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EVALUATION STUDY OF ICDS PROGRAMME IN MEGHALAYA

MARTIN LUTHER CHRISTIAN UNIVERSITY |

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We express our gratitude to the team who worked with commitment and dedication to successfully complete the evaluation study.

Rev E H Kharkongor
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Dated: Dec 19, 2012

Executive Summary:

The ICDS project in Meghalaya has been implemented since 1975 in Meghalaya starting at Songsak Block, East Garo Hills district. As on March 2010, there are 41 ICDS projects in the state with 3864 Aganwadi Centres across 39 Blocks and 7 Districts of the State. For the purpose of the evaluation, 114 villages from 21 C&RD Blocks in 7 districts were taken.

The evaluation study was done through interaction with various stakeholders at the grassroots level i.e. the women, village leaders, Aganwadi Workers, Auxiliary Nurse Midwife and also Accredited Social Health Activist. Through these interactions, it was found that in general, people were aware of the ICDS or the Aganwadi but a majority of 89 percent of respondents knew that children (0-6 years) were target groups. The awareness of target groups decreased about pregnant women and lactating mothers as only 48 percent knew that these are also target groups of the ICDS programme. None of the people mentioned adolescent girls as a target group of the ICDS.

With respect to SNP, 84 percent in East Garo Hills to 98 percent in Jaintia Hills of the children received supplementary nutrition, 3 to 5 days in a week. The main food items are Bengal gram, Biscuits, Milk, Atta, Suji, Soyabean, Chocomalt, Yummy RTE Noodles and Dried peas. Fifty two percent of the respondents rated the food as good but 32 percent and 4 percent rated the food as fair and poor respectively. In none of the villages, adolescents girls received supplementary nutrition. For malnourished children, the amount of food given is doubled.

Prophylaxis against Vitamin A deficiency although essential has not been done effectively as only 56 percent of the children have received Vitamin A tablets/syrup. In terms of immunization, the range of children being immunized is 73 percent in West Garo Hills and 95 percent in Jaintia Hills districts. Antenatal and Post natal care have not been given priority as in all the blocks a very small percentage of women receive any service.

Preschool Education is an important aspect of ICDS. The number of children attending pre school at the AWC ranged from 53 percent in East Khasi hills to 82 percent in South Garo hills. Many mothers have expressed that distance of the AWC and their home is a factor that inhibits them to send their children for PSE.

A large proportion of women (53 percent in Ri Bhoi district to 26 percent in Jaintia Hills) said that Nutrition and Health Education were not held for women in the reproductive age group. When the health talks were conducted, the main topics discussed are family planning, cleanliness, proper diet and nutrition and immunization. However, the study reveals that the NHE has made less impact on the lives of women in taking care their lives and children. For instance, in South Garo Hills, just 51 percent of women said that colostrums is best for a new born baby; the others say that it should be thrown away. This indicates that NHE needs to be enhanced so as to achieve desired impact.

The Aganwadi Centre is manned by an Aganwadi Worker assisted by an Aganwadi Helper. These are front line functionaries of the ICDS project. Although their work is heavy yet the honorarium of an AWW is Rupees 1500.00 and Rupees 1438.00 for matriculate and non matriculate respectively and the AWH receive Rupees 750.00 per month.

An important aspect of the ICDS is that there is a convergence of the Department of Social Welfare and Department of Health and Family Welfare as the services such as Immunization, Nutrition and Health Education and Health Check Up are taken care by the latter. However, it was found that there is non availability of supplements for children, pregnant and nursing mothers which results in these target groups not receiving adequate supplements during the times of need.

As mentioned earlier, people know about the ICDS but they are not aware of the services or the functioning of the Aganwadi Centre and also the roles and responsibilities of the Aganwadi Worker. Most people refer to the AWC just as a 'jaka sam shana' (Khasi) means centre that distributes channa or supplementary nutrition. Moreover the village level coordination committee although formed yet are unaware of their roles and responsibilities. The VLCC can be an important body at the village level for monitoring the activities of the AWC.

Critical gaps that have been found are the supply of Ready to Eat Noodles as part of supplementary nutrition. Instant noodles are often criticized as junk food since it is high in carbohydrates and low in fiber, vitamins and minerals. It has high level of saturated fat and transfat and also contains the Monosodium Glutamate (MSG). It is a used as a flavor enhancer but can cause neurological disorders such as Alzheimer's and Parkinson's diseases as well as rashes, headaches etc… and therefore it is not good for regular or daily consumption. Also, the supplementary nutrition for adolescent girls needs to be re-examined as people have said that none of the adolescent girls receive supplementary nutrition. Antenatal and Post natal care needs to be enhanced so as to be able to tackle the cycle of morbidity and mortality. Lack of knowledge of a majority of women about basic aspects related to child care and reproductive health.

GLOSSARY OF TERMS:

AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Aganwadi Centre
AWH	Aganwadi Helper
AWW	Aganwadi Worker
BCG	Bacillus Calmette-Guérin
CDPO	Child Development Project Officer
CGI	Corrugated Galvanized Iron
C&RD	Community and Rural Development
CRC	Convention on the Rights of a Child
DPT	Diphtheria Pertussis Tetanus
DPT BD	Diphtheria Pertussis Tetanus Booster Dose
DT	Diphtheria and Tetanus Toxoids
HIV	Human Immuno Deficiency Virus
ICDS	Integrated Child Development Services
MSG	Monosodium Glutamate
NCAER	National Council of Applied Economic Research
PHC	Primary Health Centre
PSE	Pre School Education
RTE	Ready To Eat
SNP	Supplementary Nutrition Programme
TT	Tetanus Toxoid
VLCC	Village Level Coordination Committee

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I. INTRODUCTION:

Health of women, adolescent girls and children is of prime importance. The Government of India has taken up the agenda and has developed srategies to enhance or built a foundation for a healthy population. The Government of India proclaimed a National Policy on Children in August 1974 declaring children as, "supremely important asset". India has large children population. As per 2001 census, India has around 157.86 million children, constituting 15.42% of India's population, who are below the age of 6 years. Of these 157.86 million children, 75.95 million children are girls and remaining 81.91 million children are boys. The sex ratio among children (0-6 years) as per Census 2001 is 927 i.e. 927 females per 1000 males.

The early childhood years of a child's life are crucial for cognitive, social, emotional, physical/motor development and cumulative lifelong learning. To lay the foundation for the healthy development of children, women and adolescent girls, the Integrated Child Development Services Programme was launched on October 2, 1975. The scheme was launched on an experimental basis in 33 ICDS blocks but has been gradually expanded to 6284 projects. ICDS is India's response to the challenge of breaking a vicious cycle of malnutrition, impaired development, morbidity and mortality in young children. It responds to the inter-related needs of children below 6 years, pregnant women, lactating mother and adolescent girls in a comprehensive manner. Moreover as India is a signatory to the Convention on the Rights of a Child (CRC), the ICDS can be said to be the country's response to the needs and rights of children to a healthy life.

The main objectives of the ICDS are:

i) To improve the nutritional and health status of children below the age of six years

ii) To lay the foundation for proper psychological, physical and social development of the child

iii) To reduce the incidence of mortality, morbidity and malnutrition and school drop out

iv) To achieve effective coordination of the policy and implementation among various Departments to promote child development

v) To enhance the capability of the mother to look after normal health and nutritional needs of the child through proper nutrition and health education.

To achieve the above mentioned objectives, the Government has formulated a comprehensive package of services under the ICDS. These services are aimed at meeting the inter-dimensional needs of women including pregnant women and lactating mothers, children below 6 years and adolescent girls. These services are as follows:

1. Supplementary Nutrition
2. Immunization

3. Health Check-up
4. Referral Services
5. Nutrition and Health Education
6. Pre-School Education

The Aganwadi is the focal point for implementation of the scheme. The Anganwadi, literally means a courtyard play centre, located within the village itself. In hilly areas such as Meghalaya, one Aganwadi Centre caters to a population range between 300 to 800 while a Mini Aganwadi Centre, the norm is 150 to 300 population. Hence, the distribution of aganwadi centres is based on population parameters; thus one village can have two Aganwadi Centres.

The Aganwadi Worker is the main functionary of the centre and there is also an Aganwadi Helper to assist the worker. However, the Aganwadi Worker has to network with the Auxiliary Nurse Midwife (ANM) for services such as immunization. Although the Aganwadi Worker monitors the status of immunization of children, yet the actual immunization is given by the ANM. Thus there needs to be an effective coordination between the Aganwadi Worker and the ANM for effective results. The details of the target group, services and persons responsible for each service are given in the following Table 1:

Table 1: Details of services, target groups and persons responsible:

Services	Beneficiaries	Services rendered by
Supplementary Nutrition	Children (6 months to 6 years) Pregnant and Lactating mothers Adolescent Girls	Anganwadi Worker and Helper
Immunization	Children below 6 years; Pregnant and Lactating mothers.	ANM and Aganwadi Worker
Health Check-up	Children below 6 years; Pregnant and Lactating mothers.	ANM and Agawandi Worker
Referral Services		ANM and Agawandi Worker
Pre-School Education	Children in the age group of 3-6 years	Aganwadi Worker
Nutrition and Health Education	Women in age group of 15-45 years	ANM and Agawandi Worker

The ICDS is a 100 percent centrally sponsored scheme.

A brief note of the services of ICDS:

1. Supplementary Nutrition:

Objective: to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities.

The Supplementary Nutrition service includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anaemia. The target groups receive supplementary feeding support for 300 days in a year. Growth Monitoring and nutrition surveillance are two important activities that are undertaken. The children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. Besides, severely malnourished children are given special supplementary feeding and referred to medical services.

2. Immunization:

Child mortality and morbidity can be prevented through immunization. It is given to pregnant women and infants and children to protect them from six vaccine preventable diseases- poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles.

3. Health Check-ups:

The Health Check Up includes the following:

- health care of children less than six years of age
- antenatal care of expectant mothers
- postnatal care of nursing mothers

Other health services are also provided by Anganwadi workers and Primary Health Centre (PHC) staff. These include regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhoea, de-worming and distribution of simple medicines etc.

4. Referral Services:

Children who require medical attention because of malnutrition or sickness are referred to the Primary Health Centre or its Sub-Centre. The Anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer of the Primary Health Centre/ Sub-centre.

5 Non-formal Pre-School Education (PSE)

The Non-formal Pre-school Education (PSE) is a programme for the three-to six years old children in the Anganwadi Centre. It is directed towards providing and ensuring a natural, joyful and stimulating environment, with emphasis on necessary inputs for optimal growth and development. The early learning component of the ICDS is a significant input for providing a sound foundation for cumulative lifelong learning and development. It also contributes to the universalization of primary education, by providing to the child the necessary preparation for primary schooling and offering substitute care to younger siblings, thus freeing the older ones – especially girls – to attend school.

6. Nutrition and Health Education:

The objective of the Nutrition, Health and Education component is to enhance the capacity of women between the age group of 15 to 45 years so that they can look after their own health, nutrition and development needs as well as that of their children and families.

II. INTEGRATED CHILD DEVELOPMENT SCHEME IN MEGHALAYA

In Meghalaya, the first ICDS project was launched on an experimental basis in 1975 at Songsak Community and Rural Development Block, East Garo Hills District. Since then, the Department of Social Welfare has come a long way in expanding the ICDS project to all the 7 Districts and 39 Blocks of the State. There are also two Urban ICDS Projects at Shillong and Tura. The funding pattern from 2009 – 2010 for ICDS component and SNP is 90 percent (Central Funding) and 10 percent (State Share).[1]

As of March 2010, the details of the ICDS projects in the state are given in the following Table:

Table 2: ICDS Projects, sanctions and achievements[2]

Particulars	Sanctioned	Achievement
ICDS Projects sanctioned by Government of India	41	41
No. of Anganwadi centres sanctioned by Government of India	3881	3864
Mini AWC	1234	1232

Supplementary Nutrition Programme:

The Supplementary Nutrition is provided to children 6 months to 6 years of age, pregnant and nursing mothers and adolescent girls for 300 days in a year i.e. 25 days in a month. The types of food given as part of SNP are Bengal gram, groundnut, suji, soya bean, cheera, green peas etc... and also fortified food such as dahlia and milk are also provided to children below 3 years of age. The target for providing supplementary nutrition is 6,17,947 while the achievement is 4,91,005.

In terms of nutritional status of children (0-6 years), the details are as follows:

- Grade I Malnutrition: 49311
- Grade II Malnutrition : 15283
- Grade III & IV Malnutrition: 229
- Normal 123676

Thus 34.38[3] percent of the children are malnourished in the state of Meghalaya.

[1] Department of Programme Implementation and Evaluation, Government of Meghalaya, *A Brief Note on Integrated Child Development Services Scheme (ICDS)as on March 2010*
[2] Official Website of the Department of Social Welfare, Meghalaya
[3] Formula – (Grade 1+ Grade 2+ Grade 3)/ (Grade 1+ Grade 2+ Grade 3+ normal)*100

Non Formal Pre-school Education:

As mentioned earlier, in Meghalaya also, Non Formal Pre-school Education is implemented in all the AWCs. Efforts by the Department to strengthen the linkages with primary school at the village level and to prepare children for entrance to class one level.

As on March 2010, the details of enrolment are given as follows:

- Children enrolled in Pre-School: 1,68,917
- Children who attend Pre School: 1,49,451

Thus the percentage of attendance in pre –school is 88.48 percent.

III. METHODOLOGY OF THE EVALUATION:

3.1 Need of the Evaluation:

As mentioned earlier, the ICDS is a very important programme of the central government as it aims to create a firm foundation for a healthy population i.e. children and women. However, such well intentioned programmes may not achieve its goals if proper monitoring and evaluation is done. Thus, an evaluation of the ICDS in Meghalaya is very apt as the last evaluation of the programme has been done in 2009 by the National Council of Applied Economic Research (NCAER). It would also reflect the state of affairs of the programme in the state and thus throw light on aspects and services that can be improved so that it meets the objectives.

3.2 Objectives of the Evaluation:

- To assess the impacts of the ICDS on nutritional and health status on children and women
- To identify challenges faced during the implementation of the scheme
- To identify best practices and innovative approaches adopted to enhance the effectiveness of the scheme

3.3 Sampling Design:

As mentioned earlier, the ICDS programme in Meghalaya is implemented in all the districts and blocks of the state. However, for the purpose of this study, a sample which is representative of the sample has been taken. The sampling design that has been used is multistage sampling design.

The sample covers all 7 districts of the Meghalaya. Out of 39 Blocks, 21 blocks have been taken for the study. The criterion given for selection of villages is 5 percent of the total number of villages in the block. An average of 120 villages was taken per block, thus 5 percent would constitute about 6 villages per block. Hence a total of 114[4] villages were taken for the evaluation study. In brief, the sample is as follows:

- 7 Districts
- 21 Blocks
- 114 villages

Area of the study:

As indicated earlier, the area of study for the evaluation process was across 114 villages in 21 blocks of Meghalaya. Six villages were taken per block. The criteria for choosing the blocks were as follows:

[4] Although 126 villages was the target number of villages for the evaluation study, yet due to logistical problems, only 114 could be covered during the study.

- Accessible: presence of an all weather road in the village
- Remote: a village which has a kuccha road or inaccessible by road

Based on the above criteria, the Department of Social Welfare selected 21 blocks for the evaluation study. With regards to the selection of the villages, the selection was done in consultation with the Child Development Project Officers in Khasi and Jaintia Hills. In Garo Hills, the team selected the villages and informed the lady supervisors of the concerned areas.

The details of the area covered in given in the following Table 3:

Table 3: Details of Sample

Sl no.	Names of Districts	Names of Blocks	Names of Villages
1.	East Khasi Hills	Mawphlang	Pydenlitha
			Lukhyllem
			Sawlad
			Umylle
			Mawngap kharshiing
			Laitdiker
2.		Shella bholaganj	Pdengshnong
			Mawblang
			Jasir
			Saikarap
			Mawphu
			Nongpriang
3		Mawkynrew	Tanglei
			Piengwait
			Mawkynrew
			Jatah Lakdong
			Siangkhnai
			Kharang
4.		Mawryngkneng	Mawshabuit Nonglum
			Jyntah
			Sohryngkham Lulong-'A'
			Sohryngkham Lulong-'B'
			Diengpasoh Mawiong
			Kyntoit Kseh
5.	Jaintia Hills	Thadlaskein	Tyrshang
			Umjalisiaw
			Ialong Mulang

			Nangbah Mission
			Moopyllait
			Sohmynting Wah-'A'
6.		Laskein	Nongkynrih
			Kyndong Tuber
			Laskein
			Sahsniang
			Umsalait
			Ratiang
7.		Amlarem	Thangbuli-'A'
			Khonglah
			Trangblang
			Satpator
			Sohkha Mission
			Sohkha shnong
8.	West Khasi Hills	Mawkyrwat	Mawlangwir-'1'
			Rangmaw-'1'
			Mawten-'2'
			Pynden Mawramhah
			Dom Myntong
			Rangblang Pyndenkseh
9.		Mawshynrut	Rangolpara
			Umdein
			Janepih
			Banjeng
			Kyrdum
10.		Nongstoin	Urkhli
			Porsohsat
			Miangshang
			Jaidoh
			Riangpoit
			Nongtraw
11.		Mairang	Thangmaw
			Langtor
			Tiehbah
			Nongrmai
			Nongthliew
			Maroid
12.	Ri Bhoi	Umsning	Zero Point

			Mairung
			Jair
			Mawlyngkhung
			Mawlaho
			Mawbsein
13	West Garo Hills	Dadenggre	Asimgre
			Chiditchakrel
			Rom Bazar
			Dilsegre
			Sadolpara
14		Dalu	Kherapara
			Thibapara
			Chaipani
			Dapgre
			North Khujikura
15		Betasing	Nirghini
			Godalgu
			Okkapara
			Ampati A
16		Rongram	Waribok
			Assanangre.
			Edenbari
			Baljek Agal
			Chasingre
17	South Garo Hills	Baghmara	Karukol
			Sibbira
			Masighat
			Dalram
			Nenghong
18		Rongara	Mahadeo
			Chenggin
			Bilkona
			Reserve Gittim
			Rongru A Sim
19	East Garo Hills	Samanda	Samandaprapyre
			Rikwareng
			Samanda Chemgre
			Megagri

			Dilma Chiading
20		Resulbepara	Nishangram Babuparal
			Bolsong (Kaima)
			Todam
			Bolsong B Mohol
21		Songsak	Norek Megapre
			Sawegre
			Bone Chidekgre
			Bone Chijangre
			Bone Watregre

The total number of villages covered during the study is 114 villages.

The total number of Aganwadi Centres visited during the study is given in the following Table 4:

Table 4: District wise number of Aganwadi Centres

SL no.	Name of the District	No. of Aganwadi Centres visited
1.	East Khasi hills	24
2.	Ri Bhoi	6
3.	Jaintia Hills	18
4.	West Khasi Hills	23
5.	South Garo Hills	10
6.	West Garo Hills	19
7.	East Garo Hills	14

Respondents:
To have views from a cross section of people, the evaluation study was carried out at two levels; block level and community level.

Block Level:

i. At the block level, the respondent was the Child Development Project Officer (CDPO).

Community Level:
At the community level, there were many respondents who were important stakeholders representing various sections of the community. These are as follows:

i. Village officials i.e. village elders holding positions such as Headman, Secretary, Executive Members
ii. Women (adults usually those in the reproductive age group from 15 to 45 years)
iii. Children (0-6 years, at least 30 children from one village)
iv. Aganwadi Worker (AWW)
v. Auxiliary Nurse Midwife (ANM)
vi. Accredited Social Health Activist (ASHA)

3.3 Methods of Data Collection:

The methods of data collection that have been used for the study have been the following:

i. Interview with the following respondents:
    - Women (household survey; 10 households per village)
    - Aganwadi Worker
    - Auxiliary Nurse Midwife
    - Accredited Social Health Activist
ii. Focused Group Discussion
    - Village Officials
    - Women
iii. Physical Examination of children
    - Weight
    - Height
iv. Visits to Aganwadi Centres

Project Team:

The team that was responsible for the evaluation study is as follows:
Field Assistants

- Ivan Marbaniang
- Hepzibah Jungai
- Joycy Langstieh
- Badashisha Marbaniang
- Simon Boon Swett
- Jovi Sangma
- Vencia Sangma
- Silman Sangma

Social Workers

- Badalam Dkhar
- Elizabeth Sangma
- Melari Shisha Nongrum

Data Analysis

- Alwin Ksanbok Fancon
- Ronald Evans Lyngdoh

3.4 Data Analysis:

The data entry and analysis has been done using Microsoft Excel. The findings of the study will be highlighted in the next section.

IV. FINDINGS OF THE STUDY

4.1 Profile of Respondents:

The data was collected from a number of people representing a cross section of people. The basic profile of the respondents that interacted with the project team is given in Table 5:

Table 5: Details of Respondents:

Sl no.	Districts	Total No. of Respondents	Sex		Highest Education		Main Source of Income		
			Male	Female	Class V to X	Below V	Daily Wage	Agriculture	Daily Wage & Agriculture
1.	East Khasi Hills	680	91	589	67%	32%	47%	48%	5%
2.	Jaintia Hills	402	57	345	47%	22%	35%	12%	26%
3.	West Khasi Hills	575	108	467	42%	37%	67%	32%	34%
4.	Ri Bhoi	169	26	143	33%	39%	28%	52%	13%
5.	West Garo Hills	398	121	277	40%	26%	2%	75%	2%
6.	South Garo Hills	235	66	169	39%	39%	23%	37%	15%
7.	East Garo Hills	650	225	425	27%	7%	11%	52%	3%
	Total	3109*	694	2415					

*this excludes the children whose weights and heights were measured

From Table 5, it is evident that 78 percent of the respondents were women. Except for East Khasi Hills district, less than 50 percent of all the respondents in the other districts have had upper primary education or high school. The people are also dependent on agriculture and daily wages for their livelihood.

The housing pattern in the villages covered during the study was mostly houses with CGI roofing; 58 percent of respondents had their houses with CGI roofs. The sanitation facilities in the villages were also not satisfactory as 29 percent of respondents defecated in the open. It is important to note that in Umsning Block, 93 percent of the respondents still do not have either a toilet within the house or compound and have to defecate in the open. Moreover, in terms of communication, 50 percent of the respondents had a mobile phone and 35 percent had a radio in their homes.

4.2 Profile of the villages:

In terms of accessibility, fifty percent of the villages that were covered during the evaluation study were remotely located and the other half were accessible by an all weather road. There were two villages which were taken as part of the study but were not covered under the ICDS

Project i.e. Laitdiker in Mawphlang Block and Mawngap in Mawshynrut Block. This was deliberately done so as to be able to assess the difference in nutritional status of children.

The population of villages ranged from 160 to 3000 whereby 90 percent of the villages had been electrified. In terms of presence of schools, 80 percent of the villages had Lower Primary Schools. There were 27 percent of villages which had a sub centre located within the village. The main source of income in all the villages is agriculture and daily wages; daily wages could be within the village and also outside during off seasons. The villages had infrastructure such as community halls, church buildings and football ground. Moreover, the villages had their own land and forests which was under the management of the village council. Apart from the ICDS project, there were two other schemes of the government which were operational in all the villages; these were the Mahatma Gandhi National Rural Employment Guarantee Act and Indira Awas Yojna.

4.3 Aganwadi Centre:

The number of Aganwadi Centres visited during the study was 78 percent had their own building and the rest implemented the activities from community halls or schools. Seventy seven (77) percent of the AWCs have toilet facilities but 72 percent do not have proper water facilities at the centre and therefore have to carry from nearby taps, draw from a well or fetch from a stream. All the AWCs have only 2 rooms where all the activities are conducted. In terms of assets, 99 percent of the AWCs have weighing machines, chairs, tables, utensils for cooking, teaching aids such as charts, toys etc...

4.4 Knowledge of ICDS:

The respondents were aware of the ICDS project as 96 percent of respondents said they knew about the ICDS. However, when asked about the target groups of the ICDS, 89 percent of respondents knew that children from 0 to 6 years were one of the target groups but only 77 percent and 48 percent of respondents knew that pregnant women and nursing or lactating mothers respectively were also target groups of the ICDS. However, none of the people said that adolescent girls were also a target group with respect to the SNP.

On the other hand, the functionaries of the ICDS project i.e. the AWW and the CDPO mentioned the target groups i.e. children (0 to 6 years), pregnant and lactating mothers and adolescent girls.

4.5 Attendance

In terms of attendance in Aganwadi Centre, 90 percent of children in the villages attend the ICDS. The other 10 percent do not attend due to the far distance of the centre and their homes and hence the mothers do not send their children to the centre.

There are about 19 to 25 women between the age group of 20 to 35 who attend the health talk in an Aganwadi Centre.

4.6 Supplementary Nutrition:

Although a large percentage of children receive supplementary nutrition as indicated in the adjacent Figure 1, yet all the children do not receive supplementary nutrition on daily.

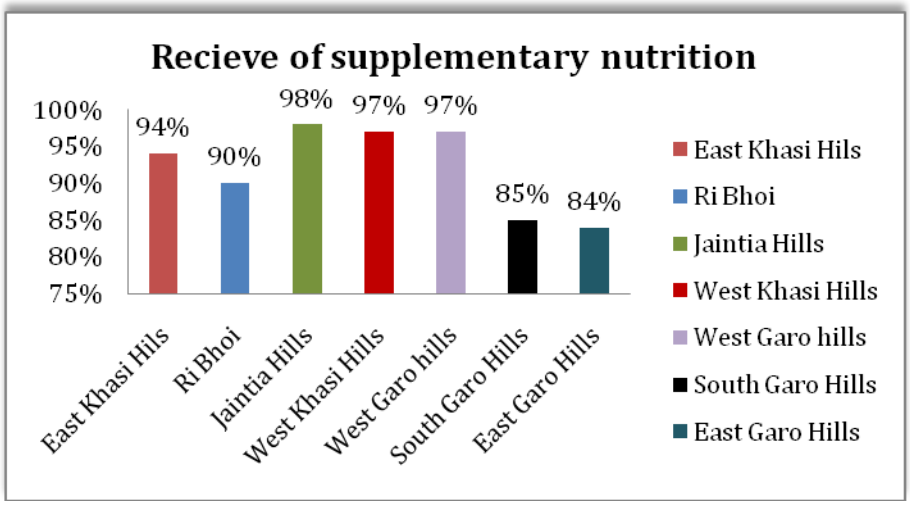


Figure 1: Receive of Supplementary Nutrition

Figure 1 gives the District wise percentage of children receiving SNP. According to the people's response, the children receive SNP for an average of 3 to 5 days per week. However, in Umdein, Mawshynrut block and Nongthliew, Mairang block it was found that children who did not attend the preschool education do not receive supplementary nutrition.

However, according to the Aganwadi Worker, following is block wise percentage of distribution of SNP is given as follows:

Table 6: Block-wise percentage distribution of SNP

Sl no.	District	Blocks	SNP received*
1	East Khasi Hills	Mawkynrew Block*	85%
		Mawphlang	78%
		Mawryngkneng	99%
		Shella	99%
2	Ri Bhoi	Umsning	90%
3	Jaintia Hills	Thadlaskein	97%
		Amlarem*	100%
		Laksein	96%
4	West Khasi Hills	Mairang	97%
		Mawkyrwat	97%

		Nongstoin	100%
		Mawshynrut	95%
5	South Garo Hills	Baghmara	81%
		Rongara	88%
6	West Garo Hills		
		Dadengere	98%
		Dalu	97%
		Rongram	97%
		Betasing	95%
7	East Garo Hills	Resulbepara	68%
		Songsak	90%
		Samanda	95%

*the denominator is taken as 300 days as it is given in the scheme

Eighty three percent of respondents said that they receive cooked food. However, 100 percent of the Aganwadi workers said that they provide cooked food to the people. The following table will indicate that a sizable number of AWC still lack a kitchen to cook the food. In such cases, the food is cooked in the Agawandi Helpers' house or AWW' s house.

Table 7: Percentage of AWC having own kitchens

Sl no.	District	Blocks	Percentage of kitchens in AWC
1	East Khasi Hills	Mawkynrew Block*	50%
		Mawphlang	60%
		Mawryngkneng	83%
		Shella	50%
2	Ri Bhoi	Umsning	50%
3	Jaintia Hills	Thadlaskein	17%
		Amlarem*	100%
		Laksein	60%
4	West Khasi Hills	Mairang	67%
		Mawkyrwat	17%
		Nongstoin	33%
		Mawshynrut	100%
	South Garo Hills	Baghmara	60%
		Rongara	100%

	West Garo Hills	Samanda	40%
		Dadengere	0%
		Dalu	40%
		Betasing	0%
	East Garo Hills	Resulbepara	33%
		Rongram	25%
		Songsak	25%

The food items that are usually given as part of the supplementary nutrition are as follows:

1. Bengal gram
2. Biscuits (papaji biscuit which is not of a good quality)
3. Milk
4. Atta
5. Suji
6. Soyabean
7. Dried peas
8. Choco Malt
9. Yummy RTE noodles
10. Refined oil
11. Mustard oil
12. Jaggery
13. Iodised salt

The respondents expressed that the food items are given on an alternate basis i.e. one day, Bengal gram would be given and then maybe suji is given, then atta and channa again so it differs from place to place. It also depends on the supplies that are available with the Centre at a particular point of time.

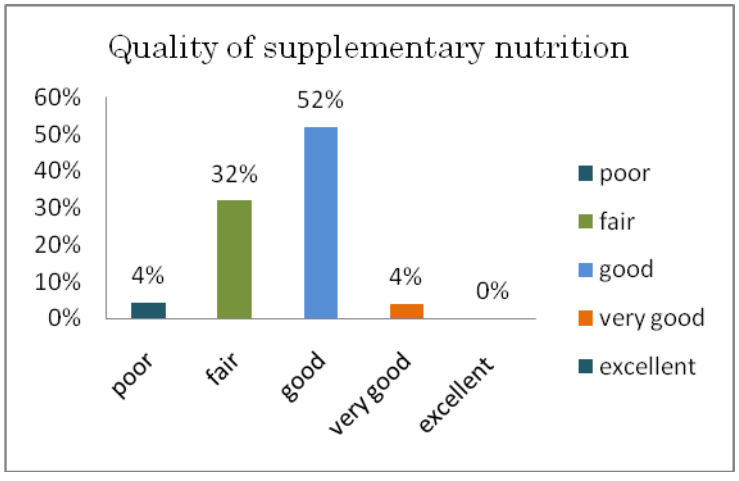


Figure 2: Quality of supplementary nutrition

Although the children like yummy noodles yet many mothers have expressed their dissatisfaction about the noodle. They say it is not good for the children's health.

The children prefer yummy noodles and biscuits to

Bengal gram, peas or any other whole food. It is just like a snack so they like it.

Sixty seven percent of respondents said that the food is usually given at the AWC or otherwise in schools or dorbar/community halls. Further, the people have rated the quality of food on a 5 point scale, from poor to excellent as shown in Figure 2:

The timing of giving the supplementary nutrition is not certain; in some AWCs, the SNP is given in the morning and in others, it is given in the afternoon. However, the duration range from 1 hour to 2 hours. In terms of adequacy, more than half of the respondents i.e. 56 percent expressed that the food is not enough for the child. Thus it is important for people to understand the concept of supplementary nutrition so that the children get adequate food at home and also receive the supplementary nutrition at the AWC. The preparation of the food is done by the Aganwadi Helper where she usually cooks in her own home if there is no kitchen in the AWC as many AWCs still do not have a kitchen as indicated in Table 7.

Another important finding in the study is the 'payment for supplementary nutrition'. This was found in Jyntah village, Mawryngkneng block where children had to pay Rs. 3.00 per week or if they do not pay in cash, they had to bring 3 pieces of firewood to the AWC for cooking the meals. The AWWs across the blocks also express their problems in relation to firewood as the quantity is very less. In most cases, they said they had to use their own fuel wood also.

Further, in New Pyndengkseh, Mawkyrwat Block, food was served in plastic bags rather than in bowls as provided by the Department of Social Welfare.

It is important to also note that all the Aganwadi Workers state that adolescent girls also receive supplementary nutrition. However, none of the households mentioned adolescent girls as recipients of SNP. Thus this needs to be studied carefully.

Moreover, there is no special nutrition for severely malnourished children but the amount of the same food is doubled.

According to the Child Development Project Officers, the following are the details of malnourished children in their respective Blocks are given in Table 8.

Table 8: Details of malnourished children

Sl no.	District	Blocks	Grade I	Grade II	Grade III
	East Khasi Hills	Mawkynrew Block*			
		Mawphlang	Nil	6415	15
		Mawryngkneng	Nil	Nil	Nil
		Shella	Nil	Nil	Nil
	Ri Bhoi	Umsning	Nil	1053	43
	Jaintia Hills	Thadlaskein	Nil	2022	414
		Amlarem*			
		Laksein	Nil	512	37

	West Khasi Hills	Mairang	Nil	11921	Nil
		Mawkyrwat	12099	8	Nil
		Nongstoin	Nil	8893	Nil
		Mawshynrut	Nil	1532	Nil
	South Garo Hills	Baghmara	Nil	807	Nil
		Rongara	Nil	Nil	Nil
	West Garo Hills	Rongram	728	Nil	4
		Dadengere	Nil	703	43
		Betasing	8354	3699	12
		Dalu	424	880	1
	East Garo Hills	Resulbepara	Nil	467	2
		Songsak	Nil	Nil	Nil
		Samanda	122	3422	Nil

* No response from CDPOs of the respective blocks

4.7 Vitamin A supplements:

Prophylaxis against Vitamin A deficiency is an important part of the ICDS project. Hence Vitamin A tablets/syrup are usually given to children. Overall, only 56 percent of children have received Vitamin A tablets/syrup. However, it is essential to note the variation among the different districts as given in Fig 3.

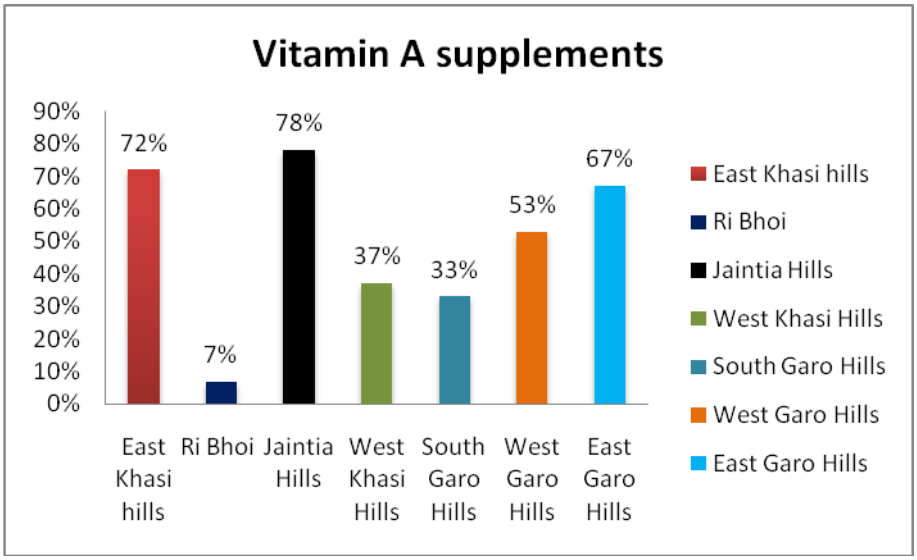


Figure 3: Vitamin A Supplements

From the figure, it is apparent that the distribution of vitamin A supplements to children is very low in Ri Bhoi District and also in West Khasi Hills and South Garo Hills. Although the other districts are relatively better, yet vitamin A supplementation needs to be enhanced so as to reduce deficiencies in Vitamin A. The response to the regularity of giving of supplements was varied but a majority of the respondents said that if at all they receive the supplements, they received only once in a year.

4.8 Growth monitoring:

Growth monitoring of children is an important aspect of the ICDS project. In this aspect, the children were weighed and also their heights were taken and these measurements were recorded so as to be able to monitor their growth and also their nutritional status.

During the study, it was found that in 83 percent of the Aganwadi Centres, the weight of children was recorded. However, it is important to note that in South Garo Hills, 67 percent of the Aganwadi centres only, weighed the children. The frequency of weight measurement was 46 percent and 10 percent for monthly and bi-monthly weighing respectively.

Measurement of heights of children was not done as in either of the blocks in East Khasi Hills, West Khasi Hills, Ri Bhoi and Jaintia Hills districts. Only 16 percent in the 3 districts of Garo Hills, the AWCs took and recorded the heights of children. This is also related to the AWW, informing the mothers about the growth of children. Overall, only 38 percent of AWWs informed the mothers about the growth of children while in South Garo Hills, only 4 percent of AWW informed the mothers about the growth of their children. The advice that the AWW gives to the mothers in this regard, is to take the children for check up and few AWCs tells the mothers to give healthy food to the children.

The Aganwadi workers maintain growth charts and all of them know how to assess the nutritional status of children from the growth charts.

4.9 Immunization:

Immunization is another service which is part of the ICDS project. As mentioned earlier, the immunization is done by the Auxiliary Nurse Midwife (ANM) while the AWW assists the ANM in identifying children who require immunizations. In terms of immunization, 88 percent of respondents said that their children were immunized. The district wise figures for immunization are given in Table 9:

Table 9: Percentage of respondents whose children are immunized

Sl no.	Districts	Percentage
1.	East Khasi hills	92%
2.	Ri Bhoi	78%
3.	Jaintia Hills	95%
4.	West Khasi Hills	91%
5.	South Garo Hills	94%
6.	West Garo Hills	73%
7.	East Garo Hills	85%

It is evident from Table 9, in all the districts except for Ri Bhoi and West Garo Hills, the percentage of immunization is above 85 percent. Immunization Cards are essential documents for maintaining records of immunization. Seven nine percent of respondents had the immunization cards.

The importance to which people gives for each type of immunization can be seen from the following figure 4.

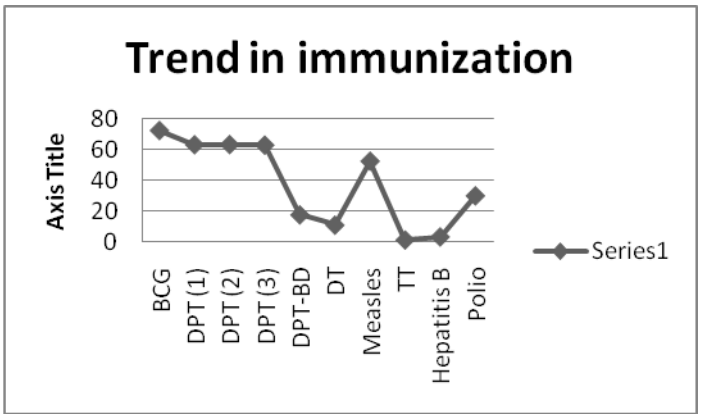


Figure 4: Trends in immunization

The trend of immunization across the blocks is based on the use of different types of immunization. From the figure, it can be seen that BCG is the highest and it drops as people do not give immunizations such as DPT BD and DT and rises again with the measles injection, as many children are immunized. Again the continuum falls with Tetanus and Hepatitis B and rises a little with Polio immunization.

4.10 Health Check Up

Health Check up of children below six years and also pregnant and lactating women is another essential service of the ICDS project. Seventy four percent of the target groups went for health check up. Whenever they went for the health check up, 35 percent of respondents said they were examined and rarely where their weights were measured. However in the three districts of Garo Hills, 36 percent of respondents said that their blood was tested. Moreover, 71 percent of respondents said that medicines were also given for common ailments. The diseases where medicines were given were mainly for fever, diarrhoea and cough. However, in most cases, the people received the medicines when they go to the Sub Centre for health check up.

As part of the health check up, antenatal and post natal care are also provided to women. The following table 10, gives the percentage of women receiving either antenatal or post natal care.

Table 10: Percentage of women receiving either antenatal or post natal care

Sl no.	District	Blocks	Antenatal Care	Post natal Care
1	East Khasi Hills	Mawkynrew Block	23%	6%
2		Mawphlang	24%	22%
3		Mawryngkneng	28%	18%
4		Shella	19%	14%
5	Ri Bhoi	Umsning	78%	25%
6	Jaintia Hills	Thadlaskein	35%	21%
7		Amlarem	37%	28%
8		Laksein	29%	18%
9	West Khasi Hills	Mairang	26%	16%
10		Mawkyrwat	18%	15%
11		Nongstoin	23%	7%
12		Mawshynrut	20%	9%
13	South Garo Hills	Baghmara	12%	2%
14		Rongara	16%	0%
15	West Garo Hills	Rongram	7%	6%
16		Dadengere	18%	13%
17		Betasing	15%	16%
18		Dalu	12%	0%
19	East Garo Hills	Samanda	37%	22%
20		Resulbepara	3%	3%
21		Songsak	48%	0%

From Table 10, it is evident that antenatal and post natal care needs to be enhanced as the percentage of women receiving any such care is minimal. Immunization, iron and calcium tablets are provided as part of the antenatal care while vitamins are provided as part of the post natal care.

4.11 Referral:

Forty three percent of the respondents expressed that the Aganwadi worker refers them to the Primary Health Centre when they have any sickness and need health care.

4.12. Non Formal Pre School Education:

The Non Formal Pre School Education forms the basis for cumulative lifelong learning and development. The attendance at preschool education ranges from 53 percent to 82 percent as indicated in Figure 5.

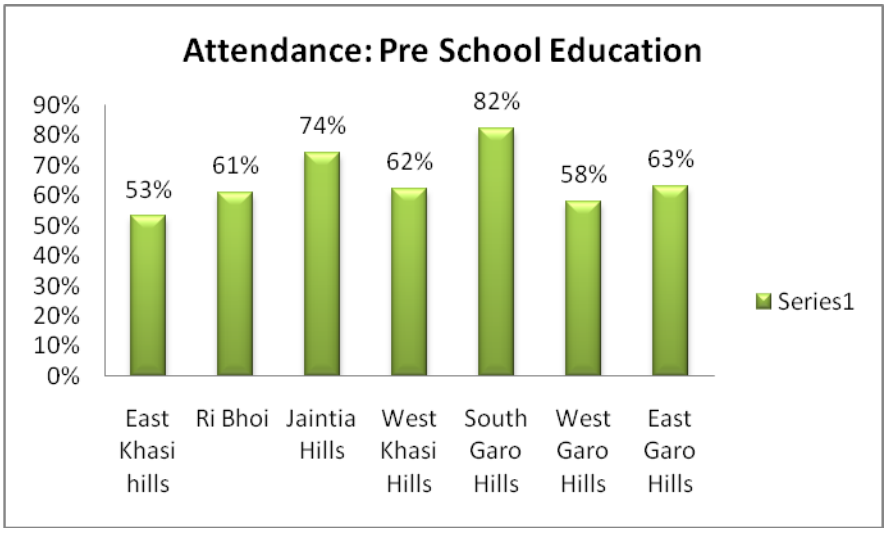


Figure 5: Attendance at Pre School Education

The PSE is provided in the Aganwadi centre and it opens 3 to 5 times a week. The duration of the PSE ranges from 1 to 2 hours either in the morning or evening. The time for the PSE is also the time where supplementary nutrition is provided. The children who attend the PSE learn singing as well as dancing to action songs (47 percent) and 23 percent learn how to read and write the Khasi Alphabets or English Alphabets and also they could read numbers, till about 50.

It is important to note that, in New Pyndengkseh, Mawkyrwat block, the AWW is irregular and do not conduct preschool education. The people complained that the preschool children do not learn anything as PSE is not held.

In two other villages in Nongstoin block, Urkhli and Riangpoid, some respondents said that their children had to pay for attending PSE and the fees charged was an exam fee. The payment was Rs. 10.00 per month.

4.13 Health and Nutrition Education

On the other hand, Health and nutrition Education caters to women's needs as it should provide timely information about health and nutrition so that women can take care of themselves and their families. In all the districts, the percentage of women who said that Health Talks are conducted is given in Table 11:

Table 11: Health Talks held

Sl no.	Districts	Percentage
1	East Khasi hills	64%
2	Ri Bhoi	47%
3	Jaintia Hills	74%
4	West Khasi Hills	69%

5	South Garo Hills	50%
6	West Garo Hills	59%
7	East Garo Hills	59%

Although as indicated in the Table 11, that Health talks were held, yet in Songsak block, the percentage is only 37 percent. In most instances, the Health Talks are held at the Aganwadi Centre. The frequency of conducting the health talks is once a month. Based on priority, the topics of discussion as follows:

1. Family Planning
2. Cleanliness
3. Proper diet and nutrition
4. Immunization

4.14. Human Resource:

Seventy two percent of the Aganwadi Workers have had high school education. Their experience as an Aganwadi Worker ranges from less than 5 years to 25 years. In almost all the centres, there is an Aganwadi Worker and an Aganwadi Helper who assists the worker and who also cooks the food and does the cleaning of the centre, utensils etc...

At the Block level, the personnel that are appointed are the Child Development Project Officer (CDPO), the Upper Division Assistant (1), the Lower Division Assistant (1), Lady Supervisor (3), Office Attendant (1) and a Chokidar.

4.15 Honorarium to Aganwadi Worker and Aganwadi Helper:

The honorarium of the AWW is as follows:

- Rupees 1500.00 for matriculate
- Rupees 1438.00 for non matriculate

The honorarium of the Aganwadi Helper is Rupees 750.00 per month.

Although the amount is the same across the state, however the workers do not receive their honorarium uniformly. It varies from monthly to quarterly. Twenty eight percent (28) of AWWs and AWHs receive their honorarium on a quarterly basis. Though it is not a large percentage of AWWs and AWHs who receive on a quarterly basis, yet such aspects need to be streamlined so that the workers receive on a monthly basis like all the others. It is important because it is directly related to motivation and efficiency in the implementation of activities.

4.16 Staff Development:

The staffs especially the Aganwadi Worker who works at the grassroots level need to have regular training so as to be updated on the latest developments and thus efficiently carry out their tasks. The types of training that they receive are mainly job orientation during the induction process, and in-service training (once in two years). The trainings are held at the Aganwadi Training Centres.

4.17 Monitoring System:

Monitoring is an essential aspect of any programme. In the ICDS project, one type of monitoring is through monthly reports. The Aganwadi workers submit their monthly report to the CDPO's office at the Block level. Another form of monitoring is through field visit of staffs. However, the staffs who visit on a rather regular basis are lady supervisors. It is important to note that one supervisor is in-charge of about 25 to 35 villages alone. Therefore in terms of monitoring, the supervisor can visit only about twice in a three month period.

4.18 Convergence at the grassroots:

As mentioned earlier, the immunization is done by the ANM who is a staff of the Sub Centre which is under the Department of Health and Family Welfare. She also conducts health talks for women in the reproductive age group although the AWW also conducts health education.

At the community level, it was found that there was coordination among the ANM and the AWW for the purpose of immunizing the children. The AWW would inform the mother (whose child/children are due for immunization) the date and time that the ANM would come to the Aganwadi centre for immunization. Moreover, many a times, the health talks are conducted on the day the mothers come to the AWC for immunization. In terms of referral, the AWW refers patients to the Sub Centre or PHC for treatments.

However there were certain difficulties also, such as the non availability of Vitamin A tablets or other supplements meant for pregnant or nursing mothers. These supplements are supplied from the Department of Health and Family Welfare. At times, there is a lack of coordination between the two Departments, Department of Social Welfare and Department of Health and Family Welfare which results in the non availability of such supplements at the AWC and therefore AWWs cannot provide to target groups in times of need.

V. IMPACT OF THE ICDS PROJECT:

It is important to assess the impact of the ICDS project on its target groups so that it would bring to light the areas that need focus. The impacts of the services of the ICDS are as follows:

Firstly, to assess the nutritional status of the children, the weight and height of children was taken in all villages. The weight and height are simple anthropometric measurements for the evaluation of nutritional status of young children. For the purpose of this study, the Weight for Age was used as a means to assess the nutritional status of the children below 6 years of age. The Voluntary Health Association India growth charts were used to plot the weights by the evaluation team. The details given in the following table 12 gives the assessment of children from 20 villages selected from 20 blocks.

Table 12: Nutritional Assessment of Children

Districts	Blocks	Total	Boys	Girls	Mild Malnutrition		Moderate Malnutrition		Severe Malnutrition	
					Boys	Girls	Boys	Girls	Boys	Girls
EKH	Mawkynrew	32	15	17	33%	47%	7%	0%	0%	0%
	Mawryngkneng	22	14	8	43%	25%	7%	25%	0%	0%
	Shella Bholaganj	32	18	14	22%	50%	6%	14%	0%	6%
	Mawphlang	28	12	16	7%	11%	18%	21%	7%	18%
WKH	Nongstoin	24	17	7	29%	29%	6%	29%	0%	0%
	Mawkyrwat	25	12	13	0%	31%	0%	0%	0%	8%
	Mawshynrut	26	14	12	21%	8%	0%	0%	0%	0%
	Mairang	24	11	13	9%	0%	9%	0%	0%	0%
Jaintia	Amlarem	15	6	9	17%	33%	33%	11%	0%	0%
	Thadlaskein	22	12	10	9%	9%	9%	9%	5%	0%
	Laskein	20	11	9	18%	11%	9%	33%	0%	0%
Ribhoi	Umsning	29	10	19	30%	37%	0%	16%	0%	0%
East Garo Hills	Resulbelpara	12	7	5	0%	0%	0%	0%	0%	0%
	Songsak	14	3	11	33%	18%	0%	0%	0%	0%
South Garo Hills	Rongara	20	6	14	0%	7%	0%	7%	17%	0%
	Baghmara	20	6	14	50%	29%	0%	0%	17%	7%
West Garo Hills	Dalu	20	9	11	44%	18%	0%	18%	0%	7%
	Dadengere	20	10	10	50%	50%	0%	0%	0%	0%
	Rongram	20	4	16	0%	31%	0%	6%	0%	0%
	Betasing	20	11	9	36%	56%	0%	0%	0%	0%
		445	208	237	23%	25%	5%	9%	2%	2%

Name of Village	Total	Boys	Girls	Mild Malnutrition		Moderate Malnutrition		Severe Malnutrition	
				Boys	Girls	Boys	Girls	Boys	Girls
Laitdiker, Mawphlang Block	22	11	11	9%	9%	36%	27%	9%	9%

The total number of children taken for assessment was 445, 208 were boys and 237 were girls. The findings of this assessment are as follows:

- 23 percent of the boys and 25 percent of the girls are in the Grade I malnutrition category
- 5 percent of boys and 9 percent of girls are in the Grade II malnutrition category
- 2 percent of girls and boys are in the Grade III malnutrition category.

It is important to note that the figures from this assessment show a larger proportion of children in the Grade I malnutrition category than in the other two categories. However, in the data of the CDPO, larger proportion of children is in the Grade II malnutrition category.

Moreover, it is important to note the nutritional status of children in Laitdiker village, Mawphlang block which does not have an Aganwadi centre and do not come within the ICDS project. After the assessment, it was found that the percentage of children in the Mild Malnutrition category was 9 percent for girls and boys and a higher proportion of children in the Grade II malnutrition category, 36 percent and 27 percent for boys and girls respectively. In terms of severe malnutrition, it is 9 percent for both girls and boys. However, the figures in Grade I category are relatively lower than other blocks. The Grade I and Grade II malnutrition categories however are higher than the blocks having ICDS project. Thus it indicates that the ICDS program has a beneficial effect on children enrolled and therefore it is important to extend the services of ICDS to all villages.

Secondly, the enrolment of children is 88 percent in the villages that were part of the study. The reasons for children not enrolling in schools are mainly due to poor economic circumstances of families, distant location of the school from the village and also due to parent's attitude towards education.

Thirdly, the impact of Nutrition and Health Education can be assessed through the women's responses to basic questions on basic child care, awareness about family planning, HIV/AIDS etc...

Child Care:

i. The best food for a new born baby is *Breast Milk*

Though this is a basic knowledge of mothers, yet none of the blocks was there 100 percent response on this. There was one percent to three percent of people who said that cow's milk or lactogen was the best food for a new born baby.

ii. Colostrum is the *best food* for a new born baby.

There was a variation in responses to this as seen in the following Figure 6.

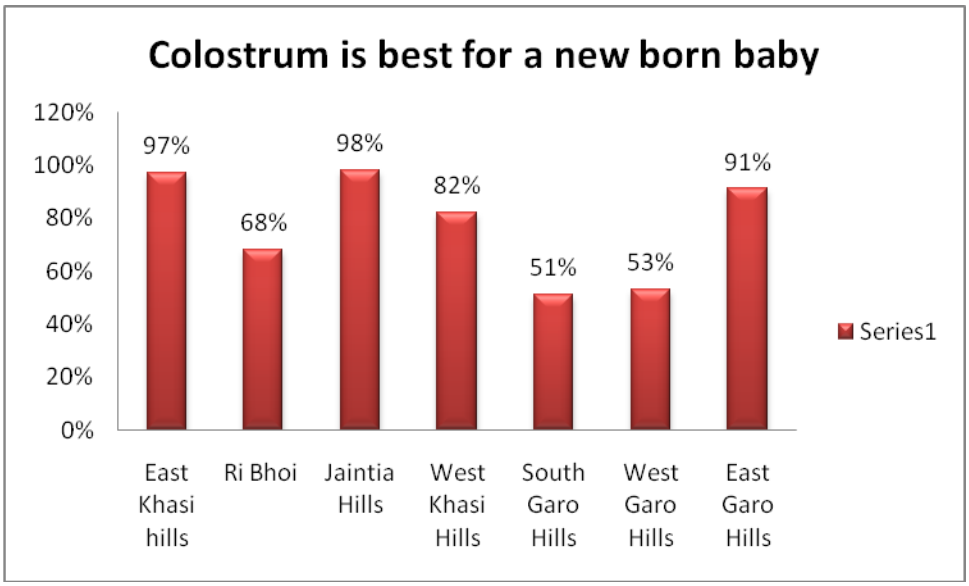


Figure 6: Colostrum is best for a new born baby

From the figure it is evident that there are at least 3 districts with a low score. Thus many mothers still do not know the importance of colostrum to a child soon after birth. Many people responded that it should be thrown away.

iii. Exclusive Breast Milk to the child till the child attains 6 months

The responses to this fact also varied from one district to another.

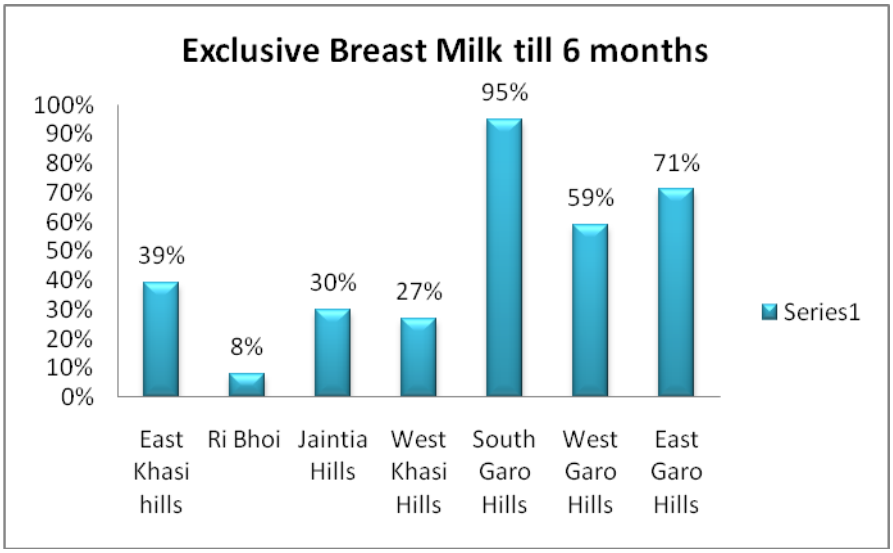


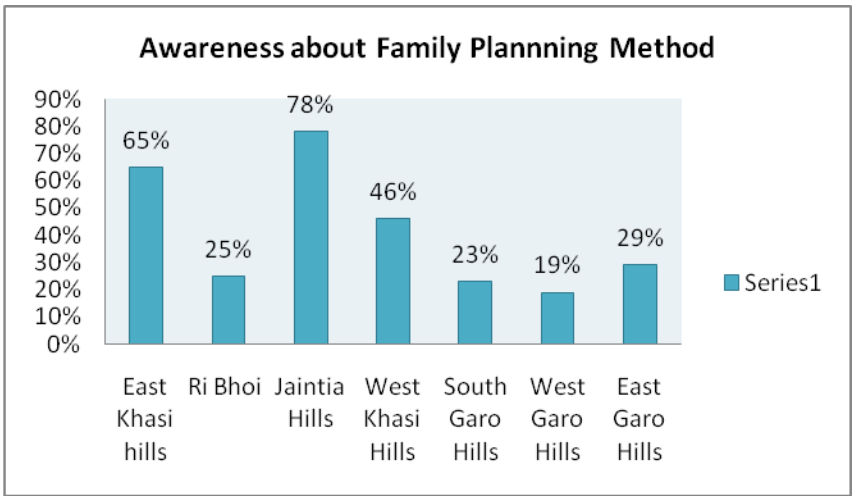
Figure 7: Exclusive breast milk till 6 months

Many respondents said that exclusive breast milk is up to four months.

Reproductive health:

In terms of Reproductive Health, the following are the responses:

i. Awareness about Family Planning Methods:



Awareness about Family Planning methods is generally low except for Jaintia Hills district.

ii. If they had a choice, would they use family planning methods:

The people's opinion is given in Table 13:

Table 13: Choice of using Family planning methods

Districts	Choice of using Family planning methods
East Khasi hills	29%
Ri Bhoi	15%
Jaintia Hills	42%
West Khasi Hills	21%
South Garo Hills	21%
West Garo Hills	17%
East Garo Hills	49%

The choice of using family planning methods is lower than their awareness level except for East Garo Hills.

Awareness about HIV/AIDS:

The awareness about HIV/AIDS is also fairly low as seen in the following Table 14:

Table 14: Awareness about HIV/AIDS:

Districts	Awareness about HIV/AIDS	Awareness about modes of transmission			
		Sexual Intercourse	Infected needles	Blood Transfusion	Mother to Child
East Khasi hills	67%	46%	33%	27%	14%
Ri Bhoi	42%	27%	5%	4%	0%
Jaintia Hills	71%	45%	16%	11%	2%
West Khasi Hills	53%	36%	8%	5%	2%
South Garo Hills	12%	6%	6%	7%	0%
West Garo Hills	2%	1%	2%	1%	1%
East Garo Hills	33%	8%	10%	7%	0%

It can be seen that women lack the knowledge about basic aspects of child care, reproductive health and sexual health. Although women attend the Health Talks yet, many are still ignorant about essential aspects related to their own health and in taking care of the children. Hence, the quality of the Nutrition and Health Education needs to be enhanced through regular training of AWWs and ANMs on the subject and also on the pedagogy used for adult learners so that the discussions are effective and people can relate to their lives.

VI. Good Practices:

Khonglah is a village in Amlarem Block, Jaintia Hills district, Meghalaya. There are 249 households with 1400 population. The village has 4 primary schools, 2 Upper Primary Schools and 1 High School. There are 2 Aganwadi Centre in the village of which the first one started in 1984. The Aganwadi centres are located in the village itself. The people in the village said that the Aganwadi centres are functioning well. The question is, why is it functioning well? The monitoring of the AWCs is done by the Seng Longkmie (Women's group). The Seng Longkmie takes active initiative to monitor the activities of the AWC. For instance, if the raw materials for supplementary nutrition is spoilt, the women gives a little of the spoilt raw material to the children to take home to show it to their mother. This ensures that the parents are aware that the raw materials are not in a good condition and therefore children do not receive supplementary nutrition in a particular period. The Seng Longkmie also monitors the regularity of the AWC in holding pre school but has not been able to play its part as it does not know its role and functions. Thus the Seng Longkmie takes the lead in ensuring the efficient functioning of the AWC.

In Banjeng village, there is no Aganwadi Helper to assist the Aganwadi Worker especially in cooking the supplementary nutrition. The women of the village take initiative to help the AWW in preparing the supplementary nutrition. They believe that through their help, their children would benefit.

The AWW in Sohryngkham A, East Khasi Hills district maintains the centre very well. It is neat and clean and very suitable for learning and also for having food. The AWW also takes the initiative to assess the supplementary nutrition in terms of children's liking. She changes the menu regularly so that children can have the nutrition joyfully.

The Agawadi Centres worth mentioning in terms of the cleanliness and neatness are Rangmaw AWC, Mawshbuit AWC and Mairang AWC. The people expressed, that it sets an example to mothers who attend the centre to also keep their homes neat and clean.

VII. Voices of the People:

During the course of the study, people as well as staffs have expressed their concerns with regard to the working of the ICDS project. Following are some of the concerns:

"Our work is very heavy; we have to see that children are immunized, for this we have to make home visits, we also have to open the AWC every day and conduct pre school education as well as provide supplementary nutrition. We also have to maintain growth charts for children and also provide other vitamins and supplements to children, pregnant women and lactating mothers. It is a full time job but our pay is very less. We also have a family where we have to look after. Therefore at times, I have to do other works to have extra earnings. When I do that, I cannot fulfil all my duties as an AWW"

- Aganwadi Workers across the districts

When the ANM comes for immunization at the AWC, it is very difficult for me to do anything when the mothers after being informed, do not bring their children for immunization.

--Aganwadi Worker, Saitpator

At times we have to pay extra to the labourer to carry the raw materials to the AWC in our villages. Sometimes we give in kind i.e. we give some food materials to them.

-- Aganwadi worker in Mawphu, Dom-myntong and Nongpriang

We do not understand what our roles and responsibilities are. Therefore, we cannot function well. We need specific rules and regulations to enable us to function and carry out our responsibilities. *-- Village Level Coordination Committee Members*

We need more capacity building on the subject of family planning. We do not know about the subject in-depth and therefore it is difficult for us to convince the women to use contraceptives or any other family planning method.

--Aganwadi Worker across the districts

The distance of the AWC and our home is far and therefore I cannot send my child to the centre.

-- Woman, Mawkyrwat Block

Food is not well cooked especially the Bengal gram. At times, there is too much water content in the milk.
-- Mother, Langtor , Mairang Block, West Khasi Hills

The Agawadi Centre needs more furniture and cooking utensils

- *Women's group, Dalu Block*

The AWW is not regular, she comes only once in two months as she is not from the village

- *Women's group, Bone Chidekgre, Songsak Block*

Milk powder is not good. We would prefer Amul milk

- *Women's group, Diengpasoh & Mawshbuit Mawryngkeng Block*

We do not know the functions of the AWC or the roles and responsibilities of the Aganwadi Worker -VLCC members across the state

VII. Critical Gaps:

During the course of the evaluation study, there were critical gaps that were seen with respect to the implementation of the programme.

Supplementary Nutrition Programme:

Firstly, in terms of supplementary nutrition which is aimed at enhancing the nutritional status of children, supply of ready to eat noodles (Yummy) is questionable. Instant noodles are often criticized as junk food since it is high in carbohydrates and low in fiber, vitamins and minerals. It has high level of saturated fat and transfat. It is bad for the health due the high calorie and the flavoring (MSG) used inside. Monosodium Glutamate (MSG) is a chemical additive used as a flavor enhancer with no substitute. MSG causes neurological disorders such as Alzheimer's and Parkinson's diseases as well as rashes, headaches etc… and therefore it is not good for regular or daily consumption.

Moreover, we have seen that other packaged food has been supplied such as Chocomalt. "Packaged foods usually have cereals and pulses with preservatives, hydrogenated fats and maybe trans fats, and they will have to be dehydrated while packaging. Nutrients are lost in dehydration. However, cooking vegetables, spices and herbs enhances the taste and nutritional value of the food," says Veena Shatrugna, Deputy Director of the National Institute of Nutrition, Hyderabad.

Moreover, the Supreme Court has directed states to ensure that hot cooked meals are provided to children between the ages of three and six.

Further, the quality of the *Papaji* biscuit needs to be assessed. It's quality is questionable and it is not seen in the market.

Therefore, if supplementary nutrition has to meet its objectives, it has to abide by Supreme Court Guidelines and the food items that are given to the target groups need to be re-examined and locally available nutritious traditional food should also be given like yam (shriew), ja shawlia, rymbai ja etc...

Secondly, on one hand, functionaries of the ICDS project stated that adolescent girls are target groups of the SNP yet none of the people across the state said that adolescent girls are recipients of the supplementary nutrition. This has to be relooked, since adolescent girls are an important age where they need their adequate nutrition for their growth and development.

Health Check Up

The ante natal care and the post natal care are minimal in almost all the blocks. The majority of people are not aware of the services provided for pregnant women and lactating mothers, therefore they totally depend on the Aganwadi workers to provide the services. As the cycle of

morbidity and mortality needs to be tackled starting with pregnant mothers to nursing mothers and children, therefore post natal care and ante natal care needs to be re examined so as to be able to enhance its implementation to the concerned target groups.

Prophylaxis against Vitamin A deficiency is also lacking in many districts. Vitamin A is important micro-nutrient that provides resistance to the body against infections as well as good eye health. The inadequate stores of vitamin A are responsible for high mortality in children, blindness, mental retardation, diminished work capacity, impaired growth and cognitive development. Children deficient in Vitamin A are prone to diarrhoea, enhances infant mortality. Thus supplementation of Vitamin A needs to be enhanced.

Lack of Awareness about the Scheme:

It was seen across the villages that the public at large are not informed about the activities of the Aganwadi Centre and the also the roles and responsibilities of the Aganwadi Worker. This is seen in the lack of participation of the people or VLCC in monitoring the activities of the AWC. Thus awareness about the ICDS project needs to be created in the villages so that people feel a sense of responsibility towards the project. This will have multiple positive repercussions as people would feel a sense of ownership, they would participate and also monitor the programme.

Nutrition and Health Education:

From the very small quiz on basic aspects of child care and reproductive health, it can be seen that people, women in particular in rural Meghalaya are still ignorant about the basic facts that are needed for quality child care and also to take care of their lives. If awareness is created through Health education then why do people lack in knowledge. An indepth examination on the content and pedagogy of the Nutrition and health Education needs to be done so that changes can be made and enhance the effectiveness of the NHE.

Convergence between Departments:

The non availability of supplements such as Vitamin A, Iron and Calcium in the AWC results in children and women not receiving adequate and required supplements. Thus it contributes to the cycle of morbidity and mortality.

Coordination between Department of Social Welfare and Department of Health and Family Welfare need to be enhanced so that the stocks of supplements for Vitamin A, iron and calcium so that the target groups receive adequate supplements at the required time.

VIII. Recommendations:

The specific recommendations for the effective implementation of the ICDS project in Meghalaya are as follows:

i. Although the Department of Social Welfare has training programmes at different levels for ICDS functionaries and also the community leaders, yet it was seen during the evaluation that the awareness level of the people about the whole package of services under ICDS is not fully understood. Therefore, awareness about the scheme need to be enhanced to the public at large and also the VLCC members so that they understand its roles and thus function effectively. They also need to be trained as to how to monitor the Aganwadi centre in their villages.

ii. During the evaluation process, most of the VLCC members who attended the meetings were mostly men. As clarified by the Department of Social Welfare, that VLCC members are mostly women, yet their involvement needs to be enhanced so that they just become members not just to fill positions but are motivated and actively participate in the functioning and monitoring of the AWC in their village.

iii. Ready to Eat Noodles Yummy was served to children as part of SNP in Jatah and Pyngwait, two of the sample villages during the evaluation study. The Department of Social Welfare clarified that during the time of the data collection, the distribution of yummy noodles and papaji biscuits were stopped and therefore it might have been one of the last few days of serving such items.

iv. Ensure availability of vitamin supplements in the AWC throughout the year. Even though there is coordination between the Department of Social Welfare and Department of Health and Family Welfare for vitamin supplements, yet target groups so not get regular supply of the supplements, therefore the coordination and supply needs to be enhanced.

v. Although as clarified, the Nutritionist is involved in imparting nutrition education, yet the pedagogy i.e. the manner in which such knowledge is imparted needs to be re-examined. The audience are adult learners and therefore their needs and interests need to be taken into consideration while imparting knowledge to them.

vii. Monitoring system needs to be enhanced. However, with the limited number of staffs, it is impossible to increase the number of visits in a month. Thus, the VLCC becomes an important body to monitor the activities of the Aganwadi. Their monitoring can be on a day to day basis. A system can be evolved where the VLCC submits a brief monthly report to the CDPO. In this manner, irregularities can be checked and gaps can be bridged at the earliest. In this manner, the CDPO gets two reports which will reflect the true picture of the implementation of the scheme in a particular village.

Closing Remarks:

An evaluation is done so that gaps can be found and bridged so that the project meets its objectives of enhancing the quality of life of children, adolescent girls and women especially in rural areas. ICDS has a major role to play in tackling malnutrition in the state of Meghalaya. Therefore, it is important to focus on good practices also so that these can be adapted to other areas as well. However, the weak points needs to taken up so that the resources that have been spent contribute positively towards the development of the people.

Although to an extent, ICDS has contributed towards a healthy life of children and women yet the project is covering only about 64 percent of the villages in Meghalaya. The rest of the villages also need Aganwadi centres. As indicated earlier, distance has been a factor for children not attending the AWC. Thus this needs to be scaled up.

The Department of Social Welfare needs to create innovative approaches and contextualise the implementation of the existing services of the ICDS project. This would be possible when all stakeholders are involved in the planning, implementation and monitoring of the programmes.