



Evaluation of Integrated Child Development Services Program in Kashmir, India

Tawheeda Yasin^{1*} and Hummara Azim¹

¹*Department of Food and Nutrition, Institute of Home Science, University of Kashmir, India.*

Authors' contributions

This work was carried out in collaboration between both authors. Author TY designed the study, conducted the data collection, wrote the protocol, and wrote the first draft of the manuscript. Author HA is the supervisor and the whole work presented has been conducted under her guidance. Both authors read and approved the final manuscript.

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ABSTRACT

Aims: Evaluation of Integrated Child Development Services (ICDS) program in the vale of Kashmir in terms of status of Anganwadi workers, facilities at Anganwadi centers, delivery of services to beneficiaries including children, pregnant women, lactating women and adolescent girls.

Study Design: Study based on facility at Anganwadi centers.

Place and Duration of Study: The present study was conducted by visiting Anganwadi centers in Kashmir Division of Jammu and Kashmir during the year 2017-2018.

Methodology: The valley of Kashmir was divided into three zones; North Kashmir comprising of three districts Baramulla, Bandipora, Kupwara, Central Kashmir comprising of three districts Srinagar, Ganderbal, Budgam and South Kashmir comprising of four districts Anantnag, Kulgam, Pulwama, Shopian. Lottery method was used to select two districts for each zone. Through multistage sampling a total of 48 anganwadi centers were evaluated.

Results: The coverage of supplementary nutrition was almost complete for all the beneficiaries. All the other services were not delivered properly. 31.51% children reported to receive pre-school education, 13.54% reported of having had health check-ups and 1.82% reported of being immunized at anganwadi centre (AWC). 94.79% of the pregnant and lactating women are covered

*Corresponding author: Email: heeduyasin@gmail.com;

under supplementary nutrition. Immunization and health check-ups were not available for pregnant and lactating women, however, 53.3% received iron and folic acid (IFA) tablets and 4.17% were provided with referral services. 71.53% of adolescent girls received IFA tablets. Health check-ups and basic skills programmes were not conducted for adolescent girls, however, 5.56% were provided with referral services.

Conclusion: The performance of ICDS in Kashmir in terms of coverage is very low and almost all the services except supplementary nutrition are not delivered properly. There are many reasons for the underperformance of the scheme including socio-economic and other aspects of the grassroots workers including anganwadi workers (AWWs) and anganwadi helpers (AWHs), inadequacy of equipment for proper implementation, undesirable condition of AWCs, lack of professionalism in implementing staff, lack of co-ordination between AWCs and other associated personals like Lady Health Visitor (LHV)/Auxiliary Nurse Midwife (ANM). In Kashmir the political environment makes the implementation of ICDS scheme even more complicated and difficult. A realignment is the need of hour and the state government must identify the specific problems faced by the scheme and convey them to all the stake holders so that a better and modified version of the scheme is implemented.

Keywords: ICDS; supplementary nutrition; Kashmir; preschool education.

1. INTRODUCTION

A holistic program to counter malnutrition and improve health quality of children was launched in India in 1975 under the name Integrated Child Development Services (ICDS) Scheme. The scheme includes children below the age of 6 years and their mothers. The scheme involves an integrated approach in which a group of services and facilities are provided to the beneficiaries which include supplementary nutrition, immunisation, regular health checks, referral services, education on nutrition and health, and preschool learning [1]. The scheme is administered locally by trained workers and helpers through small centers commonly called as AWC.

The impact of ICDS on the overall improvement in the development of children in India has not been up to the mark. Several studies conducted on the effectiveness of this programme by independent researchers and other commissions set up by the government from time to time have acknowledged the role of the scheme but most of them have concluded that the scheme is far from achieving its goals [2]. Chudasama et al. [3] in a study conducted on performance of ICDS programme in Gujarat concluded that there are gaps in implementation of almost all the schemes of ICDS resulting in poor outcome. Some of the studies have reported that the scheme has helped in the upliftment of nutritional and immunization status of children [4,5], but at the same time, few other studies have reported otherwise [6,7].

Jammu and Kashmir is the northern most state of India and constitutes of Jammu, Kashmir and Ladakh, three geographically distinct places. All the blocks of Jammu and Kashmir are covered under the Integrated Child Development Services Scheme. As per the data shared by the Ministry of Women and Child Development, Government of India on their official website, there are 31938 sanctioned AWCs in Jammu and Kashmir, out of which 29599 are operational.

This study was conducted to evaluate the quality of various services provided under the Integrated Child Development Services in Kashmir. The various aspects including infrastructure, the status of ground staff, the delivery of various services and the satisfaction among the beneficiaries were recorded and are presented in this paper.

2. METHODOLOGY

The present study was conducted in Kashmir Division of Jammu and Kashmir during the year 2017-2018. The valley of Kashmir is sub divided into North Kashmir comprising of three districts Baramulla, Bandipora, Kupwara, Central Kashmir comprising of three districts Srinagar, Ganderbal, Budgam and South Kashmir comprising of four districts Anantnag, Kulgam, Pulwama, Shopian. Two districts from each zone were selected first by using lottery method also known as simple random sampling as shown in Fig. 1 [3].

The permission for collecting the Data from AWC was taken from the office of the ICDS Mission

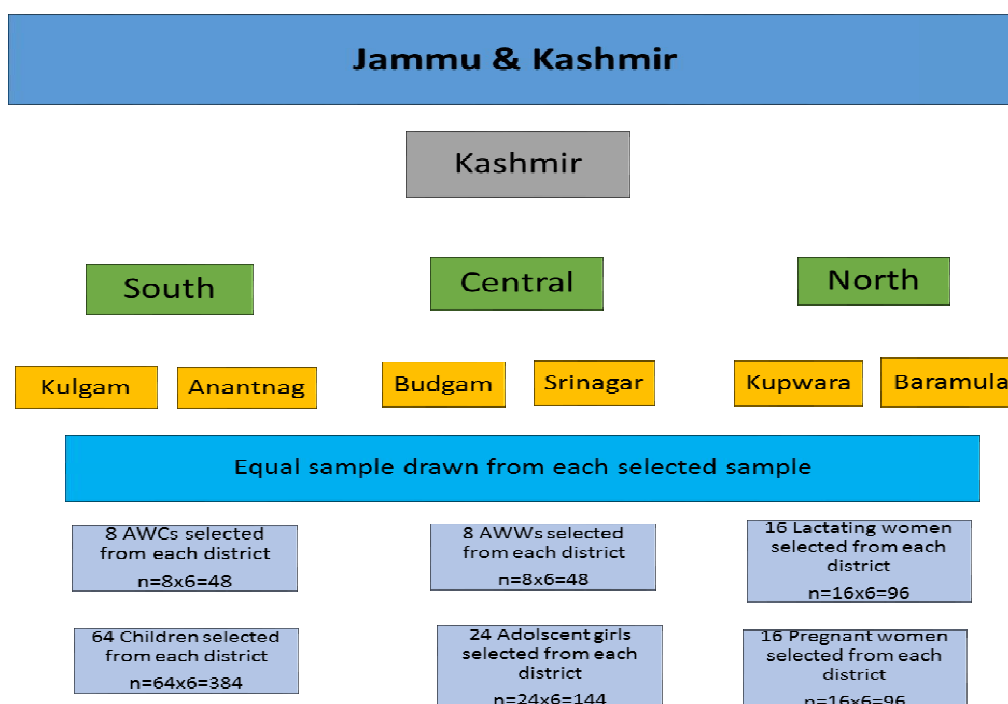


Fig. 1. Sampling design of the study

Directorate, Jammu and Kashmir. The data was collected from six districts viz. Srinagar and Budgam (Central Kashmir), Anantnag and Kulgam (South Kashmir) and, Baramulla and Kupwara (North Kashmir). Multi stage sampling technique was adopted for sample selection within each district. The sampling within the group was completely randomized [8]. A total of 48 ICDS centres were evaluated, eight centers from each district. The total number of respondents interviewed was 800, out of which 385 were children (mothers were interviewed), 192 were pregnant and lactating women, 124 were adolescent girls and 96 were AWWs and helpers. The respondents which included AWWs, mothers of children, pregnant and lactating women and adolescent girls were interviewed. The data was collected using a pre-designed questionnaire cum interview schedule.

Personal visits to AWC were made and the data was collected. Most of the information regarding the infrastructure and characteristics of AWWs was collected from AWWs and the information related to delivery of different services was collected from beneficiaries. The data collected was tabulated for further evaluation. Frequency distribution and percentage were used for the qualitative and quantitative analyses of the data.

Similar methodology has been used by different researchers for conducting similar studies [3,8,9].

3. RESULTS AND DISCUSSION

All the AWC evaluated (100%) in the study operated from the private establishments as shown in the Table 1. The AWC usually holds weighing scales, posters, toys, charts, utensils, almirahs, pre-school education kits (PSE). The availability of these necessary aids was evaluated in the selected AWC as shown in Table 1. It was observed that only 22.9% AWC's possessed adequate equipment. Majority of AWC (83.3%) did not possess the SABLA kit.

Table 1 also shows the distribution of AWC according to the fixed days of visit of LHV/ANM. It was recorded that majority (75%) of AWCs did not have a proper schedule of conducting these visits, rather the visits were irregular and arranged in an unorganized manner.

Only 15 AWWs (31.25%) were above the age of 35 years. It was observed that 70.8% (34) AWW's reside in the same village where AWC is located. 72.9% (35) AWW's reported that they have been mobilized by government to perform any duties other than AWC duties (Table 1).

Table 2 shows the distribution of children according to the services they avail at AWC. It was observed that majority of the children (99.48%) receive supplementary nutrition, 31.51% children receive pre-school education, 13.54% take advantage of health check-ups and only 1.82% children are immunized at their respective AWC.

94.79% of the pregnant and lactating women are covered under supplementary nutrition. Immunization and health check-ups were not

available for pregnant and lactating women, however, 53.3% received IFA tablets and 4.17% were provided with referral services (Table 3).

The coverage was complete in terms of supplementary nutrition scheme for adolescent girls and 71.53% also received IFA tablets. Health check-ups and basic skills programmes were not conducted for adolescent girls, however, 5.56% were provided with referral services (Table 4).

Table 1. Infrastructure of AWCs and characteristics of AWW in selected districts of Kashmir

| Parameter | Central (n=16) No. (%) | North (n=16) No. (%) | South (n=16) No. (%) | Total (n=48) No. (%) |
|--|------------------------|----------------------|----------------------|----------------------|
| AWC | | | | |
| Building ownership by State | 0(0) | 0(0) | 0(0) | 0(0) |
| Adequacy of Equipment | 4(25) | 3(18.75) | 4(25) | 11(22.9) |
| Availability of Sabla Kit | 0(0) | 5(31.25) | 3(18.75) | 8(16.7) |
| Regular visits of LHV/ANM | 0(0) | 8(50) | 4(25) | 12(25) |
| AWW | | | | |
| Age above 35 years | 7(43.75) | 3(18.75) | 5(31.25) | 15(31.25) |
| Work experience >03 years | 3(18.75) | 3(18.75) | 5(31.25) | 11(22.9) |
| Literate (10 th and above) | 16 (100) | 16 (100) | 16 (100) | 48(100) |
| Reside in the same village | 10(62.5) | 12(75) | 12(75) | 34(70.8) |
| Mobilized by govt. to perform duties other than AWC duties | 13(81.25) | 11(68.75) | 11(68.75) | 35(72.92) |

Table 2. Child services delivered under ICDS program at AWC

| Services | South (n=128) No. (%) | Central (n=128) No. (%) | North (n=128) No. (%) | Overall (n=384) No. (%) |
|-------------------------|-----------------------|-------------------------|-----------------------|-------------------------|
| Immunization | 5(3.91) | 2(1.56) | 0(0) | 7(1.82) |
| Preschool education | 35(27.34) | 66(51.56) | 20(15.63) | 121(31.51) |
| Health check-ups | 21(16.41) | 17(13.28) | 14(10.94) | 52(13.54) |
| Supplementary nutrition | 128(100) | 124(96.88) | 128(100) | 382(99.48) |

Table 3. Services delivered to pregnant and lactating women under ICDS program at AWC

| Services | South (n=64) No. (%) | Central (n=64) No. (%) | North (n=64) No. (%) | Overall (n=192) No. (%) |
|-------------------------|----------------------|------------------------|----------------------|-------------------------|
| Health check-up | 0(0) | 0(0) | 0(0) | 0(0) |
| Immunization | 0(0) | 0(0) | 0(0) | 0(0) |
| Supplementary nutrition | 64(100) | 54(84.38) | 64(100) | 182(94.79) |
| IFA tablets | 38(59.38) | 27(42.19) | 37(57.81) | 102(53.13) |
| Referral services | 0(0) | 8(12.5) | 0(0) | 8(4.17) |

Table 4. Services delivered to adolescent girls under ICDS program at AWCs

| Services | South (n=48) | Central (n=48) | North (n=48) | Overall (n=144) |
|-------------------------|--------------|----------------|--------------|-----------------|
| | No. (%) | No. (%) | No. (%) | No. (%) |
| Health check-up | 0(0) | 0(0) | 0(0) | 0(0) |
| Basic skills | 0(0) | 0(0) | 0(0) | 0(0) |
| Supplementary nutrition | 48(100) | 48(100) | 48(100) | 144(100) |
| IFA tablets | 43(89.58) | 24(50) | 36(75) | 103(71.53) |
| Referral services | 0(0) | 8(12.5) | 0(0) | 8(5.56) |

The concept of an AWC of having its own building seems to be nowhere near reality. Most of the centers were operated from the AWHs house. In an evaluation report prepared by Planning Commission in 2011, the overall percentage of AWC owned by the Government was 1.3% (lowest in the country) in Jammu and Kashmir, which was much below the national average of 42%. The present study suggests that nothing concrete has been done by the state in this regard.

Growth charts, weighing scales and support through counselling are important for the success of growth monitoring in AWCs [10]. The weighing scales should be different for children and adults, but it was observed that most of the AWCs had only one weighing scale. AWWs are supposed to keep a record of many things regarding the beneficiaries including weight of children, growth monitoring information among others. During the visit it was noted that the records were maintained in many AWC's even without the presence of weighing scales. At few centers it was observed that the maintained records were incorrect because the AWWs were not trained to carry out these calculations. The information collected at AWC is the basic source of data presented by Ministry of Women and Child Development at the national level and is the basis for evaluation and future prospect of this scheme. These observations suggest that there is need for enormous improvement in the data collection mechanism at AWCs which is the main source of information. Trainings can improve the skills of AWW [11], and this irregularity in data collection may be attributed to inadequacy in the trainings provided to AWW [12].

The Rajiv Gandhi Kishori Sasthikaran Yojna (SABLA) was launched with the purpose of empowering adolescent girls aged 11 to 18 years. The scheme includes the improvement of the nutritional and health status, enhancement of skills of handling affairs at home, in life and imparting other vocational skills. This scheme has been implemented through AWC and special

kits commonly known as SABLA kits have been provided to AWW which helps them in implementation of the scheme smoothly. Only 16.7% of AWCs possessed SABLA kits which implies that majority of the AWCs were not providing the services or they were not implementing the scheme properly. In an evaluation study of SABLA conducted by Bharti et al. [13] in Banka district of Bihar, the authors reported that the SABLA scheme is not implemented properly as the condition of majority respondents was below average.

LHV, ANM must conduct regular visits to AWC to conduct health check-ups. LHV/ANM are supposed to conduct check-ups of pregnant and lactating women, children and adolescent girls. Any ailments, if diagnosed by them, may be treated and necessary basic medicines are to be provided. LHV/ANM help AWWs in proper implementation of health schemes under ICDS including immunization, health check-up and referral services. The visits are conducted at only 25% of the AWCs which is very less and implies to inefficiency in implementation of these services throughout the valley. The regularity and frequency of visits by LHV/ANM needs to be improved for proper implementation of the scheme. Sachdev and Dasgupta [14] in a study also suggested that the proper training of LHVs and ANMs should be conducted to improve effectiveness of the service.

The efficiency in delivery of services and the credibility of feedback collected and maintenance of records is hugely dependent on AWW. The status of AWW in terms of her marriage, age, educational qualification etc. has been associated with the efficiency of their work. The age of most of the AWWs is less than 35 years which depicts that there are young and energetic people working as AWWs in most of the AWCs. The relocation of the AWW after marriage is the main reason for AWWs having different place of work than their place of residence, which is otherwise not recommended while appointing them.

AWW are meagerly paid voluntary workers meant to run AWC successfully but they are exploited by the government for other purposes off and on. Most of them have been given other assignments in addition to their duties during their tenure. These duties include census duties, election duties and in many cases the workers and helpers are forced to attend political rallies. All these issues in addition to payment of low wages are the main reasons for the poor performance of AWWs which is reflected in the results achieved by ICDS scheme. A study conducted by Thakare et al., [15] also concluded that out of many problems faced by AWW are minimum wages and extensive record keeping.

Supplementary nutrition was the only service which was provided to almost all the beneficiaries, except for few pregnant and lactating women. Out of the other services pre-school education was provided to less than half of the total respondents which needs to be improved. The children who were imparted pre-school education also reported poor skills in comparison to private creches. The distribution of IFA tablets was satisfactory among adolescent girls but only about half of the pregnant and lactating women said that they receive these tablets. Folic acid tablet distribution among the pregnant and lactating women was low in comparison to a previous study conducted in Gujarat [3].

4. CONCLUSION

The study suggests that barring supplementary nutrition program almost all the other schemes including pre -school education, immunization, health check-ups, referral service, etc under ICDS are unfortunately not being implemented properly. The implementation of services should be the priority followed by improvement in implementation. The reasons for the under performance of the scheme especially in Kashmir are multidimensional. While in other parts of the country, there are different circumstances, but the socio-economic and political conditions are completely different in Kashmir. Several studies have reported about holistic improvement in the implementation of ICDS scheme, but the rate of improvement is low, and the desired targets are still far from being achieved. In a report published by [16]Arora et al., the authors concluded that the upliftment of child and maternal health in India can be improved by better co-ordination between various stake holders which include governmental and non-governmental funding

agencies, researchers and programme implementors. It was further suggested that a complete realignment of different schemes is required for achieving the desired goals.

CONSENT

It is not applicable.

ETHICAL APPROVAL

We confirm that we have obtained all the necessary approvals to undertake this study.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Kapil U, Pradhan R. Integrated Child Development Services Scheme (ICDS) and Its Impact on the Nutritional Status of Children. *Indian Journal of Public Health*. 1999;43:21–25.
2. Agarwal KN, Agarwal DK, Agarwal A, Rai S, Prasad R, Agarwal S, et al. Impact of integrated child development services (ICDS) on internal nutrition & birth weight in rural Varanasi. *Indian Pediatr*. 2000;37:1321-7
3. Chudasama RK, Kadri AM, Verma PB, Patel U V, Joshi N, Zalavadiya D, et al. Evaluation of integrated child development services program in Gujarat, India. *Indian Pediatr*. 2014;51:707–11.
4. Saiyed F, Seshadri S. Impact of the integrated package nutrition & health services. *Indian J Pediatr*. 2000;67:322-8.
5. Bhasin S K, Bhatia V, Kumar P, Aggarwal OP. Long term nutritional effects of ICDS. *Indian J Pediatr*. 2001;63:211-6.
6. Trivedi S, Chhapparwal BC, Thore S. Utilization of ICDS scheme in children one to six years of age in a rural block of central India. *Indian J Pediatr*. 1995;32:47-50.
7. Gragmolati M, Bredenkamp C, Dasgupta M, Lee YK, Shekar M. ICDS and persistent

- under nutrition: strategies to enhance the impact. Economic and Political Weekly 2006; 1193-1201.
8. Manhas S, Dogra A. Awareness among Anganwadi Workers and the Prospect of Child Health and Nutrition: A Study in Integrated Child Development Services (ICDS) Jammu, Jammu and Kashmir, India. The Anthropologist. 2012;14:171-175
 9. Vaid S, Vaid N. Nutritional Status of ICDS and Non-ICDS Children. Journal of Human Ecology. 2005;18:207-212.
 10. Three Decades of ICDS-An Appraisal. National Institute of Public Cooperation and Child Development (NIPCCD), 2006. Available from: <http://nipccd.nic.in/reports/icdsvol3.pdf>. Accessed January 15, 2014.
 11. Halder A, Ray S, Biswas R, Biswas B, Mukherjee D. Effectiveness of training on infant feeding practices among community influencers in a rural area of West Bengal. Indian J Public Health. 2001;45:51-6.
 12. Datta SS, Boratne AV, Cherian J, Joice YS, Vignesh JT, Singh Z. Performance of Anganwadi centers in urban and rural area: a facility survey in Coastal South India. Indian J Matern Child Health. 2010;12:1-9.
 13. Bharti K, Kumar M, Prasad P. Nutritional status of adolescent girls under SABLA : An assessment of rural Anganwadi centres of Banka district. Food Sci. Res. J. 2015;6:395-399.
 14. Sachdev Y, Dasgupta J. Integrated Child Development Services (ICDS) Scheme. Medical Journal Armed Forces India.2001;57:139-143.
 15. Thakare MM, Kurli BM, Doibale MK, Goel NK. Knowledge of Anganwadi Workers and their problems in an urban ICDS block. Journal of Medical College Chandigarh. 2011;1:1
 16. Arora K, Narendra, Swaminathan, Soumya, Mohapatra, Archisman, Gopalan, et al. Research priorities in Maternal, Newborn, & Child Health & Nutrition for India: An Indian Council of Medical Research-INCLEN Initiative. Indian Journal of Medical Research. 2017;145:611-622.

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