Quality Day Care Services for Young Children

Institute of Social Studies Trust, New Delhi

Supported by Social Policy Unit, UNICEF India

Documenting Selected Efforts in Tamil Nadu - ICDS

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Foundation for the Rights of the Young Child
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List of Abbreviations

APIPs- Annual Programme Implementation Plans
ASHAs- Accredited Social health Activists
AWC-Anganwadi Centre
AWH-Anganwadi Helper
AWW-Anganwadi Worker
BCC-Behaviour Change Communication
BCG vaccine-Bacillus Calmette–Guérin
BTT-Block Training Team
CCA- City Compensatory Allowance
CDPO-Child Development Project Officer
DLHS-District Level Household and Facility Survey
DPO-District Project Officer
DPT-Diphtheria, Pertussis and Tetanus
ECCD-Early Childhood Care and Development
ECCE-Early Childhood Care and Education
ECE-Early Childhood Education
ECS-Electronic Credit System
FGD-Focus Group Discussion
FOCUS-Focus on Children Under Six
GOI-Government of India
GoTN-Government of Tamil Nadu
GPF-General Provident Fund
HMIS-Health Management Information System
HRA-House Rent Allowance
ICDS-Integrated Child Development Services Scheme
IEC-Information, Education and Communication
INR-Indian National Rupee
MA- Medical Allowances
MBC-Most Backward Castes
MDMS-Mid Day Meal Scheme
MGNREGA- Mahatma Gandhi Rural Employment Guarantee Act
MUW- Moderately Underweight Children
NFHS-National Family Health Survey
NHED-Nutrition, Health and Education

NMP-Noon Meal Programme
NRDWP- National Rural Drinking Water Programme
NRHM-National Rural health mission
OBC-Other Backward Castes
OPV-Oral Polio Vaccine
PDS-Public Distribution System
PHC-Primary Health Centre
POL-Petrol, Oil and Lubricant
PRIs- Panchayati Raj Institutions
PSE-Pre-School Education
PTNMP- Puratchi Thalavar Noon Meal Program
RCH-Reproductive Child Health
RTI-Right to Information
SNP-Supplementary Nutrition Programme
SSA-Sarva Siksha Abhiyan
SUW- Severely Underweight Children
THR-Take Home Ration
TINP-Tamil Nadu Integrated Nutrition Programme
TN-Tamil Nadu
TSC- Total Sanitation Programme
WB-ICDS-World bank-Integrated Child Development Services Scheme

I. INTRODUCTION

Tamil Nadu, which has a population of 72.1 million, is one of the most urbanized states in the country with 48.45 per cent of the population living in urban areas (Census 2011). The state has the distinction of having initiated various social reforms, often channelling political action in the desired direction. It is also known for its many interesting social welfare and health interventions, which ultimately served as models for other states to emulate. Health indicators like the infant mortality rate of 22 per 1,000 live births (Sample Registration System 2011) are better than the national average of 48 per 1,000 live births (HMIS, Tamil Nadu 2011–2012).

The Integrated Child Development Services (ICDS) in Tamil Nadu has been lauded as a success story (Dreze 2006; Rajivan 2006). In this report, we examine the reasons for the success of as well as the areas in which there are limitations in the implementation of the ICDS programme in Tamil Nadu. We also examine the perceptions of users and non-users of the benefits and limitations of the ICDS programme, and through a small sample survey of ICDS centres, we examine the components of the delivery of quality day-care services in Tamil Nadu.

II. BRIEF HISTORY OF THE ICDS IN TAMIL NADU

Tamil Nadu has been a pioneer of nutrition programmes, which has had a long history in the state. The Noon Meal Programme (NMP) for school children was started way back in 1925 in the Madras Corporation, with the intention to provide supplementary nutrition to the school-going children. Under this historic programme, elementary school-going children were provided noon meals for 200 days in a year (http://shodhganga.inflibnet.ac.in/bitstream/10603/4244/12/12_chapter%203.pdf). The post-independence period brought many changes in the NMP in Tamil Nadu owing to the state government's emphasis on provision of education along with nutrition in an attempt to increase school enrolment rate, curtail dropout rates, improve nutritional levels of children, and combat the problem of malnutrition. Most significantly, all feeding programmes have now been subsumed under a single scheme (Tamil Nadu – NMP). The major financial assistance for this scheme has come from CARE, an international organization.

The Mid Day Meal Scheme (MDMS) was introduced in rural areas of Tamil Nadu in 1925 for preschool children in the age group of 2 to 5 years and for primary school children in the age group of 5 to 9 years. Later, in 1982, the then Chief Minister, M. G. Ramachandran (MGR), launched one of the largest expansions of this programme through the Chief Minister's Nutritious Noon Meals Programme, which was solely targeted to combat hunger and get children to school. From September 1982, this scheme was extended to urban areas and even old-age pensioners were covered from January 1983. From September 1984, the scheme covered school

students of 10–15 years of age, and from December 1995, pregnant women were also brought under the scheme.

While, initially, feeding programmes may have been started to combat hunger in a visible, centre-based fashion, over the years, the government in Tamil Nadu has made serious attempts to combine provision of food under the Noon Meal Programme (NMP) with other services like health care, immunization, growth monitoring, prenatal and postnatal care for women, communication, and nutrition education. This has been done through two main nutrition and child development programmes: the ICDS, which started as a small pilot in 1976, and the Tamil Nadu Integrated Nutrition Project (TINP), phase I of which was begun in 1980. As both these nutrition schemes expanded, they were integrated with the Noon Meal Programme infrastructure for preschoolers. In 1994, the State Policy on Nutrition was drafted and given technical support from UNICEF. Tamil Nadu is probably the first state to have such a policy, following the National Nutrition Policy in 1993. It needs to be noted that there has been constant improvement in the supply of food under the MDMS in Tamil Nadu.

For the development of the MDMS, the Government of Tamil Nadu had both national and international assistance. The national assistance was provided by the central government and the international assistance by CARE and World Bank. The TINP second phase was introduced in 1989 on a pilot basis with financial assistance from the World Bank. During this period, TINP-I operated in 173 rural blocks and TINP-II covered 316 blocks. In the second phase, the programme covered twice the number of blocks as that of the first phase. While phase-I of TINP only covered ICDS areas, phase-II was concentrated in the non-ICDS areas. From 1998 onwards, the TINP was renamed the World Bank- ICDS-III and covered 19,500 centres. TINP was jointly funded by the World Bank and the Government of Tamil Nadu and overseen by the state's highest government officer, the Chief Secretary of the state, assisted by other civil servants. TINP-II was renamed the WB-ICDS-III from 1998 onwards, since it was supported by World Bank funding for the purpose of removing malnutrition among children of the state. Thus, between the two services, that is, the general ICDS and WB-ICDS III, all rural blocks in the state have in place integrated services for child development for children under 6 years, and most urban areas are also covered under ICDS.

With a strong push towards universalization of the ICDS programme, the services of the ICDS have been steadily extended to serve unreached habitations, underserved populations and hard to reach areas of the state. The scheme is currently implemented through 49,499 childcare centres (anganwadi centres) and 4,940 mini-centres, amounting to a total of 54,439 centres functioning under 434 ICDS projects. Out of 434 projects, 47 projects are in urban areas, two projects are in tribal areas and 385 projects are in rural areas (Policy Note 2013–2014 Social Welfare and Nutritious Noon Meal Programme, Chennai, 2013).

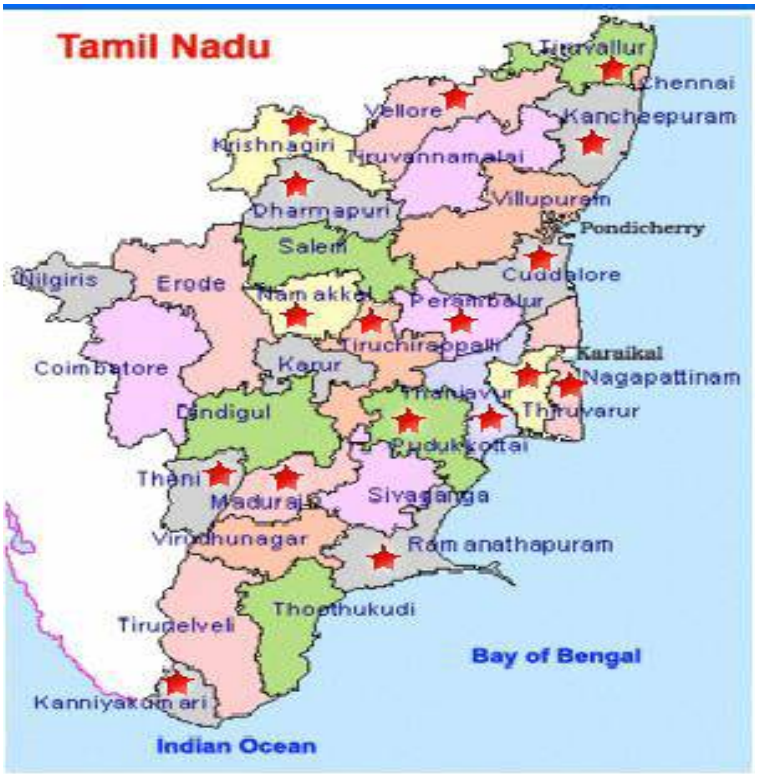


Table No: 1
Overall Profile of ICDS in Tamil Nadu

Number of Districts	**32**
Number of ICDS Blocks	**434**
Rural Projects	**385**
Urban Projects	**47**

Tribal Projects	**2**

Source: Social Welfare and Nutritious Meal Programme Department
Demand No 45, Policy Note 2013–2014, Government of Tamil Nadu 2013.

Out of 434 projects only 18 per cent of the projects are urban projects and the rest are rural projects. In the initial stage, the Government of India (GOI) had followed a gradual ICDS expansion policy based on two kinds of targeting: the first was on the most disadvantaged areas, and the second, on vulnerable preschool children and pregnant and nursing women within these areas. The initial geographical focus was on tribal, drought-prone areas and blocks with a significant proportion of Scheduled Caste population. Municipalities in Tamil Nadu town panchayats are considered as rural projects, whereas only municipal corporation areas are considered as urban projects. It is also time to review this policy and have town panchayat municipalities declared as being part of the urban projects.

Table No: 2
Expansion of ICDS Centres in Tamil Nadu

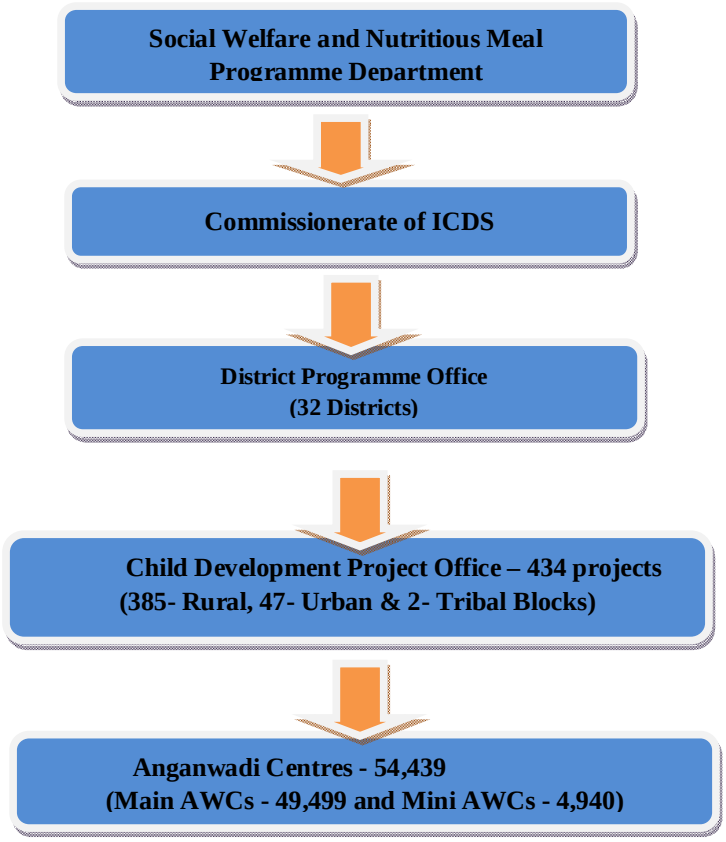
Year	Projects	No. of Anganwadi Centres (AWCs) Operational
1975–80	General ICDS	23,177
1981–97	WB assisted TINP – I & II	42,677
2006–07	Expansion phase I	45,726
2007–08	Expansion phase II	50,433
2009–10	Expansion phase III	54,439
2012–13	Anganwadi on demand	54,439 + Operationalization of 581 AWCs sanctioned in Anganwadi on demand is under progress

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014*

As per deliberations of the National Advisory Council on 28 August 2004, the total number of centres required for universalization of AWCs in Tamil Nadu is 94,505 as against the 54,439 centres presently functioning in Tamil Nadu.

III. ORGANIZATIONAL SET-UP OF ICDS IN TAMIL NADU

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014* © Government of Tamil Nadu, 2013.



IV. NUMBER OF ICDS BENEFICIARIES IN TAMIL NADU

The beneficiaries of the ICDS are children below 6 years, pregnant women, lactating mothers, adolescent girls (11–18 years) and old-age pensioners. The number of beneficiaries in the age group 0–3 years is given below in relation to the total number of beneficiaries in the age group of 0–6 years and also to the estimated total number of children in the age group of 0–3 years.

Table No: 3
Total Number of Children (0–6 years) Beneficiaries under ICDS in Tamil Nadu

S.No	Details	Number of Children	Percentage
1	Total Number of Children (0–6Years) (2011 Census)	7423832*	
2	ICDS Beneficiaries 0–5 years (March 2013)	40,39,387	59.45% as an approx percentage of total no. of children (0–6)
3	ICDS Non-Beneficiaries 0–5 years (March 2013)	27,55,434	40.55% as an approx percentage of total no. of children (0–6)
4	ICDS Beneficiaries 0–3 years (March, 2013)	23,83,656	59.01% as a percentage of ICDS beneficiaries (0–5)
5	ICDS Beneficiaries 3–5 years (March 2013)	16,55,731	40.99% as a percentage of ICDS beneficiaries (0–5)
6	Total Number of Children 0–3 years (estimation from 2011 census)	37,11,915	
7	ICDS (any one service) Beneficiaries 0–3 years	23,83,656 (72%)	72% as a percentage of estimated total no of children (0–3)

**Census –Tamil Nadu*
Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014* © Government of Tamil Nadu, 2013.
Source: RTI Letter No: 15/E-I-1/2013 dated 08-03-2013

The number of non-beneficiaries are 13,28,259 (28 per cent), which includes the higher socio-economic groups, unreached population, and population using private schools.

V. RESEARCH QUESTIONS

The research questions for this report comprised three components:

1. The provision of day-care services for children under 3 years in the Tamil Nadu ICDS, its outreach, best practices and challenges in implementations;
2. Assessing the needs of mothers and the community for day-care services;
3. Costing of the ICDS in Tamil Nadu.

VI. METHODOLOGY

The methodology for the study involved the following aspects:

- Study of existing literature regarding the case study being documented;
- Discussions with key staff;
- Parents especially mothers (users and non-users), community members and context-specific stakeholders;
- Using RTI for questions on secondary data pertaining to the ICDS financial, administrative, and programme details. .

Lessons learned in the process of design and implementation of the ICDS were gathered through discussion with different stakeholders including interviews with users and non-users of the services provided. In turn, the case studies help to fill in the 'best practice' ranges on each aspect of quality care.

VII. DATA COLLECTION

A small field survey was undertaken in 20 anganwadi centres in Tamil Nadu. Convenient sampling method was followed for the selection of the anganwadi centres and selection of user and non-user families. A total of 89 mothers were interviewed (55 user and 34 non-user).

VIII. TOOLS

Individual interviews were developed and administered for user (55 schedules) and non-user (34 schedules) mothers. Through these interviews the social profile of target groups and the ICDS services (reach, coverage and impact) were gathered. Focus group discussions (FGDs) were conducted with the user mothers, non-user mothers, AWC workers and programme staff. The details of which are as follows:

- Anganwadi workers – Chennai City;
- User ICDS families – Resettlement Colonies;
- Non-User families – MMDA Colony; and
- Child Development Project officers in the Chennai District and Vellore District.

IX. DATA COLLECTION PERIOD

The entire data for the study, interviews and FGDs took place from 1–17 May 2013. The researcher also met the Deputy Director of ICDS and Deputy Director of ICDS (Health) and District Project Officers of Dharmapuri District. The researcher had detailed FGDs with 25 supervisors in ICCW Chennai training centre.

X. FIELD WORK

As part of field work, data were collected from various categories of ICDS users and non-users. Data from different demographic respondents in both the rural and the urban areas were included, especially from the most unreached and vulnerable sections of the community.

Table No: 4
Field Work Location / Place

S.No,	Categories	Location/ Place
1.	Tribal	Krishnagiri District – Thali Block
2.	Pavement Dwellers	Chennai - Broadway area
3.	Migrant Families	Kanchipuram District – Old Madras Road, Muttukadu and Thirukazhikundram Block
4.	Coastal Families	Chennai – Nochikuppam, Uthandi, Old Madras Road
5.	Rural Families	Tiruvallur District – Minjur, Vannipakkam
6.	Slum Families	Chennai – MMDA Colony
7.	Resettlement Colonies	Chennai – Semmencherry – Tamil Nadu Slum Clearance Board Resettlement Colony

Source: Field Survey

As shown in Table 4, the field survey was conducted in Chennai, Tiruvallur, Kanchipuram and Krishnagiri districts and was focused on different categories of the population like tribals, pavement dwellers, migrants, slum dwellers, rural families, those in coastal areas and resettlement colonies.

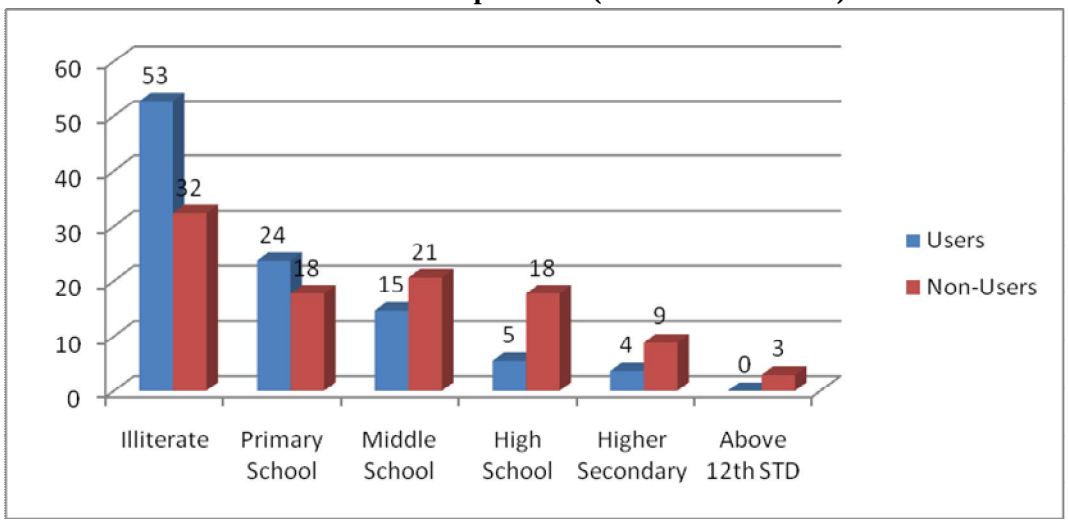
Table No: 5
Category-wise Details of Respondents (Users & Non-Users)

S.No.	Categories	Number of ICDS User Mothers	Users Percentage	Number of ICDS Non-User Mothers	Non-User Percentage
1.	Tribal families	15	**27.3**	5	**14.6**
2.	Pavement dwellers	5	**9.1**	2	**6.0**
3.	Migrant families	3	**5.5**	7	**22.8**
4.	Coastal families	12	**20.2**	9	**26.86**
5.	Rural families	5	**9.1**	5	**14.6**
6	Slum families	5	**9.1**	5	**14.6**
67	Resettlement colonies	10	**18.2**	1	**3.3**
Total		**55**	**100**	**34**	**100**

Source: Field Survey

Table 5 shows that 55 user mothers and 34 non-user mothers with children under 3 years were interviewed for the survey. These were conducted through structured interviews. Among the user mothers, 27 per cent are tribals, 9 per cent are rural families, and resettlement colonies constitute 18.2 per cent. Both pavement dwellers and slum dwellers constitute 9 per cent each, 5 per cent are migrants and 20 per cent are coastal families. Among the non-users, 22 per cent are migrants, 14 per cent are tribals, 26 per cent are coastal families, 14 per cent each are rural families and slum dwellers, 6 per cent are pavement dwellers and finally 3 per cent are from resettlement colonies.

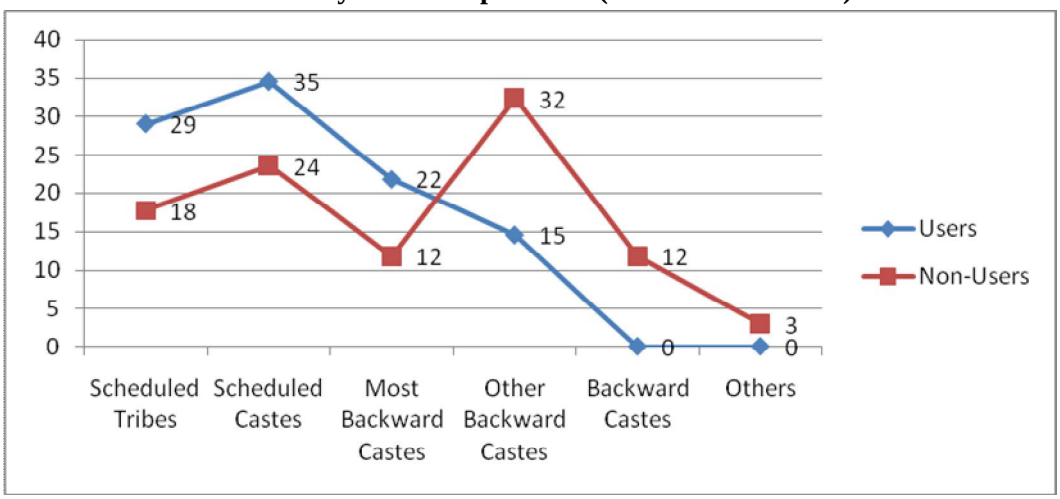
Figure: 1
Education of the Respondents (Users & Non-Users)



Source: Field Survey

Figure 1 reveals that among the user mothers, more than half (53 per cent) are illiterate; 24 per cent are educated up to primary school; 15 per cent are educated up to middle school; 5 per cent are educated up to high school; and 4 per cent up to higher secondary school. While among the non-user mothers, the highest percentage are illiterate at 32 per cent; 21 per cent are educated up to middle school; 18 per cent each are educated up to high school and primary school; 9 per cent are educated up to higher secondary level; and only 3 per cent are educated above the 12th Standard.

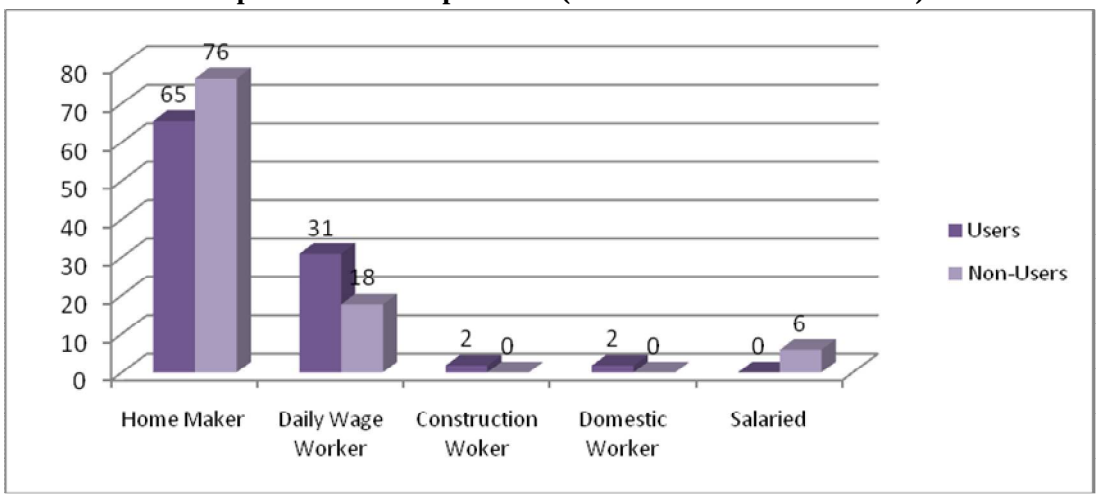
Figure: 2
Community of the Respondents (Users & Non-Users)



Source: Field Survey

Figure 2 reveals that among the user mothers the highest figure, at 35 per cent, belongs to Scheduled Castes; 29 per cent belong to Scheduled Tribes; 22 per cent belong to Most Backward Castes (MBCs); and 15 per cent are from Other Backward Castes (OBCs). Among the non-users, 32 per cent are OBCs; 24 per cent are from Scheduled Castes; 18 per cent are Scheduled Tribes; 12 per cent each are from MBCs and Backward Castes (BCs); and 3 per cent belong to other communities/castes.

Figure: 3
Occupation of the Respondents (Users & Non-Users Mothers)

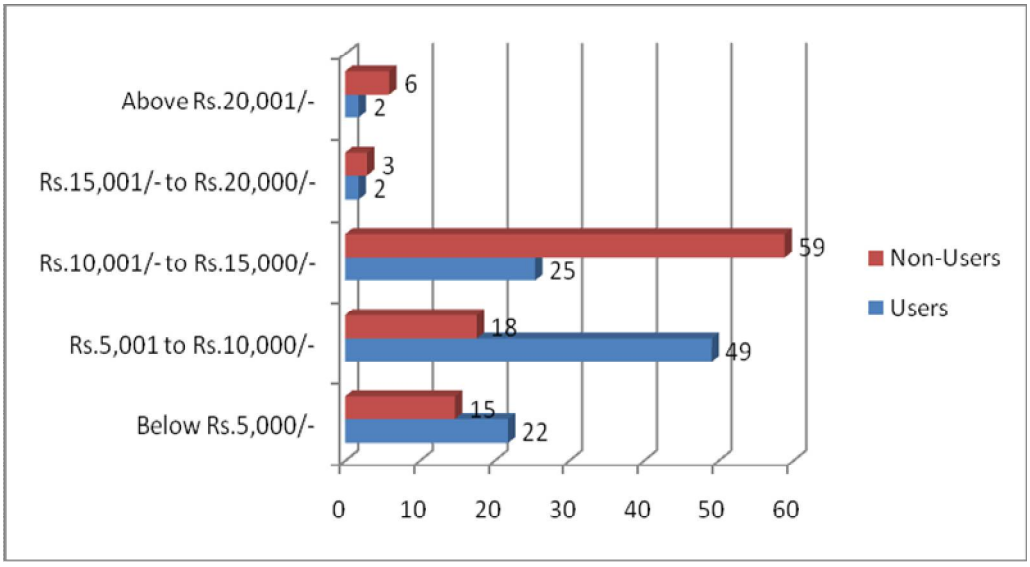


Source: Field Survey

Figure 3 reveals that a majority of the user mothers, at 65 per cent, are home makers, 31 per cent are daily wage workers and a very small per cent are in construction work (2 per cent) and domestic work (2 per cent). Among the non-user mothers, too, a majority are home makers, at 76 per cent, 18 per cent are daily wage workers and 6 per cent are salaried workers. The percentage of home makers is high among both the users and the non-user mothers, especially in the tribal, costal, resettlement, slum and rural areas owing to lack of employment opportunities and the concentration of jobs in the sub-urban and urban areas. Travel to these places is difficult for women, and they also find it difficult to manage household responsibilities if they work.

Figure: 4

Family Income of the Respondents



Source: Field Survey

Figure 4 shows that half the user families (49 per cent) earn an income within the range of Rs 5,001 to Rs 10,000; 25 per cent earn an income in the range of Rs10,001 to Rs 15,000; 22 per cent earn an income below Rs 5,000 per month; 2 per cent of the families earn an income in the range of Rs 15,001 to Rs 20,000; and another 2 per cent above Rs 20,001. Among the non-user families, more than half (59 per cent) of the families have an income in the range of Rs 10,001 to Rs 15,000; 18 per cent earn an income within the range of Rs 5,001 to Rs 10,000; 15 per cent earn an income below Rs 5,000; 6 per cent earn an income above Rs 20,001; and the rest, 3 per cent, earn an income within the range of Rs15,001 to Rs 20,000.

XI. ICDS SERVICES

Various services for children like immunization, growth monitoring, nutrition, healthy-living habits and cognitive facilities/mental stimulation are provided by ICDS. Depending upon the age groups, different services are provided for children (0–6 years), and the details are as follows:

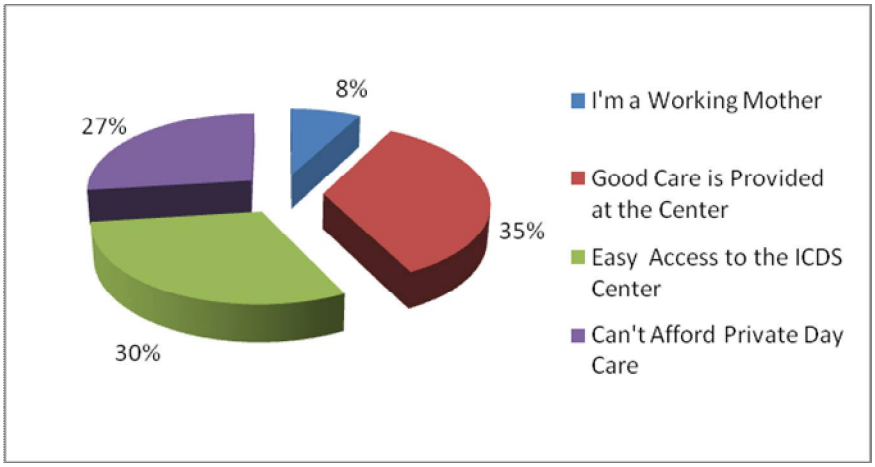
Table No: 6
Services of ICDS Based on Age Group

Age group	Services
Conception– 6 months	Maternity, immunization, antenatal care and postnatal care
7–12 months	Supplementary Nutrition Programme, immunization, health services
13–24 months	Supplementary Nutrition Programme (egg)
25–36 months	Regular ICDS services and SNP (three eggs)

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014* © Government of Tamil Nadu, 2013.

For the children in the age group of 13–24 months, as part of supplementary nutrition, one egg is given per week per child, and for children in the age group 25–36 months three eggs are given per week per child. The quantity and quality of supplementary food is comparatively more in Tamil Nadu, and apart from these, children are given *dhal*, cereals, etc. In terms of immunization, pentavalent vaccines are used, and the Government of Tamil Nadu has ensured the coverage of migrants under the immunization programme.

Figure: 5
User Mothers' Reasons for Sending Children to ICDS Centres (Multiple Responses)

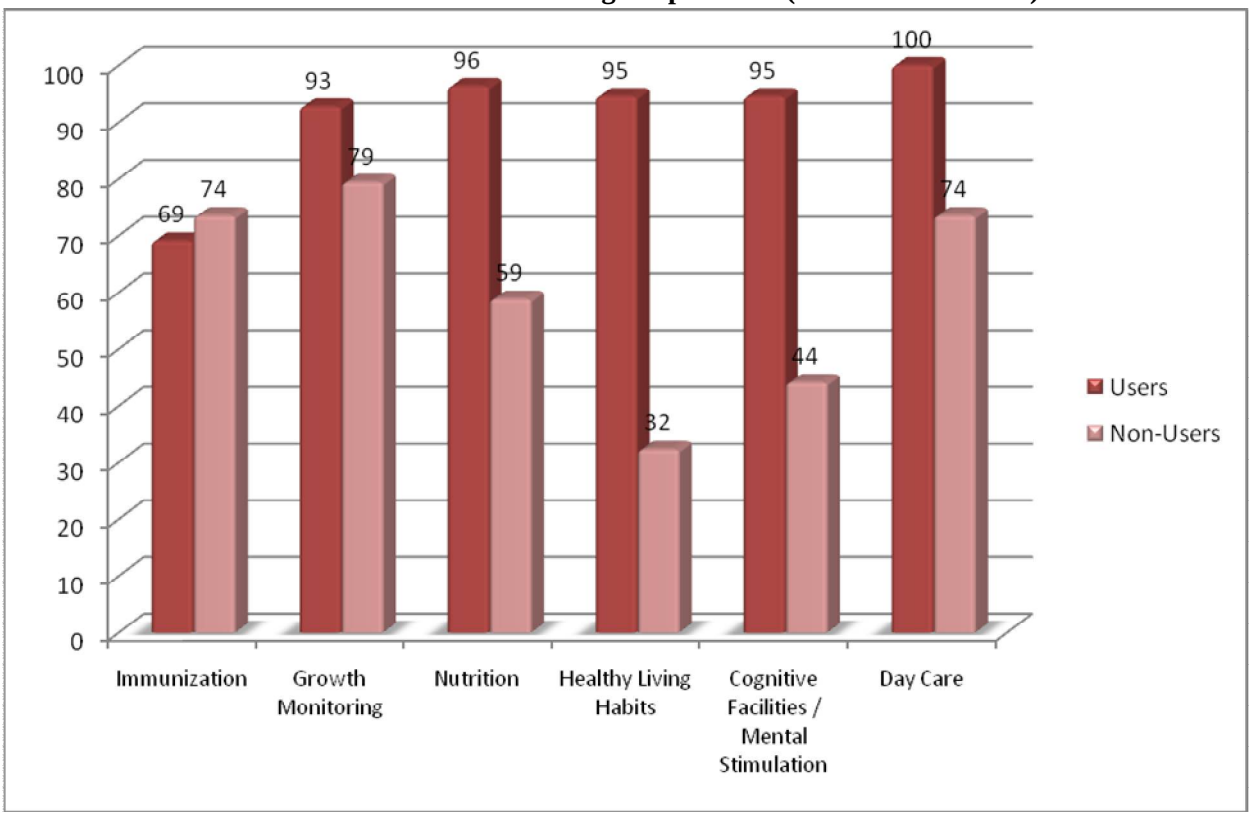


Source: Field Survey

Figure 5 reveals reasons for mothers' sending their children to ICDS centres, which are based on multiple responses of the user mothers. The highest percentage, 35 per cent, send their children to ICDS centres because good care is provided there; 30 per cent send their children, as the

centre is easily accessible; 27 per cent send their children, as they cannot afford a private day-care centre; and 8 per cent send their children there, because they are working mothers.

Figure: 6
Awareness of ICDS Services among Respondents (Users & Non-Users)



Source: Field Survey

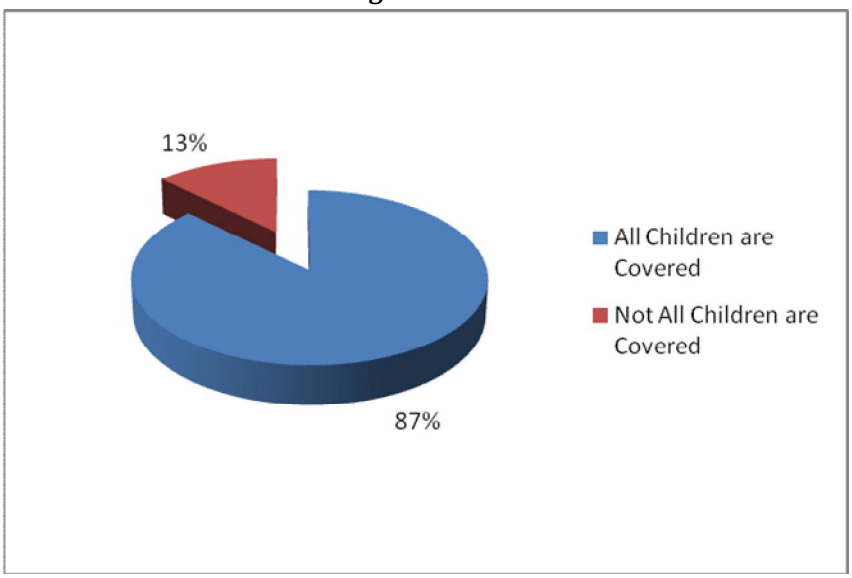
Figure 6 reveals the levels of awareness among the user and non-user respondents on the various ICDS services. Among the users, all (100 per cent) are aware of the day-care services; 96 per cent are aware of the nutrition services that are provided; 95 per cent are aware of services related to healthy-living habits and the same percentage are aware of cognitive facilities/mental stimulation aspects (95 per cent); 93 per cent are aware of growth monitoring; and 69 per cent are aware of immunization done for children. Among the non-user mothers, it is interesting to note that the majority, 79 per cent, are aware of growth monitoring services; 74 per cent are aware of immunization and the same per cent are aware of day-care (74 per cent) services; 69 per cent are aware of healthy-living habit services provided through ICDS; 59 per cent are aware of nutritional services provided through the centres; and 56 per cent are aware of the cognitive facilities/mental stimulation services that are provided for the children through ICDS centres. Except for immunization services, the user mothers have more awareness on all other ICDS services when compared with the non-user mothers.

1. IMMUNIZATION

Immunization is arguably the single most cost-effective public health intervention. The immunization of children is nearly universal in Tamil Nadu, and the coverage of administering vitamin A is 88 per cent. Immunization coverage as per DLHS -3 (2007–2008) is as follows: fully immunized: 83.2 per cent; BCG: 99.6 per cent; Measles: 97.6 per cent; DPT: 88.9 per cent. Immunization of pregnant women against tetanus also reduces maternal and neonatal mortality. This service is delivered by the Ministry of Health and Family Welfare under its Reproductive Child Health (RCH) programme. Tamil Nadu State Health Department has been claiming 92–94 per cent immunization coverage; however, studies by organizations including UNICEF have shown a 20 per cent drop in immunization coverage in the state since 2008. The Tamil Nadu Vaccination Programme has an annual budget of Rs 24,342,745 which is distributed over three main areas – medical supplies (drugs and vaccines), infrastructure (building space, roving health centre, cold chain equipment), and staff coverage (doctor, assistant, training and salary).

Introduction of Pentavalent Vaccination: About 75,000 children are dying every year in India of pneumonia and meningitis caused by Hib type-B bacteria, and many Hib-affected children are left with permanent paralysis, deafness and brain meningitis. To reduce Hib disease burden, Pentavalent vaccine was introduced from 21 December 2011 onwards in Tamil Nadu. Besides prevention of five diseases, the number of immunization injections that need to be administered is also reduced owing to the use of this vaccine.

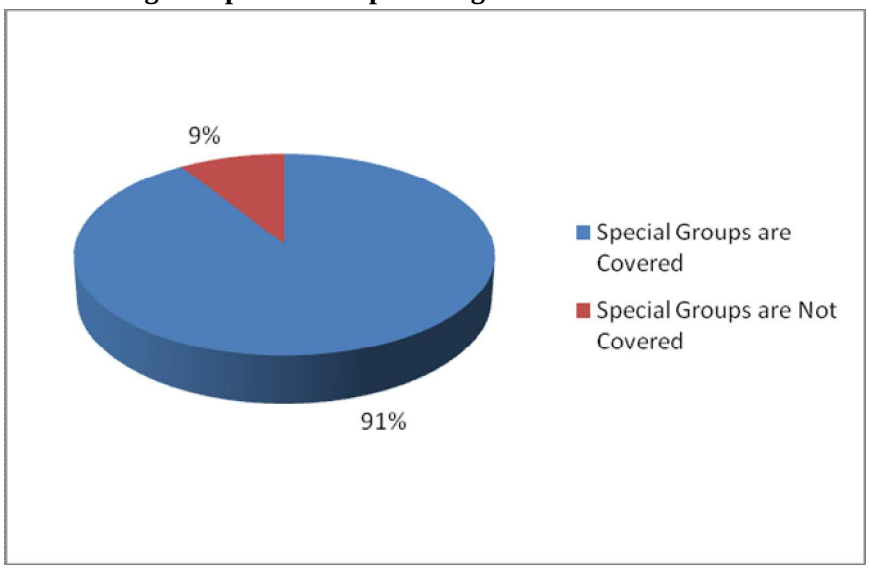
Figure: 7
Immunization Coverage of Children at ICDS Centres



Source: Field Survey

Figure 7 shows that in the majority of centres, 87 per cent, all children in the village are covered during immunization, while in 13 per cent of the centres, not all are covered.

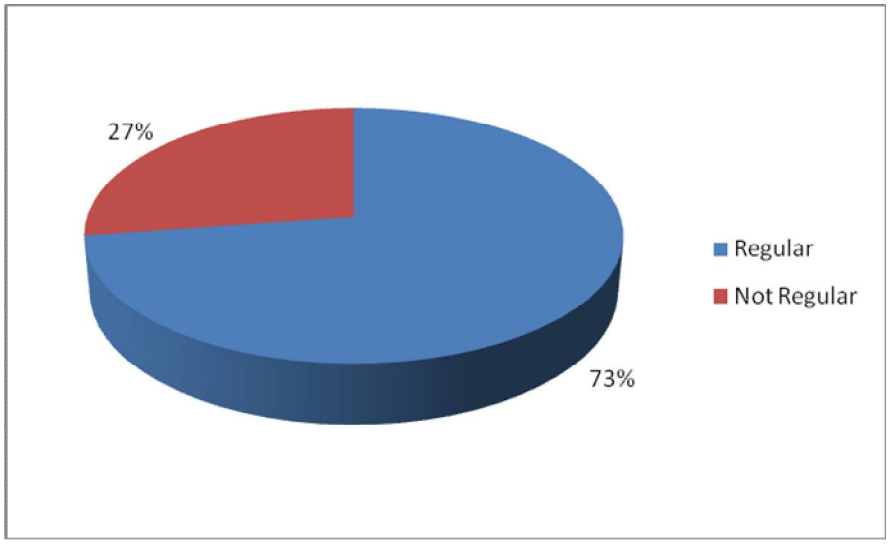
Figure: 8
Coverage of Special Groups during Immunization of Children



Source: Field Survey

Figure 8 reveals an interesting finding: in 91 per cent of the ICDS centres, special groups like tribals and migrants are also covered in the immunization programme.

Figure: 9
Immunization of Children at ICDS Centres



Source: Field Survey

Figure 9 shows that a majority, 73 per cent, of the ICDS centres provide immunization services to the children on a regular basis, while the remaining 27 per cent do not do this regularly.

2. GROWTH MONITORING

Growth monitoring by weighing and measuring the height of the children is an important component that is also linked to the nutrition component in the programme. Monitoring the weight of children under 6 years, as a component of childcare under ICDS, is done so as to identify children who are undernourished or malnourished. Serial records of the weight of children are kept with a view to keep close watch over their nutrition status, growth and development and immunization. Every month, newborn children are monitored for their weight gain for up to 6 months. Mothers of children with low weight are given counselling and advised to provide extra care and supplementary nutrition so that the child can reach the normal stage of physical development. 'We identify underweight babies in our area, adopt them and provide extra care through additional nutrition and health education for the parents apart from the regular services' (FGD with ICDS workers). Every three to six months, a general check-up is done in order to detect diseases and evidence of malnutrition or infection.

Table No: 7

Total Number of Children (0–6 years) Beneficiaries under ICDS in Tamil Nadu

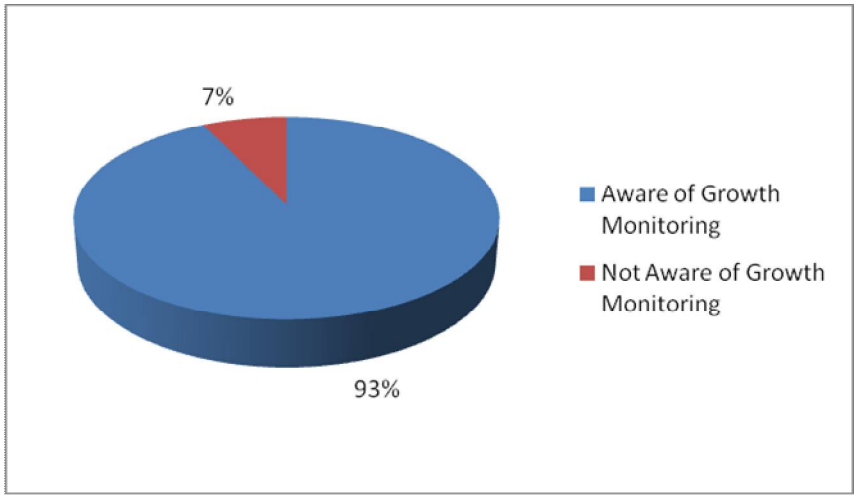
1.	**Weight taken for children 0–3 years**	**23,55,295 (99%)**
2.	**Weight taken for children 3–5 years**	**16,10,976 (97%)**
3.	**Weight taken for children 0-–5 years**	**39,66,271 (98%)**
4.	**Children eating supplementary food in ICDS (2012)**	**16,78,271**
5.	**Children eating mid-day meal (2012)**	**11,20,842**

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014* © Government of Tamil Nadu, 2013.
Source: RTI Letter No: 15/E-I-1/2013 dated 08-03-2013.

It is evident that among those who are benefiting through ICDS, the weights of 98 per cent (39,66,271) of the children (0–5 years) have been measured on a regular basis, and records are maintained by the teachers and growth-monitoring cards are provided to the mothers so that they too can be aware of their child's growth and development aspects.

Figure: 10

Awareness of Growth Monitoring among Mothers



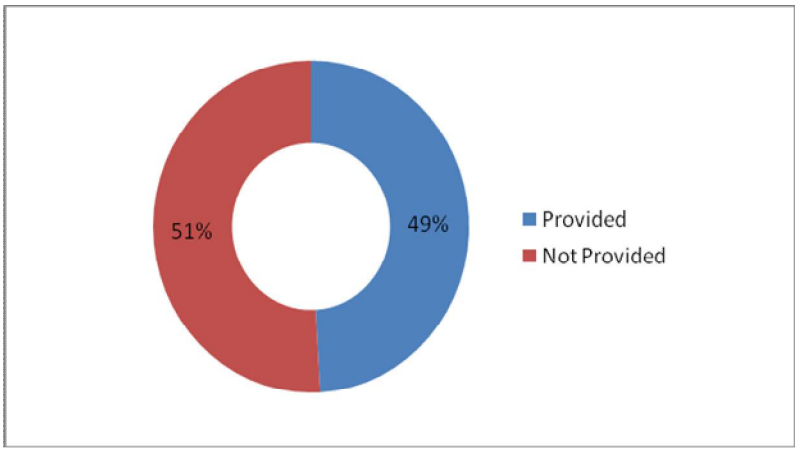
Source: Field Survey

Figure 10 describes the level of awareness on growth monitoring of children in ICDS centres. It is evident from the analysis that a majority, 93 per cent, of the mothers are aware of the growth

monitoring that is done regularly at the centre, and 7 per cent are not aware of it, only because of their ignorance and lack of awareness of such services.

Figure: 11

Growth Card Provided for Mothers

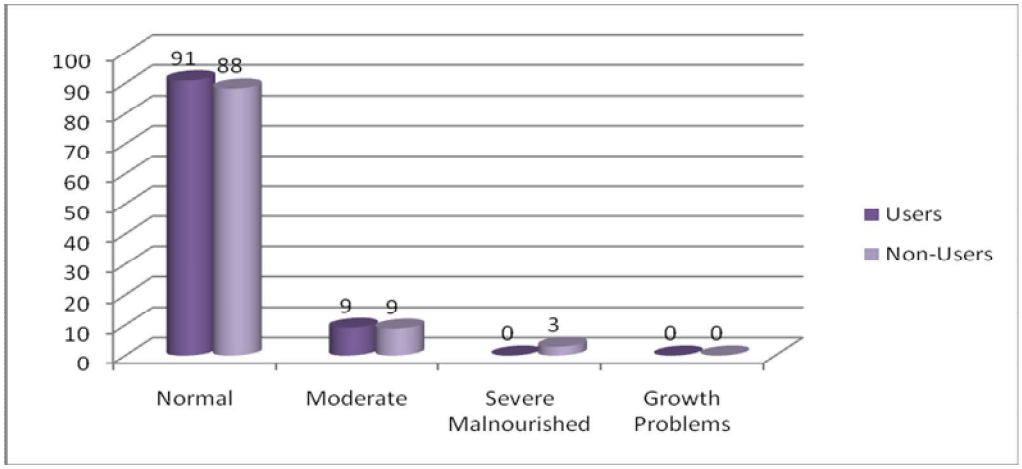


Source: Field Survey

Figure 11 reveals that from this survey, almost half (49 per cent) of the mothers are provided with growth cards, while the other half (51 per cent) are not. In some centres, the workers themselves maintain a growth monitoring record, and, hence, no such cards are issued to the mothers. 'Parents show much interest in the growth and development of their children. They pose a lot of questions and clarify their doubts on children's health' (FGD with ICDS workers). 'The growth of children has considerably improved because of the nutritional care provided at the ICDS centre' (FGD with user mothers).

Figure: 12

Awareness of Mother about their Children's Growth Category (Users & Non-Users)



Source: Field Survey

Figure 12 reveals that majority of the user mothers, 91 per cent, are aware that their children are in the normal stage of growth and 9 per cent are aware that their children are in the moderate stage of growth and development. Whereas, among the non-user mothers, similarly, a majority of them, 88 per cent, are aware that their children are in the normal stage of growth, 9 per cent are aware that their children are in the moderate level and 3 per cent are aware that their children are severely malnourished.

While much has been done in Tamil Nadu to monitor growth and to improve nutrition and health (see Table 8), it is clear that there is a long way to go.

Table No: 8

Underweight Children in Tamil Nadu for the Year 2012–2013 as on March 2013

S. No.	Category of Children	Number of Children (0–3 years)	Number of Children (3–5 years)	Number of Children (0–5 years)
1	Severely Underweight	5,094 (0.22%)	1,986 (0.12%)	7,080 (0.18%)
2	Moderately Underweight	5,19,003 (22%)	3,39,310 (25%)	8,58,313 (21.64%)
3	Overweight Children	7,016 (0.30%)	2,976 (0.18%)	9,952 (0.25%)
4	Normal Weight Children	18,24,182 (77%)	12,66,704 (79%)	30,90,886 (77.93%)
5	Moderately Underweight and Severely Underweight	5,24,097 (22%)	3,41,296 (21%)	8,65,393 (22%)

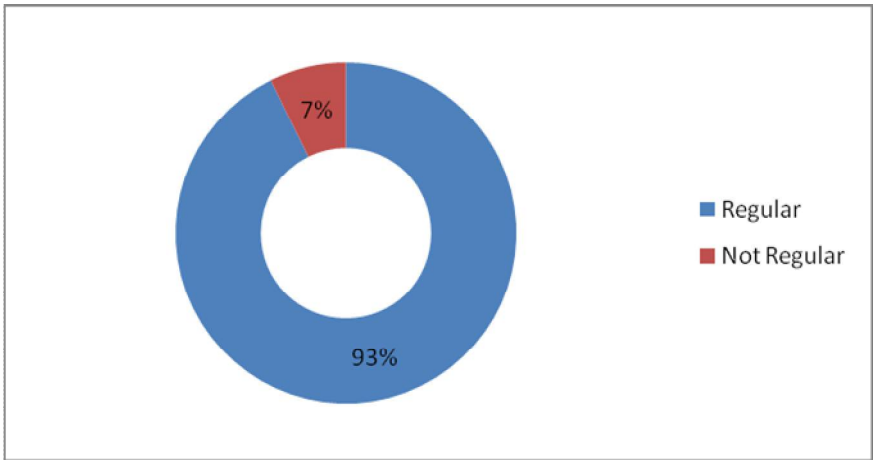
Source: http://icds.tn.nic.in/

3. HEALTH CHECK-UP IN THE ICDS CENTRES

Antenatal Care of Expectant Mothers: At the antenatal clinics, apart from complete physical and obstetrical examination of the mother, serial recording of weight, blood pressure, haemoglobin level and results of urine test is done on a routine basis. Immunization against tetanus is given; iron and folic acid tablets along with protein supplements are also given.

Postnatal Care: In villages where primary health centres (PHCs) and sub-centres are located and also in villages near these**,** efforts are made to pay postnatal visits to mothers in their homes twice within 10 days of delivery; in other areas at least one visit within the first month after delivery is aimed for. These visits are used to check on the general health and well-being of the mothers, establishment of successful breastfeeding of the newborn and attention to the general health of the infants. At the postnatal clinic, mothers are helped to adopt a suitable method for spacing the next birth or for limiting the family size as the case may be.

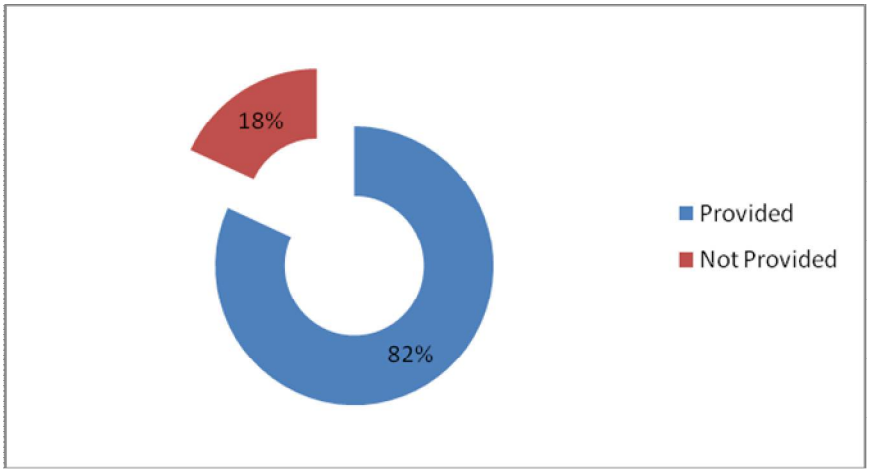
Figure: 13
Health Check Up at the ICDS Centres



Source: Field Survey

Figure 13 proves that in a majority of the ICDS centres (93 per cent), regular health check-ups are conducted, whereas in only 7 per cent of the centres are these not regularly conducted.

Figure: 14
Medical Services for Minor Ailments



Source: Field Survey

Figure 14 reveals that in 82 per cent of the ICDS centres, medical care services for minor ailments are provided, while in only 18 per cent of the centres are such services not provided. The lack of such services is due to irregular visits of health workers who offer medical services (50 per cent) and due to the non-availability of medicines (50 per cent) in the centres.

Referral Services: Pregnant women and children with health issues (such as malnutrition) requiring specialized treatment are referred to the upgraded PHC/sub-division/district headquarter hospital. The medical officer of the PHC refers such cases with a referral slip used for this purpose. The hospital after completing the treatment refers the mother/child back to the PHC with notes of treatment given and further treatment/advice to be followed. During health check-ups and growth monitoring, sick or malnourished children in need of prompt medical attention are referred to the primary health centre or its sub-centre. The anganwadi worker (AWW) has also been trained to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer of the primary health centre/ sub-centre.

4. NUTRITION

Nutrition, health and education (NHED) is a key element of the work of the anganwadi worker. This is a part of the behaviour change communication (BCC) strategy, which includes achievement of long-term goals of capacity building among women, especially in the age group of 15–45 years, so that they can look after their own health, nutrition and development needs as well as that of their children and families. The methods for carrying the messages of health and nutrition education are through mass media and other forms of publicity, special campaigns at suitable intervals and home visits by anganwadi workers.

In the 12th Five Year Plan, the Government of Tamil Nadu has allocated Rs 11,285 crores, that is, 5.3 per cent of the total outlay, for the nutrition sector (12th Five Year Plan 2012–2017, Planning Commission, Chennai).

Nutrition Components

Supplementary Nutrition: In Tamil Nadu, supplementary nutrition in the form of weaning food is being given to the ICDS scheme beneficiaries, that is, children of 6–36 months, expectant women, and lactating mothers for 300 days in a year. Further, children in the age group of 2–3 years are also provided noon meals throughout the year. By providing supplementary feeding, this scheme attempts to bridge the protein-energy gap between the recommended dietary allowance and average dietary intake of children, pregnant women and lactating mothers.

Complementary weaning food for children of 6 months – 3 years: Complementary weaning food containing amylase activity is being provided for 300 days in a year under the Supplementary Nutrition Programme (SNP) to ICDS beneficiaries. The complementary weaning food is provided in the form of *laddus/kanjee* (porridge), which is prepared and provided in the anganwadi centres itself by the anganwadi employees. In the case of children in the age group of 6 months to 1 year (and under rare circumstances to children under 3 years of age), the weaning food is provided as Take Home Ration (THR). Uniformity in implementing the SNP is practised everywhere in the state of Tamil Nadu. Details of the quantity, protein composition and energy component of the weaning food provided for ICDS beneficiaries are as follows:

Table No: 9

Quantity, Protein and Energy Component of Complementary Weaning Food

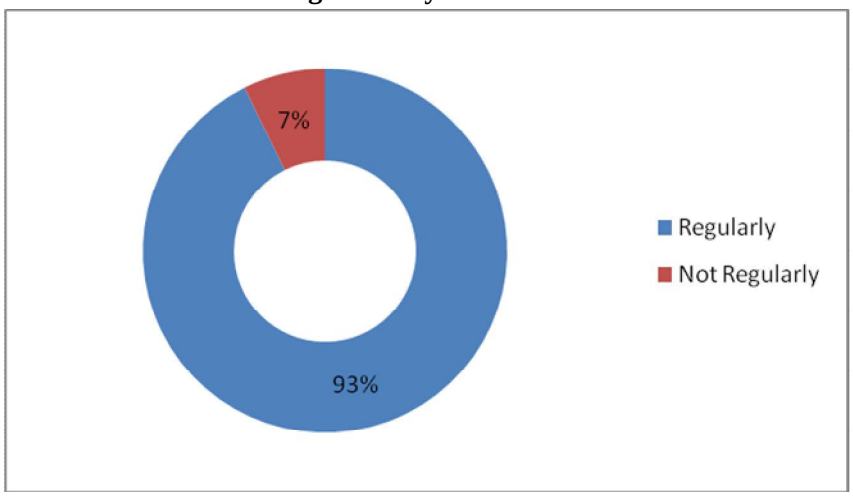
Category	Quantum of weaning food provided	Protein (gms)	Energy (Kcal)
Children 6–36 Months	130	11	455
Children 6–36 Months (Severely malnourished)	190	16	665

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014*

Supplementary nutrition for children under 5 years of age: Under the ICDS scheme in Tamil Nadu, noon meal is provided as supplementary nutrition to children of the age group 2–5 years for 365 days of the year. Further, each child is given 20 gms of boiled black bengal gram or boiled green gram every Tuesday and 20 gms of boiled potato every Friday; the potatoes are locally purchased by the anganwadi worker herself. One boiled egg per child is provided every Wednesday to children in the age group 1–2 years. Further, three boiled eggs per week per child are given to children of the age group 2–3 years, that is, a child will be given an egg every Monday, Wednesday and Thursday. Children who do not eat eggs are given bananas (100 gms), which are

purchased by the anganwadi worker. There is uniformity of practice in implementing the SNP everywhere in the state of Tamil Nadu.

Figure: 15
Children Eating Mid-Day Meals at ICDS Centres



Source: Field Survey

Figure 15 from the field survey shows that 93 per cent of the children eat mid-day meals at the ICDS centres and that 7 per cent do not do so. The sole reason for children not taking mid-day meals is that the quality of food is inferior at the centre.

The calories and protein content being provided to beneficiaries in the feeding scale as follows:

Table No: 10

Nutrition Composition of Food Provided to Beneficiaries

Category	Quantum of Supplementary food (per day) (GM) / beneficiary	Cost per beneficiary (GOI norms)	Protein (GM) (GOI norms)	Energy (Kcal) (GOI norms)	Vitamins & Minerals (% of RDA) (GOI norms)
Children 6–36 months	130	5.00 (4.00)	11 (12–15)	455 (500)	50

Children 6–36 months (severely malnourished)	190	7.50 (6.00)	16 (20–25)	665 (800)	50
Pregnant women and nursing mothers	160	6.32 (5.00)	13.5 (18–20)	560 (600)	50
Adolescent girls under SABLA in 9 districts	130	5.00 (5.00)	11 (18–20)	455 (600)	50

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014* © Government of Tamil Nadu, 2013.

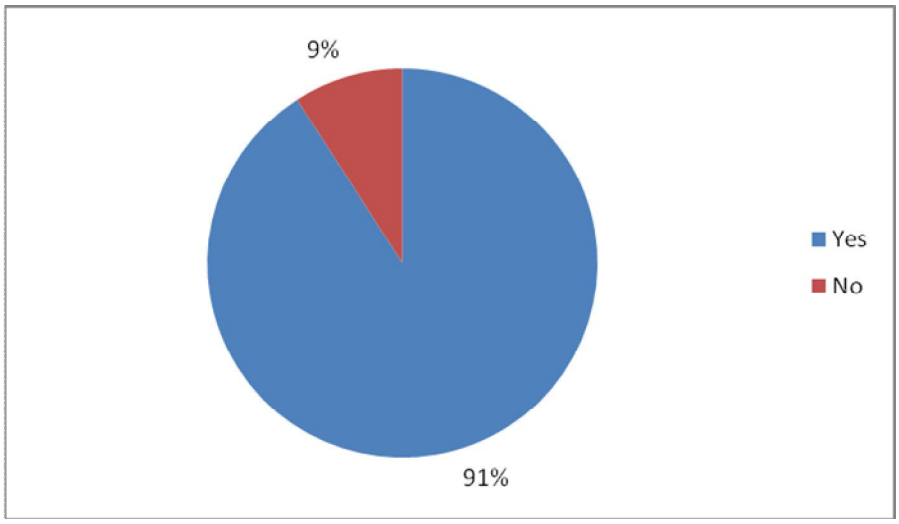
Table No: 11
Noon Meal Programme Beneficiaries

S.No	Categories	Number of Children
1	Noon Meal Programme total children (25–60 months)	11,38,831
2	Noon Meal Programme total children (37–60 months)	6,31,666
3	Egg beneficiaries under SNP, 12–24 months and NMP 25–60 months	4,80,719
4	Egg beneficiaries under SNP, 13–24 months	4,80,719
5	Egg beneficiaries under NMP, 25–60 months	11,39,015
6	Banana for non-egg eating children (2–5 years)	369

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget, 2013–2014*, © Government of Tamil Nadu, 2013.

Figure: 16

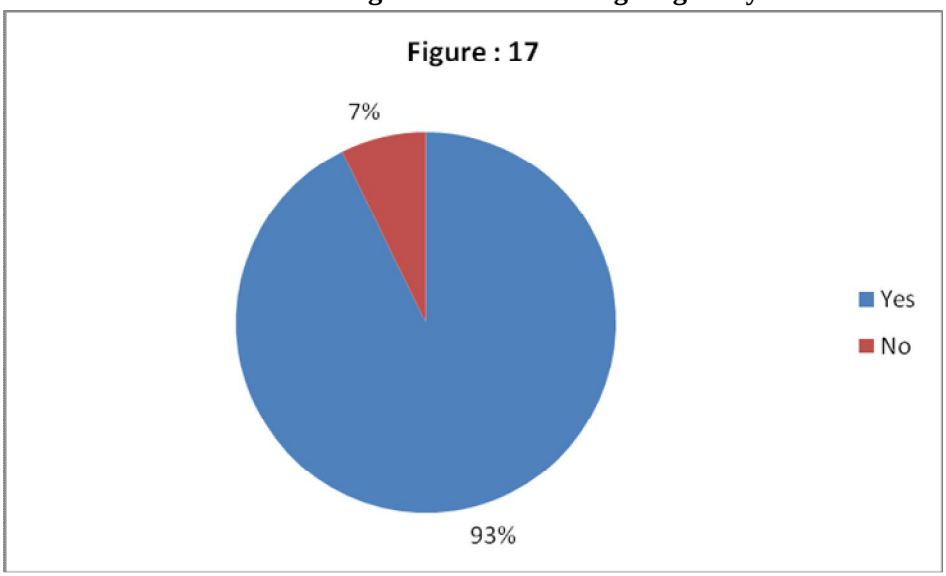
Children Eating Nutritional Balls / Take Home Ration (THR) regularly



Source: Field Survey

Figure 16 shows that 91 per cent of the children are eating nutritional balls / take home ration (THR) regularly while only 9 per cent of them do not take them regularly. The reasons for children not taking nutritional balls / THR regularly are that 60 per cent of them do not like the taste and that in 40 per cent of the centres, they are not provided to the children.

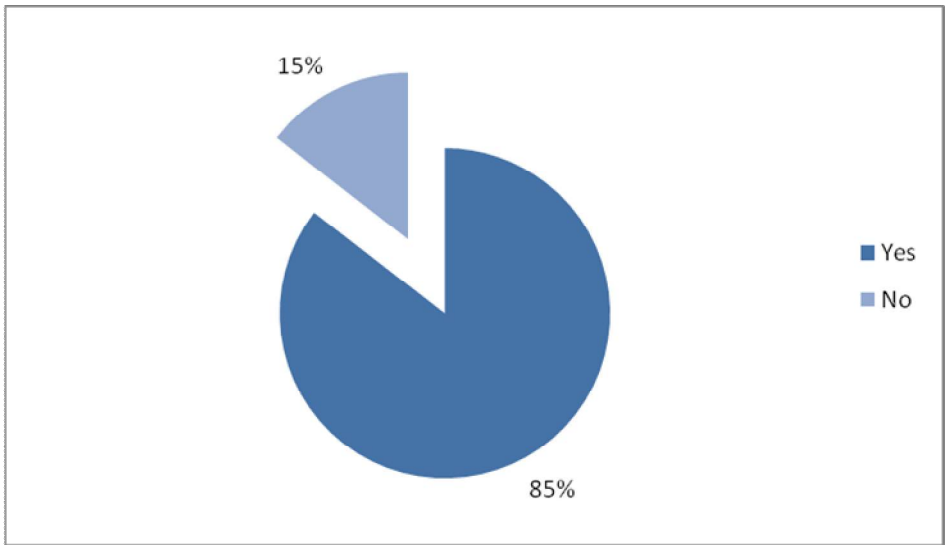
Figure: 17
Children Eating Nutritional Porridge regularly



Source: Field Survey

Figure 17 reveals that 93 per cent of the children eat nutritional porridge regularly at the ICDS centres, whereas 7 per cent do not eat them regularly. The only reason for not eating nutritional porridge regularly is dislike of the taste of porridge by the children.

Figure: 18
ICDS Menu Containing Snacks



Source: Field Survey

It is evident from Figure 18 that 85 per cent of the ICDS centre menus have snacks and 15 per cent do not have them in their menus.

Figure: 19
Snacks that Include Nutritional Balls in Proper Quantities

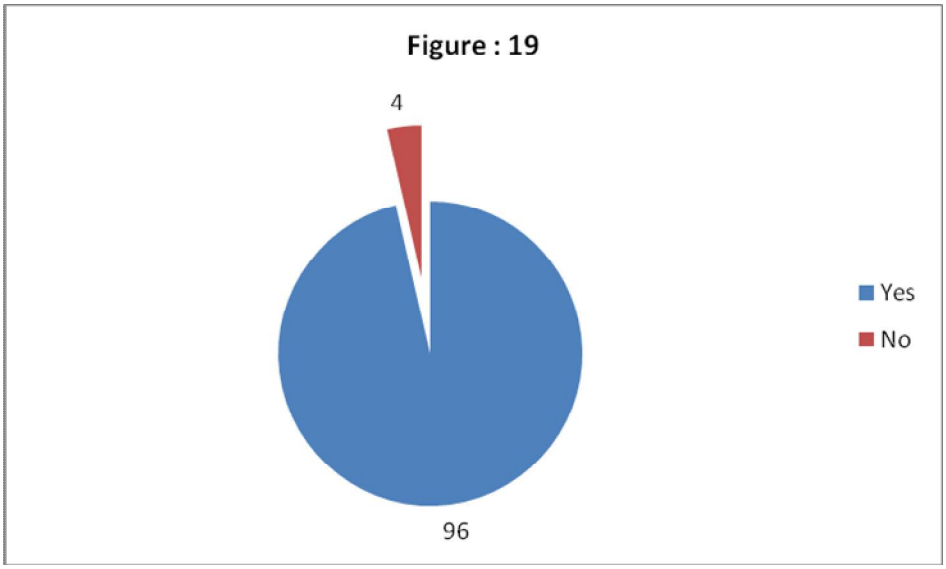
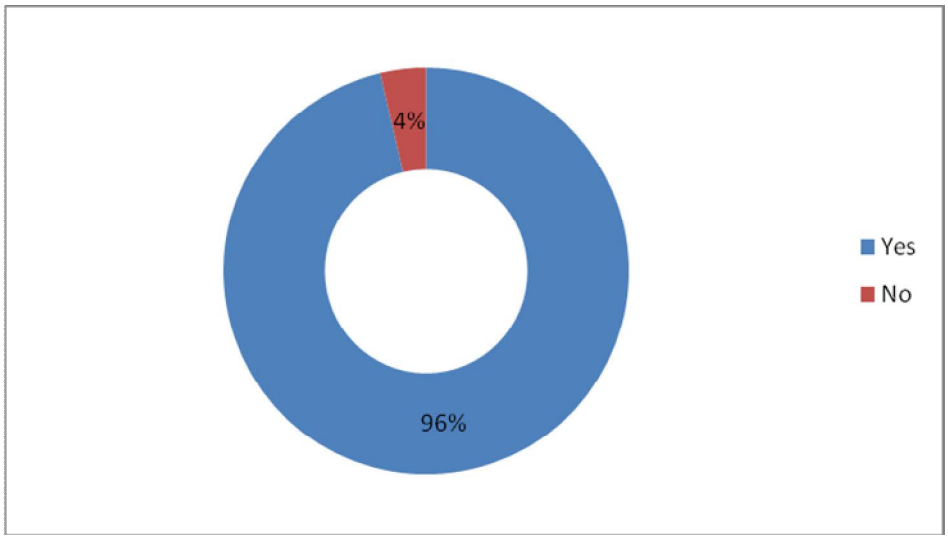


Figure 19 shows that in 96 per cent of the ICDS centres, proper quantities of nutritional balls are included as snacks, whereas in 4 per cent, they are not included in proper quantities.

Figure: 20
Opinion on Food Prepared in Hygienic Manner



Source: Field Survey

Figure 20 shows that 96 per cent of mothers were of the opinion that food was prepared in a hygienic manner at the ICDS centres, while only about 4 per cent of mothers thought that it was not prepared hygienically and needed to be improved.

Figure: 21
Children Provided Eggs Regularly

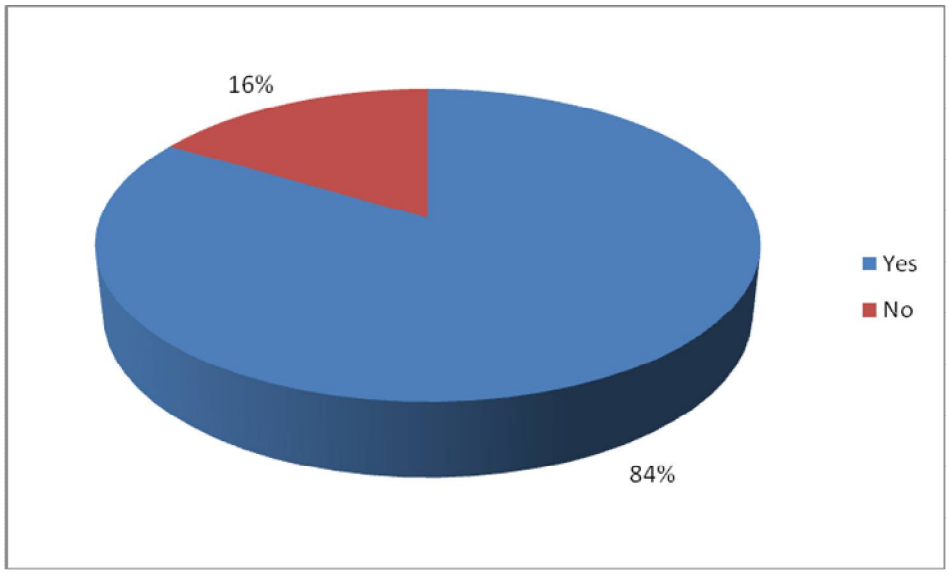


Figure 21 reveals that in 84 per cent of the ICDS centres, eggs are provided regularly, whereas in 16 per cent of the centres, eggs were not given regularly. The only reason for not giving eggs regularly is that the workers do not give them to the children.

Table No: 12
Category-wise Quantity of Weaning Food

S. No.	Category	Quantity
1	Normal children 6–36 months (per Child)	**130 grams**
2	Moderately Underweight Children (MUW) 6–36 months (per child)	**190 grams**
3	Severely Underweight Children (SUW) 6–36 months: (per child)	**190 grams**
4	Pregnant Women and Lactating Mothers (per mother):	**160 grams**

Source: Social Welfare and Nutritious Meal Programme Department, Demand No 45, Policy Note 2013–2014, Government of Tamil Nadu, 2013.

Table 12 reveals the category-wise quantity of weaning food that is provided to the different beneficiaries through ICDS centres. For a normal child in the age group of 6–36 months, the quantity of weaning food that must be given is 130 gms; for a moderately underweight child (0–36 months), 190 gms of weaning food must be given; for a child (6–36 months) who is severely underweight, 190 gms of weaning food must be given; and for pregnant women and lactating mothers, weaning food of 160 gms must be given.

And finally, the details of feeding charges are as follows:

Table No: 13

Cost of Food Materials

S.No.	Food Materials	At Present Rate	Enhanced Rate	
			Dhal used days	Non-Dhal used Days
1	Vegetable	25 paisa	70 paisa	80 paisa
2	Condiments	12 paisa	24 paisa	36 paisa
3	Fuel	19 paisa	19 paisa	19 paisa
Total		**56 paisa**	**1.13 paisa**	**1.35 paisa**

Source : GO NO:49 Social Welfare and Nutritious Noon Meal Department, dated 17-04-13.

Production and Distribution of SNP

In Tamil Nadu, the noon meals are prepared in the anganwadi centres itself and supplies such as dhal, oil, etc., are procured from the Tamil Nadu Civil Supplies Corporation. The weaning food is manufactured within the state in 18 districts. The 25 Weaning Food Manufacturing Women Development Industrial Cooperative Societies are functioning under the administrative control and supervision of the Principal Secretary/Special Commissioner, ICDS, who is also the functional Registrar of these societies. The first weaning food manufacturing society started functioning from the year 1988 onwards in Chennai to cater to local needs, and subsequently these societies have been started in the districts also to cater to the expanding needs of areas in the districts through local manufacture. These cooperative societies have 1,450 enrolled members, who are all women belonging to poor families (including widows, destitute and deserted women). As per the orders of the government and tender conditions at present, a over 65 per cent of the required weaning food is being procured from the 25 Weaning Food Manufacturing Women Development industrial Cooperative Societies every month and the balance quantity is being procured from two private manufacturers selected through open tender process. The present contract period for supplying weaning food is for 3 years, that is, from May 2010 to April 2013. The addresses of the two private manufacturers selected through open tender following Tamil Nadu Transparency in Tender Act, 1998, and Tamil Nadu Transparency in Tender Rules, 2000, is given below:

1. M/s Rasi Nutri Foods,1/67-A & 1/67-B, Salem Trichy main road, Athanur - 636 301

2. M/s. Christy Friedgram Industry, a-2 7 A-3, SIDCO Industrial estate, Andipalayam -63721

Table No: 14
Procurement of Weaning Food

Weaning food produced and supplied by	Quantity procured per month	Percentage (Approximately)
25 Weaning Food Manufacturing Women Development Industrial Cooperative Societies	4725 MTs	65 %
2 Private Agencies (selected through open tender)	2375 MTs	35 %
Total	**7100 MTs**	**100%**

Source: Commissionerate of ICDS, Pammal Nallathambi Street, Taramani, Chennai–600 113 Roc.No.11413/NC1(2)/12 dt. 24.09.12, Letter to The Supreme Court Commissioner.

Quality, Regularity and Acceptance by Children / Families of SNP

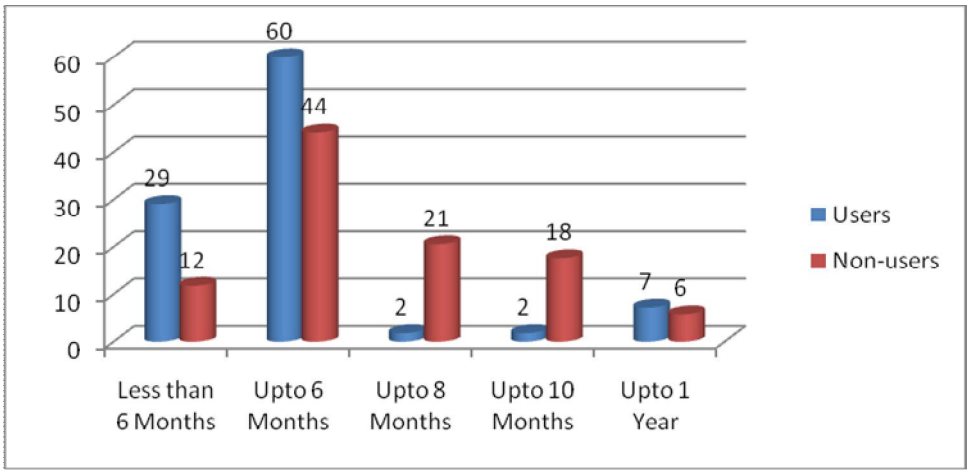
The quality of SNP is very good and is monitored regularly. The weaning food manufactured by the cooperative societies and private manufacturers is also sent for testing (to check for adherence to specifications and quality) to any government-recognized laboratory by the manufacturers themselves, and after obtaining the certificate only (each packet of weaning food is labelled as 'fit for human consumption') can the weaning food be supplied to the ICDS centres. The quality of weaning food is tested in the Food & Nutrition Board of India Laboratory, Chennai, (a Government of India organization). Supplementary nutrition is being provided to ICDS beneficiaries regularly and without any interruptions in supply.

Providing supplementary nutrition to ICDS beneficiaries is a practice that has been in existence for more than two decades and has been universally accepted. The mothers of the children, pregnant women and lactating mothers to whom weaning food is given as THR are educated to prepare various items using the weaning food such as Laddu/Kanjee (porridge), *Modak*, *Dosa*, *Puttu*, etc., and also to enrich it with ghee/oil, milk, vegetables, grams, etc.

Breastfeeding: According to the National Family Health Survey-3 (NFHS-3), Tamil Nadu was ranked 20th among the 29 states for exclusive breastfeeding of babies – 34 per cent of the babies are exclusively breastfed in Tamil Nadu. In the 'initiation of breastfeeding within one hour', Tamil Nadu was ranked 6th, where 55 .3 per cent of mothers had initiated breastfeeding for their babies within one hour of birth. Breastfeeding has been conclusively demonstrated as one of the important determinants for comprehensive growth and development of infants, more so among low birth weight infants. The prevalence of exclusive breastfeeding of babies for 6 months is lower in Tamil Nadu, at 34 per cent, than the national average of 41 per cent. Though many national health programmes were working for the improvement of mother and child health, the prevalence of exclusive breastfeeding has not reached 50 per cent. A well-drafted information, education and communication (IEC) activity, specifically targeting adolescent girls and antenatal mothers, can be implemented to encourage exclusive breastfeeding of babies. With repeated reinforcement along with research it might bring a change in the current scenario.

This key element is the long-term goal of capacity building of women in the age group of 15–45 years through different intervention strategies based at the field level and focusing on aspects related to exclusive breastfeeding, immunization, nutrition and education.

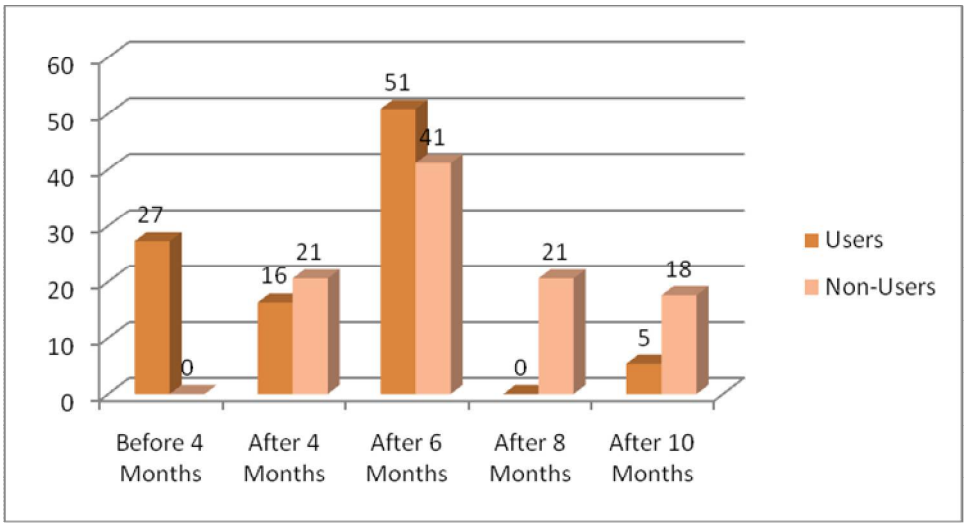
Figure: 22
Awareness of Mothers on Exclusive Breastfeeding Practice (Users & Non-Users)



Source: Field Survey

Figure 22 shows the awareness of user and non-user mothers on exclusive breastfeeding practices. A majority of the user mothers (60 per cent) are aware that exclusive breastfeeding must be given for up to 6 months; 29 per cent mentioned that it should be given for less than 6 months; 7 per cent mentioned that exclusive breastfeeding must be given for up to one year; 2 per cent mentioned that it must be given for up to 8 months; and another 2 per cent said that breastfeeding was necessary up to 10 months. Among the non-user mothers, 44 per cent are aware that exclusive breastfeeding must be given for up to 6 months; 21 per cent mentioned that it must be given for up to 8 months; 18 per cent mentioned that it has to be given for up to 10 months; 12 per cent mentioned that it should be given for less than 6 months; and 6 per cent mentioned that exclusive breastfeeding must be given for up to one year. The level of awareness on exclusive breastfeeding practice is comparatively high among user mothers than non-user mothers.

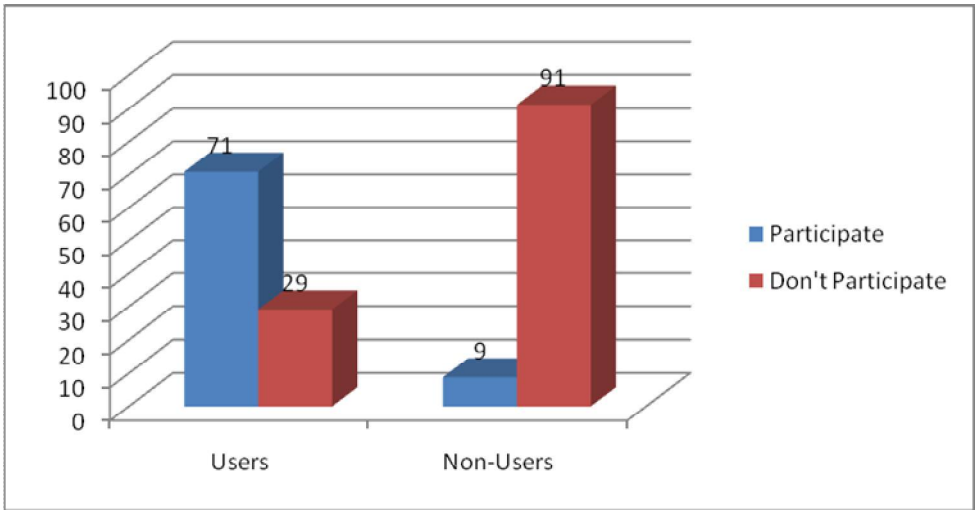
Figure: 23
Awareness of Mothers on Initiation of Supplementary Feeding (Users & Non-Users)



Source: Field Survey

As far as the awareness on the initiation of supplementary feeding for children is concerned, Figure 23 reveals that only about half, that is, 51 per cent, of the user mothers are aware that it needs to be initiated after 6 months; 27 per cent mentioned that it needs to be initiated before 4 months; 16 per cent suggested that the initiation of supplementary feeding has to happen after 4 months; and 6 per cent mentioned that supplementary feeding has to be started after 10 months. Among the non-user mothers, 41 per cent are aware that it needs to be initiated after 6 months; 21 per cent mentioned that it needs to be initiated after 4 months; another 21 per cent mentioned that it needs to be initiated after 8 months; and 18 per cent suggested that the initiation of supplementary feeding has to be started after 10 months.

Figure: 24
Participation in Nutrition Education and Awareness Programmes (Users & Non-Users)



Source: Field Survey

Figure 24 reveals the participation of the user and non-user mothers in nutrition education and health awareness programmes conducted by ICDS. It is interesting to note that a majority of the

mothers (71 per cent) have participated in such educational or awareness programmes, while 29 per cent have not. Among non-user mothers, 91 per cent have not participated in these programmes, while participation has been from only 9 per cent of the mothers.

5. COGNITIVE FACITITES / MENTAL STIMULATION

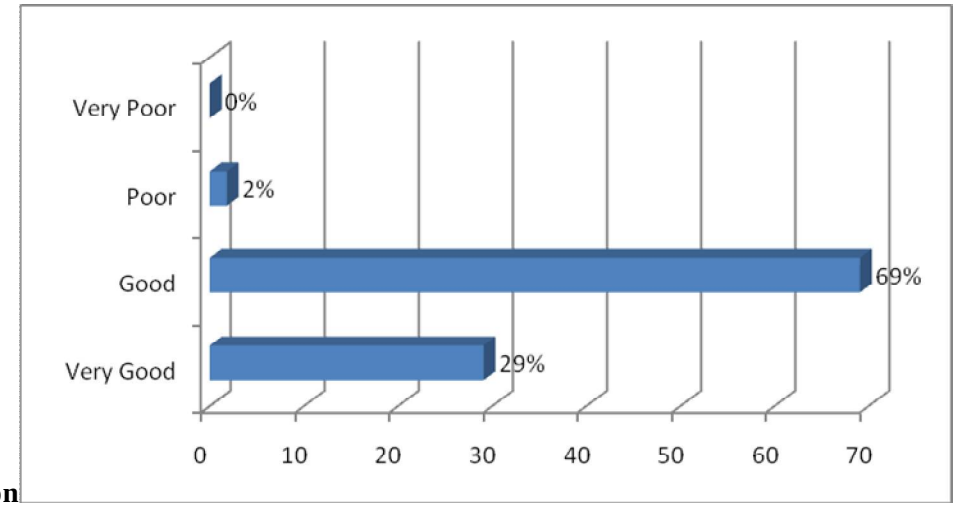
Early childhood education (ECE) is now being universally recognized as a crucial input for the overall development of the child, particularly for children from the disadvantaged sections of society. ECE has received due emphasis in the National Policy of Education (1986) as a critical input both for the holistic development of an individual and for its impact on the enrolment and retention of children in primary grades. In principle, ECE is a process and development-oriented system, in which these programmes are transacted through the medium of play and activity according to the age of the preschoolers. The programme is development oriented and child centred in approach and places a great deal of emphasis on children's interaction with and active experience of the environment. The ECE programme is exclusively for the 3–6 year olds as suggested in the national policy.

In Tamil Nadu, preschool education is also targeted at children in the age group of 2–3 years at childcare centres. Joyful play-way activities for children are scheduled for three hours a day and focus on holistic development of the child. In order to visually sustain these activities, descriptive and pictorial charts are used to teach alphabets, rhymes, numbers, etc. Sessions under this component includes storytelling, action songs, games and creative art using available materials. Both play materials and teaching-learning aids are used in the childcare centres.

While the age for entry to Class one in Tamil Nadu is 5–6 years, a considerable number of children continue to attend programmes at ECE centres, even up to the age of 6 years, particularly in the rural and urban slum areas.

Figure: 25

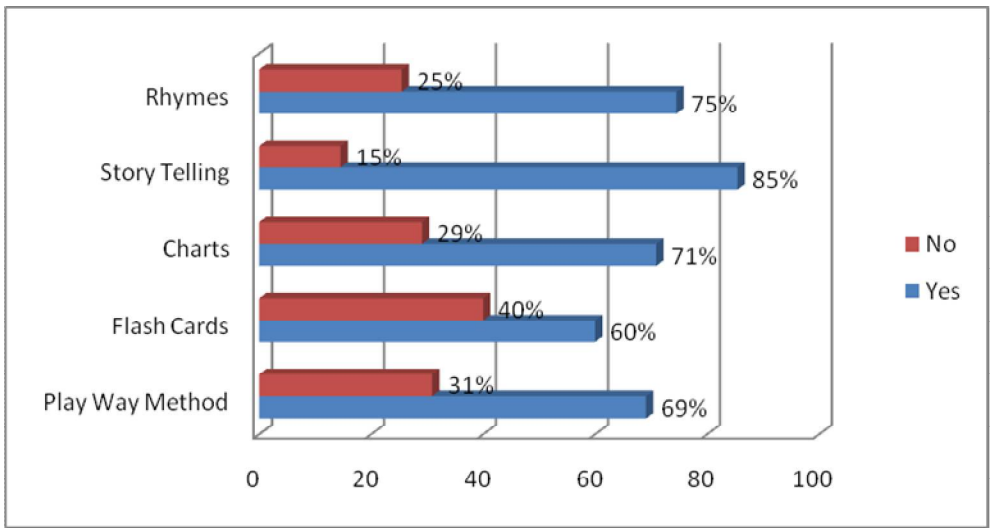
Mothers Opinion on the Cognitive Development / Mental Stimulation



Source: Field Survey

Figure 25 shows the opinion of the mothers on the cognitive development/mental stimulation aspects in the ICDS centres. It is clear from the figure that most of the mothers (69 per cent) have a good opinion about it, 29 per cent have very good opinion about these services and only 2 per cent are of the opinion that these services are poor.

Figure: 26
Different Teaching Methods Used for Teaching Children

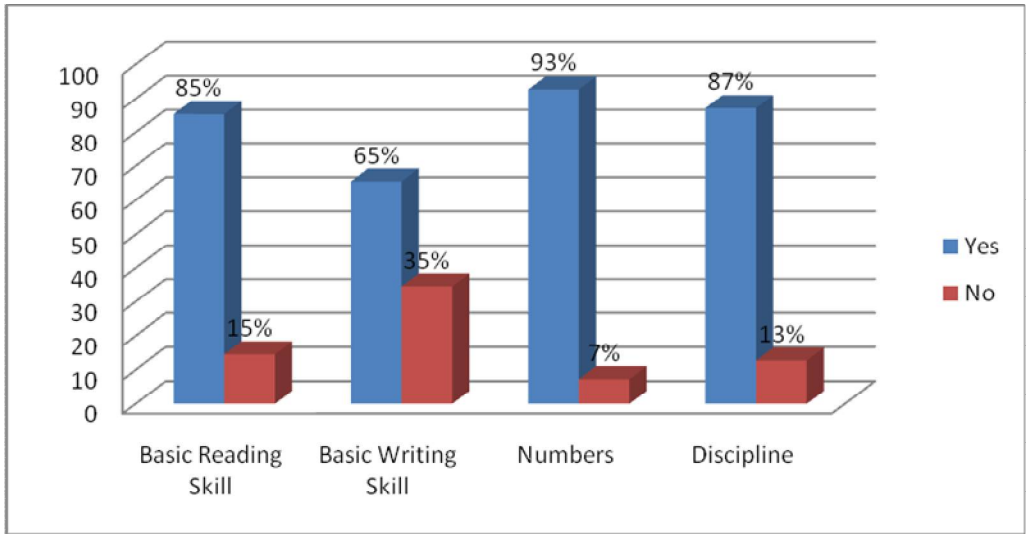


Source: Field Survey

Figure 26 reveals the different teaching methods used by the teachers at the ICDS centres. A majority of the centres (85 per cent) use stories to teach children, as opposed to the remaining 15 per cent; 75 per cent use rhymes in their teaching, while 25 per cent do not use this method; 71 per cent of the teachers use charts as opposed to 29 per cent of teachers who do not use them; flash cards are used by 60 per cent of the teachers, while 40 per cent do not seem to use them;

and, finally, a majority (69 per cent) use play-way methods, while 31 per cent do not use them at all.

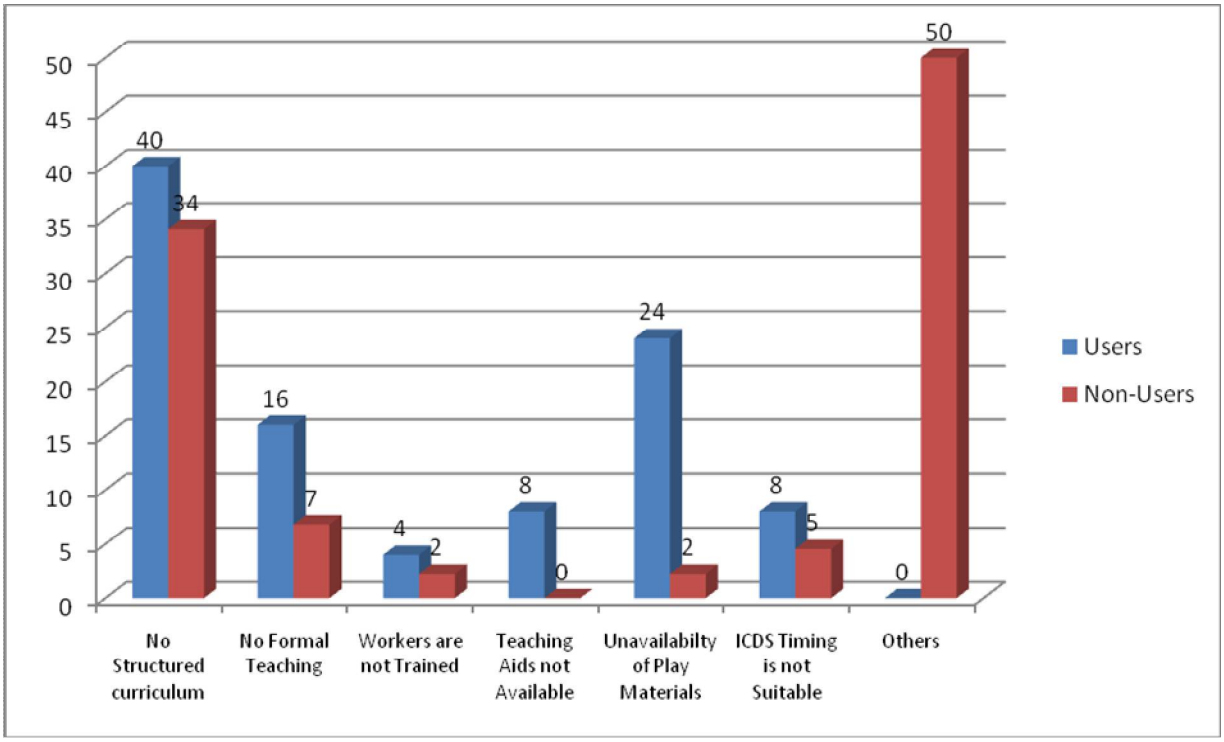
Figure: 27
Benefits Gained through ICDS Services



Source: Field Survey

Figure 27 shows the benefits gained through ICDS programmes in terms of skills development among children. A majority of the children (85 per cent) have developed basic reading skills; 65 per cent have developed basic writing skills; as much as 93 per cent of the children have developed skills in numeracy; and 87 per cent have developed discipline by being part of the ICDS programme.

Figure: 28 Benefits Gained through ICDS Services (User and Non-User Families)



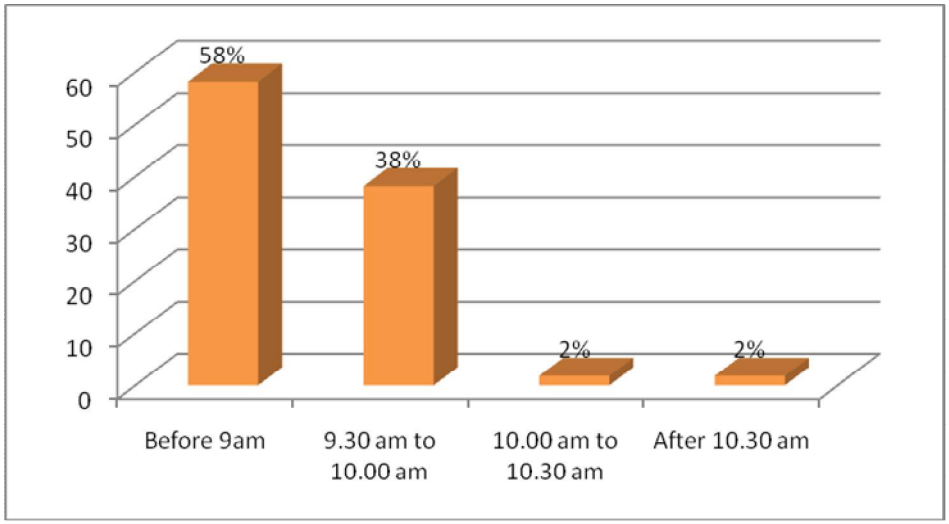
Source: Field Survey

Figure 28 provides a clear understanding of the reasons given by user and non-user mothers of ICDS for their perceiving no benefit from ICDS services. Among the user mothers, it is found that 40 per cent (the highest percentage) cited the lack of structured curriculum as a reason; 24 per cent cited the unavailability of play materials; 16 per cent expressed the view that there is no formal teaching in the ICDS centres; 8 per cent mentioned the lack of teaching aids; another 8 per cent mentioned that the ICDS timings are not suitable; and, finally, 4 per cent have cited untrained teachers as the reason. Whereas, among the non-user mothers, about half (50 per cent) cited others reasons, such as lack of parents' interest, poor infrastructure, language and distance of the centre, for not benefiting from ICDS day care; 34 per cent cited the lack of structured curriculum; 7 per cent stated that there are no formal teaching methods; 5 per cent cited that the ICDS timings are not suitable; 2 per cent cited the unavailability of trained teachers; and another 2 per cent cited the unavailability of play materials in the ICDS day care centres for not benefiting from the services.

6. DAY CARE

Apart from all the above services, the ICDS in Tamil Nadu functions also as a day care for children of mothers who go out to work. Because of the various services that are provided at the centre, both the individual development and ECE are taken care of. Anganwadi centres providing these services are open from is 8 a.m. to 3.30 p.m.

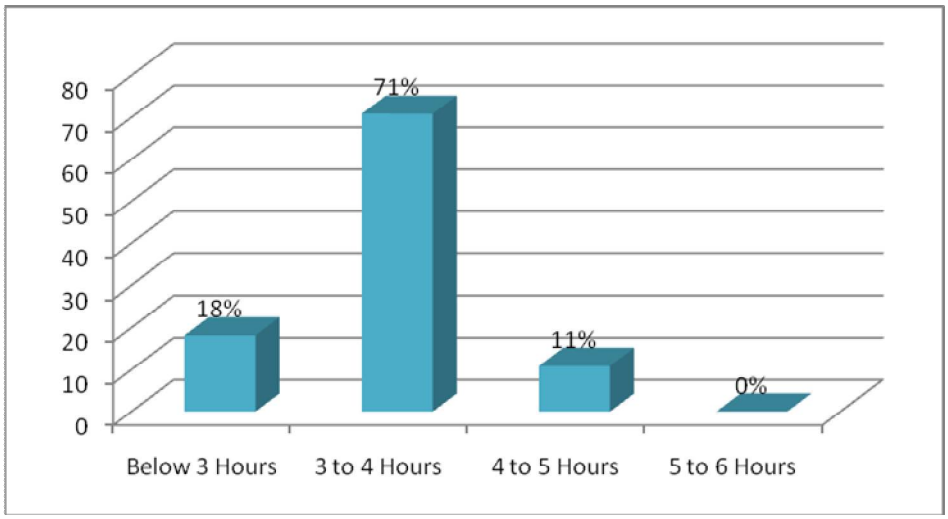
Figure: 29
ICDS Day Care Timings



Source: Field Survey

Figure 29 shows that in areas where the survey was conducted, 58 per cent of the centres start functioning before 9 a.m.; 38 per cent began between 9.30 a.m. and 10 a.m.; 2 per cent of the centres start between 10 a.m., and 10.30 a.m.; and another 2 per cent after 10.30 a.m.

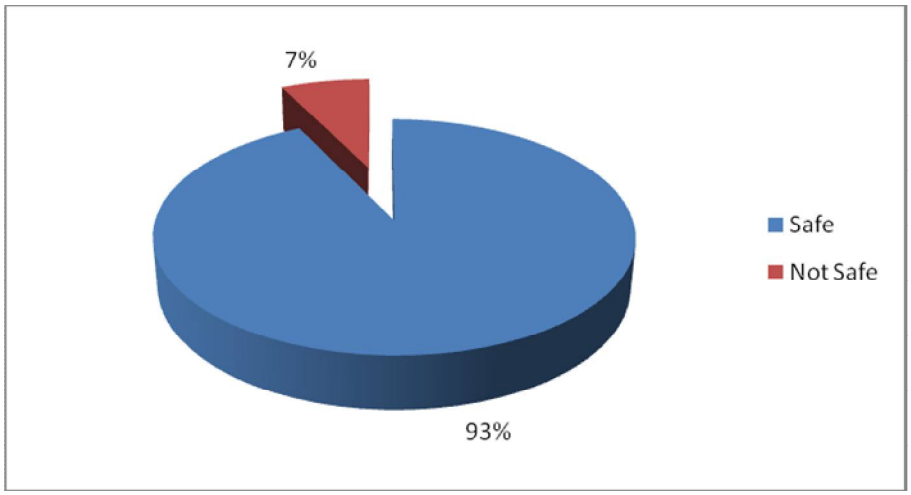
Figure: 30
Number of Hours Spent by Children at ICDS Day Care



Source: Field Survey

Figure 30 shows the number of hours children spend at ICDS centres in the surveyed areas. It is evident from the analysis that in a majority of the centres (71 per cent), children spend 3 to 4 hours; in 18 per cent of the centres, children, spend less than 3 hours; and in 11 per cent of the centres, children spend about 4 to 5 hours every day. The fewer hours spent by the majority of the children at the ICDS centre were because of the suitability and support systems that exist in the family.

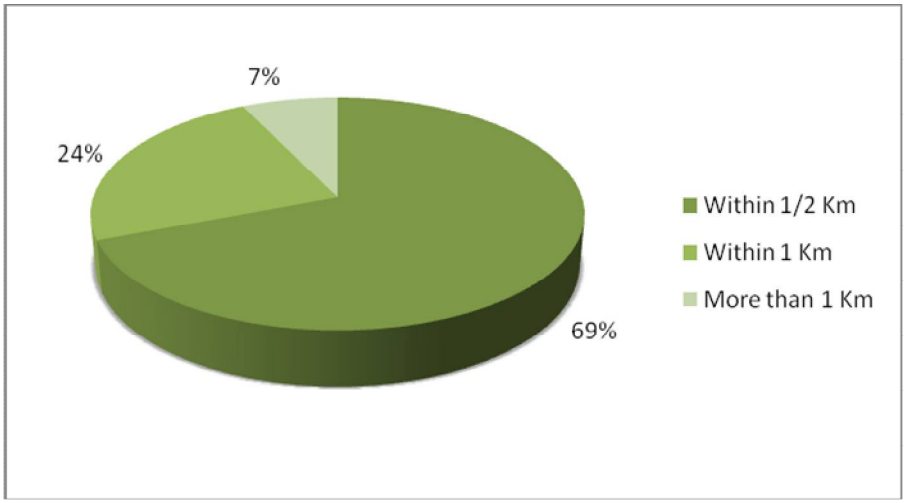
Figure: 31
Opinion of User Mothers on Safety of Children in ICDS Day Care



Source: Field Survey

Figure 31 reveals the opinions of the user mothers on the safety of their children at the ICDS centres. It is found that 93 per cent of the mothers feel that their children are safe at the centres, whereas only about 7 per cent do not think that they are safe.

Figure: 32
Distance of ICDS Day-Care Centres



Source: Field Survey

Figure 32 reveals that for a majority of the user mothers (69 per cent), the ICDS centre is located within half a kilometre; for 24 per cent, the centre is located within one kilometre; and for 7 per cent of the users, the centre is located at a distance of more than one kilometre.

Table No: 15
Caregiver at Home When a Mother is at Work (Users & Non-Users)

S.No.	Caregiver at Home	Users Per Cent	Non-Users Per Cent
1	Husband	0	0
2	Mother-in-law / Other in-laws	4	0
3	Mother / Other Natal Family Members	15	27
4	Neighbours	31	27
5	Older Children	31	9
6	Carry my child to work	0	0
7	I take care of the child myself	0	36
8	Child Left Unattended	0	0
TOTAL		**100**	**100**

Source: Field Survey

Table 15 describes the details of caregivers at home when user mothers are at work. It is interesting to note that an equal per cent of the children are taken care of by neighbours (31 per cent) and older children (31 per cent); 19 per cent of the mothers take care of their children themselves; 15 per cent of the children are taken care of by the mothers or other natal family members; and only 4 per cent are taken care of by their mothers-in-law or other in-laws. It is interesting to note that husbands do not come into the picture at all, and it is also a positive indication that no child is left unattended at home when mothers are at work. Among the non-user mothers, 36 per cent (the highest percentage) of the mothers take care of their children themselves; 27 per cent of the children are taken care of by their mothers/neo natal family members; another 27 per cent are taken care of by neighbours; and 9 per cent of the children are taken care of by older children.

Day-Care Services-for under 3 Years

- For children, especially between 2–3 years,-day-care services are available in anganwadi centres.
- For children under 2 years, no day-care services are available in ICDS (approximately 6 per cent of the population).
- If sample consists of 1,000 mothers, then 60 mothers have children under 2 years of age.
- There is a need for day-care services for the children in the age group of 7 months to 24 months in the anganwadi centres (if 1,000 is the sample then there are about 10–15 children in this age group who need AWCs).

XII. ICDS Training for Anganwadi Functionaries

Tamil Nadu has a unique decentralized pattern for their training system, which percolates from block/project level to grass-root level and vice versa. Every project/block has a trainer. The training at block level is conducted by a team of trainers. The trainers are competent enough to handle training of the grass-root level functionaries. Regular job training and refresher training are also conducted. The job training and refresher training for field functionaries are conducted by incorporating the training need, and area-specific and state-specific need in the prescribed syllabus given by the GOI. The other/innovative training programme comprises area-specific training programmes such as:

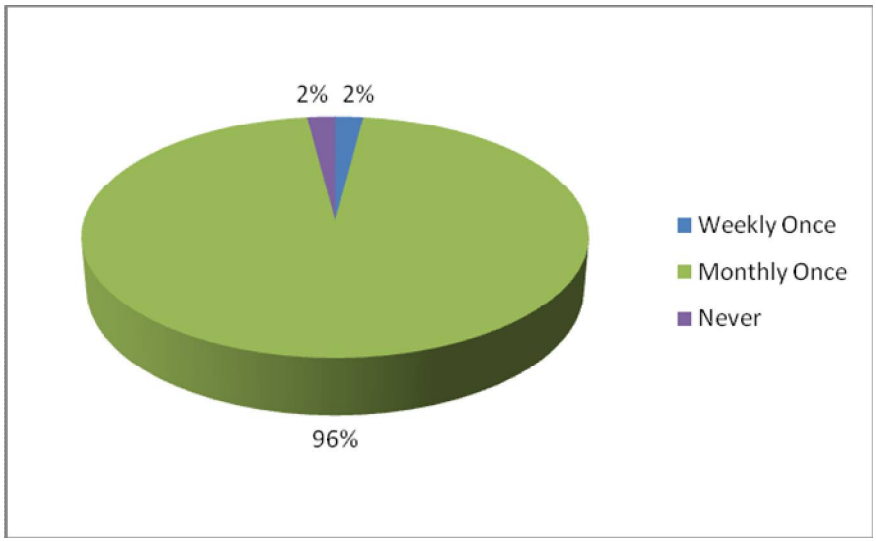
- Capacity building of intersectoral teams;
- Community-based strategy for prevention of malnutrition;
- Development of adolescent girls in all aspects;
- Gender sensitization and empowerment for elected women representatives of Panchayati Raj Institutions (PRIs);
- Personality and team development;
- Leadership and motivation;

- Infant and young child feeding;
- Integrated management of neonatal and childhood illness.

XIII. COMMUNITY PARTICIPATION AND INFRASTRUCTURE

The success of any programme depends on the involvement and participation of the community at every stage of the programme. The community's acceptance, cooperation and participation in all the activities are crucial for the success of the ICDS programme. Though there is not much contribution in monetary terms from the community, participation is through attending meetings, awareness programmes and *melas*

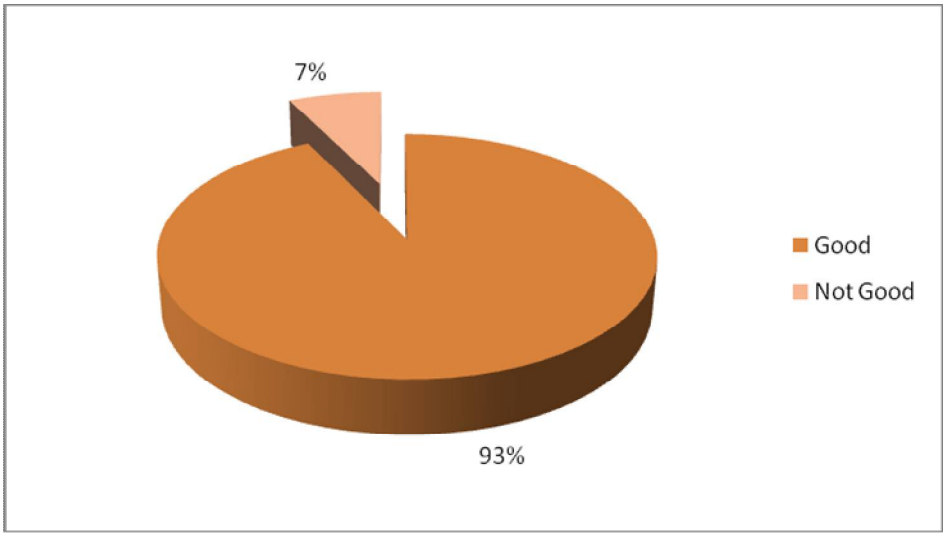
Figure: 33
Frequency of Mothers Meeting



Source: Field Survey

Figure 33 describes the frequency of mothers meetings held at the ICDS centres. It is evident from the analysis that in 96 per cent of the centres, mothers meeting is held once in a month; in 2 per cent of the centres, it is conducted weekly; in another 2 per cent of the centres, meetings are never conducted at all. In 89 per cent of the ICDS centres, mothers meetings are held on a regular basis, whereas in 11 per cent of the centres, it is not conducted regularly. In terms of community participation with regard to mothers meetings, from the analysis it is evident that in 67 per cent of the centres, mothers participate in the meetings and in 33 per cent they do not take part in the meetings. The reasons for not participating in the meeting are found to be lack of interest among the mothers (83 per cent) and no time to attend meetings, as cited by 17 per cent of mothers. In terms of benefits, 78 per cent of the mothers find these meetings to be beneficial, while the other 22 per cent do not find them beneficial.

Figure: 34
ICDS Workers Approach towards Parents & Community



Source: Field Survey

Figure 34 reveals that in 93 per cent of the ICDS centres, the approach of the workers towards the parents and community is good, whereas in only 7 per cent it is not good. In trying to understand the relationship of the workers with the mothers and parents it is found that all (100 per cent) ICDS centre workers have a good relationship.

Table No: 16
AWC Type of Housing Facility in Tamil Nadu

S. No	Type of Housing Facility	Per Cent
1	Owned	85.6
2	Rented	6.5
3	Primary School	1.4
4	Others	6.5
TOTAL		**100**

Source: Evaluation Report on ICDS, GOI, May 2011.

Table 16 shows that 85.6 per cent of the ICDS centres are run from own buildings; 6.5 per cent of the centres are run from rented buildings; another 6.5 per cent are run from other buildings,

such as AWW /AWH house, panchayat and community building; and 1.4 per cent are run in primary schools.

Table No: 17
AWC in Tamil Nadu Having Adequate Space for Different Activities

S. No.	Type of Housing Facility	Adequate in Per Cent	Inadequate in Per Cent	Per Cent
1	Cooking	92.6	7.4	100
2	Storage	91.8	8.2	100
3	Indoor Activities	86.5	13.5	100

Source: Evaluation Report on ICDS, GOI, May 2011.

Table 17 reveals that a majority of the AWCs have adequate space for different activities like cooking (92 per cent), storage (91.8 per cent) and indoor activities (86.5 per cent)

Table No: 18
AWC in Tamil Nadu Having Source of Drinking Water

S. No	Source of Drinking Water	Per Cent
1	Piped	60.7
2	Handpump	15.6
3	Others	23.7
TOTAL		**100**

Source: Evaluation Report on ICDS, GOI, May 2011.

Table 18 reveals that 60.7 per cent of the ICDS centres in Tamil Nadu have piped water source; 23.7 per cent have other sources; and 15.6 per cent have handpumps for drinking water purposes.

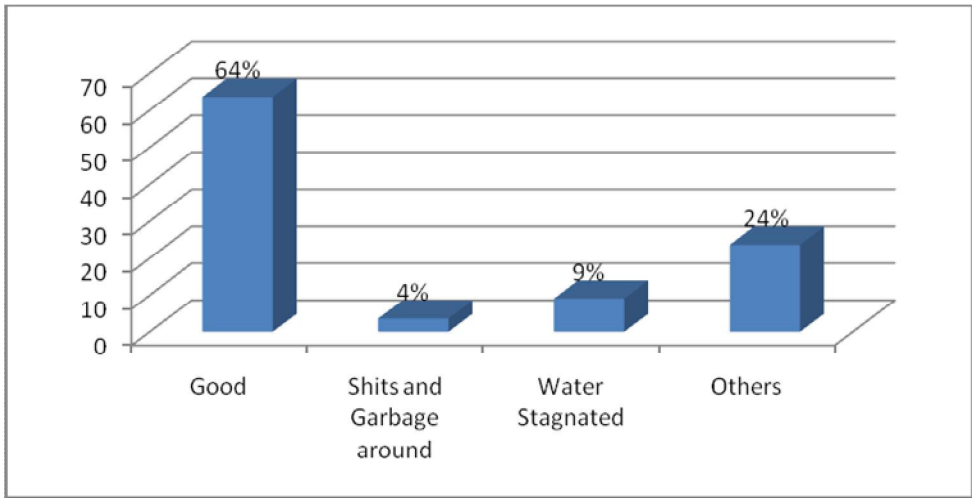
Table No: 19
Percentage of AWC Having Toilet Facilities

S. No	Toilet Facilities	Per Cent
1	Flush System	60.0
2	Pit/urinal	19.0
3	No facility	21.0
TOTAL		100

Source: Evaluation Report on ICDS, GOI, May 2011

Table 19 shows the availability of toilet facilities in the AWCs in Tamil Nadu. Thus, 60 per cent have flush system toilets; 21 per cent have no toilet facilities; and 19 per cent have pit/urinals.

Figure: 35
Mothers Opinion on the Environment around ICDS Day Care



Source: Field Survey

Figure 35 reveals the opinion of mothers about the environment around the ICDS day centres. It is found that 64 per cent of the mothers are of the opinion that the environment around the centre is good; 24 per cent cited other reasons such as no proper infrastructure; 9 per cent mentioned that there is stagnant water around the centre; and in 4 per cent of the centres, mothers cited the presence of human waste and garbage around the centre.

XIV. COSTING

The cost of provision of quality day care for children in the age group 0–3 years normally includes the types of costs listed below, which, however, varies depending upon the age groups. The following are the different categories of costs involved:

Capital Costs: The capital costs include land, buildings, vehicles, furniture and fixtures. The land and buildings are owned by the local bodies and other departments.

Revenue Costs: Revenue costs include administrative costs, depreciation, repairs and maintenance, rent, office expenses, communication, travel costs, electricity, personnel costs (pay and allowances) and programme costs.

Programme Costs: The programme costs include costs for the Supplementary Nutrition Programme, Mid Day Meal Programme, nutrition and health education, preschool education, health check-ups, immunization and referral services, training and community contribution.

Table: 20
Budget Allocation for ICDS

S.No.	Year	Financial Allocation (Rupees in Lakhs)
1	**2008–09**	**54492.36**
2	**2009–10**	**74389.54**
3	**2010–11**	**87639.43**
4	**2011–12**	**95332.29**
5	**2012–13**	**113714.97**

Source: Social Welfare and Nutritious Meal Programme Department, *Performance Budget 2012–1*, Government of Tamil Nadu, 2013.

Supplementary Nutrition Programme (SNP): This component can further be sub-divided into supplementary feeding (weaning food) and noon meals. Supplementary feeding is the reported expenditure in ICDS and is procured through the Weaning Food Manufacturing Women Development Industrial Cooperative Societies that are involved in manufacture, packaging and distribution of the food to the various childcare centres in the state. All childcare centres place an indent for every quarter based on actual feeding requirements of children in the age group of 6 months–2 years and of pregnant and lactating women. This in turn is processed and consolidated by the respective Child Development Project Offices in the state. The Child Development Project Office places an order with the Industrial Cooperative Society nearest to the demand area, for

which these societies produce the required quantities of the food and distribute them. The transport and loading expenses are borne by these societies, but which are then reimbursed by the ICDS.

Cost of Sharing between Centre and Tamil Nadu State: The cost-sharing ratio between the centre and Tamil Nadu state, effective from 2009–2010, is 50:50 for SNP, that is, 50 per cent by the centre and 50 per cent by the State of Tamil Nadu; for all other components, it is in the ratio of 90:10, that is, 90 per cent by the centre and 10 per cent by Tamil Nadu. Tamil Nadu is spending more on SNP and all other components in ICDS.

Table: 21
Cost-Sharing Norms between the Centre and State Governments

Beneficiary Group	Per Beneficiary per day - UoI	Per Beneficiary per day State Contribution	Total
6 months to 2 years	Rs 2	Rs 3	Rs 5
2 years to 3 years	Rs 2	Rs 7	Rs 9
Malnourished children	Rs 3	Rs 4.50	Rs 7.50

Source: Commissionerate of ICDS, Pammal Nallathambi Street, Taramani, Chennai – 600 113 Roc.No.11413/NC1(2)/12 dt. 24.09.12, Letter to the Supreme Court Commissioner.

Table: 22
Allocation & Expenditure

Year	No. of Children Enrolled for SNP	Average Number of Days of Feeding	Funds received from Government of India for SNP (Rs in Cr.)	Funds allocated by State Government for SNP (Rs in Cr.)	Total Expenditure in the State on SNP (Rs in Cr.)
2010–11	1939856	300	123.95 (29%)	318.71	381.09 (71%)
2011–12	2089368	300	170.73 (51%)	337.14	248.92 (49%)

Source: Commissionerate of ICDS, Pammal Nallathambi Street, Taramani, Chennai – 600 113 Roc.No.11413/NC1(2)/12 dt. 24.09.12, Letter to the Supreme Court Commissioner.

The extra Supplementary Nutrition Programme costs the Government of Tamil Nadu Rs 172 crores. The budget allotted for providing supplementary food to children, pregnant women and lactating mothers during the year 2013–2014 is Rs 190 crores. Additional ration is provided to severely malnourished children in the age group of 6 months–3 years by providing 190 gms of supplementary food per day as compared with 130 gms of supplementary food provided to normal children of the same age group.

Table: 23
Statement Showing Norms under the Existing Interventions –Govt of India Contribution

Items	Norms
Medicine kits	Rs 600 per AWC centre, per annum
Preschool education (PSE) kits	Rs 1,000 per AWC, per annum
Contingencies	Rs 600 per AWC, per annum
	Rs 40,000 per Child Development Programme Officer (CDPO), per annum
	Rs 1,00,000 per DPO, per annum
	Rs 2,00,000 per annum, per state cell
IEC	Rs1,000 per annum, per operational AWC
Rent	Rs 200 per AWC in rural /tribal projects per month Rs 750 per AWC, per month in urban projects
Petrol, oil and lubricant (POL)	Rs 1,25,000 per annum for CDPO
	Rs 1,20,000 per annum for DPO
	Rs 1,20,000 per annum for State Cell
Monitoring and evaluation mechanism(printing of various records / registers, replacement/repair of weighing scales, computerization of project office / district / state cell / data entry etc.)	Rs 500 per operational AWC, per annum
Equipment / furniture (non – recurring)	Rs 5,000 per AWC
	Rs 1,50,000 for CDPO
	Rs 1,50,000 per DPO

	Rs 2,00,000 per state
Petrol, Oil and lubricant (POL)	Rs 1,25,000 per annum for one project
	Rs 1,20,000 per annum, per district
	Rs 2.15 lakh per annum, per state

Inter-Sectoral Inflow of Resources: The resources for the ICDS services flow from the Departments of

1. Social Welfare Department and Noon Meal Programme;
2. Health and Family Welfare;
3. School Education Department;
4. Local Bodies – Rural Development Administration and Municipal Administration.

Costs of Other Services:

1. Immunization of children;
2. Administration of vitamin A solution, IFA tablets/ syrup;
3. Management of diarrhoeal disorder and acute respiratory infection;
4. Bi-annual deworming.

Noon Meal Programme: The Noon Meal Programme expenditure does not figure under the reported expenditure items of ICDS. In the process of data collection, it was found that contribution of rice, gram oil, iodized salt and eggs to ICDS was through of the Puratchi Thalavar MGR Noon Meal Programme (PTNMP) of the Department of Social Welfare. Rice, gram, oil and salt are procured from the Tamil Nadu Civil Supplies Corporation Limited (TNCSC) by the PTNMP for all childcare centres and schools in Tamil Nadu. Eggs are procured from private contractors. The quoted price varies from one region to another in Tamil Nadu, and, therefore, the average price has been calculated and quoted in this analysis (see below). The Department of Animal Husbandry checks and controls the quality supply of eggs in urban and rural areas procured from the private contractors, and the egg price covers the cost of transportation, according to the ICDS officials.

The noon meal component reports an estimated allocated expenditure incurred by the PTNMP for ICDS. Though the procurement for ICDS and PTNMP is done through the Tamil Nadu Civil Supplies Corporation Limited, it was found that ICDS received the common variety of boiled rice having less calorific value, which is also not suitable for the intake of young children. It is noted that the worst quality of rice is most often served to preschool children, while the finer quality of rice was provided to the primary and secondary school-going children. However, it may be noted that the Tamil Nadu Civil Supplies Corporation Limited offered these items at a subsidized price, which was higher than the Public Distribution System (PDS) rates and lesser

than the market value. Only transportation and pilferage costs would be the additional expenses incurred by the Tamil Nadu Civil Supplies Limited, and it is not known whether these are reimbursed by either the PTNMP or ICDS. It is evident that a major percentage of the expenditure is incurred for rice, gram and eggs.

Nutrition and Health Education: This key element has the long-term goal of capacity building of women in the age group of 15–45 years through the different intervention strategies based at the field level. It is clearly visible that not much expenditure is incurred under this component. As this is not a direct intervention with children and reports only specific activities during the financial year taken for this analysis, there is insufficient information for any analytical comments here. But, it is assumed that some of the materials bought under this head are being used for preschool education.

Health Services: This component is completely taken care of by the Department of Public Health and Department of Medical Services. Therefore, all material expenditure would be reflected in the reports of these departments with no extra cost to the ICDS programme. However, ICDS personnel contribute their time for the immunization programme, and since it is not possible to monetize this owing to lack of data and time, this is a hidden cost. Yet another aspect that needs further clarification is the nature of hidden costs being borne by either the childcare workers or the parents for travel to primary health centres and municipal dispensaries. In this report, no analysis of the hidden costs has been attempted. All children under the age of one year are immunized with BCG, DPT OPV and measles vaccine to prevent the occurrence of six killer diseases – diphtheria, pertussis, tetanus, polio, measles and tuberculosis. All pregnant women are immunized with tetanus toxoid to prevent neonatal tetanus. Vitamin A solution (to children) and iron and folic acid tablets to adolescent girls are given to the beneficiaries in the anganwadi centres.

Cost Estimation of Immunization Programme: The Tamil Nadu vaccination programme has an annual budget of Rs 24,342,745. There are three main areas into which the financing is sub-divided – medical supplies (drugs and vaccines), infrastructure (building space, mobile health centre, cold chain equipment), and staff coverage (doctor, assistant, training and salary).

Health Check-ups: In this analysis, health check-ups, as a component, has reported allocated material expenditure from the Director of Public Health for the supply of first aid kits. A basic kit contains cotton, paracetamol, band aids, dettol and other medicines. Regarding the allocated material expenditure at all levels, it is not known what procedures are followed to distribute these kits. Is it a one-time supply undertaken during the year? Do external agencies supply it to specific projects in separate phases? What is the memorandum of understanding between the Department of Social Welfare and such external agencies? How frequently is replacement done?

Are there provisions for recurring replacement costs in the allotted budget? How is money sanctioned at the meso- and micro-levels? These are questions that remained unaddressed in this analysis. Moreover, time-use data are required to monetize the hidden costs incurred by ICDS medical personnel and rural childcare workers towards this component, as their pay is shown as allocated under health costs. Information relating to other activities which form part of this component is also not discussed here owing to lack of information.

Referral Services: Referral of sick children is usually undertaken by the childcare centres and Child Development Project Offices. It can be assumed that the pay and allowances of childcare workers are considered as part of the hidden costs catering to this component. However, at the rural level, this component has an allocated expenditure since referrals are the prime responsibility of the local primary health sub-centres and since no expenditure is reported on other sub-components.

Preschool Education: The preschool materials, like play materials and teaching-learning aids, for this component do not have recurring expenditure. Details of data on purchase and supply, data on replacement and budgetary allotment at different levels are not available, and, hence, these costs could be considered hidden costs incurred by sources unknown. If there is no recurring expenditure for such materials, then how it is that childcare workers are able to manage this component? Do they mobilize contributions from the community and external agencies? Is there a monthly budgetary allotment in ICDS to cater to the needs of the childcare centres? These are issues that need further exploration.

Contribution: External participation and ownership in a programme can be established from contributions to the programme in both cash and kind. In ICDS, this aspect has no documented evidence, but for the purpose of this analysis, interviews were conducted and secondary data collected. Cash contributions by external organizations, both government and other voluntary agencies were sporadic in nature. But for contributions elicited in kind from the community (includes anganwadi workers), the cost was derived using market rates. Such contributions were in the form of vegetables, mats, fruits and painting work to the childcare centres. During 2009–2010, an amount of Rs 4.60 crores was mobilized for various activities and infrastructure development of the ICDS programme through people's participation.

Personnel: Salary and Allowances for AWWs and AWHs:

There are 43,963 anganwadi workers, 4,212 mini-anganwadi workers and 42,747 anganwadi helpers (AWHs) working in the 54,439 anganwadi centres. They are given salaries based on a special time-scale of pay (that is, salaries having fixed yearly increments). The allowances like dearness allowance (DA), house rent allowance (HRA), city compensatory allowance (CCA) and medical allowance (MAs) are provided to them along with 3 per cent annual increment.

The anganwadi workers and helpers are eligible for lump sum grants at the time of retirement – Rs 50, 000 for anganwadi workers and Rs 20,000 for anganwadi helpers, with effect from 1

April 2005. The anganwadi workers, including mini-workers and helpers, are paid a special pension of Rs 1,000 per month after their retirement.

Table No: 24
Pay Structures of AWWs/ AWHs

Name of the category	Scale of pay	Total pay as on 1.1.13 (Entry level)	HRA	CCA	MA
Anganwadi Worker	Rs 2500–5000+ Rs 500 Grade Pay (nationally w.e.f. 1.9.06 and with monetary benefit from 1.1.2007)	Rs 5160	Gr. I (a) Rs.500/- Gr. I (b) Rs.300/- Gr. II Rs 240/- Unclassified Rs 120/-	Chennai Rs 180 Others Nil	Rs 100
Anganwadi Helper	Rs 1300–3000+Rs 300/- Grade pay w.e.f. 15.09.2008	Rs 2752/-	-do-	-do-	Rs 100
Mini-Anganwadi Workers	Rs1800–3300+ Rs 400/- Grade pay w.e.f. 15.09.2008	Rs 3784/-	-do-	-do-	Rs 100

Source: Social Welfare and Nutritious Meal Programme Department, Demand No 45, Policy Note 2013–2014, Government of Tamil Nadu, 2013.

The anganwadi worker gets a salary of about of Rs 7,000 per month; helpers get Rs 3,500, which is directly deposited in their accounts through the electronic credit system (ECS). Casual leave of two days at a time is allowed in a month, including the unavailed leave of previous months. A festival advance of Rs 2,000 is sanctioned once in a year to the staff of child centres (anganwadi centres) of ICDS; extension of Special Pension Scheme is given to those who have retired before 15 September 2008; medical allowance of Rs 100 per month is given to all the staff; Additional Charge Allowance has been increased from Rs 2 to Rs 10 per day to anganwadi workers who hold additional charge of other centres. For calculating the pension of those who are appointed as grade II supervisors/multi-purpose health workers/balwadi teachers, 50 per cent of service rendered as anganwadi workers is taken into account. Medical leave for 10 days is allowed to those staff who undergo surgery under the new insurance scheme. Promotional opportunities are offered to eligible anganwadi workers for appointment as office assistants/record clerks in the

Social Welfare and Nutritious Meal Programme Department and to the anganwadi workers as grade II supervisors. Travelling allowance for anganwadi workers has been increased to Rs 40 per month from Rs 20 per month. Employment opportunity through special tests for appointing the qualified anganwadi worker as balwadi teacher is also made available. ICDS Employee GPF has been introduced from 1 April 2009.

Colour Dresses: Two sets of coloured dresses have been provided to children in the age group of 2–5 years in AWCs in the first phase in 10 districts during 2012–2013 and 2013–2014.

Government of India Contribution: The Government of India contributes 50 per cent of the cost of supplying weaning food; the total requirement of weaning food per year is 85,200 MTs at the cost of Rs 327 crores.

Human Resource: This includes provision of uniforms (2 sarees at Rs 200 per saree, per annum) and a name tag (badge at Rs 25 per badge, per annum); enhancement of honoraria to AWWs, AWHs and AWWs of Mini-AWCs with effect from 1 April 2008. The enhancement is Rs 500 more than the last honorarium drawn by AWWs, and for helpers of AWCs and workers of mini-AWCs, it is Rs 250 more than the last honorarium they have drawn (Press Release).

Financial Data:
For the 20,558 anganwadi centres in Tamil Nadu, the allocated amount for providing electric light and electricity-operated fan is Rs 12.34 crores, with the unit cost for each anganwadi centre being Rs 6,000. For child friendly toilets in 20,244 anganwadi centres, the government has allocated Rs 36.44 crores, with each toilet costing about Rs 18,000.

Payment Mechanism for the Suppliers of Weaning Food: The bills of the suppliers of weaning food are settled at the Commissionerate of ICDS as per the Government Order. The bills to TNCSC are settled monthly at the district level by personal assistants (Noon Meal Programmme) to District Collectors; the suppliers are paid also on a monthly basis. According to the Government of Tamil Nadu, the Supplementary Nutrition Programme has been running without any kind of allegation of corruption at any level.

Issues related to Fund Flow: There is no problem in Tamil Nadu in respect of allocating funds towards supplementary nutrition, both at the centre and state level.

Unit Costs: This refers to per capita costs (incurred for a child) or per anganwadi centre . Theper day unit cost for a child is influenced by the number of children reached through delivery of services. The unit costs for children will vary depend upon the age group.

Table No: 25

Tamil Nadu ICDS Unit Cost

S.No.	Food Items	Quantity in (Gms)		Ave.cost (in Rs) per day	GoI (Rs)	GoTN (Rs)
		State	GoI			
1.	Food grains (Rice)	100	100	0.56	0.56	
2.	Cooking cost				2.17	3.4 / 3.96
	i, Pulses	15	20	0.93		
	ii. Vegetables	50	50	0.32		
	iii. Oil fat	3	5	0.13		
	iv. Salt	1.9	0	0.14		
	V. Fuel and condiments	0	0	0.24		1.38
3.	Egg (3 eggs per week)	46 per egg	0	0.20		1.25
4.	Banana	100	0	0.18		
5.	Bengal gram (or) green gram (Tuesday only)	20	0	0.59 / 1.15		
6.	Potato (Friday only)	20	0	0.16		
7.	Salary AWW AWH			14.6	Rs 1,000/- per month Rs700 per month	Rs 6,500 per month Rs. 2,800per month
8.	Supplementary Nutrition 6 months–2years 2–3 years	130		5 / 9	Rs 2 Rs 2	Rs 3 Rs.7
Total				**25.3 / 27.3**	**2.17**	**3.4 / 3.96**

Observations:

The budget allocations under ICDS are comprehensive in range. It shows that except for reported expenditure on food (supplementary feeding and noon meals) and a few other specific items in other components, most other costs are being taken care of from other sources. In some cases, it is not even clear who is bearing the cost, while in the other cases, the details of how much is the contribution and from where are not known. It is not quite clear on how some of the programme activities are being financed in ICDS, and there appear to be hidden costs involved in several programme components. Allocations for infrastructure development, maintenance of buildings, purchase of vessels, provision of drinking water and child friendly toilets have to be increased.

- 6 months to 24 months per child, per day cost = Rs 22
- 24 months to 36 months per day, per child cost = Rs 27.05

This is only an approximate value, and it does not include rent, preschool education, health, local bodies' infrastructure expenses and community's contribution.

Operational Cost: The operational cost of ICDS implementation in mission mode at national, state, district, block/project and village levels work out to be Rs 1,65,315 crores. Besides, the staff and honorarium, it will include recurring expenses such as rent, travel allowances, administrative expenses, and funds for advocacy and public education, training, research, contingencies for AWW, preschool materials, information education materials and medical kits.

Proposed Budget: An average annual GOI share of about Rs 35,000 crores and a total of Rs.1,83,778 crore (as per the 12th five year plan) would be required for effectively implementing ICDS in mission mode to achieve the above-mentioned goals and objectives. A detailed summary sheet with cost break up of non-recurring expenditure is given below

Table No: 26
ICDS – Average Annual Requirement (Rupees in Crores)

S.No	Major Heads	GOI Liability	State Liability	Total
1	Recurring	30,776	12,641	43,417
2	Non Recurring	3,641	1,227	4,868
Total		**34,417**	**13,868**	**48,285**

Table No: 27
ICDS Recurring Budget Heads

S.No	Recurring budget heads	Annual GOI Liability	Annual State Liability	% of Recurring Budget (GOI Liability)
1.	Honoraria	9,411	1,046	30.58
2.	SNP (GOI share)	10,151	10,151	32.98
3.	Salary	5,997	666	19.49
4.	ECCE	926	103	3.01
5.	Others*	508	75	1.65
6.	Rent	818	91	2.66
7.	PSE & medicine kits	745	83	2.42
8.	Flexi fund + uniform	301	33	0.98
9.	Untied fund including crèches	755	265	2.45
10.	Monitoring	326	36	1.06

11.	Training (including infant & young child feeding [IYCF] training cost Rs358 Cr. & ECCE training cost of Rs151 Cr. for 5 years)	325	36	1.06
12.	Purchase,hiring, POL & maintenance	200	22	0.65
13.	IEC & advocacy (including IYCF activities @ Rs 32Cr. per annum at project level)	219	24	0.71
14.	Sneha shivirs	94	10	0.31
Total		**30,776**	**12,641**	**100**

*Others include TA, insurance (RSBY), grading and accreditation, other social security, administrative expenses and contingencies.

As seen in Table 27, the major components of total recurring budget in terms of liability of the GOI are supplementary nutrition, with the GOI's share at 33 per cent, and honoraria at 30.58 per cent; salaries constitute 19.49 per cent. Different state governments' allocation for supplementary nutrition varies – for example, Bihar spends just 15 paise per day, per child, on the cost of grain and its conversion to a cooked meal! In West Bengal, the district officials (Jalpaiguri) cited a meager budget of 80 paise per child as the reason why adequate standards could not be maintained. In Uttaranchal, allocations are even less, with a provision of just 67 paise per child, per day. In Tamil Nadu, however, against an estimated requirement of Rs 89 crore, the state was allocated more than Rs 150 crore for SNP, and the allocation per beneficiary, per day, is also the highest at Rs 1.69. Jharkhand has not allocated even a single rupee! (Fifth Report of the SC Commissioners, August 2004).

XV. CHALENGES FOR THE IMPLEMENTATION OF ICDS IN TAMIL NADU

Substantial problems plague ICDS services in Tamil Nadu.

1. Universalization of ICDS in Tamil Nadu – reliability of data, problems of access, and perceptions:

Enrolment data is an unreliable basis for assessing the degree of access to anganwadis. Firstly, enrolment figures are generally rigged and exaggerated for various administrative and political purposes. Moreover, in order to assess the progress in expanding ICDS, it is important to take into account the figures for attendance and also for dropout from among those who are enrolled. The attendance has generally been found to be at least 25 per cent below enrolment. The dropout rates are very high indeed. Thus, a huge number of children are excluded from ICDS. The total number of children 0–6 years in Tamil Nadu, as per the 2011 census, is 74,23,832. The number of ICDS beneficiaries in Tamil Nadu in the age group 0–5 years is 40,39,387; the gap is approximately 33,84,445. One official estimate shows that 30 per cent of needy children are excluded from the ICDS services.

In spite of its successes, therefore, large population groups receive no ICDS at all or receive only one or two services and remain partially protected. These populations, 'unreached' by ICDS services, fall into three distinct groups.

1) Populations living in semi-urban and other areas with usually good physical access to ICDS services in their locality, but who prefer private day-care services. These populations are the ones that are most affected by misconceptions about the value of government services. They characteristically fail to register their childbirths, and make no contact with ICDS officials.

2) Rural populations, simply because they live too far from the regional infrastructure – they, too, make no contact with routine ICDS services. In some areas, ICDS infrastructure exists, however, it is so skeletal or owing to its remoteness functions so poorly that it is of no value in providing services to the surrounding population.

3) Some segments of the population in Tamil Nadu, both rural and urban areas, have good access to services and succeed in partially using the ICDS services for their children, but drop out of the ICDS as the children join the private day-care centres. On average, this group would raise ICDS coverage in Tamil Nadu by 20 per cent, if they have good quality ICDS, especially in terms of the infrastructure.

2. Quality of Services

The reason for the exodus of children from ICDS to the private sector is the poor quality of service. This has been attributed to a variety of factors, including poor infrastructure, apathy of anganwadi workers and parents who are unconcerned. But the real reason is the unregulated private sector and English medium of instruction in Tamil Nadu. The most effective and important means of ensuring quality is to establish minimum norms and standards relating to all relevant aspects in ECCD.

3. Discrimination

The other systemic problem of ICDS in Tamil Nadu is the rampant discrimination characterizing it. Children of the rich and the elite have access to good quality private ECCE centres, whereas children of the vast majority of the poor, including the minorities and marginalized groups, go to anganwadis. Thus, the class division in the society is reflected in the division of choice of care centres. The latter has been a major contributory factor to the perpetuation and accentuation of social inequality. It also makes for bad ICDS.

XVI. LESSONS FROM TAMIL NADU ICDS

Several lessons can be drawn from Tamil Nadu's experience that may be helpful to other states. A strong focus on child development and nutrition, care and substantial investments in ICDS infrastructure are important factors. The implementation of an autonomous drug distribution system and other innovative delivery initiatives such as 24-hour health facilities, have played their part in improving health. Other enabling factors include political commitment at the national level and the involvement of state and district administrations in the design and implementation of strategic policies and programmes.

The state's total health budget increased dramatically, from Rs 4,108 million (US$ 167.9 million) in 1991–1992 to Rs 14,870 million (US$ 335.9 million) in 2005–2006. In nominal terms, spending increased by 3.6 times between 1993 and 1994 and 2005 and 2006. Medical, public health and family welfare is the second-largest expenditure category in the state budget after education. Since 1990, the central government has contributed approximately 20 per cent of the state's annual health budget, and the Health and Family Welfare Department of Tamil Nadu has consistently spent about 45 per cent of its annual budget on primary health care. By 2005, public spending on health care had become more pro-poor than a decade earlier. The Government of India should increase/revise the financial norms based on the inflationary factors.

Who accesses an AWC is influenced by its physical location as well as the caste/community profile of its workers. The fifth report of the Commissioners notes that one of the primary reasons for good coverage of needy groups under the scheme in Tamil Nadu is the location of the AWC (ICDS: Fifth Report of the Commissioners to the Supreme Court, http://www.righttofoodindia.org/icds/icds_comrs5threport.html). Access to services by deprived communities like the Scheduled Castes and Scheduled Tribes is possible if the AWC is located in Scheduled Caste/Scheduled Tribe predominant hamlets. This not only reinforces the need for implementation of the order calling for a functional anganwadi in every habitation, but also

suggests that priority must be given to cover the Scheduled Caste/Scheduled Tribe populated habitations before covering others (Fifth Report of the SC Commissioners, August 2004).

Best practices of Tamil Nadu ICDS

- A tastier and healthier menu with 13 varieties of rice and four types of egg masalas would be introduced in a block in each district on a pilot basis, and these will be extended across the state in a phased manner. The children enrolled in anganwadi centres will also be provided a new menu as per their nutritional requirement and digestive capacity. This measure will pave the way for ensuring the nutrient content of the meals offered and also help to prevent dropouts in rural areas.
- Egg supply for three days in a week for 2–3 year-olds and one egg for one day in a week for 1–2 year olds.
- One banana to non-egg-eating children on days when egg is given to others.
- 20 grams of boiled green or bengal gram once a week (Tuesdays).
- 20 grams of boiled potato once a week (Fridays).
- Joy of learning in preschool education through new system.
- Formation of mother support group in all the main centres (49,499 AWCs).
- Awareness on parenting.
- Workshop for newly married couples.
- Two sets of coloured dresses have been provided to children in the age group of 2–5 years in AWCs.
- The working time of anganwadi centres is 8. a.m. to 3.30 p.m.
- Satisfactory working conditions for anganwadi staff (including salary, pension, increment).

A field survey called Focus On Children Under Six (FOCUS) conducted in 2004 in six states revealed that an effective ICDS programme can make a considerable difference to the lives of nutritionally compromised children. For instance, the ICDS functioning in Tamil Nadu, when compared with five other States, (Chhattisgarh, Uttar Pradesh, Maharashtra, Rajasthan and Himachal Pradesh) was far better in terms of indicators such as longer working hours, the number of infants in the under-3 age group who attend regularly, basic infrastructure facilities and salaries paid regularly to the AWC workers. The quality of services, including preschool education, supplementary nutrition, health and immunization services, was found to be satisfactory by nearly 90 per cent of the mothers who used these services.

1. Reasons for the Success Story

The state has recognized that social investment in nutrition can reduce health care costs by reducing the incidence of non-communicable diseases and thereby improving productivity and economic growth and promoting educational attainment, intellectual capacity and social development. Other reasons are as follows:

- Long tradition of political will during the 40-year post-Congress regime of the Dravida Parties for welfare measures for the needy, which has maintained a focus on the social sector.

- A stable bureaucracy and effective managers have ensured continuity and have formulated, implemented, evaluated and adapted government policies to improve child-related outcomes and equity.

- Tamil Nadu has trained and deployed anganwadi workers/anganwadi helpers more rapidly to serve rural communities than in most other parts of India.

- Outside the ICDS system, several cultural and socio-economic factors have contributed to Tamil Nadu's achievements, such as a low fertility rate, better literacy rates and progress on women's empowerment. This has been essential in reducing maternal and child morbidity and mortality.

- Presence of a vibrant civil society (TN FORCES, media) as well as public demand has made the Tamil Nadu government more active and responsive in relation to the Nutrition programmes.

- Extensive improvements in roads and other infrastructure and higher incomes have also had a beneficial effect.

- Cost of sharing between the centre and Tamil Nadu state – the sharing ratio between the centre and the TN state, effective from 2009–2010 is 50:50 for SNP, that is, 50 per cent by the centre and 50 per cent by the state of Tamil Nadu, and for all other components it is 90:10, that is, 90 per cent by the centre and 10 per cent by the state. Tamil Nadu is spending more on SNP and all other components in ICDS.

2. Challenges

Even with impressive child-related indicators and in spite of all its best practices and relative success stories, the Tamil Nadu ICDS is faced with many challenges. The most pressing of these is the alarmingly low nutritional status of adults and children, as in other states of India. In addition, more could be done to lower the maternal mortality rate and the infant mortality rate. About 60 per cent of infant deaths occur at the early neonatal and post-neonatal stages and most could be prevented. Tamil Nadu, like all other states in India, needs to face the increasing burden of non-communicable diseases.

XVII. RECOMMENDATIONS

To make day-long childcare services integral to the ICDS package that are safe and child friendly to reduce the burden of working women is a real challenge.

1. Convergence

Implementation of ICDS must envisage a close working relationship between the different departments like School Education, Local Bodies, Public Health Departments, with the AWC being the physical space where all these service providers and services converge. Within the ICDS as well, the presence of two workers and a helper will help make the AWC a meaningful place for young children. As a team, they will be able to provide crèche and preschool services. This is the first step for ensuring essential convergence and complementarities. Clear division of roles and responsibilities between AWWs and ASHAs (Accredited Social health Activists) will help establish better accountability as well. Ensuring convergence with related sectors such as NRHM, TSC (Total Sanitation Programme), NRDWP (National Rural Drinking Water Programme), Sarva Siksha Abhiyan (SSA), and MGNREGA(Mahatma Gandhi Rural Employment Guarantee Act) through joint planning, inclusion of young-child-related concerns in state/district Annual Programme Implementation Plans (APIPs) of relevant sectors, joint monitoring of key results and indicators and defined roles and responsibilities would enhance the efficiency of the ICDS.

2. Integrated nature of quality childcare services

Apart from the components of ICDS, a whole range of enabling conditions such as appropriate breastfeeding and weaning, protection from communicable diseases, safe drinking water and nutrition education are important for providing quality childcare services. While ICDS alone cannot guarantee that these rights are realized (for instance, safe drinking water is outside the scope of ICDS), it does bring them within the realm of possibility by providing an integrated bundle of essential services.

3. Services for children under 3 to be disaggregated by age

Many reports and research studies have highlighted the problems regarding both policy and implementation intervention for the young child in addressing dimensions of care, health, nutrition, development and education. The various aspects of the needs of the young child, which are essentially integrated, however, require age-specific interventions and strategies. The three groups are 0–6 months, 6 months–2 years and 2–3 years.

4. Day care for children under 2 years

Analysis of three decades of ICDS functioning (http://wcd.nic.in/3dicds.htme) shows that in any village with a population of about 1,000, there are about 60 mothers who have children under 2 years (6 per cent). This indicates that there are about 60 priority households in every village for day-care services for children under 2 years. These mothers need to be educated about the importance of not only feeding the child, but also how to feed and give day-care facility for their children. This will have a better impact on the health and nutritional status of children. As a means of ensuring good health and nutrition of children under 2, giving their mothers health education and counselling should be made a priority. In addition, take home rations (THR) and guidance to lactating mothers on the preparation of foods to complement breast milk after 6 months of age is an important measure that needs to be incorporated in ICDS.

The day-care services, especially for children under 2 years, need to be restructured (frequency of supplementary food, and facilities).

5. Timings of ICDS centre

At present ICDS timings is from 8 a.m. to 3.30 p.m.; it should to be increased or made flexible based on the local needs of the population. At present, ICDS centres function for six days in a week, Because the centres are closed on Sundays, THRs are provided on the previous day itself; this needs to be changed and THRs provided on all days.

6. Diversity, flexibility in model

At present, throughout Tamil Nadu, a single model is followed, but taking into consideration the needs and diversity of the regions, different alternative models can also be developed.

7. MGNREGA implementation and linkages

For children younger than 3 years, the ICDS services should have a linkage with the MGNREGA Schemes

Although Tamil Nadu still has a long way to go to address these challenges, the signs are that it is moving in the right direction. Its successes to date provide useful lessons for the future.

References

1. CRT, Child Rights Trust, Bangalore and UNICEF, 2011, 'Challenges and Opportunities in Achieving Goals for Children in Tamil Nadu with specific reference to the XII Plan and the MDGs', CRT and UNICEF November.

2. Dreze, Jean, 2004, 'Democracy and Right to Food', *Economic and Political Weekly*, 24 April.

3. Forum for Crèches and Childcare Services (FORCES) & Centre for Women's Development Studies (CWDS), 2013, 'Need Assessment for Crèches and Child Care Services' (Draft Report), New Delhi: FORCES and CWDS.

4. Health and Family Welfare Department, 2013, Demand NO: 19, Policy Note 2013-14, Thiru K.C. Veeramani, Minister of Health, Government of Tamil Nadu.

5. 'ICDS: Fifth Report of the Commissioners to the Supreme Court', 2007, available at http://www.righttofoodindia.org/icds/icds_comrs threport.html

6. Narasimhan, T.R.L and J. Jayanthi Rani Christiana, 2001, 'Costing Child Care Services', Chennai: M.S. Swaminathan Research Foundation.

7. Planning Commission, 2011, 'Evaluation Report on Integrated Child Development Services', Programme Evaluation Organization, Government of India, May.

8. Rajivan, Anuradha Khati, 2006, 'Tamil Nadu ICDS with a Difference', *Economic and Political Weekly*, vol. XLI, no. 34, 26 August.

9. Social Welfare and Nutritious Meal Programme Department, 2013, *Performance Budget, 2013-2014*, Government of Tamil Nadu,.

10. Social Welfare and Nutritious Meal Programme Department, 2013, Demand No 45, Policy Note 2013-2014, B.Valarmathi, Minister For Social Welfare and Nutritious Meal Programme Department, Government of Tamil Nadu .

11. M.S. Swaminathan Research Foundation and Tamil Nadu Forum for Crèche and Child Care Services, 2010, 'Towards Universalisation of Maternity Entitlements – An Exploratory Case study of the Dr.Muthulakshmi Maternity Assistance Scheme', Tamil Nadu, Public Health Resource Network, May.

12. Vinnarasan, A. A., 2007, Study on Factors Influencing Non Enrollment of children in the ICDS Anganwadi Centres at Chennai Corporation, Unpublished M.Phil Social Work thesis, Loyola College, Chennai August.

13. Tamil Nadu ICDS, information available at http://icds.tn.nic.in/

14. Statistical Handbooks of Tamil Nadu, 2012.Department of Economics and Statistics, Government of Tamil Nadu, 2012, available at http://www.sp.tn.gov.in/deptst/

15. Mid-day meal Scheme in Tamil Nadu: Field Experience, available at http://shodhganga.inflibnet.ac.in/bitstream/10603/4244/12/12_chapter%203.pdf

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ANNEXURE

Annexure 1: Comparative Indicators - Tamil Nadu

Indicator	Most recent NFHS Fig.	Baseline	MDG target & achievement by '15 by extrapolation	State 12th plan aims & targets	Best state / UT	India
IMR	30 (05 –06)	68 (92-93)	23(4)	13	15-Kerala	57
U5mr	36(05-06)	87(92-93)	29(5)		16-Kerala	74
MMR*	79(08)	145(01)		44	81-Kerala	212
NNMR	19(05-06	46(92-93)	16(3)	10-NNMR	11- Kerala	49
PNMR	11(05-06)	21(92-93)	7(2)	14		
CMR	5(05-06)	20(92-93)	7(2)			
<3 Year Under Weight	33(05-06)	46(92-93)	23(23)		22-Mizoram	46
Stunted -	25 (05)	29(98)	15(19)		21-kerala	38
Wasted -	22(05)	20(98)	10(13)		8-manipur	19
C Anaemia	72 (05)	69(98)	35(77)		39-Goa	79
W Anaemia	53(05)	56(98)	28(48)		32-kerala	56
Full immunization	81-best	65(92)			81-TN	44
Vitamin A	37				81-Kerala	21
Iodised salt	21 lowest				91-mizoram	49
Bf<1hr	55				66-mizoram	23
Exclusive bf	33				82-chattisgarh	46
Cont.bf						
Still birth rate	9(07)			7		9(07)
Couple protection rate				65		

Source : *NFHS 3 ,2005 – 06; * Source : Special Bulletin on Maternal Mortality Rates in India, Ministry of Health and Family Welfare, GOI, 2008 – 09*

Annexure: 2 Lists of Investigators Involved in the Study

S.No	Name	Designation
1.	Mr S. Murthy	M.Phil Scholar, Loyola College
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5.	Ms S. Jeeva	TN-FORCES
6.	Mrs Adi Lakshmi	FORYOUCHILD
7.	Mr Jesuin John Bose P	Development Consultant

List of the anganwadi workers who participated in the Focus Group Discussion

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7	Jagadeeshwari	04018
8	Prabavathy	04019
9	Vasantha	04029
10	Kanchana	04006
11	Vimala	04028