Effectiveness of Integrated Child Development Scheme in Selected Districts of Madhya Pradesh

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Abstract - Madhya Pradesh is a hunger hotspot, not only of India, but the world. Unlike the six African nations it statistically equals in IFPRI's 2008 World Hunger Index, Madhya Pradesh has no recent history of civil war or political instability. How is it that such a 'stable' state with over half a century of democracy can have malnutrition indicators in women and children equal to those in Chad and Ethiopia, countries torn apart by civil war and ethnic conflict? Seeking answers to this question would show a much needed mirror to the true face of our democracy, which seems to have successfully expunged all ideas of equality.

Given that democracy is the system of governance chosen by our founding fathers as the best answer to all our problems, it is essential to continue democratically pushing our state's institutions into becoming more transparent and efficient, and to take responsibility for the basic rights of each of its citizens, especially all those that today have little to eat. This study may be placed in this wider perspective.

The focus is on the coverage, access, quality, problems, and grievance redressal of schemes, of Integrated Child Development Services. The sample selected for the study is that of 40 villages, situated in 4 separate districts and 4 agro-climatic zones of Madhya Pradesh.

The findings of scheme even within each agro-climatic zone are varied enough to prevent easy summarization, save for one: the implementation of the respective scheme on the whole show the true earnestness and urgency of the state and central government in addressing the problems surrounding food in Madhya Pradesh. So carefully have this scheme been planned and implemented in the last few years that conditions of hunger in Madhya Pradesh, especially amongst its dalit and tribal communities and among women and children, are far direr than ever before. This study shows the way that what is missing, what is moving and what has to be done and where in various state welfare programs to ensure that people at margin enjoy their entitlements with dignity.

I. INTRODUCTION

Data from a variety of studies and reports show that the number of people afflicted with hunger in Madhya Pradesh is increasing rapidly. The latest food consumption patterns presents a dismal picture of chronic hunger in Madhya Pradesh, the second largest state in India, having a population of 72.59 million people. According to the Indian State Hunger Index released in 2008[1], Madhya Pradesh has a score of 30.9, the highest score in the country, and therefore the only state grouped in the "extremely alarming" category of hunger

Table No.1.1

Indicators	Position and percentage
Infant Mortality Rate	70 (SRS –Oct 2009)
Maternal Mortality Rate	379 (NFHS-3)
Malnutrition	60% (NFHS-3)
*P*overty Ratio	38.3%(planning commission)

Madhya Pradesh, with less than 6% of country's population, is the state that is home to the largest number of hungry people in the country. "Why M.P. is India's Ethiopia" was the heading to a story published in 2009 in one of the country's leading newspapers that went on to elaborate the chronic and deep-rooted nature of the growing problem.
Populations of Madhya Pradesh have a low purchasing capacity. They are largely dependent on cereals. Food grain production in Madhya Pradesh has declined rapidly in the last decade. In addition, the pattern of food grain consumption also shows a significant decline. These facts underpin numerous innutrition related problems in the state that need serious attention. The NSSO report of Government of India on consumption patterns across the nation, which includes consumption of food and other essentials for life, shows a marked decline in the level of food consumption in Madhya Pradesh.
Analysis of these findings reveals the true face of poverty elimination programs, which are mistakenly isolated from a concept of development that does nothing to protect agriculture. The changing consumption pattern in Madhya Pradesh points to a deep crisis of food security in the state. On average, in 2005-06, a person in rural Madhya Pradesh consumed 11.48 kg food / grain per month and spent Rs. 86.46 to acquire this amount. The current per person food / grain consumption in Madhya Pradesh has declined to 9.718 kg per month, while expenditure has remained about the same, i.e. Rs 87.27. This decline in per capita consumption of 15.34% at more or less the same expenditure, while keeping in mind both population growth and inflation, shows an alarming trend in food consumption levels.
The Madhya Pradesh Human Development Report (HDR), 2007, shows that the state of health in Madhya Pradesh is far from satisfactory. The estimate for longevity, measured as life expectancy at birth calculated in the 2001-2006 period, stands at 59.19 years for males and 58.01 years for females. This figure for both males and females in Madhya Pradesh is the lowest amongst all major states of the country. Longevity in the state is also far below the national average, which stands at 63.87 years for males and 66.91 years for females.
IFPRI Report 2008.Madhya Pradesh has the highest figures for cases of Malnutrition and Infant Mortality in India as well as in the world. The state's performance on the infant mortality rate (IMR)[2] and the maternal mortality rate (MMR), is far below than the national average. According to National Family health Survey (NFHS-2) the infant mortality in the state in 1998-99 was estimated at 88 (96 for rural areas and 60 for urban areas) as against national IMR of 67.6[3]**,** the highest among all states in the country. With the passage of 5 years, i.e. according to the data released in NFHS-3 (2005-06), the national IMR reduced from 67.6 to 57.0, while the IMR of Madhya Pradesh also dropped, but only from 88 to 70.

According to the Millennium Development Goals (MDG's), under-5 mortality should be reduced by two-thirds and maternal mortality by three-quarters between the years 1990 and 2015. If we consider the status of MDG's between 1990 and 2006, the under-5 mortality rate in India decreased at an average annual rate of 2.6%. In order to achieve MDG goal, the under 5 mortality in India must reduce at an average annual rate of 7.6% in the 9 years between 2006 and 2015.

The issue of malnutrition in Madhya Pradesh is not new. It has come to the forefront in this decade, especially since the year 2004 when the deaths of numerous children in the state came to light. The last year has been particularly severe on children in Madhya Pradesh, with the state becoming something of a graveyard for children. Last year, at least 159 children between the ages of 0 and 5 were documented as having died due to malnutrition.

As per the 2005-2006 National Family Health Survey (NFHS-III), about 82.6% children in the age group of 6 to 35 months are anaemic and 60% children under three years of age are malnourished in Madhya Pradesh. Only 22.4% of the children aged 12-24 months are receiving immunization against all preventable diseases. As per the District Level Health Survey (DLHS-3) report only 36.2% children in the state and only 31.4% children in rural areas are fully immunized. This data flies in the face of the state government's claim that 62.5% children in 2007-08, & 63.6%1 child in 2008-09 children are fully immunized under the child vaccination programme. Furthermore, the DLHS-3 report shows that 11.3% children from rural Madhya Pradesh and 9.8% children throughout the state have not received any form of vaccination.

Anaemia is endemic in Madhya Pradesh. At a figure of 74.1%, Madhya Pradesh has the second highest percentage of anaemic children in the nation after Bihar [78%][4]. Around 56% of women in Madhya Pradesh are anaemic; they need special care during pregnancy. The problem is even more acute amongst tribal women as 74% of them live with anaemia and 1.2% of them are severely anaemic.

The statistical politics of poverty identification is one of the biggest hurdles in eliminating chronic hunger. The

estimation by the Planning Commission work to support the argument that poverty in India is reducing. For those working on the ground, it seems the Planning Commission will devise the most acceptable statistical trick or formula to ensure the image of poverty reduction is maintained. The Planning Commission had estimated that in Madhya Pradesh, a family spending Rs 327.78 per person per month in a rural settlement will not be considered as poor. In Urban settlements, the benchmark expenditure level was held at Rs 570.15 per person per month. In other words, a person spending anything more then Rs 9 every day in a village or Rs 19 in an urban area, will not be identified as poor and will not be a beneficiary of poverty elimination programs. No person can survive at this level of expenditure in India today. These figures represented a starvation line, rather than a poverty line.

The Planning Commission's recently accepted Tendulkar Committee report, which was mandated to address the above criticisms of the prevailing poverty line, is sadly another case of statistical jugglery in the guise of rectifying the poverty line. The Tendulkar Committee arbitrarily chooses the consumption basket at the prevailing arbitrary urban poverty line as the benchmark with which to measure poverty across the country. This results in a slight increase in the poverty ratio for rural areas, but does so at the cost of sanctioning a drastic reduction in the minimum calorie norms and with dubious methodology. The motive of the Tendulkar Committee is to both deflect the strong criticisms to earlier poverty ratios and allow the government to continue its economic myth making of poverty reduction over time. In terms of Madhya Pradesh, the underestimations of the Tendulkar Committee still find 53.6% of its rural population living below the poverty line. In contrast, the Dr. N.C. Saxena Committee report puts the figure at 66.55%.

It is not a coincidence that Madhya Pradesh has the lowest (and a continuously declining) food consumption, the highest malnutrition, the highest infant mortality, and amongst the lowest life expectancy levels of 57.7 years. According to the Dr. N.C Saxena Committee Report the percentage of rural population that is poor, and is not able to satisfy the minimum required calories needs, nor is able to consume the minimum cereal required for healthy living, is far greater than the present cut off line of 28.3% in India. The Dr. N. C Saxena committee report recommends that the percentage of people entitled to BPL status should be revised upwards to at least 50%, though the calories norm of 2400 would demand this figure to be about 80%.

The figure of 50% that this report mentions is based on a calorie consumption norm of 2100 for rural areas, as well as a minimum cereal consumption of 12.25 kg per month. The committee also recommends an increase in the cut off line of states, and according to these estimates the Madhya Pradesh present poverty ratio of 37.67% should actually stand at 66.55%.

The debate of poverty as reflected in discrepant statistics does not end here. As per a survey conducted by the Planning Commission, 38.35% of population of Madhya Pradesh is living below the poverty line and the numbers of poor families are 44.5 Lakh, who are direct beneficiaries under the Public Distribution System. In addition, such beneficiaries are also entitled for subsidized ration under other schemes of the government. However, the Madhya Pradesh government poverty ratio is much higher than the government of India estimates of 38%. According to state government statistics the total number of beneficiaries under the Antodaya Food Scheme should be 15.87 lakh for the poorest of the poor and 51.47 lakh for BPL families[5]. In total, 67.35 lakh families in Madhya Pradesh are required to be distributed ration, as per prescribed norms, under the centrally run public distribution system, at the rate of 35 kg of ration per card per family. As such, a total of 23.57 lakh tonnes[6] of ration is required to be distributed in Madhya Pradesh. However, as against the existing 67.35 lakh beneficiary families, the center is providing ration to the state government sufficient for only for 44.5 lakh families. In other words, no ration is being provided to about 22.85 lakh families.

'Development', 'social inclusion', and 'elimination of poverty' have long been catch phrases in Madhya Pradesh state politics. Over time the very meanings of these words have turned upside down and hollowed out. The tattered rhetoric of today mirrors large proportions of wasted populations in the state. Under the veneer of words, an incessantly rapid and iniquitous development process, made to appear as inevitable as change itself, is leaving the common person further behind.

A Selection of Districts

The geography of Madhya Pradesh is varied; the state has a number of different agro-climatic regions. For the

purpose of this study, districts were chosen according to four different agro-limatic regions of the state. Four districts from four different geographical regions of Madhya Pradesh have been selected, namely: Chatarpur district(Bundelkhand), Umariya district (Baghelkhand), Jhabua district (Malwa) and Burhanpur district (Nimar).

B Selection of Blocks

In each district, two blocks have been selected: one that is easily accessible and is close to the district head quarter and the other that is remote.
Following are the blocks selected for the study—

Table No.1.2

1	Chatarpur:	1	Bakswaha	2	Chatarpur
2	Umariya:	1	Pali	2	Karkeli
3	Jhabua:	1	Petlavad	2	Raama
4	Burhanpur:	1	Khaknaar	2	Burhanpur

[5] Data collected under RTI on Oct 11 from food and Civil supplies department. [6] http://fcamin.nic.in/ReportTable/view_reporttable.asp

C Selection of Villages

The villages were randomly selected from the census list. A total of 5 villages were selected from each block. Of the total of 10 villages selected in each district, one has an SC population in the range of 20 % to 50% and another village has a population of minorities (Muslims, Christians) or Primitive Tribal Groups. **Therefore, in total 40 villages have been selected for survey and study in 8 blocks of 4 districts of Madhya Pradesh**.

Methodology of the study

The study is based on primary and secondary data, with a survey research design for collecting primary data, and the use of government reports, websites, and RTI's for collecting secondary data. The methods employed for data collection are of two kinds .

The first method of data collection or schedule contains a set of questions for various stakeholders of the schemes. It centers on observations of the services of respective scheme and a discussion with the beneficiary and field staff, such as anganwadi workers, cooks, teachers, and ration dealers. Similarly, a schedule designed for interaction with parents of children identified as being in Grade III or Grade IV level of malnourishment by the anganwadi workers has also been used.

The second method of data collection or schedule is based on focus group discussions in the village to elicit further information on the functioning of the schemes. It is a qualitative method for data collection. In this study, focus group discussions have been conducted in the community to observe & understand the community response to various schemes.

The focus group discussions were conducted in areas where the poorest section of the village resides. For making this study more qualitative, case studies from all the four districts have been collected during interactions with community & field staff.

Description of villages covered in sample
In the survey, 10 villages have been studied in each district, so as to cover 40 villages in 4 different districts of Madhya Pradesh. In these 40 districts, 95 schools and 67 Anganwadi centers were covered. To learn about the realities of the public distribution system, we surveyed 40 ration shops serving each of the 40 villages. Apart from this, 771 beneficiaries of National Old Age Pension Scheme, 482 beneficiaries of Janani Suraksha Yojana, and 101 BPL families whose primary bread-winner aged between 18-64 years passed away, have been interviewed. With regard to the ICDS program, as a part of the study, specific talks were held with parents of 79 severe malnourished

children about the care and follow up provided to the children. Furthermore, for taking the community point of view, we undertook 51 focus group discussions in 40 villages of 4 districts.

Table No.1.3

S.No.	Districts	ICDS centres	Schools	NOAPS beneficiaries	NMBS beneficiaries	NFBS beneficiaries	FGDs
1	Umariya	12	15	147	41	19	10
2	Burhanpur	14	18	134	171	17	10
3	Chattarpur	12	32	255	111	31	10
4	Jhabua	29	32	235	159	34	21
Total		67	95	771	482	101	51

To check the implementation of ICDS in the field, this study has been carried out in 40 villages of 4 districts in Madhya Pradesh, i.e. 10 villages in each district. During the survey each and every anganwadi centre of these 10 villages has been covered. In the process, visits were made to 67 anganwadis: 12 in Umariya, 14 in Burhanpur, 12 in Chatarpur, and 29 in Jhabua district. To cross check the data provided by the anganwadi worker, focused group discussions were conducted. In this way, 51 FGDs in 40 villages involving around 2300 people were conducted. The perspective that emerges from FGD's stands in stark contrast to government records and statistics.

Integrated Child Development Scheme

Integrated Child Development Services (ICDS) is the only major national program that addresses the needs of children under six years of age. It seeks to provide young children with an integrated package of services, such as supplementary nutrition, health care, and pre-school education. Because the health-care and nutrition needs of a child cannot be addressed in isolation from that of its mother, the program also extends to adolescent girls, pregnant women and nursing mothers. The objectives of this union government scheme are as follows:

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

Basic services of ICDS

ICDS is a program that seeks to provide a package of 'integrated services' through Anganwadi Centres, i.e. a network of ICDS centers focused on children under 6 years. The anganwadi worker (AWW) is assigned the responsibility of operating an Anganwadi centre, with support from an anganwadi helper (AWH). The six basic services provided through Anganwadi Centers are as follows:

1. Supplementary nutrition,
2. Immunization,
3. Health check-ups,
4. Referral services,
5. Pre-school non-formal education, and

6. Nutrition & health education.

Introduction of ICDS in the State

Early childhood years are vital as 80 % of the brain's development takes place in this phase. It is these years that lay the foundation for later physical, emotional, cognitive and social development. Therefore proper childcare is mandatory. Apart from rapid physical and mental growth, children do the difficult task of learning languages, an assortment of physical skills, and values amongst other things required to lead a full life in today's world. Much of this cannot be achieved without sound nutrition, good health, appropriate education, love and affection.

Investing in the nutrition, health and education of the child under six is not only a moral duty of the government, but also essential in the economic development of a state. Research across the world has established that it is either impossible or too costly to make a malnourished child into a healthy adult. Thus, Integrated Child Development Scheme (ICDS) is an effort in the right direction having wide-ranging implications for overcoming the monstrous problem of malnutrition among children. The central theme of Integrated Child Development Scheme is the provision of supplementary nutrition to children, however at the implementation stage; this very theme of ICDS is continually overlooked.

The scheme basics make it expressly clear that every child, pregnant woman, lactating mother and adolescent girl should get the benefit of supplementary nutrition and other services for 300 days in a year without any limiting criteria. However in MP, the budget is created to provide this service for only 130 days. The report of Comptroller and Auditor General mentions that the scheme falls prey to corruption in MP, that children do not get the necessary 300 calories and 8 to 10 gm of protein, and that as much as 59 % children in the state are not even touched by the scheme.

Recent uncovering of corruption, especially income tax department raids on top bureaucrats and politicians of the women and child development department and the health department, betray an unconscionable truth. A whopping 200 crore of money meant for vulnerable children in the state has gone into filling the bottomless pockets of officials and leaders. Corruption in sectors like health and women and child development is unlike any other example of money eaten by the authorities. In this case, the corruption is directly eating up hundreds of thousands of lives every year especially that of children in the poor and the most marginalized communities of Madhya Pradesh.

The Supreme Court of India, in its decision dated December 13, 2006, ordered the universalisation of the ICDS scheme. At present, in Madhya Pradesh there are 78,929[8] (53%) ICDS Centres as against the huge need of 1.48 lakh[9]. The supplementary nutrition program is being currently implemented in these centres. The programme is serving around 72.85[10] lakh beneficiaries. This includes 59,91,395[11] children and 12,94,046[12] pregnant and nursing mothers. It means that government is reaching out to only 53% of the children of the state going by its own statistics and leaving 47% children out of the coverage of ICDS.
The ever-changing nutrition policy in the state has become a headache not only for the lower level officials or workers but also for the communities. A good policy is usually one which emerges from the grass-roots, but in the real sense the nutrition policy of Madhya Pradesh has emanated from the top rather than the other way around. The policy keeps changing from time to time, with contracts being shifted from SHGs to private contractors, private contractors to cooperatives, and then again from cooperatives back to SHGs. These changes have debilitated implementation, not to mention obfuscating even basic comprehension of the realities on the ground.

Whether it is the functioning days of anganwadi centers, or technical input, or the supply of nutritious food, or staff appointed for ICDS, or budget allocation for ICDS, complete negligence and violations are seen in each and every aspect of the supplementary nutrition program. The claim of spending Rs. 4 per beneficiary is the key statement in all the responses released by the state government. However, when the implementation and coverage analysis in terms of budget provision is done, it reveals that only Rs. 2 per beneficiary has been allocated in Madhya Pradesh. Even if one were to take the state government at its word of having spent Rs. 4 per beneficiary per day in this budget, then it would mean that all the covered (not actual population) beneficiaries will receive supplementary nutrition for only 126 days in a year. As per the order of the Supreme Court coverage should be for at least 300 days in a year. Even after four years of the relevant Supreme Court orders, the budget allocations are not proportionate to the needs of beneficiaries.

At present, in Madhya Pradesh, 411[13] ICDS projects are sanctioned by the government of India. Within the purview of these projects 78,929 anganwadi centres have been sanctioned. Out of 78,929 centers, the supplementary nutrition program is currently being implemented through 71,321[14] functional anganwadi centers. In order to look after such a vast number of ICDS projects covering a noticeable amount of beneficiaries, only 260 CDPOs, 42 ACDPOs and 2,497[15] supervisors have been appointed till date. A total of 131 posts of CDPOs, 69 posts of ACDPOs and 371 posts of supervisors are still lying vacant. Therefore, presently one CDPO is responsible for managing about 304 anganwadi centers. This figure puts into perspective the quality of ICDS services offered in such a time of nutrition deficiency in the state. Last, but most important, is the debate in Madhya Pradesh concerning the total number of malnourished children. According to the Monthly Progress Report of Women and Child Development Department there are 83415 children[16] identified as severely malnourished, but on the other hand National Family Health Survey (NFHS-III) comes to the conclusion that around 13,00,000 children under the age of six are in the seriously malnourished category in Madhya Pradesh.

[8] Source- Government Diary 2010
[9] Source- Supreme Court Commissioners 6th Report

[10] http://www.mpwcd.nic.in/Format-Dec09.htm accessed on May 10. [11] http://www.mpwcd.nic.in/Format-Dec09.htm accessed on May 10 [12] http://www.mpwcd.nic.in/Format-Dec09.htm accessed on May 10
[13] Monthly Progress report WCD December 2009 (http://www.mpwcd.nic.in/Format-Dec09.htm) accessed on May 10 [14] Monthly Progress report WCD December 2009 (http://www.mpwcd.nic.in/Format-Dec09.htm) accessed on May 10= there are two figures of Total number of Anganwadi sanctioned in the Monthly progress Report . At one place it is 78929 and at the other it is 75371.

[15] Monthly Progress report WCD December 2009 (http://www.mpwcd.nic.in/Format-Dec09.htm) accessed on May 10
[16] Monthly Progress report WCD December 2009 (http://www.mpwcd.nic.in/Format-Dec09.htm) accessed on May 10
This stark difference has been created as a result of the callous attitude of state functionaries. It is a matter of serious concern that whenever a child dies due to malnutrition in Madhya Pradesh, the state government switches to denial mode. While the Health Department, in its report, states that the deaths were due to malnutrition, the Women and Child Development Department (WCD) immediately denies the same report, saying that the children succumbed to a specific diseases. Other times, the same thing happens the other way around. One way or another, the concerned department tries to shake-off the burden of responsibility.

Malnutrition in Madhya Pradesh is the biggest blight in the state. The dance of deaths of innocent children across the state and the continuous neglect by the administration towards these deaths underscores the urgent need for bringing positive change for the poor and marginalized sections. A change can only be achieved by bringing a change in attitudes concerning the health of children, by winning faith of rural and tribal communities, as well as by making the state administration more accountable.

Overall Findings of the Scheme

This study represents the status of ICDS in 67 Anganwadi centers of 8 blocks from 4 districts of the state. The following issues emerge regarding the status of ICDS in Madhya Pradesh—

- During the study it has been found that 41 (61%) anganwadis have their own building while 26 (39%) are lacking the same. Most of the anganwadi centers across the state lack their own buildings, i.e. the most vital requirement for a safe, secure and spacious environment for children. Out of 67 surveyed centers only 41(61%) anganwadis have their own building.
- The FGD's show that only 2 anganwadi workers, one from Ginjari village of Umaria district and another from Mor of Jhabua district, hold meetings with pregnant and lactating mothers to discuss the nutrition and health issues
- During the survey it has been found that there are 16 anganwadis, 9 out of 12 in Umaria district and 7 out of 12 in Chatarpur district in which supplementary nutrition is not being provided to children 0-3 years of age. Umaria district is the worst performer when it comes to supplementary nutrition.

- Of the 67 surveyed anganwadi centers, there are 13 centers where no nutrition in any form is provided to pregnant women and nursing mothers. Umaria district is once again found to have the worst performance in this regard. Out of 12 centers in this district, only 3 centers are providing mandatory nutrition to pregnant and lactating mothers.
- Considering statistics for all the 4 districts surveyed, only 27 (or about 40%) centers are providing ready-to-eat mix to its beneficiaries.
- The FDG's revealed that only 29 centers out of 67 centers are providing average quality food to its beneficiaries. In 10 centers the quality of food is shamefully low. It must be noted that none of the centers were found to provide nutritious food of good quality.
- Out of 67 centers only 9 (13.4%) centers conduct pre-school activities; the remaining 58 centers were either found closed or found not to be conducting pre-school activities. When the reason for not conducting pre-school activities was asked, the anganwadi workers most often stated that in the absence of charts and other study material it is not possible to teach the children.
- The present survey collected information on visits made by the ANM in the 12 month period preceding the survey. In 14 (20%) centers, it has been found that not a single visit has been conducted by the ANM in this period of time. There are 2 villages in Umaria district and 1 village in Jhabua district where the respective ANM made only one visit in 12 months. These figures emerged in the process of the focus group discussions as in most of the anganwadi centers no inspection registers have been maintained.
- A majority of anganwadi centers across the state lack the most basic facilities that an anganwadi must provide to its beneficiaries as per the norms. The study revealed that most of the centers lack cooking facilities (39 centers), safe drinking water (45 centers), toilet facilities (49 centers), playing kit/pre-school education kit (45 centers), and medicine-kit (31 centers).
- In 37 centers children were weighed regularly but their growth has not been registered in the growth charts as the worker doesn't know how to fill the chart. The other 13 centers surveyed, do the work as a formality by weighing children once in 3 months.

- The survey found that there are 28 (42%) centres where no referral facilities have been availed to malnourished children. Out of the 4 surveyed districts, Chatarpur and Jhabua districts appear to be the worst-off as they show insufficient referral facilities. Among these 4 districts, Umaria performs the best in referral facilities.
- However, this study finds that only 40% of hamlets surveyed have an anganwadi center; out of a total of 166 hamlets in the four districts surveyed, only 67 have an anganwadi center. Therefore, children and vulnerable women in 99 hamlets are not covered for all the services under the ICDS program.
- In these discussions it has been found out of the 67 anganwadi centers where FGD's were conducted, 7 anganwadis provide services between 1-5 days a month, 31 between 11-15 days a month, 11 between 16-20 days a month, and only 7 between 21-26 days a month. Given these circumstances, eradication of malnutrition seems is a distant dream.
- However, FGD's show that out of a total of 67 anganwadi centers, 27 anganwadis operate for only 2 hours. Jhabua district appears to have the worst functioning habits. In 14 of the 29 conducted FGD's in the district, village residents stated that the anganwadi opens only to distribute 'dalia' (porridge).
- In 57 out of a total of 67 AWC's, it has been learned that the anganwadi worker does come regularly to open the centre. Moreover, this worker only distributes supplementary nutrition to some of the children, after which she closes the centre.
- Unfortunately the study finds that supervisors at best visit anganwadi centers once in two months, but entirely to fulfill a formality. They don't check registers or advise anganwadi workers.
- Out of 67 anganwadi centers surveyed, 37 (56%) centers have anganwadi workers from tribal communities. The major percentage of these centers is in Jhabua district, a predominantly tribal district. The most appallingly fact encountered in the study is that there are only 4 (6%)centers having anganwadi workers from the dalit community. The presence of dalit anganwadi workers is found only in Jhabua district; other districts have not a single dalit anganwadi worker.
- Exclusion of children and women from ICDS services on the basis of caste and community is prevalent in Madhya Pradesh due to which a vast section of tribal and dalit communities are deprived of the facilities. During the course of the study it has been learnt that social exclusion in Chhatarpur district is comparatively worse than the other 3 districts studied.
- During the survey, disabled children were found in only 4 (6%) out of 67 centers. There are 38 (56%) centers in which not a single child with any form of disability is registered under the ICDS program. Also, there are 14

AWW who don't know anything about the disability survey. There are 15 (22%) AWW who registered disabled children in their records, but this was recorded during the birth registration of the child. No separate disability survey has been undertaken in any of the 4 surveyed districts of Madhya Pradesh.

All these ground realities shows that there is considerable lacuna in the implementation procedure as well as monitoring system and accountability with regard to ICDS, which is the only scheme for children under six. The health and well-being of children is not a priority for political parties and policy makers because children do not affect vote banks in the short term.

REFERENCES

[1] Janaswastha Abhiyan (2006) Health System in India: Crisis and Alternatives, Towards the National Health Assembly II, Booklet 2, National Coordination Committee, JSA, New Delhi.
[2] Jana Swastha Abhiyan (2007): Access to Essential Medicines 2007, National Coordination Committee, JSA, New Delhi.
[3] Mukhopadhyay I (2004): Ill Health of The Health Sector Under The NDA Rule; People's Democracy, April 04, New Delhi.
[4] Duggal, Ravi (2007):Healthcare in India: Changing the Financing Strategy, Social Policy and Administration, 4(41), August, Pp. 386-94.
[5] Bajpai, N and Sangeeta Goyal (2005): Financing Health for All in India; CGSD Working Paper No. 25, The Earth Institute at Columbia University, www.earth.columbia.edu; April.
[6] Banerjee, D. (2005): Politics of Rural Health in India, International Journal of Health Services, 35(4), 783-796. http://ejournals.ebsco.com/Article.
[7] Bose A. (2007) Speeding up Reduction in Maternal Mortality, Economic and Political Weekly, January 20.
[8] Department of Women and Child Development. 1993. National Nutrition Policy Government of India. New Delhi
[9] Department of Women and Child Development. 1995. National Plan of Action. Government of India, New Delhi
[10] Planning Commission. 2002. Tenth Five-Year Plan.
[11] http://www.planningcommission.gov.in/plans/planrel/fiveyr/welcome.html accessed on 2.10.2007.
[12] Planning Commission Towards a faster and more inclusive growth: Approach paper to Eleventh Five Year Plan www.planningcommission.gov.in/plans/planrel/app11_16jan.pdf accessed on 2.10.2007
[13] Department of Women and Child Development. Annual Report 2007 www.wcd.nic.in last accessed on 2.10.2007
[14] Department of Women and Child Development. Annual Report 2003 www.wcd.nic.inlast accessed on 2.10.2007
[15] Planning Commission. Annual Plan 2003 www.planningcommission.gov.in/plans last accessed on 2.10.2007
[16] National Family Health Survey –3 www.nfhsindia.org/nfhs3_national_report.html last accessed on 2.10.2007
[17] Michele Gragnolati, Caryn Bredenkamp, Meera Shekar, Monica Das Gupta and Yi-Kyong Lee: India's undernourished children: A call for reform and action; World Bank Washington 2006
[18] Ministry of Women and Child Development: Report of the Sub group on ICDS and nutrition www.wcd.nic.in accessed on 2.10.2007
[19] http://www.nytimes.com/2009/03/13/world/asia/13malnutrition.html?em
[20] http://www.smh.com.au/world/the-hidden-hunger-behind-indias-huge-success-20090320-94f0.html
[21] http://news.bbc.co.uk/2/hi/south_asia/7669152.stm
[22] http://www.theglobeandmail.com/servlet/story/RTGAM.20090321.wstarve21/BNStory/International/home/?pageRequested=all