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A STUDY OF GOVERNMENT POLICY FOR ICDS IN GOVERNMENT VS SOCIAL SECTER NGO AND HOW CAN IT CHANGE ICDS FOR THE BETTERMENT OF THE WORLD WITH HELP OF SOCIAL WORKER TO BRING CHANGE IN THE MIND OF PEOPLE USING IT .

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ABSTRACT.

the children are our precious resources. the development of any nation on social index and economic prosperity largely depends on the physical, mental and social well being of this most supremely important asset as enumerated in national policy on children, 1974. the policy further lays down that the state shall provide adequate services to children both before and after birth and through the period of growth so as to ensure their survival and development. the policy resolution had also enjoined on the state that it shall progressively increase the scope of its minimum basic services (like comprehensive health inputs, supplementary nutrition services for preventing deficiencies in children, expectant and nursing mothers, nutrition education of mothers and non formal education to pre school children services) so that within a reasonable time, all children in the country enjoy optimum conditions for their optimal growth. as a follow up of these measures contained in the national policy resolution, the integrated child development services, popularly known as icds was evolved in 1975 by government of india voluntary organizations have come to occupy an important place in india. the spread of ngo activities in the country, as in many other parts of the world, has manifested in a number of spheres and in wide spectrum of programmes. the ngo sector is now participating in almost every field of social welfare including development oriented initiatives, empowering women and weaker sections, protecting the rights of the marginalized segments, protecting the environment, spreading literacy and alike .

in view of identifying new avenues for voluntary actions and to encourage people to contribute their time, energy and resources voluntarily to the development of the nation, the role of voluntary organizations in child welfare schemes was also emphasized by national policy for children, 1974. the policy delineates that it shall be the endeavor of the state to encourage and strengthen voluntary action so that state and voluntary efforts complement each other. the resources of voluntary organizations, trusts, charities and religious and other endowments would have to be tapped to the extent possible for promoting and developing child welfare programmes. the concluding para of the policy states that the government of india calls upon the citizens and voluntary organizations to play their part in the overall effort to attain the objectives as enunciated in the policy. subsequently , the national plan of action for children 2005 also laid emphasis on involvement of ngos in running child development initiatives . enumerating the role of ngos in child development, the 11th five year plan (2007-12) concerning child rights has mentioned that ngos will be encouraged to take up the job of social audit and performance appraisal of icds system . greater participation of ngos in icds will be sought to adopt the awcs and to augment their resources in icds. while highlighting the role of ngos in recently launched sabla scheme using the platform of icds, it has been mentioned in the scheme that effective tie ups will be developed with them not only for implementation of the scheme but for imparting training module as well. however, despite of such efforts, only 1 per cent of total operational icds projects (66 out of 6506 operational icds projects) are being wholly or partially run by ngos in the country. the state specific location of such ngo run icds projects further reveals that they are located in andhra pradesh(1) , chhattisgarh(2), delhi(4) gujarat (36) karnataka(1), madhya pradesh(2), punjab(2), rajasthan(3), andwest bengal (14). however, it may be mentioned that from very beginning of icds scheme, the ngos have been involved in planning and organizing training programmes by establishing mltcs/awtcs across the countrythe study was conducted on all voluntary

organizations involved in implementation of icds projects across the country. these voluntary organizations were mainly located in the state of andhra pradesh(), chhattisgarh(), delhi() gujarat () karnataka(), madhya pradesh(), punjab(), rajasthan() and west bengal (). a total of five awcs were randomly selected from each of these voluntary organizations running icds projects/awcs. the random selection of these awcs was made on the basis of the list provided by the concerned cdpo. in order to ensure the fair representation of awcs which were selected for in depth study, precautions were taken not to choose more than two awcs from same supervisory circle of icds project.the regular icds projects were also studied on the same basisdata analysis the formats of the data were prepared in such a way that the data could be used in variety of ways for subsequent analysis. the state wise data base was created on ms excel sheet with an intention to optimally utilize the valuable empirical information for other purposes

resultafter collecting, tabulating, interpreting the data and summarizing the results, an attempt has been made in the present some broad conclusions and recommendations. it is hoped that the recommendations of the study, if implemented, would make the implementation of icds with involvement of voluntary organizations more

thus we can say that the icds should be given to ngo they will perform better as per the directives of our prime minister of india.

key word ngo, icds,

PAPER

the integrated child development services (icds) scheme, launched on 2nd october,1975, on an experimental basis in 33 icds blocks, has been gradually expanded to 6284 projects. icds is india's response to the challenge of breaking a vicious cycle of malnutrition, impaired development, morbidity and mortality in young children. it responds to the inter related needs of children below 6 years, pregnant women, lactating mother and adolescent girls in a comprehensive manner.

OBJECTIVES: the main objectives of the icds are:

i) to improve the nutritional and health status of children below the age of six years;
ii) to lay the foundation for proper psychological, physical and social development of the child;
iii) to reduce the incidence of mortality, morbidity and malnutrition and school drop out;
iv) to achieve effective coordination of the policy and implementation among various departments to promote child development; and
v) to enhance the capability of the mother to look after normal health and nutritional needs of the child through proper nutrition and health education.

ICDS BENEFICIARIES AND SERVICES

beneficiaries: the beneficiaries under the programme are:

i) children below 6 years,
ii) pregnant and lactating women,
iii) adolescent girls

other women in the age group 15-45 years **services:** towards achieving the above objectives, a package of integrated services comprising supplementary nutrition, immunization, health check-up, referral services, nutrition and health education and non-formal education is provided in a comprehensive and cost effective manner to meet the

multi-dimensional and interrelated needs of children. anganwadi centre is the focal point for delivery of services. immunization and health-check up

iv) are provided at the anganwadi through the net work of health services in the project are

services and beneficiaries under icds

services	beneficiaries	services rendered by
i) supplementary nutrition @	children (6 months to 72 months); pregnant and lactating mothers.	anganwadi worker and helper
ii) immunization *	children below 6 years; pregnant and lactating mothers.	anm/mo
iii) health check-up*	-do-	anm/mo/aww
iv) referral services	-do-	
v) pre-school education	children in the age group of 3-6 years	aww
vi) nutrition & health education	women in age group of 15-45 years	aww/anm/mo

pattern :icds is a centrally-sponsored scheme implemented through the state govt/ut administration with 100% financial assistance for all inputs other than supplementary nutrition which the states were to provide out of their own resources. however, many states were not providing adequately for supplementary nutrition in view of resource constraints. it has, therefore, been decided, from 2005-06, to support states upto 50% of the financial norms or 50% of the expenditure incurred by them on supplementary nutrition, whichever is less. supplementary nutrition is to be provided to the beneficiaries for 300 days in a year as per norms laid down

SUPPLEMENTARY NUTRITION NORMS: on an average, the effort should be to provide daily nutritional supplements to the extent indicated below:

beneficiaries	calories (cal)	protein (g)
children 6 months – 72 months	300	8-10
severely malnourished children on medical advice after health check-up	(double of above)	
pregnant & lactating (p & l) mothers/ adolescent girls (under ksy)	500	20-25

icds team :the icds team comprises of anganwadi workers (awws) and anganwadi helper, supervisors and child development project officers (cdpos). in larger rural and tribal projects, additional child development officers (acdpos) are also part of the icds team.

the anganwadi worker and helper are the grassroots functionaries responsible for delivery of services at the anganwadi level. they are honorary workers from the local community and are paid monthly honoraria. the child development project officer/ assistant child development officer is responsible for implementation of the scheme in the project area.

TRAINING OF PERSONNEL:the training of icds functionaries is the most crucial component in icds programme. the success of this programme depends on the effectiveness of frontline workers in empowering community for improved child care practices as well as effective inter-sectoral service delivery. training of functionaries at all levels has been built into the programme. the national institute of public cooperation and child development (nipccd) has been designated as an apex institute for training of icds functionaries. training of child development project officers is conducted by nipccd. training of supervisors and anganwadi workers is organized by nipccd through selected organizations/state training institutes called the middle level training centres and anganwadi workers training centres established in the states.

LINKAGES WITH OTHER PROGRAMMES:since the icds scheme is based on the strategy of an intersectoral approach to the development ofchildren, coordination of the efforts of different programmes and departments at all levels is necessary. for the icds to achieve its objectives, an effective synergy is required between the ministry of wcd and the ministry of health & family welfare, department of elementary education, department of drinking water supply, m/panchyati raj to meet the requirements of health, sanitation, drinking water, pre-school education etc. similarly, synergy is necessary between different departments in the states also.
at national level, a coordination and advisory committee has been set upto ensure coordination amongst all the concerned departments/ ministries and to give advice, from time to time, on better delivery of services.
instructions have also been reiterated to all state/uts to activate the coordination committees at all levels (state, district, block and village level) and hold meetings at regular intervals.

IMPACT OF ICDS SCHEME: reduction in the incidence of mortality, morbidity, malnutrition and school dropout is one of the main objectives of the icds scheme. infant mortality rate (imr) has declined from 110 in 1981 to 60 per thousand live birth in 2003. similarly, under-5 mortality has declined from 161 in 1983 to 87 in 2003 (source: sample registration system). various surveys have revealed that there has been significant impact of the scheme
the national plan of action for children 2005, which is the framework for the key thrust of initiatives in the eleventh plan in all sectors, calls for collective commitment and action by all sectors and levels of governments and partnership with families, communities, voluntary monitoring of the implementation of the national plan of action for children and reporting on the status of children and the realization of their makes it necessary that mwcd adopts

inter-sectoral coordination and convergence as an important area for focus of its efforts during the eleventh plan period. it is also important to clearly define the areas for coordination and convergence, create the mechanisms for it and guide and support the integration of it in the understanding and the functioning of different departments and ministries and different levels of governance to accelerate the outcomes for children and realization of their rights. one of the largest programmes for children is icds. the programme has been universalized in all the community development blocks of the country and has been adjudged as world's largest initiative for survival, growth and development of children. the testimonial merit of the programme is further evident from the fact of identifying the programme as basic strategy to achieve the first goal of ecce as envisaged in dakar framework of action, 2000 and as part of the common minimum programme of united progressive alliance government. recently the government of india has also identified eight flagship programmes, in which icds figures as one of them.in recent years, along with expansion of the programme, there has been a paradigm shift in the focus of the programme from merely supply side interventions of increasing the availability of access of services towards demand driven strategy of improving utilization, quality, impact and sustenance of the programme. thus, within short span of time, the programme has transformed itself mere from an intervention project designed for child development to major social development programme extending beyond the limits of early childhood to the broader concept of social well being.while creating awareness among the masses on various issues of child development through nutrition and health education inputs of icds programmed, the mwcd is also actively engaged since inception of the programme on capacity building of various functionaries by formulating and implementing a ***comprehensive training strategy*** for the functionaries involved in execution of the programme. while national institute of public cooperation and child development (nipccd), an apex body in the twin field of public cooperation and child development, organizes the job training programmes (jtcs) for cdpos/ acdpos, a net work of about 40 middle level training centres (mltcs) and 400 anganwadi workers training centres (awtcs) have been assigned the task of organizing the training programmes for child care workers. further, under world bank assisted icds national training programme project udisha- a national initiative of vibrant training and communication packages for hrd and capacity building of child care workers- provisions were made for strengthening the existing ***training centres financially***- upward revision of budgetary norms, and providing one time additional grants for infrastructure facilities, -***enriching the structure of the training courses academically***- integration and coordination of training of icds functionaries, revision of training syllabus, strengthening support material, generating appropriate training resources and ***empowering training managers professionally***. besides providing focus on strengthening various indicators of child development in the country, the mwcd is also looking at child protection by creating a strong protective environment for children by mobilizing inter- sectoral resources and setting standards for care and services pertaining to child protection. mwcd is fully convinced with the fact that child protection cannot be addressed in isolation. other sectors have a vital role to play. thus, integrating a strong preventive approach in the child protection measures requires going beyond the conventional prevention strategies and also by taking into account the link between child protection and other micro and macro development issues. such a holistic understanding of prevention within the protective net calls for strong inter-sectoral collaboration at policy, implementation and monitoring of

outcomes levels. the protective approach is to deal with situations post-harm and must include immediate as well as long term protection strategies for all children who need it, including programmes for their physical and psychological recovery, rehabilitation and reintegration, legal aid and access to justice through child- friendly laws and procedures and clear standards for protection of every individual/ family/ institution dealing with children.a rights-based approach to protection calls lateral linkages with different sectors viz. education, health, rural development, labour, urban affairs, legal affairs, home affairs etc. and different departments and ministries of central and state governments, including local self- government, pris etc. even within mwcd linkages with icds and women's programming are crucial for strengthening the protective environment for children. early childhood is also full of threats for children and it is important to equip staff of these programmes and families for building safeguards for children, preventing abuse and exploitation, being aware of signs of abuse in children and reporting such cases for appropriate support and action.in order to produce a deeper impact of these initiatives mwcd is intending to strengthen child development indicators and children's right to protection, mwcd envisages that these schemes requires to be implemented after having close functional linkages not only with other allied schemes of government of india but also of the state governments/ union territory administrations. this is basically due to the fact that all these programmes are targeted towards an integrated delivery of multiplicity of services, which are handled by different departments at different levels. thus, the successes of all these programmes are mainly depending upon the effectiveness of inter sectoral convergence and coordination mechanism at various levels of policy planning and implementation. besides this, the convergence of the services also requires inter departmental coordinated efforts at different levels of administration and programmeimplementation.mwcd recognizes that such efforts are especially needed to be concentrated in the areas of basic services such as, early learning and school readiness, child protection and development, primary education, nutrition, primary health care, safe drinking water and sanitation, early detection and prevention of disabilities, law enforcement, investigation of crime against children, detection of abuse/ violence against children and provision of appropriate care and recovery services. in addition, coordination and convergence is especially important for mainstreaming a preventive approach and building a protective environment for children through a focus on identification and focused interventions to vulnerable families and children.training is a means of communicating new knowledge and skills and changing attitudes. it can raise awareness and provide people with the opportunity to explore their existing knowledge and skills. training is also defined as learning process that involves the acquisition of knowledge, sharpening of skills, concepts, rules or changing of attitudes and behaviours to enhance the performance of employee. imparting training to representatives of ngos is recognized as a key means through which these representatives are provided with the necessary knowledge and skills to improve overall agency performance and achieve the objectives of social policy. the concept of training predates history. it is as old as man himself. the earliest man learnt to hunt and grow crops for his survival. one of the earliest types of training was on the job training (ojt) which is still in wide use today. china began training of her workers through conceptual case studies in the 5th century bc. confucius presented problems to his students and asked them to contemplate possible solutions to those problems. the case study is still widely in practice even today, mostly in professional schools. it is an effective tool to encourage learners to think philosophically about difficult

and problematic situations without having to go through personal experiences. as time went on, modern theories of psychology, training and staff development were applied to training methods in order to keep staff skilled, knowledgeable and motivated
training definedthe word "training" has many meanings. to some writers, in the field of personnel management training means developing manpower for particular jobs. other writers interpret it more broadly, including training for adequate job performance and extending an employee's intellectual range through general education. still other writers speak of an overall development, which they divide into education and training. training in this instance means fitting the man to the job, whereas the purpose of education fits the man to his environment off and on-the-job. according to grey dessler, "training is the process of teaching new employees the basic skills they need, to perform their jobs". hesseling defines "training as a sequence of experiences or opportunities designed to modify behaviour in order to attain a stated objective". hamblin defines "training as any activity which deliberately attempts to improve a person's skill on the job as opposed to education which is mainly concerned with personal development". one definition of training is 'the process of bringing a person to an agreed standard of skill by practice and instruction'. another definition is 'a trainer and participant working together to transfer information from the trainer to the participant, to develop the participant's knowledge, attitudes or skills so they can perform work tasks better'. taken together these definitions say two things: 1. training is directed towards agreed standards or objectives. these are sometimes called learning outcomes — what you want people to learn from training. 2. the person being trained participates with the trainer in the training activity, rather than simply receiving instruction. training usually involves participation. this means that a person being trained has an active role in the training process, rather than a passive role. also it often takes place in the workplace or community where the skills and knowledge being communicated will be used.thus it may be stated that training is a learning experience which seeks a relatively permanent changes in the individual that will improve his/her ability to perform his duty well. every organization needs to have well trained, experienced and adjusted employees to perform their duties efficiently. training can involve the changing of skills, knowledge, attitudes or behaviour. it may mean changing what employees know, how they work, their attitudes towards their work or their interaction with their co-workers or supervisor. training is more present day oriented and focuses on individual's existing jobs and enhancement of abilities to perform well. training should not focus on new employees only, but old employees should also be put through periodical training in order to keep their knowledge updated.training is a planned scientific activity to develop and make changes in the human attitudes and qualify them to conduct their work in a professional manner and increase the productivity. in addition, it is considered an investment in human resources, gaining updated information, skills and better attitude to comply with a civilized way of living. every working individual in the society has his basic needs from training, which is different according to priorities from time to time, to age stage, capabilities and nature of job one is doing. it is a transformative process which aims to increase knowledge and to develop understanding as a way to change the behaviour, which further helps to change the behaviour.
training organizations most commonly evaluate baseline knowledge, attitudes, and skills (kas), and conduct input, process, and outcome evaluations. needs assessments are done infrequently and are generally conducted for the purpose of designing a new course or for a

large-scale, ongoing course. often, years after an initial needs assessment, the same course is still given, even though changes in the environment would suggest that a new needs assessment be conducted or that the course be revised. an impact evaluation, in spite of its importance, is rarely conducted. impact assessment is a formal evaluation type of study that assesses the extent of implementation and influence of a specific programme or project on desired outcomes and data collected is used to measure the extent of desired change in the targeted population. it is understood that a successful impact assessment needs to explore the whole 'impact chain' and so investigate the linkages between inputs and activities, how these generate the outputs which then produce outcomes and finally impact. although originally, impact assessments have been single method, there has been move towards multi-method approaches.

india's developmental efforts which are being carried out within the framework of five-year development plans have contributed a great deal towards improvements in the demographic, health, educational, and other socio economic indices of the country. india's significant progress in its demographic indicators includes reduction in birth rate (br) from 41.7 in 1951 to 22.5 in 2011; declining of death rate (dr) almost one third from 22.8 in 1951 to 7.3 in 2011; declining of total fertility rate (tfr) to 2.6 at the current level, which was 6.0 in 1951 and going up of life expectancy at birth for 41.6 and 40.6 for males and females in 1951-61 to 65.8 years for males and 68.1 years for females in 2011. india's infant mortality rate (imr) has also steadily declined from 146.0 in 1951 to 50.0 in 2011 per 1000 live births. similarly, there has been a steady decadal improvement in the literacy rate of the country from 18.33 percent in 1951, 28.3 in 1961, 34.45 in 1971, 43.57 in 1981, and 52.21 in 1991 and to 64.84 per cent in 2001 and …… in 20111.22 billion people is the second most populous country in the world. the country globally accommodates 17.5 per cent of the total population on the earth in just 2.4 per cent of total world's surface area of 135.79 million square kilometer (census of india, 2011). though, the population of india rose from 361.09 million in 1951 to 1210.19 million in 2011and is further expected to increase to 1,269 million by 2015, 1339.7 million by 2021 and 1399.8 million by 2030 (project population), however, a look at the growth rate of the populationas evident from census figures of the last five decades indicates perceptible declines in the recent decades with 24.80 per cent for 1971, 24.66 per cent for 1981, 23.87 per cent for 1991 , 21.54 for 2001and 17.64 per cent for 2011. the total number of children in the age group of 0-6 years is 158.8 million (-5 million since 2001). the proportion of child population in the age group of 0-6 years to total population is 13.1 per cent while the corresponding figure in 2001 was 15.9 per cent. as per the technical group on population projection appointed by national commission on population and ministry of health and family welfare, these demographic and health indicators are further set to show improvements. the expectation of life at birth is expected to go up for 68.8 for male and 71.1 for female in the year 2020 and 69.8 for male and 72.3 for female in the year 2025. cbr is expected to decline from 24.10 in 1996-2001 to 21.41 during 2011-16. the decline in the cdr during this period is also set to be from 8.99 in 1996-2001 to 7.48 in 2011-16. despite all these achievements, it is readily conceded that india is far from the healthy nation. india's progress on basic indicators of human development is far below as compared to neighboring (especially saarc countries) and other asian and developed countries. thus india is continue to leg behind them (table 1).

TABLE -1

(vital statistics concerning some of basic indicators)

sl no	country	life expectancy at birth	infant mortality rate	under five mortality rate	crude death rate	crude birth rate	total fertility rate
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
ten most populous countries							
1	china	73	16	18	7	12	1.6
2	india	65	48	63	8	22	2.6
3	usa	78	7	8	8	14	2.1
4	indonesia	69	27	35	7	18	2.1
5	brazil	73	17	19	6	15	1.8
6	pakistan	65	70	87	7	27	3.4
7	russian fed	69	9	12	14	12	1.5
8	bangladesh	69	38	48	6	20	2.2
9	japan	83	2	3	9	9	1.4
10	nigeria	51	73	143	14	40	5.5
south asian association for regional cooperation (saarc) countries							
1	india	65	48	63	8	22	2.6
2	maldives	77	14	15	4	17	1.8
3	sri lanka	75	14	17	7	18	2.3
4	pakistan	65	70	87	7	27	3.4
5	nepal	68	41	50	6	24	2.7
6	bhutan	67	44	56	7	20	2.4
7	bangladesh	69	38	48	6	20	2.2
8	afghanistan	48	103	149	16	44	6.3

source-the state of world's children, 2012. unicef, new york

YOUNGER CHILDREN – A PROFILE

nineteen per cent of world's children live in india. of all the children in the world, one in five is an indian. india is home to more than one billion people, of which 42 per cent are children, defined as persons under 18 years of age. in international comparisons of the status and condition of children, india continues to rank poorly on several key counts. the indian economy, which is one of the world's fast growing economies, unfortunately ranks 127 on the human development index (hdi). if all child rights indicators were to become critical measures of hdi, then india would fare even worse, because of its low levels of achievements on accepted goals for the survival and development of its children. within the childhood stage, which as per global consensus and as defined by planning commission (2008) in 11th five year plan document (2007-12) is considered up to the age of 18 years, early childhood period (0-6 years) deserves special attention. it is due to the fact of

accumulated scientific evidences that powerfully demonstrates in instituting either family and /or centre based early childhood interventions so as to nurture (i) psycho – social development (cognition ,motor, social ,emotional and language) through maturation and interaction in an properly designed appropriate environment suiting to the child and (ii) generating long term social , economic and educational benefits in terms of lower rates of grades repetition; increased earning potential; reduction in juvenile delinquency; increased social mobilization ; reduced social and economic inequalities ; psycho – social readiness for school; reduction of drop out rate ; expanding universalization of elementary education ; improved parent –child interaction and finally reducing high developmental costs at later stage of life due to inadequate care. numerically also, children less than 6 years of age constitute about 15 % of the total population. of the total child population, 2.07 crore (6 per cent) are infants who are below 1 year; 4.17 crore (12 per cent) are toddlers in the age group of 1-2 years; and 7.73 crores (22.2 per cent) are pre scholars in the age group of 3-5 years. thus one of the salient demographic features of our country is that it has a sizeable proportion of young population. india is not only home to 21 per cent of developing world's young children but its young child population size is larger than the total population size of many countries. the technical group on population projections, appointed by registrar general of census
operation in india, has further projected that in 2016, about 25 million infants would be in need of immunization services and their mothers will require maternal health services. similarly, pre school education services will need to be provided for 72 million children by 2016. no other nation in the world including china is likely to enjoy the benefits of such a large young population in the years to come.
india is the second most populous country in the world. the country globally accommodates 17.5 per cent of the total population on the earth in just 2.4 per cent of total world's surface area of 135.79 million square kilometer (census of india, 2011). though, the population of india rose from 361.09 million in 1951 to 1210.19 million in 2011and is further expected to increase to 1,269 million by 2015, 1339.7 million by 2021 and 1399.8 million by 2030 (project population), however, a look at the growth rate of the populationas evident from census figures of the last five decades indicates perceptible declines in the recent decades with 24.80 per cent for 1971, 24.66 per cent for 1981, 23.87 per cent for 1991 , 21.54 for 2001and 17.64 per cent for 2011. the total number of children in the age group of 0-6 years is 158.8 million (-5 million since 2001). the proportion of child population in the age group of 0-6 years to total population is 13.1 per cent while the corresponding figure in 2001 was 15.9 per cent. the expectation of life at birth is expected to go up for 68.8 for male and 71.1 for female in the year 2020 and 69.8 for male and 72.3 for female in the year 2025. cbr is expected to decline from 24.10 in 1996- 2001 to 21.41 during 2011-16. the decline in the cdr during this period is also set to be from 8.99 in 1996-2001 to 7.48 in 2011-16. despite all these achievements, it is readily conceded that india is far from the healthy nation. india's progress on basic indicators of human development is far below as compared to neighboring (especially saarc countries) and other asian and developed countries. thus india is continue to leg behind them.

as a social workeryou will sometimes need to play the roler in the community. this module will introduce you to social work social work is a discipline within human services. its main goal is to assist individuals and families with their needs and solve their problems

using a multidisciplined approach. in order to be effective, social workers work closely with many agencies and professionals.social work is usually a part of the human services department of a government.it serves as a link between the government's clients and other government resources, such as: manpower training leading to employment, welfare payments towards financial assistance, legal consultation in dealing with legal problems, food and water relief at times of drought, famine and war, etc.

as a social worker, you will also work closely with medical professionals in order to provide medical care for clients; with school personnel to identify children who are in need of help, and with counsellors and psychologists in order to provide psycholotoday the problems faced by individuals and families are often complicated, and assistance from many agencies is needed.social work provides an important service to society. individuals and families in need of help are the focus of it, and are referred to as clients. as social workers, our goal is to help clients live a productive life in their own community. in order to reach this goal, we often enlist the assistance of family members, relatives, local religious leaders, tribal leaders and elders, and other influential members of the community. although institutionalization may be necessary at times, it is a temporary solution. the goal is to help clients return to normal life in a natural setting. today, social workers are not only the bridge linking clients to other helpers, they also provide their clients with hope, and encourage their first steps towards a new life. social workers usually stand in the front line, and reach out to the clients soon after problems occur. they provide an initial assessment of the situation and mobilize other needed services.social work uses a team approach and is multi-disciplined. its goal is to provide a service to those who need help, especially the old, young, poor, abused, mistreated, handicapped, jobless, the sick and the homeless. its approach is to use available resources to solve problems in order to empower clients to help themselves in the long

GUIDELINES FOR SOCIAL WORKERS

these are guidelines on how social workers operate.

1. establishment of a counselling relationship - see the relationship as a process of giving the client an opportunity to grow, develop, and ultimately to understand and discover himself, and make appropriate choices.

2. acceptance - recognize the worth of the individual regardless of his/her circumstances, status, religion, race, politics, behaviour, and wish to foster human dignity and self-respect.

3. self-determination - encourage self-help as a means of growing in self-confidence, and the ability to take on more responsibility for one's own affairs.

4.freedom to choose - the client must be able to make appropriate choices, and consider how his/her choice may affect others. - be able to respect and care for clients as individuals without ridicule.

5. confidentiality -the relationship is based on trust. you must recognize that what passes between you and your client is confidential. assume that all information is given in trust, and therefore confidential, unless permission is given to use it in another context.

6. being empathetic - you must be sensitive to the client's feelings. put yourself in the client's position. it helps if you understand your strengths and weaknesses. if you accept yourself as you are, you may be able to accept others.

7. genuineness - you must be genuine and not defensive. be open, real and honest. studies indicate that positive outcomes can be achieved if the client sees in you empathy, genuineness and a positive regard the art of building a helping relationship make yourself approachable, genuine and warm.be sensitive, listen attentively. spend time listening to, and talking with, your client. disapprove the act, not the person. be firm and friendly.try not to use threats. explain the rules of the relationship.

ETHICS OF A SOCIAL WORKER

the following are the ethics of a social worker:

1. respect the dignity of the individual as the basis for all social relationships.
2. have faith in the capacity of the client to advance towards his/her goals.
3. base your relations with others on their qualities as individuals, without distinction as to race, creed, colour, or economic or social status.
4. recognize that your greatest gift to another person may be to give an opportunity for him/her to develop and exercise his/her own capacities.
5. do not invade the personal affairs of another individual without his/her consent, except in an emergency, where you must act to prevent injury to him/her or to others.
6. believe and accept the differences and individuality of others, and endeavour to build a useful relationship on them.
7. base your opinion of another person on a genuine attempt to understand the whole person, his/her situation, and what it means.
8. constantly try to seek understanding and control yourself, your attitudes, and the prejudices which may affect your relationships.

DEMANDS ON SOCIAL WORK

it is common to find clients who expect much from you. usually they expect immediate material assistance. for example, if they experience financial difficulties, they expect to be given money. it is important for you to explain to your clients what your roles are, instead of raising false hopes. it is important for you not to take on the personal problems of your clients as your own, as this could cause problems for you. you should present yourself as a person who can assist them to understand their concerns and manage them. while you, your clients, and the general public, may see social work as the embodiment of social services, you are dependent on public sponsorship. social work is not about providing solutions to problems, but it provides an arena in which clients can review their concerns, and see how they can manage them best and live an effective life. social work links clients with services, resources and opportunities, which might provide them with

the help they need. this contributes to problem-solving for clients. it is important to recognize in social work the fact that it is an adaptable service, and one which is more responsive and accountable to a particular locality and its people. social work is concerned with the provision of welfare services, when people's capacity for responding to the demands of life is strained, when capacity growth seems unattainable, and when important decisions elude resolution. social work should assist clients to deal with life, engage in growth-producing activities, and make effective decisions. naturally when people have a problem, they look for help. usually, they think they have no capacity to solve their problem unless someone helps them to do so. and even when help comes, they expect the helper to produce the magic which will solve their problems. social workers must make the role of their work clear when they are approached by a client. their role is to assist the client to know why they need help and where they can get it.

EXPECTATIONS OF THE CLIENTS

naturally, the presence of a social worker, when there is a problem, raises hope in a client. clients usually think that someone with a solution to their problem has come. as a result, they may present themselves as people who are completely helpless, even when they are able to do something themselves to resolve their concerns. a social worker should not take over the problem of the client. instead, he/she must assist the client to re-examine it and consider possible solutions to it.

THE FAMILY RATIONALE

this unit defines the family as a basic social unit which exists in all societies. the family provides important support for the individual in society. it caters for the physical, effective and emotional needs of the individual. it provides the individual with social and educational support. the family is also responsible for rearing and protecting children. it is the basic unit of socialization and cultural transmission, since children acquire their fundamental values and attitudes from their families. indeed, it is the social cell in which human beings are born, and where they learn to become members of a wider human society. however, the family is also where many interpersonal conflicts occur, problems develop, and individuals suffer. all families have difficulties from time to time. some families have resources to solve their problems while others do not. when a family is no longer able to deal with its problems, and cannot provide the basic physical, security, effective and emotional needs of its members, we call this kind of family 'dysfunctional'. there are many reasons why a family becomes dysfunctional. among others, they are alcoholism, drug addiction, physical illness, death, war, poverty, unemployment, mental illness, spouse abuse, child abuse, divorce and separation, and polygamy. this unit aims at enhancing the participants' knowledge and understanding of the basic concepts related to family life. as we discuss the importance of the family, we also note the problems that may prevent the successful functioning of the family.

many of the circumstances leading to conflict with the law are of a social nature. children who offend often live in families facing difficulties such as poverty, substance abuse or separation; they may be excluded from school or be without a job; they may be involved in risky behaviours such as drug use or prostitution. when these children enter into contact with the police, the main purpose of juvenile justice systems should be to enable them not

to reoffend. as stated in article 40 of the convention on the rights of the child, every child in conflict with the law has the right to be treated in a manner that takes into account "the desirability of promoting [his/her] reintegration and [his/her] assuming a constructive role in society." tailored support for each child and his/her family should be provided throughout the process – including after release in the case of a custodial sentence – if the intervention of justice is to be meaningful. obviously, justice systems are neither equipped nor mandated to fulfil this role alone, and need to work hand in hand with the social sector towards this end. in the absence of such intersectoral cooperation, juvenile justice interventions would miss the opportunity of supporting a sustainable change in the child's behaviour, circumstances and environment. social services and the justice system are in many ways two distinct spheres and invariably the responsibility of separate ministries, but the occasions and ways in which they could and should interface and cooperate are numerous and important for the implementation of children's rights. this paper is designed to pinpoint the main activities and tasks that should be undertaken by social work professionals within the overall juvenile justice framework. to do so, the paper first briefly reviews experience of social work in the central and eastern european/commonwealth of independent states (cee/cis) region since it is against this background that the realization of the potential of social work in conjunction with the justice system will have to be set. the paper then moves on to examine the many facets of social work, taking inspiration from the description of its wide-ranging roles as set out by its international professional body – the international federation of social workers (ifsw). these two sections provide the backdrop for examining in more depth how social work and the justice system can work together to optimize responses to children in conflict with the law.

the social work profession has a chequered history in the cee/cis region. the profession managed to retain official endorsement throughout the twentieth century in only a few countries in the region, among them notably the federal republic of yugoslavia and poland. in the pretransition era, the authorities of most countries, in contrast, viewed social work as the reflection of a charity approach to problems engendered by, and inherent to, capitalist regimes. social work was therefore considered unnecessary, irrelevant and/or unacceptable in a communist society. thus, the profession was banned as of the 1930s in the soviet union, so "social work has little tradition as an academic or professional path in most former soviet countries."[1] several central and eastern european countries followed suit, more or less gradually, once communist regimes were installed after world war ii, e.g., czechoslovakia, hungary and romania.[2] interestingly, the time taken to 'rehabilitate' the social work profession has varied greatly in the region. hungary reintroduced social work education already in 1986,[3] and the profession was reinstated in the russian federation in spring 1991, several months before the official dissolution of the soviet union, although it is currently claimed that "the status of social work as a profession is still weak and unclear even if there is more social work education being offered at universities and other signs of change."[4] in romania, social work training was re-established in june 1990, just months after the downfall of the communist regime, with a full fouryear degree course in place as of 1992 and the first 'new generation' of social workers qualified by 1994, whereas albania's first batch of qualified social workers only completed their training in 2000. elsewhere, it took even longer just to secure recognition of the profession. thus, in georgia, "[m]any health workers, teachers, and psychologists [had] been practising what qualifies as social work but lacks the official title… social work was finally recognized as an independent

profession in 2003 [but] georgian social work had no professional body or a code of standards [until 2004], and few concrete opportunities to work in the field."[5]
where the profession as such was banned, certain of its many specific functions were sometimes in principle devolved to others, such as specialized juvenile officers in the police or educational workers in schools. thus, for example, ostensibly preventive measures – such as 'registration' – have been assigned to police officers (with or without special training) rather than, more appropriately, to fully fledged social workers. if used at all, the term 'social work' often loosely referred to services whose nature or restrictiveness did not necessarily correspond to the more generally accepted conception of the profession. thus, for example, in some cases, it was applied to an essentially administrative function involving more especially the determination and provision of social security payments and other material assistance to individuals and families in difficulty. elsewhere, it was linked mainly to the (physical) health sphere: the so-called 'medical model of social care'. generally, to be sure, these perceptions have now evolved considerably, but elements of the legacy can still affect how the actual and potential role of 'social work' is viewed.

scope of social work

given these very different experiences of, and approaches to, 'social work' in the region, it is clearly all the more essential to be aware of the internationally agreed scope and forms of its action and intervention when broaching its role in relation to juvenile justice. the scope and forms involved are considerably wider than the 'popular' conception of what social work is designed to accomplish. its principal professional body, the international federation of social workers (ifsw), sets out three key action areas,[6] which can be characterized as follows: • promoting social change, on the basis of its findings regarding the needs and the avoidable causes of problems confronted by individuals and groups seeking or requiring assistance; • problem-solving in human relationships, whether interpersonal, intrafamilial, within the wider community or vis-à-vis the authorities and their agents; • empowering people to enhance their own well-being, as opposed to creating ongoing dependency and thus maintaining inherent vulnerability. the ifsw also stresses that the profession draws on theories of human development, social theory and social systems to facilitate individual, organizational, social and cultural changes, and that social work is founded on the principles of human rights and social justice.

given such a range of potential areas of intervention, together with the bases and approaches that inform its action, it is clear that the social work profession can have positive direct and indirect impacts on the juvenile justice system, and this in three main ways that loosely correspond to the three levels of the preventive framework:[7] (1) working alongside, but independently from, the juvenile justice system: this relates to both the primary prevention role of social work and to elements of secondary prevention. at the primary level, social services should be accessible on a self-referral basis to respond appropriately to any individual or family experiencing difficulties. in addition, at the secondary level, social workers help to identify proactively, and respond to, families where children are at risk, wherever possible by enabling those families to address the root causes of 'presenting problems' such as intrafamilial violence, neglect and delinquency.

(2) interfacing with the justice system: other elements of secondary prevention may fall to the social work profession as a result of the child or a parent coming into contact with the justice system. thus, social workers should be involved when the police question or arrest a child who is under the minimum age for prosecution or has not committed a criminal act but

is clearly in danger (e.g., homeless, unaccompanied migrant). if a parent is arrested and detained, social workers should be able to check and ensure the well-being of their children. (3) working within the justice system: a wide range of tasks may be allocated to the social work profession in the context of the justice system, from the moment of the child's apprehension or arrest through to disposal and, where appropriate, follow-up. importantly, there is also every advantage in inviting the social work profession, in keeping with its potential mandate, to contribute to developing relevant policy, legislation and programmes, on the basis of the needs and issues that it identifies in the course of its functioning and casework at all three of the above levels. this might include findings that could incite and inform governmental initiatives ranging from readjusting social security thresholds to the decriminalization of vagrancy. primary prevention is obviously a fundamental element in the social work agenda and can have a significant impact in a number of spheres, including that of delinquency. however, it is not discussed further in this note since, save in exceptional cases, it does not involve actors in the justice system. this review therefore concentrates on the second and third components of the above listing.

the police are the front-line actors of the criminal justice system, and it is through them that children and young people invariably have their first contact with that system. however, after this first contact, the police may have no further direct role to play. three main scenarios are involved. the first concerns children who are apprehended or arrested on suspicion of having committed a criminal offence but are below the minimum age at which they could be prosecuted for such acts. under such circumstances there is general agreement that, while police action is no longer warranted or appropriate by definition, neither is it desirable or constructive simply to ignore the event and thus to leave the child without follow-up. "for these children," notes the committee on the rights of the child, "special protective measures can be taken if necessary in their best interests."[8] thus, whatever the nature of the alleged act and the conditions in which it took place, it is essential that there be clarity as to the overall situation of the child concerned, so that, if necessary, appropriate levels and types of assistance and support can be foreseen, to avoid as far as possible subsequent behaviour inconsistent with the law. the task of investigating the child's situation and providing any necessary assistance should come within the remit of social workers. to ensure that this is an accepted and systematically applied procedure, the best solution is to draw up a protocol between the police and social services, whereby responsibility for children below the minimum age of criminal responsibility is transferred immediately and effectively by the police to the social services. it is worth pointing out in this respect that, since minimum age for prosecution in cee/cis countries is higher than average,[9] the potential roles and responsibilities of social work professionals in such countries are particularly heavy and crucial in regard to 'underage' children. the second scenario is typified by situations where children or young people are approached by the police because their behaviour or circumstances arouse concern although they are not suspected of a criminal offence as such. this is frequently the case, for example, for vagrant or homeless children. here again,
recognized and accepted procedures need to be in place for the police to contact social services (or specialized street workers) if their concern remains after initial contact with the children. the third scenario enters into play in situations where the police, having arrested a child above the age of criminal responsibility, have been granted the discretionary power to

set in place a diversionary measure instead of pursuing prosecution through the court. such diversionary measures may optimally involve initial referral to a social worker. they are currently rare in the cee/cis region, however, where diversion usually happens at the prosecutor's level. a very different but also important aspect of the police-social work interface involves children whose carer(s) have been arrested or detained by the police. one of the first questions that need to be put to an arrested or detained person concerns their family status and, in particular, whether their arrest or detention prevents them from ensuring a necessary caring role for a child or children. if such is the case, once again there must be procedures to secure the involvement of social workers who can check on the children's situation and ensure that their well-being is guaranteed.
n countries of the former soviet union and several others in the region, children dealt with by the justice system generally faced sentences (or suspended sentences) involving deprivation of liberty in some form, often for several years, albeit with the leitmotiv of 'rehabilitation' rather than pure punishment. to the extent that this legacy persists to a greater or lesser degree, "social workers have a weak position in this system."[10] there are now, however, a growing number of efforts to address this issue, implying "a chain of social treatment – from the time the youngsters were caught by the police, through the trial and during sanctions, such as serving sentence in a youth colony or being put on probation – to a new start in the society."[11] the links in such a chain are many, with the following being among the 'key' actions to be carried out by social workers in the justice system: assisting the child from the moment of arrest. in some countries, a social worker has to be present with the child during police questioning if the parents cannot be (and sometimes even when the latter are also there), providing emotional and possibly paralegal and other support to the child. a social worker may also be able 10 trygged, s., and eriksson, b., supra. 11 ibid. 7 to propose pretrial solutions other than remand in custody that will be acceptable to all parties, and can in any case maintain contact with the child throughout the pretrial period in order to provide assistance and advice as required. preparing social enquiry reports on the child's circumstances and characteristics. these reports are usually drawn up to provide the court with background information on the child – above all on all aspects of the family situation, as well as health and education status and highlighting any special problems or strengths – in order to help determine the most appropriate course of action regarding that particular child in response to the offence. at the same time, in systems allowing for 'diversion' at the pretrial stage, similar reports might also be used more especially for 'borderline' cases where the competent body is unsure as to whether diversion would be suitable. organizing diversion. if pretrial diversion is ordered, the social worker can take responsibility for selecting the most appropriate programme or setting, and assisting the child to complete the diversionary measure successfully. supervising young offenders in the community. social workers (often specialized, such as probation officers) can clearly be made responsible, by the court, for overseeing supervision orders. this involves not only working with the child concerned but also with his/her family and, where appropriate, with the school and community associations. similarly, social workers may be tasked with ensuring proper completion of measures such as community service. support during custodial sentences. the availability of a social worker for children deprived of their liberty can be an important factor for their well-being, and thus for the prognosis on completion of sentence. in such circumstances, a social worker can also suggest and mobilize other services – education, ngos, etc. – to make the detention measure more constructive. in most

cases, if the social worker concerned is also in contact with the family, this will be an added benefit (although it should never replace, of course, family visits or other communications between family and child). preparation for release. here, the direct and indirect roles of the social worker are particularly crucial; in that it is rare to find any system where this vital function is undertaken by others, save in some cases by ngos. preparation for release involves working not only with the child and trying to ensure that his/her prospects on release are as positive as possible (continued education, vocational training, employment) but also and necessarily with the family, so that the home setting is also as propitious as possible for the child's return. post-release support (aftercare). whether or not there are formal conditions attached to a child's release from a custodial sentence (such as a subsequent probationary period, close supervision or 'on licence'), which a social worker may be tasked with overseeing, the availability of support and advice from a social 8 worker at this stage can be invaluable in enabling the child to avoid reoffending.[12] in many cases, the child's overall environment (family, friendships, community, material conditions, opportunities…) will have changed little during his/her time in custody, and to the extent that these were causal factors in the original offending behaviour, the child may well need ad hoc or ongoing support to resist recidivism. enhancing the role of social workers in the justice sphere it is often said that the wide-ranging 'international' view of social work is essentially a western-based model. this is undoubtedly broadly true as such, but the pertinence here of that wide scope reviewed above lies more especially in setting out the potential range of functions – from casework to advocacy – that the social work profession as a whole can play, and the settings in which it may be called upon to do so. this enables the desirability, necessity and appropriateness (feasibility) of each function to be assessed in specific country situations with, in this instance, the goal of improving responses to children in conflict with the law, in harmony with the justice system. in a similar vein, the profession has evolved significantly over time, in keeping with documented needs, changing approaches (from a focus on assistance to a facilitating and enabling thrust), a vastly increased body of research and more systematic evaluations of effectiveness and impacts. thus, social work should be seen as a sphere of action that is responsive to societal realities rather than as an immutable set of functions and strategies. it now potentially incorporates a range of specialized professionals such as street workers, educators, residential care workers, family support workers and probation officers, and operating in a variety of settings from 'the street' to the courtroom.suffice it to say, therefore, that the aim must surely be that each country examines the extent to which each potential social work function could contribute to the promotion and protection of children's rights in the justice system and, where the result of that examination is positive, that progressive implementation of the role(s) concerned be planned and carried out. finally, if the social work profession is to be able to play its role to its fullest potential with and within the justice system, it is clearly vital that there be mutual trust and respect among all actors involved. even in countries where social work is 12 as an example of the perceived importance of this role, the full official title of the body for which probation officers worked in the united kingdom was the 'probation and aftercare service'. 9 a long-standing and well recognized profession, there are examples of lack of such trust and respect between social workers and the police, prosecutors and judges. at least five preconditions from the social work side must be met if such problems are to be avoided: • the social work profession and its roles must be fully and officially recognized. • social workers must receive adequate

professional training to fulfil – and to be seen to fulfil – those roles effectively. • social work must be given adequate resources (human and material) that enable it to offer valid responses. • roles and responsibilities of social work vis-à-vis other actors in the justice system must be clearly defined and agreed by all concerned. • multiprofessionalfora must be foreseen at all levels where actors can discuss any difficulties encountered in their cooperation and propose solutions, strategies and targets to improve their combined efforts.the world bank have given money for the development of icdsprograme
. in order to ensure the fair representation of awcs which were selected for in depth study, precautions were taken not to choose more than two awcs from same supervisory circle of icds project.the regular icds projects were also studied on the same basis**data analysis** the formats of the data were prepared in such a way that the data could be used in variety of ways for subsequent analysis. the state wise data base was created on ms excel sheet with an intention to optimally utilize the valuable empirical information for other purposes result*a*fter collecting, tabulating, interpreting the data and summarizing the results, an attempt has been made in the present some broad conclusions and recommendations. it is hoped that the recommendations of the study, if implemented, would make the implementation of icds with involvement of voluntary organizations more
.

we collected data from ngo and government states of ap ,chattisgarh,gugrat,karnatakmp,punjab,rajasthan and west bengal .

the result infrastructure *table .1* and ***table .2*** shows the comparative status of ngos and government run icds projects on four input variables of availability of toilets, indoor space, weighing scales and medicine kits. one of the interesting trend evident from ***table .1*** is that while on the one hand all ngo run icds projects/awcs located across all eight study states were found better compared to the government run icds projects in availability of toilets, on the other, all such projects were found lagging behind on another variable of availability of indoor space. similarly, while on the one hand all ngo run icds projects/awcs located across study states (except mp) were found better compared to the government run icds projects in availability of weighing scales , on the other, all such projects were found lagging behind (except rajasthan) on variable of availability of medicine kit

TABLE -.1AVAILABILITY OF TOILETS AND INDOOR SPACE

state	availability of toilets			indoor space		
	government run projects	ngos run projects	difference of ngo over govt run projects	government run projects	ngos run projects	difference of ngo over govt run projects
ap	30	80	+ 50	86	40	-46
chhatisgarh	50	100	+ 50	81	50	-31
gujarat	46	80	+ 34	89	55	-34
karnataka	35	100	+ 65	79	60	-19
mp	44	56	+ 12	80	44	-36
punjab	41	80	+ 39	76	30	-46
rajasthan	29	33	+ 4	68	67	-1
west bengal	29	69	+ 40	47	39	-8
total	38	75	+37	76	48	-28

TABLE -.2
AVAILABILITY OF WEIGHING SCALES AND MEDICINE KIT

state	availability of weighing scales			availability of medicine kit		
	government run projects	ngos run projects	difference of ngo over govt run projects	government run projects	ngos run projects	difference of ngo over govt run projects
ap	78	100	+22	91	0	-91
chhatisgarh	87	100	+13	0	0	0
gujarat	87	90	+3	93	68	-25
karnataka	85	100	+15	70	0	-70
mp	84	67	-17	19	0	-19
punjab	46	70	+24	72	0	-72
rajasthan	58	73	+15	86	100	+14
west bengal	79	96	+17	80	86	+6
total	**76**	87	+11	**64**	**32**	**-32**

delivery of services

supplementary nutrition ***table .3*** presents the coverage of nursing and pregnant women and of children (0-6 years) as percentage of those registered in awc for availing the services. it is clear from table that the performance of ngo run icds projects/awcs was found much better as compared to government run icds projects. the over all difference in effective coverage of 49 per cent in case of women icds beneficiaries and 37 per cent in case of children (0-6 years) is testimony of this fact. the average number of days for which supplementary nutrition was being distributed in ngo run icds projects was also found to be much higher (23 days in a month) than government run icds projects (15 days in a month). (***table .4***). again such difference in favour of ngos run projects were found in all such projects located across eight study states.

TABLE .3(EFFECTIVE COVERAGE UNDER SUPPLEMENTARY NUTRITION

state	effective coverage as % of those registered (nursing and pregnant women)			effective coverage as % of those registered (children)		
	government run projects	ngos run projects	difference of ngo over govt run projects	government run projects	ngos run projects	difference of ngo over govt run projects
ap	35.1	100	+ 64.9	47.2	100	+ 53
chhatisgarh	49.2	97.1	+ 47.9	65.1	88.6	+ 23
gujarat	42.8	90.5	+ 47.7	65.7	91	+ 25
karnataka	39.9	100	+ 60.1	67.5	100	+ 32
mp	25.1	92.1	+ 67	38.2	88	+ 50
punjab	56.2	74.9	+ 18.7	40.2	89	+ 49

rajasthan	13.4	97.1	+ 83.7	33.4	86.6	+ 53
west bengal	77.5	79.8	+ 2.3	65.8	78.1	+ 12
total	42.4	91.4	+ 49.0	53	90	+ 37

table .4

average number of days for distribution of supplementary nutrition

state	**average no of days per month**		
	government run projects	**ngos run projects**	**difference of ngo over govt run projects**
ap	13	24	+ 11
chhatisgarh	17	22	+ 5
gujarat	16	23	+ 7
karnataka	16	25	+ 9
mp	11	25	+ 14
punjab	16	19	+ 3
rajasthan	9	24	+ 15
west bengal	20	24	+ 4
total	**15**	23	+ 8

PRE SCHOOL EDUCATION

so far as the availability of pre school education material (toys, counting frames, pse kit, story books and aww made material) was concerned, the same was found to be better in ngo run icds projects located across all study states (except punjab) . the availability of pse material was reported in cent percent projects in chhatisgarh with an average of 69 per cent in all states under study as compared to 47 per cent government run icds projects.

TABLE .5

(AVAILABILITY OF PSE MATERIAL)

figures in %

state	**availability of teaching learning material ***		
	government run projects	**ngos run projects**	**% difference of ngo over govt run projects**
ap	55	80	+ 25
chhatisgarh	56	100	+ 44
gujarat	51	71	+ 20
karnataka	70	80	+ 10
mp	42	70	+ 28
punjab	30	30	0
rajasthan	48	53	+ 5
west bengal	25	67	+ 42
total	**47**	**69**	**+ 22**

*includes toys, counting frames, pse kit, story books and aww made material

referrals , nutrition and health education and health check up

while the organization of referral services and health check up were found better in ngo run icds projects, the organization of nhed service was reported better in government run icds projects. difference in organization of all these icds services might be attributed due to the fact that most of the ngo running icds projects across country have their own

hospitals serving as a referral hospital. further , the medical staff working in these hospitals frequently visits the awc and conducts the health check ups of icds beneficiaries. the same advantageous situation was not found in government run icds projects as they are mainly dependent on government hospitals (***table .6 and table .7***) .

TABLE .6(STATUS OF REFERRALS, NUTRITION AND HEALTH EDUCATION)

state	providing referral services			providing nhed services		
	government run projects	ngos run projects	difference of ngo over govt run projects	government run projects	ngos run projects	%difference of ngo over govt run projects
ap	97	100	+ 3	98	100	+ 2
chhatisgarh	87	89	+ 2	100	100	0
gujarat	98	91	- 7	87	95	+ 8
karnataka	77	100	+23	99	100	+1
mp	88	100	+ 12	99	100	+ 1
punjab	87	90	+ 3	100	90	-10
rajasthan	34	40	+ 6	96	82	-14
west bengal	14	84	+ 70	96	96	0
total	**73**	87	+ 14	**97**	**95**	**-2**

TABLE 7HEALTH CHECK UP

state	health check up		
	government run projects	ngos run projects	difference of ngo over govt run projects
ap	95	100	+ 5
chhatisgarh	79	78	-1
gujarat	90	85	-5
karnataka	90	100	+10
mp	76	90	+14
punjab	89	60	-29
rajasthan	36	67	+31
west bengal	55	66	+11
total	**74**	**81**	**+ 7**

KISHORI SHAKTI YOJANA

ksy scheme is being implemented across all icds projects in the country. compared to government run icds projects in implementation of various activities under ksy, ngo run icds projects were not found as much involved. (**table – .8**) .in ap, ksy was being implemented only by government run icds projects where as the involvement of ngos in the states of karnataka and mp was cent percent in implementation of such scheme.

TABLE – .8

IMPLEMENTATION OF KSY

state	ksy government run projects	ngos run projects	% difference of ngo over govt run projects
ap	79	0	-79
chhatisgarh	80	11	-69
gujarat	23	60	+37
karnataka	86	100	+14
mp	97	100	+3
punjab	77	30	-47
rajasthan	48	27	-21
west bengal	7	17	+10
total	**62**	**43**	**-19**

contribution of communityin view of the fact that ngos operates at the local level and icds functionaries working in these projects are having close relations with community than their counterparts working in government run projects, it was presumed that community contribution would be much better in ngos run icds projects. surprisingly, community contribution was little less than 48 per cent than government run projects (50 per cent). however ngos located in mp were found involving more community leaders in running awcs (***table .9***)

TABLE .9COMMUNITY CONTRIBUTION

state	community contribution		
	government run projects	**ngos run projects**	**difference of ngo over govt run projects**
ap	61	0	-61
chhatisgarh	86	50	-36
gujarat	32	73	+ 41
karnataka	49	0	-49
mp	48	100	+52
punjab	30	0	-30
rajasthan	44	62	+18
west bengal	53	96	+43
total	50	48	-2

MONITORING OF AWCS

the functionaries working in ngos are generally believed to be more committed and devoted compared to their counterparts working in government set up . the monitoring visits by the cdpo and the supervisor were found definitely better in ngos run icds projects compared to government run icds projects. while none of the cdpo working across all eight study states in government run icds projects reported of visiting awc during the last one month, 13 per cent of cdpos from ngo run icds projects reported visiting icds centres except in three study states of ap, karnataka and punjab. similarly, supervisors working across all eight study states in government run icds projects reported of visiting only one awc during the last one month, the figure was found as much higher(19) in all ngos run icds projects located across all eight study states (***table.10***) .

TABLE .10
(MONITORING OF ANGANWADICENTRES)

state	cdpo			supervisor		
	government run projects	ngos run projects	% difference of ngo over govt run projects	government run projects	ngos run projects	% difference of ngo over govt run projects
ap	-	-	-	1	17	+16
chhatisgarh	-	22	+22	1	15	+14
gujarat	-	15	+15	1	32	+31
karnataka	-	-	-	1	23	+22
mp	-	41	+41	1	10	+9
punjab	-	-	-	1	15	+14
rajasthan	-	14	+14	1	17	+16
west bengal	-	15	+15	1	25	+24
total	**-**	13	+13	**1**	**19**	**+18**

awws involvement in other assignments

awws , besides providing services under icds are being given a lot of other responsibilities . although, the awws serving in ngos run awcs were found to be engaged more in such activities compared to their counterparts serving in government run awcs , however, the number of hours engaged per day for such activities were found to be much higher for awws of government sector compared to other awws working in non government run awcs(***table .11***). during the time of data collection, it was observed that ngos besides engaging the awws in icds work also engage them from time to time in other activities which do not pertain to icds work.

TABLE -.11
ADDITIONAL TASKS PERFORMED BY AWWS

state	no of days in last fiscal year(2009-10)			number of hours per day		
	government run projects	ngo run projects	difference of ngo over govt run projects	government run projects	ngos run projects	difference of ngo over govt run projects
ap	7	64	+57	5	3	-2
chhatisgarh	10	18	+8	6	0	-6
gujarat	13	71	+58	5	2	-3
karnataka	8	198	+190	7	3	-4
mp	14	0	-14	6	0	-6
punjab	4	61	+57	7	1	-6
rajasthan	7	13	+6	7	3	-4
west bengal	13	21	+8	6	1	-5
total	**10**	50	+40	**6**	**2**	**-4**

thus when we the final report is that if we change this system then we will achieve what our prime minister wants to show india at the top.

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