ICDS and Anganwadis: A review of relevant literature

4.1 Introduction:

ICDS scheme is an ambitious multidimensional program targeted on malnutrition children as well as their illiterate, ignorant, and poverty-stricken on mothers in the lower socio-economic strata of society. Beginning with welfare extension project (WEP) in 1958 and ending with demonstration project for integrated child development services (DCPICWS) in 1973, at least ten progresses of national coverage concerning the welfare of children were launched during this period of 16 years. Each program was designed to deliver a specific service to the target child population; but used more or less the same set up in front administration to deliver the intended service.

All programs come under serious scrutiny in due course and gradually become obvious that the programs generally had failed to achieve their intentions for a variety of reasons learning from the mistakes in the innovating the service package to make it applicable nationally. Welfare policy makers designed the ICDS scheme with the aim of reaching all the needy children in the age group of 0-6 years expectant and nursing mothers and women in the age group 15-44 years with basic child welfare services. The ICDS package includes welfare services of supplementary nutrition immunization, health checkup, health referral, nutrition and health education for both children and mothers and non-formal preschool education for children.

Since inception, ICDS scheme has been a subject of considerable research and evaluation attention. Government and private organization as well as individuals in research institutions, medical college, Social work schools and home sciences college have conducted research on the different aspects of ICDS. In fact, the national institute of public cooperation and child development (NIPCCD) New Delhi have published commending of such research reports.

At the implementation level, ICDS is a highly human interactive program. An ICDS team comprising child development project officer- (CDPO), supervisor (Mukhya Sevikas), Anganwadi workers (AWS) and Anganwadi helpers (AHS) supported by medical officers (MO) and auxiliary nurse mid wife (ANM) and lady health visitors (LHVS) provide diverse services to
different beneficiaries to register an integrated impact on the target population. Accordingly different aspects from organizational behavior of functionaries to pre service delivery needs and post service delivery effects on Anganwadi beneficiaries have been researched.

This literature review, however, is being restricted to select items relevant to the present research topic, that is Anganwadi workers and helpers and the six integrated services delivered to the beneficiaries through the ICDS set up. As some commentators have covered more than one aspect in their writing, the present research has to separately call their comments and rearrange them for making a unified presentation. The exercise has led to unavoidable breaking up of a few publications into two pieces appearing at different places in the succeeding pages.

With this explanatory introduction; a concise literature review is being presented here below.

4.2 Community Participation in ICDS


This study investigated how better community participation can be ensured. It covered a total population of 854, among whom were 15 mothers and 15 fathers of beneficiary children, 10 were non beneficiary parents, representatives of local organizations and 5 were functionaries of different centers. Fathers of beneficiary children mentioned that they could not earn money if they did not go outside the home, and the adult family members looked after their children. Only 7 out of 15 mothers reported correctly about the program services for children rendered by ICDS. Mothers of the beneficiary children were encouraged by family members to send their child to the centre. 3 respondent mothers reported that slum children did not get adequate food, proper education, etc. Most respondent mothers knew about the reasons for starting ICDS in their area. 9 mothers mentioned that AWWs visited their homes once or twice every three months, while 4 said they visited every month, and 2 were not happy with the AWW because they had no fixed time and they were not delivering services satisfactorily. Out of 15 respondents, 13 were involved in Jeevandeep program to promote savings habit among
the mothers of beneficiary children. Respondents were not aware about the facilities provided to pregnant women from the centre. They said they would be more interested if the AWW could visit them more often, twice in a week, and more people would get involved in the program. The non-beneficiary respondents mentioned that there was no relation or co-ordination between the local clubs, youth organizations, and Mahila Mandals with the AWC. Out of 10 non-beneficiary respondents, 9 had not played any important role for the betterment of the centre; only one father had helped in searching space for the AWC in their locality. It showed that AWWs had no links with people who were not getting benefits from their centre. 3 non-beneficiary respondents mentioned that the behavior of AWW was not good; they favored healthy, good looking and well-dressed children. 2 mentioned that the quality of food distributed at the centre caused stomach trouble; therefore they were not sending their children to the AWC.


This paper attempted to assess the functioning of the ICDS Anganwadis at the grass roots level. 5 Anganwadi centers (AWCs) were selected from each block based on a system of grades given to them by the ICDS Department of Thiruvananthapuram district. Premkadavila block was funded under the general state government ICDS funding, while Kazahakuttam was funded by World Bank. ICDS projects have 100% coverage in Kerala. The Anganwadis of Kerala are graded as A (very good, 75-100), B (Good, 50-74), C (Average, 35-49), D (Below Average, 20-34), and E (Poor, below 19). The grading system is based on the presence of better infrastructure, quality of preschool education, and supplementary food provided. It was found that 60% of the children aged 0-6 years were in normal grade of nutrition from 2003-2005, 32% of the children were in Grade I malnutrition, 8% of the children were in Grade II, and only 0.06% children were in Grade III and IV category, which indicated that severe malnutrition was almost non-existent. Comparing the weights of children at the time of enrolment and current weights, it was
found that Grade D Anganwadis had shown remarkable improvement. The Grade of an Anganwadi centre could not completely explain the nutritional status of the children enrolled. It was also found that the nutritional status of enrolled and non-enrolled children were similar. AWCs with good grades were also the ones that were functioning well as an institution. AWCs in remote locations appeared to have achieved better outcomes. In Grade A AWC of Perumkadavila Panchayat, the Panchayat president helped in the construction of the Anganwadi building out of the block funds. The new ward member helped to build the wall and toilet, while the community collected money for the floor. It was found that three agencies namely the panchayat, the AWW of the ICDS system, and the local community were working efficiently in close coordination towards the welfare of the AWC in Perumkadavila. Kerala still faces challenges in the areas of child health and nutrition. It is, therefore, important to bring more members of local communities under the ambit of the ICDS program. It was also recommended that AWCs should be more responsive to the needs and demands of parents, particularly teaching of the English language.


There was variation in poverty and human development indicators across the 4 sites, namely Amrabad mandal, Meboobnagar district, Telengana region (south); Attur mandal, Cuddapah district, Rayalseema region; Kataram mandal, Karimnagar district, Telengana region (North); and Seethampet mandal, Srikakulam district, coastal Andhra region. The objective was to gather information on the structure and functioning of the committees in practice; barriers and catalysts to inclusive and effective participation, and the view points and attitudes of parents, school children, frontline service providers and government officials regarding the committees’ impact. All Mothers’ Committee (AMC)
and Village Education Committee (VEC) members were provided with adequate information about their mandate, role and responsibilities. Concerns were articulated about the lack of accountability of the Committee to the wider community. Mothers’ Committees were set up to improve user participation in public services, and there are limited provisions for children’s voices to be heard. Instead of addressing children’s concerns, ECs were frequently concerned about securing their future political advancement. EC members who were well connected were able to secure funds from local politicians but none of the MC members were effective at fund raising. Where ECs were not functioning the teachers did whatever they wanted, and did not bother about the children, as the Education Committee was not available to check them. Health extension work should be formally recognized and compensated; whereas Mothers’ Committees need to be reconfigured as an independent monitoring body with sufficient powers to make a difference to the quality of maternal and child health and early development services. Explicit accountability mechanisms ensure that committee chairpersons are accountable to other parents as well as the wider community. More structured opportunities to interact with authorities develop an institutional channel to articulate common concerns among committee members.


A total of 180 respondents including 40 AWWs, 26 AWHs, 36 mothers, 24 self help group members, and 26 adolescent girls (AGs) were selected for the study. It was found that ICDS staff had inadequate knowledge about the basic concept of community participation. 26% mothers, 16% SHG members, 14% youth, 36% AGs and 10% councilors participated in the range of 20-40% in the ICDS program. 30% of the community participated in the range of 40-60% and helped in the day to day activities and functioning of ICDS. 22% of the community participated in the range of 40-60% in the form of material contribution. 34% of the community participated in the range of 40-60% in the special programs of ICDS. 24% community members participated in the range
of 40-60% in monitoring ICDS centers and its functioning. Around 48% respondents mentioned that community participation was satisfactory. 60% AWWs were satisfied; 20% had low satisfaction; 10% had very low satisfaction; 6% were very highly satisfied, and 4% were highly satisfied with their job performance sometimes the quality of supplementary nutrition (SN) was poor, and it led to a poor image and negative attitude among mothers towards ICDS and its services. AWWs were maintaining 20-26 or more number of registers. Some AWWs had clubbed the contents and maintained a single register. There was lack of co-ordination and cooperation between Government departments while implementing the ICDS program in Chennai city. In a few places the Corporation was running pre-primary schools, and this created confusion among the community members about where they could send their children. Parents were sending their children to ICDS centers due to their rapport with AWWs and Helpers and services provided at AWCs. These two kinds of preschools created unnecessary internal conflict between AWWs and Corporation teachers, and created confusion among community members. The State Government should motivate all local body representatives to spend 15% of their area welfare allotment fund for the ICDS program, including infrastructure development and maintenance of the AWCs.

4.2.5 **Uttarakhand, Dept. Of Women and Child Development, ICDS Unit, Dehradun. (2007) - Community Based Monitoring System. Dehradun: ICDS Unit.**

Community based monitoring system (CBMS) aims to induce behavioral change among community members to make the program sustainable and feasible. This project seeks to induce change so that the community shares equal responsibility in the delivery of services. The study was conducted in 65 AWCs from 3 blocks of Uttarakhand and covered Thatyur (tribal block), Chamba and Bhilangana (non-tribal blocks). Focus Group Discussions (FGDs) were organized in each of the 20 villages, and the participants were Gram Pradhan, influential persons like PRI members, SHG members, teachers, and the Anganwadi worker. It was found that the respondents were generally satisfied with the frequency of distribution of supplementary nutrition. In two villages, Bangoli in Chamba and Indrola in Bhilangana, supplementary nutrition was given weekly. In Titrana, Dauni,
and Maiti villages of Bhilangana, SN was supplied irregularly. The community was hardly aware about this fact and it emerged that registration with AWC was being done primarily to receive SN. In almost 33% villages, pregnant women did not get themselves registered at the AWC. The importance of health check-up was least understood and it was advocated by all that a strong awareness drive must be launched to strengthen this component. Even though village Khaseti in Bhilangana block of Tehri district was very close to a health facility, only a few persons were visiting the health facility. Availability of ANM, lack of information about her outreach schedule, and busy schedule of the women in villages were also closely linked to the poor status of health check-ups in blocks. Overall, only in 33% villages was the status of T.T. vaccination to pregnant women satisfactory, and these villages were close to a health facility. Beneficiaries were reportedly getting IFA tablets but consumption pattern of IFA was seen to be a major bottleneck. Most pregnant women were not following the prescribed course of IFA tablets and discontinued after consuming a few tablets (20-30). Barring one village in Chamba block, there is no awareness about T.T. vaccination to adolescent girls. In 40% villages, colostrum was not being fed. About 50% children were exclusively breastfed for six months. In all villages, the mother and newborn child are kept isolated for a period of 11 to 21 days.

4.3 Enrolment of Children in ICDS


88 AWCs situated in Adyar, Besant Nagar, Mandaiveli, Santhome, Kotturpuram and Pattinapakkam were covered. Total 150 non-enrolled children aged 2.5 to 5 years residing in ICDS area were selected for the study and information was gathered from their mothers. It was found that 47.3% respondents believed that the purpose of existence of the AWC was to look after young children. Respondents mentioned that providing nutrition in the AWC was for the growth of children (47.3%) and to provide nutrition
(32.7%) to children. They were aware of the provision of supplementary nutrition, but not aware of the special care given to malnourished children under the supplementary nutrition component of ICDS. 40% respondents mentioned that they were not aware that ECE (Early Childhood Education) contributed to the child’s holistic development. 77.3% respondents were approached by either the Anganwadi worker or helper for enrollment in the ICDS centre. Only 17.3% respondents had made any attempt to enroll in ICDS. Except 11.3% of the respondents, the others were not convinced that ICDS had been offering good quality services to the beneficiaries. 29.3% respondents said that poor physical infrastructure was the reason for their child’s non-enrollment in the AWC. Every second respondent (50.7%) mentioned that the AWC in their habitation was not friendly. 100% respondents mentioned that providing PSE in the mother tongue was good for the child, and an overwhelming majority (91.3%) felt that teaching in English was also mandatory for the child’s future. 34% respondents felt pride in sending their children to English medium preschools. More than half the respondents (60%) had attributed medium of instruction, which was Tamil in AWCs, to be the reason for their child’s non-enrollment. 25.3% mothers felt that AWWs attitude was also the reason for not sending their children to the AWC. Nearly 22.7% respondents mentioned that community participation in children’s enrollment was high in their habitation.

4.4 Evaluation of ICDS


The basic aim of the FOCUS survey was to find out how ICDS is doing on the ground. The survey was started on a shoestring budget, with a modest grant from the Indian Council of Social Sciences Research (ICSSR). In each state, 3 districts and 12 villages were selected by random sampling, but of the target number of 216 sample villages, only 203 were covered. One Anganwadi was selected in a village. Interviews were conducted during office hours with a random sample of about 500 women, who had at least one child below six years enrolled at the Anganwadi. Results of the FOCUS survey point to
startling contrasts in the effectiveness of ICDS between different states. At one end of the spectrum, Tamil Nadu is doing very well - Anganwadis are open throughout the year, nutritious food is available every day, regular health services are provided, and even the preschool education program is in good shape. At the other end, a day in the life of a typical Anganwadi in Uttar Pradesh is little more than a brief ritual, involving the distribution of ready-to-eat mixture panjiri or fudging of registers. Rampant corruption was all over and there were no signs of any significant impact of ICDS on the well being of children. Himachal Pradesh, Maharashtra and Tamil Nadu have relatively active social politics, and they have also made serious efforts to ‘make ICDS work’. In contrast, the other three states (Chhattisgarh, Rajasthan, and Uttar Pradesh) were relatively passive as far as ICDS is concerned. The major difficulty observed was that Anganwadis did not have a place of their own. The FOCUS survey pointed to a whole range of issues related to the selection, training, duties, supervision, remuneration, support and empowerment of Anganwadi workers. There should be essential nutritive food available for children under the Supplementary Nutrition Program. The FOCUS survey found that pre-school education was in great demand, especially in areas where parents are relatively well educated. Many things can be done to further the rights of children under six, and ensure that every settlement has a lively Anganwadi. Public action is required at all levels, involving political parties, trade unions, women’s organizations, Panchayati Raj institutions, NGOs, and concerned citizens from various backgrounds – parents, teachers, journalists, lawyers, researchers, health activists, and others.


A total of 250 villages/ AWCs were covered. 12,621 children under 3 years, 12,468 children 3-6 years, 2221 pregnant women, 2686 lactating mothers and 13908 AGs comprised the sample. It was found that supplementary feeding was usually given for 25 days in a month and was considered adequate by over 96% of the mothers of beneficiary children. 92% mothers mentioned that the quality of food was good. 60% mothers of non-beneficiary children considered supplementary feeding to be useful for the better health
and nutritional status of children. Over 92% of the beneficiary children received 3 doses of immunization against DPT/Polio. The immunization coverage for measles was 96%, and over 96% of them had received BCG immunization. Around 26.32% children aged 9-12 months had received complete immunization. Almost 9 out of 10 mothers of beneficiary children mentioned that their children had been administered Vitamin A supplement against 77% of non-beneficiary children. 80% mothers mentioned that AWWs were capable of treating minor diseases. Nearly 73% mothers of beneficiary children had received treatment/health services from AWWs. Nearly 60% mothers of non-beneficiary children mentioned that they had been visited at home by the AWW within 1-3 months. Over 99% mothers of beneficiary children aged 3-6 years mentioned that they were sending their children for preschool education (PSE). Among pre-school children, the proportion of female children (53%) was more than that of the males (47%). It was found that 8 out of every 10 lactating mothers mentioned that they did not receive any IFA tablets from the AWCs. 93% of the pregnant women mentioned that they had received at least 1 antenatal checkup, but only 22% of the pregnant women received 3 health checkups. Around 76% of the pregnant women mentioned that they received supplementary food. The Take Home Ration (THR) was usually shared with other members of the family (49%) and children (29%). About 90% pregnant women received IFA tablets supplied mostly by AWWs (75%), followed by ANMs (14%). It was found that home (58%) was the common place of delivery, followed by hospital (39%), and family members (21%). Traditional Birth Attendants (22%) and ANMs (7%) had been the birth attendants at home. 57% of the women faced obstetric complications during delivery and they were referred to First Referral Unit (FRUs) such as PHC (34%), District Hospital (30%) and Sub-Centre (7%). 99% of the AGs mentioned that vocational training was hardly addressed by AWWs. 88% of them said there was no Balika Mandal in their village. About 70% AGs were familiar with the symptoms of anemia. About 60% of the children were found to be malnourished, 40% children had mild, 18% moderate and 0.6% had severe malnutrition. Female children (64%) were more malnourished than male children (54%). The nutritional status of beneficiary children was better than that of non-beneficiary children. 59% of the beneficiary children were malnourished compared to 69.9% of the non-beneficiary children. 92% AWWs could take the weight of children
correctly and 90% were capable of maintaining growth charts. 96% AWWs provided HNE to target groups. They faced problems of irregular supply of food (12%), irregular supply of drugs (12%), and extraneous work assignments such as formation and grading of SHGs, survey works, preparation and distribution of emergency feeding, etc. Referral units were found to be suffering due to non-availability of funds. The amount earmarked for the purpose, Rs. 10,000 per annum, was considered too small an amount and was found largely unspent.


FORCES undertook this study to ascertain the status of ICDS services in Hayathnagar, Ranga Reddy District. AWWs and beneficiaries were covered in Peddambarpet village, and the AWC at Thorroor village, Andhra Pradesh was studied. The interaction with stakeholders, beneficiaries, administrators and workers was the source of primary data. The AWCs aimed to cover 40% eligible beneficiaries with SNP and PSE services. The monthly progress report of Hayathnagar in June 2005 showed that 183 children received DPT; 207 received Polio drops; and 230, 241, and 207 children received DPT first, second and third doses respectively. Almost 100% of the children were going to preschools that are private and 95% of them were helped with their studies by relatives. Sex selective abortions were found to be frequent among Reddys and Choudharys. 154 AWCs in Hayathnagar were catering to 17073 children below the age of six years, and 2983 pregnant and lactating mothers. 148 AWCs had supplied SNP for 21 days in a month. Malnutrition was not an important issue here as 50% children belonged to normal category, 49% belonged to Grade 1 and Grade 2, and only 1% was in the Grade 3 or Grade 4 category. Deliveries were carried out mainly by dais and PHCs had permanent dais. In Peddambarpet village, mothers attending meetings had birth registration certificates for their children. The distribution of SNP and immunization was taking place regularly as described by the CDPO. Private Doctors were preferred over PHCs as they provided better care. For deliveries, the mothers depended on dais. In Thorroor village, the Centre was neat and clean and looked fit for children to enjoy their time with pictures,
drawings, etc. Only 12 beneficiaries below three years received ready mix supplementary nutrition, which was highly appreciated by the beneficiaries. The number of beneficiaries should be increased from 12 to 40 so that more children benefit from this scheme.


In Chandauli, 90% of the Anganwadi centers (AWCs) were catering to a population size of more than 1000 people as the district was densely populated. At the block level, 80 beneficiaries were interviewed in 20 Anganwadi centers. Most AWCs had no facilities for medicine storage and the centers lack both indoor and outdoor space and storage facilities for SN. All the Anganwadi centers had pucca (permanent buildings), infrastructure and 9 out of 10 centers were located in primary schools. Chandauli had the best record of all the districts in this regard as all the AWCs had drinking water and sanitation facility. Only 45% centers had toilet facilities. In Hetampur village, there were 186, 165 and 170 children below six years in three AWCs, and 28, 25 and 26 adolescent girls (AGs) each. Teaching aids in the form of charts and posters were available at the AWCs but the condition of these aids was bad. The AWWs were highly educated and 80% of them were graduates, but 90% of them did not receive any training. The block seemed to have low rate of malnutrition. Awareness about malnutrition and its gradation was not clear to most of the AWWs. Children suffering from Grade I and Grade II malnutrition were not receiving any intervention at all. The prevalence of Grade III and IV malnutrition was quite low. Disability was one area which was neglected in this region. In Kori village, every alternate house of the village had a physically challenged member. In Hetampur village, all deliveries were conducted by the ANM. A large percentage of AGs (80%) had not received any immunization. The immunization record of the children was quite impressive but Vitamin A distribution was not satisfactory. The linkage between primary schools and AWC was quite strong. All the AWCs used preschool kits for teaching. AWWs did not have medicines to treat general ailments and diarrhoea. The infrastructure of PHCs was inadequate. There were beds without mattresses, and unclean delivery rooms. Only immunization was a regular activity carried
out by ANMs. Medical Officers of PHCs mentioned that all services were provided through PHCs, but no data was given on treatment of children. Private practitioners mentioned that most mothers were aware about breastfeeding, but they were not aware of the Pre-Natal Diagnostic Techniques (PNDT) Act. 90% AWCs showed PSE as a regular activity. Community representatives mentioned that AWCs had a positive impact on health, nutrition and education. The MOs, private practitioners, Neem-Hakims and Dais mentioned that they were not aware of PNDT Act. The linkage with PHCs should be strengthened.


12 districts of Bihar were surveyed; one block was studied in-depth; and 1 CDPO, 2 supervisors, 10 AWWs each, and mothers of children in the age group of 3-6 years were chosen for data collection. The state of Bihar suffers from not only economic backwardness, but also from under utilization of facilities available in the state. Thirty five million of Bihar’s population is illiterate, of whom 21 million are women. As per Government data, Bihar has the second highest number of children in India after Uttar Pradesh. ICDS covered 50% of the eligible population. Around 26% children of Bihar suffered from acute malnutrition. Though the overall coverage of the program was very low (31%), the program covers BPL families (71% of the children below six years of age and 67% pregnant and lactating mothers) and SC/ST/OBC population as well. The survey shows a wide coverage of SCs, OBCs and minorities (78% for children below six years and 74% for pregnant and lactating mothers). 42% AWCs had pucca (permanent) infrastructure; 22% AWCs were operational from the AWWs residence; 8% AWCs had their own infrastructure; 10% AWCs had toilet facilities; and 75% centers recorded supply constraints. Percentage of children below three years of age with anemia was 81.3% in Bihar. In 1991, 1.9% of the population was disabled. About 75% of the disabled population lives in rural India. Kishori Shakti Yojana was in a desolate state. Both urban and rural Bihar record the most number of births without any health professional in attendance. 17% children die due to prenatal conditions. Analysis of the coverage of the
districts as well as the states clearly shows that AWCs are able to cover only 30% of the target group. There is a dire need to prioritize the effort to functionalize the sanctioned projects under general category. The 68% AWCs with kuccha (non-permanent) infrastructure should be provided with proper pucca (permanent) infrastructure with adequate space for activities and storage. Beneficiaries should be made aware of the requirements for nutritious food through nutrition and health education (NHE).


Data from the study showed that only 31% of the households had toilet facilities. Sewage/drainage system was reported in 57% villages under regular ICDS projects and projects assisted by World Bank. About 97% Anganwadi centers (AWCs) in urban areas, 93% in rural areas and 74% in tribal areas were connected by roads. Around 36% AWCs had health facilities. About 49% of the AWCs had inadequate space for outdoor and indoor activities. Most of the AWCs (60%) were found to be easily accessible to children as they were brought there by their parents, siblings, or older ladies of the locality. Medicine kits were not available in around 44% AWCs. It was gathered that 15% positions of Child Development Project Officers (CDPOs), 48% of Assistant Child Development Project Officers and about 18% of Supervisors were vacant in the surveyed projects. About 66% Anganwadi workers (AWWs) were of age 35 years and above, and of them 62% had 10 years experience. In 80% projects, supplementary nutrition in Anganwadis was arranged by the State Government which procured food items Maximum coverage of pregnant women was found in tribal AWCs of regular ICDS projects (61.8%) and NGO run ICDS projects (58.3%). Over all 52.8% nursing mothers were registered. Data showed that there was evidently more registration of male children (59.1%) than female children (55.2%), but female children availing supplementary nutrition was high as compared to male children. Eight out of 10 AWWs (79.8%) reported that food was totally acceptable to children and mothers, around 7% found only some of the items of nutrition served as acceptable, and 11% did not find the food items served as acceptable. It was found that AWWs weighed 63.5% of newborn children and
mothers. About 75% of the children registered attended the AWCs. On an average, 37 children were registered for preschool education at AWCs. Pre-school activities (PSE) were conducted by AWWs in almost all the AWCs. Singing songs (95%), storytelling (91.7%) and counting were the most common PSE activities which were organized in almost all the AWCs, whereas drawing/ painting/ printing were found in very few AWCs. Data obtained from mothers revealed that 6 out of 10 children (59.6%) between 6 months and 3 years were given Iron Folic Acid (IFA) tablets. About 68.9% pregnant women consumed IFA tablets regularly, whereas 16% took them sometimes, as they did not like the taste. Data showed that 66.1% children were immunized, highest being in rural projects (71.6%), and around 76.2% pregnant mothers received tetanus toxoid immunization. About 77.4% nursing mothers reported that their children were immunized, and BCG vaccine coverage was the maximum (82.4%). It was found that birth weight of 7% children was below 2 kg. The average number of visits AWWs made to families was highest in urban projects (46.7%). Around 44% AWWs were also rendering services under the Adolescent Girls Scheme (Kishori Shakti Yojana).


In all, 48 AWCs and 576 beneficiaries were selected. In 2001-02, the expenditure on supplementary nutrition (SN) component of ICDS was borne by the Central Government (57%) and by the State Government (43%). The trend of availing SN by expectant women/ nursing mothers during the years 1999-2000 to 2001-02 was decreasing. All AWWs were fully trained, while 33 (69%) helpers were not trained. It was found that the achievements under SNP was 76% in 6 months – 3 years age group for enrolled children, 83% for 3–6 years children, and 74% for pregnant and nursing mothers enrolled. A total of 16,324 children were weighed and it was found that 6583 children were normal (40%), 6105 children were in Grade I (37%), 3502 were in Grade II (21%), 127 were in Grade III (1%), and 7 were in Grade IV malnutrition (0.42%) respectively. Only 4889 (32%)
beneficiaries were medically checked up either by ANM/ LHV or Medical Officer during the preceding three months. Out of a total of 9302 families, 7323 (79%) were visited by ICDS staff. A total of 4839 (83%) children received PSE benefit, out of which 2549 (53%) were males and 2290 (47%) were females. Around 126 (88%) pregnant women received folic acid tablets from AWCs. Out of 288, 178 (89%) expecting women got ante-natal care from AWWs and were satisfied with their advice. Out of 144 nursing mothers, 97% were visited by AWWs after delivery. Out of 144 sampled beneficiary women, 139 (97%) breastfed their babies. 98% women were taking care of their children and their children were found to be in good health. Around 88% women adopted family planning norms. SN was distributed on an average of 25 days in a month. 62% children took SN to their homes thus defeating the very purpose of the scheme. Around 96% children’s mothers mentioned that SN items were of good quality. 90% beneficiary children came to AWCs for other reasons like getting non-formal education, health care and learning good habits. 93% beneficiaries were in favor of the prevailing system of SN. Only 18 (56%) Gram Panchayats extended help to AWWs in organizing cultural functions in AWCs to attract public participation. The performance of ICDS was found to be satisfactory in SN, PSE and immunization program, but supervisory staff, PO, CDPO and supervisors should increase their visits to further improve the program.


The supplementary nutrition (SN) and Amylase Rich Food (ARF) was not of good quality and distribution was not regular. Storage facilities, measuring scales and cooking facilities were not available or were inadequate. Lack of proper coordination with the health department and absence of mission mode had made the immunization program less effective. Proper buildings constructed at the right locations were a major problem. Clean drinking water was not available in many AWCs. Lack of proper transportation facilities for CDPOs and supervisors had an impact on functioning of the scheme. ACDPOs were deputed for other duties and many times did not have any delegation of power to take decisions regarding monitoring and implementation. As their post did not have proper job
description their services were not well streamlined in ICDS. The PRIs namely ZP, TP and GP did not fully participate in ICDS activities. The AWTCs and Middle Level Training Centers (MLTCs) had good physical infrastructure, but more full time faculty were needed for enriching the training program. Some AWTCs did not have adequate physical infrastructure. In both MLTCs and AWTCs, UDISHA package was implemented. As there was no reading and writing in the pre-school component under ICDS, this motivated parents to admit children of 4 years either to government or nearby private schools. There is a need to improve the buildings and provide proper toilet facilities, clean drinking water and proper storage facilities. Proper scales to measure SN, and standing scales to weigh pregnant women and adolescent girls need to be supplied. Modernization of offices of ICDS at the taluka and district level should be given utmost importance. The post of ACDPOs should be abolished; instead CDPOs should be posted in every project with a maximum of 150 centers.


The Ministry of Women and Child Development (MWCD) entrusted the National Council of Applied Economic Research (NCAER) with the task of conducting a nationwide evaluation of the ICDS Scheme to help the Government in initiating corrective measures to make the program more effective. Nearly 4000 projects, 60,000 AWCs, 4000 Mukhya Sevikas and 1.80 lakh beneficiary households with children in the age group of 0-1 years, 1-3 years and 3-6 years were selected. It was found that nearly 66% of the eligible children and 75% of the eligible women were registered at AWCs. Less than 3% children were severely malnourished, except in Bihar, where severe malnutrition among children 13-36 months was 28%, children 6-12 months were 6%, and in children aged 37-72 months was 5%. Most states indicated low levels of severe malnourishment. About 11.3% of the children were moderately malnourished and children in the age group of 37-72 months reported higher incidence of moderate
malnourishment. More than 75% AWWs were matriculate in the northern and eastern part of the country. Gujarat and Rajasthan had the lowest percentage of matriculate functionaries. About 84% of the functionaries had received training, mainly pre-service training. More than 80% children were immunized against all major diseases. More than 90% of the women mentioned that they received tetanus toxoid vaccination, but the referral system was found to be quite weak in many states. Most AWWs and community leaders were not in favor of ICDS functioning under the panchayats, either due to lack of interest or inadequate knowledge and awareness of the importance of women and child development. The community and panchayats, both provided space and other infrastructural support to AWCs, and helped in identifying beneficiaries. Community participation was mainly from mothers and family members of beneficiaries whose children derived benefits from the program. Participation of beneficiary women and adolescent girls in AWC activities was very low. Majority of households reported that they needed the services of SN, PSE, immunization and NHE provided under the ICDS program, and they were satisfied with the delivery of these components. Of the 26 states in the country, Mizoram, Meghalaya, Orissa, Gujarat and Goa were the top 5 states due to adequate infrastructure, better profile of functionaries and efficient functioning of the AWCs. Arunachal Pradesh, Bihar, Jammu and Kashmir, Nagaland and Uttar Pradesh were ranked low.


A participatory approach was employed, wherein beneficiaries, functionaries and intermediaries (NGOs, Panchayats, etc.) involved in ICDS were contacted for the study. Techniques used were Desk Research, Rapid Field Reconnaissance Survey, Participatory Interviews, Observation of Anganwadi Centers (AWCs), Facility Mapping and Stakeholders Analysis. Urban, rural and tribal areas in Maharashtra were selected for the study. Anemia appeared to be the most prevalent illness among women in urban, tribal and rural areas, whereas diarrhea was the most common illness found among children.
Poor socio-economic conditions and contaminated water respectively, accounted for these illnesses. Key reasons for malnutrition among women and children were found to be poverty, lack of nutrition, early marriages and frequent pregnancies with strenuous labor, and unhygienic living conditions. Awareness about AWCs was low in urban areas as opposed to rural and tribal areas where awareness was high. Nearly 80% of the pregnant women interviewed had registered with AWCs within 4 months of conceiving. The services people were most aware of were provision of supplementary nutrition to expectant mothers and children and the immunization programs. Lactating mothers provided with supplementary nutrition reported to be maintaining good health. Children coming to AWCs also had appropriate weight. In rural and tribal areas, children did not avail of the pre-school education programs at AWCs due to distance and illnesses. The problems encountered at AWCs were under utilization of services and sparse funds. Under utilization of resources was due to lack of knowledge and superstitions of the respondents. There is a need to improve awareness about the services provided at AWCs so that the beneficiaries can avail of them.


The study covered 40 AWCs in 3 tribal districts of Rajasthan viz., Banswara, Doongarpur and Chittorgarh. Information was collected through observation, Interviews, participatory rural appraisal in the context of the community, and through continuous dialogue with the field staff. Results revealed that Adolescents Girls Project in ICDS was in operation in six districts of Rajasthan and among the districts covered, The AWCs were not equipped to cater to under three years. Most of the women were malnourished, anaemic and too young when the first child was born. The practice of rejecting colostrums was common. The ANM handled delivery cases only in Padawa. In many villages pregnant mothers had received an immunization shot against tetanus. With the exception of Khuta Teekma in Anandpur block, women were not aware about the facility and need for immunization. There was weak perception of self-role, and disconnected role connection between the
functionaries of different departments. 26 of the 30 AWWs were illiterate. Most of the AWWs had only basic training, but not had gone for refresher course. AWCs were more functional only for the Phala (cluster of houses). Most AWCs lacked teaching aids like charts, toys, blackboards, etc. The knowledge level of mothers regarding nutrition, and AWWs regarding growth faltering and malnutrition was poor. The study recommended that (1) There was need to strengthen the integration of ICDS with other departments like medical, education, PDS, etc. (2) Community should be involved to decentralize services like supply of supplementary food and other resources. (3) The AWW should have decision making power, receive adequate teaching material and equipment, and undergo reorientation training at regular intervals. (4) Close and supportive relationship between gram panchayat and AWCs should be established. (5) There is need to have variation in the food served to match the taste of children. (6) Vacant posts should be filled. (7) Awareness building campaigns through local communication mechanisms should be initiated. (8) Gender compatibility should be established through the involvement of both, men and women. (9) Serious thought should be given to raise the salary of AW helper.


A sample of 500 beneficiaries (250 children, 250 mothers), along with 4 Child Development Project Officers (CDPO), 1 Assistant Child Development Project Officer (ACDPO), 23 Supervisors and 50 Anganwadi Workers (AWW) were selected from 10 Anganwadi centers (AWC) in each project. The sample also included principal beneficiaries like pre-school children, and pregnant and lactating mothers. For data collection, 4 different interview schedules were prepared for the four different categories of respondents. The study revealed that 50% of the pre-school children were between 2 to 4 years of age. 65% mothers of pre-school children, 80% of pregnant women, and 76% of lactating mothers were between 18 to 28 years. About 50% of the beneficiaries were housewives and were illiterate, and all of them were satisfied with the immunization service, but 34.4% expressed their dissatisfaction towards health check-up and referral services. 100% of the respondents met AWWs once in a week. More than 75% of them
had correct knowledge regarding vaccinations, and 100% children got immunized at AWC or Primary Health Centre (PHC). It was found that 30% pregnant women could not add any additional foods to their normal meal due to their low income status, and almost 35% avoided papaya, egg, mango, guava, black fruits, etc. due to ignorance about the nutritional value. Age of the AWWs ranged from 20-50 years, 34% had college education and had 3-15 years of experience as AWWs, but only 7.8% of them were local women. 80% AWCs were in rented buildings, and 75% of them neither had toilet facilities nor separate storeroom, but had safe drinking water facilities. Most of the AWWs mentioned that they were not getting proper teaching aids other than charts and some toys, and only 15 to 38 children attended each center regularly. Majority of the supervisors had passed matriculation and 26% were post-graduates. 70% supervisors expressed problems in implementation of programs and suggested improvements like every AWC should have a proper building, teaching aids and play materials.

4.5 Functioning of Anganwadis/ ICDS


Out of 150 AWCs, 50 AWCs were covered, and a total of 150 beneficiary women were selected for the study. It was found that Community Survey was conducted very often by 86.67% AWWs. Activities based on community participation and maintaining liaison with other institutions were given medium level of priority by the AWWs. Formal sessions of NHE were conducted only in 26.67% AWCs, out of which in only 6.67% AWCs, NHE sessions were conducted once in 6 months, and in 13.33% AWCs, NHE sessions were conducted once in a year. 77.33% beneficiaries expressed dissatisfaction due to irregularity of NHE program, 65.33% mentioned that teaching was not satisfactory, and 64% expressed the opinion that the content of classes and timing of classes was unsatisfactory. The immunization status of children below 1 year of age against BCG, measles, DPT and polio was 52.2%, 49.45%, 41.59% and 86.7%
respectively. Immunization of children in the age group 1-3 years for DPT booster and polio drops was 52.16% and 80.40% respectively. DT was given only to 26.12% of the total children aged 3-6 years. Of the total pregnant mothers, only 54.25% received Tetanus Toxoid vaccine. 100% of the beneficiaries were aware of the health services provided, and about 60% were satisfied with the services. 60% AWWs mentioned that health check-up was carried out for both children and women at least once in 3 months. Medicine kit was available in all AWCs, which was replenished regularly. Only 26.67% beneficiaries were aware of referral services, and only 17.33% were satisfied with the service. Only 26.67% AWWs conducted referral services at their centre, but none of them filled in the referral slips with requisite details. Only 26.67% AWWs arranged meetings for imparting NHE to mothers, and only 6.67% used aids during meetings. All the AWWs weighed the children, but only 46.67% of them interpreted the growth trends. Only 33.33% AWCs had adequate indoor space. Outdoor space and storage space was available only in 40% and 13.33% of the AWCs respectively. 100% beneficiaries were aware of the PSE component, but only 26.67% of them were satisfied with PSE being imparted at AWCs.


In Perumkadavila project 62% of the children fell under the normal weight category. The normal weight category of children in Grade A AWCs was 68%, and in Grade B AWCs 53% children were normal. Chakaparra was the only AWC where nearly 100% coverage of the child population aged 3-6 years was achieved for pre-school education. Grade A AWC of Amboori panchayat proved to be an exceptional case where 96.7% enrolment of BPL children for PSE was found which was due to the absence of private schools. In most AWCs in Perumkadavila block only 27% to 30% of the BPL children were enrolled for PSE. The Grade A AWC showed poor nutritional outcome in terms of weight of children enrolled in the AWC. Grade D AWC of Mangalapuram panchayat under Kazhakuttom ICDS project did not reflect better outcome in terms of nutritional status of
children attending the AWC from the time of their enrollment. 56.25% of the pre-school children in the Grade C AWC were in the normal grade, whereas 83% of the same preschool children were in the normal Grade at the time of their enrolment. The Grade E AWC area showed the highest percentage of children under normal nutritional category. The community here comprised mainly of uneducated migrants. Community participation and the active involvement of agencies make an AWC successful. Grade A Mangalapuram panchayat was a good case of high level of community participation. It had excellent infrastructure, land was bought by the community, and the AWC was able to get World Bank funds for building. Grade C AWC at Perumkadavila had low level of community participation in terms of contribution of funds by the local people because the area had mainly BPL families. Some private nurseries impart formal education in English and offer concessions in uniforms, provide free bus service, etc. and because of this children of BPL families were attending these schools. It was found that five AWCs out of a total sample of ten had PSE enrolment rate varying between 10% and 25%, while one AWC had an enrolment rate between 40% and 55%. In Grade D AWC at Kazhakuttom enrolment was 20.6% because the AWW belonged to the scheduled caste community and parents hesitated to send their children to the AWC. There was also lack of cooperation between the AWW and the community. Those AWCs which showed the maximum improvement in nutritional and health status were not necessarily the ones that were assigned the highest Grades. It is therefore recommended that child nutritional indicators be included as criteria in their grading system.


In Kamrup, about 35 (87.5%) centers out of 40 had 70-89 beneficiaries. On an average every centre had a total of 25.60 children in the age group of 0-3 years, and every centre provided services to nearly 6.33 pregnant mothers and 6.41 lactating mothers. The
average number of live births was 6.10 per centre per year. Only 22.5% centers recorded the total deaths. On an average 1.22 deaths occurred per year. Out of the total 40 centers, 34 centers accounting for 85% provided immunization to the beneficiaries and 6 of the centers did not keep records of immunization. Only 31 centers provided PHC services to the beneficiaries, but 9 centers did not provide immunization services, and did not keep any record. On an average the centers provided immunization services to nearly 13.23 people, indicating a very low performance of the PHCs. In Dibrugarh, nearly 68% of the centers provided services to 5-9 pregnant mothers and 8 lactating mothers. In Dhubri district, on an average every centre had 97.16 beneficiaries and 42.63 children in the age group of 0-3 years. Only 37 centers maintained records and every centre had 5 pregnant and 5 lactating mothers. Only Dhubri district provided services to adolescent girls, and no other district had any AG beneficiaries which took advantage of the AWC. Most of the centers (82.5%) had 5 AGs, whereas 15% of them did not maintain any records. On an average, the centers had 4.91 AGs as beneficiaries. The average enrollment of children per centre was 40. 26.65% of the male children and 52.5% of the female children were among the 20-24 enrolled children. On an average there were 6.4 live births in every centre per year. Most centers had not recorded live births (62.5%). 2.5% of the centers had recorded more than 10 live births. Every centre had 1.33 deaths. 85% of the centers had not recorded any death. In East Khasi Hills every centre had nearly 96 beneficiaries. Every centre provided services to nearly 8.06 pregnant women and 7 lactating mothers. The average enrollment per centre was 34.63 children. Every centre averaged 85.13 beneficiaries. 53% of the total centers provided services to 5-9 pregnant women and 8 lactating mothers. 41.10 children were enrolled per centre. In 35% of the centers children had average growth (52.18). The average number of live births was 10.31 annually. Only 27 centers maintained death records, while 13 centers did not maintained them. The number of deaths per year was 2.07. AWCs provided immunization services to nearly 28.77 beneficiaries. Only 32 centers provided immunization services through PHCs, but 8 of the centers did not keep the record or they did not provide immunization services.

A total of 109 participants, 76 CDPOs/ACDPOs and 33 trainers of ICDS functionaries were covered in the study. Slow career progression of functionaries, lack of motivation among Supervisors, and AWWs wish to become regular Class III employees were identified as most important factors adversely affecting the implementation of ICDS. Community participation is essential for the program to be successful. Two factors affect the implementation of ICDS. Firstly, community leaders stand away from the program due to their non-involvement in the initial stages of the program. Secondly, service providers mentioned their frustration with criticism of the ICDS program management. Poorly equipped AWCs were found to be the most important factor. Functionaries failed to take advantage of the richness of the local surroundings to the full extent due to inflexible nature and rigidity in making use of locally available rich sources. They were always eager to use early childhood education aids supplied by State owned agencies. This deep rooted habit of dependence of the public negates the basic challenge emanating from the community. The ICDS manual envisages on the spot feeding of vulnerable children and pregnant or lactating mothers. But sometimes the beneficiaries are unable to get ration due to inaccessible AWCs and traditions or superstitions prevailing in the community. A large number of posts are lying vacant. It is difficult for ICDS functionaries to elude the pressure exerted by local politicians. Due to inefficient work culture in the government system, new ideas and practices are never welcomed. As a consequence of this, a large amount of budgetary allocations are surrendered or remain unutilized. Proper budgetary allocations and effective utilization of financial resources could improve the quality of ICDS services. There is need to avoid high cost model of ICDS, and the system should prefer to work with a model promoting the provision of necessities.

4.6 Health Services

Study was undertaken to evaluate the health services provided to children aged 3-6 years at ICDS centers and to know the extent of awareness and its utilization. Sample was taken from urban slums of Jammu City, and comprised 15 Anganwadis, 15 Anganwadi workers and 30 parents who attended Anganwadi centers. The investigation was done through interview schedules and observations. The study revealed that majority of these centers is located in hygienic surroundings. Parents found these centers best in providing health, nutrition, and immunization and referral services, free of cost. In 60% of the Anganwadi centers, play activities are performed for promoting healthy growth and development of children. Health cards were not given by the Anganwadi workers to the beneficiaries, but they maintained their records and registers and these were up to date. It was recommended that Health Cards should be provided to the beneficiaries so that they could keep a track of the health check-ups and immunization of their children.


The integration of services as proposed under the ICDS to improve the growth and development of children was inadequate in this village. This inadequacy, combined with shortcomings of village planning initiatives and the lack of a community voice, has hampered the success achieved by an otherwise laudable immunization program. The objectives of this study were to identify the factors that led to successful implementation of the Government of Jharkhand Routine Immunization initiative in Ghutia village; the factors that contribute to the lack of improvement of child nutrition in the same village; and the patterns of discrimination in the village in the provision of health services and their impact on disparities in child health and nutrition for the tribal population of the village. The Team visited 36 households with children under 5 years, and the key informants were the District Commissioner, UNICEF officers, Devnet NGO staff of
Integrated Village Planning, village head man, ANM and AWW. It was observed that in both the ANM’s records, IVP/AWW’s records, the village as a whole reached a perfect full immunization level in 2007. However, the primary data collected by team workers showed that 94.7% children had received full immunization. It was found that most of the children in the main village receive immunization at home, either during ANM’s regular visit or during catch up rounds The Team discovered little evidence of efforts to build the capacity of youth volunteers, to transfer responsibilities from NGO workers to local leadership, or to ensure what would happen after UNICEF terminated financing of the project. The Team recommends specific measures not only to revamp access to the ICDS but also to improve the availability and quality of nutrition and immunization related services offered under the scheme. The roots of this discrimination, like the intertwined underlying causes of child malnutrition, run deep in Ghutia village. Long term changes in access to economic opportunities and education must combine with efforts to ensure equitable improvement in child health and development, regardless of caste or tribe. Improved nutrition should require behavioral change and transformation of economic and political environments. There is need for strong governmental vigilance over the ration resources, which are reportedly being manipulated by the service providers.

4.7 Health and Nutrition Education


A total of 480 beneficiary mothers (BMs) and 60 AWWs were selected for the study. AWWs and BMs in urban areas had maximum awareness about the nutritional requirements of growing children that was 100% and 87.5% respectively. Though AWWs of both rural and tribal areas were fairly well aware but the respective BMs were quite lacking in knowledge about the same. Tribal lactating mothers had better practices, and they added milk, eggs, dal (pulses), daliya (porridge), ghee, etc. to their diet, in comparison to urban and rural mothers. All urban AWWs (100%) had right knowledge
about practice of breastfeeding within 6 hours of delivery in comparison to 85% rural and 65% tribal AWWs. Similarly, 90% urban mothers started breastfeeding within 6 hours of delivery in comparison to other groups of mothers. 95%, 80% and 80% of urban, rural and tribal AWWs and 88.7%, 68.7% and 70% of mothers respectively had right practices and were using katori (bowl) for feeding milk to their children. Urban group had the highest number of women adopting good practices among the three regions. 100% urban AWWs and 87.5% urban BMs had correct knowledge regarding nutrition in diarrhea. 85% rural AWWs and 71.2% rural BMs, and 70% tribal AWWs and 82.5% tribal BMs had correct knowledge about nutrition in diarrhea. 95% urban AWWs and 100% urban BMs had good practices regarding Anganwadi food for children. They encouraged children to consume the food. 75% rural AWWs and 72.9% rural BMs, 80% tribal AWWs and 88.7% tribal BMs encouraged children to consume the food provided at AWCs. 96.3% urban BMs and 95% urban AWWs had right practices for washing grains. In rural areas 80% AWWs and 60% BMs, and 70% tribal AWWs and 58.7% tribal BMs had correct knowledge about the same. Urban AWWs had 100% knowledge of vaccination in childhood, but only 70% AWWs in rural group and 85% AWWs in tribal group were aware. Awareness of mothers regarding vaccination was found to be 86.6% in rural areas, 82.5% in urban areas and 76.2% in tribal areas. Urban AWWs were 100% aware that there should be a gap between child births, while 71.3% urban BMs were aware of the same. Rural and tribal groups of AWWs and BMs had moderate awareness about keeping the right gap between child births. To improve the overall quality of nutrition and health education (NHEd), and develop the skills of AWWs refresher training should be organized at the sector level so that AWWs can easily participate in the training.


The present study was carried out to assess the knowledge of different respondents, women, adolescent girls and AWWs, on health and nutrition issues pertaining to children, pregnant women and nursing mothers. The study was conducted in three ICDS blocks of
Udaipur and two ICDS blocks of Sirohi, Rajasthan. After the baseline survey, project interventions were introduced in the program area for two and a half years. Thereafter, the final evaluation was carried out to assess change in the knowledge and practices of respondents. The main aim of the study was to decrease malnutrition among low income children in 621 AWCs from five blocks. The knowledge of AWWs increased about five immunization preventable diseases, i.e., TB, diphtheria, pertussis, tetanus, and measles. The net change in knowledge ranged between 12% to 36%. The strategy for training illiterate AWWs would therefore have to be suitably worked out so that illiteracy does not become a constraint in organizing effective training for village women. The residential status of the AWW seemed to affect the quality of training offered by her; hence efforts should be made to recruit women who have interest and commitment. Adequate space should be provided in AWCs so that women can come together in groups for training purposes. Since coordination with the health department was still weak, greater efforts should be made to ensure better coordination at all levels. The issue of inadequate honorarium to AWW needs to be addressed in order to sustain her motivation and interest in her work.


The Integrated Child Development Services Scheme (ICDS) is India’s most ambitious multidimensional welfare program to reach millions of children and their mothers who are caught in the grip of malnutrition. This study has been designed to ascertain the knowledge, attitude and adoption of improved practices in health and nutrition of ICDS beneficiaries in the context of health and nutrition education imparted to them in the Anganwadi. All the ICDS projects in Thiruvananthapuram district were selected for this study. The total number of Anganwadi centers (AWCs) selected was 100. Six pregnant and lactating women, mothers of pre-school children, and adult women participating in
the NHE program were chosen as the respondents from each Anganwadi centre, comprising a total of 600 beneficiaries. Results indicated that ICDS beneficiaries came in the medium category with regard to knowledge, attitude and adoption of improved practices in health and nutrition. Only 27% came in the high category, and the mean score was only 5.61 out of a maximum of 10, which indicated the need for enhancing knowledge about health and nutrition among beneficiaries by strengthening HNE component. The mean attitude score of only 66.48 out of a maximum of 80 also points to the less favorable attitude of beneficiaries towards the program. 65% beneficiaries were in the medium category, and only about 20% were in high category of adoption. The mean adoption score was seen to be 24 out of a maximum of 32. Religion was found to be significantly associated with the knowledge, attitude and adoption of improved health practices of ICDS beneficiaries. The marital status of ICDS beneficiaries was not found to have any association with their knowledge, attitude or adoption of improved health practices. There was significant association between being cosmopolitan and knowledge, attitude and adoption of improved NHE practices among ICDS beneficiaries. It was suggested that a viable nutrition and health education component should be built into the ICDS program, planned according to the needs of local people, and employ participatory techniques which would motivate and help develop interest of the beneficiaries in the program.

4.8 Impact of ICDS/ Primary Health Centre


The study investigated the impact of ICDS services on maternal weight gain in pregnancy, birth weight, gestation period and caloric intake. The sample comprised 5289 pregnant women who were registered during 1987-93 in 28 ICDS and 21 non-ICDS villages in two adjoining blocks of Varanasi. Anthropometric measurements, hemoglobin estimation and dietary assessment was done of all the subjects. Results revealed that
ICDS supplemented mothers gained 100 gm more during pregnancy, and birth weight of babies was higher by 58 gm as compared to unsupplemented ICDS mothers. ICDS supplemented women had a significantly smaller proportion of low birth weight babies (14.4%) compared to ICDS unsupplemented women (20.4%) and non-ICDS women (26.3%). A comparison of unsupplemented ICDS group with non-ICDS women showed 44.2% reduction in pre-term births and 23.1% reduction in low birth weights, which were due to other inputs provided under ICDS. Increased weight gain in pregnancy, length of gestation, caloric intake and hemoglobin level were significantly associated with birth weight. Nutrition supplement given to pregnant women in ICDS area improved weight gain of women during pregnancy and birth weight of babies, with reduction in pre-term deliveries and incidence of low birth weight.


The present study was conducted in 13 Anganwadis (out of 132) in Nand Nagri, East Delhi to assess the nutritional status of children in relation to utilization of ICDS during their early childhood. Information regarding utilization of ICDS facilities, socio-demographic details, general awareness, etc. was collected through interviews, anthropometric and clinical examination of every child, and attendance score of every child at the Anganwadis was calculated. Results revealed that most of the children (59.1%) were non-beneficiaries. Parents of most of the children were illiterates (60.7% mothers and 27.6% fathers). 94.2% children were attending schools. The proportion of children utilizing ICDS services for more than 6 months ranged from 8.8% to 24.3%. Age and sex of the children, education status of their parents and total attendance at the Anganwadi showed statistically significant relation with the degree of malnutrition. Overall, children who attended Anganwadis were nutritionally better than their counterparts who did not attend Anganwadi during their childhood. The study recommended that there was need to take special care of girls, as well as to continue the special nutrition care even at a higher age.
This study was conducted to assess the performance of ICDS with focus on health and nutritional status of children and mothers in the context of role of social organizations. This comparative study covered two states namely Maharashtra and Madhya Pradesh (MP). 480 beneficiaries were selected in Maharashtra and 660 beneficiaries in MP. In Maharashtra most beneficiary women were in the age group of 20-24 years followed by 28% in the 25-29 years age group. In MP 65% were less than 30 years of age. 52% CDPOs in Maharashtra and 61% in MP were engaged in the awareness campaign. 85% of the AWWs in Maharashtra and 90% in MP had taken steps to reduce malnutrition through proper monitoring and supply of additional nutritional supplement. The attendance of children was quite satisfactory in both states with more than 80% children having an average attendance of 275-300 days per year. In both states people were not taking interest in the functioning of ICDS. The no beneficiary children, pregnant and nursing mothers and adolescent girls, 25% in Maharashtra and 34% in MP, were attending crèche/ preschools, health centers and schools. The overall health of ICDS beneficiaries was good as they had access to health check up and nutritious food supplement. Children in non-ICDS areas did not have access to PSE and their abilities were less as compared to children in ICDS areas. Supply of food items was not satisfactory in 22% cases in Maharashtra and 30% cases in Madhya Pradesh. AWWs had to purchase many of the items personally due to lack of supplies. There should be a dress code for children. AWWs should be more qualified, and Supervisors and CDPOs should be graduates and postgraduates. The local community should be facilitated to have greater participation. NGOs, Mahila Mandalas and Yuvak Mandals must be motivated to
participate through interactions. Panchayati raj institutions should provide necessary facilities in the AWCs.


The study was carried out in Chittoor district in Andhra Pradesh in Primary Health Centers (PHC), one where ICDS was operational and the other were ICDS scheme was not in operation. The aim of the study was to know the nutritional and health status of people in the PHC area; and to understand the role of health staff at the PHC in the promotion of nutrition and health programs. A sample of 380 households from each PHC was taken, and children aged 1-6 years were examined for nutritional deficiency diseases. Interviews were conducted for data collection. It was observed that anemia was more prevalent among children in the non-ICDS areas (52.2%). In both PHCs, 40% respondents preferred home deliveries. In the PHC with ICDS scheme, 32.5% reported deliveries in government hospitals and 19.5% went to private hospitals; while in the non-ICDS PHCs, 30.6% respondents went for deliveries in private hospitals, followed by government hospitals (28.3%). It was found that the health status of children was better in PHC area with ICDS scheme rather than PHC area without ICDS scheme. It was recommended that the ICDS scheme should be expanded to all PHCs in the country. ICDS functionaries and PHC staff should work in a coordinated manner for achieving higher immunization coverage, and providing better pre-natal, natal, and post-natal services to mothers.

4.9 Job Performance of ICDS Functionaries

A total of 615 AWWs and 72 Supervisors were selected. It was found that the training centers were very old and there were no additional classes or laboratories for intensive work or doing practicals. There was no feedback taken from training centers. Their training had been done long ago and there had been no refresher training courses for them. 70% Supervisors had more than 10 years experience. Out of 72 Supervisors, around 52 of them visited AWCs only once a month, while 17 of them visited twice a month and only 3 Supervisors visited AWCs more than twice a month. 50% Supervisors looked into the many registers and records maintained at AWCs like attendance, growth chart, food record, Mahila Mandal meetings, etc. They also looked at records of severely malnourished children. Some said that decorating the AWC well would induce the children to come, while others mentioned that parents need to be convinced first to send their children to the AWC. 36% children were neat, clean, hygienic and obedient, and 12% children looked physically dirty and suffered from coughs and colds. 89% Supervisors mentioned that attendance of the AWW was regular. 56% Supervisors said that AWWs participated in the block office work and 13% participated only if there was some important work. 81% AWWs were fully trained and had adequate information to measure height and weight of children. 43% AWWs were giving personal attention to each child. 58% taught according to the syllabus. AWWs mentioned that training prepared them for informal education, nutrition demonstration, home visits, plotting weight charts and health related issues. All AWWs could weigh children and interpret growth charts. 90% Supervisors agreed that AWWs got average cooperation from villagers in their work. There is need to improve the quality of training, improve board and lodging facilities. There is need for Mobile Training Units. Basic text books should be available in regional language.
4.9.2 Analysis Of Role Effectiveness Of ICDS Supervisors Of Gujarat. Indore : NIPCCD, Regional Centre Indore- Gangur, S.G. (2007).\textsuperscript{33}

The study was conducted in Ahmedabad, Vadodara, Surendranagar, Valsad and Dangs district of Gujarat. Data was collected through interviews with Supervisors, CDPOs and AWWs. It was found that majority of the Supervisors were graduates (67%), postgraduates (23%) and matriculates. The distance travelled by urban Supervisors was less compared to the distance travelled by Supervisors of tribal and rural areas. Prior to undertaking visits, many Supervisors had travelled up to 30 km from the place of their stay in tribal and rural blocks. Major job responsibilities undertaken and time spent on each activity during the visits to AWCs were supplementary nutrition, records and registers, growth monitoring, and community and official meetings, etc. 38.33% of the Supervisors had utilized a maximum of three hours and more for planning and conducting meetings. 51.66% Supervisors had spent half an hour for undertaking home visits, especially for at risk women, children and disabled children. 3.33% of them had spent maximum time ranging from three to four hours for home visits. 60% of the AWWs felt that during field visits Supervisors could have given them guidance on maintenance of growth monitoring registers, supply of food materials, sustaining the quality of food to attract women beneficiaries, and also mobilizing panchayats and community support for delivery of services. 85% of the AWWs found that Supervisors were more helpful in managing AWCs. 80% AWWs felt that their Supervisors need to ensure solutions to the problems they faced such as timely payment of honorarium, monitoring of stationary requirements for AWCs, etc. 81% of the AWWs felt that Supervisors utilized more time in verifying records and registers mainly relating to supplementary nutrition, growth monitoring, food stock registers, and targets and achievements regarding health services. It was suggested that the number of NGOs managing one ICDS block needs to be reduced so that the monitoring mechanism could be streamlined. Government could develop training modules on management of ICDS for NGO executives. The present honorarium is insufficient. Honorarium needs to be enhanced in accordance with the standard norms of Government, rather than be based on number of AWCs fixed per year.

This study was conducted in the state of Andhra Pradesh to evaluate the job performance and job expectations of Supervisors working in urban, rural and tribal ICDS projects. Three districts, namely Hyderabad (urban), Anantpur (rural) and Visakhapatnam (tribal) were covered. Majority of AWWs in Hyderabad urban projects were Muslims who could not write in Telugu language and they were not able to fill up records and registers. In rural projects there were many vacant posts of Supervisors, and the Supervisors in position were supervising about 30 AWWs or even more. In tribal projects all the Supervisors mentioned that their major concern was the selection of uneducated women as AWWs who were not able to fill up the records and registers. There is an urgent need to select educated women as AWWs. AWWs in urban projects need to be trained intensively in filling up the records and registers. Urban Supervisors also mentioned that there was no crèche facility available where they could leave their children and they were not getting loans for owning vehicles. They suggested that these facilities should be extended to them. Necessary training may be imparted to Supervisors and AWWs to utilize the locally available material for preparation of toys, because in tribal projects AWWs were unable to attract and hold the attention of children during PSE due to lack of proper play material and teaching aids, and the children just took their food and ran away. Provision of the required facilities can divert Supervisors and AWWs efforts towards the effective management of ICDS scheme activities.

4.10 Low Birth Weight/ Infant Mortality


Accordingly, AMS Consulting Pvt. Ltd. was commissioned to conduct an Infant Death Audit in the rural areas of Uttarkashi and Pithoragarh districts to identify the various
causes of infant mortality in the project area, and suggest suitable interventions at various levels to bring about behavioral changes to reduce infant mortality. Block-wise details were gathered about the number of infant deaths in the year April 2004 to March 2005 based on the Monthly Reports of the ICDS and health department functionaries. The sample size for conducting infant death audits was fixed at 70 which was more than 50% of the total reported infant deaths in the area. 3 blocks from Pithoragarh and 2 from Uttarkashi were selected for the study. ‘Verbal Autopsy’ method was used for determining the cause of death. Findings of the study indicated that ARI/ pneumonia and diarrhea were the two major killers, accounting for nearly half (47%) of the total infant deaths. In 14% cases, the deceased baby was reported to have an inborn abnormality or malformation. The outbreak of measles accounted for 10% of the infant deaths in the area. In around 12% cases, the infant was assessed to have died due to asphyxia, hypothermia or tetanus. Other causes accounted for 14% of the cases. The overall incidence of low birth weight babies (LBW) in the study area was found to be around 41%. District wise analysis revealed the incidence of LBW to be higher in Uttarkashi (45%) as compared to Pithoragarh (36%). During the interaction, parents and caretakers were asked whether the infant was ill at the time of his/ her death. In 66 cases, parents had recognized that the infant was ill. Out of these 66, in 33% cases, the parents had not sought any medical treatment, even after recognizing that the infant was ill. At one place, in 28 out of 38 (75%) cases of infant deaths, ANMs reported that they had come to know about the infant’s illness only after his/ her death. AWWs capacity should be built to identify the signs and symptoms of ARI/ Pneumonia and she should properly counsel parents on home based care in such cases and in making referrals. Mother’s knowledge regarding diarrhea management should be enhanced. Dehydration should be controlled by giving WHO-ORS and feeding more than the normal quantity of fluids during diarrhea. Pregnant women should be weighed for weight gain during pregnancy which was virtually non-existent, but which was an important indicator of the pregnancy outcome. There was need to strengthen the referral mechanism for closer coordination between ANM and AWW. AWWs should be trained to use referral slips and health functionaries should give due cognizance to the referrals made by AWWs.

This study investigated the incidence of low birth weight (LBW) babies in three distinct geographical regions of Uttaranchal namely Garhwal, Kumaun and foothills. A sample size of 50 infants was taken, and ICDS and non-ICDS villages were compared. It was found that even in most of the institutional deliveries, family members were unable to tell the weight of the infant at birth. Parents’ perception was that about 43% of the babies born in Uttarkashi were much smaller than normal, while in Pithoragarh none was much smaller than usual as per parents’ perception. It was observed that 1 out of 7 (14%) LBW babies had received both BCG and OPV drops. It was recommended that if predisposing factors associated with pre-term birth like maternal malnutrition, pregnancy, high BP, diabetes, etc. are identified well in advance and properly managed; the problem of LBW may be reduced to a great extent. There is a need to orient AWWs on pre-term milk, essence of pre-term milk for a LBW baby, and on breastfeeding a LBW baby. AWWs may be asked to submit monthly details of the weight at birth of the newborns in her village to keep a check on them. There is need to launch an awareness drive in the community to create awareness about the necessity and importance of pregnancy registration. There is a need to provide training to AWWs on the use of referral slips and sensitizing health functionaries to give due cognizance to the referrals made by AWWs.

4.11 Malnutrition/ Nutritional Status/ Supplementary Nutrition/ Nutrition in ICDS


The study was conducted among 3633 pre-school children of 108 Anganwadi centers (AWCs) in rural Kerala to find out the hemoglobin level, weight for age status and dietary habits of preschool children. Information regarding their age, sex, clinical condition and dietary habits was collected on a proforma through interviews. Most of the
children belonged to low income non-vegetarian group (74.5%). The prevalence of anemia was 11.4%, and female children were more susceptible to anemia. Normal nutritional status was seen among 46.7% of the children, and while 11.78% of the mildly undernourished children were anemic, the percentage of anemia among moderately undernourished children was 16.37%. Among vegetarians 9.27% children were anemic, and among non-vegetarians 12.1% were anemic. Dietary survey revealed that consumption of iron from natural sources was below the recommended dietary level. Changes in eating behavior have the potential to affect the bio-availability of iron.


This study was conducted in Kerala, and a sample of 593 persons was taken for the study, comprising 5 CDPOs, 38 Supervisors, 200 AWWs, 200 beneficiaries and 150 elected representatives. In Thiruvananthapuram urban I, Kazhakuttom, and rural areas of Medumangad and Parassala projects, children did not have enough space for play, and beneficiaries had no facilities to sit and take food. 84.2% CDPOs mentioned that through the feeding program nutritious food was supplied to the most deserving beneficiaries in quite a regular manner. Majority of supervisors of Medumangad said that beneficiaries were not satisfied with the variety in the menu. 62% respondents felt that only deserving people were selected as beneficiaries, but members of local self-government institutions (LSGI) were not confident of this opinion, they expressed the need for more strict procedures for the selection of beneficiaries. 92.1% Supervisors said that members of LSGIs were very co-operative in implementing the feeding program. AWWs were not interested in approaching local people for getting assistance to handle any crisis. Shopkeepers refuse to supply food materials to AWCs due to delay in payment. 97.7% AWWs mentioned that the beneficiaries showed willingness to understand the situation when there was interruption in feeding. 76.5% AWWs said that beneficiaries had no complaints regarding accessibility to AWCs, and there was no demand for establishing new AWCs in their locality. 44% of the respondents accepted that the present feeding
program was effective. There is need to construct their own building for each AWC. AWW should be aware of the quantity of food required for her AWC. There is need to increase the storage facilities for food materials in AWCs, and the same food items should be supplied in all AWCs.


The present intervention study was carried out in Udupi and Karkala districts of Karnataka. The projects in operation cover 175 taluks and 10 urban areas. 239 (66.21%) children were registered and 231 (96.65%) were availing benefits. The number of pregnant women in the sample was 96, and 90 (93.75%) were registered and availing the benefits of SN. There were 75 nursing mothers of whom 71 (94.67%) were registered and all of them were availing SN. There were 572 AGs in the sample areas and 18 girls were registered in 10 AWCs. Amylase Rich Energy Food (AREF) was given to the beneficiaries after mixing it with lukewarm water and made into laddus (round sweets)/porridge. The composition of AREF is whole wheat (roasted), Soya dhal (steamed), defatted Soya flour (roasted), Bengal gram (roasted), powdered sugar, vitamins and minerals (premix) and malted ragi. The CDPOs of both the projects had official vehicles. Community and SHGs may have contributed towards utensils. CDPOs felt that the HCF provided was very well accepted, whereas the contacted supervisors (100%) admitted that it was only partially acceptable to the target beneficiaries, and 20% of the AWWs and community leaders were also of the same opinion. All the beneficiaries felt that the HCF given to them was somewhat acceptable taste-wise, but it became very monotonous to have the same food over and over again. It was concluded that hot cooked food was preferred by the beneficiaries and the functionaries. It was recommended that there is a need for infrastructure improvement in terms of providing separate storage space in the AWCs, ensuring supply of safe drinking water to the AWCs and its appropriate storage. Utensils for cooking and serving in the AWCs should be made available in adequate
quantity. Better supervision and monitoring by the functionaries as well the community would ensure improvement in the quality of cooking and the right amount of food being distributed to the beneficiaries. Coverage of beneficiaries needs to be improved. Supervision of the AWCs by the supervisor in particular, needs to be made more regular and intensive.


Children have special nutritional needs because of their extensive growth during the preschool age. The growth pattern or anthropometric measurements of a child is a useful criterion for judging his/her nutritional status. A study was conducted to determine the anthropometric measurements of preschool children (4-5 years) of Gurgaon district of Haryana. Data was collected of 300 preschool children (150 boys and 150 girls) selected from randomly selected 6 villages namely, Vazirabad, Jharsa, Chakarapur, Badshahpur, Teekli and Palra. Mean height of boys and girls was 87.49 cm and 84.67 cm respectively which was significantly lower than the reference value. Mean weight of boys was 13.65 kg and that of girls was 12.81 kg. However weight of boys and girls was significantly lower than the reference value, and was 88.35% and 86.44% of reference value. Sex-wise analysis showed that mean weight of boys was significantly higher than that of girls. This indicated that boys were heavier than girls in the preschool age. On the basis of mid arm circumference (MAC), 76% children were healthy, 18.3% were on the borderline and 5.7% were undernourished. Sub-optimum nutritional status of the preschool children might be due to lower intake of energy, protein and iron rich foods. While studying the effect of socio-economic factors on anthropometric measurements of children, it was observed that height and weight of children were affected by caste, income, size of family, landholding and father’s occupation.

The study investigated the impact of an integrated package of nutrition and health services on the nutritional status and morbidity profile of preschool children in Baroda. 610 preschool children (0-36 months) under an urban ICDS block were placed in three categories of service utilization, viz full, partial and none. Data on socio-economic characteristics of the children included family size and type, religion, education, occupation, per capita income, house type, toilet facilities and home sanitation. The findings showed that complete utilization of all services resulted in significant improvement in nutritional status as assessed through anthropometric indices viz height/age, weight/age, and weight/height. Data on morbidity among children showed that the frequency and duration of illness were significantly lower when the services were utilized fully, than when utilized partially or not utilized at all. Thus major efforts should go into the convergence of services and their full utilization by the community.

4.12 Management of ICDS


The Project, which was started in 1975-76, delivers services in 55 AWCs and 13 Mobile Centers. Out of these, four AWCs were randomly selected as the sample for the visit. The information about various ICDS services was studied through field observations and discussions with AWWs, AWHs, CDPO, BMO and other project staff. Information was gathered about pre-school education, supplementary nutrition, growth monitoring of children, nutritional status of children, delivery/child birth practices, breast feeding and weaning food, health and nutrition education, immunization, health check-ups, mobile AWCs and education and training of AWWs. Ten suggestions were given by people from the community and ICDS functionaries which included construction of AWC building with toilet facilities; supply of dry supplementary food in winter; children should be provided roasted chana, groundnuts and sugar in winter; AWCs should be given yearly
supply of food materials instead of half yearly; AWCs should have crockery, cutlery, towels and soap; AWWs may not be entrusted with work not related to women and children; technical assistance may be provided to project functionaries for taking up income generation activities (IGA) by SHGs for women, etc. Field observations were discussed with Director, Directorate of Social, Women and SC Welfare, Government of Himachal Pradesh. Action points were listed for qualitatively improving implementation of ICDS projects in the state viz., filling up posts of supervisors and CDPOs on priority basis; orientation of AWWs on conducting PSE activities, use of PSE Kit supplied by NIPCCD; continuing education of AWWs on growth monitoring, health check-up and referral services need to be revitalized; review of availability of plates and tumblers at AWCs for serving supplementary food to children, and storage facilities available at AWCs for food materials; and exploring the use of Mahila Mandal building as AWC.

4.13 Medicine Kit


This study was conducted by NIPCCD Headquarters in 2002 to evaluate the extent of utilization of medicine kit provided to AWWs in the northern, southern, north eastern and central region ICDS projects. 16 projects which were in operation since 1996 were selected – 4 project each from northern, southern, northeastern and central region. A total of 640 AWCs, 150 ANMs, 16 CDPOs, 4-5 Supervisors, 1280 beneficiaries and 100 community leaders were selected for the study. The availability of medicine kit was found to be very poor in all the four regions, and almost half the AWCs were without a medicine kit. Medicine kits were available in 48.7% AWCs in northern, 53.7% AWCs in southern, 36.3% AWCs in north eastern and 42.5% AWCs in central region respectively. About 96.8% AWWs made regular quality checks of medicines provided in the kit such as checking the date of expiry, change in colour of the medicine, etc. Proper storage space was available only in 66.8% AWCs in the northern region, 60.6% AWCs in the southern region and 65.6% AWCs of the central region. In the northern region, 63.5%
AWWs stored medicine kits either in lofts/ cardboard boxes/ tin drums/ benches/ stools or kept them on the table in polythene bags. 68.1% AWWs of the central region felt that the medicines provided in the kit did not cover all the illnesses prevalent in their area. In all the four regions, the most common diseases were cold, cough, fever and diarrhoea. 36.3% AWWs reported the prevalence of other diseases like malaria, worm infestation, dysentery, scabies, headache, vomiting, etc. Out of 633 AWWs, 504 AWWs had received job training. About 24.6% AWWs did not receive any separate training regarding the use of medicine kit. In all the regions, the utilization of medicines ranged from 76.3% to 86.2%. The least used medicine was Sulphacetamide whereas Benzylbenzoate emulsion was used maximum. Lack of transport facilities and dissatisfaction of the community towards the facilities available at the sub-centers and PHCs were the main reason mentioned by AWWs for weak referral services under ICDS. The utilization of services for all regions ranged from 28.7 to 84.9%, and was highest for SN (84.9%) and PSE (84.8%), and lowest for Health and Nutrition Education (28.7%). The community leaders of northern region (75%) and central region (63.6%) were not aware of the availability of medicine kit at AWCs. It is essential that the functionaries of the two streams, health and ICDS, work in close cooperation with each other in a coordinated manner. Feasible mechanisms for promoting interaction and functional linkages must be identified and institutionalized. It was recommended that separate training on the use of medicine kit and also special refresher courses should be started. Additional budget should be provided to replenish the supply of medicines in the kit. There should be regular monthly meeting of health and ICDS staff to discuss their problems. Time to time periodic evaluation of the systems, health and ICDS, should be done.

4.14 Mother and Child Protection Card

The broad objective of this study was to determine the effectiveness of the MCP Card as a community management tool. Mother and Child Protection Card is a folding pictorial tool designed to assist the mother to understand and monitor individual progress of maternal and child health and psychosocial development. The ultimate common goal is improving MMR (Maternal Mortality Rate) and IMR (Infant Mortality Rate) and reducing child malnutrition. The study was carried out in Shivpur district, Madhya Pradesh. The study sample constituted Chief Medical Health Officer (1), District Program Officer(1), Child Development Program Officer (CDPO) (2), Supervisors(4), Anganwadi Workers (AWWs) (10), Auxiliary Nurse Midwives (ANMs) (5), NGO representatives (2), and Mothers (94). The sections studied were respondent’s background, service provision, use of MCP Card, service demand and directive for improvement. It was observed that mothers’ understanding about health and child care issues had increased through use of MCP Card. However, individual interpretation of the pictures in MCP Card varied considerably among illiterate mothers who were unable to put the pictures into context with the written captions. It was found that communication was generally good among primary service providers, and between service providers and mothers. The complementary Cohort Register was repeatedly raised as a key convergence tool as it monitors service delivery and promotes referral services by identifying cases needing attention. In facilitating demand, the MCP Card is an effective community management tool, which empowers mothers to take responsibility and action for mother and child health. For the Card to be more effective in achieving its end goal of improving both maternal health and the holistic health and development of children, it needs to be implemented along with effective and functionally converging schemes. MCP Card should be modified to ensure that illiterate mothers understand the Card, thereby enhancing the demand for services. There should be special training for illiterate women. Only then would it reach its full potential as a tool to reduce high infant and maternal mortality rates (IMR and MMR), malnutrition and vital psychosocial neglect, thereby improving social indices and the quality of life of mothers and children.

Data for the Pre-Test Study was collected from all over India including the NCT of Delhi. In all, 280 mothers/women beneficiaries, including expectant mothers and nursing mothers were selected randomly from Mehrauli and Najafgarh ICDS blocks, who could comprehend either Hindi/English (read and write) for eliciting their views on the Mother and Child Protection Card. Data was also collected from ICDS and health functionaries. A total of 280 mothers/women beneficiaries, including 90 expectant mothers and 90 nursing mothers were selected purposively after ascertaining that the mother/caregiver had used the card in the past two months. The basic purpose of this exercise was to assess the knowledge gain of mothers after using the card and consultation of the guidebook in case of doubt. The percentage of mothers (both pregnant and lactating mothers) on clarity and comprehension of illustrations and messages on developmental milestones increased considerably. All pregnant and lactating mothers had gone through the card and guidebook out of interest. After two months of usage of the card, about 91% pregnant mothers and 92% lactating mothers expressed the view that the card should be in the custody of mothers as it has very valuable information about their child. 95% pregnant and lactating mothers felt that the card should be priced. Findings revealed that the gain in knowledge of pregnant mothers was considerably higher than that of lactating mothers. About 80% mothers, both pregnant and lactating, learnt about important aspects of child care, maternal care and developmental milestones and care behavior after reviewing the card. The functionaries seemed fairly satisfied with the information and illustrations on developmental milestones and care behavior. The illustrated portion of antenatal care in the card has comprehensively included all essential components of obstetric care. All existing cards in the health and ICDS sectors should be immediately replaced with the Mother and Child Protection Card, in order to avoid any confusion in the minds of health and ICDS functionaries.

4.15 Preschool Education in ICDS

Study was conducted to assess the non-formal pre-school education services provided at Anganwadi centers and to know the awareness and utilization level of these services. The sample, taken from the urban slums of Jammu City, consisted of 15 Anganwadi centers (AWCs), 15 Anganwadi workers (AWWs) and 30 parents of children who were attending AWCs. Data was collected through interview schedules and observations. In spite of the poor physical set-up of the Anganwadi centers, non-formal pre-school education was provided to the children. 53% of the Anganwadi workers used two way interaction methods in which they used joint sitting and singing songs. Anganwadi workers take the help of teaching aids like posters and puppets for imparting education to the children. It was recommended that physical set-up of Anganwadi centers should be improved. Adequate measures should be taken to make the parents aware of the progress of their children, and regular activities should be conducted for this purpose. Equal emphasis should be given to all the services of ICDS rather than focusing only on nutrition.


This study was conducted to assess the qualitative inputs being provided under different public initiatives of preschool in India. A total of eight districts were selected from 4 states namely Haryana, Himachal Pradesh, Uttar Pradesh and Punjab, and two clusters (one each from rural and urban areas) were selected, bringing the number of clusters up to 16. Total 96 PSE centers were studied. In Haryana and Punjab records were in very good condition, and in Uttar Pradesh they were in good condition. The attendance of all children enrolled was highest in RGNCS centers (90.62%), followed by ICDS (81.25%) and SSA (75%) centers. Average attendance was 100% in all three public PSE settings in Punjab; it was 87.5% in Uttar Pradesh and 75% in Himachal Pradesh. In Uttar Pradesh
only 37.5% centers had full attendance in comparison to ICDS in Himachal Pradesh and Punjab (100%), and Haryana (87.5%). About 50% of SSA centers in Himachal Pradesh and ICDS centers in Uttar Pradesh had half attendance. 12.5% ICDS centers each in Haryana and Uttar Pradesh had less than half attendance. The transition rate was above 80% in most of the PSE centers. Highest transition rate was among ICDS centers (75%), followed by SSA centers (56.25%), and RGNCS centers (50%). 6.25% RGNCS centers had 0% transition rate, followed by 3.12% in ICDS and SSA centers. 0% transition rate was found in Uttar Pradesh only, and in 25% SSA centers in Himachal Pradesh. It was suggested that decentralized mode of training initiatives have to be strengthened through respective BRCs (Block Resource Centers) and CRCs (Cluster Resource Centers). NCERT may be assigned the task of doing work in pedagogical aspect for ECE initiatives under SSA/ NPEGEL, while NIPCCD may be given the responsibility of continuing with training, research and resource material availability for ECE (Early Childhood Education) under ICDS and RGNCS.

4.16 Psycho-Social Development

4.16.1 Learning Stimulation to Rural Pre-Schoolers. Psycho-Lingua, 32(1) - Saini, Sarita and Sharma, Seema. (2002).48

The study was conducted from 1997 to 1998 in Punjab to study the perceptions of the parents about the importance of learning stimulation for pre-schoolers aged 3 to 6 years, and to investigate facilities provided at home and at Anganwadis. The data was collected from 5 villages of 4 districts namely V. Sidhwan Bet (Ludhiana), Pohir (Ludhiana), Bhokhra (Bhatinda), Dhanola Khurd (Sangrur) and Kheewewal (Hoshiarpur). The sample consisted of the parents and caregivers of 370 children attending Anganwadis and Anganwadi workers (AWWs) of 13 Anganwadis, who belonged to low socio-economic status families. Home inventory scale, personal visits, structured interviews and openended questionnaires were used to collect the data. It was found that the services meant for children were quite inadequate. The supply of play materials and supplementary meals was irregular and inadequate. Only 4% Anganwadis provided
adequate play material and 24% provided mid day meals to children. The available play materials were kept locked in the room/ almirah and were rarely accessible to children. The children were irregular in attendance during the days when there was no food supply. The study indicated that the home environment was not conducive for the optimum growth and development of children. Parents hardly had any time to cater to the demands and needs of their children. Children spent most of the time roaming here and there, and just playing with their age mates. It was recommended that the developmental outcomes of children could be improved through home-based comprehensive interventions. Universal literacy program should be started to improve the socio-economic status of the people. To provide better services to disadvantaged groups, community support needs to be mobilized.

4.17 Role of Anganwadi Workers


The main causes of infant and child mortality in developing countries are diarrhea, malaria, measles and malnutrition. National Family Health Survey II (NFHS-2, 1998) data also includes fever (27% prevalence in the last 2 weeks), acute respiratory infection (ARI 17%), diarrhea (13%) and malnutrition (45%) as causes of child mortality. The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) is a new UNICEF and Government of India strategy to reduce the Infant Mortality Rate (IMR) and under-five mortality rate (U5MR). IMNCI strategy aims to improve skills of functionaries providing health services to children and the community by providing intensive training. By June 2005, 457 of the 1700 health and nutrition workers in Valsad district had been trained. Pilot scheme was implemented in Valsad district, having a large tribal population. A sample of 24 frontline functionaries from 4 PHCs and 13 villages were interviewed, as also AWWs, mothers, health functionaries, AW Supervisors, MOs, trainers and the Chief District Health Officer. 13 villages and Dharmpur and Valsad
Panchayats were connected to 4 PHCs. Post training majority of AWWs knew that they should visit newborns 3 times within the first 10 days after birth, and issues like health problems of children should be discussed. AWWs possess some medication in medicine kits to treat some common ailments of the community, especially those living in remote areas. Many AWWs were not able to use the chart books, or even know when they should be used (to assess serious illnesses). It was recommended that AWWs should be given additional training; structured assessment should be done; practice of using ANMs and Multi-Purpose Workers (MPWs) to translate lessons into local dialects should be promoted; and use of visual aids should be increased. The importance of teamwork and communication between health and ICDS functionaries should be emphasized during training and implementation. UNICEF needs to redesign the format of registers and make the contents simpler. ANMs and AWWs should receive some monetary incentives for travelling to remote areas.

4.18 School Enrolment


The present study was done to assess the long term effects of ICDS on the behavior and academic achievements of children in their post Anganwadi years. The study was conducted in Raipur Rani ICDS block, district Panchkula, Haryana. Data was collected from Anganwadis (AWs) and 1067 children in the age group 7-13 years through household survey. It was found that a majority of the children 1022 (96%) were school
going. Of the 46 children who never attended school, 72% (33/46) were girls. More regular users were studying in Government schools (76%) compared to non-users (61%). Children’s grades/ academic achievement were analyzed in relation to AW use rate. About 59% (119/202) non-Anganwadi users, 64% (188/292) irregular users and 59% (235/400) regular users had scored good grades. The user rate was defined in two ways - children having used Anganwadis from 0-6 years of age and those having availed services only from 3-6 years excluding the first 3 years of life. Analysis of general behavior and personal hygiene of children revealed that 82% children took regular bath, 90% groomed hair regularly, 79% cut nails, 91% wore washed clothes, 68% cleaned teeth daily, 88% washed hands before eating, and 94% washed hands after going to toilet. Regular users of Government schools lagged behind non-users in combing hair and in school absenteeism. The study suggested that awareness about ICDS services should be increased among community people in rural areas so that they could avail all the benefits. Also, effective training should be given to the ICDS staff such as AWWs so that they can provide proper services to the people.

4.19 Time Management of ICDS Functionaries


This study attempted to make a realistic assessment of the time utilization by AWWs in relation to their multifarious tasks, and evolve appropriate strategies for improving the functioning of AWCs in Kerala. 400 AWCs and 10,470 respondents were selected. In 76.7% centers less than 20 minutes were assigned for motor activities, which should have been 30 minutes daily. AWWs in 25.3% never attended to this aspect. AWWs in 43% centers did not assign time for creative activities but more AWWs in tribal areas undertook creative activities than AWWs in rural areas. In 37% centers, AWWs spent less than the expected time for supplementary nutrition (SN). Urban areas had highest
number of centers where AWWs allocated 90 minutes on SN. The average time spent for each house visit was to be 19-20 minutes, but AWWs in majority of the centers (69.8%) spent below 20 minutes for this. For maintaining records 27-30 minutes were spent daily, which was equivalent to the expected time. However, in certain centers more time was spent on maintaining records. Almost 100% centers had weighing scales, and children were weighed regularly. More than 75% centers utilized morning hours for weighing children. Immunization camps were organized at the AWC in 66.8% cases, the rest were organized at the primary health centers. In 80.5% of the AWCs immunization camps were organized monthly. AWWs spent one day each for project level and sectoral meetings. Time was spent on informing the community, making arrangements, taking sessions and reporting. The average time spent was 30 minutes each, but more than 90% of the AWWs spent below 30 minutes. There was no perfect referral in the centres. However, most centers provided referral services either partially or for namesake. AWWs mentioned that inadequate public cooperation hindered the smooth functioning of centres. Exhaustive tasks and lack of time stagnated their creativity for discharging their duties in a better way. Helper mentioned that absence of AWWs normally doubled their workload. Beneficiaries were satisfied with the ongoing services of the centre but they complained about the poor infrastructure in a majority of the AWCs. Majority of the key personnel appreciated the activities carried out by AWWs, but they also expressed the need to discontinue certain tasks like health services, surveys, number of meetings, number of registers to be maintained, house visits and panchayat related tasks. Efforts should be made, at the policy level, to exclude the AWW from undertaking health services. AWWs should only be entrusted with the task of supplying IFA tablets and other medicines in the kit. The number of registers and records to be maintained by AWWs should be reduced. The number of sectoral/ project level meetings should be reduced. A time frame should be fixed for specific activities/ services of the pre-school component. Indicators for monitoring allocation of time for various activities should be incorporated in the training module of the Supervisors and Child Development Project Officers (CDPOs). Strict measures should be taken by the authorities to minimize interruptions during pre-school activities.
4.20 Training of Anganwadi Workers/ ICDS Functionaries


Out of the 30 districts where the induction training of AWWs has been conducted, 9 districts namely Bastar, Raipur and Surguja in Chhattisgarh; Chhatarpur, Sagar and Shahdol in Bundelkhand; Bhind and Guna in Vindhyachal; and Jhabua in Malwa region were selected for study. Each selected district has minimum 200 AWWs who have undergone induction training for 15 days between June 1996 and June 1997. 23 ICDS projects, 12 tribal and 11 rural were selected randomly. In all, a sample of 474 AWWs was selected out of 4734 AWWs for the purpose of the study. Majority of AWWs (62%) were less than 25 years of age. Chhattisgarh and Bundelkhand regions had higher percentage of younger AWWs whereas Vindhyachal regions had higher proportional of AWWs in the age group 26-35 years. Majority of the AWWs (86%) were below the poverty line. Only 14% AWWs were from families with monthly income above Rs. 1000/-. More than 90% AWWs of Bhind, Surguja, Sagar and Guna districts were below poverty line. Induction training made AWWs aware of their job responsibilities. 85% AWWs had adequate knowledge of their job responsibilities. Chhattisgarh region had the highest number of AWWs having adequate knowledge (92%) whereas Jhabua district in Malwa region had the highest number of AWWs (36%) with inadequate information about their responsibilities. 10% AWWs could understand the criteria for conducting pre-school education activities. Teaching aids like charts, clay modeling and flash cards were prepared by 30% AWWs. Only 21% AWWs were found to have satisfactory knowledge about pre-school education. Majority of the AWWs (71%) had adequate knowledge about immunization (UIP). 54% AWWs had knowledge of using medicine kit, but it was made available to about half of them only. The objective of referral services was clear to only 46% AWWs. About 34% AWWs had knowledge about nutritious value of supplementary nutrition (SNP) items distributed to beneficiaries while 66% could not reply. 50% AWWs were aware about the grading system, and identification of malnourished and ‘at risk’ children could be done by 64% AWWs. The knowledge regarding nutrition and health
education (NHED) was found adequate for about 56% AWWs (67% AWWs in Bastar; lowest was 32% AWWs in Sagar district). Only 43% AWWs organized NHED sessions adequately in mothers/mahila mandal meetings. 85% AWWs had adequate knowledge about their job responsibilities, MPRs (76%), women’s welfare schemes and role of other ICDS functionaries, medical and paramedical staff (75%). 95% of the respondents felt that more intensive training was required. 15% of them felt that further training was required in all the subjects, while 64% were unable to express specified topics/areas of training. 10% AWWs mentioned NHED, 3% growth monitoring and 2% AWWs mentioned PSE as areas that required further training.

### 4.20.2 Impact of ICDS Training On Service Delivery by Anganwadi Workers: A Study.

This study was conducted to evaluate the impact of Job Training Course (JTC) on job responsibilities of AWWs. Two districts of Uttar Pradesh, namely Muzaffarnagar and Saharanpur were covered, and 100 AWWs, 50 from Saharanpur AWTC and 50 from Muzaffarnagar AWTC were selected. AWWs’ ability regarding composite skills concerning PSE sessions, namely storytelling, narrating children’s song, organizing outdoor games, organizing creative activities, organizing number games, organizing word games, etc. was evaluated. It was found that the AWWs who had undergone the JTC were equipped in a better way with five skills namely storytelling, narrating children’s song, organizing creative activities, organizing number and word games. AWWs who had attended the training had significantly better composite skills for communicating with children than those AWWs who had not attended JTC. In the new syllabus of JTC, the practice of STTD (Simultaneous Training Technology Design) has been adopted, in which the trainees not only use their skills in role play, but also practice these skills in institutional settings. There has been a special session on skills for interacting with preschoolers, thus JTC had a significant impact in developing the skills of AWWs to communicate with children more effectively. But there was insignificant difference on
the skills of softness in voice and appropriateness of communication at children’s level in
the field. The ICDS functionaries lacked the basic directional philosophy of the scheme.
They always seemed to need early childhood education aids supplied by state owned
agencies. This habit of AWWs negates the basic challenge emanating from the Non-
Formal Pre-School Education component of the ICDS Scheme. AWWs of both the
groups were able to keep children happy and allowed children to play with toys/play
material. The AWWs who underwent JTC did not exhibit significant gain on the
composite skill of delivery of supplementary nutrition and its constituent set of two skills,
namely maintaining hygiene and distributing supplementary nutrition as per norms under
the schematic pattern of the scheme compared to their counterparts who did not attended
JTC. After training AWWs had learnt the skill to prepare a variety of foods because there
were enough number of sessions during JTC on this. They could use locally available
food stuff and ready to eat food. AWWs who had attended JTC had better composite
skills for eliciting community participation than those who had not attended JTC. Both
the groups of AWWs had a similar attitude towards running the AWC efficiently but the
inner willingness of AWWs to go through the reading material was much more in the
case of AWWs who had attended JTC. The syllabus of JTC should be developed
according to the educational and professional background of AWWs, trainers of AWTCs
and infrastructure and process based facilities available at AWTCs. Intensive research is
required (by NIPCCD) to ensure that the concepts introduced are compatible with the
understanding of trainers as well as trainees of AWTCs. Training strategies should be
designed in such a way that the trainees are adequately prepared to handle the revised
syllabus. Trainers’ guides or handbooks should be made available to all the trainees.

4.21 Udisha Training

4.21.1 Evaluation of Project Udisha: The National Training Component of World Bank
Assisted Women and Child Development Project: 2 Vols. New Delhi: ORG-
Integrated Child Development Services (ICDS) program is the world’s largest child care program reaching out to 35.4 million children below six years of age and 6.4 million expectant and nursing mothers. Udisha, the nationwide training component of ICDS program, implemented since 1999, is the crucial foundation of the new Women and Child Development Project. The highlights of Udisha are revision of the syllabus, revised financial norms, training based on area/ region specific needs, integration and coordination of training, clearing backlog for job and refresher training for AWWs by training teams, technical support and institution building, and monitoring. Both, secondary and primary sources were utilized to study the progress of Udisha; training needs of ICDS functionaries; and impact of training on quality of service delivery. The achievement of CDPOs/ ACDPOs training was 42%. Chhattisgarh, Maharashtra, Assam, Meghalaya, Bihar and Tamil Nadu did organize a variety of innovative training programs. Out of 571 sanctioned AWTCs only 445 (80%) were operational. Shortage of training infrastructure in Madhya Pradesh, Bihar, Orissa, Andhra Pradesh, Rajasthan and Gujarat was relatively very high. The syllabus has been revised by shifting the focus on child centred development revolving around the six services of ICDS. Officials at the Central and State level had positive opinion with regard to improvement in the skills of various functionaries. Overall 91% supervisors said that training has helped the system in improving service delivery in the field. Over 50% supervisors contacted felt that there has been a change in the way pre-school activities were organized post Udisha training. Various constraints at AWCs do not allow the AWWs to perform at their best. In case of supervisors refresher training, Punjab has achieved 66% of the target, while Himachal Pradesh has achieved only 1.4% of the target. A few reasons for no achievement of the desired target was delay in creation of training infrastructure, frequent transfers or deputation of trained CDPOs to other departments, low attendance, non-availability and no accessibility of training infrastructure and aids, etc. In UP, after the launch of UDISHA, one innovative training program was organized in the year 2001-2002. Assam has undertaken 12 innovative trainings for AWWs and supervisors. CDPOs reported that there were several constraints faced by supervisors and AWWs at the grassroots level. The excess workload on AWWs and their low remuneration were also revealed as major constraints. To enable the AWWs to work in line with the objectives of the training, it is
essential that ground realities are understood and addressed, and problems related to infrastructure and supplementary nutrition is tackled effectively.

4.22 World Bank Assisted ICDS Projects


The study was carried out to provide baseline indicators to assess the effective implementation of World Bank assisted ICDS Phase III in 26 ICDS blocks spread over 20 districts of Rajasthan, selected by systematic random sampling. The survey covered 12,883 households (HHs), 21,013 children aged 0-6 years (12775 aged 0-3 years and 8238 aged 3-6 years), 1223 pregnant women, 7253 lactating mothers, 4160 non-pregnant non-lactating women and 3410 adolescent girls. About 14% children aged 0-3 years were severely malnourished, and 23% were underweight. In the 3-6 years age group 13% were severely malnourished and 24% were underweight. The incidence of low birth weight (LBW) was nearly 30%. In tribal areas in old ICDS blocks, the incidence of LBW was about 40%. Around 30% of the children surveys were registered at the AWCs, and in the tribal group in old ICDS blocks nearly 49% children were registered. Nearly 63% children aged 3-6 years were registered at AWCs and attended pre-school education. Exclusive breastfeeding of children aged 0-5 months was reported in about 10% cases, colostrums was given to 21% children, and vitamin A rich food was consumed by 23% children 3-36 months old. Nearly 27% pregnant women reported consumption of IFA supplements and 17% received supplementary food from ICDS. Around 25% of the deliveries in Rajasthan were institutional deliveries. Nearly 23% adolescent girls were aware of family life education (FLE), and AIDS awareness was found to be around 50%. Around 3% adolescent girls consumed IFA supplements. Regular weighing of children 0-36 months was found in 86% AWCs, and growth monitoring of children 0-72 months was found to be the practice in 39% AWCs.

World Bank assists ICDS projects so that qualitative improvement is achieved in services provided. The present study explored the functioning of World Bank assisted ICDS – II projects in Chhattisgarh, and assessed the existing level of ante- and post natal care; breastfeeding and childcare practices; awareness about Anganwadi centers (AWCs); nutritional status of children and growth monitoring; their perception of the causes of under nutrition, i.e. health and other specific reasons; understand the resource base of beneficiary groups; and the manner in which they met their nutritional needs. The information related with this study has been collected from heads of households, mothers of children aged 0-3 years and 3-6 years, pregnant women, lactating women, adolescent girls and Anganwadi workers (AWWs). The World Bank assisted 152 blocks in 16 districts, of which 61 were rural, 85 were tribal and 6 were urban blocks. The study covered 66 AWCs. Mahila Mandals were formed in all AWCs where health and nutrition education was imparted to women. Mothers were not aware of the causes of malnutrition in urban areas, and in tribal areas they believed malnutrition was a curse of God and Goddesses. In rural areas they believed ghee and milk would cure malnutrition. Efforts should be made to make the community aware about malnutrition and remove misconceptions about food through proper nutrition education.


The ICDS-III Project was made effective for a period of five years originally in five states covering Uttar Pradesh and Rajasthan in the northern part, Maharashtra in the western part, and Kerala and Tamil Nadu in the southern part of India. The Project envisaged introduction of ICDS services in 318 new (uncovered) blocks and strengthening and improving service quality and management in 685 existing (old) blocks.
in these states. The distinctive feature of the coverage of the Project was the inclusion of 69 tribal blocks (in Rajasthan, Maharashtra and Kerala), 51 coastal blocks (in Kerala), 804 rural disadvantaged blocks (in five states), and 79 urban blocks with poor outreach of basic services (in Rajasthan, Maharashtra and Kerala) in the Project. The National Training Component of ICDS-III Project, Udisha, aimed at improving the quality of ICDS services by providing for improved training of ICDS functionaries all over the country; strengthening/establishing training centers, developing training materials, etc. UDISHA focused on eliminating the heavy backlogs in jobs and refresher training of all functionaries. Capacities of existing AWTCs and MLTCs (Middle Level Training Centres) have been further strengthened to take up increased responsibility and new AWTCs and MLTCs have also been established for the purpose. The Project has achieved overall its main objective of clearing the backlog of job training. A total of about 928,000 ICDS functionaries, out of which 366,000 AWWs and 759,000 other persons have been imparted on the job and refresher training under the Project through a countrywide network of about 600 AWTCs, 40 MLTCs and the National Institute of Public Cooperation and Child Development and its Regional Centres. The overall performance under job training for the different categories of functionaries was 115% of the PIP target, while such performance under refresher training was 129%. The performance as per revised targets are 84% for all categories of functionaries under job training and 68% under refresher training. Information, Education and Communication (IEC) had been one of the major interventions in the Project, which laid special emphasis on IEC by focusing on communication for behavior change (BCC) for appropriate child caring and rearing practices in households. Free Expression for Quality Improvement (FREQI) provided an opportunity for the formation of quality circles to encourage better interaction among AWCs, they could exchange notes freely, bring them to the notice of the supervisory staff, and with their support achieve higher quality of service delivery. Kerala had conducted the maximum number of FREQI meetings and used up the entire allocation, followed by Tamil Nadu with 98% utilization, Uttar Pradesh with 97%, Rajasthan with 88%, Maharashtra with 74% utilization and the overall achievement was 88%. Some of the major problems identified due to FREQI meetings were that there were absence of growth monitoring charts and weighing scales, dislike of the supplementary
food by the community, operational problems regarding shifting of AWCs to primary schools, and absence of referral slips, etc. There were some new initiatives taken during the implementation of Project Udisha, like training through Mobile Training Teams, which was provided at the project level/block level by key trainers. This training has been in full operation in Tamil Nadu, and partly in the states of Uttar Pradesh, Rajasthan, Madhya Pradesh, Nagaland, Sikkim and Jharkhand. Significant progress was achieved in antenatal care, immunization, de-worming and treatment of diarrhea. Monthly growth monitoring of children under 3 years also improved overall, as was mentioned by AWWs (from 67% in Base Line Survey (BLS) to 82% in End Line Survey (ELS)). Practice of weighing infants at birth showed overall improvement from 40% in BLS to 46% in ELS. Impact of Information, Education and Communication (IEC) was increased awareness of infant feeding and breastfeeding practices among the AWWs. But knowledge transfer from AWWs to AGs and women remains a matter of concern. In Uttar Pradesh, a team of talented AWWs formed ‘Anganwadi Kala Jattha’ to spread awareness and social mobilization campaigns through rallies, door to door contact, wall writings, folk songs, group discussions, Nukkad Nataks (street plays) and quiz. By performing live in front of a large audience, AWWs have gained immense confidence, which reflected in a positive improvement in their routine work of running AWCs. AGs clubs were constituted under each AWC in the state which was an innovative initiative under the ICDS-III Project, considering the importance of adolescence period in a life cycle. There is urgent need to establish a Nutritional Surveillance System up to the block level to monitor the nutritional status of severely and moderately malnourished children and take appropriate actions for their management. Establishment of State Project Management Unit in the project states and central project unit at the central level, along with all necessary project approval processes, should be completed before the launch of the Project for an effective taking off of the Project.

The World Bank assisted Andhra Pradesh Economic Restructuring Project (APERP) under which strengthening the Integrated Child Development Services (ICDS) component was the major initiative. Under APER Project, the ICDS component covered 251 blocks, 108 old ICDS projects for service quality improvement inputs, and 143 new blocks in which ICDS services were initiated in 21 districts. Baseline data from Mehboobnagar district showed that 79% adolescent girls (AGs) were anemic, a large number of children were moderately malnourished, and the prevalence of stunting among children was widespread in the state. Objectives of the project were universalization of ICDS which has now been achieved in terms of block outreach; but to target the deserving poor households will be the real challenge during the remaining project period. Service Quality Improvement has been good where all 101 new blocks have received equipment and supplies; and Women’s Empowerment Mothers’ Committees were constituted in the newly expanded 101 blocks. Reduction of adolescent girls’ anemia (79%) is the single most important outcome indicator the Project needs to focus on in order to address inter-generational malnutrition. There was sustained progress under Civil Works. “Mother and Child Health Protection Cards”, known as “Sanjeevini Cards”, that were launched in 61 projects in Phase I of the program have now been expanded to cover 150 plus 101 blocks. Model Early Childhood Development (ECD) Centers along with ICDS were instrumental in ensuring that 0.2 million children were enrolled in Class I. There was sustained progress in implementing joint activities between the ICDS and the Andhra Pradesh State AIDS Control Society (APSACS). Under UDISHA, more than 30,000 AWWs and Helpers will require training. A visit to AWC, Rachapalem, Chittoor District revealed that the Adolescent Girls Program of the center had 15 enthusiastic participants. The Primary Health Centre (PHC) appeared to be well maintained with no cases of infant deaths or maternal deaths reported during the last one year. Under Nayudupeta Project in Nellore District, buildings were constructed in 41 centers under the Project. There were 15 cases of severe malnutrition among children in the age group 0-3 years, and 5 cases in the age group 3-6 years. Most of the women were actively participating in the management of the ICDS program, such as village mapping, and addressing advocacy issues like age at marriage. It was recommended that a rapid assessment of tribal blocks should be undertaken. In order to clear the backlog of training
of ICDS functionaries, there is need for constituting non-institutional mobile training under the scheme. It was also recommended that provisions should be made for visits by doctors to tribal blocks, and incentive schemes taken up for functionaries should be reviewed. A systematic effort is required to involve women in core issues of ICDS such as reduction of child malnutrition through improved home based care and feeding. A pilot project is recommended with some committees to be established on the line of the Community Interest Fund (CIF) based on the concept of the District Poverty Initiative Project (DPIP). The innovative activity funds under the project may be utilized to set up Anganwadi funds as revolving funds to be used for improving health referrals, emergency care of children and women at risk, and for any other purpose that the Committee finds useful.

References:


43) Paul, Dinesh, Et Al. (2003), Evaluation Of Medicine Kit Provided To Anganwadi Worker. New Delhi: NIPCCD.
50) Aggarwal, Arun Kumar and Rajesh Kumar. (2005), Long Term Effects of ICDS Services on Behavior and Academic Achievements of Children. Chandigarh: Post Graduate Institute of Medical Education and Research, Dept of Community Medicin.
57) Implementation Completion Report Of World Bank Assisted ICDS III/ WCD Project: 
India, Ministry Of Women And Child Development, New Delhi.

58) World Bank Economic Restructuring Project (APERP) (Credit 3103-IN) 
Nutrition/Integrated Child Development Services (ICDS) Component: Supervision 