INDIA'S INTEGRATED CHILD DEVELOPMENT SCHEME AND ITS IMPLEMENTATION: PERFORMANCE OF ANGANWADIS AND ANALYSIS

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Abstract: Integrated Child Development Services (ICDS) programme continues to be the world's most unique early childhood development programme, which is being satisfactorily operated since three decades of its existence. The programme provides package of services, comprising supplementary nutrition, immunisation, health check-up, referral services to children below six years of age and expectant and nursing mothers. Non-formal pre-school education is imparted to children of the age group 3-6 years and health and nutrition education to women in the age group 15-45 years. High priority is accorded to the needs of the most vulnerable younger children under three years of age in the programme through capacity building of caregivers to provide stimulation and quality early childhood care. In this backdrop the paper considers the ICDS has performance well in our socio-cultural system during last few years to ensure children's right for survival, growth, protection and development and their active participation in environment where they live, grow and develop. On the basis of ICDS programme it is to discuss in this paper about role played by anganwadis through out the country for improvement of health and nutrition status for children in rural areas especially and in particular to analyze the performance of the anganwadis in view of funds allocated through five year plans and finally to paper will conclude the project implementation progress in order to bring the universal health and education in rural areas for the growth of development and made some suggestions in implementation of the ICDS and anganwadis role performance to carry out the project in an effective and efficient manner with the cooperation of the government, semi governments and other stake holders to achieve the millennium development goals of Government of India.

Keywords: Child development, Anganwadis, Health & Nutrition

INTRODUCTION

Integrated Child Development Services (Icds) Scheme

Improvement in the standard of living and health status of the population has remained one of the important objectives in Indian planning. All five year plans had reflected long term vision consistent with the international aspirations of which India has also been a signatory. ICDS (2011) The Integrated Child Development Services (ICDS) Programme is India's primary response to the nutritional and developmental needs of the children below six years, pregnant women and nursing mothers. Implemented through a network of over one million village-level Anganwadi Centres (AWCs), staffed by Anganwadi

Workers (AWWs) and Anganwadi Helpers (AWHs), it currently reaches around 7.28 crore children1 and about 1.6 crore pregnant and nursing mothers (March 2010). The programme has since become the world's largest and unique early childhood development programme.

The ICDS Programme has remained in the forefront of the efforts of the Government of India (GoI) and the State Governments to achieve the child nutrition related Millennium Development Goal (MDG1). The Government of India has committed to achieve the nutrition MDG of halving underweight rates from 54% to 27% between 1990 and 2015, and to achieving the education MDG of universal primary education (MDG2) and the Education For All goal of expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children. GoI is also committed to reducing infant and child mortality and improving maternal health outcomes (MDGs 4 and 5). Since malnutrition is closely linked to all of these MDGs, the interventions under the ICDS programme are expected to contribute towards achievement of each of these longer-term goals. 1.3 Despite several achievements that the ICDS scheme has witnessed during its three decades of implementation, there remain some major challenges with regard to the high burden of child malnutrition in the country. The NFHS-3 (2005-06) reveals that about 43 percent children below five years in the country are still underweight (as per the WHO New Growth Standards; <-2SD) and out of these, about 16 percent are severely malnourished (<-3SD). At the country level, child malnutrition has barely declined at all in a decade and anaemia among women and children has actually risen. On the basis of a composite inputs variable score, all the 150 projects were arranged in descending order showing the rank order for all input variables. Based on the total composite input score, minimum maximum range of composite input variable score was found to be between 3.1 and 19.3. Again, based on these scores, projects were rated as very good (scoring more than 15), good (between 10 and 15) and poor (less than 10). According to composite score of input variables, it was found that out of 150 projects studied, a total of 63 projects were very good, 71 were good and 16 were poor in terms of input management.

During the 11th Five Year Plan the GoI has taken several measures to strengthen the implementation of ICDS Programme. In order to increase accessibility of the ICDS services to all households in the country, especially those belonging to disadvantaged and weaker sections in the community, the GoI has embarked upon massive expansion of the programme since 2006-07 to reach out to about 14 lakh habitations in the country. As per the order of the Supreme Court, the GoI has already sanctioned 7073 projects and 13.56 lakh AWCs (August 2009) and the programme has been nearly universalized across the villages and habitations in the country. Provision has also been made for sanction of AWCs on demand basis by the States. Population norms for opening up of the AWCs in rural, urban and tribal areas have been revised. Financial norms of various interventions/activities under the scheme including that for training and capacity building of the ICDS functionaries, have been revised upwardly with effect from April 1, 2009. Honorariums of AWWs and AWHs have been revised since April 2008. Nutritional (calorific) norms for the supplementary food to the children below six years and pregnant and lactating mothers have also been revised. The challenge before the programme authorities is now to harmonize the geographical expansion along with an improved implementation strategy in order to accelerate better and visible programme outcomes. The 11th Five Year Plan has envisaged „increased coverage in ICDS to ensure rapid universalization; changing the design; and planning the implementation in sufficient details that the programme objectives are not vitiated by the design of implementation. Besides, all its original six services have to be delivered fully for the programme to be effective: (a) supplementary nutrition, (b) immunization, (c) health check-ups, (d) health and nutrition education, (e) referral services, and (f) non-formal pre-school education

The NFHS-3 results show wide variations in the nutritional status of the children below five years and other health and nutritional parameters across the States and regions. While several States were able to reduce the level of child malnutrition significantly over the last seven years, some have already reached the MDG level of 27%, but the problem remained acute in many other States, affecting the country's overall nutritional status. It is well known that malnutrition is a multi-dimensional problem and various determinants affect the nutritional status of children including food security, educational level of parents, water and sanitation, diseases, and many other socio and demographic factors. Through a common package of six services across the 35 States and UTs, the ICDS programme follows an integrated approach for the holistic developmental of the children below six years as well as health and nutritional needs of the pregnant women and nursing mothers. It is imperative to know how effective is the existing implementation strategy in addressing the varying needs of children and women. It has been often found that service delivery mechanism in ICDS varies significantly across States, districts and blocks. But in the absence of a detailed implementation plan at the State or district level, it has not been possible to

capture the programme effectiveness against the set targets or track expenditures against the physical achievements. Though ICDS is a „centrally sponsored scheme‟, wherein the GoI provides 90 per cent of the total programme cost to the States/UTs with effect from April 2009 (except the cost for supplementary nutrition, which is 50:50 between GoI and States, and 90:10 in NE States), the basic responsibility for implementing kthe programme rests with the State Governments. The role of State Governments in monitoring the programme implementation is, therefore, paramount. Till now, the GoI has been releasing funds to the States/UTs under ICDS without having any State specific detailed implementation plan (except that for training programmes), but based on the utilization certificates and monthly/quarterly progress reports. In view of the growing concern over the programme not being able to achieve its core objectives, it has been felt that there needs to be a paradigm shift in the programme‟s annual planning in order to improve and strengthen the existing implementation mechanisms. The existing annual planning process in ICDS that is currently followed by the State Governments needs re-structuring and standardization, by bringing in clear focus on the programme „outcomes‟ rather than on „outlays‟ as was envisioned by the Government of India.

ICDS (2009) Children are our most precious resource, and nurturing our children is an investment we are making to ensure a brilliant future for our nation. ICDS, which was launched in 1975, provides an opportunity for the holistic development of children from vulnerable backgrounds. A good foundation in early childhood is provided in Anganwadi centres functioning under ICDS, where young children are provided nutritious food, an opportunity for joyful learning through informal preschool education, immunization, and mothers are guided through nutrition and health education to ensure the healthy development of children. Several researches have been undertaken on ICDS, which have revealed the positive impact of ICDS, as well as the gaps that have to be bridged to further improve the functioning of the programme. With efforts being made to universalize ICDS, it is imperative to survey the researches on ICDS which have policy implications.

A study conducted by NIPCCD (2009), in the rural ICDS project Chickaballapur, district Kolar, reveals that the Anganwadi Worker's (AWW) is the key front line worker who plays a crucial role in promoting child growth and development. One of their important roles is to detect childhood disabilities at an early stage, provide referral services, and parent education. The various disabilities identified by AWWs in all the three experiments shows that AWWs had taught 'them a few exercises that could be done by their mentally retarded children and all the cases brought by AWWs had one or the other kind of visual impairment. It was found in the study that all the specialists felt that AWWs could identify most of the cases correctly even though they could not give specific medical terminology for the problems. The detection of visual and hearing impairments and mental retardation was commendable as the symptoms of these disabilities are not very obvious. Finally the study shows in the conclusion that AWWs can play an important role in early detection and prevention of disabilities in children.

Seema.T.N (2001) The concept of ICDS is providing a package of services is based primarily on the consideration that the overall impact will be much larger if the different services develop in an integrated manner as the efficacy of a particular service depends upon the support it receives from related services. ICDS has attempted to gear up to the popular holistic vision of a comprehensive intervention programme with a child-centred approach respecting all cultural patterns and diversity, and served as an instrument of change to bridge social inequalities in the society. The concept of providing a package of services is based primarily on the consideration that the overall impact would be much larger if the different services are delivered in an integrated manner, as the efficiency of a particular service depends upon the support it receives from the related services. The other unique feature of the programme is that it utilises and mobilises all available governmental services at the level of the project. It is multi-sectoral in nature and its successful implementation depends on inter-sectoral functional linkages. It calls for coordination among concerned departments and ensures optimal use of the existing governmental infrastructure at the project level. Addressing the interrelated needs of young children, adolescent girls and women of disadvantaged community groups, ICDS solicits convergence with other services/programmes like Antodaya, Micro-Credit schemes and other development programmes of the rural development, education, environmental science and technology and so on. There are presently 5652 ICDS projects functional in the country comprising 4533 in rural, 759 in tribal and 360 in urban areas (as on December, 2004).

Table 1: The variety of services

Services	Target Group	Service Provided by
Supplementary Nutrition	Children below 6 years: Pregnant & Lactating Mother (P&LM)	Anganwadi Worker and Anganwadi Helper
Immunization*	Children below 6 years: Pregnant & Lactating Mother (P&LM)	ANM/MO
Health Check-up*	Children below 6 years: Pregnant & Lactating Mother (P&LM)	ANM/MO/AWW
Referral Services	Children below 6 years: Pregnant & Lactating Mother (P&LM)	AWW/ANM/MO
Pre-School Education	Children 3-6 years	AWW
Nutrition & Health Education	Women (15-45 years)	AWW/ANM/MO

*AWW assists ANM in identifying the target group.

Table 2: Distribution of AWC in Rural and Urban

For Rural/Urban Projects
400-800 1 AWC
800-1600 - 2 AWCs 1600-2400 - 3 AWCs Thereafter in multiples of 800 1 AWC
For Mini-AWC
150-400 1 Mini-AWC **For Tribal /Riverine/Desert, Hilly and other difficult areas/ Projects** 300-800 - 1 AWC **For Mini- AWC**
150-300 1 Mini AWC

Table 3: Expansion of the ICDs Scheme

Number of Sanctioned Projects/ AWCs	**EXISTING**	**ADDITIONAL (sanctioned in 2008-09)***	**TOTAL**
PROJECTS	6284	789	7073
ANGANWADI CENTRES (AWCs)	10.53 lakh	1.89 lakh	12.42 lakh
MINI-AWCs	36,829	77,102	1,13,931
Total AWCs			13.56 lakh#

***** State-wise no. of Projects/AWCs/Mini-AWCS sanctioned in 2008-09 under 3rd phase of expansion of the Scheme available at 'Data Table on ICDS'.

Total number of AWCs Budgeted for is 14 lakh leaving a cushion for Anganwadi – on- Demand.

Nutrition including Supplementary Nutrition

This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. They avail of supplementary feeding support for 300 days in a year. By providing supplementary feeding, the Anganwadi attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities. Growth Monitoring and nutrition surveillance are two important activities that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to detect growth faltering and helps in assessing nutritional status. Besides, severely malnourished children are given special supplementary feeding and referred to medical services.

IMMUNIZATION

(a) Health Check-ups: (b) Referral Services: 2.5 Non-formal Pre-School Education (PSE) (c) Nutrition and Health Education:

ANGANWADI CENTRES

Anganwadi Centre's are centrally sponsored flagship programme, which provides a package of six services viz., supplementary nutrition, immunization, health check-up, referral services, nutrition and health education for mothers and non-formal pre-school education for children between 3-6 years. Eligible beneficiaries covered under this programme are children below six years of age, pregnant women, nursing mothers and adolescent girls. The package of services is provided to the beneficiaries through the Anganawadi Centres managed by an Anganawadi Worker & Helper at the village level and also in urban slums. At present 60046 AWCs and 3331 mini anganwadis in 185 ICDS projects are functioning in the State, covering all 175 taluks & 10 urban areas. During 2009-10, 44.43 lakh beneficiaries have availed the benefits under the scheme. Anganwadi's centre's distribution under the project in Rural and Urban areas are shown in *Table 2* and *Table 3* which reveals the expansion of ICDS's Scheme.

Status of Anganwai Workers and Helpers

Anganwadi Workers (AWWs) & Anganwadi Helpers (AWHs), being honorary workers, are paid a monthly honoraria as decided by the Government from time to time. Government of India has enhanced the honoraria of these Workers, w.e.f. 1.4.2008 by Rs.500 above the last honorarium drawn by Anganwadi Workers (AWWs) and by Rs.250 of the last honorarium drawn by Helpers of AWCs and Workers of Mini-AWCs. Prior to enhancement, AWWs were being paid a monthly honoraria ranging from Rs. 938/ to Rs. 1063/- per month depending on their educational qualifications and experience. Similarly, AWHs were being paid monthly honoraria of Rs. 500/-. In addition to the honoraria paid by the Government of India, many States/UTs are also giving monetary incentives to these workers out of their own resources for additional functions assigned under other Schemes.

Recent Initiatives

The Ministry has recently initiated a process of consultations with the States and other stakeholders to review and identify gaps in the existing training system and make suggestions to strengthen the ICDS Training programme including its contents/syllabi, training methodology and the existing monitoring mechanism under ICDS training programme. Three regional workshops have since been organized in collaboration with NIPCCD and with technical support from USAID/CARE INDIA during July-August 2009 at three Regional centres of NIPCCD at Bangalore, Lucknow and Guwahati.

ANALYSIS & ACTION

The information received in the prescribed formats is compiled, processed and analysed at the Central level on quarterly basis. The progress and shortfalls indicated in the reports on ICDS are reviewed by the Ministry with the State Governments regularly by review meetings/ letters.

State Level

Various quantitative inputs captured through CDPO's MPR/ HPR are compiled at the State level for all Projects in the State. No technical staff has been sanctioned for the state for programme monitoring. CDPO's MPR capture information on number of beneficiaries for supplementary nutrition, pre-school education, field visit to AWCs by ICDS functionaries like Supervisors, CDPO/ ACDPO etc., information on number of meeting on nutrition and health education (NHED) and vacancy position of ICDS functionaries etc.

Block Level

At block level, Child Development Project Officer (CDPO) is the in-charge of an ICDS Project. CDPO's MPR and HPR have been prescribed at block level,. These CDPO's MPR/ HPR formats have one-to-one correspondence with AWW's MPR/ HPR. CDPO's MPR consists vacancy position of ICDS functionaries at block and AWC levels. At block level, no technical

post of officials has been sanctioned under the scheme for monitoring. However, one post of statistical Assistant./ Assistant is sanctioned at block level to consolidate the MPR/ HPR data. In between CDPO and AWW, there exists a supervisor who is required to supervise 25 AWC on an average. CDPO is required to send the Monthly Progress Report (MPR) by 7th day of the following month to State Government. Similarly, CDPO is required to send Half-yearly Progress Report (HPR) to State by 7th April and 7th October every year.

Village Level (Anganwadi Level)

At the grass-root level, delivery of various services to target groups is given at the Anganwadi Centre (AWC). An AWC is managed by an honorary Anganwadi Worker (AWW) and an honorary Anganwadi Helper (AWH). In the existing Management Information System, records and registers are prescribed at the Anganwadi level i.e. at village level. The Monthly and Half-yearly Progress Reports of Anganwadi Worker have also been prescribed. The monthly progress report of AWW capture information on population details, births and deaths of children, maternal deaths, no. of children attended AWC for supplementary nutrition and pre-school education, nutritional status of children by weight for age, information on nutrition and health education and home visits by AWW. Similarly, AWW's Half yearly Progress Report capture data on literacy standard of AWW, training details of AWW, increase/ decrease in weight of children, details on space for storing ration at AWC, availability of health cards, availability of registers, availability of growth charts etc. AWW is required to send these Monthly Progress Report (MPR) by 5th day of following month to CDPO' In-charge of an ICDS Project. Similarly, AWW is required to send Half-yearly Progress Report (HPR) to CDPO by 5th April and 5th October every year.

Rapid facility Survey by NCAER

The National Council of Applied Economic Research (NCAER) conducted a Rapid Facility Survey on ICDS infrastructure in 2004. The report submitted by NCAER in February, 2005 has, inter-alia, brought out that; (a) More than 40 per cent AWCs (Anganwadi Centres) across the country are neither housed in ICDS building nor in rented buildings. One-third of the Anganwadis are housed in ICDS building and another one-fourth are housed in rented buildings; (b) As regards the status of Anganwadi building, irrespective of own or rented, more than 46 per cent of the Anganwadis were running from pucca building, 21 per cent from semi-pucca building, 15 per cent from kutcha building and more than 9% running from open space; (c) It is quite encouraging to observe that average number of children registered at the Anganwadi centre is 52 for boys and 75 for girls; (d) The survey data reveal that more than 45 per cent Anganwadis have no toilet facility and 40 per cent have reported the availability of only urinal; (e) Of the 39 per cent Anganwadis reporting availability of handpumps, half of the handpumps were provided by the Gram Panchayat and 12 per cent provided by the ICDS; (f) Regarding the provision of services at the Anganwadi centres, more than 90 per cent Centres provided supplementary food, 90 per cent provided pre-school education and 76 per cent weighed children for growth monitoring; (g) Only 50 per cent Anganwadis reported providing referral services, 65 per cent health check-up of children, 53 per cent for health check-up of women and more than 75 for nutrition and health education; (h) Average number of days in a month in which services are provided at the Anganwadi centres are 24 for supplementary food, 28 for pre-school education and 13 for Nutrition and health education; (i) More than 57 per cent of Anganwadi centres reported availability of ready-to-eat food and 46 per cent availability of uncooked food at the Anganwadi centres; (j) Nearly three-fourth of the Anganwadis have reported the availability of medical kits and baby weighing scale. On the other hand adult weighing scale has been reported only by 49 per cent of the Anganwadis.

THREE DECADES OF ICDS – AN APPRAISAL

The study covered 150 ICDS Projects from 35 States/UTs covering rural, urban and tribal projects. A total of five Anganwadi centres (AWCs) were randomly selected from each sample projects covering 750 AWCs. The main findings of the appraisal are as under: (a) Around 59 per cent AWCs studied have no toilet facility and in 17 AWCs this facility was found to be unsatisfactory. (b) Around 75% of AWCs have pucca buildings; (c) 44 per cent AWCs covered under the study were found to be lacking PSE kits; (d) Disruption of supplementary nutrition was noticed on an average of 46.31 days at Anganwadi level. Major reasons causing disruption was reported as delay in supply of items of supplementary nutrition; (e) 36.5 per cent mothers did not report weighing of new born children; (f) 29 per cent children were born with a low weight which was below normal (less than 2500 gm); (g) 37 per cent AWWs reported non-availability of materials/aids for Nutrition and Health Education (NHED).

Table 4: Present Status of number of operational projects/AWCs/Nutrition & Education Beneficiaries

Year ending	No. of operational projects	No. of operational AWCs	No. of Supplementary nutrition beneficiaries	No. of pre-school education beneficiaries
31.03.2002	4608	545714	375.10 lakh	166.56 lakh
31.03.2003	4903	600391	387.84 lakh	188.02 lakh
31.03.2004	5267	649307	415.08 lakh	204.38 lakh
31.03.2005	5422	706872	484.42 lakh	218.41 lakh
31.03.2006	5659	748229	562.18 lakh	244.92 lakh
31.03.2007	5829	844743	705.43 lakh	300.81 lakh
31.03.2008	6070	1013337	843.26 lakh	339.11 lakh
31.03.2009	6120	1044269	873.43 lakh	340.60 lakh
31.03.2010	6509	1142029	884.34 lakh	354.93 lakh
31.12.2010	6719	1241749	918.65 lakh	355.02 lakh

INTERNATIONAL PARTNERS

Government of India partners with the following international agencies to supplement interventions under the ICDS: (a) United Nations International Children' Emergency Fund (UNICEF) (b) Cooperative for Assistance and Relief Everywhere (CARE) (c) World Food Programme (WFP)

UNICEF supports the ICDS by providing technical support for the development of training plans, organizing of regional workshops and dissemination of best practices of ICDS. It also assists in service delivery and accreditation system where the capacity of ICDS functionary is strengthened. Impact assessment in selected States on early childhood nutrition and development micro-nutrient and anemia control through Vit. 'A' supplementations and deworming interventions for children in the age group of 9-59 months is also conducted by UNICEF from time to time.

CARE is primarily implementing some non-food projects in areas of maternal and child health, girl primary education, micro-credit etc. Integrated Nutrition and Health Project (INHP)-III, which is a phase out programme of INHP series would come to an end on 31.12.2009.

WFP has been extending assistance to enhance the effectiveness and outreach of the ICDS Scheme in selected districts (Tikamgarh & Chhattarpur in Madhya Pradesh, Koraput, Malkangir & Nabrangpur in Orissa, Banswara in Rajasthan and Dantewada in Chhattisgarh), notably, by assisting the State Governments to start and expand production of low cost micronutrient fortified food known as 'Indiamix'. Under this the concerned State Government are required to contribute to the cost of Indiamix by matching the WFP wheat contribution at a 1:1 cost sharing ratio.

WHO GROWTH STANDARDS IN ICDS

The World Health Organization (WHO) based on the results of an intensive study initiated in 1997 in six countries including India has developed New International Standards for assessing the physical growth, nutritional status and motor development of children from birth to 5 years age. The Ministry of Women and Child Development and Ministry of Health have adopted the New WHO Child Growth Standard in India on 15th of August, 2008 for monitoring the Growth of Children through ICDS and NRHM.

Implications

(a) Change in current estimates (b) increase in total of normal weight children (c) increase in severely underweight children (d) increase in underweight children (mild/moderate and severe) in age group of 0-6 months.

(i) The requirement of funds for SNP; Centre and State contribution would be almost double. (ii) The Anganwadi Worker with the help of New Growth Chart would be able to assess correctly severely underweight children and number of such children would increase in each Anganwadi Centres. The

number of normal children would also increase in all the Anganwadi Centres. (iii) The new charts would now help us in comparing growth of our children within projects, districts, states & also other countries.

There has been significant progress in the implementation of ICDS Scheme during X Plan both and during XI Plan (up to 31.12.2010), in terms of increase in number of operational projects and Anganwadi Centres (AWCs) and coverage of beneficiaries as indicated below:-

The Anganwadi programme was designed to tackle the problem of malnutrition, infant mortality and immunization. Learning while playing also helps children inculcate values and bring about a desire for education. In view of the above data it can be recommend some of the points as AWWs responsibility for early detection of disabilities should be linked meaningfully with other services of the scheme. The training in early detection and prevention of childhood disabilities should be practical and field based. It should aim at inculcating skills for identifying impairments. Parents and community education should be given adequate emphasis during the training of AWWs as they provide the child the emotional support required to meet the challenges of life. The efforts of AWWs regarding early detection should be supported by referral services. Vaijayanti k (2010) a proper recording system should be evolved so that AWWs could follow up the children identified by them. An anganwadi worker has as many as 21 tasks to perform. She undertakes community surveys, maintains records of births and deaths, assists the health staff in immunization and health check-ups of children, pregnant and nursing mothers, distributes food to children, women and the community at large and undertakes home visits and organizes mothers' meetings/community meetings. The anganwadi worker has to maintain records as well.

PERFORMANCE ANALYSIS OF ANGANWADIS

(a) The number of beneficiaries through Anganwadis has increased from 12,12,000 children aged 0-3 years and 12,22,000 children aged 3-6 years in 2001 to 17,75,881 and 16,03,856 children respectively in 2010. This covers 74.70% of children in the 0-3 age group and 67.90% of the 3-6 age group. The number of Anganwadi centres has gone up from 40,301 in 2001 to 63,377 in 2010. (b) Severe malnutrition levels in Karnataka have fallen to 0.3% in 2009 (according to ICDS data); there is still scope for improvement. According to NFHS (3), the percentage of underweight children (under 3 years) is 41.1; stunted children (under 3 years) is 38% and wasted children (under 3 years) is 18.9; 17.6% children have moderate anaemia, and 1.9% have severe anaemia, Given these figures, it is important to ensure the effective implementation of nutrition programmes and work towards strategies which would effectively tackle problems related to nutrition. (c) The 2003-10 SPAC focused on reducing maternal mortality rate from 213 per lakh live births (acc to SRS conducted in 2004-06) to 100 per lakh in 2012. It aimed to increase the percentage of institutional deliveries from 51.1% in 2001 to 75% in 2010 and achieve 100% of deliveries by trained persons. In line with this, the State has achieved 93% institutional deliveries in 2010. Some important strategies employed to achieve these figures were increasing the coverage of the Reproductive and Health Care programme and spreading awareness about contraceptive methods and the need for spacing of pregnancies. (d) According to available statistics, the maternal mortality rate has reduced from 228 per lakh live births in 2001-03 to 213 (as per SRS 2004-06). In 2002-2004 (as per DLHS 2) institutional delivery was 57.9% (as per DLHS 2) and it increased to 65.1% in 2007-08 (as per DLHS3). Institutional delivery is 86.4% (CES 2009). Ante Natal registration is 91.9% (CES 2009) and three Ante Natal check-ups are 91.3% (CES 2009). The percentage of safe deliveries is 88.4%.

CONCLUSION

Since Anganwadi Centre is a focal point for activities of ICDS programme it has always been emphasised that as far as possible AWC should be built with community involvement, be of low cost design using local materials and indigenous construction techniques. Further, it should be owned and maintained by community/village panchayat/urban local bodies. This type of centre is also required to organise other activities related to different women's programmes, to provide forum for youth activities, to use for meetings of frontline workers and for gathering of mothers and children. Ministries of Rural Development and Panchayati Raj may play major role in collaboration with State Governments to provide this facility. Voluntary organisation(s) working in the field of rural development can also act as a catalysts in mobilising the community. Experience of Social Work Research Centre (Tilonia), may be of immense help as also experience of a low cost panchayat ghar in Khori village in Rewari district of Haryana which was constructed by local craftsman in less than five months and at one-third of the cost estimated by the PWD. Local materials were used and villagers participated actively in the design as well as construction of AWC.

The strategy of convergence and integration of services has proved to be highly effective in ICDS programme after devolution of responsibilities and

resources under the 73rd amendment of Constitution strengthening Panchayati Raj system became operational. Towards this direction, Ministry of Women and Child Development, Government of India needs to convene frequent meetings of coordination committees not only at central and state levels but also at district and block levels so as to enable the implementing machinery to carry the benefits of different programmes at the door steps of people with a synergetic effect.

Strengthening of ANM centres in ICDS project areas will play crucial role in the delivery of health care services to pregnant and lactating mothers as also adolescent girls. Hence, all village level voluntary health workers like ASHA, Trained Birth Attendants (TBAs), Dais need to be placed at her disposal. This will also facilitate supply of basic drugs, vaccines and equipments in abundance. Sharing of responsibilities of entire project areas among the doctors, LHVs/PHNs and ANMs is utmost important so that smooth functioning of health infrastructure could be ensured in letter and spirit.

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

REFERENCE

[1] ICDS (2011), 'Framework for development of ICDS Annual Programme Implementation Plan (APIP),' Dr.S.K.Adhikari/Sept-09/Mar-10/Dec-10, Ministry of Women and Child Development, Government of India, p. 144.

[2] ICDS (2009), 'Research on ICDS: An Overview (1986-1995),' Volume 2, National Institute of Public Cooperation and Child Development, New Delhi.

[3] Seema.T.N (2001)"Performance of Anganwadis in Kerala: An Evaluation and Experiment to Develop Model Centre and Community Participation," Discussion paper No 28, Kerala Research Programme on Local Level Development, Centre for Developmetal Studies, Thiruvananthapuram, p.2.

[4] Vaijayanti k (2010), Analyzing the ICDS Anganwadi Centres in Bengaluru, Research and Evaluation, Akshara Pre-School Programme Bengaluru, DELL Foundation, Bangalore.

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