Anganwadi is a type of rural mother and childcare centre in India. It means "courtyard shelter" in Indian languages. Anganwadi Centers (AWCs), which are the community-based, service-delivery division of the Integrated Child Development Services (ICDS), were started by the Government of India (GoI) in the period of Tenth Five Year Plan to provide primary medical care and nutritional services to infants and their mothers in the community. Anganwadi centres are run by an Anganwadi worker called the Sevika, and her helper called the Sahayika, who are typically women from poor families. The Anganwadi centres in a project are looked after by a Child Development Project Officer (CDPO) assisted by a number of supervisors. The programme has covered 7066 Blocks, with 13,39,998 operational AWCs and Mini AWCs, and has had 1032.32 lakh Supplementary nutrition beneficiaries and 349.22 lakh pre-school education beneficiaries.
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Majority of children in India have underprivileged childhoods starting from birth. The infant mortality rate of Indian children is 67 and the under-five mortality rate is 93, and 25% of newborn children are underweight among other nutritional, immunization and educational deficiencies of children. Only about one in three is exclusively breastfed for the first six months. Nearly one in two children under five years of age suffer from moderate or severe malnutrition. Figures for India are substantially worse than the country average.

One in three children do not get a full course of DPT (Diphtheria, Pertussis and Tetanus immunization), and only one in three has the opportunity to be in an early learning programme. Just about one in five is protected against vitamin A deficiency. Less than 30 per cent have access to adequate sanitation facilities. Skilled attendants handle fewer than half of all deliveries, a major factor in the country's high maternal mortality ratio of 540 deaths per 100,000 live births. Pervasive discrimination against girls and women is reflected in a range of adverse indicators, including nutritional and educational outcomes, and the declining ratio of girls to boys, particularly in the youngest age group. Against this backdrop, the Government has supported a monumental effort to improve the life chances of children. The Ministry of Women and Child Development (MWCD) of India established ICDS on 2nd October, 1975.

**Integrated Child Development Services (ICDS):** The Integrated Child Development Services scheme is one of the flagship programmes for India’s healthcare system and represents one of the world’s largest and unique programmes for child and women welfare. ICDS has provided significant assistance to the nation’s health and education system for decades and has received financial and technical support from UNICEF and the World Bank. MWCD has the overall responsibility of monitoring the ICDS scheme. The primary goal of ICDS is to break the inter-generational cycle of malnutrition, reduce morbidity and mortality caused by nutritional deficiencies.

**Purpose:** The purpose of the scheme is to reduce high infant mortality and malnutrition rates by providing medical care to mothers and their babies alongside improving physical, psychological, and financial capacity of these mothers and local community.

**Objectives:**

- To improve the nutritional health status of children in the age group of 0-6 years.
- To lay the foundation for proper psychological, physical and social development of the child.
• To reduce the incidence of morbidity, mortality, malnutrition and school dropout.
• To achieve effective coordination of policy and implementation amongst various departments to promote child development.
• To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The above objectives are achieved through the following six services as a package through the network of Anganwadis.

• Supplementary nutrition (SNP)
• Non-formal pre-school education (PSE)
• Immunisation
• Health check-up
• Referral services
• Nutrition and Health Education (NHE)

The three services, viz. immunisation, health check-up and referral, are designed to be delivered through the primary health care infrastructure. While providing SNP, PSE and NHE are the primary tasks of the Anganwadi Centre, the responsibility of coordination with the health functionaries for provision of other services rests with the Anganwadi worker (AWW).

Criteria for service providing: The ICDS target population includes poor and malnourished people at risk for malnutrition and mortality, including children below six years old, pregnant and lactating mothers, and women in the age group between fifteen and forty-five years of age.

Services provided by Anganwadi Centres are shown in the table below:

<table>
<thead>
<tr>
<th>Services</th>
<th>Children under 6 years</th>
<th>Pregnant women</th>
<th>Lactating women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementary nutrition</td>
<td>Hot meal or ready-to-eat snack providing 300 calories and 8-10g protein. Double rations for malnourished children.</td>
<td>Hot meal or ready-to-eat snack providing 500 calories and 20-25g protein.</td>
<td>Hot meal or ready-to-eat snack providing 500 calories and 20-25g protein.</td>
</tr>
<tr>
<td>Pre-school non-formal education</td>
<td>Early Childhood Care and Preschool Education (ECCE) consisting of “early stimulation” of under-threes and education “through the medium of play” for children aged 3-6 years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition &amp; health education</td>
<td></td>
<td>Advice includes infant feeding practices, child care and development, utilization of health services, family planning and sanitation.</td>
<td>Advice includes infant feeding practices, child care and development, utilization of health services, family planning and sanitation.</td>
</tr>
</tbody>
</table>

Supplementary nutrition provided by Anganwadi Centres to Beneficiaries:

<table>
<thead>
<tr>
<th>Beneficiaries</th>
<th>Calories (cal)</th>
<th>Protein (g)</th>
<th>Cost Rs. (per day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (6 months to 72 months)</td>
<td>500</td>
<td>12-15</td>
<td>4</td>
</tr>
<tr>
<td>Severely malnourished Children</td>
<td>800</td>
<td>20-25</td>
<td>6</td>
</tr>
<tr>
<td>Pregnant women and lactating mothers</td>
<td>600</td>
<td>18-20</td>
<td>5</td>
</tr>
</tbody>
</table>
Population criteria for establishment of centres: Population norms for setting up of AWCs and Mini-AWCs to cover all habitations, particularly those inhabited by SC/ST/Minorities are as under:

Anganwadi Centres for Rural/Urban Projects as per population:

- 400-800 - 1 AWC
- 800-1600 - 2 AWCs
- 1600-2400 - 3 AWCs
- Thereafter, 1 AWC in multiples of 800.

For Mini-AWC:

- 150-400 - 1 Mini-AWC

For Tribal /Riverine/Desert, Hilly and other difficult areas/Projects

- 300-800 - 1 AWC

For Mini-AWC

- 150-300 - 1 Mini AWC

Functions of Anganwadi Staff: The centre starts working at 9 am to 4:30 pm and six days in a week.

Anganwadi Worker (AWW): She is the pillar of the program. Her job is mainly to run the Anganwadi by providing the following services:

- Providing supplementary feeding to children, which is often a hot meal or snack cooked and served at the AWC.
- Distributing take-home rations from the AWC.
- Organising immunisation sessions or “Mother-Child Protection Days” on a fixed day each month. Maintaining immunisation records to ensure full coverage.
- Distributing iron and folic acid (IFA) tablets.
- Treating minor illnesses and referring cases to medical centres whenever necessary.
- Weighing children and recording weights on a growth chart for growth monitoring and to detect growth faltering.
- Providing nutritional and health related advice to women and adolescent girls in the community.
- Maintaining birth records of all children born in the community covered by the AWC.
- Assist in the implementation and execution of Kishori Shakti Yojana (KSY) to educate teenage girls and parents by organizing social awareness programmes etc.

Anganwadi Helper (AWH): The AWH is supposed to assist the AWW in her tasks. Her main duties are to bring children to the Anganwadi, cook food for them, and help with the maintenance of the AWC.

Supervision: Every 40 to 65 Anganwadi workers are supervised by one Mukhya Sevika. They provide on-the-job training. In addition to performing the responsibilities with the Anganwadi workers, they have other duties such as keeping track of who are benefitting from the programme from low economic status; specifically those who belong to the malnourished category; guide the Anganwadi workers in assessing the age and weight of children and how to plot their weights; demonstrate effective methods, for example, in providing health and nutrition education to
mothers; and maintain statistics of Anganwadis and the workers to determine what can be improved. The Mukhya Sevika then reports to the Child development Projects Officer (CDPO)

**Benefits of Anganwadi System:**

- Through the Anganwadi system, the country is trying to meet its goal of enhanced health facilities that are affordable and accessible for local populations.
- In many ways, an Anganwadi worker is better equipped than a physician in reaching out to the rural population.
- Since the worker lives with the people, she is in a better position to identify the cause of health problems and hence counter them. She has a very good insight of the health status in her region.
- Though Anganwadi workers are not as skilled or qualified as professionals, they have better social skills; thus, making it easier to interact with the people. Moreover, since these workers are from the village, they are trusted which makes it easier for them to help the people.
- Anganwadi workers are well aware of the ways of the people, are comfortable with the language, know the rural folk personally etc. This makes it very easy for them to figure out the problems being faced by the people and ensure that they are solved.

**Convergence with health department and others:** The construction of AWC buildings can be taken up in convergence with Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS).

**Community Involvement:** Community participation is an important element in the design of ICDS/Anganwadi. It can do a lot to help the effective functioning of Anganwadis. For instance, the community can be mobilized to provide the Anganwadis with better facilities, to ensure that they open on time every day, or to encourage mothers to participate in counselling sessions. Community participation can take place through Gram Panchayats, Mahila Mandals, Self-Help Groups, youth groups or just spontaneous cooperation. Unfortunately, community participation in ICDS is quite limited as things stand.

**NGOs’ Involvement:** In some areas, NGOs play an active role in the implementation of the project. In fact, sometimes entire ICDS “projects” are managed by an NGO. Also, international organizations such as CARE and UNICEF often provide specific support to ICDS. For instance, CARE used to supply food for the supplementary nutrition program, and UNICEF has been helping with the supply of medical kits.

**Problems of Implementation and Improving services:** Despite its significant roles and responsibilities, former studies have shown poor performance of the AWCs. The lack of regular program evaluation resulted in ineffective and inefficient implementation of services, and some populations have limited access to AWCs. In addition, Anganwadi workers (AWWs) have been underpaid under the government-run program. This has negatively affected workers’ motivation towards public service as well as performance.

**Improvement of monitoring system:** The Anganwadi Centres are located at varying distances from the CDPO office. The ratio of number of Centres to be monitored by CDPO and supervisors are high, and it is not practically possible to visit the centres physically on regular basis. Therefore, the number of supervisors could be increased to ensure that every centre is visited twice a month. To improve the monitoring system, the authority should devise a strong and evidence based monitoring system to be implemented. As part of monitoring system, surprise checks need to be established, any irregularities must be corrected with disciplinary actions.

**Improving Reporting System:** Many Centers do not function properly as workers do not attend on time and close the centre early. They do not follow proper nutrition food supplementary schedule, and maintain false attendance and show mismatching figures in the records. The system can be linked with IT by using SMS based reporting,
mobile based app OR web based attendance etc. The AWW can submit the reports on a monthly basis to the CDPO, the ICDS can provide a Tab or Smart phone to the centre to acquire the data up-to-date.

Toilets and other facilities: As per the studies, it was revealed that majority of the AWC are not equipped with clean toilet facilities. The Anganwadis can be an excellent starting point for students to be taught cleanliness, hygiene and basic sanitation; therefore, all AWC should have clean and hygienic toilets.

Community Participation is required: A lot can be achieved if the community, the beneficiaries of the ICDS program, can be encouraged to participate in the functioning of the Anganwadi centre. As the community becomes aware of the benefits of the Anganwadis centres, they will also be vigilant against malpractices that may be carried out by AWW and AWH. Women SHGs, Village Organisations and committees also can monitor the Anganwadi services.

Selection and training of Anganwadi Workers: Many of the workers do not have minimum knowledge about maintaining records, and they tend to take the help of their husbands on a monthly basis to write records. They do not know how to treat and teach children properly, so they need trainings. Therefore, an examination could be conducted for Sevikas where they are tested on basic knowledge levels. This would ensure that the selected Sevikas have the required knowledge levels to take care of the children and can understood the project norms for working.

Criteria to be maintained while selecting students: In certain areas, children who reside very close to the centre and who are from an economically weak background are excluded from the program, while marginally better off students who reside at a distance are selected for the programme. Therefore, students who are much more in need of the ICDS programme and who are more at risk from low nutrition levels are sometimes excluded from the programme. So, the authority of ICDS should give clear instructions to the workers as well as community. First priority should be given to children from families who are very weak economically and are at very high risk of low levels of nutrition. The Anganwadi worker should select students from the lowest socio-economic people in the community as these children are at higher risk to malnutrition and deficiency related diseases.

Maintaining Teacher – Student ratio: The current teacher – student ratio is 1:40. Increasing the number of students in a classroom would see a decline in the quality of the teaching since the teacher would have less time to spend on each student. Thus, in areas where there are another 40 eligible students, a new centre would have to be setup and staffed with a Sevika and Sahayika. Thus, more Sevikas and Sahayikas would have to be recruited. However, it would be inefficient if a new centre had to be opened up in a community where 10-20 eligible students are excluded from the program. The extra 10-20 students could be enrolled in the existing Anganwadi centre. Such centres with a student - teacher ratio of more than 40:1 should be assigned two Sahayika instead of one, this would ensure that the Sahayikas can help out and look after the kids while the Sevika concentrates on teaching.

Housing needs: The ICDS programme faces difficulty in finding premises to run the Anganwadi centres with a sum of Rs. 200/- per month (for non-urban areas) spent on renting premises. It might prove to be difficult to find centres in areas where there already exists an Anganwadi centre. The ideal centre is a government owned building and in many areas the sole government owned building might have been rented out for the ICDS programme already. Special attention must be taken to find suitable premises for both centres.

Selection from examination: Currently, the AWWs are selected on the basis of the marks obtained from their 10th grade examinations with further points being awarded to other criteria - clearing the 12th grade exams, completing an undergraduate or diploma course. There is also attention being paid to the social hierarchy the AWW comes from. In many places, the AWW is selected from the majority caste dominant in the area or selected from political recommendations.
The current selection procedure ignores the capabilities of AWW and pays no attention to their awareness of nutrition and health based issues. Therefore, an examination could be conducted for AWW where they are tested on basic knowledge levels. This would ensure that the selected AWWs have the required knowledge levels to take care of the children.

**Regular tests and continuing the education:** To ensure that the AWWs remain committed to the task at hand and to improve their knowledge levels, regular tests and training should be conducted for the AWWs. The results of these tests could be a clear indicator of the areas in which the knowledge levels are currently lacking and further training could be given in these areas. Such tests would also ensure that the AWWs pay attention during the training modules being given.

**Insufficient honorarium paid to workers:** The AWWs are responsible for all the services the ICDS provides in AWC premises but honorarium is fixed and very low. They are doing a full time job but the honorarium is not commensurate to the time and effort put in by them. Hence, the lack of interest in giving undivided attention to their work. The dismal functioning of the AWCs can be attributed to this inconsiderate remuneration to the service providers. So, ICDS authority can take an action to increase the remuneration (like increments depending on service) to workers and encourage them to improve their performance.

**Model Anganwadi:**

**Pallipuram Anganwadi**

The Pallipuram AWC is a good AWC due to dedicated AWW and community participation. First of all, the Panchayat had given the land for construction of the AWC building in the village. The village club has also donated some of the chairs for small kids. Moreover, mothers of beneficiaries as well as adolescent girls help AWW in cooking and distribution of food. Home visits by AWW play a significant role for community participation in functioning of the AWC. Moreover, the level of literacy as well as awareness about the services among the villagers makes AWW more active towards her duties. The food items are being purchased by AWW and supervisor jointly from reputed shops identified by the CDPO/DPO.

AWW visited households regularly and hence developed a good rapport with the villagers. Regular food distribution, immunisation and pre-school activities are the major reasons for identifying a good AWC. The AWW (Ms. Retnemma K.V) was awarded by the state government for her dedicated work in 2004. The AWW is very happy with such recognitions and she continues to perform better. She has an exemplary rapport with the beneficiaries. Almost all the beneficiaries are satisfied with the activities and services received through AWC.

Maintaining Registers is also one of the major activities of a good AWC. She updates all the registers regularly and provides all the relevant information without major problems. As on 8.9.09,, 60 beneficiaries were enrolled in the centre, out of 84 as per survey carried. Out of 60, 50 children are among 7 month- 6 years age group, of which 27 are girls. 5 adolescent girls are enrolled in the centre and are getting SN and other health related benefits. Out of 8 pregnant women, only 3 are enrolled. 2 lactating mothers are also getting all the expected benefits from the AWC.

**Working hours:** There are no clear-cut directives for AWCs regarding their working hours. Centres should be open for at least four hours every day, six days a week. This is not happening. Many Centres open only when they receive food items and need to distribute them. Most of the AWWs are not capable of delivering the services they are required to because of lack of education and low motivation levels. Some Centres open for two hours, others for three hours and still others for only one hour. Most mothers are not motivated to send their children only for two hours because they have to travel for at least half an hour or one hour to reach the Centre. The CDPO or authority needs to instruct and provide awareness to AWW to follow the ICDS norms without fail. The authority can conduct parents’ meeting along with workers at least once in a month to raise the parents’ awareness about
the project norms. The workers can stick a time schedule on the wall at the centre premises, so that the parents get to know about the working hours and holidays on beforehand.

Many people have no idea about the duties of AWWs and the AWCs’ services. People in villages argue with the workers on unnecessary issues because of personal (Village level) grudges, and also because they are not aware about the duties and responsibilities of the AWW. The duties and responsibilities of an AWW should be clearly marked out and a chart outlining her duties should be kept at the Centre, so that those who visit the Centre get to know what to ask for and do not make demands that are unreasonable. At the same time, they can insist that the AWW follows her work schedule properly and also adheres to the timings.

Because of malpractice of AWWs, the take-home ration is being improperly distributed, and is not reaching the children who are in need. The programme needs to consider take-home rations for children on a regular basis. Some Centres distribute food only once a month, and in some other places only once a year. To overcome malnutrition a child needs to eat nutritious food on a daily basis, especially during the age of 0-3 years. Take-home ration ensures that children under 3 years of age, who are also from the most vulnerable and neglected group also meet their nutritional needs.

Anganwadi Centres play vital role in ensuring nutrition food, health services, pre school education/non - formal education to children, pregnant and lactating women. It also reduces Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR).