before and after birth and through the period of growth, to ensure their full physical, mental and social development".

In pursuance of the National Policy for Children and recognizing that it is in early childhood that the foundations for physical, psychological, and social development are laid and that provisions of early childhood services, especially to the weaker and more vulnerable sections of the community, will help prevent or minimise the wastages arising from infant mortality, morbidity, malnutrition and stagnation in schools, the Government of India started the Integrated Child Development Services (ICDS) Scheme in 1975 in 33 pilot projects, and has now expanded into 1,300 ICDS projects in the Country.

ICDS is designed to promote holistic development of children under six years, through the strengthened capacity of caregivers and communities and improved access to basic services, at the community level. Within this group, priority is accorded to addressing the critical prenatal – under three years age group, the period of most rapid growth and development. The program is specifically designed to reach disadvantaged and low income groups. State responsibility for pre-school lies only with ICDS, which has a limited pre-school component. All other pre-school initiatives are in the private sector, which excludes the vast majority of children.

The program provides an integrated approach for converging basic services for improved childcare, early stimulation and learning, health and nutrition, water and environmental sanitation – targeting young children, expectant and nursing mothers and adolescent girls' groups. They are reached through nearly 5,00,000 trained community based anganwadi workers (AWW) and a large number of helpers, supportive community structures- through the anganwadi centres (AWC).

ICDS offers a community based tool that functions as the convergent interface between disadvantaged communities and government programs such as primary health and education. It is also the foundation of the national effort for universalization of primary education. It is designed to provide increased opportunities for promoting early development, associated with increased cognitive and social skills, enrolment and retention in the early primary stage.

3.2.2 Objectives

The main objectives of the program are:

- To lay the foundation for the proper psychological, physical and social development of the child.
- To improve the nutritional and health status of children below the age of six years.
- To reduce the incidence of mortality, morbidity, malnutrition and school dropout
- To achieve effective coordination of policy and implementation among various departments to promote child development
- To enhance the capacity of the mother to look after the normal health, nutritional and development needs of the child, through proper community education.

3.2.3 Structure of the Program

The ICDS is a centrally sponsored scheme implemented through the state governments and union territories. The Centre bears all administrative expenses and the states/union territories meet the expenditure on supplements.

Central Level: At the Central level, the Department of Women and Child Development (DWCD) of the Ministry of Human Resource Development (MHRD) is the nodal department responsible for the program.

State Level: At the State level, the Secretary of the Department of Social Welfare, or the nodal department designated by the State Government, is responsible for the implementation of the Program. Special ICDS cells have been set up at the State headquarters to monitor the Program at the State level.

District Level: At the district level, the responsibility is with the district officer. At the District level, the Deputy Commissioner or Collector is responsible for coordinating and implementing this program. Districts having 5 or more ICDS projects have ICDS monitoring cells. These cells include an ICDS Program Officer, a Statistical Assistant and Office Supervisor, an Upper Division Clerk, a Lower Division Clerk, a driver and peon. The main function at this level is planning, implementation and monitoring of

program, reporting and liaison with regional head and state government. The Program Officer is required to do the following:

- Help State Social Welfare Secretary in ensuring effective implementation of ICDS program
- Formulation of State Policy with regard to details of implementation of ICDS program in the state.
- Ensure coordination with the Central Govt. on one hand and with other Departments within States on the other so that various components of the program could be provided smoothly and continuously.
- Advance planning with respect to training facilities available in the State and deputation of various ICDS functionaries to various training institutes
- Ensure that selection of AWWs who are the focal points of delivery of services.
- Coordination with health Department for eliminating delay in posting of medical and para-medical staff and for their orientation and reorientation in ICDS
- Monitoring of the program at the state level
- Undertaking tours to ICDS projects to ensure that services are effectively rendered.
- To prepare and plan new avenues for motivating people to participate in the program.
- Ensure that new schemes like Mahila Samridhi Yojana, Mahila Vikas Yojna and Adolescent Girls schemes are implemented

Block Level: The main responsibility is with Child Development Project Officer (CDPO). The main functions include planning, implementation and monitoring of program on an average of 100 AWCs. The CDPO is also responsible for securing Anganwadi premises, identifying participants and ensuring supply of food to centres and flow of health services, conducting the play activities, monitoring of the program and reporting to state government. The CDPO also ensures convergence of services by networking with other government departments [mainly health] and voluntary agencies. In large rural and tribal blocks, the CDPO is assisted by an Additional CDPO, who liaisons and works with health and other converging departments at block level. CDPO has to do the following:

- Allocate monthly and yearly budgets to each AWC and release funds
- Supervise and guide the work of the entire project team, including Supervisors and AWWs.
- Help the AWWs in initial stages in carrying out a quick and sample census survey of the project.
- Ensure proper maintenance of registers and records both at Project and AWC level and to inspect the records periodically
- Make necessary arrangements for procurement, transportation, storage and distribution of various supplies
- Ensure all the equipment and material supplied are accounted for and used and maintained properly
- Act as the Convenor of the Project Coordination Committee or Functional Committee.
- Incur contingency expenditure on articles, materials etc. required by AWWs and other Project functionaries and would act as DDO for ICDS scheme, excluding health inputs.
- Take all necessary measures for staff recruitment and development in the capacity of incharge of ICDS team and the block level. He will depute Supervisors and AWWs for training/ orientation as and when required

Sector Level: The nodal person at this level is the Mukhiya Sevika or Lady Supervisor who is in charge of 20-25 AWCs. A Supervisor provides continuous on-the-job guidance to AWWs to bridge the gap between training and job requirements. She is required to visit each AWC at least once a month and make at least one night halt every week in a village located at a distance of more than 5 km. from her circle headquarters. During her visit to AWC, she performs the following tasks:

- Guide AWW in conducting household surveys, updating the survey data on a quarterly basis on preparing accurate lists of families and eligible beneficiaries
- Check the enlisting of beneficiaries from low economic strata and severely malnourished, particularly children those below 3 years of age
- Guide AWW in the assessment of correct ages of children, correct weighing of children and plotting their weights on the growth charts, especially in respect of severely malnourished

- Help the AWW in identifying ill children and mothers and referring them to PHC or Hospital
- Check the weight of severely malnourished children and guide the AWW in their rehabilitation.
- Maintain record of visits by ANM
- Check the records of AWWs and guide them in proper maintenance of records
- Find out the personal and work related problems of AWWs, provide guidance to them to cope with these problems, and report gaps to CDPO. The Supervisors organize monthly meetings of AWWs with the concerned LHVs and ANMs.
- The Supervisor will ensure timely submission of monthly progress reports by AWWs to the CDPOs and also check the accuracy of these reports.
- At the monthly meeting at Project HQ the Supervisor will assist CDPO

Village Level: The Anganwadi worker (AWW) is the point of contact who interacts directly with the beneficiaries on a regular basis. The main functions involve the following:

- Community survey and enlisting beneficiaries. The community to be covered should be surveyed to find out the number of children below six years of age, pregnant and nursing mothers. Data about the number of families, family members and income should be obtained. Vital statistics particularly of new births and deaths (specially child and maternal deaths) should be recorded. Handicapped, exploited and destitute children should also be listed. In the collection and compilation of all this information, the supervisor would be guiding and helping the AWWs.
- Supplementary feeding of 0-6 years of children and pregnant and nursing mothers.
- Provide health and nutrition education to women, children and community, population education to women and parent and community education
- Provide non-formal pre-school education of the children between 3 to 6 years of age.
- Primary health care and first-aid to children under six and pregnant and nursing mothers

- Detection of impairments among children in the early stage and help in the prevention of disabilities.
- Contacting the parents of children coming to the Anganwadi through home visits and enlisting their participation in the program
- Assisting health staff in immunization and health check-up.
- Referral services for severely under-nourished/ mal-nourished, sick and at-risk children and cases of communicable diseases and children with impairments
- Maintaining records/ registers particularly weight cards, child health cards, supplementary nutrition records, anganwadi attendance records etc
- Maintaining liaison with other institutions in the village/urban e.g. Panchayats, Mahila Mandals, Schools, Local organizations etc. and seeking their support and participation in the ICDS program

The Medical Officers (MOs), the Lady Health Visitors (LHVs) and female health workers from nearby Primary Health Centre (PHC) and sub-centre form a team with Social Welfare/ Women and Child Development Department functionaries to implement ICDS. The Auxiliary Nurse Midwife (ANM) acts as a crucial link between the ICDS and the Health Department. An ANM performs the following functions:

- Registration of pregnant women, married women in reproductive age group, and children through systematic home visits and at the clinics;
- Categorization of the eligible couples according to the number of children and age of mothers; care of pregnant women during the period of pregnancy
- Advice on nutrition to expectant and nursing mothers
- Distribution of iron and folic acid tablets to pregnant women and nursing mothers and Vitamin A solution to children; immunization of pregnant women with tetanus toxoid
- Conducting about 50% deliveries in her intensive area (covering about 3000 population); supervision of deliveries conducted by traditional dais (birth attendants).
- Referral of case of difficult labor and new-born with abnormalities and helping them to get institutional care and providing follow-up care to patient referred to or discharged from hospital; conducting post delivery visits for each delivery case and rendering advice regarding feeding of the new born;

- Giving family planning education to couples and motivating them for the same; distribution of conventional contraceptives to the couples and helping prospective adopters in getting family planning services
- Identification of cases that require medical help for termination of pregnancy, providing information on the availability of services and referring them to the nearest appropriate institution
- Arranging and helping the MO and LHV in conducting MCH and family planning clinics at the sub-centres; educating mothers individually and in groups in better family health including MCH and family planning, nutrition, immunization, hygiene and minor ailments

Anganwadi Centre (AWC): The anganwadi, literally a courtyard play centre, is a childcare centre, located within the village. It is the focal point for the delivery of services at the community level, to children below six years of age, pregnant women, nursing mothers and adolescent girls. Besides this, the AWC is a meeting ground where women/mother's groups can come together, with the frontline workers, to promote awareness and joint action for child development. Most of the ICDS services are provided through the AWC in an integrated manner. Each AWC is run by an Anganwadi Worker (AWW), supported by an anganwadi helper in services delivery and improved linkages with the health system.

Training - Apex Body: The National Institute for Public Cooperation and Child development [NIPCCD] is the apex body for training under ICDS. The institute plans, coordinates and monitors ICDS training and is also responsible for designing of curricula and preparation of training materials. It supervises and provides support to CDPOs and to Mukhya sevikas and AWWs through its three regional centres, 18 mid level training centres [MLTCs] and Anganwadi Training Centres [AWTCs].

Population norms: The ICDS Scheme envisages that the administrative unit for the location of ICDS Project will be the CD Blocks in rural areas, tribal blocks in tribal areas and ward(s) or slums in urban areas. These norms categorize areas based on the location in rural/tribal/urban projects. The population norms are as follows:

- Rural Projects: Population 500–1500 per AWC and 150–500 per mini AWC
- Tribal Projects: Population 300–1500 per AWC and 150 – 300 per mini AWC
- Urban Projects: Population 500 – 1500 per AWC

Supplementary nutrition norms (Table 3.1): This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anaemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. They avail of supplementary feeding support for 300 days in a year. By providing supplementary feeding, the Anganwadi attempts to bridge the protein energy gap between the recommended dietary allowance and average dietary intake of children and women.

Table 3.1: Supplementary Nutrition Norms

Beneficiaries	Calories	Protein (grams)
Children below 3 years*	300	8-10
Children 3-6 years	300	8-10
[Severely malnourished Children on medical advice after health check-up)]	(double of above)	
Pregnant & Lactating (P&L) Mothers	500	20-25

Source: DWCD, GOI

Financial Norms: The cost of supplementary nutrition varies depending upon recipes and prevailing prices. However, the Central Government issues guidelines regarding cost norms from time to time. The latest norms are as follows:

- Children (6 months to 72 months) Rs. 2 per child/per day
- Severely malnourished Children (6 months-72 months: Rs. 2.70 per child/per day
- Pregnant women and Nursing mothers/Adolescent Girls: Rs. 2.30 per beneficiary per day

Budgetary Allocations: ICDS is a Centrally Sponsored Scheme implemented through the State governments with 100 percent financial assistance from the Central Government. This scheme has seen an increasing allocation of funds under the plans. As against an expenditure of 2271.28 crores during the VIII Plan, a sum of Rs. 4556.52 crores were spent during the IX plan. The allocated budget for the XI plan is Rs. 44,400 crores.

3.2.4 Components of ICDS

ICDS is unique in its coverage of services and beneficiaries. The principal participants of the scheme i.e. children below six years, expectant and nursing mothers and women in the age group of 15 to 45 years receive supplementary feeding,

growth monitoring and promotion, immunization, health check-ups, referral services, nutrition and health education, early childhood care and pre-school education. In addition, there is coverage of other important supportive services like safe drinking water, sanitation and women's development and empowerment programs.

Health

The health component of ICDS includes health check-ups, immunization and referral services.

- Health check-ups: this includes health care of children under six years of age, antenatal care of expectant mothers and postnatal care of nursing mothers. At the AWC, children, adolescent girls, pregnant women and nursing mothers are examined regularly by Lady Health Visitor and Auxiliary Nurse Midwife.
- Immunization: Immunization of pregnant women and infants protect children from six vaccine preventable diseases – polio, diphtheria, pertusis, tetanus, tuberculosis and measles.
- Referral services: the sick or malnourished children are provided referral services. The AWW has also been oriented to detect disabilities in young children. She is supposed to inform medical officers of any such case reported. The effectiveness of this service depends on timely action and cooperation.

Nutrition

Adequate food is the most important requisite for the healthy growth of a child. While this applies throughout early childhood, adequate food is particularly crucial during the first two years, when rapid growth occurs and the child is entirely dependent on her mother and family for food. Insufficient food not only results in under-nutrition in terms of low weight, but also hinders growth. It also makes the child more vulnerable to infection and illness This includes supplementary feeding; growth monitoring and promotion; nutrition and health education and control of nutritional anaemia.

- Supplementary feeding: One of the main components of ICDS is the supplementary nutrition program (SNP). The need for supplementary nutrition arises from the fact that many children are unlikely to be well fed at home. This may be due to poverty, lack of time, nutritional needs, misguided food

habits, or even (in some cases) parental negligence. Inadequate awareness of children's nutritional needs, misguided food habits, or even (in some cases) parental negligence. Low-income families covered by ICDS scheme can avail of supplementary feeding support for 300 days in a year. By providing supplementary feeding, the AWC attempts to bridge the gap between the national recommended and average intake of children and women in low income and disadvantaged communities. This pattern of feeding aims only at supplementary and not substituting for family food. It also provides an important contact opportunity, with pregnant women and mothers of infants and young children, to promote improved behavioural actions for care for pregnant women and young children. Food supplements are provided to pregnant women and nursing mothers (up to six months), to help to meet the increased requirements during that period.

- Growth monitoring and promotion: Growth monitoring and nutrition surveillance are two important activities that are in operation at the field level in ICDS. Both are important in for assessing the impact of health and nutrition related services and enabling communities to improve the same. Children below the age of three years are weighed once a month and children 3-6 years of age are weighed quarterly. Fixed day immunization sessions or days when mothers take home ration are opportunities for growth monitoring. These services are supposed to help mother/family and AWWs/Auxiliary staff in taking timely cost-effective preventive action, to arrest any stagnancy or slipping down in weight through early detection of growth faltering. Identified severely malnourished children (Grade III and IV) are to be given special supplementary feeding which may be therapeutic in nature.
- Nutrition and Health Education: Nutrition, Health and Education (NHED), is a key element of the work of the AWW. This has a long term goal of capacity building of women- especially in the age group 15-45 years- so that they can look after their own health, nutrition and development needs, as well as those of their families and children. All women in this age group are expected to be covered by the component. NHED comprises basic health, nutrition and development information related to childcare and development, infant feeding practices, utilization of health services, family planning and environmental sanitation.

Early Childhood Care and Preschool Education (ECCE)

An important component of ICDS, ECCE focuses on total development of the child, in the age group upto six years. It includes promotion of early stimulation of the under-threes through interventions with mothers/ caregivers. Its program for the three-to-six year old children in the AWC is directed towards providing and ensuring a natural, joyful and stimulating environment, which emphasises on necessary inputs for optimal growth and development.

Antenatal Care and Maternal Health

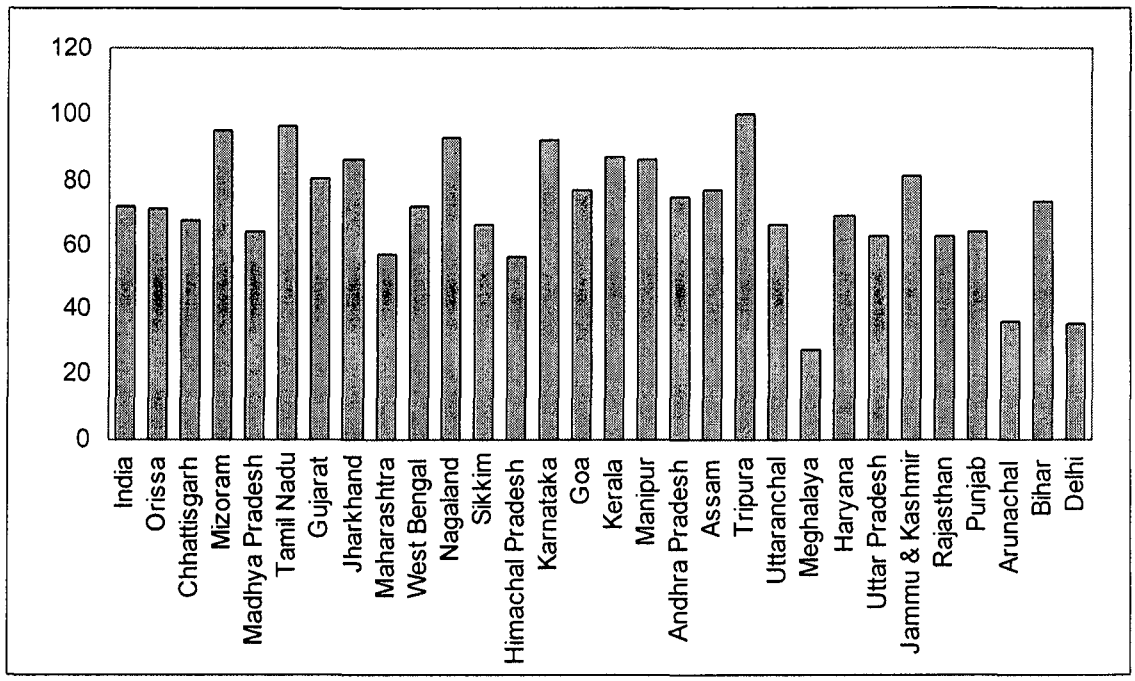
The role of a woman and that of a mother as a caregiver have been well documented in theory and in empirical research, Scores of studies done across countries have emphasized the pathways through which maternal characteristics affect the health and well-being of a child. To be able to fulfil this important role, a mother needs to be in good health herself. Antenatal care, maternal health and related services are important for at least three reasons (FOCUS Report 2006). First, they have a crucial bearing on the wellbeing of children under six, since the well-being of a child is intimately related to that of his or her mother. Second, good antenatal care and maternal health are essential to break the inter-generational perpetuation of malnutrition and ill health. Undernourished mothers tend to have undernourished children, and undernourished girls become undernourished mothers themselves later on. If pregnant women and nursing mothers do not receive adequate care, this vicious circle is bound to continue. Third, antenatal and maternal health care are important from the point of view of the well-being and rights of women themselves, aside from those of the child. ICDS provide nutritional supplements, antenatal health checkups, immunization and nutrition counselling, among other services to the pregnant women.

3.3 GEOGRAPHICAL COVERAGE UNDER ICDS

We present data from the latest round of NFHS which covers 3,850 enumeration areas and a total of 64,016 children aged 0-71 months. (Table 3.2) The geographical spread of ICDS shows that 72 percent of the sample enumeration areas are covered by an AWC and 62 percent are covered by an AWC that had, by the time of the survey, existed for at least five years. The coverage is highest in Tripura with 100 percent

coverage. Among the other states that extensive network of anganwadi centres are Mizoram (95.35 percent), Tamil Nadu (96.3 percent) and Karnataka (92 percent). As against these, Meghalaya has the lowest percentage of areas covered (26.8 percent) followed by Delhi (34.8 percent) and Arunachal Pradesh (35.4 percent). The other states where coverage is low include Maharashtra, Himachal Pradesh and Uttar Pradesh (Figure 3.1).

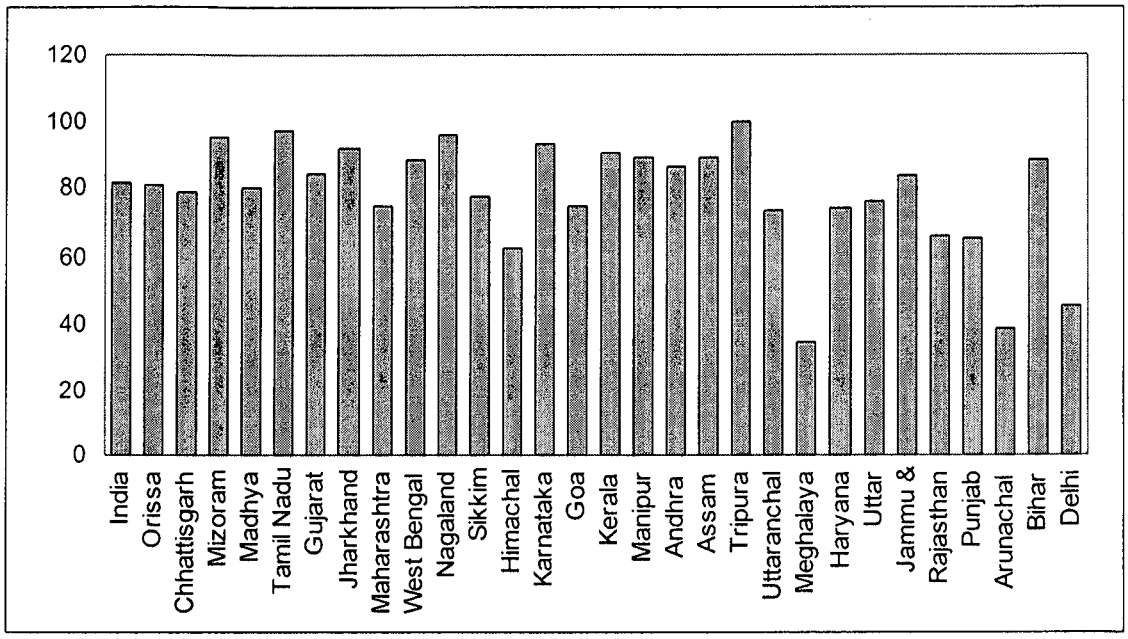
Figure 3.1: Percentage of Enumeration Areas covered by AWC



Source: Calculated from NHFS-3 Data

Looking at the percentage of targeted children covered by ICDS, figure 3.2 shows that 81 percent of children aged 0-71 months are in areas covered by an AWC, and with this proportion ranges from 100 percent in Tripura to 35 percent in Meghalaya. In 21 of the 29 states, more than three-fourths of children in 0-71 months are in areas covered by an AWC. The only states, besides Meghalaya, where less than half of children age 0-71 months are in areas covered by an AWC are Arunachal Pradesh and Delhi. These figures show extremely high variation in coverage among states implying an uneven spread of the AWCs.

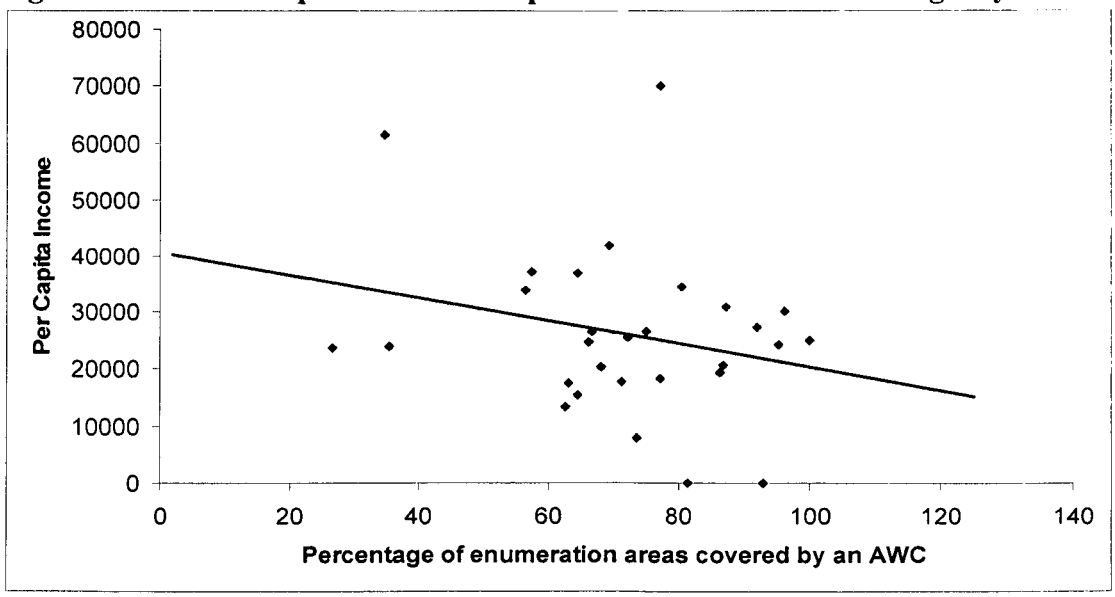
Figure 3.2: Percentage of Children under Age 6 years covered AWC



Source: Calculated from NHFS-3 Data

We examine the relationship between Per Capita Income of the states and percentage of areas covered by ICDS. Figure 3.3 shows that the states with higher levels of income have a smaller percentage of areas under ICDS. The fitted trend line implies a negative relation. This shows that ICDS has been successful in expanding in areas that are relatively poor. This trend was also observed in Das Gupta et. al. (2006) who show that the growth of program coverage from 1992 to 1998 was more rapid in the poorest villages. Also, our results are different from World Bank (2006). They report that the poorest states had smaller percentage of villages covered by ICDS.

Figure 3.3: Relationship between Per Capita Income and ICDS Coverage: by States

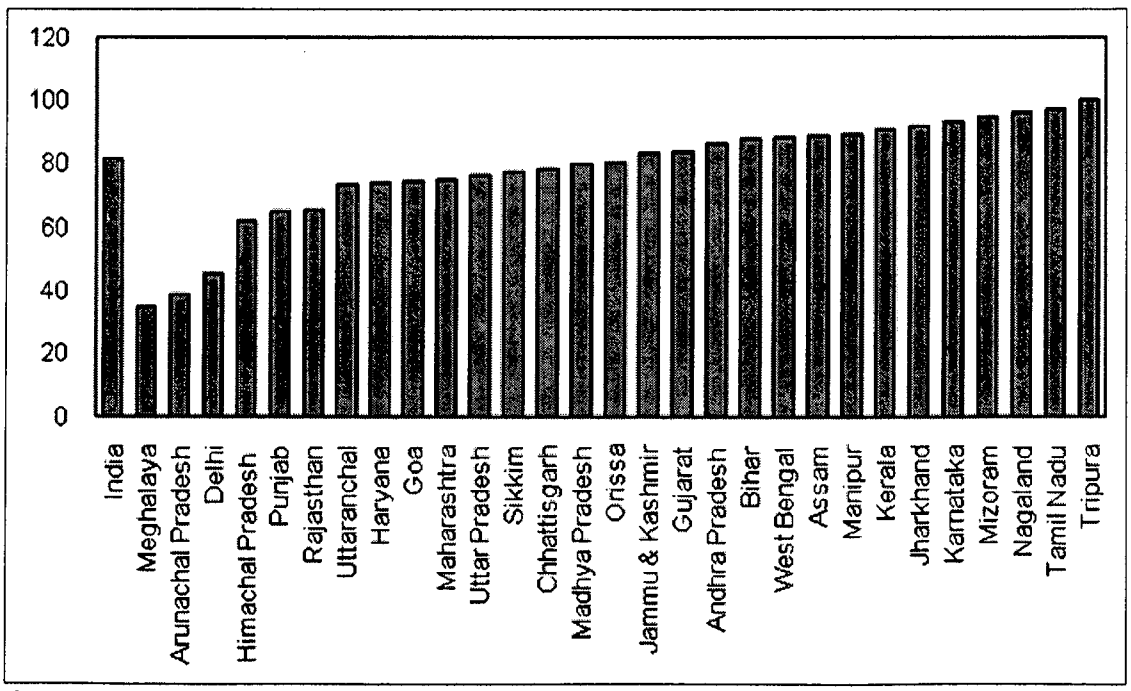


Source: Coverage of areas covered by AWC taken from NFHS3: PCI from Indiastat.com

3.4 UTILIZATION OF ICDS

Figure 3.4 shows that percentage of children receiving any service from ICDS in twelve months preceding the NFHS-3 survey. The rates of utilization were high in Orissa, Chattisgarh and Mizoram while Bihar, Punjab and Arunachal Pradesh had among the lowest rates of utilization (Table 3.2). The utilization rates show that one in three children in areas served by an AWC received one or more services from an AWC. Looking at the socio-economic profile of the children receiving any service from AWC, it was found that utilization of AWC services is higher in rural than in urban areas served by an AWC. While there is no clear pattern in the utilization of services by mother's education, a smaller proportion of children with mothers who have completed at least 12 years of education received any services (22 percent), compared with children of less educated mothers (30-42 percent). Fifty percent of scheduled-tribe children received services, compared with 28 percent of children who do not belong to any scheduled caste, scheduled tribe, or other backward class. Utilization of services is more common among children living in enumeration areas where an AWC has existed for 6 or more years (35 percent) than in areas where the AWC has been established in the past five years (27 percent). This is an indication of the groups who tend to use these services more.

Figure 3.4: Percentage of children age 0-71 months who received any service by AWC



Source: Calculated from Table 3.2

***Supplementary Nutrition*:** One of the important services of an anganwadi centre is to provide supplementary nutrition to young children in the form of cooked food served at the AWC on a daily basis or given in the form of take-home rations. However, three-fourths of children age 0-71 months in areas covered by an AWC did not receive any supplementary food. Further, only a small proportion (12 percent) received supplementary food almost daily. Six percent received supplementary food at least once a week, and another 6 percent, at least once a month. Differentials in the daily utilization of the supplementary food scheme are small. The youngest children (age 0-12 months) are least likely to have received any supplementary food from an AWC in the past 12 months, which is an expected result. Also it can be seen from Table 3.4 that there were no differentials on the basis of either gender or location (rural/urban) in receiving daily food. There is no clear differences in utilization rates based on wealth of households.

Immunization and Health Check-Ups: Table 3.5 presents utilization of immunization and health services by children in the enumeration areas. Immunization of children with the basic vaccinations (BCG, polio, DPT, and measles) and the provision of regular health check-ups are other important components of the ICDS program. The table shows that only one in five children received any vaccination through an anganwadi centre in the past 12 months; and this proportion is not much higher even among children younger than 23 months, an age when children should have received basic vaccinations. The highest proportions of children to have received vaccinations in the past 12 months from an anganwadi centre are Buddhist/Neo- Buddhist children (49 percent) and scheduled-tribe children (33 percent). The lowest utilization of ICDS immunization services is by Sikh children (4 percent), followed by children living in the wealthiest households (9 percent). The proportion of children receiving immunization as well as health service increased for mothers who had completed around 8 years of education but fell thereafter implying that highly educated mothers do not seem to be using these services. A higher proportion of rural children (21 percent) got vaccinations and health check-up (11.9 percent) from an AWC in the past 12 months, than did urban children (14 percent and 9.4 percent) living in areas served by an AWC (IIPS 2007).

Early Childhood Education: Provision of early childhood care or preschool education for children 3 to 5 years of age is another important component of the ICDS

program. Table 3.6 presents information on the utilization of early childhood care or preschool education services in the 12 months preceding the survey by children age 36-71 months in areas covered by an AWC. More than three-fourths of children age 3-5 years did not go to an anganwadi centre for early childhood care or preschool education. Only one out of seven children age 36-71 months in areas covered by an AWC went regularly for early childhood care or preschool education to an AWC and an additional one in eleven children went occasionally. There are not many apparent differences in the regular utilization of early childhood care and preschool education by background characteristics. Overall the rates of utilization are extremely low for these services.

Growth Monitoring of children is another basic component of the nutritional services provided through an *anganwadi* centre. It is recommended that children age 0-35 months be weighed monthly and older children be weighed quarterly. Table 3.6 presents information about the growth monitoring of children age 0-59 months who are in areas served by an *anganwadi* centre. The vast majority of children age 0-59 months (80 percent) in areas covered by an AWC were not weighed at all in an *anganwadi* centre in the 12 months preceding the survey; and this proportion varies little by most background characteristics. As can be seen from the table, more than 20 percent of scheduled-tribe children were weighed at least once a month, compared with less than 10 percent of children of other backward classes. Overall, 62 percent of children who were weighed in the past 12 months and for whom information on frequency is known had their weight taken at least once a month. Also, among children who were weighed in the past 12 months, the proportion weighed monthly did not vary by age. A surprising finding from the data emerges. Even though a around a high proportion of children were not weighed, yet a relatively large proportion of mothers had received counselling from an AWC after their children were weighed. This figure was around 50 percent in aggregate and the rate was much higher in rural areas. One is tempted to conclude that this could imply higher level of satisfaction by the mothers.

3.5 SUMMARY

This chapter looks at the objectives, concept and coverage of ICDS. We show that though the coverage is nearly universal across states, the rates of utilization are much lower for all the states and all the services. The service most used by households is

the supplementary food nutrition program. This low level of utilization is a troubling observation and policy measures are required to ensure greater utilization looking at the relationship between state per capita income and spread of ICDS, we observe that the richer states have a lower percentage of ICDS coverage. This shows that the government is being successful in its objective of reaching out to the relatively disadvantaged. We analyse the effects and reasons for low rates of utilization in later chapters to get a better understanding of the program and its impact.

Table 3.2: Coverage of Anganwadi Centres by State

State	Enumeration areas[1] (Percentage of enumeration areas covered by an AWC)			Children under age six (Percentage of children under age six)	
	AWC established for at least five years	All AWCs	Number of Enumeration Areas	Living in enumeration areas covered by an AWC	Received any service from an AWC in the past year [2]
India	62.1	72.4	3,850	81.1	28.4
Orissa	57.4	71.3	115	80.4	60.5
Chhattisgarh	63.8	68.1	94	78.6	55.2
Mizoram	93.8	95.3	64	94.6	52.7
Madhya Pradesh	64	64.5	186	79.8	43.8
Tamil Nadu	90.2	96.3	214	97	41.6
Gujarat	72.6	80.5	113	84	40.5
Jharkhand	57.9	86.3	95	91.5	38.6
Maharashtra	41.9	57.4	289	74.7	38
West Bengal	65.9	72.2	205	88.4	38
Nagaland	90.5	93	200	95.8	37.9
Sikkim	61.7	66.7	60	77.6	35.4
Himachal Pradesh	52.8	56.6	106	62.4	34.7
Karnataka	69.9	92	176	92.9	33.5
Goa	77	77	126	74.6	32.3
Kerala	82.4	87.2	125	90.4	28.7
Manipur	85.3	86.7	150	88.9	28
Andhra Pradesh	56.9	74.9	195	86.2	27.5
Assam	58.6	77	87	88.6	26.8
Tripura	96.4	100	56	100	26.6
Uttaranchal	15.3	66.3	98	73.3	24.5
Meghalaya	22.5	26.8	71	34.7	21.9
Haryana	64.8	69.2	91	73.8	21.2
Uttar Pradesh	45.9	62.6	353	76.2	18.6
Jammu & Kashmir	68	81.4	97	83.2	16.6
Rajasthan	60.4	63.2	106	65.7	15.9
Punjab	60.6	64.6	99	64.9	10.5
Arunachal Pradesh	32.3	35.4	65	38.7	9.6
Bihar	57.8	73.5	102	87.9	8.8
Delhi	33	34.8	112	45.5	8.4

Note: [1] *Unweighted*

[2] *AWC services include distribution of supplementary food, growth promotion, immunizations, health check-ups, health and nutrition education, and pre-school Education*

Source: IIPS (2007)

Table 3.3: Percentage of Living Children under Age Six Years who received any Service from an AWC in the last 12 Months (except SNP)

State	Received food supplements	Received immunizations	Received health check-ups	Went for PSE	Were weighed
India	26.3	20	15.8	22.8	18.2
Bihar	4.2	7.7	0.8	4.8	0.7
Delhi	11.5	4.9	3.4	7.7	3.7
Punjab	13	2.7	5.2	9.8	5.1
Arunachal Pradesh	14.7	6.5	2.4	18.6	1.7
Jammu & Kashmir	17.1	8.4	4.8	10.2	3.4
Rajasthan	17.3	12.9	9.6	10.3	9.6
Uttar Pradesh	14.7	13.5	2.7	12.8	2.8
Tripura	19.6	15.3	10.4	22.5	7.7
Haryana	22.3	17.2	14.8	18.1	9.3
Assam	28	6.5	4.9	14.7	5
Manipur	21.4	12.2	1.1	10.7	0.6
Andhra Pradesh	28	14.9	15.5	22	17.8
Kerala	24.7	9	17.6	30.7	19.2
Uttaranchal	27.9	14.3	10	20.4	12.5
Goa	31.3	19.3	15.3	15.5	26.4
Karnataka	28	26.2	17.1	32.9	17.8
Himachal Pradesh	37	6.9	14.7	24.9	24.1
Nagaland	38.8	3	1.4	3.8	0.9
Sikkim	40.8	22.7	17.6	11.1	26.7
Jharkhand	36.5	26.5	11.9	17	14.4
West Bengal	40.2	11.6	24.8	39.2	31.6
Tamil Nadu	32.2	33.7	25.5	26.5	31.6
Gujarat	31.7	33.9	26.5	37	25.3
Meghalaya	48.1	10.3	25.9	25.7	22.5
Maharashtra	42.4	33.4	36.2	49.9	37.4
Madhya Pradesh	36.4	37.8	31.5	28.9	39.1
Mizoram	54.7	21.6	14.3	45.7	35.8
Chhattisgarh	58.4	46	32.2	37.1	45.1
Orissa	52.5	41.6	43.1	27.7	56.1

Source: IIPS (2007)

Table 3.4: Utilization of ICDS Services: Supplementary Nutrition
(Percentage of children age 0-71 months covered by an AWC who received SNP in the last 12 months preceeding Survey)

Background characteristic	Among children in an area covered by an AWC, frequency of receiving supplementary food		
	Not at all	Almost daily	At least once a week
Age in Months			
0-35	75.6	8.1	6
36-71	71.5	15.5	5.6
Sex			
Male	74.2	11.2	5.9
Female	72.7	12.7	5.7
Residence			
Urban	81.5	11	3.4
Rural	71.9	12.1	6.3
Mother Education			
No Education	75	10.1	6.2
<5 Years Complete	63.6	17.3	7
5 - 7 years Complete	69.1	15.2	6.6
8 - 9 years Complete	71.1	14.5	5.8
10 - 11 years Complete	76.2	11.4	3.5
12 or more years complete	83.8	8.4	2.8
Religion			
Hindu	72.8	12.2	6.3
Muslim	78.7	9.9	3.9
Christian	68	11.5	5.2
Sikh	85.2	7.2	4.7
Caste/tribe			
Scheduled Caste	69.6	14.4	7.2
Scheduled Tribe	56.1	15.6	9.9
Other Backward Class	77.6	9.9	5.4
Other	76.8	11.5	4
Wealth Index			
Lowest	70.1	10.7	7.3
Second	71	13.5	6.1
Middle	71.1	13.8	6.3
Fourth	75.7	12.7	4.8
Highest	88.9	6	2.2

Source: IIPS (2007)

Table 3.5: Utilization of ICDS Services: Immunization and Health Check-ups
(Percentage of children age 0-71 months covered by an AWC who received Immunization and Health Check-ups in the last 12 months preceeding Survey)

Background characteristic	Percentage receiving any immunizations from an AWC	Frequency of receiving health check-ups at an AWC			Number of children in areas covered by an AWC
		Not at all	At least once a month	Less often	
Age in months					
<12	21.1	85.7	9.9	3.7	8,456
12 - 23	23.2	82.8	11.5	4.4	8,489
24-35	22.4	80.3	13.1	4.7	8,367
36-47	19.2	79.7	12.8	4.7	8,765
48-59	18.3	80.9	12.2	4.1	8,833
60-71	15.8	83.7	9.6	4.1	8,977
Sex					
Male	19.4	82.4	11.4	4.4	27,037
Female	20.5	82	11.7	4.2	24,849
Residence					
Urban	13.9	86.3	9.4	2.6	8,472
Rural	21.1	81.4	11.9	4.6	43,414
Mother's Education					
No education	19.8	84.4	9.6	3.8	26,909
<5 years complete	23.5	75	16.3	5.9	3,898
5 - 7 years complete	22.5	77.6	14.5	5.8	7,592
8 - 9 years complete	19.7	79.6	14.2	4.9	6,200
9 - 11years complete	19.1	82.7	11.9	3.6	3,673
12 or more years complete	13.5	87	8.8	2.9	3,613
Religion					
Hindu	21.4	81.3	12.2	4.4	41,096
Muslim	12.7	86.9	7.7	3.7	8,466
Christian	18.1	83.3	10.6	4.5	993
Sikh	3.8	92.4	4.5	1.3	633
Buddhist/Neo-Buddhist	49	52.7	34.6	6.4	326
Jain	-15.2	-100	0	0	37
Other	33.1	77.4	13.8	8.2	287
Caste/tribe					
Scheduled caste	21.4	80.1	13.3	4.5	10,894
Scheduled tribe	33.1	68.2	21.4	7.8	4,996
Other backward class	20.5	85.3	9.4	3.5	21,803
Other	13.3	84.2	9.6	4.1	13,766
Don't Know	19.1	66.1	22.3	5	239
Wealth Index					
Lowest	22.8	80.8	12.3	4.9	14,158
Second	21.3	81.5	11.7	4.6	12,329
Middle	22.2	79.8	13.2	4.6	10,830
Fourth	17.9	82.8	11.6	3.8	9,089
Highest	8.8	91.2	5.7	2.1	5,481

Note: Total includes children with missing information on mother's education, religion, and caste/tribe, who are not shown separately

Source: IIPS (2007)

Table 3.6: Utilization of ICDS Services: Early Childhood Care
(Percentage of children age 36-71 months covered by an AWC who received ECE in the last 12 months preceeding Survey)

Background characteristic	Frequency of going to an AWC for early childhood care or preschool education for children age 36-71 months			Number of children age 36-71 months in areas covered by an AWC
	Regularly	Occasionally	Not at all	
Age in months				
36-47	13.5	10	76	8,765
48-59	15.1	8.9	75.4	8,833
60-71	13.5	7.4	78.6	8,977
36-71	14	8.8	76.7	26,574
Sex				
Male	12.8	8.8	77.8	13,852
Female	15.3	8.7	75.4	12,722
Residence				
Urban	12	5.7	81.9	4,420
Rural	14.4	9.4	75.6	22,154
Mother's education				
No education	11.9	8.7	78.8	14,468
<5 years complete	21.8	12.4	64.9	2,070
5 - 7 years complete	17.6	10.3	71.5	3,685
8 - 9 years complete	17.3	7.9	74.3	2,959
10 - 11 years complete	13.9	6.1	79.8	1,758
12 or more	9.5	4.9	85.3	1,633
Religion				
Hindu	14.8	8.9	75.8	21,095
Muslim	10.3	7.7	81.4	4,316
Christian	14	7.3	78.2	487
Sikh	6	6.4	86.6	324
Buddhist/Neo-Buddhist	41.8	19.3	38.9	158
Other	5.6	17.4	76.9	153
Caste/tribe				
Scheduled caste	15.8	9.7	74	5,578
Scheduled tribe	16	14.4	68.8	2,551
Other backward class	12.9	7.5	79.1	11,246
Other	13.4	8.1	77.9	6,965
Don't know	28.4	7.1	64.5	132
Wealth index				
Lowest	12.4	10.5	76.4	7,334
Second	16.2	9.1	74.3	6,357
Middle	16.8	9.6	73	5,559
Fourth	14.6	7.3	77.5	4,535
Highest	6.9	4.2	88.4	2,791

Source: IIPS (2007)

Table 3.7: Utilization of ICDS Services: Growth Promotion
(Percentage of children age 0-59 months covered by an AWC who were weighed in the last 12 months preceeding the Survey)

Background characteristic	Frequency of weighing				Number of children 0-59 months	Percentage whose mothers received counselling from an AWC after child was weighed	Number of children
	Not at all	At least once a month	At least once in three months	Less often			
Age in months							
<12	85.5	9.2	2.5	2.3	8,456	53	1,185
12 - 23	81	10.5	4.3	2.9	8,489	52.1	1,512
24-35	78	12.4	4.4	3.6	8,367	50.2	1,709
36-47	77.3	12.2	4.5	3.3	8,765	45.9	1,747
48-59	78.7	11.5	4.1	3.1	8,833	45.1	1,651
0-35	81.5	10.7	3.8	2.9	25,312	51.6	4,407
36-59	78	11.9	4.3	3.2	17,597	45.5	3,398
Sex							
Male	80.4	11	3.8	3.1	22,331	49.2	4,009
Female	79.7	11.3	4.2	3	20,579	48.6	3,796
Residence							
Urban	84.4	9.8	2.9	1.5	7,020	51.8	1,002
Rural	79.2	11.4	4.2	3.3	35,890	48.5	6,803
Mother Education							
No Education	82.9	9.1	3.4	2.8	21,805	45.4	3,320
<5 years complete	71.5	15.8	5.2	4.8	3,256	47.8	843
5 - 7 years complete	74.3	15	5.7	3.4	6,367	50.1	1,535
7 - 9 years complete	76.9	13.9	4.3	3.4	5,244	54.7	1,133
10 - 11 years complete	80	11.9	4.3	2.6	3,123	52.2	588
12 or more years complete	86.5	7.9	2.8	1.7	3,113	55.4	386
Religion							
Hindu	79.2	11.7	4.3	3.1	33,872	48.9	6,463
Muslim	85.2	8.1	2.6	2.6	7,130	51.2	944
Christian	80	11.1	4.2	3	819	49.2	149
Sikh	92.1	3.4	1.8	0.7	523	-16.4	31
Buddhist/Neo-Buddhist	43.9	31.6	12.1	7.8	260	47.2	134
Jain	-92.5	-7.5	0	0	31	*	2
Other	68.4	17.4	4.6	9.1	234	39.9	73
Caste/tribe							
Scheduled caste	78.1	12.8	4.6	2.9	8,977	49	1,819
Scheduled tribe	64.2	21.4	6.5	6	4,146	48	1,407
Other backward class	83.3	9.1	3.4	2.5	17,903	52.8	2,693
Other	82.7	9.4	3.4	2.8	11,535	44	1,799
Don't know	61.2	16.9	11.1	5.2	200	55.7	66
Wealth index							
Lowest	78.3	11.9	4.5	3.7	11,653	46.7	2,348
Second	79	11.2	4.4	3.3	10,102	48.8	1,917
Middle	77.8	12.8	4	3.1	9,021	53.4	1,791
Fourth	80.7	11.6	3.8	2.6	7,558	48.9	1,356
Highest	90.6	5.3	2	1.3	4,575	42.7	394

Source: IIPS (2007)