trainings as well at work place with the LS and ANM.
- Time to time studies to undertake concurrent social assessment, evaluation of trainings and communication activities and operational research studies can provide the insight and help in improving the functioning of the AWC.

Environment building and community involvement

- Rather than making the adolescent girls as the direct beneficiary of the program it would be better to form the of kishori's (adolescent girls) and assign them the task of building environment within the village, through nukkad natak, use of posters and discussing the issues related to immunization and care of children. This would empower them, built self confidence and also internalization of key messages.

- Involvement of the community and joining hand more closely with the beneficiaries, influencers and NGO's would be important area which needs to be addressed and this would build the confidence among the people

Case Study of an AWC in Jaisalmer district

Guheda village is 3 kms away from the semi urban area of the block Sum of the Jaisalmer district. Guheda village population has been dominated by Schedule caste people and there is a government school in this village but there is no health facility in the village. Ms Jasoda 52yrs old literate is working as AWW since 22 yrs in this village. She has received three months initial training and she rated this training as very good training. In her anganwari 40 children were present and majority of people are from SC community. At the time when researcher's team arrived; she was teaching the alphabets using the charts. Children bought their slate and they were writing on it. It was heartening to see the way Anganwari worker and helper was handling the children with love and care. At the same time the anganwari helper Ms. Lundi Devi was cooking porrich (*Dalia*) for children. Her anganwari was well maintained and very clean though children were not wearing too clean cloths. After teaching the porrich was served.

Mean while 9 pregnant women, 9 lactating mothers and one adolescent girl came to the anganwari center and they stayed in the AWC for one hour and they were discussing about the safe delivery and birth preparedness. She also shown the medicine kit and medical kit had tablet iron and folic acid, paracetamol tablets, ear and eye drops and also ORS packets. Jasoda was appreciative of her supervisor and she said whenever she comes she support me in growth monitoring and in taking the decision which child should be given more nutrition, she is also helpful in conducting women's group meetings and guide me about maintaining the records.