

**Functional Assessment of Urban Anganwadi Centres of Integrated
Child Development Services (ICDS) scheme in Jaipur District of
Rajasthan**

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ACRONYMS

ASHA	ACCREDITED SOCIAL HEALTH ACTIVIST
AWC	ANGANWADI CENTRE
AWW	ANGANWADI WORKER
BNA	BOTTLE NECK ANALYSIS
ICDS	INTEGRATED CHILD DEVELOPMENT SERVICES
IEC	INFORMATION EDUCATION AND COMMUNICATION ICDS SYSTEMS STRENGTHENING AND NUTRITION
ISSNIP	IMPROVEMENT PROJECT
MCHN	MATERNAL CHILD HEALTH AND NUTRITION
MPR	MONTHLY PROGRESS REPORT
MWCD	MINISTRY OF WOMEN AND CHILD DEVELOPMENT
OVI	OBJECTIVELY VERIFIABLE INDICATOR
PEO	PROGRAMME EVALUATION ORGANIZATION
PIP	PROJECT IMPLEMENTATION PLAN
PSE	PRE-SCHOOL EDUCATION
SAR	SYSTEMIC APPRAISAL FOR RESULTS
SHG	SELF HELP GROUP
SNP	SUPPLEMENTARY NUTRITION PROGRAMME
THR	TAKE HOME RATION
UNICEF	UNITED NATIONS CHILDRENS FUND

1. INTRODUCTION

The health, education and nutrition are critical in well being of the people of a nation. A healthy educated population can contribute in productivity and economic growth. For a nation to progress or prosper, human resource development is essential. The foundation of social, emotional, language, physical development and cumulative lifelong learning is laid in the crucial early years. Nutrition has deep effects on health throughout the human life course and is inextricably linked with cognitive and social development, especially in early childhood (*Black, Robert E et al*).

The young child under three years is more vulnerable to the vicious cycle of malnutrition, diseases, infections and resulting disability. Nutritional care in the crucial period from birth to two years of age is essential and can help in managing the deficiency in this early age. This will not only check the physical growth but also affect educational attainment and productivity (*ISSNIP, PIP, 2011*).

“The period from pregnancy to 24 months of age is the critical window of opportunity for delivery of nutrition interventions. Available evidence clearly indicates that universal coverage with direct interventions such as breastfeeding, complementary feeding, specific micronutrients and access to medical care for illnesses can substantially impact malnutrition rates. It is also critical to address women’s nutrition both in its own right and as a means to address child under-nutrition” (*ISSNIP, PIP, 2011*).

The consequences of malnutrition among children are enormous. Under nutrition directly affects the children’s physical and cognitive growth. The magnitude of undernutrition in India is alarming and major variations between the Indian states noted. Further, the variation among socioeconomic groups is growing (*Michele, 2006*).

The Integrated Child Development Services (ICDS) scheme was launched and implemented by the Ministry of women and Child development in the year of 1975 in 33 community development blocks of India. The concept of the scheme was to provide a package of services to the child at early state would impact in larger way. Also is the scheme was unique by design in that the efficiency of one particular service depended on the support of other related services. The scheme integrates numerous aspects of early childhood development and provides supplementary nutrition, immunization, health checkups, and referral services to children less than six years of age and pregnant woman and lactating mothers. ICDS also offers non-formal preschool education to children in the age group of 3-6 years through the Anganwadi centres.

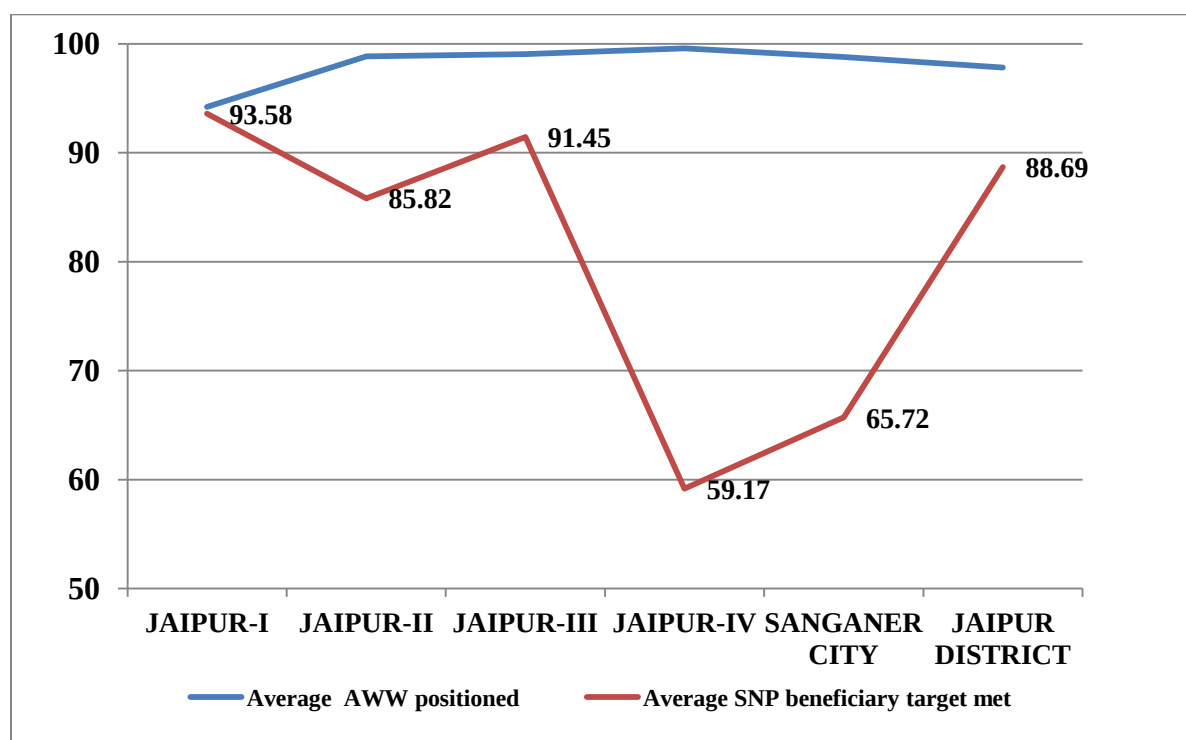
The Integrated Child Development Services scheme was launched with the following objectives:

- To improve the nutritional and health status of children in the age group of 0-6 years
- To lay the foundation for proper psychological, physical and social development of the Child
- To reduce the incidence of mortality, morbidity, malnutrition, and school dropout.
- To achieve effective co-ordination of policy and implementation among various departments to promote child development
- To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper health and nutrition education.

The Anganwadi centre is the operational unit of the ICDS at the grass root level. As per the 2014 records, 97 percent of the AWCs are in operational condition across the country (*MWCD, GoI report, 2014*). In Rajasthan 99 percent AWCs are in operational condition, where as 100 percent functional in Jaipur District (*MPR February, 2015*). Monthly targets and the percentage of target

met in terms of delivering the services to the beneficiaries are being reported in the form of monthly progress reports. At the state level, the data from all the districts is compiled. Use of MPR data allows the program manger to track the progress of the projects. The below Figure 1 shows the average of the AWW positioned and the average of SNP beneficiary target met during April 2014 to February 2015 in Jaipur district's urban ICDS projects. Compilation of MPR data was done to understand the trend of AWW positioned and SNP distribution in the urban projects of Jaipur District (Figure 1).

Figure 1: Averages of AWW positioned and SNP beneficiary target met



1.1 Services available at AWCs

Pregnant women or Lactating mothers: The services included are supplementary feeding, prophylaxis against vitamin A deficiency, control of nutritional anaemia, Immunization of pregnant women against tetanus, nutrition and health education to build the capacity to look after their children and self.

Immunisation of child/children: Immunization against six major diseases – polio, diphtheria, Pertussis, tetanus, tuberculosis, and measles.

Health check-ups for children: Including management of malnutrition, treatment of diarrhoea, deworming, and distribution of medicines. Also included were the antenatal care of expectant women, and postnatal care of nursing mothers.

Supplementary feeding: Support for children for 300 days in a year with a view to narrowing the gap between the nationally recommended calorific intake and that received by children.

Monitoring children's growth: Sick or malnourished children and children with disabilities being referred to the primary health centre.

Preschool education: In addition to preparing children for primary school, this service also offers substitute care to young children, thus freeing older siblings, particularly girls, to attend school.

Immunization to the pregnant women, children and health checkups are supposed to be delivered through the primary health care functionary. Anganwadi centres are designed to provide supplementary feeding, growth monitoring of children, non formal pre-school education to the children in 3-6 years of age and nutrition and health education. Anganwadi worker is the person who coordinates with the health functionaries in delivering the services. The services to the

pregnant women, Lactating Mothers and children are intended to reduce Maternal Mortality, Child Mortality and Morbidity. The Anganwadi Worker (AWW) at the Anganwadi Centre (AWC) is the key instrument in the ICDS scheme.

As per the National Child Policy 1974; on 2nd of October 1975, the state of Rajasthan launched the Integrated Child Development Services (ICDS) scheme in its first project in Gadi Panchayat Samithi of Banswara district. The main focus of the scheme was to provide the basic life facilities to the children, women especially pregnant and lactating mothers in the state.

2. RATIONALE

The services of the ICDS scheme are being delivered through Anganwadi centres (AWCs) across the state. The reported data from the urban projects raises questions about the effectiveness of the service delivery at the Anganwadi centres in the urban areas. It is felt appropriate to find out the constraints in operationalizing the scheme at the AWCs in urban areas. It is therefore vital to identify the bottlenecks as well as enabling factors to optimize the service delivery at AWC level.

3. OBJECTIVES

The objectives of the present study are to:

- Understand the functioning of the Urban Anganwadi centres in Jaipur district
- Identifying bottlenecks and enabling factors in delivering services of the ICDS scheme
- To recommend measures to remove the bottleneck and improve efficiency of the urban AWCs

4. METHODOLOGY

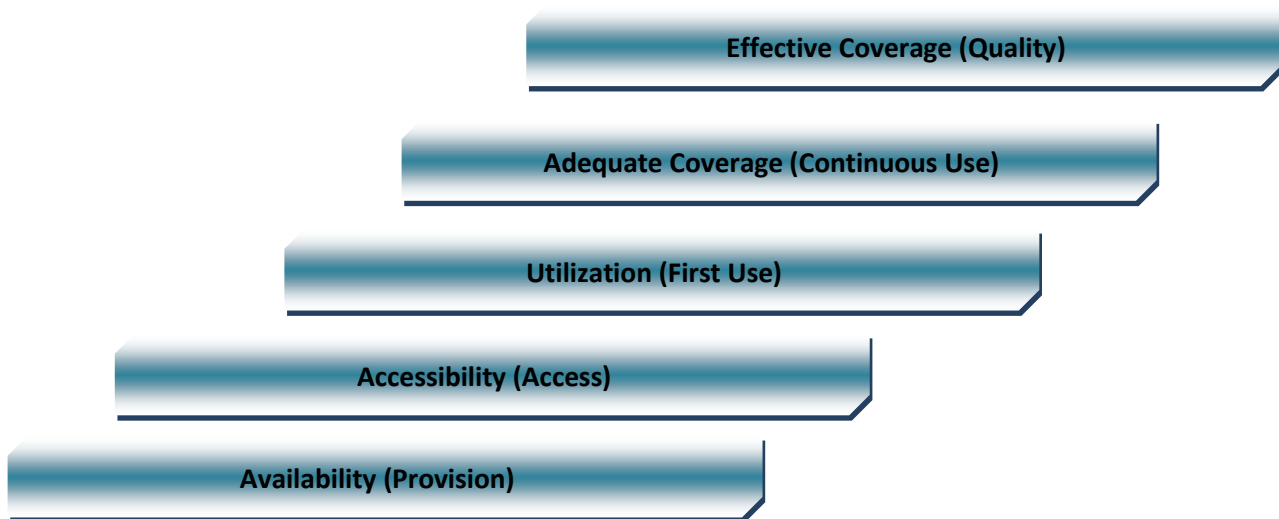
The study was based on the Systemic Appraisal for Results using the Bottleneck Analysis approach. (SAR BNA Approach)

4.1 Systemic Appraisal for Results using Bottleneck Analysis (SAR BNA)

SAR BNA is a simple and user friendly approach which provides the program managers with a way to assess the program coverage and to optimize the inputs accordingly. SAR BNA framework has been developed by IIHMR Jaipur with assistance from UNICEF State Office Rajasthan Jaipur (*IIHMR, 2012*) and has been used to evaluate many programmes in the state of Rajasthan. The framework is based on the Tanahashi's concept of "Health service coverage and its evaluation" (*Tanahashi.T, 1978*). The term "Systemic" signifies the holistic scope. It takes into account the review of all the inputs made and analyzes the coverage at all the levels of implementation and includes both the service providers and the persons who availed the services. In implementing any program, there are five essential stages of service provision which progressively lead to the final delivery of the intended service. Each of these stages is critical to achieve effective service impact on the target population. These five Critical Conditions for Impact are service availability, service accessibility, service first use, service complete use and

an overarching quality at all levels of service provision and acceptance (**Figure 2**). In addition, inter-sector coordination and inter-dependence play an important role toward achieving effective coverage to show results.

Figure 2: The Critical Steps in Service Delivery



4.2 The Bottleneck Analysis Approach

The BNA approach seeks to do an in- depth analysis on coverage and factors affective each of the five critical conditions of service delivery (Availability, Accessibility, Utilization, Adequate use and Effective coverage) at all levels of service provision and acceptance which help to identify strengths, bottle necks and impediments. The six steps of BNA approach are:

1. Identify service package to be assessed:

The program manager has to first identify the package or (packages) of service in the respective program one wishes to assess. He/She must gather the complete information on the identified

program/package including the background, evolution, eligibility criteria and entitlements to beneficiaries.

The inputs made by the manager towards various programs could serve as a guide for choosing the programs or packages for assessment. He/She may choose to go further and identify the inputs made by self/agency towards the particular service package. The inputs could be in the form of Supplies/ Distribution, Staff time, Funds or Promotion. The inputs should also be identified in the context of the level where applied viz, National, State, District or End Beneficiary Level.

2. Map the process delivery of the package or interventions and identifying stakeholders:

Process mapping of the identified intervention to identify the executing as well as the enabling stakeholders is crucial to develop an understanding of the program from the service delivery as well as the service utilization aspects. The process helps to keep in perspective both set of stakeholders. The executing stakeholders are easier to capture, being central to the program implementation. The other set of stakeholders also play a vital role in enabling the user to finally avail the service.

3. Develop objectively verifiable indicators for the package defining the five critical steps of the service delivery:

This step involves developing objectively verifiable indicators which would show the optimum result for each of the critical conditions. Review of the process tree and programme documents must be done to brainstorm indicators that will measure each objective in terms of the five critical conditions. If there are many possible indicators for one particular condition, try to reduce the list so that the most essential ones are included. Selected indicators must be specific enough to capture quality, quantity and time and could include a quantitative and qualitative mix.

4. Identify means of verification for the indicators addressing both the providers and users and development of tools:

Means of verification should specify the source of getting the required information for calculating an indicator. This requires identifying the format /documents and the competent authority to be approached for the information. Without having a valid means of verification, an indicator cannot be designated as an OVI. Once all the OVIs have been developed and means of verification identified; data collection tools are developed accordingly. Tools are also developed to get beneficiary level information. The information from beneficiaries should corroborate the findings on the OVIs derived from the stakeholders.

5. Data collection and analysis to identify the Bottlenecks and Enabling factors:

The 'systemic field visit' for data collection addresses all service provider levels and also to persons who have availed services. A quantitative and qualitative assessment helps a manager to authentically judge current situation and what needs to be done to reach out to achieve the result.

The SAR BNA approach allows the programme manager to evolve his/her own criteria to choose districts or blocks or projects incase of ICDS scheme as well as Anganwadi Centres.

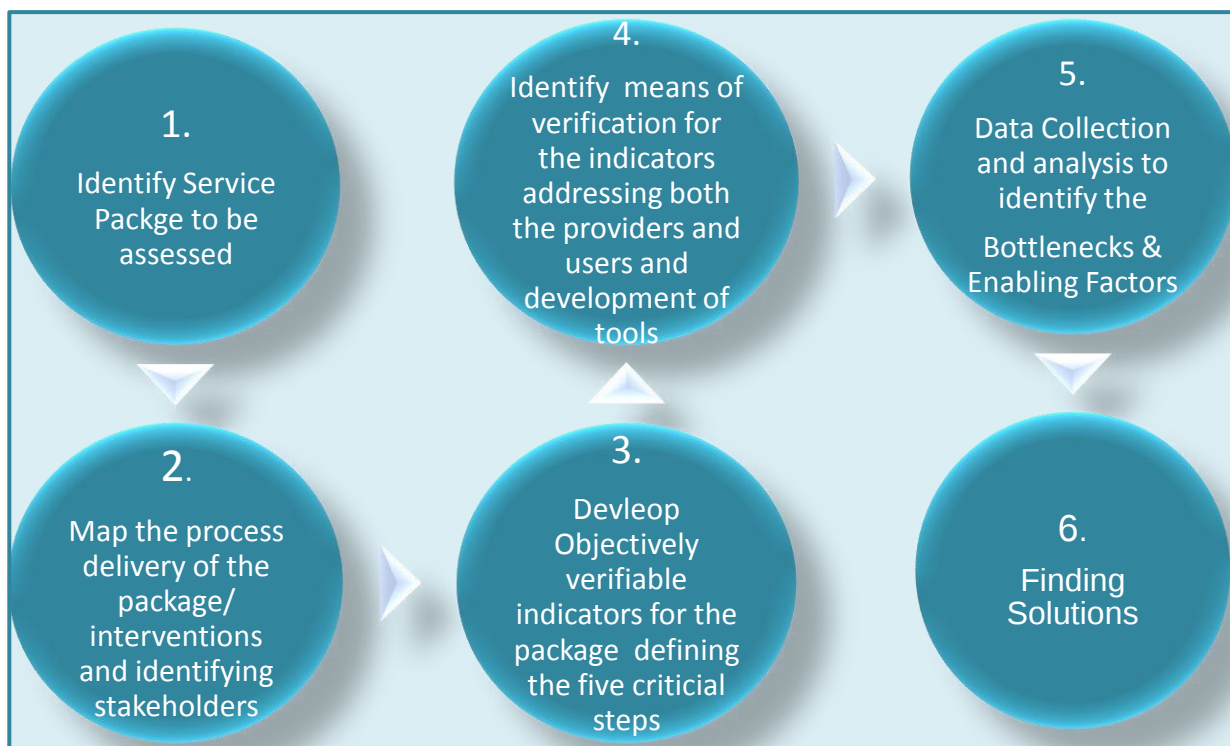
During the analysis the focus is not only on identifying the bottlenecks but also on the enabling factors which may be facilitating the intervention in the study areas.

6. Finding solutions:

Based on the findings of the analysis, solutions are formulated to remove the bottlenecks and to sustain, optimize and propagate the enabling factors identified .The focus will be on developing simple and feasible solutions.

Any service is planned with a target population in mind and starts with making the components of the service available to the population, i.e, provisioning of service (Availability) which is the basic requirement at the start of any service provision. Availability could be affected by inappropriate assessment of the target population, resource constraints, administrative and logistical limitations.

Figure 3: Steps in SAR BNA Approach



Availability alone cannot ensure that the service will reach the target population. The service should have been planned in such a way that it could be reached by the target population which is represented by access (Accessibility). Factors influencing access could be geographical, procedural or economic.

The target population should actually use the service (Utilization). Utilization signifies the acceptability of the service by the user and depicts the first interface of the user with the service.

Utilization is influenced by the social and behavioural factors of the target population.

Once the user starts utilizing the service next step is to see the continued contact which indicates the adequacy of the service for the user (Adequate Coverage).

Even continuous use does not always guarantee the achievement of the final goal for which the service provision was made. Whether the service provision was delivered in a satisfactory way has therefore to be assessed. (Effective Coverage). Effectiveness of the service provision may be appraised on the basis of certain specific criteria and reflects the quality of the service delivered.

4.3 Study Location, Sample, Tools and Methods of Data Collection

4.3.1 Study Location

The present study was conducted in Jaipur district of Rajasthan state. Jaipur was chosen because of having a good representation of urban AWCs being the capital of Rajasthan state and is also accessible for data collection.

4.3.2 Sample

Two urban ICDS projects were included in this study. Both the projects were selected based on their previous year's performance of meeting the Supplementary Nutrition Program (SNP) beneficiary target. A total of 3 Anganwadi centres were selected randomly from each project. Five beneficiaries per AWC were randomly chosen and interviewed at their home, based on their availability during the visit. A total of thirty beneficiaries were interviewed during the study.

4.3.3 Tools and Methods of Data Collection

All the interviews were conducted after taking due informed consent. Before obtaining the consent, each beneficiary was provided all necessary information regarding the study and the purpose of the study and level of confidentiality.

Objectively Verifiable Indicators (OVIs) were developed for each the five critical levels for all the above mentioned services in the scheme. Possible sources of verification were also identified to generate adequate data to derive each of these indicators. In case the identified sources of verification was not able to yield data on some indicator, it in itself is an important gap.

Form 1 for the Service Providers and **Form 2** for the beneficiaries. Form 1 captured the OVIs in addition to procedural and programmatic inputs along with availability of respective means of verification. Form 2 gathered inputs from beneficiaries by personal interview on the services entitled and utilized.

Both Form-1 and Form -2 were consisting of both qualitative and quantitative questions. The Basic information like year of establishment/function of AWC, infrastructure details, knowledge of AWW and record update information will be collected from AWW and basic demographic, socio-economic, educational and service utilization information will be collected from the beneficiaries.

4.4 Analysis

The BNA Approach quantifies the OVIs; which allows identifying the gaps in the five critical conditions of the service delivery. The major part of the analysis is qualitative and is based on the generation of BNA Matrices. No statistical analysis was performed for the study.

5. FINDINGS

Table 5.1: BNA matrix for Availability

Critical Condition	Stakeholder/ Beneficiary	Indicator	Value/ Availability	Bottlenecks	Enabling Factors
		Description			
Availability	AWC/AWW/ ASHA	• AWC Building (Owned/ Rented/Others)	Rented	- Rented small rooms.	
		• AWW/AWH/ASHA	Available		- Adequate staff
		• Separate Kitchen	No	- Meal prepared by SHG and Akshyapatra	
		• Activity Area	No	- Very limited place for activities.	- Fair number of attendance of PSE, at the time of visit
		• Updated Family Details Register	YES	- Centres maintaining different registers for this purpose.	- Regular visits to update the family details.
		• MCHN sessions planned	Yes	- Sessions held on not planned day	- Micro plan available
		• IEC on nutrition	No	- IEC was not found displayed	- IEC availability.

	Beneficiary Pregnant woman 0-6 months child & Lactating Mother, 6months - 3 year child 3-6 year child Adolescent Girl	Proportion of mothers who are aware of the AWC location.	96		- Familiar location of centre
		Proportion of mothers who know the AWW.	87.5		- AWW familiar to beneficiary by name or by face
		Proportion of mothers who are aware of MCHN sessions	73.9	- Micro plan not displayed on centre. - Irregular sessions	
		Proportion of mothers who have seen any IEC Material on AWC services	0.0	- No IEC material found displayed.	

As per norms, an Anganwadi centre is established per 400 to 800 population in both Rural and Urban areas. AWC is conceived to be a place where women and child can feel like home and can avail health education, pre-school education and nutrition. Each AWC has an Anganwadi worker (AWW) and an Anganwadi Helper (AWH) is also posted for her assistance. In addition in Rajasthan the Accredited Social Health Activist (ASHA) under NRHM is a model of convergence performing the tasks at grassroot levels for both Health and WCD departments. Under ICDS, ASHA Sahyogini assists in mobilizing the community for the activities under ICDS scheme. As per the Honourable Supreme Court's direction on November 28th, 2001 ICDS scheme has been universalised and registration all eligible beneficiaries is required. Before that only families Below Poverty Line (BPL) were eligible for availing services from the AWC. The functional effectiveness of the Anganwadi centre depends on factors like availability of adequate infrastructure facilities, adequate supplies for services and the community awareness about the Anganwadi centre and its function. The availability of commodities is critical to quality service delivery and it has significant influence on utilization (*Ensor et al, 2004*).

In terms of availability, the current study tried to see the availability of the AWC building, service providers at the AWC, separate kitchen facility and activity area for the children and to organize community events like Godhbarai, Annaprashan. It was observed all centres are being operated in rented rooms of individual houses or in community buildings like temple. Very limited, mostly no activity area is a constraint in delivering the designated services at the Anganwadi centres above. This is reflected in **Table 5.1**. Similar findings observed in the Evaluation study on ICDS (*PEO, 2011*) conducted by the then Planning Commission of India and pointed out that the performance of the AWC depends on the adequacy of the facilities.

The centres are running without separate kitchen as distribution and preparation the SNP has been decentralised (*Circular no.4(1)(321)SNP/D.I/ICDS/2014/15103-135*) so, the hot cooked meal is being prepared by the Self Help Groups (SHGs). In one of the two projects visited, this component has been given to SHGs and in other project an NGO “Akshaya Patra” is providing the meal at the centre. Display of IEC was conspicuous by its absence / poor display at almost all the AWCs as the investigator struggled to find out the place of display. Furthermore, the available content at addressed Malnutrition only.

The findings at services provider level were complimented by the beneficiary level information. Almost all the beneficiaries interviewed (96 percent) said that they were aware if the location of AWC and 87 percent knew the AWW. Although seventy four percent of the beneficiaries were aware of the MCHN session days, 40 percent did not know the particular when the MCHN session going to held. This indicates a progressively reduced awareness on availability of services at the centre. This is further apparent by the fact that none of the beneficiaries interviewed said that they have seen any IEC material on AWC services (Table 5.1).

Enabling Factors:

- Availability of adequate staff at the Anganwadi Centres and the centres are open for the services as per the time schedule. All the staff has received basic training.
- Family register is being upto date with the latest details and are maintaining the details of the recently arrived families in the locality.
- Micro plan for MCHN sessions prepared by the AWW.
- Anganwadi centres location is familiar to the beneficiaries.

Bottlenecks:

- Amongst all visited AWCs, are running in Rented and very few centres are in pacca building. Most of centres are covered with “Iron sheet” as roofing. During summer this roofing definitely causing inconvenience to the beneficiaries especially children who are coming for Pre-School Education.
- The visited centres are not having the activity area and the children are sitting in the same room where the stock and other education kits, which is causing uncomfortable sitting arrangement to the children.
- For health checkups of pregnant woman during MCHN session no separate room available at the centres. This is limiting the MCHN session for immunization only.

Table 5.2: BNA matrix for Accessibility

Critical Condition	Stakeholder/ Beneficiary	Indicator/ Description	Value/ Availability	Bottlenecks	Enabling Factors
Accessibility	AWW	Location of AWC.	Middle	Running inside Temple, where Muslim population are at large number.	-
	AWC	Proportion of MCHN sessions held out of those planned	100		- Sessions held
	Beneficiary	Proportion of mothers who are registered at AWC	88.0		- ASHA mobilizes the community
		Proportion of beneficiaries felt the AWC is very near	88.0		- Easy accessible

A physically accessible Anganwadi centre determines the service utilization by the beneficiaries. The key determinants are distance of the centre, travel time and ease with which a beneficiary can access the Anganwadi centre. Most of the centres visited were located in the middle of the catchment area and all the planned MCHN sessions held during the review period, January 2015 to March 2015. It is a matter of concern that only 88 percent of mothers in the catchment area were registered with the AWC. All those who were registered felt that the Anganwadi centre is very near to their home and accessible. Accessibility was stated by them not only in terms of only physical access to the centre but also to the workers who are supposed to provide services. (Table 5.2)

Enabling Factors:

- Good physical access to the centre and access to the workers.
- It was observed during the visit that the Anganwadi helper and ASHA are visiting the beneficiary houses and bringing the children those who are in 3-6 years group for attending Pre-School Education. It was also observed that at most of the places the functionaries are having a cordial relationship among themselves.
- MCHN sessions are being held regularly at the centres, the same has been reported by the beneficiaries.

Bottlenecks:

- One Centre was seen to be running within the premises of “Temple” due to non availability of suitable rooms. This location had a large number of beneficiaries from another religious faith who felt this to be a barrier to access the services.

- Those beneficiaries not registered at the AWC, reported that they were not aware of the location of the AWC and the available services.

Table 5.3: BNA matrix for Utilization

Critical Condition	Stakeholder/ Beneficiary	Indicator/ Description	Value/ Availability	Bottlenecks	Enabling Factors
Utilization	AWW	Enrolment of Children 6months to 3 years at AWCs	46.3%	- Same Supplementary nutrition	
		Enrolment of Children 3 to 6 years at AWCs	47%	- Less facilities	
		Proportion of Children aged 7 months who were underweight	-	- No data available	
	Beneficiaries	Proportion of beneficiaries who ever went AWC	88.4%		- Beneficiaries aware of services
		Proportion of children 6 months to 3 years who ever went to AWCs	50%	- Not aware of services available	
		Proportion of children 3 -6 years who ever went to AWCs	100%		- Due to PSE and SNP

Utilization of services by the beneficiaries (at least once) is an indicator of acceptability. The utilization is at times influenced by the factors such as cost and the religious belief (*Tanahashi.T, 1978*). It was seen that the proportion of children who ever went to AWCs has been less than 50 percent. (46.3% and 47% for children aged 6 months to 3 years and 3 – 6 years respectively. Of these it was interesting to note that 88 percent ever visited the AWC. All children of 3-6 years age group had visited the AWCs at least once while the proportion was only half (50percent) for children aged 6 months to 3 years.. (Table 5.3).

Vani and others tried to link between quality of ICDS and utilization in their study that the privileged beneficiaries (Mothers and children) would not like to utilize ICDS, because they don't wish to do utilize. This effect is possibly arising when the general perception on the quality of the service at the AWC was poor when compared to that of equivalent services available in the market (*Borooah V.K et al, 2014*). The similar kind of opinion expressed by the beneficiaries that the services are being provided to the people who are poor and they can avail same services from the private schools- for PSE, private hospitals-for ANC and Immunization.

Enabling Factors:

- Majority of the beneficiaries are aware of the services they can avail from the AWC and SNP, Immunization services are the most preferred among them.
- Preschool education and the provision of SNP at the centre makes them visit the centre for trying the facilities.

Bottlenecks:

- Lack of variety in the menu of SNP is restricting the beneficiaries in availing SNP as they are interested in variety of food provision.
- The facilities at the AWC for PSE are not upto the mark as there is no sufficient place to sit and other facilities. Beneficiaries informed that they will send their children if the AWC has all the facilities like in the private schools.
- Beneficiaries expressed the feeling of that the services being provided at the AWCs are for only poor families.

Table 5.4: BNA matrix for Continuous Use

Critical Condition	Stakeholder/ Beneficiary	Indicator/ Description	Value/ Availability	Bottlenecks	Enabling Factors
Continuous Use	AWW	Proportion of Children aged 10 months who were underweight	-	No reliable data available at centres.	
		Average monthly attendance of Children 6months to 3 years at AWCs	10	No uniform SNP distribution	
		Average monthly attendance of children 3 to 6 years at AWCs	20	Inadequate Facility	
	Beneficiaries	Proportion of children 6 months to 3 years who has been receiving THR from AWC continuously.	50%	- Weekly distribution - No THR distribution	
		Proportion of children 3 -6 years who has been receiving meal from AWC continuously.	80.0%		Centres open Regularly
		Proportion of Pregnant women enrolled who have been receiving THR regularly	75.0%	- No THR distribution - PW don't like sweet halwa	

Continuous use indicates the level of full course of contact of the service required to be effectively achieved (*UNICEF, 2013*). There has been no official data available on the underweight children 10 months of age at the centre level. The AWW were informed verbally that there are no such children in their area and one or two severely malnourished children were referred to the Malnutrition Treatment centres. The proportion of children and pregnant women continuously receiving the meal and Take Home Ration (THR) was 80 percent and 75 percent respectively. The average number of children 3-6 years present at the AWC during the visit was only 12; the same has been reflected in the attendance register. The investigator tried to interact with the parents of the children for the reason and was informed that they are getting food at the centre regularly. Few pregnant women informed that they do not like the sweet Halwa distributed at the centre.

Enabling factors:

- Beneficiaries expressed that their children who are attending the PSE are doing good and are able to learn basics before going to formal schooling.
- Regular SNP distribution to the children aged 3-6 years was also one of the factors that the beneficiaries readily sending their children to the AWC.
- In few centres the children are carrying SNP to home for their siblings who are not able to come to the centre.

Bottlenecks:

- Lack of quality space at AWCs was a deterrent to send children to AWCs especially in the 6 months to 3 years group. Almost all the centres visited were found to be functioning

in rented rooms and do not have the adequate facilities for the children to play. Children were often seen to be seated sat under trees or in open space outside the centre without boundary walls.

- Lack of space for storage was reflected in many centres .The equipment of the centre, SNP bags, other playing and education kits for children were lying in the very same room where children were sitting. The space for children to sit was also inadequate at most of the centres with lack of comfortable space between each other.

Table 5.5: BNA matrix for Quality

Critical Condition	Stakeholder/ Beneficiary	Indicator/ Description	Value/ Availability	Bottlenecks	Enabling Factors
Quality	AWW	Proportion of AWCs found open during the visit	100		- Beneficiary demand
		Awareness of AWW on Growth Charts	100	- Not all centres are filling the growth chart continuously.	- ASHAs are also aware of Growth chart
		Proportion of AWCs with Electrical connection	100		
		Proportion of AWCs with Water Connection	60	- Rented rooms	
	Beneficiaries	Proportion of mothers who said they like to send their children to AWCs	66.6	- Don't have all facilities	
		Proportion of beneficiaries who said they like to inform others to avail services from AWCs	88.7		- SNP ,PSE and Vaccination

Almost all the AWWs knew how to fill the Growth charts but not even one centre was found regularly updating the charts. The commonest reason behind was stated to be the non availability of weighing machines both baby and adult at the centres. This finding is of concern since the constant monitoring and detecting the growth faltering of the child beneficiaries is one of the most vital roles to be played by the ICDS and despite the fact that AWWs and ASHAs interviewed were had knowledge of filling the growth charts. Several studies in the past have reported related issues. The World Bank study reported the same as the supply side inadequacies at Anganwadi centres (*Granolati, M, 2006*). The planning commission report (*PEO, 2011*) also highlighted the poorly maintained growth charts at the AWCs (42.3 percent) and that only 10 percent of AWC in Rajasthan were updating the child growth chart.

Enabling factors:

- AWWs and ASHA knows to update the growth charts.

Bottlenecks:

- Non availability of weighing scales causing serious deficit in updating, monitoring and detecting the growth faltering of the children.
- Non availability of toilets at the centres.

6. RECOMENDATIONS and CONCLUSION

- Basic infrastructure and facilities including proper building with adequate space for activities, separate room for health checkups for pregnant woman, electricity, safe drinking water and toilets must be provided at the outset.
- Availability of functional weighing scales must be ensured on priority.
- PSE kits must be made available and ensure to utilize them by the staff of AWCs.
- The location of the AWC has to be carefully selected, community's religious beliefs has to be taken care.
- The provision of SNP with different menu could help in turning in the beneficiaries to the AWCs.
- Displaying the services available at the AWCs can generate awareness among the community about their entitlements. Involving the beneficiaries in mobilizing the community increases the community awareness.
- Regular visits to the beneficiaries' homes by the AWW along with ASHA can help in generating awareness among community.
- Maintaining the registers and using the data need to be implemented at all levels.
- More studies required on the AWCs in Urban areas and their effectiveness.

The Integrated Child Development Services (ICDS) scheme approach is a step forward to decrease morbidity and mortality in 0-6 year children in India and to give them the opportunity

for best growth and development. Being worlds' largest child development and nutrition supplementation program the ICDS scheme aimed to improve the nutrition and health status of children under the age of six years, lactating mothers and pregnant women in the country. With the strength of 7067 projects and 12 million AWCs & mini AWCs providing the supplementary nutrition to 10.4 crore beneficiaries and 3.7 crore PSE beneficiaries across the country (*DWCD, GoI, 2014*). The scheme is trying to address the underlying causes of persistent undernutrition in the country. The package of services in the scheme was well designed and suited to address the immediate cause of malnutrition, insufficient intake of nutritional food. The scheme is well accepted as an appropriate response to tackle malnutrition.

Despite its national infrastructure the, Integrated Child Development Services scheme is not making the expected contribution to reducing the prevalence of malnutrition in India. The basic infrastructure is not adequate and the policy intention is high. Narrowing the gap between the policy intentions of ICDS and actual implementation to provide the most effective services to the under privileged and weaker sections of the society is the single biggest challenge.

The present study has found bottlenecks at the level of availability of basic infrastructure and equipments which has reflected in all successive levels affecting the coverage of services.

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