CHAPTER II

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2.1 INTRODUCTION

A substantial amount of research has been carried out on Anganwadi workers from the perspective of social, political, health, cultural and economics. Various studies in recent past has revealed that implementation of services under ICDS are not up to satisfactory standards and still more efforts are needed for improving the quality of services for the successful achievement of expected targets (Barman 2001; Forces New Delhi 2007). In the opinion of some scholars the achievement of ICDS programme goals depends heavily upon the effectiveness of the Anganwadi workers, which in turn, depends upon their knowledge, attitude and practice (Sharma, 1987; Chattopadhyay, 1999). The studies done in past have strongly concluded on the need of improved knowledge and awareness among Anganwadi workers but unfortunately it was found to be the most underrated aspect of their job profile (Kant et al., 1984).

2.2 METHODOLOGY AND SOURCES

Information sources both primary and secondary sources were consulted for the literature review that includes

- Sociological Abstracts (2003-2013) Published by Cambridge Science Abstracts
- ERIC Database, Silver Platter (2005 – 2011),
- UGC Infonet full text journals particularly www.jstor.org
Efforts have been made to identify the existing relevant literature on the research problem by scanning, browsing and reading the original documents and consulting abstracting sources. Appropriate notes were taken and wherever the original documents were not available, the relevant information has been culled out from the abstracts for the preparation of the review.

2.3 REVIEW OF LITERATURE

Ameya et al., (2005) assessed the functioning of the ICDS Anganwadis at the grass root level. Five 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. 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.

Correct knowledge and perception for promoting complementary food practices was found to be 40% among the ICDS AWWs (Parikh, 2011). So it leads a critical gap between knowledge and practice of complementary feeding, so equipping the AWWs is the major homework has to be done for betterment of figures (Parikh, 2011). Another study shows that awareness about ICDS services increases with the increased level of education (Thakare, 2011). Also the same study indicates that fewer honorariums with excessive work can be viral to efficiency to AWWs (Thakare, 2011).
Nicola et al.,(2007) reported that there was variation in poverty and human development indicators across the 4 sites, namely Amrabad mandal, Mehboobnagar 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 viewpoints 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.

Sobha, I. (2003) analysed that 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.

**Functioning of Anganwadis**

_Nibha Rani (2001)_ reported that 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.

Ameya, et al., (2005) analysed that 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. Chakapara 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.

**Pandey, D.D. (2004)** analysed that 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.

Bharati et al., (2003.) studied 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.

Tomohiro et al., (2007) reported that 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. There is need for strong governmental vigilance over the ration resources, which are reportedly being manipulated by the service providers.

Joshi, Anita. (2001) analysed that 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.

Nagi, B. S., et al., (1997) reported that 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.

Agarwal, K. N. et al., (2000) reported that 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.

Prasanti Jena (2013) has reported on “Knowledge of Anganwadi Worker about Integrated Child Development Services (ICDS): A Study of Urban Blocks in Sundargarh District of Odisha” Today Integrated Child Development Services (ICDS) represents one of the world's largest programmes for early childhood development. The main objective of this programme is to cater to the needs of the development of children in the age group of 0-6 years. The Anganwadi worker is a community based front line voluntary worker of the ICDS programme. Though government is spending lot of money on ICDS programme, impact is very ineffective. Most of the evaluation study concentrated on the nutritional and health status of the beneficiaries of ICDS. Less focus has been shifted over to assess the knowledge and awareness among AWW regarding recommended ICDS programmes, who are actually the main resource person. The key objective of the present study is to assess the correct knowledge among Anganwadi Worker about
Integrated Child Development Services (ICDS). The sample for the present study comprises of 30 Anganwadi workers belonging to three Urban Blocks of Sundargarh Districts. Twenty six knowledge indicators are considered to estimate the mean knowledge score related to six domains of ICDS services. Total knowledge score is estimated by adding the individual scores of each response. Results from the analysis suggest that most of the Anganwadi workers are trained; but it was found that performance as well as awareness among Anganwadi workers regarding the importance of growth charts and growth monitoring was not satisfactory. The quality of knowledge was one of the neglected features among job profile of Anganwadi workers. The mean knowledge score about various ICDS services is about 12.83, and the individual score ranging from minimum of 7 to maximum of 19. Therefore, the study strongly felt the need of improving the quality of knowledge and awareness among Anganwadi workers about various ICDS Services. Hence, there is a strong and intense need for improving the training quality provided to Anganwadi workers before letting them go into the field jobs. Frequent interactions among Anganwadi workers and supervisors should be introduced for imparting information and awareness.

Patil SB, Doibale MK, (2013) reported on “Knowledge and problems of anganwadi workers in ICDS locks: a cross sectional study” which aims to study the profile of Anganwadi Workers (AWWs) and to assess knowledge of AWWs & problems faced by them while working. Anganwadi centres were selected by stratified sampling technique. From each block 10% AWWs were enrolled into study. The functioning of AWWs was assessed by interviewing Anganwadi workers for their literacy status, years
of experience, their knowledge about the services rendered by them and problems faced by them. Most of AWWs were from the age group of between 41-50 years; more than half of them were matriculate and 34(69.38%) workers had an experience of more than 10 yrs. Majority (81.63 %) of AWWs had a knowledge assessment score of above 50%. They had best knowledge about nutrition and health education (70%). 87.7% of the workers complained of inadequate honorarium, 28.5% complained of lack of help from community and other problems reported were infrastructure related supply, excessive work overload and record maintenance. Conclusions: Majority of AWWs were beyond 40 years of age, matriculate, experienced, having more than 50% of knowledge related to their job. Complaints mentioned by them were chiefly honorarium related and excessive workload.

Mayuko Yatsu (2012) explores the positive association between healthcare programs of Anganwadi Centers (AWCs) and the infant survival rate in India by using three complimentary log-log regression models. This study employed AWCs’ three services—nutritional aid, immunization, and health-check—targeting pregnant/lactating mothers and children for the performance evaluation. The India Human Development Survey I, which collected the data of households including mothers who partook in Anganwadi program in her most recent childbirth between 2000 and 2005 and households including those who did not, was used in order to investigate the effectiveness of these services. The survival status of the infants as an outcome variable, a predictor variable reflecting each service, and seven control variables are included in each complementary log-log regression model. Although prior studies illustrate ineffectiveness
and inefficiency of Anganwadi services, the results of this study show a statistically significant, positive association between those receiving supplementary nutrition from AWCs and infant survival rate. Further research is necessary to confirm this finding because there are several limitations in this study. Finally, this study recommended refining women’s education programs and assisting self-help groups to solve India’s socio-economic problems based on a discovered positive association between women’s education and the infant survival rate.

Madhavi L.H., and H.K.G. Singh., (2011) conducted a study on “A Study on Knowledge of Anganwadi Workers and Their Problems In Rural Field Practice Area of Hebbal, Gulbarga District” to assess knowledge regarding health services and problems faced by Anganwadi workers while delivering health services at Anganwadi Center under Rural Community Health Training Center Hebbal. The present study was conducted during 15/01/09 to 16/04/09. All Anganwadi workers (15) were included in survey. The data was collected using a predesigned, pretested interview method and verification of records. The basic data collected was regarding Anganwadi worker’s, age, education, work experience, different aspects of services rendered. Their statements were verified from records, and logistics available at Anganwadi center. Study revealed that Anganwadi workers who have studied upto high school (100%) have been successful in maintaining records. Knowledge of Anganwadi workers with regard to immunization services was 90% and with regard to referral services was 86.66%. AWW had very poor knowledge in growth monitoring (16%). 73.33% anganwadi workers faced overload of routine activity work and excessive record maintenance in inadequate space provided to
them. To improve quality of ICDS services one needs to strengthen regular training and Camps should be organized for the AWWs.

**Thakare Meenal M et al., (2011)** assessed knowledge of AWWs & problems. race faced by them while working. Anganwadi centres were selected by stratified sampling technique. The functioning of AWWs was assessed by interviewing Anganwadi workers for their literacy status, years of experience, their knowledge about the services rendered by them and problems faced by them. Most of AWWs were from the age group of between 41-50 years; half of them were matriculate and 82.14% workers had an experience of more than 10 years. Majority (78.58 %) of AWWs had a knowledge assessment score of above 50%. They had best knowledge about nutrition and health education (77.14%).75% of the workers complained of inadequate honorarium, lack of help from community and other problems reported were infrastructure related supply. excessive, work overload and record maintenance.

**ICDS and Anganwadis**

**Banerjee, Sangita. (1999)** has conducted a study on “ A Study on Community Participation in ICDS At North Calcutta. Kolkata : Vidyasagar School Of Social Work” 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 centres. 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. 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 coordination 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.
Balsekar Ameya. (2005) has reported on “Child Welfare and Community Participation: A Case Study Of The ICDS Program In Trivandrum District” This study 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. 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.

**Nicola et al., (2007) have reported on** “Local Institution and social policy for children: opportunities and constraints of participatory service delivery”’ There was variation in poverty and human development indicators across the 4 sites, namely Amrabad mandal, Mehboobnagar 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 viewpoints 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.

**Sampath, T. (2006)** has conducted a study on “A Study on Community Participation in Integrated Child Development Scheme (ICDS) In Chennai” 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.

ICDS Unit (2007) conducted a project on “Uttarakhand ICDS Unit and Dehradun” 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.
Enrolment of Children in ICDS

Vinnarasan, A. (2007) has reported on “A Study on Factors Influencing Non Enrolment of Children in the ICDS Anganwadi Centers at Chennai Corporation” AWCs situated in Adyar, Besant Nagar, Mandaivel, 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.

**Evaluation of ICDS**

“*Citizen's Initiative for the Rights of Children under Six, New Delhi. (2006)*” has noticed that 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 readyto-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.

Dash, N.C. et al., (2006) have conducted work on “Impact Assessment/ Evaluation of ICDS Program in the State Of Orissa. Bhubaneswar: Centre For Rural Development”. 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 New Delhi. (2005)** conducted a project on “The Micro Status of ICDS in Hayathnagar (A.P.)” 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 pre-schools 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.

Gopal, A.K. et al., (2006) have conducted a project on “Three Decades of ICDS: An Appraisal. New Delhi.” 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).

**Haryana, Dept. Of Economics and Statistics, Chandigarh. (2004)** conducted a project on “Evaluation Study of ICDS in Haryana 2002-03” 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.

**KAR-DWCD- I I M B Bangalore (2005).** conducted a project on “Social Assessment of ICDS in Karnataka” 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 centres.

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.

Singhi, N. K. et al., (1996) reported on “Strengthening Quality and Access to Services in ICDS Program: A Social Assessment” 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.

Sobha, I. (2003) has worked on “Welfare Services For Women And Children” 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.

Bharti et al., (2003) reported that “Evaluation Of Health Services Provided To Preschoolers At Anganwadi Centers” 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.

Hamakawa, Tomohiro et al., (2007) reported on “The Integration Challenge: Child Development through Immunization and Nutrition in a Tribal Community of Jharkhand. Service” 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.
BAL Niketan Sangh and Joshi, Anita. (2001) reported on “A Comparative Study of Urban, Rural and Tribal Mothers Regarding Their Knowledge, Attitude and Practices of Nutrition” 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.

Prasanna Kumari, B., Kamini, S. And Menon, A.G.G. (2006) worked on “Factors Affecting the Knowledge, Attitude and Adoption of Improved Practices In Health And Nutrition Of ICDS Beneficiaries” 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 Thiruvanthapuram 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 favourable 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.
ICDS and Primary Health Centre

Bhasin, Sanjiv K. et al., (2001) worked on “Long Term Nutritional Effects of ICDS” 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.

MMR- Midstream Marketing and Research (2005) assessed 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 Mandals and Yuvak Mandals must be motivated to participate through interactions. Panchayati raj institutions should provide necessary facilities in the AWCs.

Sandhya Rani, P. M (2002) has worked on “Role of Primary Health Centers in the Promotion of Nutrition Programs: A Study in Andhra Pradesh. Mumbai” 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.

Job Performance of ICDS Functionaries

**Datta, Vrinda. (2001)** reported on factors affecting Job Performance of Anganwadi Workers covering a total of 615 AWWs and 72 Supervisors. 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.

Gangur, S.G. (2007) 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.
Pasupuleti, Usha Rani et al., (2004) have worked on “Integrated Child Development Services.” 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.
Low Birth Weight/ Infant Mortality

K. A., et al., (2000) “Anemia and Nutritional Status of Pre-School Children in Kerala” 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 no vegetarian group (74.5%). The prevalence of anemia was 11.4%, and female children were more susceptible to anaemia. 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 moderate 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.

Thiruvananthapuram. (2006) worked on “Supplementary Feeding In ICDS: Present System of Food Purchase, Distribution and Satisfaction of Beneficiaries’’ 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.

**Manipal- Pawan Kumar and Garg, Meenakshi. (2008) worked on Quick Appraisal of Supplementary Nutrition Component of ICDS : Report on ICDS Project Udupi and Karkala, Udupi District, Karnataka *** 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.
Prekshi, Sehgal, Salil and Kawatra, Asha. (2008) worked on “Anthropometric Measurements of Preschool Children of Gurgaon District As Affected By Socioeconomic Factors” 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.

Saiyed, F. And Seshadri, S. (2000) worked on “Impact of the Integrated Package of Nutrition and Health Services” 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 communi

**Mother and Child Protection Card**

**Gunajit, Kalita et al., (2006)** have reported on “The Effectiveness of the Mother and Child Protection Card as a Community Management Tool: A Case Study. Indore: NIPCCD, Regional Centre Indore” 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.
NIPCCD (2005) given a “Report of Pre-Test Study: Mother and Child Protection Card. New Delhi: NIPCCD- National Institute of Public Cooperation and Child Development, New Delhi.” 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 behaviour 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.

Samridhi, Mahajan, Arti And Bharti, Shaveta. (2003) have reported on “Evaluation Of Non-Formal Pre-School Education Provided at Anganwadi Centers (Urban Slums Of Jammu City). Jammu 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.
Pandey, D.D. et al., (2008) have reported on “Quality of Pre-Schooling under Different Programs Including ICDS: A Study. New Delhi: NIPCCD” 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 centres 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 centres (90.62%), followed by ICDS (81.25%) and SSA (75%) centres. 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% centres had full attendance in comparison to ICDS in Himachal Pradesh and Punjab (100%), and Haryana (87.5%). About 50% of SSA centres in Himachal Pradesh and ICDS centres in Uttar Pradesh had half attendance. 12.5% ICDS centres each in Haryana and Uttar Pradesh had less than half attendance. The transition rate was above 80% in most of the PSE centres. Highest transition rate was among ICDS centres (75%), followed by SSA centres (56.25%), and RGNCS centres (50%). 6.25% RGNCS centres had 0% transition rate, followed by 3.12% in ICDS and SSA centres. 0% transition rate was found in Uttar Pradesh only, and in 25% SSA centres in Himachal Pradesh. It was suggested that decentralized mode of training initiatives have to be strengthened through respective BRCs (Block Resource Centres) and CRCs (Cluster Resource Centres). 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.

Psycho-Social Development

Seema et al., (2002) reported that 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 Kheeewewal (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.

**Time Management of ICDS Functionaries**

**Kariyil, Antony and Sunny, Celine (2001)** conducted a study 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.
Padma Mohanan et al., (2012) have worked on "Are the Anganwadi Workers Healthy and Happy? A Cross Sectional Study Using the General Health Questionnaire (GHQ 12) at Mangalore, India” states that Anganwadi Workers (AWWs) are the implementers of Integrated Child Development Scheme (ICDS). It is important to obtain the worker’s viewpoints on their job-description, the problems they face and the levels of stress that they encounter, to address the quality of their services. The stressed AWWs are likely to be unhealthy, poorly motivated, less productive and less efficient in implementing the ICDS scheme. Thus, there is a need to evaluate the stress levels among the anganwadi workers and to understand the factors that influence the stress in this class of the population. This study was planned to study the stress among the anganwadi workers and the factors that are related to the stress.

M.C. Sandhyarani and C. Usha Rao (2013) have worked on "Role and responsibilities of anganwadi workers, with special reference to Mysore district. The Integrated Child Development Service Scheme (ICDS) is one of the initiatives taken up by the Central Government, which provides a package of six services viz., supplementary nutrition, immunization, health checkups, referral services, nutrition and health education for mothers/pregnant women, nursing mothers and to adolescent girls (kishoris) through anganwadi workers. The responsibilities of anganwadi workers are ever increasing these days. They have certain prescribed responsibilities other than the above mentioned services in the anganwadi. The present study has been undertaken with the objective of assessing the role and responsibilities of anganwadi workers in Mysore district. The universe of the study is Mysore District. The tool used for the study is questionnaire.
Among 235, around 122 anganwadi workers representing grama panchayats of each taluk have been covered under the study. The results found that anganwadi workers are very active in rendering their services to the beneficiaries. Key words: Initiatives, Supplementary Nutrition, Adolescent girls, Anganwadi.

Madhavi H, Singh HK, Bendigiri ND (2011) have worked on “A study of utilization of Integrated Child Development Services (ICDS) scheme and beneficiaries-satisfaction in rural area of Gulbarga district”. The study was aimed to obtain a feed-back regarding beneficiaries-satisfaction and utilization of services by registered beneficiaries of Integrated Child Development Services (ICDS) in Rural area. The cross-sectional study was conducted in 15 Anganwadi Centers (AWCs) from 15-01-2009 to 16-04-2009. There were 3958 beneficiaries. They were categorised into five groups. Group I - Pregnant Women, Group II - Lactating Women, Group III - Women in Reproductive age-group i.e. 15-45 years, Group IV - Mothers/ Guradians of 0-3 years children, Group V - Mothers / Guardian of 3-6 years. Five beneficiaries from each group were randomly selected. Thus from each anganwadi centre 25 beneficiaries were selected. Total 375 beneficiaries from 15 AWCs constituted the study population. Beneficiary satisfaction and utilization of services were assessed by interview verification of records, logistic supply and infrastructure. Study revealed that utilization of ICDS scheme was high in pregnant women (90.83%). All children between 0-3 years were getting Vitamin-A supplementation. Beneficiary satisfaction was high (81.11%) among 15-45 years women. All AWCs were of “pucca” type, but electricity supply was available only in 20% AWCs. Sanitary toilet were present in 46.66% AWCs and 93.33% AWCs were in receipt of
receiving logistic supply on a regular has is regularly. To improve quality of ICDS scheme one needs to strengthen the ‘Information, Education and Communication’ (IEC) activities.

Meenal M Thakare et al., (2011) have conducted a study on “A Study of functioning of anganwadi centers of urban icds block of Aurangabad city” Integrated Childhood Development Services Scheme (ICDS) has generated interest worldwide amongst academicians. No external evaluation has been carried out about the functioning of urban ICDS project of Aurangabad city. Aims: To assess different aspects of functioning of Anganwadi workers in relation to health services provided, available infrastructure & logistic at Anganwadi centers. Setting and design: Urban ICDS Block, Aurangabad; Cross sectional study. Methods and Material: Anganwadi centers were selected by stratified ampling technique. Anganwadi workers were interviewed, records checked, infrastructure assessed. Statistical analysis: percentages, Chi Square test. Results and conclusion: AWCs are providing NFPSE (40%), nutrition and health education (100%), supplementary nutrition, immunization camps (60.71%). Health check ups are not conducted. More than 50% have required infrastructure, 55% of AWWs have maintained records properly; iron tablets and vitamin A syrup are not available with any AWC from last 7-8 months.

Dr. Shashi Manhas et al., (2012) have conducted a work on “Awareness Among Anganwadi Workers Related to Female Foeticide in District Kathua, J and K State ” The present investigation was undertaken to know the awareness among Anganwadi workers
regarding Female Foeticide. Sample comprised of 50 Anganwadi workers selected from 25 villages of Hiranagar Block of Kathua district. Random sampling technique was used to draw a sample for the study. A self devised interview schedule was used as a tool for data collection. The results revealed that majority of the respondents were aware about the prevalence and causes of female foeticide. Awareness regarding contributing factors for female foeticide found among anganwadi workers were mushrooming of ultrasound clinics, followed by ability to pay for abortion and son preference. Son is preferred for performing the last rites of parents, support in old age and carry on the family lineage. Anganwadi workers were also aware about the repercussions of female Foeticide. Awareness of anganwadi workers related to Medical Termination of Pregnancy and Pre-natal Diagnostic Techniques Act was negligible. They were not aware about guidelines and legal aspects regarding PNDT. Intervention programmes were also organized to aware anganwadi workers regarding law and government action plans to overcome the problem of female foeticide.

Ashok G. Jadhav (2012) has worked on “A Study Of Selected Anganwadis In Sangli City In Maharashtra” ICDS (Integrated child development scheme) is one of the best schemes for the improvement of nutritional and health status of children and women in India. It has been implemented in Maharashtra in 1979 in Anganwadis. The present paper focuses the implementation of this scheme in selected Anganwadis in Sangli district in Maharashtra. The observation of this scheme in selected Anganwadi shows that ICDS is very helpful and useful for solving problems of health and nutritional among the children and women. However, the Anganwadi workers are seen less educated. If they
are well trained, ICDS will be implemented very effectively to eradicate the problems of health and nutrition among the children and women, both in rural and urban area in Maharashtra.

Patil SB and Doibale MK (2013) have worked on “Study of profile, knowledge and problems of anganwadi workers in ICDS blocks: a cross sectional study” The present study was planned to study the profile of Anganwadi Workers (AWWs) and to assess knowledge of AWWs & problems faced by them while working. Anganwadi centres were selected by stratified sampling technique. From each block 10% AWWs were enrolled into The functioning of AWWs was assessed by interviewing Anganwadi workers for their literacy status, years of experience, their knowledge about the services rendered by them and problems faced by them. Most of AWWs were from the age group of between 41-50 years; more than half of them were matriculate and 34(69.38%) workers had an experience of more than 10 yrs. Majority (81.63 %) of AWWs had a knowledge assessment score of above 50%. They had best knowledge about nutrition and health education (70%). 87.7% of the workers complained of inadequate honorarium, 28.5% complained of lack of help from community and other problems reported were infrastructure related supply, excessive work overload and record maintenance. Conclusions: Majority of AWWs were beyond 40 years of age, matriculate, experienced, having more than 50% of knowledge related to their job. Complaints mentioned by them were chiefly honorarium related and excessive workload.
G.P. Mathur Sarla Mathur et al., (1995) have worked on “Detection and prevention of childhood disability with the help of anganwadi workers ”To evaluate the role of Anganwadi Workers (AWW) for detection and prevention of disability in children below 6 years of age. Design. Cross sectional and longitudinal follow up. In context of health experience dis- ability can be defined as ”any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered norma for human being”. In case this is not reversible, or becomes chronic it gives rise to handicap interfering with the ability to interact with the surround- ings(l). Early detection of disability will be the hallmark in reducing the high in- cidence of disabled children(2). A num- ber of these disorders are preventable and substantial proportion can be suit- ably rehabilitated(3,4). Early detection of disability though most important in preventing permanent disability cannot be left entirely on doctors alone. There- fore, the present study was undertaken to find out the role of Anganwadi work- ers in an Integrated Child Development Services (ICDS) project for detection and prevention of disability in children below 6 years.

Shashi Manhas and Annpurna Dogra (2012) have worked on “Awareness among Anganwadi Workers and the Prospect of Child Health and Nutrition: A Study in Integrated Child Development Services (ICDS) Jammu, Jammu and Kashmir, India ”The Integrated Child Development Services (ICDS), the nationwide programme of the Government of India offers the most important interventions for addressing the nutrition and health problems and promoting early childhood education among the disadvantaged population of the country. The present study was undertaken with the objective of
assessing the awareness among anganwadi workers regarding the health and nutrition services for children (0-6yrs) in ICDS. The sample of the present study was taken from Purmandal block of Jammu. The tools used for study was self devised interview schedule. In the nutrition aspect, the present study revealed that 55 % of anganwadi worker were actually aware of nutritional services provided at anganwadi centres and were able to explain it if asked but none of them was familiar with the energy and protein requirement of the targeted age group and were unaware of the fact as to how many caloric food they are providing to children. In the health perspective it was revealed that 30% of anganwadi workers, who were assessing the nutritional status of child in anganwadi, were not aware of the method applied for assessment. It was found that although anganwadi workers were maintaining monthly weight registers and growth charts records but majority (65%) of them were not aware of the importance of growth chart. The study shows that in spite of the all training of anganwadi workers, their performance as well as awareness in terms of nutrition and health perspective was not satisfactory and hence an utmost need of frequent training as well as on spot training programme was strongly felt.

**Dr. Dayanand Singh (2013)** has given a report on “Performance evaluation of Anganwadi Workers of Jaipur Jone, Rajasthan.” Integrated Child Development Service (ICDS) is India’s response to the challenge of meeting the holistic needs children below six years of age, adolescent girls expectant and nursing mothers through the network of Anganwadis. To assess the performance of Anganwadi Workers of Jaipur, 8 AWCs were selected from each of the 5 jones of Jaipur. So, total 40 AWCs were included in the
present survey. Performance of each of the AWW from identified AWCs was assessed as per the „Form no. (1)” of ICDS. Performance of various districts and various activities were analysed with chi-square/ANOVA/Post-Hoc wherever applied. Average mean time opening of AWCs of Jaipur zone was 18.8 minutes less than the ideal duration of 240 minutes per day. Maximum gap in registration (93.52%) was observed in adolescent registration. Supplementary nutrition distribution was 84.94%. 23.33% children of 3-6 years of age group attended PSE more than 20 days. 65% 12-24 years children were fully immunized. Referrals were received by surveyed ANMs from 30% of AWWs. Although HNE and distribution of supplementary nutrition was observed excellent but Services for adolescent girls were not at all proper.

**Patil Reshma (2013)** has given a report on “Assessing Anganwadi Workers knowledge on HIV/ AIDS by Using case studies: An Innovative Approach” Anganwadi workers (AWW) are the key persons to inform the community regarding approach towards diseases like HIV/ AIDS, sound knowledge of the subject is therefore essential. To assess awareness of AWW regarding high risk behavior in HIV/AIDs, a cross-sectional study was done among 30 AWW from ICDS project–1, Pune. They were divided into four groups. Each group was assigned seven case studies and was asked to rank them according to risk of transmission. Group C ranked sequencing of given case studies correctly. The remaining three groups B, A, D were in the second, third and fourth positions respectively. Eight of the study group could answer it correctly meaning their level of knowledge related to HIV/AIDs is inadequate. Assessing AWW’s knowledge on HIV/AIDs and high risk behavior using case studies was an innovative
idea to assess their awareness. AWWs were found to have inadequate knowledge related to high risk behavior for HIV/AIDS, therefore training programme is recommended.

**Farzana Alim and Farhat Jahan (2012)** have worked on “Assessment of Nutritional Status of Rural Anganwadi Children of Aligarh under the ICDS (Integrated Child Development Services) and Rural Health” survey was conducted to assess the nutritional status of children (0-3 years) among 16 Anganwadis in 5 villages in Aligarh, Uttar Pradesh (U.P.) registered under the ICDS scheme. A self-prepared structured interview schedule was used. To get the qualitative information of the study anthropometric measures include height and weight were used for assessing nutritional status of the children. To examine the relationship between nutritional status of the child and selected variable that affects nutritional status of children, Chi-square test was employed. Based on Gomez’ classification, out of 300 children, only 229 (76.4%) of children received supplementary nutrition through ICDS out of which 188 (62.7%) children were normal while 41 (13.7%) were underweight. Based on Waterlow’s classification out of 300 children, only 229 (76.4%) of children received supplementary nutrition through ICDS out of these children 148 (49.4%) were normal while 81 (27%) were stunted. It can thus be concluded that majority of children were normal who received supplementary nutrition through ICDS.