

Three Decades of ICDS

- An Appraisal



National Institute of Public Cooperation and Child Development

THREE DECADES OF ICDS

An Appraisal



National Institute of Public Cooperation and Child Development
5, Siri Institutional Area,
Hauz Khas, New Delhi - 110 016

Published in 2006

Published by

National Institute of Public Cooperation and Child Development
5 Siri Institutional Area, Hauz Khas, New Delhi - 110 016

Printed by

Chandu Press, D-97, Shakarpur, Delhi - 110 092



सत्यमेव जयते

रेणुका चौधरी

Renuka Chowdhury

राज्य मंत्री (स्वतंत्र प्रभार)
महिला एवं बाल विकास मंत्रालय
भारत सरकार
नई दिल्ली - 110 001

MINISTER OF STATE (INDEPENDENT CHARGE)
MINISTRY OF WOMEN & CHILD DEVELOPMENT
GOVERNMENT OF INDIA
NEW DELHI - 110 001

FOREWORD

Past three decades of its meaningful existence has given ample impetus to Integrated Child Development Services (ICDS) scheme, the largest Governmental intervention programme in the field of mother care and child development, for making a far reaching impact on its intended target groups. Its comprehensive outreach is an offshoot of sincere and untiring efforts of the functionaries of ICDS programme. It has, over a period of time, emerged as the most crucial developmental programme ever launched by the Government in social sector.

Looking at the rapid expansion and outreach of ICDS programme for its target groups, then Department of Women and Child Development, Government of India entrusted the National Institute of Public Cooperation and Child Development (NIPCCD) to carry out an evaluation of the ICDS programme at national level in the year 1992. The evaluation study came out with numerous interesting findings, which paved way for bringing in many changes in the implementation pattern of ICDS programme.

At the advent of the new millennium when the programme was about to turn thirty years, the Ministry of Women and Child Development desired NIPCCD to undertake a comprehensive assessment of the entire gamut of programme implementation as also to make an assessment of the impact it has made on its target groups. The study has brought forth innumerable realistic findings to substantiate the fact that ICDS programme has been able to make a sustainable positive impact on the lives of women and children belonging to underprivileged sections of the society. This reflects sincere and honest efforts made by the ICDS functionaries throughout the country.

A positive feedback does not, however, prevent a programme from doing better in future. I am confident that the conclusions of this study, would help to further strengthen the implementation of ICDS programme for the benefit of the target group(s).

(Renuka Chowdhury)



सत्यमेव जयते

REVA NAYYAR

Secretary

Tel. : 23383586, Telefax : 23381495

E-mail : secy.wcd@nic.in

भारत सरकार
महिला एवं बाल विकास मंत्रालय
शास्त्री भवन, नई दिल्ली – 110 001
GOVERNMENT OF INDIA
MINISTRY OF WOMEN & CHILD DEVELOPMENT
SHASTRI BHAWAN, NEW DELHI - 110 001
Website : <http://www.wcd.nic.in>

PREFACE

Initiated in the year 1975 as an innovative experiment, the ICDS programme has subsequently emerged as the world's most unique early childhood development programme. Not only a unique one, ICDS has comprehensively offered an integrated package of services to address the basic needs and requirements of children (below 6 years) and mothers. These services are basically the components which foster and develop human resources at the grassroots level.

The components of non-formal education supplementary nutrition, immunization, health check-up, referral services, health and nutrition education for children and expectant and nursing mothers are an integral part of package of services that ICDS programme offers. One of the most interesting features of this programme is to build up the capacity of care givers of children below three years of age by providing stimulation and quality early childhood care. ICDS programme has also carved a niche for itself in the contemporary social milieu by addressing the basic rights of children for survival, growth, protection and development and active participation in environment wherein they live, grow and develop.

The programme has always generated considerable attention of planners, administrators and researchers because of its unique and comprehensive character. Needless to mention that a number of research studies have been conducted at various points of time to assess the impact of the programme on the target groups. In the year 1990, the then Department of Women and Child Development entrusted an evaluation study to the National Institute of Public Cooperation and Child Development (NIPCCD) in order to ascertain the impact of the scheme on children and women, identify problems and strategies for further improvement in the programme. The study was carried out by NIPCCD during the year 1990-92 in 100 ICDS projects.

Since then, the ICDS programme has expanded largely. As on December 2004, there were 5652 ICDS Projects functioning in the country, of these 4533 in rural, 759 in tribal and 360 in urban areas. Such an expansion again called for a comprehensive study to assess the ICDS programme at the national

level. The Ministry of Women and Child Development entrusted NIPCCD to undertake a comprehensive assessment of the entire gamut of programme implementation including its impact on the intended beneficiaries. The study was undertaken in 150 ICDS Projects throughout the country. The study has come out with numerous interesting findings. These findings, inter-alia, highlight that there have been significant improvement in the increase of birth weight, substantial reduction in percentage of malnourished children in all grades, increase in health check-up carried out for children over the years, increase in immunization coverage so far as children are concerned. The study undoubtedly revealed an assiduous journey of ICDS programme which has proportionately addressed major aspects of lives of the vulnerable sections of the society. Looking at the innumerable findings of the study, we are left with nothing but admiring the kind of impact the ICDS programme has been able to make on its intended target groups. The study is truly a revelation so far as the nation's commitments to its women and children are concerned. At the same time, the study has been able to highlight certain gaps and shortcomings of the programme which need to be addressed with priority concern and attention. An effort will no doubt be made by the Ministry to address these gaps in the Eleventh Five Year Plan which is round the corner.

I congratulate all the staff and faculty of NIPCCD who were associated with this study for doing a wonderful job by completing the task within the stipulated time. I wish to place on record my appreciation for the overall guidance given by Dr. Adarsh Sharma, then Director of NIPCCD and Dr. A.K. Gopal, present Director. I wish to make a special mention of the hard work put in by Dr. Ashok Kumar, Joint Director, Shri Subhasis Ray and Shri Bharat Kumar both Assistant Directors and Shri H.P. Joshi, Research Assistant in finalizing the report of the study. I also wish to place on records the contributions made by the faculty of NIPCCD at its Headquarters and four Regional Centres for ably assisting in collection of data within a very short time. Special thanks are due to Ms. S. Jayalakshmi, Statistical Advisor in the Ministry of Women and Child Development for having gone through the report very carefully not only for statistical analysis but also for editing the report.

I am also grateful to the members of the peer group for giving their valuable suggestions in finalization of the report of the study.



(Reva Nayyar)

Secretary
Ministry of Women and Child Development and
Vice-Chairperson, NIPCCD

ACKNOWLEDGEMENTS

The present study was undertaken by the Institute at the instance of its the then Vice Chairperson Smt. Reva Nayyar, Secretary, Ministry of Women and Child Development. The study mainly focused on the existing pattern of implementation of ICDS programme by the Government and NGOs in rural, urban and tribal areas, gaps and problems that exist in implementation process, type of support received from community and local bodies, prevalent inter-linkages of ICDS with other developmental programmes and the benefits of the programme based on selected outcome indicators. The study covered 150 ICDS projects spread over rural, urban and tribal areas in all the 35 States and Union Territories of the country. The universe of the study was restricted to those ICDS projects which were functional for a minimum period of five years.

I am extremely happy to mention here that the study of such a voluminous nature was completed in a record time of nine months. This is a reflection of an extraordinary coordinated and harmonious team work at all levels. I am delighted to place on record the services and support of a number of people who were involved at various stages of the study.

To begin with, I would like to express my deep gratitude to Dr. Adarsh Sharma, former Director of the Institute for her overall guidance from the inception to the end of the study. Her interventions and valuable suggestions at every stage have made the study enriching and of immense academic and technical value. My special thanks to Dr. Dinesh Paul, Additional Director for his valuable inputs during the course of the study. I would also like to extend my hearty thanks to Shri K. K. Singh, former Additional Director of the Institute who worked as a Consultant in the present study for his valuable contributions in conceiving the study, preparing tools and design, collecting data from the field and preparing draft report. His long stint in the process of training of ICDS functionaries helped a great deal in this study.

I especially extend my thanks to Dr. Ashok Kumar, Joint Director in the Institute for playing the most important role in ensuring that the study gets over within the stipulated time. His wholehearted involvement in the study, particularly working throughout day and night for months together with his team has made the most difficult task a possible one. In the entire process, he was ably assisted by Shri Subhasis Ray, Assistant Director, Shri H. P. Joshi, Research Assistant of NIPCCD Hqs. and Shri M. Bharat Kumar, Assistant Director, Regional Centre, Lucknow. I thank them for their valuable contributions

in completion of the study. I would like to make a mention of the contributions made by Shri A. K. Nanda, Joint Director at the initial stage of the study. He helped us in finalizing various administrative matters involved in the study. Smt. Meenakshi Sood, Deputy Director and Ms. Deepa Garg working with the Documentation Centre on Women and Children in the Institute helped us in compiling information from secondary sources for which I extend special thanks to them. I acknowledge with thanks the contributions made by Dr. D. D. Pandey and Dr. Sandhya Gupta, both Assistant Director, in finalizing tools for the study.

I am grateful to all the faculty members of the Institute at its Headquarters and Regional Centres who were associated with the study, particularly in the data collection process without which it would have not been possible for the Institute to conduct the study. However, I apologise for not being able to name them individually as the list is too long. I also thank the Project staff and enumerators who were engaged in the process of data collection.

I extend my deep gratitude to M/s New Concept Information System for providing us with all valuable support to data processing and analysis work. I express my gratitude to Shri H. K. Barthwal, Editor of the Institute for going through the manuscript and giving his inputs.

I gratefully acknowledge the generous support of Common Services Division specially Shri S. K. Srivastava, Joint Director (CS) and Shri A. J. Kaul, Publication Officer for supervising the printing work of the report. I thank all the secretarial staff who were involved in typing the draft report.

I also extend my thanks to the members of the peer group for their valuable comments and suggestions which immensely helped us in finalizing the report. I take this opportunity to extend my gratitude also to all the State Governments and those NGOs which are running ICDS projects for cooperating with us in the task of data collection for the study. Last but not least, I express my sincere gratitude to Smt. Reva Nayyar, former Secretary, Women and Child Development and Vice-Chairperson, NIPCCD for encouraging and inspiring us throughout the course of the study with her valuable suggestions and guidance.



(A. K. Gopal)

Director

PROJECT TEAM

NIPCCD Headquarters

Chief Coordinator

A K Gopal

Director

Chief Co-Cordinator

Dinesh Paul

Additional Director

Joint Directors

Ashok Kumar

A K Nanda

Consultant

K K Singh

Preparation of Design and Tools

K K Singh

Ashok Kumar

A K Nanda

MeenakshiSood

D D Pandey

Sandhya Gupta

B Sahu

Tejinder Kaur

K C George

Manju Khanna

H P Joshi

Data Collection

Headquarters

K K Singh, Consultant

Deputy Directors

Pritam Sandhu

K G Krishnamoorthy

Nirmal Tikku

S C Srivastava

Asstt. Directors

Manorama Kaul

D D Pandey

Ravinder Singh

Sandhya Gupta

B Sahu

Res. Assistants

Anand Kumar

K C George

Manju Khanna

Satbeer Chhabra

H P Joshi

NIPCCD Regional Centres

Bangalore

Regional Director

Usha Abrol

Deputy Director

B S Anuradha

Assistant Directors

S K Tripathi

Manju Dhoundiyal

Aneel V B Sahu

D R Vijayalakshmi

Research Assistants

S K Arvind

G Jyothi

P S Manjunatha

Guwahati

Regional Director

B K Bhattacharjee

Assistant Directors

T Dung Dung

S C Joshi

Meenakshi Rego

Research Assistant

S Barik

Indore

Regional Director

M S Tara

Assistant Directors

Putul Bose

Thoapaih

Rajesh Mishra

P J Philips

Research Assistant

S G Gangur

Shashikala Bodra

Mushir Alam

Lucknow

Regional Director

Madhu Aggarwal

Assistant Directors

Salil Kumar

Suryamani Mishra

V D Gadker

N Khan

S R Sharma

M Bharat Kumar

Administrative Support

Joint Director

S K Srivastava

Deputy Director

G B Srivastava

Accts. Keeping/Processing

P K Sharma

D N Kohli

Preparation of Report

Text : A K Gopal

Ashok Kumar

Subhasis Ray

M Bharat Kumar

K K Singh

Research Review

Meenakshi Sood &
Deepa Garg

Text Editing

H K Barthwal

Graphics

M Bharat Kumar

Word Processing

Kamlesh Batra

Mohnan K

Manju Tuli

Rita

Layout & Production

A.J. Kaul

Divya Lahad

Jyoti Sethi

CONTENTS

List of Tables	xvii
List of Figures	xxi
List of Annexures	xxiii
Executive Summary	1
Chapter 1 Introduction	
1.1 Evolution of Child Care Services	33
1.2 The Scheme	34
1.2.1 Specific Objectives of ICDS	34
1.2.2 Service	35
1.2.3 Philosooy and Approach	36
1.2.4 Role of International Organisations	37
1.2.5 Role of UNICEF	37
1.2.6 Role of World Bank	37
1.2.7 Role of World Food Programme	38
1.3 Rationale for the Appraisal	38
1.3.1 Outreach of Services	39
1.3.2 Health Services	39
1.3.3 Parents' Views on AW Services	39
1.3.4 Nutrition	40
1.3.5 Nutrition and Health Education	41
1.3.6 Pre-school Education	41
1.3.7 Adolescent Girls	42
1.3.8 Role of Voluntary Organisations in ICDS	42
1.3.9 Impact of ICDS	43
1.3.10 Low Birth Weight	43
Chapter 2 Design of the Study	
2.1 Objectives of the Study	47
2.2 Methods and Procedures	47

2.2.1	Scope of the Study	47
2.2.2	Sampling Procedure	47
2.2.3	Selection of Projects	47
2.2.4	Selection of Anganwadis	48
2.2.5	Target Population	50
2.2.6	Tools of Data Collection	51
2.3	Tools	53
2.4	Operational Details	25
2.5	Manpower Planning	55
2.6	Ensuring Data Quality	56
2.7	Computerisation and Analysis	56
2.8	Parameters/Indicators of Appraisal	57
2.8.1	Inputs Indicators	57
2.8.2	Output Indicators	58
2.8.3	Outcome Indicators	58
2.8.4	Other Parametres	58
2.8.5	Summarising of Data	59
2.9	Limitations of the Study	59
2.10	Presentation of the Report	60
 Chapter 3 Infrastructure & Profile of Respondents		
3.1	Infrastructure	63
3.1.1	Drinking Water	64
3.1.2	Roads	65
3.1.3	Physical Set-up of AWCs	66
3.1.4	Availability of Space in AWCs	68
3.1.5	Availability of Equipments and Aids	69
3.1.6	Availability of Utensils	71
3.2	Profile of Functionaries	72
3.2.1	Staff Position	72
3.2.2	Status of Training	74

3.2.3	Selection of AWWs	74
3.2.4	Educational Qualification of Workers	77
3.2.5	Supervisors	77
3.2.6	Child Development Project Officer (CDPO)	78
3.2.7	Other Details about ICDS Projects	79
3.3	Profile of Beneficiaries	80
3.3.1	Target Population in Sample Households	81
3.3.2	Main Occupation of Sample Households	86
3.3.3	Subsidiary Occupation	87
3.3.4	Household Assets	87
3.4	Coordination in ICDS	90
3.5	Convergence of Services in ICDS	93
3.6	Community Participation	94
3.7	Summing-up	96

Chapter 4 Assessment of Delivery of Services

4.1	Spectrum of Service Delivery under ICDS	101
4.2	Supplementary Nutrition (SN)	102
4.2.1	Source of Supplementary Nutrition	103
4.2.2	Selection of Beneficiaries and Type of Food Served	104
4.2.3	Interruptions in Distribution of SN	107
4.2.4	Coverage of Women under Supplementary Nutrition	110
	4.2.4.1 Pregnant Women	110
	4.2.4.2 Nursing Mothers	110
4.2.5	Coverage of Children under SN	112
	4.2.5.1 Children (under supplementary nutrition) (6 Month to 3 Years)	112
	4.2.5.2 Children (3-6 years)	114
4.2.6	Acceptance Non-Acceptance of Supplementary Nutrition	115
	4.2.6.1 Acceptability of Supplementary Nutrition - Views Expressed by AWWs	115
	4.2.6.2 Reasons for Non-Acceptance of Supplementary Nutrition	116

4.2.6.3	Freshly Cooked Food	117
4.2.7	Growth Monitoring - Assessment of Performance and Problems Faced	117
4.2.7.1	Growth Monitoring - Assessment of Performance by AWWs	117
4.2.7.2	Problems in Growth Monitoring - Faced by AWWs	120
4.2.7.3	Counselling of Mothers	120
4.3.1	Pre-school Education (PSE)	122
4.3.2	PSE Activities	124
4.4.1	Immunisation	128
4.4.2	Reasons for Inadequate Immunisation	129
4.4.3	Immunisation of Pregnant Mothers	131
4.4.4	Weighing of Children at Birth	131
4.4.5	Immunisation of Children (0-6 months)	132
4.4.6	Immunisation of Children (6 months to 3 years)	133
4.4.7	Immunisation of Children (3-6 years)	133
4.5	Health Check-up	134
4.5.1	Iron and Folic Acid Tablets (IFAT)	137
4.5.2	Problems in Health Check-up	137
4.6	Nutrition and Health Education (NHED)	138
4.6.1	Methods Adopted for NHED	139
4.6.2	Contents	141
4.6.3	Problems and Difficulties in Organising NHED	142
4.6.4	Home Visits	143
4.7	Referral Services	144
4.7.1	Adolescent Girls	147
4.7.2	Help and Support to AWWs	147
4.8	Summing-up	149
Chapter 5 Benefits and Outcomes of ICDS		
5.1	Comparisons of the findings of the present study with earlier studies	155
5.1.1	Infrastructure/Equipment/Kit	155
5.1.2	Staff Position	156

5.1.3	Training	157
5.1.4	Educational Qualification of AWW	157
5.1.5	Services - Supplementary Nutrition	158
5.1.6	Birth Weight	159
5.1.7	Nutritional Grade	160
5.1.8	Pre-school Education	160
5.1.9	Health Check-up	163
5.1.10	Immunisation	163
5.2	Appraisal of ICDS Management Output Variables	164
5.2.1	Appraisal of ICDS Management - Input Variables	164
5.2.2	Appraisal of ICDS Management - Output Variables	167
5.3	Summing-up	170

Chapter 6 Innovations and Best Practices

6.1	Health Services	176
6.2	Nutrition	176
6.3	Health & Nutrition Education	179
6.4	Pre-school Education	180
6.5	Disability among Children	181
6.6	Convergence of Services	182
6.7	Monitoring	188
6.8	Communication for Behaviour Change	189
6.9	Infrastructure	189
6.10	Training of Manpower	190
6.11	Summing-up	192

Chapter 7 Conclusions and Recommendations

7.1	Conclusions	195
7.1.1	Infrastructure	195
7.1.2	Profile of Functionaries	197
7.1.2.1	Selection of AWWs	198

7.1.2.2	Supervisors	198
7.1.2.3	Child Development Project Officers (CDPOs)	198
7.1.3	Profile of Beneficiaries	199
7.1.3.1	Target Population in Sample Households	199
7.1.3.2	Main Occupation of Sample Households	200
7.1.3.3	Household Assets	201
7.1.4	Coordination in ICDS	202
7.1.4.1	Village Level Coordination Committee (VLCC)	202
7.1.4.2	Project Level Coordination Committee	203
7.1.4.3	Convergence of Services in ICDS	203
7.1.5	Community Participation	203
7.1.5.1	Contribution of Community Leaders	204
7.1.6	Assessment of Delivery of Services	204
7.1.6.1	Supplementary Nutrition (SN)	204
7.1.6.2	Pre-school Education (PSE)	209
7.1.6.3	Iron and Folic Acid Tablets (IFAT)	210
7.1.6.4	Immunisation	210
7.1.6.5	Health Check-up	210
7.1.6.6	Nutrition and Health Education	212
7.1.6.7	Referral Services	214
7.1.6.8	Adolescent Girls	215
7.1.7	Benefits and Outcomes of ICDS	215
7.1.7.1	Comparison of Findings of Present Study with Earlier Studies	216
7.1.7.2	Appraisal of ICDS	217
7.2	Recommendations	217
7.2.1	Specific Recommendations	218
7.2.2	General Recommendations	222
	References	235
	Abbreviations	241
	Glossary	243
	Annexures	247

LIST OF TABLES

2.1	State-wise distribution of sample of projects by location	48
2.2	Sample projects by type of management	50
2.3	Sample categories and size (Target and actually sample)	52
3.1	Type of educational facilities available in villages	64
3.2	Type of facilities available in AWCs	64
3.3	Source of water supply to Anganwadi Centres	65
3.4	Ownership of the building of AWCs	66
3.5	Type of building	67
3.6	Adequacy of space in AWCs	68
3.7	Accessibility of AWCs for children and mothers	68
3.8	Availability of weighing scale and its working condition	70
3.9	Availability of PSE kits	71
3.10	Availability of aids and equipment and play materials	72
3.11	Availability of utensils in AWC for cooking and serving	72
3.12	Projects staff position (CDPOs, ACDPOs and Supervisors)	73
3.13	Project staff position (Anganwadi Workers and Helpers)	74
3.14	Status of training	74
3.15	Distance of Residence of AWWs from AWCs	75
3.16	Distribution of AWWs according to Age-group	76
3.17	Marital status of AWW	76
3.18	Distribution of AWWs according to experience (yrs)	77
3.19	Age, qualification & experience of supervisors	78
3.20	Age, qualification & experience of CDPOs	79
3.21	Target population in sample households	81
3.22	Handicapped child beneficiaries	81
3.23	Beneficiary households based on caste	82
3.24	Beneficiary households vis-à-vis Types of families	83
3.25	Distribution of type of household size	84
3.26	Monthly income of beneficiary households	84

3.27	Main occupation of households	86
3.28	Subsidiary occupation of households	87
3.29	Assets possessed by beneficiary households	88
3.30	Possession of assets by sample households	89
3.31	Types of houses and electrification facilities	89
3.32	Existence of coordination committees at project level	91
3.33	Adequate coordination between health and ICDS functionaries	92
3.34	Effectiveness of coordination committee	92
3.35	Efforts to improve coordination and convergence with allied Departments (Multiple Choice)	94
3.36	Type of support/contribution by women towards AWC (views of women 15-45 years)	95
3.37	Contribution of community leaders to AWCs (views of community leader)	95
3.38	Problem faced by AWWs in involving community (Views of AWWs)	96
4.1	Source of supplementary nutrition	104
4.2	Types of supplementary nutrition	104
4.3	Interruptions of supplementary nutrition	107
4.4	Average number of days of disruption in supplementary nutrition	107
4.5	Reasons for disruption in supply of nutrition	109
4.6	Coverage of pregnant women under supplementary nutrition	110
4.7	Coverage of nursing mothers under supplementary nutrition	111
4.8	Supplementary nutrition to children (6 months to 3 years)	112
4.9	Supplementary nutrition to children (between 3 and 6 years)	114
4.10	Reasons for non-acceptance of supplementary nutrition (version of AWWs)	116
4.11	Items of cooked food served at AWCs	117
4.12	Filling of growth chart	119
4.13	Role of AWWs after weighing of children (version of AWWs)	120
4.14	Coverage of children under PSE in last three months	122
4.15	Children registered and attending PSE in Anganwadis	124
4.16	Pre-school education activities conducted by AWWs	126
4.17	Health functionaries reporting about fully immunized children	129

4.18	Reasons for not being able to fully immunize all children	130
4.19	Status of immunization of pregnant mothers (Mother's version)	131
4.20	Birth weight of children	132
4.21	Coverage of children (0-6 months) under immunization (Responses of mothers)	132
4.22	Immunisation coverage of children (6 months to 3 years) (Responses of mothers)	133
4.23	Immunisation coverage of children (3-6 years) (Responses of mothers)	133
4.24	Functionaries involved in health checkup (Version of AWWs)	135
4.25	Frequency of Health checkup	136
4.26	Iron and Folic Acid Tablets given to children (6 months' to 3 years) (Mothers version)	137
4.27	Problems encountered by AWWs in Health check-up	138
4.28	Methods/Aids used for NHed	140
4.29	Topics covered in NHed sessions	141
4.30	Purpose of Home visit (Version of AWWs)	143
4.31	Problems perceived by AWWs in conducting home visits	144
4.32	Sources of referral (Version of AWWs)	145
4.33	Problems faced by AWWs in providing referral services (Version of AWWs)	146
4.34	Services provided to the adolescent girls under Kishori Shakti Yojana (Version of AWWs)	147
4.35	Help received by AWWs from adolescent girls (Version of AWWs)	148
5.1 (a)	Infrastructure (at AWC Level)	156
5.1 (b)	Staff position	157
5.1 (c)	Training status	158
5.1 (d)	Educational qualification of AWWs	158
5.2	ICDS over the years - supplementary nutrition	158
5.3	Birth weight of new born babies	159
5.4	Nutritional grade	160
5.5	Perception of AWWs about Food Quality	161
5.6	Disruption in distribution of SN	161
5.7	PSE, Health check-up and IFA to children	162

5.8	Place of delivery and birth attended by	163
5.9	Percentage of children immunised	164
5.10	Classification of projects on the basis of composite input variable score	168
5.11	Classification of projects on the basis of composite score of outcome/output variable	169
5.12	Relationship between input, output and outcome	170

LIST OF FIGURES

1.1	Package of Services provided by ICDS	35
1.2	Intersectoral linkage of ICDS	36
2.1	Sample districts	49
2.2	Sample projects by location	50
2.3	Sample projects by type of management and location	51
2.4	Respondent category and size (target & sampled)	52
2.5	Three decades of ICDS: An appraisal–Time-line and landmarks	54
3.1	Source of water supply at AWCs	65
3.2	Ownership of AWC building	66
3.3	Type of Anganwadi centre building	67
3.4	Distance covered to reach AWC by mothers and children	69
3.5	Weighing scales - availability & condition	70
3.6	Availability of PSE kits	71
3.7	Staff position: CDPOs, ACDPOs & Supervisors	73
3.8	Staff position: AWWs & Helpers	73
3.9	Status of training	74
3.10	Distance covered by AWW to reach AWC	75
3.11	Coverage of beneficiaries under ICDS (1990-2005)	80
3.12	Caste composition of beneficiary households	82
3.13	Monthly income of beneficiary household	85
3.14	Main occupation of heads of households	86
3.15	Assets owned by households	88
3.16	Effectiveness of coordination committee	93
3.17	Priorities, problems, attitude and needs at different levels	97
4.1	Inter generation cycle of malnutrition	102
4.2	Types of supplementary nutrition at AWC	106
4.3	Disruption in supply of supplementary nutrition	108
4.4	Average days of disruptions of SN	108
4.5	Reasons for disruption of supplementary nutrition	109

4.6	Reasons for non-acceptance of SN	116
4.7	Children registered and attending AWC	124
4.8	PSE activities conducted at AWCs	128
4.9	Status of fully immunised children	129
4.10	Reasons for not fully immunising children	130
4.11	Functionaries involved in health check-up	135
4.12	Problems faced by AWWs in Health check-up	139
4.13	Methods/Aids used for NHEd by AWWs	140
4.14	Topics covered in NHEd	142
4.15	Purpose of home visits	144
4.16	Problems in conducting home visits	143
4.17	Problems faced by AWWs in providing referral services	146
4.18	Services of adolescent girls under KSY	148
4.19	Help of AGs in AWC available	149
5.1	ICDS over the years-type of AWCs building	156
5.2	ICDS over the years-staff position	157
5.3	Coverage of beneficiaries under SN	159
5.4	Nutritional grade (0-3 years children)	160
5.5	Nutritional grade (3-5 years children)	161
5.6	Quality of SN (as per AWW)	161
5.7	Disruption in distribution of SN (1992 Vs 2006)	162
5.8	Coverage under PSE (1992 Vs 2006)	162
5.9	Birth attended by	163
5.10	Appraisal of ICDS Management - Input Variables	165
5.11	Appraisal of Output and Outcomes of ICDS	171

LIST OF ANNEXURES

1.	Academic and Financial Guidelines (Developed for the study)	247
2.	List of Selected Anganwadis by States/UTs, Districts and Projects	256
3.	Status of the Projects Staff	290
4.	Reasons for inadequate coordination between Health and ICDS functionaries	292
5.	Distribution of ICDS functionaries according to Training Status (State-wise)	294
6.	Extent of achievement of objectives (CDPO view point)	296
7.	Suggestions of AWWs for better implementation of scheme (AWWs view point)	297
8.	State-wise details about distribution of supplementary nutrition and its sources of procurement	298
9.	State-wise interruption of supplementary nutrition and reasons thereof	299
10.	State-wise situation of average number of days with regard to interruption of supply of supplementary nutrition	301
11.	State-wise position of number of pregnant and lactating (nursing) mothers registered and availing benefits	302
12.	State-wise position in terms of supplementary nutrition (6 months to 3 years)	303
13.	State-wise position of acceptability of food items given in supplementary nutrition	304
14.	State-wise coverage of immunisation	305
15.	State-wise position of birth weight of children	306
16.	State-wise status of immunisation with regard to children(6 months to 3 years)	307
17.	State-wise coverage of immunisation of children (3-6 years)	309
18.	Appraisal of ICDS Management - Input Variable	310
19.	ICDS - Performance Indicators - Output and Outcome	314

EXECUTIVE SUMMARY

Executive Summary

Integrated Child Development Services (ICDS) programme continues to be the world's most unique early childhood development programme, which is being satisfactorily operated since three decades of its existence. The rich experience of ICDS has brought about a welcome transition from welfare orientation to a new challenging perspective of social change. The programme provides package of services, comprising supplementary nutrition, immunisation, health check-up, referral services to children below six years of age and expectant and nursing mothers. Non-formal pre-school education is imparted to children of the age group 3-6 years and health and nutrition education to women in the age group 15-45 years. High priority is accorded to the needs of the most vulnerable younger children under three years of age in the programme through capacity building of caregivers to provide stimulation and quality early childhood care.

The scheme of ICDS has performed considerably well in our socio-cultural system during last few years to ensure children's right for survival, growth, protection and development and their active participation in environment where they live, grow and develop. It has attempted to gear up to the popular holistic vision of a comprehensive intervention programme with a child-centred approach respecting all cultural patterns and diversity, and served as an instrument of change to bridge social inequalities in the society.

The concept of providing a package of services is based primarily on the consideration that the overall impact would be much larger if the different services are delivered in an integrated

manner, as the efficiency of a particular service depends upon the support it receives from the related services. The other unique feature of the programme is that it utilises and mobilises all available governmental services at the level of the project. It is multi-sectoral in nature and its successful implementation depends on intersectoral functional linkages. It calls for coordination among concerned departments and ensures optimal use of the existing governmental infrastructure at the project level.

Addressing the interrelated needs of young children, adolescent girls and women of disadvantaged community groups, ICDS solicits convergence with other services/programmes like *Antodaya*, Micro-Credit schemes and other development programmes of the rural development, education, environmental science and technology and so on. There are presently 5652 ICDS projects functional in the country comprising 4533 in rural, 759 in tribal and 360 in urban areas (as on December, 2004).

Researches on ICDS

In the past, a large number of research studies have been conducted to evaluate and assess the impact of the programme on the beneficiaries. At the national level, there have been only two evaluations of ICDS scheme, one conducted by National Institute of Public Cooperation and Child Development (NIPCCD) in 1992, and the second conducted by National Council of Applied Economic Research (NCAER) in 1998. Few studies on stabilisation of the programme; quality control and enhancing the social

and economic empowerment of disadvantaged women; awareness about the value of the programme are also available. It can be seen that most of the studies have provided only piecemeal information and have not taken systematic stock of the delivery of inputs vis-à-vis output; nor have these studies investigated the impact of services on the target groups in a comprehensive and coordinated fashion. These studies also have not provided ample evidence on interdependence of various variables related to implementation of the programme and its impact on the target groups. Coverage of sample has also been limited leading to inability to generalize.

Several valuable lessons have been learnt through these studies. Nonetheless the need for a comprehensive investigation to assess ICDS programme at the national level was considered most desirable since it has now been in operation for more than three decades.

The Study

The need for a comprehensive study to assess ICDS programme at the national level has been felt at the advent of the new millennium as the programme was on the verge of completing three decades of its implementation. The Department of Women and Child Development, now the Ministry of Women and Child Development, Government of India, the nodal Ministry for the implementation of ICDS programme, desired NIPCCD to undertake a comprehensive assessment of the entire gamut of programme implementation including its impact on the intended beneficiaries. The study was accordingly conceived at the national level. Such an exercise is undoubtedly being

considered essential in order to improve delivery system, ensure its optimal outreach and take decisions on matters concerning its future thrusts in the Eleventh Five-Year Plan. Accordingly, the Institute planned and carried out the present study.

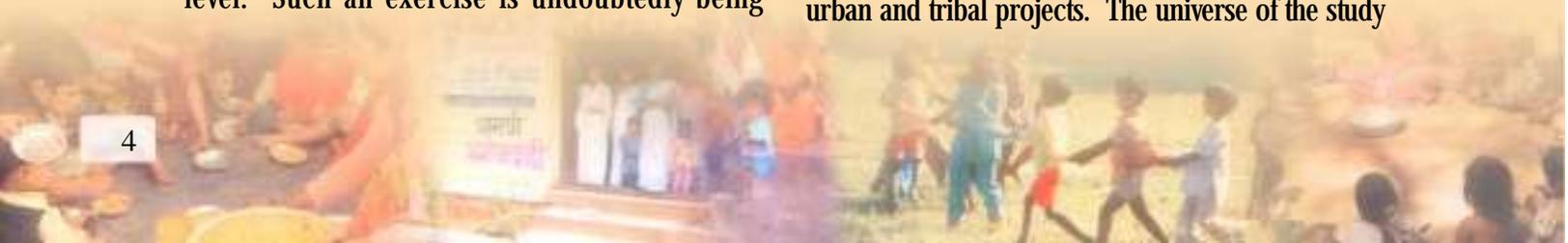
Objectives of the Study

The objectives of the study were to :

- assess the existing status of implementation of ICDS programme in terms of coverage, outreach, coordination, convergence, and innovations introduced by States and NGOs;
- compare the differences in implementation of the ICDS programme in rural, urban and tribal areas and in NGO-run projects;
- identify gaps and problems in the implementation of ICDS;
- find out the perception of community and local bodies about ICDS and the extent of support provided by them in implementation of the programme;
- exploring the inter-linkages of ICDS with other development programmes and their role in improving the quality of services, and
- ascertain the benefits of the scheme on selected outcome indicators related to different services provided to children, women and adolescent girls.

Methodology

The study covered 150 ICDS projects from all 35 States and Union Territories covering rural, urban and tribal projects. The universe of the study



was restricted to those projects which were functional for a minimum period of five years. Thus, all those projects which were in operation up to the year 2000 were included in the study. In all, 4200 ICDS projects formed the universe of the study. A sample of 150 (about four per cent) of ICDS projects was selected for the purpose of appraisal.

A multi-stage stratified random sampling technique was adopted to select state-wise total number of projects at the first stage. Whereas at the second stage, stratified sampling technique and also purposive sampling method were applied for selection of number of projects by location (rural, urban and tribal). Sample was drawn only from blocks which were operational as on 1 April, 2000 i.e. 4200 projects (3177 rural, 273 urban and 750 tribal). For the present study, a total of 150 ICDS projects were selected as a sample i.e. roughly 4 per cent of the total universe. Number of projects selected from each state was proportionate to the total number in operation and in the categories of

rural, tribal and urban. Within a project, an attempt was made to include projects run by NGOs.

For selection of actual ICDS projects, an attempt was made to select those projects which were run by NGOs wherever possible. Second criteria for selection of the ICDS project included was maximum number of Anganwadi Centres under their jurisdiction as well as their geographical location. This was done to ensure that we have a representative sample drawn from a larger population. A total of five Anganwadi Centres were randomly selected from each sample project. An attempt was made to select not more than two Anganwadi Centres from each of the supervisory circle. Thus total sample comprised 750 Anganwadis. Actual beneficiaries were selected randomly from the list of beneficiaries available with the Anganwadi Workers of selected Anganwadis. Within the Anganwadi area, a sample of the following categories of target group was selected for in-depth information:

Sample Categories and Size (Target & Actually)			
Sl No.	Respondent's Category	Target Per Project	Sampled
1	Beneficiaries	115	16138
2	Pregnant Women	20	2983
3	Nursing Mothers	20	2975
4	Mother of Children (6m to 3yrs)	25	3733
5	Mother of Children (3yrs to 6yrs)	25	3737
6	Women (15-45 yrs)	25	3771
7	Child Learning Competency Test (3-6 yrs)	30	4474
8	Community Leaders	10	1500
9	CDPOs	1	147
10	Supervisors	2	294
11	AWWs	5	748
12	AWC's Observation	5	748
13	Health Functionaries (MO, LHV, ANM)	3	444
14	Additional Observation	1	150
	TOTAL	287	41842

Tools

In order to collect the required information and data for the study, appropriate proforma/schedules were devised. These were developed in the form of recording sheets. Besides interview, observation method was also used for collecting information pertaining to delivery of services at Anganwadi level. The available reports, records, guidelines and other documents formed additional source of information.

A set of 12 schedules was devised. In view of the magnitude of the data to be collected for the study, these were pre-coded to facilitate computerisation of the data. A two-day Orientation Workshop of faculty members of Headquarters and Regional Centres was held to discuss the tools and other modalities. This was followed by pre-testing of tools by faculty members at Headquarters and all Regional Centres of the Institute. After pre-testing of tools, another workshop of Regional Coordinators (i.e. Regional Directors) was held to finalise the tools and other operational details.

Operational Details

Forty-one teams consisting of three members each were deployed to collect data from 150 projects spread over 35 States/UTs. NIPCCD's networking with training centres, academic institutions and voluntary agencies, spread all over the country further facilitated recruitment of ad-hoc Enumerators hired locally for data collection in different projects. Thus, a total of 12 Project Assistants and 81 Enumerators were recruited locally. The cooperation extended by

different institutions helped not only in identification of suitable individuals but also in holding interviews and providing venue for training of the research team. Senior faculty members at Hqrs. and Regional Directors at Regional Centres were assigned the task of coordinating the teams, monitoring and supervising data collection, and maintaining liaison with the concerned State Government for smooth completion of data collection within the stipulated time.

Ensuring Data Quality

The design, scope of the study and tools were planned in consultation with faculty members and Regional Coordinators. In addition, two workshops, one for the selected faculty members and another for Coordinators, were organised to discuss the tools and *modus operandi* of data collection work. All members of the research teams concerned with data collection were given training in procedures of implementing the design, with emphasis on filling up the schedules and its coding frame. The orientation included conducting of mock interviews, practice in coding schedules, etc. A manual containing guidelines and instructions for collection of data was prepared and provided to all concerned for ready reference.

The Institute identified M/s. New Concept Information System for computerisation and data analysis for the study. Two staff members of the said agency and a Principal System Analyst were assigned the task. The data was entered in dBase (a popular relational database package) and the resultant database was converted to appropriate file formats for further analysis. Another popular



software namely, SPSS (Statistical Package for Social Sciences) was used to generate final tables.

The formats of data files were prepared in such a way that the data could be used in variety of ways for subsequent analysis. The database has been created project-wise with an intention to optimally utilise the valuable empirical information for other purposes, besides the present study. It can be disaggregated at the State and Project levels. State Departments, individuals/ agencies concerned with ICDS can have access to the information after permission from the Ministry of Women and Child Development.

It would be appropriate to mention here that ICDS programme, in its three decades of existence, has gone through both successes and failures. The present study too, has come out with many such scenario which reflects hopes and satisfaction as well as gaps and lacunae. Let us now look at both these aspects emerging from the present study with a mind to strengthen ICDS programme in future. Sample projects were spread over rural, urban and tribal areas and managed by State Governments, World Bank and NGOs in 35 States/UTs. Statistical treatment of data includes mean, SD, composite score.

The following paragraphs carry forth the conclusions and recommendations of the present study:

Conclusions

Infrastructure

i) Availability of sanitation facilities is most crucial for reducing mortality and mobility

in rural and tribal areas. Data from the study showed that only 31 per cent of the households had toilet facilities. Sewage/ drainage system was reported in 30 per cent of villages under regular ICDS Projects whereas 27 per cent of villages of those projects, which were assisted by World Bank, were having such facilities. Out of ten villages, 4 (40%) of projects covered by NGOs had these facilities also. While around 41 per cent of Anganwadis had toilet facilities, 17 per cent of these facilities were not found to be in good condition and 59 per cent AWCs were even deprived of this amenity.

- ii) It was found that educational facility of lower primary school (class I-V) existed in nine out of 10 villages (90%). Middle school (VI-VIII) facility was available in 61 per cent of villages whereas high schools were functioning in 39 per cent of sample areas.
- iii) About 97 per cent Anganwadi Centres in urban areas, 93 per cent in rural areas and 74 per cent in tribal areas were connected by roads. Primary Health Centres and sub-centres were available in 29 per cent and 43 per cent, respectively, in Anganwadi areas. Data thus reveals that accessibility to important services of health was limited. Data also revealed that around 89 per cent of rural project areas, 94 per cent urban and 68 per cent of the tribal project areas had telephone facilities. Another interesting information was availability of LPG in 72 per cent of the Anganwadi areas.

- iv) Hand pumps and tap water were the main sources of water in majority of the Anganwadi Centres, thereby bringing home the point that ICDS programme has succeeded, to a large extent, in arranging safe drinking water for the children attending Anganwadis in collaboration with Public Health Engineering Department of State Governments.
- v) It was gratifying to note that majority of the Anganwadi Centres were located in pucca buildings. It reflects that efforts have specially been made in housing Anganwadi Centres in pucca buildings. However, space was found to be a problem in most of the Anganwadi Centres in urban areas. Adequate outdoor and indoor space and separate space for storage was available in only 44, 36 and 39 per cent Anganwadi Centres. This situation was found to be little better in rural and tribal areas. Overall, about 49 per cent of the Anganwadi Centres had inadequate space for outdoor and indoor activities and 50 per cent had no separate space for storage of various materials. Around half (49.0%) of the rural and tribal (50.6%) projects and 40 per cent of urban projects had adequate cooking space separately.
- vi) Most of the AWCs (60.3%) were found to be easily accessible to children as they were brought either by their parents/siblings/older ladies of the locality to the Anganwadi Centres. Helpers mainly concentrated in bringing newly admitted children to Anganwadis.
- vii) Weighing scales were available in 97 per cent Anganwadis of World Bank-assisted ICDS Projects, followed closely by NGO run projects (95.3%) and 85 per cent of regular ICDS projects. Around 89 per cent of them were in working condition also.
- viii) Non-availability of the kits in 44 per cent of the Centres is a matter of concern and this aspect needs to be looked into by the programme implementors carefully. Availability of adequate number of cooking and serving utensils in the Anganwadi Centres is of paramount importance for the success of the nutrition programme. The study revealed that cooking utensils were available in 61.8 per cent of rural, 49.2 per cent of urban and 65.9 per cent of tribal projects.

Profile of Functionaries

- ix) It was gathered that 15 per cent positions of Child Development Project Officers (CDPOs), 48 per cent of Assistant Child Development Project Officers (ACDPOs) and about 18 per cent of Supervisors were vacant in the surveyed projects. However, the position with regard to the appointment and availability of AWWs and Helpers has been quite satisfactory. The training status has been quite satisfactory. It was observed that Arunachal Pradesh was the only State where 50 per cent CDPOs were untrained. In other states, by and large, training of functionaries has been highly satisfactory.

Selection of AWWs

- x) It was found that around 80 per cent of the Anganwadi Workers belonged to the same village/locality. However, wide variations were observed on this aspect between projects supported by World Bank, NGO operated and regular ICDS.
- xi) Data on age of AWWs depicts that about 66 per cent of AWWs were 35 years and above. Percentage of AWWs in regular and World Bank- assisted ICDS projects was evenly divided in the age-group 35-45 years while 30 per cent of AWWs were in the age-group 25-35 years.
- xii) Sixty-two per cent of the AWWs had work experience over 10 years whereas 28 per cent of them had experience of more than five years. Majority (43.2%) of the AWWs were matriculate, 23 per cent Higher Secondary and about 10 per cent Graduates. There were hardly any illiterate workers, their percentage being around one only.

Supervisors

- xiii) It was found that direct, promotion from amongst AWWs and deputation from line departments and contractual appointment of Supervisors under World Bank Scheme was carried out in States like Uttar Pradesh. In 25 States of India, supervisors were promoted to the post of CDPO/ACDPO. Policy of reservation of seats was existing in 21 States and seven States did not adopt any such policy. A large majority of the

supervisors were above the age of 35, either graduates or post graduates and possessed experience of more than 10 years. This is a positive sign as ICDS seems to be managed by experienced and qualified supervisors.

Child Development Project Officers (CDPOs)

- xiv) Data show that 21 States had exclusive cadre of CDPOs whereas 10 States had a joint cadre comprising deputation, promotion and contract. In all, 25 States had adopted the policy of promotion of Supervisors to the post of CDPOs/ACDPOs. Mode of recruitment in terms of reservation was reported to be followed as per orders of State Governments issued from time to time.
- xv) Though the guidelines of the scheme envisages that CDPO should preferably be a female, yet it was observed that about one-third (32.7%) of CDPOs were males.
- xvi) Most of the CDPOs (48.3%) were in the age group 45-55, followed by 33 per cent in the age group 35-45. It was found that 57 per cent CDPOs were post graduate with only 6 per cent being undergraduates. About 31 per cent of CDPOs were having less than 3 years of experience which was reflective of frequent transfers of this category of functionary in some States.

Profile of Beneficiaries

- xvii) Expenditure on different services has gone up more than three times (from 144.00

crore during 1990-91 to 452.36 crore during 2004-05) in 15 years. The scenario is similar to the number of beneficiaries under various services - all categories of beneficiaries have gone up three times during the period under reference.

Target Population in Sample Households

- xviii) Data indicate that 0.83 per cent of children in households covered under the study are handicapped. Out of these children, 55.56 per cent children have been receiving benefits from ICDS programme.
- xix) Maximum percentage of beneficiaries were from backward classes (29.6%) followed by scheduled castes (26.3%). Differences between representation of other castes and that of scheduled tribes was meagre (21.4% and 20.4%, respectively).
- xx) It was found that 55 per cent of them were landless while another 28 per cent owned land which was less than one hectare. It was found that less than 8 per cent possessed land holding between one and two and above two hectares. Those who possessed land more than four hectares were residing in hilly, desert and tribal areas.
- xxi) Six out of ten families of beneficiaries were nuclear while joint family constituted one-third of all types of families. Data demonstrated that in urban areas 62 per cent families were nuclear while this type of family constituted almost similar percentage in rural (59.0%) and tribal (59.8%) projects. Increasing trend of extended families was seen in regular ICDS projects (7.03%) and drastic reduction in other categories of projects (4.12% in World Bank projects and 4.80% in NGO-run projects).
- xxii) Six out of ten families (59.7%) conformed to the national figure in respect of size of families (upto 5 persons), followed by 36 per cent of households having family members between six and ten. Another interesting finding is that households with 11 and above family members constituted four per cent. Normal belief is that urban households are nuclear and smaller in family size but the data revealed that even urban ICDS projects also recorded family size between six and ten (32.7%).
- xxiii) A little over 60 per cent families under World Bank-assisted ICDS projects (62.48%) had monthly income less than Rs. 2000/- per month, followed by NGO-run projects (51.41%) and regular ICDS projects had this share with 47 per cent of households. Income of households was analysed as per location of projects in rural, tribal and urban areas. It revealed that a little over half (52.8%) tribal families had income less than Rs. 2000/-, followed by rural families (49.5%). Forty per cent urban families belonged to this income group. Four out of ten families in urban projects had also income ranging between Rs. 2000/- and Rs. 4000/- per month, followed by rural (32.1%) and tribal projects (30.4%).

Main Occupation of Sample Households

xxiv) One-fourth of heads of households (25.7%) had non-agriculture labour as main occupation, maximum being in urban areas (36.4%), followed by heads of households in rural areas (24.2%) and tribal areas (21.9%). It was interesting to know that a little over one-third of respondents of tribal projects (34.3%) were cultivators who constituted 27 per cent in rural ICDS projects. Cultivators in urban projects were those who lived on fringe of urban areas and went to adjoining villages for cultivation were of negligible percentage (3.4%). Percentage of self employed and agricultural labourers was almost equal (16.0%). Self employed were mostly blacksmiths, carpenters, cattle grazers, potters, shoe makers, weavers, petty shop keepers etc. Around 12 per cent were in service - Government, semi-government, private companies etc.

Coordination in ICDS

Project Level Coordination Committee

xxv) More than 70 per cent projects of rural and tribal areas were having Coordination Committee at the project level, whereas urban projects (83.0%) were having Coordination Committee at project level. So far as existence of Coordination Committee at project level by type of management is concerned, regular ICDS projects and projects supported by World Bank were having lesser number of

Coordination Committees as compared to the projects run by NGOs. In urban regular ICDS projects more than 80 per cent CDPOs, Supervisors and health functionaries reported adequate coordination at their level. In NGO-run projects, coordination at CDPO level was somewhat adequate but at the field/village level, it was not up to the mark. The situation is similar to tribal projects too. Coordination with health department was somewhat lacking at field/village level especially in tribal areas. By and large coordination at project level was found to be satisfactory. A little over two-third (68.0%) CDPOs were of the view that meeting of Coordination Committee was effective whereas about one-fifth (21.0%) found it very effective. The Research team found that around 73 per cent CDPOs had reported adequate coordination between ICDS and health functionaries. But remaining 27 per cent mentioned inadequate coordination.

Convergence of Services in ICDS

xxvi) Data made it amply clear that efforts were made in rural areas to involve village *Panchayat* in activities of AWCs. It is also interesting to note that efforts were made for organising community convergence to inter-link programme and services as a substantial percentage of CDPOs reported.

Community Participation

xxvii) Thirty-two per cent women (15-45 years) extended supportive role in *Anganwadis*

like assistance in cooking food, providing fuel, collecting children for health check-up, bringing children to *Anganwadis* for immunisation, fetching drinking water. In tribal projects (39.6%) this type of support was found maximum. Contribution in kind like carrying supplementary nutrition upto AWCs using own means of transport, repair of AWCs was also found maximum (16.0%) in tribal projects. Majority (69.7%) of community leaders extended their contribution to AWCs in the form of supervision, solving personal problems of AWWs and protecting them against undesirable elements. Forty-five per cent also cooperated and supported AWWs as and when it was necessary.

Assessment of Delivery of Services

Supplementary Nutrition (SN)

xxviii) Data of the appraisal revealed that in 80 per cent projects, source of arranging nutrition in Anganwadis was State Government which procured food item(s) from Food Corporation of India and other sources identified by them. World Food Programme (WFP) was found to be supporting six per cent of Anganwadis while CARE contributed its nutritional facility to four per cent of Anganwadis. A trend was also visible wherein village panchayats/Self-Help Groups were serving cooked food to beneficiaries.

xxix) Forty-two per cent of Anganwadis received raw food items which were cooked/prepared at AWCs and served to children. This practice was found mostly in Anganwadis of tribal projects (53.5%). Ready to Eat (RTE) food was provided in all types of projects, maximum being in Anganwadis of urban projects (45.8%), followed by rural (33.6%) and tribal (23.5%) projects. Some Anganwadis (18.0%) were providing both cooked and RTE. In some states like Gujarat, Rajasthan, Maharashtra and Madhya Pradesh, all children below six years identified as severely/moderately malnourished, on the basis of weight, were given therapeutic diet cooked in soft form (pulverised) or tinned milk by benevolent organisations/individuals. This is an indication of significant efforts made by ICDS functionaries to mobilise resources at the grassroots level to make the programme effective and meaningful.

Interruption in Distribution of Supplementary Nutrition

xxx) It was heartening to note that 46 per cent of AWCs (rural-47.6%, tribal-38.2% and urban-50.8%) had no interruptions at all in terms of supply of nutritional ingredients. However, a significant number of AWCs (52.9%) reported interruptions. In such cases, tribal AWCs scored the maximum interruptions (61.2%), followed by rural (52.0%) and urban (45.0%) AWCs.



Coverage of Women under Supplementary Nutrition

- xxxi) Maximum number of pregnant women (49.5%) were registered in AWCs run under World Bank-assisted ICDS projects, followed by AWCs under NGO-run ICDS projects (48.6%) and regular ICDS projects (47.2%). Interestingly, maximum coverage of pregnant women was found in tribal AWCs of regular ICDS projects (61.8%) and NGO-run ICDS projects (58.3%).
- xxxii) The most interesting finding was that in NGO-run ICDS projects, all registered nursing mothers were availing of benefits from AWCs in tribal and urban areas, while in rural areas, the percentage was 75.6 per cent. On the whole, little more than 50 per cent nursing mothers (52.8%) were registered. Of these, 89 per cent received supplementary nutrition. More than 80 per cent nursing mothers were found to have been registered for supplementary nutrition in the States of Arunachal Pradesh (82.9%), Mizoram (80.3%), Nagaland (81.8%) and UTs of Dadra & Nagar Haveli (85.5%) and Lakshadweep (87.7%). It was also found that nutrition was provided to a high percentage of nursing mothers in these states.

Children (6 months to 3 years)

- xxxiii) Data presented that there was evidently more registration of male children (59.1%) than those of female children (55.2%). This depicts the normal scenario of male-female

representation. In all categories of ICDS projects, percentage of female children availing supplementary nutrition was quite high - 82 per cent in all - rural (81.0%), tribal (84.0%), and urban (82.5%), as against male children - 75 per cent in all - rural (72.6%), tribal (81.1%) and urban (74.4%). Another interesting feature emerged from this information was that in some of the States and Union Territories more than 90 per cent children, both male and female, availed supplementary nutrition.

Children (3-6 years)

- xxxiv) Despite the fact that more girls were registered (57.8%) than boys (51.1%), share of benefits had gone to boys in higher percentage (75.9%) whereas less percentage of girls (74.6%) got the benefits. Most children, both male and female, registered for supplementary nutrition belonged to tribal areas (62.8% and 67.5%, respectively). However, high percentage was observed for female children who availed supplementary nutrition in tribal areas (75.5%), male children scored the lowest in tribal areas (71.9%), in comparison to rural (77.3%) and urban (76.1%) areas.

Acceptability of Supplementary Nutrition

- xxxv) Eight out of ten Anganwadi Workers (79.8%) reported that food was totally acceptable to children and mothers. They found it well prepared, tasty and enjoyed its consumption. Around seven per cent found only some of the items of nutrition served

as acceptable. Eleven per cent did not find food items served as acceptable. Major complaints were found in rural projects (13.5%) followed by urban (8.4%) and tribal projects (7.1%). Acceptability of food was maximum in tribal projects (84.7%), followed by rural (78.8%) and urban projects (76.7%). AWWs of 16 States/UTs mentioned that some of the items of RTE food supplied by contractor were below the level of consumption. AWWs reported that food was acceptable below 75 per cent beneficiaries in the States of Rajasthan (67.9%), Assam (66.7%), Orissa (65.0%), Haryana (55.0%), Meghalaya (40.0%), Uttaranchal (40.0%) and the lowest was reported from Uttar Pradesh (25.7%).

Growth Monitoring

xxxvi) It was found that AWWs weighed 63.5 per cent of new born children and mothers cooperated in this exercise inspite of stigma attached to weighing of new born children. AWWs (67.5%) of urban projects weighed new born. Rural AWWs (64.0%) also succeeded in weighing newborn whereas tribal AWWs (59.4%) were also able to convince mothers and could weigh new born. Eighty-two per cent AWWs adhered to this guideline and weighed children below 3 years once in a month. However, weighing of children in the age group 3-5 years was slightly better as majority of AWWs (83.3%) were able to do so. Entire onus of weighing and plotting was shouldered by AWWs (85.8%). Supervisors extended helping

hand to monitor the growth of severely malnourished children and new born on the day of their visit to AWCs.

Pre-school Education (PSE)

xxxvii) On an average, 37 children were registered for pre-school education at Anganwadis. This signifies that AWWs made positive efforts for bringing children from deprived sections to AWCs so that they could utilise nutrition and health services as well. On the whole, 75 per cent of registered children attended the Anganwadis. Children enrolled and attending AWCs were comparatively on almost equal footing. However, contrast may be seen from figures of attendance which points out that number of girls was more in AWCs than that of boys for taking benefits. In all likelihood, therefore, boys were preferred to be sent to attend private schools especially in urban areas and towns for PSE.

PSE Activities

xxxviii) Children were engaged in singing songs in almost all AWCs (95.1%). Story telling and counting were other two activities which were organised by 91 per cent AWWs. While 78 per cent AWWs reported involvement of children in indoor activities, three-fourth of them (74.7%) also engaged children in free conversation to speak freely and apply their mind in order to organise small activities. Outdoor games could be organised by 70 per cent AWCs. Activities like painting, printing, drawing, threading and matching



colour related to fine muscle coordination and development, as also activities for emotional and intellectual development could get only limited attention in selected AWCs.

HEALTH

Iron and Folic Acid (IFA) Tablets

xxxix) Data obtained from mothers revealed that six out of ten children (59.6%) between six months and 3 years were given IFA tablets. AWWs were required to keep a close watch on pattern of consumption of these tablets with special reference to pregnant mothers during home visits and NHed sessions as also in the process of health check-up. Consumption of IFA tablets by pregnant women showed that women of this category (68.9%) consumed tablets regularly whereas another 16 per cent used it sometimes as and when they felt like swallowing it. Mothers (13.5%) kept the tablets in their possession but did not consume it because they did not like its taste.

Immunisation

xi) Immunisation against tuberculosis, diphtheria, whooping cough (pertusis), tetanus, measles and polio for children under one year of age and immunisation against tetanus of all pregnant women in ICDS project areas has been carried out by Primary Health Centre (PHCs)/ Community Health Centres (CHCs) and their subordinate

health infrastructure. Two-third of children (66.1%) were immunised, highest being in rural projects (71.6%), followed by urban (65.7%) and tribal (51.5%) projects. Health functionaries reported that the status of fully immunised children depended upon their availability when the immunisation schedule was in operation. In urban areas, status of immunisation seemed to be below expectation while situation was comparatively better in rural ICDS projects (71.6%). It was interesting to observe that records of vaccination were correctly maintained by health functionaries/AWWs.

Reasons for Inadequate Immunisation

xii) Major reason as reported by around one-fourth of health functionaries was indifferent attitude of parents towards immunisation (23.3%), followed by disbeliefs attached to immunisation (17.6%). Another major reason included age-old beliefs, customs, superstitions, stigma attached to castes/creeds. One out of ten health functionaries (10.8%) mentioned that there was stiff resistance from certain sections of communities due to inadequate awareness about advantages of immunisation.

Immunisation of Pregnant Mothers

xiii) Data revealed that pregnant mothers (76.2%) received tetanus toxoid immunisation. Twenty-seven per cent of pregnant women received first dose and 48 per cent of mothers also availed of second

dose. Coverage of immunisation in rural projects was the highest in percentage (79.0%) followed by tribal and urban projects which showed very marginal difference of one per cent between them. However, administration of first dose in tribal projects was better among tribal mothers (29.9%) in comparison with rural (26.8%) and urban (25.3%).

Immunisation of Children (0-6 months)

xliv) Nursing mothers (77.4%) reported that their children got immunised. This coverage was slightly better in urban projects (79.7%) than in rural projects wherein mothers (79.4%) reported that their children got immunised. The lowest coverage of 70 per cent was found in tribal areas.

Immunisation of Children (6 months to 3 years)

xliv) Data shows that BCG vaccine coverage was the maximum (82.4%), followed by polio 3rd dose and measles (both 70.5%), DPT 3rd dose (38.9%) and booster DPT dose (17.8%).

Immunisation of Children (3-6 years)

xliv) Mothers (54.9%) of these children reported that their children got D.T. booster for their protection against tetanus. Immunisation coverage of children in this age-group was not as wide as it was found in case of children below three years. It seems that

major focus of AWWs was on ensuring coverage of children below 3 years. Rural areas had better immunisation as narrated by mothers (56.7%), followed by tribal (52.5%) and urban (51.5%) projects.

Weighing of Children at Birth

xlvi) It was found that birth weight of seven per cent children was below 2 kg. This situation invariably calls for encouraging mothers to do breast feeding of these children. Among the reasons behind parents not agreeing for weighing of children, AWWs reported that superstitious beliefs, such as 'child will be victim of evil spirit,' 'fall sick' and the like were prevalent. Around three-fourth of children were above 2.5 kg of weight in tribal ICDS projects.

Health Check-up

xlvi) According to AWWs (75.1%), health functionaries conducted health check-up of children which included checking of eyes, ear, nose, teeth, hair and other external physical parts of the body regularly, including administering medicines of fever, eye and ear trouble, skin diseases etc. The highest percentage was prevalent in urban projects (80.8%) followed by tribal projects (78.7%) and rural projects (72.3%) in descending order.

xlvi) Fifty one per cent health-check up were carried out by ANMs, while 22 per cent health check-up was conducted by Medical Officers. In respect of LHV/PHNs it was only

14 per cent. AWWs made every possible effort for coverage of needy mothers and children of poor and marginal families who mostly remained at home and were generally deprived of the service of health check-up and medical care. Health check-up "once in a month" was followed for all categories of beneficiaries ranging between 47 per cent and 61 per cent. In the health check-up the focus was more on children below 3 years (56.1%) once in a month and ante-natal check-up of pregnant mothers as per version of 61 per cent AWWs.

Nutrition and Health Education (NHEd)

xlix) As regards the frequency of organising this programme, 69 per cent of them mentioned that they organised NHEd once a month on topics related to mothers and children. Fourteen per cent organised this activity as per expressed needs of beneficiaries. Around seven per cent conducted this activity once in two months. Seven out of ten tribal Anganwadis organised this activity once in a month, followed closely by even percentage of rural and urban projects (68.3%). Data also demonstrated that on an average 20.94 mothers participated actively in tribal Anganwadis, 18.43 in rural Anganwadis and 18.68 in urban Anganwadis. Average of attendance of mothers in these three areas was 18.68 mothers.

Methods Adopted for NHEd

l) Almost all AWWs (92.1%) used inter-personal contact and discussion as a method

to talk to mothers individually or in groups. Another method which was used more frequently than others was demonstration on recipes, preparation of oral dehydration solution, purification of water to mothers and adolescent girls (36.6%). AWWs (16.6%) also organised exhibitions on issues related to diarrhoea, immunisation, small family norms, role of Mahila Mandals/Self-Help Groups, care of severely malnourished children etc. AWWs focused on issues related to "at risk" mothers and children and imparted education to women (15-45 years) and other family members.

Problems and Difficulties in Organising NHEd

li) This was mentioned by 46 per cent AWWs. AWWs (36.9%) were also found to be in a situation where they were handicapped due to non-availability of materials/aids. AWWs (18.3%) devoid of skills in NHEd, also pointed out inadequacies of training imparted to them in training centres.

Home Visits

lii) Data reflected that average number of visits to families was highest in urban projects (46.7 families) whereas AWWs of tribal projects visited 43.1 families. Aggregate of these visits was 42.6 families in a month. When asked to explain the purpose of home visits, maximum number of AWWs (90.2%) reported that early registration and care of pregnant and lactating mothers was their foremost responsibility. Another important

purpose of home visit reportedly was to ensure regularity and punctuality of children in attending AWCs. Almost equal percentage (68.9%) of AWWs made visits to arouse a better sense of responsibility of parents in taking care of malnourished children and taking sick children to hospital and meeting their nutritional requirements.

Referral Services

- liii) A vast majority of AWWs referred the cases to Primary Health Centres which were at the nearest distance and easy to approach. Beneficiaries belonging to this service were mostly from rural (63.5%) and tribal (67.1%) ICDS projects. Beneficiaries were also referred to sub-centres (16.8%). Facility of district hospital was mostly utilised by 37 per cent AWWs of urban projects. Among various problems faced by AWWs in enhancing efficiency of referral service, most prominent ones included reluctance of parents to take children to hospitals (26.3%), far off location of PHCs/CHCs (23.3%) and absence of transport facility (25.8%).

Adolescent Girls

- iiiv) In the sample ICDS projects 44 per cent AWWs were also rendering services under the Adolescent Girls Scheme (*Kishori Shakti Yojana*) started during the year 1992. AWWs (32.2%) provided iron and folic acid tablets to adolescent girls daily - one tablet of iron and folic acid containing

60 mg of iron and 0.5 mg of folic acid. ANMs and AWWs monitored consumption of these tablets and its likely effects on the health of individual girls. Adolescent girls registered in Anganwadis also received supplementary nutrition, according to AWWs (30.7%). In order to ensure lasting impact of services rendered in Anganwadi programme of family life education was conducted by 27 per cent of AWWs. Topics covered by AWWs were appropriate age of marriage, care during puberty, personal health and hygiene, dangers of early pregnancy, psycho-social development, life cycle approach etc. Almost equal percentage (22.2%) of AWWs also emphasised on health check-up and counselling (21.4%) on issues related to this age and adjustment potentials within the peer groups and family.

Benefits and Outcomes of ICDS

Comparison of findings of present study with earlier studies

An attempt has been made to compare the findings of the present appraisal with those of other national level evaluation and macro-level studies undertaken earlier. These studies included National Evaluation of ICDS (NIPCCD, 1992) and Concurrent Evaluation of ICDS (NCAER, 2001).

Infrastructure/Equipment /Kit

- iv) A definite improvement was found in building structure of Anganwadi Centres over



the past 14 years. It was found that the percentage of AWCs housed in *kucha* structure (38.7%) in 1992 has gone down in 2006 (19.9%). On the other hand, in 1992 only 43 per cent AWCs were found to be housed in *pucca* structure whereas in 2006, this percentage has gone up to 75 per cent. This progressive trend would have been because of provision of constructing *pucca* building of AWCs under World Bank and *Jawahar Rojgar Yojana/Nehru Rojgar Yojana*. Improvement has also been noticed in terms of supply of weighing scale to AWCs and availability of pre-school education (PSE) kits.

- lvi) Increase in percentage of staff in position has been seen at all levels over a period of time except that there has been a decline in the position of helpers by 1.5 per cent. So far as training of ICDS functionaries is concerned, a progressive trend has been witnessed over the years. In case of CDPOs, the number trained has increased from 74 per cent (in 1992) to 82 per cent (in 2006) while in respect of supervisors, the increase is from 84 per cent in 1992 to 95 per cent in 2006 and in case of AWWs an increase of more than 18 per cent from 1992 to 2006 has been found. It was found that more AWWs have obtained higher qualifications.

Services

- lvii) The overall coverage of beneficiaries under supplementary nutrition had increased substantially. In our sample more than 56

per cent children were registered out of which more than 77 per cent were availing the services. Trend in case of women beneficiaries was also same but percentage availing services were quite high (more than 87%). A significant reduction has also been found in percentage of low birth weight babies. It has been reduced from 41 per cent in 1992 to 29 per cent in 2006 in respect of children born with a birth weight below 2500 gm. On the other hand, however, there was substantial increase in the percentage of children having a weight of more than 2.5 kg (from 58.9% in 1992 to 71.0% in 2006). Further, it was found that percentage of severely malnourished children had reduced drastically. In case of 0-3 years children, percentage of grade III > IV children has gone down to 1 per cent in 2006 from 7 per cent in 1992, that of grade II, 7 per cent (2006) from 22 per cent (1992) and that of grade I, 16 per cent (2006) from 35 per cent in 1992. Similarly, in case of 3-6 years children, present study scores only 0.8 per cent from Grade III and IV while the earlier study (1992) scores 4 per cent. Over the years, decline in disruption in supplementary nutrition has been noticed in percentage of both AWWs reporting disruption from (62.3% in 1992 to 54 % in 2006) and average number of days of disruption (from 63.7 in 1992 to 41.3 in 2006) Surprisingly, percentage of coverage of children per AWC - registered for PSE and attending the same has reduced.

Overall Assessment of ICDS projects on the basis of input and output/ outcome variables

- lviii) For the present study, some of the crucial variables necessary for successful implementation of the programme and impact of these in terms of output/ outcomes were identified. Scale free method was used to calculate a standard score for each of the input and output/ outcomes variables. For this individual score, each variable was divided by mean of that variable. The values thus arrived for each variable were then added to arrive at a composite score for each project which was called as composite input and output/outcome variable score.
- lix) On the basis of a composite inputs variable score, all the 150 projects were arranged in descending order showing the rank order for all input variables. Based on the total composite input score, minimum maximum range of composite input variable score was found to be between 3.1 and 19.3. Again, based on these scores, projects were rated as very good (scoring more than 15), good (between 10 and 15) and poor (less than 10).
- lx) According to composite score of input variables, it was found that out of 150 projects studied, a total of 63 projects were very good, 71 were good and 16 were poor in terms of input management.

Appraisal of ICDS management - input variables and appraisal of output/ outcomes of programme

- lxi) It has also been observed from the composite score of input variables that majority of the projects had performed well in terms of both input management and output/outcomes. However, it also clearly shows that few projects of northern BIMARU States have not performed well but all the southern states have performed upto the mark.
- lxii) Further, it is found that though 63 projects had Very Good inputs yet only 29 could show Very Good and 30 Good. Only 4 projects with very good inputs showed poor outputs/ outcomes. One needs to go into detailed reasons for this situation which could be their being located inaccessible or poorly developed areas. Forty-six of the projects had good inputs and they were rated Good on outputs which is quite understandable. However, on the whole, a large majority of ICDS projects (n=132) out of a total of 150 projects taken for the sample of the study have been rated as Good and Very Good which is an encouraging sign for the programme.

Recommendations

The present study has come out with lots of findings which have come as a 'pat on the back' so far as the implementation of ICDS programme is concerned. But at the same time, the study has



been able to highlight certain gaps and shortcomings of ICDS programme which need to be addressed with priority concern and attention. The following paragraphs would contain recommendations, both specific and general in nature, emanating from the findings of the study and a critical analysis of those findings having direct bearing on the programme.

Specific Recommendations

- i) About 60 per cent AWCs studied has no toilet facility and in 17 per cent AWCs this facility was found to be unsatisfactory. This requires immediate attention and a concrete measure of action to provide toilet facility to all the AWCs.
- ii) Accessibility to health services at the grassroot level has always remained an issue of concern and the present study has substantiated this concern. In many Anganwadi areas, availability of important health services was found to be lacking. It was found that only in 29 per cent Anganwadi areas PHCs were available and in 43 per cent Anganwadi areas sub-centres were available. It is therefore suggested that efforts should be made to coordinate with health department to make health service available in Anganwadi areas as near as possible.
- iii) Almost half of the AWCs, particularly in urban areas, are lacking space for conducting outdoor and indoor activities. This problem needs to be sorted out as it amounts to AWWs not being able to conduct PSE activities properly and meaningfully.
- iv) About 44 per cent AWCs covered under the present study were found to be lacking PSE kits. Efforts need to be initiated at all levels to ensure availability of PSE kits which is an essential part of PSE activities in all the AWCs. Cost effective and popular local resources need to be optimally utilised to develop play materials. However, it does not stop the AWCs to develop a toy bank like project in each AWC by collecting play materials from external sources.
- v) Owing to certain constraints, in many AWCs cooking and serving utensils cannot be expected to be available in desirable quantity and quality. This needs to be given a fresh thinking and initiative on the part of the Government to make sure that these facilities are available in each AWC in good quantity and quality routinely.
- vi) The present study revealed that coordination of ICDS functionaries with Health Department was somehow lacking at field/village level, especially in tribal areas and even in projects which are run by NGOs. This resulted in not-so-regular health check-ups at Anganwadi level. Concerted efforts are required to be initiated jointly by ICDS and health functionaries to have close coordination between them at all levels so that proper planning takes place to organise health check-ups.

- vii) A special drive needs to be initiated by both ICDS and health functionaries to cover all pregnant women in a given Anganwadi area to encourage them to take iron and folic acid tablets which are not otherwise consumed by these women as highlighted in the present study.
- viii) Agencies responsible for supply of supplementary nutrition need to be given clear instructions so that no disruption of supplementary nutrition takes place at Anganwadi level under any circumstances except those caused by natural calamities or extremely bad weather conditions. Apart from issuing necessary instructions to concerned agencies for regular supply of supplementary nutrition, Government must also look into the reasons for such disruption in each case and initiate necessary actions required in the given situation.
- ix) The present study reports that the boys, though registered less in number, avail more benefits than the girls. AWWs should ensure that all eligible girls avail benefits of supplementary nutrition as the future health of a nation depends largely on how healthy the girls are grown up.
- x) Efforts related to enhancement of immunisation coverage need to be strengthened so as to cover all the children for full immunisation. Therefore, concerted efforts on the part of ICDS and health functionaries are required in this direction.
- Community also needs to be sensitised adequately to the need and importance of immunisation so as to eliminate the chances of non-availability or non-cooperation of families in the process of immunisation.
- xi) The study revealed that 29 per cent children were born with a birth weight which was below normal (less than 2.5 kg). In the backdrop of this scenario, there is undoubtedly a need for regular supply of supplementary nutrition at Anganwadi level and more serious efforts for the care of pregnant mothers. This calls for regular health check-up, supply of supplementary nutrition and health and nutrition education for the pregnant mothers. AWWs should encourage mothers to breastfeed the children without fail and take personal health and nutritional care of themselves as well as their children.
- xii) It was observed from the study that the attendance of target groups in NHed sessions was quite low. It should be the responsibility of CDPOs and Supervisors to provide full support to AWWs and encourage them to continue with their efforts so that they are not discouraged by poor attendance in NHed sessions. CDPOs and supervisors, in such cases, can accompany the AWWs to pay more home visits and be a part of the process of motivating the women to participate in NHed sessions.
- xiii) Another feature observed in the present study is that 37 per cent AWWs reported non-

availability of materials/aids for NHed. Whatever aids were available with them, were procured from CDPOs as well as during their training and were not attractive at all. In many centres, available NHed aids and materials were not found to be in regional or local languages. These aspects need to be looked into seriously for remedial action.

- xiv) AWWs were found to face problems in providing referral services mainly due to non-availability of transport facilities to take the needy to health centres which are often located at far-off places. It was reported that many families cannot meet the cost of transport. In this regard, Panchayati Raj Institutions could be mobilised to extend transport facility to poor families so that they are able to avail health services. It is suggested that necessary funds may be made available at the disposal of AWWs to meet costs of medicines and transport. This would undoubtedly give referral services a shot in the arm.
- xv) Adolescent girls are the most potential groups which can do wonders provided they are properly involved in Anganwadi activities. A special provision should be made in ICDS scheme to involve and train adolescent girls in Anganwadi activities as they have the potential to extend all out support to AWWs and helpers in all the spheres of Anganwadi activities.
- xvi) Weighing of children at birth needs to be made compulsory as it determines the

course of action required immediately after the delivery. The present study reveals that 36.5 per cent mothers did not report weighing of new born children. This is a matter of grave concern. Health and ICDS functionaries should be issued necessary instructions to ensure weighing of children at birth without fail.

- xvii) Monitoring of growth of children is another important aspect of ICDS programme. Though not in a very high scale, yet non-availability of growth charts in 11 per cent AWCs and weighing scales in 4 per cent AWCs is something which needs to be seriously looked into. ICDS programme should ensure appropriate growth of all the children under its coverage.

General Recommendations

- xviii) Past experience as well as observations by the research teams have shown that mothers and children have responded enormously to supplementary nutrition programme wherever SHGs were involved in preparing cooked food in Anganwadis and serving the same to children and pregnant and lactating mothers. Since the ICDS programme is intended to be a people based one, it should, in its stride, involve the SHGs which are potentially the most effective and active grassroot level action groups. It is the high time that their contributions is sought not only to enrich the supplementary nutrition component but also to consider the shifting of responsibility of running the AWCs to

SHGs in those states where the SHG movement has shown positive contribution to the ICDS programme specially in the delivery of supplementary nutrition.

- xix) Some of the project functionaries reported that the spirit of community participation and contribution was somehow lacking in Anganwadis. People are found to be treating ICDS programme as merely Government programme rather than their own programme. They feel that everything is to be done by Government. This impression needs to be washed out by involving Panchayati Raj Institutions (PRIs) in ICDS programme. PRIs should necessarily be tapped so as to ensure suitable infrastructural support and other support such as providing toys and play materials, tables, chairs and promoting attendance of children and mothers in Anganwadi activities.
- xx) Financial provisions to social sector and its prime programme like ICDS are required to be augmented and released timely at project level to pay honorarium to AWWs and helpers and arranging supplementary nutrition. Besides, higher allocations in this programme, in view of the great cause ICDS programme has taken up, may be considered not as an expenditure but as an investment.
- xxi) Supervision should not be carried out in its old, rudimentary manner like

inspection, Rather, it should be in the form of support and guidance to the supervisee. Participatory supervision in teams comprising 'programme- friendly' and 'people-friendly' members and those who have required time and skills from different set ups and institutions should be initiated in ICDS programme. They can be drawn to monitor the efforts of ICDS programme and its problems. This kind of supervision can help preparing the ICDS programme for providing better services to children of present and future generations.

- xxii) Since networking and information and knowledge sharing assumes great significance in the area of evolving a multi-sectoral endeavour more particularly from the perspective of mother care and child development, it is equally important, to rope in PRIs, to carefully forge partnership with district and block level officials including local bodies such as Zila parishads and municipalities. To actualise this process it is important to orient district and block level officials about ICDS programme and their role in implementing the programme successfully. This exercise will accelerate the pace of coordination and convergence of services and programmes as also ensure better understanding among functionaries.
- xxiii) Popularisation of ICDS programme will call for launching of special campaigns as was done in the past in certain ICDS projects



by involving state, district and block level officials as also elected women representatives to raise consciousness of community on issues related to women and children. This would also generate community contribution, cooperation and support. The whole process would necessarily involve mahila mandals, self-help groups, youth clubs, mahila mandals, religious leaders and other functionaries of civil society organisations. Thus AWCs have to emerge as a "nerve centre" of activities and be a place where mother and children could assemble in their spare time, pursue hobbies, develop creative talents and equip themselves with different skills.

- xxiv) In Anganwadi areas where attendance of children is relatively low, crèches and day care centres need to be set up and attached to AWCs. This would widen the opportunities for all children to develop. More particularly girls would be allowed to pursue their interests. As it has been done in the States like Kerala and Tamil Nadu.
- xxv) So far as supplementary nutrition is concerned, variety and improved quality of items are required to be served. Mothers and AWWs need to be given skill training in preparing local recipes. They should be encouraged to serve freshly cooked food. It is suggested that at least two mothers should necessarily help AWWs and helpers,

in rotation, in cooking and serving supplementary nutrition. AWWs should be given suitable kit materials on personal hygiene, environmental sanitation, testing of iodised salt, safe drinking water etc. for use in AWCs as also in families covered by an Anganwadi.

- xxvi) The erstwhile Department of Women and Child Development, Government of India long back issued a circular suggesting development of "CDPO's office as a Resource Centre". However, this guideline has not received due attention and support from Nodal Department of State Governments, District ICDS cells and CDPOs. It would be desirable if each ICDS project develops a resource centre for dissemination of information, providing counselling and support services to mothers and adolescent girls, organising skill training of AWWs and generating awareness on various issues related to women and children. It may also keep data on campaigns/exhibitions/melas, rallies organised at project level as well as have adequate stocks of materials and aids to organise such events. The schemes and programmes of other departments may also be procured and disseminated among community at this resource centre to avail benefits from these schemes and programmes. Adolescent girls need to be involved in developing educational

programmes through role play, drama, songs, discussions as also in the process of developing training materials. Sample training module for adolescent girls on specific subjects may also be drawn up in consultation with project functionaries and personnel conducting various training programmes. Schools of Social Work, Home Science Colleges, teachers training institutions, extension training centre, Krishi Vigyan Kendras etc. may also provide professional support in their respective areas of expertise in developing training modules and conducting training programmes.

xxvii) Since Anganwadi Centre is a focal point for activities of ICDS programme it has always been emphasised that as far as possible AWC should be built with community involvement, be of low cost design using local materials and indigenous construction techniques. Further, it should be owned and maintained by community/village panchayat/urban local bodies. This type of centre is also required to organise other activities related to different women's programmes, to provide forum for youth activities, to use for meetings of frontline workers and for gathering of mothers and children. Ministries of Rural Development and Panchayati Raj may play major role in collaboration with State Governments to provide this facility. Voluntary

organisation(s) working in the field of rural development can also act as a catalysts in mobilising the community. Experience of Social Work Research Centre (Tilonia), may be of immense help as also experience of a low cost panchayat ghar in Khori village in Rewari district of Haryana which was constructed by local craftsman in less than five months and at one-third of the cost estimated by the PWD. Local materials were used and villagers participated actively in the design as well as construction of AWC.

xxviii) The strategy of convergence and integration of services has proved to be highly effective in ICDS programme after devolution of responsibilities and resources under the 73rd amendment of Constitution strengthening Panchayati Raj system became operational. Towards this direction, Ministry of Women and Child Development, Government of India needs to convene frequent meetings of coordination committees not only at central and state levels but also at district and block levels so as to enable the implementing machinery to carry the benefits of different programmes at the door steps of people with a synergetic effect.

xxix) Strengthening of ANM centres in ICDS project areas will play crucial role in the delivery of health care services to pregnant and lactating mothers as also adolescent girls.



Hence, all village level voluntary health workers like ASHA, Trained Birth Attendants (TBAs), Dais need to be placed at her disposal. This will also facilitate supply of basic drugs, vaccines and equipments in abundance. Sharing of responsibilities of entire project areas among the doctors, LHVs/PHNs and ANMs is utmost important so that smooth functioning of health infrastructure could be ensured in letter and spirit.

- xxx) The supply of therapeutic nutrition requires special attention at project and district level. Children with grade III and IV malnutrition are given special food which is called "therapeutic nutrition" which has to be in semi-solid form and can be easily digested by the child. Such children require a minimum of four feeds, of which two can be given at Anganwadi and two at home. The mother must be properly explained about the importance of special care for such a child and necessity of proper feeding at home. Locally available food stuff could be used to develop therapeutic food. In some Anganwadis, in the absence of therapeutic food, AWWs were found to be giving double the amount of supplementary food to the malnourished children. This practice needs to be discouraged as it is not only the amount of food required by the child but also more importantly the appropriateness of the same for the young malnourished child. Besides these, medical care for all "at risk" children need special attention in terms of their nutrition intake.

- xxxii) The Persons with Disabilities (PWD) Act of India makes a mandatory provision of early detection and early intervention services for childhood disabilities. Certain studies conducted in ICDS projects showed prevalence of developmental delay among children. This finding has led to the inclusion of Anganwadi-based developmental screening and early therapy programmes for children up to two years of age in the new World Bank supported ICDS-III projects in Kerala. It is suggested that in those areas where under 5 morbidity has come down to an acceptable level, next immediate priority should be adoption of morbidity management strategies including early detection and early intervention of disability as envisaged in PWD Act.

- xxxiii) The present study has brought forth the fact that early childhood stimulation and care for children in the age-group 3-6 years in ICDS programme calls for skill development training of AWWs in certain areas which were identified as weak areas in effective organisation of PSE activities in this appraisal. These areas include skill-based requirements, preservation of aids, use of aids and theme based programme planning. ICDS functionaries can persuade Panchayats to provide essential play equipments required in AWCs. The present study finds out absence of many essential items which are required in an AWC to

stimulate an enabling environment for pre-school children. These items include toys which teach colour, size, shape etc., puzzles for creative development, toys or games requiring refined movements, real or toy musical instruments, toys that teach names of animals, birds etc. In order to make PSE activity an effective component, it is essential to make the presence of the above-mentioned items in all AWCs mandatory.

xxxiii) Pregnant women represent approximately 3 per cent of the population. Hence, in any village having a population of 1000 or so there will be approximately 30 pregnant women who need to be given priorities in order to provide services such as NHEd, counselling, and supplementary feeding. It is well known that pregnant women are aware and scared of the risks of pregnancy, childbirth, and neonatal death and therefore, receptive to options for safe delivery, neonatal care, and family spacing. Pregnant women are marked by physical changes, which facilitate their identification for NHEd and other services. There is no denying of the fact that the importance of reaching women during pregnancy is being increasingly recognised as critical to improve maternal health, birth weight, birth outcome, and neonatal health, and has proven effective in improving the nature of care which women provide to infants in their first year of life. Hence, ICDS needs to give top most priority to

reach out to all the pregnant women with counselling and information on health issues as well as motivate them to avail supplementary food, so as to prevent malnutrition and death. This all out effort to identify and reach out to all the pregnant women would not only improve women's health, but also would influence infant and health care.

xxxiv) In any village of about 1000 population, there are about 60 mothers who are having children under 2. This indicates that there are about 60 priority households in every village for follow-up visits. These women need to be educated not only about the importance of feeding the child, but also as to how to feed and take care of the child. This will have greater impact on health and nutritional status of children. As a means of ensuring good health and nutrition of children under 2, reaching their mothers with health education and counselling should be given utmost priority. In addition, take home rations and guidance to lactating mothers on the preparation of foods to complement breast milk after 6 months of age is a welcome measure which needs to be incorporated in ICDS. It should be followed up vigorously to ensure proper utilisation of this facility.

xxxv) Though coordination with health functionaries was reported to be satisfactory by a vast majority of project functionaries, the participation of ANMs/



PHNs in referral services, health check-up, home visits and NHed was found to be marginal. There is a need to further improve the coordination between the ICDS and the health staff. The health workers should realise that at the end, their role would become easier if the activities of AWCs were properly implemented. The CDPOs and the Medical Officers of PHC should conduct joint visits to the Anganwadi areas to increase the performance of the programme. AWWs and ANMs should work in close collaboration. In order to improve accountability, work assessment report of ANMs/PHNs working in ICDS areas may include evaluation/comments of the CDPO incharge of the project as well.

xxxvi) It was observed that delivery of NHed services was far below the desired level. In this regard, it is recommended that Supervisors should be given the responsibility of organising formal NHed sessions at regular intervals in AWCs under their supervision. Continuous and effective monitoring by CDPOs and district officials, as also active participation of health functionaries, can go a long way in the effective implementation of this component. For group formation and collecting women at one place for NHed sessions, locally popular social or recreational event or activity may be organised. Utilisation of folk media such as *nautanki*, *kathputli*, etc., need to be included in the training

component of AWWs to strengthen their skills in imparting NHed effectively.

xxxvii) Undoubtedly, whatever success ICDS programme has been able to achieve so far, it has been because of strong community support and cooperation. However, there is still much to be done in this direction to ensure community participation in ICDS programme at the expected level. In this regard, it is suggested to experiment with an idea of having community mobilising team comprising functionaries, teachers having skills to effectively communicate and energise local voluntary organisations, youth clubs, community formations as well as representatives of village committees concerned with health, education, drinking water and sanitation so as to provide all back up support to ICDS programme. The other functions of the community mobilising team may include, mobilisation of people using methods like participatory rural appraisal, advocacy on local social development issues, consensus on and articulation of key issues, awareness building among people on priority issues, liaising with the intersectoral team of the village and initiating processes for thrift and credit.

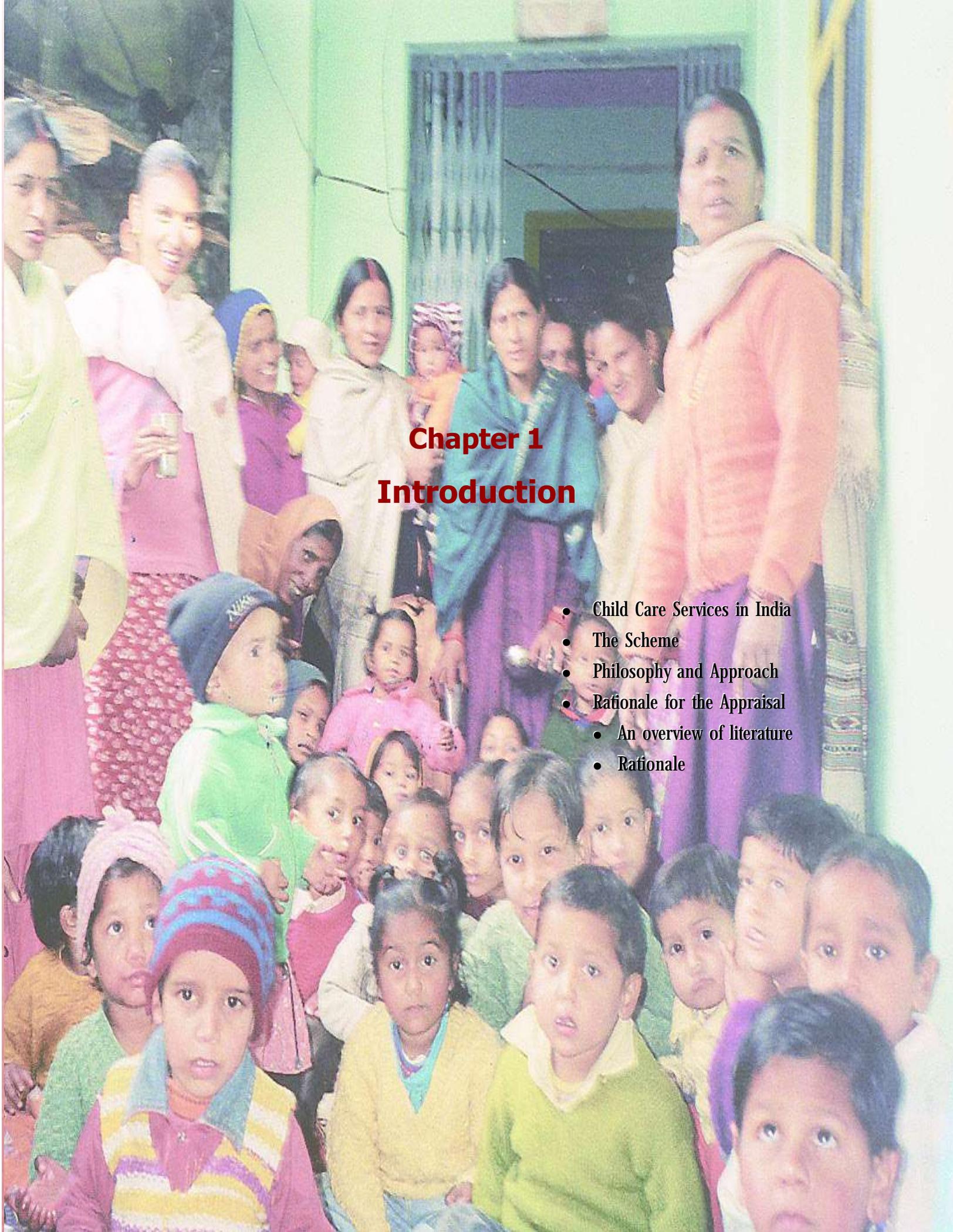
xxxviii) The concept of community monitoring could be experimented with a different perspective by technically ensuring developmental goals of ICDS programme. A community level monitoring team comprising local people from all sections of life could be developed.

The team members should be trained by service functionaries and professional experts to monitor ICDS programme based on certain process indicators and outcome indicators. This will ensure tracking of locally relevant indicators vis-a-vis developmental goals set for children, adolescent girls and women at community level.

xxxix) Moulding the mind of people, especially with such issues as discrimination against

girl child is major challenge to the ICDS programme. Female infanticide has remained to be a problem for a long time. The institution of Anganwadi can play a very important role in creating awareness in the villages about the dwindling sex ratio and its likely impact on future of the country. It is therefore imperative that project functionaries including the AWWs and the helpers are involved in creating such awareness through campaigns and other means.





Chapter 1

Introduction

- Child Care Services in India
- The Scheme
- Philosophy and Approach
- Rationale for the Appraisal
 - An overview of literature
 - Rationale

Introduction

1.1 Evolution of Child Care Services

The most valuable asset of a nation is its human resource. Developed nations are advanced not because of their high rise buildings and latest infrastructure, but because of the quality of human resource they possess. Countries who have learnt to invest in their human resource are today, the most progressive and developed nations. India also has recognized this and has made several efforts to improve the quality of its human resources.

The Constitution of India itself provides a framework for care and protection of women and children. Article 47 of the Directive Principles of State Policy states that “The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health”. Further, Article 39 *inter alia* states that “The State shall, in particular, direct its policy towards securing

- (a) that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter vocations unsuited to their age or strength;
- (b) that childhood and youth are protected against exploitation and against moral and material abandonment”.

Since India achieved Independence in 1947, the Government of India has undertaken various initiatives towards nation's human resource development. India's history of child welfare goes back to 1920 when the first children's organisation called **Balkanji Bari** was formed with child membership with Headquarters in Mumbai. In 1924, the Guild of Service started excellent child welfare services in Chennai, and its services spread to most of South India. In 1927, the Children's Aid Society, Mumbai took vagrant children in residential care. In 1958, the **Indian Council for Child Welfare**, a non-governmental organisation made a representation to Government for a specific child welfare plan. The **UN Convention on the Rights of the Child** changed the very approach to child care, and the child rights. The Government of India formulated and adopted the **National Policy for Children** in 1974 besides formulating programmes for children as a prominent part of national plans. **Department of Women and Child Development** formulated the **National Plan of Action for Children** in 1992 and in 2003, a **National Charter for Children** was adopted which redefined India's policy commitments towards the child. The revised **National Plan of Action for Children** was adopted in 2005 to remove obstacles and improve the condition of children of India.

Recognizing the need for early intervention to ensure the development of a young child's body, mind and intellect to its maximum potential, the

Government of India started **Integrated Child Development Services (ICDS)**, a centrally sponsored scheme which is a step towards responding to the child's needs in a comprehensive and holistic perspective.

1.2 The Scheme

ICDS was launched in 1975, with 33 projects. Now it is the world's largest programme having 5652 projects operational all over India with 4533 projects in rural areas, 759 projects in tribal areas and 360 projects in urban areas. This programme is formulated to enhance the health, nutrition and learning opportunities of infants, young children and their mothers, especially targeted for the poor and the deprived.

In the light of the experience gained over 30 years, the task for the ICDS in the Tenth Plan is not confined only to that of feeding and teaching the young child. It also involves adopting a synergistic approach to strengthen the capacity of caregivers and communities to provide a conducive physical and social environment for the young child in the family/ community and at the Anganwadi centres (AWCs). ICDS has already reached a stage where it is essential not only to universalise its expansion but also to enrich its contents. This emerging profile of ICDS re-dedicates itself to promoting early childhood care for survival, protection and development during the Tenth Plan. With the enunciation of the **National Population Policy (NPP)** in 2000, the Ministry of Health and Family Welfare had specific targets like bringing down the high rates of infant and child mortality, and achieve complete

Immunisation. The ICDS system works closely with the health system to achieve these goals.

The goals of the ICDS programme are reduction of Infant Mortality Rate (IMR) to less than 60 per thousand, reduction in Child Mortality Rate (CMR) to less than 10 per thousand, reduction in Maternal Mortality Rate (MMR) by at least 50%. Further, reduction in incidence of low birth weight, reduction in severe and moderate malnutrition among children under 5 years of age by at least 50 per cent, and expansion of early childhood care development intervention, contributing to universal environment and retention in primary schools are the primary goals of ICDS programme.

1.2.1 Specific Objectives of ICDS are:

- (i) to improve the nutritional and health status of children in the age group 0-6 years;
- (ii) to lay the foundation for proper psychological, physical and social development of the child;
- (iii) to reduce the incidence of mortality, morbidity, malnutrition and school dropout;
- (iv) to achieve effective coordination at the policy and implementation levels amongst the various departments to promote child development; and
- (v) to enhance the capability of mothers to look after normal health and nutritional needs of the child through proper nutrition and health education.

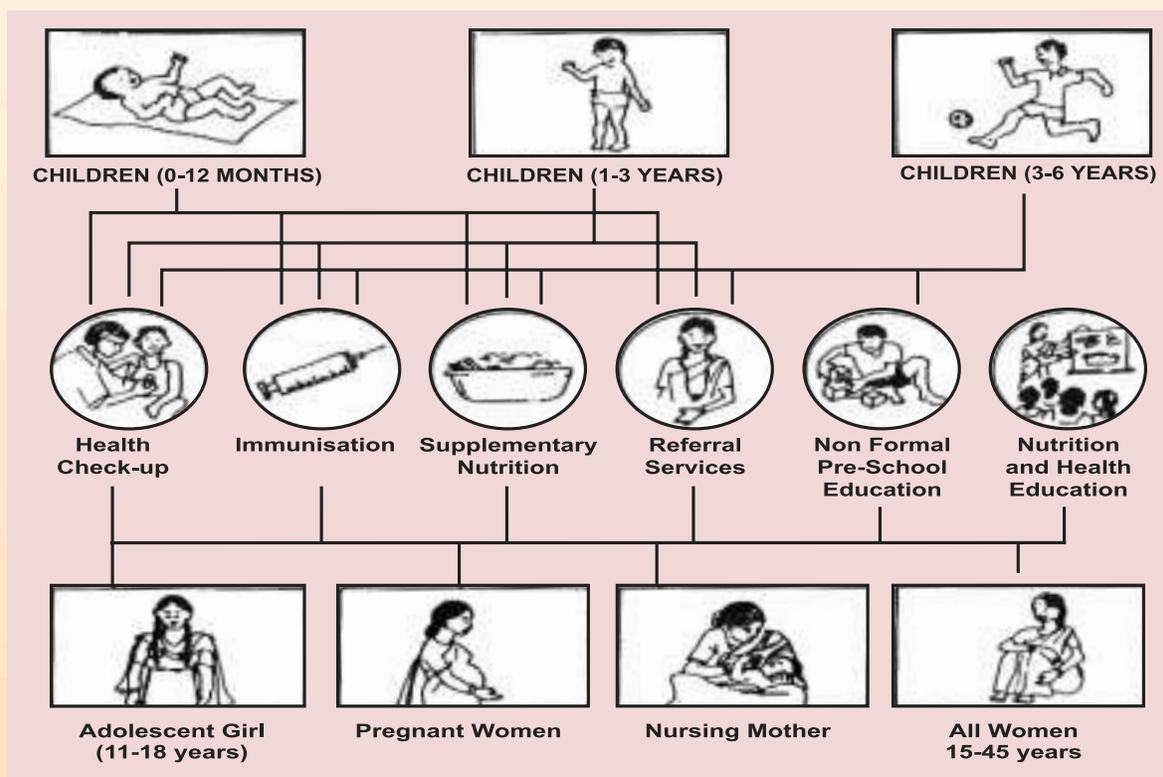


1.2.2 Services

ICDS provides a package of services to ensure the holistic development of children before birth, when they are 0-6 years, expectant and nursing mothers, and the lately introduced services for adolescent girls. The package of services (Fig 1.1) provided are:

joyful learning opportunities to children in the 3-6 years age group are provided. Convergence of other supportive services is planned such as safe drinking water, environmental sanitation, women's empowerment programmes, non-formal education and adult education.

Fig. 1.1 : Package of services provided by ICDS



1. Supplementary and therapeutic Nutrition
2. Non-formal pre-school education
3. Immunisation
4. Health Check-up
5. Referral Services
6. Nutrition and Health Education

Further, early care and stimulation for younger children under three years and early

Normally, one AWC covers a population of 1000 persons in rural and urban areas, and 700 persons in tribal areas. But in sparsely populated regions of the country like hill or desert areas, one AWC may cover a population of 300+ persons. The norms have been further relaxed, and to cover small hamlets or tribal pockets in far flung areas, a mini AWC can cover a population of 150-300 persons.

1.2.3 Philosophy and Approach

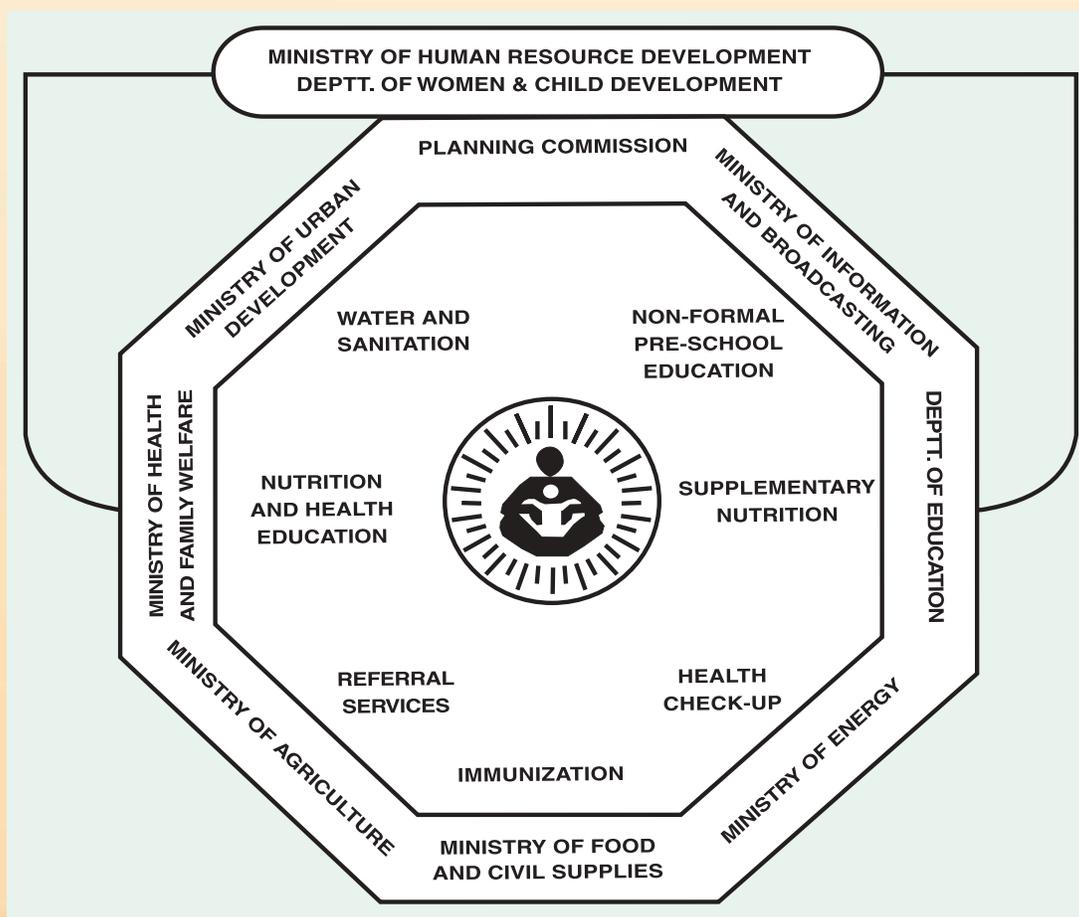
The concept of providing package of services is based primarily on the consideration that the overall impact would be much larger if the different services are delivered in an integrated manner, as the efficiency of a particular service depends upon the support it receives from the related services. The other unique feature of the programme is that it utilises and mobilises all available governmental services at the level of the project. It is **multi-sectoral in nature** and its successful implementation depends on intersectoral functional linkages (Fig. 1.2). It calls for

coordination between concerned departments and ensures optimal use of the existing governmental infrastructure at the project level.

The programme also addresses concerns of women and the girl child. Interventions designed for adolescent girls seeking to break the inter-generational cycle of nutritional disadvantage have also been brought under the ambit of ICDS services, besides the beneficiary coverage mentioned earlier.

ICDS serves the target group through a network of Anganwadis (AWs). The Anganwadi (literally meaning a courtyard play centre) is the

Fig. 1.2 : Intersectoral linkages of ICDS



focal point for delivery of services at the community level. There is a team of project level functionaries coordinating the activities of AWCs. **The focal point for the delivery of services** is the **Anganwadi**, literally a courtyard and play centre, is a child care centre. The centre is run by local community-based women called Anganwadi workers (AWW) who is supported by another local women-the AW helper in service delivery.

Coverage

Each project aims at total coverage of a population of about 100,000 each in rural and urban areas and around 35,000 in tribal areas. The population coverage through the AWC is approximately 1,000 in rural and urban areas and 700 in tribal areas, whereas in sparsely populated regions of the country like hill or desert areas, one AWC may cover a population of 300+. The norms have been further relaxed, and to cover small hamlets or tribal pockets in far flung areas, a mini AWC can cover a population of 150-300 persons. Others in the team comprise of supervisors, Assistant Child Development Project Officers (ACDPOs) and Child Development Project Officers (CDPOs).

Training of the project functionaries is the most crucial element in ICDS. The success of a programme depend on the effectiveness of frontline workers in empowering communities for improved child care practices, as well as effective intersectoral service delivery. Training of functionaries at all levels have been built into the programme. At the national level **National Institute of Public Cooperation and Child Development (NIPCCD)** has been designated as

apex training institute. At state level, other infrastructure such as Supervisors Training Institutes called as **Middle level Training Centres (MLTCs)** and **Anganwadi Training Centres (AWTCs)** exist.

1.2.4 Role of International Organisations

ICDS being world's largest programme of development of Children a number of international organisations have shown their interest in enriching the services through various interventions.

- (a) **Role of UNICEF:** UNICEF has started several initiatives to strengthen ICDS. It promoted growth monitoring to prevent malnutrition among children, provided weighing scales to monitor growth of children, promoted immunisation against vaccine preventable diseases, produced and distributed communication material, and started other initiatives also.
- (b) **Role of World Bank:** The World Bank initially assisted ICDS III projects in five states namely Kerala, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. It covered 1003 blocks with 318 new blocks where ICDS was introduced, and 685 old blocks where the services were enriched. Under World Bank assistance, quality of services was improved and infrastructure was developed. Later, States of Madhya Pradesh, Chhattisgarh, Jharkhand, Orissa and Uttaranchal were included for the remaining period of the project up to 30.9.2004. The World Bank also assisted

ICDS through UDISHA, the ICDS Training Programme under which the training component was strengthened, equipment was supplied at AWCs, and learning training material was prepared and distributed at anganwadis and training centres.

- (c) **Role of World Food Programme (WFP)** : The World Food Programme, a major initiative of United Nations organisation, has been extending support in the form of food and supplementary nutrition in some ICDS projects in the states of Madhya Pradesh (19 projects), Orissa (32 projects), Rajasthan (20 projects) and Uttaranchal (16 projects) covering nearly 0.865 million beneficiaries.

1.3 Rationale for the Appraisal

Being the world's largest outreach programme targeting infants and children below six years of age, expectant and nursing mothers, and adolescent girls, ICDS has generated interest worldwide among academicians, planners, policy makers, administrators and those responsible for implementation.

Consequently, a large number of research studies have been conducted to evaluate and assess the impact of the programme. It has been researched in depth (Box 1.3) and several studies have analyzed its various facets. The services provided under ICDS have had an impact on the health, nutrition and immunisation status of children, their cognitive development, development of social skills, school enrolment, awareness about hygiene and environmental

sanitation, and also an impact on the level of general awareness of the community about better child care practices.

At the national level, there have been only two evaluations of ICDS scheme, one conducted by NIPCCD in 1992, and the second conducted by National Council of Applied Economic Research (NCAER) in 1998, which was published in 2001.

The nationwide evaluation as a pilot study was undertaken on behalf of Department of Women and Child Development (DWCD) by the NCAER during 1996-97. The evaluation was aimed at examining the performance of the scheme on the ground with a view to assess the capability of the functionaries, to meet the objectives of the programme and to draw policy lessons for its further improvement.

The nationwide evaluation as a pilot study was undertaken on behalf of DWCD by the NCAER during 1996-97. The evaluation was aimed at examining the performance of the scheme on the ground with a view to assess the capability of the functionaries, to meet the objectives of the programme and to draw policy lessons for its further improvement. The study was based on a field survey of nearly 60,000 AWCs and 1,80,000 beneficiary households selected from 4000 operational blocks (as on 31.3.1996) spread over 32 States and Union Territories. The survey results showed that the ICDS programme in the country had benefited over 50 per cent of the eligible children and women. The survey results have been made available for selected indicators covering major components of ICDS Scheme for all the operational blocks covered in the study.



Another significant aspect of the NCAER study has been to provide separate reports for all the major states. On the whole, overall performance of the states based on the factor analysis results of the critical indicators show that Gujarat, Orissa, Maharashtra, Madhya Pradesh and Haryana are amongst the better performing states, while the performance of West Bengal, Punjab, Jammu and Kashmir, Uttar Pradesh and Bihar has been below average.

1.3.1 Outreach of Services

A study conducted by FORCES to assess the status of ICDS projects found that ICDS did not reach a sizable proportion of the Indian population. FORCES is a national network of organisations working to improve the efficacy of early childhood care and development (ECCD) services. The study covered three states, namely Rajasthan, Uttar Pradesh and Bihar. It was observed that ICDS barely covered 50 percent of the population. While there are 14 lakh habitations in India, only 6 lakh are presently covered by those centres; and while 7.5 lakh Anganwadi centres were envisaged to be set up under the Tenth Plan, and 7.4 lakh centres had already been sanctioned, only 6.4 lakh Anganwadis were functional. Bihar had a dismal coverage of 30 percent only, while UP and Rajasthan had over 60 percent coverage. UP had the highest number of children and spends Rs. 15 per beneficiary per month. Rajasthan spent Rs. 18 per beneficiary per month and Bihar spent only Rs. 6 per beneficiary per month as against the national average of Rs. 18 per beneficiary per month. The study recommended that ICDS should cover all needy beneficiaries (FORCES : 2005).

1.3.2 Health Services

A study was conducted by West Bengal Council for Child Welfare to assess the health status of mothers and children in three districts of West Bengal, namely Howrah, 24 North Parganas, and 24 South Parganas. The study found that the impact of ICDS was immense in maintaining the health of mothers and children, and raising their level of awareness. Though there were financial crunches and infrastructural handicaps, the AWCs in the three districts were working well. Poor environmental sanitation, unhygienic practices like bathing in village ponds, lack of bathrooms and toilets were some factors which were the cause of illness among children. Bleeding before delivery in rural areas, and anaemia among mothers in urban areas were important causes of prenatal deaths among children, though most causes were unknown. Although AWWs had succeeded in creating awareness about the importance of immunisation, about 8-15 percent children were not immunised, and the percentage of unimmunised children was higher in rural areas compared to urban areas. Children were also suffering from vitamin deficiencies, including Vitamin A deficiency. The study recommended opening more AWCs so that the health and nutrition status of women and children could be improved (Indian Council for Child Welfare West Bengal : 2001).

1.3.3 Parent's Views on AW Services

A study conducted in urban slums of Jammu city, to evaluate the health services provided to pre-schoolers, found that parents were of the

opinion that AWCs were the best place for children to get health, nutrition, immunisation and referral services free of cost. They would not have been able to provide these services to their children due to poverty. Parents were satisfied with the health education provided, growth monitoring, immunisation and referral services. But it was observed that no health and immunisation cards were maintained by AWWs, which caused inconvenience to parents as they could not remember the dates of their child's immunisation and health check-ups (Jammu University, Post Graduate Department of Home Science: 2001).

1.3.4 Nutrition

In a study conducted by Institute of Development Studies, Jaipur covering 40 Anganwadi centres in 3 tribal districts of Rajasthan, namely Banswara, Doongarpur and Chittorgarh, Rajasthan, it was found that malnutrition was prevalent among children 0-3 years. The practice of rejecting colostrum was common, and about 50% mothers were not feeding colostrum to infants as they considered it 'bad milk', according to their cultural beliefs. Breastfeeding was prolonged, but delayed additional supplementary feeding resulted in malnutrition among children. Children were found to be suffering from various diseases. AWCs were not equipped enough to cater to the needs of under-threes. With the exception of Anandpur Block, mothers were not aware of the need for immunisation. The knowledge level of mothers regarding nutrition, and AWWs regarding growth faltering and malnutrition, was found to be poor. Casual attitude of families towards children, large

families, neglect of the girl child, and delayed start of supplementary food to infants were found to be the major factors associated with malnutrition. The study recommended that health and nutrition messages imparted under the ICDS system should be clear and unambiguous to create the desired awareness among the community and achieve the stated objectives (Singhi, N.K.: 1996).

A study was carried out by Government Medical College, Vadodara in 1998 in 30 AWCs to assess the nutritional status of children below 5 years of age in slums of Vadodara city. Of a total of 3157 children, 705 (22.4%) were moderately to severely malnourished (Grade II and III), 1280 (40.5%) were mildly malnourished, and 1172 (37.1%) were not malnourished. No child was in Grade IV malnutrition. Only 6.1% children under 6 months were malnourished compared to 29.5% in the age group 36-59 months, and there was a steep rise in malnutrition in the second year of life. There was not much change in the malnutrition situation among children during 1996-98. Among the malnourished children, only 24.2% improved, while the rest remained the same or worsened. Gender differentials analysis of the shift favoured males. A detailed analysis was required to understand the reasons for failure of the programme and devise methods to improve the nutritional status of children attending AWCs (Bhalani and Kotecha : 2002).

The Annual ICDS Evaluation Survey 1994-95 in Pune Urban ICDS Project, covering 4 AWCs and 500 women found that the calorie deficit for non-pregnant non-lactating (NPNL) women was 783 calories (41.8%), for lactating women 1089



calories (48%), and for pregnant women 1075 calories (49.9%). The protein deficit was found to be 16.1 gm (32.3%), 31.4 gm (46.2%), and 33.4 gm (51.4%) for non-pregnant non-lactating women, lactating women, and pregnant women, respectively. The dietary pattern of women in child bearing age was uniformly deficit in calories and proteins in Pune slums, in spite of being covered under ICDS scheme. Health and nutrition education and creating awareness about the need for additional nutrition supplements such as an extra meal during pregnancy and lactation were simple interventions that could help improve the birth weight of babies and nutritional status of women (Gandham, 1998).

A study, conducted in Alwar and Bharatpur districts of Rajasthan assessed the nutritional status of all children in 50 AWCs. About 10% children were found to be severely malnourished. Supplementary nutrition was received by 84.6% severely malnourished children, but only 39.2% received double ration, 45.4% received single ration, and 15.4% received no ration. The guidelines for distribution and consumption of supplementary nutrition should be adhered to for management of severe malnutrition through the ICDS scheme (Kapil, U : 1999).

1.3.5 Nutrition and Health Education

ICDS aims at bringing about attitudinal change in the health and nutrition habits of the target beneficiaries, in order to attain elevated health standards. A study conducted by NIPCCD, Bangalore in Arekal rural project and Bangalore urban project, Karnataka assessed the efficacy and

impact of these nutrition and health education (NHE) messages imparted under ICDS on the knowledge and practice of mothers. The efficacy of the ICDS system in imparting 12 key messages for child survival and development covering breastfeeding, importance of feeding colostrum to newborns, weaning and supplementary foods, immunization, small family norm, anaemia prophylaxis programme growth monitoring, low-cost nutritious food, management of diarrhoea, and feeding children during illness were evaluated. A majority of the mothers had satisfactory knowledge (60%) and practice (61%). The knowledge level of rural mothers (64%) was better than that of urban mothers (56%), as AWWs had difficulty in contacting urban mothers, who went out for work the whole day, and could not be contacted during home visits. The study recommended that for the messages to be effective, these should be prioritised and based on the needs of the target group. Indigenous material can be used to reinforce the messages. The NHE component should be an integral activity of all related activities (NIPCCD, Bangalore: 1996).

1.3.6 Pre-school Education

In a study conducted by Institute of Development Studies, Jaipur it was observed that in ICDS projects where AWWs took keen interest in pre-school activities, whether they were run by the Government or NGOs, there was positive impact of pre-school activities on the cognitive development of children. Four main pre-school education activities undertaken by the Anganwadi Workers were: teaching alphabets and seating arrangement, counting, poetry recitation and

games. In Padawa village of Pratapgarh block, the Anganwadi Worker used indigenous materials to foster creative learning and taught the children to make figures out of clay mud. These methods have potential for replication, and permit scope for innovation. In villages where NGOs like VIHAN were involved in Anganwadi activities, children were more aware and confident, as VIHAN laid stress on cognitive creative learning. In a majority of the Anganwadi centres there were no charts, blackboards, toys or other relevant equipment. AWCs need to be provided with pre-school learning material. The process of learning should enable children to creatively express their potential (Singhi, N.K. : 1996).

1.3.7 Adolescent Girls

The study was carried out in Dhar tribal district of Madhya Pradesh and covered 10 percent AWCs in 4 ICDS projects. Training was imparted to 1920 adolescent girls (AGs) and 640 AWWs / Helpers, 2560 trainees in all, and the pre- and post-training scenario was assessed. It was observed that training improved the self-confidence and self-esteem of adolescent girls, the health status and hygiene practices of adolescent girls, and their health and nutrition knowledge. It also improved their skills in carrying out AW activities. Qualitative improvement was observed in the delivery of NHE, growth monitoring and pre-school education in AWCs where adolescent girls were involved. Health check-ups and referral services were also strengthened through the efforts of AGs. The training programme did not influence the parents of adolescent girls to the extent desired.

Community meetings, though difficult to organise, were found to be effective. The training of AWWs needs re-orientation to provide more hands-on training experience. Nutrition and health education messages should be broadcast on radio at least weekly. NHE material must be available in every AWC, so that the community can be educated on these aspects (World Food Programme : 1997).

1.3.8 Role of Voluntary Organisations in ICDS

A study conducted by Department of Foods and Nutrition, M. S. University of Baroda covered 610 pre-school children aged 0-36 months and pregnant mothers who were availing ICDS services under Baroda Municipal Corporation and a Voluntary Trust. It compared the performance of service delivery of ICDS under these two sectors, namely, the Government sector and the Voluntary sector. The socio-demographic characteristics of children and mothers did not differ under these two sectors. The Government sector achieved better and higher coverage for many services, but no appreciable differences were observed in the nutritional status of these children. Age of the child was a factor which affected the nutritional status, infants having better nutritional status than older children. Utilisation of the full package of services produced a mutually reinforcing effect by reducing the morbidity burden, and increasing the number of morbidity-free days, in children as well as pregnant mothers. Utilisation of iron supplementation and supplementary food resulted in better birth weights of their infants and absence of very low birth weight infants (Saiyed and Seshadri, 1996).



1.3.9 Impact of ICDS

A study was conducted in 12 Anganwadi areas of Jasra ICDS block in Allahabad district of Uttar Pradesh. Children aged 7-13 years were covered, and the experimental group constituted children who had been ICDS beneficiaries, while the control group were children who had not availed ICDS services. It was found that school dropout rate was higher for beneficiaries compared to non-beneficiaries. The incidence of moderate to severe malnutrition was found to be higher among non-beneficiaries (73%) compared to beneficiaries (54%). Iron deficiency anaemia was the most widely prevalent deficiency observed. The prevalence of Vitamin A deficiency was 10.7 per thousand among beneficiaries and 12.7 per thousand among non-beneficiaries. Academic performance of beneficiaries was better than that of non-beneficiaries, and 21 percent beneficiaries participated in various school activities compared to 9 percent non-beneficiaries. The behaviour pattern of children with respect to obedience, behaviour with peers, elders and teachers indicated a long-term positive effect of ICDS services (Gyanendra Singh, 1997).

1.3.10 Low Birth Weight

The study was done in Haratha, a rural ICDS block, and the adjoining non-ICDS block of Kashi Vidyapeeth in Varanasi district of Uttar Pradesh. It covered women in the ICDS block who were supplemented, women in the ICDS block who were not supplemented, and women in the non-ICDS

Box 1.1 Research on ICDS

- ❖ Baseline survey was conducted by PEO in 1976
- ❖ A repeat survey by PEO in 1977-78
- ❖ Study on perspective of ICDS carried out by Krishnamurty & Nadkarni in 1983
- ❖ Monitoring Social Component of ICDS by NIPCCD in 1985-86
- ❖ Health aspect of the programme was investigated by Gopalan et.al. in 1990
- ❖ National Evaluation by NIPCCD in 1992
- ❖ In 1995 NIN & CTC highlighted the impact of ICDS on psycho-social development.
- ❖ A concurrent evaluation of ICDS (on selected indicators) was undertaken by NCEAR (2001)

area who were not supplemented. Supplementary nutrition was reaching only 34.4% pregnant women in the ICDS area; it was irregular, of poor quality and inadequate in amount. About 13.8% women in ICDS supplemented group, 12.7% women in ICDS non-supplemented group, and 27.4% women in non-ICDS non-supplemented group remained less than 45.0 kg. It was found that birth weight of babies born to supplemented women was 58 gm more than that of babies born to non-supplemented women. The birth weight of babies of non-supplemented ICDS area mothers was 25 gm more than the babies of non-ICDS area mothers. ICDS supplemented mothers had fewer low birth weight babies (14.4%) compared to ICDS non-supplemented women (20.4%) and non-ICDS non-supplemented women (26.3%). The prevalence of preterm babies was 2.0%, 2.4% and 4.3% in the supplemented ICDS area, non-supplemented ICDS area, and non-ICDS area respectively. It was found that weight gain in

pregnancy, length of gestation, and caloric intake in the third trimester made significant contribution to birth weight in both, ICDS and non-ICDS blocks. But in spite of the lacunae observed, supplementary nutrition improved weight gain in mothers, improved the birth weight of infants, and reduced the incidence of pre-term and low birth weight babies (Aggarwal, K.N. et al : 2000).

Fewer studies are available on stabilisation of the programme; quality control and enhancing the social and economic empowerment of disadvantaged women awareness about the value of the programme are available. As can be seen that most of the studies have provided only piecemeal information and have not taken systematic stock of the delivery of inputs vis-à-vis output; nor have these investigated the impact of services on the target groups in a comprehensive and coordinated fashion. These studies also have not provided ample evidence on interdependence of various variables related to implementation of the programme and its impact on the Target Group. Coverage of sample has also been limited leading to inability to generalise.

Several valuable lessons have been learnt through these studies. **None-the-less the need for a comprehensive investigation to assess ICDS at the national level was most desirable since the ICDS programme now has been in operation over a period of three decades.** Moreover the profile of ICDS has been changing specially in the last decade because of expansion,

decentralisation, universalisation, World Bank inputs and convergence with other schemes, all of which call for a fresh assessment of the programme. Keeping this in view, it is essential to find out the impact of ICDS programme on beneficiaries so as to improve its optimal outreach and taking decision regarding its improved implementation. The feedback will be of paramount importance to bring about changes in the programme, role of States and NGOs/Civil Society Organisations, Panchayati Raj Institutions and beneficiaries as also to improve quality of life of children and mothers. The present appraisal may also enable to identify factors associated with success or otherwise of the project both at macro and micro level.

Moreover in a public interest litigation the Supreme Court recently directed the Government of India to increase the number of Anganwadi Centres to cover 14 lakh habitations. The National Common Minimum Programme (NCMP) of the government also envisages that the ICDS scheme will be universalised. There was, therefore, a need to get an empirical feed back to identify factors associated with its positive impact of the scheme. This can help in improving both delivery of the services as also ensuring its optimal out reach and impact on target groups.

The Department of Women and Child Development, Government of India, thus, had requested the Institute to undertake a study of impact of ICDS.





Chapter 2

Design of the Study

- Objectives of the Study
- Methods and Procedures
 - Scope of the Study
 - Sampling Procedure
 - Selection of Samples
 - Target Population
 - Tools of Data Collection
- Operational Details
- Manpower Planning
- Ensuring Data Quality
- Computerisation and Analysis
- Parameters/Indicators of Appraisal
- Summarising of Data
- Limitations of the Study
- Presentation of the Report

Design of the Study

2.1 Objectives of the Study

The objectives of the study were to :

- assess the existing status of implementation of ICDS programme in terms of coverage, out reach, coordination, convergence, and innovations introduced by States and NGO;
- compare the differences in implementation of the ICDS programme in rural, urban and tribal areas and in NGO-run projects;
- identify gaps and problems in the implementation of ICDS;
- find out the perception of community and local bodies about ICDS and the extent of support provided by them in implementation of the programme;
- exploring the inter-linkages of ICDS with other development programmes and their role in improving the quality of services; and
- ascertain the benefits of the scheme on selected outcome indicators related to different services provided to children, women and adolescent girls.

2.2 Methods and Procedures

2.2.1 Scope of the Study

One hundred and fifty ICDS projects from all 35 States and Union Territories covering rural, urban and tribal projects were selected for the study. The universe of the study was restricted to those projects which were functional for a

minimum period of five years. Thus, all those projects which were in operation 'A' upto the year 2000 were included in the study. In all 4200 ICDS projects formed the universe of the study. A sample of 150 (about 4%) of ICDS projects was selected for the purpose of appraisal.

2.2.2 Sampling Procedure

A multi-stage stratified random sampling technique was adopted to select state-wise total number of projects at the first stage. Whereas at the second stage, stratified sampling technique and also purposive sampling method were applied for selection of number of projects by location (Rural, Urban and Tribal). State-wise and location-wise total number of projects selected are given in the Table 2.1 and Fig. 2.2.

Distribution of sample projects by location from where projects were selected are given below in Fig. 2.2.

The actual physical location of sample districts from where projects were selected is given in the map of India (Fig. 2.1).

2.2.3 Selection of Projects

As mentioned earlier, a project is expected to become operational after 18 months of its sanction and likely to take at least two years before it functions smoothly. Therefore, April 2000 was taken as a cut-off year for selection of projects for the study. Sample was drawn only from blocks

Table 2.1: State-wise Distribution of Sample of Projects by Location

State/UT Code	States / UTs	Location			
		Rural	Urban	Tribal	Total
01	Andhra Pradesh	4	2	1	7
02	Arunachal Pradesh	0	0	2	2
03	Assam	3	1	2	6
04	Bihar	5	1	0	6
05	Chattisgarh	2	1	1	4
06	Goa	1	0	0	1
07	Gujarat	7	1	4	12
08	Haryana	3	1	0	4
09	Himachal Pradesh	2	0	0	2
10	Jammu & Kashmir	3	1	0	4
11	Jharkhand	1	1	3	5
12	Karnataka	4	1	1	6
13	Kerala	2	1	1	4
14	Madhya Pradesh	5	1	2	8
15	Maharashtra	5	1	2	8
16	Manipur	0	0	1	1
17	Meghalaya	0	0	1	1
18	Mizoram	0	0	1	1
19	Nagaland	0	0	2	2
20	Orissa	4	1	3	8
21	Punjab	4	1	0	5
22	Rajasthan	4	1	1	6
23	Sikkim	1	0	0	1
24	Tamil Nadu	10	2	1	13
25	Tripura	1	0	0	1
26	Uttar Pradesh	12	1	1	14
27	Uttaranchal	1	1	1	3
28	West Bengal	6	1	1	8
29	A&N Islands	0	1	0	1
30	Chandigarh	0	1	0	1
31	Delhi	0	1	0	1
32	Dadra & Nagar Haveli	0	0	1	1
33	Daman & Diu	1	0	0	1
34	Lakshadweep	0	0	1	1
35	Pondichery	1	0	0	1
	TOTAL	92	24	34	150

which were operational as on 01-04-2000 i.e. 4200 projects (3177 rural, 273 urban and 750 tribal). For the present study, a total of 150 ICDS projects were selected as a sample i.e. roughly 4 percent of the total universe. Number of projects selected from each state was proportionate to the total number in operation and in the categories of Rural, Tribal and Urban (**Annexure-1**). Within a project, an attempt was made to include projects run by NGOs.

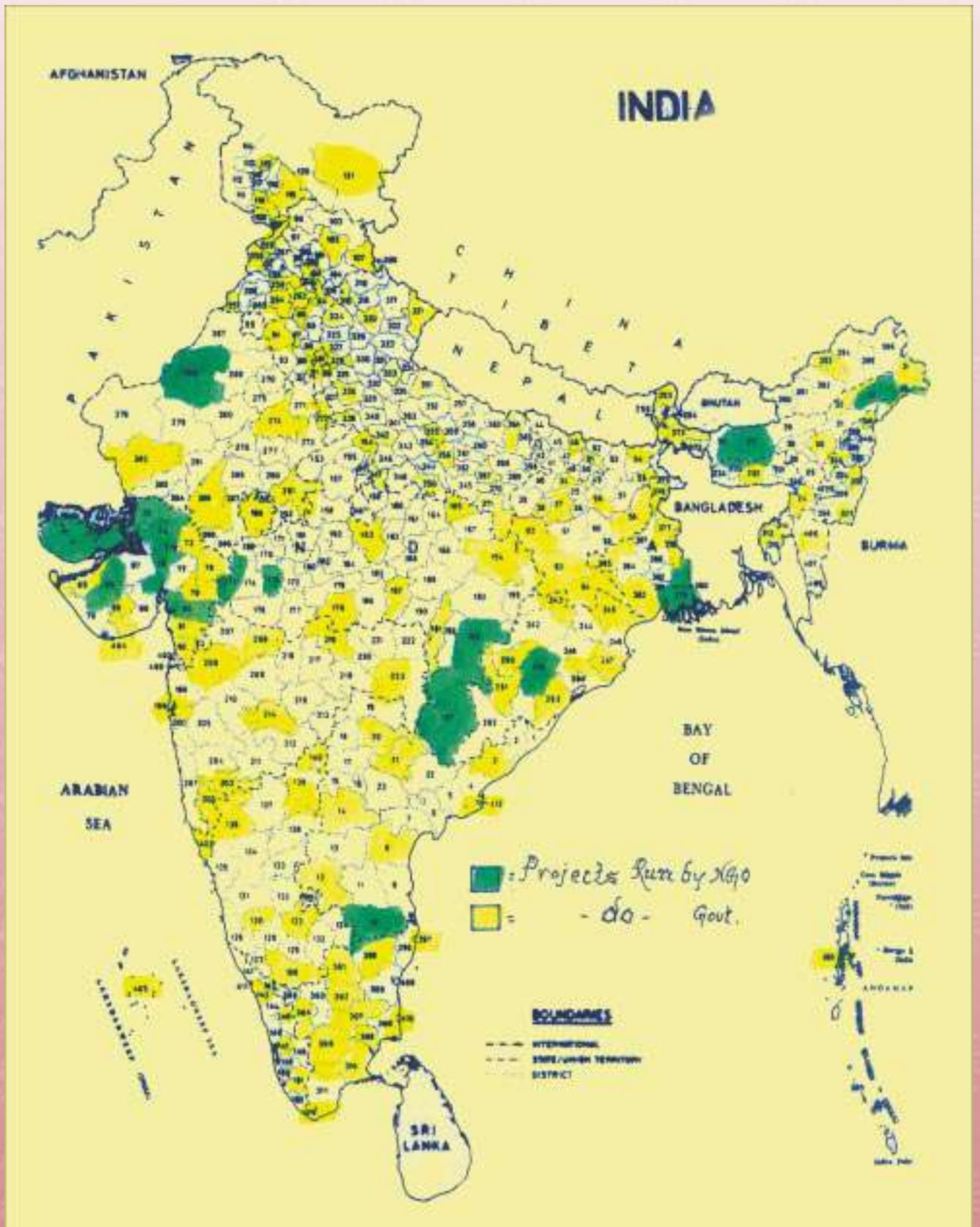
For selection of actual ICDS projects, an attempt was made to select those projects which were run by NGOs wherever possible. Second criteria for selection of the ICDS project included in the study was maximum number of Anganwadi Centres and also its geographical location. This was done to ensure that we should have a representative sample drawn from a larger population. An attempt was also made to plot the selected districts on map which facilitated in planning of deputing faculty/teams for data collection as also adopting cluster approach for the same. Since one of the purpose of the survey was to study the differences in implementation in three categories of ICDS projects, the sample was so selected within each State/UT that it had at least one rural, one urban and one tribal project wherever possible. Thus, the sample covered 150

district in 35 States/UTs. The number of projects drawn from each of the three categories were: 92 rural, 36 tribal and 22 urban. State/district-wise distribution of ICDS projects are given at Annexure 1.

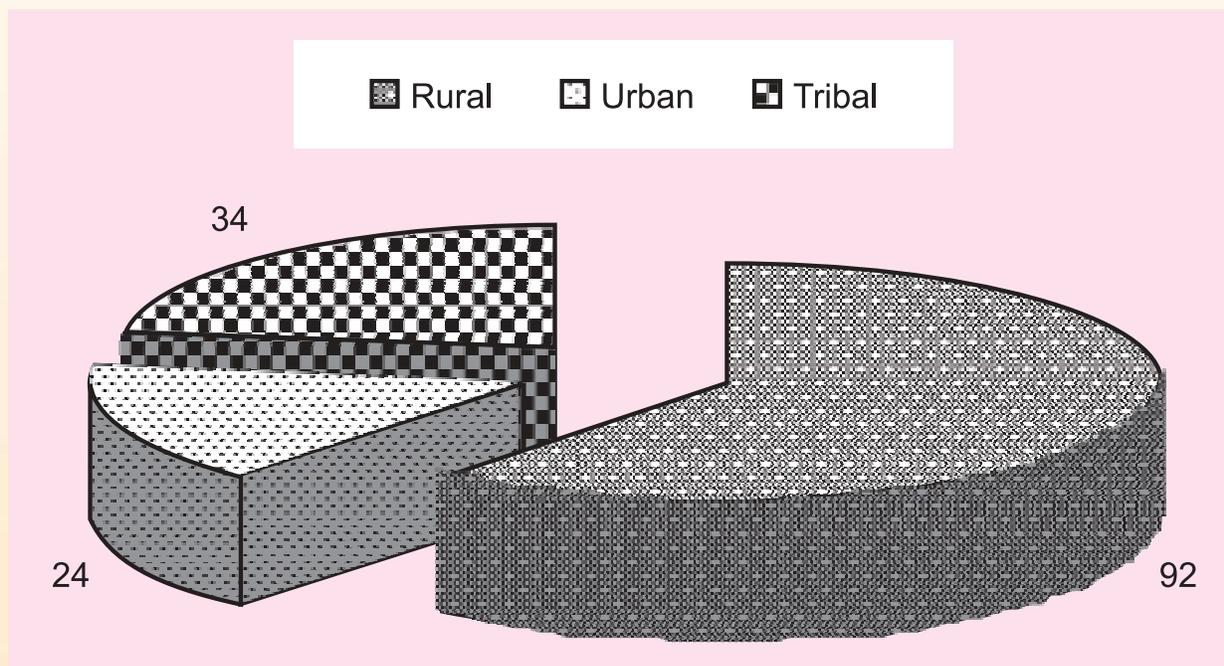
2.2.4 Selection of Anganwadis

A total of five Anganwadi Centres were randomly selected from each sample project. An

Fig. 2.1 : Three Decades of ICDS Sample Districts



Map not to the scale

Fig. 2.2 Sample Projects by Location

attempt was made to select not more than two Anganwadi centres from each of the Supervisory circle. Thus total sample comprised of 750 Anganwadis. Project-wise list of Anganwadis is given at Annexure 1.

Actual beneficiaries from the selected Anganwadis were selected randomly with the list of beneficiaries of Anganwadi Workers. Within the Anganwadi area, a sample of the following categories of target group was selected for in-depth interview and information.

2.2.5 Target Population

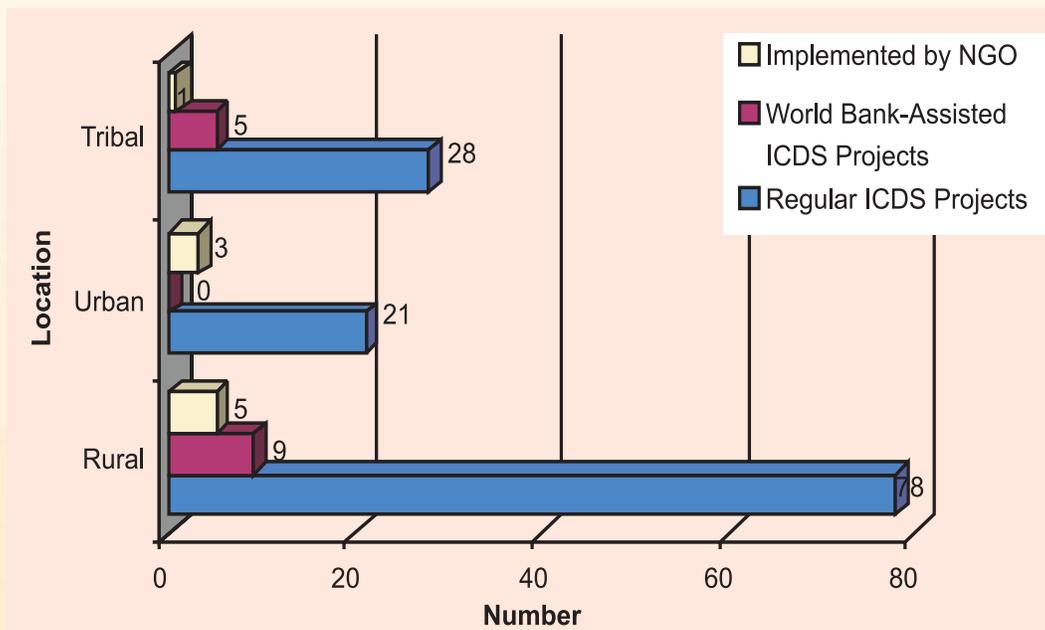
The following sample comprising different categories of target group was included in the study from each Anganwadi Centre.

Other Respondents

In addition to the above target population in the sample, ICDS functionaries and community/opinion leaders were also covered under the study for 150 projects.

Table 2.2 : Sample Projects by Type of Management

S.No.	Type of Project	Rural	Urban	Tribal	Total
i)	Regular ICDS Projects	78	21	28	127
ii)	World Bank- Assisted ICDS Projects	09	-	05	14
iii)	Implemented by NGO	05	03	01	09
	Total	92	24	34	150

Fig. 2.3 Sample Projects by Type of Management and Location

2.2.6 Tools for Data Collection

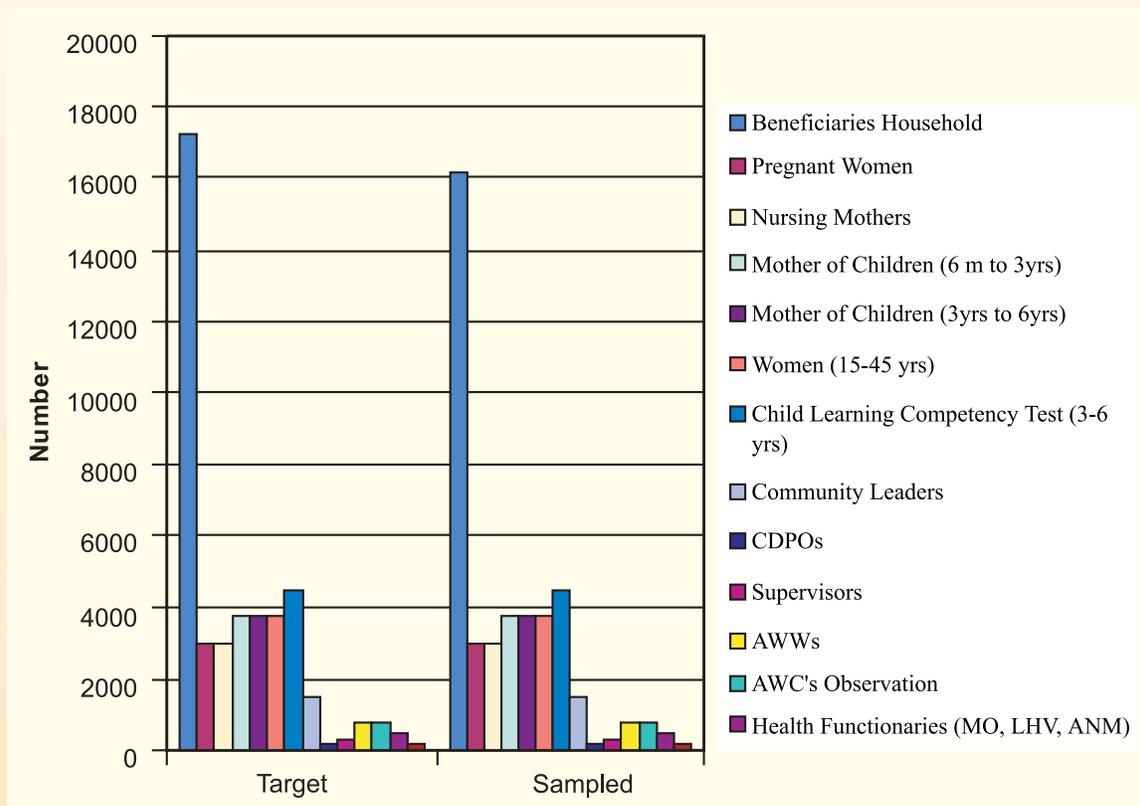
In order to collect the required information and data for the study appropriate proforma/schedules were devised. These were administered to facilitate communication with respondents. Besides interview, observation method was also used for collecting information pertaining to delivery of services at the Anganwadi level. The available reports, records, guidelines, instructions and other documents were form additional source of data. The type of schedules used for data collection were **Household Schedule (HHS)**, **Local Support Schedule**, **ICDS Functionary's Schedules (AWWs, Supervisors, CDPOs)**, **Investigators Observation Schedule** and **Children's Performance Schedule**, and schedules for

Health Functionaries. Category-wise number of schedules administered are presented in Fig. 2.4.

Actual beneficiaries from the selected Anganwadis were selected randomly from the list of beneficiaries of Anganwadi Workers. Within the Anganwadi area, a sample of the following categories of target group was selected for in-depth information.

Efforts were made to cover fixed number of target population sample given above by combing all households of the area. In case of non-availability of expectant and nursing mothers as respondents, additional number of women in the age group 15-45 years were taken, so as to complete the sample of 20 women per unit of the study. The distribution

Fig. 2.4 : Respondent Category & Size (Target & Sampled)



of the target population sample is given in Table 2.3.

The team of ICDS functionaries namely AWWs, Supervisors and CDPOs comprised an important

Table 2.3 : Sample Categories and Size (Target & Actually Sampled)

Sl No.	Schedule Code	Respondent's Category	Target Per Project	Target	Sampled
1	BH-1	Beneficiaries Household	115	17250	16138
2	BP-2	Pregnant Women	20	3000	2983
3	BL-3	Nursing Mothers	20	3000	2975
4	BC-4	Mother of Children (6m to 3yrs.)	25	3750	3733
5	BC-5	Mother of Children (3yrs to 6yrs.)	25	3750	3737
6	BW-6	Women (15-45 yrs.)	25	3750	3771
7	BD-7	Child Learning Competency Test (3-6 yrs.)	30	4500	4474
8	CL-8	Community Leaders	10	1500	1500
9	FC-1	CDPOs	1	150	147
10	FS-2	Supervisors	2	300	294
11	FW-3	AWWs	5	750	748
12	FO-4	AWC's Observation	5	750	748
13	FH-5	Health Functionaries (MO,LHV,ANM)	3	450	444
14	AOB	Additional Observation	1	150	150
		TOTAL	287	43050	41842

set of respondents. The sample of the concerned functionaries from the selected projects included 748 AWWs, 294 Supervisors and 147 CDPOs. Area-wise distribution of functionaries is given in Table 2.3.

In order to assess the involvement and extent of community participation in ICDS programme, two community leaders were interviewed from each of the selected Anganwadi. These were identified out of the following, subject to availability and willingness to participate in the study:

- Pradhan / Sarpanch
- Secretary of Youth Club
- School Headmaster Teacher
- President, Mahila Mandal
- Reputed/Recognised Community leader

In all, 1,500 community representatives were interviewed for the study (Table 2.3).

2.3 Tools

In order to collect the required information and data for the study, appropriate proformae/schedules were devised. These were developed in the form of recording sheets. Besides interview, observation method was also used for collecting information pertaining to delivery of services at AW level. The available reports, records, guidelines and other documents formed additional source of information.

A set of 12 schedules was devised. In view of the magnitude of the data to be collected for the study, these were pre-coded to facilitate

computerization of the data. A two-day Orientation Workshop for faculty members of Headquarters and Regional Centres was held to discuss the tools and other modalities. This was followed by pre-testing of tools by faculty members at Headquarters and all Regional Centres. After pre-testing of tools, another workshop of Regional Coordinators (i.e. Regional Directors) was held to finalise the tools and other operational details. Tools were field-tested before finalising the format for printing. Schedules were printed in English and different colours. This facilitated smoother communication and interaction of investigators with the respondents. Items within each set of schedules were constructed in such a way so as to generate reliable data. The schedules used for the study are described below.

Household Schedule (HHS) : It aimed at getting information on family composition and other background variables as well as vital events regarding children and other members of the family. It elicited information with respect to utilisation of services such as health, nutrition and education by concerned members of the family.

Schedule for Beneficiaries: Five types of schedules to cover various categories of beneficiaries namely, expectant and nursing mothers, women in the age group 15-45 years, children 0-3 years and 3-6 years were prepared. These were administered to women respondents and mothers of children under six years of age. The information collected was related to utilisation of services, perceptions and views regarding ICDS programme and the quality of benefits derived from the project inputs.

Schedule for Community Leaders: It aims at getting a feedback from the various organisations and community representatives

Fig. 2.5 : Three Decades of ICDS: An Appraisal – Time-line & Landmarks

S. No	Activity	May, 2005	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06
1	Request from Vice-Chairperson-cum-Secretary, DWCD for Proposal	■										
2	Submission of TOR / Project Proposal to the Department of Women and Child Development		■									
3	Approval of the Project		■									
4	Preparatory Phase -Formulation of Tools			■								
5	Workshop of core research team			■								
6	Pre-testing of Tools				■							
7	Workshop of Regional Coordinators					■						
8	Approval of Revised Budget					■						
9	Printing of Schedules					■						
10	Liaison with State Governments for Data Collection					■						
11	Data Collection					■	■	■	■			
12	Identification of Computer Agency i.e. New Concept Information System Pvt. Ltd. For computerization of data							■				
13	Data entry and verification								■			
14	Data Validation								■			
15	Data Analysis and Tabulation								■	■		
16	Report Writing and Processing of Manuscript								■	■	■	
17	Preparation of Draft Report								■	■	■	■

regarding their involvement and participation in ICDS. The schedules were administered to an available representative from any two of the specified organisations, namely Panchayat, Mahila Mandal, Cooperative Society, Primary School or other Voluntary Organisation at Anganwadi level.

Schedule for Functionaries: Four schedules were designed to collect information from functionaries namely, AWWs, Supervisors, CDPOs and Health functionaries namely; Medical Officer in-charge of PHC, LHV and ANM of Sub-Centres. These provided the profile, and role played by them in implementing the programme. Feedback was also taken with respect to problems faced by them in implementing the scheme. Anganwadi Workers' Schedule included detailed information on vital statistics of the village and infrastructural facilities available at Anganwadi. The skills of the workers on tasks related to growth monitoring, pre-school education, nutrition and health education, etc. were also rated. Investigators observed the performance of selected children for physical, motor and cognitive abilities to ascertain the quality of non-formal pre-school education component of the scheme with the help of Child Learning Competency Test (CLCT) proforma.

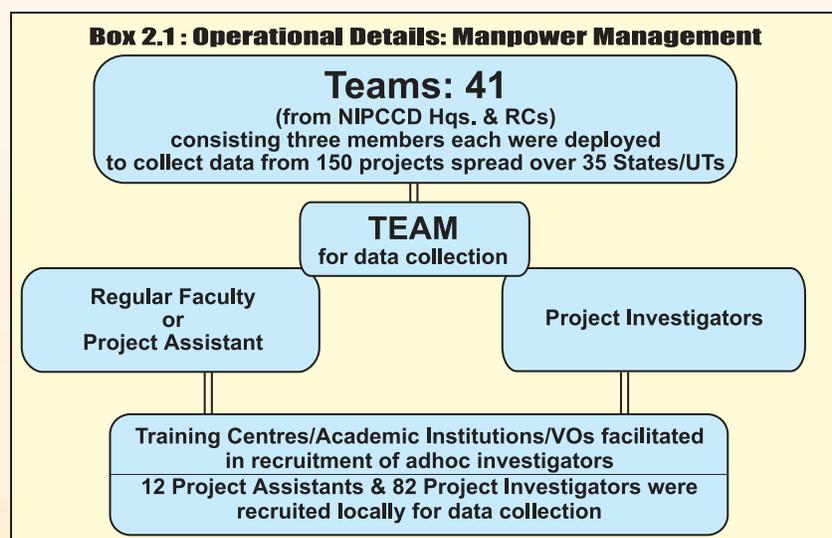
The success of ICDS programme is greatly influenced to the extent it gets administrative, financial and service delivery inputs like manpower, training, infrastructural facilities, coordination and convergence with health and

other allied departments, attitude and involvement etc. In order to gather details on these aspects, another proforma was developed to obtain additional information from all the 35 States/UTs and sent to the Directors dealing with ICDS. These information would have wider ramifications for policy formulation, programme planning and implementation of ICDS in coming years.

2.4 Operational Details

Needless to say, implementation of a research project of this kind required careful planning of logistics and other operational details. It warranted cooperation from various State Departments associated with ICDS, to facilitate data collection by the research team of NIPCCD. The circular / communication readily issued by the Ministry of Women and Child Development to that effect proved extremely useful in ensuring necessary assistance of the concerned ICDS officials during data collection.

Networking of NIPCCD with training centres, academic institutions and voluntary agencies, spread all over the country further facilitated recruitment of ad-hoc Enumerators hired locally for data collection in different projects. The cooperation extended helped not only in identification of suitable individuals but also in holding interviews and providing venue for training of the research team (Box 2.1).



2.5 Manpower Planning

Selected faculty members of NIPCCD Hqrs. and its Regional Centres having research and field experience were associated with the study. Research teams consisting of three to four members in each team, were deployed to collect data from 150 ICDS blocks spread over 35 States/UTs. Each team composed of either one regular faculty member of NIPCCD or one Project Assistant, and two to three research investigators recruited locally at the project level (Table 2.3). Senior faculty members at Hqrs. and Regional Directors at Regional Centres were assigned the task of coordinating the teams, monitoring and supervising data collection, and maintaining liaison with the concerned State Government for smooth completion of data collection within the stipulated time of 12 to 15 days per project.

For collecting data all teams worked simultaneously in different projects from September 2005 to 15 January, 2006. In all, three and half months were spent in data collection.

2.6 Ensuring Data Quality

Several measures were taken to generate and collect reliable and good quality data (Box 2). NIPCCD Headquarters

monitored and coordinated the implementation of the research project. The design, scope of the study and tools were planned in consultation with faculty members and Regional Coordinators. In addition, two workshops one for the selected faculty members and another for Coordinators were organized to discuss the tools and *modus operandi* of data collection work. All members of the research teams concerned with data collection were given training in procedures of implementing the design, with a focus and emphasis on filling up the schedules and its

Box 2.2 DATA QUALITY

Measures taken:

- ⇒ Preparation of detailed Guidelines
- ⇒ Preparation of Pre-coded Interview Schedules
- ⇒ Orientation Workshop of NIPCCD Faculty & Regional Coordinators
- ⇒ Rigorous training to field staff
- ⇒ Editing to detect errors & omissions in entries of the schedules
- ⇒ Data revalidation at the time of entry & validation with the help of “Clipper” software
- ⇒ Checked range/consistency of every coded response
- ⇒ Manual checking of 10% entries

coding frame. The orientation included conducting of mock interviews, practice in coding schedules, etc. A manual containing guidelines and instructions for collection of data was prepared and provided to all concerned for ready reference. A copy of the same is enclosed at Annexure 2.

The team leaders provided training to the Enumerators before commencement of data collection at the project level. They were expected to check and countersign every schedule administered by the Enumerators. Supervisors (senior faculty members of NIPCCD or Project Assistants) visited various data collection sites to oversee the implementation of the study.

Rigorous editing was carried out to detect errors and omissions in entries of the schedules. Once the data collection was over, workshops of two days duration each, were held at the Institute's Headquarters and four of its Regional Centres for Data Cleaning. Data Cleaning is aimed at ensuring accuracy, reliability, internal and external consistency and uniformity in data. Further, it improved the fitness of data for entry and tabulation. The data was further revalidated at the time of data entry by using specially developed software to **check range / consistency of every coded response of all schedules**. Besides this, manual checking of approximately 10 percent entries was carried out in database tables (on continuous sheet) to eliminate errors arising during data entry.

2.7 Computerisation and Analysis

The Institute identified M/s. New Concept Information System for computerisation and data analysis for the study. Two staff members of the said agency and a Principal System Analyst were assigned this task. They became integral members of the research team and worked in close liaison with concerned faculty members of NIPCCD from initial stages of planning to data analysis. Their technical input proved useful in identifying data entry agency, creating database files and in generating tables, graphs, etc.

The data was entered in database (a popular relational data base package) the resultant database was converted to appropriate file formats for further analysis. Another popular software entitle SPSS (Statistical Package for Social Sciences) was used to generate final tables.

The formats of data files were prepared in such a way that the data could be used in variety of ways for subsequent analysis. The database has been created project-wise with an intention to optimally utilise the valuable empirical information for other purposes, besides the present study. It can be disaggregated at the State and Project levels. State Departments, individuals/ agencies concerned with ICDS can have access to the information after getting permission from the Ministry of Women and Child Development.

2.8 Parameters/Indicators of Appraisal

In order to cover all services of ICDS, input, output and outcome model was used and following

input, output and outcome indicators were selected.

2.8.1 Inputs Indicators

- Project location
- Profile of functionaries-- age, qualification, skills, training etc. Number of years and experience
- Infrastructural facilities, AWCs setup, equipment and supplies
- Supportive supervision
- Number of visits of supervisor, kind of inputs etc.
- Time allocation for different services
- Coordination and convergence with Health and other allied Departments
- Community and state's holders support
- Contribution and participation of target group in the programme
- Quantum and SNP- Quality and Regularity
- Knowledge level of AWW-helper
- Attitude and involvement of Functionaries
- Procurement of PSE and Medicine kit

2.8.2 Output Indicators

- Coverage of target group by services, immunisation, health check-up, supplementary nutrition, referral services, prophylaxis (Vitamin A, Iron, Iodine, folic acid), pre-school education
- Outreach in terms of eligibility criteria and norms

- Attendance pattern and utilisation of services
- Registration of eligible beneficiary
- Acceptability of supplementary nutrition in terms of quantity, quality, variety and taste, and substitute food
- ANM visits, frequency and inputs

2.8.3 Outcome Indicators

- Maternal Mortality Rate
- Still Birth Rate
- Supervised delivery of services
- Extent of pre-natal and post-natal care available to pregnant and expectant and nursing mothers as counselling services
- Prevalence of malnutrition – weight for age among children (0-6 yrs)
- Stunted Growth (0-6 years) – height for age
- Practices of Early Young Childhood Care, and feeding and weaning
- Early detection of disability among children
- Enrolment rate, retention and dropout rate in primary school
- Effect of pre-school education on primary school enrolment
- Cognitive and language competence of children 3-6 years
- Knowledge and awareness of adolescent and mothers about reproductive health issues.



2.8.4 Other Parameters

Besides the above listed indicators following aspects were also be assessed :

- Support service provided by households to ICDS/Child Development Programme
- Community leader's perceptions regarding constraints in covering disadvantaged sections
- Contribution of adolescent girls to Anganwadis
- Problems faced by functionaries in delivery of ICDS services
- Attention received by women at the time of delivery and during post-natal period
- Contributions of Community leaders/PRIS in implementation of ICDS
- Perception of beneficiaries of ICDS programme of its services
- Perception of beneficiaries regarding life of 5 years old children
- Utilisation of programmes/services rendered by rural development department, micro credit (Self-Help Groups), Balika Samridhhi Yojana, Women Technology Park, employment generation schemes and other programmes and services leading to convergence and integration
- Innovative practices introduced in implementation of the programme

2.8.5 Summarising of Data

The data was tabulated for the input, output and outcome indicators identified. In a few cases,

bivariate tables have been created. Simple statistical measures such as frequencies, percentages, averages and ranges have been used for interpretation. An attempt has also been made to present data graphically wherever possible. The analysis is also presented separately for rural, tribal and urban projects and has been collated for providing a national level picture. An effort has also been made to compare the findings of the present study with the results of other evaluations carried out at the national, state and project level, wherever possible.

2.9 Limitations of the Study

The research team faced certain constraints (like difficult terrain in hilly area and intense rainfall in the South Coastal belt of our country during the course of data collection) which sometimes affected smooth data collection of the study. The major obstacle in data collection was naxalites/militants in remote tribal areas and some part of north-eastern region.

A master copy of all the interview schedules was translated into local languages to facilitate enumerators in data collection. However, since several people were involved in data collection, some human errors were noticed which were rectified during data cleaning. Secondly accommodation for the members of the research team could not be made in the project area because of several constraints. The research team had to travel considerable distances at times.

2.10 Presentation of the Report

In accordance with the objectives of the study, the differences in implementation of ICDS in rural, tribal and urban projects were ascertained. The figures were also collated for national level status. The findings with respect to various aspects are presented in the subsequent sections of the report under the following heads:

- * Infrastructure and Profile of Respondents
- * Delivery of Services and Outcomes : An Assessment

- * Benefits and Outcomes of ICDS
- * Innovation and Best Practices
- * Conclusions and Recommendations

This report has been prepared after analysing selected indicators (Annexure 3) considered crucial for appraisal of ICDS programme. However, the data has the potential to further generate State-wise and Project-wise reports.



Chapter 3

Infrastructure and Profile of Respondents



3.1 Infrastructure

- 3.1.1 Drinking Water
- 3.1.2 Roads
- 3.1.3 Physical Set-up of AWCs
- 3.1.4 Availability of Space in AWCs
- 3.1.5 Availability of Equipments and Aids
- 3.1.6 Availability of Utensils

3.2 Profile of Functionaries

- 3.2.1 Staff Position
- 3.2.2 Status of Training
- 3.2.3 Selection of AWWs
- 3.2.4 Educational Qualification of Workers
- 3.2.5 Supervisors
- 3.2.6 CDPOs
- 3.2.7 Other Detail about ICDS Projects



3.3 Profile of Beneficiaries

- 3.3.1 Target Population in Sample Households
- 3.3.2 Main Occupation of Sample Households
- 3.3.3 Subsidiary Occupation
- 3.3.4 Household Assets
- 3.4 Coordination in ICDS
- 3.5 Convergence of Services in ICDS
- 3.6 Community Participation
- 3.7 Summing-up

Infrastructure and Profile of Respondents

3.1 Infrastructure

Infrastructure is an umbrella term for a number of services such as power, transport, housing, roads, drinking water etc. The development and expansion of infrastructure is an essential pre-requisite for the prosperity of any nation. It has been perceived that link between infrastructure and development is not a once-for-all effort. It is a continuous process and progress in development has to be preceded, accompanied and followed by development in infrastructure. Planners of ICDS programme were fully aware of the link between infrastructural facilities and all round development of children. Strategy of Department (Now Ministry) of Women and Child Development, Government of India in terms of coordination and cooperation with other departments of Government of India attached high priority to the development of efficient infrastructure so as to create an enabling environment for all-round development of children.

Linkage of ICDS programme with other developmental programmes to augment infrastructural support was used as a major strategy in earlier plan periods. Convergence of services was considered as a vehicle for infrastructural development and improving the quality of life of Women and Children. Since adequate infrastructural facilities are a pre-requisite for successful implementation of any programme, therefore, in this section of the

Chapter an effort has been made to assess the availability of various facilities in ICDS areas.

Sanitation Facilities

Sanitation facilities are most important for reduction in mortality and morbidity in rural and tribal areas. Even at the turn of the new millennium and almost a decade since reform began, a meagre 25 percent of rural population was covered by adequate sanitation in comparison to 70 percent in urban areas. Tribal population possessed this facility in around 18 percent of villages. This is also of immediate concern to reduce infant mortality and a major cause in diarrhoea, which occurs mostly due to oral focal infection.

Data from the study showed that only 31 percent of the households had toilet facilities. Sewage / drainage system was reported in 30% of villages under regular ICDS projects whereas 27 percent of World Bank-Assisted villages of these projects were having such facilities. Four (41.9%) out of ten villages of projects covered by NGOs had these facilities also. While around 41 percent of Anganwadis had also toilet facilities, 17% of these facilities were unsatisfactory and 59% of AWC were deprived of this amenity. Sanitation thus remains a crucial area of concern where more concreted efforts need to be put in.

The position of educational facilities in villages covered in the sample is given in Table 3.1.

Table 3.1 : Type of Educational Facilities Available in Villages (N=748)

Location	Primary school I – V (%)	Middle school VI – VIII (%)	High school (%)
Rural	424 (92.6)	273 (59.6)	165 (36)
Tribal	158 (92.9)	94 (55.3)	57 (33.5)
Urban	101 (84.2)	90 (75.1)	72 (60.0)
Total	683 (91.3)	457 (61.1)	294 (39.3)

Table 3.1 shows that educational facility of lower primary school (class I-V) was existing in nine out of 10 villages (91.3%). Middle school (VI-VIII) facility was available in 61 percent of villages whereas high schools were functioning in 39 percent of sample areas. Table 3.1 further indicates the satisfactory status of existence of primary schools (93%) both in rural and tribal areas followed by 84% in urban areas.

Data was also collected on some other important facilities such as Primary Health Centres (PHCs), sub-centres and means of communication. Table 3.2 summarises the availability of these services in sample villages.

It is evident from Table 3.2 that about 97 percent of the anganwadi centres in urban areas, 93 percent in rural areas and 74 percent in tribal areas were connected by roads. Rail connections were available in less frequency in the habitations

where AWCs were located. In fact, in all, only 16 percent of the centres were connected by Rail, the highest percentage being 52 in urban areas. Post office

was available in around 55 percent of the anganwadi areas, again with highest percentage of about 68 in urban areas. Primary Health Centres and sub-centres were available in 29 percent and 43 percent, respectively, in anganwadis areas. The data thus reveals that accessibility to important services of health were limited.

Information was also collected on the availability of telephone connections and LPG in the project area. Data revealed that around 89 percent of rural project areas, 94 percent urban and 68 percent of the tribal project areas had telephone connection facilities. Another interesting information was availability of LPG in 72 percent of the Anganwadi areas. Ninety-one percent of urban projects had this amenity followed by 75 percent in rural ICDS projects and about 50 percent in tribal projects.

3.1.1 Drinking Water

Safe drinking water is still a luxury for millions of women and children - though coverage of population with drinking water supply has increased rapidly. Providing clean and safe drinking water

Table 3.2 : Type of Facilities Available in AWCs (N=748)

Location	Primary Health Centres (%)	Sub-Centres of PHCs (%)	Post Office (%)	Connection by Rail (%)	Connection by road (%)
Rural	109 (23.8)	194 (42.4)	240 (52.4)	41 (9.0)	428 (93.4)
Urban	59 (49.2)	47 (39.2)	82 (68.3)	62 (51.7)	116 (96.7)
Tribal	51 (30.0)	81 (47.6)	92 (54.1)	15 (8.8)	125 (73.5)
Total	219 (29.3)	322 (43.0)	414 (55.3)	118 (15.0)	669 (89.4)

has emerged as major challenge in ICDS project areas especially in far flung rural and tribal areas.

Table 3.3 (Fig. 3.1) reveals the source of water supply to Anganwadis Centres. It would be seen that hand pump and tap water were the main sources of water in majority of the Anganwadis Centres, thereby proving that ICDS has succeeded to a large extent in providing safe drinking water to the children. Only a small percentage of Anganwadi Centres specially in rural and tribal areas were dependent on well and

3.1.2 Roads

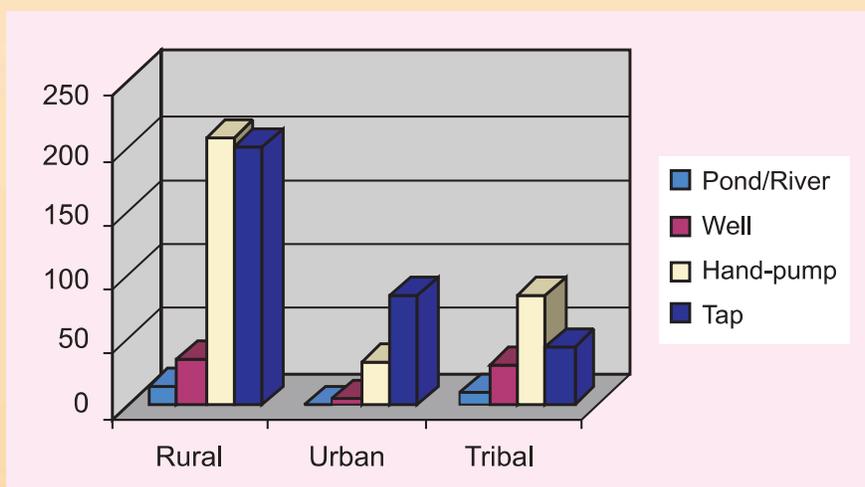
Villagers believed that promotion of rural roads has one of the most beneficial impact on rural and tribal population. Investment in roads not only reduced rural poverty through productivity growth but also through increased non-agricultural employment opportunities and higher wages (et al, 2000:35.8.7) Empirical data also show positive relationship between rural connectivity and development; rural roads provided vital links that foster effective access to and utilisation of a host of important social and physical infrastructure like access to PHCs, schools, market, numerous benefits were attributed by leaders to rural road development including increased agricultural production, better farm prices, growth of dairying, better educational standards and higher life expectancy, in short, balanced and faster development of rural areas. Construction and maintenance of rural roads

Table 3.3 : Source of Water Supply to Anganwadi Centres

Location	Pond / River	Well	Hand Pump	Tap	Total
Rural	14 (3.10)	36 (7.96)	207 (45.2)	201 (43.9)	458 (100.0)
Urban	0 (0.0)	4 (3.3)	32 (26.2)	84 (70.0)	120 (100.0)
Tribal	10 (5.8)	30 (17.6)	85 (50.0)	45 (26.4)	170 (100.0)
Total	24 (3.2)	70 (9.3)	324 (43.3)	330 (44.1)	748 (100.0)

pond water supply. Provision of tap and handpump water supply also proves that there has been convergence of services under different schemes of development like PHED, JRY, NRY etc.

Fig. 3.1 Source of Water Supply at AWCs



in sample villages have remained an important component in a number of development schemes including Food for Work Programme, Minimum Needs Programme, National Rural Employment Programme (NREP), Rural Landless Employment Guarantee Programme (RLEGP) and Jawahar Rozgar Yojana. Further, the Basic Minimum Services Programme (Rural Roads) envisages connectivity of all villages and habitations by all weather roads. Benefits accrued due to these programme initiatives

were evident from the fact that 97 percent of centres in urban areas, 93 percent in rural areas and 74 percent in tribal areas were connected by roads.

3.1.3 Physical Set-up of Anganwadi Centres

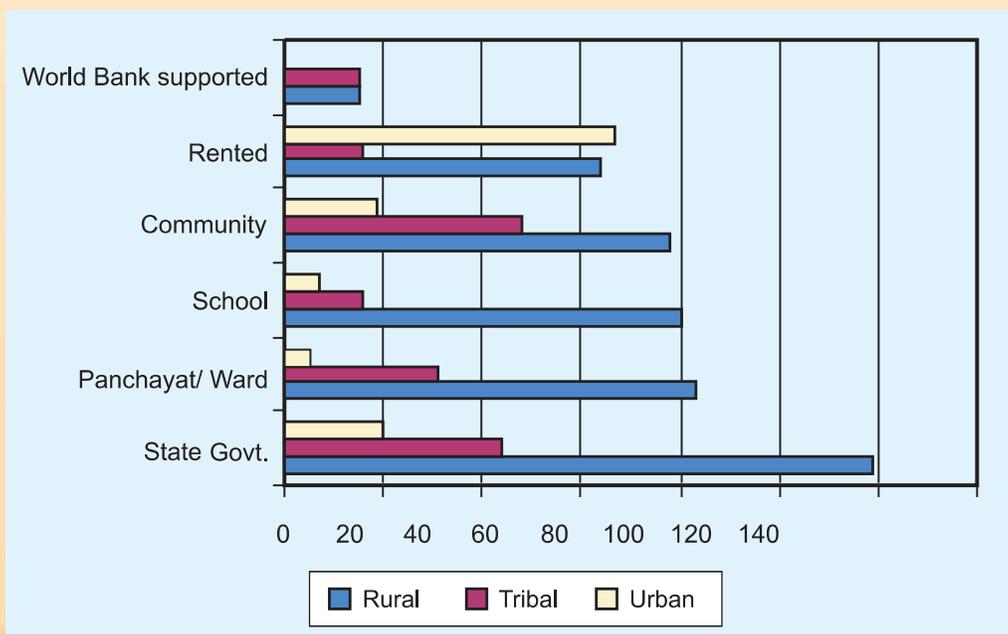
Data was collected on different aspects of physical set up of Anganwadi Centres in terms of location, ownership of buildings, availability

Table 3.4 : Ownership of the building of AWCs (N=727)*

Location	State Govt. (%)	Panchayat/ ward (%)	School (%)	Community (%)	Rented (%)	World Bank construction (%)	Total (%)
Rural	119 (26.0)	83 (18.1)	80 (17.5)	78 (17.0)	64 (14.0)	15 (3.3)	439 (96.0)
Tribal	44 (25.9)	31 (18.2)	16 (9.4)	48 (28.2)	16 (9.4)	15 (8.8)	170 (100.0)
Urban	20 (16.7)	5 (4.2)	7 (5.8)	19 (15.8)	67 (55.8)	0 (0.0)	118 (98.0)
Total	183 (24.5)	119 (15.9)	103 (13.8)	145 (19.4)	147 (19.7)	30 (4.0)	727 (97.2)

* Value of NR not included

Fig. 3.2 Ownership of AWC Building



of space, accessibility, availability of equipments and teaching aids etc. Table 3.4 and Fig. 3.2 describe the ownership of the buildings of AWCs.

It would be seen from Table 3.4 that about 25 percent of the buildings of AWCS in all areas were provided by the State Government. About 19 percent buildings or building sites were provided by the community with Panchayats'

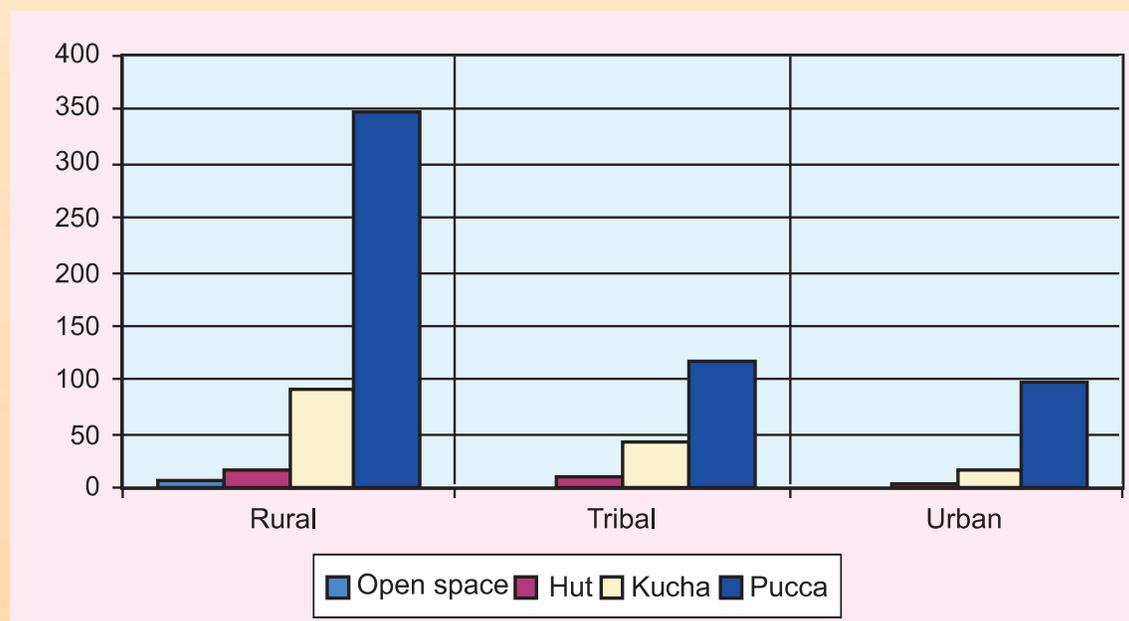
contribution to 16 percent of the buildings. About 14 percent of the AWCs were housed in school buildings. Table 3.5 and Fig. 3.3 summarise the type of buildings.

It is a matter of satisfaction to note that majority of the Anganwadi Centres were located in pucca buildings. It seems that enough strides have been made in provision of pucca buildings to Anganwadi Centres since last one decade. In the National Evaluation of ICDS by NIPCCD in 1995 only 50 percent of buildings of AWC were found to be located in pucca buildings whereas in the present study more than 75 percent of the centres were found located in pucca buildings which is definite sign of improvement of the ICDS infrastructure.

Table 3.5 : Type of Buildings (N=748)

Location	Open space	Hut	Kucha	Pucca	Total
Rural	5 (1.1)	16 (3.5)	90 (19.7)	347 (75.8)	458 (100.0)
Tribal	0 (0.0)	10 (5.9)	42 (24.7)	118 (69.4)	170 (100.0)
Urban	0 (0.0)	4 (3.3)	17 (14.7)	99 (82.5)	120 (100.0)
Total	5 (0.7)	30 (4.0)	149 (19.9)	564 (75.4)	748 (100.0)

Fig. 3.3 Type of Anganwadi Centre Building



3.1.4 Availability of Space in AWCs

AWCs need to be arranged to provide space for group activities. Ideally it should have a sufficient covered floor area for children to sit on for different, individual and group. AWCs should also have provision for display of children's work as well as charts, posters, pictures. There should be separate space for cooking and storage of supplementary nutrition items etc. Black board provision at low height also needs to be made if possible. AWCs should have adequate play materials for free play and mechanism for replacing these when broken or worn out. Organisation of space of AWCs also calls for skills in AWWs. Information was gathered in respect of availability of space for different activities of AWCs as presented in Table 3.6.

Table 3.6 : Adequacy of Space in AWCs

Location	Outdoor	Indoor	Availability of separate storage
Rural	245 (53.5)	256 (55.9)	234 (51.1)
Tribal	87 (51.2)	86 (50.6)	95 (55.9)
Urban	53 (44.2)	43 (35.8)	47 (39.2)
Total	385 (51.3)	385 (51.5)	376 (50.3)

Table 3.6 shows that space was a problem in most of the Anganwadi centres in urban areas. Adequate outdoor and indoor space and separate space for storage was available in only 44, 36 and 39 percent of the Anganwadi centres. This situation was a little better in rural and tribal areas.

However, overall, about 49 percent of the Anganwadi centres had inadequate space for outdoor and indoor activities and 50 percent had no separate space for storage of various materials.

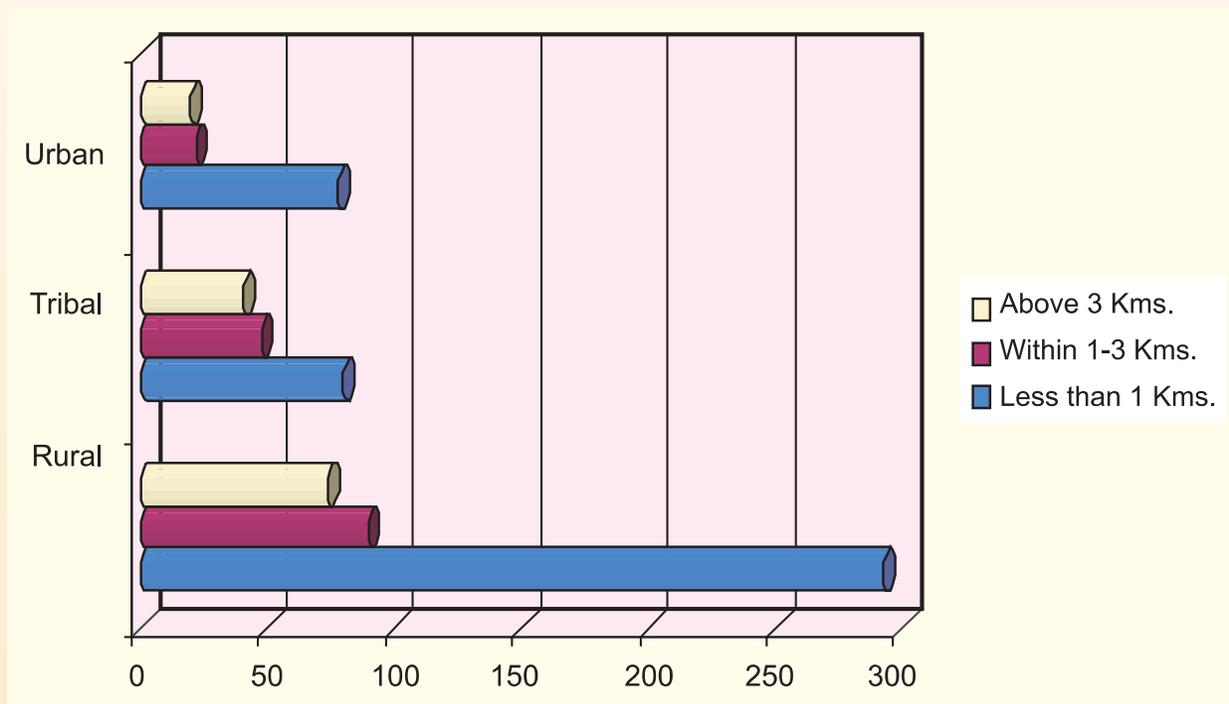
Information was also gathered in respect of availability of separate cooking space. It was found that 81 percent World Bank-Assisted ICDS Projects had this facility followed by NGO-run projects (53.49%) and regular ICDS projects (43.94%). Around half (49.0%) of the rural and tribal (50.6%) projects had adequate cooking space separately and 40 percent of urban projects. Thus the data shows that more efforts are required to improve these facilities at the Anganwadi Centres as these are crucial for effective implementation of the programme.

Accessibility of AWCs

Most of the AWCs (60.3%) were easily accessible to children as they were brought either by their parents/ siblings/ older ladies of the locality. Child-to-child approach was also observed to ensure presence of children at the time of supply of supplementary nutrition. In rural and tribal areas, children were coming on their own from nearby vicinity of Anganwadis. Helpers mainly concentrated in bringing newly admitted children to Anganwadis. Table 3.7 and Fig. 3.4 summarise

Table 3.7 : Accessibility of AWCs for Children & Mothers (N=748)

Location	Distance to be covered by children & mothers to reach AWCs			
	Less than 1 km (%)	Within 1-3 km (%)	Above 3 km (%)	Total (%)
Rural	293 (64.0)	90 (19.7)	74 (16.2)	458 (100.0)
Tribal	80 (47.1)	48 (28.2)	41 (24.1)	170 (100)
Urban	78 (65.0)	22 (18.3)	20 (16.7)	120 (100)
Total	451 (60.3)	160 (21.4)	135 (18.0)	748 (100)

Fig. 3.4 Distance Covered to Reach AWC by Mothers & Children

the data with regard to accessibility of the Anganwadi Centres.

It is noticed that in tribal areas about 52 percent of children had to travel more than one kilometer and sometimes even more than 3 kilometers to reach the Anganwadi Centres. Implications of this finding will be related to attendance of children and availing of services in the Chapter 4 of this Appraisal on Delivery of Services.

3.1.5 Availability of Equipments and Aids

Weighing Scales

Regular weighing of children is very important to identify the 'at risk' children because

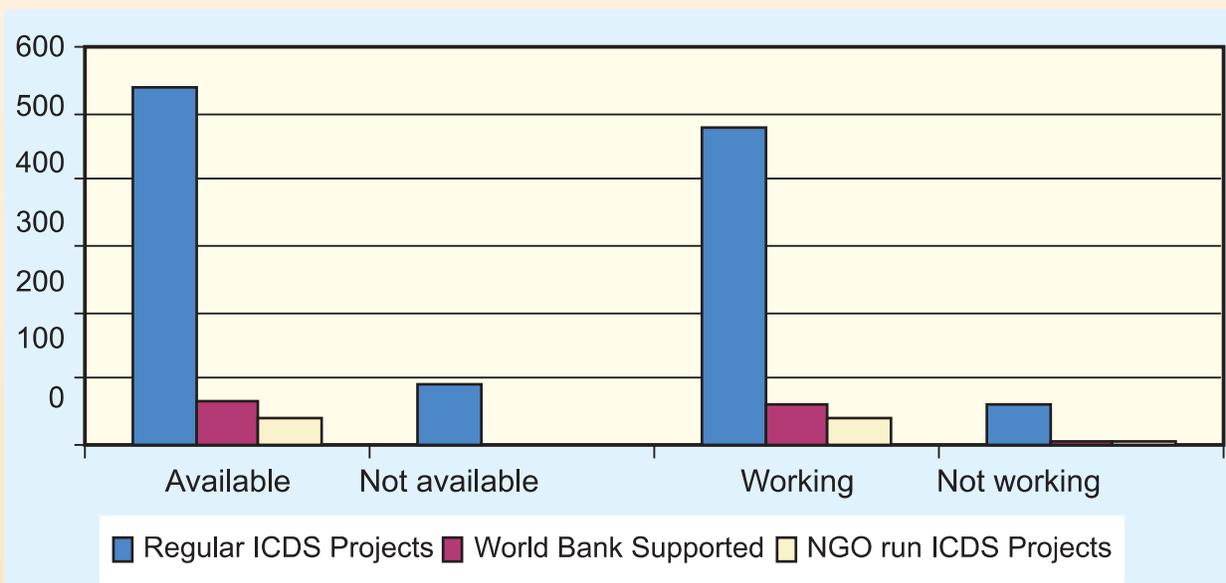
special care has to be given to following category of children.

- Children with birth weight of less than 2.5 kg
- Children who lose weight for two successive months
- Children in grade III and IV

Above category of children are to be separately listed and weighed carefully. In order to perform above tasks weighing scale is of vital value and it is supposed to be supplied to all AWCs. Position with regard to availability and use of weighing scales is given in Table 3.8 and Fig. 3.5.

Table 3.8 : Availability of Weighing Scale and its Working Condition

Nature of Project	Availability of Weighing Machine		Working condition	
	Available (%)	Not available (%)	Working (%)	Not working (%)
Regular ICDS Projects	540 (85.0)	90 (14.1)	477 (88.3)	63 (11.7)
World Bank- supported	68 (97.1)	02 (2.8)	63 (92.6)	05 (7.4)
NGO-run ICDS Projects	41 (95.3)	02 (4.6)	39 (95.1)	02 (4.9)

Fig. 3.5 Weighing Scales - Availability & Condition

The table points out that weighing scales were available in 97 percent Anganwadis of World Bank-Assisted ICDS Projects followed very closely by NGO-run projects (95.3%) and 85 percent of regular ICDS projects. Around 91 percent of them were in working condition also. The data reveals that an overwhelming majority of AWCs had the facility to measure nutritional status of children. It was learnt from AWWs that weighing scales were shared with other AWCs where they were defective.

Equipments and Aids

AWCs have been supplied PSE kits, toys, counting frame, primers, picture books, play materials and equipments. Data was collected regarding their adequacy or otherwise to find out their contribution as an input for delivery of services. Position of these aids, equipments and materials according to the nature of project has been presented in Table 3.9.

It may be seen that PSE Kit was not available in majority of the Anganwadi Centres run under

Table 3.9 : Availability of PSE Kits (N=748)

Nature of Project by Management	Available (%)	Not Available (%)	No Response (%)	Total (%)
Regular ICDS	359 (56.5)	275 (43.3)	1 (0.10)	635 (100.0)
World Bank- Assisted	29 (41.4)	41 (58.6)	0 (0.0)	70 (100.0)
NGO-Run	30 (69.8)	13 (30.2)	0 (0.0)	43 (100.0)
Total	418 (55.9)	329 (44.0)	1 (0.10)	748 (100.0)

which needs to be looked into by the programme implementers carefully. Data with regard to other aids is given in Table 3.10.

A glance at the above table reflects inadequacy of the play materials in most of the

the World Bank-Assisted projects whereas majority (56.5%) of the regular ICDS projects had PSE Kits. PSE is an important component of ICDS programme, hence, availability of the kit is crucial to the successful delivery of the programme. Non-availability of the kits in 44 percent of the centres is a matter of concern

Anganwadi Centres which calls for serious efforts to augment the supply of these to the ICDS projects.

3.1.6 Availability of Utensils

Supplementary nutrition is of paramount importance in ICDS project not

Fig. 3.6 Availability of PSE Kits

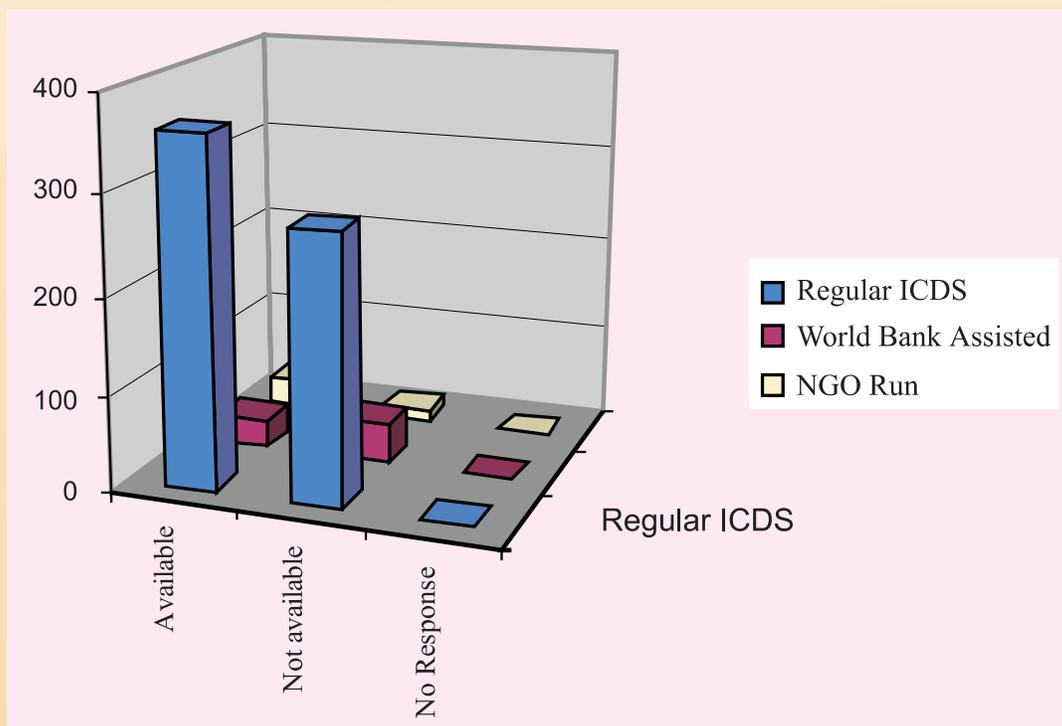


Table 3.10 : Availability of Aids & Equipments and Play Materials (N=748)

Types of aids / equipments / play materials	Nature of Project					
	Regular ICDS (%)		World Bank-supported (%)		NGO-run project (%)	
	Adequate	Inadequate	Adequate	Inadequate	Adequate	Inadequate
Toys	172 (27.1)	315 (49.6)	18 (25.7)	30 (42.9)	23 (53.5)	19 (44.2)
Counting frame	150 (23.6)	274 (43.1)	12 (17.1)	36 (51.4)	12 (27.9)	14 (32.6)
Aids material by AWW	172 (27.1)	315 (49.6)	18 (25.7)	30 (42.9)	23 (53.5)	19 (44.2)
Primer	84 (13.2)	173 (27.2)	08 (11.4)	18 (25.7)	26 (60.5)	11 (25.6)
Picture Book/ Story Book	161 (25.4)	214 (33.7)	08 (11.4)	29 (41.4)	19 (44.2)	18 (41.9)

only to meet nutritional requirement of beneficiaries but also promotion of attendance. Availability of adequate number of cooking and serving utensils in the Anganwadi Centres is of paramount importance to the success of the nutrition programme. Table 3.11 summarises the availability of cooking and serving utensils in the Anganwadi Centres. It is evident from Table 3.11 that cooking utensils were available in 61.8 percent rural, 49.2 percent urban and 65.9 percent of the tribal projects whereas serving utensils were found 60.5

percent. This data also suggests non-availability of utensils in quite a large number of Anganwadi Centres which would be adversely affecting the functioning of supplementary nutrition programme.

3.2 Profile of Functionaries

3.2.1 Staff Position

Figs 3.7 & 3.8 describe the staff position of the project areas.

Table 3.12 shows that 15 percent of the positions of CDPOs, 48 percent of ACDPOs

Table 3.11 : Availability of Utensils in AWC for Cooking and Serving (N=748)

Nature of Project	Rural (%)		Urban (%)		Tribal (%)	
	Cooking	Serving	Cooking	Serving	Cooking	Serving
Regular ICDS Project	247 (63.3)	243 (62.3)	48 (45.7)	68 (64.8)	90 (64.3)	84 (60.0)
World Bank-supported	21 (46.7)	22 (48.9)	--	--	17 (68.0)	13 (52.0)
NGO-run Project	15 (65.2)	12 (52.2)	11 (73.3)	15 (100.0)	05 (100.0)	05 (100.0)
All areas	283 (61.8)	277 (60.5)	59 (49.2)	83 (69.2)	112 (65.9)	102 (60.0)

Fig. 3.7 Staff Position : CDPOs, ACDPOs & Supervisors

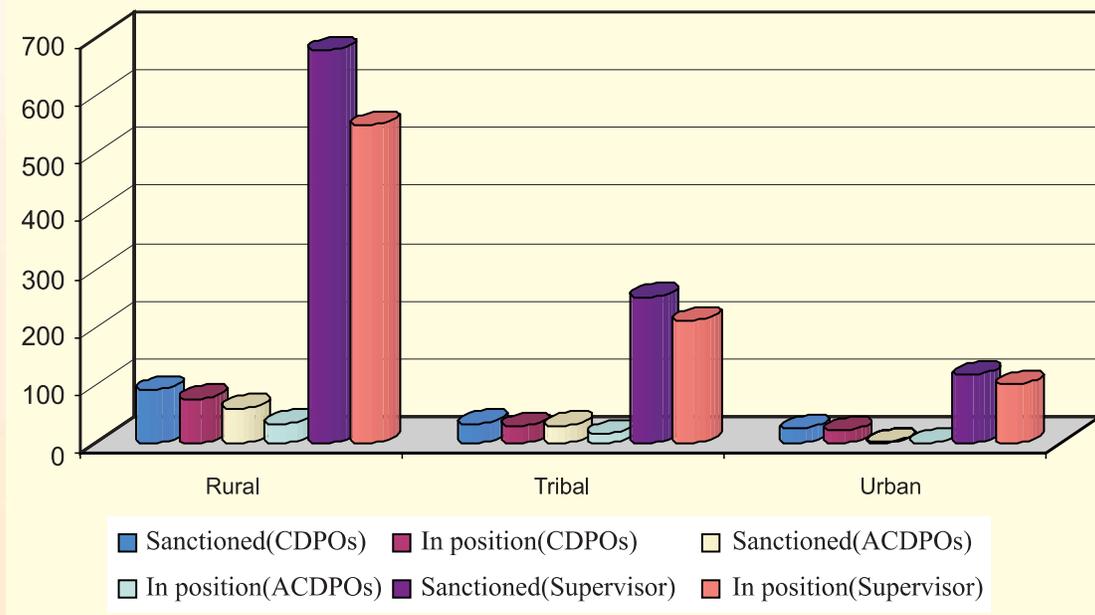


Fig. 3.8 Staff Position : AWWs & Helpers

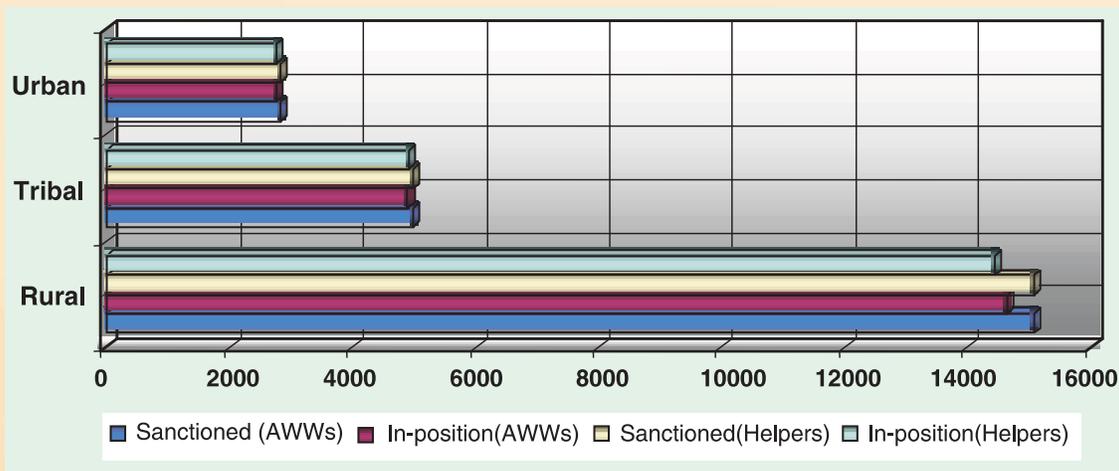


Table 3.12 : Project Staff Position (CDPOs, ACDPOs & Supervisors)

Location	CDPO		ACDPO		Supervisors	
	Sanctioned	In position (%)	Sanctioned	In position (%)	Sanctioned	In position (%)
Rural	91	76 (83.5)	60	32 (53.3)	676	547 (80.9)
Tribal	32	28 (87.3)	29	15 (51.7)	250	210 (89.0)
Urban	24	21 (87.5)	1	0 (0.0)	117	100 (85.5)
Total	147	125 (85.0)	90	47 (52.2)	1043	857 (82.3)

Table 3.13 : Project Staff Position (Anganwadi Workers & Helpers)

Location	AWW		Helpers	
	Sanctioned	In position (%)	Sanctioned	In position (%)
Rural	15084	14645 (97.1)	15084	14446 (95.8)
Tribal	4978	4908 (98.6)	4978	4933 (99.1)
Urban	2848	2783 (97.7)	2848	2765 (97.1)
Total	22910	22336 (97.5)	22910	22144 (96.7)

Table 3.14 : Status of Training

Category	Trained (%)	Untrained (%)	Total (%)
CDPOs	120 (81.6)	27 (18.4)	147 (100.0)
Supervisors	280 (95.2)	14 (4.8)	294 (100.0)
AWWs	735 (98.3)	13 (1.7)	748 (100.0)

3.2.2 Status of Training

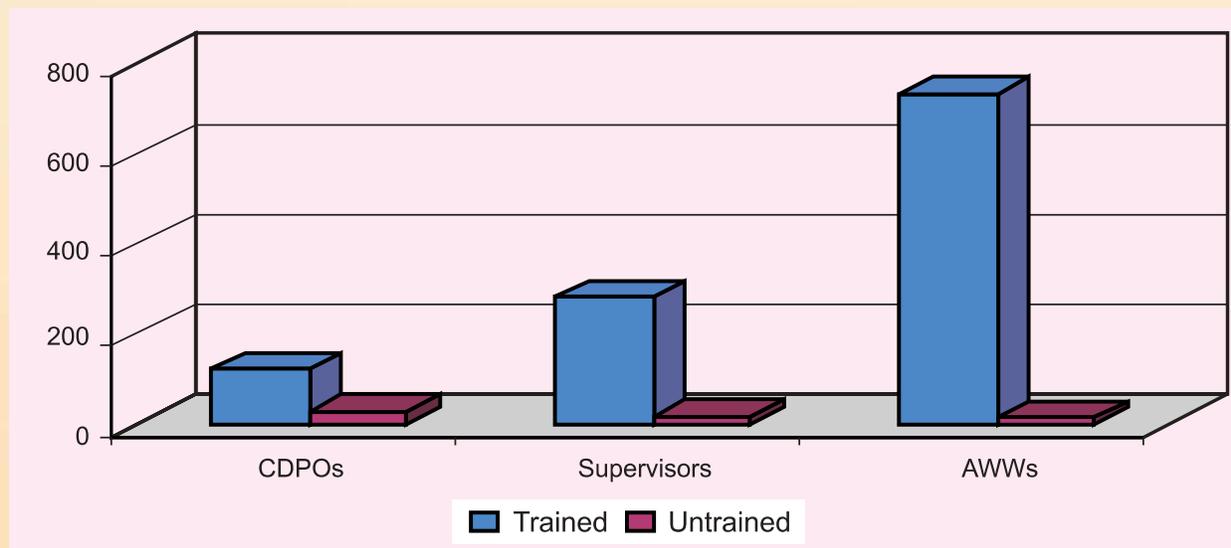
The status of training of functionaries in Table 3.14 and Fig. 3.9

Shows satisfactory condition. State-wise, it was observed that Arunachal Pradesh was the only State where 50 percent of CDPOs were untrained. In other states, by and large, training of functionaries has been highly satisfactory.

3.2.3 Selection of AWWs

As per guidelines of the scheme, AWW should preferably be a local girl i.e. from the

Fig. 3.9 Status of Training



and about 18 percent Supervisors were vacant in the projects surveyed. However, the position with regard to the appointment and availability of AWWs and Helpers has been quite satisfactory as is evident from the Table 3.13.

same village / area as it was envisaged that being local makes her more acceptable to the community and she will be able to seek maximum support of the people. In order to find out the extent to which this guideline is being adhered to, an effort was made to study this aspect. It was found that overall around

80 percent of the Anganwadi workers belonged to the same village / locality. However, wide variations were observed on this aspect between projects supported by World Bank, NGO-operated and regular ICDS. Whereas in regular ICDS projects 83 percent of workers were from the same village / locality, there were only 56 percent of workers from same locality in World Bank-supported projects and 30% in NGO-operated projects. Table 3.15 and Fig. 3.10 show the distance being travelled by the Anganwadi Workers to reach their respective centres. It would be seen that about 7 percent of workers had to travel more than 5 kilometers a day to reach the Anganwadi Centre.

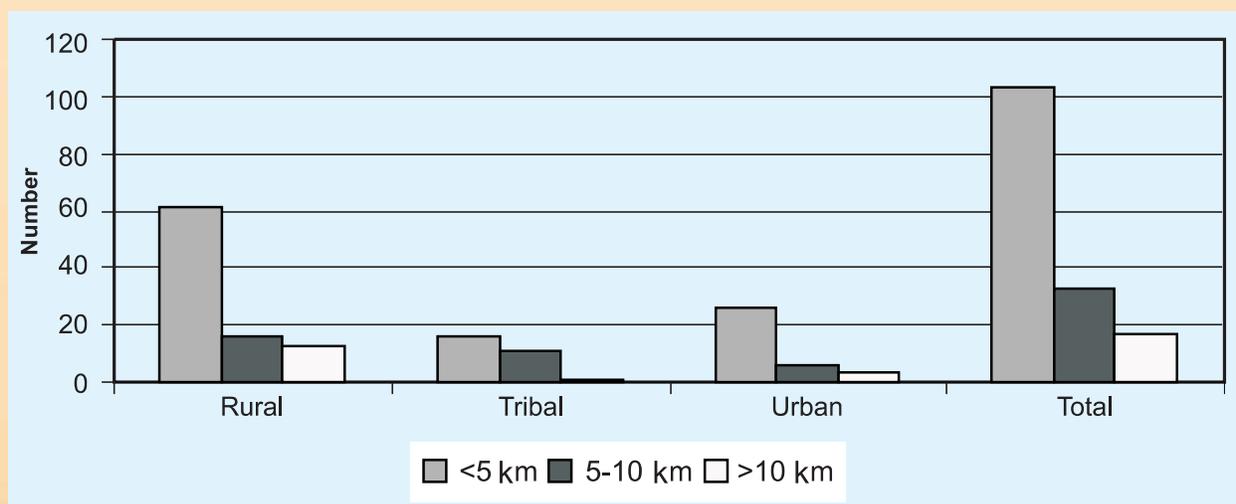
Table 3.15 : Distance of Residence of AWWs from AWCs (N=748)

Location	Distance from residence to be travelled by AWWs		
	<5 kms (%)	5-10 kms (%)	>10 kms (%)
Rural	61 (13.3)	16 (3.5)	13 (2.8)
Tribal	16 (9.4)	11 (6.5)	01 (0.6)
Urban	26 (21.7)	06 (5.0)	03 (2.5)
Total	103 (13.8)	33 (4.4)	17 (2.3)

Information was also collected regarding mode of transport utilised to reach the AWCs. AWWs belonging to the same village / adjoining villages located within the radius of two kilometers normally walked down the distance whereas others (9%) utilised public transport buses plying on the route. Rest of them, around 4 percent, used their own scooter/ motor cycle/ cycle. It was observed during discussion with respondents that those travelling a distance of beyond 5 kilometers were not as punctual and regular as other AWWs.

Initially, selection of AWWs was the basic responsibility of Child Development Project Officer (CDPO) who was required to select a female worker from the same village. She was educated and possessed necessary aptitude to work with young children and mothers. In 13 states recruitment of AWWs was carried out by CDPOs whereas 11 states had empowered district programme officers to select AWWs. Gram Panchayat was a party to selection of AWWs in two States. Further, State ICDS cell was responsible for recruitment in one of the states. This

Fig. 3.10 Distance covered by AWW to reach AWC



system of selection of AWWs directly by CDPOs got diluted with the massive expansion of ICDS programme. Procedure for recruitment was enlarged and involvement of village panchayats/ block samities president(s) as also Zila Parishad was introduced to identify suitable persons. Apart from CDPO, District Programme Officer (DPO) was made incharge for selection work. System(s) of reservation of seats was also applied in 21 States including major states of the country. Seven States did not introduce this system. Applications were invited through advertisements in local vernacular newspapers. CDPOs mentioned that “push and pull” factors also played vital role in selection of AWWs in late 1990’s onwards. All AWWs were female and above 18 years of age. Age group of these workers is given in Table 3.16.

of AWWs in regular and World Bank-assisted ICDS projects was evenly divided in age-group of 35-45 years of age while 30 percent of AWWs were in age-group of 25-35 years. Their length of service differed based on their age and date(s) of selection.

The position with regard to marital status showed that 82 percent were married and 9 percent unmarried. In Gujarat, the preference in selection of AWWs was given to widowed and divorced/ separated women. A little over nine percent (9.1%) were widowed (8.2%) and divorced (0.9%). Position with regard to nature of project and age group may be seen from Table 3.17. Policy of reservation in selection of AWWs had positive impact in utilising the services by

Table 3.16 : Distribution of AWWs according to Age-group (N=748)

Location	Age Group, years					Total (%)
	18-25 (%)	25-35 (%)	35-45 (%)	45-55 (%)	55+ (%)	
Rural	15 (3.3)	150 (32.8)	208 (45.4)	77 (16.8)	08 (1.7)	458 (100.0)
Tribal	08 (4.7)	53 (31.2)	76 (44.7)	29 (17.1)	04 (2.4)	170 (100.0)
Urban	03 (2.5)	25 (20.8)	61 (50.8)	31 (25.8)	0 (0.00)	120 (100.0)
Total	26 (3.5)	228 (30.5)	345 (46.1)	137 (18.3)	12 (1.6)	748 (100.0)

Table 3.16 depicts that about 66 percent of AWWs were aged 35 years and above. Percentage

scheduled castes families and AWWs of these groups.

Table 3.17 : Marital Status of AWW (N=748)

Location	Marital Status				All (%)
	Unmarried (%)	Married (%)	Widowed (%)	Divorced / Separated (%)	
Rural	25 (5.5)	393 (85.8)	36 (7.9)	04 (0.9)	458 (100.0)
Tribal	17 (10.2)	137 (80.6)	14 (8.2)	02 (1.2)	170 (100.0)
Urban	23 (10.2)	85 (70.8)	11 (9.2)	01 (0.8)	120 (100.0)
Total	65 (8.7)	615 (82.2)	61 (8.2)	07 (0.9)	748 (100.0)

Experience

Information was also gathered on work experience of AWWs. Data on work experience of AWWs is shown in Table 3.18.

Table 3.18 : Distribution of AWWs according to Experience (yrs) (N=748)

Location	Experience (yrs)				Total (%)
	1-3 (%)	3-5 (%)	5-10 (%)	10+ (%)	
Rural	13 (2.8)	33 (7.2)	155 (33.8)	257 (56.1)	458 (100.0)
Tribal	06 (3.5)	07 (4.1)	32 (18.8)	125 (73.5)	170 (100.0)
Urban	07 (5.8)	05 (4.2)	24 (20.0)	84 (70.0)	120 (100.0)
Total	26 (3.5)	45 (6.0)	211 (28.2)	466 (62.3)	748 (100.0)

Sixty-two percent of the AWWs had work experience over 10 years whereas only 28 percent of them had experience of more than 5 years.

As mentioned earlier, almost all AWWs (97%) had undergone job training; the position with regard to refresher training was 74 percent. Apart from these two basic trainings, about half of them (48.9%) had also undergone issue-based special sectoral level training organised for a day or so. These capsule trainings were on care of severely malnourished children, growth monitoring, immunisation, diarrhoea, formation of groups, seeking community participation and allied schemes of nodal department of ICDS.

3.2.4 Educational Qualifications of Workers

It would be seen from data that majority (43.2%) of the AWWs were matriculate 23.3 percent Higher Secondary and about 10 percent Graduates. There were hardly any illiterate workers (around 1%).

3.2.5 Supervisors

ICDS programme envisages that number of Supervisors in ICDS Projects will depend upon norms decided for rural, tribal and urban ICDS projects.

There would be three to five Supervisors in each ICDS project in order to improve and guide the work of AWWs in different types of ICDS projects. Guidelines lay that supervisor should be a female between ages of 21 and 45 years and preferably graduates in Social Work, Home Science or related field. It is also emphasised that she should have in aptitude to work in rural and tribal areas. Since the State Governments are running a large number of ICDS projects they have also formed a cadre of Supervisors based on criteria adopted and mode of recruitment – direct, promotion from amongst AWWs and deputation from like departments. Contractual appointment of Supervisors under World Bank Scheme was also carried out in the State like Uttar Pradesh. In 25 States, Mukhya Sevikas could be promoted to the post of CDPO/ Assistant Child Development Project Officer (ACDPO). Reservation of seats was existing in 21 states and seven states had no reservation. The mode of recruitment of Supervisors as per data received from States / UTs administration (nodal department) was as under:

- i) Only promotion in 3 States / UTs
- ii) Only direct method in 8 States / UTs
- iii) Promotion and direct both methods in 13 States / UTs
- iv) Promotion, deputation and direct recruitment was reported in one state Ten States / UTs did not give this data.

Age, Experience and Qualification of Supervisors

Age, experience and qualification of functionaries assume importance in the effective delivery of services. Hence an attempt was made to study this aspect.

It would be seen from Table 3.19 that a large majority of the supervisors were above the age of 35, were either graduates or post graduates and possessed experience of more than 10 years. This is a positive sign as ICDS seems to be managed by experienced and qualified supervisors.

Table 3.19 : Age, Qualifications and Experience of Supervisors (N=294)

Location	Age (years)				Qualification			Experience			
	18-25 (%)	25-35 (%)	35-45 (%)	45+ (%)	Under graduate (%)	Graduate (%)	PG (%)	< -3 (%)	3-5 (%)	5-10 (%)	10+ (%)
Rural	01 (0.6)	33 (18.6)	87 (49.2)	56 (31.6)	37 (20.9)	73 (41.2)	67 (37.9)	13 (7.4)	11 (6.2)	37 (20.9)	114 (64.4)
Tribal	02 (3.0)	13 (19.4)	33 (49.3)	19 (28.4)	14 (20.9)	33 (49.3)	20 (29.9)	08 (12.0)	01 (1.5)	11 (16.4)	46 (68.7)
Urban	0 (0.0)	05 (10.0)	31 (62.0)	14 (28.0)	05 (10.0)	22 (44.0)	23 (46.0)	03 (6.0)	0 (0.0)	09 (18.0)	38 (76.0)
Total	03 (1.0)	51 (17.3)	151 (51.4)	89 (30.3)	56 (19.0)	128 (43.5)	110 (37.4)	24 (8.1)	12 (4.1)	57 (19.4)	198 (67.3)

Analysis of educational, experience, age and training status of AWWs thus reveals that a large majority of them were matriculate or above, had put in more than 10 years of service, were between the age groups of 25-35 and were all trained. This is a very positive achievement of ICDS programme because such kind of workers are definitely assets in effective delivery of services.

3.2.6 Child Development Project Officer (CDPO)

One CDPO is to be selected and made incharge of each ICDS project. Guidelines stipulate

that CDPO should be preferably a woman having master's degree in any of the following disciplines:

- i) Child Development
- ii) Social Work
- iii) Home Science
- iv) Nutrition
- v) Any other allied field.

Achievement of the objectives of ICDS projects depends to a great extent on abilities and skills of a CDPO who has to act as a leader of the

team. Her dynamism and skills, besides her qualifications determine the pace and direction of the project. She is also required to

have abilities to get along with other members of project team, voluntary workers and leaders and other non-officials. A CDPO has not to be necessarily "desk bound" but should be able to reach people as she has to supervise clientele, workers and community leaders over 100 villages or slum sub-units. Department of Women and Child Development, GOI has also made provisions for Assistant Child Development Project Officer(s) in rural, and tribal ICDS projects of very large size vide its circular No. 13(4)/86-CD dated 18 June, 1981. With gradual expansion of ICDS programme state Governments were advised to create a cadre

for recruitment of CDPOs and Supervisors. Most of the thickly populated states have evolved their own mode of recruitment. Data showed that 21 states had exclusive cadre of CDPOs whereas 10 states had a joint cadre comprising deputation, promotion and contract. In all, 25 states had adopted the policy of promotion of Supervisors to the post of CDPOs/ ACDPOs. Thirteen states of the country also provided all circulars/ guidelines issued by Government of India to their CDPOs regularly as also issued by State nodal department of ICDS. Mode of recruitment in terms of reservation was followed as per order of state governments from time to time.

Though the guidelines of the scheme envisages that CDPO should be preferably a female, yet it was observed that about one third (32.7%) of all CDPOs were males. This percentage was only 14 in case of World Bank-Assisted projects where females CDPOs were about 86 percent. Table 3.20 outlines the age, qualifications and experience of CDPOs.

It is seen from the above table that most of the CDPOs (48.3%) were from the age group of 45-55, followed by 32.7 percent in the age group of 35-45. 57.2 percent of CDPOs were Post Graduates with only 6.1 percent being under

graduates. About 31 percent of CDPOs were having less than 3 years of experience which was reflective of frequent transfers of this category of functionary in some states. By and large the profile of all the functionaries indicate a satisfactory state of affair as majority of them are mature, experienced, qualified and trained functionaries. This goes to prove that the efforts of ICDS in ensuring that the programme is managed by qualified and trained personnel has been successful.

3.2.7 Other Details about ICDS Projects

Information was collected on some administrative and organisational set up from State Governments in terms of provision of vehicle, adequacy of funds under contingency and POL and so on. It was reported by officials of 25 State nodal departments of ICDS that they provided adequate fund for contingent expenditure, Information, Education and Communication (IEC) activities and POL. Honorarium of AWWs and Helpers was paid regularly in 20 States / UTs whereas 12 States reported delayed payment ranging beyond 2-4 months.

Availability of circulars and guidelines to CDPOs facilitates their work as ready reckoners.

Table 3.20 : Age, Qualification and Experience of CDPOs (N=147)

Location	Age (years)				Qualification			Experience			
	25-35 (%)	35-45 (%)	45-55 (%)	55+ (%)	Under graduate (%)	Graduate (%)	PG (%)	0-3 (%)	3-5 (%)	5-10 (%)	10+ (%)
Rural	9 (9.9)	24 (26.4)	51 (56.0)	7 (7.7)	7 (7.7)	32 (35.2)	52 (57.1)	33 (36.3)	08 (8.8)	19 (20.9)	31 (34.1)
Tribal	6 (18.8)	12 (37.5)	12 (37.5)	2 (6.3)	2 (6.3)	14 (43.8)	16 (50.0)	08 (25.1)	01 (3.1)	14 (43.8)	09 (28.1)
Urban	2 (8.3)	12 (50.0)	8 (33.3)	2 (8.3)	0 (0.0)	8 (33.3)	16 (66.7)	05 (20.9)	04 (16.7)	05 (20.8)	10 (41.7)
Total	17 (11.6)	48 (32.7)	71 (48.3)	11 (7.5)	9 (6.12)	54 (36.7)	84 (57.2)	96 (31.3)	13 (8.8)	38 (25.9)	50 (24.0)

But the set of circulars was available in 13 States only at project level. From the information gathered it has been found that 24 states/UTs had provided vehicles and timely fund for POL whereas in four states/UTs this facility was not being adequately provided. No information from remaining 7 states/UTs was received on this aspect.

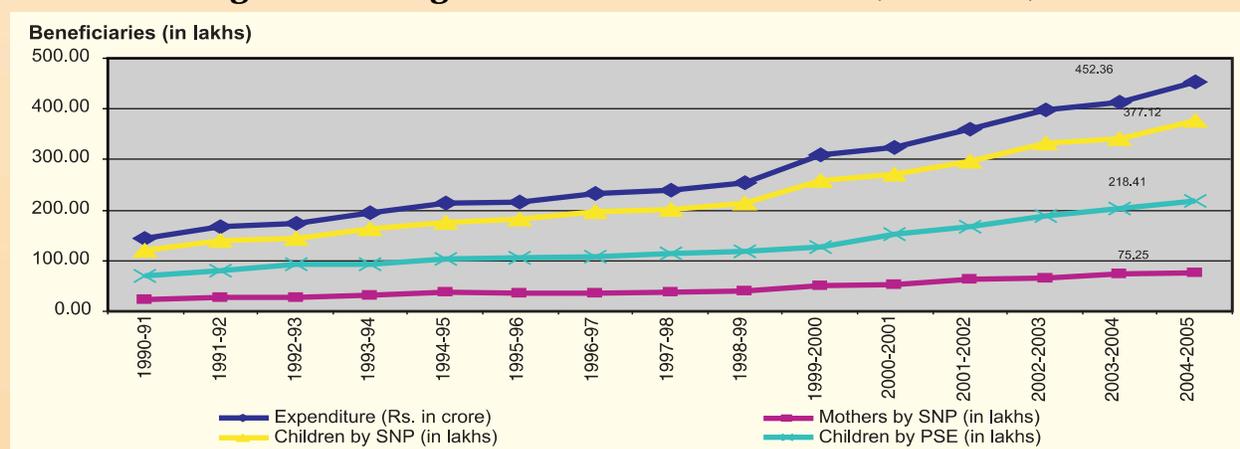
3.3 Profile of Beneficiaries

The following paragraphs draw out the salient features of beneficiaries belonging to sample families covered under the study. These features, *inter-alia*, include their socio-economic conditions, types of families they belong to, size of households and so on. A sample of 16,138 beneficiary households spreading over 750 Anganwadis was drawn.

Fig. 3.11 indicates the coverage of beneficiaries vis-à-vis different services under ICDS as well as expenditure incurred on these

services from 1990 to 2005 has been given to present an incremental situation in the last 15 years. It clearly reveals that expenditure on different services has gone up more than three times (from 144.00 crore during 1990-91 to 452.36 crore during 2004-05) in 15 years. The scenario is similar to the number of beneficiaries under various services – all categories of beneficiaries have gone up three times during the period under reference. In case of beneficiaries (children) receiving supplementary nutrition 120.79 lakh children benefitted during 1990-91 while 377.12 lakh of them were covered during 2004-05. Similarly, number of mothers receiving supplementary nutrition during 1990-91 were 23.21 lakh while 75.25 lakh mothers received benefit during 2004-05. In case of children covered under pre-school education component of ICDS, the number was 69.00 lakh in 1990-91 which rose upto 218.41 lakh in 2004-05.

Fig. 3.11 Coverage of Beneficiaries under ICDS (1990-2005)*



* Source: Different Annual Reports of Ministry of WCD, Government of India

3.3.1 Target Population in Sample Households

Coverage of households was equal in all anganwadis in terms of number of respondents. Table 3.21 shows that children 0-3 years constitute

of small family norm has made effective inroads in families covered under ICDS programme due to utilisation of health and nutritional services and health education activities. Figures in urban and tribal projects are slightly higher

Table 3.21 : Target Population in Sample Households (N=16,138)

S.No.	Beneficiaries	Population					
		Rural	%	Urban	%	Tribal	%
	Children						
i)	Children (0 - 3 yrs)	7260	12.9	1842	13.7	2362	11.9
ii)	Children (3-6 yrs)	6367	11.4	1662	12.3	2255	11.3
	All Children	13627	24.3	3504	26.0	4617	23.2
	Women						
i)	Pregnant Women	1840	3.3	488	3.6	683	3.4
ii)	Nursing Mother	1852	3.3	480	3.6	710	3.6
iii)	Other Women (15-45 yrs)	9427	16.8	2187	16.2	2737	13.7
	All Women	13119	23.4	3155	23.4	4130	20.7
	Total Population	56079	–	13476	–	19924	–

12 percent of the household population in tribal projects. However, this figure was relatively higher (13.7%) in urban projects, followed by tribal projects (12.9). A similar trend is found in the other category of beneficiary children of 3-6 years – 11.4 percent in rural projects, 12.3 percent in urban projects and finally, 11.3 percent in tribal projects. So far as pregnant women are concerned, rural projects occupy the lowest percentage, i.e. 3.3 percent. In this case, tribal and urban projects remain slightly better as 3.4 percent and 3.6 percent respectively. In case of nursing mothers, urban and tribal projects go hand in hand (3.6%) whereas rural projects occupy only 3.3 percent. The data also demonstrates that concept

due to presence of more women in highly reproductive age-groups below 35 years in target population as also due to higher preponderance of nuclear families.

Table 3.22 indicates that 0.83 per cent of children in households covered under the study are handicapped. Out of these children, 55.56 per cent children have been receiving benefits from ICDS programme. It has been found that coverage of handicapped children in the age-group 3-6 years (67.86%) is more than that of children belonging to the age-group 0-3 years (44.79%).

Table 3.22 : Handicapped Child Beneficiaries (N=16,138)

S. No.	Target Groups	Total Children	Handicapped		Handicapped Beneficiaries	
			Number	Percentage of total	Number	Percentage
	Children					
1.	Children (0-3 years)	11464	96	0.83	43	44.79
2.	Children (3-6 years)	10284	84	0.82	57	67.86
	All	21748	180	0.83	100	55.56

Data was also analysed based on caste(s) to see coverage of beneficiaries belonging to scheduled castes/tribes, backward classes and other categories (Table 3.23).

Data of Table 3.23 (also Fig. 3.12) point out that maximum percentage of beneficiaries were from backward classes (29.6%) followed by scheduled castes (26.3%). Differences between representation of other castes and that of scheduled tribes was meagre (21.4% and 20.4% respectively). The underlying significance of the

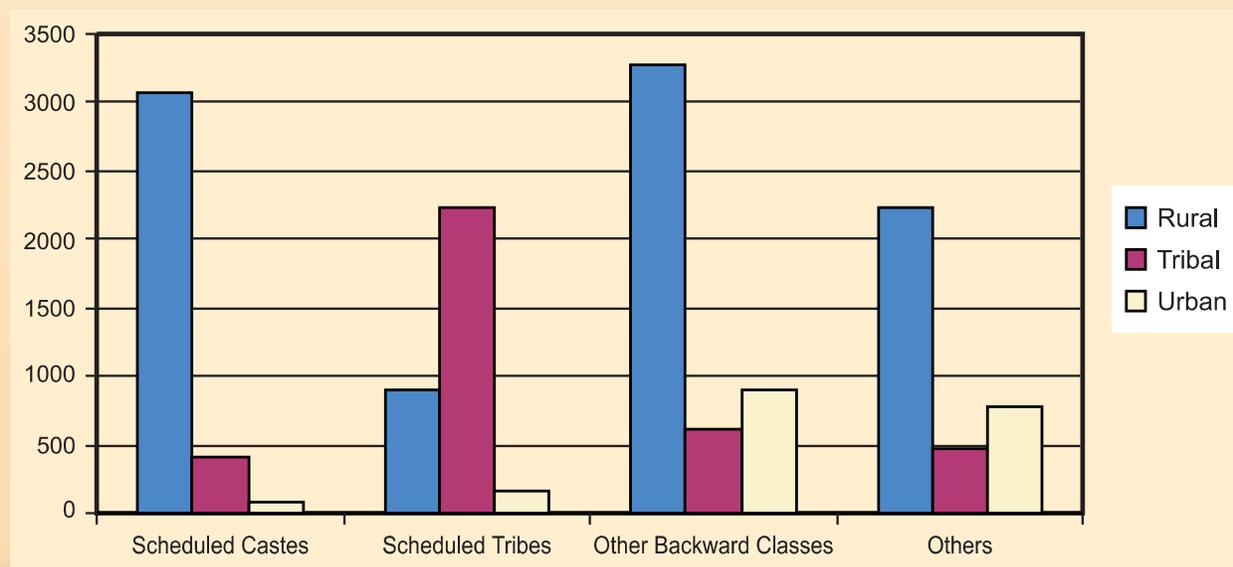
findings of the table clearly indicates that anganwadis mainly catered to the needs of poor families particularly those which are below poverty line.

It is well known that better off persons prefer to send their children to private schools, balwadis, nursery etc. It was also observed during the data collection process that preference in sending to private nurseries was for male child. Data revealed that World Bank-assisted ICDS projects had 46

Table 3.23 : Beneficiary Households based on Caste (N=16138)

Location of Project	Castes				Total (%)
	Scheduled Castes (%)	Scheduled Tribes (%)	Other Backward Classes (%)	Others (%)	
Rural	3062 (31.7)	900 (9.3)	3274 (33.9)	2222 (23.0)	9661 (100.0)
Tribal	402 (10.8)	2227 (59.6)	607 (16.2)	461 (12.3)	3737 (100.0)
Urban	775 (28.3)	165 (6.0)	900 (32.8)	771 (28.1)	2740 (100.0)
Total	4239 (26.3)	3292 (20.4)	4781 (29.6)	3454 (21.4)	16138 (100.0)

Fig. 3.12 Caste Composition of Beneficiary Households



percent representation of backward classes and almost equal percentage of scheduled castes and scheduled tribes (21.6%). Regular ICDS projects had also maximum percentage of backward classes (28.3%) followed by scheduled castes (27.0%). NGO-run projects had equal percentage of scheduled tribes and other castes followed by backward classes and scheduled castes (23.5%). Anganwadis had representation of population depending upon population of area(s).

Data on religious affiliation of respondents revealed that rural ICDS projects constituted 85 percent Hindus, followed by 81 percent in urban projects and 72 percent in tribal projects. In all, Hindus were 82 percent, Muslims 8.6 percent and Christians 6.1 percent. Persons from other religions like Jainism, Buddhism, Sikhism etc. were negligible (2.9%).

Information was sought from the respondents on their agricultural land holding status. It was found that 55 percent of them were landless while another 28 percent owned land which was less than one hectare. It was found that less than 8 percent possessed land holding between one and two and above two hectares. Those who possessed land more than four hectares were residing in hilly, desert and tribal areas. This indicates that ICDS programme has been able to bring landless, small and marginal farmers as also families residing in difficult terrain under its coverage. Further, data has shown that landless constituted six out of ten families covered under World Bank-assisted ICDS projects, followed by regular ICDS projects (54.8%) and almost equal percentage was found in NGO-run projects.

Indian family has undergone transition from its joint and extended entity to nuclear family. This study revealed that six out of ten families of beneficiaries were nuclear while joint family constituted one-third of all types of families. It was also found that in urban areas 62 percent families were nuclear while this type of family constituted almost similar percentage in rural (59.0%) and tribal (59.8%) projects. Maximum percentage of joint families (36.0) were found in rural ICDS projects, probably due to agrarian nature of society followed by urban (30.4%) and tribal (29.0%) projects. Table 3.24 shows the distribution of beneficiary households according to types of families.

Table 3.24 : Beneficiary Households vis-a-vis Types of Families (N=16138)

Nature of ICDS Project	Details of type of households			
	Nuclear %	Joint %	Extended %	All %
Rural	5696 (59.0)	347 (36.0)	466 (4.8)	9661 (100.0)
Tribal	2233 (59.8)	1083 (29.0)	412 (11.0)	3737 (100.0)
Urban	1706 (62.3)	833 (30.4)	192 (7.0)	2740 (100.0)
Total	9635 (59.7)	5393 (33.4)	1070 (6.6)	16138 (100.0)

Data was also analysed to assess the types of families vis-à-vis beneficiary households taking into account location of regular, World Bank-assisted and NGO-run projects. In regular ICDS projects percentage of joint families marginally reduced to 33 and an incremental trend was found in case of World Bank (38.1%), whereas a decline was found in case of NGO-run projects (32.0%). Increasing trend of extended families was seen in regular ICDS

projects (7.0%) and drastic reduction in other categories of projects (4.1% in World Bank projects and 4.8% in NGO-run projects).

Table 3.25 shows size of families in various types of ICDS projects and brings out interesting findings.

Table 3.25 : Distribution of Type of Household Size (N=16138)

Nature of ICDS Project	House hold size (persons)				
	Up to 5 (%)	6-10 (%)	11-15 (%)	16 and above (%)	All%
Rural	5624 (58.2)	3560 (36.8)	432 (4.5)	45 (0.5)	9661 (100.0)
Tribal	2277 (60.9)	1336 (35.8)	114 (3.1)	10 (0.3)	3737 (100.0)
Urban	1739 (63.5)	897 (32.7)	97 (3.5)	7 (0.3)	2740 (100.0)
Total	9640 (59.7)	5793 (35.9)	643 (4.0)	62 (0.4)	16138 (100.0)

Table 3.25 reveals that six out of ten families (59.7%) conformed to the national figure in respect of size of families (upto 5 persons), followed by 36 percent of households having family members between six and ten. Another interesting finding was that of households with 11 and above family members which constituted 4 percent. Normal belief is that urban households are nuclear and smaller in family size but the data revealed that even urban ICDS projects also recorded family size between six and ten (32.7%).

Further analysis of study data shows that regular and NGOs-run ICDS projects had family size between six and ten (36.3% and 36.5%, respectively. Two-third World Bank-assisted

ICDS projects reported household size upto five. In terms of other variables differences observed were negligible. Data shows that persistent efforts are required to be made by project level functionaries to motivate community undertaking appropriate steps so that in future the size of the households is reduced and the goal of all-round development of women and children can be achieved.

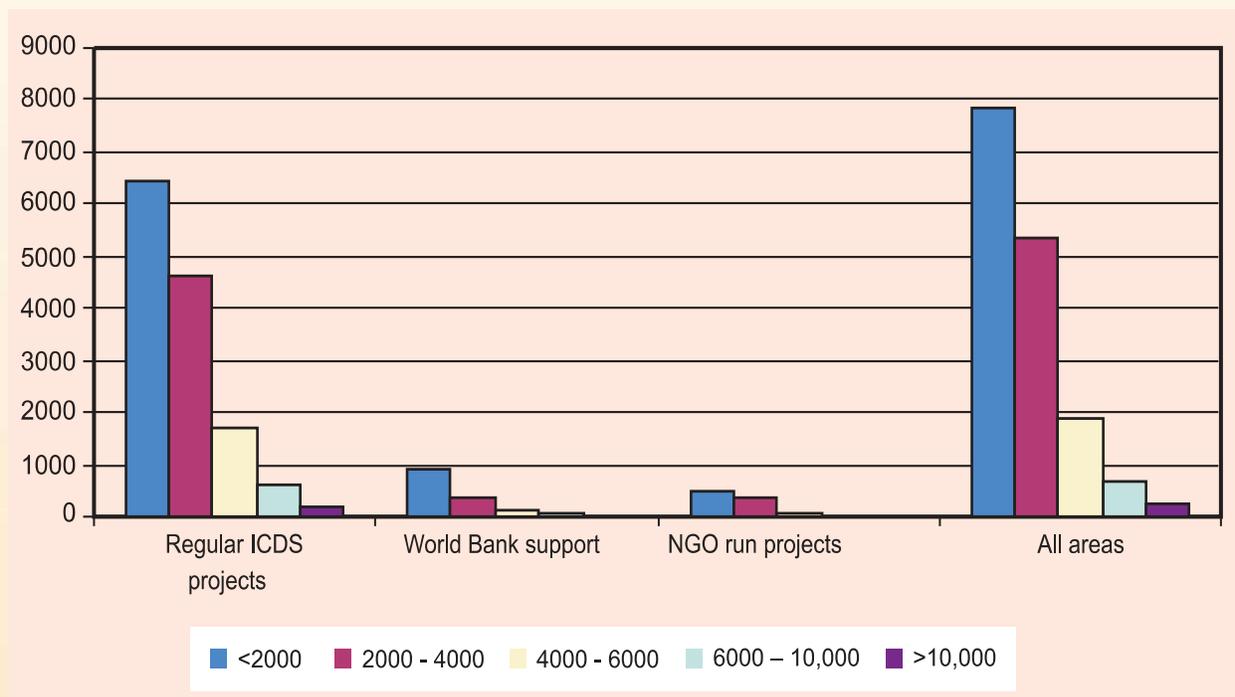
Well being of a household mainly depends upon family income linked with planned family budgeting so that needs of families particularly children and women could be fulfilled

adequately. A family is considered to be above poverty line when its monthly income is above Rs. 2,000/- per month (Economic Survey of India-2004). On this premise, the analysis of the monthly income of sample households which has been presented in Table 3.26.

Table 3.26 (also Fig. 3.13) shows that a little over 60 percent families under World Bank-assisted ICDS projects (62.5%) had monthly income less than Rs. 2000/- per month followed

Table 3.26 : Monthly Income of Beneficiary Households (N=16138)

Nature of ICDS Projects	Monthly income in rupees per household					Total (%)
	<2000 (%)	2000-4000 (%)	4000-6000 (%)	6000 - 10,000 (%)	>10,000 (%)	
Regular ICDS projects	6455 (47.04)	4600 (33.53)	1716 (12.51)	601 (4.38)	201 (1.46)	13721 (100.0)
World Bank support	911 (62.48)	387 (26.54)	108 (7.41)	32 (2.19)	13 (0.89)	1458 (100.0)
NGO-run projects	493 (51.41)	353 (36.81)	69 (7.19)	26 (2.71)	8 (0.83)	959 (100.0)
All areas	7859 (48.7)	5340 (33.1)	1893 (11.7)	659 (4.1)	222 (1.4)	16138 (100.0)

Fig. 3.13 Monthly Income of Beneficiary Households

by NGO run projects (51.41) and regular ICDS projects had this share with 47 percent of households. About 37 percent of households of NGO-run projects reported income between Rs. 2000 and Rs. 4000 per month followed by regular ICDS projects (33.5%) and a little over one fourth (26.5%) in World Bank-assisted ICDS projects. It was found that households with income above Rs. 4000 – 6000 were 12 percent. Families (5.5%) having income beyond this limit were joint families. During the visits of research team to households, it was observed that very few households were in a position to possess well-ventilated house with capacity to provide adequate nutrition and health care to their families.

When income of households was examined in terms of location of projects in rural, tribal and

urban areas, it was found that a little over half (52.8%) tribal families had income less than Rs. 2000/- followed by rural families (49.5%). Forty percent urban families were found to be in this income group. This may be perhaps because of better avenues of work and wages available in urban areas. Four out of ten families in urban projects had also income ranging between Rs. 2000 and 4000 per month, followed by rural (32.1%) and tribal projects (30.4%). Income beyond this limit (Rs. 4000-6000) was earned by 12.8 percent households of urban projects and 11.5 percent each of rural and tribal projects. Tribal families showed lowest percentage beyond this limit. Almost equal percentage (5.8%) was seen in case of urban and rural projects in respect of higher income group. This variation may be

attributed to better sources of income in rural and urban families including availability of more job opportunities.

3.3.2 Main Occupation of Sample Households

Since there is a direct relationship between income and occupation, the present study collected data regarding main occupation of the head of the households as also subsidiary occupation being carried out by other family

members. Most of the respondents mentioned their main occupations to be traditional ones. Subsidiary occupations were also mentioned by those who made a departure from traditional occupations. Table 3.27 and Fig. 3.14 present a glimpse of main occupations of households.

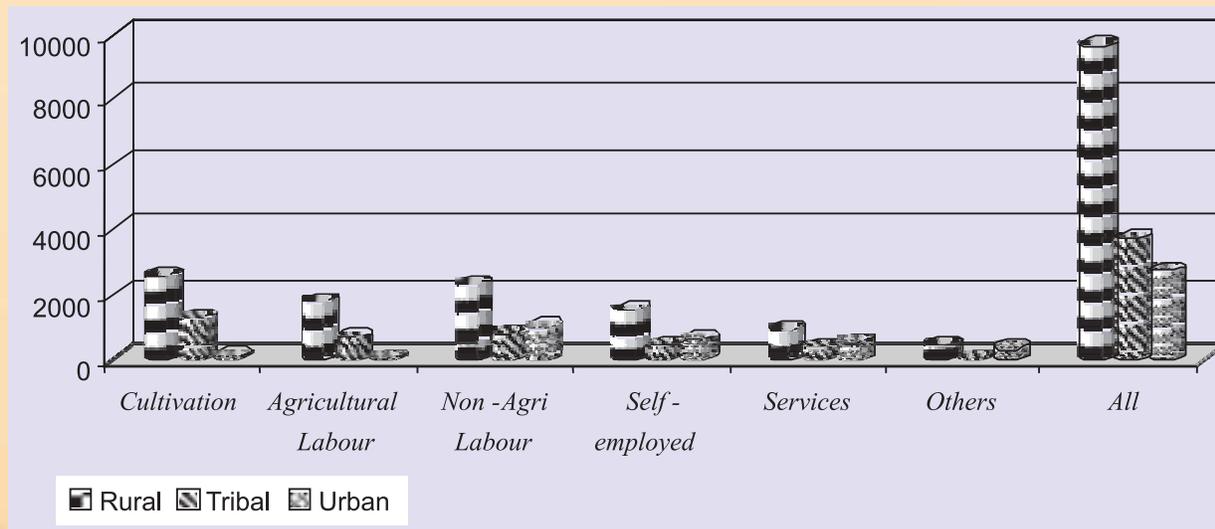
Data reflects that one-fourth of head of households (25.7%) had non-agriculture labour as main occupation, maximum being in urban areas (36.4%), followed by heads of households in rural (24.2%) and tribal areas (21.9%). It

was also found that a little over one-third of respondents of tribal projects (34.3%) were cultivators who constituted 27 percent in rural ICDS projects.

Table 3.27 : Main Occupation of Households (N=16138)

Nature of ICDS Project	Nature of main occupation of the head of households						
	Cultivation (%)	Agricultural Labour (%)	Non-Agri Labour (%)	Self-employed (%)	Services (%)	Others (%)	All (%)
Rural	2575 (26.7)	1780 (18.4)	2338 (24.2)	1539 (15.9)	923 (9.6)	470 (4.9)	9661 (100.0)
Tribal	1280 (34.3)	701 (18.8)	817 (21.9)	470 (12.6)	389 (10.4)	68 (1.8)	3737 (100.0)
Urban	94 (3.4)	87 (3.2)	998 (36.4)	611 (22.3)	567 (20.7)	364 (13.3)	2740 (100.0)
Total	3949 (24.5)	2568 (15.9)	4153 (25.7)	2620 (16.2)	1879 (11.6)	902 (5.6)	16138 (100.0)

Fig. 3.14 Main Occupation of Heads of Households



Cultivators in urban projects who lived on fringe of urban areas and went to adjoining villages for cultivation were negligible (3.4%). Percentage of self employed and agricultural labourers was almost equal (16.0%). Self employed were mostly blacksmiths, carpenters, cattle grazers, potters, shoe makers, weavers, petty shop keepers etc. Around 12 percent were in service – Government, semi-government, private companies etc. It was also observed from data that 30 percent of heads of households working as non-agricultural labourers were from World Bank-assisted ICDS projects and almost equal percentage was found under the categories of cultivation (23.5%) and agriculture labourers (23.5%). In regular ICDS projects almost equitable percentage were found in the categories of cultivators (24.3%) and non-agricultural labourers (25.4%). Differences in terms of NGO-run projects and other projects were marginal in terms of self-employment, services etc.

3.3.3 Subsidiary Occupation

Information, gathered from head(s) of households about their subsidiary occupations is given in Table 3.28.

Data depicts rather a peculiar picture of this category of occupation. Ten percent households reported agriculture and non-agricultural labour as subsidiary occupation. As many respondents reported occupations in other categories like pulling carts, rickshaws, selling woods, graying cattle. Agricultural labour as occupation was reported by 17 percent of tribal households followed by non-agriculture labour (12.0%) and cultivation (10.5%). Other categories of subsidiary occupations were reported marginally. Data reflects that avenues of subsidiary employment are not available for poor and efforts are required to create and strengthen such opportunities with particular focus on traditional employment.

3.3.4 Household Assets

Information was also collected to find out different kinds of assets possessed by beneficiary households (Table 3.29).

Data shown in Table 3.29 (also in Fig. 3.15) indicates the availability of television in maximum number of households (42.2%), followed by radio/transistors (35.0%). Maximum number of television sets were possessed by urban households (65.4%), followed by rural households (41.3%). Position of availability of radio/transistor was almost equal in

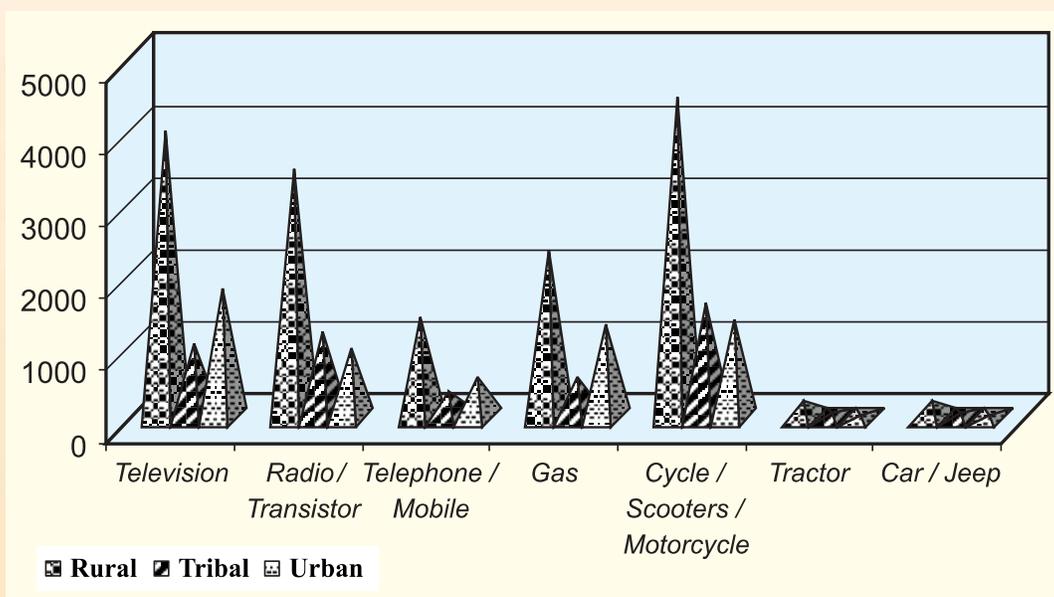
Table 3.28 : Subsidiary Occupations of Households (N=16138)

Nature of ICDS Project	Categories of Subsidiary Occupation(s)						
	Cultivation	Agricultural Labour	Non-Agri Labour	Self-employed(%)	Services (%)	Others (%)	All (%)
Regular ICDS	890 (6.51)	1490 (10.9)	1421 (10.4)	797 (5.8)	321 (2.3)	1539 (11.2)	13721 (100.0)
World Bank-supported	138 (9.51)	198 (13.6)	190 (13.0)	90 (6.2)	41 (02.8)	77 (5.3)	1458 (100.0)
NGO-operated	90 (9.41)	47 (4.9)	58 (6.0)	57 (5.9)	18 (1.9)	91 (9.5)	959 (100.0)
All areas	1118 (6.9)	1735 (10.8)	1669 (10.3)	944 (5.8)	380 (2.4)	1707 (10.6)	16138 (100.0)

Table 3.29 : Assets Possessed by Beneficiary Households (N=16138)

Nature of ICDS Project	Nature of Assets in Possession of Respondents						
	Television	Radio/ Transistor (%)	Telephone/ Mobile (%)	Cooking Gas (%)	Cycle / Scooters / Motorcycle(%)	Tractor(%)	Car / Jeep (%)
Rural	3988 (41.3)	3462 (35.8)	1396 (14.4)	2333 (24.1)	4472 (46.3)	245 (2.5)	238 (2.5)
Tribal	1024 (27.4)	1218 (32.6)	357 (9.4)	581 (15.5)	1611 (43.1)	66 (1.8)	66 (1.8)
Urban	1792 (65.4)	974 (35.5)	557 (20.3)	1314 (48.0)	1363 (49.7)	23 (0.8)	44 (1.6)
Total	6804 (42.2)	5654 (35.0)	2304 (14.3)	4228 (26.2)	7446 (46.1)	334 (2.1)	348 (2.2)

Fig. 3.15 Assets owned by Households



rural (35.8%) and urban (35.5%) projects, followed by tribal projects (32.6%). Respondents of urban areas possessed comparatively better assets like telephone/mobiles (20.3%), gas connection (48.0%) and cycles/scooters/motorcycles (49.7%). Rural areas recorded the second position as the general impression goes that urban areas followed by rural areas are the major beneficiaries of instruments of communication. One of the advantages of telephone was reported to be timely availability of assistance of health facilities in emergent situations. Villagers reported that television provided them not only political news but

also information on social problems like crime against women, health and nutrition, family planning, information about government programmes/ schemes. They could also view films and serials on social issues. Similar advantages were reported of radio/transistors also. As the table shows, almost half of urban respondents (48.0) were beneficiaries of LPG connections and one-fourth (24.1) were rural respondents residing in close vicinity of cities/town areas. It may be mentioned that supply of television, radio/transistors, scooters/ motorcycles on easy installments of payment led to greater availability of these assets.

Information was also gathered on this aspect from the angle of management of the projects – regular, World Bank-assisted and NGO-run projects. Table 3.30 presents a picture about possession of assets by sample households.

Table 3.30 shows that 42.7 percent respondents had television in regular ICDS projects,

as telephone/mobile is concerned, it was found that 14.9 percent respondents of regular ICDS projects had this facility, followed by NGO run (12.0%) and World Bank (10.1%) ICDS projects.

Housing conditions of an individual along with facilities of toilets, electricity, open space, ventilation etc. contributes to a healthy living conditions and protects the inmates from illnesses.

Table 3.30 : Possession of Assets by Sample Households (N=16138)

Nature of ICDS Project	Assets						
	Television	Radio/ Transistor (%)	Telephone/ Mobile (%)	Cooking Gas (%)	Cycle / Scooters / Motorcycle(%)	Tractor (%)	Car / Jeep (%)
Regular ICDS	5861 (42.7)	4853 (35.4)	2042 (14.9)	3776 (27.5)	6282 (45.8)	289 (2.1)	308 (2.2)
World Bank-supported	551 (37.8)	443 (30.4)	147 (10.1)	182 (12.5)	730 (50.1)	19 (1.3)	16 (1.1)
NGO-operated	392 (40.9)	358 (37.3)	115 (12.0)	270 (28.1)	434 (45.3)	26 (2.7)	24 (2.5)
All areas	6804 (42.2)	5654 (35.0)	2304 (14.3)	4228 (26.2)	7446 (46.1)	334 (2.1)	348 (2.2)

followed by NGO-run ICDS projects (40.9%) and World Bank-assisted ICDS projects (37.8%). Maximum gas connections were available in NGO-run projects (28.1%), followed by regular (27.5%) and World Bank (12.5%) projects. While cycles/scooters/motorcycles were possessed by 46.1 percent in all categories of projects, car/jeep is owned by only 2.2 percent households. Radio/transistor again has been found to be second most popular medium of entertainment (35.0%). So far

Availability of these facilities is possible through coordination mechanism and integration of services of other departments in beneficiaries' households. Data were collected from head(s) of households as also based on observation by enumerators to assess types of houses and electrification facilities available in beneficiary households (Table 3.31).

While 39 percent households lived in kutchha house(s)/huts, 32 percent could afford to

Table 3.31 : Types of Houses and Electrification Facilities (N=16138)

Nature of ICDS Project	Assets						
	Television	Radio/ Transistor (%)	Telephone/ Mobile (%)	Cooking Gas (%)	Cycle / Scooters / Motorcycle(%)	Tractor (%)	Car / Jeep (%)
Regular ICDS	5861 (42.7)	4853 (35.4)	2042 (14.9)	3776 (27.5)	6282 (45.8)	289 (2.1)	308 (2.2)
World Bank-supported	551 (37.8)	443 (30.4)	147 (10.1)	182 (12.5)	730 (50.1)	19 (1.3)	16 (1.1)
NGO-operated	392 (40.9)	358 (37.3)	115 (12.0)	270 (28.1)	434 (45.3)	26 (2.7)	24 (2.5)
All areas	6804 (42.2)	5654 (35.0)	2304 (14.3)	4228 (26.2)	7446 (46.1)	334 (2.1)	348 (2.2)

construct pucca houses made of bricks and cement. Another 29 percent could construct semi-pucca houses wherein walls were made of brick and plastered with cement and roofs were of tiles. Varandahs were made of mud and floor of these semi-pucca houses were kutcha. Most of these houses were with facility of one/two rooms. Sunlight was available through ventilation and through maximum two small windows and a door. These rooms were also shared with cattle to protect them from theft. Tribal projects had hut/kutcha construction (57.5%), followed by 28 percent semi-pucca houses. Urban projects possessed 45 percent households with pucca house comprising single room with little facilities of toilet and bathroom. Rural projects had pucca houses (35.9%) and kutcha/huts (34.2%). An interesting feature of this data is that semi-pucca construction ranged between 27 and 29 percent for all categories of projects. Most of the pucca/ semi-pucca houses were constructed on receipt of loan for construction of houses under Indira Awas Yojana.

In all categories, electrification of houses was 69 percent and the lion share was in urban areas (87.9), followed by 68 percent in rural areas and 56.5 percent in tribal areas. Electrification was done basically under the scheme on supply of electricity to all villages and particularly for those families which are below poverty line. This has also been done under other schemes in operation at different points of time. However, supply of power was virtually non-existent due to acute shortage barring Delhi, Himachal Pradesh, Punjab, Kerala, Karnataka and part of Gujarat state.

3.4 Coordination in ICDS

As the ICDS Scheme adopts an inter-sectoral approach involving more than one department or agency of the government, Panchayats and voluntary agencies, there is all the more need for coordination of their efforts in delivering the package of services for children and mothers. Coordination is expected to help optimum utilisation of the available resources (Amarjeet & Kaur, 1998; Nayyar, Kapil & Nandan 1998; Trivedi, Chhapparwal & Thora, 1995). The Scheme provides for formal maximum coordination through Coordination Committees at different levels. General guidelines for the setting up of Coordination Committees have also been issued by GOI (letter no. 6-11/75-CD, 1 August, 1975). The constitution of the committees at different levels by the State Governments was communicated to (now) Ministry of Women and Child Development, Government of India. In this section, an attempt has been made to find out extent of coordination at different levels and convergence of services at Anganwadi centre level. Broadly, four sources of information were utilized for writing this Chapter: one, Government orders/ circulars issued in this regard, two, information furnished by State Governments/UTs in a questionnaire developed by the Institute, three, Interview Schedule of different respondents and, four, Observation of the research team.

Coordination Committees

State Level Coordination Committee (SLCC)

Ideally, meetings of the State Level Coordination Committee need to be convened on



a quarterly basis and, if necessary, more frequently. All Secretaries of Departments of health and family welfare, education, public health, engineering, rural development, environment and sanitation, employment, information and publicity and President of Zila Parishad and Members of Parliament etc. in the State concerned were normally found in the State Level Coordination Committees for ICDS Scheme.

District Level Coordination Committee (DLCC)

The Collector or the District Development Officer, ICDS Consultants belonging to Department of Pediatrics or Medical Colleges, District Level Medical Officer were included in the District Level Coordination Committee. The meetings of this Committee were convened on monthly/quarterly basis. As per the guidelines, the Chairman of the Committee was inviting some other officials and non-officials in the meetings of the Committee as he deems fit. Representatives of local bodies (e.g. Zila Parishad/Zila Panchayats) and important voluntary organisations working in the field of Child Welfare were also included in the Committee.

Block Level Coordination Committee (BLCC)

Child Development Project Officer, Medical Officer of PHC and the BDO were found to be the members of this committee. It was presided over by President of Block Samiti/

Taluka Panchayats. MLA (Member of Legislative Assembly) of the area was also a member of this committee. It was observed that meeting of the Block Level Coordination Committee was convened on monthly basis wherever this was set up.

Village Level Coordination Committee (VLCC)

Anganwadi Centre is the focal point for delivery of services. Therefore, coordination at village level is very important. However, Anganwadi Worker, ANM, local influential people, social workers, Dais and elected representatives of PRIs were normally included in the Committee.

Existence of Coordination Committee (at project level)

Data were collected on coordination mechanism in ICDS, its existence, adequacy, impact on ICDS, efforts made to improve coordination etc. CDPOs of sample projects were asked to express their views about existence of Coordination Committee and the same is presented at Table 3.32.

Table 3.32 : Existence of Coordination Committee at Project Level (N=147)

Nature of Project	Rural		Tribal		Urban	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
Regular ICDS Project	56 (72.7)	14 (18.2)	20 (76.9)	06 (23.1)	18 (85.7)	03 (14.3)
World Bank-Supported	05 (54.6)	04 (44.4)	62 (40.0)	03 (60.0)	-	-
NGO-Run Project	04 (80.0)	01 (20.0)	01 (100.0)	0 (0.0)	02 (66.7)	0 (0.0)
All Areas	65 (71.4)	19 (20.0)	23 (71.9)	09 (28.1)	20 (83.3)	03 (12.5)

It is evident from Table 3.32 that more than 70 percent projects of rural and tribal areas were having Coordination Committee at the project level, whereas urban areas were having more than 83 percent Coordination Committee at project level.

As far the existence of Coordination Committee at project level by type of management, regular ICDS projects and projects supported by World Bank were having less number of Coordination Committees as compared to the projects run by non-governmental organisations. It can be inferred from Table 3.32 that projects of urban areas, due to better communication facilities, were having Coordination Committee at the project level.

An effort has also been made to find out whether coordination is adequate between health and ICDS functionaries or not and data in this

coordination at CDPO level was somewhat adequate but at the field/village level, it was not up to the mark. The situation is similar to tribal projects too. Coordination with health department was somewhat lacking at field/ village level especially in tribal areas and also in NGO-run projects. By and large coordination at project level was found to be satisfactory.

Child Development Project Officers were also asked question regarding effectiveness of meetings of coordination committee at block level. Data in this regard (Table 3.34) shows that a little over two-third (68%) CDPOs were of the view that meeting of Coordination Committee was effective whereas about one-fifth (21%) found it very effective. Effectiveness of the meeting of coordination committee was well recognized by a majority of CDPOs of tribal areas.

Table 3.33 : Adequate Coordination between Health and ICDS Functionaries

Nature of ICDS Projects	CDPOs (N=147)				Supervisors (N=296)				Health Functionaries (N=443)			
	Regular ICDS Projects	W.B.- Supported	NGO-run Projects	All Areas	Regular ICDS Projects	W.B.- Supported	NGO-run Projects	All Areas	Regular ICDS Projects	W.B.- Supported	NGO-run Projects	All Areas
Rural	56 (72.7)	05 (55.6)	04 (80.0)	65 (71.4)	114 (76.5)	13 (72.2)	05 (50.0)	45 (25.4)	179 (76.5)	17 (65.4)	04 (26.7)	200 (72.7)
Tribal	20 (76.9)	02 (40.0)	01 (100.0)	23 (71.9)	42 (75.0)	04 (44.4)	01 (50.0)	20 (29.9)	58 (69.9)	09 (60.0)	02 (66.7)	69 (68.3)
Urban	18 (85.7)	-	02 (66.7)	20 (83.3)	36 (81.8)	-	0 (0.0)	08 (16.0)	49 (83.1)	-	07 (87.5)	56 (83.6)
Total	94 (75.8)	07 (50.0)	07 (77.8)	108 (73.5)	192 (77.1)	17 (63.0)	06 (33.3)	73 (24.8)	286 (76.1)	26 (63.4)	13 (50.0)	325 (73.4)

regard are presented at Table 3.33. It is evident from the Table 3.33 that in urban projects more than 80 percent CDPOs, Supervisors and health functionaries had reported adequate coordination at their level. In NGO-run projects, adequacy of

Table 3.34 : Effectiveness of Coordination Committee (N=147)

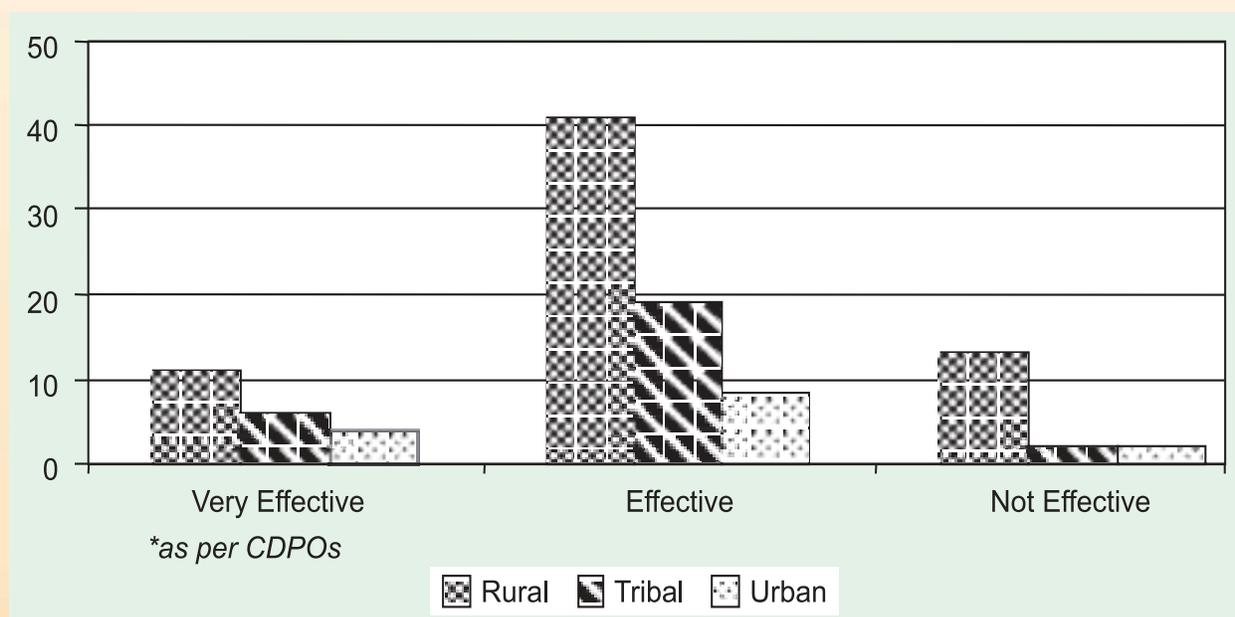
Nature of Project	Very Effective	Effective	Not Effective	Total
Rural	11 (18.8)	41 (12.1)	13 (45.1)	91 (14.3)
Tribal	6 (18.8)	19 (59.4)	2 (6.3)	32
Urban	4 (16.7)	8 (33.3)	2 (8.3)	24
Total	21	68	17	147

Table 3.33 further reveals that around 73 percent CDPOs have reported that there were adequate coordination between ICDS and health functionaries. But remaining around 27 percent had mentioned inadequate coordination. However, reasons for the same are presented in Table 3.35 (Annexure 4).

3.5 Convergence of Services in ICDS

Coordination and convergence of services at different level has a positive impact on output and outcomes of ICDS Scheme and it could be achieved by the inputs received from allied departments. However, some of the mechanisms used by them were as under:

Fig. 3.16 Effectiveness of Coordination Committees*



It is observed from Table 3.33 that a substantial percentage of CDPOs and health functionaries were pre-occupied because of which coordination was lacking. Another important reason for inadequate coordination was indifferent attitude of health functionaries. It was also observed during data collection by the field team that ANMs at the village level were not coordinating very well with the Anganwadi Workers.

- Convening regular meetings of Committees
- Taking up follow-up measures
- Involving Village *Panchayats* in activities of AWCs
- Approaching higher authority for help and support for BPL families
- Organising convergence of services at community level

ICDS being multi-sectoral in nature, utilises all the existing resources and services provided at state, district and block levels by various Government Departments, particularly Department of Health and Education (NIPCCD, 1992). Availability of such support services at the Anganwadi level especially of health department are presented in Table 3.35. It is evident from the table that in rural areas efforts

3.6 Community Participation

ICDS has been envisaged and conceptualised as a community-based programme. The choice of having AWW at the grassroots level as a honorary worker and not a salaried one, makes it a scheme of the people. The assumption is that the AWW, being a local woman, would be much more effective in delivery of services due to her familiarity with the

community. This would facilitate acceptance of the scheme and community's participation in it (NIPCCD, 1992). This can also be substantiated with data presented in Chapter 3 related to ownership of AWC building. A total of 35.3

Table 3.35 : Efforts to Improve Coordination and Convergence with Allied Departments (Multiple Choice)

Category of Responses	Category-wise views of Respondents					
	CDPOs (%)			Health Functionaries (%)		
	Rural	Tribal	Urban	Rural	Tribal	Urban
Convening Regular meeting of Coordination Committee	52 (57.1)	21 (65.6)	13 (54.2)	144 (52.4)	50 (49.5)	42 (62.7)
Follow-up measure with Block Level Functionaries	62 (68.1)	17 (53.1)	13 (54.2)	138 (50.2)	44 (43.6)	33 (49.3)
Involving village panchayat in AWC activities	66 (72.5)	17 (53.1)	11 (45.8)	140 (50.9)	44 (43.6)	20 (29.9)
Approaching District Level officials for seeking help & support of BPL families	46 (50.5)	13 (40.6)	09 (37.5)	92 (33.5)	37 (36.6)	21 (31.3)
Organising community convergence to interlink, programme & services	49 (53.8)	15 (46.9)	13 (54.2)	95 (34.5)	32 (31.7)	33 (49.3)

were made to involve village *Panchayat* in AWC activities. It is also interesting to note that efforts were made for organising community convergence to interlink programme and services as a substantial percentage of CDPOs reported.

In order to make policies and programmes effective for beneficiaries, it was imperative to have perfect coordination and convergence not only among various departments but with ICDS as well because it is a nodal point for the convergence of these efforts.

percent centres were running in a building provided either by Panchayat or local community. Views of women beneficiaries, community leaders and AWWs were obtained to know about the kind of support/contribution provided to the programme.

It can be seen from Table 3.36 that women (15-45 years) mainly (32.4%) extended supportive role in Anganwadis (like assistance in cooking of food, providing fuel, collecting children for health check-up, bringing children to Anganwadis for immunisation, fetching drinking

Table 3.36 : Type of Support/Contribution by Women towards AWC (Views of women 15-45 years) (N=3771)

Category of support/Contribution	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Cash	84 (3.6)	39 (4.6)	27 (4.5)	150 (4)
Kind	283 (12.2)	141 (16.5)	57 (9.5)	481 (12.8)
Supportive Role	725 (31.3)	338 (39.6)	160 (26.6)	1223 (32.4)
Others	67 (2.9)	21 (2.5)	15 (2.5)	103 (2.7)

water etc.). In tribal projects this type of support was found maximum (39.6%). Contribution in kind like carrying supplementary nutrition upto AWCs using own means of transport, repair of AWCs was also found maximum (16%) in tribal projects.

Contribution of Community Leaders

Nature of contribution of community leaders is presented in Table 3.37. Majority

Table 3.37 : Contribution of Community Leaders to AWCs (Views of Community Leaders) (N=1500)

Nature of Contributions	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Contribution of AWC	636 (69)	246 (72.6)	163 (68.2)	1045 (69.7)
Pre-school Education	183 (19.8)	52 (15.3)	41 (17.2)	276 (18.4)
Supplementary Nutrition	142 (15.4)	58 (17.1)	26 (10.9)	226 (15.1)
Referral Services	138 (15)	51 (15)	19 (7.9)	208 (13.9)
Physical Infrastructure	232 (25.2)	79 (23.3)	42 (17.56)	353 (23.56)
Preparing community for ICDS	316 (34.23)	111 (32.63)	82 (34.17)	508 (33.87)
Contribution in cash and kind	180 (19.5)	44 (13)	43 (17.8)	266 (17.75)
Support to AWWs	448 (46.6)	164 (48.25)	107 (44.8)	700 (46.65)
Others	54 (05.9)	20 (05.9)	08 (03.3)	82 (05.5)

(69.7%) of community leaders extended their contribution to AWCs in the form of supervision, solving personal problems of AWWs and protecting them against undesirable elements. They (44.65%) also cooperated and supported AWWs as and when it was necessary. This contribution was also reported in direct support to AWWs which included extending help in promoting attendance, maintenance of records and registers and help in seeking cooperation and help from primary school in admitting children in 1st standard. Thirty-four percent community leaders also supported AWWs in motivating community members to send their children to AWCs. It has been found that few of them (17.75%) also contributed in cash and kind. On the whole, it can be inferred that over a period of three decades, community has become aware about ICDS programme and is now providing support to AWCs.

Problems Faced in Community Involvement

Few AWWs reported that sometimes they faced problems in eliciting community participation in their day-to-day activities. Reasons attributed to this problem by them were many which have been clubbed together and classified under different categories in Table 3.38.

As discussed in Chapter 3, AWWs were mostly from the same community. It was expected that they would prove to be an effective agent to seek involvement and

Table 3.38 : Problem Faced by AWWs in Involving Community (Views of AWWs) (N=748)

Nature of problems/difficulties	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Indifferent Attitude	118 (25.8)	40 (23.5)	11 (9.2)	169 (22.6)
Hostility towards ICDS programme	33 (7.2)	17 (10)	04 (3.3)	54 (7.2)
No time to seek involvement	89 (19.4)	32 (18.8)	23 (19.2)	144 (19.3)
Lack of support from Supervisor/CDPO	50 (10.9)	28 (16.5)	05 (04.2)	83 (11.1)
Caste discrimination	36 (7.9)	16 (09.4)	07 (05.8)	59 (07.9)
Community has no time	164 (35.8)	55 (32.4)	32 (26.7)	251 (33.6)
Inability to contribute in cash & kind	146 (31.9)	52 (30.6)	30 (25)	228 (30.5)
Others	32 (7)	15 (8.8)	02 (1.7)	49 (6.6)

support of community people. But they faced problems and difficulties in this regard. About one-third (33.6%) mentioned that community had no time as most of them went out in search of employment for their livelihood. It was true in case of rural and tribal communities. Poverty was another factor prevailing among target families. About 23 percent AWWs found that population was least concerned about AWWs and they behaved indifferently. Inadequate awareness among project functionaries particularly AWWs was a serious drawback in respect of involvement of community.

3.7 Summing up

A majority of the CDPOs (more than 70%) had reported that Coordination Committee existed at project level. Regular ICDS projects and projects supported by World Bank were having less number of Coordination Committees as compared to the projects run by non-governmental organisations. Due to better communication facilities in urban

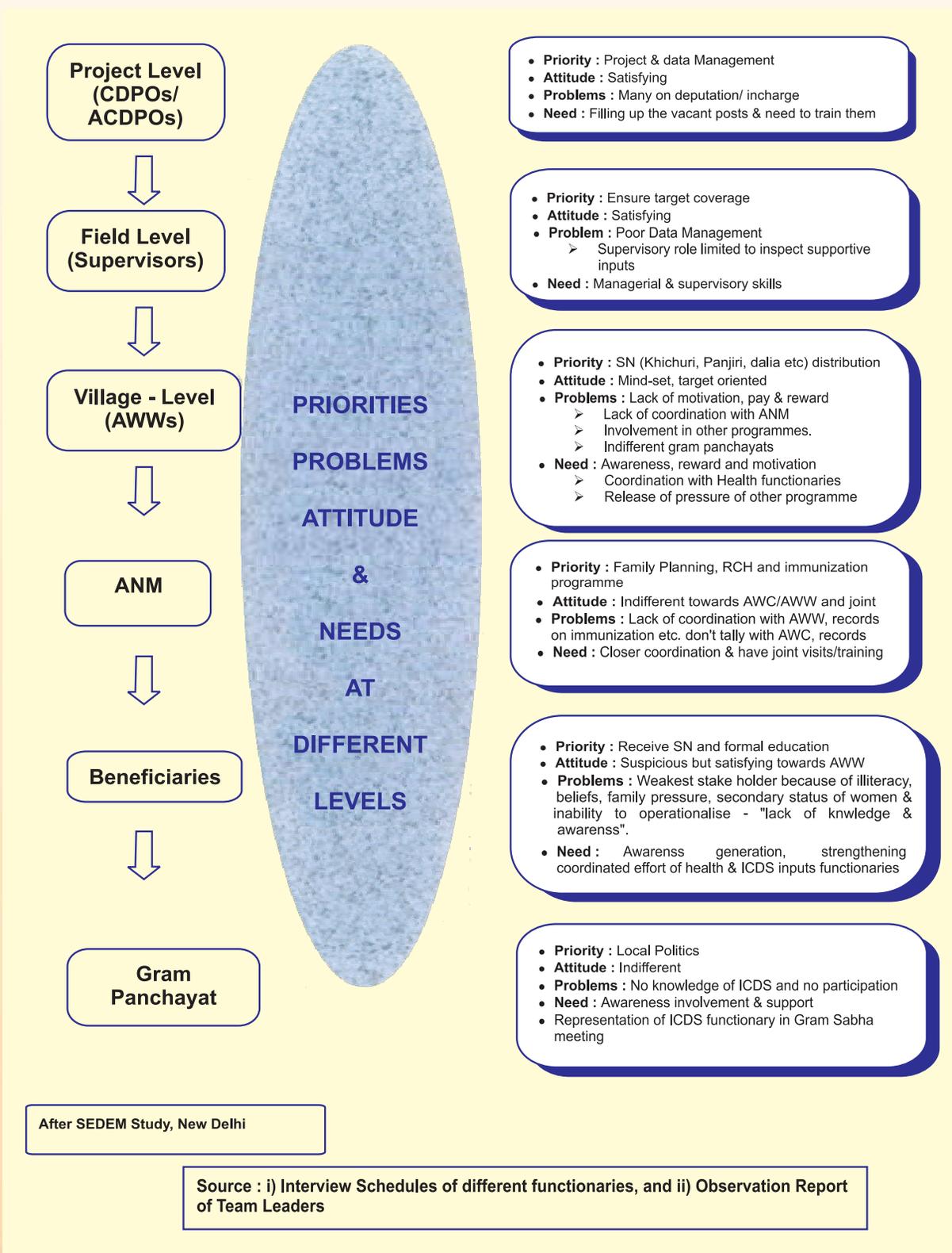
project areas (83.3%) had Coordination Committee. Coordination with health department was somewhat lacking at field level/village level especially in tribal areas and also in NGO-run projects but by and large coordination at project level was found to be satisfactory. A little over two-third (68%) CDPOs were of the view that meeting of Coordination Committee was effective whereas about one-fifth (21%) found it very effective. A substantial percentage of health functionaries were pre-occupied with other work because of which coordination was lacking. A substantial percentage of CDPOs reported that efforts were made for organising community convergence to interlink programme and services.

The above discussion brings forth certain adequacies and inadequacies in terms of infrastructure as well as benefits accruing to target groups through ICDS programme.

It was found that sanitation remained a crucial area of concern in ICDS project areas where basic amenities like toilets in Anganwadis needed to be given more attention. The study revealed that accessibility to important services of health such as Primary Health Centres and Sub-Centres was limited. It was found that hand pump and tap water were the main sources of water in majority of Anganwadi Centres, which is indicative of provision of safe drinking water.

The study showed that majority of Anganwadi Centres were located in pucca buildings. However,

Fig. 3.17 : Priorities, Problems, Attitude and Needs at Different Levels



outdoor and indoor space and separate space for storage and cooking in majority of Anganwadi Centres were found to be inadequate. It was noticed that in tribal areas about 52 percent children had to travel more than one kilometer, sometime even more than three kilometers to reach Anganwadi centres.

An overwhelming majority of Anganwadi Centres were found to have the facility of weighing machine for measuring nutritional status of children. However, pre-school kits were not available in 44 per cent Anganwadi centres covered under the study. Even play materials were found to be inadequate in Anganwadi Centres. Cooking and serving utensils were not available in a large number of Anganwadi Centres.

Positions of CDPOs/ ACDPOs and supervisors were found to be vacant in many projects, however, appointment and availability of AWWs and Helpers were satisfactory. So for training of ICDS functionaries, by and large, the study revealed a satisfactory status. Wide variation was found in World Bank, NGO-run and regular ICDS projects in terms of Anganwadi workers belonging to same village/ locality. By and large the profile of all categories of ICDS functionaries was satisfactory as majority of them were found to be mature, experienced, qualified and trained.

The study revealed satisfactory coverage of all categories of beneficiaries in all types of ICDS projects, thereby covering the target population to a great extent, particularly coverage of handicapped child beneficiaries which was found to be 55.6 percent. The study came out with the finding that the Anganwadi Centres mainly catered to the needs of poor families particularly those which are below poverty line. The size of the beneficiary households was mostly confined to five members. Non-agriculture labour was found to be the main occupation in case of 25.7 percent of beneficiary households, followed by cultivation (24.5%), self-employed (16.2%), agriculture labour (15.9%), service (11.6%) and others (5.6%).

A chart has been prepared on the basis of qualitative information and observation reports of the team leaders to understand the priorities, attitudes, problems and needs as expressed by different functionaries from project to village level. Although almost all the CDPOs and AWWs were of the view that objectives of scheme have been achieved to a great extent (Annexure-6) but issue the priorities, problems and needs varied from project to village level (Fig. 3.17). It is observed from the figure that there was a mismatch between priorities and needs. Therefore, there is a scope for effective managerial or administrative intervention at all level.





Chapter 4

Assessment of Delivery of Services

- 4.1 Spectrum of Service Delivery under ICDS
- 4.2 Supplementary Nutrition (SN)
- 4.3 Pre-school Education (PSE)
- 4.4 Immunisation
- 4.5 Health Check-up
- 4.6 Nutrition and Health Education (NHEd)
- 4.7 Referral Services
- 4.8 Summing-up



Assessment of Delivery of Services

4.1 Spectrum of Service Delivery under ICDS

In this chapter, an attempt has been made to assess the efficacy and extent to which the package of services under ICDS is delivered to benefit various target groups. Services under ICDS programme are meant for different categories of beneficiaries and are offered so as to serve definite envisaged purpose. Each service integrated into ICDS programme was chosen to realise certain goals. ICDS programme has been designed to provide a back up support to innumerable families belonging to poor and underprivileged sections of the society in improving not only the health and nutritional status of women and children but to provide services for their all round development. The present chapter attempts to find out nutritional and health status of pregnant and lactating mothers as also the new born and children between six months and six years. It also describes utilisation of services

such as health, nutrition and pre-school education and the factors influencing the beneficiaries in effective utilisation of services. The conclusions of this chapter may facilitate changes in policy, revision of guidelines for planning, coordination, monitoring, supervision and implementation of ICDS programme so as to strengthen the process and quality of delivery of services.

ICDS Programme envisages the delivery of following services:

1. Supplementary nutrition
2. Immunisation
3. Health Check-up
4. Referral
5. Nutrition and Health Education
6. Non-formal Pre-school education

The following table gives an idea about different categories of beneficiaries under ICDS programme vis-à-vis various services provided to them.

Beneficiaries of ICDS vis-à-vis Services Provided	
Category of Beneficiaries	Services Provided
Children less than 1 year	a) Supplementary nutrition b) Immunisation c) Health Check-up d) Referral Services
Children 1-2 years	a) Supplementary nutrition b) Immunisation c) Health Check-up d) Referral Services
Children (3-6 years)	a) Supplementary nutrition b) Immunisation c) Health Check-up d) Referral Services e) Non-formal pre-school education
Expectant and nursing mothers	a) Health check-up b) Immunisation of expectant mothers against tetanus c) Supplementary nutrition d) Nutrition and health education
Other Women (15-45 years)	Nutrition and health education

Services under ICDS are inter-sectoral in nature and these are provided with an aim to have synergistic effect on the overall development of children. One of the strategies adopted in ICDS is the simultaneous delivery of early childhood services in an integrated

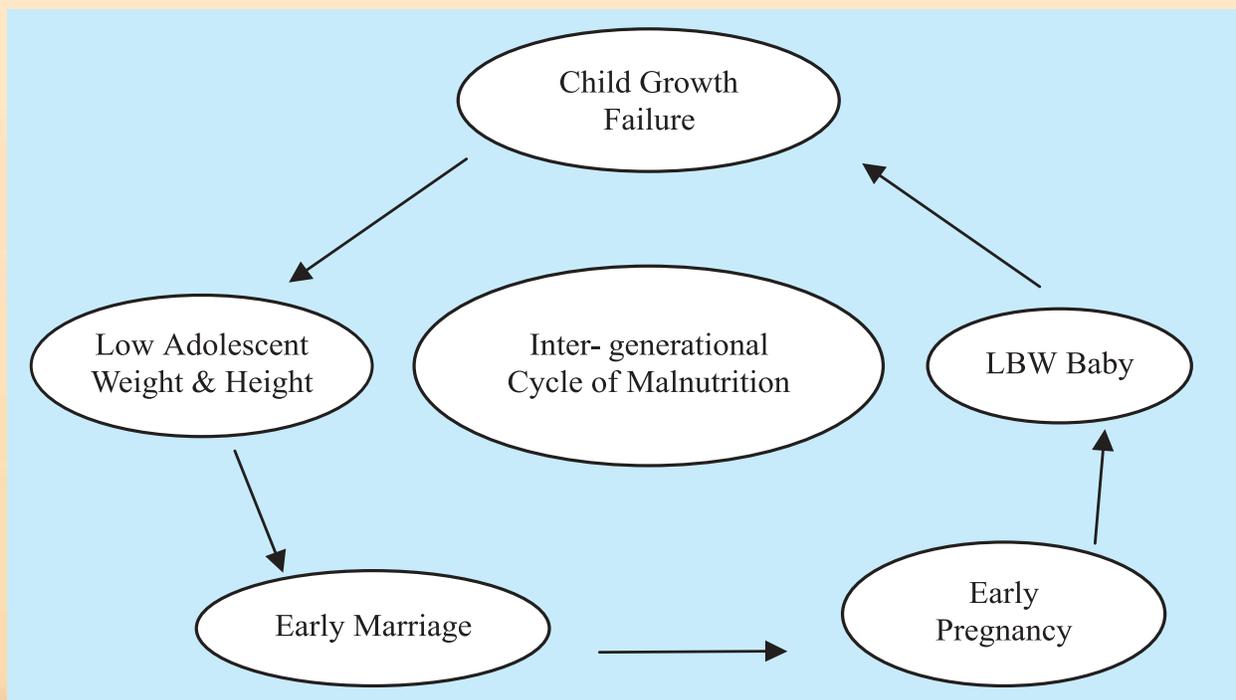
manner so that overall impact is much greater, as impact of one service is dependent upon the support received by it from other related services. For example, protected water supply is an essential supportive programme in ICDS project areas as adequate and safe drinking water is vital for health of children and mothers. Therefore, availability of safe drinking water needed to be ensured as a priority in ICDS project areas. The health component constitutes a major part of package of services under ICDS programme.

4.2 Supplementary Nutrition (SN)

Supplementary nutrition is provided to children below 6 years of age and nursing and expectant mothers from low income families based on the guidelines issued from time to time by the Ministry of Women and Child Development,

Government of India related to selection of beneficiaries. Supplementary nutrition leads to fulfillment of the deficiencies of calories, proteins, minerals and vitamins in the existing diets, avoiding cutbacks in the family diet and taking other measures for nutritional rehabilitation of IIIrd and IVth grade malnourished children and mothers. Several studies and nutritional surveys of National Institute of Nutrition (NIN) and National Nutrition Monitoring Bureau (NNMB) have pointed out that the cycle of malnutrition is the single largest factor which contributes to high rate of infant and child mortality and morbidity in India. An illustrative inter-generation cycle of malnutrition (Fig 4.1) depicts a dismal picture of malnutrition, and suggests that the cycle needs to be broken so as to eliminate prevalence of malnutrition.

Fig. 4.1 : Inter-Generation Cycle of Malnutrition



Nutrition services provided under ICDS have had a marked impact on the nutritional status of beneficiaries. A study was undertaken by NIPCCD to assess the utilisation of ICDS services and its impact on the nutritional status of 7-13 years old children. It was found that the proportion of children not availing ICDS services ranged from 57.4 percent in the age group of 2 to < 3 years to as high as 87.6 percent in the 5 to < 6 years age group. The most important determinants of the onset of malnutrition were found to be 'increasing age' and 'being a female' (NIPCCD: 2005: p.92-93).

Supplementary nutrition is a high cost input of ICDS programme. Beneficiaries have expressed dissatisfaction with respect to the quantity, taste, lack of variety and non-acceptability of supplementary nutrition due to varied food habits (Singh, 1984; Visveswaran, 1985; Venugopal, 1985). But there is ample evidence to indicate the positive impact of nutrition supplements on children and women. ICDS programme has reduced the prevalence of malnutrition, and brought significant change in the anthropometric measurements and nutritional status of children (NIPCCD: 1992).

In ICDS, special attention is paid to children below three years of age. The amount of nutrition varied as per the age of the child. The type of food (milk pre-processed or semi-processed food or food prepared on the spot from locally available foodstuff) was determined depending upon local availability, type of beneficiary, location of the project, administrative feasibility etc. Supplementary nutrition was provided for 300 days

in a year. Ministry of Women and Child Development, Government of India, in the letters dated 21st January 2002 and 31st January 2006 has issued revised guidelines on revision of nutritional norms as also supplementary nutrition under ICDS and nutrition component under Pradhan Mantri Gramodaya Yojana (PMGY). The summary of these two letters is reproduced below:

Nutritional Norms

Beneficiaries	Calories (Cal K)	Protein (g)
Children (0-3 years)*	300	8-10
Children (3-6 years)	300	8-10
Severely malnourished children (on medical advice after health check-up)	Double of above	Double of above
Pregnant and lactating (PL) mothers	500	20-25
Adolescent Girls	500	20-25

** In this context attention is drawn to provisions regarding promotion of breast feeding in the IMS Act.*

In order to meet the aforesaid nutritional norms, a financial norm of about Rs. 1 per beneficiary per day (average) for 300 days in a year was assessed in 1991 to include the cost of food, transport, administration, fuel etc. States have to ensure registration of all eligible beneficiaries in accordance with applicable guidelines and norms. A coverage of 40 beneficiaries for 0-3 years, 40 for 3 to 6 years and 20 for pregnant and lactating mothers (including four being those recommended by ANM/ doctor on medical grounds) 1 per AWC in non-tribal areas and 42, 42 and 25 per AWC, respectively, in tribal areas is ideally stipulated.

4.2.1 Source of Supplementary Nutrition

The findings of the survey are based on 748 AW Centres of the sample. Generally speaking,

aim of providing supplementary nutrition has being to supplement the nutritional intake as per prevalent norms upto March 31 2000. Supplementary nutrition in ICDS is procured from various sources. AWWs were asked to report these sources of supplementary nutrition procured in their Anganwadis. Data of the present study revealed that in 80 percent projects, source of arranging nutrition in Anganwadis was State Government which procured food item(s) from Food Corporation of India and other sources identified by them. World Food Programme (WFP) was found to be supporting six percent of Anganwadis while CARE contributed its nutritional facility to four percent of Anganwadis. A trend was also visible wherein village panchayats/Self-Help Groups were serving cooked food to beneficiaries. Though percentage of such contribution is nominal, credit goes to the efforts made by ICDS functionaries particularly AWWs to involve community in activities of Anganwadis. It was found that in some of the NGO-run projects the concerned NGO providing food mobilised their own resources. Wherever feeding was arranged twice a day, it was reported that extra meal came from other sources such as industrial houses/ other civil society organisations (10%). Table 4.1 reveals that State/UT Governments are major contributor for supplementary nutrition in all areas rural, urban and tribal. However this extent of contribution was lower (68.8%) in tribal areas in comparison to urban (72.5%) and rural (85.8%).

Table 4.1 : Sources of Supplementary Nutrition (N=748)

(Multiple Response)

Sources	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
CARE	16 (3.5)	07 (4.1)	08 (6.7)	31 (4.1)
WFP	10 (2.2)	29 (17.1)	05 (4.2)	44 (5.9)
State/UT Govt.	393 (85.8)	117 (68.8)	87 (72.5)	597 (79.8)
Community	02 (0.4)	02 (1.2)	0 (0.0)	04 (0.5)
Others	37 (8.1)	15 (8.8)	20 (16.7)	72 (9.6)
Total	458 (100)	170 (100)	120 (100)	748 (100)

4.2.2 Selection of Beneficiaries and Type of Food Served

It was found from the data that selection of beneficiaries was made by following the criteria prescribed by the concerned State Government. Data was also collected about types of food served in Anganwadis (Table 4.2). The table shows that 42% of Anganwadis received raw food items which were cooked/prepared at AWCs and served to children. This practice was found most prevalent in Anganwadis of tribal projects (53.5%). Ready-to-Eat (RTE) food was provided in all types of projects, maximum being in Anganwadis of urban projects (45.8%), followed by rural (33.6%) and tribal (23.5%) projects. Some Anganwadis

Table 4.2 : Types of Supplementary Nutrition (N=748)

(Multiple Response)

Type of Food Supplied	Location of Projects			
	Rural %	Tribal %	Urban %	Total %
Ready-to-eat	154 (33.6)	40 (23.5)	55 (45.8)	249 (33.3)
Raw/ kucha	201 (43.9)	91 (53.5)	24 (20.0)	316 (42.2)
Both/ Mixed	84 (18.3)	32 (18.8)	19 (15.8)	135 (18.0)
Others	19 (4.1)	07 (4.1)	22 (18.3)	48 (6.4)
Total	458 (100)	170 (100)	120 (100)	748 (100)

**Supplementary Nutrition Storage at Anganwadi Centres
..... some typical examples**



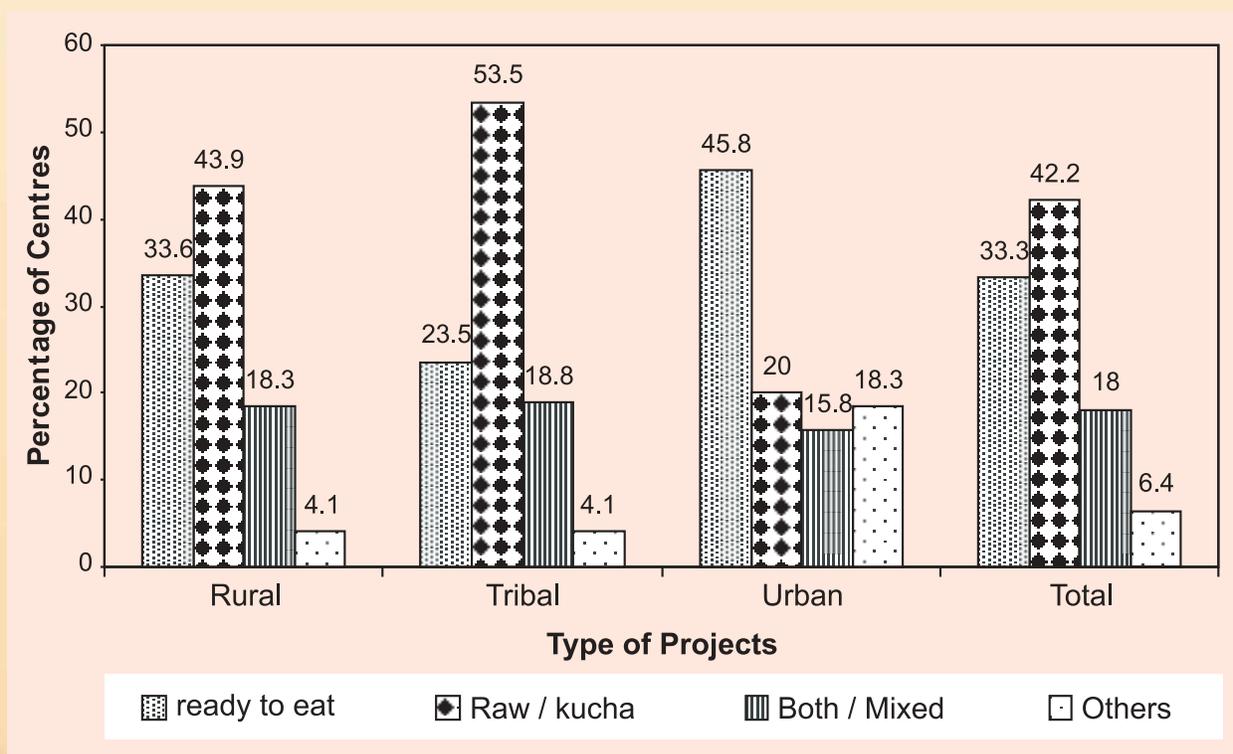
(18.0%) were providing both cooked and RTE food. In Table 4.2, category "others" includes food cooked at a centralised place as also food brought by beneficiaries from home and shared jointly at Anganwadis. In some states like Gujarat, Rajasthan, Maharashtra and Madhya Pradesh, all children below six years identified as severely/moderately malnourished, on the basis of weight, were given therapeutic diet cooked in soft form (pulverised) or tinned milk by benevolent organisations/individuals. This is an indication of significant efforts made by ICDS functionaries to mobilise resources at the grassroots level to make the programme effective and meaningful.

In Andhra Pradesh, Jammu & Kashmir, Jharkhand, Meghalaya, Mizoram, Uttaranchal and West Bengal two types of food items (both RTE and raw/kucha food) were supplied to AWCs. Mostly

single food item, mainly kucha/raw or RTE, was served in the States/ UTs of Bihar, Delhi, Goa, Manipur, Sikkim, Tripura, Uttar Pradesh, Andaman & Nicobar, Chandigarh, Dadara & Nagar Haveli and Pondicherry. Other States/UTs had more than two sources i.e. RTE, raw/kucha and mixed. Further, analysis of data revealed that 14 States/UTs had also other categories of food item(s) like biscuits, bread, banana. Thus, out of 748 Anganwadis, 249 had provisions of RTE food followed by raw/kucha (316) another 135 AWCs served RTE and cooked food from raw/kucha items; 48 AWCs adopted local level provisions depending upon availability of these provisions at project level. State-wise details and types of supplementary nutrition and its sources of procurement have been given at Annexure 7.

Figure 4.2 is the graphical presentation of types of supplementary nutrition at AWCs.

Fig 4.2 Types of Supplementary Nutrition at AWC



4.2.3 Interruptions in Distribution of Supplementary Nutrition

It has been proved that supplementary nutrition not only improves the nutritional level of children and reduces malnutrition, it also works as an incentive for promoting attendance of children and mothers to participate in the activities of AWCs and as such plays a vital role in ICDS programme. CDPOs and AWWs were asked to mention about interruptions, if any, in supply of supplementary nutrition to children and mothers. Table 4.3 shows

months, but not more than three months); (25.5%). Anganwadis confronted this problem thrice and more. In special cases longer gaps were reported, reasons being flood, non-accessibility due to difficult terrain and so on, by Anganwadis constituting negligible percentage (4.1%). State-wise interruption and reasons thereof may be seen from Annexure 8. It was observed that interruption in supply of supplementary nutrition also affected the image of AWWs and credibility to the activities of AWCs, and had a negative impact on community support and participation.

Table 4.3 : Interruptions of Supplementary Nutrition

Location of Projects	Interruption in supply of SN				Frequency of Interruption				
	NR (%)	No Interruption (%)	Interruption Reported (%)	All (%)	Once (%)	Twice (%)	Thrice (%)	Special case (%)	Total (%)
Rural	2 (0.4)	218 (47.6)	238 (52.0)	458 (100.0)	99 (41.6)	75 (31.5)	49 (20.6)	15 (6.3)	238 (100.0)
Tribal	1 (0.6)	65 (38.2)	104 (61.2)	170 (100.0)	47 (45.2)	21 (20.2)	35 (33.6)	1 (1.0)	104 (100.0)
Urban	5 (4.2)	61 (50.8)	54 (45.0)	120 (100.0)	26 (48.1)	11 (20.4)	17 (31.5)	0 (0.0)	54 (100.0)
Total	8 (1.1)	344 (46.0)	396 (52.9)	748 (100.0)	172 (43.4)	107 (27.0)	101 (25.5)	16 (4.1)	396 (100.0)

the frequency of interruptions in supply of supplementary nutrition in Anganwadis in a year.

Overall, while 46 percent of AWCs (rural-47.6%, tribal-38.2% and urban-50.8%) had no interruption at all in terms of supply of nutritional ingredients, 52.9 percent reported interruptions. Tribal AWCs suffered the most due to interruptions: 61.0 percent of tribal AWCs, followed by rural (52.0%) and urban (45.0%) AWCs. Out of the AWCs which reported interruptions in supply of supplementary nutrition, 43 percent faced this situation once which did not go beyond two months; another 27 percent came across this situation twice (beyond two

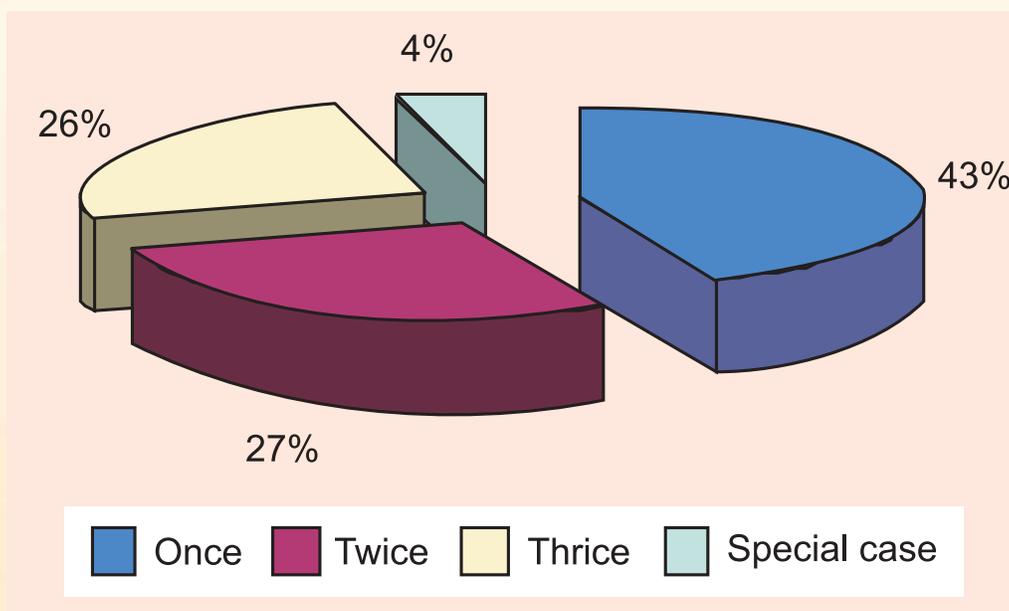
A graphical presentation on the frequency of disruptions in supply of supplementary nutrition has been given in Fig. 4.3.

Table 4.4 shows average number of days in which disruption took place in supply of supplementary nutrition in various types of projects. The table depicts a dismal position of disruption of supplementary nutrition in regular

Table 4.4 : Average Number of Days of Disruptions in Supplementary Nutrition

Nature of ICDS Projects	Location of Projects			
	Rural	Tribal	Urban	Total
Regular	50.48	41.12	37.48	46.31
World Bank-Assisted	11.36	26.48	-	16.76
NGO-supported	6.52	29.20	2.80	7.86

Fig. 4.3 Frequency of Disruption in Supply of Supplementary Nutrition

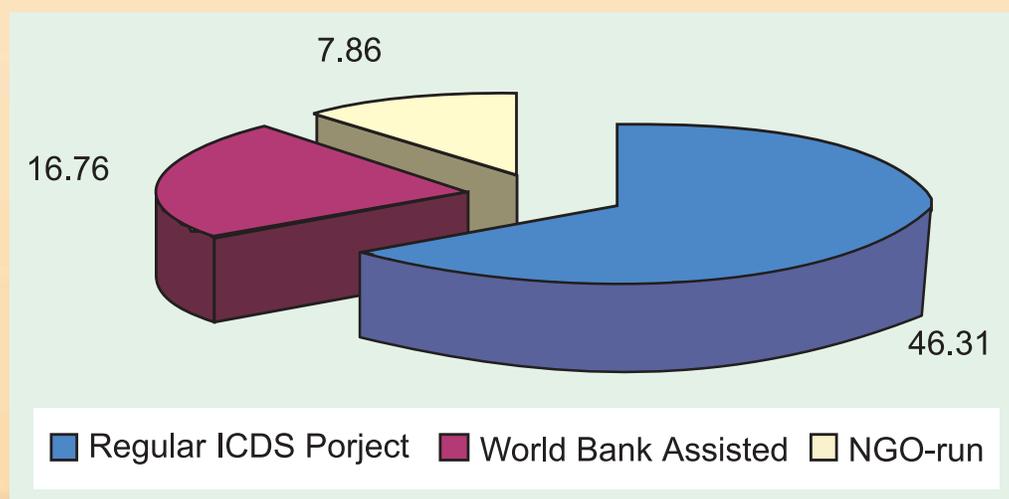


ICDS (46.31 average days) projects which is required to be tackled with special efforts. This will also impact on the delivery of other services due to poor attendance of children in Anganwadis. Respondents of such project areas also expressed their dissatisfaction over this situation. State-wise situation of average number

of days with regard to interruption of supply of supplementary nutrition is appended at Annexure 9.

Average number of days of disruption in supplementary nutrition by nature of ICDS projects has also been given in Fig. 4.4.

Fig. 4.4 Average Days of Disruptions of SN



The contributing factors/reasons for disruption in supply of supplementary nutrition to Anganwadis is tabulated in Table 4.5.

which suggests the need for careful handling of the food material. Transportation problems were

Table 4.5 : Reasons for Disruption in Supply of Nutrition (N=748)

(Multiple Response)

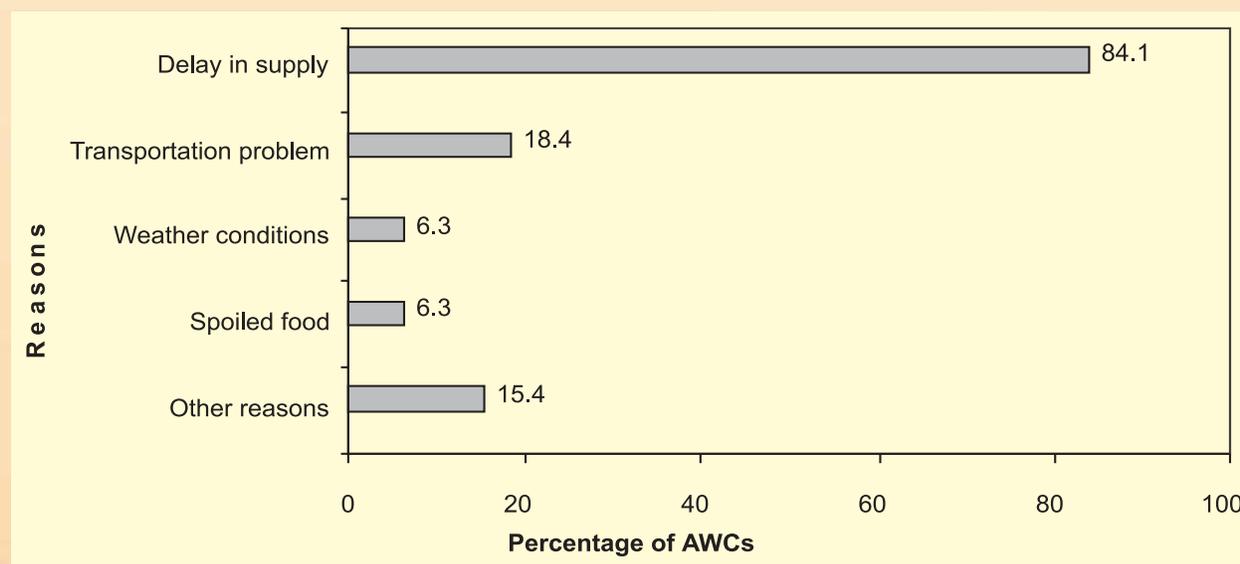
Location	No. of AWCs reporting interruptions	Reasons						
		Delay in supply (%)	Transportation problem (%)	Weather conditions (%)	Project staff on leave (%)	AWW /Helper not in position (%)	Spoiled food (%)	Other reasons (%)
Rural	238	209 (87.8)	36 (15.1)	12 (5.0)	7 (2.9)	0 (0.0)	12 (5.0)	34 (14.3)
Tribal	104	88 (84.6)	35 (33.6)	11 (10.6)	1 (1.0)	1 (1.0)	7 (6.7)	13 (12.5)
Urban	54	36 (66.7)	2 (3.7)	2 (3.7)	0 (0.0)	0 (0.0)	6 (11.1)	5 (9.2)
Total	396	333 (84.1)	73 (18.4)	25 (6.3)	8 (2.0)	1 (0.3)	25 (6.3)	52 (13.1)

Of the projects which faced interruptions, 88 percent reported delay in supply of supplementary nutrition as one of the main reasons for interruption. It could perhaps be attributed mainly to non-payment to transporter or problems related to fixing up transport for projects. Another 6.3 projects reported spoilt food as the reason

faced by 18.4% of projects. Other reasons, reported were untimely release of fund, procedural wrangling in having tender and weather condition by 6.3 percent of projects.

Fig. 4.5 depicts in graphical form, the reasons for disruption of supplementary nutrition.

Fig 4.5 Reasons for Disruption of Supplementary Nutrition at AWCs



4.2.4 Coverage of Women under Supplementary Nutrition

4.2.4.1 Pregnant Women

Table 4.6 draws out the situation as to what has been the coverage of pregnant women under supplementary nutrition in sample AWCs. As against 13750 pregnant women reporting in AWCs, 6526 (47.5%) pregnant women have been registered out of which 5696 (87.3%) pregnant women are

in AWCs, percentage of those availing benefits from AWCs was found to be quite encouraging, in most cases being more than 80 percent. Only in rural AWCs run by NGOs the percentage was 68.3.

4.2.4.2 Nursing Mothers

Criteria adopted for selection of pregnant mothers was also adhered to in case of nursing mothers. A continuous and close watch and attention was paid by CDPOs and Medical Officers for meeting the nutritional needs of these mothers.

Table 4.6 : Coverage of Pregnant Women under Supplementary Nutrition

Area	Location	Number of AWC		Pregnant women					
		Total	Reporting Coverage	Total	Average / AWC	Registered		Availing benefit	
						Number	% of Total	Number	% of Registered
Regular ICDS	Rural	390	380	7435	19.6	3399	45.7	2944	86.6
	Tribal	140	140	1902	13.6	1176	61.8	1109	94.3
	Urban	105	103	2331	22.6	927	39.8	773	83.4
	Total	635	625	11668	18.7	5502	47.2	4826	87.7
World Bank-Supported	Rural	45	45	945	21.0	470	49.8	416	88.5
	Tribal	25	25	377	15.1	184	48.8	164	89.1
	Total	70	70	1322	18.9	654	49.5	580	88.7
NGO-Operated	Rural	23	23	414	18.0	208	50.3	142	68.3
	Tribal	5	5	36	7.2	21	58.3	18	85.7
	Urban	15	15	311	20.7	141	45.3	130	92.2
	Total	43	43	761	17.7	370	48.6	290	78.4
All Areas	Rural	458	448	8793	19.6	4077	46.4	3502	85.9
	Tribal	170	170	2315	13.6	1381	59.6	1291	93.5
	Urban	120	118	2642	22.4	1068	40.4	903	84.6
	Total	748	738	13750	18.6	6526	47.5	5696	87.3

availing benefits of supplementary nutrition. The survey data clearly indicates that the registration levels of pregnant women were similar among the regular, World Bank NGO projects. Interestingly enough, coverage of pregnant women was found maximum in tribal AWCs in regular ICDS projects (61.8%) and NGO-run ICDS projects (58.3%). Coverage of maximum pregnant women was found in rural areas of AWCs (49.8%) run by World Bank projects. Out of these pregnant women registered

Data obtained with regard to this category of mothers have been presented in Table 4.7.

Significantly, World Bank-supported ICDS projects provided nutrition to nine out of ten (91.6%) nursing mothers, followed by Regular ICDS projects (88.4%) and NGO-run ICDS projects (85.9%). Interestingly in NGO-run ICDS projects, 100 percent nursing mothers were found availing benefits from AWCs in tribal and urban areas, while in rural areas,

Table 4.7 : Coverage of Nursing Mothers under Supplementary Nutrition

Area	Location	Number of AWC		Nursing Mothers					
		Total	Reporting Coverage	Total	Average / AWC	Registered		Availing benefit	
						Number	% of Total	Number	% of Registered
Regular ICDS	Rural	390	380	6790	17.9	3238	47.7	2830	87.4
	Tribal	140	140	1582	11.3	1126	71.2	1032	91.7
	Urban	105	103	1885	18.3	998	52.9	878	88.0
	Total	635	625	10257	16.4	5362	52.3	4740	88.4
World Bank Supported	Rural	45	45	895	19.9	423	47.3	369	87.2
	Tribal	25	25	304	12.2	235	77.3	234	99.6
	Total	70	70	1199	17.1	658	54.9	603	91.6
NGO Operated	Rural	23	23	390	17.0	225	57.7	170	75.6
	Tribal	5	5	35	7.0	31	88.6	31	100.0
	Urban	15	15	265	17.7	133	50.1	133	100.0
	Total	43	43	690	16.1	389	56.3	334	85.9
All Areas	Rural	458	448	8075	18.0	3886	48.1	3369	86.7
	Tribal	170	170	1921	11.3	1392	72.5	1297	93.2
	Urban	120	118	2150	18.2	1131	52.6	1011	89.4
	Total	748	738	12147	16.5	6409	52.8	5677	88.6

the percentage was 75.6. Even in regular ICDS projects and World Bank ICDS projects, nursing mothers availing supplementary nutrition was found to be overwhelming in tribal areas (91.7% and 99.6%, respectively). These figures are clear indication of the fact that ICDS programme has been able to reach out to the target population of pregnant women and nursing mothers.

State-wise position of number of pregnant women registered and availing benefits has been given in Annexure 10. This distribution shows that only in the State of Meghalaya (90.7%) above 90 percent registration of pregnant mothers was reported. The States/UTs which registered pregnant mothers between 80 and 90 percent were Mizoram (81.7%) and Dadra and Nagar Haveli (82.0%). The lowest percentage of registered pregnant women was reported in Goa (31.3%). It was found that all registered pregnant women availed benefits of supplementary nutrition in the States and UTs of Arunachal Pradesh, Nagaland,

Tripura, Lakshadweep and Pondicherry. In the States/UTs wherein supplementary nutrition was availed by more than 90 percent beneficiaries were Andhra Pradesh (93.4%), Goa (96.8%), Himachal Pradesh (93.9%), Jammu & Kashmir (90.5%), Jharkhand (93.0%), Karnataka (91.7%), Maharashtra (92.5%), Manipur (96.9%), Meghalaya (93.9%), Mizoram (94.4%), Uttar Pradesh (93.7%), Dadra & Nagar Haveli (92.7%) and Daman & Diu (94.1%). It was found that in 14 states, between 18 and 90 percent pregnant women were found to be wanting supplementary nutrition.

State-wise position of nursing or lactating mothers registered and availing supplementary nutrition has also been given in Annexure 10. On the whole, little more than 50 percent nursing mothers (52.8%) were registered. Of these, 89 percent received supplementary nutrition. More than 80 percent nursing mothers were found to have been registered for supplementary nutrition in the States of Arunachal Pradesh (82.9%), Mizoram (80.3%), Nagaland (81.8%) and UTs of

Dadra & Nagar Haveli (85.5%) and Lakshadweep (87.7%). It was also found that nutrition was provided to a high percentage of nursing mothers in these states. Registration of nursing mothers was again higher in some of the States which depicted higher registration of pregnant mothers such as Mizoram, Dadra & Nagar Haveli. Among the registered beneficiaries (nursing mothers) in quite a large number of states more than 90 percent nursing mothers were availing supplementary nutrition. These States and Union Territories are: Andhra Pradesh (94.5%), Chhattisgarh (94.5%), Goa (97.2%), Haryana (90.3%), Himachal Pradesh (93.5%), Jammu & Kashmir (94.4%), Jharkhand (96.0%), Karnataka (91.4%), Kerala (95.2%), Madhya Pradesh (96.0%), Manipur (94.7%), Meghalaya (96.9%), Mizoram (93.3%), Sikkim (91.7%), Tamil Nadu (90.5%), Uttar Pradesh (93.8%), Uttaranchal (96.9%), Delhi (93.1%), Daman & Diu (94.9%), Lakshadweep (96.0%) and Pondicherry (97.2%). In Tripura, Andaman & Nicobar, Chandigarh and Dadra & Nagar Haveli, cent percent nursing mothers were reported to have been availing benefits of supplementary nutrition.

4.2.5 Coverage of Children under Supplementary Nutrition

4.2.5.1 Children (under supplementary nutrition) (6 month to 3 years)

Survey results reveal that selection of children for supplementary nutrition

was made by following the criteria prescribed by the concerned State/UT administration. All children below three years identified as severely or moderately malnourished (on the basis of weight for age) were entitled to get this support. In all sample Anganwadis, growth charts, a graphical presentation of weight for age, were reported to have been supplied. Wherever growth charts were not available, weight by age was recorded in a register from birth to five years. It was observed that weighing procedure seemed to have been working satisfactorily in case of grade III and IV malnourished children, both quantitatively and qualitatively. The concept of "at risk" children was used for assessing the progress of specially needy children. Such children were listed separately, and were weighed carefully every month. ANMs/PHNs and doctors paid special attention and provided therapeutic diet. AWWs and CDPOs monitored records and provided information about number of malnourished children. ICDS functionaries utilised this information for working out food requirements and timely procurement and supply thereof to Anganwadis.

Table 4.8 : Supplementary Nutrition to Children (6 months to 3 years)

Children 6 months to 3 years	Location of Projects			
	Rural	Tribal	Urban	Total
Male	14705	4066	4050	22821
Total in the village	(100.0)	(100.0)	(100.0)	(100.0)
Registered	8619	2713	2146	13496
	(58.6)	(66.7)	(53.4)	(59.1)
Availing benefits	6261	2199	1609	10069
	(72.6)	(81.1)	(74.4)	(74.6)
Female	13828	3879	3838	21545
Total in the village	(100.0)	(100.0)	(100.0)	(100.0)
Registered	7464	2401	2026	11891
	(54.0)	(61.9)	(52.8)	(55.2)
Availing benefits	6047	2017	1671	9735
	(81.0)	(84.0)	(82.5)	(81.9)



The overall picture points out that there was evidently more registration of male children (59.1%) than those of female children (55.2%); this is also true in respect of ICDS projects of different areas - rural, tribal and urban. As for availing benefits of supplementary nutrition, the scenario was found to be the reverse. On the whole, the percentage of female children availing supplementary nutrition was quite high - 82 percent in all - rural (81.0%), tribal (84.0%), and urban (82.5%), as against male children - 75 percent in all - rural (72.6%), tribal (81.1%) and urban (74.4%).

State-wise position in terms of supplementary nutrition so far as children of 6 months to 3 years are concerned has been given in Annexure 11. In the States of Tripura and Arunachal Pradesh, it was found that more than 80 percent of both male and female children were registered and availed supplementary nutrition. In case of Tripura, male and female children registered were 86 percent and 81 percent, respectively and those who availed supplementary nutrition were 92 percent and 96 percent, respectively. Similarly, in the states of Arunachal Pradesh, male and female children registered were 86 percent and 82 percent, respectively while percentage of those availed supplementary nutrition was 97 percent and 89 percent, respectively. Another interesting feature emerged from this information was that in some of the States and Union Territories more than 90 percent children, both male and female,

availed supplementary nutrition. These States were Goa (94.0% and 94.5%, respectively), Himachal Pradesh (94.4% and 90.4% respectively), Manipur (90.8% and 90.4%, respectively) and Chandigarh (96.6% and 90.4%, respectively).

4.2.5.2 Children (3-6 Years)

Children attending pre-school education were also entitled to receive supplementary nutrition at Anganwadis. This worked as an incentive to promote attendance in Anganwadis as also to meet calorie requirements of children belonging to this age-group. Data shown in Table 4.9 presents the prevalent trend in terms of availing benefits of supplementary nutrition. Despite the fact that more girls (57.8%) were registered than boys (51.1%), boys availed benefits more (75.9%) in comparison to girls (74.6%). Further in tribal areas, percentage of registered children was more both in boy and girl category, though on the whole availing of benefits was fluctuating in the range 72-76 percent irrespective of gender or areas of project.

Table 4.9 : Supplementary Nutrition to Children (between 3 and 6 years)

Children (3-6 years)	Location of Projects			
	Rural	Tribal	Urban	Total
Male				
Total in the village/ ward	17143 (100.0)	4598 (100.0)	4574 (100.0)	26315 (100.0)
Registered in Anganwadis	8311 (48.5)	2889 (62.8)	2255 (49.3)	13455 (51.1)
Availing benefits	6425 (77.3)	2078 (71.9)	1716 (76.1)	10219 (75.09)
Female				
Total in the village/ ward	15491 (100.0)	4294 (100.0)	4138 (100.0)	23923 (100.0)
Registered in Anganwadis	8545 (55.2)	2898 (67.5)	2385 (57.6)	13828 (57.8)
Availing benefits	6386 (74.7)	2187 (75.5)	1747 (73.2)	10320 (74.6)

4.2.6 Acceptance / Non-Acceptance of Supplementary Nutrition

ICDS programme provides adequate flexibility in the selection of nutritious food with respect to items prepared from locally available food materials. Local seasonal crops were utilised to produce simple blended mixes which consist of combination of cereal-pulse, a cereal-pulse oil seeds or a cereal pulse jaggery mixture and so on. The idea behind this is that food supplements need to be increasingly based on locally available foods; further, the food selected should be palatable and acceptable to mothers and children residing within a geographical area, easily digestible especially by young children, and has to be nutritious and low cost. Recipe is to be simple and should have minimum number of ingredients. Development of "ready-to-eat" formulation was also accepted and encouraged in the form of Sev, Boondi, Mathari, Murukku and Sakkarapara. Preparation of these items was observed in some of the Anganwadis on weekly basis. In case of infants/toddlers, the same preparation was made as powder and pulp by addition of milk/water. Eggs were also being given to children in Tamil Nadu and Kerala.

4.2.6.1 Acceptability of Supplementary Nutrition - Views Expressed by AWWs

AWWs expressed their views about acceptability of supplementary nutrition by beneficiaries. Eight out of ten Anganwadi workers (79.8%) reported that food was totally acceptable to children and mothers. They found

it well prepared, tasty and enjoyed its consumption. Around 7 percent found only some of the items of nutrition served as acceptable; 11 percent did not find food items served as acceptable. Major complaints from beneficiaries were found in rural projects (13.5%) followed by urban (8.4%) and tribal projects (7.1%). Acceptability of food was maximum in tribal projects (84.7%) followed by rural (78.8%) and urban projects (76.7%). The problem of non-acceptability was in case of 13 percent Anganwadis of rural projects followed by urban (8.3%) and tribal (7.1%).

State-wise analysis of data showed that all items of food were acceptable by beneficiaries as reported by AWWs in the States/UTs of Arunachal Pradesh, Bihar, Goa, Himachal Pradesh, Jammu & Kashmir, Manipur, Mizoram, Sikkim, Tripura and Pondicherry, Andaman & Nicobar, Chandigarh, Dadra & Nagar Haveli and other Union Territories. AWWs of 13 States and four UTs found the supplementary nutrition totally acceptable. AWWs of 16 States/UTs mentioned that some of the item(s) of RTE food supplied by contract were below the level of consumption. AWWs reported that food was acceptable by below 75 percent beneficiaries in the States of Rajasthan (67.9%), Assam (66.7%), Orissa (65.0%), Haryana (55.0%), Meghalaya (40.0%), Uttaranchal (40.0%) and the lowest was reported from Uttar Pradesh (25.7%). State-wise position of acceptability of food items given in supplementary nutrition as stated by beneficiaries is shown in Annexure 12.

4.2.6.2 Reasons for Non-Acceptance of Supplementary Nutrition

AWWs also stated various reasons for non-acceptability of supplementary nutrition by beneficiaries. Views expressed by them in this regard are described in Table 4.10.

Table 4.10 : Reasons for Non-acceptance of Supplementary Nutrition (version of AWWs) (N=748)

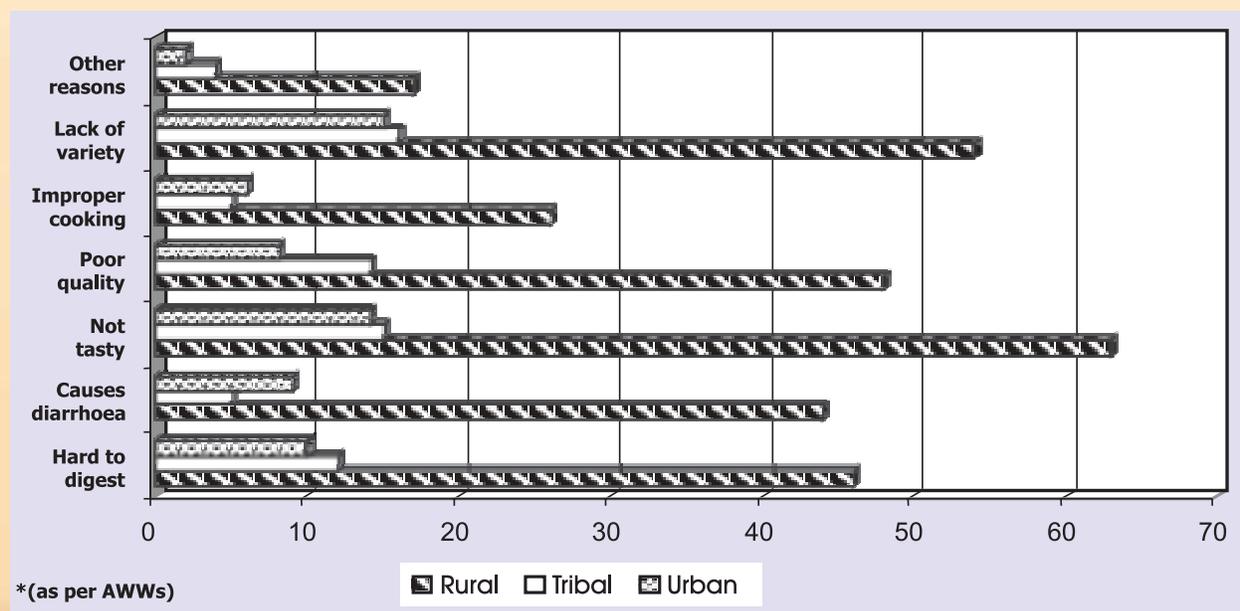
(Multiple Response)

Reason for non-acceptance of nutrition	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Hard to digest	46 (10.0)	12 (7.1)	10 (8.3)	68 (9.1)
Causes diarrhoea	44 (9.6)	5 (2.9)	9 (7.5)	58 (7.8)
Not tasty	63 (13.8)	15 (8.8)	14 (11.7)	92 (12.3)
Poor quality	48 (10.5)	14 (8.2)	8 (6.7)	17 (9.4)
Improper cooking	26 (5.7)	5 (2.9)	6 (5.0)	37 (4.9)
Lack of variety	54 (11.8)	16 (9.4)	15 (12.5)	85 (11.4)
Other reasons	17 (3.7)	4 (2.4)	2 (1.7)	23 (3.1)

Twelve percent beneficiaries found that food items were not tasty and therefore, did not accept it. Table 4.10 also shows that there was no variety in food items served. The same panjiri or like was served on all days which was disliked by children and mothers. This led to wastage of food item. Sometimes it also got spoiled due to inclement weather conditions and poor packaging. Another reason in descending order was poor quality of food items supplied. Purchased and supplied items were of the lowest bid and reported to be substandard in quantity and quality. Many of the AWWs reported that they did not want to accept such substandard supply but were forced to keep and use it. Equally valuable reason was question of digestibility of food. AWWs reported that children complained of stomach pain, nausea and similar complaints after consuming spoiled food supplies.

Fig. 4.6 shows the reasons for non-acceptance of supplementary nutrition in a bar diagram.

Fig. 4.6 Reasons* for Non-acceptance of SN



4.2.6.3 Freshly Cooked Food

ICDS programme also recognised that special food needed to be served to pregnant and nursing mothers as also severely malnourished children which were culturally and psychologically acceptable to their families. In case of children below three years (infants/toddlers), the same preparation is to be made as powder, halwa and pulp by mixing it with water or milk. A question was asked, "Are you serving freshly cooked food?" Overall, two-third of AWWs (67.1%) replied in affirmative. In case of 69 percent of AWWs from tribal and rural projects affirmative replies were received, followed by urban projects (57%). They further elaborated that freshly cooked food items were Khichri, Pongal/idly, Dalia, Gram, Pullav/Halwa/Poha, green gram etc. Table 4.11 describes the variety of freshly cooked items served to children and mothers in relation to location of the projects.

Table 4.11 reflects that Khichri (40.4%) was freshly cooked and served followed by green gram

Table 4.11 : Items of Freshly Cooked Food Served at AWCs (N=748)
(Multiple Response)

Type of food item served	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Khichri	188 (41.0)	67 (39.4)	47 (39.2)	302 (40.4)
Pongal	56 (12.2)	8 (4.7)	16 (13.3)	80 (10.7)
Dalia	95 (20.7)	30 (17.6)	22 (18.3)	147 (19.7)
Channa	137 (29.9)	46 (27.1)	14 (11.7)	197 (26.3)
Pullav / Halwa / Poha	73 (15.9)	21 (12.4)	16 (13.3)	110 (14.7)
Green Gram (Moong)	128 (27.9)	41 (24.1)	31 (25.8)	20 (26.7)
Other item(s)	148 (32.3)	49 (28.8)	36 (30.0)	233 (31.1)

and channa in (27%) in Anganwadis. One out of five Anganwadis (19.7%) also cooked and served Dalia to mothers and children. While pongal was served in Anganwadis of Southern India, Pullav/Halwa/Poha was found prevalent in Maharashtra, Gujarat and Rajasthan. Other categories of food served included Roti (loaf), rice and dal, puri Bhaji etc. It may also be mentioned that fuel charges were paid to AWWs by concerned State Government in 376 out of 748 AWCs which works out to roughly 50%. Another 161 AWWs i.e. roughly 22 percent were reported not to have received this amount. Two hundred and ten Anganwadis (about 28%) served only "ready-to-eat" food, hence, this issue was irrelevant to them. The States which paid fuel charges and served only cooked foods were Bihar, Chhattisgarh, Goa, Himachal Pradesh, Meghalaya, Pondicherry, Tripura and West Bengal and UTs of Andaman & Nicobar, Dadra & Nagar Haveli and Daman and Diu.

4.2.7 Growth Monitoring – Assessment of Performance and Problems Faced

4.2.7.1 Growth Monitoring – Assessment of Performance by AWWs

Special emphasis has been laid on weighing of new born children and ensure their survival, growth and development by ICDS intervention. A continuous close watch and attention was being paid by CDPOs and Medical Officers of PHCs/CHCs for care of these



Growth Monitoring



children as also meeting the needs of severely malnourished children. District and State level officials also arranged to ensure better nutritional and health care of such children to keep them in normal categories. Information was collected in the survey about weighing of new born children. It was found that AWWs weighed 63.5 percent of new born children and mothers cooperated in this exercise in spite of stigma attached to weighing of new born children. AWWs (67.5%) of urban projects weighed new born. Rural AWWs (64.0%) also succeeded in weighing new born whereas tribal AWWs (59.4%) were able to convince mothers and could weigh new born.

Data was also collected about weighing of children as per guidelines issued on this subject. AWWs reported that children below 3 years were to be weighed once in a month and those falling in the age group 3-5 years required to be weighed on quarterly basis. Eighty-two percent AWWs adhered to this guideline and weighed children below 3 years once in a month. However, weighing of children in the age-group 3-5 years was slightly better as majority of AWWs (83.3%) were able to do so. Location-wise analysis of data showed that 92 percent AWWs of urban projects weighed children below three years, whereas this figure was 89 percent in case of children of 3-6 years. In rural projects, 84 percent AWWs weighed children between 3 to 6 years age-group which was comparatively lower (80.3%) for beneficiaries below 3 years. It was observed that weighing procedure was working satisfactorily in

case of children both quantitatively as well as qualitatively.

Table 4.12 makes it amply clear that entire onus of weighing and plotting was shouldered by AWWs (85.8%). Supervisors extended help in monitoring the growth of severely malnourished children and new born on the day of their visit to AWCs. ANMs/LHVs also provided support during their presence in the AWCs or when the child was available in PHCs/Sub-Centres. It was also

Table 4.12 : Filling of Growth Charts (N=748)
(Multiple Response)

Growth Charts Filled By	Location of Projects			Total (%)
	Rural (%)	Tribal (%)	Urban (%)	
AWWs	390 (85.2)	140 (82.4)	110 (93.2)	642 (85.8)
Supervisors	42 (9.2)	8 (4.7)	15 (12.5)	65 (8.7)
ANMs / LHVs	13 (2.8)	5 (2.9)	4 (3.3)	22 (2.9)
Others	14 (3.1)	11 (6.5)	1 (0.8)	26 (3.4)

observed that ANMs were more supportive to AWWs provided they stayed in the village(s) wherein their sub-centres were located. Weighing and plotting was also carried out by others who included school teachers, members of Mahila Mandals, adolescent girls etc.

A study was undertaken by the Department of Paediatrics, Institute of Medical Sciences, Banaras Hindu University, to assess the impact of ICDS on maternal nutrition and birth weight of newborns in rural Varanasi. It was found that during pregnancy, women gained about 6.3 -7.4 kg. In the ICDS block, birth weight of children of women provided supplementation was significantly higher by 58 gm as compared to the birth weight

of children of unsupplemented women (NIPCCD: 2005: pp.94-95).

4.2.7.2 Problems in Growth Monitoring - Faced by AWWs

Success of growth monitoring depended upon the extent to which counselling support, weighing scales, growth charts etc. were available in Anganwadis. Training of AWWs also contributed not only in weighing and plotting of weight but also counselling to mothers. Problems were reported by AWWs in conducting this exercise. Out of 748 AWCs, a little over one out of ten (11.1%) had no growth charts and 4 percent AWCs lacked weighing scales. Other reasons reported by AWWs included weighing scale under repair (3.3%) and lack of time (2.4%). While 5 percent parents were not cooperative in getting their children weighed, AWWs (3.2%) were also not able to fill in growth charts. A negligible percentage (1.9%) of AWWs were not skilled adequately to weigh children. AWWs of urban projects did not face much of these listed problems/ difficulties. These were more visible in tribal and rural projects almost at even level. Seventeen percent AWWs of tribal projects reported non-availability of growth charts, followed by rural projects (10.5%). A little over 12 percent of AWWs of tribal projects had also no weighing scales. One out of five tribal AWWs reported that parents were also non-cooperative in getting their children weighed whereas position was identical in rural and urban projects (13.3%).

The prophylaxis programmes, both for Vitamin A and iron deficiency, showed better coverage of women and children in ICDS areas as compared to non-ICDS areas. About 36.3 percent AWWs were not able to monitor growth of children. The reasons given were non-availability of growth charts, lack of skills in filling growth charts, non-availability of weighing scales or their not being in working condition, etc. The coverage of children for immunisation was found to be higher in ICDS areas as compared to non-ICDS areas (NIPCCD: 1992)

4.2.7.3 Counselling of Mothers

Weighing is carried out with the purpose of assuring the progress of "at risk" needy children. ANMs and doctors also paid special attention and provided therapeutic diet. Children often needed hospitalisation. AWWs were required to take up follow-up action based on weighing outcome and advice of health staff. Table 4.13 throws light on role of AWWs after weighing of children.

Data in Table 4.13 shows that equal percentage (84.1%) of AWWs educated mothers

Table 4.13 : Role of AWWs in Weighing of Children (version of AWWs) (N=748)

(Multiple Response)

Category of responses	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Educating mothers about outcome of weighing	379 (82.8)	141 (82.9)	109 (90.8)	629 (84.1)
Ensuring consumption of supplementary nutrition in Anganwadis	281 (61.4)	97 (57.1)	77 (64.2)	455 (60.8)
Advising mothers to feed frequently	374 (81.7)	139 (81.8)	115 (95.8)	628 (84.0)
Regular health check-up	298 (65.1)	109 (64.1)	79 (65.8)	486 (65.0)
Others	65 (14.2)	22 (12.9)	16 (13.2)	103 (13.8)

Some Snapshots of PSE Activities



about consequences of weighing and its repercussions on child's health and nutrition as also advised them to feed the child frequently particularly those who were either severely malnourished or their weight was falling below normal curve of growth chart. Further, the focus was on health check-up of such children by 65 percent of AWWs. AWWs (60.8%) also arranged to feed children in Anganwadis so that the food was consumed only by intended child and was not shared with other children at home.

4.3.1 Pre-school Education (PSE)

The crux of human resource development lies in providing an enabling environment to the young children so that they are able to grow as healthy and productive adult. Efforts have already been initiated in this direction through ICDS programme by placing children on the priority agenda of ICDS programme. Pre-school education has been envisaged in ICDS programme as an essential component for children who are on the verge of going into formal education system. The importance of pre-school education is also universally recognised because it caters to those children who, during this phase of their life, undergo the most important educative process. Further, there has been a growing awareness among the parents about the crucial significance of the pre-school years (2½ to 6 years) as optimum development of a child's personality takes place

in these years. The need for pre-school education is also considered most pronounced in case of children from culturally and socio-economically disadvantaged families. Programme contents of PSE largely centre around organised play activities.

Data of the present study in respect of PSE activities was obtained in terms of coverage of children, types of PSE activities conducted by AWWs and other related aspects.

Table 4.14 shows that on an average, 37 children were registered for pre-school education at Anganwadis in a span of three months. This signifies that AWWs made positive efforts for bringing children from deprived sections to AWCs so that they could utilise nutrition and health services as well. On the whole, 75 percent of the registered children attended the Anganwadis.

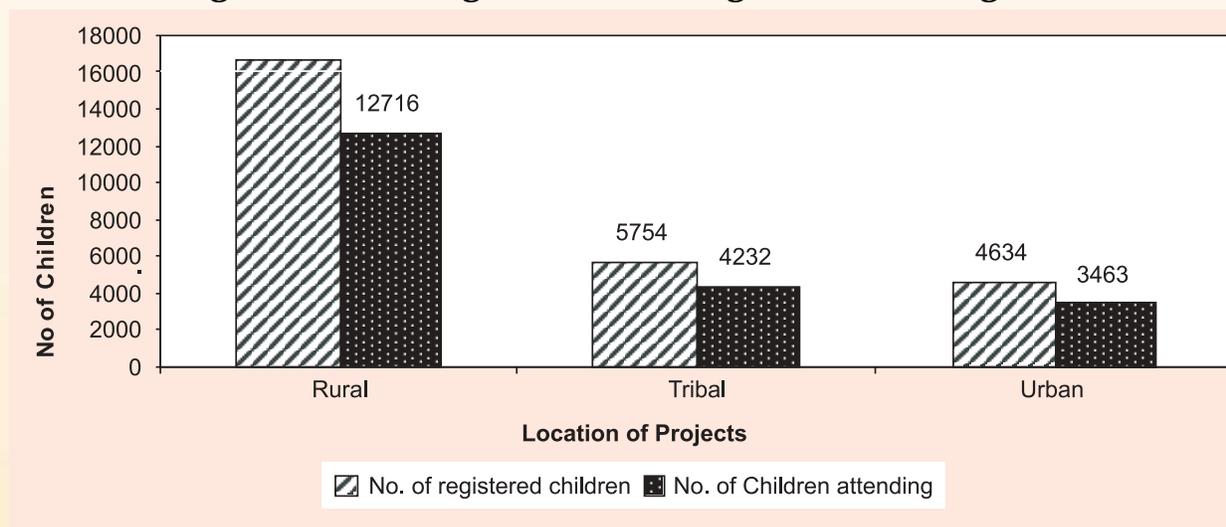
Table 4.14 : Coverage of Children under PSE in Last Three Months (N=748)

Category of responses	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Total No. of AWCs	458	170	120	748
Total No. of centres reporting	445	169	118	732
Average No. of registered children	38	34	39	37
Average No. of children attending AWCs	29	25	29	28
Percentage of children attending AWCs	75.8	73.5	74.7	75.1

Fig. 4.7 draws a comparative picture between children registered and children attending pre-school activities.

Outdoor Activities by Anganwadi Children



Fig. 4.7 Children Registered & Attending AWC (absolute figures)

Data was also collected on absolute number of children registered and admitted in Anganwadis according to the location of projects which is presented in Table 4.15.

Table 4.15 : Children Registered and Attending PSE in Anganwadis (absolute number) (N=732)

Location of project	No. of registered children			No. of Children attending		
	Male	Female	Total	Male	Female	Total
Rural	8267	8509	16776	6366	6350	12716
Tribal	2871	2883	5754	2061	2171	4232
Urban	2255	2379	4634	1716	1747	3463
Total	13393	13771	27164	10143	10268	20411

Figures in Table 4.15 show that children enrolled and attending AWCs were comparatively on almost equal footing. However, contrast may be seen from figures of attendance which points out that number of girls was more in AWCs than that of boys for taking benefits. In all likelihood, it could be that boys were preferred to be sent to attend private schools especially in urban areas and towns for PSE.

A study was carried out to determine the long-term effects of ICDS programme on children and mothers in 12 AW areas of Jasra ICDS block

of Allahabad district of Uttar Pradesh showed that school going rate of ICDS beneficiaries was slightly higher than that of non-beneficiaries. School dropout rate was found to be significantly higher

for beneficiaries as compared to non-beneficiaries. This is because they were from poorer families, and in times of crises, the children had to drop out from school to help the family out. Academic

performance of non-beneficiaries was found to be poor as compared to beneficiaries. This is because children had no interest in studies and children did not find the studies relevant (NIPCCD: 2005: pp.87).

4.3.2 PSE Activities

The idea behind PSE activities is that children attending these activities are helped to develop desirable attitudes by way of providing intellectual stimulation through non-formal play activities

**Prayer at the
Anganwadi Centre**



**PSE activites in
progress**



(rather than being involved in formal learning process). However, experience of ICDS functionaries highlighted that the parents did not hold the same perception. Parents are reported to be laying stress on formal learning process for their children. Vigorous efforts were made by AWWs and project staff to correct parents' perception towards PSE activities. In view of this, some elements of formal learning have been introduced in AWCs for children who are above four years of age. Activities conducted by AWWs with regard to PSE are depicted in Table 4.16.

Table 4.16 reveals that children were engaged in singing songs in almost all AWCs (95.1%). Story telling and counting were two other activities which were organised by 91 percent AWWs. While 78 percent AWWs reported

involvement of children in indoor activities, three-fourth of them (74.7%) also engaged children in free conversation to speak freely and apply their mind in order to organise small activities. Outdoor games could be organised by 70 percent AWCs. It is also evident from the table that painting, printing, drawing, threading and matching colour related to fine muscle coordination and development, as also activities for emotional and intellectual development could get only qualified attention in selected AWCs. Open space was a serious problem for outdoor games of children hence it got restricted to only 70 percent of Anganwadis. Other minor differences in activities carried out in rural, tribal and urban areas were perhaps because of inadequacies of physical space, facilities and skills of AWWs. A tendency for dependency upon non-indigenous play equipments was observed which needs to be minimised. Emphasis on improvisation of preparation of materials from local resources is required so as to raise the status of PSE including training of AWWs in this service component. Possibilities need to be explored for maximum use of materials like sand, clay, leaves, water, twig, sandpits, crayons and brush drawings and paintings, paper cuttings, beads etc. which have been found both cost effective and popular. Sophisticated toys need to be discarded as resources of AWCs are very much limited. In Table 4.16 "Others" includes use of picture books and toys, folk dolls, sea-saw, swings, rings etc.

**Table 4.16 : Pre-school Education Activities Conducted by AWWs
(N=748)**

(Multiple Response)

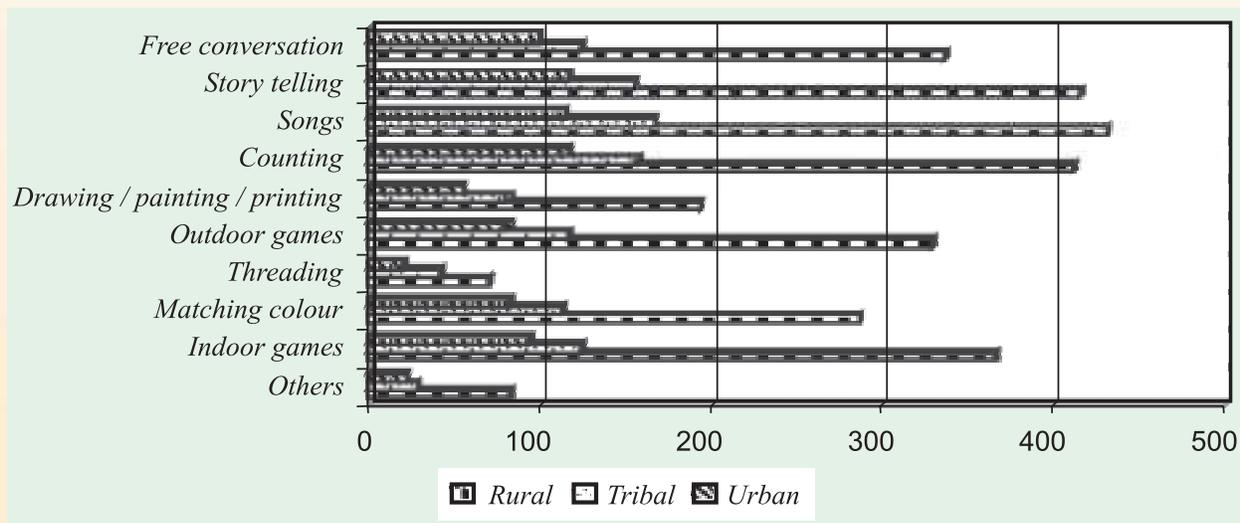
Type of activities conducted	Location of Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Free conversation	335 (73.1)	124 (72.9)	100 (83.3)	559 (74.7)
Story telling	415 (90.6)	155 (91.2)	116 (96.7)	686 (91.7)
Songs	430 (93.9)	166 (97.6)	115 (95.8)	711 (95.1)
Counting	410 (89.5)	157 (92.4)	116 (96.7)	683 (91.3)
Drawing / painting / printing	193 (42.1)	81 (47.6)	55 (45.8)	329 (44.4)
Outdoor games	328 (71.6)	117 (68.8)	81 (67.5)	526 (70.3)
Threading	70 (15.3)	41 (24.1)	21 (17.5)	132 (17.6)
Matching colour	286 (62.4)	113 (66.5)	82 (68.3)	481 (64.3)
Indoor games	364 (79.5)	124 (72.9)	93 (77.5)	581 (77.7)
Others	82 (17.9)	29 (17.1)	23 (19.2)	134 (17.9)

**Child Learning Competency Test (CLCT)
in action**



Figure 4.8 also describes graphically various PSE activities conducted at Anganwadis. the age-group 15-45 also need special attention in this regard.

Fig. 4.8 : PSE Activities Conducted at AWCs



4.4.1 Immunisation

The task of improving the health of children depends much on the preventive measures rather than curative measures. The following paragraphs reveal the important aspects of peripheral health system that exists to meet the basic health needs of mothers and children. The existing Indian situation with regard to maternal and child health reflects inadequacy of health facilities for the rural and tribal poor. The primary health needs of mothers are that every expectant and nursing mother maintains good health, learns the art of child care, has normal delivery, bears healthy children, and every child is born alive and grows in a family unit with love and security, has healthy surroundings, gets adequate nourishment, health supervision and efficient medical attention and is taught to lead a healthy living. Children below 6 years and women in

Although attention has been paid to immunise children against tetanus and poliomyelitis, unfortunately, the gap in the provision of health care services between rural and urban areas has also been increasing. The problem gets further accentuated by other factors like age-old customs, beliefs, traditions and taboos, bad communication and acute poverty. Besides these, vast gaps are also found between rural, urban and tribal areas in the field of health education, provision of safe drinking water, sewage disposal and environmental sanitation which have direct bearing on child and maternal health.

Right from birth, children are exposed to various health hazards including communicable diseases. Immunisation enhances the capacity of the body to fight against occurrence of these diseases. Immunisation, as a preventive measure, is needed to build up protective capacity of the

body against certain infections. Immunisation against tuberculosis, diphtheria, whooping cough (pertussis), tetanus, measles and polio for children under one year of age and immunisation against tetanus of all pregnant women has been envisaged in ICDS project areas. Immunisation activities are carried out by PHCs/CHCs and their subordinate health infrastructure. Data of the present study regarding the scenario of immunisation in sample ICDS projects has been presented in Table 4.17.

that the status of fully immunised children depended upon their availability when the immunisation schedule was in operation. Table 4.17 also reflects that in urban areas status of immunisation seemed to be below expectation while situation was comparatively better in rural ICDS projects (71.6%). Eight percent of health functionaries were found to have faced the problem of non-availability of vaccine. It was interesting to observe that records of vaccination were correctly maintained by health functionaries/AWWs.

Table 4.17 : Health Functionaries Reporting about Fully Immunised Children (N=443)

Location of Projects	Responses in respect of fully immunised children			
	Yes	No	No	Total response
Rural ICDS Projects	197 (71.6)	74 (26.9)	4 (1.5)	275 (100.0)
Tribal Projects	52 (51.5)	46 (45.5)	3 (3.0)	101 (100.0)
Urban Projects	44 (65.7)	20 (29.9)	3 (4.5)	67 (100.0)
Total	293 (66.1)	140 (31.6)	10 (2.3)	443 (100.0)

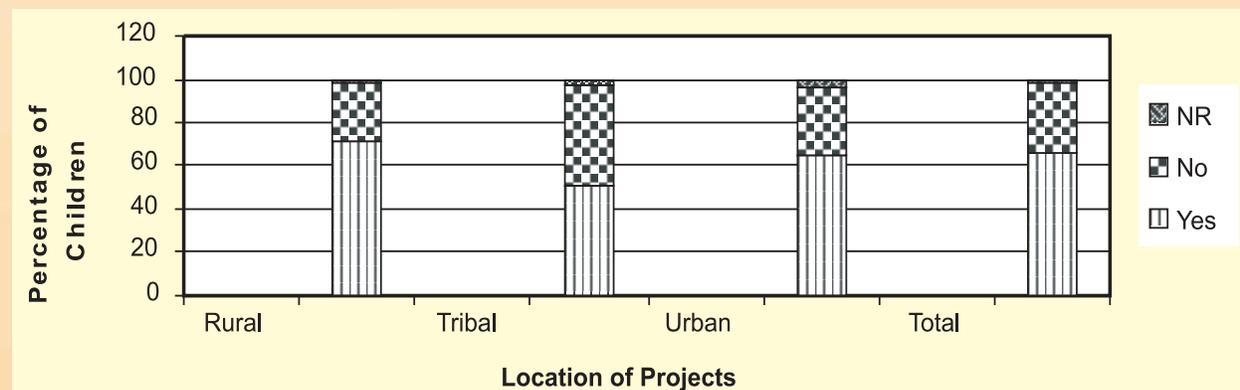
According to Table 4.17, about 66 percent health functionaries reported full immunisation of children, highest being in rural projects (71.6%), followed by urban (65.7%) and tribal (51.5%) projects. Health functionaries reported

Fig. 4.9 presents a diagram showing number of health functionaries reporting about fully immunised children.

4.4.2 Reasons for Inadequate Immunisation

AWWs and ANMs jointly educated and motivated the mothers and local community for total coverage of target population under various immunisation and prophylaxis programmes. Local groups, local committee, Panchayats, Mahila Mandals and Self-Help Groups played supportive role in this

Fig. 4.9 Status of Fully Immunised Children*



**as reported by health functionaries*

programme. In spite of the best intentions and sincere efforts of these groups and individuals, problems and difficulties were encountered in achieving the objective of full immunisation of all beneficiaries. Table 4.18 highlights various reasons for not being able to fully immunise all children as mentioned by health functionaries.

Table 4.18 : Reasons for Not Being Able to Fully Immunise All Children (N=443)

(Multiple Response)

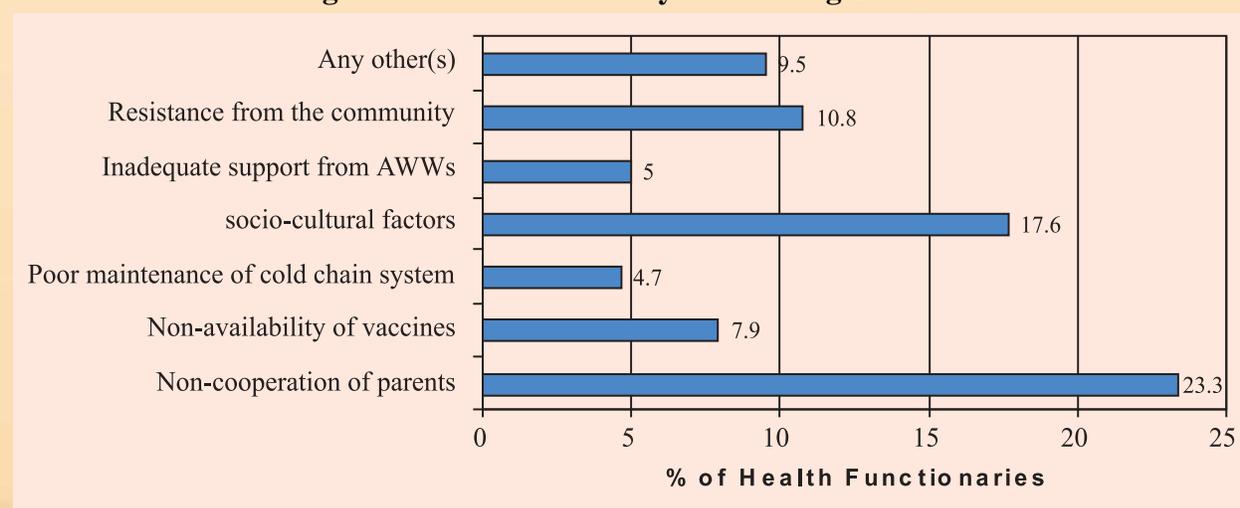
Reasons for inadequate immunisation	Location of ICDS Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Non-cooperation of parents	50 (18.2)	37 (36.6)	16 (23.9)	103 (23.3)
Non-availability of vaccines	15 (5.5)	17 (16.8)	3 (4.5)	35 (7.9)
Poor maintenance of cold chain system	6 (2.2)	13 (12.9)	2 (3.0)	21 (4.7)
Superstitions / beliefs / stigma etc. (socio-cultural factors)	34 (12.4)	31 (30.7)	13 (19.4)	78 (17.6)
Inadequate support from AWWs	12 (4.4)	9 (8.9)	1 (1.5)	22 (5.0)
Resistance from the community	22 (8.0)	20 (9.8)	6 (9.0)	48 (10.8)
Any other(s)	26 (9.5)	12 (11.9)	4 (6.0)	42 (9.5)

of parents towards immunisation (23.3%), followed by disbeliefs attached to immunisation (17.6%). It would be interesting to note the remarks of one of the parents who said, "I was not immunised, even then, I am hale and hearty" (*Mujhe tika nahi laga magar mei swasth hun evam bimar nahi pada*). Another major reason included age-old beliefs, customs, superstitions stigma attached to castes/creeds. One out of ten health functionaries (10.8%) mentioned that there was stiff resistance from certain sections of communities due to inadequate awareness about advantages of immunisation and role of rumour mongers. These factors are affecting the thinking and attitude of parents/communities adversely to a great extent. Other reasons may be attributed to administrative difficulties or problems related to information, education and communication strategy.

Major reason as reported by around one-fourth of health functionaries was indifferent attitude

Fig. 4.10 shows graphically the reasons, as reported by health functionaries, for not being able to fully immunise all children.

Fig 4.10 Reasons for not fully Immunising Children



4.4.3 Immunisation of Pregnant Mothers

As per norms, two doses of tetanus toxoid (TT) were to be given to expectant mothers at an interval of 12 weeks; second dose was being given four weeks before expected day of child birth. However, none of the pregnant women should be denied even one dose of tetanus toxoid even if she was late. Beneficiaries felt that immunisation protected not only the mother but the child also. Data given in Table 4.19 revealed that 76.2 percent pregnant mothers received tetanus toxoid immunisation. Twenty-seven percent of pregnant women received first dose and 48 percent of mothers also availed second dose.

percentage (3.5%) had also received third dose on advice of medical officer(s) of PHCs/CHCs. Discussions of research team with AWWs revealed that immunisation of pregnant mothers including the earliest registration of pregnancy was accorded the highest priority by AWWs. Care was also taken by AWWs to ensure that gap between the two was not less than four weeks. State-wise coverage of immunisation with regard to pregnant women in given at Annexure 13.

4.4.4 Weighing of Children at Birth

Criteria of 'weight-related to age' in selecting beneficiaries for supplementary nutrition was

Table 4.19 : Status of Immunisation of Pregnant Women (Mothers' version) (N=2983)

Location of projects	No. of Respondents	No. of mothers immunized (%)	Tetanus Toxoid					
			NR (%)	1st dose (%)	2nd dose (%)	Don't Know (%)	NA (%)	All (%)
Rural	1827	1443 (79.0)	5 (0.3)	490 (26.8)	936 (51.2)	12 (0.7)	384 (21.0)	1827 (100.0)
Tribal	678	488 (72.0)	2 (0.3)	203 (29.9)	280 (41.3)	3 (0.4)	190 (28.0)	678 (100.0)
Urban	478	341 (71.3)	0 (0.0)	121 (25.3)	218 (45.6)	2 (0.4)	137 (28.7)	478 (100.0)
Total	2983	2272 (76.2)	7 (0.2)	814 (27.3)	1434 (48.1)	17 (0.6)	711 (23.8)	2983 (100.0)

Table 4.19 shows that coverage of immunisation in rural projects was the highest in percentage (79.0%) followed by tribal and urban projects which showed very marginal difference of one percent between them. However, administration of first dose in tribal projects was better among tribal mothers (29.9%) in comparison with rural (26.8%) and urban (25.3%). However, percentage of receiving second dose was highest in rural projects (51.2%), followed by mothers in urban (45.6%) and mothers in tribal (41.3%) projects. It was found during data collection process that a negligible

based on the assumption that even in villages/urban walled city/slum clusters all children could be weighed and graded in terms of their nutritional status. This also implied that AWWs would also have fully developed skills in correctly assessing age and completing procedure of weighing, recording the weight on growth chart and interpreting it, taking necessary action as also explaining to mothers. This weighing was to be carried from the birth of child. To assess the health and nutritional status mothers were asked

about weighing of their children at birth by AWWs. Wherever mothers mentioned that their children were weighed, records were verified which were available at AWCs or with mothers to know the actual weight recorded. Table 4.20 presents the weight of children at birth.

It would be seen from the Table 4.20 that 72.8 percent of the mothers reported that their children

study only 29 percent of children were found to be below this level. This is a positive impact of the programme. However, there is a need to make more efforts to ensure that there is cent percent coverage of children for monitoring of birth weight as against 72.8 percent found in the present study. State-wise position of birth weight of children is given at Annexure 14.

Table 4.20 : Birth Weight of Children (N=3733)

Location of projects	Total No. of children	Weighed at birth (%)	Birth Weight of Children				Not Known (%)
			Less than 2000 gm (%)	2000 -< 2500 gm (%)	2500 -< 3000 gm (%)	3000 and above (%)	
Rural	2284	1659 (72.6)	80 (4.8)	403 (24.3)	675 (40.7)	340 (20.5)	161 (9.7)
Tribal	848	564 (66.5)	45 (8.0)	137 (24.3)	203 (36.0)	149 (26.4)	30 (5.3)
Urban	601	495 (82.4)	17 (3.4)	123 (24.8)	183 (37.0)	122 (24.6)	50 (10.1)
Total	3733	2718 (72.8)	142 (5.2)	663 (24.4)	1061 (39.0)	611 (22.5)	241 (8.9)

were weighed at birth. When records at Anganwadi Centres in respect of these children were verified it was seen that no records in respect of almost 9 percent children were found. Of the rest, almost 5 percent children were born with a birth weight less than 2 kg and 24 percent less than 2.5 kg which means that about 29 percent of the total children were born with a birth weight less than normal. The percentage of children below the normal birth weight was little more (32%) in tribal areas.

The overall picture that emerges from the above table points out the fact that there has been significant improvement in the increase of birth weight of children. Whereas in the 1992 study of NIPCCD, 41 percent of the children were found to be with a birth weight of less than 2.5 kg, in the present

4.4.5 Immunisation of Children (0-6 months)

Coverage of immunisation of children (0-6 months) in ICDS project areas is reflected in Table 4.21. Seventy-seven nursing mothers reported that their children got immunised. This coverage was slightly better in urban projects at 79.7 percent than in rural projects wherein 79.4 percent mothers

Table 4.21 : Coverage of Children (0-6 months) under Immunisation (Responses of Mothers) (N=2975)

Location of projects	Child Immunised			
	NR (%)	Yes (%)	No (%)	All (%)
Rural	7 (0.4)	1454 (79.4)	370 (20.2)	1831 (100.0)
Tribal	4 (0.6)	467 (70.1)	195 (29.3)	666 (100.0)
Urban	4 (0.8)	381 (79.7)	93 (19.5)	478 (100.0)
All	15 (0.5)	2302 (77.4)	658 (22.1)	2975 (100.0)

reported that their children got immunised. The lowest coverage of 70 percent was found in tribal areas.

4.4.6 Immunisation of Children (6 months to 3 years)

Data with regard to status of immunisation of children between 6 months and 3 years was collected from mothers of beneficiaries who were asked whether their children were immunised or not. Further, their responses were verified from the records maintained at the Centres. Table 4.22 gives a picture about various vaccines provided to children belonging to the category of 6 months to 3 years.

**Table 4.22 : Immunisation Coverage of Children (6 months to 3 years)
(Responses of Mothers) (N=3733)**

Location of projects	Immunisation Coverage								
	DPT Doses			Booster	BCG	Polio Drops			Measles %
	1st (%)	2nd (%)	3rd (%)			1st (%)	2nd (%)	3rd (%)	
Rural	394 (17.3)	232 (10.2)	913 (40.0)	354 (15.5)	1874 (82.0)	381 (16.7)	252 (11.0)	1632 (71.5)	1623 (71.1)
Tribal	160 (18.9)	92 (10.8)	287 (33.8)	162 (9.1)	673 (79.4)	171 (20.2)	109 (12.9)	555 (65.4)	5400 (63.7)
Urban	85 (14.1)	50 (8.3)	253 (42.1)	147 (24.5)	530 (88.2)	95 (15.8)	60 (10.0)	443 (73.7)	467 (77.7)
Total	639 (17.1)	374 (10.0)	1453 (38.9)	63 (17.8)	3077 (82.4)	647 (17.3)	421 (11.3)	2630 (70.5)	2630 (70.5)

Data in Table 4.22 explains the position of immunisation against different types of diseases. These responses were received from the mothers of children belonging to the age-group 6 months to 3 years. The table shows that BCG vaccine coverage was maximum (82%), followed by polio 3rd dose and measles (both 70.5%), DPT 3rd dose (38.9%) and booster DPT dose (17.8%). It is important to mention here that these data were based on the responses given by mothers and therefore, a definite inference could not be drawn in terms of immunisation coverage of children. Despite this, however, a not very encouraging trend is visible in the overall immunisation coverage. Hence, special

efforts need to be initiated to have the required coverage in future. State/UT wise status of immunisation with regard to children (6 months to 3 years) is given in Annexure 15.

4.4.7 Immunisation of Children (3-6 years)

Children of this age-group were given DT booster (diphtheria - tetanus). Mothers (54.9%) of these children reported that their children got DT booster for their protection against tetanus. Table 4.23 indicates the immunisation coverage of children belonging to the age-group 3-6 years.

Table 4.23 shows that rural areas had better immunisation as narrated by mothers (56.7%) in comparison to tribal (52.5%) and urban (51.5%) projects. AWWs informed that children of this age-group worked as a baby sitter or cattle grazer, hence, it was difficult to ensure required percentage of coverage. Children of urban projects

Table 4.23 : Immunisation Coverage of Children (3-6 years) (Responses of Mothers) (N=3737)

Location of Projects	No. of children	DT booster given (%)
Rural	2286	1296 (56.7)
Tribal	851	447 (52.5)
Urban	600	309 (51.5)
Total	3737	2052 (54.9)

were also reportedly taken to the sites of chores of their mothers or elder siblings. State-wise coverage of immunisation of children of this age-group is given at Annexure 16.

4.5 Health Check-up

ICDS programme lays great emphasis on health check-up for antenatal care of expectant mothers, post-natal care of nursing mothers and care of new born and care of children below six years of age. Entire population of expectant and nursing mothers and children under six years of age of a given project area is expected to be covered under this service. It was, therefore, necessary to ensure that health services were provided not only to those children who were present at the Anganwadis at the time of visit of the ANMs/PHNs and medical officers but also to all those who were supposedly covered by ICDS programme. A study was undertaken by the Department of Paediatrics, Institute of Medical Sciences, Banaras Hindu University to assess the impact of ICDS on maternal nutrition and birth weight of newborns in rural Varanasi. It was found in ICDS areas that during pregnancy women gained about 6.3 -7.4 kg. In the ICDS block, birth weight of children of supplemented women was found to be significantly higher by 58 gm as compared to the birth weight of children of unsupplemented women (NIPCCD: 2005: pp.94-95).

A study was conducted in Anganwadi Centres situated in slum areas of Jammu City to evaluate the health services provided to pre-schoolers at ICDS centres. The study revealed

that a majority of the anganwadis had a safe and hygienic environment, which played a positive role on the growth and development of children. A majority of the parents found positive physical changes in the child's height, weight, and demeanour after they started attending anganwadi centres due to supplementary nutrition, education and care they received. Health cards were not maintained by anganwadi workers. All the anganwadi workers discussed the health status of children with their parents and also provided them necessary information. Parents were of the view that children in anganwadis received services which they would otherwise not have been able to provide. This indicated the value parents attached to services provided under ICDS (Jammu University, Department of Home Science: 2003).

According to AWWs (75.1%), health functionaries conducted health check-up of children which included checking of eyes, ear, nose, teeth, hair and other external physical parts of the body regularly, including administering medicines of fever, eye and ear trouble, skin diseases etc. The highest percentage of health check-up was done in urban projects (80.8%) followed by tribal projects (78.7%) and rural projects (72.3%) in descending order.

Data was also collected to know about the categories of functionaries who carried out health check-up. Table 4.24 shows various categories of functionaries who were instrumental in carrying out health check-up.



From Table 4.24 it can be seen that 51 percent health check-up were carried out by ANMs. Health check-up was conducted by Medical Officers in 22 percent cases while in respect of LHV/PHNs, it was only 14 percent.

ANMs did regular follow-up of pregnant and lactating mothers as also severely malnourished children accompanied by AWWs and adolescent girls. It was observed that better health care of these categories of beneficiaries was possible where ANMs stayed near their subcentres.

Table 4.24 : Functionaries Involved in Health Check-up (version of AWWs) (N=748)

Category of beneficiaries	Category of functionaries involved				Total (%)
	Medical Officers (%)	LHV / PHNs (%)	ANMs (%)	No response (%)	
Children (0-3 years)	170 (22.7)	85 (11.4)	387 (51.7)	106 (14.2)	748 (100.0)
Children (3-6 years)	154 (20.6)	90 (12.0)	396 (52.9)	108 (14.4)	748 (100.0)
Ante-natal care (Pregnant women)	183 (24.5)	101 (13.5)	365 (48.8)	99 (13.2)	748 (100.0)
Post-natal care	163 (21.8)	103 (13.8)	380 (50.8)	102 (13.7)	748 (100.0)

Fig. 4.11 indicates the functionaries involved in health check-up.

Information was also analysed regarding frequency of health check-up of above

Fig. 4.11 Functionaries Involved in Health Check-up

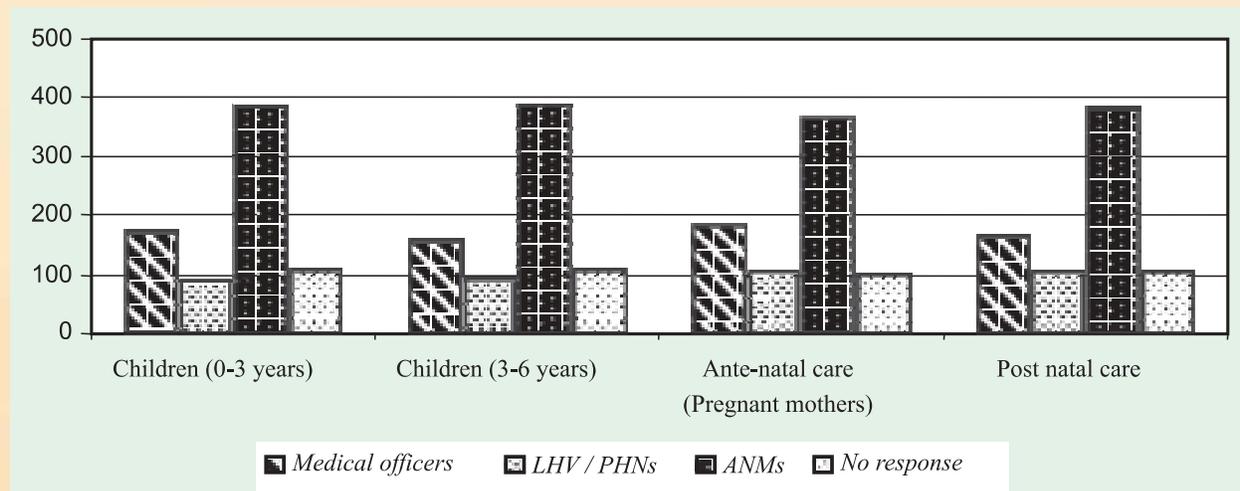


Table 4.24 also indicates that ANMs were the major source of health check-up because they were readily available. Medical officers and LHVs/PHNs attended to "at risk" children, particularly severely malnourished (Grade I - IV) as also mothers who faced complications during pregnancy and were treated as "at risk"

categories of beneficiaries. Data in this regard are given in Table 4.25.

Research team did not come across any circular/guidelines issued relating to frequency of health check-up and description of process of health check up of children. It was only general physical health check-up of children

Table 4.25 : Frequency of Health Check-up

Category of beneficiaries and projects	NR (%)	Once a month (%)	Once a quarter (%)	Twice a year (%)	No such periodicity (%)	Others (%)	NA (%)	Total (%)
Children (0-3 years)	6 (0.8)	420 (56.1)	121 (16.2)	13 (1.7)	75 (10.0)	28 (3.7)	85 (11.4)	748 (100.0)
Children (3-6 years)	7 (0.9)	349 (46.7)	157 (21.0)	38 (5.1)	85 (11.4)	26 (3.5)	86 (11.5)	748 (100.0)
Women (antenatal)	6 (0.8)	455 (60.8)	106 (14.2)	9 (1.2)	67 (9.0)	25 (3.3)	80 (10.7)	748 (100.0)
Women (postnatal)	14 (1.9)	430 (57.5)	104 (13.9)	9 (1.2)	78 (10.4)	30 (4.0)	83 (11.1)	748 (100.0)

which was reported. However, severely malnourished children and mothers having complication(s) of delivery got due attention of medical officers at PHCs/CHCs. Table 4.25 points out that frequency of health check-up "once in a month" was followed for all categories of beneficiaries ranging between 47 percent and 61 percent. Focus of health check up was more for children below 3 years (56.1%) once in a month and ante-natal check-up of pregnant mothers as per version of 61 percent AWWs. Those who, reportedly, had access to hospitals and were in a position to afford expenditure had gone to private medical practioners/hospitals for care of pregnant mothers and children.

NIPCCD undertook a study to evaluate the utilisation of medicine kit provided to anganwadi workers. Under the ICDS scheme, delivery of health services and dispensing simple medicines to children and mothers was considered to be a part of the routine work of health functionaries. An innovation tried out under ICDS was the supply of a medicine kit to AWWs and they were trained to deal with minor ailments. The study evaluated the usage and efficacy of the medicine kit provided to AWWs in select ICDS projects. It was found that the entire procedure to replenish drugs was yet to

be streamlined as it took a long time to replenish the kit. The availability of medicines was found to be very poor in all the four regions and almost half the AWCs under study were

without the medicine kit, which was available in only 36.3 percent AWCs in the north eastern region as compared to 53.7 percent AWCs of the southern region. Hardly any projects under study had received the kit since 1997. Proper storage space was available only in about half (54.6%) of the AWCs in all regions. The common diseases prevalent in all the four regions of the country included cold, cough, fever and diarrhoea. AWWs reported that beneficiaries contacted them for many other illnesses like leprosy, diabetes, asthma, etc. which they did not think they were competent enough to handle. However, the AWWs reported that diseases in general, had reduced moderately (47.2%) in all the regions, but due to non-availability of medicines there was slight or no reduction in disease prevalence in the southern and central regions. Majority (96.6%) of the AWWs were able to tell the correct method of preparation of ORS and the amount to be administered to children and adults. The study revealed that non-availability of medicines was the major constraint in providing services to the community. The medicine kits supplied to the AWCs were complimentary items and also an effort to enhance availability of essential drugs at the village level (NIPCCD: 2003).

4.5.1 Iron and Folic Acid Tablets (IFAT)

Iron and folic acid tablets (IFAT) were given to pregnant mothers and children. For children, one tablet containing 20 mg of iron and 0.1 mg of folic acid was given daily. The tablets were sugar-coated. Children were also given tablets continuously for 100 days. However, exact period for taking the tablets depended upon the progress of individual child/mother. These tablets were supplied for one month at a time. Data obtained from mothers revealed that 60 percent children between six months and 3 years and 65 percent children in the age-group 3-6 years were given IFATs (Table 4.26). Of these, 62 percent were from rural and tribal ICDS projects and 47 percent from urban projects in case of children (6 months to 3 years) and 68 percent from tribal, 66 percent from rural and 65 percent from urban areas in respect of children belonging to 3-6 year age-group.

facilitated them to further provide IFA Tablets in better percentage. These functionaries also undertook home visits to ensure utilisation of tablets by beneficiaries. They also kept a check on wastage and misutilisation of these items in the market for sale to others.

AWWs were required to keep a close watch on pattern of consumption of these tablets with special reference to pregnant mothers during home visits, NHed sessions as also in the process of health check-up. Data analyzed in relation to consumption of IFA tablets by pregnant women showed that women of this category (68.9%) consumed tablets regularly whereas another 16 percent enjoyed its use sometimes "as and when" they felt like swallowing it. Mothers (13.5%) kept the tablets in their possession but did not consume it because they did not like its taste. Consumption pattern was the lowest in tribal projects (64.9%) in terms of its regular use.

Table 4.26 : Iron and Folic Acid Tablets given to Children (6 months to 6 years) (Mothers' version)

Location of Projects	6 Months - 3 Years		3 - 6 Years	
	Total No of children	No. of children received %	Total No of children	No. of children received (%)
Rural	2284	1412 (61.8)	2286	1505 (65.8)
Tribal	848	531 (62.6)	851	579 (68.0)
Urban	601	283 (47.1)	600	336 (56.0)
Total	3733	2226 (59.6)	3737	2420 (64.8)

In fact, ANMs/LHVs and AWWs were in direct contact with mothers. This contact

4.5.2 Problems in Health Check-up

AWWs reported problems/difficulties in conducting health check-up and enlisting cooperation of beneficiaries and health functionaries. Table 4.27

shows the nature of problems encountered by AWWs in this regard.

Table 4.27 shows that 29 percent of AWWs reported shortage of medical and para medical staff as reasons for inadequate health check-up

of needy beneficiaries on scheduled date(s). This also influenced coverage of immunisation programme in some Anganwadis.

Table 4.27 : Problems Encountered by AWWs in Health Check-up (N=748)

(Multiple Response)

Nature of problems faced	Location of ICDS projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Shortage of medical / para medical staff	138 (30.1)	48 (28.2)	29 (24.2)	215 (28.7)
Resistance of health functionaries to come to AWCs	132 (28.8)	60 (35.3)	24 (20.0)	216 (28.9)
Lack of awareness and cooperation of community members to avail of services	83 (18.1)	51 (30.0)	20 (16.7)	154 (20.6)
Non-adherence to scheduled date(s) of health check-up	78 (17.0)	28 (16.5)	13 (10.8)	119 (15.9)
Dependence of community over quacks / traditional healers	73 (15.9)	53 (31.2)	13 (10.8)	139 (18.6)
Any other(s)	33 (7.2)	16 (9.4)	3 (2.5)	52 (7.0)

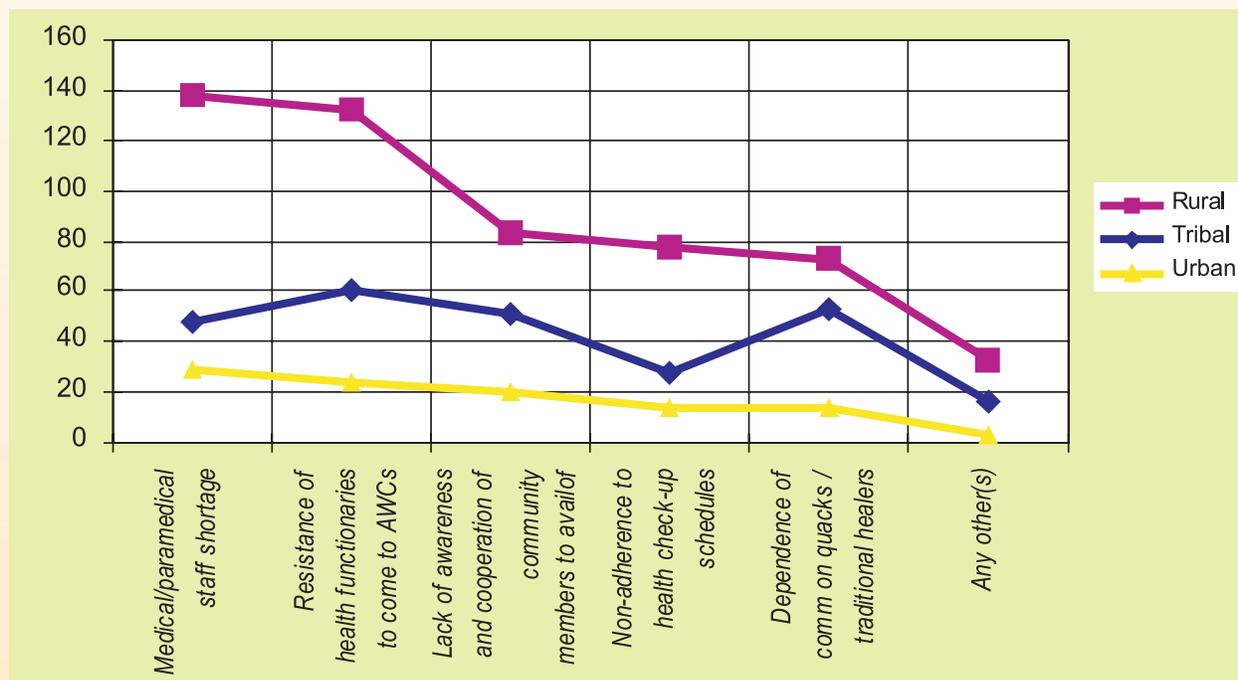
of beneficiaries. Equally important was the response of AWWs (28.9%) which stated inability of health functionaries to visit AWCs due to their reluctance arising out of heavy pressure of work at OPD or indifferent attitude. Another problem being faced by AWWs was the non-cooperation of community due to its ignorance about need and importance of health check-up or its indifferent attitude to avail this service effectively (20.6%). Around one out of five AWWs (18.6%) also mentioned that traditional healers/quacks enjoyed better confidence of community members particularly menfolk and directed beneficiaries to avail expertise of these quacks. Community was also found to have a sense of uncertainty and mistrust in their mind as same health functionaries (15.9%) did not turn up on pre-decided dates. Hence, AWWs found it difficult to ensure presence

Fig. 4.12 shows the problems faced by AWWs in conducting health check-up in various locations of projects.

4.6 Nutrition and Health Education (NHED)

This component of ICDS is meant for effective transmission of certain basic health and nutrition messages to enhance level of awareness of mothers about child's needs and her capacity for care, protection and development of child within family environment. All women in the age-group of 15-45 years are entitled to get this education which also tackles problems of ignorance, ill-health and malnutrition. This section deals with messages disseminated, NHED materials, aids and methods used etc. This section basically analyses the data based on responses of AWWs.

All AWWs reported that they organised nutrition and health education with the help and support of supervisors and ANMs/PHNs. As regards the frequency of organising this programme, 69 percent of them said that they organised NHED once in a month on topics related to mothers and children. Fourteen percent organised this activity as per expressed needs of beneficiaries. Around seven percent conducted this activity once in two months. Seven out of ten tribal Anganwadis organised this activity once in a

Fig. 4.12 Problems Faced by AWWs in Health Check-up

month, followed closely by even percentage of rural and urban projects (68.3%). A question was asked to AWWs about organisation of NHEd session a month prior to visit of research team. Nine out of ten AWWs (90.0%) reported that they organised it between 1-3 months whereas a negligible percentage (4.4%) between 3-6 months. Data also demonstrated that on an average 20.94 mothers participated actively in tribal Anganwadis, 18.43 in rural Anganwadis and 18.68 in urban Anganwadis. Average of attendance of mothers in these three areas was 18.68 mothers.

4.6.1 Methods Adopted for NHEd

The success of NHEd depended upon proper training of AWWs, supervisors, ANMs and LHVs in content delivery and communication techniques. Some useful materials were expected to be procured

from organisations like National Institute of Nutrition, Indian Council of Medical Research (ICMR), Central Health Education Bureau, Voluntary Health Association of India, Food and Nutrition Board, State Departments of Publicity, Information and Audio-visual Aids and others. Provisions for translation of materials also exist in IEC budget of ICDS. AWWs reported about various methods adopted by them to impart NHEd to mothers. It is important to mention here that the major focus of AWWs was on pregnant and lactating mothers. Their responses are presented in Table 4.28.

Table 4.28 points out that AWWs (92.1%) used inter-personal contact and discussion as a method to talk to mothers individually or in groups. Another method which was used more frequently than others was demonstration of recipes, preparation of oral dehydration solution,

Table 4.28 : Methods/Aids Used for NHed (N=748)
(Multiple Response)

Methods / aids used for NHed	Location of ICDS Projects			
	Rural %	Tribal %	Urban %	Total %
Discussions	409 (89.3)	167 (98.2)	113 (94.2)	689 (92.1)
Demonstrations	159 (34.7)	52 (30.6)	64 (53.3)	275 (36.8)
Exhibitions	75 (16.4)	13 (7.6)	36 (30.0)	124 (16.6)
Rally	60 (13.1)	16 (9.4)	10 (8.3)	86 (11.5)
Dance and Songs	71 (15.5)	15 (8.8)	22 (18.3)	108 (14.4)
Role play	56 (12.2)	13 (7.6)	24 (20.0)	93 (12.4)
Film Show	12 (2.6)	2 (1.2)	12 (10.0)	26 (3.5)
Other(s)	50 (10.9)	17 (10.0)	8 (6.7)	75 (10.0)

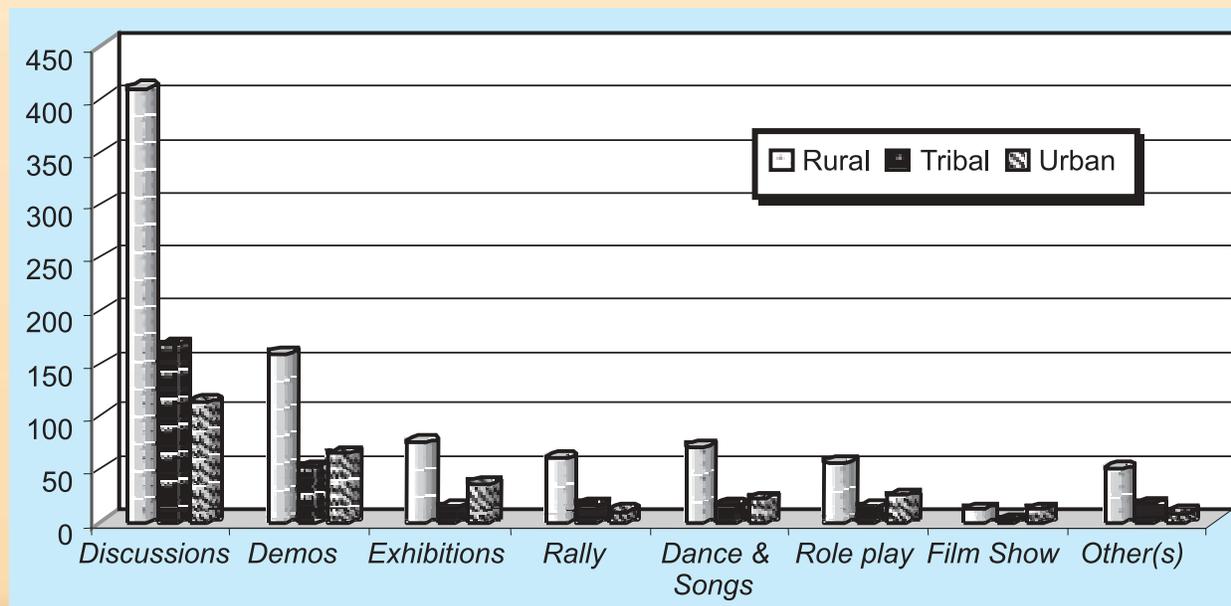
purification of water to mothers and adolescent girls (36.6%). AWWs (16.6%) also organised exhibitions on issues related to diarrhoea, immunisation, small family norms, mode of Mahila Mandals/Self-Help Groups, care of severely malnourished children etc. Dance and songs programmes were also conducted related to female

foeticide, dowry, wife beating, different festivals and so on. Use of other methods was minimal as reflected in Table 4.28. Non-conventional methods of special campaigns like rally and role play at suitable intervals were used in few AWCs. Nutrition and health education messages were put across to the target population by organising short courses in Anganwadis for a group of 15-20 women. Data also reflects that use of conventional and non-conventional methods was not effectively carried out. In Table 4.28, category 'others' includes methods like stories, drama, folk tales, puppetry etc.

which were used by 10 percent AWWs. Educational and communication aids were found to be grossly inadequate in AWCs under study. Oral conversation was observed as the most used methods by AWWs.

Fig. 4.13 presents the various methods/aids used for NHed by AWW

Fig. 4.13 Methods / Aids used for NHed by AWWs



4.6.2 Contents

AWWs also mentioned about different topics covered by them in NHEd sessions. These topics included breastfeeding, diarrhoea, complimentary feeding, limiting family size etc. Details of contents have been given in Table 4.29.

Table 4.29 : Topics Covered in NHEd Sessions (N=748)
(Multiple Response)

Topics covered in NHEd sessions	Location of ICDS Projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Immunisation	381 (83.2)	126 (74.1)	107 (89.2)	614 (82.1)
Breastfeeding	328 (71.6)	104 (61.2)	92 (76.7)	524 (70.1)
Health, hygiene and sanitation	299 (65.3)	123 (72.4)	45 (79.2)	517 (69.1)
Complementary feeding	264 (57.6)	96 (56.5)	84 (70.0)	444 (59.4)
Prevention of mal nutrition	233 (50.9)	98 (57.6)	89 (74.2)	420 (56.1)
Limiting family size	250 (54.6)	90 (52.9)	77 (64.2)	417 (55.7)
Diarrhoea prevention	230 (50.2)	95 (55.9)	73 (60.8)	398 (53.2)
Safe drinking water	217 (47.4)	89 (52.4)	73 (60.8)	379 (50.7)
Use of health facilities	210 (45.9)	78 (45.9)	56 (46.7)	344 (46.0)
Importance of growth monitoring	196 (42.8)	61 (35.9)	61 (50.8)	318 (42.5)
Common childhood disease / Acute respiratory infections	127 (27.7)	77 (45.3)	58 (48.3)	262 (35.0)
Home made remedies	141 (30.8)	72 (42.4)	42 (35.0)	255 (34.1)
Others	79 (17.2)	37 (21.8)	34 (28.3)	150 (20.1)

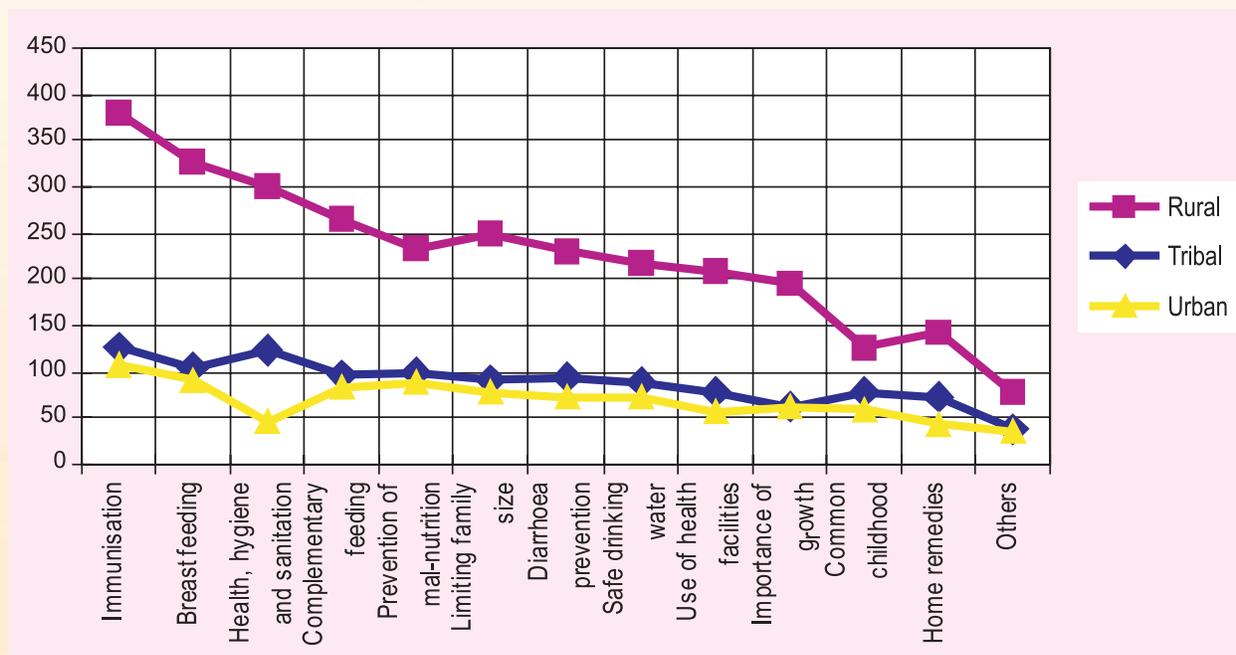
It is evident from Table 4.29 that AWWs focused on issues related to "at risk" mothers and children and imparted education to women (15-45 years) and other family members. A

special emphasis was laid on mothers whose children suffered from malnutrition and frequent illnesses. NHEd enabled mothers to overcome problems of ignorance, ill-health and malnutrition which go hand-in-hand. Poor and vulnerable sections of community were better placed in taking care of children which is reflected in the chapter on Benefits and

Outcomes of ICDS Programme. Success of NHEd is quite visible in immunisation, breastfeeding and promotion of health and hygiene which were major areas of concern for AWWs. Messages imparted seemed to be simple, straight forward and relevant based on needs of mothers, easily understood, practical and easy to adopt. Though transmission of above messages is considered to be the basic responsibility of medical and para-medical staff, yet AWWs, supervisors and CDPOs contributed adequately to organise NHEd as part of their responsibility. This was so because of their training, orientation and intractional dialogue with health functionaries, which equipped them to transmit messages in an effective and

meaningful manner.

Various topics covered in NHEd have been shown in Fig. 4.14.

Fig. 4.14 : Topics Covered in NHEd

4.6.3 Problems and Difficulties in Organising NHEd

Data collected through the present study indicated that major problem with the organisation of NHEd was stated to be lack of time of women as they had to be at their place of work from morning till evening to earn livelihood. This was mentioned by 46 percent AWWs. About a third of AWWs (36.9%) were also found to be in a situation where they were handicapped due to non-availability of materials/aids. Aids already supplied to them by CDPOs or obtained during training were not attractive. These were also not available in local/regional languages. Films/slide, flash cards and puppets/Nukkad Natak were rarely used. In view of this, IEC activities need to be intensified in ICDS project areas to overcome problems related to stagnation in MMR and IMR, rendering of better quality of services

and tackling problems concerning referral and community participation.

If these measures are taken, interest among mothers towards NHEd would enhance which is otherwise posing a problem for AWWs (32.5%). It also emerged from data that lesser educated (upto VIII standard) AWWs also lacked skills to conduct NHEd. They were able to collect mothers for NHEd services but required help of supervisors and CDPOs as also health functionaries to talk to mothers on various issues of the research team. AWWs (18.3%) devoid of skills in NHEd, also pointed out inadequacies of training imparted to them in training centres. One of the observations was that support to AWWs in developing simple and educative health and nutrition education messages, utilising publicity materials and providing help and guidance to AWWs in organising NHEd was not of the expected level.

4.6.4 Home Visits

AWWs are required to make home visits for educating parents particularly mothers of children who are attending the Anganwadis so that they can take better care of their children, and also motivate and encourage parents to send children to AWCs and avail services. She is also required to elicit cooperation of mothers in providing services of the Anganwadis and ensure children from vulnerable sections taking advantage of services of AWCs. To a question about purpose of their home visits responses of AWWs have been presented in Table 4.30.

Table 4.30 : Purpose of Home Visits (N=748) (Version of AWWs)
(Multiple Response)

Category of responses	Location of ICDS projects			
	Rural %	Tribal %	Urban %	Total %
Educating parents of mal-nourished children	303 (66.2)	112 (65.9)	10 (83.3)	515 (68.9)
Advising pregnant and lactating mothers	413 (90.2)	151 (88.8)	111 (92.5)	675 (90.2)
Advice to parents of sick children	292 (63.8)	117 (68.8)	42 (76.7)	501 (67.0)
Motivating parents to send children to AWCs regularly	367 (80.1)	126 (74.1)	98 (81.7)	591 (79.0)
Social visits	223 (48.7)	50 (29.4)	63 (52.5)	336 (44.9)
Others	68 (14.8)	28 (16.5)	23 (19.2)	119 (15.9)

AWWs visited, on an average, 41.4 families in the month preceding the survey. This response was obtained when AWWs were asked to state the number of visits made by them in preceding month of visit of research team. It was gathered that average number of visits to families was highest in urban projects (46.7 families) whereas AWWs of tribal projects visited 43.1 families. Aggregate

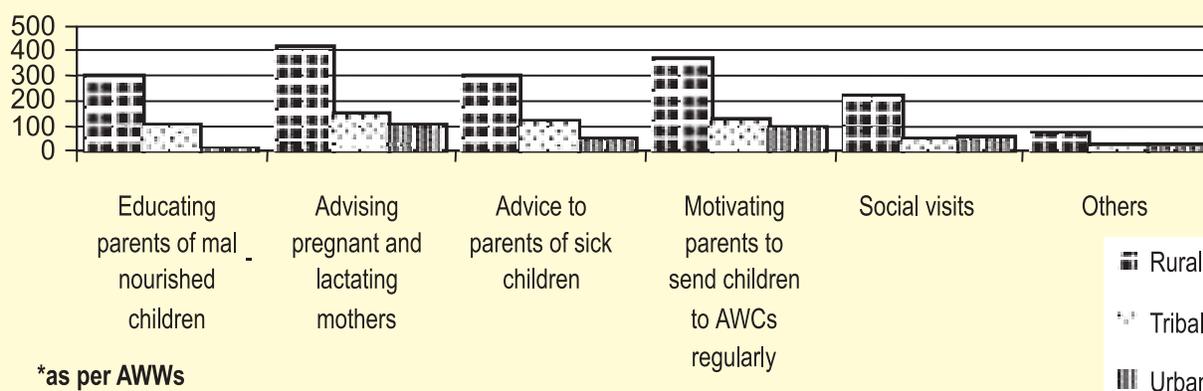
of these visits was 42.6 families in a month. When asked to explain the purpose of home visits, maximum number of AWWs (90.2%) reported that early registration and care of pregnant and lactating mothers was their foremost responsibility as it ensured better survival and protection of infants which would further lead to reduction in IMR. Another important purpose of home visit reportedly was to ensure regularity and punctuality of children in attending AWCs, which was possible only when parents got motivated and convinced about advantages of services of AWCs. Almost equal percentage (68.9%) of AWWs made visits to arouse a better sense of responsibility of parents in taking

care of malnourished children and taking sick children to hospital and meeting their nutritional requirements. Rapport building with mothers and seeking community participation through social visits were considered useful by AWWs (44.9%). These AWWs participated in marriage, birth day celebrations, religious festivals at community etc. to establish their perfect identity with the families and community.

Fig 4.15 also depicts various purposes of home visits as reported by AWWs.

AWWs also encountered problems/difficulties in conducting home visits which have been presented in Table 4.31.

Table 4.31 depicts that three out of six problems stated by AWWs are directly associated with parents. Reasons attributed to the first two

Fig. 4.15 Purpose of Home Visits*

categories of problems - 'were away from home to earn wages' and 'coming back at odd hours'. Nineteen percent AWWs found that the parents were least concerned about their child's welfare due to illiteracy and influences of customs, beliefs and superstitions or more worried about earning their livelihood. Scattered location of houses was a serious problem for conducting home visits as AWWs were always in an uncertain state of mind about availability of parents in case they made a

visit to families of beneficiaries living in such houses. Since AWWs were also involved in activities other than ICDS, they reported lack of time (10.7%) for contacting parents during home visits. These other tasks were related to old age/ widow pension, survey work etc.

Bar diagram (Fig. 4.16) also indicates various problems faced by AWWs while conducting home visits.

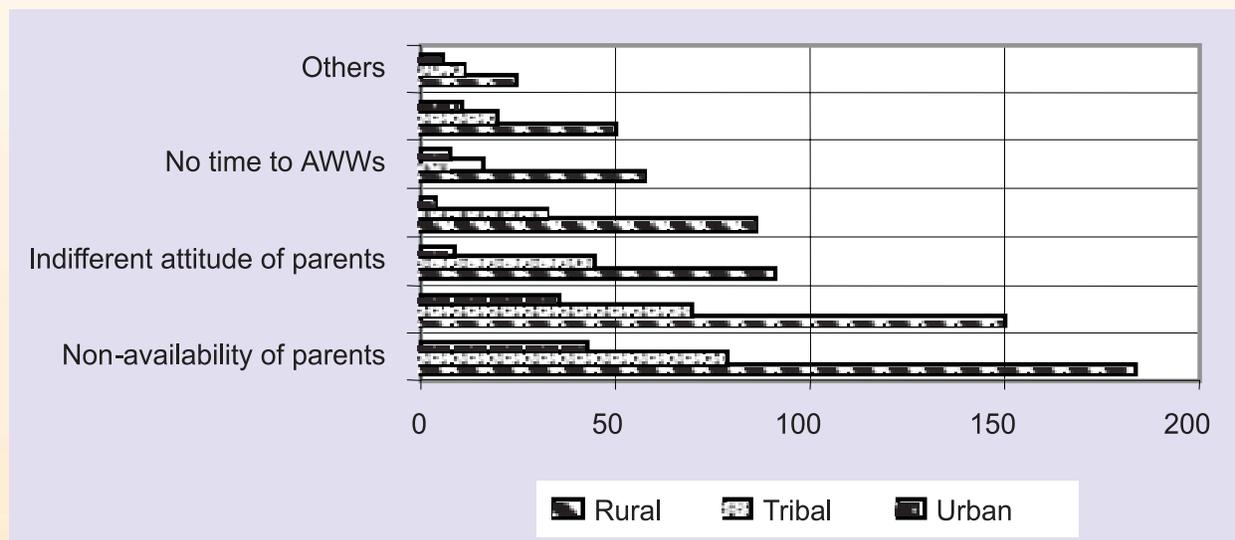
Table 4.31 : Problems Perceived by AWWs in Conducting Home Visits (N=748)

(Multiple Response)

Category of responses	Location of ICDS projects			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Non-availability of parents	183 (40.4)	79 (46.5)	43 (35.8)	305 (40.8)
Lack of time with parents	150 (32.8)	69 (40.6)	35 (29.2)	254 (34.0)
Indifferent attitude of parents	91 (19.9)	44 (25.9)	8 (6.7)	143 (19.1)
Scattered location of houses	86 (18.8)	32 (18.8)	4 (3.3)	122 (16.3)
Lack of time of AWWs	57 (12.4)	16 (9.4)	7 (5.8)	80 (10.7)
Non-cooperation of elders of the family	50 (10.9)	19 (11.2)	10 (8.3)	79 (10.6)
Others	24 (5.2)	11 (6.5)	6 (5.0)	41 (5.5)

4.7 Referral Services

Children, identified as "at risk" are required to be registered in a separate register and weighed with utmost care and attention. They also needed to be referred to ANM/ PHN/ Doctor for proper treatment and timely immunisation. AWWs and ANMs are required to undertake visits to their homes regularly and educate and advice mothers of children of this category on the need for special food and care. Such children were also given therapeutic diet

Fig. 4.16 Problems in Conducting Home Visits

on the advice of doctors. Referral service was intended to provide medical care of an appropriate standard. Pregnant women and children with problems who needed special treatment were referred by AWWs, ANMs/LHVs/PHNs to the Primary Health Centres/Community Health Centre(s). Ninety-four percent AWWs reported that they referred children/mothers who were at risk to above institution(s). Table 4.32 depicts the position with regard to sources of referral by AWWs.

Table 4.32 shows that a vast majority of AWWs referred the cases to Primary Health Centres which

Table 4.32 : Sources of Referral (Version of AWWs) (N=748)

Location of Projects	Sources of referral				
	PHC Centre (%)	Sub-Hospital (%)	District Hospital (%)	Private (%)	Others (%)
Rural	291 (63.5)	79 (17.2)	26 (5.7)	9 (2.0)	17 (3.7)
Tribal	114 (67.1)	33 (19.4)	11 (6.5)	0 (0.0)	3 (1.8)
Urban	42 (35.0)	14 (11.7)	44 (36.7)	3 (2.5)	13 (10.8)
Total	447 (59.8)	126 (16.8)	81 (10.8)	12 (1.6)	33 (4.4)

were at the nearest distance and easy to approach. Beneficiaries belonging to this service were mostly from rural (63.5%) and tribal (67.1%) ICDS projects. Beneficiaries were also referred to sub-centres (16.8%). It is also evident from the table under reference that facility of district hospital was most utilised by AWWs of urban projects (36.7%). AWWs of other two types of projects could not take much advantage because of the expenditure involved in travelling long distance and in taking care of beneficiaries away from home and shortage of money. There were AWWs who reported that they had to often face problems in providing referral services to beneficiaries. Major reasons as reported by AWWs have been described in Table 4.33.

In order to ensure that health services under ICDS optimally benefit its target groups, referral services provided through ICDS has to function effectively. No norms have been

Table 4.33 : Problems Faced by AWWs in Providing Referral Services (Version of AWWs) (N=748)
(Multiple Response)

Nature of problems and / or difficulties faced	Location of ICDS projects			Total (%)
	Rural (%)	Tribal (%)	Urban (%)	
Reluctance of parents to take children to hospital	108 (23.6)	63 (37.1)	26 (21.7)	197 (26.3)
Transportation problem	116 (25.3)	67 (39.4)	10 (8.3)	193 (25.8)
Far off location of PHC / CHC	108 (23.6)	50 (29.4)	16 (13.3)	174 (23.3)
Non-availability of medicines at PHC / CHC / Sub-centre	84 (18.3)	33 (19.4)	18 (15.0)	135 (18.0)
Long queue in hospital	61 (13.3)	26 (15.3)	37 (30.8)	124 (16.6)
No system of follow-up of referral case(s)	56 (12.2)	30 (17.6)	23 (19.2)	109 (14.6)
Dishonouring of referral slip of AWCs by PHC / CHC	49 (10.7)	19 (11.2)	27 (22.5)	95 (12.7)
Non availability of staff at PHC / Sub-centre	27 (5.9)	10 (5.9)	5 (4.2)	42 (5.6)
Other(s)	27 (5.9)	10 (5.9)	5 (4.2)	42 (5.6)

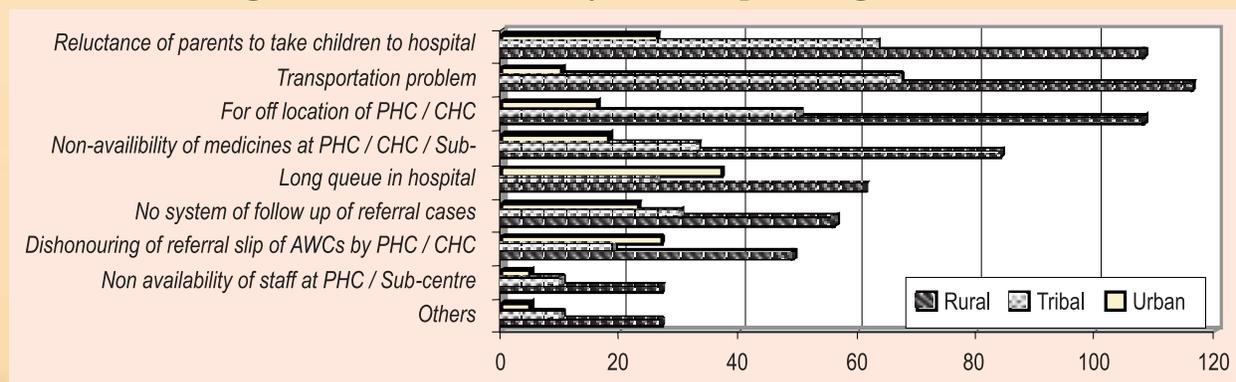
prescribed with regard to fixing up of any particular day or time for dealing with referral cases. It was observed during data collection that sufficient stock of therapeutic diet was either not maintained or was not made available to treat cases of severely malnourished children. It was also gathered that good responses from Panchayat Raj Institutions were also lacking for providing transport facilities for needy children and

mothers. Many parents were unable to afford even minimum transport cost. Table 4.33 shows that among various problems faced by AWWs in providing referral service, most prominent ones include reluctance of parents to take children to hospitals (26.3%) far off location of PHCs/CHCs (23.3%) and absence of transport facility (25.8%). Other major problems as reported by AWWs are in the range between 12 percent and 18 percent but it is crucial to tackle them to protect the children and mothers. This could be possible if adequate financial provisions are made available at the disposal of AWWs to meet costs of medicines and

transport. Percentage of non-availability of medical functionaries is the lowest (5.6%). However, it often worked as psychological barrier for AWWs to refer cases and motivating beneficiaries to go to referral hospital.

Fig. 4.17 also highlights various problems faced by AWWs in providing referral services.

Fig. 4.17 Problems faced by AWWs in providing Referral Services



4.7.1 Adolescent Girls

ICDS programme envisages involvement of adolescent girls within the ambit of its services. The revised Scheme of Adolescent Girls is also operationalised through selected AWCs in ICDS projects. In the sample ICDS projects 44 per cent AWWs were also rendering services under the Adolescent Girls Scheme (Kishori Shakti Yojana) of 1992. Services provided by AWCs to adolescent girls under the above-mentioned scheme are presented in Table 4.34.

Table 4.34 : Services Provided to the Adolescent Girls under Kishori Shakti Yojana (version of AWWs) (N=748)
(Multiple Response)

Type of services provided to Adolescent Girls	Location and management of KSY			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Iron and folic acid tablets	160 (34.9)	56 (32.9)	25 (20.8)	241 (32.2)
Supply of supplementary nutrition	145 (31.7)	54 (31.8)	31 (25.8)	230 (30.7)
Family life education	124 (27.1)	43 (25.3)	32 (26.7)	19 (26.6)
Immunisation	111 (24.2)	35 (20.6)	25 (20.8)	171 (22.9)
Health check-up	119 (26.0)	26 (15.3)	21 (17.5)	166 (22.2)
Counselling	96 (21.0)	37 (21.8)	27 (22.5)	160 (21.4)
Deworming tablets	76 (16.6)	31 (18.2)	16 (13.3)	123 (16.4)
Treatment of minor ailments	55 (12.0)	13 (7.6)	9 (7.5)	77 (10.3)
Referral services	50 (10.9)	13 (7.6)	10 (8.3)	73 (9.8)
Other(s)	24 (5.2)	12 (7.1)	8 (6.7)	44 (5.9)

Data in Table 4.34 demonstrates that AWWs (32.2%) provided iron and folic acid tablets to adolescent girls daily - one tablet of iron and folic acid containing 60 mg of iron and 0.5 mg of folic acid. This tablet was required to be given for 100

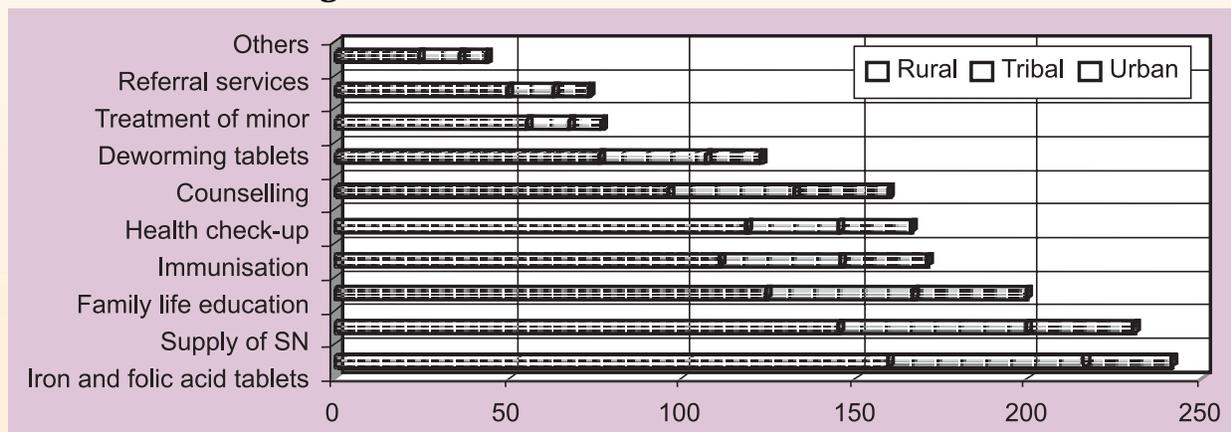
days for regular consumption. ANMs and AWWs were also reported to be monitoring consumption of these tablets and its likely adverse effects on the health of individual girls. Adolescent girls registered in Anganwadis also received supplementary nutrition, according to AWWs (30.7%). In order to ensure lasting impact of services rendered in Anganwadis, programme of family life education was conducted by 27 percent AWWs. Topics covered by AWWs were appropriate age of marriage, care during puberty, personal health and hygiene, dangers of early pregnancy, psycho-social development, life cycle approach etc. Almost equal percentage (22.2%) of AWWs also emphasised on health check-up and counselling (21.4%) on issues related to this age and adjustment potentials within the peer groups and family. AWWs and ANMs jointly counselled these girls in sessions on NHED and individually also. Other services rendered were of peripheral in nature as evident from the table.

Various services provided to adolescent girls under KSY as reported by AWWs have been shown in Fig. 4.18.

4.7.2 Help and Support to AWWs

Adolescent girls were required to assist the AWWs in promotion of services in the community and strengthening of these services by way of extending help to AWWs in better coverage and

Fig. 4.18 Services to Adolescent Girls under KSY



utilisation of services of Anganwadis. Half of the AWWs (49.6%) reported that adolescent girls provided help in conducting activities of AWCs. The areas in which adolescent girls provided help and support to AWWs in Anganwadi Activities were analysed and outcome has been shown in Table 4.35.

From Table 4.35 it is found that around 40 per cent AWWs got help in collecting children to organise outdoor games, ensuring their attendance regularly, organising mothers' meetings, singing songs, story telling etc. Nature

of help across the location of projects remained in equivalent percentage. The toughest challenge faced by AWWs was immunisation of all eligible children and ensuring their presence on the day of immunisation. Adolescent girls were proved to be a boon to ensure all eligible children coming at the venue of immunisation and subsequent follow-up to get them fully immunised. AWWs (38.2%) successfully received help from girls to meet the target of immunisation. Another activity which received important help and support from adolescent girls was preparation and distribution of supplementary

nutrition. AWWs (32.0%) utilised them in feeding malnourished children, taking care of children during feeding sessions to avoid wastage of food and cleaning of utensils. Besides these, they also helped AWWs in taking the "take home food" for pregnant and lactating mothers and children below three years at their respective homes. Another noteworthy assistance extended by adolescent girls was in collecting mothers for NHEd sessions

Table 4.35 : Help Received by AWWs from Adolescent Girls (version of AWWs) (N=748)

(Multiple Response)

Items of receiving help	Location and management of KSY			
	Rural (%)	Tribal (%)	Urban (%)	Total (%)
Pre-school activities	174 (38.0)	63 (37.1)	56 (46.7)	293 (39.2)
Collecting children for immunisation	174 (38.0)	65 (38.2)	47 (39.2)	286 (38.2)
Preparation and distribution of supplementary nutrition	142 (31.0)	56 (32.9)	41 (34.2)	239 (32.0)
Organising NHEd sessions	110 (24.0)	39 (22.9)	28 (23.3)	177 (23.7)
Organising socio-religious programmes	102 (22.3)	27 (15.9)	29 (24.2)	158 (21.1)
Other(s)	43 (9.4)	18 (10.6)	6 (5.0)	67 (9.0)

and conducting home visits with AWWs to create awareness about adopting practices of feeding colostrums, introduction of semi solid feed, TT immunisation and weighing of new born. A little over one-fifth of AWWs (21.1%) also involved these girls in organising local festivals along with mothers and in organising activities such as singing, dancing, decoration of AWCs, collecting tables, chairs, durries etc. Research team observed that adolescent girls were able to ensure better attendance of beneficiaries to avail services and became a good support to "reaching the unreached." AWWs also reported marked improvement in attendance and positive attitude towards AWCs because of the support received from adolescent girls.

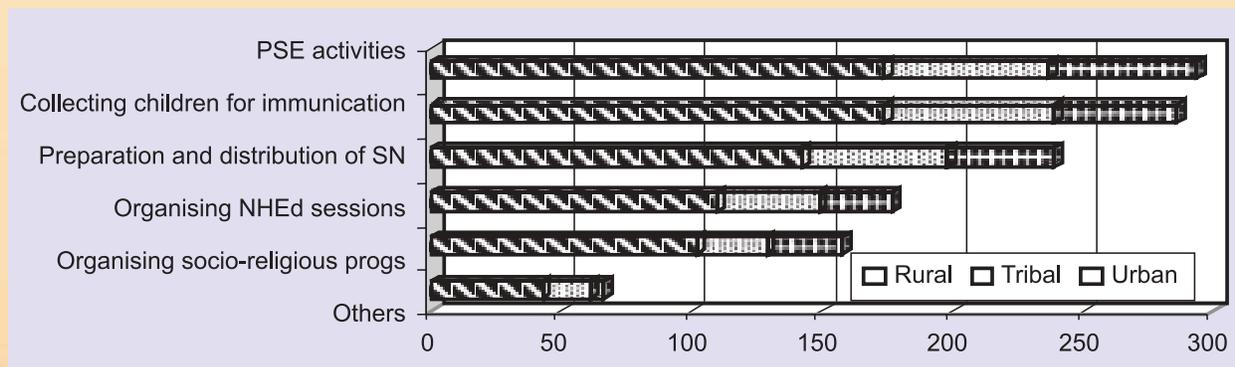
Fig. 4.19 represents the types of help adolescent girls extended in AWC activities.

4.8 Summing-up

Data of the present study revealed that in 80 percent projects, source of arranging nutrition in Anganwadis was State Government. A trend was also visible wherein village panchayats/Self-Help Groups were serving

cooked food to beneficiaries. It was found that in some of the NGO-run projects the concerned NGO providing food mobilised their own resources. Forty-two percent of Anganwadis received raw food items which were cooked/prepared at AWCs and served to children. Ready-to-Eat (RTE) food was provided in all types of projects, maximum being in Anganwadis of urban projects (45.8%), followed by rural (33.6%) and tribal (23.5%) projects. It was heartening to note that 46 percent of AWCs (rural-47.6%, tribal-38.2% and urban-50.8%) had no interruptions at all in terms of supply of nutritional ingredients. However, a significant number of AWCs (52.9%) reported interruptions. A dismal position of disruption of supplementary nutrition was found in regular ICDS (46.31 average days) projects which require special attention. Eighty-eight percent projects which faced interruptions and delay in supply of supplementary nutrition was reported to be one of the main reasons behind such happening. Significantly, though in negligible percentage (6.3%), spoiled food items were reported to have been supplied in some projects which suggests careful handling of the situation. Transport problem (18.4%) and

Fig. 4.19 Help of AGs in AWC Activities



weather condition (6.3%) were also reported to be the reasons for interruption.

As against 13,750 women reporting in AWCs 6,526 pregnant women have been registered, out of which 5,696 pregnant women are availing benefits. Coverage of pregnant women was found maximum in tribal AWCs in regular ICDS projects (61.8%) and NGO-run ICDS projects (58.3%). One of the most interesting findings emerged from the study was that in NGO-run ICDS projects, cent percent nursing mothers were found availing benefits from AWCs in tribal and urban areas, while in rural areas, the percentage was 75.6. Even in regular ICDS projects and World Bank ICDS projects, nursing mothers availing supplementary nutrition was found to be overwhelming in tribal areas (91.7% and 99.6%, respectively). In all categories of ICDS projects, percentage of female children in the age-group 6 months to 3 years availing supplementary nutrition was quite high - 82 percent in all - rural (81.0%), tribal (84.0%), and urban (82.5%), as against male children - 75 percent in all - rural (72.6%), tribal (81.1%) and urban (74.4%). In the age group 3 to 6 years, despite the fact that more girls were registered (57.8%) than boys (51.1%), share of benefits had gone to boys in higher percentage (75.9%) whereas less percentage of girls (74.6%) got the benefits.

Eight out of ten Anganwadi workers (79.8%) reported that food was totally acceptable to children and mothers. They found it well prepared, tasty and enjoyed its consumption. AWWs also stated various reasons for non-acceptability of supplementary nutrition by

beneficiaries. These reasons included 'food items were not tasty and therefore, did not accept it', 'there were no variety in food items served', 'sometimes it got spoilt due to inclement weather conditions and poor packaging', 'poor quality of food items supplied'. To a question, "Are you serving freshly cooked food?", two-third of AWWs (67.1%) replied in affirmative.

AWWs reported that children below 3 years were to be weighed once in a month and those falling in the age group 3-5 years required to be weighed on quarterly basis. Eighty-two percent AWWs adhered to this guideline and weighed children below 3 years once in a month. However, weighing of children in the age-group 3-5 years was slightly better as majority of AWWs (83.3%) were able to do so. Entire onus of weighing and plotting was shouldered by AWWs (85.8%). Supervisors extended helping hand to monitor the growth of severely malnourished children and new born on the day of their visit to AWCs. ANMs/LHVs also provided support during their presence in the AWCs or when the child was available in PHCs/Sub-Centres. It was also observed that ANMs were more supportive to AWWs provided they stayed in the village(s) wherein their sub-centres were located. Problems were reported by AWWs in conducting this exercise. Out of 748 AWCs, a little over one out of ten (11.1%) had no growth charts and four percent AWCs lacked weighing scales. Other reasons reported by AWWs included weighing scale under repair (3.3%) and lack of time (2.4%). Equal percentage (84.1%) of AWWs reported that they educated mothers about consequences of



weighing and its repercussions on child's health and nutrition as also advised them to feed the child frequently particularly those children who were either severely malnourished or their weight was falling below normal curve of growth chart.

AWWs made positive efforts for bringing children from deprived sections to AWCs so that they could utilise nutrition and health services as well. Data further indicates that systematic efforts had also been made by ICDS functionaries to enrol and encourage children belonging to Harijan and other weaker sections of the community so as to ensure that they could take advantage of Anganwadi activities and services. Children were engaged in singing songs in almost all AWCs (95.1%). Story telling and counting were other two activities which were organised by 91 percent AWWs. While 78 percent AWWs reported involvement of children in indoor activities, three-fourth of them (74.7%) also engaged children in free conversation to speak freely and apply their mind in order to organise small activities.

Two-third of children (66.1%) were immunised, highest being in rural projects (71.6%), followed by urban (65.7%) and tribal (51.5%) projects. Major reason for not being able to fully immunise children as reported by around one-fourth of health functionaries was indifferent attitude of parents towards immunisation (23.3%), followed by disbeliefs attached to immunisation (17.6%). Among other reasons, stiff resistance from certain sections of communities due to inadequate awareness about advantages of

immunisation and role of rumour mongers were reported.

Pregnant mothers (76.2%) received tetanus toxoid immunisation. Twenty-seven percent of pregnant women received first dose between 16 and 22 weeks and 48 percent of mothers also availed second dose between 24-28 weeks.

Birth weight of five percent children was below 2000 grams and 24 percent less than 2500 gm which means that about 29 percent children were born with a birth weight less than the normal. This should be a major concern for mothers and AWWs to bring them at the level of minimum weight of 2500 gm. This situation invariably calls for encouraging mothers to do breastfeeding of these children. In this regard, supply of supplementary nutrition and other personal health and nutritional care of mothers and children were reported by the AWWs to be the problems associated with this situation. Nursing mothers (77.4%) reported that their children got immunised. It was found that in case of children in the age-group 6 months to 3 years, a relatively low percentage was found in case of measles in tribal ICDS projects (63.7%). Besides this, data calls for more efforts need to be taken to enhance the coverage of children of this age-group to provide 1st and 2nd doses of DPT vaccine and Polio drops as well as DT booster. Immunisation coverage of children (DT booster) in the age-group 3-6 years as narrated by mothers was 57 percent in rural areas, 53 percent in tribal areas and 52 percent in urban areas.

Fifty-one percent health check-up were carried out by ANMs. Health check-up was conducted by Medical Officers in 22 percent cases while in respect of LHV/PHNs, it was only 14 percent. ANMs were the major source of health check-up because they were readily available. Medical officers and LHVs/PHNs attended to "at risk" children, particularly severely malnourished (Grade I - IV) as also mothers who faced complications during pregnancy and were treated as "at risk" ones. Frequency of health check-up "once in a month" was followed for all categories of beneficiaries ranging between 47 percent and 61 percent. Twenty-nine percent of AWWs reported shortage of medical and para medical staff as reasons for inadequate health check-up of beneficiaries. Other reasons included inability of health functionaries to visit AWCs due to their reluctance arising out of heavy pressure of work at OPD or indifferent attitude, non-cooperation of community due to its ignorance about need and importance of health check-up or its indifferent attitude to avail this service effectively, traditional healers/quacks enjoyed better confidence of community members.

As regards the frequency of organising this programme 69 percent of them said that they organised NHEd once a month on topics related to mothers and children. Fourteen percent organised this activity as per expressed needs of beneficiaries. Around seven percent conducted this activity once in two months. AWWs (92.1%) used inter-personal contact and discussion as a method to talk to mothers individually or in groups. Among other methods, demonstration of

recipes, preparation of oral dehydration solution, purification of water to mothers and adolescent girls were also reported. AWWs also mentioned about different topics covered by them in NHEd sessions. These topics included breast feeding, diarrhoea, complimentary feeding, limiting family size etc. Major problem with the organisation of NHEd was stated to be lack of time of women as they had to be at their place of work from morning till evening to earn livelihood. This was mentioned by 46 percent AWWs. Non-availability of materials/aids, unattractive aids, non-availability of these materials in local/regional languages were some of the other problems as stated by AWWs.

Ninety-four percent AWWs reported that they referred children/mothers who were at risk to PHCs/CHCs. The study revealed that problems faced by AWWs in providing referral service included 'sufficient stock of therapeutic diet was not maintained and made available to treat cases of severely malnourished children', 'good responses from Panchayat Raj Institutions were also lacking to provide transport facilities for such children and mothers', 'many parents were unable to afford even minimum transport cost', 'reluctance of parents to take children to hospitals', 'far off location of PHCs/CHCs'. This problem could somehow be overcome if adequate financial provisions are made available at the disposal of AWWs to meet costs of medicines and transport. So far as the help and support from adolescent girls is concerned, half of the AWWs (49.6%) reported that adolescent girls provided help in conducting activities of AWCs.





Chapter 5

Benefits and Outcomes of ICDS

5.1 Comparisons of the findings of the present study with earlier studies.

5.1.1 Infrastructure/Equipment/Kit

5.1.2 Staff Position

5.1.3 Training

5.1.4 Educational Qualification of AWWs

5.1.5 Services–Supplementary Nutrition

5.1.6 Birth Weight

5.1.7 Nutritional Grade

5.1.8 Pre-school Education

5.1.9 Health Check-up

5.1.10 Immunisation

5.2 Appraisal of Inputs and Output/Outcomes

5.2.1 Appraisal of ICDS management - input variables

5.2.2 Appraisal of output/outcomes of programme

5.3 Summing-up



Benefits and Outcomes of ICDS

The ICDS Scheme has now come to be regarded as the most viable vehicle for achieving the goals set for in the National Plan of Action for Children (NPA - 2005) and Millennium Goals. During the past three decades of planned development, ICDS has acquired great significance, as it is evident from its widening interface with other departments and increasing participation by stakeholders. The programme has been evaluated through various studies, (NIPCCD, 1992, NCAER, 2001, SEDEM, 2005, etc.) which revealed that some of the beneficiaries noticed in the early stages had been looked into. The coverage of children below 3 years of age, which was found to be low, had started improving and there was an increase in the level of preventive health care and also greater utilisation of health services. An outstanding achievement in the implementation of the ICDS scheme has been the increase in the convergence of various mutually supportive services.

However, the concept of providing a package of services is based primarily on the consideration that the overall impact would be much stronger if different services are delivered in an integrated manner, as the efficiency of a particular service depends upon the support it receives from the related services.

An attempt has, therefore, been made in this chapter to analyse the role of input variables on output and outcomes. Having

examined the infrastructure, organisational set-up, profile of beneficiaries, delivery of services, coordination, convergence and community participation in the preceding chapters, some interlinked variables have been identified. An attempt has been made to compare the findings of the present appraisal with the other national level evaluations and macro-level studies undertaken earlier. An effort has also been made to assess the performance of the programme in terms of input, output (process) and outcomes. The present Chapter accordingly is divided into Comparisons of the findings of the present study with earlier studies, and Appraisal of input and outputs/outcomes.

5.1 Comparisons of the findings of the present study with earlier studies

Comparative data on selected inputs, output and outcomes variables have been culled out from two national level evaluation studies namely; *National Evaluation of ICDS* (NIPCCD, 1992) and *Concurrent Evaluation of ICDS* (NCAER, 2001). Only those variables were taken into account which were found relevant and feasible in the context of the present study. The main purpose of this exercise was to see the trend of the programme in terms of selected variables over the years.

5.1.1 Infrastructure/Equipment/Kit

Comparative data in terms of availability of equipment/Kit in usable conditions at AWCs are

presented in Table 5.1 (a) shows that there was a definite improvement in building structure of Anganwadi Centres over the period of 14 years. Only 43.1 percent AWCs were in pucca building in the year 1992 whereas in 2005-06, 75.4 percent centres were housed in pucca building. It is also interesting to note that 36.7 percent AWCs were shifted to pucca building from kucha (Fig. 5.1). The progressive trend could be because of provisions of constructing pucca building of AWCs under World Bank and Jawahar Rojgar Yojana /Nehru Rojgar Yojana.

It is evident from the Table that there was significant improvement in supply of weighing scale (from 73.4 percent in 1991-92 to 89.2 percent in 2005-06). About 32.9 percent AWCs in 2000 were having kit for pre-school education in usable conditions and this percentage has gone up to 55.9 percent (2005-06). The data in this regard shows that World Bank, UNICEF and DPEP had played an important role in improving the situation.

5.1.2 Staff Position

Comparative data regarding staff position have been presented in Table 5.1 (b). It is evident that percentage of staff in position had increased at all levels over a period of time except that there has been a decline in the position of helpers by 2.5 percent. It may be further mentioned that in 1992 NIPCCD study the percentage of CDPOs and

Table 5.1 (a) : ICDS Over the Years - Infrastructure (at AWC level)

S.No.	Structure/Space	NIPCCD* Study 1992	NCAER Study** 2001	Present Appraisal*** 2005-2006
a)	Building Structure (% of AWC)			
	(i) Kucha	38.7	D.N.A.	19.9
	(ii) Pucca	43.1	43.2	75.47
b)	Availability of Equipment/ Kit in usable Condition			
	(i) Weighing Scale	73.4	76.3	89.2
	(ii) Availability of Learning Kit (PSE)	D.N.A.	32.9	55.9

* National Evaluation of ICDS - NIPCCD, 1992

** Concurrent Evaluation of ICDS - NCAER, 2000 *** Three Decades of ICDS : An Appraisal - NIPCCD, 2006

DNA - Data not available

Fig. 5.1 ICDS over the Years-Type of AWCs Building

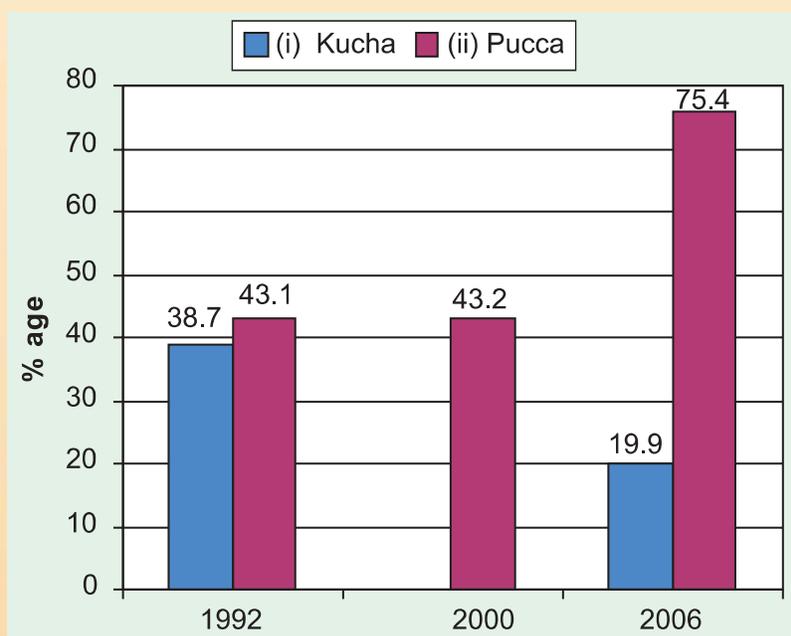


Table 5.1 (b) : Staff Position (in %)

S.No.	Staff	NIPCCD Study *1992	NCAER Study** 2001	Present Study*** 2006
(i)	CDPOs in Position	79.3	DNA	85.0
(ii)	ACDPOs in Position	DNA	DNA	52.2
(iii)	Supervisor in Position	72.5	DNA	82.3
(iv)	AWWs in Position	95.1	97.0	97.5
(v)	AWHs in Position	98.2	91.0	96.7

* National Evaluation of ICDS - NIPCCD, 1992

** Concurrent Evaluation of ICDS - NCAER, 2000 *** Three Decades of ICDS : An Appraisal - NIPCCD, 2006

DNA - Data not available

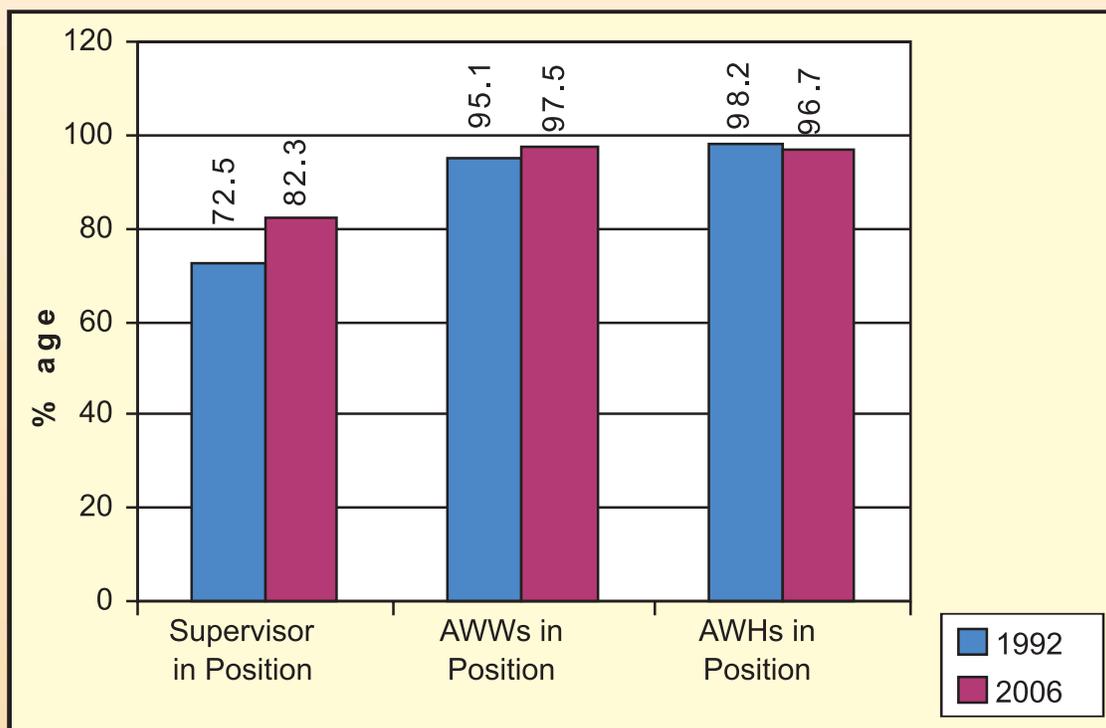
ACDPOs were clubbed together whereas in the present study these have been shown separately. Moreover in 1992 the post of ACDPOs was newly created and only a very few posts had come into existence.

training were taken into consideration. Table 5.1(c) shows a progressive trend as indicated in the table. This could be due to MWCD's renewed policy related to training under Udisha and a mandatory rule under World Bank-assisted ICDS projects.

5.1.4 Educational Qualification of AWW

With development in educational facilities and also opportunities, more number of AWWs had

Fig. 5.2 : ICDS over the Years-Staff Position



5.1.3 Training

In order to compare training status, percentage of functionaries who had received job

moved towards obtaining higher qualification as evident from Table 5.1(d). It is heartening to note that 10 per cent AWWs were graduate and more

Table 5.1(c) : Training Status (% trained)

S.No.	Staff	NIPCCD Study *1992	NCAER Study **2001	Present Study ***2006
(i)	CDPOs	73.6	DNA	81.6
(ii)	Supervisors	84.0	DNA	95.2
(iii)	AWWs	80.0	83.6	98.3

* National Evaluation of ICDS - NIPCCD, 1992

** Concurrent Evaluation of ICDS - NCAER, 2000 *** Three Decades of ICDS : An Appraisal - NIPCCD, 2006

DNA - Data not available

than one-fifth (23.3%) were higher secondary/intermediate. However, there was a reduction in percentage of AWWs having just high school/matriculate qualification as they had moved towards higher education. This could be because of the fact that most of the States/UTs have prescribed high school qualification for the post of AWWs except remote areas.

Table 5.1(d) : Educational Qualification of AWWs (% age)

S.No.	Staff	NIPCCD Study 1992	Present Study 2006
(i)	Matriculate (H.S.)	49.6	43.2
(ii)	Higher Secondary/ Inter	13.6	23.3
(iii)	Graduate	D.N.A.	10.0

Services

5.1.5 Supplementary Nutrition

In the context of coverage under Supplementary Nutrition, the guidelines issued by MWCD (Reference : Para 4.1.11 of Handbook and G.O. No. 2-7/2000-CD-I dated 08-05-2000) gave clear instructions about coverage of beneficiaries under supplementary nutrition. By the very nature of these norms, the same (i) would vary from area to area, (ii) are but indicative and, and (iii) cannot be construed to imply either an upper-limit or a lower-limit for registration.

However, in our sample more than 57 percent (6months-3years) children were registered, out of which more than 78 percent were availing the services (Table 5.2 and Fig. 5.3). Trend in case of women beneficiaries was also same but

MWCD's Guidelines

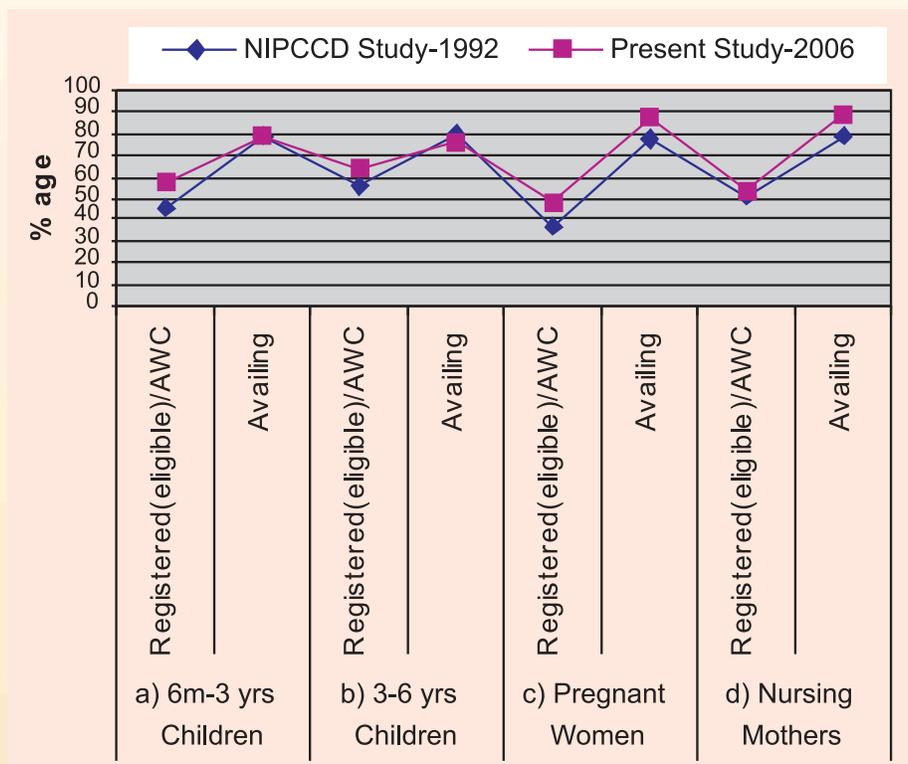
"States have to ensure registration of all eligible beneficiaries in accordance with the applicable guidelines and norms. The norms are based on average population coverage in an average AWC and were indicated in 1982 (based on the 1981 Census). They imply a coverage of 40 for 0-3 years, 40 for 3-6 years and 20 for pregnant and lactating mothers (including 4 being those recommended by the ANM/Doctor on medical grounds), per AWC, in non-tribal areas and 42, 42 and 25 respectively in tribal areas".

(Ref. Para 4.1.11 of Handbook and G.O. No. 2-7/2000-CD-I dated 08-05-2000)

Table 5.2 : ICDS Over the Years–Supplementary Nutrition

Category	NIPCCD Study-1992	Present Study-2006
Coverage of Beneficiaries under SN	%	%
a) 6 m-3 yrs Children		
Registered/ AWC	45.4	57.22
Availing out of registered	78	78.00
b) 3-6 yrs Children		
Registered/ AWC	56	54.31
Availing out of registered	79.7	75.28
c) Pregnant Women		
Registered/ AWC	36.1	47.5
Availing out of registered	77.8	87.3
d) Nursing Mothers		
Registered/ AWC	50.2	52.8
Availing	78	88.6

Fig 5.3 Coverage of Beneficiaries under SN (%) (1992 vs 2006)



percentage availing services were quite high (more than 87%). If we compare these figures across the years, we find that coverage of beneficiaries under Supplementary Nutrition had increased substantially. It may be because of above-mentioned order from governmental end.

It is evident that there was a significant reduction in percentage of low birth weight babies. Further, there was substantial increase in the percentage of children having more than 2.5 kg weight.

5.1.6 Birth Weight

Birth Weight is a very important and reliable indicator of the health of the mother and the care that has been provided to her during pregnancy. Since

one of the important services of ICDS programme is to provide sufficient nutrition and health care to pregnant women, therefore data on birth weight could indicate the strides the programme has made since the last study in 1992. Table 5.3 shows the birth weight of the children across the two studies.

Table 5.3 : Birth Weight of New Born Children

S.No.	Weight at Birth	NIPCCD Study 1992	Present Study 2006
1.	Percentage of children less than 2500 gm of children	41.0	29.0
2.	Percentage of children more than 2500 gm	58.9	71.0

It is heartening to note that there has been almost 18 percent reduction in low birth weight babies in the project areas which shows that the programme is making positive impact in improving the child health situation.

5.1.7 Nutritional Grade

The ultimate outcome of supplementary nutrition is to enhance the nutritional status. Data in this regard shows that only 35.5 percent children were normal in 1992 whereas it went up to 53 percent during 2006 (present study). It is interesting to note that percentage of severely malnourished children had reduced substantially (Table 5.4, Fig. 5.4 & 5.5). It can be inferred that

Table 5.4 : Nutritional Grade of Children (%)

Categories	NIPCCD Study-1992	Present Study-2006
(a) 0-3 yrs Children		
Normal 35.5	53	
Grade-I 35.2	16.3	
Grade-II 22.4	7	
Grade-III & IV	6.8	1.1
(b) 3-5 yrs Children		
Normal 35.9	49.1	
Grade-I 38.8	12.8	
Grade-II 21.3	3.2	
Grade-III & IV	4	0.8

ICDS has a definite positive impact over the years on enhancing nutritional status of children.

Views of AWWs, are obtained regarding quality of food supplied at the AWCs. As compared to 1992 a majority of the workers were satisfied with the food quality as very few percentage of them had stated poor quality, not tasty etc (Table 5.5 and Fig. 5.6).

Over the years, decline in disruption of Supplementary Nutrition has been noticed in both percentage of AWWs reporting disruption and average number of days of disruption. It has come down to almost 41 days from 63 (Table 5.6 and Fig 5.7). However, in both the studies major reason for disruption was 'food items not supplied.

5.1.8 Pre-school Education

So far as average coverage of children registered and availing Pre-school Education

Fig. 5.4 Nutritional Grade (0-3 yrs. Children)

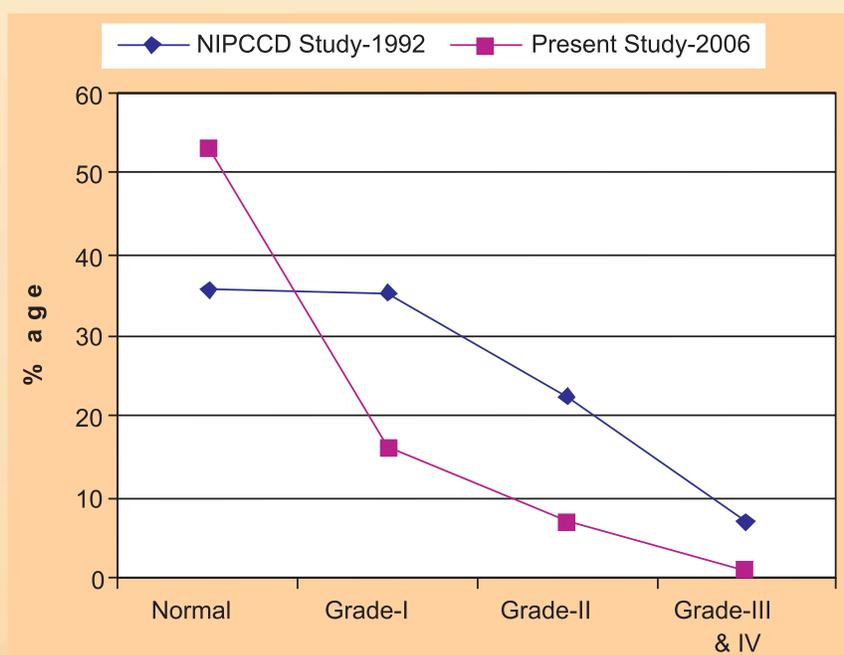


Fig. 5.5 : Nutritional Grade (3-5 yrs. Children)

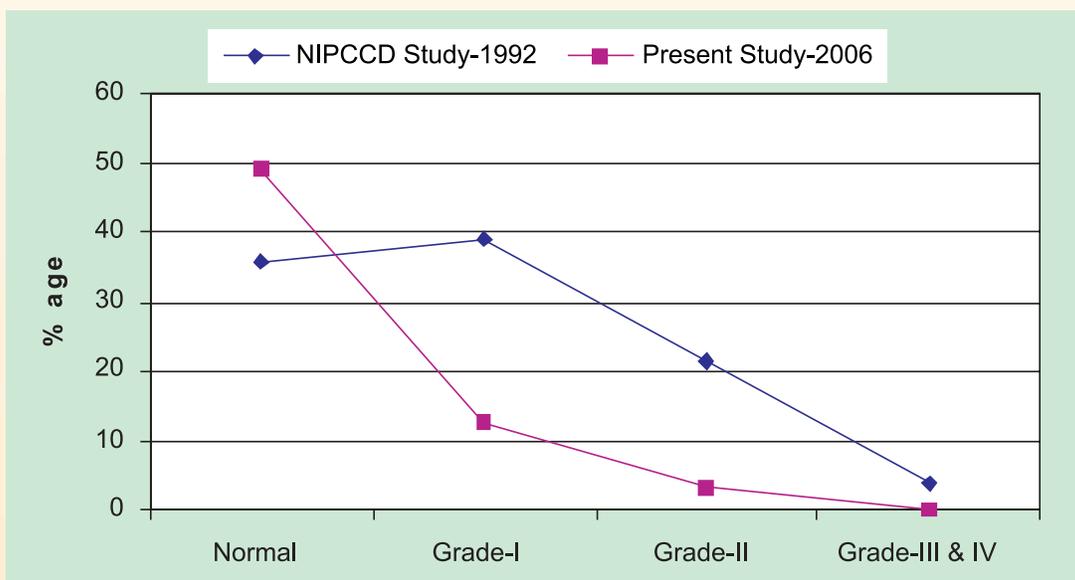


Table 5.5 : Perception of AWWs about Food Quality

Perceived by AWWs	NIPCCD Study-1992	Present Study-2006
Poor Quality	32.0	9.4
Not Tasty	41.6	12.3
Causes Diarrhoea	34.6	7.8
Difficult to Digest	31.2	9.1

Table 5.6 Disruption in Distribution of SN

	NIPCCD Study-1992	Present Study-2006
AWWs reporting disruption (%)	62.3	52.9
Average No. of days of disruption in a year	63.7	41.3
Reasons for Disruption (% AWWs)		
Food items not supplied	89	84.1
Weather conditions	15.6	6.3
Transportation problem	21	18.4

Fig. 5.6 : Quality of SN (as per AWWs)

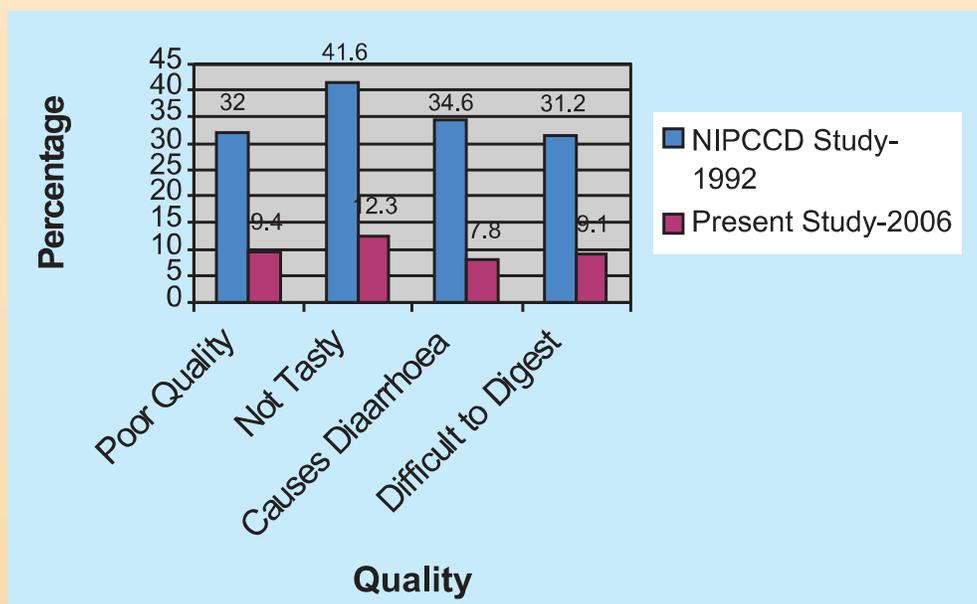


Fig. 5.7 Disruption in Distribution of SN (1992 vs 2006)

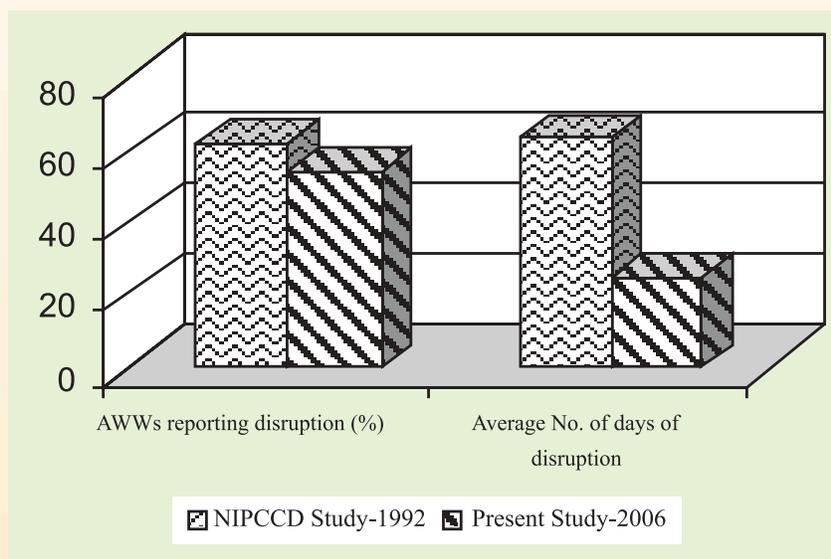
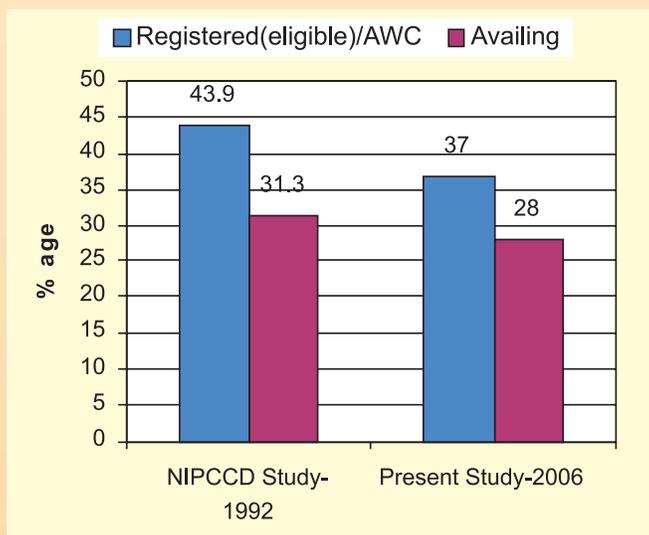


Table 5.7 : PSE, Health Check-up & IFA to Children

Coverage under PSE (1992 vs 2006)	NIPCCD Study-1992	Present Study-2006
Registered(eligible)/AWC (Average/AWC)%	43.9	37.0
Availing %	31.3	28.0
Health Check-up		
0-3 yrs Children (%)	45.9	56.1
3-6 yrs Children (%)	29.9	46.7
Children receiving IFA Tabs. (%)		
6 m - 3 yrs %	30.0	59.6
3 - 6 yrs %	37.0	64.8

per AWC is concerned, surprisingly, it has reduced (Table 5.7, Fig. 5.8). This could be because of opening of a number of other alternative institutions specially nursery and convent schools. Moreover programmes of *Sarva Shiksha Abhiyan (SSA)* and *Mid Day Meals (MDM)* etc. might have also contributed to this situation.

Fig. 5.8 Coverage under PSE (1992 vs 2006)



5.1.9 Health Check-up

Percentage of children availing regular health check-up had increased substantially from 1992 to 2006. It shows the spread of health infrastructure and network. An attempt has also been made to compare data related to place of delivery and birth attended and the same is presented in Table 5.8 (Fig 5.9). It is evident that on the one hand, there has been reduction in home delivery, on the other, substantial increase

(46.2%) in institutional delivery. Around 50 percent births were attended by health staff and private practitioners (Table 5.8 and Fig 5.9).

On the basis of what has been stated above, it can be inferred that despite some limitations, programme has made positive impact in output and outcomes over the years.

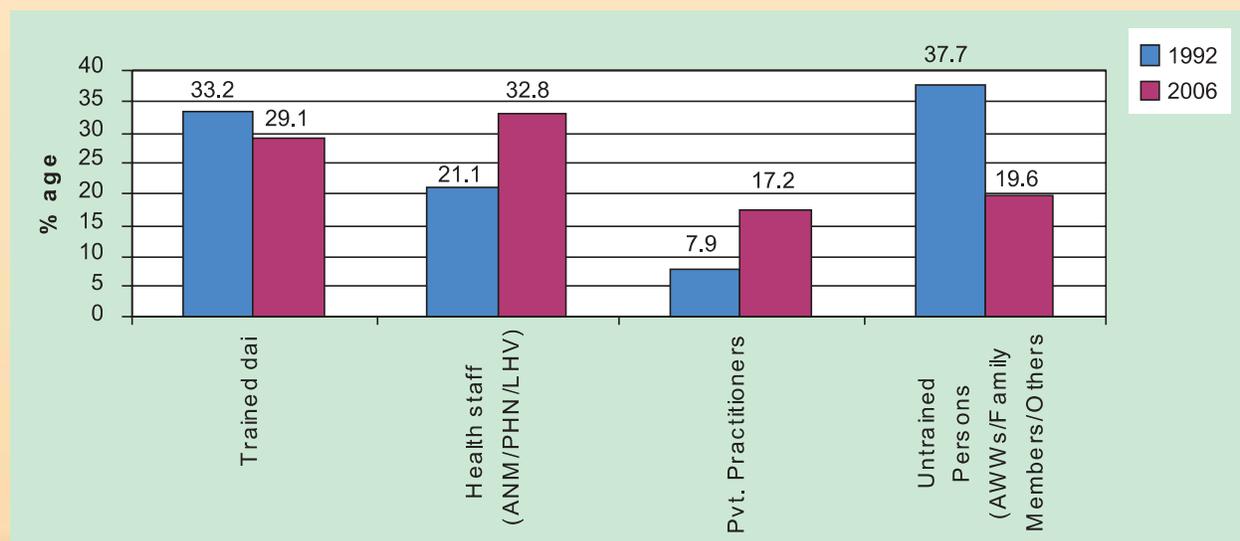
5.1.10 Immunisation

Immunisation is an important service provided to all children between 0-6 years and pregnant mothers under the ICDS programme. Immunisations are provided in coordination with the health department and the AW Centres are supposed to keep records of the children immunised. It was seen though immunisations were being provided to the beneficiaries yet the records were not properly kept at the centres. The data that the study generated on exact number of children immunised and the types of immunisation provided was quite erratic and a

Table 5.8 Place of Delivery & Birth attended by

Place of Delivery	NIPCCD Study-1992	Present Study-2006
Home Delivery (%)	72	53.4
PHC/Sub-Centre/Govt. Hospital (%)	19.5	29.6
Pvt. Hospital (%)	6.3	16.5
Others (%)	0.5	0.4
Birth attended by (%)		
Trained dai	33.2	29.1
Health staff (ANM/PHN/LHV)	21.1	32.8
Pvt. Practitioners	7.9	17.2
Untrained Persons (AWWs/Family Members/Others)	37.7	19.6
Total Inst. Delivery	25.8	46.2
Post-natal Care	37.2	57.5

Fig. 5.9 Birth Attended by



large number of inconsistencies were observed at the time of analysis of the figures that were collected. In view of the unreliable nature of such data analysis on the basis of records was not attempted. However, an effort was made to assess the situation of immunisations with the help of mother's responses and to some extent verification of these with the available records in the Centres. Table 5.9 presents mothers responses as to whether their children were immunised against various diseases.

Table 5.9 : Percentage of Children Immunised

Children	NIPCCD Study 1992	Present Study 2006 *
Children (0-1 years)		
BCG	71.5	82.4
Measles	50.4	70.5
Polio	37.5	70.5
Children (3-6 years)		
DT Booster	28.4	54.9

It is evident that there was substantial increase in immunisation coverage over the period. As stated earlier since the information is basically based on mothers' responses, there could be some limitations in the dependability of this information.

5.2 Appraisal of Inputs and Output/ Outcomes

Provisions of adequate inputs is a prerequisite for successful implementation of any programme. Unless the projects have good infrastructure, adequate number of staff, their regular monitoring and supervisory visits to the AWCs, availability of regular supplementary nutrition, sufficient play materials also NHED materials, medicine kit etc., the programme cannot

be expected to show positive output/ outcomes. Therefore in the following sections an attempt has been made to study the extent of inputs being provided in the sample projects and relate these to the outputs / outcomes.

5.2.1 Appraisal of ICDS Management

A. Input Variable

Although it is difficult to quantify the management inputs in any programme, yet there are several methods to assign weights to the crucial variables and work out a composite score which could give a quantitative view of the input variables (Fig 5.10). For the present study a similar attempt has been made. Some of the crucial inputs necessary for successful implementation of the programme were identified. A list of these is given below:

X_1 = No. of CDPOs in position

X_2 = No. of Supervisors in position

X_3 = No. of AWWs in position

X_4 = No. of trained CDPOs

X_5 = No. of trained Supervisors

X_6 = No. of trained AWWs

X_7 = No. of visit of CDPO

X_8 = No. of supervisory visits

X_9 = Coordination (as reported by CDPO) with Health Department

X_{10} = Average No. of days SN supplied

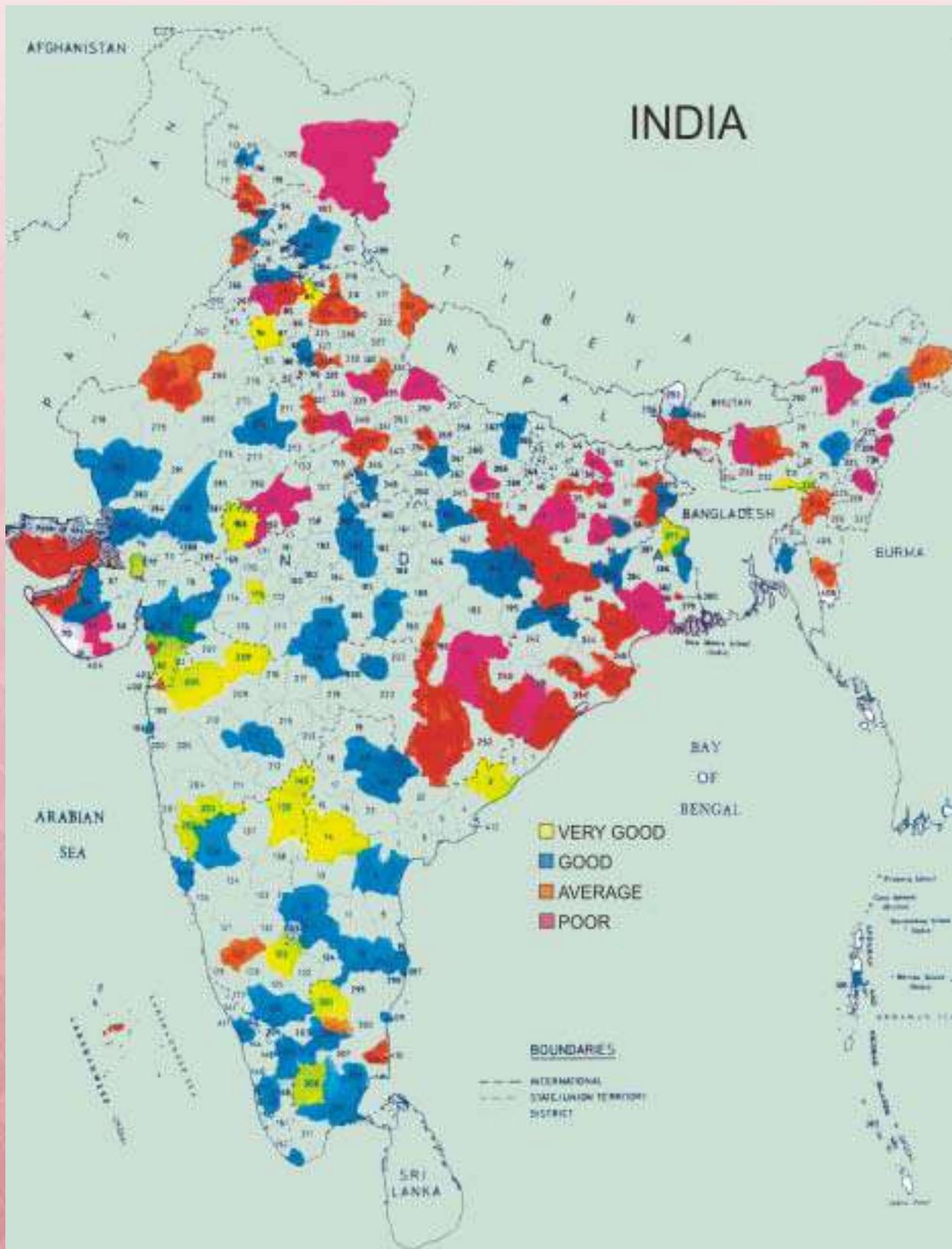
X_{11} = Availability of Weighing Scale

X_{12} = Availability of PSE Kit

X_{13} = Availability of NHED Materials

X_{14} = Availability of Medicine Kit

Fig 5.10 : Appraisal of ICDS Management - Input Variables



Map not to the scale

Z-Score method was used to calculate a standard score for each of the input variables. For this individual raw score of each variable was subtracted from mean of that variable and divided by standard deviation of that variable. The values thus arrived for each variable were then added to arrive at a composite score for each project which was called as composite input variable score.

A widely used standard score that plays an important role in statistical analysis is the Z-score. It is an accepted process of normalizing values. It is defined as the distance of a score from the mean, as measured by standard deviation units. The formula for finding a Z-score is :

$$\frac{Z = X - \bar{X}}{\sigma} = \frac{x}{\sigma}$$

Where,

X = raw score

\bar{X} = the mean of the distribution

σ = the standard deviation of the distribution

x = deviation score (x - \bar{x})

Applying this formula, a score exactly one standard deviation above the mean becomes + 1, a score exactly one standard deviation below the mean becomes - 1, and so on. A score with the same numerical value as the mean will have a z- score value of zero. As per the note on the statistical infirmities Z-value has been categorised as follows:

Z-Value	Category	Assigned rating
Z > m + s	Very Good	4 (highest)
m < Z <= m + s	Good	3
m - s <= Z < m	Average	2
Z <= m - s	Poor	1 (Lowest)

Input Parameters:

Projects: 150

Mean (m): 0.0

Std. Dev (s) : 6.522

Z-Value	Category	Range	Assigned rating
Z > m + s	Very Good	Z > 6.018	4 (highest)
m < Z <= m + s	Good	0 < Z <= 6.018	3
m - s <= Z < m	Average	- 6.018 <= Z < 0	2
Z <= m - s	Poor	Z <= - 6.018	1 (Lowest)

Lowest Z value: -16.5
Highest Z value: 12.9

Output/ Outcome Parameters:

Projects: 150

Mean (m): 0.0

Std. Dev (s) : 6.018

Z-Value	Category	Range	Assigned rating
Z > m + s	Very Good	Z > 6.522	4 (highest)
m < Z <= m + s	Good	0 < Z <= 6.522	3
m - s <= Z < m	Average	- 6.522 <= Z < 0	2
Z <= m - s	Poor	Z <= -6.522	1 (Lowest)

Lowest Z value: -21.9
Highest Z value: 11.3

On the basis of this composite input variable score of all the 150 projects, the normal frequency distribution curve was drawn which is a symmetrical distribution of measures with the same number of cases at specified distances below the mean as above the mean. In as much as so many naturally occurring distribution resemble the normal curve, this theoretical model has proved to be highly useful. Wherever actual data known or believed to resemble the normal curve in distribution, we can deduce many useful estimates from the theoretical properties of the normal curve.

Thus, on the basis of composite input and output/outcomes variables overall frequency of

rating obtained for all the 150 ICDS projects are given below:

Input Rating

	Frequency	Percent
Poor	22	14.7
Average	46	30.6
Good	60	40.0
Very Good	22	14.7
Total	150	100.0

Output Rating

	Frequency	Percent
Poor	34	22.70
Average	39	26.00
Good	56	37.30
Very Good	21	14.0
Total	150	100.0

Histogram and normal frequency curve drawn on the basis of above rating shows that more than fifty per cent projects are rated as good and very good categories both in terms of input and output/outcomes.

State-wise number of ICDS projects, according to composite score of input variables, are presented at Table 5.7. It is observed from the table that out of 150 projects, a total of 22 projects were very good, 60 were good, 46 were average and 22 were poor in terms of provisions of various inputs into the programme. If we look at state-wise distribution we find that Maharashtra (4) Gujarat (4) and Karnataka (3) had maximum number of projects under **very good** category as far as inputs into the programme are concerned. On the contrary, Uttar Pradesh (4), Bihar (4), Nagaland (2) and Orissa (2), were the States, which had **few poor** projects too. The spatial distribution of these projects is shown on the map (Fig. 5.10). It is evident from

the map that projects in southern and western parts of the country had succeeded in providing better inputs in the projects.

5.2.2 Appraisal of ICDS Management

B. Output Variable

Following variables were identified as output variables.

$Y_1 = \text{Observation Score}$: A schedule titled Anganwadi Centre's observation schedule was specially developed to make assessment of infrastructure facilities, availability of weighing scales, skills of AWWs, in conducting pre-school activities and quality of maintenance of records. These aspects were rated on a scale ranging from 3-5 points in ascending order for quality. Therefore, higher the scores on these aspects, the better was the performance of the Anganwadi Centre.

Scores on each variables which described the quality of services being provided were added to give a composite observations score. The schedule was administered by a trained observer, who after continuous observation of PSE setting for period of 1-2 days, entered the rating for each items.

$Y_2 = \text{CLCT Score (Child Learning Competency Test)}$: Over a period of time researchers have been trying to make judgments about the concept of quality in pre-school education. Quality has to be evaluated using value judgments of individual and it has relative importance for individual stakeholders (Evans, 1996; Woodhead, 1996; Swaminathan, 2000).

Table 5.10 : Classification of Projects on the basis of Composite Input Variable Score

Sl.No.	Name of States/UTs	No. of Projects				Total
		Very Good	Good	Average	Poor	
1	Andhra Pradesh	2	5	0	0	7
2	Arunachal Pradesh	0	0	1	1	2
3	Assam	0	3	2	1	6
4	Bihar	0	0	2	4	6
5	Chattisgarh	0	1	2	1	4
6	Goa	0	1	0	0	1
7	Gujarat	4	4	3	1	12
8	Haryana	2	2	0	0	4
9	Himachal Pradesh	0	2	0	0	2
10	Jammu & Kashmir	0	1	2	1	4
11	Jharkhand	0	1	3	1	5
12	Karnataka	3	2	1	0	6
13	Kerala -	0	3	1	0	4
14	Madhya Pradesh	2	5	1	0	8
15	Maharashtra	4	4	0	0	8
16	Manipur	0	0	0	1	1
17	Meghalaya	1	0	0	0	1
18	Mizoram	0	0	1	0	1
19	Nagaland	0	0	0	2	2
20	Orissa	0	1	5	2	8
21	Punjab	0	2	2	1	5
22	Rajasthan	0	3	2	1	6
23	Sikkim	0	1	0	0	1
24	Tamil Nadu	2	9	2	0	13
25	Tripura	0	1	0	0	1
26	Uttar Pradesh	0	4	6	4	14
27	Uttaranchal	0	0	3	0	3
28	West Bengal	1	3	3	1	8
29	Andaman & Nicobar Island	0	1	0	0	1
30	Chandigarh	1	0	0	0	1
31	Delhi	0	0	1	0	1
32	Dadra & Nagar Haveli	0	0	1	0	1
33	Daman & Diu	0	0	1	0	1
34	Lakshadweep	0	0	1	0	1
35	Pondicherry	0	1	0	0	1
	Total	22	60	46	22	150

The six dimensions of quality - effectiveness, acceptability, efficiency, access, equity and relevance suggested by Manton et.al. (1995) seem very appropriate. However, in the present study for the assessment of child's abilities a Child Learning Competency Test (CLCT) was developed

by consulting a number of tools already prepared by different agencies/experts (Sood, 1987; Sharma, 1987, Sood 1997, Vasudevan, 1999; Swaminathan, 2000). Test items were prepared to test ability of children and field tested by the research team. Thus, tool prepared was administered to a total of six children per AWC (two children each from the age group 3-4, 4-5 and 5-6 years). With the help of this tool child's abilities were assessed in the following domains:

- Cognitive (including numerical)
- Language
- Socio-emotional
- Perceptual-mother

The score obtained with the help of this tool was considered as one of the output / outcomes of the programme in the context of the present study.

$Y_3 =$ No. of Children under Normal category

$Y_4 =$ No. of Grade I Children

$Y_5 =$ No. of Grade II Children

$Y_6 =$ No. of Grade III and IV Children

Y_7 = No. of 3-6 years children attending PSE classes

Y_8 = No. of fully immunised (children)

Y_9 = No. of fully immunized (pregnant women)

Y_{10} = Health check-up (No. of Women)

Y_{11} = Health check-up (No. of Children)

Y_{12} = No. of NHed sessions organised

Y_{13} = No. of Referral Cases

Y_{14} = No. of Pass out Children admitted to Primary School

For appraisal of output/outcomes of ICDS programme, composite score of above listed variables was calculated by the same Z-Score method as it was done for input management variables. Composite scores, thus calculated for outcome/output variables in respect of each project is given at Annexure 18.

State-wise number of ICDS Projects rated according to composite score of output/outcomes variables is presented

in Table 5.8. It can be seen in the table that out of 150 projects, majority (56) of the projects had performed good in terms of output/outcomes. However, performance of 21 projects out of 150 were **very good** and 34 projects had not performed well. If we look at the state-wise

Table 5.11 : Classification of Projects on the basis of Composite Score of Outcome/Output Variables

Sl.No.	Name of States/UTs	No. of Projects				Total
		Very Good	Good	Average	Poor	
1	Andhra Pradesh	4	3	0	0	7
2	Arunachal Pradesh	0	0	1	1	2
3	Assam	0	0	1	5	6
4	Bihar	0	0	1	5	6
5	Chattisgarh	0	0	1	3	4
6	Goa	0	1	0	0	1
7	Gujarat	1	7	3	1	12
8	Haryana	0	4	0	0	4
9	Himachal Pradesh	1	1	0	0	2
10	Jammu & Kashmir	0	2	2	0	4
11	Jharkhand	0	0	4	1	5
12	Karnataka	1	4	1	0	6
13	Kerala	1	2	1	0	4
14	Madhya Pradesh	0	3	2	3	8
15	Maharashtra	3	5	0	0	8
16	Manipur	0	0	0	1	1
17	Meghalaya	0	1	0	0	1
18	Mizoram	0	0	1	0	1
19	Nagaland	0	0	2	0	2
20	Orissa	0	0	2	6	8
21	Punjab	2	1	1	1	5
22	Rajasthan	0	2	3	1	6
23	Sikkim	0	1	0	0	1
24	Tamil Nadu	5	6	2	0	13
25	Tripura	0	0	1	0	1
26	Uttar Pradesh	0	1	7	6	14
27	Uttaranchal	0	1	2	0	3
28	West Bengal	2	6	0	0	8
29	Andaman & Nicobar Island	0	1	0	0	1
30	Chandigarh	0	1	0	0	1
31	Delhi	0	1	0	0	1
32	Dadra & Nagar Haveli	0	1	0	0	1
33	Daman & Diu	1	0	0	0	1
34	Lakshadweep	0	0	1	0	1
35	Pondicherry	0	1	0	0	1
	Total	21	56	39	34	150

distribution, we find that 5 projects of Tamil Nadu, 4 projects of Andhra Pradesh and 3 projects of Maharashtra had performed very well in terms of outputs/outcomes. In case of Maharashtra probable reason could be the better infrastructure facilities. Almost similar trend has been observed (as it was for input) in case of states of Bihar, Orissa and Uttar Pradesh so far as projects under "poor" categories are concerned.

Looking at the map (Fig. 5.11) one can easily visualize that few projects of "BIMARU" states have not performed well whereas projects of southern and western part of the country were performing well in terms of output/outcome variables. However, few projects of bordering districts were also poor performers and this could be because of disturbances at the border or at remote location.

It would be further interesting to examine the projects performance in terms of relationship between inputs and outputs. Table 5.10 presents comparison of projects in terms of inputs and outputs.

From the above table it is seen that 8 projects had very good inputs and output. But

13 projects with very good inputs had shown only good output. Majority (27) projects had shown both good input and output. Only one project with very good inputs shown average output. One needs to go into detailed reasons for this situation which could be their being located in-accessible or poorly developed areas. Eighteen projects had average inputs and they were rated average on outputs also which is quite understandable. However, on the whole, a majority of ICDS projects (74) out of a total of 150 projects taken for the sample of the study have been rated as Good and Very Good on outputs which is an encouraging sign for the programme.

5.3 Summing-up

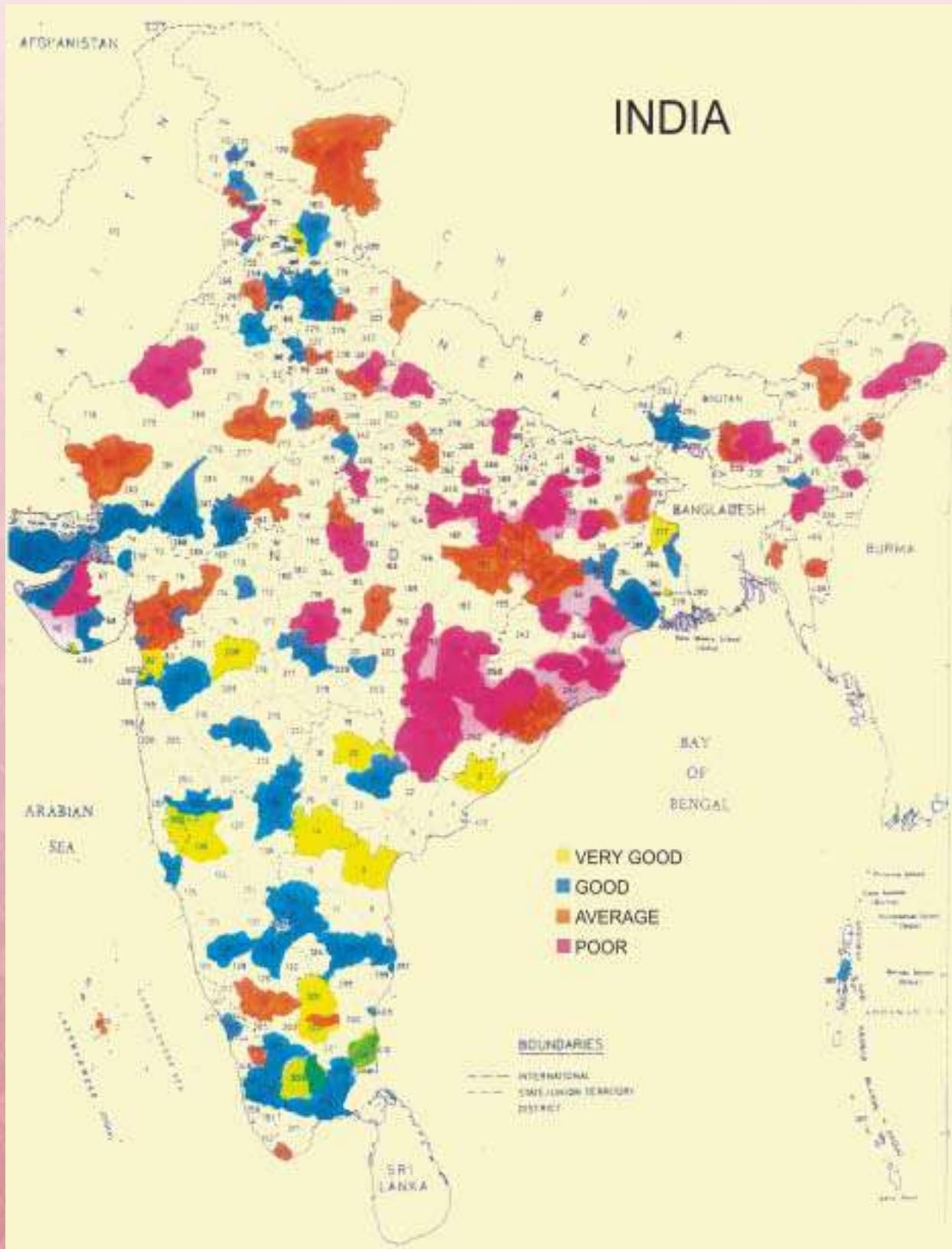
Comparisons of the findings of present study with earlier studies confirms a definite improvement in building structure of AWCs and in supply of weighing scales over the period of 14 years. Even percentage of staff in position had also increased at all levels over the period of time. Due to the Government's renewed policy related to training under *Udisha* and a mandatory rule under World Bank assisted ICDS projects, there was a substantial improvement in trained manpower.

If we compare the figures related to coverage of beneficiaries under supplementary nutrition over the period, we find that it has increased

Table 5.12 Relationship between Input and Output Variables

		Output Variables (No. of Projects)				
		Very Good	Good	Average	Poor	Total
Input Variables (No. of Projects)	Very Good	8	13	1	0	22
	Good	9	27	13	11	60
	Average	4	11	18	13	46
	Poor	0	2	10	10	22
	Total	21	53	42	34	150

Fig 5.11 : Appraisal of Output & Outcomes of ICDS



Map not to the scale

substantially. And, this had a positive impact on the nutritional status of the children. Percentage of severely malnourished children had substantially reduced over a period of time. There has been improvement in the birth weight of the children in project areas. Though there have been disruptions in the supply of supplementary nutrition yet the frequency and periodicity of these disruptions have reduced. The quality of food being served in the centres has also shown improvements. Provision of overall health services have also shown marked improvements such as increase in institutional deliveries, increase in number of beneficiaries availing health

services, increase in distribution of IFA tablets etc. The study has amply proved that good and quality inputs being better outcomes, therefore Government's recent decision to increase the budgetary provisions on supplementary nutrition is bound to bring better results for the programme in the context of children and women's health. The study has pointed out certain areas such as immunisation, record keeping etc. where more efforts are needed to be made. On the whole ICDS programme presents a very positive and forward looking picture for the children and women of the country.

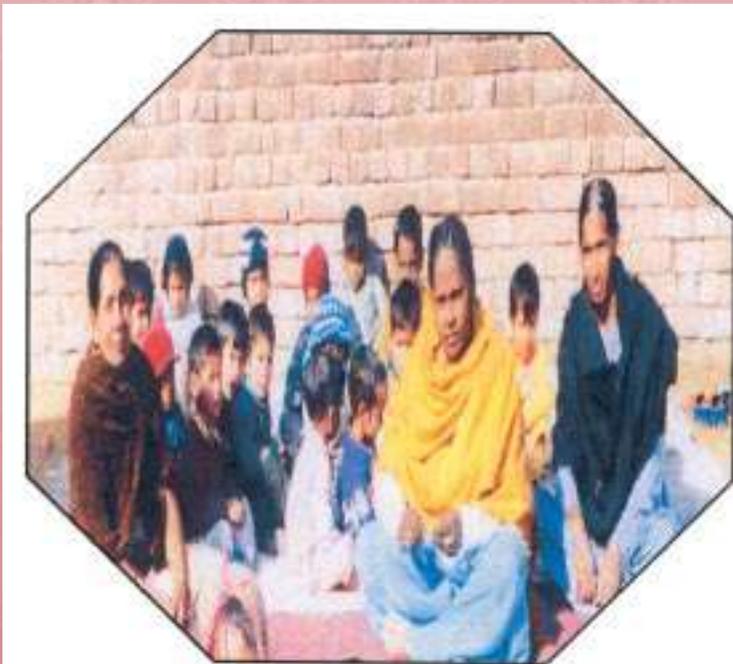




Chapter 6

Innovations and Best Practices

- 6.1 Health Services
- 6.2 Nutrition
- 6.3 Health & Nutrition Education
- 6.4 Pre-school Education
- 6.5 Disability among Children
- 6.6 Convergence of Services
- 6.7 Monitoring
- 6.8 Communication for Behaviour Change
- 6.9 Infrastructure
- 6.10 Training of Manpower
- 6.11 Summing-up



Innovations and Best Practices

Over the years, with the growth and expansion of ICDS programme, numerous innovative practices have been experimented in order to effectively implement the programme for the benefit of women and children at the grassroots level. This chapter presents some innovations and best practices experimented successfully in ICDS programme in different States and Union Territories. These experiments have been made to enrich the organisational and administrative structure and also service delivery system in terms of additional inputs, improvement in coordination machinery, training, convergence with other development programmes and community support and involvement. While documenting various experiments, three sources of information were utilised: one, reports of team leaders engaged in data collection process for the study; two, information given by State Governments; and three, relevant documents available with Institute's Documentation Centre on Women and Children.

Any new experiment undoubtedly calls for a pattern of change within the system which is otherwise unable to keep pace with changing needs and requirements of the intended beneficiaries. However, the implementing machinery of a set programme is sometime found to be putting resistance to such change in the system. However, despite their resistance, on many occasions, they have given their best in carrying out innovative experiments which are often too difficult to accomplish and call for doing away with familiar and comfortable ways because this process

requires a strong spirit of joint planning and openness to experiment and renewal.

Experiences in ICDS have brought home the point that the conventional method deployed in implementing ICDS programme does not always help in achieving its objectives in reality. With the passage of time, new strategic interventions have been made at many levels so as to set the tone of the programme according to real life situation as well as changing organisational and administrative pattern. Moreover, gaps and loopholes in programme planning and implementation gradually surfaced in the system which often resulted in non-realisation of intended targets. There is no denying of the fact that whenever there is failure or difficulties, there is an urge to explore new strategies so as to replace the failed strategy and bring improvement in the existing pattern. Above all, when the entire nation is focusing on all-round development of children, it is obvious that the State Governments and ICDS functionaries are looking for new innovations. At the same time, these new experiments are not the final answer to the changing needs and requirements of child development programmes. However small or localized these innovations, these have contributed tremendously to achieve objectives of ICDS programme by way of providing improved services through a joint effort of all concerned stake holders.

The following paragraphs give a brief description of some of the innovations and best

practices experimented and adopted in ICDS programme over the years.

6.1 Health Services

(a) *Andhra Pradesh Economic Restructuring Project (APER)*

The Project for the World Bank-assisted ICDS component of the Andhra Pradesh Economic Restructuring (APER) Project, a centrally sponsored project, is now effective. The project focuses on promoting early childhood care for survival, growth and development through service quality improvements in ICDS. The Project proposes to cover 251 blocks at a total cost of about Rs. 392 crore for a period of five years. The State has made satisfactory progress and the women are being oriented to work as social mobilisers for achieving project development objectives and outcomes. The procurement and distribution of supplementary feeding material has been decentralised with greater community involvement in monitoring at the village level (India, Ministry of Human Resource Development, Department of Women and Child Development: 2002).

(b) *Experiments in Other States*

Among several large groups of malnourished "at risk" beneficiaries

some of the projects in Rajasthan and Gujarat, where children upto one year of age and pregnant and lactating mothers are at risk, have been identified for intensive coverage by way of joint visits by AWWs and ANMs. In the newly introduced scheme of Ministry of Health and Family Welfare, Government of India, called ASHA, provision of therapeutic diet and support for employment to augment family income to take care of nutritional and health care needs of mothers who are "at risk" has been kept. CDPOs and Medical Officers have evinced special interest in this arrangement by linking their activities with other income generation schemes implemented at block/district levels.

6.2 Nutrition

(a) *Annaprashan Abhiyan*

Malnutrition is a major challenge in India and 53% of Indian children under four years were malnourished according to NFHS 1992-93. In Madhya Pradesh, 57.4% of the young children under four years were malnourished (NFHS 1992-93). To generate awareness on complementary feeding in Madhya Pradesh, the Department of Women and Child Development began the *Annaprashan Abhiyan* (Cereals



Initiation Campaign). '*Annaprashan*', the ceremony wherein a child is introduced to complementary food, in addition to breast milk, is celebrated with much gaiety and fanfare in all households. This campaign raised awareness about good infant feeding practices (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

(b) CARE Feeding Programme

In Chandrapur and Panchmahals, an attempt was made to refocus the existing CARE feeding programme to serve a higher proportion of infants and toddlers, as well as pregnant and nursing women. The programme used Corn-soy-Milk, oil and other nutrient-rich commodities along with locally produced sugar and spices. In Panchmahals, these were cooked into a kind of cereal, while ICDS Projects in Chandrapur offered a ready-to-eat snack called *Sukhada*, which was mixed and roasted in a new USAID-financed processing plant. Mobile In-Service (MIST) training emphasised the value of these and home-based foods and the impact was shown to the community, which was reinforced by growth monitoring. In addition, the AWWs were permitted to distribute Vitamin A and iron/ folic acid tablets at the village level instead of having

to refer people to Health Centres for them. These tablets make a marked difference in the incidence of night blindness and other signs of Vitamin A deficiency in children and reduction of anaemia in pregnant and nursing women (USAID:1992).

(c) Eradicating Severe Malnutrition by 2001

Orissa has emerged as a pioneer in the effort to eradicate severe malnutrition, using a focused strategy to promote development of young children as early as possible. Launched on 14 November 1988 (Universal Children's Day), the Anti-Malnutrition Campaign seeks to eradicate severe malnutrition, that is, Grades III and IV. The key elements include intensive community contact with unreached vulnerable families; focus on mothers and young children under three years of age; growth monitoring and promotion, nutrition and development counselling, health care, and links to community support for improved child care. Improved monitoring of child-related outcomes at family, community, circle, project, district and state levels is fundamental to the campaign strategy. A redesigned 'user-friendly' ICDS MIS package suited to state-specific needs was initiated through a state level workshop in 1998 (India, Ministry of

Human Resource and Development, Department of Women and Children: 2002).

(d) *The Tamil Nadu Integrated Nutrition Project: Taking Nutrition and Health Services to the Villages*

With the help of a credit of US \$ 32 million from the IDA, the World Bank's concessionary lending arm, TINP started out in 1981 in a few districts of Tamil Nadu as a nutrition and health programme. During its second incarnation as TINP II in 1990, the Project received a credit of US \$ 72.8 million from IDA and widened its services to include pre-school activities for young children. TINP I started purely as a nutrition and health programme; but the second project included pre-school activities for young children. TINP II has some other new features as well. While promoting breastfeeding in the first few months of a baby's life, the Program tries to detect malnutrition in young children at an early stage and manage it before further deterioration sets in. The nutrient-dense flour supplied to all TINP Centres by the Christy Fried Gram Industry near Salem is produced in keeping with these specifications. Made of roasted wheat, Bengal gram, and powdered soy, the flour is

sweetened and fortified with micronutrients. A vitamin pre-mix of iron and calcium is added during the last phase of the mixing process. The impact of TINP has been tremendous and the number of malnutrition cases among children reduced considerably (Catch Them Young: The Tamil Nadu Integrated Nutrition Project: Taking Nutrition and Health Services to the Villages, New Delhi, World Bank: 1998).

(e) *Suposhan Abhiyan*

To check and prevent rampant malnourishment prevailing in the State, a scheme called *Suposhan Abhiyan* (adequate balanced diet campaign) has been launched in February 2004 in Mission Mode at Chhattisgarh to achieve the target of Complete Nourishment. Under this scheme, 110 blocks have been selected and in each of these blocks, 10 selected AWCs would be developed as Model Centres. To give these AWCs a new, attractive and fascinating look, financial provision has been earmarked for carrying out painting work. For this, identical colour has been selected for the entire State. Active women SHGs would be linked up with the services of AWCs with a view to gradually turning these selected Government-run AWCs into 'Community-run AWCs.'



This scheme has been launched in time bound manner and sufficient provision has been earmarked to meet out various expenditures towards training, award giving, awareness camps, and competition etc. (Reported by Team Leader)

(f) *Dattak Palak Yojana*

Another unique scheme called *Dattak Palak Yojana* (scheme for adopted children) is being implemented in Maharashtra. Under this scheme, the responsibility of malnourished children is given to individuals including *sarpanches*, *Panchayat* members, community leaders, Government employees, industrialists or any other willing person who voluntarily take all financial and other responsibilities such as food, medicine, making necessary arrangements for regular health check-up and referral services etc. for them till their nutritional level becomes normal. There is a major challenging role of concerned CDPOs to search for and motivate responsible and interested persons to take the responsibility of malnourished children.

(g) *Resource Mapping*

An innovative technique of resource mapping is being experimented at Chhattisgarh. This technique is found

to be one of the most useful tools, in identifying malnourished and uncovered beneficiaries. A one-day training was especially organised at the project level to get a clear picture of the village (Village Level Resource Mapping) and subsequently of the entire block (Block Level Resource Mapping). After the mapping process, the entire scenario becomes clearer not only to supervisors and project officers but also to the district officers who used the compiled information for the entire district (Reported by Team Leader).

6.3 Health and Nutrition Education

(a) *Bubble Growth Charts*

Health and Nutrition Education component of the USAID-assisted project included attractive, informative Pregnant Women Action Cards and Bubble Growth Charts. These charts are to be kept at home to remind mothers of health messages. The other aspects of the project included radio spots and a number of full-length programmes broadcast by All India Radio to listening groups organised by AWWs; five one-minute films produced through the ICDS Directorate in Gujarati, Marathi and Hindi, to be shown in cinema halls to enlist the support of husbands and the

community (these films were later converted to video and shown on roving vans in remote areas, interspersed with excerpts from popular films); and an educational booklet to solicit support for the ICDS programme from village leaders (USAID:1992).

(b) Model Resource Centres

As training is essential to promote nutrition and health education, Innovative Training was organised in World Food Programme (WFP)-assisted ICDS Districts in Orissa, Madhya Pradesh, Rajasthan and Uttaranchal, using cascade model, by training of trainers based on TNA in 2000-01.

Currently a District Model Resource Centre on Nutrition and Health Education is being set up in Tikkamgarh District, Madhya Pradesh with WFP assistance.

A Health and Nutrition Training Module, using life cycle approach and participatory learning techniques, was developed and finalised after it was pre-tested on various clientele - MNGOs and FNGOs of RCH Programme, Swa-Shakti, etc. This was distributed and widely used in training.

6.4 Pre-School Education

(a) Toy Bank Initiative in Gujarat

The Government of Gujarat is exploring the idea of setting up a Toy Bank to provide deprived children the opportunity to play with toys and experience play-based learning. There are about 17 lakh children covered by around 25,000 AWCs in Gujarat who will be catered to by the Toy Bank initiative. The distribution at the community level would be one set of toys per AWC encouraging group play activities. The concept of the toy bank highlights action to fulfill the rights of the child - to be a child and to enjoy childhood (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

(a) Educational Support

In Meghalaya, the NCERT prepared Educational Kits and sent these to 27 ICDS projects to be utilised at the Resource Centres. School buildings are also utilised for running AWCs. Primary School Teachers refer the children to AWCs Centres for Pre-Primary Non-Formal Education. The Resource personnel of SCERT are being utilised at the Anganwadi Training Centres.



The Department of Information and Public Relations translated the pamphlets/ posters/ booklets into local languages (in Khasi language) (Meghalaya, Department of Women and Child Development: 2005).

6.5 Disability among Children

(a) *Community Action to Reach the One-in-Ten Differently-abled Child*

The Spastics Society of Tamil Nadu (SPASTN) has successfully experimented with a 'Linkage Model of Community Based Rehabilitation (CBR) in five blocks of Chengelpet district of Tamil Nadu. The activities commence at the pre-natal stage through identification of high risk pregnancies and continue up to the integration of children with disabilities into balwadis and schools. The most significant aspect of the model is skill-transfer to the local grassroot level workers in existing government infrastructures. Innovative ideas, like Mobile Intervention Vans, and making use of local resources for making assistive devices, have also been undertaken (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

Community Participation

- (a) In Menjanahalli, a small hamlet in rural Karnataka, a joint initiative by Gram Vikas - a local NGO, the ICDS and the women's group Mahila Samiti has led to unprecedented community participation in the supplementary feeding and nutritional programme at the local Anganwadi. The three-pronged approach meant that the children at this Anganwadi Centre get to eat three mini meals a day rather than just one. The mini meals kept the children in contact with the Anganwadi for most of the day and in the process children got additional benefits of joyful learning, health and hygiene inputs besides supplementary food. The food supply was supported by three agencies. While Gram Vikas funded the morning meal, ICDS provided the lunch, and the Mahila Samiti gave the evening meal. Menjanahalli is an example of community spirit in action where limited resources have been optimised for achieving their child development goals (India, Ministry of Human Resource Development, Department of Women and Child Development: 2002).
- (b) In Chavara, ICDS project (Kerala), involvement of mothers in PSE activities has brought out qualitative changes in attendance of children and

utilisation of mothers in preparation of local PSE aids and story telling. Interventions aiming at improving the PSE Skills of Anganwadi Workers (AWWs) are thus capable of bringing about changes. AWWs oriented with use of material with children and well trained are able to organise effective pre-school programmes.

6.6 Convergence of Services

(a) *Anganwadi Centres*

Child Development Teams formed at Sub-Centres and AWCs were combined in many villages in the state of Haryana. This was a demonstration of the integration of two institutions and two functionaries, namely the health and ICDS systems, at the field level. Combination of Sub-Centres and AWCs ensured that Child Development Teams at the village level provided better services to the community.

(b) *Convergence of Services, Meghalaya*

The Supplementary Nutrition provided by the Department could hardly meet the minimum required calories and protein by the beneficiaries. Many of the deserving beneficiaries have been left out of the programme due to fund constraints. The State Government has taken a number of measures for convergence

of services to bridge these gaps through different departments. The Government is fully utilising the services of Food and Nutrition Board's Demonstration Programme in food processing, preservation and preparation of locally available fruits, vegetables, pulses in ICDS Projects/AWCs. The ICDS Projects jointly observe the World Breast Feeding Week, National Nutrition Week and Nutrition Health Education Camps. For ICDS Projects, the Department of Community and Rural Development constructed 129 Anganwadi buildings under E.A.S Scheme. They have also constructed Community Halls under JRY scheme. The Public Health Engineering Department had installed number of hand pumps in AWCs. The Department had provided safe drinking water supply in 1423 villages and the work is in progress to cover 114 villages for safe drinking water.

The Department of Social Welfare in Meghalaya has set up a system for State level coordination in ICDS meetings. This Committee had taken up with the Agriculture and Horticulture Department, Meghalaya to provide free vegetable seeds and kitchen garden tools to AWCs, wherever the Centre had land for maintaining a kitchen garden. They have also been requested to promote planting of fast growing fruit plants like bananas,



pineapples, papayas, amlas, peaches, etc.

The Department had provided 250 smokeless chulhas, solar lamps, kerosene stoves and biogas plants in ICDS projects. Science and Technology Cell of Planning Department had provided subsidised low cost water filters to AWCs (Meghalaya, Department of Women and Children, 2005).

(c) *KOPAL Strategy in Uttar Pradesh*

Directorate of Child Development Services and Nutrition, Government of Uttar Pradesh introduced this scheme initially in two districts of the State, namely Shravasti and Lucknow, during the year 2002 based on the outcome of two workshops organised to ensure quality care and protection of children upto three years of age. Reference Groups have been organised at district and block levels to motivate families and communities to encourage planned parenthood, promote safe motherhood, improved quality care of new borns, and adopt best practices for child care so that child mortality rate is reduced and around development of the child is ensured. Since the programme aims at early childhood survival, care and protection, it was named as KOPAL in Hindi. The word KOPAL stands for:

K - Knowledge, O - Orientation, P - Participation of people, A - Awareness, and L - Love

The Programme sensitises frontline ICDS, health, primary education and Panchayat functionaries, as also block level officials/ functionaries to evolve a consensus about care of children upto three years. It also determines health, nutrition and psychosocial needs of women and children to build capacity of the community. It develops team spirit among CDPOs, supervisors and AWWs to upgrade skills and knowledge of families and community in general. The Project basically focuses on promoting interactional dialogue among community, beneficiary families and care givers at AWCs. Strategy of KOPAL includes formation of Convergent Groups of Officials of ICDS, health and education departments as also elected representatives of PRIs. This Group, called Reference Group, organised continuing education to aid, advise and guide the frontline workers at village level. Initially, the programme was conducted in one Community Development Block each of five districts namely Barabanki, Baharaich, Faizabad, Chitrakut and Varanasi. All AWCs were covered in these five blocks.

Major achievements of KOPAL strategy are as follows:

- Creation of team spirit among functionaries of different Departments
- Increase in the number of early registration of pregnant mothers and better ante-natal care
- Increased involvement of the community, particularly father, in preparation for safe delivery
- Better care of new born
- Promotion of feeding of colostrum, breastfeeding and introduction of semi solid food after six months
- Effective growth promotion and monitoring
- Care of girl child without discrimination
- Registration of births

(Uttar Pradesh, Department of Women and Child Development: 2005).

(d) Dular Strategy in the States of Bihar and Jharkhand

This strategy is implemented aiming at community and family empowerment by Department of Social Welfare, Government of Jharkhand, which is the nodal agency designated for this programme. The Departments

of Medical, Health and Family Welfare, Directorate of Primary Education and Jharkhand Education Project are the other active partners implementing this programme. This Programme was implemented in four districts of the State - Ranchi, East Singhbhum, West Singhbhum and Saraikela. Dular Strategy attempted to improve health and nutritional status of mothers, children and adolescent girls, as also reduce maternal mortality and infant mortality rates. The contribution of the programme was evident from marked reduction in the incidence of anaemia among adolescent girls and mothers. 'Life cycle approach' of the programme concentrated on the following areas in an intensive manner, involving multifarious departmental activities with an inbuilt reporting and monitoring mechanism:

- Anaemia control programme for adolescent girls
- Improvement in quality of life of adolescent girls - Kishori Shakti Yojana
- Safe motherhood and adequate nutrition during pregnancy
- Improvement of nutritional and health status of children between 0-3 years
- Monitoring at community and family levels.



Activities included orientation of district level functionaries like District Programme Officers, ICDS, District Medical Officer and officials of Education Department, who were in a position to help achieve goals of the programme. Further, intensive capacity building training of block level functionaries and village level workers was organised. One of the salient features of the strategy adopted was *Village Contact Drive*. Activities under Village Contact Drive included:

- Prabhat Pheri (singing morning hymns) by villagers for creating awareness
- Social mapping and Resource mapping through PLA
- Village mapping
- Focus group discussions with target groups highlighting health and nutrition issues (weighing and growth monitoring), immunisation, case studies for safe motherhood, counselling, etc.
- Demonstration on vital mother and childcare practices
- Nukkad Nataks (street plays).

(Jharkhand, Department of Social Welfare, Women and Child Development:2005)

Major Achievements of Dular strategy are as follows:

- Improvement in early initiation of breast feeding
- Improvement in complementary feeding
- Better infant care
- Improved ante-natal care
- Reduction in incidence of anaemia among adolescent girls
- Enhanced coverage of immunisation

(e) **Bal Bhoj**

Department of Women and Child Development, Government of Chhattisgarh has taken up the Bal Bhoj (children's feast) initiative to elicit community participation in ICDS programme. Women SHGs, formed in AWCs, collect handful of rice, fruits and other eatables from families, pool them and organise Bal Bhojan for children. Bal Bhojan is arranged weekly, fortnightly and monthly in different villages. This arrangement is managed and controlled by the members of SHGs. The food so served is nutritious and delicious. Bal Bhojan so arranged also ensures better supervision of the ICDS Nutrition programme. The representatives of PRIs i.e. Gram Panchayat are now seen actively

participating and coming forward encouraging this practice in nearby villages too. The Bal Bhoj Day is arranged in such a way that health and other related activities could get converged on the same day. Thus on the day of Bal Bhoj, on the one hand, community is seen to be proactively involved in serving nutritious food to the children and on the other hand, AWWs are found engaged in weighing the children, pregnant and lactating mothers with the active participation of the members of SHGs. Apart from this, ANMs/LHVs are found providing immunisation services in the AWCs. In fact, the Bal Bhoj initiative has turned AWCs as convergent point.

Following are some of the major achievements of Bal Bhoj initiative:

- Awareness is evident amongst members of women SHGs about the objectives and services of ICDS programme
- Women are found to be actively participating in immunisation, health check-up and other programme
- Improved awareness about malnourishment as also an active follow-up is made of children's weight to detect and prevent malnourishment
- Women SHGs are now coming forward to adopt malnourished children and

taking complete responsibility for their balance diet

- List of malnourished children is read out in the meetings of gram sabhas.
(Reported by Team Leader)

(f) NGO Experiment in Gujarat

SEWA (RURAL), Jhagadia, Bharuch and Bhansali Trust, Sabarkantha, two NGOs implementing ICDS programme in Gujarat, are working in close unison with Taluka and District Panchayats for convergent community action. Taluka Panchayat of Jamjodhpur, Jam Nagar district has roped into better off donors to provide financial and personal support to families of the children who are in grade III and IV to bring them at the level of a normal child and avoid their reversal to previous stage. Institutional services provide multiple opportunities for a working collaboration within the district/ Taluka/ block level framework. Primary health Centres and community-based services of other Government Departments have established two-way educational and referral relationships with government health Centres or community services or vice versa.

(g) Experiment in Kerala

Experiments carried out by Government of Kerala entitled ALPPUZHA Community Development



Society (CDS) promoting child development through women empowerment, is worth-mentioning. It is basically implementation of Community-based Nutrition Programme (CBNP) and the Urban Basic Services Programme (UBSP) covering a risk index with nine non-economic indicators for identifying high risk families. These indicators are: kutcha (made of mud) house; access to safe drinking water; access to sanitary latrines; illiterate adult members in family; earning member in family not more than one; family barely getting two meals a day; children below five years in the family; scheduled castes/scheduled tribes families; and alcoholic/drug addict in the family.

(g) District Primary Education Programme (DPEP)

All DPEP plans, strategies and interventions are tailored to address the special needs of the disadvantaged groups such as SC, ST and disabled children and also children belonging to minority groups particularly girl child. Programme has succeeded considerably in seeking active involvement of the community in general and the SC, ST and backward classes of the society and women in particular. DPEP also stresses on the participative process whereby the

local community is enabled to play an active role in promoting enrolment, achievements and social change. Interventions do include construction of school buildings, improvement of teaching learning materials, training practices and capacity building for academic support. The efforts of DPEP to build overall environment and facilitate advocacy with respect to enrolment of girls focused on areas where ICDS programme was being implemented because AWCs prepare children for school enrolment and further facilitate retention including reduction in school dropouts.

To cite the example of Haryana, wherein a high level of community participation and mobilisation in DPEP has been witnessed through representation and active participation of women members and Anganwadis. In Maharashtra, Village Education Committees have been constituted and women comprise half of total member which reviews among other items like the dropout position of girls. In addition functionalities of AWCs and effectiveness of mobilisation campaign are often discussed. In fact Early Childhood Care and Education (ECCE) Centres working in areas covered under ICDS have timings of AWCs from 8.00 a.m to 4.00 p.m with extra honorarium to AWWs from DPEP fund.

DPEP Centres have also convergence of timings with DPEP primary schools. This has resulted in rich dividends for improving the quality of services of AWCs as also have achieved mutually supportive goal. A direct 'spin off' was envisaged in enhanced awareness and emphasis on girls education. Joint efforts of AWCs and ECCE Centres of DPEP have enabled to incorporate a gender perspective which aims to reduce gender disparities in education as reflected in lower enrolment, retention and achievements of girls. AWCs have also evolved specific strategies to enhance girls' access, enrolment and retention in school system. ECCE Centres close to primary schools and convergence with ICDS supports girls' attendance in primary schools.

6.7 Monitoring

(a) *Computerised Information System (CIS)*

The USAID-supported project made an effort to assist the Government by developing a Computerised Information System for ICDS and training technicians to operate it. Four inter-related activities were involved: basic hardware and software for generating monthly progress reports at central and state level; steps to improve the quality of basic data

entering into the system; incorporation of appropriate health information into the ICDS system; and development of feedback mechanisms useful to decision-makers at central, state and district levels (USAID:1992).

(b) *Progress Reporting System*

The heart of the Management Information System is the monthly Computerised Progress Reporting System (PRS). This software has been progressively refined by the Department of WCD. PRS is standardised and easy to use; highlights priority activities; checks the accuracy of field data; is a useful management tool; and produces timely feedback. The Government of India has now authorised extension of the Progress Reporting System to 11 States and Union Territories, namely Tamil Nadu, Rajasthan, West Bengal, Arunachal Pradesh, Bihar, Uttar Pradesh, Kerala, Pondicherry, and Delhi (USAID:1992).

(c) *Self-Monitoring Tool (SMT)*

This experiment is being conducted at Chhattisgarh. Self-Monitoring Tools are one of the best practices, being created, managed and monitored at the individual level. Each set of the system consists of monitoring tools or wall-paintings (*sakhi-saheli kalash, suraj-mukhi, chand-suraj, tulsi-chaura*), and with help of these



devices women are able to monitor the intake of iron folic acid tablets, ANC, immunization, exclusive and early breastfeeding for the child. These tools have helped in having the beneficiaries and the family members understand the importance of the interventions in a more practical manner.

6.8 Communication for Behaviour Change

(a) *'Meena' Communication Package*

Meena is a media initiative aimed at bringing about social change among the SAARC countries using animation for portraying social themes in regional languages. Meena, a girl child, is portrayed as being very curious and full of questions: Why are girls cared for less? Why can't girls go to school? Why do girls get a smaller share of food? Why are girls married off early? Why do parents prefer boys to girls? Meena is a crusader for child rights. ICDS has been identified through action research as one of the most effective channels for bringing Meena to young children and disadvantaged communities (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

6.9 Infrastructure

(a) *'Poriyawadis' - Reaching the Unreached*

Jhabua is a tribal district in the south-western part of Madhya Pradesh bordering the adjacent states of Gujarat and Rajasthan. ICDS has been implemented in all the 12 blocks for over two decades. However, initially, reaching the scattered tribal populations across a difficult terrain posed a big challenge. A detailed survey was conducted and the village panchayats approached the district administration for additional mini Anganwadis (Poriyawadis), so as to provide effective access to these scattered populations, as well as the high-risk population groups. Thus Poriyawadis i.e. community-based child care centres (mini AWCs linked to AWCs) were born, with contribution from the Panchayats. There are two to three Poriyawadis per AWC and the local women are trained as Poriyawadi workers.

Today, there are over 2000 Poriyawadi workers in Jhabua district catering to the community's needs of child care and development, besides expanding access to basic services. Poriyawadi workers act as social animators enabling communities and women to improve caring and feeding practices, conduct play way activities, and improve utilisation of existing services

like antenatal care, immunisation, Vitamin A supplementation, etc. Some of the Poriyawadi workers have been working as ORS Depot holders, besides mobilising the communities for using iodised salt, through demonstrations using salt testing kits. Women's thrift groups have also been set up - "bairani kulri" - functioning as a supportive forum for child care. ICDS emerges as the critical convergent interface between government programme for basic services and unreached communities (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

(b) *Mini Anganwadis Covering Remote and Sparsely-Populated Hamlets*

Reaching unreached and scattered populations in remote rural, hilly and tribal areas with the basic services remains a challenge. ICDS has devised the mini Anganwadi concept, where 5 mini AWCs can function linked to an Anganwadi. A mini Anganwadi is proposed for a village/ hamlet with a population of 150 people. It should be located within one kilometer from the main Anganwadi. Until now, 1881 mini AWCs have been sanctioned in tribal blocks of Maharashtra, 1708 in the tribal blocks of Orissa and 2878 mini AWCs have been sanctioned in Madhya Pradesh (India, Ministry of Human

Resource and Development, Department of Women and Child Development: 2002).

6.10 Training of Manpower

(a) *UDISHA*

Udisha, the national initiative for quality improvement in training of child care functionaries and care-givers, is fundamental to improvement in the quality of early childhood care for survival, growth and development. Udisha seeks to address the physical, social, emotional and intellectual development of children by promoting convergence of action in the areas of health, nutrition, early learning and better parenting. Udisha is seen as an important element in empowering child care workers, parents and communities for a continuous process of assessment, analysis and informed action (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

(b) *Anganwadi Training Centres*

In order to clear the huge backlog of refresher training for AWWs in a time bound manner, an innovative mode of training was experimented with, on pilot basis, in the State of Karnataka. Under this Pilot Project, the workers received refresher training in their own districts from District Level Core



Box: 6.1 Glimpses of Innovations & Best Practices

Health Services marring

- (a) Andhra Pradesh Economic Restructuring Project (APER)
- (b) Experiments in other States

Nutrition

- *Annaprashan Abhiyan* (Cereals Initiation Campaign)
- CARE Feeding Programme
- Eradicating Severe Malnutrition by 2001
- The Tamil Nadu Integrated Nutrition Project (TINP)
- *Suposhan Abhiyan* (Adequate Balanced Diet Campaign)
- *Dattak Palak Yojana*
- Resource Mapping

Health and Nutrition Education

- Bubble Growth Charts
- Model Resource Centres

Pre-School Education

- Toy Bank Initiative in Gujarat
- Education Support

Disability among Children

- Community Action to Reach the One-in-Ten Differently-abled Child

Community Participation

- In Karnataka, initiated the process of providing three mini meals in *Anganwadi*
- In Kerala, mothers were involved in preparation of local PSE aids and storytelling

Convergence of Services

- *Anganwadi* Centres
- Convergence of Services, Meghalaya
- KOPAL Strategy in Uttar Pradesh
- Dular Strategy in the States of Bihar and Jharkhand
- *Bal Bhoj*
- NGO Experiment in Gujarat
- Experiment in Kerala
- District Primary Education Programme (DPEP)

Monitoring

- Computerised Information System (CIS)
- Progress Reporting System
- Self-Monitoring Tool (SMT)

Communication for Behaviour Change

- Meena Communication Package
- Poriyawadis – Reaching the Unreached
- Mini *Anganwadis* Covering Remote and Sparsely-Populated Hamlets

Training Manpower

- *Udisha*
- *Anganwadi* Training Centres
- Satellite-Based Training for the New Millennium (SABICON)

Training Teams, consisting of one Assistant Director, one Medical Officer, one CDPO, one Instructor of an Anganwadi Training Centre and one Supervisor. The main features include participatory approach, condensed courses, field level staff of different sectors and from different levels as trainers, decentralised field-based training and team building, focus on joint analyses of field situations and experiences, and development of training material, suited to local needs (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

(c) *Satellite-Based Training for the New Millennium (SABICON)*

Alternate strategies for training ICDS functionaries on a wider scale were developed, learning from the GRAMSAT experiment of the Government of Karnataka with elected women members of Gram Panchayats. Three distance training programmes for the training of Child Development Project Officers (CDPOs), as also Supervisors of the ICDS scheme working in Madhya Pradesh, were organised covering 20 districts in 1996 and 45 districts in 1997, using SABICON (India, Ministry of Human Resource and Development, Department of Women and Child Development: 2002).

6.11 Summing - up

Description and review of a programme are found to be well covered in government documents, declaration and annual reports or quarterly returns and on the basis of these documents to formulate an opinion about the programme based on the reflections appeared therein. These documents are basically routine ones to look at the programme as it goes on. Besides this, innovations experimented at grassroots level are equally valuable to make an assessment of changing needs and requirements of target population benefiting from a given programme. Innovations at micro level thus provide not only new dimensions to a programme, but also enrich its contents so as to facilitate a paradigm shift for futuristic planning, management and evaluation. This chapter attempted to provide an analytical picture under different captions keeping in view regional and state specific profile with respect to innovations in ICDS programme, thereby focusing on multidimensional innovative strategy and action.

Innovative style, whether it is managerial or related to programme planning and other allied aspects in one area may be very successful and its possibility of giving similar dividends in different locale is high. However, success stories with area specific modulation are worth experimenting. The message may be drawn from the presentation in the form of this chapter. Interventions for innovative experiments do not always require extra, additional, higher or special resource inputs. Rather, such inducements may work for shorter periods. To facilitate and make the innovations sustainable, associated factors could be part of future studies in this direction.





Chapter 7

Conclusions & Recommendations



Conclusions and Recommendations

7.1 Conclusions

Since its inception, the ICDS programme has generated considerable interest among academicians, planners, administrators and those who are responsible for its implementation because of the clear mandate, wide outreach and far reaching impact it has. Many studies have been conducted to evaluate and assess the impact of the programme on the beneficiaries. However, in most of these studies have been sporadic and regional in nature, except the one which was conducted by NIPCCD in the year 1992. However, the need for a comprehensive study to assess ICDS programme at the national level has been felt at the advent of the new millennium as the programme was on the verge of completing three decades of its implementation. The Department (now Ministry) of Women & Child Development, Government of India, the nodal body for implementation of ICDS programme, desired NIPCCD to undertake a comprehensive assessment of the entire gamut of programme implementation including its impact on the intended beneficiaries. The study was accordingly conceived at the national level.

Information was gathered, on a variety of items such as infrastructure of villages and anganwadis, types of housing and living pattern of beneficiaries, profile of functionaries and

beneficiaries, coordination and convergence, community participation and delivery of services and related aspects. An analysis of the situation of mothers and children of ICDS programme has brought forth an encouraging and bright prospect for the programme. In the context of reduction of malnutrition among women and children, ICDS programme has emerged as one of the largest innovative programmes and the most ambitious one run by Government of India. It is a well known fact that ICDS programme serves the target groups through a network of Anganwadis. The Anganwadi, which literally means a courtyard play centre, is the focal point for delivery of services at the community level.

In all, 150 ICDS projects, drawn out of those projects which were operational in the year 2000, were covered under the study. These projects were spread over rural, urban and tribal areas and managed by State Governments, World Bank and NGOs in 35 States/UTs.

The following paragraphs carry forth the conclusions and recommendations emerged from the present study.

7.1.1 Infrastructure

Infrastructure is an umbrella term used for a number of services such as power, transport, housing, roads, drinking water etc. The

development and expansion of infrastructure is an essential pre-requisite for efficient implementation of developmental programmes. However, link between infrastructure and development is not a once-for-all effort and thus goes hand in hand to elevate the condition of beneficiaries, though different modes and strategies. In ICDS programme linkage with other developmental programmes to augment infrastructural support has been used as a major strategy. Since adequate infrastructural facilities are a pre-requisite for successful implementation of any programme, an effort was made to assess the availability of various facilities in ICDS areas.

Availability of sanitation facilities is most crucial for reduction in mortality and morbidity in rural and tribal areas. Sewage/drainage system was reported in 30 per cent of villages under regular ICDS Projects whereas 27 percent of villages of those projects, which were assisted by World Bank, were having such facilities. Four (41.9%) out of ten villages of projects covered by NGOs had these facilities also. On the whole 41 percent of Anganwadis had toilet facilities; 24 percent of Anganwadis had toilet facilities in good condition.

It was found that educational facility of lower primary school (class I-V) existed in nine out of 10 villages (91.3%). Middle school (VI-VIII) facility was available in 61 percent of villages

whereas high schools were functioning in 39 percent of sample areas.

Empirical data show positive relationship between rural connectivity and development. Rural roads facilitated access to and utilisation of a host of important social and physical infrastructures like PHCs, schools, market etc. About 97 percent Anganwadi Centres in urban areas, 93 percent in rural areas and 74 percent in tribal areas were connected by roads. Primary Health Centres and sub-centres were available in 29 percent and 43 percent respectively in Anganwadi areas. Thus, accessibility to important services of health was limited. Data also revealed that around 89 percent of rural project areas, 94 percent urban and 68 percent of the tribal project areas had telephone connection facilities. Interesting information was availability of LPG in 72 percent of the Anganwadi areas.

Safe drinking water is still a luxury for millions of women and children - though coverage of population with drinking water supply has increased rapidly. Hand pumps and tap water were the main sources of water in majority of the Anganwadi Centres, thereby bringing home the point that ICDS programme has succeeded, to a large extent, in arranging safe drinking water for the children attending Anganwadis in collaboration with Public Health Engineering Department of State Governments.



Data was collected on different aspects of physical set up of Anganwadi Centres in terms of location, ownership of buildings, availability of space, accessibility, availability of equipments and teaching aids etc. It was gratifying that majority of the Anganwadi Centres were located in pucca buildings. It reflects that efforts made in housing Anganwadi Centres. Ideally, AWCs should have sufficient covered floor area for children to sit and for conducting different activities. Space was found to be a problem in most of the Anganwadi Centres in urban areas. Adequate outdoor and indoor space and separate space for storage was available in only 44, 36 and 39 percent Anganwadi Centres of rural, tribal and urban ICDS projects respectively. This situation was found to be little better in rural and tribal areas. Overall, about 49 percent of the Anganwadi Centres had inadequate space for outdoor and indoor activities and 50 percent had no separate space for storage of various materials. Around half (49.0%) of the rural and tribal (50.6%) projects and 40 percent of urban projects had adequate cooking space separately.

Most of the AWCs (60.3%) were found to be easily accessible to children as they were brought either by their parents/siblings/older ladies of the locality to the Anganwadi Centres. Helpers mainly concentrated in bringing newly admitted children to Anganwadis. It was noticed that in tribal areas about 52 percent of children had to travel more than one kilometer and

sometimes even more than 3 kilometers to reach the Anganwadi Centres.

Weighing scales were available in 97 percent Anganwadis of World Bank-assisted ICDS Projects, followed closely by NGO-run projects (95.3%) and 85 percent of regular ICDS projects. Around 89 percent of them were in working condition also. AWCs were supplied PSE kits, toys, counting frame, primers, picture books, play materials and equipments. PSE Kit was not available in majority of the Anganwadi Centres run under the World Bank-assisted projects whereas majority (56.5%) of the regular ICDS projects had PSE Kits. Non-availability of the kits in 44 percent of the Centres is a matter of concern and this aspect needs to be looked into by the programme implementors carefully. Availability of adequate number of cooking and serving utensils in the Anganwadi Centres is of paramount importance for the success of the nutrition programme. The study revealed that cooking utensils were available in 61.8 percent of rural, 49.2 percent of urban and 65.9 percent of tribal projects whereas serving utensils were found in 60 percent Anganwadis.

7.1.2 Profile of Functionaries

It was gathered that 15 percent positions of CDPOs, 48 percent of ACDPOs and about 18 percent of Supervisors were vacant in the surveyed projects. However, the position with regard to the appointment and availability of AWWs and

Helpers has been quite satisfactory. The training status has been quite satisfactory. It was observed that Arunachal Pradesh was the only State where 50 percent CDPOs were untrained. In other states, by and large, training of functionaries has been highly satisfactory.

7.1.2.1 Selection of AWWs

It was found that around 80 percent of the Anganwadi Workers belonged to the same village/locality. AWWs belonging to the same village/adjoining villages located within the radius of two kilometers normally walked down the distance whereas other (9.0%) utilised public transport plying on the route. Rest of them, around four percent, used their own (family)scooter/motor cycle/cycle. It was found that the system of selection of AWWs directly by CDPOs got diluted with the massive expansion of ICDS programme.

Data on age of AWWs depicts that about 64 percent of AWWs were 35 years and above. Percentage of AWWs in regular and World Bank-assisted ICDS projects was evenly divided in the age-group 35-45 years while 30 percent of AWWs were in the age-group 25-35 years. In Gujarat, the preference in selection of AWWs was given to widowed and divorced/separated women. Sixty-two percent of the AWWs had work experience over 10 years whereas 28 percent of them had experience of more than five years. Majority (43.2%) of the AWWs were matriculate, 23 percent Higher Secondary and about 10

percent Graduates. There were hardly any illiterate workers, their percentage being around one only.

7.1.2.2 Supervisors

Guidelines say that supervisor should be a female between 21 and 45 years of age and preferably graduate in Social Work, Home Science or related fields. Since the State Governments are running a large number of ICDS projects they have also formed a cadre of Supervisors based on required criteria. It was found that direct promotion from amongst AWWs and deputation from line departments and contractual appointment of Supervisors under World Bank Scheme was carried out in States like Uttar Pradesh. In 25 States of India, supervisors were promoted to the post of CDPO/ACDPO. Policy of reservation of seats was existing in 21 States and 7 States did not adopt any such policy. A large majority of the supervisors were above the age of 35, either graduates or post graduates and possessed experience of more than 10 years. This is a positive sign as ICDS seems to be managed by experienced and qualified supervisors.

7.1.2.3 Child Development Project Officers (CDPOs)

Most of the thickly populated States have evolved their own mode of recruitment of CDPOs. Data show that 21 States had exclusive cadre of CDPOs whereas 10 States had a joint cadre



comprising deputation, promotion and contract. In all, 25 States had adopted the policy of promotion of Supervisors to the post of CDPOs/ACDPOs. Mode of recruitment in terms of reservation was reported to be followed as per orders of State Governments issued from time to time.

Though the guidelines of the scheme envisage that CDPO should preferably be a female, yet it was observed that about one-third (32.7 %) of CDPOs were males. Most of the CDPOs (48.3 %) were in the age group 45-55, followed by 33 percent in the age group 35-45. It was found that 57 percent CDPOs were Post Graduates with only 6 percent being under graduates. About 31 percent of CDPOs were having less than 3 years of experience which was reflective of frequent transfers of this category of functionary in some States. Majority of them were experienced, qualified and trained functionaries. This goes to prove that the efforts of ICDS programme in ensuring that the programme is managed by qualified and trained personnel has been successful.

7.1.3 Profile of Beneficiaries

The following paragraphs draw out the salient features of beneficiaries belonging to sample families covered under the study. These features, inter-alia, include their socio-economic conditions, types of families they belong to, size

of households and so on. A sample of 16,138 beneficiary households were drawn spreading over 750 Anganwadis.

7.1.3.1 Target Population in Sample Households

Analysed data show that in case of tribal projects, out of total household population, children below to 0-3 years constituted 12 percent. However, this figure was relatively higher (13.7%) in urban projects, followed by rural projects (12.9%). A similar trend was found in the other category of beneficiary children of 3-6 years - 11.4 percent in rural projects, 12.3 percent in urban projects and finally, 11.3 percent in tribal projects. So far as pregnant women are concerned, rural projects occupy the lowest percentage, i.e. 3.3 percent. While urban and tribal projects remain slightly at the top, both scoring 3.4 percent. In case of nursing mothers, all categories of projects go hand in hand (3.2 %). Data indicate that 0.83 percent of children in households covered under the study are handicapped. Out of these children, 55.56 percent children have been receiving benefits from ICDS programme.

Maximum percentage of beneficiaries were from backward classes (29.6%) followed by scheduled castes (26.3%). Differences between representation of other castes and that of scheduled tribes was meager (21.4% and 20.4%, respectively). This clearly indicates that

Anganwadis mainly catered to the needs of SC/ST and backward class beneficiaries belonging to lower strata of society.

It was found that 55 percent of them were landless while another 28 percent owned land which was less than one hectare. It was found that less than 8 percent possessed land holding between one and two and above two hectares. Those who possessed land more than four hectares were residing in hilly, desert and tribal areas. Landless constituted six out of ten families covered under World Bank-assisted ICDS projects, followed by regular ICDS projects (54.77%) and almost equal percentage was found in NGO-run projects. Six out of ten families of beneficiaries were nuclear while joint family constituted one-third of all types of families. Data demonstrated that in urban areas 62 percent families were nuclear while this type of family constituted almost similar percentage in rural (59.0%) and tribal (59.8%) projects. Increasing trend of extended families was seen in regular ICDS projects (7.03%) and drastic reduction in other categories of projects (4.12% in World Bank projects and 4.80% in NGO-run projects).

Six out of ten families (59.7%) conformed to the national figure in respect of size of families (upto 5 persons), followed by 36 percent of households having family members between six and ten. Another interesting finding is that households with 11 and above family members constituted four percent. Normal belief is that

urban households are nuclear and smaller in family size but the data revealed that even urban ICDS projects also recorded family size between six and ten (32.7%).

A family is considered to be above poverty line when its monthly income is above Rs. 2,000/- per month (Economic Survey of India-2004). A little over 60 percent families under World Bank-assisted ICDS projects (62.48%) had monthly income less than Rs. 2000/- per month, followed by NGO-run projects (51.41%) and regular ICDS projects with share of 47 percent of households. During the visits of research team to households, it was observed that very few households were in a position to possess well-ventilated house with capacity to provide adequate nutrition and health care to their families.

Income of households was analysed as per location of projects in rural, tribal and urban areas. It revealed that a little over half (52.8%) tribal families had income less than Rs. 2000/-, per month followed by rural families (49.5%). Forty percent urban families belonged to this income group. Four out of ten families in urban projects had also income ranging between Rs. 2000 and 4000 per month, followed by rural (32.1%) and tribal projects (30.4%).

7.1.3.2 Main Occupation of Sample Households

Most of the respondents informed that their main occupation was a traditional occupation(s).



One-fourth of heads of households (25.7%) had non-agriculture labour as main occupation, maximum being in urban areas (36.4%), followed by heads of households in rural areas (24.2%) and tribal areas (21.9%). It was interesting to know that a little over one-third of respondents of tribal projects (34.3%) were cultivators who constituted 27 percent in rural ICDS projects. Cultivators in urban projects were those who lived on fringe of urban areas and went to adjoining villages for cultivation, and were of negligible percentage (3.4%). Percentage of self employed and agricultural labourers was almost equal (16.0%). Self employed were mostly blacksmiths, carpenters, cattle grazers, potters, shoe makers, weavers, petty shop keepers etc. Around 12 percent were in service - Government, semi-government, private companies etc.

Ten percent households reported agriculture and non-agricultural labour as subsidiary occupation. Many respondents reported their occupation in other categories like pulling carts, rickshaws, selling woods, grazing cattle. Agricultural labour as occupation was reported by 17 percent of tribal households, followed by non-agriculture labour (12.0%) and cultivation (10.5%). Other categories of subsidiary occupations were reported marginally.

7.1.3.3 Household Assets

Data showed that availability of television was in maximum number of households (42.2%),

followed by radio/transistors (35.0%). Among these, maximum number of television was possessed by urban households (65.4%), followed by rural households (41.3%). Position in terms of availability of radio/transistor was almost equal in rural (35.8%) and urban (35.5%) projects, followed by tribal projects (32.6%). Respondents of urban areas possessed comparatively better assets like telephone/mobiles (20.3%), gas connection (48.0%) and cycles/scooters/motorcycles (49.7%). Rural areas recorded the second position.

Respondents mentioned that one of the advantages of telephone was reported to be timely availability of assistance of health facilities in emergency situations. Villagers reported that television provided them not only political news but also information on social problems like crime against women, health and nutrition, family planning, information about government programmes/schemes. Almost half of urban respondents (48.0%) were beneficiaries of LPG connection and about one-fourth (24.1%) were rural respondents residing in close vicinity of cities/town areas. It may be mentioned that supply of television, radio/transistors, scooters/motorcycles on easy installments of payment led to greater availability of these assets.

Housing conditions of an individual along with facilities of toilets, electricity, open space, ventilation etc. contributes to a healthy living

conditions and protect them from illnesses. Availability of these facilities is possible through coordination mechanism and integration of services of other departments in beneficiaries' households. While 39 percent household lived in kucha house(s)/huts, 32 percent could afford to construct pucca houses made of bricks and cement. Another 29 percent could construct semi-pucca houses wherein walls were made of brick and plastered with cement and roofs were of tiles. Varandah were made of mud while floor of these semi-pucca houses were kucha. Most of these houses were with facility of one/two rooms. Sunlight was available through ventilation, two small windows and a door. These rooms were also shared with cattle to protect them from theft. Tribal projects had hut/kucha construction (57.5%), followed by 28 percent semi-pucca houses.

In all categories, electrification of houses was 69 percent and the lion share was in urban areas (87.9%) followed by 68 percent in rural areas and 56.5 percent in tribal areas. Electrification was done basically under the scheme on supply of electricity to all villages and particularly to those families which are below poverty line.

7.1.4 Coordination in ICDS

The constitution of various committees at different levels by the State Governments was communicated to nodal Department(s) of ICDS

by Department (now Ministry) of Women and Child Development, Government of India. In this section, an attempt has been made to find out extent of coordination at different levels and convergence of services at Anganwadi centre level.

7.1.4.1 Village Level Coordination Committee (VLCC)

Anganwadi Centre is the focal point for delivery of services. Therefore, coordination at village level is very important. However, Anganwadi Worker, ANM, local influential people, social workers, Dais and elected representatives of PRIs were normally included in the Committee.

7.1.4.2 Project Level Coordination Committee

More than 70 percent projects of rural and tribal areas were having Coordination Committee at the project level, whereas urban projects (83.0%) were having Coordination Committee at project level. So far as existence of Coordination Committee at project level by type of management is concerned, regular ICDS projects and projects supported by World Bank were having lesser number of Coordination Committees as compared to the projects run by NGOs.

In urban projects, more than 80 percent CDPOs, Supervisors and health functionaries had reported adequate coordination at their level. In NGO-run projects, coordination at CDPO level was



somewhat adequate but at the field/village level, it was not upto the mark. The situation is similar to tribal projects too. Coordination with health department was somewhat lacking at field/village level especially in tribal areas. By and large coordination at project level was found to be satisfactory. A little over two- third (68.0%) CDPOs were of the view that meeting of Coordination Committee was effective whereas about one-fifth (21.0%) found it very effective. The Research team found that around 73 percent CDPOs had reported that there has been adequate coordination between ICDS and health functionaries. But remaining 27 percent had mentioned inadequate coordination. A substantial percentage of CDPOs and health functionaries were pre-occupied because of which coordination was lacking. Another important reason for inadequate coordination was indifferent attitude of health functionaries. It was also observed during data collection by the field team that ANMs at the village level were not coordinating very well with the Anganwadi Workers.

7.1.4.3 Convergence of Services in ICDS

Coordination and convergence of services at different levels has a positive impact on output and outcomes of ICDS. Some of the mechanisms used by them were as under:

- Convening regular meetings of Committees

- Taking follow-up measures
- Involving Village Panchayats in activities of AWCs
- Approaching higher authority for help and support for BPL families
- Organising convergence of services at community level

Data made it amply clear that efforts were made in rural areas to involve village Panchayat in activities of AWCs. It is also interesting to note that efforts were made for organising community convergence to inter-link programme and services as a substantial percentage of CDPOs reported. In order to make policies and programmes effective for beneficiaries, it was imperative to have perfect coordination and convergence not only among various departments but within ICDS as well because it is a good nodal point for the convergence of these efforts.

7.1.5 Community Participation

ICDS programme assumes that the AWW, being a local woman, would be much more effective in delivery of services due to her familiarity with the community. Thirty- two percent women (15-45 years) extended supportive role in Anganwadis like assistance in cooking food, providing fuel, collecting children for health check-up, bringing children to Anganwadis for immunisation, fetching drinking

water. In tribal projects (39.6%), this type of support was found maximum. Contribution in kind like carrying supplementary nutrition upto AWCs using own means of transport, repair of AWCs was also found maximum (16.0 %) in tribal projects.

7.1.5.1 Contribution of Community Leaders

Majority (69.7 %) of community leaders extended their contribution to AWCs in the form of supervision, solving personal problems of AWWs and protecting them against undesirable elements. Forty-five percent also cooperated and supported AWWs as and when it was necessary. This contribution was also reflected in direct support to AWWs which included in extending help in promoting attendance, maintenance of records and registers and seeking cooperation and help from primary schools in admitting children in 1st standard. It has been found that few of them (17.75%) also contributed in cash and kind. On the whole, it can be inferred that over a period of three decades, community has become aware about ICDS programme and is now moving ahead to support AWCs.

Few AWWs reported that they faced problems in eliciting community participation in their day-to-day activities. AWWs were mostly from the same community. It was expected that they would prove to be an effective agent to seek involvement and support of community people.

But they faced difficulties in this regard. About one-third (33.6%) mentioned that community had no time as most of them went out in search of employment for their livelihood. It was true in case of rural and tribal communities. Poverty was another factor prevailing among target families. About 23 percent AWWs found that population was least concerned about AWWs and they behaved indifferently. Inadequate awareness among project functionaries particularly AWWs was a serious drawback in respect of involvement of community as she lacked communication skills in methods and techniques of enlisting community participants.

7.1.6 Assessment of Delivery of Services

An attempt has been made to assess the efficacy and extent to which the package of services under ICDS is delivered to benefit various target groups. Appraisal brought out nutritional and health status of pregnant and lactating mothers and new born and children between six months and six years. It also describes extent of utilisation of ICDS services such as health, nutrition and pre-school and the factors influencing the beneficiaries in effective utilisation of these services.

7.1.6.1 Supplementary Nutrition (SN)

Supplementary nutrition is provided to children below 6 years of age and nursing and expectant mothers from low income families



based on the guidelines issued from time to time by the Ministry of Women and Child Development, Government of India related to selection of beneficiaries.

Distribution of Nutrition

Supplementary nutrition in ICDS is procured from various sources. Data of the appraisal revealed that in 80 percent projects, source of arranging nutrition in Anganwadis was State Government which procured food item(s) from Food Corporation of India and other sources identified by them. World Food Programme (WFP) was found to be supporting six percent of Anganwadis while CARE contributed its nutritional facility to four percent of Anganwadis. A trend was also visible wherein village panchayats/Self-Help Groups were serving cooked food to beneficiaries. Though percentage of such contribution is nominal, credit goes to the efforts made by ICDS functionaries particularly AWWs to involve community in activities of Anganwadis. States/UTs Government are major contributor for supplementary nutrition in all areas – rural, urban and tribal, however this extent of contribution was lower (68.8%) in tribal areas in comparison to urban (72.5%) and rural (85.8%). Selection of beneficiaries was made by following the criteria prescribed by the concerned State Government.

Data was also collected about types of food served in Anganwadis. Forty-two percent of Anganwadis received raw food items which were

cooked/prepared at AWCs and served to children. This practice was found most prevalent in Anganwadis of tribal projects (53.5%). Ready-to-Eat (RTE) food was provided in all types of projects, maximum being in Anganwadis of urban projects (45.8%), followed by rural (33.6%) and tribal (23.5%) projects. Some Anganwadis (18.0%) were providing both cooked and RTE food. In some states like Gujarat, Rajasthan, Maharashtra and Madhya Pradesh, all children below six years identified as severely/moderately malnourished, on the basis of weight, were given therapeutic diet cooked in soft form (pulverised) or tinned milk by benevolent organisations/individuals. This is an indication of significant efforts made by ICDS functionaries to mobilise resources at the grassroots level to make the programme effective and meaningful.

Interruption in Distribution of Supplementary Nutrition

Overall, while 46 percent of AWCs (rural-47.6%, tribal-38.2% and urban-50.8%) had no interruption at all in terms of supply of nutritional ingredients, 52.9 percent reported interruptions. Tribal AWCs suffered the most due to interruptions (61%) of AWCs, followed by rural (52.0%) and urban (45.0%) AWCs. Out of the AWCs which reported interruptions in supply of supplementary nutrition, 43 percent faced this situation once which did not go beyond two months; another 27 percent of Anganwadis came across this situation

twice (beyond two months, but not more than three months); (25.5%) Anganwadis confronted this problem thrice and more. Data presented a dismal position of disruption of supplementary nutrition in regular ICDS (46.31 average days) projects which is required to be tackled with special efforts. Of the projects which faced interruptions, 88 percent projects reported delay in supply of supplementary nutrition as one of the main reasons for interruption. It could perhaps be attributed mainly to non-payment to transporter or problems related to fixing up transport for projects.

Coverage of Women under Supplementary Nutrition

Supplementary nutrition is provided to pregnant women and nursing mothers in AWCs. As against 13750 women reporting in AWCs (8,793 in rural areas, 2,315 in tribal areas and 2,642 in urban areas) 6,526 (47.5%) pregnant women were registered (rural-46.4 %, tribal-59.6% and urban-40.4%), out of which 5, 696 (87.3%) pregnant women received benefits (rural-85.9%, tribal-93.5% and urban-84.6%). Maximum number of pregnant women (49.5%) were registered in AWCs run under World Bank-assisted ICDS projects, followed by AWCs under NGO-run ICDS projects (48.6%) and regular ICDS projects (47.2%). Interestingly, maximum coverage of pregnant women was found in tribal

AWCs of regular ICDS projects (61.8%) and NGO-run ICDS projects (58.3%).

Criteria adopted for selection of pregnant women was also adhered to in case of nursing mothers. Significantly, World Bank-supported ICDS projects provides nutrition to nine out of ten (91.6%) nursing mothers, followed by regular ICDS projects (88.4%) and NGO-run ICDS projects (85.9%). The most interesting finding was that in NGO-run ICDS projects, all registered nursing mothers were availing of benefits from AWCs in tribal and urban areas, while in rural areas, the percentage was 75.6. On the whole, little more than half the nursing mothers (52.8%) were registered. Of these, 89 percent received supplementary nutrition. More than 80 percent nursing mothers were found to have been registered for supplementary nutrition in the States of Arunachal Pradesh (82.9%), Mizoram (80.3%), Nagaland (81.8%) and UTs of Dadra & Nagar Haveli (85.5%) and Lakshadweep (87.7%). It was also found that nutrition was provided to a high percentage of nursing mothers in these states.

Children (6 Months to 3 Years)

It was found that selection of children for supplementary nutrition was made by following the criteria prescribed by the concerned State/UT Administration. In all sample Anganwadis, growth charts, a graphical presentation of weight for age, were reported to have been supplied. Wherever



growth charts were not available, weight by age was recorded in a register from birth to five years. It was observed that weighing procedure seemed to have been working satisfactorily in case of grade III and IV malnourished children, both quantitatively and qualitatively. ANMs/PHNs and doctors paid special attention and provided therapeutic diet. AWWs and CDPOs monitored records and provided information about number of malnourished children. Data presented that there was evidently more registration of male children (59.1%) than those of female children (55.2%). On the whole, the percentage of female children availing supplementary nutrition was quite high - 82 percent in all - rural (81.0%), tribal (84.0%), and urban (82.5%), as against male children - 75 percent in all - rural (72.6%), tribal (81.1%) and urban (74.4%). Another interesting feature emerged from this information was that in some of the States and Union Territories more than 90 percent children, both male and female, availed supplementary nutrition.

Children (3-6 years)

Children attending pre-school education were also entitled to receive supplementary nutrition at Anganwadis. This worked as an incentive to promote attendance in Anganwadis as also to meet calorie requirements of children belonging to this age-group. Despite the fact that more girls were registered (57.8%) than boys (51.1%), boys availed benefits more (75.9%) in

comparison to girls (74.6%). Further, in tribal areas percentage of registered children were more both in boy and girl category, though on the whole availing of benefits was fluctuating in the range 72-76 percent irrespective of gender/areas of project. Development of "ready-to-eat" formulation was also accepted and encouraged in the form of Sev, Boondi, Mathari, Murukku and Sakarapara. Preparation of these items was observed in some of the Anganwadis on weekly basis. In case of infants/toddlers, the same preparation was made as powder and pulp by addition of milk/water.

Acceptability of Supplementary Nutrition

ICDS programme also recognised that special food needed to be served to pregnant and nursing mothers as also severely malnourished children which were culturally and psychologically acceptable to their families. In reply to a question regarding serving freshly cooked food, two-thirds of AWWs (67.1%) replied in affirmative. Out of this, 69 percent were from tribal and rural projects followed by urban projects (57.5%). They further elaborated that freshly cooked food items were Khichri, Pongal/Iddly, Dalia, Gram, Pullav/Halwa/Poha, green gram etc.

Eight out of ten Anganwadi Workers (80%) reported that food was totally acceptable to children and mothers. They found it well prepared, tasty and enjoyed its consumption.

Around seven percent found only some of the items of nutrition served as acceptable. Eleven percent did not find food items served as acceptable. Major complaints were found in rural projects (13.5%) followed by urban (8.4%) and tribal projects (7.1%). Acceptability of food was maximum in tribal projects (84.7%), followed by rural (78.8%) and urban projects (76.7%). AWWs of 16 States/UTs mentioned that some of the items of RTE food supplied by contractor were below the level of consumption. AWWs reported that food was acceptable below 75 percent beneficiaries in the States of Rajasthan (67.9%), Assam (66.7%), Orissa (65.0%), Haryana (55.0%), Meghalaya (40.0%), Uttaranchal (40.0%) and the lowest was reported from Uttar Pradesh (25.7%). Beneficiaries found that food items were not tasty and therefore, did not accept it. There were no variety in food items served. This led to wastage of food items. Sometimes it also got spoiled due to inclement weather conditions and poor packaging. Another reason was reported to be poor quality of food items supplied.

Growth Monitoring

A continuous close watch and attention was being paid by CDPOs and Medical Officers of PHCs/CHCs for care of these children as also meeting the needs of severely malnourished children. District and State level officials also arranged to ensure better nutritional and health care of such children to keep them in normal categories. It

was found that AWWs weighed 63.5 percent of new born children and mothers cooperated in this exercise inspite of stigma attached to weighing of new born children. AWWs (67.5%) of urban projects weighed new born. Rural AWWs (64.0%) also succeeded in weighing new born whereas tribal AWWs (59.4%) were also able to convince mothers and could weigh new born. AWWs reported that children below 3 years were to be weighed once in a month and those falling in the age group 3-5 years required to be weighed on quarterly basis. Eighty-two percent AWWs adhered to this guideline and weighed children below 3 years once in a month. However, weighing of children in the age-group 3-5 years was slightly better as majority of AWWs (83.3%) were able to do so. Entire onus of weighing and plotting was shouldered by AWWs (85.8%). Supervisors extended helping hand to monitor the growth of severely malnourished children and new born on the day of their visit to AWCs.

Problems Faced by AWWs in Growth Monitoring

Problems were reported by AWWs in conducting this exercise. Out of 748 AWCs, a little over one-third (11.1%) had no growth charts and four percent AWCs lacked weighing scales. Other reasons reported by AWWs included weighing scale under repair (3.3%) and lack of time (2.4%). While five percent parents were not cooperative to get their children weighed, AWWs (3.2%) were also not able to fill in growth charts.



A negligible percentage (1.9%) of AWWs were not skilled adequately to weigh children. AWWs of urban projects did not face much of these listed problems/ difficulties.

Counselling of Mothers

AWWs were required to take up follow-up action based on weighing outcome and advice of health staff. Substantial percentage (84.1%) of AWWs educated mothers about consequences of weighing and its repercussions on child's health and nutrition as also advised them to feed the child frequently particularly those children who were either severely malnourished or their weight was falling below normal curve of growth chart. Further, the focus was on health check-up of such children by 65 percent of AWWs. AWWs (60.8%) also arranged to feed children in Anganwadis so that the food was consumed only by intended child and was not shared with other children at home.

7.1.6.2 Pre-school Education (PSE)

Data of the present study on this aspect was obtained in terms of coverage of children, types of PSE activities conducted by AWWs and other related aspects. On an average, 37 children were registered for pre-school education at Anganwadis. This signifies that AWWs made positive efforts for bringing children from deprived sections to AWCs so that they could utilise nutrition and health services as well. On the whole, 75 percent of registered children attended the Anganwadis.

Children enrolled and attending AWCs were comparatively on almost equal footing. However, contrast may be seen from figures of attendance which points out that number of girls was more in AWCs than that of boys for taking benefits. In all likelihood, therefore, boys were preferred to be sent to attend private schools specially in urban areas and towns for PSE.

PSE Activities

Vigorous efforts were made by AWWs and project staff to correct parents' perception towards PSE activities. In view of this, some elements of formal learning had been introduced in AWCs for children to meet expectations of their parents. Children were engaged in singing songs in almost all AWCs (95.1%). Story telling and counting were other two activities which were organised by 91 percent AWWs. While 78 percent AWWs reported involvement of children in indoor activities, three-fourth of them (74.7%) also engaged children in free conversation to speak freely and apply their mind in order to organise small activities. Outdoor games could be organised by 70 percent AWCs. Other activities like painting, printing, drawing, threading and matching colour related to fine muscle coordination and development, as also activities for emotional and intellectual development could get only qualified attention in selected AWCs. Open space was a serious problem for outdoor games of children hence it got restricted to only 70 percent of Anganwadis. A

tendency for dependency upon non-indigenous play equipments was observed which needs to be minimised.

7.1.6.3 Iron and Folic Acid Tablets (IFAT)

Data obtained from mothers revealed that six out of ten children (59.6%) between six months and 3 years were given IFA tablets. AWWs were required to keep a close watch on pattern of consumption of these tablets with special reference to pregnant mothers during home visits and NHEd sessions as also in the process of health check-up. Consumption of IFA tablets by pregnant women showed that women of this category (68.9%) consumed tablets regularly whereas another 16 percent consumed it sometimes "as and when" they felt like swallowing it. Mothers (13.5%) kept the tablets in their possession but did not consume it because they did not like its taste.

7.1.6.4 Immunisation

Due attention has been paid to immunise children against tetanus and poliomyelitis. Unfortunately, the gap in the provision of health care services between rural and urban areas has also been increasing. The problem gets further accentuated by other factors like age-old customs, beliefs, traditions and taboos, bad communication and acute poverty. Immunisation against tuberculosis, diphtheria, whooping cough

(pertusis), tetanus, measles and polio for children under one year of age and immunisation against tetanus of all pregnant women in ICDS project areas has been carried out by PHCs/CHCs and their subordinate health infrastructure. Two-third (66.1%) of health functionaries reported full immunisation of children, highest being in rural projects (71.6%), followed by urban (65.7%) and tribal (51.5%) projects. Health functionaries reported that the status of fully immunised children depended upon their availability when the immunisation schedule was in operation. In urban areas, status of immunisation seemed to be below expectation while situation was comparatively better in rural ICDS projects (71.6%). It was interesting to observe that records of vaccination were correctly maintained by health functionaries/AWWs.

Reasons for Inadequate Immunisation

In spite of the best intentions and sincere efforts of ICDS and health functionaries, these groups and individuals, problems and difficulties were encountered in achieving the objective of full immunisation of all beneficiaries. Major reason as reported by around one-fourth of health functionaries was indifferent attitude of parents towards immunisation (23.3%), followed by disbeliefs attached to immunisation (17.6%). Other major reasons included age-old beliefs, customs, superstitions, stigma attached to castes/creeds. One out of ten health functionaries



(10.8%) mentioned that there was stiff resistance from certain sections of communities due to inadequate awareness about advantages of immunisation.

Immunisation of Pregnant Mothers

As per norms, two doses of tetanus toxoid (TT) were to be given to expectant mothers at an interval of 12 weeks; second dose was being given four weeks before expected day of child birth. Immunisation data revealed that pregnant mothers (76.2%) received tetanus toxoid immunisation. Twenty-seven percent of pregnant women received first dose between 16 and 22 weeks and 48 percent of mothers also availed of second dose between 24-28 weeks. Coverage of immunisation in rural projects was highest in percentage (79.0%) followed by tribal and urban projects which showed very marginal difference of one percent between them. However, administration of first dose in tribal projects was better among tribal mothers (29.9%) in comparison with rural (26.8%) and urban (25.3%).

Immunisation of Children (0-6 months)

Nursing mothers (77.4%) reported that their children got immunised. This coverage was slightly better in urban projects (79.7%) than rural projects wherein mothers (79.4%) reported that their children got immunised. The lowest coverage of 70 percent was found in tribal areas.

Immunisation of Children (6 months to 3 years)

Data shows that BCG vaccine coverage was the maximum (82.4%), followed by polio 3rd dose and measles (both 70.5%), DPT 3rd dose (38.9%) and booster DPT dose (17.8%). In this age-group, a not very encouraging trend is visible in the overall immunisation coverage.

Immunisation of Children (3-6 years)

Mothers (54.9%) of these children reported that their children got DT booster for their protection against tetanus. Immunisation coverage of children in this age-group was not as wide as it was found in case of children below three years. It seems that major focus of AWWs was to ensure coverage of children below 3 years. Rural areas had better immunisation as narrated by mothers (56.7%), followed by tribal (52.5%) and urban (51.5%) projects. AWWs informed that children of this age-group worked as a baby sitter or cattle grazer, hence, difficult to ensure required percentage of coverage.

Weighing of Children at Birth

Weighing is supposed to be done from the birth of a child. In order to assess the health and nutritional status of children, mothers were asked about weighing of their children at birth by AWWs. It was found that birth weight of seven percent children was below 2000 gm. This situation

invariably calls for encouraging mothers to do breastfeeding of these children. Among the reasons behind parents not agreeing for weighing of children, AWWs reported that superstitious beliefs, such as 'child will be victim of evil spirit,' 'fall sick' and the like were prevalent. Around three-fourth of children were above 2500 gm of weight in tribal ICDS projects.

7.1.6.5 Health Check-up

ICDS programme lays great emphasis on health check-up for antenatal care of expectant mothers, post-natal care of nursing mothers and care of new born and care of children below six years of age. According to most AWWs (75.1%), health functionaries conducted health check-up of children which included checking of eyes, ear, nose, teeth, hair and other external physical parts of the body regularly, including administering medicines of fever, eye and ear trouble, skin diseases etc. The highest percentage was prevalent in urban projects (80.8%) followed by tribal projects (78.7%) and rural projects (72.3%) in descending order.

Among categories of functionaries who were instrumental in carrying out health check-up, 51% health check-ups were carried out by ANMs, while 22 percent health check-ups were conducted by Medical Officers. In respect of LHV/PHNs it was only 14 percent. AWWs made every possible effort for coverage of more needy mothers and children

of poor and marginal families who mostly remained at home and were generally deprived of the service of health check-up and medical care. ANMs were the major source of health check-up because they were readily available. Medical Officers and LHVs/PHNs attended to "at risk" children, particularly severely malnourished (Grade I - IV) as also mothers who faced complications during pregnancy and were treated as "at risk" ones.

Research team did not come across any circular/guidelines issued relating to frequency of health check-up and description of process of health check-up of children. It was only general physical health check-up of children which was reported. However, severely malnourished children and mothers having complication(s) of delivery got due attention of medical officers at PHCs/CHCs. Health check up "once in a month" was followed for all categories of beneficiaries ranging between 47 percent and 61 percent. Focus of health check-up was more for children below 3 years (56.1%) once in a month and ante-natal check-up of pregnant mothers as per version of 61 percent AWWs.

7.1.6.6 Nutrition and Health Education

All AWWs reported that they organised nutrition and health education with the help and support of supervisors and ANMs/PHNs. As



regards the frequency of organising this programme 69 percent of them mentioned that they organised NHEd once a month on topics related to mothers and children. Fourteen percent organised this activity as per expressed needs of beneficiaries. Around seven percent conducted this activity once in two months. Seven out of ten tribal Anganwadis organised this activity once in a month, followed closely by even percentage of rural and urban projects (68.3%). Data also demonstrated that on an average 20.94 mothers participated actively in tribal Anganwadis, 18.43 in rural Anganwadis and 18.68 in urban Anganwadis. Average of attendance of mothers in these three areas was 18.68 mothers.

Methods Adopted for NHEd

The success of NHEd depended upon proper training of AWWs, supervisors, ANMs and LHVs in content delivery and communication techniques. AWWs reported about various methods adopted by them to impart NHEd to mothers. Oral conversation was observed as the most used methods by AWWs. The major focus of AWWs was on pregnant and lactating mothers. Almost all AWWs (92.1%) used inter-personal contact and discussion as a method to talk to mothers individually or in groups. Another method which was used more frequently than others was demonstration on recipes, preparation of oral dehydration solution, purification of water to mothers and adolescent girls (36.6%). AWWs

(16.6%) also organised exhibitions on issues related to diarrhoea, immunisation, small family norms, role of Mahila Mandals/Self-Help Groups, care of severely malnourished children etc. Dance and songs were also conducted related to female foeticide, dowry, wife beating, different festivals and so on. Non-conventional methods of special campaigns like rally and role play at suitable intervals were used in few AWCs. Data also reflects inadequate use of conventional and non-conventional methods. Educational and communication aids were found to be grossly inadequate in AWCs under study.

AWWs focused on issues related to "at risk" mothers and children and imparted education to women (15-45 years) and other family members. A special emphasis was laid on mothers whose children suffered from malnutrition and frequent illnesses. NHEd enabled mothers to overcome problems of ignorance, ill-health and malnutrition which go hand-in-hand.

Problems and Difficulties in Organising NHEd

Major problem regarding organisation of NHEd was stated to be lack of time of women as they had to be at their place of work from morning till evening to earn livelihood. This was mentioned by 46 percent AWWs. AWWs (36.9%) were also found to be in a situation where they were handicapped due to non-availability of materials/aids. Aids already supplied to them by CDPOs or obtained during training were not attractive. These

were also not available in local/regional languages. Films/slide, flash cards and puppets/Nukkad Natak were rarely used. AWWs (18.3%) devoid of skills in NHEd, also pointed out inadequacies of training imparted to them in training centres.

Home Visits

AWWs are required to make home visits for educating parents particularly mothers of children who are attending the Anganwadis so that they get empowered for better care of their children as also to motivate and encourage parents to send children to AWCs and avail services. It was reported that AWWs, on an average, visited 41.4 families in the month preceding the survey. Data reflected that average number of visits to families was highest in urban projects (46.7 families) whereas AWWs of tribal projects visited 43.1 families. Aggregate of these visits was 42.6 families in a month. When asked to explain the purpose of home visits, maximum number of AWWs (90.2%) reported that early registration and care of pregnant and lactating mothers was their foremost responsibility. Another important purpose of home visit reportedly was to ensure regularity and punctuality of children in attending AWCs. Almost equal percentage (68.9%) of AWWs made visits to arouse a better sense of responsibility of parents in taking care of malnourished children and taking sick children to hospital and meeting their nutritional requirements. Scattered location of houses was a

serious problem for conducting home visits as AWWs were always in a state of double mind about availability of parents in case they made a visit to families of beneficiaries living in such houses.

7.1.6.7 Referral Services

Referral service was intended to provide medical care of an appropriate standard. Pregnant women and children with problems who needed special treatment were referred by AWWs, ANMs/LHVs/PHNs to the Primary Health Centres/Community Health Centre(s). Ninety-four percent AWWs had referred children/mothers who were "at risk" to these institution(s). A vast majority of AWWs referred the cases to Primary Health Centres which were at the nearest distance and easy to approach. Beneficiaries belonging to this service were mostly from rural (63.5%) and tribal (67.1%) ICDS projects. Beneficiaries were also referred to sub-centres (16.8%). Facility of district hospital was mostly utilised by 37 percent AWWs of urban projects. It was observed during data collection that sufficient stock of therapeutic diet was not maintained and made available to treat cases of severely malnourished children. Many parents were unable to afford even minimum transport cost. Among various problems faced by AWWs in enhancing efficiency of referral service, most prominent ones included reluctance of parents to take children to hospitals (26.3%), far off location of PHCs/CHCs (23.3%) and absence of transport facility (25.8%).



7.1.6.8 Adolescent Girls

In the sample ICDS projects 44 percent AWWs were also rendering services under the Adolescent Girls Scheme (Kishori Shakti Yojana) started in 1992. AWWs (32.2%) provided iron and folic acid tablets to adolescent girls daily - one tablet of iron and folic acid containing 60 mg of iron and 0.5 mg of folic acid. ANMs and AWWs monitored consumption of these tablets and its likely effects on the health of individual girls. Adolescent girls registered in Anganwadis also received supplementary nutrition, according to AWWs (30.7%). In order to ensure lasting impact of services rendered in Anganwadi programme of family life education was conducted by 27 percent of AWWs. Topics covered by AWWs were appropriate age of marriage, care during puberty, personal health and hygiene, dangers of early pregnancy, psycho-social development, life cycle approach etc. Almost equal percentage (22.2%) of AWWs also emphasised on health check-up and counselling (21.4%) on issues related to this age and adjustment potentials within the peer groups and family.

Help and Support to AWWs

Half of the AWWs (49.6%) reported that adolescent girls provided help in conducting activities of AWCs. The areas in which adolescent girls provided help and support to AWWs were: collecting children to organise outdoor games, mothers meetings, singing songs, story telling etc.

as also regularity in attendance. Nature of help across the location of projects remained in equivalent percentage. The toughest challenge faced by AWWs was immunisation of all eligible children and ensuring their presence on the day of immunisation. Adolescent girls proved to be a boon to ensure all eligible children coming at the venue of immunisation and subsequent follow-up to get them fully immunised. AWWs (38.2%) successfully received help from girls to meet the target of immunisation. Another activity which received important help and support from adolescent girls was preparation and distribution of supplementary nutrition. AWWs (32.0%) utilised them in feeding malnourished children, taking care of children during feeding sessions to avoid wastage of food and cleaning of utensils. Besides these, they also helped AWWs in taking the "take home food" for pregnant and lactating mothers and children below three years at their respective homes. Research team observed that adolescent girls were able to ensure better attendance of beneficiaries to avail services and became a good support to "reaching the unreached." AWWs also reported marked improvement in attendance and positive attitude towards AWCs because of the support received from adolescent girls.

7.1.7 Benefits and Outcomes of ICDS

Having examined the infrastructure, organisational set-up, profile of beneficiaries,

delivery of services, coordination, convergence and community participation, some interlinked variables have been identified.

7.1.7.1 Comparison with Earlier Studies

An attempt has been made to compare the findings of the present appraisal with the other national level evaluation and macro-level studies undertaken earlier. These include National Evaluation of ICDS (NIPCCD, 1992) and Concurrent Evaluation of ICDS (NCAER, 2001).

Infrastructure/Equipment/Kit

A definite improvement was found in building structure of Anganwadi Centres over the past 14 years. It was found that the percentage of AWCs housed in kucha structure (38.7%) in 1992 has gone down in 2006 (19.9%). On the other hand, in 1992 only 43 percent AWCs were found to be housed in pucca structure whereas in 2006, this percentage has gone up to 75 percent. This progressive trend would have been because of provision of constructing pucca building of AWCs under World Bank and Jawahar Rojgar Yojana/ Nehru Rojgar Yojana. Improvement has also been noticed in terms of supply of weighing scale to AWCs and availability of PSE kits.

Increase in percentage of staff in position has been seen at all levels over a period of time except that there has been a decline in the position of helpers by 1.5 percent. So far as training of

ICDS functionaries is concerned, a progressive trend has been witnessed over the years. In case of CDPOs, the number trained has increased from 74 percent (in 1992) to 82 percent (in 2006) while in respect of supervisors, the increase is from 84 percent in 1992 to 95 percent in 2006 and in case of AWWs an increase of more than 18 percent from 1992 to 2006 was found. It was also seen that more AWWs have obtained higher qualifications.

Services

The overall coverage of beneficiaries under supplementary nutrition had increased substantially. In our sample more than 57 percent eligible children were registered out of which more than 75 percent were availing the services. Trend in case of women beneficiaries was also same but percentage availing services were quite high (more than 87%). A significant reduction has also been found in percentage of low birth weight babies, it was reduced to 29 percent in 2006 from 1 percent in 1992 in respect of children born with a birth weight below 2500 gm. However, there was substantial increase in the percentage of children having a weight of more than 2.5 kg (from 58.9% in 1992 to 71.0% in 2006). Further, it was found that percentage of severely malnourished children had reduced drastically. In case of 0-3 years children, percentage of grade III > IV children has gone down to 1 percent in 2006 from 7 percent in 1992, that of grade II, 7 percent (2006) from

22 percent (1992) and that of grade I, 16 percent (2006) from 35 percent in 1992. Similarly, in case of 3-6 years children, present study scores only 0.8 percent from Grade III and IV while the entire study (1992) scores 4 percent. Over the years, decline in disruption in supplementary nutrition has been noticed in percentage of both AWWs reporting disruption (from 62.3% in 1992 to 54 % in 2006) and average number of days of disruption (from 63.7% in 1992 to 25.1% in 2006). Surprisingly, percentage of coverage of children per AWC, registered for PSE and attending the same has reduced.

7.1.7.2 Appraisal of ICDS

An effort has also been made to assess the performance of ICDS programme in terms of input, output (process) and outcomes. According to composite score of input variables, it was found that out of 150 projects studied, a total of 63 projects were very good, 71 were good and 16 were poor in terms of input management.

Appraisal of ICDS Management - Input Variables and Appraisal of Output/Outcomes of Programme

On the basis of a composite inputs variable score, all the 150 projects were arranged in descending order showing the rank order for all input variables. Based on the total composite input score, minimum maximum range of composite input variable score was found to be between 3.1

and 19.3. Again, based on these scores, projects were rated as very good (scoring more than 15), good (between 10 and 15) and poor (less than 10).

It has also been observed from the composite score of input variables that majority of the projects had performed well in terms of both input management and output/outcomes. However, it also clearly shows that few projects of northern BIMARU States have not performed well but all the southern states have performed upto the mark.

7.2 Recommendations

The conclusions drawn in this chapter on various findings of the present study make adequate rooms for further strengthening the ICDS programme in the years to come so that the intended beneficiaries derive maximum benefits from the programme. The present study has come out with lots of findings which have come as a 'pat on the back' so far as the implementation of ICDS programme is concerned. At the same time, the study has been able to highlight certain gaps and shortcomings of ICDS programme which need to be addressed with priority. The following paragraphs contain recommendations, both general and specific, emanating from the study, and a critical analysis of those findings having direct bearing on the programme.

7.2.1 Specific Recommendations

- i. Sanitation is an essential component of hygienic living of a person. Children attending AWCs spend quite a lot of time there everyday and require good toilet facility to answer nature's call and keep themselves clean and tidy. The present study came out with a rather shocking finding - around 59 percent AWCs studied have no toilet facility and in 17 percent AWCs this facility was found to be unsatisfactory. This requires immediate attention and a concrete measure of action to provide toilet facility to all the AWCs.
- ii. Accessibility to health services at the grassroots level has always remained an issue of concern and the present study has substantiated this concern. In many Anganwadi areas, availability of important health services was found to be lacking. It was found that only in 29 percent Anganwadi areas PHCs were available and in 43 percent Anganwadi areas sub-centres were available. It is therefore suggested that efforts should be made to coordinate with health department to make health service available in Anganwadi areas as near as possible so that maximum benefits of these services are availed by needy and poor who otherwise have no other alternative to avail these services. The ideal situation would be to make the population norms for sub-centres and Anganwadi centres same so that both these centres can come up side by side, facilitating easy access to both nutrition and health services.
- iii. The present study came out with another revelation that almost half of the AWCs, particularly in urban areas, are lacking space for conducting outdoor and indoor activities. This problem needs to be sorted out as it amounts to AWCs not being able to conduct Pre-School Education activities properly and meaningfully. Separate space for storage was also found to be lacking in these AWCs. Cooking space was reported to be a major problem in many AWCs. Adequate space for outdoor, indoor activities, separate storage space and cooking space are to be ensured at on all Anganwadis.
- iv. As of now, around 75% of AWCs have pucca buildings; concerted efforts need to be made to rope in the funds available under other welfare scheme for construction of pucca building for AW centres



- v. As pre-school activities call for a complete informal method of involving children in various developmental activities leading to their mental, physical, cognitive and other growth and development, it is essential to use different methodologies which require variety of aids to supplement them. These aids, in the form of PSE kits, are provided to AWCs to facilitate PSE activities. However, 44 percent AWCs covered under the present study were found to be lacking in PSE kits. This is a matter of serious concern. Action is to be taken to ensure availability of PSE kits in all the AWCs. It is also essential to impart training to AWWs to develop special skills on preparing PSE kits using local materials as this would further ensure availability of PSE kits at Anganwadi level. Alongside, in most of the Anganwadis, play materials were reported to be not adequately available. This again calls for developing special skills among AWWs to develop play materials by utilizing locally available materials. There is also a need to minimise the tendency of depending upon non-indigenous play equipments. Cost effective and popular local resources need to be optimally utilised to develop play materials. These resources include sand, clay, leaves, water, twig, sandpits, crayons, brush drawings, paintings, paper cuttings, beads etc. However, it does not stop the AWCs to develop a toy bank like project in each AWC by collecting play materials from external sources.
- vi. Provision for adequate cooking and serving utensils in AWCs is required to be made to strengthen the supplementary nutrition component of ICDS programme. Further, initiatives on the part of the Government are to be taken to ensure that utensils are available in each AWC in adequate quantity and quality, not for once, but continually. There has to be a system of replenishment for broken/damaged vessels.
- vii. It was found in the present study that coordination of ICDS functionaries with Health Department was somehow lacking at field/village level, specially in tribal areas and even in projects which are run by NGOs. This resulted in not-so-regular health check-ups at Anganwadi level. Concerted efforts are required to be initiated jointly by ICDS and health

- functionaries especially ASHA (Accredited Social Health Activist) to have close coordination between them at all levels so that proper planning takes place to organise health check-ups.
- viii. A special drive needs to be initiated by both ICDS and health functionaries to cover all pregnant women in a given Anganwadi area to encourage them to take Iron and Folic Acid tablets which are not otherwise consumed by these women as highlighted in the present study. Non-consumption of these tablets has enormous repercussions on the health of the child at pre-, neo- and post-natal periods.
- ix. Agencies responsible for supply of supplementary nutrition need to be given clear instructions so that no disruption of supplementary nutrition takes place at Anganwadi level under any circumstances except those caused by natural calamities or extremely bad weather conditions. The present study mentions that disruption was noticed on an average of 46.31 days. The major reasons causing disruption was reported as delay in supply of items of supplementary nutrition. Beside this, 6.3 percent ICDS projects reported supply of spoiled food items. This situation not only affects the health of malnourished children, expectant women and lactating mothers, but also adversely affects community's image of AWCs. In this context, apart from issuing necessary instructions to concerned agencies for regular supply of supplementary nutrition, Government must also look into the reasons for such disruption in each case and initiate necessary actions required in the given situation.
- x. It is imperative to ensure that gender should not play any role in making supplementary nutrition available to the children. The present study reports that the boys, though registered less in number, avail more benefits than the girls. AWWs should ensure that all eligible girls avail benefits of supplementary nutrition as the future health of a nation depends largely on how healthy the girls are grown up.
- Emphasis should also be given on freshly cooked food as it helps develop healthy habit among the beneficiaries as also it attracts the



beneficiaries to avail supplementary nutrition in a better way.

- xi. Although it was found through the present study that full immunisation of children was reported by about 66 percent health functionaries, efforts related to enhancement of immunisation coverage need to be strengthened so as to cover all the children for full immunisation. Therefore, it is again suggested that concerted joint efforts on the part of ICDS and health functionaries are required in this direction to ensure full immunisation of all children. Community also needs to be sensitised adequately to the need and importance of immunisation so as to eliminate the chances of non-availability or non-cooperation of families in the process of immunisation.
- xii. The study revealed that 29 percent children were born with a birth weight which was below normal (less than 2500 gm). Looking at this scenario, there is undoubtedly a need for regular supply of supplementary nutrition at Anganwadi level and more serious efforts for the care of pregnant mothers are made. This

calls for regular health check-ups, supply of supplementary nutrition and health and nutrition education for the pregnant mothers. AWWs should encourage mothers to breastfeed the children without fail and take personal health and nutritional care of themselves as well as their children.

- xiii. It was gathered from the study that the attendance of target groups in NHed sessions was quite low. It should be the responsibility of CDPOs and supervisors to provide full support to AWWs and encourage them to continue with their efforts so that they are not discouraged by poor attendance in NHed sessions. CDPOs and supervisors, in such cases, can accompany the AWWs to make more home visits and be a part of the process of motivating the women to come for NHed sessions.

Another feature observed in the present study is that 37 percent AWWs reported non-availability of materials/aids for NHed. They reported that whatever aids were available with them, were procured from CDPOs as well as during their training and were not attractive at all. In many centres, available NHed aids and materials

were not found to be in regional or local languages. These aspects need to be looked into seriously for remedial action.

- xiv. AWWs were found to have been facing problems in providing referral services mainly due to non-availability of transport facilities to take the needy to health centres which are often located at far off places. It was reported that many families cannot meet the cost of transport. In this regard, Panchayati Raj Institutions could be mobilised to extend transport facility to poor families so that they are able to avail health services. It can also be suggested that adequate financial provisions may be made available at the disposal of AWWs to meet costs of medicines and transport. This would undoubtedly give referral services a shot in the arm.
- xv. Adolescent girls are the most potential groups which can do wonders provided they are properly involved in Anganwadi activities. A special provision should be made in ICDS scheme to involve and train adolescent girls in Anganwadi activities as they have the potential to

extend all out support to AWWs and helpers in all the spheres of Anganwadi activities.

- xvi. Weighing of children at birth needs to be made compulsory as it determines the course of action required immediately after the birth of a child. The present study reveals that 36.5 percent mothers did not report weighing of new born children. This is a matter of grave concern. Health and ICDS functionaries should be issued necessary instructions to ensure weighing of children at birth without fail.

Further, monitoring of growth of children is another important aspect of ICDS programme. Though not in a very high scale, yet non-availability of growth charts in 11 percent AWCs and weighing scales in 4 percent AWCs is something which needs to be seriously looked into. ICDS programme should ensure appropriate growth of all the children under its coverage.

7.2.2 General Recommendations

- i. Past experience as well as observations by the research teams



has shown that mothers and children have responded enormously to supplementary nutrition programme wherever SHGs were involved in preparing cooked food in Anganwadis and serving the same to children and pregnant and lactating mothers. Since the ICDS programme is intended to be a people based one, it should, in its stride, involve the Self-Help Groups (SHGs) which are potentially the most effective and active grass-root level action groups. It is the high time that their contributions must be sought not only to enrich the supplementary nutrition component but also to consider the shifting of responsibility of running the AWCs to SHGs in those states where the SHG movement has shown positive contribution to the ICDS programme especially in the delivery of supplementary nutrition.

- ii. Some of the project functionaries reported that the spirit of community participation and contribution was somehow lacking in Anganwadis. People are found to treat ICDS programme as merely Government programme rather than their own programme. They feel that everything is to be done by Government. This impression needs to be washed out

by involving Panchayati Raj Institutions (PRIs) in ICDS programme. PRIs should necessarily be tapped so as to ensure suitable infrastructural support and other support such as providing toys and play materials, tables, chairs and promoting attendance of children and mothers in Anganwadi activities. Panchayats must function as a body for implementation of schemes of Ministry of Social Justice, Ministry of Women and Child Development, Government of India may organise consultation(s) at central, state and district levels to rope in PRIs to play their legitimate role in relation to development of women and children.

- iii. Financial provisions to social sector and its prime programme like ICDS are required to be augmented and released timely at project level to pay honorarium to AWWs and helpers and arranging supplementary nutrition. Besides, higher allocations in this programme, in view of the great cause ICDS programme has taken up, may be considered not as an expenditure but as an investment.
- iv. Supervision should not be carried out in its old, rudimentary manner like

inspection, rather, it should be in the form of support and guidance to the supervisee. Participatory supervision in teams comprising 'programme friendly' and 'people friendly' members and those who have required time and skills from different set ups and institutions should be initiated in ICDS programme. They can be drawn to monitor the efforts of ICDS programme and its problems. This kind of supervision can help preparing the ICDS programme for providing better services to children of present and future generations.

- v. Since networking and information and knowledge sharing assumes great significance in the area of evolving a multi-sectoral endeavour more particularly from the perspective of mother care and child development, it is equally important, at par with the efforts to rope in PRIs, to carefully forge partnership with district and block level officials including local bodies such as Zila parishads and municipalities. This would have a wider impact on the community to understand and support ICDS programme in a much better way. This will also facilitate the process of

seeking help and cooperation from other concerned Government Departments. To actualise this process it is important to orient district and block level officials about ICDS programme and their role in implementing the programme successfully. This exercise will accelerate the pace of coordination and convergence of services and programmes as also ensure better understanding among functionaries.

- vi. ICDS programme needs popularisation at village and block levels so that the most needy are able to derive benefits from the programme. This would also enable them to take benefits of other development programmes also. This will call for launching of special campaigns as was done in the past in certain ICDS projects by involving state, district and block level officials as also elected women representatives to raise consciousness of community on issues related to women and children. This would also generate community contribution, cooperation and support. The whole process would necessarily involve mahila mandals, SHGs, youth clubs, yuvathi mandals, religious leaders



and other functionaries of civil society organisations. It would further enable these groups of people to pay special attention to the needs of children and more particularly mothers and to do away with unwholesome and discriminating elements prevalent in the practices traditionally followed in families. Thus, AWCs have to emerge as a "nerve centre" of activities and be a place where mother and children could assemble in their spare time, pursue hobbies, develop creative talents and equip themselves with different skills.

- vii. In Anganwadi areas where attendance of children is relatively low, crèches and day care centres need to be set up and attached to AWCs. This would widen the opportunities for all children to develop. More particularly girls would be allowed to pursue their interests. As in the States like Kerala, Tamil Nadu timings of AWCs need to be extended. It could be made from 9.30 a.m. to 3.30 p.m. This will ensure adequate attention of AWWs to all activities as also effective supervision and guidance by supervisors. Mothers will also feel relaxed and find enough time to discharge their own role and

responsibilities. If qualitative improvement is to be brought into services rendered, AWCs will also require equipments, aids and play materials to ensure suitable utilisation of enhanced timing. Otherwise, only enhancement of time will be of no use. Back-up support is of paramount importance.

- viii. So far as supplementary nutrition is concerned, variety and improved quality of items are required to be served. Mothers and AWWs need to be given skill training in preparing local recipes. This should be encouraged to serve freshly cooked food. It is suggested that at least two mothers should necessarily help AWWs and helpers, in rotation, in cooking and serving supplementary nutrition. AWWs should be given suitable kit materials on personal hygiene, environmental sanitation, testing for iodised salt, safe drinking water etc. for use in AWCs as also in families covered by an Anganwadi.
- ix. The erstwhile Department of Women and Child Development, Government of India long back issued a circular suggesting development of "CDPO's office as a Resource Centre".

However, this guideline has not received due attention and support from Nodal Department of State Governments, District ICDS cells and CDPOs. It would be desirable if each ICDS project develops a resource centre for dissemination of information, providing counselling and support services to mothers and adolescent girls, organising skill training of AWWs and generating awareness on various issues related to women and children. It may also keep data on campaigns/exhibitions/melas, rallies organised at project level as well as have adequate stocks of materials and aids to organise such events. The schemes and programmes of other departments may also be procured and disseminated among community at this resource centre to avail benefits from these schemes and programmes. Adolescent girls need to be involved in developing educational programmes through role play, drama, songs, discussions as also in the process of developing training materials. Sample training module for adolescent girls on specific subjects may also be drawn up in consultation with project

functionaries and personnel conducting various training programmes. Schools of Social Work, Home Science Colleges, teachers training institutions, extension training centre, Krishi Vigyan Kendras etc. may also provide professional support in their respective areas of expertise in developing training modules and conducting training programmes.

- x. In ICDS programme, construction of AWCs is intended to provide a facility which serves as a base for AWWs and more importantly, it becomes a focal point for activities of ICDS programme and related departments. It has always been emphasised that as far as possible AWC should be built with community involvement, be of low cost design using local materials and indigenous construction techniques. Further, it should be owned and maintained by community/village panchayat/urban local bodies. This type of centre is also required to organise other activities related to different women's programmes, to provide forum for youth activities, to use for meetings of frontline workers and for gathering of mothers and children. Ministries of Rural



Development and Panchayati Raj may play major role in collaboration with State Governments to provide this facility. Voluntary organisation(s) working in the field of rural development can also act as a catalyst in mobilising the community. Experience of Social Work Research Centre, (Tilonia) may be of immense help as also experience of a low cost panchayat ghar in Khori village in Rewari district (Haryana) which was constructed by local craftsman in less than five months and at one-third of the cost estimated by the PWD. Local materials were used and villagers participated actively in the design as well as construction of AWC.

- xi. The strategy of convergence and integration of services has proved to be highly effective in ICDS programme after devolution of responsibilities and resources under the 73rd amendment of Constitution strengthening Panchayati Raj system became operational. This convergence was required to be accelerated at a faster pace so that developmental benefits reach out to the intended target groups meaningfully. Towards this direction, Ministry of Women and Child

Development, Government of India needs to convene frequent meetings of coordination committees not only at central and state levels but also at district and block levels so as to enable the implementing machinery to carry the benefits of different programmes at the door steps of people with a synergetic effect. Unless Government of India takes special interest in actualising convergence at all levels, it will remain incomplete in respect of empowering women and children.

- xii. ICDS programme needs a complete face-lift in order to bring in the element of participatory management in it. Project level functionaries need to be encouraged to reflect on the prevailing situation, analyse them, think about possible alternatives, plan for suitable appropriate action and more importantly grasp the necessity and urgency for change. All this could be carried out on the solid premise of collective thinking, decision making and delegating responsibilities towards cultivating trust and strengthening the shared commitment for effective utilisation of services of ICDS. As inbuilt mechanism of openness and freedom

for exchange of ideas and views among ICDS functionaries on various issues concerning implementation of the programme on regular basis needs to be evolved. This needs to be done at all levels.

- xiii. Strengthening of sub-centres in ICDS project areas will play crucial role in the delivery of health care services to pregnant and lactating mothers as also adolescent girls. Hence, all village level voluntary health workers like ASHA, Trained Birth Attendants, Dais need to be placed at her disposal. This will also facilitate supply of basic drugs, vaccines and equipments in abundance. The delivery of health services is bound to suffer in project areas until leadership necessary for rendering services is available in full strength at the PHCs/urban health centres/rural and tribal sub-centres. Sharing of responsibilities of entire project areas among the doctors, LHVs/PHNs and ANMs is important for smooth functioning of health infrastructure in letter and spirit.
- xiv. The supply of therapeutic nutrition requires special attention at project and district levels. Children with

grade III and IV malnutrition are given special food which is called "therapeutic nutrition" which has to be in semi-solid form and can be easily digested by the child. Such children require a minimum of four feeds, of which two can be given at Anganwadi and two at home. The mother must be properly explained about the importance of special care for such a child and necessity of proper feeding at home. Locally available food stuff could be used to develop therapeutic food. These could be cereal-pulse mixture which can be partially pre-cooked, roasted, powdered and stored in air tight tins. At the time of serving, this should be converted into a smooth paste - by adding clean water to it. Jaggery and little oil can also be added to increase its calorie value. As prevailing in past years, any branded milk could be given to those children who are admitted in hospitals. In some Anganwadis, in the absence of therapeutic food, AWWs were found to be giving double the amount of supplementary food to the malnourished children. This practice needs to be discouraged as it is not only the amount of food required by



the child but also more importantly, the appropriateness of the same for the young malnourished child. Besides these, medical care for all "at risk" children need special attention in terms of their nutrition intake.

- xv. The Persons with Disabilities (PWD) Act of India makes a mandatory provision of early detection and early intervention services for childhood disabilities. Certain studies conducted in ICDS projects showed prevalence of developmental delay among children. This finding has led to the inclusion of Anganwadi-based developmental screening and early therapy programmes for children upto two years of age in the new World Bank-supported ICDS-III projects in Kerala. It is suggested that in those areas where under 5 morbidity has come down to an acceptable level, next immediate priority should be adoption of morbidity management strategies including early detection and early intervention of disability as envisaged in PWD Act.
- xvi. The present study has brought forth the fact that early childhood stimulation and care for children in the age-group 3-6 years in ICDS

programme calls for skill development training of AWWs in certain areas which were identified as weak areas in effective organisation of PSE activities in this appraisal. These areas include skill-based requirements, preservation of aids, use of aids and theme-based programme planning. ICDS functionaries can persuade Panchayats to provide essential play equipments required in AWCs. The present study finds out absence of many essential items which are required in an AWC to stimulate an enabling environment for pre-school children. These items include toys which teach colour, size, shape etc., puzzles for creative development, toys or games requiring refined movements, real or toy musical instruments, toys that teach names of animals, birds etc. In order to make PSE activity an effective component, it is essential to make mandatory the presence of the PSE kits/equipments in all AWCs.

- xvii. Pregnant women represent approximately 3 percent of the population. Hence, in any village having a population of 1000 or so

there will be approximately 30 pregnant women who need to be given the priority in order to provide services such as NHEd, counselling, and supplementary feeding. It is a known fact that pregnant women are aware and scared of the risks of pregnancy, childbirth, and neonatal death, and therefore, receptive to options for safe delivery, neonatal care, and family spacing. Pregnant women are marked by physical changes, which facilitate their identification for NHEd and other services. There is no denying that the importance of reaching women during pregnancy is being increasingly recognized as critical to improve maternal health, birth weight, birth outcome, and neonatal health, and has proven effective in improving the nature of care which women provide to infants in their first year of life. Hence, ICDS needs to give topmost priority to reach out to all the pregnant women with counselling and information on health issues as well as motivate them to avail supplementary food, so as to prevent malnutrition and death. Such efforts to identify and reach out to all the pregnant women would not only

improve women's health, but also influence infant and health care.

- xviii. Children under 2 represent approximately 5 percent of the population. Hence, in any village of 1000 population there will be about 50 children under 2, and as many mothers of children under 2. Since there is a possibility that some women with children under 2 are pregnant or have another child under 2, the total number of women in the target group in any village will be 60 or more. This indicates that there are about 60 priority households in every village for follow-up visits. These women need to be educated not only about the importance of feeding the child, but also as to how to feed and take care of the child. This will have greater impact on health and nutritional status of children. As a means of ensuring good health and nutrition of children under 2, reaching their mothers with health education and counselling should be given utmost priority. In addition, the special requirements of lactating mothers need to be specifically addressed. Take home rations and guidance on the preparation of foods to complement breast milk after 6



months of age is a welcome measure which need to be incorporated in ICDS. It should be followed up vigorously to ensure proper utilisation of this facility.

- xix. In order to make health services more effective, strategies need to be evolved to bridge the gap between knowledge and practice, and training and implementation. In this regard, two-pronged training strategy is required - one for women and another for ICDS functionary concerned with health services. Training of women will lead to an increase in outreach and ultimate prevalence of widespread health practices necessary for a good living and generate demand for health services. Training of staff will result in developing concrete plans for subsequent action and follow-up of that action. All training and capacity building measures need to be focused on achieving health targets and improving coverage rates. In this context, adequate emphasis needs to be given on certain priority areas which include strategies for increasing coverage, observance of health day for pregnant women and mothers of children under 2, emphasis on individual counselling and expanding
- the number and type of community health workers.
- xx. Currently, monitoring system is based on looking at centre-based records. These are generally neat but not necessarily complete or organised, and give no indication of the coverage of the eligible population or the quality of services rendered. In this regard, it is suggested that each time field officers or project officers go to the field, families must be randomly selected (by walking to any home, rather than by choosing the individual from the centre-based register), and asked a few questions. Their query should include questions about the health status of children in the household, actions taken for preventing and treating illness, use of spacing methods etc. This process should be used to monitor the outreach and coverage of the programme and to provide input to the accompanying AWW about what can be done to improve her performance.
- xxi. Though coordination with health functionaries was reported to be satisfactory by a vast majority of project functionaries, the

participation of ANMs/PHNs in referral services, health check-up, home visits and NHEd was found to be marginal. There is a need to further improve the coordination between the ICDS and the health staff. The health workers should realise that at the end, their role would become easier if the activities of AWCs were properly implemented. The CDPOs and the MOs of PHC should conduct joint visits to the Anganwadi areas to increase the performance of the programme. AWWs and ANMs and ASHA should work in close collaboration. Ways and means need to be worked out to make them join hands for taking care of the health needs of women and children. In order to improve accountability, work assessment report of ANMs/PHNs working in ICDS areas may include evaluation/comments of the CDPO incharge of the project as well.

- xxii. It was observed that delivery of NHEd services was far below the desired level. In this regard, it is recommended that Supervisors should be given the responsibility of organising formal NHEd sessions at regular intervals in AWCs under their supervision. Continuous and effective

monitoring by CDPOs and district officials, as also active participation of health functionaries, can go a long way in the effective implementation of this component. For group formation and collecting women at one place for NHEd sessions, locally popular social or recreational event or activity may be organised. Utilisation of folk media such as nautanki, kathputli, etc., need to be included in the training component of AWWs to strengthen their skills in imparting NHEd effectively.

- xxiii. As media plays an important role in influencing the attitudes and behaviour of women and people in general. Most of the messages, overt and covert, which are currently being broadcast need to be made more appropriate and relevant from the point of view of development of women and children. These messages have to be appropriately worked out by professionals and artists with a view to educate mothers, families and society in general. Indigenous media resources need to be tapped for NHEd and raising awareness of community in general on issues related to women and children.



- xxiv. The mandate of ICDS programme is to make the programme a community-based one and for this, participation and involvement of community in Anganwadi activities is essential. Undoubtedly, whatever success ICDS programme has been able to achieve so far, has been because of strong community support and cooperation. However, there is still much to be done in this direction to ensure community participation in ICDS programme at the expected level. In this regard, it is suggested to experiment with an idea of having community mobilising team comprising functionaries, teachers having skills to effectively communicate and energise local voluntary organisations, youth clubs, community formations as well as representatives of village committees concerned with health, education, drinking water and sanitation so as to provide back up support to ICDS programme. The other functions of the community mobilising team may include, mobilisation of people using methods like participatory rural appraisal, advocacy on local social development issues, consensus on and articulation of key issues, awareness building among people on
- priority issues, liaising with the intersectoral team of the village and initiating processes for thrift and credit.
- xxv. The concept of community monitoring could be experimented with a different perspective by technically ensuring developmental goals of ICDS programme. A community level monitoring team comprising local people from all sections of life could be developed. The team members should be trained by service functionaries and professional experts to monitor ICDS programme based on certain process indicators and outcome indicators. This will ensure tracking of locally relevant indicators vis-a-vis developmental goals set for children, adolescent girls and women at community level. These indicators could be based on household's accessibility to safe drinking water, means of waste disposal, full immunisation of children, children under 3 receiving regular doses of vitamin A, presence of a depot-holder for ORS, condoms and contraceptive pills within the community, all pregnant women and/or lactating mothers receiving supplementary

nutrition, ante-natal care, iron and folic acid tablets and TT doses regularly and without fail, every child above six months of age receiving compulsory feeding, every child above five years enrolled and attending formal schools, existence of a functional mothers' or women's group, incidence of birth or death among children and pregnant women in a given period, accessibility to transport facility to go to health centre whenever a pregnant mother developing complications and so on.

- xxvi. Moulding the mind of people, especially with such issues as discrimination against girl child is a major challenge to the ICDS programme. Female foeticide and infanticide are to be contained and the general population is to be educated adequately on these issues. Protecting girls child is a sensitive issue and persuasion is the only recourse. The institution of Anganwadi can play an important role in creating awareness in the villages about the dwindling sex ratio and its likely impact on future of the country. It is therefore imperative that project

functionaries including the AWWs and the helpers are involved in creating such an awareness through campaigns and other means.

- xxvii. As per a circular issued by Government of India in 1992, where any district has been covered to the extent of 80 percent or more by ICDS programme, additional one post each of Instructors in Nutrition, Pre-school education, Health and Social Work was sanctioned. However, utilisation of this provision has remained much below the level of satisfaction. Many district ICDS cells could not avail this provision. Filling up posts of these Instructors is crucial in view of the fact that the Instructors play an important role in preparing ICDS functionaries in variety of ways including explaining to them various guidelines and circulars issued by Government of India and State Governments so that these could be translated into action.
- xxviii. ICDS needs to be universalised to improve the nutrition levels of children and women in the population.



References

Chapter- 1 - Introduction

Aggarwal, K.N, et al. (2000).

Impact of ICDS on maternal nutrition and birth weight in rural Varanasi. Varanasi : Banaras Hindu Univ., Institute of Medical Sciences, Department of Pediatrics. *Indian Pediatrics*, 2000, 37(12) : 1321-27.

Bhalani, K D & Kotecha, P.V. (2002).

Nutritional status and gender differences in the children of less than 5 years of age attending ICDS anganwadis in Vadodara city. Vadodara, Gujarat : Government Medical College. Department of Prevention and Social Medicine. *Indian Journal of Community Medicine*, 27(3) : 124-129.

Bharti, Shaveta, Mahajan, Arshi and Arora, Samridhi. (2003).

Evaluation of health services provided to preschoolers at anganwadi centres (urban slums of Jammu city). Jammu : Jammu Univ., Post Graduate Deptt. of Home Science. 3 p.

Bhowmick, Probodh Kumar & Manna, Samita. (2001).

Mortality and morbidity pattern in children 0 to 6 years attending

anganwadi extent to primary health care through awareness and community health problem, follow up case of Grade III and IV of malnutrition children under ICDS. Kolkata : Indian Council for Child Welfare West Bengal. 153 p.

FORCES, New Delhi. (2005).

The micro status of ICDS in Hayathnagar (A.P.) : a study by FORCES. New Delhi : FORCES. 16 p.

FORCES, New Delhi. (2005).

A micro study of the status of the young child - a block level study in Chandauli district of UP by FORCES. New Delhi: FORCES. 20 p.

FORCES, New Delhi. (2005).

A Social audit of ICDS in the state of Bihar : a study by FORCES. New Delhi : FORCES. 44 p.

FORCES, New Delhi. (2005).

A social audit of ICDS in the state of Uttar Pradesh : a study by FORCES. New Delhi : FORCES. 51 p.

FORCES, New Delhi. (2005).

The status of the young child in Rajasthan : a study by FORCES. New Delhi : FORCES. 64 p.

Gandham, S.V., Pratinidhi, A.K & Gupta, A.M. (1998).

Nutritional assessment of women in the reproductive age group from ICDS slum area in Pune city. Pune : B.J. Medical College. *Indian Journal of Community Medicine*, 28(4) : 161-64.

Gyanendra Singh. (1997).

Long term effects of ICDS programme on Indian children. Allahabad : MLN Medical College, Dept of Preventive and Social Medicine. 11 p.

George, K.A., et al. (2000).

Anaemia and nutritional status of pre-school children in Kerala. Trivandrum : Nutrition Research Centre Kerala. *Indian Journal of Pediatrics*, 67(8) : 575-78.

Haryana, Department of Social Welfare, Chandigarh. (1986).

A Decade of ICDS : Integrated Child Development Services 1975-1985. Chandigarh : Department of Social Welfare Haryana. 32 p.

Haryana, Department of Social Welfare, Chandigarh. (1995).

Two Decades of ICDS : Integrated Child Development Services in Haryana 1975-1995. Chandigarh :

Department of Social Welfare Haryana. 24 p.

India, Ministry of Human Resource Development, Department of Women and Child Development. (2005).

Annual Report 2004-05. New Delhi: DWCD. 287 p.

India, Ministry of Human Resource Development, Department of Women and Child Development (1996).

Integrated Child Development Services (ICDS). New Delhi : DWCD. 24 p.

India, Ministry of Human Resource Development, Department of Women and Child Development. (1991).

15 years of ICDS : an overview. New Delhi : DWCD. 150 p.

India, Ministry of Human Resource Development, Department of Women and Child Development. (1997).

Universal Children's Day 14 November 1997 : 50 years of child development-the challenges ahead 1787 to 1997 : child welfare and development : the historical perspective. New Delhi : DWCD. 31 p.

India, Ministry of Human Resource Development, Department of Women and

- Child Development, (1992).
National Plan of Action for the SAARC Decade of the Girl Child 1991-2000 AD. New Delhi : DWCD. 29 p.
- India, Ministry of Human Resource Development, Department of Women and Child Development, (1994).
Universal Children's Day 14 November 1994 rights of the child : a commitment. New Delhi : DWCD. 65 p.
- India, Ministry of Human Resource Development, Department of Women and Child Development, (1997).
Universal Children's Day 14 November 1997 : 50 years of child development the challenges ahead. New Delhi : DWCD. 40 p.
- India, Ministry of Law Justice and Company Affairs (2000).
The Constitution of India. New Delhi : MLJCA. ~ 231 p.
- India, Ministry of Social Welfare, New Delhi. (1980).
Profile of the child in India : policies and programmes. New Delhi : Ministry of Social Welfare. 371 p.
- India, Ministry of Human Resource Development, Department of Women and Child Development. (2005).
National Plan of Action for Children 2005. New Delhi : DWCD. 51 p.
- India, Planning Commission, (2002).
Tenth Five Year Plan 2002-2007 : 3 Vol. New Delhi : Planning Commission. ~ 1000 p.
- Kapadia, Kamini R. (1998).
Process and outcome documentation study of the young child (0-6 years) of the urban disadvantaged in Patna: an executive summary. New Delhi : National Institute of Urban Affairs. 17 p.
- Kapil, Umesh, et al. (1999).
Nutrient intake and consumption of supplementary nutrition by severely malnourished children in two ICDS Projects in Rajasthan state. New Delhi: AIIMS, Dept of Human Nutrition. *Indian Pediatrics*, 1999, 36(8): 799-802.
- Mathew, Minnie. (1997).
Making a difference : a document on a project for tribal adolescent girls in Dhar District, Madhya Pradesh. New Delhi : World Food Programme. 33 p.
- NIPCCD. Regional Centre Bangalore, Bangalore. (1996).
Effectiveness of health and nutrition education through home

- visit as a strategy: a study.* Bangalore: NIPCCD-RCB. 33 p.
- NIPCCD. (1978).
Government policies and programmes for child welfare/development : 0-14 years with special emphasis on 0-6 age group of children. New Delhi : NIPCCD. 53 p.
- NIPCCD. (1984).
Perspective plan on child development : 1980-2000. New Delhi: NIPCCD. 184 p.
- National Archives of India, New Delhi. (1979).
Archives and the child : international archives week : 23-29 October, 1979. New Delhi : National Archives of India. 30 p.
- National Council of Applied Economic Research, New Delhi. (2001).
Concurrent evaluation of Integrated Child Development Services : National report Vol. 1 & 2. New Delhi : NCAER. ~200 p.
- Saiyed, Farhat & Seshadri, S. (1996).
Studies on availability, utilization and impact of nutrition and health services in pre-school children (0-36 months) and pregnant mothers in an urban slum setting under two different health delivery systems : (Voluntary vs Government). Baroda : MS Univ., Dept of Foods and Nutrition. 3 p.
- Shantha, E.V. (1997).
Process and outcome documentation of ECD in urban disadvantaged areas. New Delhi : National Ins. for Urban Affairs. 50 p.
- Singhi, N K, Joshi, Varsha & Pal, Pritam. (1996).
Strengthening quality and access to services in ICDS programme : a social assessment. Jaipur : Institute of Development Studies. ~200 p.

Chapter- 2 - Design of the Study

National Council of Applied Economic Research, New Delhi. (2001).

Concurrent evaluation of Integrated Child Development Services : National report Vol. 1 & 2. New Delhi : NCAER. ~200 p.

Sharma, Adarsh (1987).

Monitoring social components of Integrated Child Development Services : a pilot project. New Delhi : NIPCCD. 153 p.

Sharma, Adarsh, et al. (1992).

National evaluation of Integrated Child Development Services. New Delhi : NIPCCD. 204 p.

Chapter- 3 Infrastructure and Profile of Respondents

Operation Research Group, Centre for Social Research, New Delhi (2005).

Evaluation of Project Udisha : the national training component of World Bank assisted Women and Child Development Project : 2 vols. New Delhi: ORG. ~400 p.

World Bank, New Delhi. (2002)

Women and Child Development (WCD)/Integrated Child Development Services (ICDS III) Project (Credit No. 42-IN) : Supervision Mission. New Delhi : WB. 60 p.

Chapter- 4 - Assessment of Delivery of Services

Bharti, Shaveta, Mahajan, Arshi and Arora, Samridhi. (2003).

Evaluation of health services provided to preschoolers at anganwadi centres (urban slums of Jammu city). Jammu :Jammu Univ., Post Graduate Dept. of Home Science. 3 p.

Mathew, Minnie (1997).

Making a difference : a document on a project for tribal adolescent girls in

Dhar District, Madhya Pradesh. New Delhi : World Food Programme. 33 p.

NIPCCD, Regional Centre Lucknow, Lucknow. (2005).

A Quick appraisal of AWTCs in Bihar. Lucknow : NIPCCD-RCL. 165 p.

Operation Research Group, Centre for Social Research, New Delhi. (2005).

Evaluation of Project Udisha : the national training component of World Bank assisted Women and Child Development Project : 2 vols. New Delhi: ORG. ~400 p.

Pandey, D D. (2005).

Research abstracts on ICDS 1995-2002. New Delhi : NIPCCD. 95 p.

Paul, Dinesh, et al. (2003).

Evaluation of medicine kit provided to anganwadi worker. New Delhi : NIPCCD. 150 p.

UNESCO, New Delhi. (1997).

Strengthening project management in ICDS - focusing on early childhood care and development. New Delhi : UNESCO. 48 p.

World Bank, New Delhi. (2002)

Women and Child Development (WCD)/Integrated Child Development

Services (ICDS III) Project (Credit No. 42-IN) : Supervision Mission. New Delhi : WB. 60 p.

World Food Programme (WFP), New Delhi (2000).

"Improving child survival through ICDS : a district initiative, Banswara, Rajasthan" : Hajo Soru documentation of the project. New Delhi : WFP. 26 p.

Chapter- 5 - Benefits and Outcomes of Integrated Child Development Services

National Council of Applied Economic Research, New Delhi. (2001).

Concurrent evaluation of Integrated Child Development Services : National report Vol. 1 & 2. New Delhi : NCAER. ~200 p.

Sharma, Adarsh. (1987).

Monitoring social components of Integrated Child Development Services : a pilot project. New Delhi : NIPCCD. 153 p.

Sharma, Adarsh, et al. (1992).

National evaluation of Integrated Child Development Services. New Delhi : NIPCCD. 204 p.

Chapter- 6 - Innovations and Best Practices

India, Ministry of Human Resource Development, Dept of Women and Child Development, New Delhi. (2000).

Integrated Child Development Services ICDS. New Delhi: DWCD. 56 p.

Meghalaya, Dept of Women and Child Development, Shillong. (2005)

Convergence of services in ICDS projects with the different Departments of the Government and the community. Shillong : MEG-DWCD. 5 p

USAID, New Delhi. (1993).

ICDS innovative approaches to enhance services. New Delhi : USAID. 31 p.

NIPCCD. (2005).

Nutrition and health education : experiences of NIPCCD (Pune : 2005, May 19-20). New Delhi: NIPCCD. 50 p



Abbreviations

AIIMS	All India Institute of Medical Sciences	GOI	Government of India
ANM	Auxiliary Nurse Midwife	HA	Health Assistant
ANP	Applied Nutrition Programme	HHs	Households
AW/AWC	Anganwadi/Anganwadi Centre	HHS	Household Schedule
AWW	Anganwadi Worker	HRD	Ministry of Human Resource Development
AWTC	Anganwadi Workers Training Centre	ICCW	Indian Council for Child Welfare
BDO	Block Development Officer	ICDS	Integrated Child Development Services
CARE	Cooperative American Relief Everywhere	IMR	Infant Mortality Rate
CBR	Crude Birth Rate	KAP	Knowledge, Attitude and Practice
CDPO	Child Development Project Officer	LHV	Lady Health Visitor
CHC	Community Health Centre	MEU	Mobile Food and Nutrition Extension Unit
CSWB	Central Social Welfare Board	MLTC	Middle Level Training Centre
CTC	Central Technical Committee	MMR	Monthly Monitoring Report
DDR	Delivery Death Rate	MO	Medical Officer
Dists.	Districts	MPR	Monthly Progress Report
DPT	Diphtheria, Pertussis and Tetanus	MPW	Multipurpose Health Worker
DT	Diphtheria, Tetanus	NGO	Non-governmental Organisation
DWCD	Department of Women and Child Development	NHE	Nutrition and Health Education
ECCE	Early Childhood Care and Education	NIC	National Informatics Centre
ECE	Early Child Education	NIPCCD	National Institute of Public Cooperation and Child Development
EPI	Expanded Programme of Immunisation	NORAD	Norwegian Agency for International Development
FLAW	Functional Literacy for Adult Women	ORT	Oral Rehydration Therapy
GFR	General Fertility Rate	PEO	Programme Evaluation Organisation
GM	Growth Monitoring		

PO	Programme Officer	ST	Scheduled Tribes
PHC	Primary Health Centre	T	Tribal
PSE	Pre-school Education	TT	Tetanus Toxoid
R	Rural	U	Urban
RGI	Registrar General of India	UNICEF	United Nations Children's Fund
SAARC	South Asian Association for Regional Cooperation	USAID	United States Agency for International Development
SC	Schedule Castes	UT	Union Territory
SNP	Supplementary Nutrition Programme	WFP	World Food Programme
SRS	Sample Registration System	WILL	Women's Integrated Learning for Life
		WHO	World Health Organisation



Glossary

Anganwadi Centre	A centre for delivery of package of services under ICDS in a village/urban slum.
Anganwadi Worker	Principal functionaries of an anganwadi who is responsible for delivery of services under ICDS.
Block	A unit for rural planning and development comprising approximately 100 villages and about 80,000 - 1,20,000 population.
Crude Birth Rate	Number of live births during the year per 1,000 estimated mid-year population.

$$\text{Birth Rate} = \frac{\text{Number of live births During the year} \times 1,000}{\text{Estimated mid-year Population}}$$

Composite Score (CS)	$14 \sum_{i=1}^{n} X_i \dots\dots X_n$
General Fertility Rate	Number of live births per thousand women aged 15-49 years in a given year.
Dai	Traditional birth attendant
Kucha	Temporary construction
Kathputli	Puppets
Kirtans	A congregation of devotees where devotional songs are sung.
Life Expectancy at Birth	The number of years new-born children would live subject to the mortality risks prevailing for the cross-section of population at the time of their birth.
Low Birth Weight Babies	Infants at birth weighing 2,500 gm or less.
Mahila Mandal	Local women's organisation
Maternal Mortality Rate	Number of deaths from puerperal causes per 1,000 live births.

$$\text{MMR} = \frac{\text{Number of deaths directly due to pregnancy or child birth and occurs during pregnancy or within 42 days of the delivery} \times 1,000}{\text{Total live births in the year}}$$



Multi-stage Random Sampling	Using a form of random sampling in each of the sampling stages where there are at least two stages.
Non-formal Education	Any organised, systematic, educational activity carried on outside the framework of the formal system to provide selected types of learning to particular sub-groups in the population, adults as well as children.
Nutritional Status	The state of health of an individual as influenced by his intake and utilisation of the essential food nutrients. As an individual progress through the various stages of his life, his nutritional status is subjected to many physiological and environmental influences which may cause a fluctuation on the continuum between adequate nutrition and malnutrition.
Panchayat	Village council
Perinatal	This period is considered to begin with completion of 28 weeks of gestation and variously defined as ending one to four weeks after the birth.
Perinatal Mortality Rate	Mortality occurring during the period from 28 weeks of pregnancy to under seven days of the post-natal life, per 1,000 total births. $PMR = \frac{\text{Late foetal deaths} + \text{deaths under one week of babies weighing over 1,000 gm at birth} \times 1,000}{\text{Total No. of babies weighing over 1,000 gm at birth}}$
Post-natal	This period is considered to begin after birth.
Pre-school Child	A child in the age group 3-6 years. This period extends from about three years of age until entrance into formal school at five or six years of age.
Primary Health Centre	An institution for providing comprehensive (preventive, promotive and curative) health care services to people living in a defined geographical areas.
Pucca	Permanent construction.
Yuvak Mandal	Youth organisation.



ANNEXURES

Academic and Financial Guidelines

General Procedural Guidelines

Role of Chief Coordinator

The Chief Coordinator of the project is to take periodic reviews related to the progress of the study from the core team at the Headquarters comprising Consultant, Dr Ashok Kumar, Joint Director (PC), Shri A.K. Nanda, Project Manager, and Dr. D.D. Pandey, Assistant Director. The review must ensure that the study is being implemented as per the time frame and the design finalised. The Chief Coordinator is also required to facilitate coordination between administration and the academic team for timely accomplishment of tasks such as appointment of staff, financial sanctions related to travel and other requirements related to the study.

2. The Chief Coordinator will also ensure formation of the data collection teams and distribution of work as also the sample projects between Headquarters and Regional Centres and within Headquarters' teams. Once the schedules / tools for the study are finalised, these will be printed at Headquarters. The faculty members associated with it are Shri K.K. Singh, Dr. Ashok Kumar, Dr. Sandhya Gupta and Shri H.P. Joshi. They may ensure that all suggestions and changes made at various stages are incorporated in these schedules before these are sent for printing to the Publication

Officer. The Publication Officer be given instructions to use the electronic version of the schedule to get these reformatted into the folders of a size of 10" X 4" and **printed in different ink** for each schedule.

Composition of the Core Teams at Hqrs & RCs

3. Each team would comprise **one regular faculty member of NIPCCD and two Project Assistants** appointed on adhoc basis for the study. **Regular faculty member** from NIPCCD Hqrs / RC will be responsible to coordinate data collection activities in the field and act as Team Leader. The Team Leaders identified from the faculty have research and field experience and are particularly familiar with ICDS. There will be one core team at each of the RCs and two at Hqrs.

4. The formation of core team will be coordinated by Chief Coordinator at NIPCCD HQs and by Coordinators (Regional Directors) at RCs. The team be assigned Projects for data collection out of the sample selected for the study and allotted to Hqrs. & RCs. It needs to be ensured that projects are clustered together for a team from adjacent districts as shown in the map prepared by Hqrs. indicating location of the sample selected. This would facilitate faster movement of the team from one Project to another and will be cost effective in terms of time and money. The travel be also planned with this thumb rule.

5. The coordinators will approve tour programmes of the Core Team members. Travel Itinerary chart be prepared of the team/teams indicating dates of their travel from project to project. The travel plans of Hqrs and Regional Centres for duration of data collection be consolidated and forwarded to Chief Coordinator, Dr. A.K. Gopal. This should be available with coordinator to facilitate surprise visits and follow-up.

6. The Team leaders will select two enumerators for each of the three members of core team resulting in to nine individuals (3+6) responsible for data collection in the field. These be divided in to three teams consisting of one faculty member/adhoc Project Assistant and two enumerators locally selected on job basis for data collection.

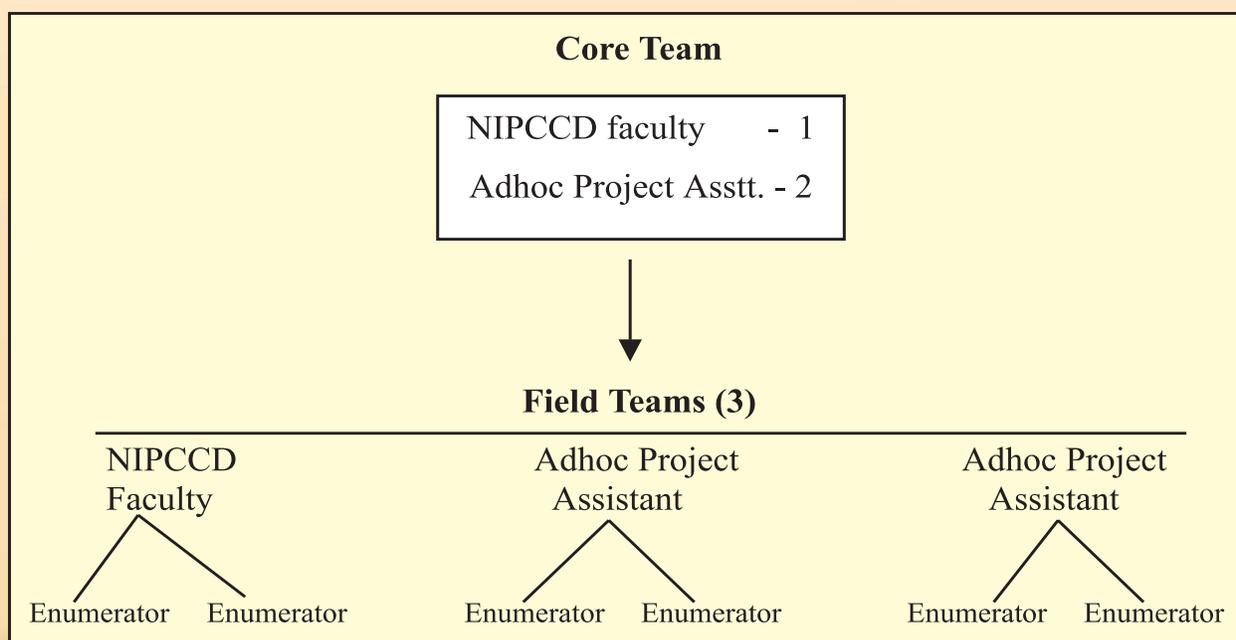
7. The regular faculty member of NIPCCD acting as a Team Leader may use his

discretion and judgement to distribute Project / AWCs.

Selection of Enumerators

8. The coordinators at Hqrs/RCs depending on the location of projects, identify an organisation/institution where potential candidates for enumerators could be interviewed on the specified dates as per data collection plans. These organisations/institutions be contacted in advance to collect biodatas as per the requirements for the study through circular/available contacts. The text of same is as follows.

9. The Selection Committee may consists a **team leader**, one representative of State Department of Women & Child Development preferably above the level of Supervisor and from or of the organisation where interviews are held (AWTC, NGO, MLTC, Academic and Technical Institutions).



National Institute of Public Cooperation and Child Development

5, Siri Institutional Area, Hauz Khas, New Delhi-110 016

Three Decades of Integrated Child Development Services - An Appraisal

Selection of Enumerators for Data Collection

National Institute of Public Cooperation and Child Development (NIPCCD), an autonomous organisation under the aegis of Department of Women and Child Development, Ministry of Human Resource Development, Government of India is conducting a study on ICDS.

The Institute intends to deploy six enumerators for collection of Data in Block _____ of Distt. _____ of State _____ for a short duration. The eligibility criteria are as follows:

- i) Graduate in Social Sciences / Home Science / Social Work / Sociology / Education etc. PGs will be given preference.
- ii) Knowledge of local language/dialect
- iii) Familiarity with ICDS and field research experience desirable

Remuneration will be paid @ Rs.300/- per day for the no. of days of work including time spent on training / orientation. Transportation, Board and Lodging charges would be paid extra as per norms.

Interested candidates may send their Biodata by _____ (date) to:

Walk in interview will be held at

Date: _____ Time: _____

Signature

Name: _____

Designation: _____

- i) Minutes be prepared and signed by Team Leader and other Committee members.
- ii) Offer be given on the spot in the **prescribed format provided by Hqrs.** It would include the terms and conditions specifying like remuneration and travel cost etc. This would be followed uniformly in every selection made for enumerators for this study (copy enclosed in Annexure).
- iii) In view of the focus of the study involving women respondents for soliciting information on sensitive aspects preferably among the two enumerators at least one women candidate be selected. The selected women candidate should necessarily be given the responsibilities to interview pregnant and lactating mothers as also children below three years.
- iv) Selected enumerators be informed before accepting the offer that the job entails field work and travelling in remote areas of ICDS. In case enumerators leave the job without completing data collection of one project no payment would be made to them for the work undertaken.

Training of Enumerators

10. After selection of enumerators the training / orientation be undertaken by the Team Leader at the **Field Camp** where selection of enumerators is made. It could be district Hqrs/technical institutions and MLTCs/AWTCs. The objective of the training is to familiarise enumerators with tools and procedure of data collection.

The team leader would plan orientation of the enumerators covering following contents:

- a) Orientation of the ICDS scheme
 - b) Weighing and plotting of weight for age
 - c) Filling up of schedules (beneficiary schedules)
 - d) Techniques of interviewing
 - e) Practical hands on experience and mock session
- **Team leader should carry copies of ICDS Scheme and AG Scheme for use and reference during training.**
 - **Carry sufficient copies of growth cards, crayons, pencils, erasers, stationery, file and file-boards for training and field work.**



Logistics

- The research team should travel together to the field for data collection. Team leader soliciting help of ICDS staff and local community should arrange for safe, secure and cost effective lodging arrangement.
 - Rapport and introduction of the team should be made with ICDS functionaries / community before initiating data collection.
11. **Despatch 3 teams to different AWCs/ Project each comprising** one regular NIPCCD faculty / adhoc Project Assistant and two enumerators hired in the field. This planning will be done by the Team Leaders.

12. Task at Project Level

- i) Fix prior appointment with the concerned CDPO / Supervisor to have

- ii) Look at the Project Map and select five AWCs of the Project covering **at least two** Supervisory Circles.
- iii) Communication/letter be taken from the office of CDPO for Supervisor/ AWW to facilitate data collection in the respective AWCs.
- iv) Field Coordinator may like to interview CDPO while at Project Hqrs.
- v) Health functionaries such as MO / LHV / PHN/ANM be also contacted for information related to health check-up and so on.
- vi) Organise a weighing scale from CDPO's office for Research team to oversee weighing skills.

Specific Responsibilities of Team Leader

Team Leader would function as overall coordinator and supervisor of the three teams. He/she would perform the following duties:

- i) recruitment of enumerators for data collection according to the guidelines
- ii) training of enumerators in filling the schedules
- iii) liaison with District Programme Officer, ICDS and CDPO at the project level
- iv) organising data collection so as to finish the required number of interviews in each anganwadi area within the stipulated time
- v) arrange local language interpreter in the areas where required.

- vii) Take the copy of the last MPR completed for the Project.
- viii) Population details of each of the selected AWC, if available, may also be collected.
- iv) Team leader to coordinate and supervise selection of sample beneficiaries.
- v) Team leader to assign enumerators the respective Households to be visited for completing Household Schedule and different categories of beneficiary schedules.

13. At AWC

i) Each enumerator while visiting AWC **must carry with him/her:**

- a) Verbatim of Questions in local regional language.
- b) Adequate number of schedule for each beneficiaries' category likely to be interviewed
- c) Pencil, sharpener and erasers and a tag.
- d) File and file board.

ii) On reaching the AWC of a Project, one should brief the programme functionaries about the purpose of the visit. It must be stated clearly that the appraisal of ICDS is being conducted by the Institute at the request of the Department of Women and Child Development, GOI. This is with an objective to improve implementation of ICDS and they are fortunate to be part of this endeavour. The information is purely for research and thus confidential.

iii) It is essential to spend enough time to establish rapport with AWW and helper to facilitate soliciting responses from beneficiaries

- vi) Team leader to undertake observation at AWCs and complete AWW's Schedule and concerned Supervisor.
- vii) Community Leader / PRI / Teacher to be interviewed as per feasibility of time availability by any member of the team.

14. Selection of the Sample Households

i) At the AWC go through the **records and registers maintained by the AWW** and do a **random selection** of each of the beneficiary category. Select required number of sample beneficiaries indicated below by drawing lots / chit from the total number enrolled in that particular category.

The number of each category of beneficiary/ other respondents to be covered are:

- | | |
|---|----|
| 1. Pregnant women | 04 |
| 2. Nursing mothers (having 0-6 months child) | 04 |
| 3. Mothers of 6 months to 3 years children | 05 |
| 4. Mothers of 3-6 yrs children | 05 |
| 5. Mothers in reproductive age groups (15-45 yrs) | 05 |

- **Household schedule** is to be filled for each one of the above mentioned categories of beneficiary (S.No. 1-5). In case more than one beneficiary comes under the sample from one family **only one household schedule has to be filled in for all selected beneficiaries of that family** giving careful coding for interlinking all the schedules as per instructions written on household schedule.
- ii) In all the schedules there is an *Identification Data Sheet on the first page having* question nos. 8-10 to maintain uniformity and linking of schedules
- a. For *question nos. 3, 4 and 5*, a list is provided to all team leaders. Use the codes for State, District and ICDS Project provided against the selected sample from the list only.
 - b. For *question no. 7* use the actual code available at the project / centre level for that particular Anganwadi.
 - c. For *question no. 8*, for each project; five AWCs are to be covered start with 1 and end with code number 5 of the last AWC covered.
 - d. It may be noted that in **all schedules of beneficiary in Ques.10 (a)** the S.No. of the beneficiary should be filled from corresponding Ques.23 column (1) of Household schedule (HHS). For **Ques. 10 (b)**, team leaders will give S.No. from 1-5 for each beneficiary

category to ensure that required number have been interviewed.

15. Filling of Schedules

- i) Questions need to be asked in the same order as given in the schedule.
- ii) The responses should be put neatly against the questions.
- iii) In open-ended question, the responses should be filled neatly.
- iv) All Questions should be asked and no question should be left unattended or incomplete. **Do not leave any box vacant/empty.** The **universal coding system** has to be followed which will run across all schedules as follows:

Code 0 - To be used for *no response* (NR)

Code 8 - To be used/filled for '**Do not know**' (DK)

Code 9 - To be used for '*Not Applicable*' (N.A) wherever actual no. is to be filled

If two boxes say for 6 fill 0 6

If three boxes fill 0 0 6
- v) *In multiple choice questions* whatever response is given by the respondent is considered as 1 (i.e. yes or tick) the other response choices/blank boxes will be filled by 0 (i.e. no response). Otherwise for each question/item, code

to be filled is specified against the question itself.

- vi) *In Multiple Choice Questions*, try to fit the responses in one of the answers given. In case not able to do so, however, if still a problem, write the remarks / answer received on the side. **Do not increase or make any box on your own.**
- vii) While filling schedules enumerators be cautioned to assess if respondent are giving socially desirable answers. They may probe carefully to solicit the true information. This requires them to be alert and observant to record valid and realistic reply only.
- viii) Biases and Prejudices should not in any way creep in while administering the schedule.
- ix) Questions should be translated in local dialect without distorting the meaning. However while administering respective schedules the responses should be recorded in the programme schedule for the purpose as per coded system.
- x) Researcher must not disapprove the statement made by the respondent and should be in non-committable gestures. At the same time researcher should maintain permissive atmosphere and avoid evaluative gestures or comments.
- xi) Researcher should not give suggestive comments and possible reply to a respondent.

16. Checking and Verifications of Schedules

- i) The team leader should supervise the filling up of at least one or two schedules in the field.
- ii) The team leader should check in the schedules filled by the enumerators everyday and put their signature on each schedule. If there are any gaps they should be filled up before leaving the Anganwadi Centre's areas.
- iii) In case of any doubt Team leader should get in touch with Dr. A.K. Gopal, Additional Director (MC) or Dr. Ashok Kumar, Joint Director of NIPCCD Hqs. All queries regarding the financial management and logistics of the study should be directed to Joint Director (CS) so as to provide an immediate solution.

17. Stacking / Packing of Schedules

- i) Arrange and bundle complete set of schedules for each Anganwadi Centres separately in the following packs

First Pack

AWW	}	
Supervisor	}	One packet
Observation Schedules	}	
PRIs/Community leaders	}	
Household Schedule	}	Second packet
With corresponding	}	

Beneficiary category }

Schedule)

Tagged together }

Put both packets together in a single bundle be labelled with following slips on top.

Project Name _____

Project Type _____

AWCs S.No. _____ (1-5)

ii) Once data has been collected for all 5 AWCs of the project this be packed in one bundle with 5 separate bundles of each AWCs. It would also include on top the schedules of CDPO & check list of Medical Officer/health functionaries.

iii) The bundle would have identification slip as follows:

1. Name of the State _____

2. Name of the District _____

3. Name of the Project _____

4. Type of the Project _____

5. Data collected by HQs / RC (B), RC(L), RC(G), RC(I) _____

6. Packed by _____
Name & Signatures

18. Financial Guidelines for Project Staff

i) Payments to Enumerator(s) will be made @ Rs.300 per day for each working day

including training period. Further, an amount of Rs.100/- per day will be paid to each enumerator as incidental charges on the days during which data are collected. No incidental charges will be payable for the days spent on training, traveling. In case enumerators are provided transport facilities by a team leader for field work, the incidental charges will be reduced to Rs.75 per day.

ii) If the services of enumerators, appointed for a project is utilised for data collection in another project, they will be paid TA for sleeper class or actual bus fare, as the case may be, to shift that project besides remuneration of Rs.300/- per day as mentioned above.

iii) Team leaders will make arrangements for transport for field duties preferably by hiring a Govt. vehicle on POL basis for data collection. The team leader will furnish cash memo in support of purchase of POL, a certificate of the controlling authority of the vehicle towards use of the same by the team leader in respect of the kilometers covered (date wise). In case Govt. vehicle is not available, team leaders may hire vehicle locally on most competitive rates available and furnish a record of places visited daily.

iv) In order to meet the expenditure, team leaders may draw adequate contingent advance. The team leader will make payment to enumerators only on satisfactory completion of data collection of a project.

List of Selected Anganwadis by States / Uts, Districts & Projects

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
01	Andhra Pradesh	01	Chittoor	001	Tirupati	1. STV Napar
					(Rural)	2. Singala Gunta
						3. Manchala Veadhi
						4. Linges Waranagar
						5. Yasoda Nagar
		03	Anantapur	003	Hindupur	1. Sevamandir
					(Rural)	2. Kalauapacci
						3. Lepakshi-2
						4. Lepakshi-1
						5. Cholamudram
		02	Visakhapatnam	003	Bheemunipatnam	1. Aguvapeta
			(Regular ICDS)		(Urban)	2. Chakalipeta, Haruanapeta
						3. K. Moolaknddu
						4. Vemagottipalem
						5. Yerrayymlen
		04	Karimnagar	004	Sirsilla	1. Geetha Nagar
			(Regular ICDS)		(Rural)	2. Baddenpalli
						3. Peddalingpur
						4. Narsakkapeta
						5. Bandankal
		05	Warangal	005	Eturinagaram	1. Gampanagudam
			(Regular ICDS)		(Tribal)	2. Borunassapur - 1
						3. Gogupally

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						4. Shivapuram
						5 .Chinaboganapally
		06	Prakasam	006	Ongole	1. Gundamala
			(Regular ICDS)		(Rural)	2. Gamallepale
						3. Jammulapalem
						4. K.K.T.Palem
						5. Jayavaram
		07	Mahabubnagar	007	Mahabubnagar	1. Appanapalli
			(Regular ICDS)		(Rural)	2. Yadira
						3. Koyanagar
						4. Parpally
						5. Manikonda
02	Arunachal Pradesh	01	Lalit	008	Namsai	1. Namsai - II
			(Regular ICDS)		(Tribal)	2. Namasai - I
						3. Samugsai - I
						4. Dunsai
						5. Eraloni
		02	Papumpare	009	Doimukh ICDS	1. Lekhi AWC
			(Regular ICDS)		(Tribal)	2. Banderdewa
						3. Kristaniya
						4. Model Village
						5. Metekon

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
03	Assam	01	Barpeta	010	Jalah	1. Barapars
			(Regular ICDS)		(Rural)	2. Kaklabari
						3. Dihira Hojua
						4. Ghorpars
						5. Chaudhuripars
		02	Kamrup	011	Dimoria	1. Lumsum Pathar
			(Regular ICDS)		(Rural)	2. Amara Pathar
						3. Kapalkata
						4. Luri
						5. Helagog
		03	Dibrugarh	012	Lahoal	1. Hileidhari
					(Rural)	2. Titadimoru
						3. Kardaibam
						4. Aazel Bank T. Estate
						5. Rangliting T. Estate
		04	Karibianglong	013	Howraghat	1. Sar-Et Hanse
			(Regular ICDS)		(Tribal)	2. Pan Engti
						3. Era Digkhol PANI
						4. Mohori Rongpi
						5. Kehai Zerang
		05	Cachar	014	Lakhipur	1. Haskipunjee
			(Regular ICDS)		(Tribal)	2. Old Khairabad & Lalpani

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Kashipur
						4. Gobindapur Part - III
						5. Kungabasti
		06	Tinsukhia	015	Tinsukhia	1. Bishnu Jyoti
			(Regular ICDS)		(Urban)	2. Gellapukhusi
						3. Dhekiajuri Mazio Patty
						4. Missionpara
						5. Hizuguri Rly Mahila Samieta
04	Bihar	01	Gaya	016	Gaya	1. Saleempur
			(Regular ICDS)		(Urban)	2. Gunghritar
						3. Sisauria Chouraha
						4. Ramshila Pahad
						5. Ramdanpur
		02	Patna	017	Bikram	1. Azad Nagar
			(Regular ICDS)		(Rural)	2. Patut East
						3. Bilhori
						4. Barah
						5. Mariyava
		03	Aurangabad	018	Nabi Nagar	1. Janak Pur
					(Rural)	2. Parasiya
						3. Kanker - I
						4. Badem
						5. Barki Padhi

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		04	Darbhanga	019	Biraul	1. Dumarimadhya
			(Regular ICDS)		(Rural)	2. Tarwara - II
						3. Hati
						4. Gamahriya
						5. Navtoluttri
		05	Katihar	020	Korha	1. Banjara Tola
					(Rural)	2. Saadpur Rajwara West
						3. Adivasi Dah Tola
						4. Vinodpur
						5. Brindavan
		06	Jamni	021	Lakshmipur	1. Kolhuakewal
			(Regular ICDS)		(Rural)	2. Sahawam Khudra Tola Ratanpur
						3. Chinveriya Paschim
						4. Goddi Paschim
						5. Tenghara Paschimi
05	Chhattisgarh	01	Sarguja	022	Wadraf Nagar	1. Gotiapara
			(World Bank)		(Rural)	2. Kurthidara
						3. Bartikala
						4. Kotrahi
						5. Rajkheta
		02	Raipur	023	Raipur	1. New Rajendra Nagar
			(Regular ICDS)		(Urban)	2. Kapa Lodhi Para

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Chattisgarh Nagar
						4. Daugnia - 2
						5. Machi Talab - 2
		03	Rajnand Gaown	024	Dongar Garh	1. Adarsh A.W. Acholi
			(Regular ICDS)		(Rural)	2. Siwanikala
						3. Lal Bahadur Nagar
						4. Medha
						5. Pitepani
		04	Bastar	025	Orchha	1. Orchha
			(NGO)		(Tribal)	2. Goddri
						3. Jabgunda
						4. Kundla
						5. Basin
06	Goa	01	South Goa	026	Salcete	1. Castel Wado
			(Regular ICDS)		(Rural)	2. Goenchem Bhat
						3. Colva Beach
						4. Micro Wave - 1
						5. Eklate
07	Gujarat	01	Rajkot	027	Rajkot Urban	1. Lodheswr Society
			(Regular ICDS)		(Urban)	2. HUDCO - C
						3. Chamundapara
						4. Sagar Nagar
						5. Sora Thiya Plot - A

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		02	Kantha	028	Vav	1. Chuva
			(NGO)		(Rural)	2. Madhka - 1
						3. Khimanavas - 1
						4. Dheema - 1
						5. Maisan
		03	Kutch	029	Mundra	1. Bhadreshwar - 2
			(NGO)		(Rural)	2. Chasara
						3. Tapper
						4. Bhujpur - 1
						5. Nani Tumdi
		04	Bharuch	030	Jhagadia	1. Mota Sanja
			(Regular ICDS)		(Tribal)	2. Nana Sanja
						3. Limodra
						4. Karad
						5. Phulwadi
		05	Vadodara	031	Sankheda	1. Jhakarapura
			Gujarat Kcivani Trust		(Rural)	2. Modasar
			Market Yardapo			3. Dhokalya
			Bodeu			4. Alikherva
			Sankhed, Vadodara Distt.			5. Kadila
		06	Patan	032	Chonasma	1. Sardarpura
			Gandhi Ashram		(Rural)	2. Jasalpur

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
			Zilla, Th. Chonasma			3. Jasalpur - II
			Distt. Patan			4. Karada - I
						5. Karada - II
		07	Surat	033	Mangrol	1. Palod - II
					(Tribal)	2. Tarsadi - I
						3. Ghorbad - I
						4. Ishanpur - I
						5. Simadra - I
		08	Jamnagar	34	Jamjodhpur	1. Samana
			(Regular ICDS)		(Rural)	2. Dhrafa - II
						3. Bagadara - II
						4. Nandana
						5. Mahiki
		09	Valsad	035	Valsad - I	1. Malwad - I
			(Regular ICDS)		(Tribal)	2. Olgam - II
						3. Khajuradi - I
						4. Magodh - II
						5. Bhagrakud - 3
		10	Amneli	036	Rajula	1. Morangi
			(Regular ICDS)		(Rural)	2. Dodhiyaagaaya
						3. Rampara
						4. Rajparada
						5. Dhareswar
		11	Narmada	037	Nandod	1. Kuarapura
					(Tribal)	2. Bhadam
						3. Gopal Pura

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						4. Khadgda
						5. Jetpor
		12	Navsari	038	Navsari - I	1. Datech
			(Regular ICDS)		(Rural)	2. Asundan
						3. Sarpone
						4. Sambala
						5. Pera
08	Haryana	01	Ambala	039	Barara	1. Dhakola - I
					(Rural)	2. Jawahargarh
						3. Mahmudpur
						4. Adhoya
						5. Thambad
		02	Gurgaon	040	Gurgaon	1. Dhondaheera
			(Regular ICDS)		(Rural)	2. Wazirabad
						3. Balmikichaupd
						4. Shikandrapur Ghorhi
						5. Chakkarpur
		03	Panipat	041	Panipat	1. Rajeev Colony
			(Regular ICDS)		(Urban)	2. Saine Mohalla
						3. Khatikan Basti
						4. Krishan Nagar
						5. Ward No. 12
		04	Hissar	042	Hansi - I	1. Gurana
			(Regular ICDS)		(Rural)	2. Data
						3. Mehzad

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						4. Depal
						5. Hazampur
09	Himachal Pradesh	01	Kullu	043	Nither	1. Gharoli
			(Regular ICDS)		(Rural)	2. Nither
						3. Gawal
						4. Brow
						5. Chatti
		02	Mandi	044	Gohar	1. Kohalu
			(Regular ICDS)		(Rural)	2. Naun
						3. Bagsaid - I
						4. Bagsaid - II
						5. Chchoit
10	Jammu & Kashmir	01	Jammu	045	Jammu	1. Muthi Camp
			(Regular ICDS)		(Urban)	2. Mandazone
						3. Gol Panch PIV
						4. Jogigrate
						5. Ramdasi Basti
		02	Udhampur	046	Udhampur	1. No. 70 (W. No. 12-13)
					(Rural)	2. No. 127 (Nai basti)
						3. No. 47 (Sukkikarllai)
						4. No. 68 (Sukkikarlla B)
						5. No. 14 (battal A)

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		03	Badgaon	047	Badgaon	1. Soibugh (Centre)
					(Rural)	2. Hanjie Pora
						3. Harran (Centre)
						4. Gungbudh
						5. Nadirgund
		04	Leh	048	Leh	1. Skalzangling
			(Regular ICDS)		(Rural)	2. Water Pump
						3. Skampari - II
						4. Zanakmany - I
						5. Zanakmankly - II
11	Jharkhand	01	Ranchi	049	Sadar	1. Madhukam Hedal
			(Regular ICDS)		(Urban)	2. Hesal Urav Toli
						3. Morahbadi
						4. Hindpidi Bhatti Choak
						5. Hindu Shishu Bhawan
		02	Saraikela	050	Saraikela	1. Ward No. 10
			(World Bank)		(Tribal)	2. Hat Road
						3. Dudhi
						4. Mohitpur
						5. Sawada
		03	Sahebganj	051	Borio	1. Bichpura
			(Regular ICDS)		(Tribal)	2. Telo bathan

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Barkhori
						4. Mandro
						5. Baji Santhali
		04	Jamtara	052	Jamtara	1. Rani Ganj
			(World Bank)		(Tribal)	2. Bhaga
						3. Dhobna - 2
						4. Kumirpara - 1
						5. Haripara
		05	Palamau	053	Daltonganj	1. Pokhra Khurd
			(Regular ICDS)		(Rural)	2. Kundevautri
						3. Rajwadi Purvi
						4. Lalhai
						5. Sambhuchak
12	Karnataka	01	Belgaum	054	Belgalum	1. Shivaji Nagar
			(Regular ICDS)		(Urban)	2. Husur
						3. Tilakawadi
						4. Shiva Basava Nagar
						5. Konwal Galli
		02	Bidar	055	Basava Kalyana	1. Shivapur
					(Rural)	2. Batagera
						3. Manthal
						4. Sharana Nagar
						5. Gour

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		03	Chickmagaluru	056	Sringeri (Tribal)	1. Shidle 2. Addagadde 3. Harur 4. Ulavalli 5. Ginigini
		04	Gulbarga	057	Chittapur (Rural)	1. Gundagurti 2. Bennur 3. Deventegnoor 4. Kardal 5. Watcha
		05	Mysore (Regular ICDS)	058	Mysore (Rural)	1. Madhavagere 2. Kalstharadi 3. Kerehundi 4. Gungaral Chatra 5. Sindhu Valli
		06	Tunkur	059	Tunkur (Rural)	1. Byatha 2. Kora-II 3. Kalkere 4. Bellavi 5. Naraganahalli
13	Kerala	01	Kollam (Regular ICDS)	060	Pathanapuram (Rural)	1. Aruvi Lhara 2. Vilakudi

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Pattazhi
						4. Patlazhi North
						5. Piravanthoor
		02	Ernakulam	061	Vadavucode	1. Erappumpara
			(Regular ICDS)		(Rural)	2. Narikuzipeedika
						3. Mazuvanoor
						4. Koorachy
						5. Puthenkurish
		03	Kozhikode	062	Urban - 7	1. West Hill Urban
			(Regular ICDS)		(Rural)	2. Aviyil
						3. Gandhi Road
						4. Chaappayil
						5. Pallikandi Beach
		04	Palakkad	063	Attappadi	1. Vasakarpul
			(World Bank)		(Tribal)	2. Narikarappadi
						3. N. Kottathara
						4. Norkottathara
						5. Kavundikal
14	Madhya Pradesh	01	Indore	064	Indore City	1. Shivaji Nagar
			(NGO)		(Urban)	2. Namsai - I
						3. Saqmugani - II
						4. Dunsai
						5. Eraloni Centre

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		02	Jhabua	065	Jobat	1. Kandhu Gram
			(Regular ICDS)		(Tribal)	2. Beechphalitya
						3. Imli Phalia
						4. Kali Kettor
						5. Ghonsiya Jobat
		03	Betul	066	Ghoradongri	1. Bazardhana No. - 1
			(Regular ICDS)		(Tribal)	2. Salidhana - 1
						3. Bandidhana
						4. Kanhawadi - 1
						5. Mehkaar - 2
		04	Mandsor	067	Sitamau	1. Titrod - 2
			(Regular ICDS)		(Rural)	2. Ladune - 3
						3. Suwasra -1
						4. Kyampuva - 5
						5. Kheda
		05	Bhind	068	Mehegoon	1. Neemgaon
					(Rural)	2. Khatma
						3. Mehedoli - 1
						4. Soni - 2
						5. Kalyanpure
		06	Rewa	069	Karchalia	1. Ramnai - 2
					(Rural)	2. Sirkhini

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Sagra - 2
						4. Itawra
						5. Manikwar
		07	Sagar	070	Raheli	1. Kadhta
			(Regular ICDS)		(Rural)	2. Sanjara
						3. Parasia
						4. Roun - B
						5. Chourai
		08	Seoni	071	Keolari	1. Malari
			(Regular ICDS)		(Rural)	2. Malara
						3. Sonkhar
						4. Chinda
						5. Maria
15	Maharashtra	01	Mumbai	072	Dharai	1. Ramabai Nagar
			(Regular ICDS)		(Urban)	2. Panchasilkside Mandal
						3. Muslim Nagar
						4. Kalakilla
						5. Jeevan Jothi Society
		02	Gadchorili	073	Chamorshi	1. Talori
			(Regular ICDS)		(Tribal)	2. Walsara
						3. Srinivaspuri
						4. Konsari
						5. Jairampur

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		03	Nasik	074	Dindori	1. Pandane
			(Regular ICDS)		(Tribal)	2. Nigdol
						3. Pimpri Anchala
						4. Nalwadi
						5. Nalwad Pada
		04	Amravati	075	Tiwsa	1. Police Anganwadi
			(Regular ICDS)		(Rural)	2. Shendurjana Mahora
						3. Shendurjana Bazar
						4. Gurudev Nagar
						5. Shiraj Gaon
15	Maharashtra	05	Beed	076	Ambajogai	1. Shepwadi
			(Regular ICDS)		(Rural)	2. Jogai Wadi
						3. Jawalgaon
						4. Bharaj
						5. Nandgaon
		06	Sangli	077	Walva	1. Walva - 1
			(Regular ICDS)		(Rural)	2. Walva - 2
						3. Tatkari
						4. Borgagaon
						5. Kamari
		07	Jalgaon	078	Erendol	1. Toli
			(Regular ICDS)		(Rural)	2. Vikhran

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Vankothe - 3
						4. Jalu
						5. Pinpalkotha - 2
		08	Kolhapur	079	Karveer	1. Ambawadi - 1
					(Rural)	2. Ambawadi - 2
						3. Unchgaon - 1
						4. Unchgaon - 2
						5. Karli
16	Manipur	01	Senapati	080	Maomaram	1. Maromkhullalpa
			(Regular ICDS)		(Tribal)	2. Punanamei
						3. Tadubi - B
						4. Maram Nepali
						5. Senapati - A
17	Meghalaya	01	Jayantia Hills	081	Thadlaskriem	1. Tyrshang
			(Regular ICDS)		(Tribal)	2. Nartiang South
						3. Nongbah Lumoor
						4. Sohmynting West
						5. Lumsabah
18	Mizoram	01	Kolasib	082	Thingolawal	1. Thingolawal - 5
			(Regular ICDS)		(Tribal)	2. Thingolawal - 2
						3. Kolasib - 2
						4. Kolasib - 1
						5. Kolasib - 4

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
19	Nagaland	01	Mon	083	Monicds	1. Papong
			(Regular ICDS)		(Tribal)	2. ADC Colony
						3. Doglas Colony
						4. Fine Brigade
						5. D.B. Colony
		02	Paren	084	Jalukie	1. Jalukie - I
			(Regular ICDS)		(Tribal)	2. Samziuram - II
						3. Samziuram - I
						4. Mhainamisi - II
						5. Mhainamchi - III
20	Orissa	01	Angul	085	Pallahara	1. Jhimirpalli
			(World Bank)		(Rural)	2. Batisuan
						3. Kantala
						4. Dalo
						5. Jokapani
		02	Nayasara	086	Paspalla	1. Patapur Patna
			(Regular ICDS)		(Rural)	2. Khanda Pada
						3. Jari Patha
						4. Dina Gaon
						5. Gada Sahi
		03	Cuttack	087	Mahanga	1. Jahala
			(Regular ICDS)		(Rural)	2. Diha Sahi

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Pandarbatia
						4. Jaleshar - '01
						5. Pasulunda
		04	Ganjam	088	Khalikote	1. Bhejiput
					(Rural)	2. Singadapath
						3. Balantar
						4. Chandipitha
						5. Nathura - I
		05	Kalahande	089	Bpatna	1. Mosanpada
			(Regular ICDS)		(Urban)	2. TV Centre pada
						3. Kalimondirpade
						4. Ramsagorpada
						5. Gupabindnn
		06	Mayurbhanj	090	Kapitipada	1. Rathadanda Saai
			(World Bank)		(Tribal)	2. Sarbana
						3. Solagadia
						4. Dunduria
						5. Parasabani
		07	Kandhamal	091	Baliguda	1. Danda padar - I
			(Regular ICDS)		(Tribal)	2. Sitreusahi
						3. Harijan Sathi
						4. Midiakia
						5. Mundapada

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		08	Sundargarh	092	Lahonipada	1. Gamlei
			(World Bank)		(Tribal)	2. Gadapalli
						3. Birtola
						4. Khuntgaon
						5. Kurda
21	Punjab	01	Amritsar	093	Raiyya	1. Melta
			(Regular ICDS)		(Rural)	2. Batala
						3. Khilchian
						4. Beas
						5. Baba - Bakala
		02	Gurdaspur	094	Pathankot	1. Malakpur
			(Regular ICDS)		(Rural)	2. Phangrian
						3. Bhoa
						4. Kailashpur
						5. Badolikhund
		03	Ludhiana	095	Ludhiana	1. Islamgunj Centre No. 17
			(Regular ICDS)		(Urban)	2. Islam Gomt Centre No. 20
						3. Abdullahpur Basti, Centre No. 36
						4. Abdullahpur Basti, Centre No. 37
						5. Shimla Puri, Centre No. 73
		04	Patiala	096	Bhumerhari	1. Dewan
			(Regular ICDS)		(Rural)	2. Behru

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Puniakhana
						4. Bhunarheri
						5. Meera Pur
		05	Sangrur	097	Lehargaga	1. Arkwas
			(Regular ICDS)		(Rural)	2. Ladal
						3. Sadi Hari
						4. Moonak
						5. Chotian
22	Rajasthan	01	Bikaner	098	Kolayat	1. Mud - A
			Urmul Simant		(Rural)	2. Kolasar West
			Samiti Kolayat			3. Gariyala
			Bikaner			4. Kharicharnana
						5. Gangapura
		02	Barmer	099	Barmer	1. Ramasar - II
			(Regular ICDS)		(Rural)	2. Mahabar
						3. Khadeen
						4. Njacnjar
						5. Sura Narpataa
		03	Udaipur	100	Dhariyawad	1. Dabiyakheda
			(Regular ICDS)		(Tribal)	2. Kun - I
						3. Dhawadi
						4. Khuta - 3
						5. Jaikhedla

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		04	Kota	101	Cwechar	1. Manda
			(Regular ICDS)		(Rural)	2. Julami - I
						3. Sahravda - I
						4. Suket
						5. Khaerabad - I
		05	Bharatpur	102	Bharatpur	1. Twand Sarak
			(Regular ICDS)		(Urban)	2. Nutan Vidya Mandir
						3. Jaghinaget
						4. Jarota Mohala
						5. Nadiya Mohala
		06	Jaipur	103	Govind Gardh	1. Barakidori
			(Regular ICDS)		(Rural)	2. Dodrari
						3. Dodarsar
						4. Bagdoka Bas
						5. Jait Puri
23	Sikkim	01	East Sikkim	104	Singtam	1. Khani Khola
					(Rural)	2. Lower Zitlang
						3. Bordang
						4. Upper Zitlang
						5. Rhenock Chalsey
24	Tamil Nadu	01	Chennai	105	Chennai	1. G.K.M. Colony
			(Regular ICDS)		(Urban)	2. C. Kalayanpoyam

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Shivagamyammayar Colony
						4. Pudunagar
						5. Bagthualhhlam Colony
		02	Madurai	106	Thiruparamkundram	1. Thuppur
					(Rural)	2. Valayankulam
						3. Niliyur
						4. Vadapalaniji
						5. Nedunkulum
		03	Dindugal	107	Nilakottai	1. Kodanginaya Kanpatti
			(Regular ICDS)		(Rural)	2. Chakayanayakanur - II
						3. Kundalappatti
						4. Mattaparai - II
						5. Micheal Palayam - I
		04	Salem	108	Salem	1. Andipatti
			(World Bank)		(Rural)	2. Vattamuthampatti
						3. Sathanagar
						4. Periarnagar
						5. Perumalkoil Karadi
		05	Dharma PURI	109	Hosur	1. Basthi
			(Regular ICDS)		(Rural)	2. Sunambujibi
						3. Zuzuvadi
						4. Bauawrnw
						5. Kothapalli

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		06	Vellore	110	Vaniyambadi	1. Pudur - 2
					(Urban)	2. Perumal Pet
						3. Netaji Nagar
						4. Sanangkuppam
						5. Pudumandi
		07	Pudukottai	111	Annavasal	1. Parambur - III
			(Regular ICDS)		(Rural)	2. Irundirapatti
						3. Ariyur
						4. Sathyamangalm
						5. Annavasal - 5
		08	Ramanathapuram	112	R.S. Mangalam	1. Sanaveli
			(WB supported)		(Rural)	2. Melpanayur
						3. Kudalur
						4. Uppoor
						5. Morpannait
		09	Theni	113	Bodi	1. Dharmapuri
			(WB supported)		(Rural)	2. Thiruchar
						3. Sillomorathupatti
						4. Mindal
						5. Nadapatty
		10	Coimbatore	114	Karamadal	1. Nedur
			(WB supported)		(Rural)	2. Kannara Palayam

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Pethikuttai
						4. Kandyur
						5. Sromugai Pudur
		11	Nagapattinam	115	Nagapattinam	1. Azhiyur
					(Rural)	2. Orathur
						3. Alanguid
						4. Perungadambanur
						5. Kallar
		12	Kanyakumari	116	Munsirai	1. Kappukadu
					(Rural)	2. Sumitherivilakam
					(WB Supported)	3. Vavarai
						4. Mekkadu
						5. Melangalam
		13	Namakkal	117	Kolli Hills	1. Asakattu Patti
					(Tribal)	2. Solakkad Patti
						3. Vasalur Patti
						4. Semmedu
						5. Adakum Patti
25	Tripura	01	South Tripura	118	Bogafa	1. Gamjerfilla
			(Regular ICDS)		(Rural)	2. Anantadas Pana
						3. Bhubandas Pana
						4. Sudhire Sarkar Pana
						5. Dashagharia

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		01	Lucknow	119	Alam Nagar	1. Peer Bakka
			(Regular ICDS)		(Urban)	2. Harijan Basti
						3. Asiya Mall
						4. Bhusa Mandi
						5. Bagn Aainabeevi
26	Uttar Pradesh	02	Lakshimpur Kheri	120	Pallia	1. Lalpur dhaka
			(Regular ICDS)		(Tribal)	2. Afimipura
						3. Balpur
						4. Trikoliya
						5. Kisanmohalu
		03	Bareilly	121	Majgawah	1. Majgawah - II
			(Regular ICDS)		(Rural)	2. Bhetta Junun
						3. Parah
						4. Khateta - I
						5. Gaini - I
		04	Etawah	122	Mahewa	1. Bijauli - I
					(Rural)	2. Naglashukul
						3. Sunvarsha - II
						4. Ujhiani - II
						5. Mahewa Basti
		05	Gorakhpur	123	Bansgaon	1. Jotgotki
			(Regular ICDS)		(Rural)	2. Dakshin Tola - I

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Kasba Sangrampur
						4. Attapauli Kanta
						5. Deokali
		06	Jhansi	124	Babina	1. Ghisoli
			(Regular ICDS		(Rural)	2. Babina
			Rural)			3. Rasina
						4. Bijauli
						5. Brahm Nagar
		07	Saharanpur	125	Muzafferabad	1. Rasulpur
			(Regular ICDS)		(Rural)	2. Chenehek - I
						3. Bhojpur
						4. Kandela
						5. Alliwala
		08	Jaunpur	126	Sikrar	1. Rithi - II
			(Regular ICDS)		(Rural)	2. Palpur (Kandharpur)
						3. Baki - I
						4. Lakhawaon - I
						5. Bisawaon - I
		09	Agra	127	Shamsabad	1. Hirner - I
					(Rural)	2. Hirner - II
						3. Doki - I
						4. Doki - II
						5. Siktara - I

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
		10	Mirzapur	128	Rajgarh	1. Daadara - II
					(Rural)	2. Daadara - I
						3. Nadihaar
						4. Bhaavan
						5. Bishunpur
		11	Raebareli	129	Unchahar	1. Kamoli
			(Regular ICDS)		(Rural)	2. Kalyanpur
						3. Kishundaspur
						4. Sabispur
						5. Kotrabaha Durgan
		12	Badaun	130	Jagat	1. Naglasharki
			(Regular ICDS)		(Rural)	2. Arif Purnavada - I
						3. Khunak - III
						4. Mohammadpur Sulara - I
						5. Jagat - I
		13	Ghaziabad	131	Hapur	1. Dhanaura - I
					(Rural)	2. Dhanaura - II
						3. Achchhaja - I
						4. Achchhaja - II
						5. Achchhaja - III
		14	Lalitpur	132	Jakhora	1. Salegan
			(Regular ICDS)		(Rural)	2. Delwara

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Anghiyaari
						4. Rajghat
						5. Jakhora
27	Uttaranchal	01	Dehradun	133	Dehradun City	1. Nimbuwala
			(Regular ICDS)		(Urban)	2. Comed Bulb Factory
						3. Amar Nath Colony
						4. Ambedkar Nagar - I
						5. Ambedkar Nagar - II
		02	Pithoragarh	134	Dharchula	1. Phultari
			(Regular ICDS)		(Tribal)	2. Chhori Bagar Bangapani
						3. Pangala
						4. Bon (Gothi)
						5. Khotila
		03	Hardwar	135	Roorkee	1. Khanjarpur - I
			(Regular ICDS)		(Rural)	2. Beladi
						3. Sherpur
						4. Rampur
						5. Safipur
28	West Bengal	01	24 Paragona (NGO)	136	Burtala	1. Youth Club One Rata Bazar
			R.K. Mission		(Urban)	2. Sikdar Bagan Bagmari
			Narenderpur			3. (Gauribari) Arohi
			Kolkata			4. Gobagan CNK Sponl 7 Cul

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
			West Bengal			Farum
						5. Anchlik Saanti Committee
		02	Purulia	137	Kashipur	1. Kaibartapara
			(Regular ICDS)		(Tribal)	2. Madhyapara
						3. Dhabari
						4. Tibampur
						5. Majhidi
		03	Medinapur	138	Ghatal	1. Rani bazar
					(Rural)	2. Manoharpur (North)
						3. Mulgram
						4. Mulgram
						5. Nandipur
		04	Darjiling	139	Kursecong	1. Upper Naya Basti
			(Regular ICDS)		(Rural)	2. Kharia Basti
						3. Bim Primary School
						4. Gayabari
						5. Giddkapahar
		05	Murshidabad	140	Berhampur	1. Anandamayee Bid Yama
			(Regular ICDS)		(Rural)	2. Goaljam Seba Samiti
						3. Luther Colony

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						4. Monindra Nagare
						5. Baamjetia GSFP
		06	Malda	141	Gajole	1. Lakhitala
			(Regular ICDS)		(Rural)	2. Haripatty
						3. Gebindapur
						4. Sahhrol
						5. Pandua
		07	Jalpaiguri	142	Alipurduar	1. Uttare Bairaguri
			(Regular ICDS)		(Rural)	2. Patkapara
						3. Chakuakheti
						4. Topshikhata
						5. Bibekamnda
		08	Nadia	143	Ranaghat - II	1. Pratapgarh Paschimpara
			(Regular ICDS)		(Rural)	2. Doula
						3. Dattapulia
						4. Dultapara
						5. Meghergram
29	A & N Island	01	Port Blair	144	Port Blair	1. Bunidabad
			(Regular ICDS)		(Urban)	2. Austinabad
						3. Brichgunj

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						4. Brichgunh T Sunami Centre
						5. Garacharama
30	Chandigarh	01	Chandigarh	145	Town Hall - I	1. Mouli Colony
			(Regular ICDS)		(Urban)	2. Mouli Village
						3. Mani Majra
						4. Daria
						5. Bapudhan Colony
31	Delhi	01	East Delhi	146	Trilok Puri	1. Line - 7 Trilok Puri - A
			(Regular ICDS)		(Urban)	2. Trilokpuri Block - 24
						3. Kalyanpuri - Block - 15
						4. Trilokpuri Block - 1
						5. Trilokpuri Block - 21
32	Dadra &	01	D.N. Haveli	147	Silvasa	1. Gandhi Gram
	Nagar Haveli		(Regular ICDS)		(Tribal)	2. Bonda Kanlipada
						3. Moroli Kakadphadie
						4. Bendrabin
						5. Khanvel Kumharma
33	Daman & Diu	01	Daman & Diu	148	Diu	1. Patilwadi
			(Regular ICDS)		(Rural)	2. Dangarwadi

State	State	District		Project		Anganwadi Centre
Code	Name	Code	Name	Code	Name	Name
						3. Vanakbasa
						4. Vaniyabadi
						5. Vaniaseri
34	Lakshadweep	01	Lakshadweep	149	Lakshadweep	1. Awthakathyabad
			(Regular ICDS)		(Tribal)	2. High School
						3. Nrtiber Feutory
						4. Govt. AWC
						5. Aganthi Novth
35	Pondicherry	01	Pondicherry	150	Karikal	1. Karakalacherry
			(Regular ICDS)		(Rural)	2. Subbarayapuram
						3. Pattanacherry
						4. Kotapadi
						5. Talateru

State-wise Status of the Project Staff

Sl.No.	State	CDPO			ACDPO			Supervisor		
		Sanctioned	Position	% in position	Sanctioned	Position	% in position	Sanctioned	Position	% in position
1	Andhra Pradesh	7	6	85.7	11	3	27.3	75	62	82.7
2	Arunachal Pradesh	2	2	100.00	0	0	-	12	10	83.3
3	Assam	6	6	100.0	7	3	42.9	48	44	91.7
4	Bihar	6	3	50.0	3	0	0.0	46	5	10.9
5	Chhatisgarh	4	2	50.0	2	1	50.0	23	21	91.3
6	Goa	1	1	100.0	0	0	-	7	6	85.7
7	Gujarat	12	11	91.7	11	7	63.6	103	77	74.8
8	Haryana	4	4	100.0	1	0	0.0	27	27	100.0
9	Himachal Pradesh	2	2	100.0	2	2	100.0	12	12	100.0
10	Jammu & Kashmir	4	4	100.0	2	2	100.0	23	23	100.0
11	Jharkhand	5	5	100.0	0	0	-	25	14	56.0
12	Karnataka	6	5	83.3	8	8	100.0	57	54	94.7
13	Kerala	4	4	100.0	3	2	66.7	23	21	91.3
14	Madhya Pradesh	8	6	75.0	4	2	50.0	58	46	79.3
15	Maharashtra	8	8	100.0	12	6	50.0	89	82	92.1
16	Manipur	1	1	100.0	0	0	--	5	7	140.0
17	Meghalaya	1	1	100.0	1	1	100.0	8	8	100.0
18	Mizoram	1	1	100.0	0	0	--	4	4	100.0
19	Nagaland	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA
20	Orissa	8	6	75.0	0	0	--	50	27	54.0
21	Punjab	5	3	60.0	1	1	100.0	27	27	100.0
22	Rajasthan	6	5	83.3	7	2	28.6	49	42	85.7
23	Sikkim	1	1	100.0	0	0	--	7	7	100.0
24	Tamil Nadu	13	12	92.3	0	0	--	58	50	86.2
25	Tripura	1	1	100.0	0	0	--	7	6	85.7
26	Uttar Pradesh	14	9	64.3	5	0	0.0	88	75	85.2
27	Uttaranchal	3	3	100.0	0	0	--	13	13	100.0
28	West Bengal	7	6	85.7	9	6	66.7	61	58	95.1
29	Andaman & Nico. Islands	1	1	100.0	0	0	--	10	5	50.0
30	Chandigarh	1	1	100.0	0	0	--	4	4	100.0
31	Delhi	1	1	100.0	0	0	--	5	5	100.0
32	Dadar & Nagar Haveli	1	1	100.0	0	0	--	8	5	62.5
33	Daman & Diu	1	1	100.0	0	0	--	2	1	50.0
34	Lakshadweep	1	1	100.0	1	1	100.0	4	4	100.0
35	Pondicherry	1	1	100.0	0	0	--	5	5	100.0
	Total	147	125	85.0	90	47	52.2	1043	857	82.2

Contd.

Sl.No.	State	AWWs			Helpers		
		Sanctioned	Position	% in position	Sanctioned	Position	% in position
1	Andhra Pradesh	1550	1468	94.7	1550	1475	95.2
2	Arunachal Pradesh	245	245	100.0	245	245	100.0
3	Assam	963	951	98.8	963	949	98.5
4	Bihar	1014	1009	99.5	1014	1008	99.4
5	Chhatisgarh	531	526	99.1	531	524	98.7
6	Goa	148	142	95.9	148	139	93.9
7	Gujarat	2062	1961	95.1	2062	1963	95.2
8	Haryana	573	570	95.5	573	573	100.0
9	Himachal Pradesh	227	218	96.0	227	224	98.7
10	Jammu & Kashmir	474	472	99.6	474	474	100.0
11	Jharkhand	654	637	97.4	654	639	97.7
12	Karnataka	1234	1233	99.9	1234	1234	100.0
13	Kerala	527	513	97.3	527	496	94.1
14	Madhya Pradesh	1323	1315	99.4	1323	1312	99.2
15	Maharashtra	1947	1930	99.1	1947	1920	98.6
16	Manipur	150	138	92.0	150	138	92.0
17	Meghalaya	136	136	100.0	136	136	100.0
18	Mizoram	61	61	100.0	61	61	100.0
19	Nagaland	DNA	DNA	DNA			DNA
20	Orissa	971	955	98.4	971	963	99.2
21	Punjab	617	611	99.0	617	617	100.0
22	Rajasthan	993	981	98.8	993	990	99.7
23	Sikkim	150	150	100.0	150	150	100.0
24	Tamil Nadu	1615	1460	90.4	1615	1274	78.9
25	Tripura	141	141	100.0	141	141	100.0
26	Uttar Pradesh	2193	2133	97.3	2193	2100	95.8
27	Uttaranchal	321	320	99.7	321	318	99.1
28	West Bengal	1238	1209	97.7	1238	1229	99.3
29	Andaman & Nico. Islands	240	240	100.0	240	240	100.0
30	Chandigarh	100	100	100.0	100	100	100.0
31	Delhi	127	127	100.0	127	127	100.0
32	Dadar & Nagar Haveli	138	138	100.0	138	138	100.0
33	Daman & Diu	33	32	97.0	33	33	100.0
34	Lakshadweep	74	74	100.0	74	74	100.0
35	Pondicherry	140	140	100.0	140	140	100.0
	Total	22910	22336	97.5	22910	22144	96.7

Reason for Inadequate Coordination between Health and ICDS Functionaries

Management	Location	No. reporting inadequate coordination	As reported by CDPO Reasons							
			Indifferent Attitude of health functionaries	Indifferent Attitude of ICDS functionaries	Inadequate supply of medicine	Pre-occupation of health functionaries	Pre-occupation of ICDS functionaries	AWWs non-co-operative	ANM non-co-operative	Any other
ICDS Run	Rural	14	11	2	6	11	6	0	4	0
	%		78.6	14.3	42.9	78.6	42.9	0.0	28.6	0.0
	Tribal	6	3	2	3	1	1	1	3	2
	%		50.0	33.3	50.0	16.7	16.7	16.7	50.0	33.3
	Urban	3	1	0	0	2	1	0	0	3
	%		33.3	0.0	0.0	66.7	33.3	0.0	0.0	100.0
	Total	23	15	4	9	14	8	1	7	5
	%		65.2	17.4	39.1	60.9	34.8	4.3	30.4	21.7
World Bank Supported	Rural	4	1	1	3	4	2	0	0	2
	%		25.0	25.0	75.0	100.0	50.0	0.0	0.0	50.0
	Tribal	3	2	2	2	2	2	2	2	1
	%		66.7	66.7	66.7	66.7	66.7	66.7	66.7	33.3
	Total	7	3	3	5	6	4	2	2	3
	%		42.9	42.9	71.4	85.7	57.1	28.6	28.6	42.9
NGO. Operated	Rural	1	1	0	0	0	0	0	1	0
	%		100.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0
	Tribal	0	0	0	0	0	0	0	0	0
	%		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Urban	0	0	0	0	0	0	0	0	0
	%		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	1	1	0	0	0	0	0	1	0
	%		100.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0
All Areas	Rural	19	13	3	9	15	8	0	5	2
	%		68.4	15.8	47.4	78.9	42.1	0.0	026.3	10.5
	Tribal	9	5	4	5	3	3	3	5	3
	%		55.6	44.4	55.6	33.3	33.3	33.3	55.6	33.3
	Urban	3	1	0	0	2	1	0	0	3
	%		33.3	0.0	0.0	66.7	33.3	0.0	0.0	100
	Total	31	19	7	14	20	12	3	10	8
	%		61.3	22.6	45.2	64.5	38.7	9.7	32.3	25.8
		48	23	14	19	30	26	9	7	5
	%		47.9	29.2	39.6	62.5	54.2	18.8	14.6	10.4
		22	11	9	11	7	2	3	3	6
	%		50.0	40.9	50.0	31.8	9.1	13.6	13.6	27.3
		6	1	2	0	4	2	1	2	0
	%		16.7	33.3	0.0	66.7	33.3	16.7	33.3	0.0
		76	35	25	30	41	30	13	12	11
	%		46.1	32.9	39.5	53.9	39.5	17.1	15.8	14.5
		9	1	0	6	4	4	4	0	1
	%		11.1	0.0	66.7	44.4	44.4	44.4	0.0	11.1
		6	5	5	6	6	5	5	5	0
	%		83.3	83.3	100.0	100.0	83.3	83.3	83.3	0.0
		15	6	5	12	10	9	9	5	1
	%		40.0	33.3	80.0	66.7	60.0	60.0	33.3	6.7

Contd.

Managements	Location	No. reporting inadequate coordination	As reported by CDPO Reasons							
			Indifferent Attitude of health functionaries	Indifferent Attitude of ICDS functionaries	Inadequate supply of medicine	Pre-occupation of health functionaries	Pre-occupation of ICDS functionaries	AWWs non-co-operative	ANW non-co-operative	Any other
		10	3	3	7	6	3	4	2	3
		%	30.0	30.3	70.0	60.0	30.0	40.0	20.0	30.0
		1	0	0	0	0	0	0	0	0
		%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		0	0	0	0	0	0	0	0	0
		%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		11	3	3	7	6	3	4	2	3
		%	27.3	27.3	63.6	54.5	27.3	36.4	18.2	27.3
		67	27	17	32	40	33	17	9	9
		%	40.3	25.4	47.8	59.7	49.3	25.4	13.4	13.4
		29	16	14	17	13	7	8	8	6
		%	55.2	48.3	58.6	44.8	24.1	27.6	27.6	20.7
		6	1	2	0	4	2	1	2	0
		%	16.7	33.3	0.0	66.7	33.3	16.7	33.3	0.0
		102	44	33	49	57	42	26	19	15
		%	43.1	32.4	48.0	55.9	41.2	25.5	18.6	14.7
		35	25	11	14	29	17	18	32	9
		%	71.4	31.4	40.0	82.9	48.6	51.4	91.4	27.7
		14	7	2	11	9	2	9	11	5
		%	50.0	14.3	78.6	64.3	14.3	64.3	78.6	35.7
		8	5	0	5	5	0	4	2	2
		%	62.5	0.0	62.5	62.5	0.0	50.0	25.0	25.0
		57	37	13	30	43	19	31	45	16
		%	64.9	22.8	52.6	75.4	33.3	54.4	78.9	28.1
		5	0	0	3	4	3	3	1	1
		%	0.0	0.0	60.0	80.0	60.0	60.0	20.0	20.0
		5	3	0	4	4	3	4	3	0
		%	60.0	0.0	80.0	80.0	60.0	80.0	60.0	0.0
		10	3	0	7	8	6	7	4	1
		%	30.0	0.0	70.0	80.0	60.0	70.0	40.0	10.0
		5	3	0	2	4	2	3	4	3
		%	60.0	0.0	40.0	80.0	40.0	60.0	80.0	60.0
		1	1	0	0	0	0	0	0	0
		%	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		0	0	0	0	0	0	0	0	0
		%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		6	4	0	2	4	2	3	4	3
		%	66.7	0.0	33.3	66.7	33.3	50.0	66.7	50.0
		45	28	11	19	37	22	24	37	13
		%	62.2	24.4	42.2	82.2	48.9	53.3	82.2	28.9
		20	11	2	15	13	5	13	14	5
		%	55.0	10.0	75.0	65.0	25.0	65.0	70.0	25.0
		8	5	0	5	5	0	4	2	2
		%	62.5	0.0	62.5	62.5	0.0	50.0	25.0	25.0
		73	44	13	39	55	27	41	53	20
		%	60.3	17.8	53.4	75.3	37.0	56.2	72.6	27.4

Distribution of ICDS Functionaries According to Training Status

Sl.No.	State	CDPO				Supervisor			
		Trained		Not Trained		Trained		Not Trained	
		No.	%	(No.)	Total	No.	%	(No.)	Total
1	Andhra Pradesh	6	85.7	1	7	14	100.0	0	14
2	Arunachal Pradesh	2	100.0	0	2	4	100.0	0	4
3	Assam	5	83.3	1	6	15	88.2	2	17
4	Bihar	6	100.0	0	6	5	100.0	0	5
5	Chhatisgarh	2	50.0	2	4	8	100.0	0	8
6	Goa	1	100.0	0	1	2	100.0	0	2
7	Gujarat	8	66.7	4	12	24	96.0	1	25
8	Haryana	4	100.0	0	4	8	100.0	0	8
9	Himachal Pradesh	2	100.0	0	2	2	50.0	2	4
10	Jammu & Kashmir	2	50.0	2	4	7	87.5	1	8
11	Jharkhand	5	100.0	0	5	7	77.8	2	9
12	Karnataka	5	83.3	1	6	15	100.0	0	15
13	Kerala	3	75.0	1	4	7	87.5	1	8
14	Madhya Pradesh	7	87.5	1	8	16	100.0	0	16
15	Maharashtra	6	75.0	2	8	16	100.0	0	16
16	Manipur	1	100.0	0	1	2	100.0	0	2
17	Meghalaya	1	100.0	0	1	4	100.0	0	4
18	Mizoram	1	100.0	0	1	2	100.0	0	2
19	Nagaland	0	--	0	0	2	66.7	1	3
20	Orissa	6	75.0	2	8	12	92.3	1	13
21	Punjab	5	100.0	0	5	10	100.0	0	10
22	Rajasthan	3	50.0	3	6	12	100.0	0	12
23	Sikkim	1	100.0	0	1	2	100.0	0	2
24	Tamil Nadu	13	100.0	0	13	26	100.0	0	26
25	Tripura	1	100.0	0	1	2	100.0	0	2
26	Uttar Pradesh	11	78.6	3	14	27	100.0	0	27
27	Uttaranchal	3	100.0	0	3	6	100.0	0	6
28	West Bengal	7	100.0	0	7	14	100.0	0	14
29	Andaman & Nico. Island	0	0.0	1	1	1	50.0	1	2
30	Chandigarh	1	100.0	0	1	2	100.0	0	2
31	Delhi	1	100.0	0	1	2	100.0	0	2
32	Dadar & Nagar Haveli	0	0.0	1	1	0	0.0	2	2
33	Daman & Diu	0	0.0	1	1	1	100.0	0	1
34	Lakshadweep	1	100.0	0	1	1	100.0	0	1
35	Pondicherry	0	0.0	1	1	2	100.0	0	2
	Total	120	81.6	27	147	280	95.2	14	294

Contd.

Sl.No.	State	Anganwadi Workers				Job Training				Anganwadi workers-Nature of Training							
		Trained		Not Trained		Not (No.)	Recd.	%	Total (no.)	Refresher Training				Special Training			
		No.	%	(No.)	Total Recd.					Not Recd. (no.)	Recd.	%	Total	Not Recd.	Recd. (No)	%	Total
1	Andhra Pradesh	35	100.0	0	35	0	35	100.0	35	0	35	100.0	35	10	25	71.4	35
2	Arunachal Pradesh	5	50.0	5	10	5	5	50.0	10	10	0	0.0	10	10	0	0.0	10
3	Assam	30	100.0	0	30	0	30	100.0	30	9	21	70.0	30	10	20	66.7	30
4	Bihar	30	100.0	0	30	0	30	100.0	30	15	15	50.0	30	21	9	30.0	30
5	Chhatisgarh	20	100.0	0	20	0	20	100.0	20	1	19	95.0	20	10	10	50.0	20
6	Goa	5	100.0	0	5	0	5	100.0	5	3	2	40.0	5	0	5	100.0	5
7	Gujarat	58	96.7	2	60	2	58	96.7	60	16	44	73.3	60	15	45	75.0	60
8	Haryana	20	100.0	0	20	1	19	95.0	20	1	19	95.0	20	3	17	85.0	20
9	Himachal Pradesh	10	100.0	0	10	0	10	100.0	10	0	10	100.0	10	9	1	10.0	10
10	Jammu & Kashmir	19	95.0	1	20	3	17	85.0	20	4	16	80.0	20	7	13	65.0	20
11	Jharkhand	25	100.0	0	25	0	25	100.0	25	10	15	60.0	25	12	13	52.0	25
12	Karnataka	30	100.0	0	30	0	30	100.0	30	4	26	86.7	30	23	7	23.3	30
13	Kerala	19	95.0	1	20	1	19	95.0	20	1	19	95.0	20	13	7	35.0	20
14	Madhya Pradesh	40	100.0	0	40	0	40	100.0	40	1	39	97.5	40	3	37	92.5	40
15	Maharashtra	39	97.5	1	40	1	39	97.5	40	12	28	70.0	40	22	18	45.0	40
16	Manipur	5	100.0	0	5	0	5	100.0	5	0	5	100.0	5	4	1	20.0	5
17	Meghalaya	5	100.0	0	5	0	5	100.0	5	1	4	80.0	5	1	4	80.0	5
18	Mizoram	5	100.0	0	5	0	5	100.0	5	2	3	60.0	5	3	2	40.0	5
19	Nagaland	10	100.0	0	10	0	10	100.0	10	8	2	20.0	10	8	2	20.0	10
20	Orissa	39	97.5	1	40	1	39	97.5	40	4	36	90.0	40	34	6	15.0	40
21	Punjab	25	100.0	0	25	0	25	100.0	25	4	21	84.0	25	16	9	36.0	25
22	Rajasthan	27	96.4	1	28	1	27	96.4	28	6	22	78.6	28	12	16	57.1	28
23	Sikkim	5	100.0	0	5	0	5	100.0	5	0	5	100.0	5	2	3	60.0	5
24	Tamil Nadu	64	98.5	1	65	4	61	93.8	65	4	61	93.8	65	25	40	61.5	65
25	Tripura	5	100.0	0	5	0	5	100.0	5	1	4	80.0	5	5	0	0.0	5
26	Uttar Pradesh	70	100.0	0	70	0	70	100.0	70	48	22	31.4	70	44	26	37.1	70
27	Uttaranchal	15	100.0	0	15	0	15	100.0	15	2	13	86.7	15	6	9	60.0	15
28	West Bengal	40	100.0	0	40	0	40	100.0	40	19	21	52.5	40	29	11	27.5	40
29	A & N Islands	5	100.0	0	5	1	4	80.0	5	1	4	80.0	5	1	4	80.0	5
30	Chandigarh	5	100.0	0	5	0	5	100.0	5	0	5	100.0	5	3	2	40.0	5
31	Delhi	5	100.0	0	5	0	5	100.0	5	0	5	100.0	5	1	4	80.0	5
32	Dadar & Nagar Haveli	5	100.0	0	5	0	5	100.0	5	0	5	100.0	5	5	0	0.0	5
33	Daman & Diu	5	100.0	0	5	0	5	100.0	5	5	0	0.0	5	5	0	0.0	5
34	Lakshadweep	5	100.0	0	5	1	4	80.0	5	5	0	0.0	5	5	0	0.0	5
35	Pondicherry	5	100.0	0	5	0	5	100.0	5	1	4	80.0	5	5	0	0.0	5
	Total	735	98.3	13	748	21	727	97.2	748	198	550	73.5	748	382	366	48.9	748

Extent of Achievement of Objectives

Sl.No.	States/UTs	No of Projects	Max. Cov. of Target Pop.	Regn. in Pse and S.N. Services	Low School Dropout	Reducing in Malnutrition	Reducing IMR & MMR	Enhanced Awareness (PRIs about Health, Hygiene & Sanitation)	Change in Attitude of ANM/AWW? Beneficiaries
1	Andhra Pradesh	07	07	04	-	-	-	05	-
2	Arunachal Pradesh	02	01	-	-	-	-	-	-
3	Assam	06	01	03	-	-	-	03	-
4	Bihar	06	01	03	-	-	-	09	04
5	Chhatisgarh	04	-	01	-	-	-	01	-
6	Goa	01	-	01	-	-	-	01	-
7	Gujarat	12	04	06	-	-	-	11	-
8	Haryana	04	01	01	-	02	01	02	02
9	Himachal Pradesh	02	03	01	-	-	-	01	-
10	Jammu & Kashmir	04	03	01	-	-	-	-	-
11	Jharkhand	05	07	06	-	-	03	15	06
12	Karnataka	06	04	02	02	01	-	06	03
13	Kerala	04	03	02	-	-	02	04	01
14	Madhya Pradesh	08	07	04	02	02	01	12	07
15	Maharashtra	08	09	06	02	02	02	12	07
16	Manipur	01	01	-	-	-	-	-	-
17	Meghalaya	01	01	01	-	-	01	03	02
18	Mizoram	01	-	-	-	-	-	-	-
19	Nagaland	02	-	-	-	-	-	-	-
20	Orissa	08	04	07	-	03	-	08	07
21	Punjab	05	04	07	1	01	03	06	03
22	Rajasthan	06	11	-	-	-	04	05	-
23	Sikkim	01	00	-	-	-	-	-	-
24	Tamil Nadu	13	09	04	-	01	01	10	03
25	Tripura	01	01	-	-	-	-	10	-
26	Uttar Pradesh	14	09	06	05	01	03	12	02
27	Uttaranchal	03	03	07	-	-	03	10	02
28	West Bengal	08	08	08	02	02	01	07	04
29	Andaman & Nico. Islands	01	01	02	-	-	-	01	01
30	Chandigarh	01	01	02	-	-	-	01	-
31	Delhi	01	-	-	-	-	-	01	-
32	Dadar & Nagar Haveli	01	01	-	-	-	-	-	-
33	Daman & Diu	01	01	-	-	-	-	-	-
34	Lakshadweep	01	-	-	-	-	-	-	01
35	Pondicherry	01	01	-	-	01	-	03	01

Source: i) Report of Research Team (ii) Filled-in Questionnaires sent by State Governments (iii) Field Survey

Suggestions of AWWs for Better Implementation of Scheme (AWWs Viewpoint)

Sl.No.	States/UTs	No of Project	Improve-ment in SN and GM	PSE, Uniform and Linking up with PSE	Immu., Health Check-up and Joint Visit	Facilities to Adoles. Girls	Mgmt. of Records and Registers	Medicine Kit & Replish-ment	Better Infrastru-cture	Service Related issues/ Suggestions	Min. Involvement in other progs.	Support from Commu-nity	Awareness
1	Andhra Pradesh	07	16	12	03	0	06	0	28	14	0	04	03
2	Arunachal Pradesh	02	02	0	01	0	0	0	01	0	0	03	0
3	Assam	06	213	11	07	0	0	06	21	15	0	01	0
4	Bihar	06	11	07	02	0	0	04	29	05	0	01	0
5	Chhattisgarh	04	04	03	0	0	0	0	10	05	0	0	0
6	Goa	01	0	05	0	0	0	0	04	01	01	0	0
7	Gujarat	12	14	28	10	02	-	02	39	35	0	06	0
8	Haryana	04	08	08	0	0	01	0	198	13	0	0	0
9	Himachal Pradesh	02	0	02	0	0	0	0	10	05	0	0	0
10	Jammu & Kashmir	04	06	12	01	0	0	01	17	16	0	0	0
11	Jharkhand	05	09	14	06	0	02	03	12	22	0	0	0
12	Karnataka	06	05	24	03	0	03	0	18	14	03	01	0
13	Kerala	04	08	08	03	0	0	06	03	6	0	0	0
14	Madhya Pradesh	08	14	04	0	0	01	0	12	16	0	05	0
15	Maharashtra	08	04	08	01	0	0	01	21	20	0	0	0
16	Manipur	01	06	05	0	0	0	04	18	04	0	0	0
17	Meghalaya	01	09	0	01	0	01	01	06	02	0	0	0
18	Mizoram	01	0	04	02	0	0	01	04	04	0	0	0
19	Nagaland	02	09	02	07	0	0	03	04	01	0	0	0
20	Orissa	08	17	24	12	0	01	08	42	37	0	02	0
21	Punjab	05	20	15	07	01	05	05	40	33	0	01	0
22	Rajasthan	06	10	15	09	0	05	0	23	09	0	0	05
23	Sikkim	01	02	03	0	0	0	05	01	01	0	0	0
24	Tamil Nadu	13	12	42	03	0	08	0	80	53	0	03	03
25	Tripura	01	0	01	01	0	0	01	51	03	0	01	0
26	Uttar Pradesh	14	48	14	07	0	07	07	17	31	0	04	0
27	Uttaranchal	03	06	04	03	0	03	01	34	06	0	03	0
28	West Bengal	08	14	15	01	0	03	06	02	18	0	01	0
29	A & N Islands	01	0	0	0	0	01	0	06	05	0	01	0
30	Chandigarh	01	03	03	01	0	0	01	01	03	0	0	0
31	Delhi	01	01	01	0	0	0	0	02	0	0	0	0
32	Dadar & Nagar Haveli	01	0	0	0	0	0	0	0	03	0	0	0
33	Daman & Diu	01	0	0	0	0	0	0	0	10	0	0	0
34	Lakshadweep	01	0	0	0	0	0	0	0	0	0	0	0
35	Pondicherry	01	03	01	02	0	0	0	06	0	0	0	0

State-wise Distribution of Supplementary Nutrition and its Sources of Procurement

Sl.No.	State	Type of SN Supplies					Sources of SN					
		1 RTE	2 Raw/kaccha	3 Both/Mixed	4 Others	5 All	1 CARE	2 WFP	3 State Govt.	4 Community	5 Others	6 All
1	Andhra Pradesh	25	5	0	5	35	2	0	29	0	4	35
2	Arunachal Pradesh	1	5	4	0	10	1	9	0	0	0	10
3	Assam	1	14	9	6	30	0	0	25	0	5	30
4	Bihar	0	20	0	10	30	0	0	10	0	20	30
5	Chhattisgarh	7	8	1	4	20	0	0	20	0	0	20
6	Goa	0	5	0	0	5	0	0	5	0	0	5
7	Gujarat	13	42	4	1	60	2	0	58	0	0	60
8	Haryana	19	0	0	1	20	1	1	18	0	0	20
9	Himachal Pradesh	1	8	0	1	10	0	0	10	0	0	10
10	Jammu & Kashmir	4	16	0	0	20	1	0	19	0	0	20
11	Jharkhand	15	10	0	0	25	0	0	22	0	3	25
12	Karnataka	1	3	26	0	30	0	0	30	0	0	30
13	Kerala	2	10	5	3	20	1	2	6	0	11	20
14	Madhya Pradesh	12	22	3	3	40	2	0	36	1	1	40
15	Maharashtra	14	19	7	0	40	3	0	34	2	1	40
16	Manipur	0	0	0	5	5	1	0	4	0	0	5
17	Meghalaya	0	0	4	1	5	0	0	5	0	0	5
18	Mizoram	0	2	3	0	5	0	0	5	0	0	5
19	Nagaland	10	0	0	0	10	0	10	0	0	0	10
20	Orissa	1	34	0	5	40	5	6	15	0	14	40
21	Punjab	1	2	22	0	25	2	0	23	0	0	25
22	Rajasthan	22	1	5	0	28	5	0	22	0	1	28
23	Sikkim	5	0	0	0	5	0	0	5	0	0	5
24	Tamil Nadu	14	27	24	0	65	2	0	63	0	0	65
25	Tripura	0	0	5	0	5	0	0	5	0	0	5
26	Uttar Pradesh	70	0	0	0	70	0	1	66	0	3	70
27	Uttaranchal	0	11	4	0	15	0	15	0	0	0	15
28	West Bengal	0	38	0	2	40	0	0	35	0	5	40
29	A & N Islands	0	5	0	0	5	0	0	5	0	0	5
30	Chandigarh	5	0	0	0	5	0	0	5	0	0	5
31	Delhi	5	0	0	0	5	1	0	4	0	0	5
32	Dadar & Nagar Haveli	0	5	0	0	5	0	0	4	1	0	5
33	Daman & Diu	1	3	0	1	5	2	0	3	0	0	5
34	Lakshadweep	0	1	4	0	5	0	0	1	0	4	5
35	Pondicherry	0	0	5	0	5	0	0	5	0	0	5
	Total	249	316	135	48	748	31	44	597	4	72	748

State-wise Interruption of Supplementary Nutrition and Reasons Thereof

S.No.	State	Interruption in Distribution of SNP							Anganwadi Workers Schedule																			
		Frequency in last one year							No supply				Delayed supply				Transport. problem				Weather conditions				ICDS staff on leave			
		NR	Never	Once	Twice	Thrice and above	Special cases	All	NR	Yes	NA	All	NR	Yes	NA	All	NR	Yes	NA	All	NR	Yes	NA	All				
1	Andhra Pradesh	0	18	4	4	8	1	35	19	7	9	35	12	14	9	35	23	3	9	35	27	0	8	35				
2	Arunachal Pradesh	0	5	0	1	4	0	10	0	5	5	10	4	1	5	10	5	0	5	10	5	0	5	10				
3	Assam	0	0	1	11	13	5	30	0	30	0	30	26	4	0	30	30	0	0	30	30	0	0	30				
4	Bihar	0	2	0	10	18	0	30	6	22	2	30	28	0	2	30	28	0	2	30	23	5	2	30				
5	Chhattisgarh	0	6	13	1	0	0	20	7	9	4	20	11	5	4	20	11	5	4	20	16	0	4	20				
6	Goa	0	5	0	0	0	0	5	0	0	5	5	0	0	5	5	0	0	5	5	0	0	5	5				
7	Gujarat	0	32	17	5	6	0	60	7	26	27	60	22	11	27	60	33	0	27	60	35	0	25	60				
8	Haryana	1	7	6	6	0	0	20	5	7	8	20	12	0	8	20	12	0	8	20	13	0	7	20				
9	Himachal Pradesh	0	10	0	0	0	0	10	8	0	2	10	8	0	2	10	8	0	2	10	8	0	2	10				
10	Jammu & Kashmir	0	19	0	1	0	0	20	7	0	13	20	7	0	13	20	7	0	13	20	7	0	13	20				
11	Jharkhand	0	6	17	2	0	0	25	0	19	6	25	19	0	6	25	19	0	6	25	19	0	6	25				
12	Karnataka	0	21	6	2	0	1	30	4	8	18	30	4	1	25	30	5	0	25	30	5	0	25	30				
13	Kerala	1	18	0	1	0	0	20	13	1	6	20	14	0	6	20	14	0	6	20	14	0	6	20				
14	Madhya Pradesh	1	11	12	8	6	2	40	18	18	4	40	27	9	4	40	33	3	4	40	34	2	4	40				
15	Maharashtra	0	32	6	2	0	0	40	13	6	21	40	18	1	21	40	18	1	21	40	18	0	22	40				
16	Manipur	0	1	2	1	1	0	5	3	1	1	5	4	0	1	5	4	0	1	5	4	0	1	5				
17	Meghalaya	0	5	0	0	0	0	5	1	0	4	5	1	0	4	5	1	0	4	5	1	0	4	5				
18	Mizoram	0	5	0	0	0	0	5	5	0	0	5	5	0	0	5	5	0	0	5	5	0	0	5				
19	Nagaland	0	0	0	4	6	0	10	3	7	0	10	0	10	0	10	10	0	0	10	9	0	1	10				
20	Orissa	5	1	11	8	13	2	40	2	34	4	40	30	6	4	40	29	7	4	40	34	1	5	40				
21	Punjab	0	5	10	9	1	0	25	0	20	5	25	20	0	5	25	20	0	5	25	20	0	5	25				
22	Rajasthan	0	11	15	1	1	0	28	1	17	10	28	13	5	10	28	17	1	10	28	18	0	10	28				
23	Sikkim	0	0	5	0	0	0	5	0	5	0	5	5	0	0	5	5	0	0	5	5	0	0	5				
24	Tamil Nadu	0	56	0	5	0	4	65	15	1	49	65	15	1	49	65	16	0	49	65	22	0	43	65				
25	Tripura	0	5	0	0	0	0	5	0	0	5	5	0	0	5	5	0	0	5	5	0	0	5	5				
26	Uttar Pradesh	0	10	30	23	7	0	70	4	56	10	70	56	3	11	70	57	2	11	70	60	0	10	70				
27	Uttaranchal	0	0	0	0	15	0	15	0	15	0	15	15	0	0	15	15	0	0	15	15	0	0	15				
28	West Bengal	0	27	12	1	0	0	40	0	13	27	40	13	0	27	40	13	0	27	40	13	0	27	40				
29	A & N Islands	0	5	0	0	0	0	5	4	0	1	5	4	0	1	5	4	0	1	5	4	0	1	5				
30	Chandigarh	0	5	0	0	0	0	5	0	0	5	5	0	0	5	5	0	0	5	5	0	0	5	5				
31	Delhi	0	0	2	1	2	0	5	0	5	0	5	4	1	0	5	5	0	0	5	5	0	0	5				
32	Dadar & Nagar Haveli	0	5	0	0	0	0	5	0	0	5	5	0	0	5	5	0	0	5	5	0	0	5	5				
33	Daman & Diu	0	5	0	0	0	0	5	2	0	3	5	2	0	3	5	2	0	3	5	2	0	3	5				
34	Lakshadweep	0	4	1	0	0	0	5	0	1	4	5	0	1	4	5	1	0	4	5	1	0	4	5				
35	Pondicherry	0	2	2	0	0	1	5	3	0	2	5	3	0	2	5	0	3	2	5	3	0	2	5				
	Total	8	344	172	107	101	16	748	150	333	265	748	402	73	273	748	450	25	273	748	475	8	265	748				

Contd.

S.No.	State	AWW/helper not in Position				Spoiled food items				Other reasons				Average No. of Day of Disruption
		NR	Yes	NA	All	NR	Yes	NA	All	NR	Yes	NA	All	
1	Andhra Pradesh	27	0	8	35	27	0	8	35	26	2	7	35	14.7
2	Arunachal Pradesh	5	0	5	10	4	1	5	10	5	0	5	10	43.5
3	Assam	30	0	0	30	30	0	0	30	26	4	0	30	188.9
4	Bihar	28	0	2	30	27	1	2	30	22	7	1	30	114.4
5	Chhattisgarh	16	0	4	20	14	2	4	20	13	3	4	20	18.0
6	Goa	0	0	5	5	0	0	5	5	0	0	5	5	0.0
7	Gujarat	35	0	25	60	33	2	25	60	31	5	24	60	7.5
8	Haryana	13	0	7	20	8	5	7	20	12	1	7	20	9.8
9	Himachal Pradesh	8	0	2	10	8	0	2	10	8	0	2	10	0.0
10	Jammu & Kashmir	7	0	13	20	7	0	13	20	6	1	13	20	3.0
11	Jharkhand	19	0	6	25	19	0	6	25	18	1	6	25	32.9
12	Karnataka	5	0	25	30	5	0	25	30	5	1	24	30	4.4
13	Kerala	14	0	6	20	14	0	6	20	14	0	6	20	0.7
14	Madhya Pradesh	36	0	4	40	31	5	4	40	31	5	4	40	34.0
15	Maharashtra	18	0	22	40	19	0	21	40	21	1	18	40	4.4
16	Manipur	4	0	1	5	4	0	1	5	2	2	1	5	32.8
17	Meghalaya	1	0	4	5	1	0	4	5	1	0	4	5	0.0
18	Mizoram	5	0	0	5	5	0	0	5	5	0	0	5	0.0
19	Nagaland	9	0	1	10	9	0	1	10	9	0	1	10	75.0
20	Orissa	34	1	5	40	35	0	5	40	32	2	6	40	62.6
21	Punjab	20	0	5	25	18	2	5	25	11	9	5	25	100.8
22	Rajasthan	18	0	10	28	14	4	10	28	16	2	10	28	12.5
23	Sikkim	5	0	0	5	5	0	0	5	5	0	0	5	60.0
24	Tamil Nadu	22	0	43	65	21	1	43	65	18	4	43	65	0.9
25	Tripura	0	0	5	5	0	0	5	5	0	0	5	5	0.0
26	Uttar Pradesh	60	0	10	70	58	2	10	70	62	2	6	70	96.1
27	Uttaranchal	15	0	0	15	15	0	0	15	15	0	0	15	172.5
28	West Bengal	13	0	27	40	13	0	27	40	13	0	27	40	9.5
29	Andaman & N. Islands	4	0	1	5	4	0	1	5	4	0	1	5	0.0
30	Chandigarh	0	0	5	5	0	0	5	5	0	0	5	5	0.0
31	Delhi	5	0	0	5	5	0	0	5	5	0	0	5	178.0
32	Dadar & Nagar Haveli	0	0	5	5	0	0	5	5	1	0	4	5	0.0
33	Daman & Diu	2	0	3	5	2	0	3	5	2	0	3	5	0.0
34	Lakshadweep	1	0	4	5	1	0	4	5	1	0	4	5	3.0
35	Pondicherry	3	0	2	5	3	0	2	5	3	0	2	5	5.6
	Total	482	1	265	748	459	25	264	748	443	52	253	748	41.3

State-wise situation of Average Number of Days with Regard to Interruption of Supply of Supplementary Nutrition

S.No.	State	Interruption in Distribution of SN								Total
		Never	< 30 Days	30-60 Days	60-90 Days	90-120 Days	120-150 Days	150-180 Days	>180 Days	
1	Andhra Pradesh	18	12	1	4	0	0	0	0	35
2	Arunachal Pradesh	5	0	2	2	0	1	0	0	10
3	Assam	0	0	2	3	1	4	2	18	30
4	Bihar	2	0	1	11	3	2	11	0	30
5	Chhattisgarh	6	10	4	0	0	0	0	0	20
6	Goa	5	0	0	0	0	0	0	0	5
7	Gujarat	32	25	3	0	0	0	0	0	60
8	Haryana	8	12	0	0	0	0	0	0	20
9	Himachal Pradesh	10	0	0	0	0	0	0	0	10
10	Jammu & Kashmir	19	0	1	0	0	0	0	0	20
11	Jharkhand	6	13	2	4	0	0	0	0	25
12	Karnataka	21	9	0	0	0	0	0	0	30
13	Kerala	19	1	0	0	0	0	0	0	20
14	Madhya Pradesh	12	13	6	5	2	2	0	0	40
15	Maharashtra	32	6	2	0	0	0	0	0	40
16	Manipur	1	2	1	1	0	0	0	0	5
17	Meghalaya	5	0	0	0	0	0	0	0	5
18	Mizoram	5	0	0	0	0	0	0	0	5
19	Nagaland	0	5	0	1	1	3	0	0	10
20	Orissa	6	7	12	5	4	3	1	2	40
21	Punjab	5	0	1	3	7	2	5	2	25
22	Rajasthan	11	16	1	0	0	0	0	0	28
23	Sikkim	0	0	5	0	0	0	0	0	5
24	Tamil Nadu	56	9	0	0	0	0	0	0	65
25	Tripura	5	0	0	0	0	0	0	0	5
26	Uttar Pradesh	10	15	9	2	3	14	4	13	70
27	Uttaranchal	0	0	0	0	0	1	10	4	15
28	West Bengal	27	9	4	0	0	0	0	0	40
29	Andaman & N. Islands	5	0	0	0	0	0	0	0	5
30	Chandigarh	5	0	0	0	0	0	0	0	5
31	Delhi	0	0	0	0	0	0	4	1	5
32	Dadar & Nagar Haveli	5	0	0	0	0	0	0	0	5
33	Daman & Diu	5	0	0	0	0	0	0	0	5
34	Lakshadweep	4	1	0	0	0	0	0	0	5
35	Pondicherry	2	3	0	0	0	0	0	0	5
	Total	352	168	57	41	21	32	37	40	748

State-wise Position of Number of Pregnant and Lactating (Nursing) Mothers Registered and Availing Supplementary Nutrition

S.No.	State	Pregnant women					Nursing Mother				
		Registered			Availing benefit		Registered			Availing benefit	
		Total	No.	% of total	No.	% of Regist.	Total	No.	% of total	No.	% of Regist.
1	Andhra Pradesh	693	349	50.3	326	93.4	624	327	52.4	309	94.5
2	Arunachal Pradesh	81	54	66.7	54	100.0	64	53	82.4	42	79.2
3	Assam	459	201	43.8	136	67.7	432	190	44.0	137	72.1
4	Bihar	422	174	41.2	147	84.5	362	152	42.0	132	86.8
5	Chhattisgarh	415	189	45.5	163	86.2	344	217	63.1	205	94.5
6	Goa	99	31	31.3	30	96.8	82	36	43.9	35	97.2
7	Gujarat	1058	554	52.3	462	83.4	930	544	58.5	437	80.3
8	Haryana	418	206	49.3	180	87.4	360	226	62.8	204	90.3
9	Himachal Pradesh	114	66	57.9	62	93.9	109	62	56.9	58	93.5
10	Jammu & Kashmir	266	137	51.4	124	90.5	238	125	52.6	118	94.4
11	Jharkhand	483	228	47.2	212	93.0	428	276	64.5	265	96.0
12	Karnataka	575	266	46.3	244	91.7	515	245	47.5	224	91.4
13	Kerala	380	150	39.5	133	88.7	329	166	50.5	158	95.2
14	Madhya Pradesh	785	431	54.9	373	86.5	678	423	62.4	406	96.0
15	Maharashtra	847	399	47.1	369	92.5	737	362	49.1	314	86.7
16	Manipur	51	32	62.7	31	96.9	51	38	73.8	36	94.7
17	Meghalaya	54	49	90.7	46	93.9	48	32	66.7	31	96.9
18	Mizoram	66	54	81.7	51	94.4	56	45	80.3	42	93.3
19	Nagaland	87	57	65.5	57	100.0	72	59	81.8	49	83.1
20	Orissa	677	320	47.3	253	79.1	584	338	57.9	261	77.2
21	Punjab	562	215	38.3	148	68.8	496	193	38.9	127	65.8
22	Rajasthan	475	256	53.9	229	89.5	422	251	59.4	216	86.1
23	Sikkim	71	35	49.3	29	82.9	69	48	69.6	44	91.7
24	Tamil Nadu	1392	616	44.3	546	88.6	1264	633	50.1	573	90.5
25	Tripura	47	24	51.1	24	100.0	48	25	52.1	25	100.0
26	Uttar Pradesh	1415	648	45.8	607	93.7	1266	548	43.3	514	93.8
27	Uttaranchal	295	150	50.8	132	88.0	254	127	50.0	123	96.9
28	West Bengal	799	327	40.9	246	75.2	717	358	49.9	291	81.3
29	Andaman & N. Islands	75	25	33.3	20	80.0	58	30	51.7	30	100.0
30	Chandigarh	104	58	55.8	51	87.9	80	50	62.5	50	100.0
31	Delhi	135	40	29.6	33	82.5	108	58	53.7	54	93.1
32	Dadar & Nagar Haveli	67	55	82.0	51	92.7	55	47	85.5	47	100.0
33	Daman & Diu	141	51	36.2	48	94.1	132	39	29.5	37	94.9
34	Lakshadweep	65	36	55.4	36	100.0	57	50	87.7	48	96.0
35	Pondicherry	77	43	55.8	43	100.0	78	36	46.2	35	97.2
	Total	13750	6526	47.5	5696	87.3	12147	6409	52.8	5677	88.6

State-wise Position in Terms of Supplementary Nutrition (6 months to 3 years)

Sl.No.	Location State	Children 6m - 3 yrs									
		Male					Female				
		Total in the village Number	Registered		Availing benefit		Total in the village Number	Registered		Availing benefit	
	No.	% of Total	Number	% of Registered	Number	No.	% of Total	No.	% of Registered		
1	Andhra Pradesh	1072	633	59.0	472	74.6	1001	582	58.1	477	82.0
2	Arunachal Pradesh	119	102	85.7	99	97.1	125	102	81.6	91	89.2
3	Assam	793	456	57.5	291	63.8	768	502	65.4	299	59.6
4	Bihar	813	468	57.6	278	59.4	759	362	47.7	260	71.8
5	Chhattisgarh	622	347	55.8	228	65.7	579	306	53.1	247	80.7
6	Goa	147	83	56.5	78	94.0	133	73	54.9	69	94.5
7	Gujarat	1814	1038	57.2	885	85.3	1717	889	51.8	796	89.5
8	Haryana	659	332	50.4	276	83.1	633	354	55.9	312	88.1
9	Himachal Pradesh	206	160	77.7	151	94.4	177	136	76.8	123	90.4
10	Jammu & Kashmir	439	284	64.7	237	83.5	423	281	66.4	215	76.5
11	Jharkhand	835	498	59.6	404	81.1	777	390	50.2	329	84.4
12	Karnataka	951	570	59.9	461	80.9	928	465	50.1	385	82.8
13	Kerala	592	372	62.8	289	77.7	562	324	57.7	301	92.9
14	Madhya Pradesh	1290	707	54.8	519	73.4	1213	643	53.0	548	85.2
15	Maharashtra	1441	829	57.5	645	77.8	1369	742	54.2	626	84.4
16	Manipur	96	65	67.7	59	90.8	93	52	55.9	47	90.4
17	Meghalaya	98	82	83.7	68	82.9	96	69	71.9	64	92.8
18	Mizoram	111	80	72.1	57	71.3	92	60	65.2	53	88.3
19	Nagaland	158	126	79.7	117	92.9	145	113	77.9	96	85.0
20	Orissa	1134	691	60.9	466	67.4	1069	631	59.0	450	71.3
21	Punjab	885	448	50.6	254	56.7	855	387	45.3	256	66.1
22	Rajasthan	742	446	60.1	378	84.8	672	422	62.8	375	88.9
23	Sikkim	128	80	62.5	64	80.0	123	83	67.5	70	84.3
24	Tamil Nadu	2326	1331	57.2	958	72.0	2218	1140	51.4	985	86.4
25	Tripura	77	66	85.7	61	92.4	59	48	81.4	46	95.8
26	Uttar Pradesh	2290	1459	63.7	1009	69.2	2164	1285	59.4	1013	78.8
27	Uttaranchal	559	287	51.3	183	63.8	521	211	40.5	160	75.8
28	West Bengal	1299	772	59.4	547	70.9	1212	691	57.0	567	82.1
29	Andaman & N. Islands	121	62	51.2	57	91.9	103	49	47.6	41	83.7
30	Chandigarh	177	88	49.7	85	96.6	165	104	63.0	94	90.4
31	Delhi	186	85	45.7	62	72.9	184	62	33.7	52	83.9
32	Dadar & Nagar Haveli	118	87	73.7	78	89.7	107	64	59.8	56	87.5
33	Daman & Diu	240	168	70.0	95	56.5	236	117	49.6	104	88.9
34	Lakshadweep	134	92	68.7	85	92.4	132	80	60.6	68	85.0
35	Pondicherry	149	102	68.5	73	71.6	138	72	52.2	60	83.3
	Total	22821	13496	59.1	10069	74.6	21545	11891	55.2	9735	81.9

State-wise Position of Acceptability of Food Items Given in Supplementary Nutrition

Sl.No.	State	Acceptability of Food by the Community					
		NR	Yes	No	Only some items	Total	% Yes
1	Andhra Pradesh	0	31	1	3	35	88.6
2	Arunachal Pradesh	1	9	0	0	10	90
3	Assam	5	20	1	4	30	66.7
4	Bihar	0	30	0	0	30	100
5	Chhattisgarh	0	16	4	0	20	80
6	Goa	0	5	0	0	5	100
7	Gujarat	1	52	4	3	60	86.7
8	Haryana	0	11	2	7	20	55
9	Himachal Pradesh	0	10	0	0	10	100
10	Jammu & Kashmir	0	20	0	0	20	100
11	Jharkhand	0	23	1	1	25	92
12	Karnataka	0	26	1	3	30	86.7
13	Kerala	0	17	2	1	20	85
14	Madhya Pradesh	0	35	3	2	40	87.5
15	Maharashtra	0	37	0	2	40	92.5
16	Manipur	0	5	0	0	5	100
17	Meghalaya	0	2	0	3	5	40
18	Mizoram	0	5	0	0	5	100
19	Nagaland	0	8	2	0	10	80
20	Orissa	6	26	7	1	40	65
21	Punjab	0	24	0	1	25	96
22	Rajasthan	0	19	3	6	28	67.9
23	Sikkim	0	5	0	0	5	100
24	Tamil Nadu	0	62	3	0	65	95.4
25	Tripura	0	5	0	0	5	100
26	Uttar Pradesh	1	18	46	5	70	25.7
27	Uttaranchal	0	6	2	7	15	40
28	West Bengal	0	38	2	0	40	95
29	Andaman & N. Islands	0	5	0	0	5	100
30	Chandigarh	0	5	0	0	5	100
31	Delhi	0	4	0	1	5	80
32	Dadar & Nagar Haveli	0	5	0	0	5	100
33	Daman & Diu	2	3	0	0	5	60
34	Lakshadweep	0	5	0	0	5	100
35	Pondicherry	0	5	0	0	5	100
	Total	17	597	84	50	748	79.8

State-wise Coverage of Immunisation with Regard to Pregnant Women

SL.No.	State	Pregnant women received TT vaccine				% Immunised	NR	Number of doses received				NA	All
		NR	Yes	No	Don't Know			All	1 dose	2 doses	Don't know		
1	Andhra Pradesh	0	102	38	0	140	72.9	2	23	77	0	38	140
2	Arunachal Pradesh	0	32	8	0	40	80.0	0	9	23	0	8	40
3	Assam	0	80	39	1	120	66.7	0	31	49	0	40	120
4	Bihar	0	66	52	3	121	54.5	0	21	44	1	55	121
5	Chhattisgarh	8	44	28	0	80	55.0	0	15	29	0	36	80
6	Goa	0	11	7	0	18	61.1	0	4	7	0	7	18
7	Gujarat	0	212	28	0	240	88.3	0	90	122	0	28	240
8	Haryana	0	70	10	0	80	87.5	0	30	40	0	10	80
9	Himachal Pradesh	2	30	8	0	40	75.0	0	5	25	0	10	40
10	Jammu & Kashmir	4	64	6	5	79	81.0	0	21	42	1	15	79
11	Jharkhand	4	61	35	0	100	61.0	0	20	41	0	39	100
12	Karnataka	0	102	18	0	120	85.0	0	42	60	0	18	120
13	Kerala	0	69	11	0	80	86.3	0	31	38	0	11	80
14	Madhya Pradesh	7	109	44	0	160	68.1	0	51	58	0	51	160
15	Maharashtra	1	139	20	0	160	86.9	0	68	71	0	21	160
16	Manipur	0	11	9	0	20	55.0	0	7	4	0	9	20
17	Meghalaya	0	15	5	0	20	75.0	0	7	8	0	5	20
18	Mizoram	0	16	3	1	20	80.0	2	8	6	0	4	20
19	Nagaland	1	33	6	0	40	82.5	0	12	20	1	7	40
20	Orissa	1	98	59	0	158	62.0	1	30	66	1	60	158
21	Punjab	1	91	8	0	100	91.0	0	26	65	0	9	100
22	Rajasthan	5	86	29	0	120	71.7	0	13	72	1	34	120
23	Sikkim	0	17	3	0	20	85.0	0	7	10	0	3	20
24	Tamil Nadu	0	225	28	5	258	87.2	0	71	151	3	33	258
25	Tripura	1	15	4	0	20	75.0	0	1	14	0	5	20
26	Uttar Pradesh	0	195	81	0	276	70.7	1	82	107	5	81	276
27	Uttaranchal	1	45	13	0	59	76.3	0	14	31	0	14	59
28	West Bengal	1	123	31	1	156	78.8	0	37	83	3	33	156
29	Andaman & N. Islands	0	11	7	0	18	61.1	0	4	7	0	7	18
30	Chandigarh	0	19	1	0	20	95.0	0	3	16	0	1	20
31	Delhi	0	18	2	0	20	90.0	0	5	13	0	2	20
32	Dadar & Nagar Haveli	0	14	6	0	20	70.0	0	9	5	0	6	20
33	Daman & Diu	0	15	5	0	20	75.0	1	7	6	1	5	20
34	Lakshadweep	0	15	5	0	20	75.0	0	5	10	0	5	20
35	Pondicherry	0	19	1	0	20	95.0	0	5	14	0	1	20
	Total	37	2272	658	16	2983	76.2	7	814	1434	17	711	2983

State-wise Position of Birth Weight of Children

SL.No.	State	Child weighted at Birth					2000 gm	2000-2500 gm	2500-3000 gm	3000 gm and above	Not Know	NA	All
		NR	Yes	No	Don't Know	All							
1	Andhra Pradesh	0	171	3	1	175	6	37	88	39	1	4	175
2	Arunachal Pradesh	0	25	24	1	50	5	2	7	11	0	25	50
3	Assam	0	93	55	2	150	9	21	40	15	8	57	150
4	Bihar	0	37	112	1	150	1	3	24	7	2	113	150
5	Chhattisgarh	0	68	32	0	100	5	26	25	5	7	32	100
6	Goa	0	21	4	0	25	1	2	6	6	6	4	25
7	Gujarat	0	257	42	1	300	10	59	119	57	12	43	300
8	Haryana	0	93	7	0	100	4	28	36	21	4	7	100
9	Himachal Pradesh	0	50	0	0	50	0	4	40	6	0	0	50
10	Jammu & Kashmir	3	67	29	1	100	3	28	21	9	6	33	100
11	Jharkhand	0	40	85	0	125	1	2	13	19	5	85	125
12	Karnataka	0	119	29	0	148	0	21	51	42	5	29	148
13	Kerala	0	98	2	0	100	6	19	39	34	0	2	100
14	Madhya Pradesh	1	145	52	2	200	12	42	45	26	20	55	200
15	Maharashtra	0	179	20	1	200	19	65	48	36	11	21	200
16	Manipur	0	2	23	0	25	0	0	1	0	1	23	25
17	Meghalaya	0	24	1	0	25	1	9	11	3	0	1	25
18	Mizoram	0	23	0	2	25	0	0	8	15	0	2	25
19	Nagaland	0	17	32	0	49	0	8	2	0	7	32	49
20	Orissa	0	143	56	1	200	9	41	42	38	13	57	200
21	Punjab	1	105	17	2	125	11	10	51	14	19	20	125
22	Rajasthan	0	99	36	0	135	1	4	14	7	73	36	135
23	Sikkim	0	19	6	0	25	0	6	6	7	0	6	25
24	Tamil Nadu	0	303	21	1	325	13	66	121	100	3	22	325
25	Tripura	0	25	0	0	25	0	25	0	0	0	0	25
26	Uttar Pradesh	0	129	221	0	350	10	33	52	18	16	221	350
27	Uttaranchal	0	34	41	0	75	0	14	6	4	10	41	75
28	West Bengal	0	173	26	1	200	7	61	71	31	3	27	200
29	Andaman & N. Islands	0	26	0	0	26	1	6	15	3	1	0	26
30	Chandigarh	0	19	6	0	25	1	7	7	3	1	6	25
31	Delhi	0	20	4	1	25	1	3	12	3	1	5	25
32	Dadar & Nagar Haveli	0	25	0	0	25	1	1	8	14	1	0	25
33	Daman & Diu	0	20	3	2	25	2	2	10	6	0	5	25
34	Lakshadweep	0	24	1	0	25	2	7	6	4	5	1	25
35	Pondicherry	0	25	0	0	25	0	1	16	8	0	0	25
	Total	5	2718	990	20	3733	142	663	1061	611	241	1015	3733

State-wise Status of Immunisation with Regard to Children (6 months to 3 years)

Sl.No.	State	DPT										BCG				
		NR	1 Dose	2 Doses	3 Doses	Booster	Not Given	Don't Know	All	% Given	NR	Yes	No	Don't Know	All	% Given
1	Andhra Pradesh	1	16	11	128	9	10	0	175	93.7	0	162	13	0	175	92.6
2	Arunachal Pradesh	0	16	10	8	5	11	0	50	78.0	0	34	16	0	50	68.0
3	Assam	4	28	5	73	7	33	0	150	75.3	4	113	33	0	150	75.3
4	Bihar	1	17	40	24	1	67	0	150	54.7	1	80	69	0	150	53.3
5	Chhattisgarh	1	24	13	20	17	25	0	100	74.0	0	68	32	0	100	68.0
6	Goa	0	1	1	22	0	1	0	25	96.0	0	24	1	0	25	96.0
7	Gujarat	1	28	17	174	64	16	0	300	94.3	1	279	20	0	300	93.0
8	Haryana	0	16	5	50	25	4	0	100	96.0	0	96	4	0	100	96.0
9	Himachal Pradesh	2	5	0	25	18	0	0	50	96.0	0	48	2	0	50	96.0
10	Jammu & Kashmir	10	26	23	39	1	1	0	100	89.0	9	89	2	0	100	89.0
11	Jharkhand	6	5	12	40	18	44	0	125	60.0	6	75	44	0	125	60.0
12	Karnataka	0	2	3	75	61	7	0	148	95.3	0	141	7	0	148	95.3
13	Kerala	0	22	6	12	59	1	0	100	99.0	0	95	5	0	100	95.0
14	Madhya Pradesh	3	63	27	79	7	21	0	200	88.0	3	166	31	0	200	83.0
15	Maharashtra	1	57	6	77	45	11	3	200	92.5	0	188	12	0	200	94.0
16	Manipur	0	8	3	8	3	3	0	25	88.0	0	20	5	0	25	8.0
17	Meghalaya	0	5	5	3	3	9	0	25	64.0	0	16	9	0	25	64.0
18	Mizoram	1	1	1	5	16	1	0	25	92.0	0	23	2	0	25	92.0
19	Nagaland	5	21	4	5	4	10	0	49	69.4	3	20	26	0	49	40.8
20	Orissa	17	83	24	29	14	18	15	200	75.0	15	152	19	14	200	76.0
21	Punjab	2	37	14	48	20	4	0	125	95.2	0	121	4	0	125	96.8
22	Rajasthan	3	10	8	50	14	24	26	135	60.7	3	81	25	26	135	60.0
23	Sikkim	0	3	12	7	0	3	0	25	88.0	0	19	6	0	25	76.0
24	Tamil Nadu	1	49	23	130	122	0	0	325	99.7	0	325	0	0	325	100.0
25	Tripura	0	10	9	3	0	3	0	25	88.0	1	20	4	0	25	80.0
26	Uttar Pradesh	3	45	67	100	27	108	0	350	68.3	2	234	114	0	350	66.9
27	Uttaranchal	0	0	0	39	22	14	0	75	81.3	0	60	15	0	75	80.0
28	West Bengal	4	15	4	98	45	34	0	200	81.0	1	165	34	0	200	82.5
29	Andaman & N. Islands	1	3	4	7	8	3	0	26	84.6	0	23	3	0	26	88.5
30	Chandigarh	0	3	3	9	10	0	0	25	100.0	0	22	2	1	25	88.0
31	Delhi	0	0	0	24	0	1	0	25	96.0	0	24	1	0	25	96.0
32	Dadar & Nagar Haveli	0	13	5	3	2	2	0	25	92.0	0	23	2	0	25	92.0
33	Daman & Diu	1	6	0	11	6	1	0	25	92.0	1	23	1	0	25	92.0
34	Lakshadweep	2	1	0	12	10	0	0	25	92.0	2	23	0	0	25	92.0
35	Pondicherry	0	0	0	16	0	0	0	25	100.0	0	25	0	0	25	100.0
	Total	70	639	374	1453	663	490	44	3733	83.8	52	3077	563	41	3733	82.4

Contd.

SI.No.	State	Polio					Meales with Vitamin-A						
		NR	1 Dose	2 Doses	3 Doses	All	NR	Yes	No	Don't Know	NA	All	% Given
1	Andhra Pradesh	0	18	12	145	175	2	144	28	0	1	175	82.3
2	Arunachal Pradesh	0	13	17	20	50	0	20	30	0	0	50	40.0
3	Assam	3	41	12	94	150	8	96	45	0	1	150	64.0
4	Bihar	1	10	49	90	150	3	74	72	0	1	150	49.3
5	Chhattisgarh	1	20	24	55	100	3	43	52	0	2	100	43.0
6	Goa	0	1	1	23	25	0	19	5	0	1	25	76.0
7	Gujarat	1	27	15	257	300	3	246	44	0	7	300	82.0
8	Haryana	0	23	6	71	100	4	82	13	0	1	100	82.0
9	Himachal Pradesh	0	7	4	39	50	0	43	7	0	0	50	86.0
10	Jammu & Kashmir	1	24	24	51	100	12	79	9	0	0	100	79.0
11	Jharkhand	1	11	16	97	125	5	58	60	0	2	125	46.4
12	Karnataka	0	2	3	143	148	1	120	27	0	0	148	81.1
13	Kerala	0	16	7	77	100	0	90	10	0	0	100	90.0
14	Madhya Pradesh	1	50	40	109	200	6	148	46	0	0	200	74.0
15	Maharashtra	1	54	3	142	200	2	167	27	3	1	200	83.5
16	Manipur	0	8	3	14	25	1	16	8	0	0	25	64.0
17	Meghalaya	0	4	6	15	25	0	12	13	0	0	25	48.0
18	Mizoram	0	3	0	22	25	0	20	5	0	0	25	80.0
19	Nagaland	0	35	14	0	49	3	18	28	0	0	49	36.7
20	Orissa	13	53	12	122	200	31	105	44	12	8	200	52.5
21	Punjab	0	44	8	73	125	4	107	12	0	2	125	85.6
22	Rajasthan	3	8	5	119	135	2	72	32	25	4	135	53.3
23	Sikkim	0	8	15	2	25	0	15	10	0	0	25	60.0
24	Tamil Nadu	1	61	29	234	325	6	291	26	0	2	325	89.5
25	Tripura	2	6	17	0	25	3	14	8	0	0	25	56.0
26	Uttar Pradesh	4	40	57	249	350	8	184	156	0	2	350	52.6
27	Uttaranchal	0	2	2	71	75	0	54	14	0	7	75	72.0
28	West Bengal	0	20	6	174	200	1	152	44	0	3	200	76.0
29	Andaman & N. Islands	0	5	6	15	26	1	20	5	0	0	26	76.0
30	Chandigarh	1	2	1	21	25	1	20	3	1	0	25	80.0
31	Delhi	0	1	0	24	25	0	20	5	0	0	25	80.0
32	Dadar & Nagar Haveli	0	20	4	1	25	1	19	5	0	0	25	76.0
33	Daman & Diu	1	7	0	17	25	1	20	4	0	0	25	80.0
34	Lakshadweep	0	3	0	22	25	2	17	5	0	1	25	68.0
35	Pondicherry	0	0	3	22	25	0	25	0	0	0	25	100.0
	Total	35	647	421	2630	3733	114	2635	897	41	46	3733	70.6

State-wise Coverage of Immunisation of children (3-6 years)

Sl.No.	State	DT Booster Given					Total	% Given
		NR	Yes	No	Don't Know			
1	Andhra Pradesh	6	87	81	0	174	50.0	
2	Arunachal Pradesh	4	28	19	0	51	54.9	
3	Assam	2	74	72	2	150	49.3	
4	Bihar	0	58	91	1	150	38.7	
5	Chhattisgarh	2	40	58	0	100	40.0	
6	Goa	1	17	7	0	25	68.0	
7	Gujarat	1	194	102	3	300	64.7	
8	Haryana	2	59	39	0	100	59.0	
9	Himachal Pradesh	1	27	22	0	50	54.0	
10	Jammu & Kashmir	1	45	54	0	100	45.0	
11	Jharkhand	0	41	82	2	125	32.8	
12	Karnataka	0	85	62	3	150	56.7	
13	Kerala	1	54	45	0	100	54.0	
14	Madhya Pradesh	6	128	66	0	200	64.0	
15	Maharashtra	2	122	76	1	201	60.7	
16	Manipur	0	19	6	0	25	76.0	
17	Meghalaya	0	14	11	0	25	56.0	
18	Mizoram	0	15	10	0	25	60.0	
19	Nagaland	1	25	24	0	50	50.0	
20	Orissa	1	119	75	3	198	60.1	
21	Punjab	3	85	37	0	125	68.0	
22	Rajasthan	0	87	54	0	141	61.7	
23	Sikkim	2	12	11	0	25	48.0	
24	Tamil Nadu	7	220	96	1	324	67.9	
25	Tripura	1	13	11	0	25	52.0	
26	Uttar Pradesh	3	143	203	1	350	40.9	
27	Uttaranchal	1	39	35	0	75	52.0	
28	West Bengal	2	122	73	1	198	61.6	
29	A & N Islands	1	10	14	0	25	40.0	
30	Chandigarh	0	12	13	0	25	48.0	
31	Delhi	1	15	9	0	25	60.0	
32	Dadar & Nagar Haveli	1	9	15	0	25	36.0	
33	Daman & Diu	0	9	16	0	25	36.0	
34	Lakshadweep	1	13	11	0	25	52.0	
35	Pondicherry	0	12	13	0	25	48.0	
	Total	54	2052	1613	18	3737	54.9	

Indicators Related to Performance of ICDS Scheme-Input Management

		% in position		Trained				Visit to AWW				Coordin- ation	SN Supply		Weighing Scale	PSE Kit		NHED Kit	Medicine kit	Composit Index	Input Rating				
		Z1	Z2	Z3	Z4	Z5	AWW	Z6	CDPO	Z7	Z8		CDPO	Z9		Days	Z10					Available	Z11	Available	Z12
State	Project						Nos.	Nos.			Score		average		Score		Score		Score		Score				
AP	001	-2.2	-0.5	-0.6	-1.6	0.2	5	0.2	25	0.4	0.0	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	0.7	3
AP	002	0.4	-0.2	-0.1	0.6	0.2	5	0.2	23	0.3	-0.4	1	0.6	365	0.7	4	-0.3	1	0.6	1	1.3	5	0.9	4.9	3
AP	003	0.4	0.9	1.6	0.6	0.2	5	0.2	40	1.7	-0.6	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	9.8	4
AP	004	0.4	0.1	1.7	0.6	0.2	5	0.2	37	1.4	-1.1	1	0.6	359	0.6	5	0.6	1	0.6	0	-0.7	5	0.9	6.1	4
AP	005	0.4	1.2	0.8	0.6	0.2	5	0.2	20	0.0	-0.7	1	0.6	291	-0.5	5	0.6	1	0.6	0	-0.7	0	-1.6	1.8	3
AP	006	0.4	0.9	0.7	0.6	0.2	5	0.2	10	-0.8	0.0	1	0.6	352	0.5	4	-0.3	1	0.6	1	1.3	0	-1.6	3.5	4
AP	007	0.4	3.8	2.4	0.6	0.2	5	0.2	25	0.4	-0.6	1	0.6	354	0.5	5	0.6	1	0.6	0	-0.7	3	-0.1	9.0	4
Arunachal P	008	0.4	-0.2	-0.2	0.6	0.2	4	-2.1	10	-0.8	-0.4	1	0.6	278	-0.7	0	-3.7	1	0.6	1	1.3	4	0.4	-3.9	1
Arunachal P	009	0.4	-0.2	-0.6	0.6	0.2	1	-9.1	18	-0.1	-0.2	1	0.6	365	0.7	0	-3.7	1	0.6	0	-0.7	0	-1.6	-13.1	2
Assam	010	0.4	-0.2	-0.5	0.6	0.2	5	0.2	3	-1.4	-0.8	1	0.6	89.8	-3.7	5	0.6	0	-1.6	0	-0.7	0	-1.6	-7.9	2
Assam	011	0.4	-0.2	-0.6	0.6	0.2	5	0.2	10	-0.8	-0.4	1	0.6	201	-2.0	4	-0.3	1	0.6	0	-0.7	3	-0.1	-2.4	1
Assam	012	0.4	-0.2	-0.7	0.6	1.9	5	0.2	8	-1.0	2.4	1	0.6	160	-2.6	5	0.6	1	0.6	0	-0.7	0	-1.6	0.6	1
Assam	013	0.4	2.4	1.5	0.6	0.2	5	0.2	20	0.0	0.1	1	0.6	105	-3.5	4	-0.3	1	0.6	0	-0.7	3	-0.1	2.1	2
Assam	014	0.4	1.5	1.8	-1.6	0.2	5	0.2	30	0.8	-0.3	0	-1.6	229	-1.5	1	-2.8	0	-1.6	0	-0.7	2	-0.6	-5.7	2
Assam	015	0.4	-0.5	-0.6	0.6	3.6	5	0.2	25	0.4	1.6	1	0.6	272	-0.8	5	0.6	1	0.6	0	-0.7	0	-1.6	4.4	1
Bihar	016	-2.2	-1.4	-0.6	-1.6	-1.4	5	0.2	33	1.1	-1.6	1	0.6	199	-2.0	5	0.6	0	-1.6	0	-0.7	5	0.9	-9.8	1
Bihar	017	0.4	-1.4	0.8	0.6	-1.4	5	0.2	17	-0.2	-1.2	1	0.6	281	-0.7	5	0.6	0	-1.6	0	-0.7	0	-1.6	-5.6	1
Bihar	018	0.4	-1.4	0.3	0.6	-1.4	5	0.2	15	-0.4	0.0	1	0.6	299	-0.4	5	0.6	0	-1.6	0	-0.7	0	-1.6	-4.8	1
Bihar	019	-2.2	-1.4	0.8	-1.6	-1.4	5	0.2	11	-0.7	-0.3	0	-1.6	249	-1.2	5	0.6	0	-1.6	0	-0.7	0	-1.6	-12.9	1
Bihar	020	0.4	-1.4	0.0	0.6	-1.4	5	0.2	40	1.7	0.3	0	-1.6	288	-0.9	5	0.6	1	0.6	0	-0.7	0	-1.6	-3.2	2
Bihar	021	-2.2	-1.6	0.5	-1.6	-3.1	5	0.2	3	-1.4	-2.2	1	0.6	208	-1.9	3	-1.1	0	-1.6	0	-0.7	5	0.9	-15.3	1
Chhatisgarh	022	0.4	1.5	1.3	0.6	0.2	5	0.2	38	1.5	-0.1	1	0.6	335	0.2	5	0.6	0	-1.6	0	-0.7	1	-1.1	3.6	2
Chhatisgarh	023	-2.2	-0.5	-0.6	-1.6	0.2	5	0.2	8	-1.0	0.0	0	-1.6	358	0.6	5	0.6	1	0.6	0	-0.7	0	-1.6	-7.7	2
Chhatisgarh	024	-2.2	-0.5	-0.5	-1.6	0.2	5	0.2	10	-0.8	-1.3	1	0.6	359	0.6	4	-0.3	1	0.6	1	1.3	5	0.9	-2.7	1
Chhatisgarh	025	0.4	-1.1	-1.2	0.6	0.2	5	0.2	2	-1.5	-1.2	1	0.6	336	0.2	4	-0.3	1	0.6	0	-0.7	5	0.9	-2.1	1
Goa	026	0.4	0.1	-0.1	0.6	0.2	5	0.2	25	0.4	-1.2	0	-1.6	365	0.7	5	0.6	1	0.6	1	1.3	0	-1.6	0.6	3
Gujarat	027	0.4	-0.8	0.2	0.6	0.2	5	0.2	11	-0.7	3.6	1	0.6	365	0.7	4	-0.3	0	-1.6	0	-0.7	4	0.4	2.8	2

Contd.

State	Project	% in position		Trained				Visit to AWW				Coordination	SN Supply		Weighting Scale	PSE Kit		NHED Kit		Medicine kit		Composit	Input Rating		
		Z1	Z2	Z3	Z4	Z5	AWW	Z6	CDPO	Z7	Z8		CDPO	Z9		Days	Z10	Available	Z11	Available	Z12			Available	Z13
						Nos.		Nos.			Score		average		Score		Score		Score		Score		Sigma-Z		
Gujarat	028	0.4	0.4	0.3	-1.6	0.2	5	0.2	16	-0.3	0.8	1	0.6	364	0.6	5	0.6	1	0.6	1	1.3	5	0.9	5.1	3
Gujarat	029	0.4	-0.8	-1.4	-1.6	0.2	5	0.2	19	-0.1	0.1	0	-1.6	353	0.5	5	0.6	1	0.6	1	1.3	5	0.9	-0.6	3
Gujarat	030	0.4	0.9	0.8	0.6	0.2	5	0.2	3	-1.4	-0.5	1	0.6	360	0.6	4	-0.3	0	-1.6	0	-0.7	5	0.9	0.8	3
Gujarat	031	0.4	-0.2	-0.8	-1.6	0.2	5	0.2	20	0.0	0.3	1	0.6	363	0.6	5	0.6	1	0.6	1	1.3	5	0.9	3.3	3
Gujarat	032	0.4	1.8	1.7	0.6	0.2	5	0.2	16	-0.3	0.2	1	0.6	351	0.4	5	0.6	1	0.6	0	-0.7	5	0.9	7.2	3
Gujarat	033	0.4	1.5	0.3	0.6	0.2	5	0.2	15	-0.4	-0.4	0	-1.6	360	0.6	5	0.6	0	-1.6	0	-0.7	5	0.9	0.7	2
Gujarat	034	0.4	-0.8	-0.2	0.6	0.2	4	-2.1	7	-1.1	0.8	1	0.6	348	0.4	4	-0.3	1	0.6	0	-0.7	5	0.9	-0.6	3
Gujarat	035	0.4	1.2	0.6	0.6	0.2	5	0.2	28	0.7	0.0	1	0.6	362	0.6	5	0.6	1	0.6	1	1.3	4	0.4	8.2	4
Gujarat	036	-2.2	-1.1	0.1	-1.6	-1.4	5	0.2	25	0.4	-0.9	0	-1.6	357	0.5	4	-0.3	1	0.6	0	-0.7	2	-0.6	-8.6	3
Gujarat	037	0.4	0.9	1.4	0.6	1.9	5	0.2	19	-0.1	0.1	1	0.6	346	0.3	5	0.6	1	0.6	1	1.3	5	0.9	9.9	3
Gujarat	038	0.4	-0.8	-0.3	0.6	0.2	4	-2.1	15	-0.4	0.8	0	-1.6	361	0.6	3	-1.1	1	0.6	0	-0.7	4	0.4	-3.3	3
Haryana	039	0.4	0.9	0.6	0.6	0.2	5	0.2	40	1.7	0.6	1	0.6	361	0.6	5	0.6	1	0.6	0	-0.7	5	0.9	7.9	3
Haryana	040	0.4	0.4	0.0	0.6	0.2	5	0.2	21	0.1	0.6	1	0.6	365	0.7	3	-1.1	1	0.6	0	-0.7	5	0.9	3.6	3
Haryana	041	0.4	-0.8	-1.3	0.6	0.2	5	0.2	27	0.6	0.6	0	-1.6	347	0.4	5	0.6	1	0.6	1	1.3	5	0.9	2.9	3
Haryana	042	0.4	0.7	0.3	0.6	0.2	5	0.2	40	1.7	0.5	1	0.6	347	0.4	5	0.6	1	0.6	1	1.3	4	0.4	8.5	3
HP	043	0.4	-0.2	-0.9	0.6	0.2	5	0.2	12	-0.6	-0.9	1	0.6	365	0.7	4	-0.3	1	0.6	0	-0.7	5	0.9	0.6	3
HP	044	0.4	0.4	-0.3	0.6	-3.1	5	0.2	20	0.0	0.0	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	2.9	4
JK	045	0.4	0.4	-0.2	0.6	0.2	5	0.2	20	0.0	-1.2	1	0.6	365	0.7	4	-0.3	1	0.6	0	-0.7	0	-1.6	-0.3	2
JK	046	0.4	0.4	-0.2	0.6	0.2	5	0.2	4	-1.3	0.0	1	0.6	365	0.7	5	0.6	0	-1.6	0	-0.7	0	-1.6	-1.7	3
JK	047	0.4	0.4	-0.5	-1.6	0.2	5	0.2	40	1.7	3.2	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	0	-1.6	6.3	3
JK	048	0.4	-1.1	-1.0	-1.6	-1.4	4	-2.1	26	0.5	0.7	0	-1.6	353	0.5	0	-3.7	0	-1.6	0	-0.7	0	-1.6	-14.3	2
Jharkhand	049	0.4	-0.5	-0.7	0.6	-1.4	5	0.2	34	1.2	0.5	1	0.6	287	-0.6	4	-0.3	0	-1.6	1	1.3	0	-1.6	-1.7	2
Jharkhand	050	0.4	-1.4	-1.0	0.6	-1.4	5	0.2	20	0.0	-0.6	0	-1.6	343	0.3	5	0.6	0	-1.6	0	-0.7	0	-1.6	-7.8	1
Jharkhand	051	0.4	-1.1	0.1	0.6	-1.4	5	0.2	10	-0.8	-0.9	1	0.6	335	0.2	4	-0.3	1	0.6	0	-0.7	0	-1.6	-4.0	2
Jharkhand	052	0.4	-0.2	1.0	0.6	0.2	5	0.2	32	1.0	2.9	0	-1.6	336	0.2	5	0.6	0	-1.6	0	-0.7	0	-1.6	1.3	2
Jharkhand	053	0.4	-1.1	-1.1	0.6	0.2	5	0.2	0	-1.6	-1.1	1	0.6	359	0.6	2	-2.0	1	0.6	0	-0.7	0	-1.6	-5.8	2
Karnataka	054	0.4	-0.5	-0.6	0.6	1.9	5	0.2	28	0.7	-0.4	1	0.6	352	0.5	5	0.6	1	0.6	0	-0.7	5	0.9	4.8	4
Karnataka	055	0.4	0.7	1.1	0.6	1.9	5	0.2	24	0.3	1.1	0	-1.6	354	0.5	5	0.6	1	0.6	0	-0.7	5	0.9	6.6	3
Karnataka	056	-2.2	-0.2	-0.8	-1.6	0.2	5	0.2	22	0.2	-0.5	1	0.6	365	0.7	5	0.6	1	0.6	0	-0.7	5	0.9	-2.1	3
Karnataka	057	0.4	2.1	2.4	-1.6	1.9	5	0.2	27	0.6	0.8	1	0.6	365	0.7	5	0.6	1	0.6	0	-0.7	5	0.9	9.4	3
Karnataka	058	0.4	1.2	0.8	0.6	0.2	5	0.2	37	1.4	-0.2	1	0.6	364	0.6	5	0.6	0	-1.6	0	-0.7	5	0.9	5.1	2
Karnataka	059	0.4	2.4	2.3	0.6	0.2	5	0.2	40	1.7	0.8	1	0.6	363	0.6	5	0.6	1	0.6	0	-0.7	4	0.4	10.7	3
Kerala	060	0.4	0.4	0.1	0.6	0.2	5	0.2	40	1.7	0.3	1	0.6	365	0.7	5	0.6	1	0.6	0	-0.7	1	-1.1	4.6	4
Kerala	061	0.4	0.1	-0.3	0.6	0.2	5	0.2	30	0.8	0.3	1	0.6	365	0.7	4	-0.3	1	0.6	1	1.3	4	0.4	5.7	3
Kerala	062	0.4	-0.5	-0.7	0.6	0.2	4	-2.1	35	1.3	0.7	1	0.6	362	0.6	5	0.6	1	0.6	0	-0.7	2	-0.6	1.0	3
Kerala	063	0.4	-0.5	-0.4	-1.6	-1.4	5	0.2	8	-1.0	0.2	1	0.6	365	0.7	4	-0.3	0	-1.6	0	-0.7	2	-0.6	-6.0	2
MP	064	0.4	-0.2	-0.6	0.6	0.2	5	0.2	40	1.7	2.2	1	0.6	357	0.5	5	0.6	1	0.6	1	1.3	5	0.9	9.1	3

Contd.

State	Project	% in position		Trained				Visit to AWW				Coordination	SN Supply		Weighing Scale	PSE Kit		NHED Kit		Medicine kit		Compost Index	Input Rating		
		Z1	Z2	Z3	Z4	Z5	AWW Nos.	Z6	CDPO Nos.	Z7	Z8		CDPO Score	Z9		Days average	Z10	Available Score	Z11	Available Score	Z12			Available Score	Z13
MP	065	0.4	0.1	-0.6	0.6	0.2	5	0.2	10	-0.8	-0.2	1	0.6	353	0.5	5	0.6	1	0.6	1	1.3	5	0.9	4.5	2
MP	066	-2.2	1.2	2.1	-1.6	0.2	5	0.2	18	-0.1	-0.5	1	0.6	331	0.1	4	-0.3	1	0.6	1	1.3	5	0.9	2.6	1
MP	067	0.4	-0.2	0.9	0.6	0.2	5	0.2	25	0.4	0.3	1	0.6	343	0.3	5	0.6	1	0.6	1	1.3	5	0.9	7.3	3
MP	068	-2.2	-0.2	1.0	-1.6	0.2	5	0.2	12	-0.6	0.1	1	0.6	265	-0.9	5	0.6	1	0.6	0	-0.7	4	0.4	-2.6	3
MP	069	0.4	0.1	0.0	0.6	0.2	5	0.2	14	-0.5	-0.2	1	0.6	352	0.5	5	0.6	1	0.6	0	-0.7	5	0.9	3.3	1
MP	070	0.4	0.1	-0.2	0.6	0.2	5	0.2	10	-0.8	-0.8	1	0.6	289	-0.6	5	0.6	1	0.6	0	-0.7	5	0.9	1.1	2
MP	071	0.4	-0.8	-0.6	0.6	0.2	5	0.2	40	1.7	-0.7	1	0.6	357	0.5	2	-2.0	1	0.6	1	1.3	5	0.9	3.1	2
Maharashtra	072	0.4	-0.8	0.3	0.6	0.2	4	-2.1	10	-0.8	1.2	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	3.8	4
Maharashtra	073	0.4	1.5	1.8	-1.6	0.2	5	0.2	0	-1.6	0.3	1	0.6	362	0.6	5	0.6	1	0.6	1	1.3	5	0.9	5.9	3
Maharashtra	074	0.4	0.7	0.2	0.6	0.2	5	0.2	40	1.7	0.0	1	0.6	365	0.7	5	0.6	1	0.6	0	-0.7	5	0.9	6.7	3
Maharashtra	075	0.4	0.1	0.0	-1.6	0.2	5	0.2	30	0.8	0.0	1	0.6	339	0.2	5	0.6	1	0.6	1	1.3	5	0.9	4.4	3
Maharashtra	076	0.4	1.5	1.6	0.6	0.2	5	0.2	40	1.7	0.5	1	0.6	365	0.7	4	-0.3	0	-1.6	0	-0.7	5	0.9	6.3	3
Maharashtra	077	0.4	3.0	3.2	0.6	0.2	5	0.2	30	0.8	0.8	0	-1.6	359	0.6	5	0.6	1	0.6	1	1.3	4	0.4	11.3	3
Maharashtra	078	0.4	2.4	1.2	0.6	0.2	5	0.2	40	1.7	0.0	0	-1.6	365	0.7	4	-0.3	1	0.6	1	1.3	5	0.9	8.4	4
Maharashtra	079	0.4	2.1	3.1	0.6	0.2	5	0.2	15	-0.4	0.6	1	0.6	365	0.7	4	-0.3	1	0.6	1	1.3	5	0.9	10.8	4
Manipur	080	0.4	0.4	-0.2	0.6	0.2	5	0.2	23	0.3	-1.2	0	-1.6	332	0.1	0	-3.7	0	-1.6	0	-0.7	0	-1.6	-8.3	1
Meghalaya	081	0.4	0.7	-0.2	0.6	3.6	5	0.2	13	-0.6	1.6	1	0.6	365	0.7	5	0.6	1	0.6	0	-0.7	5	0.9	9.0	3
Mizoram	082	0.4	-0.5	-1.4	0.6	0.2	5	0.2	5	-1.2	-0.9	1	0.6	365	0.7	3	-1.1	0	-1.6	0	-0.7	4	0.4	-4.2	2
Nagaland	083	-2.2	-1.6	-2.3	-1.6	-1.4	5	0.2	0	-1.6	-1.1	0	-1.6	233	-1.5	0	-3.7	0	-1.6	0	-0.7	1	-1.1	-21.9	2
Nagaland	084	-2.2	-1.6	-2.3	-1.6	-1.4	5	0.2	0	-1.6	-1.4	0	-1.6	347	0.4	0	-3.7	0	-1.6	0	-0.7	5	0.9	-18.4	2
Orissa	085	0.4	-1.1	-0.3	0.6	-1.4	5	0.2	30	0.8	-0.8	0	-1.6	294	-0.5	4	-0.3	1	0.6	0	-0.7	5	0.9	-3.1	1
Orissa	086	-2.2	-0.8	-0.7	-1.6	-3.1	5	0.2	15	-0.4	-2.2	0	-1.6	334	0.2	4	-0.3	0	-1.6	0	-0.7	5	0.9	-14.0	2
Orissa	087	0.4	-1.1	-0.1	0.6	0.2	5	0.2	8	-1.0	-0.4	1	0.6	195	-2.1	5	0.6	0	-1.6	0	-0.7	5	0.9	-3.4	1
Orissa	088	0.4	-1.1	-0.3	0.6	0.2	4	-2.1	25	0.4	-0.2	1	0.6	292	-0.5	4	-0.3	0	-1.6	0	-0.7	5	0.9	-3.6	2
Orissa	089	0.4	-1.1	-1.5	0.6	0.2	5	0.2	21	0.1	0.7	0	-1.6	365	0.7	5	0.6	1	0.6	0	-0.7	1	-1.1	-1.9	1
Orissa	090	0.4	0.4	0.4	0.6	0.2	5	0.2	13	-0.6	-1.1	0	-1.6	308	-0.3	5	0.6	0	-1.6	0	-0.7	0	-1.6	-4.6	1
Orissa	091	-2.2	-0.8	-0.7	-1.6	-1.4	5	0.2	33	1.1	-1.2	1	0.6	292	-0.5	5	0.6	0	-1.6	0	-0.7	2	-0.6	-9.0	1
Orissa	092	0.4	0.1	-0.4	0.6	0.2	5	0.2	16	-0.3	-0.4	1	0.6	340	0.3	5	0.6	1	0.6	1	1.3	3	-0.1	3.9	1
Punjab	093	0.4	0.1	-0.4	0.6	0.2	5	0.2	15	-0.4	-0.5	0	-1.6	222	-1.6	5	0.6	1	0.6	0	-0.7	4	0.4	-2.1	4
Punjab	094	0.4	0.7	0.5	0.6	0.2	5	0.2	24	0.3	0.3	1	0.6	262	-1.0	3	-1.1	1	0.6	0	-0.7	0	-1.6	0.1	1
Punjab	095	0.4	-0.5	-0.6	0.6	0.2	5	0.2	31	0.9	0.4	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	6.4	4
Punjab	096	-2.2	-0.2	-0.7	-1.6	0.2	5	0.2	0	-1.6	0.3	1	0.6	259	-1.0	5	0.6	1	0.6	1	1.3	0	-1.6	-5.1	3
Punjab	097	-2.2	-0.5	-0.8	-1.6	0.2	5	0.2	2	-1.5	-0.3	1	0.6	213	-1.8	4	-0.3	1	0.6	0	-0.7	0	-1.6	-9.6	2
Rajasthan	098	0.4	-0.2	-0.5	-1.6	0.2	3	-4.4	23	0.3	-0.3	1	0.6	365	0.7	3	-1.1	1	0.6	1	1.3	1	-1.1	-5.1	1
Rajasthan	099	0.4	0.1	0.7	0.6	0.2	4	-2.1	35	1.3	0.4	0	-1.6	351	0.4	4	-0.3	1	0.6	0	-0.7	5	0.9	0.9	2
Rajasthan	100	0.4	1.2	1.1	0.6	0.2	5	0.2	16	-0.3	0.0	0	-1.6	329	0.1	5	0.6	1	0.6	0	-0.7	5	0.9	3.3	3
Rajasthan	101	-2.2	0.1	-0.1	-1.6	0.2	5	0.2	0	-1.6	-0.2	0	-1.6	359	0.6	5	0.6	0	-1.6	0	-0.7	1	-1.1	-9.2	2

Contd.

State	Project	% in position		Trained				Visit to AWW				Coordination	SN Supply		Weighing Scale Available	PSE Kit		NHED Kit Available	Medicine kit Available	Composit Index	Input Rating				
		Z1	Z2	Z3	Z4	Z5	AWW Nos.	Z6	CDPO Nos.	Z7	Z8		CDPO Score	Z9		Days average	Z10					Z11	Z12	Z13	Z14
Rajasthan	102	0.4	-0.5	-0.8	-1.6	0.2	5	0.2	20	0.0	0.4	1	0.6	365	0.7	4	-0.3	0	-1.6	0	-0.7	2	-0.6	-3.6	3
Rajasthan	103	0.4	1.5	0.9	0.6	0.2	5	0.2	7	-1.1	-0.2	1	0.6	351	0.4	5	0.6	0	-1.6	0	-0.7	1	-1.1	0.9	2
Sikkim	104	0.4	0.4	0.0	0.6	0.2	5	0.2	5	-1.2	-1.0	1	0.6	305	-0.3	5	0.6	1	0.6	1	1.3	3	-0.1	2.4	3
TN	105	0.4	0.7	-0.7	0.6	0.2	5	0.2	40	1.7	1.2	1	0.6	359	0.6	5	0.6	0	-1.6	1	1.3	0	-1.6	4.2	3
TN	106	0.4	-0.2	0.3	0.6	0.2	5	0.2	29	0.8	0.6	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	7.6	4
TN	107	0.4	-0.2	-0.2	0.6	0.2	5	0.2	37	1.4	0.2	1	0.6	365	0.7	4	-0.3	1	0.6	1	1.3	4	0.4	6.0	4
TN	108	0.4	0.1	0.7	0.6	1.9	4	-2.1	16	-0.3	2.4	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	0	-1.6	5.9	4
TN	109	0.4	-0.5	-0.8	0.6	1.9	5	0.2	30	0.8	3.1	1	0.6	365	0.7	5	0.6	1	0.6	0	-0.7	2	-0.6	6.9	4
TN	110	0.4	-0.5	-0.7	0.6	0.2	5	0.2	5	-1.2	1.0	1	0.6	361	0.6	4	-0.3	1	0.6	1	1.3	0	-1.6	1.4	3
TN	111	0.4	-0.2	-0.4	0.6	0.2	5	0.2	22	0.2	0.8	0	-1.6	365	0.7	5	0.6	1	0.6	1	1.3	3	-0.1	3.3	3
TN	112	0.4	-1.1	-0.7	0.6	0.2	5	0.2	28	0.7	-0.3	0	-1.6	365	0.7	5	0.6	1	0.6	0	-0.7	5	0.9	0.5	3
TN	113	0.4	-0.8	-0.7	0.6	0.2	5	0.2	26	0.5	1.3	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	3	-0.1	5.5	3
TN	114	0.4	-1.1	-0.4	0.6	0.2	5	0.2	30	0.8	0.8	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	3	-0.1	5.4	3
TN	115	-2.2	-1.1	-1.7	-1.6	-1.4	5	0.2	40	1.7	1.1	0	-1.6	364	0.6	5	0.6	1	0.6	1	1.3	3	-0.1	-3.7	4
TN	116	0.4	-0.8	-0.3	0.6	0.2	5	0.2	30	0.8	-0.1	0	-1.6	365	0.7	5	0.6	1	0.6	1	1.3	4	0.4	3.1	2
TN	117	0.4	-1.4	-1.6	0.6	-1.4	5	0.2	27	0.6	-1.6	1	0.6	365	0.7	4	-0.3	1	0.6	0	-0.7	2	-0.6	-3.8	2
Tripura	118	0.4	0.1	-0.1	0.6	0.2	5	0.2	12	-0.6	0.4	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	5.9	2
UP	119	0.4	-0.5	-0.8	0.6	0.2	5	0.2	6	-1.1	-1.3	1	0.6	320	-0.1	4	-0.3	1	0.6	0	-0.7	5	0.9	-1.1	2
UP	120	-2.2	-0.8	-0.7	-1.6	0.2	5	0.2	17	-0.2	-0.4	0	-1.6	334	0.2	1	-2.8	0	-1.6	0	-0.7	5	0.9	-11.3	1
UP	121	-2.2	-0.2	-0.2	-1.6	0.2	5	0.2	12	-0.6	-1.1	1	0.6	217	-1.7	5	0.6	1	0.6	1	1.3	5	0.9	-3.2	1
UP	122	0.4	-0.2	0.6	0.6	0.2	5	0.2	5	-1.2	-0.6	0	-1.6	155	-2.7	4	-0.3	1	0.6	0	-0.7	4	0.4	-4.2	2
UP	123	0.4	0.9	1.2	0.6	0.2	5	0.2	12	-0.6	0.0	1	0.6	355	0.5	5	0.6	0	-1.6	0	-0.7	4	0.4	2.6	1
UP	124	0.4	0.4	0.2	0.6	0.2	5	0.2	12	-0.6	0.4	1	0.6	317	-0.1	5	0.6	1	0.6	1	1.3	5	0.9	5.8	1
UP	125	0.4	0.4	0.8	0.6	0.2	5	0.2	11	-0.7	-0.2	0	-1.6	251	-1.2	4	-0.3	1	0.6	0	-0.7	5	0.9	-0.6	3
UP	126	-2.2	0.4	0.6	-1.6	0.2	5	0.2	9	-0.9	0.6	0	-1.6	172	-2.4	5	0.6	0	-1.6	0	-0.7	0	-1.6	-10.2	1
UP	127	-2.2	-0.5	-0.3	-1.6	0.2	5	0.2	0	-1.6	0.3	0	-1.6	169	-2.5	3	-1.1	0	-1.6	0	-0.7	5	0.9	-12.2	2
UP	128	0.4	-0.5	-0.4	0.6	0.2	5	0.2	17	-0.2	0.0	1	0.6	225	-1.6	5	0.6	1	0.6	0	-0.7	2	-0.6	-0.7	1
UP	129	0.4	-0.2	-0.4	0.6	0.2	5	0.2	30	0.8	-0.6	1	0.6	365	0.7	4	-0.3	1	0.6	1	1.3	3	-0.1	4.0	2
UP	130	-2.2	-1.4	-0.4	-1.6	-1.4	5	0.2	16	-0.3	-1.2	1	0.6	347	0.4	4	-0.3	1	0.6	0	-0.7	2	-0.6	-8.4	2
UP	131	0.4	0.9	1.1	0.6	0.2	5	0.2	0	-1.6	-0.6	0	-1.6	221	-1.6	5	0.6	0	-1.6	0	-0.7	5	0.9	-2.8	2
UP	132	0.4	-0.2	-0.5	0.6	0.2	5	0.2	12	-0.6	0.0	1	0.6	317	-0.1	5	0.6	1	0.6	1	1.3	5	0.9	4.1	2
Uttaranchal	133	0.4	-0.5	-0.8	0.6	0.2	5	0.2	5	-1.2	-1.0	1	0.6	188	-2.2	4	-0.3	1	0.6	0	-0.7	5	0.9	-3.0	3
Uttaranchal	134	0.4	-0.8	-1.2	0.6	0.2	5	0.2	8	-1.0	-1.6	0	-1.6	207	-1.9	5	0.6	1	0.6	0	-0.7	3	-0.1	-6.2	2
Uttaranchal	135	0.4	0.1	0.0	0.6	0.2	5	0.2	8	-1.0	-1.2	1	0.6	182	-2.3	4	-0.3	1	0.6	0	-0.7	5	0.9	-1.8	2
WB	136	0.4	-0.2	-0.4	0.6	0.2	5	0.2	20	0.0	0.8	0	-1.6	365	0.7	4	-0.3	0	-1.6	0	-0.7	5	0.9	-1.0	4
WB	137	0.4	1.5	0.8	0.6	0.2	5	0.2	20	0.0	0.3	1	0.6	365	0.7	5	0.6	1	0.6	0	-0.7	4	0.4	6.3	3
WB	138	-2.2	-1.6	-2.3	-1.6	-3.1	5	0.2	0	-1.6	-2.2	0	-1.6	335	0.2	5	0.6	0	-1.6	0	-0.7	2	-0.6	-18.3	3

Contd.

		% in position			Trained			Visit to AWW			Coordin- ation	SN Supply		Weighing Scale	PSE Kit		NHED Kit	Medicine kit		Compost Index	Input Rating				
		Z1	Z2	Z3	Z4	Z5	AWW	Z6	CDPO	Z7		Z8	CDPO		Z9	Days		Z10	Available			Z11	Available	Z12	Available
State	Project						Nos.		Nos.		Score		average		Score		Score		Score		Score		Sigma-Z		
WB	139	0.4	-0.8	-1.3	0.6	0.2	5	0.2	12	-0.6	0.0	1	0.6	350	0.4	5	0.6	0	-1.6	0	-0.7	4	0.4	-1.6	3
WB	140	0.4	1.5	1.4	0.6	0.2	5	0.2	25	0.4	0.7	1	0.6	360	0.6	4	-0.3	1	0.6	1	1.3	3	-0.1	8.4	4
WB	141	0.4	1.5	1.1	0.6	0.2	5	0.2	14	-0.5	-0.2	1	0.6	351	0.4	3	-1.1	1	0.6	0	-0.7	4	0.4	3.6	3
WB	142	-2.2	0.4	0.0	-1.6	0.2	5	0.2	5	-1.2	0.1	0	-1.6	353	0.5	5	0.6	1	0.6	0	-0.7	5	0.9	-3.9	3
WB	143	0.4	1.2	0.9	0.6	0.2	5	0.2	37	1.4	0.8	1	0.6	365	0.7	5	0.6	0	-1.6	0	-0.7	5	0.9	6.3	3
Andaman	144	0.4	-0.2	1.4	-1.6	-1.4	5	0.2	34	1.2	-0.4	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	4.2	3
Chandigarh	145	0.4	-0.5	-0.8	0.6	0.2	5	0.2	40	1.7	0.8	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	4	0.4	7.0	3
Delhi	146	0.4	-0.2	-0.3	0.6	0.2	5	0.2	33	1.1	0.9	1	0.6	187	-2.2	5	0.6	0	-1.6	0	-0.7	1	-1.1	-1.5	3
Dadar & Nagar	147	0.4	-0.2	-0.2	-1.6	-3.1	5	0.2	40	1.7	0.0	1	0.6	365	0.7	5	0.6	1	0.6	1	1.3	0	-1.6	-0.6	3
Daman Diu	148	0.4	-1.4	-1.8	-1.6	-1.4	5	0.2	33	1.1	-0.9	0	-1.6	365	0.7	5	0.6	1	0.6	1	1.3	5	0.9	-2.9	4
Lakshadweep	149	0.4	-0.5	-1.2	0.6	-1.4	5	0.2	7	-1.1	-1.6	1	0.6	362	0.6	3	-1.1	1	0.6	0	-0.7	3	-0.1	-4.6	2
Pondicheri	150	0.4	-0.2	-0.1	-1.6	0.2	5	0.2	4	-1.3	1.2	1	0.6	359	0.6	4	-0.3	1	0.6	0	-0.7	5	0.9	0.5	3
SUM							735.0		2967.0			108.0		48571.6		649.0		108.0		54.0		485.0		0.000	
MEAN							4.9		19.8			0.7		323.8		4.3		0.7		0.4		3.2		0.000	
STDEV							0.4		12.1			0.5		62.4		1.2		0.5		0.5		2.0		6.522	
																					Lowest Score		-21.9		
																					Highest Score		11.3		

ICDS Performance Indicators – Output and Outcomes

State	Project	AWC - Observation		CLCT		Nutrition Grade						PSE		Full Immunization				Health Checkup			NHED Session		Referral		Primary School		COMPO SITE			
		Score	Z1	Score	Z2	Normal	Z3	GRD-1	Z4	GRD-2	Z5	GRD-3+4	Z6	Attendance	Z7	Child	Z8	PW	Z9	Women	Z10	Child	Z11	Nos	Z12	Cases	Z13	admitted	Z14	Index
AP	001	124.2	0.98	27.3	0.08	33	0.53	8	0.11	3	0.13	0	-0.46	139	0.11	40	0.05	9	-0.16	36	0.91	45	0.82	5	0.44	6	-0.01	47	-0.27	3.9264
AP	002	124.0	0.96	27.9	0.18	30	0.32	7	-0.04	5	0.70	1	0.53	136	0.00	45	0.25	8	-0.43	34	0.66	44	0.74	5	0.44	9	0.56	100	1.97	4.3914
AP	003	124.6	1.01	26.5	-0.06	38	0.88	8	0.11	3	0.13	0	-0.46	161	0.93	39	0.02	11	0.38	37	1.03	49	1.16	5	0.44	9	0.56	73	0.82	7.6135
AP	004	121.4	0.76	33.7	1.20	25	-0.04	21	2.02	2	-0.16	0	-0.46	147	0.41	56	0.69	10	0.11	34	0.66	41	0.49	5	0.44	13	1.31	68	0.61	9.2889
AP	005	102.6	-0.72	29.4	0.45	38	0.88	4	-0.48	2	-0.16	0	-0.46	101	-1.30	48	0.37	8	-0.43	40	1.40	48	1.08	5	0.44	8	0.37	33	-0.87	1.8127
AP	006	111.6	-0.01	28.6	0.30	20	-0.39	22	2.17	1	-0.44	0	-0.46	155	0.70	69	1.21	16	1.72	39	1.27	45	0.82	5	0.44	13	1.31	50	-0.15	10.3112
AP	007	110.4	-0.11	30.4	0.62	26	0.03	23	2.32	0	-0.72	0	-0.46	141	0.18	72	1.33	15	1.46	40	1.40	50	1.24	5	0.44	21	2.81	52	-0.06	12.8554
Arunachal P	008	79.0	-2.57	33.1	1.09	2	-1.66	0	-1.07	0	-0.72	0	-0.46	92	-1.64	18	-0.82	7	-0.70	22	-0.81	26	-0.77	1	-3.07	14	1.50	67	0.57	-8.7325
Arunachal P	009	80.4	-2.46	30.3	0.60	44	1.30	2	-0.77	0	-0.72	0	-0.46	79	-2.12	12	-1.06	16	1.72	27	-0.19	47	0.99	3	-1.31	4	-0.38	19	-1.46	-3.9490
Assam	010	113.2	0.11	26.5	-0.07	25	-0.04	5	-0.33	0	-0.72	1	0.53	97	-1.45	14	-0.98	8	-0.43	33	0.54	44	0.74	5	0.44	4	-0.38	63	0.40	-1.2401
Assam	011	112.4	0.05	30.3	0.60	20	-0.39	4	-0.48	2	-0.16	1	0.53	118	-0.67	21	-0.70	6	-0.96	20	-1.05	10	-2.11	4	-0.43	6	-0.01	47	-0.27	-6.7948
Assam	012	111.4	-0.03	28.7	0.33	12	-0.95	0	-1.07	0	-0.72	1	0.53	112	-0.90	72	1.33	10	0.11	17	-1.42	24	-0.93	0	-3.94	1	-0.95	67	0.57	-7.6489
Assam	013	121.6	0.77	31.1	0.74	34	0.60	4	-0.48	1	-0.44	0	-0.46	96	-1.49	55	0.65	6	-0.96	33	0.54	45	0.82	3	-1.31	7	0.18	22	-1.33	-0.3654
Assam	014	101.0	-0.84	27.5	0.12	25	-0.04	4	-0.48	0	-0.72	0	-0.46	117	-0.71	0	-1.54	9	-0.16	30	0.17	27	-0.68	5	0.44	12	1.12	59	0.23	-1.1632
Assam	015	107.0	-0.37	29.2	0.42	4	-1.52	0	-1.07	0	-0.72	0	-0.46	117	-0.71	42	0.13	10	0.11	25	-0.44	33	-0.18	1	-3.07	2	-0.76	42	-0.49	-6.7450
Bihar	016	89.4	-1.75	25.5	-0.23	0	-1.80	1	-0.92	2	-0.16	3	2.51	116	-0.75	6	-1.30	8	-0.43	14	-1.78	5	-2.52	5	0.44	4	-0.38	42	-0.49	-14.2592
Bihar	017	106.4	-0.42	26.5	-0.06	41	1.09	0	-1.07	4	0.41	1	0.53	0	-5.06	6	-1.30	0	-2.58	21	-0.93	44	0.74	5	0.44	12	1.12	31	-0.95	-9.9017
Bihar	018	108.4	-0.26	25.8	-0.18	33	0.53	3	-0.63	4	0.41	0	-0.46	0	-5.06	3	-1.42	10	0.11	24	-0.56	33	-0.18	5	0.44	7	0.18	29	-1.04	-8.0057
Bihar	019	101.6	-0.80	20.0	-1.20	0	-1.80	0	-1.07	0	-0.72	0	-0.46	144	0.29	0	-1.54	4	-1.50	0	-3.49	14	-1.77	3	-1.31	0	-1.13	12	-1.76	-15.8813
Bihar	020	105.6	-0.48	29.1	0.39	10	-1.09	2	-0.77	1	-0.44	0	-0.46	125	-0.41	21	-0.70	12	0.65	11	-2.15	18	-1.44	5	0.44	3	-0.57	60	0.27	-4.9582
Bihar	021	89.6	-1.74	28.5	0.29	0	-1.80	0	-1.07	0	-0.72	0	-0.46	140	0.15	31	-0.30	10	0.11	15	-1.66	4	-2.61	5	0.44	1	-0.95	54	0.02	-7.9153
Chhatisgarh	022	102.0	-0.76	18.4	-1.47	25	-0.04	0	-1.07	0	-0.72	0	-0.46	145	0.33	7	-1.26	7	-0.70	26	-0.32	22	-1.10	5	0.44	10	0.75	38	-0.66	-4.6573
Chhatisgarh	023	114.2	0.19	23.1	-0.65	18	-0.53	8	0.11	5	0.70	1	0.53	151	0.56	10	-1.14	8	-0.43	18	-1.29	17	-1.52	5	0.44	5	-0.19	67	0.57	-5.1038
Chhatisgarh	024	113.0	0.10	14.8	-2.10	11	-1.02	1	-0.92	5	0.70	0	-0.46	101	-1.30	26	-0.50	15	1.46	21	-0.93	24	-0.93	5	0.44	5	-0.19	51	-0.11	-6.2421
Chhatisgarh	025	120.8	0.71	10.7	-2.81	5	-1.45	6	-0.18	4	0.41	1	0.53	100	-1.34	33	-0.22	3	-1.77	29	0.05	43	0.66	5	0.44	9	0.56	29	-1.04	-7.3370
Goa	026	114.0	0.18	34.2	1.28	37	0.81	8	0.11	0	-0.72	0	-0.46	162	0.96	54	0.61	7	-0.70	19	-1.17	25	-0.85	5	0.44	4	-0.38	71	0.74	3.2261
Gujarat	027	123.0	0.88	32.2	0.94	31	0.39	5	-0.33	1	-0.44	7	6.48	163	1.00	49	0.41	10	0.11	21	-0.93	46	0.91	5	0.44	4	-0.38	56	0.11	-2.4921
Gujarat	028	112.8	0.08	28.7	0.32	26	0.03	15	1.14	7	1.27	2	1.52	158	0.82	42	0.13	11	0.38	40	1.40	50	1.24	5	0.44	10	0.75	80	1.12	5.0708

State	Project	AWC - Observation		CLCT		Nutrition Grade							PSE		Full Immunization				Health Checkup			NHED Session		Referral		Primary School		COMPO SITE		
		Score	Z1	Score	Z2	Normal	Z3	GRD-1	Z4	GRD-2	Z5	GRD-3+4	Z6	Attendance	Z7	Child	Z8	PW	Z9	Women	Z10	Child	Z11	Nos	Z12	Cases	Z13	admitted	Z14	Index
Gujarat	029	119.0	0.57	31.6	0.83	17	-0.60	20	1.88	#	2.97	0	-0.46	156	0.74	44	0.21	13	0.92	29	0.05	40	0.41	3	-1.31	0	-1.13	95	1.76	1.8096
Gujarat	030	122.6	0.85	24.5	-0.40	25	-0.04	0	-1.07	0	-0.72	0	-0.46	138	0.07	45	0.25	6	-0.96	35	0.78	47	0.99	5	0.44	12	1.12	113	2.52	5.7497
Gujarat	031	118.2	0.51	25.8	-0.19	39	0.95	4	-0.48	0	-0.72	0	-0.46	151	0.56	45	0.25	9	-0.16	35	0.78	48	1.08	4	-0.43	6	-0.01	59	0.23	4.2786
Gujarat	032	115.2	0.27	32.1	0.91	39	0.95	5	-0.33	0	-0.72	0	-0.46	158	0.82	54	0.61	7	-0.70	25	-0.44	31	-0.35	5	0.44	4	-0.38	69	0.66	3.6553
Gujarat	033	109.6	-0.17	30.8	0.68	38	0.88	2	-0.77	4	0.41	4	3.51	132	-0.15	83	1.76	7	-0.70	35	0.78	32	-0.26	5	0.44	4	-0.38	66	0.53	-1.2692
Gujarat	034	100.0	-0.92	30.4	0.61	44	1.30	0	-1.07	2	-0.16	0	-0.46	134	-0.08	81	1.68	12	0.65	35	0.78	26	-0.77	5	0.44	3	-0.57	47	-0.27	2.4203
Gujarat	035	113.6	0.15	33.0	1.07	41	1.09	5	-0.33	4	0.41	0	-0.46	129	-0.26	82	1.72	14	1.19	39	1.27	37	0.16	5	0.44	0	-1.13	78	1.04	6.4444
Gujarat	036	113.4	0.13	21.9	-0.86	35	0.67	11	0.55	4	0.41	0	-0.46	161	0.93	54	0.61	10	0.11	34	0.66	43	0.66	5	0.44	11	0.93	40	-0.57	4.3113
Gujarat	037	120.8	0.71	21.3	-0.97	37	0.81	11	0.55	2	-0.16	0	-0.46	119	-0.64	64	1.01	10	0.11	38	1.15	47	0.99	5	0.44	6	-0.01	48	-0.23	4.5481
Gujarat	038	102.2	-0.75	22.8	-0.70	26	0.03	15	1.14	6	0.98	0	-0.46	146	0.37	62	0.93	13	0.92	37	1.03	47	0.99	5	0.44	2	-0.76	52	-0.06	3.0662
Haryana	039	125.0	1.04	29.5	0.47	48	1.58	0	-1.07	0	-0.72	0	-0.46	152	0.59	35	-0.14	9	-0.16	22	-0.81	11	-2.02	5	0.44	4	-0.38	39	-0.61	0.1244
Haryana	040	117.4	0.44	24.5	-0.41	28	0.18	16	1.29	5	0.70	0	-0.46	170	1.26	58	0.77	9	-0.16	34	0.66	41	0.49	5	0.44	3	-0.57	70	0.70	4.8592
Haryana	041	125.2	1.05	26.8	-0.01	32	0.46	16	1.29	2	-0.16	0	-0.46	155	0.70	76	1.49	11	0.38	23	-0.68	44	0.74	5	0.44	2	-0.76	52	-0.06	5.6535
Haryana	042	109.0	-0.22	30.2	0.59	47	1.51	2	-0.77	0	-0.72	0	-0.46	156	0.74	36	-0.10	11	0.38	32	0.42	31	-0.35	5	0.44	4	-0.38	40	-0.57	2.8816
HP	043	125.8	1.10	30.9	0.70	45	1.37	3	-0.63	2	-0.16	0	-0.46	128	-0.30	70	1.25	10	0.11	23	-0.68	47	0.99	5	0.44	9	0.56	30	-0.99	4.5437
HP	044	133.4	1.70	32.8	1.04	50	1.73	0	-1.07	0	-0.72	0	-0.46	158	0.82	49	0.41	15	1.46	33	0.54	50	1.24	5	0.44	0	-1.13	56	0.11	8.4641
JK	045	106.0	-0.45	25.4	-0.25	20	-0.39	4	-0.48	2	-0.16	0	-0.46	143	0.26	36	-0.10	10	0.11	20	-1.05	47	0.99	2	-2.19	16	1.87	47	-0.27	-1.3291
JK	046	125.0	1.04	30.1	0.57	33	0.53	14	0.99	3	0.13	0	-0.46	91	-1.68	9	-1.18	12	0.65	21	-0.93	29	-0.51	5	0.44	14	1.50	16	-1.59	0.1741
JK	047	120.6	0.69	29.3	0.42	45	1.37	3	-0.63	0	-0.72	0	-0.46	121	-0.56	54	0.61	13	0.92	27	-0.19	44	0.74	5	0.44	3	-0.57	37	-0.70	3.7422
JK	048	103.6	-0.64	24.8	-0.35	40	1.02	2	-0.77	0	-0.72	0	-0.46	78	-2.16	0	-1.54	7	-0.70	20	-1.05	11	-2.02	5	0.44	12	1.12	58	0.19	-5.2619
Jharkhand	049	99.8	-0.94	28.9	0.35	21	-0.32	13	0.85	6	0.98	3	2.51	145	0.33	34	-0.18	8	-0.43	21	-0.93	48	1.08	5	0.44	2	-0.76	27	-1.12	-5.1171
Jharkhand	050	93.0	-1.47	19.4	-1.29	16	-0.67	9	0.26	5	0.70	2	1.52	147	0.41	25	-0.54	3	-1.77	22	-0.81	21	-1.18	5	0.44	0	-1.13	33	-0.87	-10.8482
Jharkhand	051	108.0	-0.29	28.7	0.32	3	-1.59	2	-0.77	0	-0.72	0	-0.46	145	0.33	12	-1.06	10	0.11	22	-0.81	20	-1.27	5	0.44	0	-1.13	33	-0.87	-5.3882
Jharkhand	052	98.4	-1.05	21.7	-0.90	16	-0.67	14	0.99	1	-0.44	0	-0.46	131	-0.19	62	0.93	13	0.92	24	-0.56	14	-1.77	5	0.44	0	-1.13	41	-0.53	-2.6166
Jharkhand	053	102.2	-0.75	29.3	0.42	2	-1.66	6	-0.18	2	-0.16	0	-0.46	143	0.26	19	-0.78	7	-0.70	23	-0.68	29	-0.51	5	0.44	4	-0.38	33	-0.87	-4.7701
Karnataka	054	119.4	0.60	36.5	1.69	50	1.73	0	-1.07	0	-0.72	0	-0.46	155	0.70	87	1.92	10	0.11	38	1.15	38	0.24	5	0.44	3	-0.57	67	0.57	8.7075
Karnataka	055	112.4	0.05	33.7	1.20	44	1.30	1	-0.92	0	-0.72	0	-0.46	161	0.93	63	0.97	11	0.38	35	0.78	19	-1.35	5	0.44	4	-0.38	60	0.27	4.8671
Karnataka	056	131.2	1.52	35.9	1.57	28	0.18	5	-0.33	2	-0.16	0	-0.46	151	0.56	70	1.25	10	0.11	31	0.29	42	0.57	5	0.44	4	-0.38	35	-0.78	5.6221
Karnataka	057	116.8	0.40	28.0	0.20	27	0.10	0	-1.07	0	-0.72	0	-0.46	164	1.04	68	1.17	10	0.11	29	0.05	31	-0.35	5	0.44	7	0.18	55	0.06	3.5320
Karnataka	058	114.8	0.24	27.6	0.12	6	-1.38	9	0.26	6	0.98	0	-0.46	143	0.26	50	0.45	9	-0.16	25	-0.44	32	-0.26	4	-0.43	7	0.18	49	-0.19	-1.8643
Karnataka	059	118.2	0.51	32.8	1.04	12	-0.95	11	0.55	2	-0.16	2	1.52	140	0.15	73	1.37	10	0.11	38	1.15	46	0.91	5	0.44	4	-0.38	53	-0.02	3.5006
Kerala	060	129.0	1.35	35.0	1.43	38	0.88	10	0.40	1	-0.44	0	-0.46	142	0.22	41	0.09	13	0.92	35	0.78	42	0.57	5	0.44	2	-0.76	56	0.11	7.3494
Kerala	061	135.0	1.82	37.5	1.85	40	1.02	10	0.40	0	-0.72	0	-0.46	145	0.33	42	0.13	5	-1.23	32	0.42	41	0.49	5	0.44	0	-1.13	44	-0.40	5.3356
Kerala	062	127.2	1.21	33.2	1.10	49	1.66	1	-0.92	0	-0.72	0	-0.46	135	-0.04	72	1.33	9	-0.16	28	-0.07	42	0.57	5	0.44	0	-1.13	61	0.32	5.4942
Kerala	063	114.0	0.18	20.0	-1.20	35	0.67	2	-0.77	3	0.13	1	0.53	128	-0.30	77	1.53	11	0.38	32	0.42	42	0.57	3	-1.31	0	-1.13	70	0.70	-0.9370
MP	064	133.6	1.71	28.7	0.32	43	1.23	2	-0.77	3	0.13	1	0.53	145	0.33	57	0.73	7	-0.70	37	1.03	44	0.74	4	-0.43	3	-0.57	43	-0.44	2.5264

Contd.

State	Project	AWC-Observation		CLCT		Nutrition Grade						PSE		Full Immunization				Health Checkup				NHED Session		Referral		Primary School		COMPO SITE		
		Score	Z1	Score	Z2	Normal	Z3	GRD-1	Z4	GRD-2	Z5	GRD-3+4	Z6	Attendance	Z7	Child	Z8	PW	Z9	Women	Z10	Child	Z11	Nos	Z12	Cases	Z13	admitted	Z14	Index
MP	065	125.0	1.04	19.8	-1.22	30	0.32	4	-0.48	0	-0.72	0	-0.46	158	0.82	3	-1.42	1	-2.31	29	0.05	38	0.24	4	-0.43	5	-0.19	51	-0.11	-2.5133
MP	066	109.4	-0.18	12.2	-2.55	22	-0.25	1	-0.92	5	0.70	1	0.53	102	-1.27	9	-1.18	7	-0.70	27	-0.19	28	-0.60	5	0.44	11	0.93	39	-0.61	-8.2964
MP	067	123.8	0.94	25.5	-0.24	43	1.23	2	-0.77	3	0.13	2	1.52	162	0.96	57	0.73	0	-2.58	36	0.91	47	0.99	5	0.44	2	-0.76	95	1.76	1.9755
MP	068	116.4	0.36	26.0	-0.14	46	1.44	1	-0.92	0	-0.72	0	-0.46	170	1.26	12	-1.06	11	0.38	36	0.91	46	0.91	5	0.44	1	-0.95	84	1.29	5.1204
MP	069	120.8	0.71	22.0	-0.85	16	-0.67	9	0.26	#	4.11	1	0.53	160	0.89	3	-1.42	9	-0.16	30	0.17	46	0.91	5	0.44	2	-0.76	25	-1.21	-6.3095
MP	070	97.0	-1.16	25.5	-0.24	16	-0.67	4	-0.48	0	-0.72	0	-0.46	158	0.82	9	-1.18	11	0.38	14	-1.78	27	-0.68	3	-1.31	3	-0.57	111	2.43	-3.2491
MP	071	102.0	-0.76	14.1	-2.23	20	-0.39	7	-0.04	2	-0.16	0	-0.46	145	0.33	63	0.97	12	0.65	37	1.03	37	0.16	5	0.44	4	-0.38	39	-0.61	-0.2187
Maharashtra	072	111.4	-0.03	26.1	-0.13	49	1.66	1	-0.92	0	-0.72	0	-0.46	144	0.29	50	0.45	10	0.11	38	1.15	49	1.16	5	0.44	24	3.38	41	-0.53	8.2257
Maharashtra	073	119.8	0.63	33.1	1.09	26	0.03	16	1.29	2	-0.16	1	0.53	144	0.29	19	-0.78	10	0.11	34	0.66	39	0.32	5	0.44	3	-0.57	59	0.23	3.3860
Maharashtra	074	123.6	0.93	25.8	-0.19	23	-0.18	16	1.29	#	2.12	1	0.53	152	0.59	59	0.81	6	-0.96	34	0.66	49	1.16	5	0.44	11	0.93	61	0.32	3.1559
Maharashtra	075	109.6	-0.17	27.8	0.17	27	0.10	14	0.99	4	0.41	0	-0.46	155	0.70	39	0.02	5	-1.23	28	-0.07	33	-0.18	5	0.44	18	2.25	44	-0.40	2.6701
Maharashtra	076	122.0	0.80	26.7	-0.03	48	1.58	2	-0.77	0	-0.72	0	-0.46	160	0.89	48	0.37	7	-0.70	24	-0.56	27	-0.68	5	0.44	7	0.18	103	2.09	4.8166
Maharashtra	077	137.2	2.00	33.2	1.11	40	1.02	3	-0.63	1	-0.44	4	3.51	161	0.93	21	-0.70	12	0.65	37	1.03	44	0.74	5	0.44	11	0.93	62	0.36	4.8145
Maharashtra	078	120.4	0.68	26.6	-0.04	27	0.10	12	0.70	4	0.41	0	-0.46	157	0.78	75	1.45	10	0.11	25	-0.44	31	-0.35	5	0.44	16	1.87	74	0.87	6.2256
Maharashtra	079	137.4	2.01	33.5	1.15	31	0.39	17	1.43	1	-0.44	0	-0.46	157	0.78	13	-1.02	11	0.38	33	0.54	46	0.91	5	0.44	8	0.37	78	1.04	9.3269
Manipur	080	100.6	-0.87	29.4	0.44	0	-1.80	1	-0.92	0	-0.72	0	-0.46	116	-0.75	29	-0.38	4	-1.50	8	-2.52	18	-1.44	5	0.44	7	0.18	49	-0.19	-8.1115
Meghalaya	081	113.0	0.10	24.4	-0.42	49	1.66	1	-0.92	0	-0.72	0	-0.46	135	-0.04	14	-0.98	8	-0.43	31	0.29	40	0.41	4	-0.43	21	2.81	52	-0.06	3.1685
Mizoram	082	114.8	0.24	0.0	-4.68	47	1.51	1	-0.92	0	-0.72	0	-0.46	130	-0.23	66	1.09	6	-0.96	40	1.40	30	-0.43	5	0.44	7	0.18	36	-0.74	-1.9149
Nagaland	083	83.4	-2.22	28.5	0.28	0	-1.80	0	-1.07	0	-0.72	0	-0.46	128	-0.30	0	-1.54	12	0.65	36	0.91	34	-0.10	4	-0.43	6	-0.01	111	2.43	-2.0021
Nagaland	084	80.0	-2.49	28.1	0.22	1	-1.73	10	0.40	6	0.98	0	-0.46	91	-1.68	0	-1.54	8	-0.43	39	1.27	39	0.32	3	-1.31	14	1.50	99	1.92	-4.0454
Orissa	085	85.4	-2.07	20.6	-1.08	20	-0.39	3	-0.63	4	0.41	1	0.53	136	0.00	10	-1.14	4	-1.50	21	-0.93	19	-1.35	0	-3.94	3	-0.57	40	-0.57	-15.1129
Orissa	086	115.2	0.27	23.1	-0.65	33	0.53	10	0.40	2	-0.16	0	-0.46	147	0.41	0	-1.54	5	-1.23	16	-1.54	24	-0.93	5	0.44	3	-0.57	44	-0.40	-4.1890
Orissa	087	86.0	-2.02	25.9	-0.17	16	-0.67	6	-0.18	1	-0.44	0	-0.46	140	0.15	3	-1.42	13	0.92	19	-1.17	23	-1.02	0	-3.94	3	-0.57	55	0.06	-9.1327
Orissa	088	118.0	0.49	28.6	0.31	24	-0.11	14	0.99	4	0.41	0	-0.46	132	-0.15	4	-1.38	11	0.38	23	-0.68	35	-0.01	5	0.44	1	-0.95	56	0.11	-0.5018
Orissa	089	107.6	-0.33	22.7	-0.72	14	-0.81	13	0.85	4	0.41	3	2.51	145	0.33	23	-0.62	5	-1.23	21	-0.93	29	-0.51	5	0.44	6	-0.01	23	-1.29	-7.7523
Orissa	090	94.0	-1.39	23.5	-0.58	18	-0.53	4	-0.48	4	0.41	0	-0.46	103	-1.23	6	-1.30	6	-0.96	32	0.42	22	-1.10	5	0.44	5	-0.19	37	-0.70	-7.5509
Orissa	091	123.4	0.91	24.9	-0.35	14	-0.81	19	1.73	8	1.55	3	2.51	116	-0.75	10	-1.14	10	0.11	24	-0.56	26	-0.77	5	0.44	1	-0.95	34	-0.82	-7.0061
Orissa	092	98.0	-1.08	25.4	-0.25	12	-0.95	5	-0.33	5	0.70	1	0.53	106	-1.12	29	-0.38	12	0.65	19	-1.17	30	-0.43	5	0.44	7	0.18	44	-0.40	-6.0720
Punjab	093	109.4	-0.18	31.0	0.73	49	1.66	1	-0.92	0	-0.72	0	-0.46	119	-0.64	78	1.57	18	2.26	28	-0.07	44	0.74	5	0.44	1	-0.95	69	0.66	6.4839
Punjab	094	109.4	-0.18	33.6	1.18	19	-0.46	2	-0.77	#	7.24	0	-0.46	106	-1.12	63	0.97	9	-0.16	38	1.15	37	0.16	5	0.44	0	-1.13	44	-0.40	-7.1056
Punjab	095	122.4	0.84	33.0	1.08	34	0.60	7	-0.04	3	0.13	0	-0.46	136	0.00	15	-0.94	9	-0.16	37	1.03	39	0.32	5	0.44	9	0.56	117	2.69	6.7477
Punjab	096	118.4	0.52	35.6	1.53	49	1.66	0	-1.07	0	-0.72	0	-0.46	110	-0.97	0	-1.54	13	0.92	34	0.66	38	0.24	5	0.44	8	0.37	85	1.33	5.2824
Punjab	097	106.8	-0.39	33.1	1.08	22	-0.25	13	0.85	3	0.13	4	3.51	117	-0.71	49	0.41	16	1.72	24	-0.56	40	0.41	5	0.44	1	-0.95	40	-0.57	-2.1399
Rajasthan	098	119.3	0.59	27.8	0.16	7	-1.30	10	0.40	0	-0.72	0	-0.46	58	-2.90	9	-1.18	4	-1.50	34	0.66	22	-1.10	3	-1.31	2	-0.76	31	-0.95	-7.9998
Rajasthan	099	94.4	-1.36	28.8	0.34	42	1.16	5	-0.33	1	-0.44	0	-0.46	146	0.37	56	0.69	10	0.11	26	-0.32	37	0.16	3	-1.31	1	-0.95	48	-0.23	-0.7658
Rajasthan	100	111.8	0.00	28.7	0.32	25	-0.04	16	1.29	8	1.55	1	0.53	130	-0.23	6	-1.30	4	-1.50	37	1.03	49	1.16	5	0.44	20	2.62	35	-0.78	0.9418

Contd.

State	Project	AWC- Observ- ation		CLCT		Nutrition Grade						PSE		Full Immunization				Health Checkup				NHED Session		Referral		Primary School		COMPO SITE		
		Score	Z1	Score	Z2	Normal	Z3	GRD-1	Z4	GRD-2	Z5	GRD-3+4	Z6	Attendance	Z7	Child	Z8	PW	Z9	Women	Z10	Child	Z11	Nos	Z12	Cases	Z13	admitted	Z14	Index
Rajasthan	101	86.8	-1.96	10.1	-2.92	22	-0.25	5	-0.33	1	-0.44	1	0.53	149	0.48	51	0.49	19	2.53	40	1.40	50	1.24	5	0.44	0	-1.13	27	-1.12	-1.2082
Rajasthan	102	96.6	-1.19	20.1	-1.18	18	-0.53	6	-0.18	0	-0.72	0	-0.46	161	0.93	66	1.09	19	2.53	36	0.91	50	1.24	5	0.44	4	-0.38	17	-1.54	3.3178
Rajasthan	103	97.0	-1.16	17.6	-1.61	13	-0.88	9	0.26	2	-0.16	0	-0.46	56	-2.98	8	-1.22	16	1.72	29	0.05	47	0.99	4	-0.43	0	-1.13	151	4.12	-1.6420
Sikkim	104	125.6	1.09	27.1	0.04	50	1.73	0	-1.07	0	-0.72	0	-0.46	150	0.52	3	-1.42	10	0.11	38	1.15	41	0.49	5	0.44	5	-0.19	39	-0.61	3.4602
TN	105	122.4	0.84	28.9	0.35	38	0.88	9	0.26	3	0.13	0	-0.46	153	0.63	3	-1.42	7	-0.70	40	1.40	48	1.08	5	0.44	9	0.56	49	-0.19	4.4589
TN	106	135.4	1.85	28.8	0.33	32	0.46	13	0.85	5	0.70	0	-0.46	157	0.78	62	0.93	8	-0.43	29	0.05	45	0.82	5	0.44	5	-0.19	84	1.29	6.9532
TN	107	131.2	1.52	27.7	0.14	31	0.39	16	1.29	1	-0.44	0	-0.46	152	0.59	55	0.65	15	1.46	34	0.66	38	0.24	5	0.44	7	0.18	72	0.78	9.2518
TN	108	124.8	1.02	29.9	0.53	20	-0.39	13	0.85	3	0.13	0	-0.46	154	0.67	68	1.17	14	1.19	32	0.42	34	-0.10	5	0.44	19	2.44	78	1.04	9.6063
TN	109	114.0	0.18	26.5	-0.07	30	0.32	8	0.11	2	-0.16	1	0.53	156	0.74	66	1.09	14	1.19	26	-0.32	46	0.91	5	0.44	10	0.75	98	1.88	6.8427
TN	110	117.0	0.41	25.9	-0.17	34	0.60	9	0.26	3	0.13	0	-0.46	156	0.74	25	-0.54	10	0.11	39	1.27	47	0.99	5	0.44	9	0.56	44	-0.40	4.6058
TN	111	136.6	1.95	25.0	-0.32	16	-0.67	19	1.73	2	-0.16	0	-0.46	155	0.70	66	1.09	13	0.92	32	0.42	32	-0.26	4	-0.43	2	-0.76	75	0.91	5.8897
TN	112	122.0	0.80	25.7	-0.20	23	-0.18	20	1.88	3	0.13	1	0.53	151	0.56	56	0.69	12	0.65	35	0.78	34	-0.10	5	0.44	3	-0.57	60	0.27	4.3811
TN	113	120.4	0.68	22.8	-0.71	20	-0.39	10	0.40	1	-0.44	2	1.52	138	0.07	66	1.09	17	1.99	33	0.54	33	-0.18	3	-1.31	4	-0.38	46	-0.32	0.4030
TN	114	124.0	0.96	29.6	0.47	31	0.39	13	0.85	5	0.70	0	-0.46	153	0.63	24	-0.58	10	0.11	38	1.15	49	1.16	5	0.44	4	-0.38	75	0.91	5.8736
TN	115	100.0	-0.92	14.8	-2.10	6	-1.38	44	5.41	0	-0.72	0	-0.46	155	0.70	95	2.24	9	-0.16	34	0.66	49	1.16	5	0.44	0	-1.13	62	0.36	6.4799
TN	116	114.0	0.18	22.3	-0.79	30	0.32	7	-0.04	0	-0.72	0	-0.46	151	0.56	60	0.85	12	0.65	31	0.29	34	-0.10	1	-3.07	2	-0.76	68	0.61	-0.1086
TN	117	115.2	0.27	19.6	-1.26	12	-0.95	8	0.11	3	0.13	1	0.53	110	-0.97	57	0.73	10	0.11	33	0.54	19	-1.35	5	0.44	17	2.06	39	-0.61	-1.5375
Tripura	118	114.2	0.19	29.2	0.42	1	-1.73	1	-0.92	0	-0.72	0	-0.46	129	-0.26	0	-1.54	14	1.19	41	1.52	50	1.24	4	-0.43	2	-0.76	37	-0.70	-0.5920
UP	119	104.4	-0.58	29.7	0.49	26	0.03	14	0.99	4	0.41	0	-0.46	160	0.89	67	1.13	5	-1.23	25	-0.44	25	-0.85	5	0.44	0	-1.13	36	-0.74	-0.9411
UP	120	93.6	-1.42	29.6	0.49	0	-1.80	0	-1.07	0	-0.72	0	-0.46	156	0.74	39	0.02	2	-2.04	11	-2.15	13	-1.85	5	0.44	1	-0.95	32	-0.91	-9.3139
UP	121	100.4	-0.89	23.6	-0.57	2	-1.66	1	-0.92	2	-0.16	0	-0.46	137	0.03	17	-0.86	6	-0.96	25	-0.44	23	-1.02	4	-0.43	4	-0.38	28	-1.08	-8.5595
UP	122	101.6	-0.80	24.6	-0.39	5	-1.45	14	0.99	1	-0.44	0	-0.46	144	0.29	27	-0.46	3	-1.77	28	-0.07	37	0.16	5	0.44	1	-0.95	21	-1.37	-4.4670
UP	123	101.4	-0.81	20.2	-1.15	0	-1.80	0	-1.07	0	-0.72	0	-0.46	139	0.11	3	-1.42	7	-0.70	5	-2.88	6	-2.44	0	-3.94	1	-0.95	69	0.66	-15.2030
UP	124	107.8	-0.31	30.6	0.66	2	-1.66	3	-0.63	3	0.13	1	0.53	155	0.70	17	-0.86	5	-1.23	12	-2.03	10	-2.11	5	0.44	1	-0.95	61	0.32	-8.2987
UP	125	111.6	-0.01	24.4	-0.43	18	-0.53	22	2.17	2	-0.16	1	0.53	145	0.33	26	-0.50	12	0.65	31	0.29	42	0.57	5	0.44	5	-0.19	12	-1.76	0.6704
UP	126	92.4	-1.52	25.7	-0.21	0	-1.80	0	-1.07	0	-0.72	0	-0.46	144	0.29	6	-1.30	5	-1.23	10	-2.27	3	-2.69	1	-3.07	0	-1.13	13	-1.71	-16.5123
UP	127	91.2	-1.61	23.5	-0.58	12	-0.95	7	-0.04	3	0.13	0	-0.46	137	0.03	27	-0.46	14	1.19	33	0.54	48	1.08	5	0.44	4	-0.38	22	-1.33	-1.7399
UP	128	104.8	-0.54	25.7	-0.20	14	-0.81	1	-0.92	0	-0.72	1	0.53	144	0.29	30	-0.34	6	-0.96	20	-1.05	13	-1.85	3	-1.31	2	-0.76	25	-1.21	-9.4720
UP	129	119.2	0.58	20.7	-1.07	24	-0.11	10	0.40	7	1.27	0	-0.46	150	0.52	24	-0.58	9	-0.16	25	-0.44	47	0.99	5	0.44	7	0.18	48	-0.23	-0.2619
UP	130	122.2	0.82	27.7	0.15	13	-0.88	0	-1.07	1	-0.44	0	-0.46	140	0.15	21	-0.70	11	0.38	22	-0.81	22	-1.10	4	-0.43	6	-0.01	51	-0.11	-2.6980
UP	131	95.2	-1.30	25.4	-0.25	20	-0.39	11	0.55	0	-0.72	0	-0.46	144	0.29	23	-0.62	13	0.92	26	-0.32	21	-1.18	5	0.44	3	-0.57	31	-0.95	-2.1807
UP	132	120.2	0.66	26.6	-0.04	0	-1.80	0	-1.07	0	-0.72	0	-0.46	139	0.11	6	-1.30	9	-0.16	20	-1.05	19	-1.35	5	0.44	3	-0.57	75	0.91	-4.0224
Uttaranchal	133	113.0	0.10	25.7	-0.20	30	0.32	8	0.11	2	-0.16	0	-0.46	152	0.59	73	1.37	10	0.11	25	-0.44	32	-0.26	5	0.44	2	-0.76	59	0.23	2.2351
Uttaranchal	134	102.2	-0.75	23.0	-0.67	27	0.10	11	0.55	2	-0.16	1	0.53	124	-0.45	67	1.13	11	0.38	31	0.29	37	0.16	4	-0.43	2	-0.76	38	-0.66	-1.4698
Uttaranchal	135	88.8	-1.80	21.2	-0.99	24	-0.11	0	-1.07	1	-0.44	1	0.53	97	-1.45	38	-0.02	10	0.11	26	-0.32	25	-0.85	5	0.44	4	-0.38	66	0.53	-5.9897
WB	136	120.2	0.66	31.8	0.86	29	0.25	10	0.40	2	-0.16	0	-0.46	154	0.67	66	1.09	2	-2.04	38	1.15	47	0.99	5	0.44	17	2.06	35	-0.78	6.3693

Contd.

State	Project	AWC- Observation		CLCT		Nutrition Grade							PSE	Attendance	Full Immunization				Health Checkup				NHED Session		Referral		Primary School		COMPO SITE	
		Score	Z1	Score	Z2	Normal	Z3	GRD-1	Z4	GRD-2	Z5	GRD-3+4			Z6	Z7	Child	Z8	PW	Z9	Women	Z10	Child	Z11	Nos	Z12	Cases	Z13	admitted	Z14
WB	137	101.4	-0.81	35.4	1.49	30	0.32	16	1.29	4	0.41	0	-0.46	144	0.29	63	0.97	15	1.46	39	1.27	28	-0.60	5	0.44	4	-0.38	38	-0.66	5.1300
WB	138	104.4	-0.58	34.7	1.37	31	0.39	11	0.55	8	1.55	0	-0.46	149	0.48	71	1.29	8	-0.43	21	-0.93	39	0.32	5	0.44	6	-0.01	32	-0.91	0.9146
WB	139	118.2	0.51	28.2	0.24	44	1.30	1	-0.92	1	-0.44	0	-0.46	146	0.37	33	-0.22	10	0.11	31	0.29	32	-0.26	4	-0.43	14	1.50	27	-1.12	2.2644
WB	140	108.2	-0.28	36.0	1.60	37	0.81	11	0.55	1	-0.44	0	-0.46	154	0.67	49	0.41	11	0.38	35	0.78	45	0.82	5	0.44	4	-0.38	77	0.99	7.7116
WB	141	97.2	-1.14	34.8	1.38	26	0.03	16	1.29	4	0.41	0	-0.46	155	0.70	58	0.77	12	0.65	25	-0.44	37	0.16	5	0.44	10	0.75	47	-0.27	4.3662
WB	142	106.8	-0.39	31.6	0.83	25	-0.04	15	1.14	8	1.55	1	0.53	153	0.63	27	-0.46	12	0.65	36	0.91	48	1.08	4	-0.43	2	-0.76	51	-0.11	0.9665
WB	143	117.4	0.44	29.9	0.54	29	0.25	11	0.55	4	0.41	1	0.53	154	0.67	46	0.29	13	0.92	28	-0.07	36	0.07	5	0.44	9	0.56	73	0.82	4.5398
Andaman	144	127.8	1.26	21.7	-0.89	32	0.46	1	-0.92	0	-0.72	0	-0.46	136	0.00	46	0.29	7	-0.70	18	-1.29	45	0.82	5	0.44	17	2.06	56	0.11	2.8271
Chandigarh	145	121.8	0.79	29.6	0.48	20	-0.39	11	0.55	4	0.41	0	-0.46	151	0.56	60	0.85	16	1.72	22	-0.81	42	0.57	5	0.44	7	0.18	49	-0.19	4.8118
Delhi	146	98.0	-1.08	17.3	-1.67	28	0.18	9	0.26	8	1.55	0	-0.46	115	-0.78	57	0.73	13	0.92	34	0.66	44	0.74	5	0.44	13	1.31	43	-0.44	0.1723
Dadar & Nagar	147	124.8	1.02	35.6	1.53	47	1.51	3	-0.63	0	-0.72	0	-0.46	146	0.37	4	-1.38	5	-1.23	24	-0.56	49	1.16	5	0.44	3	-0.57	91	1.59	4.4442
Daman Diu	148	125.6	1.09	32.0	0.89	41	1.09	0	-1.07	0	-0.72	0	-0.46	157	0.78	44	0.21	6	-0.96	34	0.66	35	-0.01	5	0.44	10	0.75	105	2.18	7.2349
Lakshadweep	149	97.8	-1.09	16.9	-1.74	17	-0.60	7	-0.04	1	-0.44	0	-0.46	136	0.00	52	0.53	10	0.11	26	-0.32	43	0.66	5	0.44	12	1.12	35	-0.78	-0.7987
Pondicheri	150	114.0	0.18	24.4	-0.42	16	-0.67	15	1.14	#	2.97	2	1.52	127	-0.34	45	0.25	14	1.19	38	1.15	44	0.74	5	0.44	19	2.44	42	-0.49	1.1201
SUM		16762.1		4027.9		3827.0		1088.0		382.0		70.0		20411.0		5793.0		1438.0		4288.0		5272.0		674.0		905.0		8025.0		0.0
MEAN		111.7		26.9		25.5		7.3		2.5		0.5		136.1		38.6		9.6		28.6		35.1		4.5		6.0		53.5		0.0
STDEV		12.8		5.7		14.2		6.8		3.5		1.0		26.9		25.2		3.7		8.2		11.9		1.1		5.3		23.6		6.018
																										Lowest Score		-16.5		
																										Highest Score		12.9		



National Institute of Public Cooperation and Child Development
5, Siri Institutional Area, Hauz Khas
New Delhi - 110 016