

Rapid Assessment of Integrated Child Development Scheme in Delhi

Aakanksha Sinha

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Acknowledgements

Among the schemes identified for evaluation studies under the Delhi Chair on Human Development Issues which has instituted by the Government of National Capital Territory of Delhi (GoNCTD), the Integrated Child Development Scheme in Delhi was chosen given its major significance for child well being and the recent deliberations for restructuring and strengthening the scheme further. We were happy to find a willing partner in Ms. Aakanksha Sinha from Boston University, a keen researcher on children's issues who undertook this rapid assessment study through rigorous and intense survey across the National Capital Territory of Delhi. This was a study completed in record time with very useful insights on the strengths and weakness of the scheme, gaps in implementation and challenges faced by the service providers and the community.

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Preface

The Integrated Child Development Scheme (ICDS) is the flagship programme of the national government to improve child nutritional status in the country. The programme targets a large section of the Indian population, particularly those in low-income communities. Although more than 13 lakh beneficiaries are enrolled in the programme, the positive nutritional status for majority of the child population still remains out of reach. While India boasts of a rapidly growing economy, it continues to suffer from high rates of child malnutrition and infant mortality, which are important indicators of human development. India currently ranks at 135 out of 187 countries in the Human Development Index. Also, its ranking has increased from 103 to 112 in the Child Development Index (CDI) since 2004, indicating very poor progress towards child health, education and nutrition. Although education rates are relatively high, India ranks poorly in child nutritional status, with 40 per cent of the child population being moderately or severely underweight and the infant mortality rates at 55 per 1,000 live births. The supplementary nutrition programme (SNP) through the ICDS provides supplementary meals to children between 0–6 years and pregnant, nursing and lactating mothers to ensure improved nutrition outcomes. This being said, the nutritional value of the meals has been under scrutiny. While the meals might meet the caloric value required to stave off starvation, it is questionable whether they help improve the nutritional status of the participating children and women. As a result, those who cannot afford meals due to financial constraints and are dependent on ICDS to provide daily sustenance for their children, often confront issues of malnutrition and at times death.

The National Food Security Act, 2013 gives every Indian citizen the legal entitlement to food. Food security however does not only refer to freedom from hunger, but also access to nutritious food that leads to proper development of the individual. Without including nutritious food in the 'daily free meals a large section of the child population and nursing and lactating mothers who are receiving supplementary meals through the ICDS are unable to reach their

optimal development. Malnutrition during childhood impacts an individual's life long health trajectory. Therefore, ICDS must work towards including nutritious food and ensure that it reaches all their beneficiaries.

Gaps in implementation due to lack of effective monitoring, regular evaluations and participation of grassroots-level service providers and community members has contributed to the ineffectiveness of ICDS. This study attempts to understand the challenges and barriers faced by the chain of service providers, through a rapid assessment so as to express the need for a more in-depth evaluation of the ICDS programme in the NCT and other parts of the country. This will help identify gaps as well as possible alterations that are needed in the ICDS programme to achieve its primary objective.

Preet Rustagi

Professor

Delhi Government Chair on Human Development Issues

IHD, New Delhi

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1 Introduction

Background of the ICDS

The Integrated Child Development Scheme (ICDS) is the primary nutrition and early child development programme in India, which targets children less than 6 years of age, and pregnant and nursing mothers (Adhikari and Bredenkamp, 2009). The Government of India (GOI) established the ICDS on 2nd October 1975. The programme started with only 33 projects in 1975, but rapidly expanded to 1161 projects, covering approximately 23 per cent of the country's population (Tondon, 1989). ICDS currently has more than 13.8 lakh beneficiaries that utilize services provided by a network of Anganwadi centres that are run by Anganwadi workers (AWW) and helpers (AWH) (WCD, 2014).

The ICDS, primarily targets low-income areas in urban and rural locations. There is one Anganwadi centre per 800–1000 individual beneficiaries. Although the primary objective of the ICDS is to improve child nutrition, it provides a holistic set of services that target other factors that are strongly correlated to child well-being and positive nutritional outcomes. Thus, the objectives of ICDS as laid out by the Union Ministry of Women and Child Development (WCD) include: (i) laying the foundation for the proper psychological, physical and social development of the child; (ii) improve nutritional and health status of children below 6 years of age; (iii) reduce incidence of mortality, morbidity, malnutrition, and school dropouts; and (iv) enhance the capabilities of the mother to look after the normal health and nutritional needs of children through proper nutrition and health education. To achieve these objectives, the ICDS provides services targeting nutrition, health and education. The specific services that are provided through the Anganwadi centre include: Supplementary Nutrition Programme (SNP), Immunization, Health Check-ups, Referral Services, Pre-School Education, and Nutrition and Health Education (WCD, 2014) [See Figure 1].

Figure 1: Beneficiaries of the Integrated Child Development Scheme (ICDS)



Source: Ministry of Women and Child Development, ICDS Report

For approximately four decades, the ICDS has been recognized as the flagship programme to curb child malnutrition in India. As a result, the GOI has continued to support its expansion. This support is reflective in the successive increase in financial allocation to the program over the years. The GOI recognizing the importance of the ICDS, has currently allocated Rs17.7 crores, which is an increase by approximately 11.7 per cent from the 2012–13 budget.

In addition to financial support, the Supreme Court in 2001, ordered the central and state governments to 'implement the ICDS in full', that is, universalization of the project. Since 2005–06, the programme has expanded in three phases to cover approximately 14 lakh habitations/ communities throughout the country (Adhikari and Bredenkamp, 2009; WCD, 2014). The last phase of universalization was approved in 2008–09. As a result of the rapid universalization and expansion of the programme, certain institutional, programmatic and management challenges became apparent, which needed to be addressed. In order to bridge the gaps and strengthen the programme, GOI endorsed the restructuring and strengthening of

the ICDS. An Inter-Ministerial Group (IMG) led by the Member (incharge WCD) of the Planning Commission was formed to suggest the restructuring and strengthening. These changes in the scheme were incorporated in the 12th Five Year Plan.

Restructuring and Strengthening of ICDS

The GOI has allocated Rs 1.2 crore to support the restructuring and strengthening of the ICDS [a detailed explanation of the components of the restructured ICDS is in APPENDIX 1]. The restructuring and strengthening process will be rolled out in three phases, covering 200 high burden districts in the first year (2012–13) including 41 districts in Uttar Pradesh; additional 200 districts in the second year (2013–14) including special category states and NER; and the remaining districts in the third year (2014–15). The specific changes in the ICDS include:

- The Anganwadi will now be the first village outpost for health, nutrition and early learning for children and mothers
- Around 2 lakh Anganwadis will now get pucca buildings at the cost of Rs.4.5 lakh each
- Around 70,000 Anganwadis will now have facility of a crèche, which will benefit working mothers in both rural and urban areas
- Amongst high burden districts, 200 will now have an additional Anganwadi worker cum nutrition counselor. In other districts, provision of link worker has been made
- Cost norms for supplementary nutrition increased from Rs. 4–6 for children (6–72 months), from Rs.6–9/ for severely underweight children and from Rs.5–7 for pregnant and nursing mothers.

There is hope that the restructuring and strengthening initiative by the GOI, will help bridge existing gaps, as well as improve the dismal situation of child malnutrition and infant mortality that is still existent throughout the country.

2 Literature Review

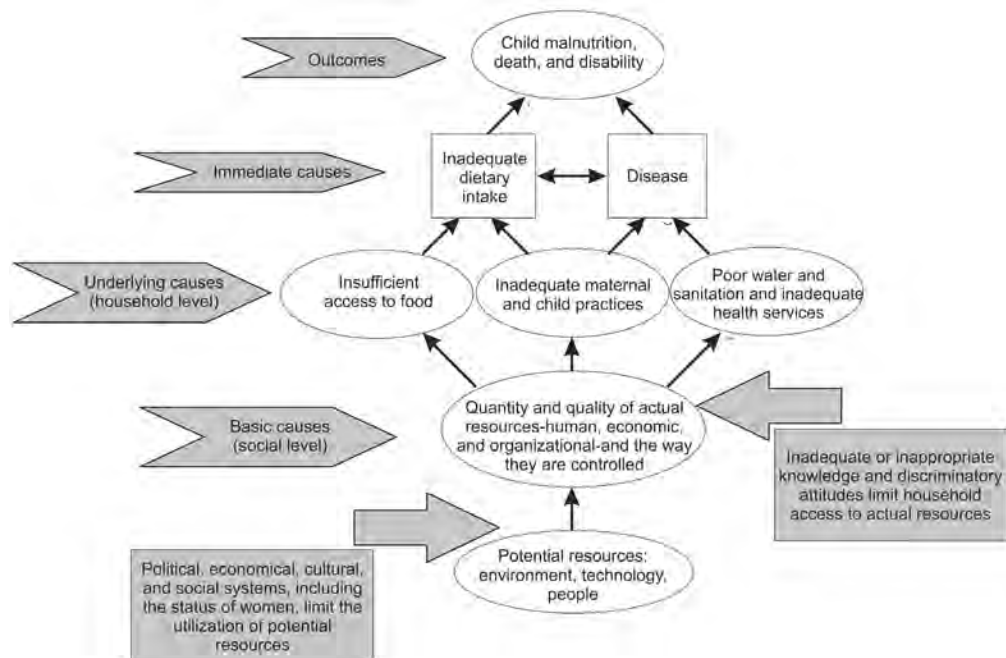
Child health and malnutrition

India boasts of a steep growth in the economy and increased agricultural productivity over the past years (Dreze and Sen, 2013). Despite this, it suffers from persistent and significantly high rates of child malnutrition. According to Alderman et al. (2006), the impact of malnutrition in the early years of a child, particularly the first two years, has a lifelong impact on their overall development and growth. The most recent UNICEF (2013) reports indicate that India has a very high prevalence of child malnutrition. Although there has been a steady decline in under-five mortality rates since 2010, the incidences still remain high at 55 deaths per 1,000 live births as of 2012, which do not match the rates that should have been achieved by 2015 as stipulated by Millennium Development Goals. The World Health Organization (WHO) reported that 48 per cent children suffer from moderate to severe stunting, which is one of the primary indicators of child malnutrition (WHO, 2014).

There are immediate and underlying factors that contribute to child malnutrition and poor health (Kent, 2005; UNICEF, 2008). While the immediate causes include insufficient food or sickness, the underlying causes are more at the household and community level (Smith et al., 2003; UNICEF, 2008). These include household food insecurity, inadequate maternal and child care practices and poor health environment and services (Smith et al., 2003). The UNICEF child malnutrition model presented in Figure 2 illustrates various factors that directly and indirectly impact child malnutrition.

According to Smith et al. (2003), maternal health and education are important determinants of child nutrition status and overall health. Women's health pre and post-pregnancy as well as her knowledge on issues regarding feeding practices and care directly and indirectly impact their children's health outcomes. Inadequate food, illnesses, family planning knowledge, lack of safe prenatal and

Figure 2: Causes of Child Malnutrition



Source: UNICEF 2008

post-natal care, poor knowledge regarding self and child health, and overall healthy living practices, have a significant impact on children's health (Smith et al., 2003; Kent, 2005)

Keeping in mind the direct and indirect factors leading to child malnutrition, India's largest child nutrition programme provides a multi-sectorial approach that not only targets availability of food, but also factors such as immunizations, health care facilities, maternal health amongst other social and environmental factors (WCD, 2014). The programme currently caters to 13.8 lakh beneficiaries, providing them holistic services to ensure healthy development of children.

The ICDS is the largest and most widespread programme that has been developed to focus on child nutrition. While it has reached a large proportion of children and women, throughout the country, its impact on reducing child malnutrition still remains debatable. A study by Deolalikar (2005), indicated that the presence of an ICDS centre was associated with a 5 per cent decrease in the

probability of being underweight for boys, but not for girls. Another study that was conducted by Lokshin et al. (2005) using the NFHS-1 and NFHS-2 found limited evidence to support the positive impact of ICDS on child nutrition. Bredenkamp and Akin (2004) and Kandpal (2011) reported similar results. Studies that have evaluated early childhood development programmes in other countries, such as Mexico, Philippines, South Africa and Jamaica, have also reported that short-term nutrition programmes don't have a significant impact on child stunting, and long-term positive effects (Armecin et al., 2006; Behrman and Hodinott, 2005; Walker et al., 1996; Walsh et al., 2002). The studies indicate the need for a more multi-sectorial approach, which includes maternal health, quality of living and sanitation.

According to Kandpal (2011), these multi-sectorial services of the ICDS are provided at local Anganwadi centres, the proper implementation of which might result in health and nutritional benefits. Unfortunately, most of the services are poorly implemented, and a majority of households only use nutritional supplements, immunization referral or day care facilities, which do not yield positive results. Saiyed and Seshadri (2000) conducted a study where they followed 610 children who received no, partial or full services through the ICDS. The results indicated that those children that were fully utilizing the services showed significant improvements in their nutritional status that was measured by stunting, wasting and weight, whereas those with partial utilization had significantly poorer results.

Based on the findings of previous studies, a pilot study was conducted to evaluate the ICDS services that are provided through Anganwadi centres in the National Capital Territory (NCT). Understanding that the service providers are key factors that transmit the ICDS policies into services that are consumed by the beneficiaries, the pilot study aims to understand the challenges faced by service providers, that is, AWW, AWH, supervisors, and Child Development Programme Officers (CDPOs) in providing quality services. This pilot study attempts to provide a foundation for future in depth studies to understand the complexities regarding the implementation and outcomes of the ICDS in the NCT.

3 | The Study

Location

The pilot study to explore the functioning and gaps of the ICDS from the viewpoint of the service providers was conducted in the National Capital Territory (NCT), India, within 16 distinct Anganwadi Centres (AWCs). The AWCs were divided into: (i) slums and unauthorized areas, (ii) rural and semi-rural areas, (iii) school-run AWC, and (iv) Model HUBcentres.

Delhi is the national capital territory of the country (see figure 4 for a map of Delhi). Along with metropolis such as Kolkata, Mumbai, and Chennai, it accounts for 15.4 per cent of the total urban population. It currently has a population of 1.5 crore, with a density of 11,297 persons per sq km (Census of India, 2011). The National Capital Territory (NCT) contains approximately 7.6 per cent of the total urban population and 2.1 per cent of the total rural population of the country. Due to an increase in the number of small industries, there has been a steep escalation in the number of migrants. A report by Census of India indicates an increase in the share of urban population from 50.2 per cent in 1991 to 62.5 per cent in 2011, whereas the rural population has been declining. The Delhi Statistical Handbook (Directorate of Economics and Statistics, 2011) indicates a steep decline of more than 55 per cent of rural population in the last decade. A large number of rural villages have converted to urbanized villages due to extension of urban areas. The number of rural villages has declined from 304 in 1951 to 165 in 2001 (Census of India, 2001).

Although Delhi is one of the fastest growing cities in the world, it also has a large population that is suffering from poverty. According to a report by the Delhi State Government, there are approximately 22.93 lakh individuals living below the poverty line, that is, 14.7 per cent of the total population (Government of NCT, 2009). The number of people that are below the poverty line has doubled from 11.49 lakh in 1999–2000 to 22.93 lakh during 2004–05. Census of India

Figure 3. Delhi Map with approximate locations of study sites marked



Source: Maps of India

indicates that 52 percent of Delhi’s urban population lives in slums, and do not have access to basic amenities including electricity, clean drinking water, toilets, sewage and proper living conditions (The Hindu, December 17th, 2009). NCT also has a low sex ratio of 866 females per 1000 males. It boasts of a high literacy rate of 86.34 per cent (Census of India, 2011). The birth rate is 20.03 and infant mortality rate is 13.08 per 1000 live births.

With regard to ICDS, there are currently 95 sanctioned projects in Delhi, all of which are operational [See Figure 5]. A total of 10,897 out of 11,150 sanctioned AWCs are operational. There is an acute shortage of AWW, supervisors and CDPO’s resulting in additional burden of managing more centers than allotted to them. There are currently 10.8 lakh beneficiaries including infants from 0–3 years [5.2 lakh]; children between 3–6 years [3.8 lakh]; pregnant, nursing and lactating mothers [1.7 lakh]. With regard to pre-school, early childhood care and development programme, there are approximately 3.8 lakh beneficiaries that are aged between 3–6 years. Out of these 1.9 lakh are boys and 1.8 lakh girls.

Sample

Mixed purposive sampling was utilized to conduct the pilot study. A combination of theory-based and emergent sampling procedure was used to determine the appropriate sample for the study. In order to gather information from different types of AWCs that are functional in Delhi currently, four project districts were identified (south-west, west, east and south). Further, project areas within these districts were identified after consultation with officers from the WCD of the GOI, the NGOs and NPOs that have been working on the ICDS in Delhi. The stakeholders identified areas that have existing AWCs representing each distinct type. These include the slum and unauthorized area, semi rural and rural area, school based AWC and model HUB center. A description of each of these sites is provided below.

Slum and unauthorized area: The urban poor in Delhi are predominantly housed in slums¹, unauthorized colonies² and JJ Clusters³. Approximately 73.5 lakh people of the 1.5 crore in Delhi live in slums and unauthorized colonies, and do not have access to basic civic amenities. Only 25 per cent of the population live in planned development areas (Mahapatra, 2012). There are approximately 4390 slums with a population of 28 lakh people residing in them (Government of India, 2010). Approximately 8 per cent slums are built along the municipal drains (nalas), 25.19 per cent are along the railways lines, and the remaining are located in other areas including open construction plots, disputed lands, amongst others (Ibid.). Unauthorized colonies have existed since the establishment of the Delhi Development Authority (DDA) in 1975. This was because DDA was unable to construct sufficient number of low cost housings and accommodate large-scale migration into the capital region. There are currently about 7 lakh families residing in unauthorized colonies.

¹ According to the Delhi Government, 'Slums' are defined as a compact settlement of at least 20 households with a collection of poorly built tenements, mostly temporary in nature, crowded together usually with inadequate sanitary and drinking water facilities in unhygienic conditions.

² Unauthorized colonies are illegal settlements in an area not earmarked for the purpose wherein development is being carried out, without obtaining permission.

³ JJ (*Jhuggi-jhopri*) Clusters are illegal settlements in an area consisting of badly built, overcrowded houses. *Jhuggi-jhopri* means a small roughly built house or shelter, which is usually made of mud, wood, metal having a thatch or tin roof. The materials used for construction of the *jhuggi-jhopris* are extremely toxic and hazardous to health.

People residing in slums and unauthorized colonies are mostly migrants involved in menial work, such as, construction, domestic work and other daily wage jobs. The family's monthly income ranges between Rs 5000–10,000. The households do not have access to basic civic amenities including electricity, sanitation, toilets, garbage and solid waste disposal, clean drinking water and a decent living. The living conditions have a negative impact on the healthy development of the child, as well as the community as a whole. We selected four AWCs in the Jawahar Camp slum and four AWCs in Geeta Colony (unauthorized colony) to study the functioning and impact of ICDS in communities that are not only financially constrained but also lack basic civic amenities and a decent standard of living.

Semi rural and rural areas: Delhi's rural population is slowly declining as it is becoming urbanized. During the inception of the ICDS, five projects were identified as rural in Delhi. These included Alipur, Mehrauli, Narela, Najafgarh and Kanjhawla. Although all these areas still come under the 'rural projects', due to urbanization and industrialization, most of them can be defined as semi-urban in nature. We therefore selected two sites under the rural projects, so as to learn about the functioning of ICDS in currently urbanized areas, such as, Mehrauli (four AWCs), as well as predominantly rural areas that are still existent in some parts of Najafgarh (two AWCs).

School based AWC: There is only one AWC in the Delhi region that is based within a school premises. This was the third distinct site for our pilot study. The AWC is located within the premises of the Government Senior Secondary School, Lado Sarai, Mehrauli Project. The place was allotted to ICDS by the government in 1984. The AWC was previously a *balwadi*. Upon discontinuation of the *balwadi*⁴, the government sanctioned the establishment of the AWC.

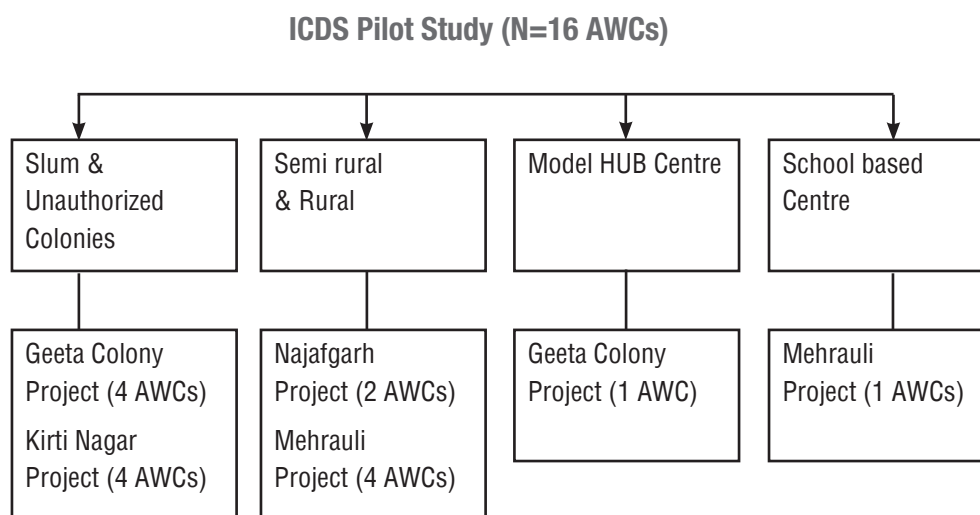
Model Anganwadi cum HUB Centre: The WCD has been involved in efforts towards universalization of the ICDS, since 2008–09. In order to increase the outreach as

⁴ *Balwadi* is a pre-school, which is usually run in rural areas and for economically weaker sections of the society either by the government or NGOs. It is typically for children between the ages of 3-6 years.

well as improve the quality of services being provided, the Delhi Government has approved an alternative Plan Scheme of 'Model Anganwadi cum HUB Centres'. Initially, eight Model Anganwadi cum HUB Centres were established in the northeast district of Delhi. Consequently, five more HUB centres have been set up in other parts of the city. The HUB centres act as a resource centre for 10 AWCs that are located in the nearby areas. It also has a 'model' AWC within its premises. By putting these HUB centres in place, the Government aims to improve the quality of services, particularly, growth monitoring, support to pregnant/ nursing women, immunization and early child-care education. According to MoWCD, the Anganwadi cum HUB centre would act as a catalyst to upgrade the skills of AWW, thus improving the quality of services provided. There is one AWC run at the HUB centre on a regular basis, and 10 other AWC's function through this HUB centre on a weekly basis. In order to understand the feasibility, implementation and functioning of the new model AWC at the grassroots level, the model HUB center in Geeta Colony was observed and information from the CDPO, supervisor, AWW and AWH was gathered. The HUB Centre observed was operated by a non-profit organization (NPO) called Stri Shakti.

Information for this study was therefore collected from a total of 16 AWCs across the four categories. Within each site the Anganwadi worker (AWW) [N= 16] and Anganwadi helper (AWH) [N=16] were interviewed using a rapid assessment questionnaire, semi-structured interview questions and focus group discussions. To ensure triangulation and to enhance the credibility and validity of results, supervisors [N= 6]; CDPOs [N=5]; officials of the Ministry of Women and Child Development [N= 4] and officials from Mobile Crèches [N=2] were also interviewed. The total sample for the study was 49. See Figure 6 for the sample distribution.

Figure 4: ICDS Pilot Study – Site Distribution



Data Analysis Plan

In order to evaluate the ICDS in Delhi, consultations were held with officials from the WCD and NGOs that are working on issues of early child care and have sufficient knowledge on the ICDS. These consultations were held to learn about the various types of ICDS centres and the overall working of the programme. In addition to this, meetings with NGO's such as mobile crèches also helped narrow down the sample sites for the study. After these consultations, study sites were selected through a mixed purposive sampling methodology. Firstly, theory-based sampling method was used to categorize the AWCs based on the kinds of ICDS location and centres described by the ministry. Four distinct categories of AWCs were identified:

1. AWCs in slum and unauthorized colonies in urban areas
2. AWCs in semi-rural and rural locations
3. AWCs in school-based setting
4. AWCs in Model Anganwadi cum HUB Centres

After identification of the four types of AWCs, emergent sampling was used to decide the study sites. The study locations that were chosen included:

1. Jawahar Camp, Kirti Nagar Project [slum area] [N= 4]
2. Geeta Colony [unauthorized colony] [N=4]
3. Lado Sarai/ Mehrauli Project [semi-rural] [N= 4]
4. Najafgarh [rural] [N=2]
5. Senior Secondary School, Lado Sarai/Mehrauli Project [school based] [N=1]
6. Geeta Colony [Model HUB Centre] [N=1]

Rapid assessment questionnaires, semi-structured interview questions and focus group discussions [FGDs] were utilized to gather information from AWW and AWH from AWCs in each of these study locations. In addition to this supervisors [N=6] and CDPOs [N=5] were also interviewed.

Rapid Assessment questionnaires consisted of topics such as basic services provided; number of beneficiaries; the timings and location of AWC; equipment's available at the centre; demographic characteristics of the AWW and AWH, amongst other questions. The semi-structured interview questions were a set of 29 questions that were divided into 4 topic areas (i) demographics (ii) knowledge on services provided at the centre, (iii) supervision, evaluation and financial disbursement, and (iv) overall working conditions and challenges. FGDs also utilized the semi-structured interview questions. These FGDs developed organically, in locations where more than one AWC was being observed. AWWs and AWHs from neighbouring centres also joined the discussions and provided imperative information on the functioning of the ICDS [See APPENDIX 2 for complete questionnaire].

Results

Rapid Assessment

Rapid assessment was conducted in all the study sites. The results from the assessment are presented in Table 1. Results indicate a presence of ICDS

equipment in all study sites, but a variation in availability of basic amenities. Our observation of the AWCs brought to light the poor state of the equipments in many study sites, particularly in the slum and unauthorized colonies. Therefore, even though the AWCs had the tools, they could not be used in an optimal manner due to their poor quality. The study sites in slum and unauthorized colony areas did not have weighing machines for children and quality pre-school educational kits (PSE). They also had small rooms that were poorly ventilated thus causing overcrowding.

With regard to basic civic amenities, while the semi-rural, rural, school based and model hub AWCs boasted of the presence of basic civic amenities, the slum and unauthorized colonies did not have most of them. They lacked clean drinking water, toilets, well-ventilated houses and an overall decent living condition. AWW, AWH and the community dwellers utilized tap water for drinking, cooking and bathing purposes. This water was not treated with any chemicals and therefore was unfit for consumption. Workers informed that many children and women who visited the AWC had symptoms of diarrhea, cholera, jaundice, and constant stomach pain as a result of lack of clean drinking water. Also, there was a recent breakout of measles (Khasra) in the community, which was attributed to unhygienic living conditions and lack of medical services. Jawahar Camp did not have any functional toilets in their area. The houses were not equipped with private bathrooms. The municipality has installed only 2 communal bathrooms for a population of approximately 12,000 people. This highlights the severe lack of investment by the municipal government and other responsible parties towards sanitation and hygiene. As a result of lack of amenities, open defecation was noted to be a wide spread phenomenon. Open drains/ nalas are utilized for defecation and garbage disposal. Unhygienic living conditions result in many illnesses causing poor health and development of majority of the children. The lack of basic amenities and proper tools act as a barrier in the successful implementation of various services offered by ICDS.

Table 1: Results from the Rapid Assessment

Service	Slum Area	Unauthorized Colony	Semi-Rural	Rural	School Based	Model Hub Centre
Equipment						
Medicinal Kit	Yes	Yes	Yes	Yes	Yes	Yes
Pre-School Educational Kit (PSE)	Yes	Yes	Yes	Yes	Yes	Yes
Weighing machine for adults	Yes	Yes	Yes	Yes	Yes	Yes
Weighing machine for children	No	No	Yes	Yes	Yes	Yes
Child growth charts	Yes	No	Yes	Yes	Yes	Yes
Utensils	Yes	Yes	Yes	Yes	Yes	Yes
Amenities						
Electricity	Yes	Yes	Yes	Yes	Yes	Yes
Clean Drinking Water	Yes	No	Yes	Yes	Yes	Yes
Functional Toilet	No	No	Yes	Yes	Yes	Yes
Awareness Posters	Yes	No	Yes	Yes	Yes	Yes
Food Storage Facility	No	No	No	No	No	No

Under the ICDS, the AWCs provide holistic services that are targeted towards curbing child malnutrition and overall child development and welfare of adolescent girls and women. The services provided include early childcare education and development programmes (ECCE), care and nutrition counselling, health services, community mobilization and awareness and day care services. Informally, the AWCs also act as resource/information centers for the community. The findings regarding the functioning of each of these programmes as well as the barriers that are faced by the AWWs, AWHs, supervisors and CDPOs in implementing these services, are presented below. The impact of these findings will be discussed more in-depth in the discussion and implications section of the report.

Supplemental Nutrition Programme (SNP)

All beneficiaries of the ICDS are provided with nutritious meals between 11.30 AM–12.00 PM through the Supplementary Nutrition Programme (SNP). The menu is decided in consultation with nutritionists, keeping in mind the budget that has been allocated. Upon restructuring of the ICDS, a budgetary allocation of Rs 6 per day for 140 gms per day, is made with respect to infants (7 months to 1 year; 1–3 years) and Rs 6 per day for 270 gms cooked food and 50 gms snacks, for children (3–6 years). All malnourished children are allotted Rs 9 per day. The adolescent girls and Kishori's (11–18 years) are allocated Rs 7 per day. Pregnant, nursing and lactating mothers are allotted Rs 9 per day. When the study was conducted, the updated budgetary allocations were not yet implemented in most of the sites. Although there was a regular supply of food through the SNP in all sites including the rural, semi-rural, slum, unauthorized colonies, school based and model HUB centre, the overall quality and nutrition content was not satisfactory. There were concerns regarding the nutritional composition of the diet, as there were limited vegetables and mostly food that was rich in carbohydrate and starch. Foods such as daliya, khichdi and rice pulao are high in carbohydrates and do not contain other essential food groups including protein, minerals, vitamins and fiber. Therefore while the participants might be meeting their required caloric intake, they are falling short of essential nutrients required for optimal growth.

Additionally, the preparation of food was another concern. The AWWs stated that many participants criticized the preparation techniques and lack of flavor. Some also complained that the menu is not culturally sensitive. Migrants from all over the country reside in majority of slums and unauthorized colonies. With varying food habits, meals provided to the community are not always catered to their specific pallet. Studies that focus on poverty and nutrition indicate that although people are poor, that does not mean they should be deprived of food with flavor (Banerjee and Duflo, 2005). Some AWWs suggested that addition of spices and vegetables might increase the cost marginally, but will lead to better nutritional outcomes. Also, providing alternate foods, such as chapatis instead of rice, a full vegetable dish instead of vegetable rice pulao might increase satisfaction with the food as well as its nutritional value.

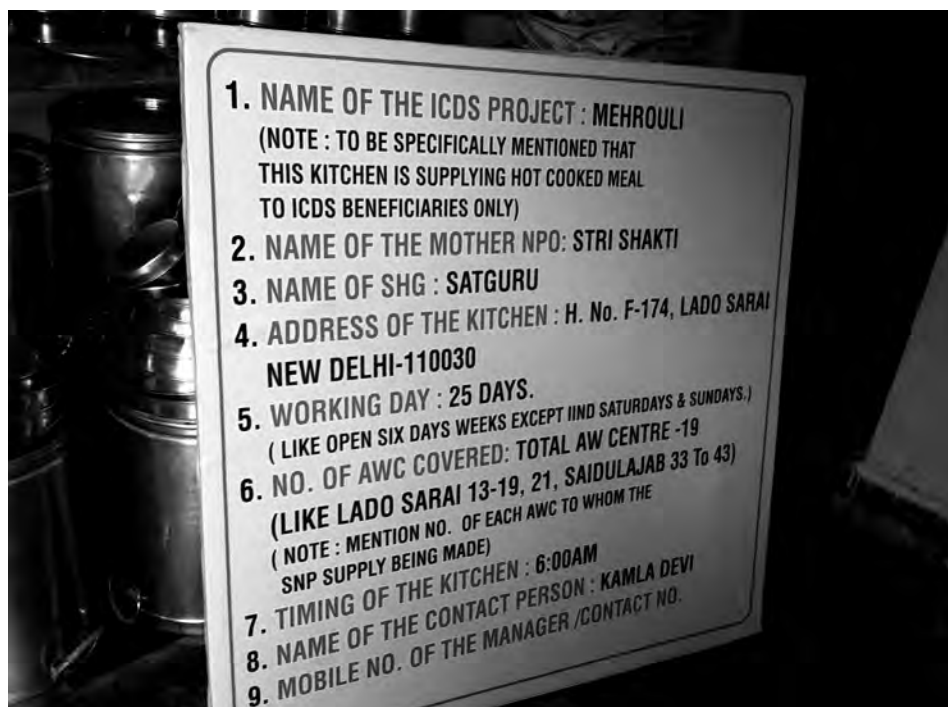
A specific concern of the AWCs in the rural areas was the distance of the kitchen from the centre. The AWW, AWH, and supervisor in the rural sites of Najafgarh indicated the need to have on site kitchens, where fresh food could be prepared and served to the beneficiaries. They suggested that in rural areas, since there is no problem related to space, kitchens should be on site and an additional helper/ cook should be provided. This would solve the problem of transporting food from kitchens that are located far away. This would also reduce chances of contamination and health hazards. This suggestion by the AWWs was in light of the high temperatures during the summer, and lack of air-conditioned transportation for the food, thus increasing the risk of food spoilage and contamination.

The SNP is facilitated by NPOs and is prepared by Self-Help Groups (SHGs). There are currently 23 NPOs facilitating SNP, and 411 SHG kitchens that are providing daily meals to the beneficiaries. Upon observing a SHG kitchen in the semi-rural site, we found that the food is provided regularly and the quantity is sufficient to feed the beneficiaries. Although our visit was unplanned, we observed that the sanitary conditions in the kitchen and storage area were optimal. While gathering information about the functioning of the kitchen and food delivery procedure we learnt that, the Government decides the menu for each day of the week. The NPOs calculate the quantity of raw products, including flour, rice, spices, and lentils amongst other things that are required for preparation of the meals. These materials are sent to the kitchens directly. Each kitchen cooks for approximately 13–21 AWCs in the area. Each morning the food is dispatched for AWCs at about 9.00 AM. Prior to dispatching the food it is tasted by the cook and ICDS supervisor. Upon arrival to the AWC, it is again checked by the AWW and AWH before distribution. This procedure is conducted to ensure that the food has not been tampered with and is safe to eat. See Figure 7, 8 and 9 for images of the kitchen and the weekly menu.

Figure 5: SHG Kitchen



Figure 6: Information Poster for SHG Kitchen



Immunizations, Health Care and Referrals

AWWs keep a record of all immunizations given to children from 0–6 years. These include the basic eight immunizations, that is, polio (3), BCG (1), DPT (3) and measles (1). Children and pregnant, nursing and lactating mothers are referred to the nearby dispensary to get immunizations and regular health check-ups. The AWWs also have the responsibility to remind women in their jurisdiction to get all required immunizations done on time. The AWWs at all sites mentioned irregularities in immunization of children, due to frequent visits to the village by them. As a result, the AWWs are unable to keep track of the immunizations received. This was more apparent in slum and unauthorized colonies, which is home to migrant workers, who return to their villages when they are unable find work or are required to visit family. The irregularities in immunizations also highlight frequent absenteeism from schools thus impacting overall well-being of the children. Rural sites expressed concerns about not having any dispensary close to their community, therefore finding it challenging for the children and women to get immunizations done on a regular basis. The AWCs in slums and unauthorized colonies informed us that there are no regular health camps conducted within the community by government hospitals. As a result, many households are often unmotivated to get immunizations, or fear the costs and issues of convenience related to it and are thus left behind. The AWWs reported that some government and private hospitals had previously conducted medical camps, which received a positive response from the community, but recently there have been no such efforts.

Along with required immunizations, the ICDS through the AWC provides health check-up referrals as well. This includes regular check-ups for children and women at the nearby dispensary. In addition to this, the AWWs are required to regularly check the weight and height of the children, to ensure that they are not underweight. The AWCs in the slum and unauthorized colony sites did not have infant weighing machines that have been allocated by the government to each Anganwadi centre implementing the ICDS programme. The AWWs when asked about the reason for the absence of these weighing machines stated that they did not know about the infant weighing machines and only adult weighing machines

were provided to them. This was contradictory to the information gathered from the other study sites and the WCD. This highlights the lack of efficient supervision and monitoring to ensure good quality implementation of the ICDS. This also suggests that there are disparities in tools provided to the AWCs in some areas, specifically the slum and unauthorized colonies. This has important implications for the ICDS, specifically in the context of its ‘universalization’, which should not be limited to universalization of services but also the quality of services offered.

Nutrition and Health Education

With respect to care and nutrition counselling, the AWW helps mobilize the community and spreads awareness with regard to importance of sanitation, nutritious diet, immunizations, family planning, prenatal and postnatal care for women, and general welfare of adolescent girls. In addition to this community mobilization and awareness building tactics are used to keep a record of any new pregnant mothers or infants in the community. Mahila mandals are held once a month, where pregnant and lactating mothers, as well as mothers of children between 0–6 years voice their concerns and are made aware on issues such as birth registration, immunizations, malnutrition, nutritious food, amongst others. As a part of nutrition and health education, the AWCs have awareness posters that provide information regarding nursing, nutrition, and health services. Interestingly, while these awareness posters are one of the required materials that are supposed to be provided by the WCD, only the rural and semi-rural sites had the posters. This is another example of discrepancy in materials provided to AWCs across different areas. See Figure 10.

Figure 7: Awareness Posters



Early Childcare Education and Development Program (ECCE)

This service recognizes the importance of early childcare and education. It is focused towards providing early childhood education services to children between the ages 3–6 years at the AWCs. The early education services are provided from 9.00 AM–11.30 AM. The tools for education and other related activities that are provided by the government are rudimentary. The tools include charts for alphabets and fruits, wooden toys to identify body parts and counting, and other small games to familiarize children with different hand movements. The AWWs reported that they are not provided additional resources to make innovative charts for the center. They have to often use a portion of their own salary to buy sketch pens, chart papers and decorative items to make informational charts for the children.

In addition to rudimentary education tools, the AWWs have limited training to impart quality early education to children. They are not trained as pre-school or early education teachers, and thus mostly work on imparting education after a short training offered to all AWWs and through their own experience and creativity.

The quality of services with regard to early education varied drastically through the different sites. The slum and unauthorized colony sites had very poor early education services. Most of this was related to the limited space available to the AWC as well as the lack of educational material. On the other hand, some AWCs exhibited self-motivation, despite having access to limited resources. A good example is the AWCs in the semi-rural site, [Lado Sarai/ Mehrauli] which were well decorated with awareness and education posters and charts created by AWWs with the help of the supervisor. In addition to this, AWWs in this site took extra initiative to develop early childhood education tools such as drawings depicting a poem, story-telling tactics, toys made from scrap material, amongst others (See Figures 11). However, it should be kept in mind that this was one of the unique cases, and other AWCs across the NCT might not have such features.

It should be highlighted that the model HUB centre had exceptional pre-school education services, as compared to all other sites. A detailed description

of components of the model HUBcentre is provided in the ‘sample section’ of the report.

Figure 8: ECCE Material by AWW and Supervisor in Mehrauli Project



Source: AWC in Lado Sarai/Mehrauli Project

The model HUB centre in Geeta Colony was observed and information from the CDPO, supervisor, AWW and AWH was gathered. The HUB Centre was operated by a NPO called Stri Shakti. All HUB centres in Delhi have been outsourced to NPOs. Although financial support for these centres has been taken into consideration in the budget, the NPO have not yet received any such assistance to run the centre. The Model HUB Centre is situated in a pucca building in a posh colony in Geeta Colony, and is rented for approximately Rs 17,000/-, which is significantly more than the rent money that is allotted to regular AWCs (Rs 750/- before restructuring of ICDS). The centre is equipped with all basic amenities, including clean drinking water, toilet, electricity, sanitary environment, well-ventilated rooms, separate area for playing and other activities. In addition to this the centre is also equipped with an air conditioner, separate kitchen and

supporting staff. This is vastly different from the situation of the regular AWCs in urban as well as rural areas of Delhi.

The centre simultaneously runs a private pre-school, thus teaching children from wealthier families in addition to children of low-income families participating in the ECCE programme offered through the ICDS. In addition to the AWW and AWH, there is a trained pre-school teacher who is hired at the centre from the NPO directly. This teacher is responsible for the early childhood education and development (ECCE) component of the ICDS and provides support to the AWW. In addition to this the CDPO along with the pre-school teacher developed a timetable for the children attending the AWC. The timetable had provisions for daily prayer, alphabet and number learning, drawing and other activities (see Figure 12 and 13). The quality of services provided at the HUB centre was distinctly better than those at regular centres.

Services for Adolescent Girls

In addition to services that are targeted towards children and mothers, an important aspect of the ICDS is also welfare and development of adolescent girls. There are two programmes, namely Kishori Shakti Yojna (KSY)⁵ and Sabla Programme⁶ that focus on overall well-being, vocational training and awareness

⁵ Kishori Shakti Yojna (KSY) is operational in 35 ICDS projects within Delhi. The objective of the programme is to make the adolescent girl understand and learn the significance of personal hygiene, environmental sanitation, nutrition, home nursing, first aid, health and nutrition education, family life, child care amongst other issues. In each selected Anganwadi area, 2 girls between 11–15 years are identified. These adolescent girls are provided with a meal equivalent to the pregnant women or nursing mother, that is, 500 calories of energy and 20 gms of protein. The two girls receive in service training at the Anganwadi from the AWW and Supervisor over a period of six months to become fully equipped individuals, capable of managing the centre on their own, so as to fully realize the objectives in all aspects, of the Anganwadi worker, including management of stores, the organization of the feeding programme, immunization schedules, weighing children, home visits, pre-school activities etc. For more information on KSY please see <http://wcdcl.in/ksy.html>

⁶ SABLA programme or the 'Rajiv Gandhi Scheme for Empowerment of Adolescent Girls' is implemented using the platform of the ICDS through the Anganwadi centres. The scheme would cover adolescent girls in the age group of 11–18 years under all ICDS projects in selected 200 districts in all the States/UTs in the country. In order to give appropriate attention, the target group would be subdivided into two categories, viz. 11–15 and 15–18 years and interventions planned accordingly. The scheme focuses on all out-of-school adolescent girls who would assemble at the Anganwadi centre as per the timetable and frequency decided by the States/UTs. The others, i.e., the school-going girls would meet at the AWC at least twice a month and more frequently during vacations/holidays, where they will receive life skill education, nutrition and health education, awareness about other socio-legal issues etc. This will give an opportunity for mixed group interaction between in-school and out-of-school girls, motivating the latter to join school. For more information on SABLA please see <http://www.cdpo.myewebsite.com/articles/sabla-scheme.html>

building of girls aged 11–18 years. The slum, school-based, rural and semi-rural sites did not have a functional Sabla Programme. KSY was functional in all sites. Also adolescent girls that were school dropouts were given iron tablets once a week. There were no services offered to school-going girls. Some of the challenges that are faced in implementing the Sabla programme include:

- Unavailability of proper infrastructure to conduct activities of the Sabla programme. The AWCs in urban areas have limited space and cannot accommodate many girls. School buildings were suggested as an alternative, but authorities expressed concerns about safety, and obstruction of school routine.
- The timing of the Sabla programme is 4.00 PM onwards. As the AWCs are mostly rented for a particular time frame, that is, 9.00 AM–2.00 PM, it is sometimes difficult to negotiate with landlords to extend the time.
- The work timings for supervisors is from 7.00 AM–2.00 PM. There is therefore no official to supervise and monitor AWWs and AWH at 4.00 PM and to keep a check on whether the programme is functioning.
- Due to increase in crimes against girls and women in Delhi, parents are afraid to send their daughters for vocational training programmes and activities that are conducted outside their community.

Figure 9: Learning activities at the HUB Centre



Source: Model Anganwadi cum HUB center, Geeta Colony

4 | Discussion of the Results

The major gaps and challenges experienced by the ICDS service providers during the implementation of the program across all study sites have been depicted in Table 2. Table 2 indicates that challenges related to basic civic amenities, such as, clean drinking water, functional toilet and sanitary environment was most prevalent in slum and unauthorized colonies. As a result of poor hygiene and sanitation, children and women who are participating in the ICDS program as well as their families are unable to reap the full benefits of the programme. This is because, the environmental factors expose them to various diseases, thus impacting their overall health conditions. On the other hand, it also impacts the work conditions of the service providers. As mentioned in the previous section, Jawahar camp had only two toilets for approximately 12,000 people residing in the camp. Unsanitary and unsafe toilets were noted to have a significant impact on the working conditions and feelings of motivation for the service providers.

Another challenge was the limited space and number of households utilizing the ICDS services. The rented homes for the AWCs have limited space and are poorly ventilated. This is partly due to limited space available in the locations where AWCs are placed as well as the very low rent that is allocated to house the ICDS programme [Rs750 before restructuring of ICDS]. In addition to this, although most of the households are enrolled in the ICDS, they do not regularly visit the AWC, except for using the SNP service. Many AWCs have limited number of children that attend the ECCE program, due to an increase in number of private pre-schools that are being established in the neighbourhood.

AWWs and supervisors expressed that parents prefer to send their children to private schools rather than the ECCE programme due to the perception of obtaining better education and environment for the children. Although most private schools might not be educationally invigorating as they are perceived to be, the early education services offered through ICDS do not meet quality standards as well. The AWWs are far from being trained early education professionals and therefore

lack the skills to provide quality education to the children. The Model HUB Centre was the only study site that had well-developed facilities and resources to provide good quality early education. Interestingly, the AWW in the semi-rural Mehrauli AWC had innovative methods to educate children, despite limited resources. After speaking with the supervisor, we learnt that this was one of the unique cases, as most AWWs are not trained as pre school teachers. Most families are not fortunate to send their children to AWCs such as the above and are obligated to participate in the ECCE programme as they do not have a choice due to financial constraints or lack of good early education schools in their vicinity.

Additionally, many households stay enrolled in the ICDS programme through the AWC, to take advantage of any new government services and concessions that might be offered in the future. Thus, while the number of enrollments might be high, it is not a true reflection of the regular beneficiaries and thus the direct impact of the ICDS cannot be measured.

Another challenge was the implementation of the SABLA programme across all study sites. Although the SABLA programme has a noble aim, it fails to reach the target population. Some of the major barriers for the success of the programme include lack of safety and proper infrastructure; lack of effective supervision; and restricting the target population to 'school dropout girls' only, amongst other issues. The service providers expressed concerns about poor planning and execution of the SABLA programme. According to them most of the AWCs are rented for a short period of time (approximately 4–5 hours) exclusively for the ECCE and SNP service. As the SABLA programme is scheduled for the evenings, most AWCs are unavailable for use. This leads to lack of space to conduct the programme. Although some schools have allowed ICDS to conduct the SABLA programme in their premises there are reservations against it due to additional responsibility for the school administration and potential risks specifically in all-boys school premises. Also, families of SABLA participants have concerns regarding safety issues as the services are not offered within the community. As a result, parents fear that their daughters are exposed to risks if they attend the programme. Lastly, the service providers also expressed a disconnect in the life skills that are being taught as against what is considered

more relevant in today's time. The life skills programme has been set by policy makers that are not in touch with the skills and information that the youth need in today's time. Therefore, most participants do not find the life skills classes helpful. Additionally the methods used to impart knowledge are uninteresting. Use of innovative and creative methods to impart knowledge might increase the interest of the participants in the programme and therefore reduce dropout rate and attract more adolescent girls to participate.

With regard to SNP, concerns were raised across all sites about preparation of meals according to cultural tastes and requirements. They stated that due to a high percentage of migrants in the NCT, beneficiaries belong to various parts of the country. Therefore the diversity of the beneficiaries should be taken into consideration while preparing the menu for the SNP meals. For example, in the rural area of Najafgarh, the beneficiaries belong to the Haryana belt, and as such are not rice eaters. Therefore rice and daliya products should be replaced with chapatis, atleast for once a week. More importantly, the nutritional content of the food provided were of concern. The nutritional value of the meals is limited and does not provide a complete combination of required foods that ensure healthy development of the children and women. The lack of nutrients in the food provided by SNP makes one question the validity of the overarching aim of the ICDS programme which was established to improve child nutrition rather merely tackle only starvation.

With regard to challenges faced by the service providers, the AWWs as well as supervisors expressed deep concerns with regard to their employment status as also honorarium received. The AWWs are not accorded status of an employee. The AWWs receive an honorarium of only Rs 5000/- per month. The payments are irregular. As the AWWs are mostly not the sole earners within their household, they manage to get support from other family members, especially in months when they do not get paid. In addition to this AWWs also expressed concerns about being hired on a contractual basis and not getting any travel or day allowances or health care benefits. They expressed that the work timings and the work load was similar to that of a full time employee. Supervisor's expressed similar apprehensions as well. In addition to the low and irregular honorarium

and the status of a contractual worker, the supervisors expressed concerns about the timings of work, which is a cause of family discord. Supervisors have to arrive everyday at 7.00 AM at the kitchen that supplies food for the SNP to their respective AWCs. Due to recent incidences of contamination in food, the supervisors have been directed by the WCD to be present during preparation and dispatchment of the food, in order to check the quality of the food. As a result, supervisors have to often leave their homes at early hours, ranging from 5.00–6.30 AM to reach the kitchens. This has led to neglect of their own households and family life. Some supervisors informed us, that they have frequent arguments with their husbands and the children often feel neglected. Although some husbands are supportive and have taken up the responsibility of making breakfast, packing lunch and dropping children to school, there are others who are not supportive of the change in working hours. Lastly, due to shortage in staff the supervisors and CDPOs have increased work loads. As per the WCD each supervisor is responsible for 20–25 projects, but due to shortage in staff, they have to supervise and manage between 50–60 AWCs. Similarly, CDPOs are responsible for three projects (one project= 100 AWCs). There are some CDPOs that are currently handling upto five projects. As a result of the increased workload, the quality of service that is being provided at each level is being affected. The supervisors and CDPOs are overworked and therefore are unable to effectively supervise and manage the AWCs. This, as a result impacts the quality of work of the AWWs and AWHs as well as the overall implementation of ICDS.

Table 2: Gaps and Challenges across Study Sites (N = 16)

	<i>Slum and Unauthorized Colonies</i>	<i>Semi-Rural and Rural</i>	<i>Model Hub Centre</i>	<i>School-run Centre</i>
Basic Amenities				
Electricity	X	Yes	Yes	Yes
Functional Toilet	X	Yes	Yes	Yes
Clean Drinking water	X	X	Yes	Yes
Food Storage Facility	X	X	No	No
AWC room	X	X	Yes	Yes
Provision of meals	Yes	Yes	Yes	Yes
Services				
ECCE	X	X	Yes	No
SABLA Program	X	X	No	No
Kishori Shakti Yojna	X	Yes	Yes	Yes
SNP	X	Yes	Yes	Yes
Health Services	Yes	X	Yes	Yes
Counseling & Community awareness	Yes	Yes	Yes	Yes
SNP Functioning				
Quality of food	Yes	Yes	Yes	Yes
Culturally relevant food	X	X	X	X
Service by SHG	Yes	Yes	Yes	Yes
Daily check of food	Yes	Yes	Yes	Yes
AWW challenges				
Honorarium	X	X	X	X
Work environment	X	X	Yes	Yes
Safety	X	X	Yes	Yes
Uniform	X	X	Yes	Yes
Work contract	X	X	X	X
Community Support	X	Yes	X	Yes
Supervisor Challenges				
Honorarium	X	X	X	X
Timings	X	X	X	X
Transportation	X	X	Yes	Yes
Work Environment	X	X	X	X
Work Load	X	X	X	X

Note: 'X' represents presence of challenge

'Yes' represents availability of the resource in the AWC

5 Recommendations

The ICDS is India's flagship programme that is focused towards eliminating child malnutrition. Despite an extensive budget and implementation plan, India continues to have one of the highest child malnutrition and under five mortality rates. The findings of this pilot study highlight some of the challenges that the ICDS is facing. Based on the findings, below are some recommendations:

- **Focus on child malnutrition:** The ICDS was established to reduce child malnutrition and food insecurity. Despite the extensive planning by the government, millions of children still continue to suffer from malnutrition. Reports by the right to food campaign have highlighted the failures of the program and waste in resources. The failures have been attributed to limited funding in ratio to the growing child population, mismanagement of funds, corruption and lack of coordination between various stakeholders that are responsible for the implementation. In addition to this, there is little focus on the first two years of child's nutrition, which are the most important years to ensure child health (Smith et al, 2003). The current ICDS programme does not have any significant impact on infant malnutrition. In order to ensure reduction in malnutrition and under-five mortality rates, there is need to refocus the programme on the issue of food and nutrition security of children and, pregnant, lactating and nursing mothers, rather than broadening the goals of the programme to include other services. This will ensure that all present resources are directed towards improving the nutritional status of the beneficiaries.
- **Inadequate resources:** The ICDS budget allocates Rs 750/- as rent for each AWC [these rates are prior to the implementation of the restructured ICDS budget]. The AWW is responsible to find a room to rent for the AWC in their area. Keeping in mind the property prices in NCT, it is nearly impossible to get a decent sized, well ventilated room in this price range. As such most AWCs are rented for a specific time frame, that is, 9.00

AM–2.30 PM, from private home owners. After 2.30 PM, the home owners return, and the AWC is then converted back into a home of the owner. Usually the owners furniture, such as, bed frame, almira, utensils, amongst others occupy more than 50 percent of the room. Some landlords do not allow AWWs to put posters and charts on the wall. As a result AWWs in some centres have a daily routine of putting up the posters in the morning and bringing them down at the end of the day. In addition to this, the rents are often not paid regularly to the landlords. They receive payments once in 3–4 months, thus leading to harassment of the AWW to vacate the premises. Another issue concerning space, specifically in slum and unauthorized colonies, is that even if the rent amount is increased, there is no space available due to the high density of population and overcrowded construction, to house an AWC in a place that is well ventilated and spacious. To tackle this problem, the Delhi Government should allot government-owned rooms that are built specifically to run the AWC. This will help save the AWWs from harassment faced at the hands of the landlords, save the rent that is going to private home owners and lastly, and most importantly, provide a well established infrastructure that is designed specifically for the AWC. Another method that could be used to provide a suitable space to the AWC is by establishing them in government schools. This suggestion was also put forth by the officials at the WCD, as well as the supervisor, and CDPO of the school-run centre. By locating AWCs within schools, service providers and beneficiaries can benefit from the infrastructure of the school, thereby getting access to clean drinking water, functional toilets, and a sanitary environment. In addition to this, children between ages 3–6 years that are attending the day-care creche service of the ICDS, will get acquainted to the school environment and will therefore be school ready.

The budget allocation to the meals through the SNP also needs to be revisited. Keeping in mind the inflation in food prices, adequate nutrition cannot be ensured with the present per person per meal budgeting norms. The WCD should therefore enhance the current limit in order to have the flexibility to include food items that will improve the nutritional status of the beneficiaries.

- **Basic Civic Amenities:** The environment in which one lives in, has a significant impact on the overall well being and development of an individual (Brofenbrenner,1979) . While the ICDS aims at providing health services, nutrition, education, counselling and awareness services, all these efforts would be futile if the environment of the target population is not enabling. A large number of beneficiaries of the ICDS live in communities that have very poor sanitation, specifically: lack functional toilets, absence of proper garbage disposal facilities, and clean drinking water. The overall living conditions are inhumane and uninhabitable. In this context, individuals are exposed to innumerable infections and diseases that have a negative impact on their health. Even if the AWCs provide nutrition, and health services such as immunizations and health awareness strategies, the health of the beneficiaries will remain poor due to lack of basic civic amenities. Therefore, the ICDS should partner with the Municipal Corporation of Delhi (MCD) to make communities more habitable and hygienic. Steps by the MCD should include ensuring proper garbage disposal; regular cleaning of open sewage and an effort to convert them into closed sewage systems; communal toilets that are at a ratio of 1:2 households and where possible private toilets should be constructed; safety and cleanliness of the toilets; clean drinking water and an effort to stop open defecation. The MCD can partner with corporates that are providing chlorine tablets and other innovative methods to have clean drinking water in low income communities as a part of corporate social responsibility (CSR) , for example, Proctor & Gamble's Children's Safe Drinking Water Project. With an improvement in the environment of the beneficiary, the ICDS services will lead to better results.
- **Early Childhood Education and Development (ECCE) Initiative:** Pre-school education is an important catalyst towards proper brain development and functioning. While the policy developed on ECCE is remarkable and highlights the importance of preschool education, its implementation at the grassroots is tardy. Most of the AWWs are ill-equipped as they are not trained as pre-school teachers, resulting in low quality early education services. Most of the centres do not have

the resources to provide an enabling environment and resources to aid pre-school teaching. Very few centres, such as one of the AWC's in the Mehrauli project, boasted of innovative early education practices. The Model HUB Center at Geeta Colony is an apt example of good quality early education, as it has a trained pre-school teacher, as well as proper facilities to cater to the needs of the children. The government should attempt to relocate AWCs to schools which have a conducive environment and a well developed educational infrastructure that is equipped to undertake the ECCE initiative. In addition to this, the government can partner with private pre-schools and day schools, to open AWCs within their premises and thus benefit from their resources. Also trained pre-school teachers should be appointed to visit the AWC atleast once a week to monitor the teaching as well as provide new techniques.

- **Model Anganwadi cum Hub Centre:** Though the Model Anganwadi cum HUB Centre in theory is a noble solution towards improving the quality of services of AWCs, it is not a very pragmatic approach. The Model Anganwadi cum HUB Centres cater to a very limited population. According to the WCD, each HUB Centre should cater to 10 other AWCs. By this calculation as of now there are only 143 out of 10,897 AWCs that are being supported by the HUB Centre (there are currently only 13 HUB Centres opened in Delhi). In addition to this, the infrastructure of the HUB Centres is far superior than that of the regular AWCs. Keeping this in mind, it poses a grave challenge to AWWs to provide similar services to the beneficiaries as that being provided in the HUB Centre. In order to improve the quality of services of the AWCs it is important to reach out to the majority of the AWCs and to provide each of them with an infrastructure which is similar to the HUB Centres. This will help to provide good quality service to a wider audience, and will benefit all beneficiaries equally.
- **Overall working conditions of service providers (AWWs, AWHs, supervisors and CDPOs and SHGs associated with the kitchens):** The service providers are the primary facilitators of the ICDS services at

the ground level. It is therefore imperative to provide enabling working conditions and proper training to them, in order to ensure delivery of good quality services. The AWWs are hired on contractual terms and are given an honorarium of Rs 5000/- per month. These payments are not given regularly. They are also not paid any travel or daily allowances and do not have any health care protection. The AWWs work for five and a half hours on an average. Their workload is similar to that of a full time employee. Steps should be taken towards timely payment of honorarium. In addition to this, keeping in mind the high living expenses in the NCT, the honorarium should be either increased, or health benefits, travel and daily allowances should be given to the AWWs as well as the AWHs (AWHs earn Rs 2500/- per month). With regard to supervisors, in addition to the low and irregular payment, they do not have an office space to work. The supervisors are often found working in the AWCs when they are not supervising or monitoring AWWs. An office space should be allotted to the supervisors, to conduct any official work, such as preparing reports. In addition to this, the work timings of the supervisors, which is from 7.00 AM–2.30 PM has been causing family discord. The supervisor has to leave her house between 5.30 AM and 6.30 AM daily, to monitor the food being prepared at the kitchens for the AWCs. Measures should be taken to ensure that the SHGs and NPOs are doing their work efficiently, so that supervisors do not have to make daily visits to the kitchens. The supervisor can visit the kitchens twice a week or on a weekly basis to do random/ surprise checks to ensure that the food quality is satisfactory.

Each supervisor is responsible for 20–25 AWCs. Due to shortage in staff, supervisors are handling upto 50–60 AWCs. As a result of the increased workload, the supervisors are unable to perform well. They are heavily burdened by paper work, and are unable to do more than 2–3 visits per day. As a result many of their centres get neglected. In order to ensure effective monitoring and supervision of the AWCs, the workload of the supervisors should be reduced and additional supervisors should be hired. Also, those supervisors that are responsible for remote rural projects should be provided with proper transportation facilities, as there

is lack of appropriate conveyance to get to the centres, thus affecting timely supervision.

- **Access of ICDS for at-risk population:** The WCD has taken measures to universalize the ICDS, from 2008–09 onwards. In an advent to universalize the scheme, it is important to take measures to incorporate at-risk and vulnerable populations that are often left behind, such as street children, special needs children, and orphan and abandoned children. Although these children are covered under other national schemes and policies, measures should be taken to increase accessibility of ICDS to these groups. Steps such as introduction of ICDS in orphanages; census of number of orphans, abandoned and street children in the district; active targeting and mobilization of these groups; special training to AWWs and AWHs to deal with special needs children; amongst others.

6 | Caveats

Although this pilot study provides important information regarding the ICDS and its implementation through the AWCs, it has limitations that should be recognized and addressed in future studies. Firstly, the study is a pilot and therefore provides information about very few sites within the NCT. Therefore, the study results cannot be generalized to all AWCs in the NCT or other areas. Secondly, the study was designed to look at the challenges and barriers that are faced primarily by the service providers, and therefore does not give a holistic overview, which encompasses views of the community and beneficiaries.

In order to develop a stronger study that provides a complete account of the ICDS, there is a need to do an in-depth mixed method study that looks at both the views of the service providers and the beneficiaries. In addition the study should focus on the assessment of the quality of services provided through quantitative measures as well as qualitative focus group discussions and interviews with service providers and beneficiaries.

7 | Conclusion

The Integrated Child Development Scheme (ICDS) implemented through the AWCs is a flagship of the Government of India to address child malnutrition. It is the only government program within the country that can serve to support children realize their right to adequate food as stipulated in the National Food Security Act, 2013, Convention on the Rights of the Child (CRC) and the Universal Declaration of Human Rights (UDHR). Despite ongoing efforts of restructuring ICDS, the rates of child malnutrition continue to grow. There is also a limited focus on maternal well-being, which an essential determinant of child health. Woman empowerment, nutrition and household allocation of food continues to be an issue that is interrelated to the successful implementation of the ICDS.

Although the scheme is well-developed, there are many gaps that have been affecting its implementation, thus marginalizing its overall impact. This pilot study helped to explore and gain an insight on some of the challenges that are faced by the service providers. It also helped to highlight areas of gaps between policy formulation and their implementation. However, in order to obtain a deeper understanding of the challenges and gaps, and to provide recommendations to restructure the ICDS to target its original aim of reducing child malnutrition, there is need to conduct a more in-depth study encompassing views of service providers as well as the beneficiaries.

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APPENDIX 1

1. STRENGTHENING & RESTRUCTURING OF ICDS (Source: WCD, 2014)

The components of the restructured ICDS include:

- i) Repositioning AWC as a 'vibrant ECD centre' to become the first village outpost for health, nutrition and early learning – minimum of six hours of working, focus on under-3s, care and nutrition counselling particularly for mothers of under-3s, identification and management of severe and moderate underweight through community-based interventions Sneha Shivirs, decentralized planning and management, flexible architecture–flexibility to states in implementation for innovations, strengthening governance – including PRIs, partnerships with civil society, introducing APIP and MoUs with states/UTs, etc.
- ii) ICDS will be implemented in a Mission Mode with National Mission Directorate and National Mission Resource Centre to become operational from the first year of 12th Five Year Plan.
- iii) Restructured and strengthened ICDS will be rolled out in three years as under:
 - a) In 200 high burden districts in the first year (2012–13);
 - b) In additional 200 districts in second year (2013–14) (i.e. w.e.f. 1.4.2013) including districts from special-category states (Jammu and Kashmir, Himachal Pradesh and Uttarakhand) and North-East Region.
 - c) In remaining districts in third year (2014–15) (i.e. w.e.f. 1.4.2014).
- iv) Cost norms for Supplementary Nutrition Programme (SNP) have been revised, as per details given below on an existing cost sharing of 50:50 (NER 90:10).

Category	Existing Norms (w.e.f. 16.10.08)	Proposed Norms effective from the date of approval (per beneficiary per day) as per phased roll out.
(i) Children (6-72 months)	Rs.4.00	Rs.6.00
(ii) Severely underweight children (6-72 months)	Rs.6.00	Rs.9.00
(iii) Pregnant women and Nursing mothers	Rs.5.00	Rs.7.00

However, the revised rates would follow the phasing of the programme.

- v) Cost norms of other existing components, such as medicine kits, pre-school education (PSE) kits its, monitoring, rent for AWC buildings and for the office of child development project officers (CDPOs), POL, information, education and communication (IEC) (old component), uniforms and badges, procurement of equipment/furniture (non-recurring), administrative expenses, etc. have been revised.
- vi) Additional human resource will be provided at different levels.
- vii) Introduction of following new components under the ICDS Mission on a cost sharing pattern of 75:25 between the centre and the states (NER 90:10) to be implemented in a phased manner as per the roll-out plan:
 - a) Construction of 2 lakh AWCs buildings during 12th five year plan, funding for which would be provided @ Rs 4.50 lakh per unit. It has also been decided that the rate for construction of AWC building @ Rs4.5 lakh per unit be extended to NER States also.

Planning commission would issue directives to states and line Ministries for mandatory allotment of funds from state resources and leverage funds under different similar schemes for construction of AWC buildings.

 - b) Provision for maintenance of AWC buildings housed in a government building @ Rs2000 per AWC per annum has been made.

- c) With a view to address the menace of malnutrition in those districts where it is prevalent most, a Nutrition Counsellor cum Additional Worker (per AWC) would be provided in 200 high burden districts on demand.

A link worker to be provided in other districts, on demand. The incentives proposed for link workers including ASHA under NRHM would be linked to outcomes.

- d) 5 per cent of the existing AWCs would be converted into AWC-cum-creche. States/UTs will have the flexibility in choosing such AWCs.
- e) It has been decided to re-design and strengthen the package of six services. This is with a view to transform AWC as a vibrant ECD Centre. The components under the re-designed and strengthened package inter-alia include Early Childhood Care Education and Development (ECCED) (ECCE/Pre-school non-formal education and supplementary nutrition), Care and Nutrition Counselling (IYCF Promotion & Counselling, maternal care and counselling, care, nutrition, health & hygiene education, community based care and management of underweight children), health services (immunization and micronutrient supplementation, health check-up and referral services) and community mobilization, awareness, advocacy and IEC (IEC, campaigns and drives, etc).
- f) Roll-out of Mother and Child Protection Cards prepared by using new WHO child growth and development standards would be universalized.
- g) It has been decided to assign management and operation of upto 10 per cent projects to PRIs and separately to NGOs/voluntary organizations.
- h) Further, management of moderately and severely undernourished children (Sneha Shivirs), IEC/Advocacy, promoting IYCF practices, strengthening monitoring and evaluation and MIS and ICT, grading and accreditation of AWCs and reward scheme would also be undertaken.
- i) In respect of health check-up of beneficiaries at the AWC, NRHM would provide the doctors preferably on monthly basis but at least once in a quarter.

- vii). The Government has also approved various measures to improve human resource management under the ICDS.
- ix) Training and capacity building would be strengthened inter-alia consisting of (i) strengthening training at state levels – setting up of training cells at state levels, setting up of state training institutes for ICDS (in 10 states); (ii) strengthening of NIPCCD through training resource centre for ICDS; (iii) strengthening of MLTCs and AWTCs – monitoring and accreditation; (iv) revision and development of course curricula /modules/training and learning materials; (v) upgradation of training facilities; (vi) regular training programmes; (vii) training-need assessment; and (viii) revision of financial norms.
- x) Institutional Arrangements for ICDS Mission:
- a) A National Mission Steering Group (NMSG) under the Chairpersonship of Minister in charge of MWCD will be constituted. NMSG will be the apex body for providing direction, policy and guidance for implementation of ICDS.
- b) An Empowered Programme Committee (EPC) under the Chairmanship of Secretary, MWCD would be formed at the national level for effective planning, implementation, monitoring and supervision of ICDS Mission.
- Similar structures at the state level would be created under the Chairpersonship of Chief Minister and Chief Secretary, respectively; ICDS mission will report to Prime Minister's Council at national level on nutrition, child development including early learning, etc. Similarly, at the state level, the State Mission will report to the Chief Minister of the State on the above aspects.
- c) There would be a National ICDS Mission Directorate to be headed by the Joint Secretary as Mission Director vested with appropriate executive and financial powers.

- d) Similarly, a state ICDS Mission Directorate will be established which will be headed by the state Mission Director who will be a senior officer of the state government/UT. The state Mission Director would be vested with appropriate executive and financial powers as approved by the state ICDS Mission/SEPC.
- e) District Mission Unit will be operationalized as per the phasing plan of the ICDS Mission.
- f) EPC has been empowered to approve APIPs as well as make modifications of norms of approved schemes / items of expenditure, within the overall budget of ICDS Mission / Ministry of Women and Child Development;
- g) Decentralized planning and management will be ensured through Annual Programme of Implementation Plan (APIP) and MoUs with flexibility to states for innovations.
- h) State Child Development Society will be set up at the state level with powers to set up its District Units. Fund transfer of the ICDS Mission will be channelled through the consolidated fund of the state. In the event, the State fails to transfer the funds within 15 days, it will be liable to pay interest on the amount on the pattern of releases for the finance commission funds.
- xi). The goal of the ICDS Mission would be to attain three main outcomes namely;
 - i) prevent and reduce young child under-nutrition (percentage underweight children 0–3 years) by 10 percentage point; (ii) enhance early development and learning outcomes in all children 0–6 years of age; and (iii) improve care and nutrition of girls and women and reduce anemia prevalence in young children, girls and women by one-fifth. Annual Health Survey (AHS) and District Level Household Survey (DLHS) will be used as baseline for measuring the outcomes of ICDS mission.

APPENDIX 2

QUESTIONNAIRE FOR ANGANWADI WORKERS AND HELPERS

Complete Information below for all AWCs

District: _____

Location/ Town: _____

Type of Area:

- Urban
- Rural

AWC ID: _____

Date: _____

Full Name of AWW: _____

Interviewer's Name: _____

SECTION I: RAPID ASSESSMENT OF ICDS & AWC*Staff/ Children (Q1)*

Person	Appointed/ Enrolled		Present	
	Anganwadi Worker			
Helper				
Total No. of children between 0-6months	BOYS	GIRLS	BOYS	GIRLS
Total no. of children between 7months to 1 year	Boys	Girls	Boys	Girls
Total no. of children between 1-3 years	Boys	Girls	Boys	Girls
Total No. of children between 3-6	BOYS	GIRLS	BOYS	GIRLS
Total No. of Pregnant and Lactating Mothers / Adolescent Girls				

Information on Anganwadi Centre

Q2. Was the centre open when it was visited?	<ol style="list-style-type: none"> 1. Yes 2. No
Q3. In the last month, How many days did the Anganwadi Centre work? If it was not open for all days, what were the hurdles?	
Q4. What is the opening and closing time of the centre?	
Q5. Are there any official records kept for services provided at the centre? How do you manage the recording keeping process?	
Q6. Where does the AWC run from?	<ol style="list-style-type: none"> 1. School 2. Private building other than AWW home 3. Government Building 4. Home of AWW 5. Other _____
Q7. What type of building is the AWC in?	<ol style="list-style-type: none"> 1. Pucca 2. Semi-Pucca 3. Kutcha 4. In the Open

Equipment (Q8) (Tick mark)

Equipment	Not Present (<i>Interviewer prompt- why is the equipment not present?</i>)	Present (<i>Interviewer prompt- ask about condition of equipment and its usability</i>)
Medicinal Kit		
Pre-School Education Kit (PSE) including toys		
Weighing Machine for Adults		
Weighing machine for children		
Child growth charts		
Utensils and stove		
Food menu/ posters		
Education posters (ABC/ numbers)		

Basic Services (Q9)

Basic Service	Yes/No	Remarks
Electricity		
Clean Drinking Water		
Functional Toilet		
Source of Food (Known or Unknown?)- <i>Ask about quality of food, regularity, and knowledge about source of food.</i>		
Place to store food supplies at the center		
Awareness posters		
Any services provided to special needs children (<i>Ask about disabled, orphaned, lower caste children</i>)		

Knowledge on Services provided at the Centre

Q10. What is the role of the Anganwadi Worker?

Q11. What is the role of the Anganwadi Helper?

Q12. What are the services provided at the center relating to ICDS programme categories?

Program/ Service	Remarks (<i>Interviewer should ask about services provided and hurdles faced in provision of services</i>)
Early child care education and development programme (ECCE)	
Care and Nutrition Counselling	
Health Services For children	
Health services for adolescent girls/ lactating and nursing mothers	
Community Mobilization and Awareness building [talk about role of Worker]	
Day Care/ Creches	
Sabla and Kishori Shakti Yojna for Adolescent Girls	

Q13. What is the type of training that the AWW and helper receive? Are there any specific tools provided to help workers work with special needs children? *(Ask about early childhood games; number of disabled children that come to the centre; any exclusion faced by them?)*

Q14. Are there any orphan and abandoned children; children in child-headed households in your community where you run the AWC? How do you reach out to these children to implement the ICDS?

Q15. Have children been given food at the center regularly?

1. Yes
2. No
3. Don't know

Q16. If Yes, how frequently?

1. Daily
2. Weekly
3. Once in 15 days
4. Monthly
5. Once in 6 months
6. Yearly
7. NA

Q17. Where does the food come from? What is the process of receiving the food at the AWC?

Q18. Is there any shortage in food supply at the center?

1. Yes
2. No

Q19. Is there any left over food at the center after giving it to the children and women? If no, skip Q18.

1. Yes
2. No

Q20. What is done with the leftover food?

1. Stored at the center
2. Taken home with the AWW or AWH
3. Thrown away
4. Other _____

Q21. Do pregnant and lactating mothers get food to take home? Are there any other services provided to them? What problems do you face in providing these services?

Q22. What services provided for adolescent girls (Age 13 years and above)?
What other services according to you should be provided? Eg. – health camps,
education on sanitation etc.

Supervision, Evaluation and Financial disbursement

Q23. How many times have the supervisor and or health worker visited the center
for monitoring in the last two months?

1. Weekly
2. Monthly
3. Once in 3 months/ quarterly
4. Once in 6 months
5. Other _____

Q24. How many times has the CDPO visited the center for monitoring in the last
three months?

1. Weekly
2. Monthly

3. Once in 3 months

- 4. Once in 6 months
- 5. Other_____

Q25. What information do the supervisor and CDPO ask for when they come for these monthly visits?

Social and Demographic Characteristics of the Anganwadi Worker and Helper (Q27)

Demographic Characteristics	Anganwadi Worker	Anganwadi Helper
Age		
Level of education		
Monthly Income		
Previous Occupation		

Q28. Did you get your last months salary?

- 1. Yes
- 2. No

If not, why haven't you received it?

Q29. Are you satisfied with your salary? If not, why aren't you satisfied?
[Interviewer should ask about cost of living, additional expenditure on work related material; other expenses]

Q30. Do you have any other source of income besides working at the centre?

Where do you get this income?

- 1. Yes
- 2. No

Q31. What is your contribution to the total household income? Who are the other people in your household that are working? [*Interviewer should ask about additional family members, how many dependents are there, and what the worker does with the income?*]

Q32. How did you hear about AWC jobs?

- A friend
- Community
- Awareness campaigns by the government
- Newspaper
- Other_____

Q33. What did the application process consist of?[Interviewer should ask about what did each step in the application process consist of and procedure they went through after they were accepted in the job]

Q34. Have you worked with children and women professionally before this job?

1. Yes
2. No

Q35. In the past year have you had illnesses because of which you were unable to provide services at the AWC? If yes, please explain how you manage the center when you are unwell?

1. Yes
2. No

Q36. How far do you come from to the AWC? (Please give distance in kms)

Q37. What is your mode of transportation?

1. Walking
2. Bus
3. Auto
4. Car
5. Other _____

Q38. If you have children, who is responsible for them when you are at work?

Q39. What do you think about the overall work conditions? [*Interviewer should ask about overall job satisfaction including issues of salary, safety, working conditions etc.*]

Q40 . Please share four major challenges that you face at the center based on priority?

Q41. What are the best services that are provided at your center? (Ask about hub center/ sabla/ kishori shakti yojna/ early childhood programme/ services to nursing and lactating mothers)

Q 42. Please give three suggestions to improve the AWC service provision?



**INSTITUTE FOR
HUMAN DEVELOPMENT**

NIDM Building, 3rd Floor, IIPA Campus, IP Estate, Mahatma Gandhi Marg, New Delhi - 110002, India

Phones: +91 11 23358166; 23321610; Fax: +91 11 23765410; Email: mail@ihdindia.org; Website: ihdindia.org