Research Report Series: 120

ASSESSMENT OF ICDS PROGRAMME

Citizen Report Card Approach

C.Dheeraja
K.Prabhakar

Centre for Good Governance and Policy Analysis (CGG&PA)
National Institute of Rural Development and Panchayati Raj
Ministry of Rural Development, Government of India
Rajendranagar, Hyderabad - 500 030,India
www.nirdpr.org.in

ASSESSMENT OF ICDS PROGRAMME

Citizen Report Card Approach

C. Dheeraja

K. Prabhakar

Centre for Good Governance and Policy Advocacy

National Institute of Rural Development and Panchayati Raj

Ministry of Rural Development

Rajendranagar, Hyderabad- 500030

ASSESSMENT OF ICDPROGRAMME : Citizen Report Card Approach

Authors: **Dr.C.Dheeraja, Dr.K.Prabhakar**

@ National Institute of Rural Development and Panchayati Raj

ISBN: 978-81-951169-2-8

February, 2021

Published by:
NATIONAL INSTITUTE OF RURAL DEVELOPMENT AND PANCHAYATI RAJ
(Ministry of Rural Development, Government of India)
Rajendranagar, Hyderabad-500030, India
nirdpr.org.in

Table of contents

Acknowledgements .....

Executive Summary .....

1.0 Introduction 1

1.1 Review of Literature 4

1.2 Objectives of the study 7

1.3 Study Area 7

1.4 Methodology and Sampling 7

1.5 Analytical Framework 8

1.6 Output 8

2.0 Findings from User Interviews 10

2.1 Awareness of / Access to ICDS scheme 14

2.2 Quality and Usage of services 15

2.2.1 Supplementary nutrition 15

2.2.2 Immunisation 16

2.2.3 Referral services 16

2.2.4 Health checkups 16

2.2.5 Nutrition and Health Education 17

2.2.6 Non-formal pre-school education 18

2.3 Problem incidence and resolution 18

2.4 Satisfaction with services under ICDS programme 19

2.5 Suggestions for improvement 22

3.0 Findings from Interviews of Anganwadi workers and ANMs 23

3.1 Work of an Anganwadi Worker (AWW) 24

3.1.1 Nature of services 24

3.1.2 Service Reach 25

3.1.3 Quantity and quality of services 25

3.2 Support Services 27

3.3 Problem incidence and resolution 28

3.4 Suggestions and Improvements 29

4.0 Service Delivery Index (SDI) 30

5.0 Conclusions and Recommendations 35

5.1 Conclusions 36

5.2 Recommendations 38

References 39

Annexure-I 40

List of Figures

Figure 1: State- wise occupation details of respondents (in per cent) 11
Figure 2: State- wise education details of respondents (in per cent) 11
Figure 3: State- wise annual household income details (in per cent) 12
Figure 4: State- wise household ration card details (in per cent) 13
Figure 5: State - wise details of food items given under the supplementary nutrition component of ICDS (in per cent) 15
Figure 6: Usefulness of nutrition and health education services under ICDS (in per cent) 17
Figure 7: State -wise satisfaction levels of respondents on infrastructure of Anganwadi centres 19
Figure 8: State -wise satisfaction levels of respondents with supplementary nutrition under ICDS 19
Figure 9: State -wise satisfaction levels of respondents with immunisation under ICDS 20
Figure 10: State -wise satisfaction levels of respondents with health check-ups under ICDS 20
Figure 11: State -wise satisfaction levels of respondents with nutrition and health education under ICDS 21
Figure 12: State -wise satisfaction levels of respondents with non-formal pre-school education under ICDS 21
Figure 13: Overall satisfaction with ICDS 22
Figure 14: Regular services of AWW at the AWC (in per cent) 24
Figure 15: Reach of AWC services to beneficiaries (in per cent) 25
Figure 16: Quantity of services in AWCs 25
Figure 17: Quality of services at AWCs 26
Figure 18: Activities of the AWC where the committee members actively involve (in per cent) 27
Figure 19: AWWs satisfied with support received 28
Figure 20: Satisfaction levels of AWWs with their job at AWC 28
Figure 21: Changes in quality of service delivery at AWC 29
Figure 22: Suggestions from AWWs for improvement of services at AWCs (in per cent) 29

List of Tables

Table 1: Household asset details (in per cent) 20
Table 2: Household Livestock details 20
Table 3: Type of vaccines received under Immunisation services 23
Table 4: Type of vaccines received under health check-up services 23
Table 5: Service delivery Index 44
Table 6: Indicators selected dimension/ service-wise 45

Acknowledgements

We are indebted to many individuals and organisations that helped us to complete this study successfully. We take this opportunity to place on record our gratitude to them, particularly:

We would like to thank Dr. W. R. Reddy, IAS, Director General, NIRDPR for his valuable guidance and support for this study. We would like to express our sincere thanks to the Ministry of Women and Child Welfare, GoI, New Delhi, especially in three States (Rajasthan, Madhya Pradesh and Karnataka).

We deliver our great thanks to the officers, (CEO's) of Zilla Panchayats for extending field support and arrangement for data collection in respective State. We would like to thank all the interviewed ICDS beneficiaries as well as department personnel in respective States who gave their time and shared experiences with us and providing us with information that helped us to the study.

Our sincere thanks to Dr. S. V. Rangacharyulu, Consultant, NIRDPR, who supported in the preparation of Service Delivery Index (SDI) chapter.

Our sincere thanks to the data enumerators representing different NGOs in the field for excellent support in data collection across all the States for timely and smooth data collection process.

We, the study team deliver sincere thanks to project staff Ms. Sunitha and Shri M. Parandham at NIRDPR for their rigorous data field monitoring and data entry.

While we are indebted to the individuals mentioned above for their contribution, we authors are solely responsible for the opinion expressed and any errors therein.

Authors

Dr. C. Dheeraja

Dr. K. Prabhakar

Executive Summary

ICDS is one of India's flagship programmes targeted towards providing nutrition to eradicate malnutrition in children below six years of age. It is in existence since 1975 and has proved to be one of the important social development programmes in the country.

The present study is proposed to assess the quality and accessibility of services provided under ICDS program.

The objectives of the study are

1. To obtain feedback from parents and their children on the quality of services delivered in terms of accessibility, reliability and satisfaction

2. To obtain feedback from Anganwadi Worker (AWW)/Anganwadi Helper (AWH) on their assessment of the quality of services they provide in view of the training imparted to them, the infrastructure and support services provided to them

3. To assess the Anganwadi Centre (AWC) in terms of adequacy and quality of infrastructure provided and their utilisation

4. To assess the services delivered to the number of target children with special reference to equity

5. To suggest measures to improve the initiatives in the direction of achieving the goal of ICDS

The study was conducted in three States based on the performance of ICDS – Karnataka, Madhya Pradesh and Rajasthan. The study was conducted in five Gram Panchayats of each State. In each Gram Panchayat (GP), cent per cent Anganwadi centres were selected. Sample comprised of lactating mothers, expectant mothers and children aged 0 to 3 years. Based on the number of beneficiaries the sample was fixed as 250 per State.

Survey instruments included interviews with officials implementing ICDS and beneficiaries (pregnant and lactating mothers, children up to three years) applying Citizen Report Card approach. Statistical and Qualitative techniques (percentages and cross-tabs) were used to analyse the data to understand the aspects involved in delivering the required services under ICDS, the constraints faced and the outcomes. **Service Delivery Index (SDI)** was also developed. Content analysis was used to analyse the opinions, perceptions and satisfaction levels

of the stakeholders at different levels.

Major findings

Awareness of / Access to ICDS scheme

Most respondents are aware of the various services available under the ICDS programme. Among various services availed at the anganwadi Centre, supplementary nutrition, immunisation and health check-ups topped the list with maximum number of respondents availing these services under the ICDS programme. The least availed service was Referral service.

Quality of services

Type of food received under the programme varied from State to State. The quality of the food supplied is rated high across the three States. Immunisation was another most availed service under ICDS across the three States. Both pregnant women and children have availed these services at the anganwadi centres.

Non-formal education for both health and nutrition was widely availed by the users. There is some variation seen in terms of user opinion on the usefulness of the education programme. Many users from Karnataka have not found this very useful in contrast to the opinions of users from other two States.

The service reach has been far from what is required. Many beneficiaries are not covered under the programme. The reason is not known however for this gap as reported by the anganwadi workers.

Problem Incidence and Resolution

It is delighting to note that the reporting of problem incidence is very negligible in all three States.

Satisfaction with the services

Though the overall satisfaction reported by the users with regard to ICDS services has been good, among the three States, the complete satisfaction reported by users across various service parameters is generally low as compared to Madhya Pradesh and Rajasthan.

The sense of being able to serve children is one of the main motivating factors that keep the Anganwadi workers going in spite of various tasks they are required to do in their daily job.

Conclusion and Recommendations

The ICDS programme is being implemented well in the study area. The quality and quantity of services given are adequate. Most users are happy with the services received. The anganwadi workers are happy discharging their duties and have reported getting adequate support from users, peers and superiors. The satisfaction levels with the service delivery are encouraging. With some amendments this programme can be made more successful and the set objectives can be achieved without much difficulty.

Some of the steps that can be taken towards improving the service and taking it to the next level are:

- Since Referral services are least availed, efforts must be made to build awareness among users about the availability and procedure to avail this service extended under the ICDS programme
- Essential infrastructure needs of the anganwadi centres have to be met such as electricity, water and toilet facilities
- Obtaining feedback from the current and past users of nutritional education service to understand the gaps in actual content and ease in understanding the content to enrich the programme.

1. Introduction

1.0 Background

To counter the issues of under-five mortality, immunisation, underweight and malnutrition among the children, Integrated Child Development Service (ICDS) programme emerged in 1975 and became India's flagship nutrition programme. The ICDS aims at providing services to pre-school children in an integrated manner so as to ensure proper growth and development of children in rural, tribal and slum areas.

Goals and Policy framework of ICDS

- To reduce malnutrition in 0-6 year Children
- Reduction of children with low birth weight
- To reduce Infant Mortality Rate
- To reduce Maternal Mortality Rate
- To educate mothers about nutrition and health
- To reduce anaemia, Vitamin A deficiency and Iodine deficiency among the children below six years and mothers
- To improve the feeding practices
- To achieve the above goals Supplementary Nutrition Programme is provided to the Children from six months- six years, pregnant and lactating mothers.

To achieve the said goals, ICDS provides following Services:

1. Supplementary Nutrition Programme to pregnant and lactating women and children between seven months to 6 years
2. Immunisation
3. Health check-ups
4. Referral services
5. Health and nutrition education to children, women and adolescent girls
6. Non-formal pre-school education to children.

India's status on key child development and health indicators did not compare well with its own targets as well as with the neighbours and other regions. The Infant Mortality Rate (IMR) was 48 for 1000 live births and the Child Mortality Rate (CMR) was 63 for 1000 live births in 2010 as against the targets of 30 and 31 respectively.

Social accountability

In this context the present study is proposed to apply the Citizen Report Card method to assess the quality and accessibility of services provided under ICDS programme.

Social accountability refers to the various actions, tools and mechanisms that can be used by Civil Society Organisations (CSOs), the media, citizens and communities to hold elected public officials and non-elected public servants accountable. These tools complement and reinforce conventional modes and mechanisms of accountability, which include elections, political checks and balances, legal rules and processes and administrative regulations. The social accountability mechanisms, conventional and non-conventional, have increasingly come to play an important role in promoting good governance, development and social justice.

While the tools and methods of social accountability are diverse and varied, there are certain basic similarities. Common components include collection, analysis and dissemination of information, mobilisation of public support, advocacy and negotiation for change. Social accountability practices may also include enhancing citizen's knowledge regarding the conventional mechanisms of accountability and efforts to enhance citizen/ CSO participation in the 'internal' mechanisms of accountability (e.g., citizen involvement in public hearing and commissions). Social accountability mechanisms become extremely effective when institutionalised and linked to the various structures of governance and institutions involved in service delivery.

Participatory Performance Monitoring, one of the social accountability mechanisms, refers to the involvement of citizens, users of services, or civil society organisations in the monitoring and evaluation of service delivery and public works.

Participatory Performance Monitoring can make an important contribution to improving the quality of service delivery and reducing corruption and leakages in the system. Three commonly used methods of participatory performance monitoring are Citizen Report Cards, Community Score Cards and Social Audits.

Citizen Report Cards

Citizen Report Cards (CRCs) are participatory surveys that solicit user feedback on the performance of public services. CRCs can significantly enhance public accountability through the extensive media coverage and civil society advocacy that accompanies the process.

Citizen Report Cards are used in situations where demand side data, such as user perceptions on quality and satisfaction with public services is absent. By systematically gathering and disseminating public feedback, CRCs can check state-owned monopolies that lack the incentive to be as responsive as private enterprises to their clients' needs. They are a useful medium through which citizens can credibly and collectively 'signal' to agencies about their performance and advocate for change where necessary.

Citizen Report Cards have been used at the national and local levels in many projects:
Specific CRC methodologies may vary depending on the local context. **Following are some basic steps that apply to all CRC methodologies**:

1. Deciding on agencies/services to be evaluated
2. Identification of scope and key actors that will be involved
3. Design of questionnaires in a manner that is simple enough for ordinary citizens to understand
4. Careful demographic assessment to select the appropriate sample and size for survey
5. Raising awareness of the survey respondents to the process
6. Providing training to the individuals involved in conducting the survey
7. Analysing the data: compilation and analysis of the responses to survey questionnaires
8. Dissemination of findings with due consideration of the power relationships and political economy of the situation and,
9. Institutionalising the process of providing citizen feedback to service providers on a periodic basis. (Social Accountability Source Book, Chapter 3, Methods and Tools)

1.1 Review of Literature

In Philippines CRCs were conducted as a basis for performance based budget allocations to pro-poor services (World Bank 2001). In India, a cross-state comparison on access, use, reliability and satisfaction with public services was conducted using CRC (Paul, n.d.). An impact assessment of the use of CRCs in Bengaluru showed that as a result of the public attention received by the publication of the results of the survey, significant efforts were made at improving quality of services and infrastructure. There was an increase in satisfaction with services from 1993-94 to 1999. The percentage of users satisfied with services increased from 10.5 per cent to 40.1 per cent, while the percentage of dissatisfied users declined from 37.5 per cent to 17.9 per cent (World Bank 2005). In Ukraine, The World Bank funded People's

Voice Project has used CRCs to track local government quality of service delivery. (Monastyrski 2004).

CRC methodology was used by the Sirajganj Local Governance Development Fund in Bangladesh to assess the space for participatory governance at the local level. The CRC process brought together citizens, local government authorities and civil society organisations in public meetings where citizen assessments of local government performance in areas such as tax collecting, financing and accounting, public participation in budget process and project development were discussed. The report cards showed low levels of government responsiveness to citizen demands and needs. Annual CRCs have now been institutionalised by the local government and have resulted in a greater transparency and accountability, higher levels of citizen participation and improved services.

Transparency International in Bangladesh has used CRCs as a tool to fight corruption in the fields of health and education. More information can be found on pages 216-220 of Transparency International's 2001 Corruption Fighters Toolkit.

CRCs were used to assess national health services delivery in Uganda: A notable and pioneering public report card example is that from Uganda. The Yellow Star Programme, sponsored by the Ministry of Health in collaboration with donor organisations, evaluated health care facilities on a quarterly basis using 35 indicators. It compared providers within a specified region on a routine basis according to certain standards of quality performance. Indicators span technical and interpersonal domains and included standards for infrastructure, management systems, infection prevention, health education and interpersonal communication, clinical skills and client services. Ratings were made available in a general way to the community; facilities receiving a 100 per cent score for two consecutive quarters were awarded a yellow star, which is then posted prominently on the outside of each recognised facility for the community to see. A yellow star can be removed subsequently if performance falters.

In the Philippines, CRCs have been used as a basis for performance-based budget allocations to pro-poor services. The Filipino Report Card survey was conducted in spring 2000 by the World Bank in collaboration with Social Weather Stations (SWS), an independent survey research organisation in the Philippines.

The survey included 1,200 households distributed across four regions. The Report Card asked poor Filipinos about constraints they encountered in accessing public services, their views on the quality and adequacy of services, and the responsiveness of government

officials. In keeping with global best practice, the client satisfaction with Philippine public services was measured by comparing it with customer satisfaction with private sector services.

Through the Report Card, the Filipinos could voice their opinion and demand improvement in services meant to benefit the poor. The Report Card feedback revealed a high degree of dissatisfaction among the poor clients. The analysis of survey results provided insight into citizens' priorities and problems and raised the issue of how different services could better meet people's needs—especially the needs of the poor. The citizens now have the authority and control over the quality of services that they receive and through the Report Card they could express their satisfaction or hold the agencies accountable if they are not satisfied. To assure continuous improvement in service delivery to the citizens, the government is now keen on getting such feedback regularly and there is a felt need to institutionalise these report cards.

Ukraine People's Voice Project

The World Bank– funded People's Voice Project (PVP) was initiated in March 1999 as a pilot project in four Ukrainian cities, with the objective of improving the quality of public services through public participation. The project intended to induce integrity in government functioning and moderate the high level of corruption in governance that had led to poor service delivery. Non-Governmental Organisations (NGOs) in the form of citizens' groups conducted surveys, voiced demands, held discussions with public officials, and monitored the steps taken by the government toward enhancing service delivery. Capacity-building exercises were conducted for both the public officials and the NGOs so that they could work together effectively toward improving service delivery.

Citizen engagement mechanisms such as conferences, public hearings, media campaigns, and report cards empowered citizens to be a part of the project proceedings and thereby gain easy access to project-related information. These mechanisms also helped to induce transparency and promote accountability in government operations.

Twelve policy groups that were formed as a part of the capacity-building exercises for the public officials are in the process of developing policy documents in areas such as strategic planning, budgeting, human resource planning, and transportation. Initiatives such as the Education Reform Program, Communal Housing Program, and a gender audit have commenced in the pilot cities of the project. It may be too early to ascertain the impact of the

project in terms of building integrity and reducing corruption.

In Ethiopia, a pilot CRC was carried out covering water, health, sanitation, education, and agricultural extension services .

1.2 Objectives of the study

Using the CRC, an extensive assessment of the ICDS programme was done with following objectives:

- To obtain feedback from parents and their children on the quality of services delivered in terms of accessibility, reliability and satisfaction
- To obtain feedback from AWW/AWH on their assessment of the quality of services they provide in view of the trainings imparted to them, the infrastructure and support services provided to them
- To assess the AWC in terms of adequacy and quality of infrastructure provided and their utilisation.
- To suggest measures to improve the initiatives in the direction of achieving the goal of ICDS

1.3 Study Area

The study was conducted in three States based on the performance of ICDS. Planning commission has come out with Performance Index of ICDS taking into account the indicators like average number of days received SNP, percentage of children fully immunised, percentage of children able to write alphabets/words, percentage of women who reporting attended NHE meetings, percentage of mothers reporting seeking help from AWW when their child gets sick, percentage of mothers reporting received deworming tablets from AWC (Annexure-1). Thus the States identified are Karnataka (highest performance), Madhya Pradesh (moderate performance) and Rajasthan (lowest performance) districts, blocks and GPs were selected based on the same criteria.

1.4 Methodology and Sampling

The study was conducted in five GPs of each State. In each GP, cent percent anganwadi

centres were selected. Sample comprised of lactating mothers, expectant mothers and children aged 0 to three years. Based on the number of beneficiaries the sample was fixed as 250 per State.

Survey instruments included interviews with officials implementing ICDS and beneficiaries (pregnant and lactating mothers, children up to three years) applying Citizen Report Card approach and Focused Group Discussions (FGDs) with the non-beneficiaries. Information was collected through structured data collection instruments (questionnaires) on the quality, accessibility and reliability of the services delivered under ICDS, infrastructure and support services available to AWW/AWH to deliver the services, satisfaction levels of the beneficiaries and non-beneficiaries regarding the services delivered and overall performance of the anganwadi centres.

1.5 Analytical Framework

Statistical and qualitative techniques (percentages and cross-tabs) were used to analyse the data to understand the aspects involved in delivering the required services under ICDS, the constraints faced and the outcomes. Service Delivery Index (SDI) was developed. Content analysis was used to analyse the opinions, perceptions and satisfaction levels of the stakeholders at different levels.

1.6 Output

Study Report on the social accountability mechanisms and the application of Citizen Report Card Method in ICDS programme.

2.

Findings from User Interviews

2.0 Respondent profile

Occupation

Among the respondents, around 42 per cent were beneficiaries themselves while the remaining 58 per cent were family members of the beneficiaries. Overall, one-third of the respondents were non-agricultural labourers, 22 per cent were agricultural labourers, 10 per cent were self – employed. However there were some differences across the States. In Karnataka, 21 per cent were cultivators while only 7 per cent were non-agricultural labourers. In Rajasthan 65 per cent were non-agricultural labourers. The following chart gives State-wise details of the occupation of the respondents.

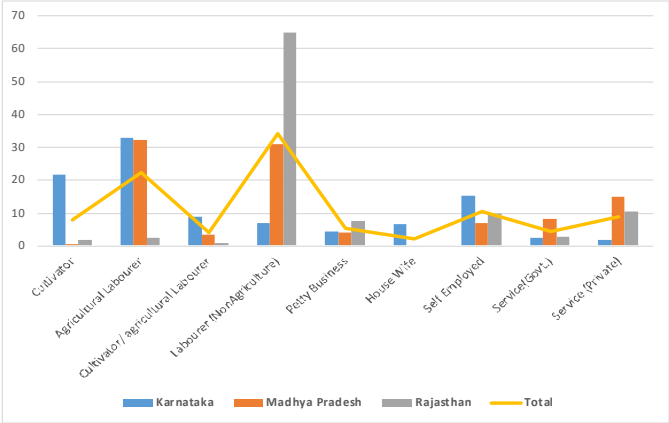


Figure 1: State- wise occupation details of respondents (in per cent)

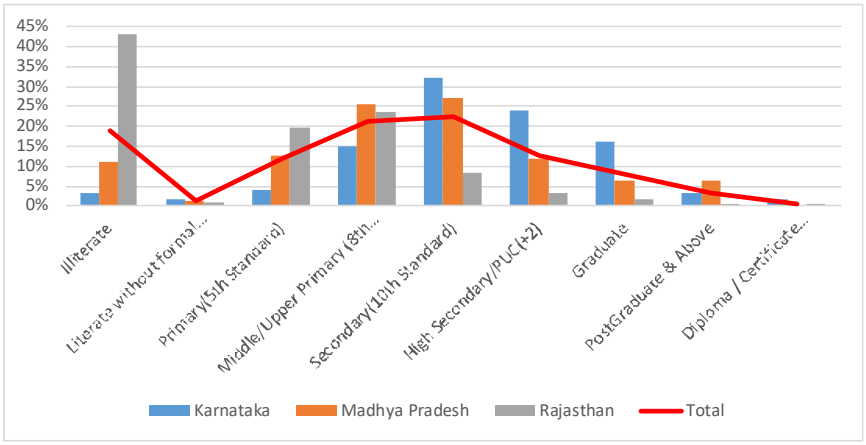


Figure 2: State- wise education details of respondents (in per cent)

Education

Nearly half of the respondents (47 per cent) were formally educated with secondary education or more. On an average 19 per cent were illiterates. However, the proportion of illiterate respondents was higher in Rajasthan (43 per cent) as compared to other States.

Karnataka had the highest literate respondents among the three States studied. The following graph gives State-wise details on the education of the respondents:

Annual Income of the household

More than one-third households in Karnataka (42 per cent) and Madhya Pradesh (33 per cent) had an annual household income which was less than Rs. 40,000. One–fourth of the respondent households in Karnataka had an annual income of more than Rs 1,00,000. The detailed breakup of household incomes of the respondent families across the three States and the average is shown in the graph below:

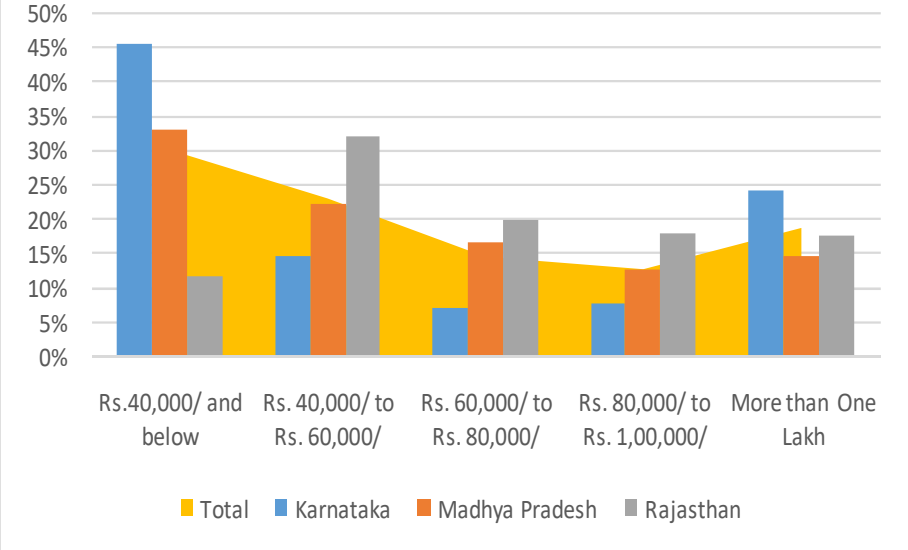


Figure 3: State- wise annual household income details (in per cent)

Ownership of house

More than 90 per cent of respondents in all the three States live in their own houses. However there is significant difference in the type of houses owned by them across States. While 42 per cent of the respondents in Madhya Pradesh lived in kutcha houses, 83 per cent of the respondents in Karnataka lived in semi-pucca houses. In Rajasthan, a majority of them (62 per cent) lived in pucca houses. More than 75 per cent respondents in all the three States had Ration Cards issued to their households. A majority of the households in Rajasthan had APL cards while households with BPL cards were found in majority in the other two States.

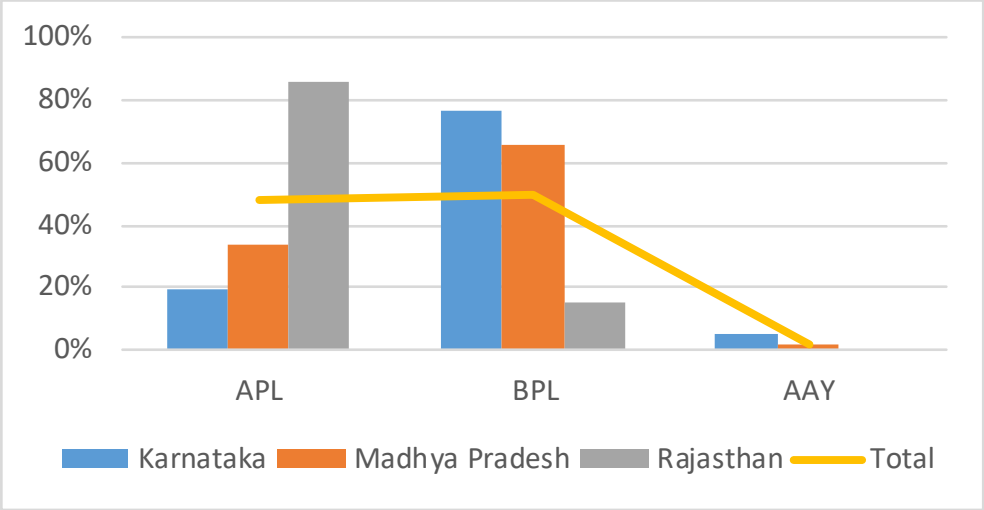


Figure 4: State- wise household ration card details (in per cent)

A majority of the households reported possessing Aadhaar and Voter ID cards (>90 per cent). Other forms of social IDs such as passports, PAN cards, etc., were found in very few households. A vast majority of them (98 per cent) reported that having Aadhaar was useful.

Table 1: Household asset details (in per cent)

Type of Asset	Karnataka	Madhya Pradesh	Rajasthan	Total
LPG	95	77	76	83
Electricity	100	96	87	94
Bicycle	25	34	28	29
Radio	4	6	12	7
Television	95	82	64	80
Cable connection	90	51	49	63
Two wheeler/Motor cycle/scooter	59	58	63	60
Four wheeler	18	6	9	11
Mobile Phone	98	94	88	93

Table 2: Household Livestock details

Type of Animal	Karnataka	Madhya Pradesh	Rajasthan	Total
Goat	0	1	28	10
Sheep	2		1	1
Cow/Bull/Buffaloes	38	58	39	45
Chicken/Fowl/Duck	2	0		1

In terms of landholding of the households, close to half of the respondents in Karnataka (57 per cent) and Rajasthan (42 per cent) reported positive where as 72 per cent in Rajasthan reported negative.

Debts and Savings

A majority of the households across states had bank accounts (97 per cent) and were using the accounts regularly for savings (84 per cent) and day to day transactions (36 per cent).

A majority of the households (73 per cent) in Madhya Pradesh and Rajasthan were debt free. In Karnataka 57 per cent households reported having debt. While banks were the main source of borrowing money for households in Karnataka and Madhya Pradesh, in Rajasthan, family and friends were reported as main sources.

2.1 Awareness of / Access to ICDS scheme

The main source of information about ICDS scheme for a vast majority (98 per cent) of the households across all States is anganwadi worker. More than 90 per cent respondents across States have availed many services under the scheme such as supplementary nutrition, immunisation and health check-ups. Around 80 per cent of them have also obtained nutrition & health education and less than 50 per cent have availed non formal Pre-School Education (PSE). The least used service under the ICDS programme is the referral service across States with negligible number of households accessing the service.

Among those who have availed the services, children below six years of age top the list with 70 per cent households availing the services, followed by nursing mothers (25 per cent) and pregnant women (21 per cent). Almost all respondents (99.5 per cent) who have availed the services have visited anganwadi centres to avail these services.

Respondents from different States had to travel different distances to reach the anganwadi centres to avail these benefits. In Madhya Pradesh, the centres were close to the houses of a vast majority of them, 92 per cent reported travelling a distance of less than or equal to 100 metres from their houses to reach anganwadi centres. In Karnataka 35 per cent of them had to travel more than 500 metres to receive the same. In Rajasthan however, it was a mix with 58 per cent travelling less than 100 metres and the remaining travelling more. All respondents (100 per cent) have reported the presence of anganwadi worker at the time of

their visit to the centre.

2.2 Quality and Usage of services

The following section details the experiences of the respondents in availing various services offered under the ICDS programme.

2.2.1 Supplementary nutrition

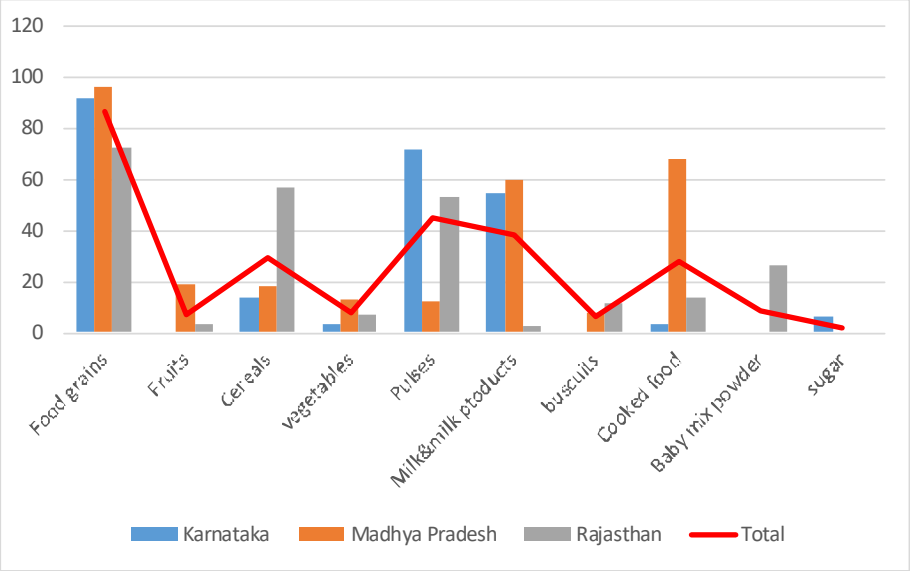


Figure 5: State - wise details of food items given under the supplementary nutrition component of ICDS (in per cent)

All respondents from all the three States have availed the supplementary nutrition services under the ICDS programme. Among various categories offered, food for child for up to six years (72 per cent), food for lactating mothers (25 per cent) and food for pregnant women (21 per cent) were the popular ones in the same order across States.

Type of food received under the programme varied across States. In Karnataka, food grains, pulses, milk and milk products were the most popular forms of food supplied under the programme. In Madhya Pradesh, food grains, milk and milk products were popular too, but along with that cooked food was also popular. In Rajasthan, however, cereals were popular along with food grains and pulses. Milk and milk products were not popular like in the other two States.

Table 3: Type of vaccines received under Immunisation services

	Karnataka	Madhya Pradesh	Rajasthan	Total
Poliomyelitis Vaccine	82 %	92 %	86%	87%
Diphtheria Vaccine	80%	76%	72%	76%
Pertussis Vaccine	80%	87%	78%	82%
Tetanus Vaccine	85%	68%	80%	78%
Tuberculosis Vaccine	23%	37%	34%	31%
Measles Vaccine	54%	46%	34%	45%

The quality of the food supplied is rated high with more than 90 per cent respondents across States reporting that the quality of food is good.

2.2.2 Immunisation

More than 90 per cent respondent across all the States have reported availing immunisation services from the centres under the ICDS programme. Here again this service was obtained for children below the age of six years by 60 per cent households in all the three States. Less than 20 per cent have obtained immunisation service for pregnant women in their households. The remaining have obtained services for both children as well as pregnant women.

Among the various vaccines given under the programme, the vaccine for tuberculosis has been availed by the least number of respondents.

A majority of those who have availed the immunisation services (80 per cent) have taken the vaccines at the anganwadi centres across the States. Most of them (97 per cent) have received immunisation free of cost.

2.2.3 Referral services

Referral service is the least used service under the ICDS programme. The responses were negligible hence not reported.

2.2.4 Health checkups

More than 80 per cent households in all the States have got health check-ups done under the ICDS programme. Among several kinds of check-ups availed, immunisation tops the list

Table 4: Type of vaccines received under health check-up services

Type of service	Karnataka	Madhya Pradesh	Rajasthan	Total
Immunization	88	82	85	85
Record of Weight and height of children at periodical intervals	74	74	75	75
General checkup for detection of disease	47	62	64	58
Deworming	13	14	12	13
Watch over milestones	21	3	12	12
Treatment of disease like diarrhea, ARI	5	2	24	10
Prophylaxis against vitamin A deficiency and anemia	7	1	22	10
Referral of serious cases	0	1	4	2

followed by entering of height and weight of children into the record. The least used service is the referral service for serious cases. A majority of them have availed these services free of cost (88 per cent). The following table gives a State-wise break up of various kinds of health check-up services availed by households.

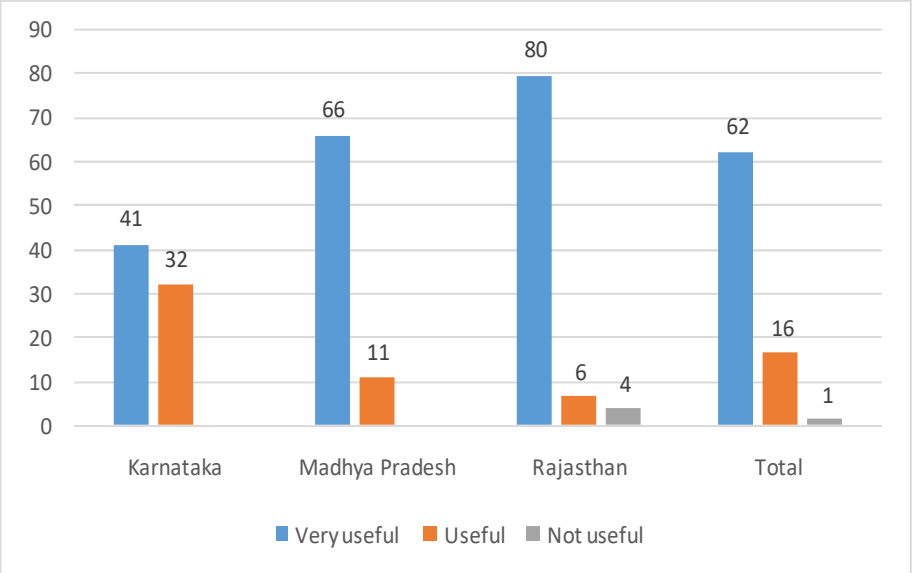


Figure 6: Usefulness of nutrition and health education services under ICDS (in per cent)

2.2.5 Nutrition and Health Education

At least 80 per cent respondents across all States have received nutrition and health education services under the ICDS programme. Most of them (68 per cent) have received non

-formal education for both health and nutrition. It is mostly the mother in the house who has received this education across States (60 per cent).

In terms of usefulness of this education there is varied opinion among the respondents from the three States. In Karnataka only 41 per cent find it useful as against Rajasthan where 80 per cent find it useful. Many respondents in Maharashtra also find the education useful (66 per cent).

2.2.6 Non-formal pre-school education

Less than half of the respondents across all the three States have availed non-formal pre-school education service under the ICDS. Half of those who have received the service have reported that under the programme, children are given toys and are taught to sing and play games. These services are given free of cost as reported by the respondents in all the three States.

2.3 Problem incidence and resolution

Around 44 per cent of the respondents have not noticed the existence of a complaint box to lodge their complaints at the anganwadi centres. Among the remaining who have observed, 32 per cent have reported that there is no complaint box at the centres. In Rajasthan, this number is high with 62 per cent reporting that there is no complaint box.

Close to half of the respondents (47 per cent) have not noticed the display of contact numbers of officers for lodging complaints. However, among those who have noticed, 44 per cent in Rajasthan, 22 per cent in Karnataka and 14 per cent in Madhya Pradesh have reported that the numbers of officers are not displayed at the centres.

A vast majority of the respondents (>98 per cent) across the States have not reported on facing any problems related to ICDS services in the past one year.

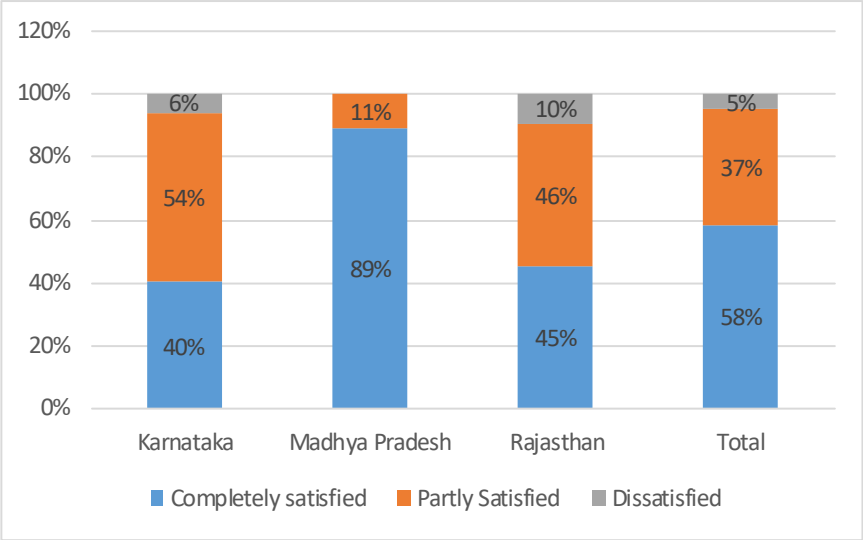


Figure 7: State -wise satisfaction levels of respondents on infrastructure of anganwadi centres

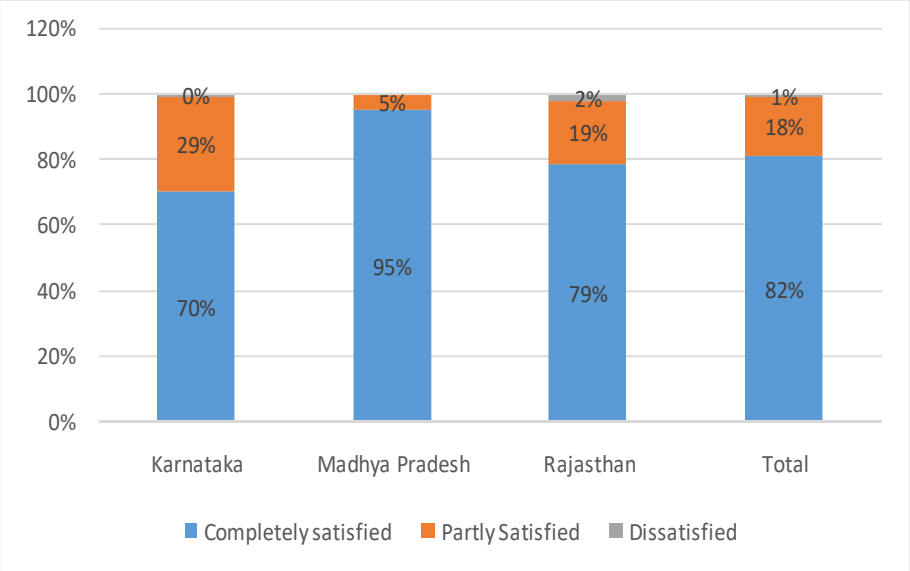


Figure 8: State -wise satisfaction levels of respondents with supplementary nutrition under ICDS

2.4 Satisfaction with services under ICDS programme

Respondents were asked to rate their satisfaction levels on various services availed by them under the ICDS programme. The responses have been varying on different services among the States.

Infrastructure

Among the three States, a majority of the respondents in Madhya Pradesh are completely satisfied with the infrastructure at the anganwadi centre.

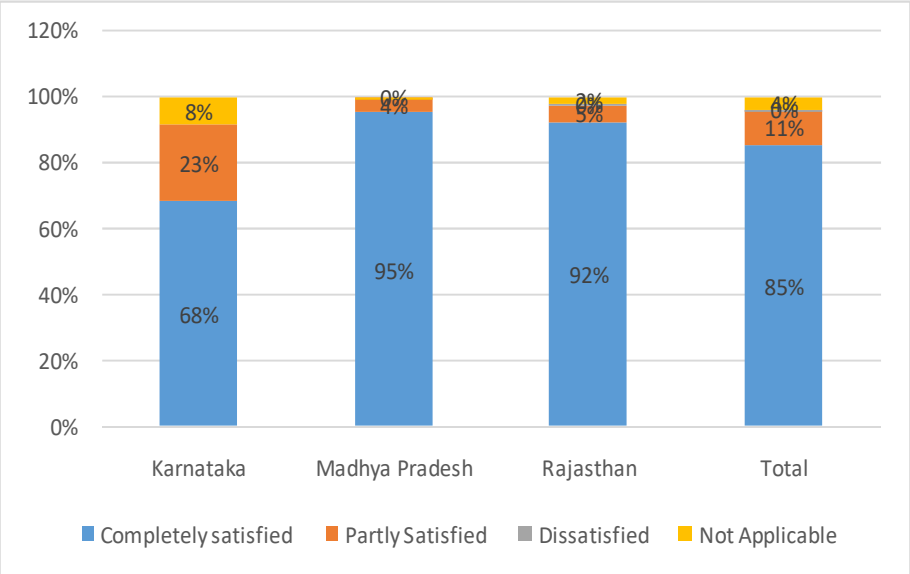


Figure 9: State -wise satisfaction levels of respondents with immunisation under ICDS

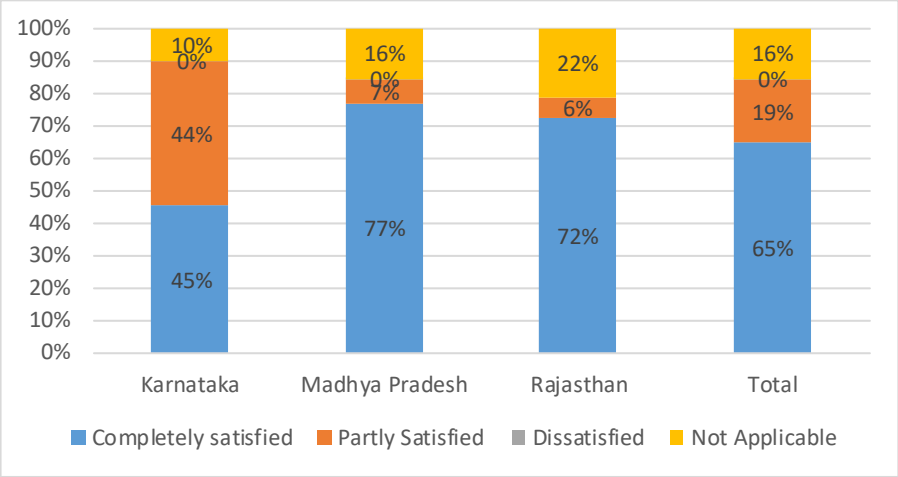


Figure 10: State -wise satisfaction levels of respondents with health check-ups under ICDS

Supplementary nutrition

Among the three States, a majority of the respondents in Madhya Pradesh are completely satisfied with the supplementary nutrition at the anganwadi centre.

Immunisation

More than 90 per cent respondents in Madhya Pradesh and Rajasthan are completely satisfied with the immunisation service under ICDS. In Karnataka, however, there is a decrease in the number of respondents who are completely satisfied with immunisation with 68 per cent reporting complete satisfaction.

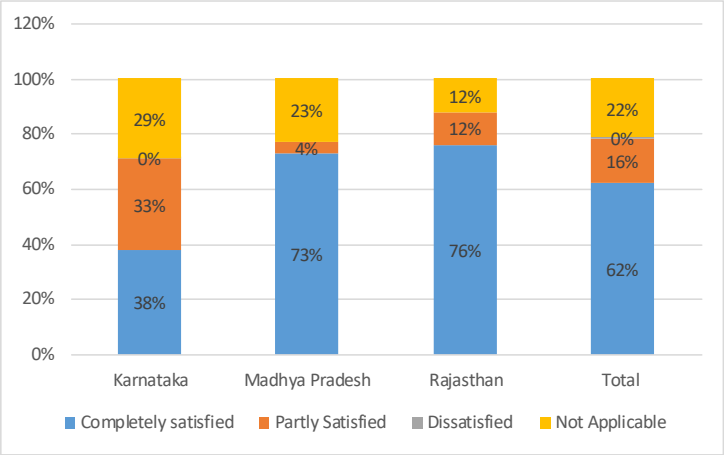


Figure 11: State -wise satisfaction levels of respondents with nutrition and health education under ICDS

Health Check-ups

Less than half of the respondents in Karnataka are completely satisfied with the health check – up service under ICDS as against more than 70 per cent in Madhya Pradesh and Rajasthan.

Nutrition and health education services

Only one-third of the respondents from Karnataka are completely satisfied with the nutrition and health education services offered under the ICDS programme. An equal proportion of respondents from Karnataka are partially satisfied with the service indicating scope for improvement.

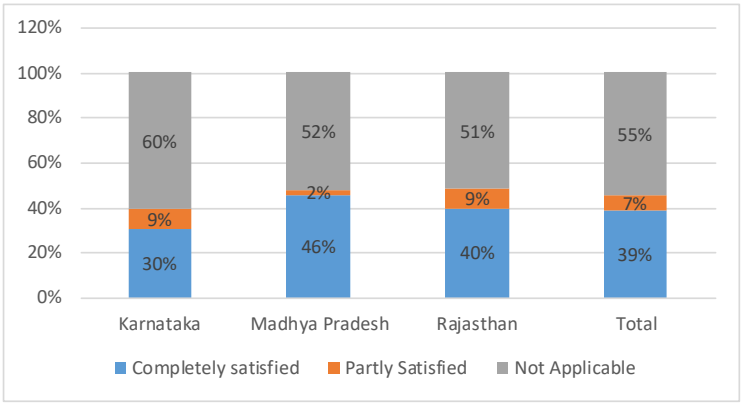


Figure 12: State -wise satisfaction levels of respondents with non-formal pre-school education under ICDS

Non-formal pre-school education

None of the respondents from the three States were dissatisfied with the non-formal pre-school education offered under the ICDS.

Overall satisfaction with ICDS programme

More than seven per cent respondents across the States reported complete satisfaction with regard to the various services offered at the anganwadi centres under ICDS programme.

Madhya Pradesh reported highest level of complete satisfaction (86 per cent) among the three States with none of the respondents reporting dissatisfaction with services.

Two main reasons given for dissatisfaction with services were lack of regularity in conducting health check – ups (20 per cent) and lack of infrastructure facilities like electricity (45 per cent).

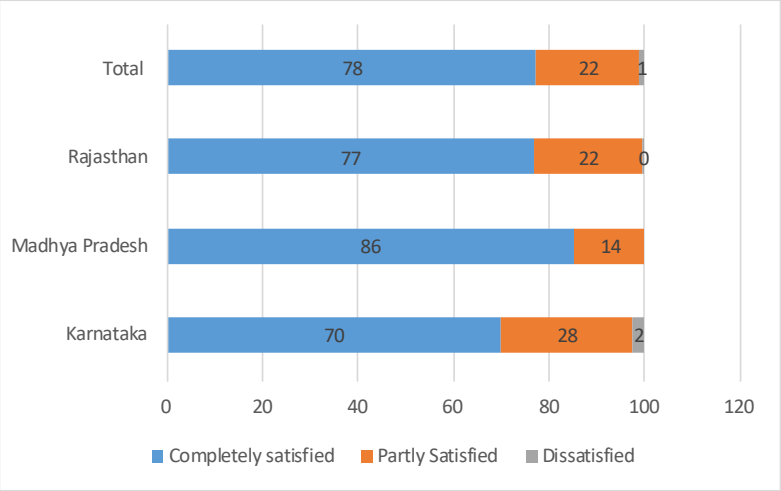


Figure 13: Overall satisfaction with ICDS

2.5 Suggestions for improvement

Since complete satisfaction on various services under ICDS was not 100 per cent, this only reflected to show that there is definitely scope for improvement. Many suggestions were given by the respondents to change their partial satisfaction to complete satisfaction. These included infrastructure facilities like providing water supply and electricity (10 per cent), building and playground (7 per cent); quality improvement measures like improving the supplementary nutrition (21 per cent), making health check – ups more regular (7 per cent); increasing awareness building activities about the ICDS services (15 per cent) etc.

3.
Findings from Interviews of Anganwadi Workers and ANMs

3.0 Anganwadi Worker Profile

A total of 48 anganwadi workers were interviewed to get their feedback on the ICDS programme. All respondents were females. Among them 35 per cent were 10th pass, 21 per cent were graduates with degrees, 12.5 per cent were post graduates. Around 52 per cent of them have been working at the anganwadi centre (AWC) for 16-26 years and another 48 per cent for <=15 years.

3.1 Work of an Anganwadi Worker (AWW)

3.1.1 Nature of services

On a normal day, the AWW's duties include providing supplementary nutrition, immunisation, referral services, health check-ups, nutrition and health education, non-formal pre-school education, regular house visits, advice on breast feeding and family planning, promoting institutional delivery, awareness building about various health schemes and advice on food and diet. The workers have reported that some of these duties are performed on a daily basis while some others are performed on need basis. The following chart gives the frequency at which these duties are performed by the AWW:

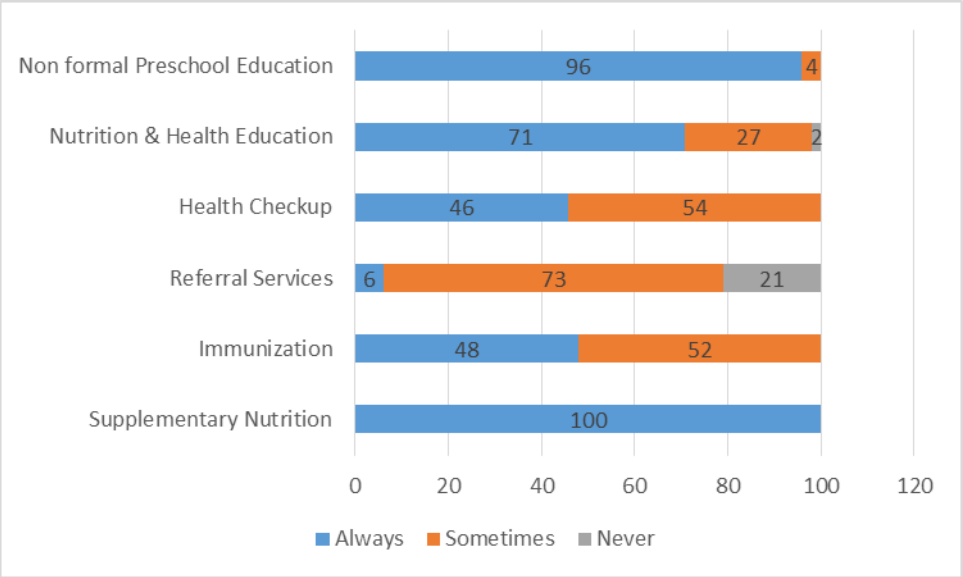


Figure 14: Regular services of AWW at the AWC (in per cent)

It is clear from Fig. 1 that providing supplementary nutrition and non-formal pre-school education is being given by AWW on a daily basis.

3.1.2 Service Reach

When AWW were asked about the reach of the AWC services, it was clearly seen that the reach of the service irrespective of the type (daily or need based) has been less than required. All eligible beneficiaries have not received the respective services from the centre. The following chart (fig.2) gives a detailed picture on the same:

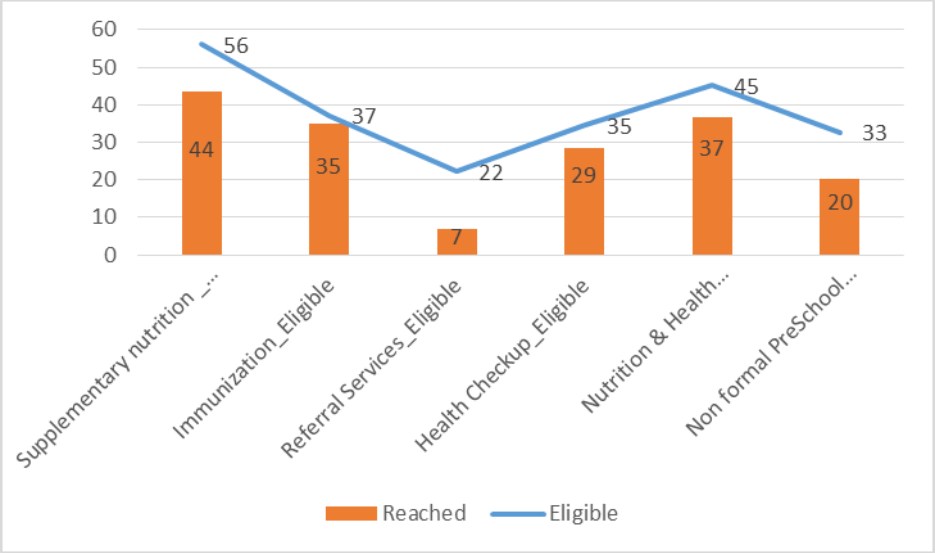
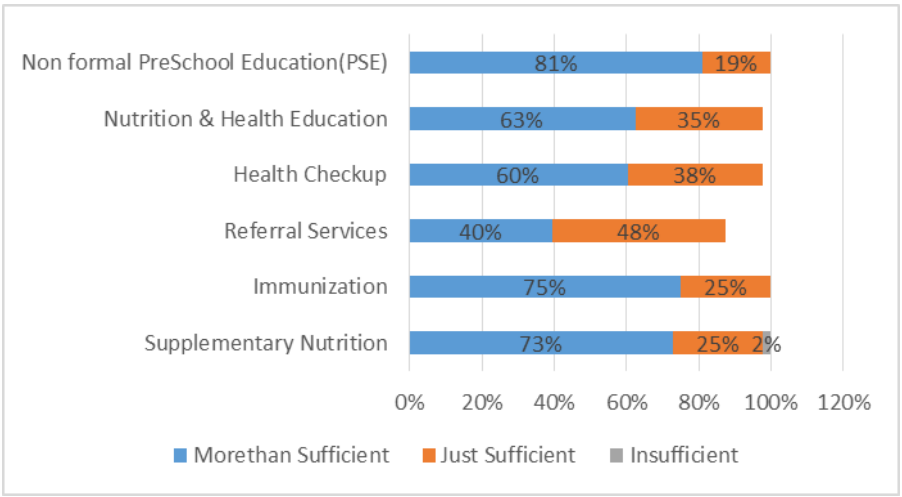


Figure 15: Reach of AWC services to beneficiaries (in per cent)

3.1.3 Quantity and quality of services

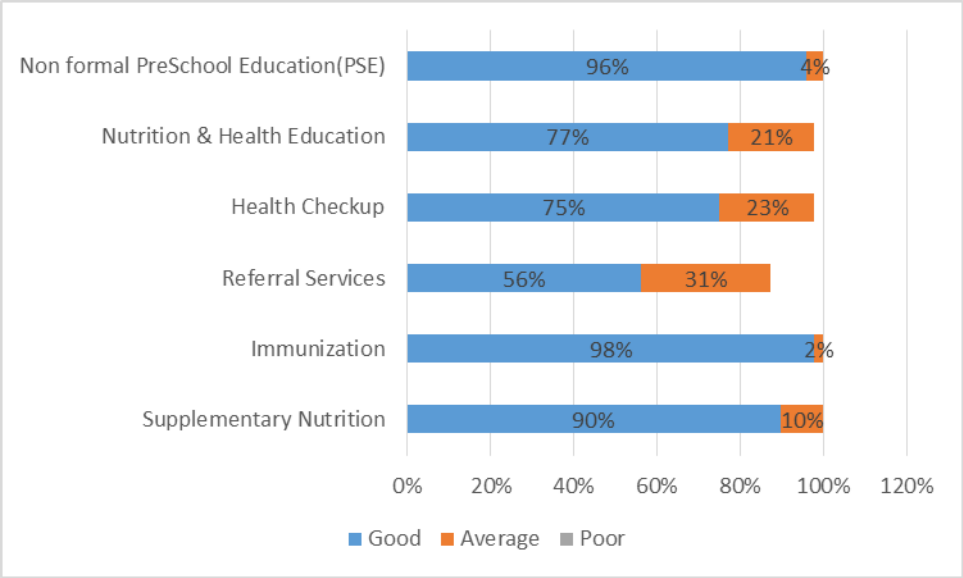
In their opinion, a majority of the AWWs have reported that most of the services available are more than sufficient.



Note: Some of the responses do not add up to 100 per cent

Figure 16: Quantity of services in AWCs

Similarly, most of the services offered are of good quality in their opinion as reported by a majority of the AWWs. Figures 3 and 4 share specific responses of the AWWs.



Note: Some of the responses do not add up to 100 per cent

Figure 17: Quality of services at AWCs

Three quarter (75 per cent) of the AWWs reported making field trips on a weekly basis. For a majority of them (75 per cent) the number of households that they had had to visit was <500 in their field area. Close to 83 per cent reported that there is always only one AWW at the AWC at any given time. A majority of the AWWs reported that they were expected to play multiple roles in their job that included advisory, supervisory, administrative, medical, counselling and building awareness.

The reasons for taking this job varied from person to person. However, for many (41 per cent) it was serving children, for a few others (15 per cent) it was social service, for around 20 per cent of them it meant a regular source of income to their family (salary).

AWWs recollect several achievements in their work life. Top on the list is a certificate of good work reported by (54 per cent), the respect they earn in the society and the fact that they are a part of the awareness building and capacity development activity (16 per cent). They also have received appreciation for good work from beneficiaries (44 per cent), they encourage the AWWs to continue their good work (48 per cent) and some of them (8 per cent) have also given donations to improve the AWC.

3.2 Support Services

A majority of them (98 per cent) reported getting regular trainings required to perform their duties. A majority of them (96 per cent) have also reported that they are handheld by their supervisors in their work. In terms of infrastructure availability like own building, drinking water, toilets and play area, etc., 63 per cent have reported positive while the remaining 37 per cent reported negative.

Teaching materials provided was sufficient for 71 per cent AWWs while it was insufficient for the remaining 29 per cent of them. Fund support is regular as reported by 80 per cent of AWWs.

Many of the AWWs (85 per cent) are aware of the existence of Anganwadi Level Monitoring Committees (ALMC). Majority of the members (98 per cent) of the committee get involved in the AWC activities as reported by the AWWs.

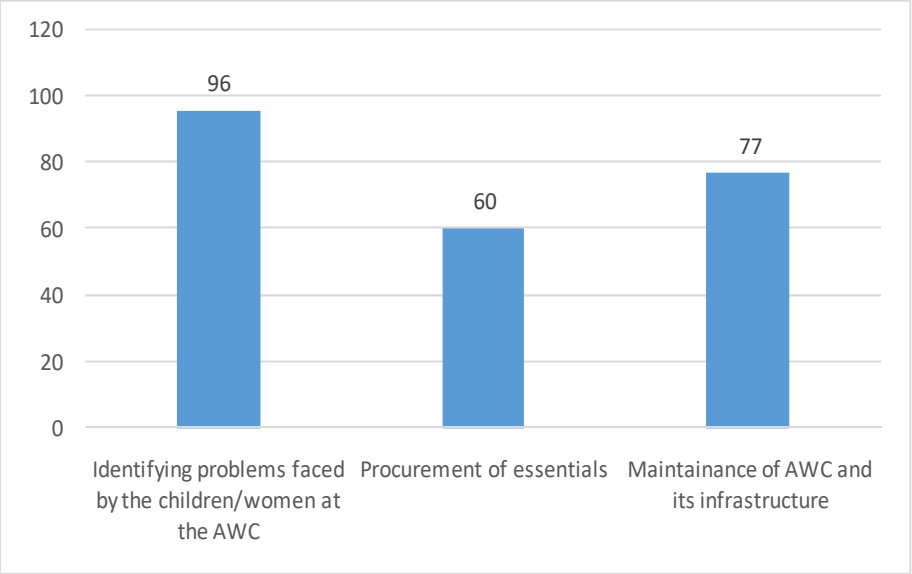


Figure 18: Activities of the AWC where the committee members actively involve (in per cent)

More than 90 per cent AWWs have reported that they get the required support from Villagers and coordinating departments like health department in carrying out their activities at the centre. Most of them are satisfied with the support they get from department officials, superiors and peers.

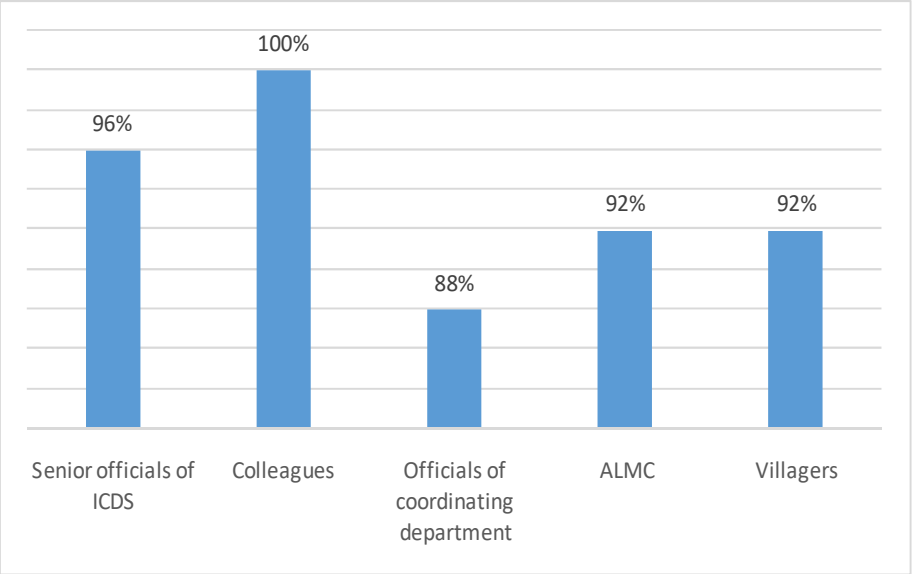


Figure 19: AWWs satisfied with support received

3.3 Problem incidence and resolution

When asked if the AWWs faced any problem in discharging their duties, everyone (100 per cent) have reported negative. There was NO problem incidence reported.

Satisfaction

All respondents (100 per cent) have reported that they are satisfied with their job at the AWC. Among them 73 per cent are fully satisfied while the remaining 27 per cent are partially satisfied with their job at the anganwadi centre.

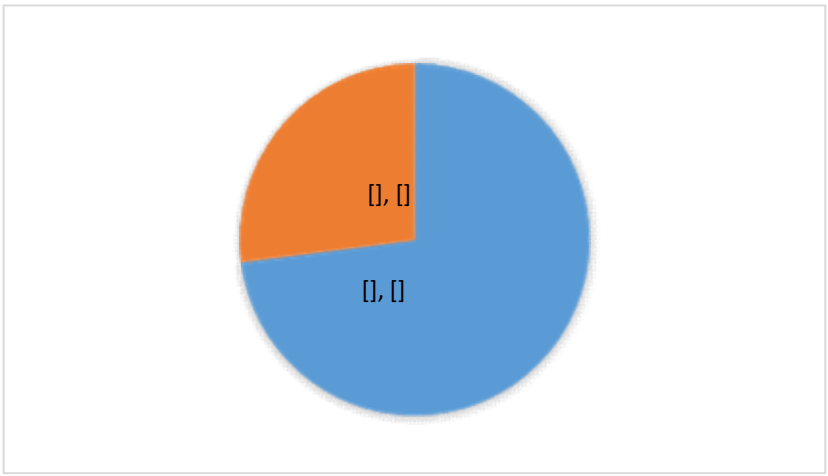


Figure 20: Satisfaction levels of AWWs with their job at AWC

3.4 Suggestions and Improvements

Around 71 per cent AWWs reported observing changes in the quality of services provided at the AWCs in the last two years. The nature of changes observed include increased awareness among the villagers, increase in enrolment of children, improved quality of educated imparted to children. Improvements in building infrastructure, supply and quality of food, transparency in functioning is also reported by some of the AWWs.

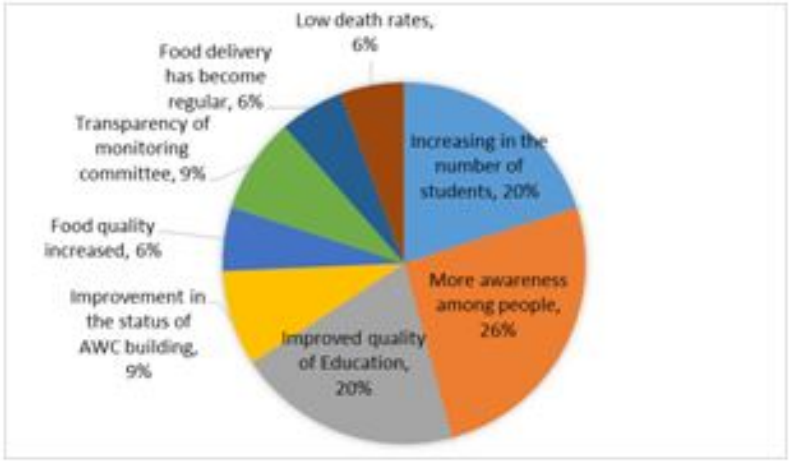


Figure 21: Changes in quality of service delivery at AWC

AWWs have been forth coming in making some very relevant suggestions, if implemented can improve the functioning of the AWCs significantly. One of the most important and pertinent suggestion made is making provisions for toilets (26 per cent). Some of the centres reported the need for water supply while some others suggested provision of more play materials and playground facility.

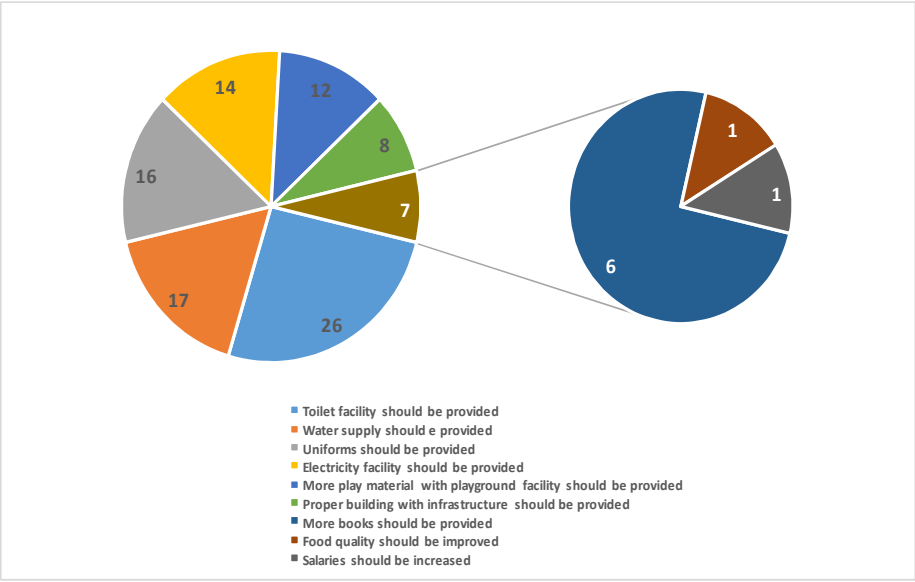


Figure 22: Suggestions from AWWs for improvement of services at AWCs (in per cent)

4
Service Delivery Index (SDI)

4.1 Service Delivery Index (SDI)

It has become critical to assess the current levels of service delivery experienced by the population, as there is great demand for right to qualitative service delivery. An understanding of the strengths and weaknesses in ICDS structures comes with many benefits. It highlights the actual shortcomings in service delivery which can then be addressed appropriately. It also provides a benchmark to assess the future performance of ICDS on the need to strengthen anganwadi centres and reinforce a culture of service delivery at all levels.

The service delivery framework, of late, has undergone a change where a need was felt that service delivery should be measured in a holistic and comprehensive way. Thus in the present study, Service Delivery Index (SDI) was calculated for better understanding and improving performance of ICDS.

There are a variety of indexes that are developed to measure various concepts. After the introduction of Physical Quality of Life Index (PQLI), the UNDP has come out with multiple indexes for measuring various concepts and they are Human Poverty Index, Gender Development Index, Gender Empowerment Measure, Multi-dimensional Poverty Index besides Human Development Index. However, some of these measures have been criticised for poor data availability, the underlying concept of indicator being not uniform across various spatial units (like literacy, there are varying definitions across different countries), incorrect choice of indicators and so on.

An index is a measure that combines a set of indicators to provide an assessment of various concepts like accessibility, cost, quality and frequency, etc. An indicator points towards a broad direction of movement of the index and a good indicator should possess important properties that include relevance, uniqueness, sensitivity, feasibility and stability. The indicators that constitute Service Delivery Index include services to be provided mandatorily by the concerned agency and the sub components of it.

Thus an index is constructed based on a set of indicators which are assigned different weights depending upon their relative importance. The formula used for construction of index provides some limits for the index which will enable us to go in for comparison of various spatial units for a given point of time.

The objective of this exercise is to arrive at Service Delivery Index (SDI) for each one of the anganwadi centres in the study area covering Karnataka, Madhya Pradesh and Rajasthan.

For computing such an index, besides the selection of indicators, the method adopted is also equally important. As regards the first aspect, six services are considered and they are

i) Immunisation ii) Supplementary nutrition programme to pregnant and lactating mothers and children between seven-months to six-years iii) Non-formal pre-school education iv) Health check-ups V) referral services and lastly Vi) Health and Nutritional Education to children, women and adolescent girls. Each dimension is broken down into indicators mainly in terms of awareness about the service, accessibility to the service, quality of the service and cost paid to avail the service and in all it ended up with 18 indicators across the six dimensions and the choice for selection of the indicators is mostly determined by the relevance and availability of data. The actual list of indicators under each of the dimensions is given in Table 6.

Having decided about the indicators that constitute the dimensions, the next issue is with reference to the selection of method for working out the Service Delivery Index (SDI). The simplest of all methods is simple ranking method where each anganwadi centre is given a rank on each indicator and later, an overall rank is arrived at by aggregating indicator-wise ranks. This is said to be the simplest as it does not pose any restrictions on the values of the indicators (like normality of the values). Slightly complex methods are available which can be applied only when the assumptions that underlie the method are fulfilled and one such method is "Factor Analysis or Principal Components Approach (a)".

As seen from Table 6, some of the indicators chosen for the exercise do not conform to normality and therefore the approach followed in papers referred to above cannot be adopted. As an alternative, the method suggested by 'Iyengar and Sudarshan (1982) in their paper 'On a method of classifying regions from multivariate data, Regional Dimensions of India's Economic Development, Proceedings of seminar held at Nainital is followed. This method can be applied even when some indicators do not follow normality.

Thus the methodology adopted is given below

Let x_{id} represent the size or value of the i-th indicator (i=1,2,…m) in the d-th Anganwadi center (GP)(d=1,2,3,,…n say)of Karnataka, Madhya Pradesh and Rajasthan. Let us write:

$Y_{id}=X_{id}$-Min X_{id}/ Max X_{id}- Min X_{id}

Where Min X_{id} and Min X_{id} are minimum and maximum values of ($x_{i1},x_{i2},x_{i3}\ldots\ldots x_{in}$).if however, x_I is negatively associated ,then y_{id} will be written as

Y_{id}=Max X_{id}-X_{id}/ Max X_{id}- Min X_{id}

Obviously, the scaled values are Y_{id} vary from 0 to 1 the matrix of scaled values, y= ((Y_{id})),we may construct a measure for the services delivered by different anganwadi centres as follows:

$Y_{id}=W_1 Y_{1d}+ w_2 Y_{2d}+ W_3 Y_{3d}+\ldots\ldots\ldots\ldots\ldots+W_m Y_{md}$

Where W's are $0<W_1<1$ and $W_1 + w_2 + W_3+\ldots\ldots\ldots\ldots+W_m=1$ arbitrary weights reflecting the relative importance of individual indicators.

A special case of this when the weights are assumed to be equal for different indicators.

However, a more rational view would be to assume unequal weights for different indicators and they vary inversely as the variation in the respective indicators of devolution/ development. Here, we shall assume.

$W_{i=}K/\sqrt{var}(Y_I)$

Where $k[\sum_{i=1}^{m}\sqrt{var}\ Y_i]^{-1}$

The overall anganwadi centre index Y_{id} also varies from zero to one. After obtaining the composite index value for each anganwadi centre, the AWCs can be classified into Groups based on the extent of variability in the index values like vary low, low, moderate, high and very high on service delivery.

Table 5: Service Delivery Index

S.No	Name of the GP	Dimension Wise Index						Composite Index	Rank
		SPN	IMM	REF	Health	Nutrition and Health	Pre-School		
1	Raisalapur (MP)	1	1	1	1	0.82	1	0.98	1
2	Khokharia (RAJ)	0.81	0.84	0.38	0.64	0.72	0.86	0.73	2
3	Banwarla (RAJ)	0.76	0.77	0.38	0.54	0.61	0.77	0.66	3
4	Biaora (MP)	0.49	0.65	0.75	0.68	0.92	0.41	0.61	4
5	Chokha (RAJ)	0.61	0.61	0.25	0.68	0.94	0.59	0.60	5
6	Jajiwal Gehlota (RAJ)	0.6	0.68	0.25	0.75	1	0.41	0.60	6
7	Shivani (KAR)	0.57	0.43	0.75	0.75	0.57	0.41	0.57	7
8	Hunasagatta (KAR)	0.57	0.46	0.75	0.65	0.29	0.41	0.53	8
9	Ajjampura (KAR)	0.55	0.46	0.25	0.71	0.66	0.19	0.48	9
10	Kudlur (KAR)	0.46	0.39	0.25	0.45	0.36	0.81	0.47	10
11	Ankhamau (MP)	0.55	0.68	0.25	0.19	0.17	0.54	0.44	11
12	Rampur (MP)	0.54	0.61	0.25	0.22	0	0.72	0.44	12
13	Anchala Kheda (MP)	0.14	0.37	0.5	0.53	0.84	0.26	0.38	13
14	Amrutha Pura (KAR)	0.49	0.17	0.25	0.62	0.11	0.28	0.35	14
15	Banar (RAJ)	0.00	0.29	0.5	0.43	0.83	0.48	0.35	15

The above Table 5 presents the Service Delivery Index calculated for the anganwadi centres in the study area. The composite index varies from 0.35 to 0.98 points. Though there are no much variations across the States, services wise variations are observed. Intra- State

variations across the services are also observed. Referral services and health check- ups are rated low compared to pre-school education, supplementary nutrition and immunisation. The ranks were given based on the overall composite index and where ever the indices value is same the SNP value was taken as preference and ranks were given.

Table 6: Indicators selected dimension/ service-wise

S.No of service	S.No of sub - indicator	**Services/Dimension**	Indicator
1	1	Supplementary nutrition programme to pregnant and lactating mothers and children between seven months to six	Awareness
	2		Access to the service
	3		Cost paid
	4		Quality of the service
2	5	Immunisation	Awareness
	6		Access to the service
	7		Cost paid
3	8	referral services	Awareness
	9		Access to the service
	10		Cost paid
4	11	Health check-ups	Awareness
	12		Access to the service
	13		Cost paid
5	14	Health and Nutritional Education to children, women and adolescent girls	Awareness
	15		usefulness
6	16	Non- formal preschool education	Awareness
	17		Access to the service
	18		Cost paid

5
Conclusions and Recommendations

5.1 Conclusions

Among the respondents, on an average close to half were beneficiaries themselves while the remaining were family members of the beneficiaries. Nearly half of the respondents were formally educated till secondary education or more. In terms of occupation, income levels and house ownership there were differences seen within the States. Rajasthan had the maximum illiterate respondents in comparison to other two States. Karnataka had the maximum number of households with more than Rs. 1,00,000 of annual household income. More respondents from Madhya Pradesh lived in kutcha houses as compared to other two States.

Awareness of / Access to ICDS scheme

- Among various services availed at the anganwadi centre supplementary nutrition, immunisation and health check-ups topped the list with maximum numbers of respondents availing these services under the ICDS programme. The least availed service was Referral service.
- Among the three States, Madhya Pradesh had a good spread of anganwadi centres which enabled most respondents to access services within 100 meters from their residence. In the other two States many respondents had to travel more than 500 metres to access services from the anganwadi centres.

Quality of services

- Supplementary nutrition was the most availed service across States. Type of food received under the programme varied from State to State. In Karnataka, food grains, pulses, milk and milk products were the most popular forms of food supplied under the programme. In Madhya Pradesh, food grains, milk and milk products were popular too. But along with that cooked food was very popular. In Rajasthan, however, cereals were popular along with food grains and pulses. Milk and milk products were not popular like in the other two study States. The quality of the food supplied was rated high across the three States.
- Immunisation was another most availed service under ICDS across the three States. Both pregnant women and children have availed these services at the anganwadi centres.
- Non-formal education for both health and nutrition were widely availed by the users.

However there is some variation seen in terms of users' opinion on the usefulness of the education programme. Many users from Karnataka have not found this very useful in contrast to the opinions of users from other two States.

- On a normal day, the AWW's duties include providing supplementary nutrition, immunisation, referral services, health check-ups, nutrition and health education, non-formal pre-school education, regular house visits, advice on breast feeding and family planning, promoting institutional delivery, building awareness about various health schemes and advice on food and diet.
- The quality and quantity of services provided at the anganwadi centres are sufficient as reported by anganwadi workers. However the service reach has been far from what is required. Many beneficiaries are not covered under the programme. However the reason for this gap is not known.

Problem Incidence and Resolution

- It is delighting to note that the reporting of problem incidence is very negligible in all three States which makes one believe that the implementation of ICDS has been good.
- None of them have reported facing any problems in discharging their duties. On a positive note they say that they get support, appreciation needed from villagers, peers as well as superiors.

Satisfaction with the services

- Though the overall satisfaction reported by the users with regard to ICDS services has been good, among the three States, the complete satisfaction reported by users across various service parameters is generally low as compared to Madhya Pradesh and Rajasthan.
- Often it is seen that the anganwadi workers play multiple roles that include advisory, supervisory, administrative, medical, and counselling which includes building awareness activities. With so many tasks to perform, they are all satisfied with their job at the AWC. The sense of being able to serve children is one of the main motivating factors that keeps them going.

Suggestions for improvement

Since complete satisfaction on various services under ICDS was not 100 per cent, this only reflected to show that there is definitely scope for improvement. There have been relevant suggestions made by the anganwadi workers that will help them improve the quality of services provided under the ICDS programme. These include improving teaching materials, building awareness among villagers to improve the enrolment of children, providing essential infrastructure facilities like toilets and drinking water at the anganwadi centres. Many of these suggestions resonate with others made by the users.

5.2 Recommendations

Since Referral services are least availed, efforts must be made to build awareness among users about the availability and procedure to avail this service extended under the ICDS programme.

- A detailed mapping of the locations of anganwadi centres will help determine areas where the centres are not easily accessible. Such a mapping effort will help plan and locate the centres at critical locations enabling easy access to more users. This would also probably resolve the issue of inadequate enrolment of children as reported by anganwadi workers.
- Essential infrastructure needs of the anganwadi centres have to be met such as electricity, water and toilet facilities. The GP administration and the district level authorities should allocate funds by making appropriate inclusions in the development plans to ensure these essential facilities are in place. This will definitely create a healthier environment for the users and workers at the anganwadi centre.
- A relook at the format and content of the nutritional education programme may be useful in order to incorporate elements that might be more useful to the end users. It may be a worthwhile exercise to get feedback from the current and past users of this service to understand the gaps in actual content and ease in understanding the content to enrich the programme.

References

The World Bank (2005). *Influential Evaluations: Detailed Case Studies*, Operations Evaluation Department. Washington, DC: The World Bank

The World Bank (2004a). *Citizen Report Card: Ghana Workshop, July 2004.*

The World Bank (2004b). *Citizen Report Card Surveys, A Note on the Concept and Methodology*, Social Development Notes, Participation and Civic Engagement, No. 91, February 2004

The World Bank (2001). *Filipino Report Card on Pro-Poor Services,* Report No. 22181-PH. Washington, DC: The World Bank

Monastyrski, Tom (2004). *Ukraine: Better Governance through Public Participation – The People's Voice Project,* A case study from "Reducing Poverty, Sustaining Growth. What Works, What Doesn't, and Why," A Global Exchange for Scaling Up Success Scaling Up Poverty Reduction: A Global Learning Process and Conference Shanghai, May 25.27, 2004

Paul, Samuel (n.d.). *Making Voice Work, The Report Card on Bangalore's Public Services.* Bangalore: Public Affairs Centre

(http://www.undp.org.bd/library/publications/Bangladesh%20Case-WBI.doc)

(http://www.transparency.org/tools/e_toolkit/corruption_fighters_tool_kit_2001)

(http://heapol.oxfordjournals.org/cgi/content/full/21/2/101#SEC5)

(http://siteresources.worldbank.org/INTEMPOWERMENT/Resources/14875_FilipinoReportCard)-

http://siteresources.worldbank.org/INTPCENG/1143333-1116505690049/20509283/Filipino+Report+Card+on+Pro-chapter7-report-cards.pdf

(http://siteresources.worldbank.org/INTEMPOWERMENT/Resources/14662_Ukr-Ppls-Voice-web.pdf

(http://www.capabilityapproach.com/pubs/4_5_Bekele.pdf)

Annexure-I

State	Rank	Average number of days received food	Percentage of children (12-23 months) fully immunised	Percentage of children able to write alphabets/ words	Percentage of women reporting attended NHE meetings	Percentage of mother reporting seeking help from AWW when their child gets sick	Percentage of mother reporting received deworming tablets from AWC	Average attendance (number of children aged 3-6 years) based on 3 sudden visits by field team	Overall Performance Index
Karnataka	1	1	0.59	0.87	0.38	0.7	0.7	0.86	0.728
Maharashtra	2	1	0.62	0.38	0.43	0.75	0.84	1	0.716
Andhra Pradesh	3	0.74	0.35	0.94	0.48	1	0.82	0.5	0.689
West Bengal	4	1	0.66	0.71	0.36	0.87	0.38	0.79	0.682
Jharkhand	5	0.84	0.37	0.86	0.34	0.74	0.68	0.93	0.68
Tamil Nadu	6	1	1	0.45	0.43	0.59	0.51	0.71	0.671
Orissa	7	1	0.51	0.5	0.5	0.35	0.65	0.93	0.635
Kerala	8	0.95	0.88	0.98	1	0.1	0.02	0.36	0.612
Madhya Pradesh	9	0.63	0.33	0.35	0.12	0.57	1	1	0.572
Haryana	10	1	0.79	0.28	0.11	0.61	0.92	0.29	0.57
Gujarat	11	0.89	0.45	0.13	0.48	0.69	0.87	0.43	0.563
Himachal Pradesh	12	0.79	0.76	0.45	0.57	0.41	0.8	0	0.54
Chhattisgarh	13	0.89	0.43	0.13	0.54	0.27	0.74	0.71	0.53
Jammu and Kashmir	14	0.84	0.85	0.8	0.17	0.04	0.76	0	0.494
Punjab	15	0.79	0.67	0.57	0	0	0.43	0.36	0.402
Uttaranchal	16	0.32	0.59	0.51	0.14	0.04	0.57	0.43	0.372
Rajasthan	17	0.68	0.04	0	0.08	0.33	0.87	0.21	0.317
Uttar Pradesh	18	0.63	0	0.11	0.01	0.12	0.76	0.43	0.295
Assam	19	0	0.13	1	0.19	0.1	0	0.36	0.253
Bihar	20	0.63	0.18	0.25	0.06	0.15	0.05	0.43	0.248
Total		0.74	0.38	0.41	0.25	0.43	0.56	0.57	0.476

https://data.gov.in/catalog/state-wise-performance-icds-programme-estimated-indices (2014)

Cover Design: V G Bhat

www.nirdpr.org.in


TRAINING
& CAPACITY
BUILDING


RESEARCH
& CONSULTANCY


POLICY
FORMULATION
& ADVOCACY


TECHNOLOGY
TRANSFER


ACADEMIC
PROGRAMMES


INNOVATIVE
SKILLING
& LIVELIHOOD