

Report of the Social Audit of the  
ICDS Programme in the District of Anantapur  
in the State of Andhra Pradesh

29<sup>th</sup> July 2009

# C O N T E N T S

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# PREFACE

The rights of women and children have been recognized in the Constitution of India and various international instruments which India is a signatory to, has acceded to and has ratified. However, after the lapse of six decades since we gave ourselves a Constitution, the status of the Indian women and children in regard to health and nutrition and other social development indices is pretty dismal as shown by the National Family Health Survey (NFHS-3), 2005-06. The picture presented by this Survey and the UNICEF's "State of the World's Children 2009" is not very flattering to India. The picture that the National Family Health Survey (NFHS-3) presents of Andhra Pradesh, a State repeatedly proclaimed as a highly progressive Southern Indian state is actually a timely lesson in self importance. In fact, this picture of India and Andhra Pradesh is a dangerously dismal one hidden behind highly-vaunted macro economic growth indicators.

The idea of a Social Audit was born during an informal discussion between Prof. Muchkund Dubey, President of the Council for Social Development (CSD), New Delhi and me in the year 2007. We agreed that given the unacceptable levels of malnutrition and morbidity among women and children in general and the pregnant and nursing women and children in the 0-6 age group in particular in the country, which led in turn to irreversible birth defects among newborns that vitally prejudiced the country's human resource development, there was no programme that merited more urgent attention than the Integrated Child Development Services (ICDS), which aimed at holistically dealing with these problems through an integrated package of seven services that combined all vital elements relevant to the nutrition and health needs of this segment of our society.

Prof. Dubey accepted the suggestion that in this exercise may be involved three well known NGOs of Andhra Pradesh, namely, the Centre for Environment Concern, Hyderabad headed by Dr. K. S. Gopal; the Accion Fraternal headed by its Director, Ecology Centre Dr. Y. V. Malla Reddy; and the Rural and Environmental Development Society (REDS), Kadiri headed by its Director Smt. Bhanuja, who already had extensive hands-on experience at the field level of the concept, dynamics and practice of the Social Audit methodology in the light of their Social Audit work of the NREGP in Anantapur district. Also, the highly credible and considerable presence the Rural Development Trust (RDT) has had in the area of health in

Anantapur District over a long period and the commitment REDS has always displayed in its work in the Kadiri area were bound to be of great value to this work in this District. This proposal was taken up with Smt. Chaya Ratan IAS, Principal Secretary, Department of Women Development and Child Welfare, Government of Andhra Pradesh, who promptly approved of the idea, interested deeply as she is in improving the implementation of the ICDS programme in her State. The next step was the preparation of a concept note by me on the Social Audit of the ICDS programme in consultation with Prof. Dubey for discussions with the three participating NGOs and the District Collector, Anantapur. Shri. N. Sridhar IAS, Collector, who had a great commitment to improving over all governance in his District saw merit in this idea and held several rounds of discussions with me and the three participating NGOs and the District officers of the Departments of Women Development and Child Welfare (DWDCW) and Health on the details relating to the technicalities of the programme as also its logistics. The Principal Secretary to the Government of Andhra Pradesh, DWDCW and Smt. Y.V. Anuradha IAS, Commissioner, DWDCW were kept continuously briefed of this ongoing process of consultations at various levels. No words of thanks can do adequate justice to Ms. Chaya Ratan's sense of objectivity and the encouragement she gave us to bring out all that needs to be brought out about the ICDS programme as implemented in the field. We received similar support from Smt. Y V Anuradha IAS, Commissioner, DWDCW in all respects and we owe her much gratitude. Special mention needs to be made of the brilliant leadership that Shri N Sridhar IAS gave to the Social Audit work from the beginning. Thanks to him and his unflinching commitment to this Social Audit and of his successor Shri. Anil Kumar IAS and their district officers in Anantapur, namely, Shri. G. Gopal, Project Director, District Water Development and Management Agency; Smt. Mutyalamma, Project Director, ICDS; and Dr. N. Bala Ramaiah, District Medical and Health Officer we faced, if at all, minimal problems in carrying out our work. The smooth completion of our Social Audit work in the District owes with out doubt an enormous debt to these officers of the Government of Andhra Pradesh.

Special thanks are due to Sister Anne Ferrer, Programme Director, Rural Development Trust, Anantapur for blessing our Social Audit effort and providing us the services of her expert personnel and the infrastructure of her renowned organization.

Dr. L.V.Subrahmanyam IAS, Principal Secretary, Department of Health, Medical and Family Welfare and Sri A.K. Punetha IAS, Commissioner, Health and Family Welfare intervened at crucial times to ensure support to us in our work at the field level.

We are happy to acknowledge that despite initial hiccups, by and large, we were able to secure all the information we required thanks to the cooperation of the Project Director, ICDS, Anantapur Smt. Muthyalamma and her senior aide Smt. Sridevi, Supervisor. Also, the support we received from Shri G Gopal, Project Director, District Water Development and Management Agency (DWAMA) deserves special mention because not only did he make available to us his staff and trained activists experienced in Social Audit but was also our frontline support in solving all problems relating to logistics relating to the Social Audit and in our interface with the District Collector himself, as an ever reliable bridge and trouble shooter.

A special word of thanks is owed to Dr. A. K. Gopal, Director, National Institute of Public Cooperation and Child Development (NIPPCD), New Delhi. His inputs have been invaluable to me. Considerable contribution was made by Smt. Lakshmi Chary, former principal of the Andhra Mahila Sabha College, Hyderabad and Dr. Balaramaiah, District Medical and Health Officer, Anantapur in regard to their respective areas of Pre- school Education and Health and two articles written by them are featured in this Report.

**It is important for me to emphasize here that both the Council for Social Development, New Delhi and the Department of Women Development and Child Welfare, Government of Andhra Pradesh have looked upon this social audit as a *joint effort*.**

This Social Audit work has been done with the utmost independence and we were not “guided” by any external considerations or pressures. The Council for Social Development gave me and my Team of three NGOs and about sixty social activists who did the grueling job of canvassing the Work Book schedule in the villages to audit as many as 154 Anganwadi Centres in three different phases total autonomy and there was never any pressure placed on us by the Government either. Special mention needs to be made of the earnest, sincere and painstaking efforts put in by our team of social activists who did the audit at the Anganwadi centre level. They showed during this audit what a reliable, dedicated group they were.

The findings of this Social Audit come in two phases as may be seen in Chapters 4 and 5. They may be read together in continuum. **The findings of this Social Audit would certainly appear critical at many places but at no time has the intention been negative or to be negative. There are many good things that are happening in the ICDS programme in Anantapur District but we obviously tried to critically look at what more needs to be done.** After all, that is what a Social Audit is about and that is what we all owe to our people. The effort has been to hold the mirror to the reality as it was seen so that when we place this Report before a wider audience it would serve at least two purposes: one, the general public gets to understand what its rights are and where they stand; and secondly, the experts would have an opportunity to tell the Government and all concerned stakeholders how things can be improved. In this belief the Department of Women Development and Child Welfare, Government of Andhra Pradesh and the Council for Social Development have decided to hold two Workshops, one at the District level at Anantapur on the 19<sup>th</sup> July 09 and another at Delhi on the 4<sup>th</sup> August 09 to elicit inputs for a better ICDS programme from all the stakeholders and experts. Our final Report would be the result of our findings and recommendations seen through expert eyes in these two Workshops. Meanwhile, a reading of this Draft Report would show that certain recommendations have indeed been made at appropriate places depending on the context but the final recommendations obviously should await the outcome of these two Workshops.

Of the two Workshops planned to consider this Draft Report - one in Anantapur on the 19<sup>th</sup> July 2009, and another at Delhi on the 4<sup>th</sup> August 2009, we have now completed the Anantapur Workshop. Smt. Konda Surekha, Honourable Minister for Women Development, Child Welfare, Disabled Welfare, and Juvenile Welfare inaugurated the Workshop at Anantapur while the District's senior Minister Shri N Raghuvendra Reddy, Honourable Minister for Agriculture was the Chief Guest. At the Workshop we saw large participation including the media. The Minister for Women Development and Child Welfare wholeheartedly welcomed the findings of the Social Audit and stated that such Social Audits would be got done all over Andhra Pradesh so that the people at large came to know about their rights in the ICDS Programme and the programme could be implemented more effectively and transparently. She made reference to specific recommendations such as non-residence of Anganwadi Workers and their being burdened with irrelevant work and promised to eliminate these dysfunctional aspects in the implementation of the programme. She affirmed that people's rights and the tax payers' money were involved in Government programmes and

therefore it was essential that all Government Departments undertook such Social Audit in regard to their programmes. Honourable Shri N Raghuvveera Reddy acknowledged the defects in the implementation of the ICDS programme and stated that this was a systemic failure which needed to be addressed honestly and through a proper mechanism that would ensure that these defects did not recur. He wanted the participants in the Workshop to indicate concrete solutions to the issues raised in the Report so that such recommendations could be implemented by the Collector immediately. The Minister referred to the low levels of honorarium paid to the Anganwadi Workers and urged that this issue be effectively represented before the Government of India so that these workers were adequately compensated for the services they are expected to deliver. The Minister felt that the findings of this Report were of relevance not only to Anantapur and Andhra Pradesh but for the nation as a whole. Smt. Chaya Ratan, Principal Secretary to the Government, DWDCW welcomed the findings as reflective of ground realities and referred to the several measures already initiated by Government and sought to be implemented in a campaign mode. She expressed Government's determination to do more in areas like convergence, adolescent girls and monitoring mechanisms. Observing that ICDS must be declared an essential service, she deplored the existence of discrimination in its implementation and stressed the need for action to change mindsets. Shri Janardhan Reddy, Collector, Anantapur promised to undertake the translation of the major findings into Telugu and take them to every village and have them discussed at the grass roots level for rectification of the defects seen. He said he would motivate the self-help groups to involve themselves in the functioning of the Anganwadi Centres to bring about needed changes, especially in regard to convergence issues relating to the Health and ICDS functionaries. Dr A K Gopal, Director, NIPCCD felt that the findings of the Report were relevant all over the country and stressed the importance of training and monitoring in improving the functioning of the programme. The discussions that followed saw extensive participation from the floor, which included the representatives of CARE (India), UNICEF, several civil society organizations, the social activists who participated in the Social Audit process and the ICDS functionaries. The many recommendations made by them are being processed. We believe that this Workshop held in Anantapur has generated wide spread awareness of the ICDS programme as well as of the concept of Social Audit and was witness to an affirmation of political will on the part of the Government of Andhra Pradesh to address the issues raised in the Report.

As would be seen from this draft Report, the Department of Women Development and Child Welfare, Government of Andhra Pradesh has already initiated several measures that would address some of the concerns that have been raised by us in this Report. The Principal Secretary, Department of Women Development and Child Welfare, Government of Andhra Pradesh has already held a meeting with the Social Audit team and the Director of the Council for Social Development and discussed the core findings of this audit. In this meeting the Commissioner of Health and Family Welfare and the Commissioner, DWDCW were also present. The Social Audit Team has every reason to believe that these are positive developments and if these measures are purposefully implemented could make a new beginning in the cause of the woman and her child.

**K. R. VENUGOPAL IAS (RETD.)**  
FORMERLY SECRETARY TO THE PRIME MINISTER AND  
SPECIAL RAPPORTEUR, NATIONAL HUMAN RIGHTS  
COMMISSION, HYDERABAD.

## *Introduction*

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**1.1** The United Nations Universal Declaration of Human Rights 1948 proclaims in Article 25 (ii) that motherhood and childhood are entitled to special care and assistance. Reaffirming this, the Convention on the Rights of the Child (CRC) adopted by the UN General Assembly in November 1989 and acceded to by India in December 1992 recalls that the Declaration of the Rights of the Child, 1959 had affirmed that the child needs special safeguards and care before as well as after birth. The CRC obligates India to ensure that every Indian child is entitled to a life without discrimination of any kind irrespective of the child's social origin; that the State should ensure that the institutions, services and facilities responsible for the care of the children shall conform with the standards established by competent authorities particularly in the area of health, in the number and suitability of staff as well as competent supervision; that the State shall ensure the development of institutions, facilities and services for the care of children; ensure that the children of the working parents have the right to benefit of the child care units and facilities; that the State should recognize the right of the disabled children to special care; that the State should recognize the right of the child to the enjoyment of the highest attainable standard of health and ensure that no child is deprived of his or her right to access to such health care services; that the State shall take appropriate measures to bring down infant and child mortality; to ensure medical assistance and health care; to combat disease and malnutrition through the provision of adequate nutritious food and clean drinking water; to ensure appropriate prenatal and postnatal health care for mothers; to ensure access to parents and children basic knowledge of child health and nutrition and the advantages of breast feeding; recognize the right of the child to education directed at the development of the child's mental and physical abilities to their fullest potential.

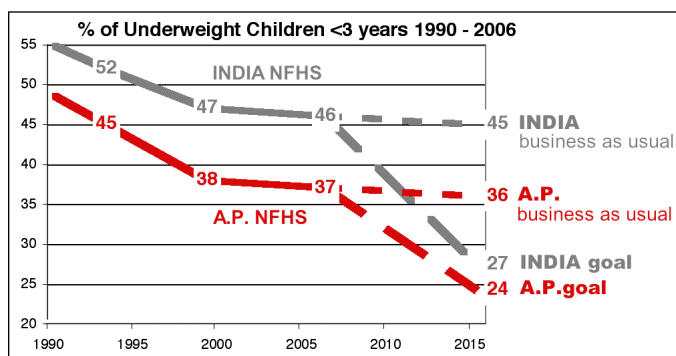
**1.2** The Constitution of India in Article 39 mandates that children be given opportunities and facilities to develop in a healthy manner and lays down in Article 45 that the State shall endeavor to provide early childhood care and education for all children until

they complete the age of 6 years. Article 46 of the Constitution also lays down that the weaker sections of the people and in particular the scheduled castes and scheduled tribes shall be protected by the state from social injustice. The Indian Constitution in Article 47 mandates that the state shall regard the raising of the level of the nutrition of its people and the improvement of public health as among its primary duties.

**1.3** The International Covenant on Economic, Social and Cultural Rights, 1966 stipulates in Article 12 that the signatory States should take steps for the reduction of still birth-rate and of infant mortality and for the healthy development of the child as part of the overall right of every one to the enjoyment of the highest attainable standard of physical and mental health. The International Covenant on Civil and Political Rights, 1966 in Article 6 proclaims that every human being has the inherent right to life. The Convention on the Elimination of all forms of Discrimination Against Women, 1979 in Article 11 (c) mandates that the State should encourage the provision of social services to enable parents to combine family obligations with work responsibilities through promoting a network of child care facilities; in Article 12 (2) it mandates that the States should ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary as well as adequate nutrition during pregnancy and lactation.

**1.4** These then are the rights of women and children as recognized in the Constitution of India and various international instruments which India is a signatory to, and has acceded to and has ratified. However, after the lapse of 6 decades since we gave ourselves a Constitution, where do the Indian women and children stand in regard to the specific rights highlighted above?

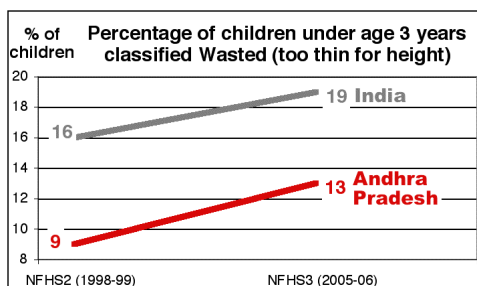
**1.5 Nutritional status of children:**



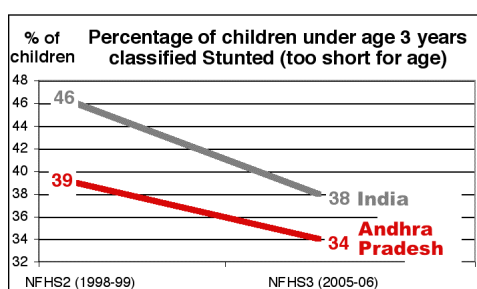
The National Family Health Survey (NFHS-3), 2005-06 shows that for all India the percentage of children under age-3 who are under weight for their age is 46, only 1 percentage point less than the figure for NFHS-2 of the year 1998-99. This alarming trend is similar in Andhra

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Pradesh, although at a lower level (37%). If this trend is to continue the Millennium Development Goals of 27 for India and 24 for A.P. will never be achieved in time.



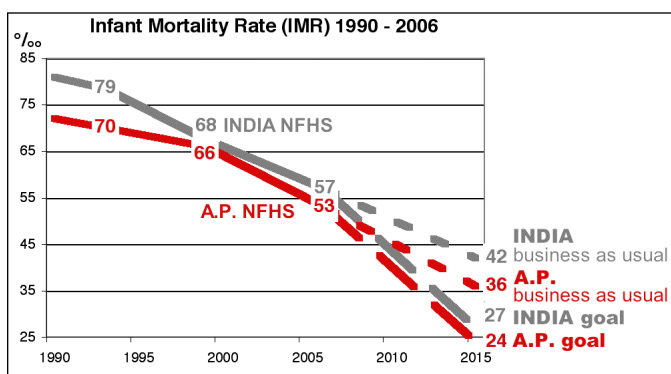
If this is alarming, the proportion of children under-3 who are wasted (too thin for height) has increased compared to NFHS-2 by 3 percentage points for all India to reach 19% and by 4 for Andhra Pradesh (13%).



The figure for children under 3 who are stunted (too short for age) is 38% for all India and 34 for Andhra Pradesh. But the trend in decrease in Andhra Pradesh, 5 percentage points, is much slower than that of all India, 8.

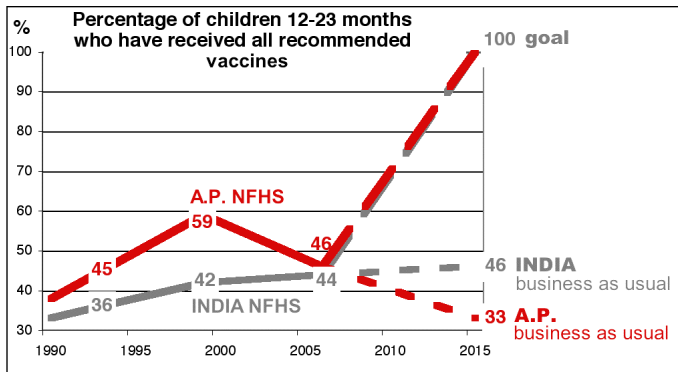
**These are strikingly unflattering truths for a State that has no dearth of nutrition resources.**

### 1.6 Infant mortality rate and vaccination:



The total infant mortality rate for all India is shown as 57 in NFHS-3, though it is as high as 62 for Rural India. For Andhra Pradesh the NFHS-3 data shows that the total IMR is 53, better than for All India but **the**

**IMR in rural Andhra Pradesh is 64, which is worse than the figure of 62 for all India. And the present trend will not allow achieving the MDG goals by 2015.**



As for vaccination coverage according to NFHS-3, the percentage of children 12-23 months, who have received all recommended vaccines, is 44 for all India while it is 39 for the rural areas. In Andhra Pradesh the combined figure

for urban and rural is 46, the figure for rural areas is 43 which is slightly better than the figures for rural India as a whole. If these figures of NFHS-3 are discouraging the further bad news, however, is that **the trends in vaccination coverage shows drastic decline compared to the results of the NFHS-2 survey 1998-99. The NFHS-2 figures for urban Andhra Pradesh were 73% against 51% according to NFHS-3. Similarly the vaccination coverage was 54% according to NFHS-2 1998-99 in rural Andhra Pradesh which declined drastically to 43% according to NFHS-3 of 2005-06. The overall decline for all of Andhra Pradesh – Urban and Rural – is from 59% from 1998-99 to 46% in 2005-06. These figures speak for themselves about the dangerous decline in the health security of the children of Andhra Pradesh.**

**1.7** Safe drinking water and access to toilet facility are two necessary adjuncts to food and nutrition security, for such security to be really meaningful. **While, according to NFHS-3, the percentage of households that use piped drinking water is 27.9 for all of rural India, for Andhra Pradesh it is 60.3 %. As for access to toilet facility the percentage for rural India is 25.9, while it is 26.9 for rural Andhra Pradesh. The dangers that such large numbers defecating in the open pose in terms of the general infection load and to subsoil and neighborhood water bodies in particular can not be overstated.**

**1.8 Maternity Care (for birth in the last 3 years)**

According to NFHS-3, the percentage of mothers in India who had at least 3 antenatal care visits for their last birth was 42.8 in the rural areas and 73.8 in the urban areas. The corresponding figures for Andhra Pradesh are shown as 84 % for rural and 90.2% for urban areas. The figures for percentage of mothers who consumed IFA for 90

days or more when they were pregnant with their last child was 18.1 for rural India and 34.5 for the urban India. These figures for IFA for Andhra Pradesh are 35.8 for rural areas and 46.2 for urban areas. Looking at these low figures of IFA consumption one is left wondering what then were those large percentages of antenatal checks were doing to pregnant women in Andhra Pradesh in regard to their IFA consumption. For all India, percentage of births assisted by a Doctor or a nurse / LHV / ANM / other health personnel was 39.1 in rural India and 75.2 for urban India, while the percentage of institutional births was 31.1 for rural areas and 69.4 in urban areas. Percentage of mothers who received post natal care from a Doctor / Nurse / LHV/ ANM / other health personnel within 2 days of delivery for their last birth was 28.1 in rural areas and 60.7 for urban areas. The corresponding figures from NFHS-3 for Andhra Pradesh are: the percentage of births assisted by a Doctor or a nurse / LHV / ANM / other health personnel are 66.9 for rural areas and 89.1 for urban areas; the percentage of institutional births in Andhra Pradesh for rural areas is 60.5 and 85 for urban areas; the percentage of mothers who received post natal care from a doctor / nurse / LHV / ANM / another health personnel within two days of delivery for their last birth was 63.7 for rural Andhra Pradesh and 82.1 for urban areas in Andhra Pradesh.

**1.9** Child Immunization, Vitamin-A Supplementation and other vital data for All India Percentage of children 12-23 months fully immunized for BCG, measles and 3 doses each of polio and DPT, according to NFHS-3, 2005-06 was 38.6 % for rural India and 57.5 % for urban India. Percentage of children 12-23 months who have received BCG according to NFHS-3 was 75.1 in rural areas and 86.9 in urban areas. Percentage of children 12-23 months who have received 3 doses of polio vaccine was 76.5 in rural India and 83.1 in urban areas. Percentage of children 12-23 months who have received 3 doses of DPT vaccine was 50.4 in the rural areas and 69.1 in urban areas. Percentage of children 12-23 months who have received measles vaccine was 54.2 in rural and 71.2 in urban India. Percentage of children 12-23 months who received a vitamin-A dose in the last 6 months was 20.4 in rural areas and 22.7 in the urban areas. Percentage of children with diarrhea in the last two weeks who received ORS was 24 in rural India and 32.7 in urban areas. Percentage of children under 3 years breast fed within one hour of birth was 21.5 in rural India and 28.9 in urban areas. Percentage of children age 0-5 months exclusively breast fed was 48.3 in rural areas and 40.3 in urban areas. In rural India, the percentage of children under-3 who

are stunted is 40.7; those wasted is 19.8; those who are under weight is a whopping 49. The percentage is a high 36.4 in urban India for under-3 children who are under weight.

### **1.10 Anemia among Children and Women for All India**

Percentage of children age 6-35 months who are anemic is 81.2 in rural areas and for urban areas this figure is 72.7. Percentage of ever married women age 15-49 that are anemic is 58.2 in rural areas and 51.5 in urban areas. Pregnant women age 15-49 who are anemic are 59.5 % in rural areas and 54.6 % in urban India. The percentage for ever married men age 15-49 who are anemic is lower at 27.7 in rural areas and 17.2 in urban areas. The figures for these for men conclusively show the gender and the urban-rural divides in India.

### **1.11 Child Immunization and Vitamin Supplementation and other vital data for in Andhra Pradesh:**

According to NFHS-3, **percentage of children 12-23 months fully immunized with BCG, measles and 3 does of each of polio and DPT is 42.9 in rural areas and 51.2 in urban areas;** percentage of the same group for BCG is 93.2 in rural areas and 92.5 in urban areas; for the same group percentage who received 3 doses of polio vaccine is 76.9 for rural areas and 83.1 for urban areas. **For the same age group percentage who have received 3 doses of DPT is 57.8 for rural areas and 67.6 in urban areas;** for the same age group for measles the rural percentage is 70.1 and urban is 68.3; **for the same age group percentage, who received a vitamin-A dose in the last 6 months is 21 for rural areas and 22.4 in the urban areas;** percentage of children with diarrhoeal in the last two weeks who received ORS is 31 for rural and 42.6 for urban areas; **percentage of children under 3 breast fed within one hour of birth is 24.1 for rural and 18.9 for urban;** children age 0-5 months exclusively breast fed is 67.2 percent in rural areas and 53.3 % in urban areas. **Children under-3 who are stunted are 37.3% in rural areas and 27.4 % in urban areas;** children under 3 who are wasted are 12.5 % in rural areas and 13% in urban areas; **percentage of children under-3 who are under weight is 40.4 in rural areas and 29.1 in urban areas;** children age 6-35 months who are anemic are 82.7 % in rural areas and 72 % in urban areas; **ever married women age 15-49 who are anemic are 63.7% in rural Andhra Pradesh and 58.4 % in urban areas.**

**Pregnant women 15-49 who are anemic are 58.2% in rural areas and 57.7% in urban areas. Against all these, ever married men 15-49 who are anemic are 26 % in rural areas and 15.2 % in urban areas, indicating as in the case of the data for All India, the gender and urban-rural divides in Andhra Pradesh.**

**1.12 According to the UNICEF's "State of the World's Children 2009", during the period 2000-07 the percentage of infants born in India with low birth weight was 28; according to WHO / NCHS the percentage of under-5 children, who were under weight (moderate and severe) was 46; for the same category of children the percentage for wasting (moderate and severe) was 19; for stunting (moderate and severe) it was 38 %. Full coverage of Vitamin-A supplementation rate (6-59 months) in 2007 was 33 % and for at least one dose it was 53 %. The percentage of households consuming iodized salt for the reference period 2000-07 was 51. The percentage of population using improved sanitation facilities in India in rural areas in 2006 was a low 18 %, and for urban India 52 %, giving an overall figure of just 28 %. The immunization figures for the year 2007 for children one year old for DPT 3 doses was 62%; for Polio 3 doses 62% and for Measles 67%. The percentage of under - 5 children with diarrhea receiving oral dehydration and continued feeding was 33. The percentage of women receiving antenatal coverage at least four times in the period 2000-2007 was 37% while for the same reference period the percentage of delivery care coverage by a skilled attendant at birth was 47 and institutional delivery 39. The MMR for the year 2005 was 450.**

**1.13 This picture over all is flattering neither to India as a whole nor to Andhra Pradesh, a State repeatedly proclaimed as a highly progressive Southern Indian state. In fact, these are dangerously dismal figures hidden behind highly-vaunted macro economic growth figures.**

**1.14 The idea generally of a Social Audit was born during an informal discussion between Prof. Muchkund Dubey, President of the Council for Social Development (CSD), New Delhi and the Coordinator of this project late in the year 2007 when it was agreed that given the unacceptable levels of malnutrition and morbidity among the women and children in general and the pregnant and nursing women and children in the 0-6 age group in particular in the country, which led in turn to irreversible birth**

defects among newborns that vitally prejudiced human resource development, there was no programme that merited more urgent attention than the Integrated Child Development Services (ICDS), which aimed at holistically dealing with these problems through an integrated package of six services that combined all vital elements relevant to the nutrition and health needs of this segment of our society. It was recognized that, brilliantly conceived as the ICDS programme indeed was, it had nevertheless run into serious difficulties in implementation. It was agreed that before embarking on a social audit of the programme it was necessary to take a general view of where the programme stood. The Coordinator, therefore, prepared a concept paper highlighting the issues in the implementation of the ICDS programme in the context of its current status. This concept paper, or more humbly the draft approach note, on which is based Chapter III of this report spelt out what the existent situation was in the ICDS and therefore what the issues were that needed to be addressed. This note spelt out the objectives, parameters and the scope of the Audit and also brought out the elements of the integrated approach under which the Audit will be carried out and the points of convergence between different programmes, different departments of the Government and different stakeholders. Prof. Dubey discussed this paper with the Coordinator at a meeting in Delhi on the 7<sup>th</sup> May 2008 and felt that it would be appropriate to do the Social Audit of the ICDS programme in the Anantapur district of Andhra Pradesh, a district that required attention from the point of view of its extreme vulnerability in regard to most socio-economic parameters. Prof. Dubey accepted the suggestion of the Coordinator that in this exercise should be involved three well known and dedicated NGOs, namely, the Centre for Environment Concern, Hyderabad headed by Dr. K. S. Gopal; the Rayalaseema Development Trust (RDT), headed by Dr. Y. V. Malla Reddy; and the Rural and Environmental Development Society (REDS), Kadiri headed by Ms. Bhanuja, all three of whom already had extensive hands-on experience at the field level of the concept, dynamics and practice of the Social Audit methodology and even more importantly of the dynamics of various socio- economic issues that affect people's every day lives. Further, the experience of the Social Audit being undertaken by the Centre for Environment Concern, Hyderabad of the NREGP in Anantapur district; the highly credible and considerable presence the RDT has had in the area of health in Anantapur District over a long period and the commitment REDS has always displayed in its work in the Kadiri area were bound to be of great value to this work in this District. In pursuance

of this proposal, the Coordinator prepared a background paper on the ICDS programme for discussions with the District Collector, Anantapur and the three participating NGOs. Discussions were held by the Coordinator with Collector at Anantapur on the 19<sup>th</sup> April 2008 when the former explained to the Collector the significance of and the need for a Social Audit of the ICDS programme in his district. The inputs required for the Social Audit in the context of the background paper were discussed with the three participating NGOs by the Coordinator at Anantapur on the same day. On the basis of these discussions another paper was formulated incorporating the views of the District Collector and the approach of the NGOs in regard to the Social Audit aspects and this paper was discussed in a another meeting chaired by the Collector in his camp office on the 21<sup>st</sup> April 2008 with the Social Audit team and the District officers of the Department of Women Development and Child Welfare (DWDCW). The Coordinator was all the while in close touch with the Principal Secretary to the Government of Andhra Pradesh, DWDCW and the Commissioner, DWDCW keeping them informed of these discussions.

- 1.15** The Council for Development (CSD), New Delhi set a very high store by the Social Audit planned by it as it regarded this Social Audit as one of the Council's most important interventions in the country at the District level. The CSD looked upon the objectives of the Audit as an endeavour to (i) inject a new dynamism into the functioning of the ICDS programme in the District; (ii) arouse the consciousness of the people about this programme, particularly the way it can enable them to exercise some of the fundamental rights granted to them under the Constitution of India; and (iii) train a group of persons, including government officials, Panchayat Raj functionaries and NGO activists, who would help in implementing the scheme in the future in a comprehensive manner and on a sustained basis consistent with the philosophy underpinning it. The Council attached great importance to meticulously recording the details of the procedures followed, activities undertaken, guidelines issued, lessons learned and the results achieved during the course of the Audit and to conveying, among others, the message of the supreme necessity of universalizing the ICDS with in a time bound framework and of the need to ensure the rights of the children in the age group of 3 to 5 to pre-primary education. The CSD shared the belief of the Coordinator that disseminating the objectives and importance of the ICDS and paving the ground for its full-fledged implementation through a Social

Audit would itself constitute an important contribution to universalizing the scheme, while eliminating the defects noticed in the Social Audit. The CSD hoped that the lessons from this exercise would travel beyond the district of Anantapur so as to reach the entire state of Andhra Pradesh and beyond Andhra Pradesh, the entire nation, and thus help implement the ICDS programme in a more purposeful fashion.

**1.16** The Council in particular, endorsed the following approach outlined by the Social Audit Team:

(a) The ICDS Social Audit should be a joint exercise of the CSD represented by the NGOs CEC, Hyderabad; RDT, Anantapur; REDS, Kadiri; and the Department of Women Development and Child Welfare, Government of Andhra Pradesh.

(b) The teams auditing the Anganwadi Centers would predominantly consist of women activists.

(c) The effort would be to audit 300 rural and 10 urban Anganwadi centers representing roughly 10% of the total number of such Centers in the district (in the event we audited 154 Anganwadi Centres).

(d) The timeframe of the Audit would be from May 2008 to April 2009.

**1.17** The CSD, New Delhi approved a budget of Rs. 7, 52,000/- for this Audit with flexibility for the project Coordinator to transfer funds from one head to another and, if necessary, to incur any expenditure not specified in the budget, so long as the total expenditure remained within the approved budget.

**1.18** All the above expectations of the CSDND were communicated in the form of a letter by Prof. Dubey to the Coordinator of this Social Audit and this was to be regarded as a contract between the Council for Social Development and the Coordinator of the Project. The contents of this letter were shared with the collaborating NGOs and the Principal Secretary to the Government of Andhra Pradesh, Department of Women Development and Child Welfare (DWDCW) and on the basis of this proposal, the Principal Secretary, DWDCW was addressed by the Coordinator in May 2008 for her approval for the conduct of the Social Audit. Smt. Chaya Ratan IAS, Principal Secretary, DWDCW wrote to the Coordinator in her reference D.O. Letter

No.2238/ICDS/AI/2008 dated the 17<sup>th</sup> May 2008 giving the Government's concurrence to the CSD to conduct the Social Audit of the ICDS programme in Anantapur District. She assured the Coordinator that "the Department of Women Development and Child Welfare and the District Administration under the guidance of the Collector, Anantapur will extend necessary cooperation as such an audit would help us to take appropriate corrective measures for streamlining and proper implementation of this important scheme".

**1.19** With all basic formalities thus completed in regard to the Integrated Child Development Services Social Audit, the District Collector, Anantapur Shri N Sridhar IAS convened a meeting with the Coordinator and the heads of the CEC, the RDT and the REDS (to be known hereafter as the Social Audit Team) and the concerned District officers on the 20<sup>th</sup> May 2008 so that a plan could be developed for the ensuing Social Audit. At this meeting the Collector was requested to designate an officer with the necessary authority to provide the Social Audit Team with all the information needed throughout the period of the Audit. The Collector agreed to provide all required support for the success of the Social Audit efforts and also promised that he would set up a District Committee for coordinating the work of the Social Audit at his level with himself as the Chairman. That Committee would include the Social Audit Team conducting the SA on behalf of the CSD; the Project Director, ICDS, who is also the District Women and Child Development Officer; the Additional District Medical and Health Officer; and officers of the Departments of Women Development and Child Welfare and Health, Medical and Family Welfare. The stage was thus set for the conduct of the Social Audit of the ICDS programme in the District of Anantapur in Andhra Pradesh as a joint effort of the Council for Social Development, New Delhi and the Department of Women Development and Child Welfare, Government of Andhra Pradesh.

## ***Social Audit***

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- 2.1** Social Audit (SA) of a scheme is a process whereby stake holders of the scheme including beneficiaries and representatives of the community examine the implementation of the scheme publicly, with the participation of the larger community to see whether that scheme is achieving its stated objectives. Social Audit looks at all the documentary evidence available and cross checks them with and in the presence of the stakeholders. The term stakeholders should always be understood to mean, and primarily, the people for whom a scheme is designed and the larger public of whom the target groups is an organic part. Social Audit provides an institutional platform for people to seek and obtain information including on financial expenditure; verify that information; examine the provision for entitlements; reflection of priorities through choices made; and quality of services and work of the staff. Social Audit is an important platform to ensure people’s participation in the critical examination of all aspects of the scheme audited. This process tries to ensure that public interest is served by examining different activities in the programme in public transparently and with integrity, at various levels of the administration of the scheme.
- 2.2** Social Audit not only gives people an opportunity to review compliance and promote transparency and accountability but also serves as a forum where people can conduct a detailed public audit of all components of the scheme seeing them as people’s rights and entitlements that have to be realized by the manner in which a programme has to be implemented and indeed been implemented in the area. When we talk of entitlements in the context of a programme, such entitlement has at least two meanings – one is the entitlement (s) stated in the programme and the other is the entitlement of the public to full access to all relevant information connected with the implementation of the programme. Without the latter entitlement, the former entitlement (s) would never be realized. This is what a Social Audit emphasizes and should emphasize in public. It leads to an opportunity to the people, particularly those

for the benefit of whom it has been designed, to have a say in the administration of or decision making in the scheme in the future. That is how empowerment of the people emerges through a Social Audit by creating awareness of their rights in a programme and the consciousness that they have a right to be involved in the processes of decision making in that programme. The importance of this platform is not only the independent value of publicly auditing a particular work, but also from the opportunity it provides to review the relevance of the existing provisions themselves and what more needs to be built into the scheme, in the process at various points in the implementation of the scheme involving the beneficiaries and the other stakeholders residing in the community. Public answerability of elected representatives and government officials is obviously the most important aspect of a Social Audit. Social Audit, by definition, must have to ensure the participation of the Government officials as implementers and also all other actors who have been given a place in the scheme of the programme such as the gram panchayat, local leaders, self help groups, civil society organizations and the community as a whole with centrality to women.

**2.3 A Social Audit has to be thought through as a process that recognizes its objectives as:**

- (i). the Empowerment of the people, directly benefited by the programme in terms of the knowledge of their rights and entitlements; knowledge of what outcomes these entitlements and rights brings to the target groups; and empowerment of the larger community in terms of internalizing this knowledge so they can be effective advocates of these rights for all.
- (ii). Effective use of resources through plugging leakage and waste.
- (iii). Improve the quality of the programme in terms of its efficacy, local appropriateness, and in the achievement of its social objectives.
- (iv). Developing among the beneficiaries a sense of ownership of the programme as judged by their understanding of the objectives of the programme and their relevance to the community as a whole.
- (v). Promoting public participation in the programme audited and in other government schemes, both as an end in itself and as a means to public accountability exemplified by elimination of corruption, and promotion of efficiency of implementation.

#### **2.4 Social Audit promotes to this end:**

- (a) Involvement of all the stakeholders in the auditing process, as one cohesive group.
- (b) Timely and universal dissemination of relevant information in an easily understandable form to all the stakeholders.
- (c) Extensive consultations with the community in order to factor in local knowledge, priorities and preferences in designing and implementing different activities of the programme audited.
- (d) Prior informed consent of the target community on important decisions relating to the different activities in a scheme based on such consultation with the communities and genuine experts known for their objectivity.
- (e) Participatory and transparent monitoring and evaluation of the progress of the scheme and of its components and specifications, as an essential ingredient of community empowerment.
- (f) The concept and establishment of a mechanism for immediate response in public by officials to demands and questions raised by members of the community, on a concurrent and continuous basis.

#### **2.5 Therefore, the preconditions to a proper social audit include:**

- (i) Genuine transparency, where information is shared at each stage, in a form easily understood not only on paper but in alternate forms.
- (ii) Mobilization of communities to encourage demand for participation in the Social Audit.
- (iii) Development of capacity in the community the participating and other NGOs and government agencies to conduct and effectively participate in the social audit through orientation sessions conducted by knowledgeable and objective experts with hands on experience of the programme audited.
- (iv) Establishment of a secure and effective platform for conducting the social audit by way of a Group that would guide the social audit and ensure it stays on course.
- (v) Assurance of an ongoing and regular process whereby auditing is done frequently and regularly in the future.
- (vi) Assurance of an adequate, timely, transparent and appropriate follow-up on the findings of the social audit.

- (vii) An effective feedback mechanism that keeps the community informed of the impact and outcome of the social audit.

Some of the major vulnerabilities that can paralyze social audits include:

- a. Collusion among various functionaries and authorities resulting in the practitioners themselves acting as “vested interests.”
- b. Paper or ghost social audits that are conducted on files and not in reality.
- c. Inadequate, “last-minute” (or incomprehensible) information resulting in ineffectual social auditing.
- d. Lack of preparation or inadequate capacity to conduct/participate in a social audit.
- e. Unwillingness of the people to speak up, because of fear, cynicism, or “influence” of the bureaucracy and political interests.
- f. Disruption of social audits due to threats or threats of conflict.
- g. Unwillingness of the Government to meaningfully participate in the social audit process.
- h. Unwillingness of the community to continue engaging with social audits due to lack of follow up; lack of reporting back on the follow up; or the development of hostile conditions.

**2.6** The Community, by and large, welcomes social audit. Often the Community’s main concern is the possible adverse repercussions of questioning or exposing corruption or other irregularities by those in power, bureaucratic and political. The community becomes cynical and non-responsive if social audits do not lead to action and positive changes. Social audits properly executed obviously give the Community a sense of empowerment, but for them to be actually empowered, these audits should not be a flash in the pan but must be instrumental in real changes people always aspire for.

**2.7** The dilemmas of the bureaucrats are perhaps the most vexatious. They have to juggle with and reconcile the multiple and often contradictory demands made on them in their work by the political leadership at all levels. They also have an instinct and a well established tradition of not admitting to “outsiders” any weakness within their own establishment, and to publicly deny any wrongdoing at all. In programmes that require coordination between more than one department – as is almost always the case in governance – “territorial” ambitions can render any thought of coordination, leave

alone convergence of efforts, a non-starter. Action, if ever, where it is absolutely necessary, would be quietly taken within the department but social audits and their very philosophy demand just the opposite. We have no hesitation in acknowledging that there are exceptions to this general rule but these exceptions are so exceptional and rare that they serve to prove the general rule decisively.

**2.8** Middle level bureaucracy is also faced with a very real threat of rebellion within their establishments if they start taking cognizance of, and acting on, the indictments coming out of social audits though social audits demand this of them. Also, most bureaucrats develop a “practical way” of dealing with corruption, essentially by ignoring all but the most blatant or “unacceptable” instances. Often, cosmetic actions well orchestrated in the media, brings them great accolades with the crux of the problems remaining really unaddressed. However, social audits do not permit this, for the expectation levels of the poor, who have been deprived of critical survival resources because of “commonplace” corruption for so long, are increasing and becoming more strident. Finally, there is also the problem of social audits being applied selectively to only one or two schemes, exposing the head of department so subjected to the discomfort that only his officers are being “found out”.

**2.9** In most instances of social audits, it is the very junior local official who is directly in the firing line. While the corrupt ones would do everything possible to scuttle truth, even the honest and sincere ones can be under a lot of pressure, for social audits not only monitor financial leakages but also levels of efficiency that is broader based. This is inevitable since local officers are now under pressure not only to meet the expectations of their bureaucrat superiors but also of the community. However, as social audits get better established, the efficient and sincere officials would start being appreciated by the community, if for no other reason than because of the contrast with the corrupt and inefficient ones. This highlights why and how the social auditors must learn to be discriminating in highlighting the various dimensions of work performance so that social audits are truly constructive and not sensational witch hunts.

**2.10** NGOs and people’s groups often take the lead in mobilizing people and training them to participate in social audits. Many have whole heartedly embraced the social audit method as a preferred means for bringing about public accountability in various

public schemes. There is always, nevertheless, the danger of NGOs developing a vested interest in being social audit “middlemen” leading and controlling the social audit process in a manner that helps them become centers of power and collaborators in corruption and this needs a close watch on the part of the civil society.

## **2.11 The Method**

Social Audit involves different important activities. One of them, at the very outset, is to make all the relevant information about a programme public. This can be done through easy to read posters, pamphlets, notice boards, public hoardings and announcements through the public address system. Any other method can be employed to familiarize the public about the details of the scheme being audited from a rights perspective. This information will have to be cross checked and verified for its authenticity with the participation of the public. The results of this verification will be placed before the community through meetings of the Gram Sabha. The Gram Sabha meetings shall have to be attended by the officials of all concerned departments so they take stock of the state of things by way of a reality check as perceived in the audit, and by the community, and initiate appropriate follow up action. In other words, SA leads to participatory scrutiny, decision making as regards the future and monitoring and evaluation.

- 2.12** Three important parts of the SA are: preparation including publicity aspects before starting the conduct of the Social Audit; organizing the logistics and determining of the procedural aspects with respect to the manner of eliciting information pertaining to the various aspects of the subject of Social Audit; and conducting of the Social Audit in a manner that enlists the understanding and cooperation of the community to the Social Audit effort.
- 2.13** It is vital that Social Audit is seen as a dynamic process tool aimed at triggering accountability amidst unequal power relations to ensure delivery of legally enshrined rights. In this task it poses challenges, opportunities and obstacles and its integrity calls for an attitude that admits of no ambiguity, compromises or “accommodation” while facing the several attendant risks.
- 2.14** The basic change this concept endeavours to confer on the people is to generate in them an awareness of all their rights, all of which taken together lead to their Right to

Life and placing accountability for delivering that right on the shoulders of the Government in the context of programmes that declare, or claim to incorporate, those rights or where such rights are inherent in such programmes because of their content. It needs to be recognized that while to some extent citizen's vigil and proactive information obtained during a Social Audit can help deter indifference and non-compliance, the discharge of the responsibility to deliver rights and entitlements is a duty cast unambiguously on the Government and its official agencies by the Constitution of India and that empowering truth must be internalized by the people and is the central task of a Social Audit.

**2.15** The basic need in a Social Audit is that activists have to obtain and scrutinize several documents to track, trail and verify facts. The purpose of seeking information proactively is to strengthen the Social Audit and help it focus on making the rights of the vulnerable, especially women and children real, and on making the officials and the elected Government accountable to delivering those rights. In this way the community gets to realize the value of information and in a short time comes to see the process of Social Audit as a source of strength for the poor in their struggles and in tackling the currently, widely prevalent political and bureaucratic indifference to social development issues the consequences of which have been described in Chapter I.

**2.16** Having analyzed the many issues and difficulties involved in the conduct of a Social Audit, it is with utmost gratitude and in all genuine sincerity that this Social Audit team acknowledges the complete and total support it has received from Smt. Chaya Ratan IAS, Principal Secretary, Department of Women Development and Child Welfare, Government of Andhra Pradesh in the conduct of this Social Audit. No words of thanks can do adequate justice to her commitment to truth and sense of objectivity and the encouragement she gave us to bring out all that needs to be brought out about the ICDS programme as implemented in the field. The consideration and support she showed to this Social Audit was overwhelming.

We have received similar support from Smt. Y V Anuradha IAS, Commissioner, Department of Women Development and Child Welfare and for this we owe her deep gratitude.

Sri A K Punetha IAS, Commissioner, Health and Family Welfare extended to us his support whenever we asked for it. Special mention needs to be made of the brilliant leadership that Shri N Sridhar IAS, Collector gave to the Social Audit work from the beginning. Thanks to him and his unflinching commitment to this Social Audit, and of his successor Shri. Anil Kumar IAS, and their district officers in Anantapur Shri. G. Gopal, Project Director, District Water Development and Management Agency; Smt. Mutyalamma, Project Director, ICDS, and Dr. N.Bala Ramaiah, District Medical and Health Officer we faced, if at all, minimal problems in carrying out our work. The successful completion of our Social Audit work in the District owes with out doubt an enormous debt to these officers of the Government of Andhra Pradesh.

## ***Social Audit of the ICDS in Anantapur District***

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**3.1** Having seen what constitutes a Social Audit in the previous chapter, we now turn to what should the Social Audit look for specifically in the Integrated Child Development Services (ICDS) programme in Anantapur District. The ICDS programme, as conceived by the Government of India in 1975, seeks to provide the delivery of a package of the following services:

1. Supplementary nutrition.
2. Immunization.
3. Health checkup.
4. Referral services.
5. Nutrition and Health Education.
6. Pre-school Education (PSE)

**3.2** In the late 1980s it was recognized in the Union Department of Women and Child Development itself that one of the reasons for the objectives of the ICDS programme not being achieved was the non-recognition of the importance of the place and role of the adolescent girl in the life cycle of a woman. Advocacy was undertaken of her cause by the Government of India's Department of Women and Child Development itself with great support from the eminent nutrition scientist Dr. C. Gopalan, resulting in her becoming in the early 1990s a part of the ICDS programme as the 7<sup>th</sup> service.

**3.3** These services are to be delivered in an integrated manner to children in the 0-6 age group and expectant and nursing mothers and women in the age group 15-44 years, as relevant to them. For example, 0-5 will not have Nutrition Education or Health Education, while 0-2 will not have PSE. While expectant mothers will have

immunization against Tetanus, other women will not have immunization or nutrition supplementation but will receive nutrition and health education along with the former. When we talk of the 2 cohorts in the age group 0-6, the age in the upper limit of the group up to 2 years means 2 + and the group 3-5 means 5 + but less than 6 years.

**3.4** The objectives of the Integrated Child Development Services are:

- (i) To improve the nutritional and health status of children in the age group 0-6 years;
- (ii) To lay the foundation for proper psychological, physical and social development of the child;
- (iii) To reduce the incidence of mortality, morbidity, malnutrition and school drop-out;
- (iv) To achieve effectively coordination of policy and implementation amongst the various departments to promote child development; and
- (v) To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

**3.5** The concept of providing a package was based on the premise that the total or overall impact of a programme will be much larger if the different services develop in an integrated manner as the efficiency of a particular service depends upon the support it receives from related services. For instance, provision of Supplementary Nutrition is unlikely to improve the health of the child if it continues to be exposed to diarrheal infections or unprotected drinking water supply.

**3.6** In embarking upon the Social Audit of the ICDS programme in Anantapur District, as a starting point we thought we should plan to look at the following aspects of the implementation of the ICDS Programme even if eventually we did not cover all these aspects to our own full satisfaction:

**3.7** One of the objectives of the Integrated Child Development Services is to achieve effectively coordination of policy and implementation amongst the various departments to promote child development.

**3.8** Under-nutrition, for example, results from inadequate intake of food or essential nutrients or both. This affects physical growth and health. This condition enhances mortality and morbidity among children that denies them their future life itself. However, hunger is the first threshold of poverty and therefore hunger or under-

nutrition has to be dealt with on priority at the household level. We have programmes aimed at this such as the NREGP and the Public Distribution System. However, under-nutrition in addition has to be addressed at the institutional level relevant to vulnerable groups such as children at the 0-6 stage in the Integrated Child Development Services system. We, therefore, need to look at all these programmes in the context of their convergence and through such convergence the synergy they can create.

**3.9** Equally, the way each one of these programmes is designed with reference to the rights of the groups involved and implemented as individual programmes is very important. Thus there are two convergences we need to be concerned about. One, the extent of internal synergy and convergence achieved in Integrated Child Development Services in the delivery of the seven services projected to be delivered has to be evaluated as also the effectiveness of the outcome of each of the seven services in that context. A simple illustration for the rationale of this is that while about 70 percent of the health problems of the infants and children could be answered by proper nutrition, the importance of immunization and nutrition education and health education as an adjunct to the nutritional outcome can hardly be over emphasized. Thus convergence with the activities of the Health Department for the DWDCW to achieve the ICDS objectives is an internal convergence imperative. The other convergence is the manner in which convergence has to be achieved through the objectives of the other related programmes designed for the benefit of women and children. This external convergence can be illustrated by a reference to the NREGP.

**3.10** The Integrated Child Development Services is a social development programme *par excellence* and lends itself eminently for convergence with the objectives of the other anti-poverty programmes given the large scale participation of women in almost all such programmes. At present, the NREGA is under implementation all over Andhra Pradesh and more significantly a Social Audit of NREGP is also under way in Anantapur District. In the context of one of the basic objectives of the Integrated Child Development Services, namely, achieving effective coordination of policy and implementation amongst the various departments to promote child development, the NREGA is a great opportunity. An important strategy of defending and expanding the rights of the poor, especially of women, is to fine-tune schemes in a manner that they

pull together and incorporate the various rights that are due to various participants in such schemes. NREGA could be an excellent example of this in regard to gender and child rights if only the Government wants it to be. In rural areas women's participation in employment is very high. Poor rural women work till late into their pregnancy and from days immediately after delivery. The former require to rest while at work and the latter need to breastfeed their infants – both these in privacy. These are verily the inalienable rights of these women and their infants and these entitlements are part of their right to work and right to life with dignity. These are rights that come under Article 21 of the constitution in Part III and under Articles 42 and 43 in Part IV of our Constitution. In the context of laboring women these rights can be protected through the provision of a crèche at the worksite including by modifying the terms of reference of the mandate of the existing ICDS Anganwadis. A crèche that provides services during the day for 8 to 9 hours, six days in a week, when the working mothers are away at their work, to the children especially of the crucial under - 3 cohort, a cohort that hardly benefits today in the ICDS programme in any worthwhile manner, is what we need in the NREGA as a real help and an entitlement to the rural working women labourers. Such crèches could have 2 AWWs and 2 helpers and provide nutrition twice or thrice to the children. The rights of women labourers to rest in privacy while at work especially during pregnancy, and to breastfeed their infants, and the right of the infant to her mother's breast, as also the safety and security of the children when their mothers are at work are fundamental ingredients to the right to work and the right to life of a woman. These will be violated if all that a law can provide is a mere "shade" as provided for in the NREGA, 2005 and not a properly designed crèche. Since this has crucial relevance to the concept of guaranteed employment to women, we should redress this serious omission by prompting the setting up of crèches at the work spots. If it is argued that providing crèches at different work spots is logistically difficult, a beginning should be made in the long-delayed start for converting the existing ICDS Anganwadis into crèches - a reform that is a crying need to make the ICDS programme relevant to the rights both of the rural working class mother and her child. It will be a great boost to women in realizing the benefits of the NREGA and the Integrated Child Development Services at the same time. A crèche is a fundamental institutional need for employment security of women and therefore for employment guarantee for the rural women labour. The opportunities for enhancing outcomes of different socio-economic

development programmes through synergizing by way of effective coordination of policy and implementation amongst the various departments therefore obviously exist. Whether through the NREGA–ICDS convergence the interests of mothers and children under 6, especially under - 3, are being promoted should be explored in the Social Audit of the NREGP and of the ICDS programme.

### **3.11 Local Food vs. Ready to eat Food.**

The Social Audit has to look at the pros and cons of providing local food at the AWCs as against the current Government of Andhra Pradesh practice of providing Ready to Eat food and Ready to Cook Mixes in the District of Anantapur. While there may be no objection to providing nutrition-dense and fortified items like this *in addition* to local items of cooked food in our nutrition schemes, we must remember that “satisfying” the hunger of the beneficiaries is important, especially because what the child from a poverty household gets, say in an Anganwadi, is probably the first meal of the day. So, supply of regular food for the child’s psychological and physical satisfaction is important, as pointed out in their book “Nutritive Values of Indian Foods” by C. Gopalan, B.V. Rama Sastry and S.C. Balasubramanian – National Institute of Nutrition, Indian Council of Medical Research, Hyderabad, 1971. At page 9, this is what they say: “In drawing up new diet schedules or in assessing the value of existing ones, the question is often posed whether greater importance should be attached to the question of quantity or quality. Naturally, ensuring both is obviously the most desirable. But where a priority is inevitable, the question of *enough* food should take precedence over quality and other considerations. It is comparatively easy to decide whether or not enough is being provided because in the absence of enough food, *complaints of hunger* (emphasis mine) can reasonably be expected”. In the ICDS, we can ensure both these needs of quantity and quality through a properly balanced, nutritive, locally cooked meal. The Social Audit should look at the issues relevant to this question, particularly in the context of the directions of the Supreme Court of India in WP (Civil) NO. 196/2001 – PUCL vs. UOI and others that a hot cooked meal should be supplied at the AWC. We should conjoin this directive with the time-honored concept of involving the community in many facets of the activities of the Integrated Child Development Services, including in regard to those relating to nutrition.

### **3.12 Immunization**

Though the Department of Women Development and Child Welfare at the district and project level should have full involvement and even a say in the implementation of this programme, it seems to be looked upon purely as a programme of the Health and Family Welfare Department. The fact that cannot be forgotten is that Immunization is not so much a discrete technical intervention as it is about the holistic welfare of the women and the child concerned in the context of the other services delivered at the Anganwadi Centre and therefore there should be accountability to convergence with the Integrated Child Development Services functionaries on the part of the health establishment. “Using” the AWW for collection of the women or children for “targeting” them for immunization alone is not “convergence”, - not by a long shot. The AWW should have a greater say in regard to all health matters that affect women in their relationship with the health establishment for the simple reason she sees them on a regular basis. Apart from this, in the services relating to Immunization the cold chain is of the greatest importance in terms of the effectualness of the vaccines and that can be seen only by a functionary who is in touch with the target groups on a sustained basis. Also important for the same reason is the schedule of immunization in terms of the periodicity and dosage and the follow-up watch for after effects. An all-important issue is the convergence of services of the PHCs through the SHCs in this context and the synergy of the efforts of the ANM and the AWW. While assessing the outcomes against the objective under this programme these issues would need attention in the Social Audit.

### **3.13 Nutrition Education and Health Education.**

Knowledge of the mother and the household about the nutritive values of certain foods, as a routine, is part of the Integrated Child Development Services objectives. So, also, certain simple practices relating to hygiene and instant measures that can be readily taken by the mother and the household to meet the biggest killers of the child like diarrhea, through adoption of methods like ORT. Put together these measures can save so many lives of infants and children that these practices and nutrition knowledge need to become household education. This applies to breast feeding as well as the significance of colostrum for the new born infant. These are only illustrations. It must be verified in the Social Audit whether these have been achieved

and determined how this can be done if there are shortcomings. These are all issues that impinge on the right to food (Nutrition), health and education. The mother has also to internalize the knowledge of and the benefits from the practice of growth monitoring. The Integrated Child Development Services personnel and Health personnel should make this the basis of the concept of nutrition surveillance and must be equipped to provide nutrition rehabilitation where needed to avert mortality. The Social Audit would have to assess how and whether these objectives have been achieved and find correctives.

### **3.14 Health Check-up and Referral.**

This is an area of work that is the responsibility of the Medical, Family Welfare and Health Department staff – ANMs, MPWs and the MOs of the PHC system – though the mobilization of the women and children for this purpose and getting these done is the responsibility of the Anganwadi worker. We need to study the extent of the schedules of pre-natal and ante-natal check-ups being conformed to as also those relating to the children. There are clearly laid down instructions in regards to these but reports do not speak of anything worthwhile happening in this area of work. As for referrals, this is something that hardly ever seems to happen and when it does happen seems to have little meaning for the infants or the children of the rural catchments areas of PHCs or the District Headquarters Hospitals or for that matter even of the tertiary hospitals like Niloufer Hospital in Hyderabad. This failure raises issues relating to the functioning of the ANMs, the SHCs and PHCs at one level and the convergence of their efforts with those of the Anganwadi Worker (AWW) including the attendance levels and supply level of drugs and medicines at another. The failure in achieving this objective is reflected in the exponential rise of private health expenditure and consequential indebtedness of the rural and urban poor whose children it is we want to benefit under this service from Integrated Child Development Services system. Social Audit should address all relevant issues here.

### **3.15 Pre-School Education**

The well known philosophy behind the play way method of imparting learning to the 3-6 age group is that the child should not lose out on its childhood while starting on her learning skills. This method encourages language, inter-personal, social and creative skills of the child. Toys and dolls and charts and songs and well-planned rest are fundamental to this mode of learning, not to mention the crucial role of training in regard to all this of the AWW and the personnel who supervise her work. It is doubtful that this very important element of the programme is being implemented in a manner appropriate to achieve the objects intended. If the attention to the 0-3 cohort is dismal as revealed in the data relating to this age group in the AWCs, attendance of 3 - 6 children for PSE is not overwhelming either, though children do turn up for supplementary nutrition. The absence of response by way of attendance at PSE needs to be studied with reference to the reasons including the capacity imparted to the AWW during her training or even her educational qualifications. A successful pre-School promotes primary school enrolment because of the school-friendly environment generated in the mind of the child and the links the Anganwadi Center (AWC) establishes with the local primary school. An evaluation of the achievement of these objectives will be one way of judging the success of the very functioning of the AWC. A critical input will be an examination of the material that is being supplied to the AWCs and its regularity and how well the important resource that the Andhra Mahila Sabha undoubtedly is for PSE in Andhra Pradesh has been used optimally.

### **3.16 The Adolescent Girl in the Integrated Child Development Services Programme.**

In the late 1980s it was recognized in the Union Department of Women and Child Development itself that one of the reasons for the objectives of the ICDS programme not being achieved was the non-recognition of the importance of the place and role of the adolescent girl in the life cycle of a woman. Advocacy was undertaken of her cause by the Department itself and the eminent scientist Dr. C. Gopalan, resulting in her becoming in the early 1990s a part of the ICDS programme. The Social Audit in Anantapur District has to assess the success of the interventions presently under implementation for the Adolescent Girls.

### **3.17 Reduction of incidence of mortality, morbidity and malnutrition**

Among the objectives of the integrated Child Development Services is the reduction of incidence of mortality, morbidity, malnutrition and school drop-out. The Social Audit must examine if in the implementation of the Integrated Child Development Services programme the Government has built in methods by which the reduction of the incidence of mortality, morbidity, malnutrition and school drop-outs is measured and make appropriate recommendations.

### **3.18 Other important issues:**

(a) The AWW is the key to the success of the Integrated Child Development Services programme. The Social Audit has to look at her job chart with reference to the services to be delivered and the objectives of the programme. Her existential circumstances are a huge factor in the way she functions on a day-to-day basis and her self esteem. These determine her status and the pressures she comes under, which may even affect certain crucial duties of hers like home visits. Often, she is burdened with duties totally unconnected with her job like doing cattle census which prejudices the outcome of her efforts in crucial areas like PSE. The Social Audit would need to look at the life and times of this functionary over a period to determine how she should be helped and what changes are needed in the institution of the AWW itself including her training.

(b) We need several types of convergence in Government programmes. In addition to what has been stated above already, the role of the NGOs and the community in the context of the concept of convergence is very vital. The Social Audit would have to look at the role of the NGOs and the Community severally and together in the Integrated Child Development Services scheme. At present the NGOs are involved in training but at least for a quarter century many thinkers including some in the Government have campaigned for a direct role for them in running at least a few of the ICDS projects. This has not happened but for a lone case in Andhra Pradesh. Social Audit should look at this as a possible answer to some of the problems in the Integrated Child Development Services scheme in the delivery of the services including nutrition and fulfillment of its other objectives. The Social Audit should

also examine to what extent parallel programmes interfere with mandate of the Integrated Child Development Services programme affecting true convergence.

(c) The entire training system may be looked at because our object in this programme should be to demystify the issues that relate to the life cycle of the child in the context of her mother - be it nutrition or immunization or other services. Demystification is possible only through training. How do we do this? The Social Audit should try and evolve an answer so the mother (and the child) and the would-be mother (the adolescent girl) can be empowered to handle their problems with minimum dependence while enabled to assert their rights.

(d) The key to the success of the ICDS concept is enhancing the attention of the system to the 0-3 cohort in terms of all its needs. That is not happening at the present time to the desired extent. There can be no human resource development if this does not happen as the window of opportunity to the development of the human brain closes, by and large, at 36 months. We need reforms in the very structure of the system if the participation of the 0-3 cohort and attention to this cohort has to be enriched, such as the Anganwadis giving way to crèches, while retaining all the 7 services as now, as discussed earlier. The Social Audit should examine this. Resources cannot be a constraint for this if the Government, the community and the voluntary sector can come together, as indeed they should, and the energies of the Adolescent Girls are fully mobilized. In any case, there is a constitutional responsibility cast on the State to bring about changes of this kind. The Social Audit should help highlight how this can be done.

(e) Lastly, the Anganwadi Centre (AWC) must become a place where the woman and the child can find rest and assurance. Many of the AWCs have no place of their own by way of a building or kitchen garden or open spaces for learning and accessing services. These features of an AWC epitomize the very concept of the ICDS. The Social Audit in Anantapur District should identify the status in the district in regard to this so as to generate among the people a demand for a land policy from the State that would provide priority to the construction of Anganwadi Centers, where an Anganwadi building would provide adequately for the envisaged services backed by a kitchen garden that would act as the infrastructure to provide nutrition and nutrition and health education to the women and child beneficiaries and the entire community.

## ***The Social Audit Process as it Actually Happened in Anantapur District – certain Specific Findings and Comments***

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- 4.1** The proposal as formulated in the previous chapter on what the Social Audit should look for in the ICDS programme as implemented in Anantapur District was discussed by the Social Audit Team with Shri N Sridhar IAS, Collector, Anantapur at a meeting chaired by him on the 25<sup>th</sup> June 2008 in his camp office. After discussions, the Collector felt that the Social Audit could be on the following lines.
- 4.1.1** Given the motivation behind the idea of a Social Audit and objectives of the ICDS, as also the services the ICDS is designed to deliver, we should move in the direction of the Gram Panchayats owning the programme fully. In view of this it is essential we involve the (Gram Panchayat) Sarpanch fully, especially women Sarpanchas or Upa - Sarpanchas, in the Social Audit we were planning.
- 4.1.2** The Village organizations (VOs) and the women's self help groups (SHGs) would have as their members pregnant women and nursing mothers and, therefore, their representatives, members of the Gram Panchayat, supervisory officials of the ICDS and the Health Department and social activists from the participating NGOs could form the SA Team. This team could audit 2-3 AWCS that are in a Gram Panchayat. We need to have similar teams at the Mandal and District levels, the former to supervise, motivate and review the work and the latter to give guidance, and importantly, to ensure the full cooperation of the officers of all departments concerned with the ICDS, including in ensuring that all information is made available for the success of the SA.

**4.1.3** It was important that in order for every one concerned to fully understand and assimilate the details of the ICDS as a scheme and the philosophy behind it; to understand the various steps involved in a Social Audit and get all required feedback from all the stakeholders and the participants, a pilot SA as proposed by the Social Audit Team of the AWCs in one rural mandal and the Anantapur Urban Mandal would be taken up. That would be a good forerunner for a proper SA of the scheme as a whole.

**4.1.4** In addition to the departments directly involved in the ICDS such as Health and Women Development and Child Welfare, there was need to involve those dealing with allied programmes such as the PDS, so as to promote an understanding of the linkages and convergence in the food and nutrition security context. The Collector envisaged the principles of holistic convergence to be fully understood as a part of good governance as applicable to all the departments for the overall development of the district. He looked at the SA as an opportunity to take stock of this important programme as if it is an evaluation, identify and bridge the gaps that would be noticed and thereafter provide for a concurrent audit of the program. The goal of this Social Audit effort should be, from the District Administration's point of view, to synergize the objectives of the ICDS development effort so that it forms the model to help synergize the district development efforts over all.

**4.2** It was obvious to the Social Audit Team that given the detailed work in front of us that we would need several visits to the District and discussions with District Collector and the District officers of the Women's Development and Child Welfare and Health Departments and with the participating field level SA activists before we could put on ground the SA efforts based on necessary documentation such as schedules, questionnaires etc.

Originally we had planned that the field level Social Audit teams should ideally consist of the following personnel:

(a) Village Organization	: 2 members
(b) Gram Panchayat	: 1 member
(c) Health Department	: 1 member
(d) ICDS Supervisor or a senior Anganwadi worker	: member
(e) Social Activists from the NGO	: /3 members
(f) Community Activists	: 2/3 Members
<b>Total Team</b>	<b>: 10 members</b>

- 4.3** While the Collector and we planned with all sincerity to organize the field level Social Audit teams with representatives drawn from among Sarpanchas, women representatives of the Gram Panchayats and from other community activists, in the event our Social Audit teams came to be composed of the activists from the three participating NGOs; social activists drawn from the District Water Development and Management Agency (DWAMA) who had experience of Social Audit work in the NREGP; Anganwadi Workers; ICDS supervisors; in about 50 percent of the cases representatives from the village organizations; and sometimes the ASHA workers and the ANMs.
- 4.4** Social Audit of the ICDS programme demanded that the Project Director, District Women and Child Development Agency would make available all required information such as the job charts of the AWW, supervisor etc; the training curricula, all details of supplies, minutes of interdepartmental meetings of the past one year; the monthly progress reports (MPR etc) in the monitoring formats for the last six months and a comprehensive note detailing how an AWC functions on a typical day in terms of the charter of services including convergence with the health staff. Similar information would have to be made available to us in regard to the points relevant to them by the District Health Department. We are happy to acknowledge that despite initial hiccups, by and large, we were able to secure all the information we required thanks to the cooperation of the Project Director, ICDS, Anantapur Smt. Muthyalamma and her senior aide Smt. Sridevi, Supervisor and above all the unflinching support of Shri N Sridhar IAS, Collector, Anantapur. Also, the support we received from Shri G Gopal, Project Director, District Water Development and Management Agency (DWAMA) deserves special mention because not only did he make available to us his staff and trained activists experienced in Social Audit but was also our frontline support in solving all problems relating to logistics relating to the Social Audit and in our interface with the District Collector himself, as an ever reliable bridge and trouble shooter.
- 4.5** The Social audit of each Anganwadi Centre would be done with the field level team going to the village in the evening and explaining the purpose to the people and build rapport with them and understand the special characteristics of the village. The next morning they would conduct the social audit exercise as a team observing the daily

routine at the anganwadi and scrutinizing the records and cross checking these observations with the beneficiaries including through home visits and surveys and interacting with the general public. In the evening they would present their findings in a meeting of the Gram Sabha organized by the gram panchayat. The responses from the people by way of comments, questions and other observations along with the clarifications and commitments made by officials to deal with specific issues would be included in the social audit report that the Social Audit Team would frame.

**4.6** Any social audit that involves serious field work over an extended period of time has to take into consideration the agro-climatic conditions and seasons related to agricultural operations as also political events like elections. An important consideration we had to bear in mind in this Social Audit was the fact that we were doing this Social Audit of ours in a year and at a time preceding an election year and in fact at a time that was close to the announcement of the election schedule. It was essential, therefore, that we completed the field work by the end of November 2008. This apart, given the seasonal conditions and the related agricultural operations, the SA work in Anantapur District had to be done only during the period April-June and again during mid August-October and again mid January-March. January- March 09 would be out of the question as the Elections would be upon us by then and so we worked out an actual schedule of work for the Social Audit which slated the preparatory work between June and September 2008 such as selecting the field level teams, collecting and analyzing materials / documents, developing training and human resource development material, building linkages and obtaining commitments from various Government organizations and NGOs; undertaking the pilot; then training the field level auditors, followed by field work during the period September 2008 to end of December 08 in all the planned mandals and finalizing the findings and presenting the same at the District level Workshop between February 2009 and April 2009. Most of this schedule was achieved ahead of time, but because of the intervening elections, we preferred to hold our District level Workshop in July, 2009.

**4.7** The pilot Social Audit planned in two mandals was most important as that would help in finalizing and validating a social audit exercise protocol that would be used for the full-fledged Social Audit by the field level Social Audit teams. The Social Audit was so planned as to start immediately after the completion of the training following the

pilot, leaving no time to lapse between the period of training and the start of the Social Audit work, so that all the motivation and methods imparted during the pilot and the following training exercise would remain fresh in the minds of the activists, intact. The findings of the Social Audit at the village level would be reported to the people on the same evening of the day of the Social Audit, - to the mothers, all women and others of the habitation in each case through a public meeting of the Gram Sabha, presided over by the Sarpanch and the comments and questions of the assemblage invited on the findings. This would incorporate the technique of Jan Sunvai, made famous in Rajasthan in the 1990s. This entire design was planned by us in the belief that it would generate the necessary understanding in the communities of what the ICDS was about, including their rights and entitlements in that programme; the extent of the non-realization of those; would draw the attention of the government personnel to the perception of the ICDS in the public mind and therefore what needs to be done by the Government by way improvements; and help the Government at the highest level to reformulate aspects of the programme where needed and undertake generally changes and innovations required in the programme.

**4.8** Our plan was to do the Social Audit in this manner in 20 mandals selecting a few Anganwadi Centers in each of them using random sampling. Considering that several teams were to move in different directions in these mandals during the various phases of the Social Audit, appropriate route maps would need to be prepared for the teams and this was done.

#### **4.9 The Orientation Training Efforts:**

By far the most important step we took equip the social audit teams was to endeavour to motivate them to identify themselves with the target groups. To this end we held orientation training meetings for one full day preceding each of the three phases of our Social Audit in the months of September, October and November 2008. In order to provide the right motivation to the Social Audit teams in terms of the prestige and significance attached to the Social Audit work, we associated ourselves with the Collector, Anantapur at each and every step of the Social Audit and in particular we ensured the presence of the District Collector in each of these three orientation meetings where he addressed the Social Audit teams and encouraged them to give of their best in the field, given the noble objectives of the ICDS programme. During the

Social Audit period in 2008 we had two Collectors in the District – Shri N. Sreedhar IAS and subsequently Shri Anil Kumar IAS. Both involved themselves whole heartedly with the Social Audit effort because they came to personally believe in the importance of the ICDS programme and its great significance for the human resource development in general of the people as a whole in their district and its importance in the universalisation of education in particular. They also looked upon this Social Audit as a programme that was a path breaking effort in improving governance overall of the various programmes of the Government connected with poverty eradication given the significance and relevance of the ICDS to the poorest of the poor in terms of their most fundamental needs. Thus securing their support, leadership, association and inspiration at various stages in the Social Audit effort through explaining to them the great potential of the ICDS programme was an extremely significant constituent of our Social Audit effort.

- 4.10** In the orientation programmes we ensured the participation of the Project Director, ICDS, Anantapur; the District Medical and Health Officer, Anantapur; senior CDPOs and senior supervisors of the ICDS programme. Senior Officers of the three participating NGOs as also their Directors themselves and the Coordinator were not only present at these orientation training meetings but also spoke at great length and in detail on the manner in which relationships should be established with all the stakeholders and the community at the village level so as to ensure the success of the Social Audit. Representative of the CARE participated in one of these meetings and addressed the activists. A thorough understanding of what the ICDS programme stands for was imparted to the members of the field level Social Audit teams and the details of the programme and the philosophy underpinning the programme were made available to them in the form of a Social Audit Manual. The foundation for the Social Audit work was the Social Audit Manual and the Social Audit Work Book (see Annex – IV) in the form of a comprehensive, detailed and in-depth questionnaire evolved by us after prolonged discussions amongst the Coordinator and heads of the three participating NGOs. This foundation was strengthened in the orientation training meetings where the significance of each of the questions finding place in the Work Book was explained to the field level auditors. It was repeatedly made clear to the field level team members that they should go well beyond the Work Book questionnaire itself while eliciting information from the ICDS personnel, the health

personnel and above all from the beneficiaries and the community. Actual illustrations were given, taking specific questions as to how the questions should be expanded and explained to the stakeholders in order to elicit all relevant information from them in great detail. The teams were specifically guided to make sure that laconic answers were not entered in the Work Book by way of information but that the answers recorded were detailed enough to be meaningful. In addition to recording the answers to the questions actually finding place in the Work Book, the team leaders were specifically requested and encouraged to use separate sheets to write out freely their views about the manner in which the ICDS programme was being implemented at the Anganwadi level and how they saw the role of the officers at various levels of the departments of Women Development and Child Welfare and Health and Family Welfare. The significance of the Gram Sabha meetings was highlighted and the importance of placing all the information before the Gram Sabha and encouraging the participating public to seek clarifications and raise questions in regard to the services offered under the programme was stressed. The dominant guideline to the teams given by us in the Orientation Training Meetings was that these services in the ICDS programme were not to be seen as mere benefits but the fundamental rights of the children, the pregnant women, the nursing mothers and adolescent girls and also the members of the general community.

- 4.11** It was impressed upon the field level social audit teams that the ICDS was not an isolated, technical programme but an integrated social development programme as its services affected every human being individually and, therefore, the community as a whole. The teams were called upon to encourage all stakeholders to speak freely to them as to how to improve the implementation of the objectives of the programme and also give their own views. The most important elements of the programme like plotting out the growth monitoring chart; distribution of IFA tablets and Vitamin-A; the philosophy behind the concept of pre-school education as provided to the 3-6 year old children at the Anganwadi Center were all explained in detail repeatedly. Since Pre-school Education was felt to be a complex subject, we ensured that an expert on the subject was brought to Anantapur to address the members of the Social Audit teams as also the senior functionaries in the ICDS programme like CDPOs and Supervisors. This eminent authority, Ms. Lakshmi Chary, former principal of the Andhra Mahila Sabha College of Teaching not only addressed the CDPOs and

Supervisors of the ICDS programme and the officers of the Department of Health and social activists participating in the SA at the Training Orientation meeting but also visited an Anganwadi Center accompanied by the Coordinator in a far flung area of Anantapur district to personally study the way pre-school education was being imparted at an Anganwadi Center. An illuminating article by her on pre-school education is also being carried as part of this Report as Annex- II. Dr. Balaramaiah, District Medical and Health Officer, Anantapur also participated wholeheartedly in these orientation training meetings and spoke at length to the team members on the issues they should address in this Social Audit and the manner in which those issues must be studied. Dr. Balaramaiah painstakingly assisted the Coordinator in the latter's field studies of the functioning of staff and facilities at the PHC and SHC levels and clarified issues raised by the Coordinator relating to supplies of IFA and Vitamin-A tablets; the maintenance of the cold chain; and the administrative problems faced by professional Doctors in their every day work. A focused article by Dr. Balaramaiah on health related issues in the ICDS is carried as part of this Report as Annex -III

- 4.12** A significant point stressed at these orientation training meetings was the fundamental importance of the convergence, and through that the synergy, that ought to be achieved in the field by the ICDS and Medical and Health functionaries in the delivery of the ICDS services.
- 4.13** In these orientation meetings the Social Audit activists raised questions like how to verify particular registers; what were the programmes of the Department of Women and Child Development other than the ICDS scheme itself; how to map the growth chart; the immunization schedules etc. Such questions and questioning were not only encouraged but suggested to them as well since performance of the Anganwadi Centre personnel relating to these determined the quality of the services delivered.
- 4.14** To ensure the quality of the Social Audit, the Heads and seniors functionaries of the participating NGOs and the Coordinator himself led the field level Social Audit teams in the village level work of visiting the Anganwadi Centres and interacting with the field level staff of both the Departments of Women Development, Child Welfare and Disabled Welfare and Health, and the target groups in a few cases. In addition, the Coordinator visited two Anganwadi Training Centres to see the processes of training

of the AWWs and Helpers and held extensive discussions with senior officers of the ICDS programme working in the field.

**4.15** The Coordinator visited the Anganwadi Centres located in Pemanakuntapalli Tanda of Nallamada Panchayat of Nallamada Mandal; Kalasamudram village (S.C. Colony) of Kalasumudram Panchayat in Kadiri Mandal; Dhonnikota village of Dhonnikota Panchayat of Nallamada Mandal; Erradoddi village of Erradoddi Panchayat of Kadiri Mandal; Brahamanapalli Tanda of Ramanepalli Gram Panchayat of Belugoppa mandal; Bhoopasamudram village of Bhoopasamudram Panchayat of Gummagatta Mandal; and Ambedkar Nagar in Anantapur town. These visits were preceded by detailed discussions and briefings at Kadiri and Kalyandurg respectively with Smt. C. Bhanuja of REDS, Kadiri and Shri Sudhir, Director, Community Health of the RDT who lead the social development activities of their respective organizations in these areas. A visit to the RDT's hospital at Kalyandurg was also undertaken to get an understanding of how an NGO-lead health facility delivers services to the people of the area competently. Among the methods adopted during the Social Audit of these AWCs were some like making the Anganwadi Workers express themselves fully; encouraging them to describe all the activities they performed in a day at their Anganwadi Centres minute to minute and also to give their own personal suggestions as to how the implementation of the ICDS programme can be improved and strengthened; interacting with pregnant women, nursing mothers and children and the general community. While the findings of all the teams participating in the Social Audit of the 154 Anganwadi Centres all over the District have been put together and presented in Chapter-V of this Report titled "FINDINGS", some of the points as observed by the Coordinator in his work in these areas are briefly given below:

**(i) Children below 3 years:** There is remarkable failure in reaching out to this cohort. Children need stimulation from the time they are born and appropriate nutrition complementary to mother's milk after they are 6 months old. Given the poverty of our target households and the fact that all adults in labour households have to work, special efforts are needed to provide children below 3 with proper early childhood care and stimulation and complementary nutrition, in addition to what is available in their own immediate environment. The idea that children below 3 need to be taken to the AWC only once in a while for weighing and receiving "take home"

supplementary food has, therefore, limited validity. They need to spend time in an environment that guarantees them required care, appropriate stimulation and complementary nutrition. Such an environment needs to be created at the AWC. The design of the AWC services should be consistent with these needs of the below-3 years cohort. However, it was observed that the rural, working women did not feel confident about leaving their under-3 children at the Anganwadi Centre as they were uncertain that the close care and security that such very young children would need, would be given at the Anganwadi Centre as presently staffed. Because of this uncertainty, these mothers preferred to leave such children quite often in the care of their elder siblings, girls that is, resulting in these slightly older girls staying home instead of going to school. There were even occasions when the mothers themselves had to stay home foregoing their work and therefore their wages and livelihood, to be able to take care of these children. The other common occurrence was that these children were left in the custody and “care” of the very old members of the family. The problem with the older members of the family, often if not always, was that they were too old, with restricted mobility and even vision and hearing to give the required “care” to these children, leave alone provide them active stimulation, so essentially required for this cohort. Cases were there where these and even the children above three were taken by their mothers along with them to the fields where the mothers worked, depriving them of Pre-school Education. It is obvious, therefore, that in order to safeguard the educational interests of the siblings; the livelihood interests of the bread winning mothers; the early childhood care and stimulation needs of the child; and even the pre-school needs of the children above 3 years, changes are required to be made in the ICDS programme. One obvious change is to extend the working hours of the Anganwadi Centre beyond the current working hours up to 5 PM so as to be consistent with the working hours of the rural mothers in the fields or elsewhere. Concomitant to this will be expanding the space and the strengthening of the staff at the Anganwadi Centres and paying them more for the longer hours; strengthening the adolescent girl programme so as to be able to utilize the energy of the adolescent girls also to provide close care, security and stimulation to this cohort; and provision of additional supplementary nutrition considering the longer hours of stay of the children at the Centre. In short, we need to convert our Anganwadi Centres in the ICDS programme into crèches (day care centres) while retaining all the services presently being delivered, to protect the early childhood rights of these children, the rights of

the sibling girl child and the rights of the working women. This is verily a gender and human rights issue and, in addition, one impacting on the rights of the child below 3 years and some times even above 3 years and should be addressed forthwith accordingly. A crèche would also be better able to deliver services like Immunization and Pre School Education. This reform will be fundamental for laying the foundation for building the future human and social capital of India.

**(ii) Immunization:** Often, from the Immunization register, it was found that all three doses of DPT had not been administered. BCG was most often delayed as was measles vaccination. In Brahamanapalli Tanda of Ramanepalli Gram Panchayat in Belugoppa Mandal, 2 children who are 3 months old had not received BCG though they had both received one dose of DPT. Of the 2 pregnant women, T.T. had not been received by one of them, who was 9 months pregnant. There were cases like these in different places. In Pemanakuntapalli Tanda, it was reported that for immunization they had to go to the Primary Health Centre - including the pregnant women – located at Nallamada. In Erradoddi village the Social Audit found that the ANM visited the village only once a month. The obvious consequence was that BCG was invariably delayed. In one case here the delay was all of one month; however, the AWC records reflected a delay of only 5 days. In Brahamanapalli Tanda 2 children who were 3 months old had not received BCG because the ANM visited the village only once in 3 months. These children, it was however reported, had both got DPT one dose and polio immunization once. One registered pregnant woman did not receive T.T. It is a matter for investigation whether all this is the result of the immunization work currently having been entrusted to the ASHA worker, to the extent that even the ANMs are diluting their responsibility towards this work. One fact is emerging, which is that BCG immunization is a definite casualty and so is Measles immunization while, relatively, the DPT immunization is perhaps better. The reason for BCG being a casualty is the irregularity of the ANM's visits and absence of institutional deliveries. As for Measles, the fact that this is to be administered after a time gap in relation to DPT renders it vulnerable to the absence any more of a focal point like the AWC for immunization work. To the extent DPT takes place, the fixed day immunization approach may be seen as successful. However, for total immunization, the right answer would be the AWC located in the village unlike the ANM's health sub centre located beyond a certain radius. The AWC should be the

primary location. The Sub Centre should be the secondary location to immunize those missing it at the AWC. The third strategy should be the “out reach” strategy of the fixed day approach. All the three choices must be available and implemented giving all of them equal importance if total immunization has to become a reality.

In Dhonnikota AWC-I, children who had not received immunization were shown as having been immunized. These were detected by the Social Audit team by verifying the health card entries by going to the homes of the beneficiaries and checking the children’s immunization status.

The standard answer or explanation for failure to immunize was that children were “not available”, as in Pemanakuntapalli Tanda. Enquires with the Anganwadi Centre, if this “non-availability” was because of the failure of the ANM to turn up regularly, always resulted in denial, though there was no evidence to show in the registers maintained at the Anganwadi Centre that the ANM has been regular in her visits to ensure the observance of the Immunization regimen. This left a lot of doubt in regard to proper and complete immunization of the children as per schedule; and about the convergence that ought to exist between the Anganwadi Worker and other functionaries of the ICDS system on the one hand and the ANM (or the current ASHA worker) and other functionaries of the Health Department on the other. The very meaning of “outreach” in the ICDS is about reaching out to the children (and pregnant women) as a routine every day activity but to say that children were “not available” begs the question as if it is the target group’s exclusive responsibility to make themselves “available”. Immunization (and other health check-up and referral issues) in the urban areas seems to be a very dicey issue. It would appear that the total responsibility for immunization in towns rests with the Maternal and Child Health out posts run by the Municipal bodies. There appears to be little verification, or coordination with these out posts, by the ICDS authorities in regard to the immunization status of the children or pregnant women. Further, children who go to other places with their parents on visits or on migration and pregnant women returning to their parental homes are not monitored in regard to their immunization (or nutrition) at all by the AWCs in whose jurisdiction they are original residents, and where they eventually return. In such conditions and absence of monitoring, there is little chance of either our achieving total immunization or our protecting our women

and children in regard to their right to health.

All these need the immediate attention of the Departments of WDCW and Health at the highest level.

**It is not by any means suggested in this Report that coordination is totally non-existent between the two departments but it is clear beyond doubt that such coordination or convergence of efforts is extremely perfunctory and the trends for the future are clear that the Health Department wants to carry on with its work in isolation, perhaps unaware of the issues relating to the rights of women and children involved.**

**(iii) Supplementary Nutrition:** There was near unanimity amongst the pregnant women beneficiaries that they would prefer *ragi* or rice dishes cooked at the Anganwadi centre and served hot. They were not enthusiastic about any type of ready to eat foods if they had this alternative. They would further like varied recipes in such local foods instead of the same monotonous items even when cooked, local food becomes the order of the day. Some of the “better off” among the pregnant women that come to receive supplementary nutrition at the Anganwadi Centre prefer not to eat at the Anganwadi Centre for “social” reasons but like to take the food home. In such cases ready to eat foods are “convenient”. Some among these women reported, however, that the “take home” food was shared at home by family members, including their husbands. All these questions need addressing for a comprehensive solution that should result in a hot meal made of local food materials being served in appropriate privacy so that coming to the Anganwadi Centre by pregnant women and consuming it at the AWC itself, rather than a “take home” meal, becomes the norm. Exceptions can be made where absolutely essential through a fully participatory discussion among the beneficiaries themselves, depending upon exceptional circumstances, on a case by case basis in each AWC.

In Kalasamudram 2 pregnant women and 1 nursing mother were found not registered for supplementary nutrition and thus excluded from the services. A general observation showed in Dhonnikota that the target groups do indeed depend in a big way on the supplementary nutrition supplied at the AWC. Here, in a group of 5 pregnant women interviewed by the Coordinator, 2 were found to be very weak and

extremely tired-looking. Both were in their first pregnancy. One was 7 months into her pregnancy and another 3 months. A deeper probe revealed that in Dhonnikota Anganwadi Centre-I there had been no supplementary nutrition supplied for the previous 7 days. Smt. Nagalaxmi, the 7 months-pregnant woman told the Coordinator that she ate only 1/3 of what was given to her under the SNP as, when she carried it home, her husband and children also ate what she brought home. This led to the further questioning of all the pregnant women present and all of them stated that their food taken home under the SNP was shared at home by others. This practice is antithetical to the ICDS guidelines including those on NHE and also indicative perhaps of the outcomes of some of our much-acclaimed anti-poverty programmes aimed at keeping hunger at bay. Cases like these are symptomatic of the deeper maladies in our other programmes as well.

At Brahamanapalli Tanda the new type of Ready to Cook Mixes being supplied under the SNP which the Government has recently introduced was found to be popular among pregnant women. The Upma mix is cooked at the Anganwadi Centre and was reported tasty, but only while served hot. It became tasteless, however, when it turned cold. Therefore, since the 16<sup>th</sup> October, 2008 the pregnant women and nursing mothers have started preferring to come to the Anganwadi Centre to eat the food at the Anganwadi Centre itself as they feared carrying the cooked Upma home rendered it cold and tasteless. The children also find the new Upma recipe “satisfying” unlike the previously distributed “powder” and now stay longer in the Anganwadi Centre. This finding regarding “satisfaction” with the food eaten validates the point made by C. Gopalan et al quoted in Chapter-III of this Report. However, cooking the Upma mix brings with it certain problems like the expenditure on fuel wood (a cart load costs Rs.1, 000/-) which has reportedly not been provided yet by the Government. It was also mentioned that the Helper here was actually spending her own money on wood, wood in retail costing Rs.25 for 2 kgs (in towns this cost would be more).

While these are the emerging pros and cons of the new SNP initiatives taken during the past year, there was nutrition interruption at the AWC at the Brahamanapalli Tanda in the last 1 year on 57 days during the periods 26.11.2007 to 7.12.2007; 11.1.08 to 25.1.08; 28.2.2008 to 4.3.2008; and 9.4.2008 to 6.5.2008. Similarly in the Bhoopasamudram village Anganwadi Centre there were 58 days of nutrition

interruption between the 1<sup>st</sup> January 2008 and 19<sup>th</sup> October 2008 and in the month of October, 2008 alone for 14 days. In Dhonnikota village there was nutrition interruption on 91 days out of the 300 days stipulated for nutrition supply. In Pemanakuntapalli Tanda there had been nutrition interruption for 33 days preceding the date of Social Audit. For 2 months food supplies had not been made to the AWC.

The consequences of such interruptions can be easily imagined for the BPL pregnant women, nursing mothers and children who depend on the SNP in the ICDS scheme.

**(iv) Vitamin-A, IFA tablets, Medicine chests, Health check-ups and Referrals:**

No one appears certain as to whose responsibility it is to supply IFA tablets to the target groups. With ANMs and MPHWS (M) visiting villages irregularly, IFA distribution is a big casualty, especially considering that this responsibility does not seem at present to be recognized as one to be discharged by the AWW. A girl of 13 years, Manjula Bai, from the Ramanepalli Gram Panchayat area, had to be hospitalized recently for low hemoglobin by the Rural Development Trust. IFA tablets were not distributed over long periods in Dhonnikota because the Government failed to supply them to the AWC. This was the position in regard to Vitamin-A and other medicines as well. Health check-ups were not done nor any referrals. Ninety percent of deliveries in the village took place at home with the AWW or ANM not taking any interest in regard to promoting awareness or sending the pregnant women to hospitals for delivery. Simply put, there was near total failure in regard to matters relating to the health of pregnant women, nursing mothers and children. The position of near total failure in regard to all aspects obtained in Pemanakuntapalli Tanda as well, including the Government's failure to supply Vitamin-A, IFA tablets and medicines to the AWC. This failure was seen at Brahmanapalli Tanda also where inadequacy of Government supplies and irregular visits of the health staff were identified as the cause of failure. There was total failure in regard to supply of medicines to the AWC and supply of IFA tablets because of Government's failure to supply stocks of these in Bhoopasamudram village. Here, as regards Vitamin-A, inadequate Government supplies saw inadequate distribution to the target groups.

For years together referral slips have not been supplied to any of the AWCs making the entire concept of accountability in regard to referral services a mockery.

The non-supply or the near total non-supply of IFA tablets to the target groups, practically everywhere, renders the pregnancy of almost all the women seen in these anganwadi areas most risky and dangerous with implications for the lives of the would be mothers and their progeny. The most conspicuous fact that emerges from the audit is either the failure of the State Government to supply of IFA tablets and Vitamin-A to the Districts or if supplied by the State Government, the near total failure of the District machinery to supply these IFA tablets and vitamin-A to the field level formations or to ensure that the field level formations did indeed deliver them to the pregnant women and the adolescent girls. The implications of this failure in terms of risks like maternal anemia, unsafe pregnancies and consequential birth defects are too serious even to contemplate but they are a reality in the areas audited.

**(v) Community Participation:** This appeared more or less non-existent in the villages audited by the Coordinator. Most mothers had no knowledge of what the children gained through pre-school education at the Anganwadi Centre. The labouring, working women stated that they had little time for this either. It is obvious that Anganwadi Workers are not reaching out to women through regular and leisurely home visits or encouraging them to visit the Anganwadi Centre to further their awareness of or involvement in the Anganwadi services and activities. There is need to go beyond “Fixed days” for NHE even assuming that those days are regularly observed by the AWWs and attended by the women. Thanks to a situation where no worthwhile interest has been created about the functioning of the Anganwadi Centres in the minds of the general public through proper delivery of services, the question of their making any contribution to the advancement of the ICDS work does not arise. In Erradoddi Village the Coordinator was told by the people that they were not interested in attending the Gram Sabha meetings called at the end of the Social Audit in the village because they did not find the Anganwadi Centre delivering any worthwhile services. In one village, the ICDS supervisor told the Coordinator that the very concept of Mothers Committee in the ICDS “has been abolished”. Community participation is a two way street and the services rendered fully in an AWC reinforce the people’s faith in the programme and make them come forward to make their own contribution as well. Therefore competent functioning of the AWC is a *sine qua non* for community participation. In community participation it takes two to tango but it is

clearly the duty of the ICDS personnel to take the initiative to establish the required rapport with the community. The leadership for such initiative has to come from the senior personnel of the ICDS programme such as the CDPOs and supervisors, who should also keep renewing such rapport periodically to make it sustainable. This understanding seems to be lacking, as seen in our Social Audit and need to be revived.

**(vi) Pre-School Education (PSE):** It was heart-warming to hear the primary school children with whom the Coordinator interacted at Pemanakuntapalli Tanda, recalling with joy the toys they had played with while attending the Anganwadi Centre when they were below 6. All the 15 school going children present and interviewed said they had attended the Anganwadi Centre earlier and loved the time they had spent there as also the games they had played and what they had eaten. There was no better proof needed than this finding that emerged in the Coordinator's Social Audit to show how important PSE at the AWC is for enrolment of children in the primary school and how relevant the Anganwadi Centre is for the universalisation of the concept of the Right to Education; and the important role supplementary nutrition at the Anganwadi Centre plays in attracting them there and how they enjoy the play way methods of learning. Regrettably, however, this is not the experience elsewhere. While generally the mothers and the community neither had knowledge of, nor were interested in, what was imparted under PSE to the children at the AWCs, many parents preferred to send their children below 6 to "convent" schools as was found in the Social Audit. This was the case in 3 AWCs out of 6 AWCs checked by the Coordinator. There were also cases of mothers being accompanied by their 3-6 year children to their work places in 2 of the 3 other AWCs. Therefore, the need to strengthen all the services at the Anganwadi Centre in the ICDS programme to attract all the 3-6 children to the AWC and in particular equip the AWW to properly impart the PSE component through proper training and motivation of the Anganwadi Worker to observe and practice her schedule of activities scrupulously and the need for the supervisory officers to ensure that this happens, would need reiteration.

**(vii) Non-residence of Anganwadi Workers in the villages where their Anganwadi Centres are located and Home Visits:**

Cases of this type were noticed in an overwhelming majority of the villages audited

by the Coordinator. The Kalasamudram AWW, who is currently resident at the village, had not been resident for the previous 11 years, living at Kadiri and taking up residence at Kalasamudram only during the past 1 year. The AWW of Pemanakuntapalli Tanda lives 3 km away from her AWC, visits her AWC only once a week and makes no home visits. The Brahmanapalli Tanda AWW lives in Ramanepalli, at a distance of 1 ½ km from her AWC. There are no proper home visits done by her. The AWW of Ambedkar Nagar AWC-II centre of Anantapur town lives at a distance of 8 kms from her centre. She told the Coordinator she does 10 home visits a day, but, given the distance she had to travel every day, this must be an exaggeration or at least difficult to achieve. The AWW of Dhonnikota lives at a distance of 18 kms at Kadiri and her home visits are perfunctory. This, however, is not the whole story because she belongs to the Scheduled Caste and there is the practice of discrimination against the Schedule Castes here, rendering it impossible for her to do home visits. Thus we find the cross currents of non-residence and situations like untouchability rendering the all important home visits a failure. We face problems that are not only related to poor supervision or poor administration but related to the kind of society in which we are living as well. Therefore, in the ICDS programme, social action by activist groups is as much a need as improvement in various areas of governance. In fact, governance itself has to recognize that there is a social dimension that it needs to address.

**(viii) Anganwadi Centres:** Practically all Anganwadi Centres are located in structures with very little area, cramped for space and almost all the time with no open space. Wiring was done for electricity supply at the Kalasamudram Anganwadi Centre 10 years ago but no electricity was ever supplied to the AWC since then, though the entire surrounding area has power supply. In Ambedkar Nagar in Anantapur town, Anganwadi Centre-II, serving Dalit children does not have a toilet and, therefore, the bathroom is used as the urinal. The Anganwadi Centre has so little space that no activities can be conducted, - not certainly PSE activities. All such Anganwadi Centres need to be shifted to better accommodation on the basis of a crash programme; else services will not improve. The Anganwadi Centre here needs a fresh supply of toys as well. The Brahmanapalli Tanda AWC has a very nice building built by the Gram Panchayat which would make for an ideal AWC but it has been in disuse for several years, overgrown with bushes and shrubs. That no one in the Government

thought of repairing it and putting it to use speaks volumes of the importance attached to the ICDS programme. The result is the AWC is located in the RDT's school.

Four of the AWCs seen by the Coordinator did not have their own buildings. Five of the AWCs had drinking water supply but five of the AWCs had no toilets.

Going home to the parental home for delivery is a common practice with our women. However, there is a lack of monitoring by the Anganwadi Workers of the pregnant women who go to their parental homes for delivery. Such monitoring through coordination between Anganwadi Workers concerned is essential if these women's needs are not to be missed out. Not only was this neglect seen in the rural areas but was the position in Anantapur town as well. This lacuna needs to be plugged if we want to ensure institutional deliveries for women who go out of sight of the Anganwadi Centre where their pregnancy had been first registered.

**(ix) Convergence between ICDS and Health Personnel:** Inter-personal relations between the Anganwadi Worker and ANM, in the context of the ICDS mandate, appeared poor most of the time. When the ASHA worker was requested to assist at our Social Audit at Kalasamudram she reportedly refused on the ground that she had received no instructions from the ANM. For her part, the ANM reportedly took the stand that there was no need for them to be at the audit for any length of time, dropped in for ½ an hour and went away. All this, despite our Social Audit being conducted with full official support and Government's concurrence at the highest levels. This was the case in the Social Audit of the Anganwadi Centre at Bhoopasamudram village also where the ANM failed to turn up either for the Social Audit during the day or for the Gram Sabha meeting in the evening. In Erradoddi village, the Social Audit team could not compare the ANM's Immunization register with the AWC's Immunization register as the ANM did not turn up for the Social Audit here. At Pemanakuntapalli Tanda the people did not remember when the Medical Officer of the Primary Health Centre had last visited the AWC. They were certain that for at least a year preceding the Social Audit there had been no visit from him. In Dhonnikota the Coordinator heard that the pregnant agricultural labour women miss immunization because of the compulsions of work. A most serious complaint that the Coordinator heard at Dhonnikota was that the Medical Officer, Area Hospital, Kadiri allegedly refused to treat a nursing mother suffering from

edema because she failed to produce a sterilization certificate. In the same village the Coordinator met a pregnant women named Radha Madhavi who was in the third month of her pregnancy but weighed a mere 32 kg. She is 20 years old and hers was a case of sheer poverty. She had no where to go and it was mentioned that even the Puttaparthi Hospital refused to assist her on grounds of jurisdiction. Proper convergence between the ICDS and Health personnel would have obviated this situation. In Erradoddi there was late registration of pregnant women by several months and non – registration of nursing mothers. In Bhoopasamudram it was mentioned that after the ASHA worker came into the Health Department from January 2008, that Department has started sidelining the Anganwadi Worker since then in regard to immunization work and made it clear by its actions that hence forward immunization work would be taken forward only through the ASHA worker. At present, therefore, convergence in the efforts of the staff of the DWDCW and the Department of Health was nearly non-existent. The basic problem lay in the payment of an incentive to the ASHA worker for her “achievements” in terms of “targets” given to her by the Department of Health.

The incentive amounts payable to women for institutional deliveries do not always get paid on time or in full. While this is the responsibility of the ANM, the problem finds its way to the Anganwadi Worker as she is the ones regularly accessible to the women of the village. The management of this programme as also other associated programmes like the GCPS requires to be streamlined by the Government.

When asked to give her views on how to achieve greater coordination and convergence in regard to delivery efforts between the Health and the ICDS staff, one Anganwadi Worker of considerable experience recalled that till 1998-99 there existed a combined joint training programme of the CDPO and MO; ICDS Supervisor and the Lady Health Visitor (LHV); and the ANM and the Anganwadi Worker, for 3 days. This has been given up since, leading to loss of proper inter-personal relationships between the functionaries of the two departments. Revival of this joint training programme would be an important measure to review this synergy, she advised. This is a very valid recommendation and merits immediate attention.

**(x) Problems of Anganwadi Workers and Helpers:** In many Anganwadi Centres the Coordinator found that the Anganwadi Workers and Helpers had not been paid their honorarium for a period of 4 months and 7 months respectively. Enquiries elicited the further information that this was case in all the Anganwadi Centres of entire mandals like Nallamada, ODC and Ammadaguru and the Kadiri Municipality. This problem of delay in releasing the regular honorarium provided by the Government of India is further complicated by the State Government making a promise of enhanced honorarium in the year 2008 by Rs.400 to Rs.1, 400 but failing to release the budget required. Thus the Anganwadi Worker received only Rs.1, 000 per month for several months. In other words, she received her full honorarium of Rs.1, 400 only on three occasions in the 7 months prior to October 2008. The position in regard to the Helper was worse since in regard to her honorarium the delays were longer. As it is, the honorarium paid for the AWW and Helper in the ICDS programme can only be described as negligible. That even this amount is delayed unconscionably makes any comment totally superfluous. It is from ill paid functionaries like these that we are expecting the services most crucial to the pregnant women and children to be delivered meticulously at the village level. The Government of India and the Government of Andhra Pradesh should together examine the resulting predicament of both the functionaries and the target groups from the point of view of their respective human rights and find solutions to them. In addition, we have to look at these conditions of service of the AWWs in juxtaposition with the absence of infrastructure facilities at the AWCs described at paragraph 4.15 (vii) and failure of supplies and absence of timely supplies in regard to supplementary nutrition, medicines, Vitamin-A, IFA tablets, weighing scales, adequate toys etc., described elsewhere, to appreciate how precariously poised the entire ICDS programme is. All these need to be addressed as a package to rescue the programme from its currently dysfunctional situation.

#### **4.16 Certain Other Serious Irregularities:**

While analyzing the way the ICDS programme functions at the ground level, it would be invidious to distinguish the importance of one service from another for the simple essential reason that holism and convergence are the bedrock on which this programme has been conceived, and sought to be built upon. Therefore, the issues

referred to here are not by any means less significant than those discussed earlier under certain sub heads.

Thus, the neglect of the adolescent girl who has been included in the ICDS programme since the early 1990's is a serious default in the holistic implementation of the ICDS programme. She needs all the services herself contemplated in the ICDS programme with vocational training substituted for Pre-school Education; and she can be a brilliant agent in helping to deliver all these services to the target groups, and in the process training herself in the art of learning and internalizing the fundamental human rights ingredients of nutrition security; health security and livelihood security. Regrettably, she has been seen to be almost totally neglected in the villages audited by the Coordinator, the ICDS programme thus foregoing the great social development returns this precious human asset and social capital would have delivered. The Department of WDCW and Health, Government of Andhra Pradesh should re-visit her without delay to tap her huge potential, universalizing the attention due to her in the jurisdiction of every single Anganwadi Centre.

It was seen in the Erradoddi Anganwadi Centre-I, that attendance for PSE was only 9 but over a long period attendance was being shown as 20. This was the position in regard to provision of supplementary nutrition as well. Mothers Committee meetings did not seem to have been held at all but records seem to have been created to the contrary. The Anganwadi Centre at Erradoddi did not have story books or adequate number of toys or aids or charts required for imparting PSE.

An AWW should open and close the AWC on time. An Anganwadi Centre should adhere to the time allotted for health, nutrition and education activities as shown below so that *all* the services are provided to the beneficiaries with out fail, home visits are made and records are properly maintained as required:

Daily Tasks	Expected Time
Pre-school education	2 hours (120 min)
Preparation and distribution of supplementary nutrition	½ hour (30 min)
<i>Treatment of common childhood illness ailments and referral</i>	½ hour (30 min)
Filling up records and registers	½ hours (30 min)
<i>Making 2-3 home visits</i>	1 hour (60 min)
Total	4 ½ hours (270 min)

Many Anganwadi Workers had no concept of the division of time as stipulated above for different activities. Almost invariably the AWWs thought that PSE was to be imparted all the 4 ½ hours, never mind if it happened in reality or not. There was also the case in Erradoddi where an Anganwadi Worker opened the AWC at 10.30 AM and closed the AWC at 11.30 AM after distribution of the SNP “powder”. Here, against a total number of 48 beneficiaries shown under the SNP, a house to house verification showed that only 31 persons were receiving supplementary nutrition while 17 stated that they were not receiving supplementary nutrition. The village survey had not been updated for a year though expected to be done every quarter. Pregnant women turning nursing mothers have not been shown when that happens. Pregnant women were registered late and 2 nursing women were not registered at all. When a pregnant woman sent her mother to collect her nutrition supply, she was refused but yet her name was shown as receiving the supplies under SNP though she had stayed away from the Anganwadi Centre on having been denied food. Three infants had not been registered but were shown as receiving supplementary nutrition.

**4.17** Hardly any institutional deliveries seem to take place in Dhonnikota. Almost all deliveries take place at home, which means the BCG immunization would not take place immediately. Children not immunized had been shown as immunized. To this Anganwadi Centre some children have to come from across the road but they do not come for fear of risk of crossing the road, which indicates that no home visits are undertaken by the Anganwadi Worker or Helper to escort them to the AWC. In the Gram Sabha convened to report these findings, as required by our Social Audit procedure, though the attendance was good with 75 persons attending, many others openly refused to come on the ground that even nutrition had not been properly distributed at the Anganwadi Centre here; and towards the end of the Gram Sabha meeting hardly 15 adults – 14 women and 1 man were present. (However, the Coordinator and Smt. Bhanuja of REDS, explained to the Gram Sabha how the services under the ICDS constituted people’s rights and that the functioning of the Anganwadi Centre can be improved only by generating a demand in regard to those rights, organized by the action of the villagers).

**4.18** Discussion with the CDPO, Kalyandurg and Supervisors and Shri Sudheer, Director, Community Health of the RDT revealed that as many as 11 Anganwadi Centres did not have Anganwadi Workers and that these vacancies were all in the areas

predominantly inhabited by dalits. Obviously, this serious situation demands immediate rectification.

- 4.19** In Bhoopasamudram, the Anganwadi Worker's survey list of beneficiaries did not tally with the results of the survey based on house to house check made by the Social Audit team. There were 2 nursing mothers in the village but they not were found in the Anganwadi Worker's survey register. One pregnant woman Smt. Madhyanakka, though found in the AWC register, was not receiving benefits and yet she was shown as receiving them.

Home visits were either absent or casually made.

It is regrettable that adult weighing scales so essential for weight gain monitoring in pregnancy were invariably absent in the AWCs audited. There were occasions when children's weighing scales were non-functional prejudicing their all-vital growth monitoring.

Maintenance of registers that reflect ground realities, work programmed and serve the all-important purpose of accountability has been poor most of the time and some times even fabricated. Pre-School Education methods were shown to be known to them by a few AWWs but its imparting and even the use of some of the materials supplied to them in this context was poor. These two aspects of failure in regard to the imparting of Pre-School Education and maintenance of registers seen in conjunction with the absence of, and casual, home visits highlight the failure of training in the ICDS programme. This fear is more than confirmed by the absence of the helpful and constant supervision required on the part of the CDPOs and Supervisors of the AWCs and AWWs. These aspects regarding Pre-School Education as already referred to earlier and Training were therefore taken up by the Coordinator with two experts on the subject namely Smt. Lakshmi Chary, former Principal, the Andhra Mahila Sabha College of Education, Hyderabad and an expert on Pre-School Education and Dr Arun Gopal, Director, National Institute of Public Cooperation and Child Development (NIPCCD), New Delhi and their respective views and suggestions for improvement in regard to PSE and Training feature in this Report. Dr. Arun Gopal's article appears at Annex-I and Ms. Chari's article is at Annex-II of this Report.

Last, but not the least, is the irrational practice of discrimination against the Scheduled Castes Anganwadi Workers and Helpers noted in the Community at quite a few places. This is not just discrimination against a few functionaries but manifests against the AWCs located in Scheduled Caste “colonies” and children coming there as well. It is not as if this discrimination is practiced only by the so-called upper castes or people practicing a particular religion. This is a huge Governance and Constitutional issue and also represents a huge failure of the activists in the Civil Society at large. That the ICDS programme designed exactly to fight exclusion and promote inclusiveness should continue to be confronted by this predicament 3 ½ decades after we brought it into existence is a tragic irony, tragic because this discrimination is located and perpetuated in the context of child development, so fundamental to India’s current and future existence as a plural and inclusive nation. We need Government backed social action to deal with this problem.

- 4.20** While these are some of the points that came to the notice of the Coordinator during his field level Social Audit work, given below are some of the findings that emerged from a scrutiny done at random by the Coordinator of the Work Books submitted by the Social Audit teams, pertaining to Anganwadi Centres audited by them:

**1. Gunduvaripalli Village of Gunduvaripalli Gram Panchayat of Amadaguru Mandal – Anganwadi Centre-I.**

The AWC does not have a toilet. There was failure on the part of the Department to reach supplementary nutrition stocks to the AWC for nearly 3 months. There was nutrition interruption for nearly 85 days of which on 10 days such interruption occurred even when there were stocks. The Pre-school Education component seemed to be a failure while the impression was inescapable that the AWW was not discharging here duties properly. The community seemed to have no confidence in her. The problem in regard to supplementary nutrition got compounded considering that serious discrimination against the scheduled castes existed as was evident from the fact that the Helper, hailing from the scheduled castes, does not cook food for fear that the beneficiaries would not eat what was cooked by her. Furthermore, the currently distributed Ready to Cook mixes food was not found palatable by the beneficiaries. There was no distribution of Vitamin A or IFA tablets to the

beneficiaries, the reason being “non-supply of stocks” to the Anganwadi Centre by the Government. NHE and referrals are non-existent. There is no involvement of the community in the functioning of the Anganwadi Centre. The fact that discrimination against the *Dalits* is seen to exist shows that the community’s attitude is positively detrimental to the objective of the ICDS programme. This Anganwadi Centre was established in the year 1991 and the over all conclusions about this centre can only be described as most discouraging.

## **2. Gunduvaripalli Village of Gunduvaripalli Gram Panchayat of Amadaguru Mandal – Anganwadi Centre-II.**

There was nutrition interruption at this centre for 15 days out of the 30 days prior to the Social Audit. The reason was the failure of the Department to supply stocks to the AWC. No vitamin A was supplied nor was there regular supply of IFA tablets. Fifteen days prior to the Social Audit 20 beneficiaries were provided with IFA tablets. Health checkups, referrals and provision of medicines were all found to be nil. The ANM was not regular in her work. Because the Anganwadi Centre is located in the S.C. colony the beneficiaries belonging to the backward classes were not willing to come to the centre for supplementary nutrition. The community here was both unaware of and unresponsive to the ICDS efforts.

## **3. G. Kothapalli Village of G. Kothapalli Gram Panchayat of Raptadu Mandal**

The Anganwadi Worker of this Anganwadi Centre established in the year 1993 does not live in the village where the Anganwadi Centre is located. She is living at a place 15 Kms away. There is no evidence of any supervisory officer having visited this Anganwadi Centre. The last visit of the CDPO was in 2007, and again now in September 2008. In the Gram Sabha conducted at the end of the Social Audit, the assembled public complained of non-delivery of the 6 services of the ICDS programme, which were their rights. The currently distributed Ready to Cook mixes food was not being consumed by the beneficiaries because of diarrhea cases attributed to it. Weighing scales at the Anganwadi Centre were defective. Malnourished children are not being identified. There was total failure in regard to availability of medicines or Vitamin A and the ANM stated that there were “no stocks of Vitamin A”. While the Anganwadi Worker is herself a non-resident, she complained of non-cooperation of the community in her work – a consequential double jeopardy! The

surroundings of the Anganwadi Centre were maintained in a most unhygienic fashion. As regards IFA, this gets distributed only when there are stocks suggesting that its supply is irregular and in any case there had been no supply after February 2008. After February 2008, no hemoglobin tests were done; nor was there distribution of medicines or administration of TT injections. This is a case of failure of the ICDS in most respects.

#### **4. Kadarakunta village of Kuderu Panchayat of Kuderu mandal**

The AWC does not have a toilet. The Anganwadi Worker of this Anganwadi Centre does not reside in the village where her centre is located and comes from a distance of 25 kms to her work. The Ready to Cook mixes supplementary nutrition being supplied currently is not found suitable or acceptable to the beneficiaries, who complained of incidence of diarrhea because of it. The Anganwadi Centre does not have adult weighing scales. There were no health check-ups. There was total failure in regard to the supply by the Government of medicines, Vitamin A and IFA tablets to the Anganwadi Centre, leading to non-distribution of these to the beneficiaries. Functionaries like the ICDS supervisor, the ANM and the ASHA worker rarely visited the AWC. Nursing mothers complained about varying scales of payment for institutional deliveries. Children under 6 were going to convent schools instead of attending the PSE at the AWC. At the Gram Sabha, the public stated that no worthwhile services are being delivered to the beneficiaries at this Anganwadi Centre. There were complaints at the Gram Sabha that the food material supplied to the Anganwadi Centre was infested with insects. It was also stated in the Gram Sabha that the ANM was inaccessible and that there was complete neglect of the adolescent girls. There were variations in regard to figures entered, relating to the same subject, in different registers. Enquiries also showed that the payment of honorarium to the Anganwadi Worker and Helper was irregular

#### **5 and 6. P. Narayanapuram village of P Narayanapuram Gram Panchayat of Kuderu Mandal – AWC-I and AWC-II.**

AWC-I is an old Anganwadi Centre set up in 1993 but yet Pre-school Education (PSE) has not been properly established. Of the children registered for PSE, as many as 14 were not attending the Anganwadi Centre for PSE because they were all “going to a convent school”. No medicines are available at the Anganwadi Centre as none

has been supplied to the Centre for months on end. For want of stocks of IFA tablets, there is no distribution of these to the adolescent girls since 2-1-2007. AWC-II, which was established in February, 2007 is in hired accommodation and very cramped. It has no toilet. Here, the malnourished children are reportedly being given double ration, which is commendable. No referral slips have been supplied to the AWC just as in the case of all other AWCs. While Vitamin-A has not been supplied at all by the Government, IFA tablets supply seems inadequate.

### **7. Raptadu village of Raptadu Gram Panchayat of Raptadu mandal**

This is a very old Anganwadi Centre, established in the year 1980. A scrutiny of the work book relating to this centre shows that there is no item in regard to which any thing good at all has happened here. It is a total loss and is indicative of the utter failure of the Government on the one hand in regard to supply of all the basic materials that require to be provided to an Anganwadi Centre and the failure of personnel at the ground level to deliver any services at all properly, on the other. Since the Project Director, ICDS, Anantapur herself took the trouble of accompanying the Social Audit team to audit this Anganwadi Centre (as part of our pilot work prior to the start of the Social Audit programme) we hope that this work book would be studied by the DWDCW and the Department of Health to get a view of the parlous status of the ICDS programme, though admittedly this is an extreme example of what ought not to be the case in regard to the implementation of the ICDS programme. Still doing justice to our work demands highlighting a few points which are: only 46 of the total number of 73 children in the 0-3 year cohort have been registered, the reason emerging from the audit being that it was on account of the “failure to impart awareness”. As regards non-registration of as many as 36 out of the 76 children in the age group 3-6, “failure to impart awareness” has again been recorded as the reason. Obviously, this lack of awareness is more on the part of the ICDS personnel about their duty to the rights of the parents, given the magnitude of the numbers that went unregistered. Four of the ten pregnant women in the village have not been registered because of the failure of the ANM to do the survey of the pregnant women in the village comprehensively. Seven out of the 17 nursing mothers were not registered, some on account of their going to their parental homes and the rest because of the failure of the Anganwadi Worker to do her survey thoroughly. This work book of our

Social Audit is an endless story of such failures in regard to almost all the questions we have incorporated in it pertaining to the various services under the ICDS programme. The AWC has neither drinking water supply nor a toilet. Both the adult and children's weighing scales are in a state of disrepair. Distribution of supplementary nutrition is irregular in the sense that some do not receive it and others do not like the food supplied. There is no weighing of children or growth monitoring, the reason being the indifference of the AWW. Health check-ups of pregnant and nursing women are done with no regard for timeliness. Home visits do not take place. Visits of ICDS Supervisors to the AWC are infrequent. Failure to observe timeliness on the part of the ANM in administering immunization resulting from an attitude of indifference on her part is only one of the many similar highlights of our findings in this village. There is no supply of medicines or vitamin A thanks to the Government's failure in this regard while the supply of IFA tablets is not regular. No IFA tablets have been issued for a year now to the adolescent girls. The Government's failure extended to other areas as well as seen from the proceedings of the Gram Sabha where the public complained that in about 80 cases of women beneficiaries under the JSY scheme, over a period of one year prior to the date of our Social Audit, incentive amounts had not been paid. When questioned why, the ANM revealed that she had with her an un-disbursed amount of Rs.15, 000/- which she would distribute the next day. Similar response in regard to delays in disbursement of incentive amounts under the Balika Samrakshana Pathakam showed Government's failure over a period of 3 years in the administration of this scheme. Malnourished children have not been identified. The Social Audit team found (19) cases of malnourished children which they reported to the Gram Sabha.

#### **8. Dimmagudi Village of Dimmagudi Gram Panchayat of Pedda Veeduguru mandal**

This Anganwadi Centre was started in 1993. The AWW hails from the Scheduled Caste. In this Anganwadi Centre, located close to the Scheduled Caste colony, there are no drinking water or toilet facilities. The weighing scales are in a state of disrepair. Thirty one out of 61 under-3 children have not enrolled themselves for the reason that the Anganwadi Centre is at a distance that renders it inaccessible to some of them, especially those belonging to the OC and BC communities, and they do not get therefore supplementary nutrition. 37 out of the 84 children in the 3-6 cohort have

not enrolled themselves on account of reasons attributable to “discrimination” and further more the Anganwadi Centre is at a distance for them that renders the centre inaccessible to them. Twelve of the 23 nursing mothers have not registered themselves because of issues attributable to caste discrimination. On 25 of the 30 days previous to the Social Audit supplementary nutrition had not been provided at the AWC. Apart from the question of distance, it is clear that the children belonging to the other castes (OC) and backward castes (BC) do not come to the Anganwadi Centre for nutrition services as the food there is cooked by a scheduled caste person, thus missing out on growth monitoring as well. In the case of pregnant women and nursing mothers, those who belong to the scheduled castes eat the supplementary nutrition provided, while the women belonging to the other castes (OC) and backward castes (BC) do not do so. This refusal of the OCs and BCs to partake of the supplementary nutrition has also meant that their children are not being weighed for growth monitoring purposes. Verification in regard to Immunization could not be properly done as the ANM left the place a little after the Social Audit started while with out showing any of her registers to the Social Audit team. IFA tablets have not been distributed since January 2008 and it was reported that vitamin A was not supplied to the AWC by the Government because of want of stocks. The sad fact that emerges about this village is that because of discriminatory attitudes adopted towards the SCs, children of OCs and BCs are not attending the Anganwadi Centre to receive supplementary nutrition or PSE. In fact, the Social Audit report records that they do not even come near the Anganwadi Centre suggesting the deep-rooted prejudices relating to caste and gross discrimination against the Anganwadi Worker who belongs to the Scheduled Caste.

There were reports of diarrhea resulting from the currently distributed Ready to Cook mixes supplementary nutrition recipes. People wanted the restoration of the MTF powder distributed earlier under the SNP.

### **9. Nayaknagar area of Anantapur Town**

This urban Anganwadi Centre established in 1984 does not have a toilet. It does not have a medicine chest either. The adult weighing scale is out of order and is not functional. Pigs were seen moving around the AWC and its surroundings are unhygienic. Not all the under-3 children numbering 43 have been enrolled; 7 have

been left out. While 29 children were identified as undernourished in different grades including 1 in Grade-III, no additional ration was given to the one in Grade-III. As in all other Anganwadi Centres audited, in this urban centre also, no referral slips were available because of its non-supply since many years. No medicines have been made available to the Anganwadi Centre since 6 months prior to the date of Social Audit though vitamin A was given to 11 persons and IFA tablets have been distributed by the ANM. In the Gram Sabha people complained that health checkups were inadequate in the sense no drugs or injections were administered on grounds of lack of supply from the Government to the health sub centre. ANM was reported to be indifferent even to the simple needs of the beneficiaries. People complained against the failure of the Government in paying the incentive amounts under the JSY despite submission of applications and repeated representations. Visitors are not enrolled at the Anganwadi Centre. People were aggrieved that there was no understanding on the part of the staff of the issues connected with the causes of why the currently distributed Ready to Cook mixes led to diarrhea among the beneficiaries. Erukulas were being excluded from the ICDS benefits by the ICDS staff on the untenable ground that they were nomads even though they were living within the Anganwadi area. The Anganwadi centre had no proper water supply resulting in the Helper going from house to house to collect and fetch drinking water for the Anganwadi Centre.

**10. and 11. Marur village (Anganwadi Centres I and II) of Marur Gram Panchayat of Raptadu Mandal.**

The AWC-I was established in the year 1993. This centre is located in the AWW's house. It has no toilet. The adult weighing scale is in a state of disrepair. There is significant failure to provide supplementary nutrition for the 0-3 cohort, with only 60 out of the 134 children receiving this service as only they have been enrolled. Distance leading to lack of access has been argued as a reason though the failure of the Anganwadi Worker and Helper to get the children and their mothers for the services is obvious. This situation also reflects the failure of the supervisory officers to lay emphasis on the importance of serving this cohort adequately, which is a serious omission. No medicines or IFA tablets have been supplied to the Anganwadi Centre as is indeed the case in most cases, for more than a year, but occasionally the ANM seems to be providing these to the women. This raises the fundamental question

whether the Government does not believe any more that the Anganwadis have a role at all in making these vital supplies to the beneficiary groups. The Anganwadi Centre-II here established also in 1993, is in a pucca building but it leaks in the rainy season. As in all Anganwadi Centres audited, this centre has not been supplied, over several years, with the health referral slips. Maintenance of registers leaves much to be desired in both centres I and II indicating indifference of the Anganwadi Workers, as also their lack of skills. The Anganwadi Worker's gross indifference to her work in Centre-I was exemplified by the finding that in August, 2008 the Anganwadi Worker did not care to feed the children on a day on account of the Anganwadi Workers' strike but yet it was shown that the children were present for at the PSE. She recorded that she was on strike in the supplementary nutrition register. While registers showed attendance at PSE to be 100 % for months together at Centre-II, on the day of the Social Audit of this Centre only 7 of the 14 children were present but even on that day 100 % attendance was recorded. Home visits were given no importance by the AWWs of either Centre. The Anganwadi Workers at both these centres are thus in dire need of training. At the Gram Sabha the people demanded supply of hot cooked food under the SNP and skills training for the adolescent girls.

## **12. Jalalapuram Village of Garisenapalli Gram Panchayat, Bathalapalli Mandal**

This Anganwadi Centre set up here in 1982 is a badly run one. We have here the Government's failure to supply medicines, vitamin A and IFA tablets and we also see here the practice of discrimination by the Anganwadi Worker herself against the Scheduled Castes. She belongs to a "forward" caste and does not make any home visits. She accepts no hospitality from the villagers. She does not reside in the village where her centre is located and lives in the neighboring village 2 kms away. The Sarpanch at the Gram Sabha complained vehemently against the AWW and her attitudes and lack of punctuality and demanded appointment of a local AWW for the centre. The AWW explained that she is a widow and if the community provided her with a house, she would take up residence at Jalalapuram. The villagers agreed to this on condition of proper performance of her work by her. The AWC here has not been supplied with basic things like toys. Maintenance of registers at the Anganwadi Centre is poor. There is little support from the community to the ICDS efforts here mainly because of the AWW's attitude. The Anganwadi Centre has no toilet. The

Anganwadi Centre has no weighing scales either. The adolescent girls here have not been given any productive training nor have they been supplied IFA tablets. There was nutrition interruption on 6 occasions during the 30 days preceding the date of the social audit and this was because of the failure of the Government to supply the stocks to the Anganwadi Centre. There were complaints that the Upma now being supplied under the SNP had caused diarrhea for 2 children. Given such serious issues at stake, it is painful that the senior officers of the programme made no effort to set them right over the years.

### **13. Bathalapalli Village of Bathalapalli Gram Panchayat of Bathalapalli Mandal**

Established in 1982, as in several other Anganwadi Centres, in this centre there is neither a toilet nor medicines nor weighing scales that are functioning. No referral slips have been supplied to the Anganwadi Centre. The good fortune here is the well known NGO Rayalaseema Development Trust caters to the health needs of the people. The Anganwadi Centre here is so cramped that 12 children are kept outside the centre for all activities. Since there is no place for cooking here, cooking of supplementary nutrition is done on the street. Maintenance of records and registers was found to be poor. The most distressing finding here was that because the Anganwadi Centre was located in the scheduled caste colony, people belonging to the “upper castes” (OCs) and Muslim women and children were reportedly not coming to the Anganwadi Centre for services. However, the backward castes and scheduled castes did not have any problems between themselves. The Gram Sabha conducted at the end of the Social Audit helped discuss many of the shortcomings leading to demands such as a spacious building for the Anganwadi Centre and skill training for adolescent girls.

### **14. Chapatla Village of Marur Gram Panchayat of Raptadu Mandal**

Established in late 1993 the centre here has no adult weighing scales jeopardizing the weight monitoring of the pregnant women. The toilet at the centre has been rendered useless as it has unattended plumbing problems. Because of Government’s non-supply of Vitamin-A, it is not distributed to the target groups. Malnourished children have not been identified. There seems to be prevalent here considerable stunting among children; child marriages; and delayed pregnancies. A still birth occurred here

recently. There are two cases of polio of children of about 5 years with no medical assistance available or provided to them. New born babies are being branded on their stomachs and this superstitious practice exists along side the belief that consumption of highly spicy food by nursing mothers promotes production of more breast milk in them. All these show the failure of the ICDS services in general and, in particular, the failure of the Nutrition and Health Education component of the programme. The failure of the field level supervisory officers of the Health and WDCW departments in the context of the ICDS work is obvious.

The Social Audit of Anganwadi Centre after Anganwadi Centre revealed the same kind of defects at the Anganwadi Centres in regard to the various services as discussed in the scrutiny sample of the work books above. At the Anganwadi Centre in Maddulapuram village of Kuderu mandal, the non-resident Anganwadi Worker came to work daily from a distance of 25 kms while the Anganwadi Worker of Udiripikonda of the same mandal lived in a village 18 kms away. There were instances galore of this kind. Practice of gross discrimination against the scheduled castes was seen in a number of villages at the Anganwadi Centres including in Kondravandlapalli of Nallamada Gram Panchayat of Nallamada mandal; in Donnikota village of Donnikota Gram Panchayat of Nallamada mandal; in Bhoopasamudram village of Bhoopasamudram Gram Panchayat of Gummagatta mandal; in Gummagatta village of Gummagatta Panchayat of Gummagatta mandal; in K. Nagireddipalli village of K Nagireddipalli mandal; in Somaravandlapalli village of Narasampalli Gram Panchayat of Kanaganapalli mandal; and Pothulakunta village of Pothulakunta Gram Panchayat of Kothacheruvu mandal. Discrimination against *dalits* came in the form of prejudice against *dalit* Anganwadi Workers and *dalit* Helpers; area where the Anganwadi Centre was located and so on. Home visits became the causality in many areas because of prejudice against *dalits*. If we found that after 33 years of the ICDS programme, its services were in jeopardy, we also found that our caste system was fully alive in our villages and communities, defeating one of the fundamental aims of the ICDS programme, namely, integrated service delivery to the poor to build an inclusive society. The Central and State Governments have to examine what efforts have been made to deal with this in this programme, which was designed as a premier social development programme, by the society on the one hand and institutions of governance right from the State level through to the

Gram Panchayat level on the other. Such an examination should lead to organized social action in a campaign mode against untouchability, fully backed by the State Government.

## ***Findings and Comments***

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**5.1** In the foregoing chapters we saw what the facts and conditions are in regard to various indicators pertaining to nutrition and health and other environmental parameters in India and Andhra Pradesh according to national and international surveys; what a social audit is as we understood it; how we planned it at various levels and how we executed it in the field. Against this background, our findings based on the Social Audit of 154 rural and urban Anganwadi Centres in the district of Anantapur in the state of Andhra Pradesh are presented here in this chapter. It is important, however, that we look at our grassroots level findings relating to the ICDS programme and the understanding we have gathered from discussions with people involved at all levels in the programme against the background of the work responsibilities of the Anganwadi Worker as assigned to her by the Government in the ICDS programme, and the milieu in which she discharges them. These responsibilities of the Anganwadi Worker and those of the other actors involved in the ICDS programme in relation to her, particularly of the Health functionaries, are spelt out in the Handbook for Anganwadi Workers compiled by the National Institute of Public Cooperation and Child Development, New Delhi of the Department of Women and Child Development of the Government of India. This Handbook is a good reference point.

**5.2** An Anganwadi Worker is a community based frontline voluntary worker, selected from within the local community. The AWW is mainly responsible for the effective delivery of ICDS Services to children and women in the community. An Anganwadi Worker's multifarious role requires managerial, education, communication and counseling skills. The various job responsibilities of an Anganwadi Worker include rapport building with the community; conducting community survey and enlisting beneficiaries, namely, children 0-6 years, children 'at risk', expectant and nursing mothers and adolescent girls; birth and death registration; preparation and distribution

of supplementary nutrition to the target group beneficiaries; growth monitoring and promoting breast feeding and counseling mothers on IYCF; counseling women on birth preparedness; management of neonatal and childhood illness; assisting health staff in immunization and health check-up of children and mothers; hold the medicine kit and provide treatment for minor ailments and first aid and render referral services where needed; detection of disability among children; health and nutrition education to adolescent girls, women and the community; organising non-formal preschool education activities; assist CDPOs / Supervisors in implementation of KSY and NPAG. Her daily activities include conducting home visits. Her work has an important Information, Education and Communication (IEC) component that calls for communicating with and counseling parents, families and communities; organising awareness campaigns, street plays etc., and preparation of communication and education material. This aspect of her work is important for the reason that she needs to be in constant communication with the community so as to mobilize the community and elicit community participation and maintain liaison with the Gram Panchayat, primary schools, mahila mandals, health functionaries etc. In other words, the discharge of these formidable sets of responsibilities involve the management and organisation of an Anganwadi Centre, based on the accountability mechanisms of maintenance of records and registers and the preparation and submission of monthly progress reports to her superiors.

- 5.3** An Anganwadi Worker should plan and organize activities at the Anganwadi Centre in such a manner that all the ICDS services are delivered covering *all* the beneficiaries in the village.
- 5.4** On the health side, the relevant services in the ICDS are to be provided by a team of health functionaries comprising the Medical Officer of the Primary Health Centre, Health Supervisors and Assistants from the Primary Health Centre, the ANM and at the community level the ASHA worker.
- 5.6** The following findings of our Social Audit would give an idea of how the ICDS programme is getting implemented against its stated objectives and the responsibilities expected of the stakeholders. To the extent possible certain remedies have also been suggested here even as it has been done at different places in this Report though our comprehensive recommendations would await the discussions we

propose to hold in the Workshops that we intend to convene in the coming days in Anantapur and Delhi to consider our Report.

## **5.7 INADEQUATE ENROLMENT OF THE TARGET GROUPS:**

Non-enrolment or inadequate enrolment of those entitled to the services means non – delivery of services which is a violation of the rights of the people and the target groups for whom the ICDS programme has been designed.

**(a) 0-3 Cohort:** In 61 (40%) AWCs it was seen that all the children in this group have not been enrolled. In 93 (60%) AWCs no variation has been recorded between the children in this age group in the village and those shown as enrolled. However, the audit showed hardly any worth-while attendance of this group of children at the centres. We consider this to be a very serious failure given the importance of early childhood care and stimulation for brain, cognitive, social and language development for this cohort and the NHE for the mothers of this cohort, not to mention the cohort's immunization needs. Obviously, there is great and irremediable failure of the entire ICDS set up in regard to this most important group of children, including in regard to generating awareness among the mothers of this cohort and in the community, even if there are other difficulties like accessibility. The neglect of this cohort represents a lack of awareness at all levels of the ICDS functionaries of the importance of this age group. This calls for a new orientation in the system.

**(b) 3-6 year old children:** In 74 (48%) AWCs it was seen that all the children in this group have not been enrolled. We consider this to be a very serious short coming given the importance of early childhood education for this cohort as the foundation, through stimulating intellectual curiosity and social attitudes, for the universalisation of primary education to which we attach the highest importance. Obviously, there is great failure of the entire ICDS machinery in regard to this including in regard to generating awareness among the mothers and in the community about ECE, even if there are other causes like accessibility and poor quality of SNP, including in particular the problems in the Supplementary Nutrition menu that has recently been introduced. One very worrisome cause that has been cited in as many as 30 AWCs is that the children in this age group are going to private “convent” schools. This non-enrollment and non-attendance is further compounded by inflated figures in some

AWCs including in 2 centres where the figures exceeded the actual children in the village.

**(c) Pregnant Women:** In 58 (38%) AWCs it was seen that all the pregnant women in the area covered by these centres have not been enrolled. It is our finding that in the case of 30 (51%) of these 58 centres this is attributable to negligence on the part of the Anganwadi Workers including in regard to the conduct of the periodical house to house surveys. Part of the problem is lack of understanding of the instructions in regard to accounting for, and registering, pregnant women visiting their parental homes at the current place of residence for the duration. In 23 (15%) AWCs pregnant women visiting their parental homes were not enrolled for supplementary nutrition. There are also other serious issues like non-enrolment because of the need not to cross the “targets” given; inflation of the numbers; and non-Scheduled Caste women not wanting to enroll because the Anganwadi Centre is located in the Scheduled Caste area. Given the perils of malnutrition and absence of health monitoring that would result from non-enrolment impacting on safe pregnancy with potential for irreparable birth defects, this failure can hardly be exaggerated.

**(d) Nursing Mothers:** In 44 (29%) AWCs it was seen that all the nursing mothers in the area covered by these centres have not been enrolled. It is our finding here again that this is attributable to negligence especially on the part of the Anganwadi Workers including in regard to the conduct of the periodical house to house surveys to identify them. In 12 AWCs visiting nursing mothers were not enrolled. Here again there are other serious issues like non- Scheduled Caste women not wanting to enroll because the AWC is located in the Scheduled Caste area. There were also cases where it was believed that the supplementary nutrition provided was actually harmful to the health of the recipient, indicating poor Nutrition and Health Education (NHE) work by the ICDS-cum-health personnel. The failure thus to serve this category constitutes sadly lost opportunities to promote practices like breast feeding and the all-important task of getting the 0-3 cohort to the Anganwadi Centre.

## **5.8 SUPPLEMENTARY NUTRITION:**

Supplementary Nutrition includes supplementary feeding and distribution of nutrition supplements, namely, Vitamin-A and Iron and Folic Acid tablets to the beneficiaries,

supplementary feeding at the Anganwadi Centre with an aim to meet the gap of nearly 1/3<sup>rd</sup> of calories and protein requirements for a day of children below 6 years as well as of adolescent girls, pregnant women and nursing mothers. Supplementary food is provided for 300 days in a year which means six days per week or 25 days per month. Supplementary food given to severely malnourished children is twice the quantity (double ration) given to moderately malnourished children. While distributing supplementary food, special attention is to be given to children below 3 years of age. It would be important for the Anganwadi Worker to ask the beneficiaries to eat the food at the AWC itself.

### **Prevalent Norms for Supplementary Food**

Beneficiaries	Nutritive Value of Supplementary Food	
	Calories	Protein
Children (0-3 years)	300	10 gms
Children (3-6 years)	300	10 gms
Severely malnourished children (6 months-72 months)	600	20 gms
Pregnant Women and nursing mothers/ adolescent girls (under KSY)	500	20 gms

We may mention here of the need to decide when exactly the child should be served its meal on her reaching the Anganwadi Centre in the morning; it seems to some of us that the child is made to starve till 11-30 AM or 12 noon just to retain her presence at the AWC which in our opinion damage her attention span etc.

#### **(a) Nutrition Interruption:**

It was found that in 96 (62%) Anganwadi Centres Supplementary Nutrition was not being supplied regularly. It was noticed that such nutrition interruption ranged from 46 days to 150 days. There were Anganwadi Centres where such nutrition interruption took place for 46 days, 80 days, 100 days, 128 days, 138 days and in one case up to 200 days during a period of one year. In Balepalem centre of Kanaganipalli Mandal there are no records on food distribution at all. In A. Kondapuram of Putlur Mandal Supplementary Nutrition was not supplied for 76 days including for the whole month of August 2008. At two Anganwadi Centres Supplementary Nutrition was not supplied as they could not find a place to cook the food. The main reason for nutrition interruption was the failure of the Department to

supply the food material in time. This happened in 85 Anganwadi Centres. In 30 (19%) Anganwadi Centres nutrition interruption was attributed to the Anganwadi Worker not being regular. While in 100 (65%) Anganwadi Centres all enrolled children of 0-3 years did not receive Supplementary Nutrition regularly, a similar situation obtained for the 3-6 year children in 109 (71%) Anganwadi Centres. This situation obtained for pregnant women in 91 (59%) Anganwadi Centres and for nursing mothers in 89 (58%) Anganwadi Centres. The long distances between Anganwadi Centres and beneficiaries' houses in some cases also resulted in Supplementary Nutrition not being accessed by the beneficiaries. Lack of awareness and absence of proper Nutrition and Health Education (NHE) resulted in some pregnant women and nursing mothers not consuming the Supplementary Nutrition offered fearing it would affect their health adversely. A very serious problem that we came across was that the take-home Supplementary Nutrition was consumed by the entire family instead of by the pregnant women or the mothers. Conditions need to be created in the Anganwadi Centre by promoting greater privacy for women to consume the supplementary nutrition provided to obviate this problem.

**(b) Under nourished Children and Women:**

Under nourished children were identified in 48 (31%) Anganwadis out of the 154 Anganwadi Centres audited. It is worth mentioning that in some of the Anganwadi Centres the visiting Social Audit teams identified such cases, ignored by the Anganwadi Workers. In 23 (15%) Anganwadi Centres, though the children had been identified as under nourished, no additional Supplementary Nutrition was provided to them. All in all, only in 11 (7%) Anganwadi Centres additional supplementary nutrition was effectively given while in 9 (6%) Anganwadi Centres such children were referred to the PHC. As for anemic pregnant women, they were identified in 49 (32%) Anganwadi Centres. However, in 31 (20%) Anganwadi Centres no additional Supplementary Nutrition was provided to these women. In the Bathalapalli SC Colony 6 pregnant women were seen whose hemoglobin (HG) was 8 gms or less but they had not been provided with any attention. As for anemic nursing mothers, they were identified in 33 Anganwadi Centres but in 16 Anganwadi Centres no assistance was provided to them. In Muddalapuram Anganwadi Centre of Kuderu Mandal one nursing mother weighed only 29 kgs. and her HG count was only 6 gms.

**(c) Quality of Supplementary Nutrition:**

During the Social Audit under taken by us the Government introduced “Ready to Cook Mixes”, a new Supplementary Nutrition menu consisting of 3 items – Upma, Kichidi and Halwa. The new menu was found unpalatable by the beneficiaries. Discussions with the Anganwadi staff, especially the helpers, showed that the texture of some of these items was rubbery and sticky which the children found extremely difficult to eat. In particular, the food became inedible within minutes of its being cooked and becoming cold. The consequence for a woman who takes the food home is not difficult to imagine. There is some evidence that the newly introduced menu has kept children away from the Anganwadi Centres in the 3-6 age group at least in some places. This parlous situation calls for an immediate review that should lead to children and women being provided with locally cooked, hot food made out of locally available and procured food material like ragi, jowar and (even) rice, groundnut and GLVs. However, the Coordinator’s own field work also showed, while confirming the general trend, that at least in one village the “Ready to Cook Mixes” were popular and well liked as detailed elsewhere in this Report. We need to review this situation and evaluate it carefully. In 18 (12%) Anganwadi Centres children were reported to have fallen ill after consuming the new supplementary nutrition menu and that included suffering from diarrhea in 16 Anganwadi centres. A majority of these cases were centres where the children had consumed the newly supplied Upma material. 100 (65%) Anganwadi Centres reported problems in receiving supplies and distributing supplementary nutrition. In 73 (73%) of them the problem arose from irregular supply of stocks from the District Office. In 23 (15%) Anganwadi Centres the Anganwadi Workers were not regular in attending to their duties. Absence of Helpers often contributed to problems. In the attendance cum food distribution register pertaining to the pre-school children supplementary nutrition is shown as having been distributed to *all* enrolled children. In other words, full attendance is always shown for supplementary nutrition. During the Social Audit visits to the Anganwadi centres the actual attendance of the 3-6 years age group was generally found to be only between 50 and 60 % of the listed names. Thus, absentee children are being shown as having received Supplementary Nutrition.

**(d) Growth Monitoring:**

Growth Monitoring means keeping a regular track of the growth of the child through key indicators like weight, height according to age etc. at regular intervals. Growth monitoring is a way to detect growth failure in children at an early stage and take immediate and effective action. Growth monitoring must start right from the birth of the child. In the ICDS, Growth Monitoring is done with the help of the Growth Chart, using weight-for-age as indicator. It is a visual record of the growth pattern of a child showing the grades of malnutrition of a child and identifies beneficiaries for supplementary feeding and is used for imparting nutrition and health education to mothers. The Anganwadi Worker should weigh all children up to 3 years of age every month. Weigh children 3-6 years old every three months. Severely malnourished children and children who have not gained weight consecutively for three months should be weighed every month (irrespective of age).

The following Table shows the action the Anganwadi Worker should take depending upon the nutritional status of the child:

Status	Role of AWW
Normal	Nutrition and health education and counseling to the mothers.
Grade-I	Nutrition and health education and counseling to the mother.
Grade-II	<ul style="list-style-type: none"><li>• Supplementary Nutrition at AWC</li><li>• Nutrition and health education and counseling to mothers.</li></ul>
Grade-III	<ul style="list-style-type: none"><li>• Supplementary nutrition (double) at the AWC.</li><li>• Refer to PHC/Hospitals</li><li>• Nutrition and health education and counseling to mothers.</li></ul>
Grade-IV	<ul style="list-style-type: none"><li>• Supplementary nutrition (double) at AWC</li><li>• Refer to PHC / Hospitals</li><li>• Nutrition and health education and counseling to mother.</li></ul>

In addition, the Anganwadi Worker has to discuss the child's growth with the mother and follow it up. The Anganwadi Worker must monitor the growth of children on the growth chart, every month in the presence of their mothers and encourage them to come and ask questions regarding the feeding and care of the child. She has to prioritize children who are malnourished and whose mothers need counseling; show the growth chart to the mother and explain the direction of the growth; discuss with and ask the parents the reasons for absence of or poor weight gain and advise parents about nutrition care, frequency of feeding and blending with family food patterns. She

should monitor the growth of the malnourished child regularly and persuade the mothers to bring the children regularly to AWC for weighing. Where needed she should refer the children whose growth is faltering consecutively for 2-3 months or who are severely malnourished, to the PHC/ Hospital. She should also follow the progress of the malnourished children at home during her home visits.

***Guidelines for Management of Malnutrition in Children in the Handbook for Anganwadi Workers (Page: 141-142) lay down that additional food to Grade I, Grade II, Grade III and Grade IV malnourished children should be provided at the Anganwadis. We need clarification in the programme whether additional food is to be served to all grades of the malnourished or only those in Grade III and Grade IV.***

Regular recording of weights is essential for growth monitoring. It was found that only in 92 (60%) Anganwadi Centres the 0-3 year children were weighed. In 58 (38%) Anganwadi Centres regular measurements were not taken. In the case of children in the age group 3-6 years, weighing was done only in 89 (58%) Anganwadi Centres. In 57 (38%) Anganwadi Centres weights were not taken regularly. In 76 (49%) Anganwadi Centres weights were not recorded properly. The main reasons for these failures are the malfunctioning of weighing machines and Anganwadi Workers not being regular in regard to this work and thus failing to bring the children to the Anganwadi Centres in time. In 34 (22%) Anganwadi Centres irregular measurement and recording of weights were attributed to absence of weighing machines or weighing machines not being in working condition. In 25 (16%) Anganwadi Centres this was because of Anganwadi Workers not being regular in attending to this activity. Children in grade III and IV were found in 35 (23%) centres. In 19 of these no additional Supplementary Nutrition was given while in 10 of these centres the identified children were given double the quantity of Supplementary Nutrition. In the other 6 cases parents were counseled. The general failure of the growth monitoring work represents a failure of one of the cardinal aims of the ICDS programme.

### **(e) Nutrition and Health Education (NHE)**

Nutrition and Health Education (NHE) is provided with an aim to enhance the capacity of the mothers and the community to look after the health and nutritional needs of children within the family environment. NHE helps in promoting antenatal care, maternal and child health, child survival and development. Government guidelines stipulate that a special follow up has to be made of mothers whose children suffer from malnutrition or frequent illnesses. Sustained support and guidance are expected to be provided to mothers of young children, keeping in view their knowledge, attitude and local practices. The Anganwadi Worker is expected to use fixed day immunization sessions, mother–child days and growth monitoring days, small group meetings of mothers / mahila mandals / community and home visits for imparting NHE.

The mothers' meetings relating to this are expected to be held regularly. However, in 23 (15%) Anganwadi Centres these meetings were never held. In 45 (29%) of the Centres they were not regularly held. In 27 (17%) Anganwadi Centres these were held once a month. Even where these were held, they were mostly ritualistic, and devoid of purpose, just to coincide with the distribution of Supplementary Nutrition to pregnant women and nursing mothers. While all women in the 18-45 age group are expected to participate in these meetings, only the pregnant and nursing mothers attend these meetings but then not all of them. Home visits are mandated for NHE on fixed days to generate household level awareness of these issues but only in 66 (43%) Anganwadi Centres these fixed day visits were undertaken regularly. In 40 (26%) centres these never took place. In 48 (31%) Anganwadi Centre these visits were made but not on a regular basis.

### **5.9. HEALTH AND CONVERGENCE OF HEALTH RELATED SERVICES:**

The following table gives us the directions regarding the most important ICDS strategy namely, convergence of efforts among ANM, AWW and the ASHA worker in delivering the services at the village level as expected by the Government:

Sl. No.	ANM	AWW	ASHA
1	To be invited to the meeting of the village Health and Sanitation Committee.	To be invited to the meetings of the Village Health and Sanitation Committee	To be invited to the meetings of the Village Health and Sanitation Committee
2	To assist in preparation of village Health Plan	To assist in preparation of village Health Plan	To assist in preparation of village Health Plan
3	Organize village Health Day at Anganwadi Centre (Immunization, Antenatal checkups (ANC), Postnatal checkups (PNC), Health checkups etc.)	Assist in organizing village Health Day. Register children and women for immunization, ANC, PNC, Health checkups etc.	Assist in organizing village Health Day. Help Anganwadi Worker in registering children and women for immunization, ANC, PNC, Health checkups etc.
4		Mobilize beneficiaries (with the AWH /ASHA) for the Village Health Day through SHGs, Mothers Committee, beneficiaries of the ICDS Scheme.	Mobilize beneficiaries for the Village Health Day under the guidance of the Anganwadi Worker.
5	Attend to such referred cases on priority	Refer sick children, pregnant / lactating mothers to sub-centre, PHC / CHCs	Refer cases to sub-centre PHC/CHC.
6	Impart health and hygiene education to the beneficiaries of Kishori Shakti Yojna (KSY) / Nutrition Programme of Adolescent Girls (NPAG)	Assist CDPO/ICDS Supervisor in implementation of Kishori Shakti Yojana (KSY) / Nutrition Programme of Adolescent Girls (NPAG)	Assist Anganwadi Worker in her activities pertaining to KSY and NPAG.
7		Depot holder of Medicine Kit / Contraceptives of ASHA and under ICDS	Receive ASHA Kits / Contraceptives from Anganwadi Worker.
8	Administer such drugs as specified by the M/O HFW	Administer OTC drugs Distribution for ORS / IFA Tabs, DDK, OP and Condoms.	Administer OTC drugs Distribution of ORS/IFA Tabs, DDK, OP & and Condoms.
9	Implement IMNCI Home visits once in two months during pregnancy. (Once in the first week of delivery)	Home visits – once a month during pregnancy, once in the first week of delivery. Second visit in second or third week as per the need.	Implement IMNCI Home visits at least once in a month during pregnancy. (Once in the first week of delivery).
10	Maintain and update eligible couple register	-	Help ANM to maintain and update eligible couple register.
11	-	Counsel women on birth preparedness.	Counsel women on birth preparedness.
12	Guide/Counsel women on safe institutional delivery	Guide/Counsel women on safe institutional delivery	Assist ANM/AWW in this work
13	-	-	Assist / Escort women for institutional delivery.
14	Guide TBA (Trained Birth Attendant)	-	Guide TBA (Trained Birth Attendant)
15	-	-	Facilitate referral of difficult cases.

16	Nutrition and Health Education	Nutrition and Health Education	Nutrition and Health Education
17	Promote breastfeeding of infant and young child feeding practices	Promote breastfeeding of infant and young child feeding practices	Promote breastfeeding of infant and young child feeding practices
18	Share available information with the Village Registrar of Birth and Deaths	Share available information with the Village Registrar of Birth and Deaths	Ensure registration of all Birth and deaths of mothers with the Village Registrar of Birth and Deaths

\* In addition to the above listed activities, ASHA will also play an active role in preventive and promotive (sic) activities of all health programmes in the villages, including communicable and chronic diseases. She will be guided and monitored both by the ANM and the AWW. The Anganwadi Centre will form the base of her activities.

The points that are relevant for a Social Audit in this Table are the fundamental relevance of the importance of the two Departments – Health and DWDCW - converging their efforts as they address the *same* target groups; the centrality of the Anganwadi Centre in the village for effectively converging these efforts *physically*; the specific assignment of a role of *assistance* on the part of the ASHA worker to the Anganwadi Worker to help the Anganwadi Worker in registering children and women for immunization, ANC, PNC, health checkups; to mobilize beneficiaries for the Village Health Day under the guidance of Anganwadi Worker; and to assist the Anganwadi Worker in her activities pertaining to KSY and NPAG; and that many tasks like Nutrition and Health Education to promote breastfeeding of infant and young child feeding practices are common to all the three functionaries implying that they could be addressed at a common forum like the Anganwadi Centre which is where primarily the target groups gather. Further, the task relating to the referral of sick children, pregnant / lactating mothers to the sub-centre, PHC / CHCs is clearly mentioned as a responsibility of the Anganwadi Worker.

**Regrettably our findings show that the observance of these convergence imperatives is more in the breach than in its practice. This absence of convergence raises serious doubts whether the Anganwadi Centre is looked upon any more by any of these functionaries as a focal point for Immunization or any of the health services. The original paradigm in the ICDS programme was that the Anganwadi Worker mobilizes women in general and the target groups of children and pregnant women and the adolescent girls in particular in the**

context of all their gender needs and rights *including* those such as nutrition; immunization; health check-ups and referrals; and pre-school education etc at the AWC, as a focal point of those women and child rights. *In such an overall mobilization context* are anchored the related Immunization and other health services. The recent advent of the new incentive-based institution of ASHA appears to have bypassed this wholesome gender-based paradigm, in that the attempt now is to deliver services like immunization to the women and children as if they are some technical answers to diseases; and as if participation by these women and children as human individuals, under pinned by health education and awareness, is not relevant. The Anganwadi Worker and the Anganwadi Centre have also been by passed in the process to a substantial degree already. It is important for the senior officers of the Government in the Ministries and Departments of Women and Child and Health to sit together and examine the questions: should Immunization (and other health services) be looked upon merely as a discrete, technical activity or should it be seen as a part also of the over all social, gender and other development issues affecting women in general and pregnant women and children in particular? Is a paradigm, which believes that by bringing together the various services contemplated in the ICDS programme and delivering them at the Anganwadi Centre through a convergence of effort of two different departments, not relevant to a greater understanding and synergy for the over all outcomes for women and children in the context of their fundamental rights guaranteed in our Constitution?

**(a) Immunization:**

Immunization protects children against six killer diseases, namely, Tuberculosis, Diphtheria, Whooping Cough, Tetanus, Poliomyelitis and Measles. During pregnancy, the woman is immunized with Tetanus Toxoid (TT) to protect her against Tetanus. Every child must be fully immunized as per the Immunization Schedule for complete protection against these diseases as shown in the following schedule:

## Immunization Schedule:

### Children

Vaccines	1½ months	2 ½ month	3 ½ month	9 ½ month	16-24 month	5 years
BCG (At Birth)						
DPT HBV	1 <sup>st</sup> injection	2 <sup>nd</sup> injection	3 <sup>rd</sup> injection		Booster injection	
OPV (Polio Drops)	1 <sup>st</sup> does	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose		Booster dose	
Measles				One		
DT						One

### Pregnant Women

Tetanus Toxoid	Time
1 Dose 2 Dose Booster Dose	As early as possible One month after the first dose One booster dose in subsequent pregnancy, if TT vaccine has been taken within the last 3 years.

In the ICDS programme 'a fixed day' strategy is adopted to immunize children. Government's instructions on this subject are that immunization facilities should be made available at the AWC and the Sub Centre and the Primary Health Centre free of cost.

By far the most important short coming noticed in regard to the immunization work in the Anganwadi Centres audited by us was the complete lack of coordination or convergence in efforts of the ICDS and the Health personnel. Specific days in a month are fixed for the visit to a village by the ANM or the MPHA for immunization purposes. The ASHA worker has to visit the village a day prior to this vaccine day to inform the target group about the visit of the Health staff the next day. It was seen that such prior notice was not provided in the case of 23 (15%) Anganwadi Centres. The reason for this was absence of coordination. This apart, the ANM in one case (Gummagatta SC Colony) had not visited the place for 3 months continuously previous to the Social Audit. In a number of cases the vaccines are administered in villages other than those where the Anganwadi Centres are located. Further, there is

no uniformity in regard to the venue for administering the vaccine. In a few villages it is done at the Anganwadi Centre on some occasions and at the sub-centers on other occasions or at the PHC on some others. In the case of Azad Nagar Anganwadi Centre in Anantapur town immunization is done under a tree in the locality and it is also worth mentioning that the Anganwadi Worker here, being the president of the Anganwadi Workers' Association District Unit, reportedly never attends to immunization work. Lack of uniformity and certainty of the venue for administering vaccines is found to create confusion in regard to delivery of this important service. As many as 69 (45%) Anganwadi Centres reported delay or other problems in administering vaccines to children. In 5 of these the parents were not properly informed about the date and time of vaccination leading to the child missing the dose which means that she would not get that dose until the next visit of the ANM to that village, which, as verified by us, takes some times even two months. A serious omission noticed was that in 5 Anganwadi Centres BCG vaccine was not administered on the excuse that the number of children needing immunization was not sufficient to justify the opening of a new vaccine vial. The ANMs want at least 5 children to open the vials as otherwise the vaccine might go waste. Often, the habitations being small, that many children are not available. We noticed that in 28 Anganwadi Centres the ANM was not regular in her work. There were cases of the ANM asking pregnant women and children to come to neighbouring settlements on ground that she cannot visit two settlements on the same day. In 22 (15%) Anganwadi Centres we identified absence of proper coordination between Anganwadi Worker and ANM, as evidenced by the records maintained by the two not tallying. Absence of coordination was very common in bigger villages because of multiple numbers of Anganwadi Centres handled by one PHC. There were also cases of Anganwadi Workers not being regular in attending to the immunization activity. Often it appeared that the Anganwadi Workers did not think that immunization is a part of their work any more as they considered this to be the exclusive responsibility of the Health Department, especially after the introduction of the new Health worker called ASHA. The advent of the ASHA worker, whose work is based on incentives, seems to have demoralized the Anganwadi Workers and adversely affected the convergence mechanism hitherto in place for immunization (and health and referral) work. This situation needs an urgent review. In regard to immunizing pregnant women, 50 (32%) Anganwadi Centres reported delays and other problems. In 26

Anganwadi Centres the problem related to lack of coordination between the ANM and Anganwadi Worker. In 19 Anganwadi Centres absence or delay in administering vaccines to pregnant women was attributed to irregular visits of the ANM.

**(b) Health Checkup:**

This area of work is also one that entails the joint responsibility of the Department of Health and the ICDS functionaries, calling for close convergence of the efforts of both. The main contribution of the Anganwadi Worker at the village level is the mobilization of the women and children for this purpose so that the ANM can carry out her health checkup responsibility. The schedules of ante-natal checkups and the frequency of checkup of children require strict adherence. Based on need, referrals to the hospitals will have to be made.

It is clearly laid down that it is the duty of the Anganwadi Worker to ensure that health check-up of all the beneficiaries is done by health staff, namely, the ANM / LHVs / Medical Officer. Health check-up includes antenatal checkup of pregnant women, post-natal checkup of the nursing mothers and health checkup of children under 6 years of age. An AWW must ensure that a pregnant woman gets three complete antenatal checkups during pregnancy and ensure that the woman has tetanus toxoid immunization, takes IFA supplementation and takes her supplementary food at the Anganwadi Centre; has her delivery conducted by a trained dai or in the hospital; has complete information on prenatal, natal and postnatal care. The Anganwadi Worker should provide information to pregnant women on care, diet and rest during pregnancy and care of the new born, and should keep a record of ante-natal care in the 'Mother Child Card' provided for the purpose. She should identify 'at risk' pregnant women and refer them to the nearest health facility. The Anganwadi Worker should make sure that at least two visits are paid to the nursing mother by the Health staff within the first 10 days of delivery for observing the condition of the cord and general health of the mother; weigh the baby as soon as possible after birth and record the weight on the growth chart; check whether the baby is 'at risk' or not and if yes, inform ANM / LHV / Medical officer; ensure that breastfeeding is well established; ensure that the child is given BCG immunization at birth and other immunization according to the schedule after 6 weeks and ensure that the nursing mother is registered for supplementary nutrition provided at the AWC.

The Anganwadi Worker should get the health checkup of children done quarterly by the health staff; keep a watch over their development as per the milestones and monitor their growth. She should give special attention to children 'at risk' and monitor their growth regularly. She should ensure that all children are immunized as per the Immunization Schedule and given vitamin-A and maintain a record of the health check-up of children.

Infants with low birth weight (less than 2.5 kg) and gaining inadequate or no weight gain for three consecutive months would need special attention as also children having repeated infections especially diarrhea.

The audit found that in 34 (22%) Anganwadi Centres no checkups were ever done at all for children while in 23 (15%) others they were not done regularly. In 4 Anganwadi Centres it was done once in three months. The audit showed that checkups were done as a ritual, without substance. Of the 73 Anganwadi centres where sick children were identified, only in 36 were they referred to the PHCs or hospitals run by the Rural Development Trust (RDT). In Anganwadi Centres it was reported that sick children were given medicines as some sort of first aid but considering that no medicines were supplied to the Anganwadis, these had to be obtained from the ANMs. In regard to pregnant women, 92 (60%) Anganwadi Centres reported taking health checkups once in a month, while 41 (27%) centres reported that health checkups were not taken up on a regular basis. In 9 Anganwadi Centres no checkups took place. The main reason for irregular or absence of checkups of pregnant women is that ANMs are irregular in attending to their duties. 32 (21%) Anganwadi Centres reported such irregular attendance of ANMs while in 11 Anganwadi Centres lack of coordination between the ANMs and Anganwadi Workers was apparent. In the case of 11 other Anganwadi Centres health checkups were done at other Anganwadi Centres. In regard to nursing mothers no regular health checkups were reported in 55 (36%) Anganwadi Centres, while in 8 Anganwadi Centres there were no health checkups at all. Irregular and absence of health checkups for nursing mothers were attributed to irregular working of ANMs in 47 (31%) Anganwadi Centres; lack of coordination between ANMs and Anganwadi Workers in 12 Anganwadi Centres and health checkups being done in "other" Anganwadi Centres in the case of 10 Anganwadi Centres. A serious shortcoming in the Anganwadi Centres

in regard to health checkup of pregnant women and nursing mothers is that most Anganwadi Centres did not have adult weighing machines. Further, check of Blood Pressure (BP) and other blood tests are undertaken only at the PHC. The sub-centres do not have facilities or equipment to conduct these tests. Since the sub-centres are manned by ANMs, their absence at these centres while they are on village visits means lack of attention to patients who visit the sub-centres. The result of all this is cursory examination of pregnant women by looking at the color of their nails or eyes to determine whether they are anemic. This parlous situation calls for a review of the existing mechanisms and the setting up of new mechanisms to ensure proper convergence, and provision of equipment and appropriate remedies.

**(c) Referral Services:**

The Anganwadi Worker should refer children and women who need immediate medical care to the PHC / hospital using a prescribed Referral Slip. Referral services include providing immediate medical care according to the seriousness of disease as well as follow-up care of treated cases. Pregnant women and children requiring specialized medical treatment are referred by AWW/ANM/LHV to the PHC/hospital. According to Government guidelines the referral slip would have three parts. One part is to be retained at the Anganwadi Centre; the second part is for the patients; and the third part is to be given to PHC doctor by the patient. It is to be returned to the AWW after the patient comes back for 'follow up action'. The local bodies or Panchayats may be involved to provide transportation for referral cases, in case it is not available or the family is unable to bear the cost.

**The tragic irony that emerged from our Social Audit is that despite all these detailed instructions and guidelines no referral slips were supplied at all to the Anganwadi Centres over a long period of time, which is absolutely deplorable.** It is not as if that the Anganwadi Centres were not approached by women and children for help in matters related to health. 93 (60%) Anganwadi Centres reported women and children approaching them for aid and in 64 (42%) Anganwadi Centres either they were referred or advised to visit PHCs and nearby RDT hospitals. The situation in regard to pregnant women is a matter of grave concern because in 26 (17%) Anganwadi Centres not a single pregnant woman was referred to hospitals for institutional delivery in the recent past. Further, under the Janani Suraksha Yojana

(JSY) where incentive for child delivery in Government or private hospitals is provided for, in some cases women reported that they did not receive the promised incentive while in other cases they complained they were not paid the full amount. Nursing mothers from Gummagatta Scheduled Caste Colony stated that instead of receiving the incentive when they visited the PHC for delivery, money was demanded of them. Similarly, the incentive of insurance cover depending on the number of girl children parents have, promised to be provided under the Balika Samrakshana Pathakam (Girl Child Protection Scheme), has been a non-starter. Regrettably, wide publicity has not been given for this scheme. Further, until now, despite receipt of applications from 15 Anganwadi Centres only one girl child has been provided the insurance cover but even the formality of issuing the bond in this case is yet to be fulfilled. There is near-complete failure of the health referral services in the ICDS.

**(d) Medicines for common illnesses and minor ailments:**

An AWW is to be provided with a Medicine Kit for treating common ailments of children and for providing first aid in case of injuries and accidents. The cost of each Medicine Kit is Rs.600/.

However, during the last one year no medicines were supplied to as many as 128 (83%) Anganwadi Centres and therefore no medicines were distributed to patients in these Anganwadi Centres. Any comment on this is superfluous. Way back in May 2007 these Anganwadi Centres had been supplied with some medicines and they were exhausted rapidly and after that stocks have not been replenished. 85 (55%) Anganwadi Centres reported that they were supplied with medical kits but the medicines boxes are all empty. Yet Anganwadi Workers in 96 (62%) Anganwadi Centres claimed that they did provide treatment to minor ailments of women and children, which is not credible. However, in some cases the Anganwadi Workers did take the help of ANMs and ASHA worker in providing minor treatment. Further, 26 (17%) Anganwadi Centres reported that they received medicines recently, just before the final phase of the Social Audit. Even here certain essential medicines or even surgical cotton were not supplied.

**(e) Iron and Folic Acid (IFA) and Vitamin A.**

At the Anganwadi Centre children have to be administered Vitamin A at periodic intervals according to their age to prevent vitamin A deficiency. The Anganwadi Worker has a duty to see that the children receive at least nine oral doses of Vitamin A between 9 months and 5 years. All pregnant women and children (1-5 years) are to be given Iron and Folic Acid tablets to prevent Anemia. A pregnant woman must take IFA Supplementation – one tablet of Iron and Folic Acid containing 100 mg elemental iron and 0.5 mg. of folic acid daily for 100 days in the third trimester to prevent anemia. Children born to iron deficient anemic mothers are known to be at great risk of being anemic by their first birthday. Iron and folic acid tablets should be given to children regularly. Iron is essential for healthy growth and development including formation of hemoglobin, development of brain, and regulation of body temperature and muscle activity. Iron deficiency in diet leads to nutritional anemia. In addition, deficiency of folic acid and Vitamin B also contribute to anemia. Anemia is a widespread health problem affecting infant, children, adolescent girls and women of reproductive age. As priority, all pregnant women irrespective of hemoglobin levels must be provided with the recommended dose of iron and folic acid supplements. The Anganwadi Worker is mandated to ensure that pregnant women are provided with the complete recommended dosage of iron and folic acid tablets during pregnancy. She should supervise, monitor and keep a record of distribution of iron and folic acid tablets. **However, there is failure of this responsibility in regard to this as seen in the Social Audit.**

**There is acute confusion in regard to availability and distribution of Iron and Folic Acid tablets (IFA) as also about whose responsibility it is in the ICDS programme to distribute these to the pregnant women. It is our clear finding in the Social Audit that these tablets have not been supplied even to the extent of a fraction of the actual requirements to the Anganwadi Centres. Our apprehension is that there has been shortage of supply of IFA from the Government itself over an extended period. The near total non-supply of IFA tablets to the target groups in many Anganwadi areas have implications in terms of risks like maternal anemia, unsafe pregnancies and consequential birth defects and this renders the pregnancy of almost all the women seen in these anganwadi areas most risky and**

**dangerous with implications for the lives of the would be mothers and their progeny. This situation would merit an examination by a high level committee to determine the source and method of procurement of IFA by the Government and its transport to and availability in every Anganwadi Centre so that this vital problem finds an answer once for all. The same goes for Vitamin - A as well.** It was found in the SA that all the children had not been supplied with Vitamin A in 79 (51%) Anganwadi Centres and a cross verification by way of discussions with the top officers of the ICDS programme revealed that Vitamin A has not been adequately supplied for nearly half a decade. These are among the more serious findings of this Social Audit.

#### **5.10 PRE-SCHOOL EDUCATION (PSE):**

The need for the successful implementation of this service can not be overemphasized in the context of its importance for the universalisation of primary education and, in particular, female literacy. However, in 9 (6%) centres this service was not delivered at all. In 115 (75%) out of the 154 Anganwadi Centres it was reported that children were not attending pre-school regularly. That number ranged from 3 to 30 in a centre. In most of the Anganwadi Centres there were no regular or uniform timings set apart for this activity. In some Anganwadi Centres the time spent by children being less than the stipulated hours, this activity was given a go by. In Narsampalli village of Kanaganipalli mandal this activity was not taken up because the Anganwadi Centre did not have space for this activity. The main reasons for children not attending pre-school are: ill health; absence of regularity in providing Supplementary Nutrition; absence of interest on the part of the Anganwadi Worker in this work, which was observed in 30 Anganwadi Centres; parents not interested in this activity and taking the children to the fields where they work for their livelihood. All these can be set right by improving supervision of the work of the AWW so that the stipulated services are delivered which would, by that very fact, improve PSE attendance. However, the reason pertaining to the role of the parents that affected 42 (27%) Anganwadi Centres needs a special mention. **The concern of the rural labour mother is that once the Anganwadi Centre was closed for the day at 1-30 PM the child had no where to go and there was no mechanism to care for the child till she, the mother, returned from her work in the evening. The solution to this situation calls for a day-long child care approach replacing the half-a-day**

anganwadi centre. It is, therefore, essential and urgent that we convert all Anganwadi Centres into crèches that function from 8-30 AM to 5-30 PM, retaining all the current services with additional provision for serving supplementary nutrition twice or thrice a day, doubling the strength of the anganwadi staff and utilizing the services of trained adolescent girls and also raising the honorarium of Anganwadi Workers for the longer hours of work. This would also encourage the mothers who have children in the 0-3 age group to leave them in the Anganwadi Centre with enormous benefits for the 0-3 cohort in terms of early childhood stimulation so essential for the development of the child. Long distances from home also contributed to poor PSE attendance in 19 Anganwadi Centres. Most significantly, even existing PSE attendance dwindled in the Anganwadi Centres at Chamaluru, Theliki and Gundlapadu in the Narpala, Peddavaduguru and Putlur mandals respectively because of the problems relating to the new supplementary nutrition menu introduced recently by the Government. The phenomenon of children even at this tender age staying back at home to look after siblings was also noticed in Anantapur town in one centre. A most disturbing feature was the hopelessly inadequate training of the Anganwadi Worker to handle this all-important activity in terms of concept and methods, detected by us in the audit. This was manifested in many ways including by an inability even to fully use the teaching aids supplied to the centres. This was the case in as many as 74 (48%) Anganwadi Centres. We saw a case of the Anganwadi Worker not even opening the teaching aids box. PSE needs to be urgently demystified. As part of this effort in our Social Audit, we exposed the Social Audit teams and the District level ICDS functionaries, at one of our training orientation sessions, to a refresher lecture by, and interaction with, one of the foremost experts on PSE, namely, Smt. Lakshmi Chari, former principal of the Andhra Mahila Sabha College of Teaching, Hyderabad. Her guidelines on this subject appear as Annex II in this Report. A disheartening aspect of the PSE effort is the lack of interest of the parents in this activity resulting from lack of involvement of the community in the Anganwadi Centre activities though in 62 (40%) Anganwadi Centres parents did show involvement enough to say that they were not satisfied with the PSE part of the work at the Anganwadi Centre. While the predicament of most poorly educated rural parents in this context is understandable, **we need also to counter in this context through information, education and communication the dangerously dysfunctional attitude widely prevalent currently in our rural areas**

**that sets a lot of store by the expensive but sub standard “English education” purveyed in the mushrooming private “convent” and “nursery schools”.** Senior officers in charge of the ICDS programme at the District level have their job cut out to set all these dysfunctional attitudes right. The entire paradigm of PSE as practiced in the ICDS programme currently requires to be revisited with structural issues addressed as well.

#### **5.11. ADOLESCENT GIRLS:**

Under the ICDS Programme, since 2000, Kishori Shakti Yojna (KSY) is being implemented to empower adolescent girls so as to enable them to grow and develop to take charge of their own lives. KSY is a redesign of the already existing Adolescent Girls Scheme being implemented since 1992 using the ICDS infrastructure. The scheme comprises two sub-schemes i.e. Girl to Girl Approach for Adolescent Girls in the age group 11-15 years and Balika Mandal to reach Adolescent Girl in the age group 11-18 years. Under sub-scheme-I, at a time, 3 Adolescent Girls are attached to the Anganwadi Centre for 6 months. They receive 3 days basic training from a Supervisor followed by a one day session every month *so as to become capable of managing the centre on their own. During this period, they assist the Anganwadi Worker in delivery of services also.* Under sub-scheme-II (Balika Mandal), twenty girls in the age-group of 11-18 years are identified from all eligible girls in the Anganwadi Centre area. Only 10 % of the total AWCs in the ICDS projects are selected to serve as “Balika Mandals”. All the 20 girls are enrolled for a period of 6 months in the Balika Mandal. Thus during the year, each Balika Mandal caters to 40 adolescent girls in the age group of 11-18 years. The Anganwadi Worker is the regular honorary instructor for the Balika Mandal and provides general education and literacy to these adolescent girls. Instructors of AWTCs and MLTCs and training centres of the Health and Family Welfare Department are enlisted for visiting Balika Mandals from time to time to provide continuing education to these adolescent girls. These girls participate in the activities of the Balika Mandal and are provided with supplementary nutrition equivalent to the entitlement for a pregnant / lactating woman for 6 days in a week. KSY is being implemented through AWCs in rural and urban setting in all the 6118 of ICDS of the country.

In the Adolescent Girls Scheme-I, namely, the Girl to Girl Approach (11-15 years old girls), simple and practical messages on promoting health, hygiene, nutrition, education, the working of the Anganwadi Centre, family life education and supplementary nutrition are taught.. In the Adolescent Girls Scheme-II, namely, Balika Mandal, the 11-18 year old girls learn about the significance of Education and life skills, personal hygiene, environmental sanitation, nutrition and home nursing, first aid, communicable diseases, vaccine- preventable diseases, family life, child care and development, constitutional rights and their impact on the quality of life. They participate in creative activities and learn through sharing of experiences and discussions about issues that affect their lives. Skill development is also imparted under this scheme.

The objectives of Kishori Shakti Yojna (KSY) are to improve the nutrition and health status of girls in the age group of 11-18 years; provide them the required literacy and numerate skills through the non-formal stream of education; stimulate a desire for more social exposure and knowledge and to help them improve their decision making capabilities; train and equip the adolescent girls to improve/upgrade home based and vocational skills; promote awareness of health, hygiene, nutrition and family welfare, home management and child care, and to take all measures so as to facilitate their marrying only after attaining the age of 18 years and if possible, even later; gain a better understanding of environment-related social issues and their impact on their lives; and encourage adolescent girls to take up activities that would help them become productive and useful members of the society.

**The component of the adolescent girl was introduced into the ICDS programme because of her importance as a future mother and her potential to become a fully empowered future leader of women. Regrettably, our audit has shown that for all practical purposes this component does not exist in any meaningful way in the Anganwadi Centres studied.** In 59 (38%) Anganwadi Centres, not all the adolescent girls were enrolled. In one centre not even one was enrolled. In 88 (57%) centres they did not participate in any programme of the Anganwadi Centres, while in 21 (14%) Anganwadi Centres less than 25 percent of the enrolled girls participated in their activities. In 117 (76%) Anganwadi Centres the girls were not provided any training. In 28 (18%) centers they were trained in tailoring and at 7 centres computer training

was imparted to a few of them. The girls were not supplied with IFA tablets in 139 (90%) Anganwadi Centres, which is deplorable. Even where they were distributed, that was at the ANM's discretion and not as part of a regular programme. The reason for this was, of course, the failure of the Government to supply the tablets. It was the impression of the Social Audit team that in the Belugoppa Scheduled Castes colony 90 percent of the adolescent girls were anemic; this also is a place where girls are usually married off at 14 years of age. We realize that the adolescent girl scheme is implemented in two parts – one scheme which trains three girls attached to an Anganwadi Centre for 6 months so as to make her capable of managing the Anganwadi Centres by assisting the Anganwadi Worker in all matters; and the other implemented only in a certain percentage of the Anganwadi Centres in each project. It is not, however, certain that either of these concepts has been understood in the District properly and this has led to the near total neglect of this most precious social asset and capital. The whole approach to the Scheme requires an immediate review so that the original concept of a certain number of adolescent girls being trained in all villages in the ways of the ICDS programme to assume their future responsibilities as part of the paradigm of women's empowerment and child development conceived in the ICDS programme, could be restored and its implementation achieved.

## **5.12 THE ANGANWADI WORKER AND THE CURRENT REALITY RELATING TO HER.**

### **(a) Conditions of work:**

At the beginning of this chapter we saw how formidable the job responsibilities of the Anganwadi Worker are in the eyes of the Government and therefore the public at large. There are two sides to any expectation of accountability. The foremost and the most elementary requirement to handle a job with such responsibilities as have been assigned to an Anganwadi Worker is the need for the Anganwadi Worker to reside in the village where her Anganwadi Centre is located. Equally important, her service conditions must be such that she is properly remunerated and provided with facilities which make the job responsibilities expected of her possible of fulfillment. Neither of this obtains in this context.

We noticed in our Social Audit that in 53 (34%) Anganwadi Centres the Anganwadi Workers did not reside in the village and some of them traveled more than 25 kms to

reach their centres. The Anganwadi Workers of Gandlapadu village of Putlur mandal and Banancheruvupalli of Gandlapenta mandal travel 30 and 35 kms respectively to reach their centres. In 108 (70%) Anganwadi Centres maintenance of records was found unsatisfactory, indicating the need for training in record keeping. The visits of the supervisors and CDPOs have not been regular and those visits, in any case, seem to have made no contribution to better maintenance of records. Home visits, a most fundamental duty of the Anganwadi Workers, were not done regularly in 69 Anganwadi Centres. 102 (66%) Anganwadi Workers reported that they were entrusted by the Government with work unrelated to the Anganwadi Centres, diverting their energies away from their legitimate responsibilities and leaving those responsibilities in the hands of the helper. The honorarium paid to the Anganwadi Workers of Rs. 1, 400 (now enhanced to Rs. 2, 200 including the State's own contribution) is less than the minimum statutory wages payable to similar work but the most tragic part of their lives is that even this honorarium is not being paid regularly with many of them receiving their remuneration once in 4 or 5 months, as verified by us. Often, Rs. 1,000 is paid first and the balance of Rs. 400 months later with all attendant consequences. This applies to the helpers as well whose salaries are even lower. Full amounts for agreed Anganwadi Centre rents are not provided and some times the Anganwadi Worker pays part of it from her own pocket. The Anganwadi Workers on the whole, excepting the brand new recruits, are a dispirited and de-motivated lot including for the reason that the facilities made available at the Anganwadi Centres to discharge their duties are dismally inadequate. These include: lack of their own building; the bad condition of the buildings; the buildings being far too small and located in unhygienic surroundings; absence of drinking water; absence of toilets; absence of open spaces for children to play; inadequacy of toys; interruptions in supply of materials relating to Supplementary Nutrition; Vitamin-A, medicines and IFA tablets; non-functioning or absent weighing scales, particularly the adult weighing scales; lack of furniture to keep records and containers for other material; and even having to meet expenses relating to conduct of programmes like the Nutrition week, Breast Feeding Promotion week and Children's Day since these expenses are hardly ever reimbursed. The ICDS is designed as a community-based programme per excellence but very little community support seems actually to have been mobilized. Anganwadi Workers of 125 (81%) centers averred that they received little or no community support for their work while in 28 centres we did find help

coming from the people in a number of ways. All is not lost but the situation is quite grim. There has been an odd case or two of work being even obstructed. Indifference to the ICDS on the part of the people is obviously because of poor delivery of services as well as the staff's failure to explain how important these services are for the target groups in terms of the human rights of women and comprehensive human resources development and the child's right to its future. Staying with the problems faced in the Anganwadi Centres by the Anganwadi Workers, some of the centres have no helpers. In some cases these helpers are too old to be of any help any way. The Government needs to review the entire gamut of these conditions.

**(b) Accessibility of Anganwadi Centres to beneficiaries:**

Out of the 154 AWCs studied at least 39 (25%) are not easily accessible to the beneficiaries, the reasons being the distances involved; the pathways being water-logged; the necessity to cross busy roadways including in one case even a busy highway in Anantapur town.

**(c) Anganwadi Centre (AWC) Buildings:**

Most Anganwadis function in rooms that are extremely cramped for space. Of the 154 AWCs studied, only 60 (39%) have their own accommodation. 74 (48%) of them function in rented accommodation while the rest function in buildings owned by village Panchayats and school buildings. Though 137 of these have been described as *pucca*, only 80 of them have been seen to be in good condition. 63 (41%) of them have been found to be in bad condition, many of them found to be even leaking in rainy season rendering them unfit for storing materials and for pre-school and other activities. Some of these are so cramped and congested that they can not accommodate all the enrolled children if they elect to turn up at the centre. The question of holding meetings of Mothers Committees in such conditions does not even arise. A couple of these have dimensions not exceeding 6x6 feet and some have no doors or windows. Unhygienic conditions and surroundings are common, including where the buildings may otherwise be good. Overgrown bushes of thorn, grazing of pigs and cattle, dung heaps, cesspools and in one case toilets meant for teachers constructed adjacent to the Anganwadi Centre, were all seen vitiating the environment of the Anganwadi Centres.

**(d) Facilities in the AWCs:**

Of the 154 AWCs only 26 (17%) have toilet facilities. In 16 others (10%) toilets do exist but are not in use as they are either in a state of disrepair or have no water supply. 112 (73%) AWCs have no toilets. In one Tanda a government-sanctioned toilet could not be constructed because of villagers' opposition.

Only 88 (57%) AWCs have accessible drinking water sources of which 36 (23%) are street corner taps. However, availability of water in these depends on power supply in the village, which is irregular, causing problems. The other 66 AWCs face acute problems of drinking water supply.

95 (62%) AWCs have child weighing machines while 19 (12%) do not have them at all. In 40 (26%) centres the child weighing machines are not in working order. As for adult weighing machines, 41 (27%) centres have not been supplied with them at all. In 53 (34%) centers these are not in working condition either. 35 (24%) AWCs alone have the adult weighing machines in working order. (We are re-verifying information relating to 25 other centres). The consequences for the entire concept of growth monitoring of children and the nutrition status of pregnant women need no comment in this context. This defeats by far the most cardinal objective of the ICDS programme.

Only 67 (43%) of the 154 AWCs have any kind of open spaces available for children to play or undertake activities. 87 (56%) centres did not have any open space. In one case where there was open space, the villagers encroached upon it.

While all AWCs had toys except 9 of them, in most places they were inadequate or broken or old.

While all AWCs had teaching aids except 2 of them, some of the AWCs that received the new teaching aids recently are unable to use them in the absence of training to use these aids.

Because of the conditions prevalent at the AWCs such as those relating to the cramped nature of the accommodation, leaking roofs and absence of doors related earlier, materials and equipment are not safely or properly stored at the centres.

**(e) Quality of Anganwadi Workers, Service Conditions and Disciplinary Issues.**

Our audit showed poor quality of staff at the anganwadi level and extremely poor levels of motivation. Often local enquiries revealed that Anganwadi Centres were not kept open from 9-30 AM to 1.30 PM. These aspects of quality and motivation in our view is attributable to poor recruitment methods currently prevailing, mindless reduction of the initial job training period to 26 days from the previous three months, absence of disciplinary action where merited, poor facilities at the Anganwadi Centres and bonded labour-like monthly wages. In recruitment there is far too much political interference. Though the District Collector is the chairman of the selection committee, he hardly presides over these meetings and often it appears that the Revenue Divisional Officer presides over these selection committee meetings. The MLA is a member of this committee and the general impression in the public mind is that the MLA's word, not always based on merit, prevails as to who should be selected. Discreet discussions reveal that 350 –500 candidates have been interviewed on a single day in one recruitment effort, a candidate getting an opportunity of no more than a few seconds. In such a farcical interview great scope exists for fudged nativity certificates; lack of examination of the genuineness of qualification; and partisan politics based appointments and other kinds of consideration. Thanks to this kind of recruitment, about 20% of all new recruits are just desperately dysfunctional and can not discharge their functions properly.

Service conditions of the AWWs can not be discussed in isolation from their training needs. The Coordinator, as part of the Social Audit, visited two Anganwadi Workers Training Centres (AWTCS) and watched the process of training imparted to the AWWs and Helpers. At the Anganwadi Training centre visited by the Coordinator training was being imparted to a batch of fresh recruits as AWWs. Answering questions as to why they opted to become AWWs, many of them answered they wanted to “change the way things were happening in the ICDS programme”. They said that they had often seen AWWs in their area not coming on time to their work; not attending to their work properly; some of them residing outside the village where the AWC was located etc. They wanted to be different and wanted to improve the lives of the children and their conditions and attend to issues like domestic violence. They wanted to promote education and change the conditions in the society for the

better. The attitude of sincerity and the enthusiasm that the new recruits displayed was absolutely genuine and inevitably a comparison between these attitudes and the attitudes of AWWs who had put in a few years of service arises. It is clear that our young women have their hearts in a right place but what they require is appropriate training to enhance their motivation and providing them with appropriate conditions of service and facilities so that their idealism does not get dimmed over the years. These young recruits also felt, beginners as they were that they were being called upon to discharge duties that were not relevant to their work in the ICDS programme thus diverting their energies from their main occupation. Such work, they explained, related to Electoral Identity Cards, issuing Arogya Shree Cards, surveys assigned to self help groups, the Indiramma Hosing Programme work and even surveys relating to Narcotics which an international agency wanted done. These views of the freshly recruited AWWs reflect truly the kind of reforms that we require in the ICDS programme relating to the working conditions of the AWWs. Their earnestness, discipline and the serious attention they gave to the lectures were all indicative of the excellent material these young women are and it is entirely up to the Government to equip them properly through appropriate job training and periodical refresher training. Senior officers of the ICDS System present at this visit were of the unanimous opinion that we need to revert to the 3 month training programme for AWWs if they were to be adequately trained. A point was also made that a very useful manual has been evolved in regard to all the work that an AWW has to perform but that for want of budget provision copies of this manual were not being supplied to the AWWs at training. It was further learnt that this manual was being routinely given when the duration of the job training was for 3 month training but that has now stopped. It also emerged during this visit while there is provision for giving this manual at the time of the refresher training, it is not so for the job training! There were suggestions that these “reforms” came in after the World Bank came to fund some ICDS projects. It is for the authorities to examine these issues to ensure that in the name of the efficiency and economy negative steps of this kind are not taken. It also appears desirable that we have separate manuals designed for the various services delivered at the AWC so that there is always a reference point available to the AWW for doing her job perfectly in regard to all these services. Such a manual does exist for pre-school education, developed by the Andhra Mahila Sabha. A conclusion is also inescapable while looking at the AWWs and Helper Training centres that they need the constant

supervision of the senior officers of the ICDS system without the entire management in regard to these centres being left exclusively to the NGOs. Attention in this regard should include not only the upgrading of the standards of training but also of the basic living and learning facilities provided at these teaching centres.

A CDPO is in overall charge of an ICDS project and is responsible for planning and implementation of the Project. In large ICDS Projects, where there are more than 150 AWCs in a Project, an Assistant Child Development Project Officer is also a part of the team. It is extraordinary that the CDPO does not have any disciplinary powers with regard to Anganwadi Workers or Helpers. Even the Project Director has no powers in regard to these functionaries. These powers are vested in the Collector. In this situation the expectation that the senior officers can motivate or obtain high standards of work, beyond a point, is a non-starter. Lack of discipline in Anganwadi Workers was pretty apparent in the Social Audit. One of the Anantapur Urban Anganwadi Workers just gave a leave letter to CDPO when her Anganwadi Centre was random-selected by us for the Social Audit and when her leave was refused she just left a note and disappeared. Prior to the start of our Social Audit work there was demonstrable, literally that is, resistance to the whole idea with trade union undertones inconsistent with the philosophy of work and service that we associate with the ICDS movement. We need to examine why these attitudes exist so we may address them.

**(f) Required reforms relating to service matters:**

The situation relating to personnel administration in regard to all relevant aspects detailed above is alarming enough to call for urgent reforms. The State Government may consider the following suggestions to reform the situation:

- (i) Selection process** – A written examination to assess the basic ability and capacity of the AWW based on an ICDS-oriented questionnaire on APPSC lines needs to be held. There should be a minimum requirement of 40 % marks for a pass. This should be followed by an interview for selection for award of a maximum of 10 marks. Selection should be on the basis of the combined marks obtained in the order of merit. Relaxations obviously should be provided for reserved categories. The interview committee should have experts relevant to the

services the ICDS delivers presided over only by the Collector with no discretion to the Collector to nominate any one else to chair these selection committee meetings. It is respectfully recommended that there is no need for the MLA to be a member of the Anganwadi Workers Recruitment Committee. The minimum educational qualification should be 10<sup>th</sup> passed for Anganwadi Workers and a pass in 7<sup>th</sup> for Helpers. They should be locally resident and married but an unmarried woman could be appointed as an exception showing reasons in writing. Age of retirement should be 60 years for both Anganwadi Worker and Helper. Serious consideration should be given to making Anganwadi Workers and Helpers quazi-Government servants for ensuring accountability and discipline. There is urgent need for a well designed HRD strategy that includes selection, training, performance standards, performance assessment, systems rewards and punishment. The need for an on going system of Performance Assessment in the department not only at the level of the worker / centre but at all the layers up to the District level and remedial measures where the performance has been found wanting, can hardly be over stated. The salary and working conditions of AWWs are deplorable. Salaries and other elements that contribute to the right working conditions need to be addressed and with out this it would be impossible to improve the functioning of the Anganwadi Centres. This should, however, also accompany removal of all unsuitable personnel from service. We would advert to this in our Report after more detailed examination of all factors involved in regard to this in our District and Delhi level Workshops.

**(ii) Mobility:** Every CDPO should have a vehicle backed by adequate provision for POL budget. The ban on recruitment of drivers needs to be removed once for all. Most existing vehicles need to be replaced as most of them are of 1980s vintage, as seen in Anantapur. A Supervisor has the responsibility of supervising 20, 25 and 17 Anganwadi Workers in rural, urban and tribal projects respectively. A Supervisor guides an AWW in planning and organising delivery of ICDS services at an AWC and also gives on the spot guidance and training as and when required. If these are to be achieved the supervisors should be provided with two wheelers suitable for women with adequate budget for POL so they may travel adequately to discharge their functions.

**(iii) Crucial Posts:** The post of the Nutritionist and PSE instructor for each Project Director's office at the district level should be filled with out exception and without loss of time.

**(iv) Discipline:** Original, appellate and revision disciplinary powers should vest respectively with the Supervisor, CDPO and the Project Director. The ICDS programme is in dire need of a balanced combination of appropriate measures of welfare and discipline in regard to personnel matters.

**(g) Efforts at Convergence:**

(i) We need special efforts from the Health side to tackle malnutrition in terms of NHE and micro nutrients supply and a review of such efforts periodically through joint meetings with the ICDS machinery. The quarterly meetings at the District Level that ought to be convened by the District Medical and Health Officer (DMHO) are not being actually held. This practice should be immediately revived.

(ii) Convergence in the years gone by was better because till about a decade ago monthly meetings used to be held at the project level either at the CDPO's office or at the PHC where the CDPO, the Medical Officer, Supervisors, LHVs and ANMs gathered for a comprehensive review of the ICDS work. This institutional mechanism is not in force any more. This must be revived.

(iii) For the urban ICDS projects there is even now a separate Medical Officer specifically assigned with support staff like ANMs etc. Such an arrangement is essential for the rural projects also as was in the past. However, convergence needs to be more effective in urban areas as pointed out elsewhere in this Report.

(iv) It is essential that the long-standing institutional mechanism of the ICDS Supervisors having to attend the sectoral meeting of the Medical Officers of the PHCs at mandal level is revived for better convergence.

**(h) ASHA:**

The introduction of the ASHA worker whose motivation for work done is incentive-based has serious implications for the paradigm of convergence between the ICDS staff and the Health staff in the field. This has been referred to elsewhere in this

Report. We shall advert to this problem in our final Report after a more detailed discussion and examination, at our District and Delhi Level Workshops.

### **5.13 COMMUNITY PARTICIPATION AND THE PRACTICE OF DISCRIMINATION:**

The ICDS programme incorporates certain vital human rights of women and children and seeks to deliver them as services. It is the community alone that can ensure that the ICDS programme delivers these services as designed. Thus the community in truth is the guarantor at the Anganwadi level of these rights of women and children and it is in this rights perspective that this Social Audit has been conducted by us.

ICDS is a community based programme. For effective implementation of the programme, members of the community i.e. functionaries of the panchayat raj system; mahila mandals and youth clubs; religious and local leaders; voluntary organizations and primary school committees etc., should be actively involved. Being basically a community based programme, its success essentially depends on active community participation. This is vital for the ICDS programme because it enhances the reach of the programme, encourages ownership of the programme and accountability for success or failure of the programme. An Anganwadi Worker is mandated to educate, mobilize and organize the community so that the community can participate in the ICDS programme to ensure for the cause of child survival and development. The community can participate in the programme by providing a building for the Anganwadi Centre, motivating parents to send children to Anganwadi Centre and bringing children to the Anganwadi, contributing food and fuel and most importantly by creating a demand for the ICDS services as a matter of right, acting as a pressure group for the efficient functioning of the Anganwadi center. The Hand Book for Anganwadi Workers even lays down how the various constituents of the Community like the Gram Panchayat, the adolescent girls, the mahila mandals, the primary school teacher, the traditional birth attendant, groups of village women and non-Governmental Organization can contribute to the better functioning of the ICDS programme.

In the selection of the location of a project, priority policy consideration is given by the Government to the areas inhabited predominantly by Scheduled Castes or Tribes, especially Backward Tribes, nutritionally dependent areas and areas poor in the reach

of social services. The human rights of these classes of society are therefore involved in the proper execution of the ICDS programme.

This being the design and beneficent role and responsibility of the community, the most deplorable situation seen by us during the Social Audit is one that relates to man's inhumanity to man in many places. Various kinds of discrimination were reported from 20 (13%) Anganwadi Centres. In the Anganwadi Centre at the Gummagatta Scheduled Caste colony the helper belongs to a Scheduled Caste. Children from BC and OC families do not like to partake of the food cooked by her. In Bhoopasamudram Scheduled Caste colony of Gummagatta mandal the Anganwadi Worker belongs to an "upper" caste. She did not visit Scheduled Caste houses as a part of the house-to-house survey. She reportedly did not touch the children, pregnant women and nursing mothers belonging to Scheduled Caste families either. In Jakkalavadiki of Kanekal mandal the Anganwadi Centre is located in the Scheduled Caste colony and the backward classes children do not go there for supplementary nutrition. In Donnikota village of Nallamada mandal, as the Anganwadi Worker is from a Scheduled Caste community, she was not able to visit "upper caste" houses as a part of her periodic house visits. In Kondravaripalli village of the same mandal the Anganwadi Centre is located in the Scheduled Caste colony and the Anganwadi Worker hails from a Scheduled Caste community. "Upper caste" families are reportedly not showing interest in sending their children to this centre. Here, house visits also have become difficult. The Backward Classes, OC and Muslim families are not using the services in the Anganwadi Centre of Bathalapalli Scheduled Caste colony because of its location. In Jalaapuram of Bathalapalli mandal, the Anganwadi Worker is reportedly an "upper caste" person, comes from another village and does not visit other houses. Except butter milk she reportedly does not touch any food offered by villagers. In Naik Nagar AWC located in Anantapur town the local households do not reportedly like the enrollment of the children of Erukulas, a nomadic tribe. In Gunduvaripalli of Amadaguru mandal the helper is from the Scheduled Caste and therefore no food is cooked at the centre because of the apprehension that if she cooked others might not eat the food. Therefore, the uncooked material is given to the children to be cooked in their homes. In Kassamudram of the same mandal the Anganwadi Worker is from the SC community. She is therefore reportedly not involved in distribution or serving of food. Because of

the same reason she is unable to do home visits. In Thummala of the same mandal both AWW and Helper are from the scheduled castes and they are therefore reportedly not cooking supplementary nutrition food nor are they able to take up house visits. In Dimmagudi of Peddavadagur mandal the AWC is located in the Scheduled Caste colony and households from other castes are not using its services reportedly for that reason. In Kondapalli village of Kanaganipalli mandal Scheduled Caste children are not allowed inside the Anganwadi Centre. They are given the supplementary nutrition food and asked to go home. Because of this, the Scheduled Caste families are not sending their children to the Anganwadi Centre. In Somaravandlapalli of the same mandal even if Scheduled Caste children come to the centre, they have to come with their own plates and glasses. In Pothulakunta of Kothacheruvu mandal both the Anganwadi Worker and Helper belong to a Scheduled Caste community and OC families in the village reportedly do not want their children to partake of the food cooked by them. In Nagireddypalli of the same Mandal, since the introduction of the new menu, OC children are sitting away from the Scheduled Caste children obviously because the new menu involves cooking. Our Social Audit thus shows that apart from the absence of worthwhile community participation, the ICDS programme faces the huge issue of untouchability and that highlights the need for larger social reforms of a comprehensive nature to make our programmes meaningful. Considering that such very serious shortcomings exist, it is hard to escape the conclusion that the ICDS programme designed as a social development programme *par excellence* has failed in many places in its objective of holistic inclusiveness. We need to discuss at the District level Workshop this issue in detail to evolve the kind of social action needed to promote social inclusiveness in our communities.

#### **5.14. CHILDREN WITH DISABILITY:**

In 56 (36%) Anganwadi Centres such children were identified but in 29 of them no support was provided to the disabled children. In 23 (15%) Anganwadi Centres children were referred to hospitals.

#### **5.15 The Way Forward.**

Some of the major findings of the Social Audit were discussed by the Social Audit Team on 12th May, 2009 at a meeting with Smt. Chaya Ratan IAS, Principal

Secretary, Department of Women Development and Child Welfare (DWDCW) Government of Andhra Pradesh, Smt. Y V Anuradha IAS, Commissioner, Department of Women Development and Child Welfare, Government Andhra Pradesh and Shri A K Punetha IAS, Commissioner of Health and Family Welfare, Government of Andhra Pradesh DWDCW in the chambers of the Principal Secretary, DWDCW. The Issues raised were:

1. Issues and solutions pertaining to the supply and availability of food materials supplied under the SNP and their timely movement to the Districts and the AWCs as serious nutrition interruptions have been noticed in the Social Audit.
2. Issues and solutions pertaining to the non-availability of adult weighing scales and also short availability of child weighing scales and the poor condition of their maintenance affecting growth monitoring.
3. Issues and solutions pertaining to the non-availability or short availability of teaching aids and toys and the absence of training to the AWW in regard to the use of teaching aids.
4. Issues and solutions pertaining to the non-supply or short supply to the AWCs of medicines; Vitamin A; Iron and Folic Acid; referral slips; and inadequate identification, check-up and follow-up of children with disabilities. The issues relating to the **Cold Chain** in Immunization in the ICDS such as the entire logistics relating to movement of vaccines over long distances from the source of manufacture to the Anganwadi Centres over several stages and how we ensure that the vaccines do remain potent till the time of their administration to the child and the pregnant woman.
5. As between the Health and DWDCW, what are the specific responsibilities to be discharged by the functionaries of each Department in regard to Immunization; NHE; health check-ups; referrals; distribution of Vitamin-A; distribution of Iron and Folic Acid; and dispensing medicines for minor ailments. What are the problems and solutions in achieving convergence of efforts?
6. Issues relating to the motivation levels of the AWWs and helpers. What are the remedies? Are there any incentives possible to enhance motivation? Non-residence and absence of home visits would need a discussion in this

connection. Also, an examination of the adequacy of their training and how to strengthen it.

7. What are the issues pertaining to the practice of “taking home” the supplementary nutrition? Is this a good policy at all and if yes, what are the safe guards that need to be followed? The quality and acceptability of the current SNP menu will need to be touched upon. Also, the reasons why additional nutrition is not being provided to the anemic women and malnourished children as required under the programme guidelines. How to move towards nutrition that is based on locally available food, locally cooked and served hot?
8. Is the ASHA worker rendering the Anganwadi Worker and the Anganwadi Centre irrelevant to all health-related services? If not, how to get the best out of both these functionaries?
9. How to strengthen the Adolescent Girl programme so that she is involved in the implementation of the ICDS programme in every village as originally conceived?
10. What are the steps required to enhance community involvement in the ICDS programme, especially at the Anganwadi Centre level?

**5.16** Clarifying the issue relating to the supply of iron and folic acid (IFA) and Vitamin A tablets, the Commissioner, Health and Family Welfare stated that there was no dearth of supply of IFA tablets in the State. Under the Fixed Day Health Scheme a population of 4 crores has been covered and there were 475 vehicles working under this service and therefore, from now onward every body would be able to secure IFA tablets. The ASHA and Anganwadi Worker are authorized to distribute these and the supply position was so comfortable that two months’ buffer stock was available. The recently introduced “104 Service” takes care of this issue in recognition of the failure in this regard. As regards referral services, it was really the responsibility of the ANM who should register all pregnant women, but the population of 5,000 she has to deal with being high, the ASHA has been introduced to serve a population of 1000 now. The ASHA worker gets paid incentive money for registering the pregnant woman and delivering her the services she needs. This arrangement has been designed under the National Rural Health Mission (NRHM). A second additional ANM is also being

appointed and their number would be 950 in the State. The Managing Director of the Andhra Pradesh Health, Medical, Housing and Infrastructure Development Corporation (APMHIDC) purchases and supplies IFA and Vitamin A tablets to the District Medical Health Officers who in turn supply them to the ANMs through the Primary Health Centre (PHC). Under the NRHM enough money was available at various levels in the health system so that local purchases of IFA can always be made. To a specific question from the Coordinator whether or not the Anganwadi Worker should be made fully responsible for the distribution of IFA since all the categories of beneficiaries for whom IFA has to be distributed are expected to converge at the Anganwadi Centre so that there is no dilution of responsibility by more than one person being made responsible for IFA and Vitamin A distribution, the Commissioner said that such a course was not desirable in view of the possibility that complications like nausea might arise needing expert medical attention. The Social Audit team believes such a possibility to be negligible. The Coordinator suggested that in addition to the Anganwadi Worker who should be the *main* person entrusted with this responsibility and, therefore, who should be supplied with the *total* requirement of IFA tablets, the ANMs could also carry with them additional supplies of IFA tablets so that where needed and required the gaps could be filled during the tours and visits of the ANM. This suggestion needed serious consideration since not all participants in the ICDS programme necessarily go to the Health Sub-centre whereas almost all of them do so to the Anganwadi Centre. The nutrition and health education (NHE) day is also based on a fixed day concept held at the Anganwadi Centre. The point to remember is that no single person requiring IFA should go un-served and that can be best ensured only by making that institution which is located right in the village which is the Anganwadi Centre, mainly and fully responsible, even if not exclusively responsible for the distribution of IFA tablets and Vitamin A to the target groups. The strategy that should be followed must be one which makes the AWC and AWW responsible fully for the distribution of IFA and Vitamin A but also one which backs it up with supplies of these to the ANM and ASHA at the Health Sub-Centre and while they are on tour, so that not a single member of the target group is missed in regard to the supply of IFA. The Coordinator reiterated that we need a saturation supply strategy in regard to IFA tablets. **It would be a good idea for Government to give the powers of purchase and distribution of IFA back to the Department of Health so that procurement and accountability go together.**

**5.17** As regards Vitamin A supplies, there is no doubt that a shortage exists. The public sector enterprises that were manufacturing Vitamin-A have all closed down and the private sector has more or less the monopoly of manufacture of Vitamin-A. With little regulation of the private sector, the manufacturers are imposing their own prices leading to serious difficulties in procurement. Vitamin-A supplies were being made by the Government of India to the States till 2005 but since then the State Government has been given the “powers” to buy Vitamin-A by way of “decentralization”. The authorities expect therefore that there would be no problem in the future in regard to supplies of Vitamin-A. The Social Audit Team is of the view, however, that this is doubtful because if the prices of Vitamin-A manufactures in the private sector are not properly regulated and deliveries ensured, the problem will only worsen because of “decentralization”. The private sector, instead of making the Central Government pay high prices, would now make the State Governments do the same and the problem could only become more acute, given the resources position of the State Governments. **The Central and State Governments need to sort out this problem keeping the interests of the target groups above in view.** Unless these issues are seriously addressed by the Government of India taking the lead, the health of the Indian women would continue to be in grave jeopardy even as it presently is.

**5.18** In the context of the issue of referral and also the failure in the distribution of IFA and Vitamin A tablets, the question of absenteeism of the Health and Medical staff in the field came up for detailed discussion. **It was agreed and concluded that unless issues of governance relating to enforcing the stay of the Medical Officers at the PHC headquarters and the ANMs at their headquarters is addressed, the basic issues of health that impinge on regular visits and uninterrupted distribution of essential supplies would not get addressed. In matters of governance, display of political will is what matters and this must be recognized by the Health Ministers of the Central and State Governments.** A related governance issue is the undue burdening of the health personnel with administrative matters they are not equipped to handle, resulting in poor governance of both procedural matters and administration and delivery of health itself. This needed to be addressed by the State Government by relieving the doctors of this responsibility or by fully training a few of them specifically to equip them to handle administrative matters exclusively.

- 5.19** As for the Cold Chain, it was mentioned by the Commissioner that the vaccines procured from various manufacturing sources including from outside Andhra Pradesh are transported from Hyderabad to six Regional Centres in the State and from the Regional Centres transported to the Districts and from there on to the Primary Health Centres and there existed no real problem in regard to this. **The Social Audit team feels that we would need some independent experts to study the operation and functioning of the Cold Chain for the public to be satisfied that the Cold Chain maintenance is beyond any sort of doubt.**
- 5.20** As regards the absence of supply of Adult Weighing Scales, the Commissioner, DWDCW pointed out that the main problem in regard to them was that these scales were being misused at the Anganwadi Centres by the staff weighing food stocks etc., resulting in these scales going into a state of frequent disrepair. To avoid this the solution she felt could be to let the ANM carry the Adult Weighing Scale with her during her visits to the AWC. As for the Salter scales for weighing children, it was mentioned that 51,000 weighing scales had been recently supplied. **The Social Audit Team feels that these must be the exclusive responsibility of the DWDCW including their maintenance through trained women's self help groups so that accountability in this regard is not diluted.**
- 5.21** Two issues came up for discussion in the context of the supplementary nutrition supplies to the Anganwadi centres – one, that relating to the quality and palatability of the new recipes and the other, the failure to make supplies to the AWC in a timely fashion leading to serious nutrition interruption. The Principal Secretary, DWDCW clarified that the newly introduced recipes were all highly nutritive thanks to their ingredients and that the initial problems faced as mentioned in the Social Audit findings have since been rectified as far as palatability was concerned. Part of the resistance to new recipes was also because these recipes required cooking and the Anganwadi workers and Helpers were not happy to undertake that work. It was agreed in the meeting that a second look should be taken at this issue. As regards nutrition interruptions, it was explained that there were problems in the transportation of the materials to the Anganwadi Centres from the project point. The calling of

tenders and their finalization for transportation of food materials to the Anganwadi Centres are the responsibility of the Joint Collector in the District and these formalities including issues relating to costs do create problems. The Department needs to find a solution to this as nutrition interruptions are costing the pregnant women and children dearly with the grave consequences documented in this Report. **Local food would obviate all these problems.**

**5.22** Supply and maintenance of medicine kits at the Anganwadi Centres is the exclusive responsibility of the Department of Women Development and Child Welfare. The problem, however, is that whereas tenders have to be called for by the Department of Women and Child Development, the rates for these medicines have to be determined by the APMHIDC. Without APMHIDC determining the rates, the Department of Women's Development and Child Welfare cannot call for tenders. This is a conundrum. **It was agreed at the meeting that the obvious solution to this problem is to transfer the powers to the DWDCW and decentralize powers to the District level.**

**5.23** The grossly delayed payments of honorarium to the Anganwadi Workers and Helpers was discussed and it was found that there have been delays on the part of the Government of India in releasing the amounts relating to the additional honorarium recently sanctioned by them. As against the funds that should have been released on 1<sup>st</sup> April 2008, these did not come till 1<sup>st</sup> October 2008. The State Government does not lag behind in this regard either, because the Government of Andhra Pradesh does not release funds for payment of honorarium in time. **The low remuneration levels of the workers and these delays that compound the problems of poor compensation further, which have decisive implications for the motivation levels of the workers in the ICDS programme need urgent attention.**

**5.24** The Principal Secretary, Department of Women and Child Development, Government of Andhra Pradesh outlined the several policy and implementation measures that have been taken by the Government recently to rectify the several defects noticed in the functioning of the ICDS programme. These were:

The formulation of new recipes for the SNP which are highly nutritious and which would be prepared at the Anganwadi Centre and served to the beneficiaries hot; distribution of IFA tablets and administration of Tetanus Toxoid to pregnant women in a more streamlined fashion; promotion of the concept of feeding colostrum within the first hour of the delivery of the baby; emphasis on the exclusive breast feeding of the baby for the first six months and continuation of breast feeding with supplementary foods up to 2 years; emphasis on total immunization; revamping the Pre-School Education component; and strengthening of the Adolescent Girl Programme. The Department of Women and Child Development was also revising and rationalizing the various registers that are expected to be maintained at the Anganwadi Centre as also the format of the Monthly Progress Report.

- 5.25 The Social Audit team suggested to the Principal Secretary, DWDCW that the success of the ICDS programme should be judged by the out comes in terms of the objectives of the various services that are sought to be delivered in the programme. To judge these outcomes we need to evolve indices for each outcome.**
- 5.26 An important point that was emphasized during the discussions was the efforts that the Department needs to make to improve the attendance of children in the 0-3 age group at the Anganwadi Centre because of the extreme importance of early childhood care including proper nutrition and stimulation to improve the child’s cognitive, language, social and other skills – in short the child’s sensory development, for which the window of opportunity generally closes by the 36<sup>th</sup> month. The concept of “attendance” of this cohort at the AWC was discussed at length and it was agreed that enhanced efforts were called for to make children in this cohort actually physically attend the Anganwadi Centre to the maximum extent possible. The Social Audit team referred to the recommendations pertaining to converting all Anganwadi Centres into crèches running for longer hours with additional manpower including the involvement of the adolescent girls and additional nutrition to be provided – put simply, to run the AWCs as day-care centres. The Social Audit team advocated the need for frequent visits**

**on the part of the nursing mothers and mothers of children up to 3 years to the Anganwadi Centre so that they participate actively in the nutritional supplementation and early childhood care which includes stimulation of the 0-3 cohort. This not only would help make the immunization schedule a reality and therefore the health security of the child, but also enhance community involvement and participation in the ICDS programme on the whole. The Social Audit team also emphasized the need for expanding the Adolescent Girl Scheme to every Anganwadi Centre in the State so that their interests and the interests of the Anganwadi Centre in relation to all its activities could be mutually strengthened. Involvement of the adolescent girls in the ICDS programme would promote the much needed gender equity overall. The need to rectify gaps like failure to provide services to pregnant women and nursing mothers who return to their own villages for delivery was also emphasized by the Social Audit team.**

**5.27** The Social Audit team was impressed by certain progressive measures taken in recent months by the DWDCW of the Andhra Pradesh Government to improve the quality of implementation of the ICDS programme. The more significant amongst them are the devolving of the powers and functions of the Department to the Panchayat Raj institutions to monitor, review and ensure proper implementation of the ICDS programme including the Anganwadi Worker Training Centre (AWTCs) and the Middle Level Training Centres (MLTCs). As part of the effort at improving the functioning of these programmes, significant powers are being devolved to the Panchayat Raj Institutions. According to the instructions issued in G.O.Ms.No.41 dated the 19<sup>th</sup> November 2008 the Panchayat Raj institutions would prepare and approve the Annual Action Plan for these schemes and funds would be released and adjusted to the Zilla Parishad, the Mandal Parishad and the Gram Panchayat as applicable. The officers concerned with these programmes would submit progress reports to the Panchayat Raj institutions concerned in formats as prescribed by the Government and the Commissioner, DWDCW. The Panchayat Raj Institutions have been empowered to review, inspect and monitor the implementing institutions and activities connected with these programmes. The suggestions of the Panchayat Raj Institutions in regard to improvements shall have to be acted upon by the authorities who would also send an Action Taken Report to those Panchayat Raj Institutions. The Panchayat Raj Institutions in turn should strive for systems improvement; promote

appropriate relations between the stakeholders and the Department and take steps to achieve convergence of schemes and activities so as to ensure proper and effective delivery of services. Any irregularities in regard to funds would attract action as prescribed in the Andhra Pradesh Gram Panchayat Act, 1994. In G.O.Ms. No. 42 dated the 21st November 2008 the DWDCW have issued instructions enforcing residence of Anganwadi Workers and Helpers in the same habitation where their centres are located, on pain of being replaced with local women; extending the working hours of the Anganwadi Workers and Helpers to 3.30 PM deeming the Anganwadi Centre as a crèche; penalizing unauthorized absence of the Anganwadi Workers with provision for termination for repeated absence; liability for being removed from service for incorrect and incomplete recording of data in the registers; provision for exhibiting a Board carrying all information relevant to the Anganwadi Centre updated at the end of every month; and making provision for the Anganwadi Worker issuing pre-school certificates to children below 6 years enrolled at the Anganwadi Centre and casting a responsibility on the Anganwadi Worker to ensure that children who cross their 5th year are enrolled at the Primary School. In G.O.Ms.No.2 dated the 7th January 2009, the DWDCW has also created an opportunity for considering requests for postings from Anganwadi Workers in their native villages or villages where their husbands live. In G.O.Ms.No.390 dated the 23rd December, 2008 the DWDCW, in consultation with the Information Technology (IT) department and in partnership with Care India, have introduced as a pilot project a Geographical Management and Monitoring Information System (GMIS) in 3 revenue sub divisions and in the District of Nizamabad. In this project GMIS software would be developed for the ICDS programme for monitoring the data relating to it to improve implementation support to the programme. In G.O.RT.No.379 dated the 27<sup>th</sup> December, 2008 the DWDCW has adopted a campaign mode till the end of the year 2009 to improve the quality of implementation of the ICDS scheme in regard to seven important concerns which need priority attention in the ICDS. These seven concerns would be taken up for action each in turn for a period of two months in this campaign, such as improving access to and strengthening of the Anganwadi Centres; care of pregnant women; post and neonatal care; care of children under 3 years; early childhood education; prevention and early detection of disability; and empowerment of Adolescent girls and awareness of social issues. This campaign will include house visits by the ICDS and the health staff, street plays, rallies and mobilization of groups

like the self-help groups, NGOs and the Panchayat Raj Institutions. The Department has secured the agreement of the UNICEF, CARE and Home Science Colleges to partner with the Department in this campaign. In G.O.RT.No.333 dated the 27<sup>th</sup> April 2009 the DWDCW has persuaded the Department of Higher Education to facilitate in all higher education institutions the distribution and reading out of handouts to students to disseminate key messages connected with these seven concerns of the ICDS programme to create awareness in the future generations in regard to these human resource development issues.

The Social Audit Team believes that all these efforts are commendable and if properly implemented would eliminate some of the concerns raised in this Social Audit Report.

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### **Training of ICDS Functionaries – A Critical Review**

**By Dr. Arun K Gopal<sup>1</sup>**

#### **1. INTRODUCTION**

Launched on 2<sup>nd</sup> October, 1975 in 33 community Development Blocks (19 Rural, 10 tribal and 4 Urban) spread all over the country the Integrated Child Development Services Scheme (ICDS) today represents not only one amongst eight flagship programmes of Government of India but also has come out as the world's largest initiative for holistic development of children between 0-6 years of age. The programme was initiated with the sole aim of breaking the vicious cycle of malnutrition, impaired development, morbidity and mortality in infants and children below the age of six years. The programme adopts a multi-sectoral approach and is implemented through a network of 'Anganwadi' centres at the community level. At these centres, Anganwadi Workers (AWWs) and their Helpers (AWHs) provide a package of six key services to 0-6 year old children and their mothers, viz., supplementary nutrition, immunization, health check-ups, referrals, health and nutrition education to adult women and non-formal pre-school education to the 3-6 years old children. Besides these, the programme also provides micro-nutrient supplementation, early care and stimulation for younger children under three years. These services are being provided in consonance with the objectives of laying a proper foundation for all-round development of children below six years of age as well as enhancing the capabilities of mothers so that they can look after the health, nutritional and educational needs of their children. With the gradual passage of time, a range of interventions have been weaved into the programme so as to take care of adolescent girls' nutrition, health, awareness and skill development, as well as income generation schemes for women. Other than this, there is convergence of other supportive services such as safe drinking water, environmental sanitation, non-formal education and adult education. Given the overall potential of the programme, the Eleventh Five-Year Plan of the Government of India has laid much emphasis on its 'universalisation with quality'.

The objectives of the ICDS scheme are to:

- i) improve the nutritional and health status of children in the age group of 0-6 years;
- ii) lay the foundation for proper psychological, physical and social development of the child;
- iii) reduce the incidence of mortality, morbidity, malnutrition and school drop-out;

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The views expressed in this paper are that of the author and not necessarily of the Institute or Government of India.

- iv) achieve effective coordination of policy and implementation amongst the various departments to promote child development; and
- v) enhance the capability of the mothers to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The scheme has been restructured with effect from April 1, 2009. So far ICDS was a centrally sponsored scheme with 100% financial assistance to all states/UTs for the key services except for the supplementary nutrition. According to the restructured scheme, funds for implementing the scheme would be shared between central and state governments/Union Territory Administration in the ratio of 90:10. The ratio would be maintained for provision of supplementary nutrition in all North-Eastern States as well whereas for other States/UTs, it would be in the ratio of 50:50.

The Scheme is currently covering almost all the Development Blocks in the country and is catering to 69.64 million children across the country who are below 6 years of age through 10,20,537 Anganwadi Centres in 6,108 operational ICDS projects (June 2008). In order to reach each and every vulnerable child and their mothers, particularly, those who are residing in remote and far-flung sparsely populated villages/hamlets, it is proposed during the Eleventh Five-Year Plan to open 'Mini-Anganwadis' in order to provide all the requisite services.

## **2. TRAINING OF FUNCTIONARIES- A CRUCIAL COMPONENT IN ICDS**

Training is the most crucial element in ICDS, since the achievement of programme goals depends upon the effectiveness of frontline workers in improved delivery of packages under ICDS. Recognizing this, from the inception of the ICDS scheme itself, a comprehensive training strategy was evolved by the then Department of Women and Child Development for different functionaries of ICDS, such as the Anganwadi Worker (AWW), Supervisor, Additional Child Development Project Officer (ACDPO) and Child Development Project Officer (CDPO). The Government of India has been allocating sufficient resources for training of ICDS functionaries in different Five Year Plans. In the Eleventh Five Year Plan, an amount of Rs. 500 crore has been allocated for training tasks only.

## **3. TRAINING INFRASTRUCTURE**

At the national level, National Institute of Public Cooperation and Child Development (NIPCCD) under aegis of Ministry of Women and Child Development, Government of India has been identified as an apex institution for ICDS training programme since the inception of the scheme. It has the overall responsibility of planning, coordination and monitoring of ICDS training programme and designing curricula and preparation of training contents and materials. The Institute is also the nodal institute for conducting regular training of CDPOs/ACDPOs and regular refresher courses for them from time to time. Apart from this, it is also engaged in conducting several skill development training programmes for Instructors of Middle Level Training Centres (MLTCs) and Anganwadi Workers Training Centres (AWTCs). Its other responsibilities include building up of training infrastructure and capabilities of the training centres

(MLTCs/AWTCs) across the country engaged in the training of Supervisors, Anganwadi Workers and Helpers; preparation and revision of modules, syllabi, manuals and guidebooks for various categories of ICDS functionaries; and development & procurement of training material including audio-visual aids.

At the State level training centres engaged in the training of Supervisors and Instructors of AWWs and Helpers are called as Middle Level Training Centres (MLTCs) whereas those engaged in the training of Anganwadi Workers and Helpers are known as Anganwadi Workers Training Centres (AWTCs). The MLTCs and AWTCs are engaged in different kinds of training on a regular basis such as Induction, Job/orientation and Refresher Training for Supervisors, AWWs and Helpers. Other than this, the MLTCs are also engaged in imparting Orientation Training to Instructors of AWTCs.

There are altogether 530 Training Centres including 500 AWTCs and 30 MLTCs (as on 31.12.2008) that are functioning all over the country. Most of these Training Centres are run by NGOs, Trusts and professional/technical institutions like Schools of Social Work and Colleges of Home Science. There are also a few States/UTs which are running their own AWTCs and MLTCs for imparting training to AWWs and Supervisors. The criteria for selecting these training institutions, by and large, is that they should have the required infrastructure for training, such as well-equipped class-rooms, hostel facilities, audio-visual aids/equipments, qualified and experienced staff. Besides, these organizations should have requisite knowledge and experience of running programmes related to development of women and children. These Training Centres thus play an important task in grooming different ICDS functionaries towards their roles and responsibilities so that they could work as 'agents of social change'. It would also be pertinent to mention that Government of Tamil Nadu has established a State Training Institute (STI) at the State level for the training of Trainers of MLTCs and CDPOs/ACDPOs.

To carry out training of ICDS functionaries, NIPCCD has its own organizational structure with its HQs at New Delhi and four Regional Centres located at Bangalore, Guwahati, Indore and Lucknow. At HQs there is a separate Training Division which has the overall responsibility of planning, organizing, coordinating, monitoring & training, building capabilities of other institutions involved in training of ICDS functionaries, revising and standardizing the syllabi for training of all categories of ICDS functionaries, preparation of training modules and procuring and distributing training materials. It has a multi disciplinary faculty drawn from subjects of Home Science, Early Childhood Education, Child Development, Psychology, Health, Nutrition, Social Work and the alike. The multidisciplinary faculty of NIPCCD is responsible for carrying out all the tasks relating to training of ICDS functionaries. Prior to 1999, the Middle Level Training Centers (MLTCs) were under the administrative & financial control of NIPCCD and therefore it was also responsible for quality monitoring of training of Supervisors. However, with the launch of Project UDISHA during 1998-99, training was decentralized and the MLTCs were brought under the control of respective State Governments.

The training staff at MLTCs and AWTCs include three full time instructors, one each in Child Development, Nutrition and Social Work/Extension Education and two/three

part time instructors in Health, Arts and Crafts and Music. While the full time Instructors are required to have Masters Degree in the concerned subject, the part time instructors in health may have MBBS degree or should be a trained public health nurse or lady health visitor with knowledge of health component in ICDS programme. Part time Instructors in Arts and Crafts and Music may be those with a degree or diploma or requisite skills and experience. A MLTC is headed by a part time Coordinator however, in case of AWTC the senior most regular Instructor is designated as Principal. Besides AWTCs and MLTCs are also provided with a Accounts Clerk/Assistant Accountant, a Peon cum Chowkidar and a Typist and part time posts of Lady Warden and Cook. However these two posts have been made full time recently under restructured scheme. All staff members working in these MLTCs and AWTCs are paid consolidated honoraria which have also been revised recently<sup>2</sup>.

In case of MLTCs and AWTCs both, the regular training and other administrative staff members are required to be present in the training centre throughout the working hours and are permitted to take casual/earned leave as per the rules of the parent organization. The gap between two training courses is not counted as vacations for these regular ICDS training staff members. During this period, they are required to evaluate the previous courses, identify the gaps and to initiate the actions to rectify the shortcomings. They are also required to update their class notes, prepare/translate reference material for distribution among the trainees, prepare new training aids and improve upon the existing one, if necessary. The training staff is also required to maintain a diary of classes taken, aids prepared and used and the same is required to be reviewed by Principal and/or by coordinator of the training institution. The performance of visiting/part time instructors is also required to be reviewed at the conclusion of the course and only those who are found useful and effective are required to be invited for the next course.

#### **4. PHYSICAL FACILITIES AT TRAINING CENTRES**

Government of India has laid down certain minimum facilities necessary for running a MLTC/AWTC to ensure that quality of training is maintained. These include hostel accommodation, class room facilities, bathrooms and toilets, library, recreation facilities, office and staff rooms etc. It has also laid down the requirements of minimum furniture, audio visual aids for training, training materials etc.

#### **5. FUNDING OF TRAINING CENTERS**

While NIPCCD being an autonomous organization of the MWCD draws funds for training directly from the Ministry, however, the funds to the MLTCs and AWTCs are given by the State Governments. The funds to the states are released on the basis of a State Training Action Plan (STRAP) delineating details of all types of training programmes for ICDS functionaries that are to be taken up during the year and the budgetary requirements. It is only after the approval of STRAPs by the MWCD that funds are released to the States/UTs. The funds for the training are released according to

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<sup>2</sup> Guidelines on revised financial norms, MWCD, April 2009 ([www.wcd.nic.in/childdevelopment](http://www.wcd.nic.in/childdevelopment))

the financial norms fixed by the Government of India. These financial norms have been revised upwardly very recently as mentioned earlier, after a gap of about 10 years and have fulfilled a long pending requirement of training which was adversely affecting its quality.

## 6. TRAINING CURRICULA

Initially when ICDS scheme was launched, NIPCCD developed training curricula for following categories of the functionaries of ICDS.

- (i) Job Training Course for Child Development/Additional Child Development Project Officer (Two months - 44 working days)
- (ii) Job Training Course for Supervisors (Three months - 64 working days)
- (iii) Job Training Course for Anganwadi Workers (Four months - 72 working days)
- (iv) Orientation Training for Helpers (Eight working days)
- (v) Refresher Training of CDPOs/ACDPOs (Eight working days)
- (vi) Refresher Training Course for Supervisors (One week - six working days)
- (vii) Refresher Training Course for Anganwadi Workers (One week - six working days)
- (viii) Refresher Training for Helpers (One week - six working days)
- (ix) Orientation Training of Instructors of MLTCs and AWTCs (Three weeks - 18 working days)
- (x) Refresher Training Course for Instructors of MLTCs and State Training Institutes (Eight working days)
- (xi) Refresher Training of Instructors of AWTCs (Eight working days)

The curricula were developed keeping in view the job responsibilities of various functionaries, their educational background, the capacity to comprehend various concepts and the skills required to carryout various tasks relating to delivery of services. The content of Job Training course for various categories of ICDS functionaries include knowledge and skill building on subjects like Early Childhood Care & Development, Nutritional Assessment and Counselling, Management of Childhood illness and Early detection of Disabilities, Life cycle approach, Growth monitoring in children, Child survival & Development, planning & managerial skills for implementation of the scheme, supervision & monitoring of ICDS programme, leadership, motivation & Team building, improved parenting skills, community participation and mobilization of community resources. Refresher training courses for various functionaries emphasize on upgrading the knowledge & skills of the participants on various new developments that take place in the programme from time to time.

Field Work Practice has been one of the strongest components of the training curricula wherein strong emphasis is given on development of skills required by various functionaries in delivery of various services of the programme. However, in 2002 the duration of training of various categories of functionaries was reduced substantially. Job Training of Supervisors and AWWs was reduced to 45 working days from 69 and 72 days respectively. However Refresher Training for AWWs was enhanced from 6 to 12 working days possibly to cover up the reduction in the job training. A new training

programme called Induction Training of AWWs of 12 days duration was introduced during this period. This was basically introduced to cover the huge number of freshly recruited AWWs in view of the expansion of the scheme. The duration of almost all training programmes was further reduced in 2005, the job training courses being the most affected. Job training courses for all the three crucial functionaries namely CDPO, Supervisor and the AWW were cut down to 26 working days from the existing 45 days.

## **7. Project UDISHA**

During 1998-99, the entire ICDS Training programme was brought under a five-year project called project Udisha (in Sanskrit it means 'new dawn') as part of the World Bank assisted ICDS-III/WCD Project (1999-2006). An allocation of Rs.600 crore was originally made under the project. It was based on the premise that there was a need to mould ICDS functionaries as *agents of social and behavioral change* to reorient and revitalize the ICDS programme to make it a dynamic and responsive intervention programme for human resource development. The inputs for training were aimed at improving quality of the existing ICDS training by strengthening and establishing training infrastructure at national, state and district levels and by developing training materials. UDISHA had an institutional development plan for NIPCCD. Additional AWTCs and MLTCs were sanctioned to State Governments and UTs depending upon their training needs for the next five years. Whereas the original pattern of conducting three months JTC for AWWs at AWTCs under the traditional method was continued, the State Governments were also given the second option of organizing sandwich Training programme (evolved in 1995-96) for Job Training of Anganwadi Workers (phase-I at AWTC, Phase-II in the field and Phase-III by training teams). A third option to provide Job Training to Anganwadi workers through training teams constituted by the State Governments/UTs was also given to the States. The financial norms for conducting various training programmes were also revised upwardly. Up-gradation of training facilities was also a notable feature of the project UDISHA. An additional MLTC was given to the States (except the States covered under the World Bank assisted ICDS-II, ICDS-III and ICDS-APER projects ) to function as State Resource Units (SRUs) for monitoring of the project UDISHA. Each of the existing MLTCs and AWTCs were given an additional lumpsum grant of Rs. 50,000/- for up gradation, replenishment and creation of basic facilities. State Governments were also given grant-in-aid for developing printing and distribution of all training and IEC materials and provision of kits for Anganwadi Workers on early learning. The States were also encouraged to develop training materials in regional languages. To further strengthen the training, a National level training task force was set up in the Ministry of Women and Child Development. Similarly, State Governments were also asked to set up state training task forces. The basic function of these task forces was to integrate and coordinate all aspects of ICDS training at all levels and to recommend changes in the curriculum strategies and methodologies. While the NIPCCD had the main responsibility of framing the training curricula of various levels of functionaries, however, the states were given the flexibility to include 25% of the contents based on local problems and needs. Each state was also free to develop innovative training strategies and curriculum in response to areas specific needs.

It is worth mentioning that a mammoth total of about 928,000 ICDS functionaries , out of which 366,000 AWWs and another 759,000 functionaries were imparted the job and refresher training respectively under the project UDISHA through a countrywide network of about 600 AWTCs, 40 MLTCs and the NIPCCD and its Regional Centres (MWCD, 2006). After completion of Project Udisha on 31 March 2006, ICDS Training programme is being continued with domestic resources.

## **8. MONITORING & EVALUATION OF ICDS TRAINING PROGRAMME**

At the Central level a separate training unit within the Ministry of Women and Child Development headed by a Director level officer is responsible for approval of the state training annual action plans (STRAPs), release of grants to the states, and also monitoring, supervision and evaluation of the training programme. Regular monitoring of the training programme is done through the following:

- (i) Physical and financial progress are captured through Quarterly Progress Reports (QPRs) in a standardized format that are submitted by States/UTs to the Ministry at the end of every quarter.
- (ii) A detailed analysis of the QPR vis-à-vis the targets fixed in the STRAPs is carried out and based on the same, quarterly review meetings are organized with the State Directors and nodal officers to discuss the shortfalls and implementation of the STRAPs.
- (iii) Necessary feedback and guidelines are issued to States after each of the review meetings.

At the state level, monitoring and supervision of the training programmes is generally taken through the following:

- (i) Monthly/quarterly review meetings with Training Centres
- (ii) Field visits to AWTCs/MLTCs by nodal officer or District Programme Officers DPOs/CDPOs and
- (iii) Annual meeting of State Training Task Force (STTF) for approval of STRAP and review of past performance and chalking out future actions.

However, in most of the states, there is inadequate focus on the monitoring of the training programmes. Meetings of the STTFs are not held regularly and also monitoring and supervision of the training centres is not undertaken in a planned manner.

Besides above monitoring mechanism, NIPCCD also from the past two years have been undertaking the monitoring of AWTCs/MLTCs by regular visits of its faculty members to various training centres all over the country. From January 2007 to December 2008 a total of 145 training centres (133 AWTCs and 12 MLTCs) were monitoring by the faculty of NIPCCD with the help of a structured Performa. The feedback of such visits was shared on regular basis with the State Governments. Besides this at the instance of Ministry of WCD, a Central Monitoring Unit (CMU) has been established at NIPCCD in 2008 on pilot basis to undertake regular monitoring and supervision of the ICDS programme including training through 45 selected Institutions in various states.

The Ministry of WCD undertakes periodic evaluation of the ICDS training programme through external research agencies to assess the outcomes and other aspects of the training. During 2007-08, an impact evaluation of the erstwhile Project Udisha was undertaken through an external research agency. Findings of this study are discussed in the subsequent section. Another evaluation of the functioning of AWTCs & MLTCs all over India was undertaken in 2007-08. The study covered 125 AWTCs and 17 MLTCs spread over the country.

## 9. FINDINGS OF THE EVALUATION OF ICDS TRAINING PROGRAMME

A Government of India sponsored study titled *Impact Evaluation of Project Udisha (the National Training Component of World Bank assisted ICDS-III Project)* was conducted by the Indian Institute of Development Management, Bhopal during 2007-08 with an overall three fold objectives of assessing the training needs and quality of training being imparted to AWWs under ICDS and investigating the impact of training in development of knowledge and skills and delivery of services. The study covered 90 ICDS projects, 41 AWTCs and 13 MLTCs located in 52 districts across 15 states of Rajasthan, Haryana, Himachal Pradesh, Madhya Pradesh, Uttar Pradesh, Bihar, Orissa, West Bengal, Assam, Meghalaya, Tamil Nadu, Kerala, Andhra Pradesh, Gujarat and Maharashtra, covering each region of the country. The study found that growth monitoring was one of the areas where a large proportion of functionaries had inadequate knowledge. Correct steps of growth monitoring were known to only 21%, 41% and 39% of the AWWs, Supervisors and CDPOs respectively. Knowledge about immunization was found to be low. Only 39% of the AWWs, 50% of the Supervisors and 58% the CDPOs knew about DPT/Polio booster and 48%, 72% and 75% respectively were aware of measles immunization. Knowledge among all categories of ICDS functionaries about management of children with diarrhoea/ARI was in general adequate. Over three fourths of ICDS functionaries were aware that ORS should be given to children suffering from diarrhoea. But, the need to continue breastfeeding during illness was poorly understood.

More than four fifths of the AWWs reported that the training had improved their job performance. The ICDS beneficiaries (mothers and adolescent girls) in the villages corroborated this fact by stating that of late, performance of their AWCs had shown improvement. After undergoing the training, improvement in job performance was found to be not uniform across all components of ICDS services. Improvement in carrying out growth monitoring, health and nutrition education, and eliciting community participation was reported by 47%, 50% and 29% AWWs respectively as against 61% for record maintenance and pre-school education activities. Majority (over three fourths) of the CDPOs facilitated or conducted monthly review meetings, analyzed the MPR data and checked food stocks as part of their supervisory function. But support and guidance to the AWWs and home visits to contact the beneficiaries got lower priority. The impact of the training in areas like monitoring and supervision, community participation and inter-departmental coordination was not significant. The study revealed that only 81% of the Training Instructors knew about exclusive breast

feeding up to six months, 51% knew about correct steps of growth monitoring and only 53% were aware about the importance of institutional deliveries.

The manifold recommendations made in the study included of undertaking systematic TNA, redesigning of curriculum inputs with more emphasis on competency based training and considering the rationalization of AWTCs in all the states/UTs.

## 10. CRITICAL REVIEW

In the previous sections, an attempt has been made to describe the system which is in place for training of various ICDS functionaries. However it is pertinent to analyze and critically look at the gaps and lacunae in the existing system so that necessary corrective actions could be taken to improve this most critical component on which the success of the ICDS programme highly depends.

*(i) Ad-hocism in Training:* One of the most important factors that have adversely affected the quality of training in ICDS has been the continued ad-hocism in the training. It is now more than 35 years that ICDS was launched on experimental basis. However with every successive five year plan the programme has expanded to the extent that now not only it is universalized but Hon'ble Supreme Court of India has also directed that GOI to extend it each and every habitation to benefit the children between 0-6 years. However, unfortunately the training programmes have been continued on ad-hoc basis except for the State of Tamil Nadu which has established its own training centre at the state level. All other States & UTs have continued to depend upon AWTCs & MLTCs run by NGOs/Trusts and some of the professional institutions and in very few cases Government Institutions. All these institutions are run on year-to-year basis and always are uncertain about their continuance. This has not only led to high turn over of the Instructors but in many cases to extreme frustration in those who have continued to work for long years in these training centres. The salary (honoraria) structures of the staff of the training centres have remained poor except for a recent upward revision after about 10 years of gap. The grants to these training centres are linked to the amount of training programmes conducted by them in a year, therefore there have been instances where the instructors and other staff members have not been paid their honoraria in the interim period when there have been no training programmes. In many states the training centres are closed and opened on the whims and fancies of certain persons at the State level. This leads to unavoidable wastage of the trained manpower who gained not only sufficient experiences but deep insights into the training process. A programme like ICDS which has become the world's largest programme of child survival and development, needs to pay attention to this aspect and consider at least in a phased manner to establish and set up training centres with adequate infrastructural facilities on permanent basis. This will not only attract better quality Instructors but also go a long way in improving the quality of training imparted.

*(ii) Selection of Training Institutions:* The responsibility of identification and selection of training centres (both AWTCs and MLTCs) lies with the States/UTs, based on the guidelines laid down by the MWCD. It is essential that the selection of training centres is

done with utmost care, in order to ensure that good quality training is imparted to the functionaries. Only those institutions having adequate infrastructure as well as expertise of training in the field of women and child development are selected. However, experience and findings from many studies show that most of the Training Centres in the country do not have all essential requirements as laid down in the guidelines. Many of the training centres have congested class rooms or one big training hall that is used as a class room in the morning and in the evening for sleeping purposes. This gives very different pictures of the training centres because the belongings of trainees are scattered all over the place. The ambience of the classroom is not conducive at all for the training purposes. In this kind of atmosphere the trainees too adopt a casual approach. Many of the centres lack basic training equipments like white board, OHP, LCD projector etc. In many cases sufficient number of bathrooms and toilets are not available. Library facilities are also lacking in many of the training centres. Therefore, this aspect does need thorough consideration and only such institutions, which have infrastructure facilities as per the guidelines, should be considered for the training.

It has also been seen that majority of the training centres do not have the required number of instructors or instructors with prescribed qualifications because they are appointed on contract basis and there is high turn over because of this.

*(iii) Management Structure at State level:* For successful implementation of any social sector programme, a strong management structure at critical level of programme implementation is desired. However, as per the existing staffing pattern under ICDS scheme, there is no provision for separate ICDS training cell within the State Directorate of WCD/Social Welfare at the State/UT level and no specific manpower is approved to plan, organize and manage the training programmes. Also, despite having a separate budgetary allocation for training under ICDS, this budget does not provide for any administrative cost for implementation of training programme at the state level. Allocations made under the programme are all meant for training programmes that are all transferred to the training centres. One official in the rank of Assistant Director/Deputy Director from within the ICDS general is designated as the State nodal officer for ICDS training. However, the nodal officer, in general, is assigned with many other activities, leaving the training related tasks mostly limited to deputation of trainees and release of grants to the training centres. Also, in the absence of any specific orientation training on various aspects of the ICDS training programme, especially its quality issues, the nodal officers are often clueless about those critical areas which need to be monitored in order to ensure quality training.

*(iv) Planning & Organization of Training Programmes:* One of the crucial factors that determine the quality of training is proper planning and organization of the programmes. For planning programmes, there has to be a very good coordination between the State Government Nodal Department and various training centres. The first step in this regard is formulation of the STRAP by the State/UT Government in consultation with the training centres. This generally does not happen. There are delays reported or the STRAPs being prepared without consultation of training centres. Training Centres remain in dark as to when they will be required to start a particular

training course. In many states, AWWs/AWHs are generally deputed to the training centres on a very short notice, thus leaving the centres with very little time for pre-training preparation. Many times it has been observed the same trainees who have already undergone training the same course have been deputed again. All this leads to poor organization of the programmes. It has also been seen that many of the centres do not even have recent copies of prescribed syllabi, which leads to organization of training on the basis of old syllabi.

This kind of situation is due to the fact that there is no training cell with adequate staff at the State/UT level, as discussed in the previous paragraph. There is no proper database on the status of training backlogs, especially for the functionaries who become due for refresher training once in every two years. Most of the states do not maintain proper records of functionaries who have been trained for job courses, for refresher and other kinds of training. This is more true of the bigger states where there are large numbers of projects. There is hardly any staff that can monitor the training and its quality. This situation needs very serious consideration if the quality of the training has to be improved. Not only the role of State Training Task Forces (STTFs) needs to be redefined but also they need to be rejuvenated. Provision for establishment of training cell in each of the State/UT with adequate staff needs to be made in the training component of the scheme. This cell should be exclusively responsible for maintenance of database of the training, liaising with the training centres, developing a training calendar sufficiently in advance and finally monitoring the training in the State/UT. Unless and until a training cell is established in each and every State/UT, the value of money spent on actual training would always be suspect.

*(v) Revision of Syllabi and Contents:* As mentioned earlier in this paper, duration of various training programmes has been increased or decreased mostly in an ad hoc manner sometimes purely on administrative grounds, without any systematic and scientific evaluation. This has led to serious gaps in development of knowledge and skills in the functionaries. A case in the point is reduction of duration of Job Training of CDPOs, Supervisors and Anganwadi Workers to 26 days. Firstly, since the qualifications and levels of knowledge of all the three functionaries is very heterogeneous, therefore, they need different durations training for proper understanding of various concepts as well as skills to manage the programme whereas CDPOs/Supervisors may need less duration, Anganwadi workers definitely need a training of much longer duration. The substantial decrease in training duration for Job Training Courses has affected the hands-on training component that is now almost nil. Secondly, contents of the training need to be reviewed at regular intervals to ensure that all latest development on women and child health and nutrition issues on which the functionaries need knowledge and skills are adequately addressed to in the syllabi. There is also a need to make the training syllabus more oriented towards developing the functionaries into agents of social change. Therefore, there is a need to devise a formal mechanism where the contents and duration of various training programmes is reviewed on regular basis and in consultation with experts and various State Governments.

*(vi) Funding of Training:* Timely flow of funds from States to Training Centres has remained a major problem. A number of evaluation studies as well as formal and informal feedback from various training centres has revealed that there are recurrent delays in release of grants to the training centres by most of the States. There are cases where the training centres do not receive grants as long as nine months but are still expected to conduct training programmes. This only affects the quality of training adversely.

Revision of financial norms for training at regular intervals is also an absolute necessity to maintain quality in the training. Though recently the Government of India has revised the financial norms, however, it was only after almost a decade when the training centres had almost felt helpless to conduct training, that the norms were revised. It is extremely important to link the financial norms to the price index wherein automatically with the rise in the prices, the norms are enhanced.

*(vii) Monitoring and Evaluation:* Though some kind of monitoring system does exist at the Central and State levels, however its efficacy is suspect. At the Central level the meeting of National Task Force on Training does not take place regularly. Similarly at the State level also there is hardly any monitoring of the training. Even if the State Government Officials visit the training centres, these are more of formalities than with the objective of making serious interventions. There are no feedback mechanisms as well as follow up of the monitoring. The responsibility of monitoring and evaluation of training at central level may be delegated to NIPCCD with suitable strengthening of its Monitoring and Evaluation Division, which has become almost non-functional due to down sizing policy of the Government. Eleventh Five Year Plan has allocated an amount of Rs. 10 crore for monitoring and evaluation activities under the ICDS training programme. However, this amount is required to be sufficiently enhanced to develop strong and adequate monitoring system at the Central and State levels to make the training of ICDS functionaries more result and outcome-oriented.

Finally to quote from the report of the Working Group on Development of Children in the Eleventh Five Year Plan *“Training functions should be planned, implemented and monitored at state levels by a competent technical body (State level Resource Centre – SRC); this body must provide dynamic guidelines for determining training content from time to time, which should be fully aligned to carefully determined program priorities”*. In case we wish to see tangible improvements in the delivery of services of ICDS, there is an urgent need to initiate discussion and take urgent steps to revamp the entire training of ICDS functionaries

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### ***Early Childhood Education By Smt. Lakshmi Chari***

1. In the context of human resource development Early Childhood Education (ECE) is a critical component. The quality and competency of future population is based on the development of children who are born today. The first few years of life are particularly important because vital development occurs during this period in all domains. Many children below the age of 6 years in developing countries are exposed to multiple risks including poverty, malnutrition, poor health and unstimulating home environments which detrimentally affect their cognitive, motor, social and emotional development. Brain development is modified by the quality of the environment.
2. Early Childhood Education is a significant input to compensate for early environmental deprivation at home by providing a stimulating environment. Early cognitive, social, and emotional developments are strong determinants of school progress in developed countries. Hence ensuring at least 2 years of quality Early Childhood Education programme prior to formal school entry becomes essential especially to the most vulnerable and disadvantaged children. Interventions at this age can have sustained cognitive and school achievement benefits. The launching of the Integrated Child Development Services (ICDS) in 1975 for overall development of children with a focus on preschool education for 3 to 6 years age group therefore is a major breakthrough in the human response development efforts of the country.
3. **Why ECE:**

From a learning point of view, the first 6 to 8 years of child life are recognized to be the most critical years for life long development. It is therefore crucial as children receive the stimulation they need to promote positive learning and healthy brain development.

  - Every Child deserves a good start in life.
  - The child's early experiences create the base for all subsequent learning.
  - Strong early childhood foundations can help

- ✓ Easier transition to primary grades
- ✓ Better completion rates
- ✓ Reduced poverty
- ✓ Increased social equity
- ✓ High economic returns

#### 4. Hence the need for effective ECE programmes

##### **Challenge:**

Growing body of scientific knowledge has provided exciting opportunities to care for and nurture children. By the age of 3 brains of children are 2.5 times more active than brains of adults; we “use it or lose it.”

The challenge is to provide an enabling environment which –

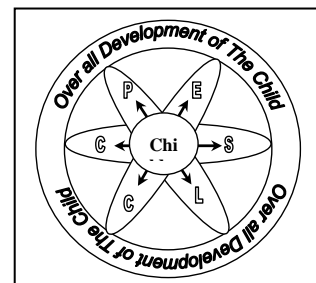
- ✓ ensures best possible start to life for all children
- ✓ ensures optimal early development and learning
- ✓ creates the base for children to succeed in education systems.

Only quality ECCE has a strong and lasting impact .Poor quality may have little or no impact and hence waste of resources could occur.

#### 5. What is a good ECE programme?

6. Any ECE programme should include activities and experiences related to all the developmental areas.

- ✘ Physical and motor
- ✘ Emotional
- ✘ Social
- ✘ Language
- ✘ Cognitive or Intellectual
- ✘ Creative expression and aesthetic appreciation.



7. There is a fund of knowledge emerging from a synthesis of principles and ideologies of some of the prominent forerunners of ECE as well as developmental psychologists and the latest trends in Neuroscience on how the brain learns should be fruitfully utilized for any ECE Programme.

8. The effectiveness of a preschool programme depends on the extent it (is) and covers the

Following:

- Developmentally appropriate, designed to address the needs of the whole child - physical, motor, socio-emotional, cognitive and language, correlates activities for the holistic development of the child.
- A planned programme yet flexible to suit individual needs.
- Balanced and process oriented approach.
- Contribution to overall development of a child in a holistic manner
- Child centered programme catering to individual needs, interests and abilities
- Provides learning experiences to the child in a concrete form through play and activity approach.
- Lays foundation for the development of reading, writing, and number work
- Provides first hand experiences to children that help in the development of skills related to the process of learning
- Helps in developing good, healthy habits and building basic skills and encourages independence
- Designed to be used in a variety of settings with a variety of children.
- Facilitates continuous evaluation (formative and summative) of children and programmes.
- A preparatory programme for primary grades.

**9. Key components of an effective ECE programme:**

1. Understanding children
2. Play as a medium of learning
3. Establishing flexible learning environments
4. Building partnerships
5. Exploring content

**10. Status of ECE in Andhra Pradesh:**

11. Early Childhood Education popularly known as Preschool Education is offered in the state of Andhra Pradesh in a wide variety of settings and is diverse in nature. While a small section of children enjoy the privilege of enriching programmes, many children are provided a diluted primary programme - a backward extension of primary classes.

It needs to be always recognized that an effective preschool programme is a highly demanding one. While the need for some form of child care services is recognized relatively well, the general understanding of ECE in the context of developmental support is relatively weak. Where the understanding has been adequate the route to the objectives has been ridden with obstacles in the services delivery system. Hence despite 3 decades of this intervention it is yet to reach the shore.

12. An over view of existing programmes and services related to the care of the young child in the state reflects the need for a more holistic and comprehensive approach in addressing the needs of the young child.
13. The variety of programmes that is available for preschool children in the state reflects the variety of interpretations of young children's needs and ways they can be fulfilled. In the non Government sector respective organizational imperatives seem to shape the programmatic feature and component of the child care services. While some organizations are content to provide custodial day care services, some preschool centres attached to primary schools emphasize only teaching and learning to the exclusion of the child's other developmental needs. The corporate sector has further confused the situation.
14. Initially, preschool programmes had their roots in developmental theories and were focusing on social skills, language and self esteem through the use of play and informal activities. More recently programmes have emerged with different banners. The aspiring parents often send the very young children to such schools in the hope that such participation might ensure their success in the later educational programmes. On account of this, preschools are mostly dragged down primary schools to which these children seek entry with purely academic programmes. The increase in load of facts focusing on memory has now become a matter of concern not only for child development experts but even to the medical practitioners.
15. When young children are placed in highly structured formal programmes before they are developmentally ready to meet the programme demands there may be negative effects of both short and long term .The short term negative effects are related to stress a child experiences in such learning situations and the long term effects may

negatively influence motivation and creativity. We are gambling on these potential negative effects with little guarantee of achieving any significant long lasting positive benefits. Hence the need to scan our preschool programmes.

16. In all these programmes we notice variations in curricular, physical and organizational infrastructure, financial allocations, staff quality and target beneficiary. These diversities are evident not only between schemes but within the same programme from one region to another. A recurrent recommendation has been that there should be some system of licensing or accreditation of preschool / ECCE programmes.

17. The prevailing scenario of preschool programme can be summarized as follows:

- The few initiatives that have gone in are not yielding satisfactory results.
- The increases in outlays are not helping in realizing the outcomes expected from them.
- Critical community groups are still not aware of the significance of the programme.
- Gaps in training and hence in-effective implementation and under utilization of materials remain.
- Lack of supportive monitoring.
- Minimal community participation.

#### **18. Challenges:**

The effectiveness of any ECE / preschool programme depends on the capacity levels of different stake holders.

##### **a) Strengthening capacities of personnel**

- Teachers , Child Care workers (AWWs, BWWs, Crèche/Day Care Workers)
- Supervisory Staff
- Trainers and Trainer of Trainers
- Curriculum framers
- Material Manufacturers
- Monitoring and regulatory personnel

##### **b) Policy makers and policy implementers.**

##### **c) Community.**

#### **19. Personnel Preparation**

The following are some of the issues related to quality work force at the ECE level.

Lack of trained personnel in ECCD either in terms of adequate numbers or in terms of appropriate quality to meet the minimum standards.

- Private sector, which is a major employer, is not under any regulation. The teacher preferences of this sector range from highly, but inappropriately, qualified persons to totally untrained teachers, who have no concept of ECCD. When employers are not interested in hiring specifically trained workers, potential workers have no incentive in getting trained. This in turn is affecting the demand for ECCD training resulting in closure of such training institutions.
- Nursery training institutions are flourishing in the private sector while government supported programmes are gradually closing down due to diminishing employment prospects for those trainees.
- Most of the projects and private sector opt for in-service training, whose curriculum and duration varies from 3 months to 3 days.
- A recent trend is mushrooming of training institutions.

Training which is very crucial is hardly emphasized .Existing training programmes vary enormously in terms of duration of training, methodology and exposure to theory and practice, among others. Hence the following concerns need addressing:

- ECE training needs urgent regulation and monitoring
- Professional inputs are needed.
- Lack of good role models
- Training institutions are unable to demonstrate or place trainees in model ECCD programmes in the field. Most of the teacher training programmes give theoretical exposure or practice in unrelated situations or at best in a simulated situation. Hence every training institute should adopt 20 to 25 model ECCD centres.
- Teacher Education has not gone deep into ECE. In most cases teacher educators have know-how but not do-how as far as ECCD pedagogy and programmes are concerned.
- Resource teams with good practicing teachers / workers need to be created to strengthen the practical aspects.
- Distance and continuous education is most essential in terms of capacity building.
- Preparation of modules to upgrade skills and knowledge of teachers/caregivers.

- The need for teachers to be able to take refresher courses after completing five years of service.
- Good training depends on practical exposure during training period. Good practical exposure is possible when good training centres are available. A good centre needs to follow a good programme.
- Training along with institution of regulation and control will emerge as the most critical element that can impact on the quality of an ECE programme.

## **20 Materials manufacturers:**

It is not merely the personnel required in ECE but also facilities and the materials needed do not get any serious attention. As a result the markets (in the context of globalization) are getting flooded with materials which are useful, not so useful and never useful. It is the luck of the child which decides what she/he gets.

## **21. Convergence**

There is a need to improve coordination of various child-focused services at all levels especially at the local level where implementation is crucial. This is particularly important to achieve convergence between health, education and the welfare sectors.

## **22. Community**

One of the weakest links in the preschool component of the ICDS programme is community participation in the programme. It is not just physical resources that a community can share but far more valuable and important is the interaction between the Anganwadi worker and the community and the relationship that gets built. Often the coordination communication between AWW and the community does not happen. If the community is behind the AWW the problem of supervision is taken care. It is necessary that the community is made to understand the relevance of ECE / Preschool programme and their role in making it effective. Just as we have campaigns in the health sector there should be strong campaigns for preschool / ECE programmes also. Parents must be made to understand the key elements of a good preschool programme and importance of such a programme in helping their children do better in life. Ultimately the community perspective must be such that the Anganwadi centre becomes part of the community as children are the assets of the community.

### 23. Ensuring quality for all.

Provision of quality programmes requires concerted efforts on many fronts.

To sum up initiatives on the following are essential:

- 1) **Curriculum** for developmentally appropriate stimulation and learning programme.
- 2) **Developing norms and standards** – indicators or standards will have to be set in relation to the following items:
  - a) appropriate curriculum
  - b) appropriately trained teachers
  - c) infrastructure supportive of children's needs , low cost and culture specific
  - d) supervision and monitoring, focussing on maintenance of quality.
- 3) **Regulation** – it is imperative that the government takes up the responsibility of controlling the mushrooming of poor quality of ECE programmes and ECE training through appropriate regulatory processes.
- 4) **Provision of work force** - as the staff associated with the ECE programmes finally determine the quality of the programme, it is essential, as already discussed, to provide quality work force at all levels.
- 5) **advocacy** – to sensitize the public at every level, from parents to policy level, an extensive and sustained campaign for advocacy incorporating different strategies is needed.

### 24. Conclusion:

Studies in the Indian context show that developmentally suitable programmes can make a positive difference to the lives of children. Hence only quality ECE would have a strong and lasting impact. Poor quality ECE would have the wrong impact or no impact. Our generation is the first to be equipped with scientific knowledge on child's development and let us not miss this **WINDOW of OPPORTUNITY** available to us.

***Convergence of the Efforts of the ICDS Personnel and the Personnel of the Department of Medical and Health By Dr. N Bala Ramaiah***

District Medical and Health Officer, Anantapur, Andhra Pradesh

1. As a universal truth Health is wealth and healthy individuals build a healthy nation. As “Health” is a state of complete physical, mental, social and spiritual well being and not merely the absence of disease or infirmity, the Government aims to care of the health of the people since from the womb of the mother.
2. In pursuance of the National Policy for Children the Government of India initiated a scheme known as Integrate Child Development Services Scheme in 1975. The aim of the Government was to deliver a package of services viz. Supplementary Nutrition; Immunization; Health Checkup and Referral Services; Health and Nutrition Education; and non-formal Pre-School Education in an integrated manner to preschool children, expectant and nursing mothers and women in the age group of 15-44 Years. Down the line, another important component, namely, the empowerment of the Adolescent girls was added to these services in the ICDS programme. Of these services, antenatal care, post natal care, immunization, nutrition and health education, health care of Adolescent girls including the right age at marriage, are the items common to the Health Department also, which provides a package of these services under the National Rural Health Mission (NRHM).

## COMMON GOALS FOR THE DEPARTMENTS OF HEALTH AND WOMEN DEVELOPMENT AND CHILD WELFARE (DWDCW)

### I.C.D.S.

### HEALTH

- |    |                  |                  |
|----|------------------|------------------|
| 1. | Reduction of MMR | Reduction of MMR |
| 2. | Reduction of IMR | Reduction of IMR |
3. As the services and goals are common the need for convergence of the efforts of the DWDCW and Health Department arises by which integrated and wholesome services can be delivered to the public.

#### 4. **Nutrition:**

The provision of nutrition to the mothers and children in the programme must be supplementary but not a substitute. A sound body will have sound mind and good supplementary nutrition to the pregnant mother and children leads to the build up of a healthy nation. Especially, pregnant women need good nutrition for the healthy development of the foetus and later for healthy babies to grow into healthy future citizens of the country.

#### 5. **Benefits of Nutrition to Antenatal Mothers & Children**

- Prevention of low birth weight of babies
- Growth and development of brain and nerve tissues will be completed by the end of the first 2 years of age, which is the crucial period for the development of intelligence.
- Normal birth weight babies will have adequate immunity to resist diseases.
- Prevention of high risk during delivery.
- Ultimate reduction of MMR and IMR

#### 6. **Certain Nutritional Supplements and their importance**

**Iron and Folic Acid** are both essential for the improvement of Hemoglobin in the mother and the child, which prevents low birth weight and anemia in the mother, which is the major cause for maternal deaths. Most people tend to concentrate on the importance of iron only by ignoring folic acid. They assume that mere Iron will prevent anemia but it is not so. Consumption of folic acid by antenatal mothers is also

very essential because Folic Acid is necessary for the development of nerve tissue and brain in the baby, fundamental to develop the intelligence of the future citizens of the country. It has been observed that the deficiency of Folic acid leads to babies being born with neural tube defects.

7. The components of Hemoglobin are haem + globin. The haem part is taken care of by Iron supplements but the globin part is to be supplemented by the proteins as also co-factors like B1, B6, B12 vitamins, which are essential for formation of Hemoglobin.

**8. Immunization:**

9. By providing immunization to the mother and children we prevent 7 vaccine preventable deaths which contribute to 33% of IMR. The required Immunization schedule is given below:

Age of the Child	Name of the Vaccine	No. of Doses
By Birth	Oral Polio	0 Dose
By Birth	B.C.G.	1 Dose
1 ½ Month	D.P.T., Hepatitis-B, Oral Polio	First Dose
2 ½ Months	D.P.T., Hepatitis-B, Oral Polio	Second Dose
3 ½ months	D.P.T., Hepatitis-B, Oral Polio	Third Dose
9 + Months	Measles	Single Dose
9 + Months	Vitamin – A	First Dose
18 to 24 Months	D.P.T. and Polio	Booster Dose
Pregnant Mothers	3 to 5 Months of Pregnancy	First Dose of T.T. Injection
Pregnant Mothers	After 1 Month of First Dose	Second Dose of T.T. Injection

**10. Empowerment of Adolescent Girls:**

The DWDCW is providing services and education on the empowerment of the Adolescent girls in the ICDS programme. The Health Department insists in this context upon personal, menstrual hygiene of the adolescent girls; right age of marriage; nutritional education; and health of the reproductive organs, in the context of her being the future mother. If the mother is healthy, the foetus will be healthy as well.

## **11. Activities at Grassroots Level:**

- 1. Antenatal (AN) Registration :** Early registration of pregnant women ensures the close monitoring of the AN mothers by providing them Tetanus Toxoid (TT) injection to prevent tetanus; provision of IFA tablets; nutrition education; regular health checkups and also identification of high risk factors for providing referral services in time.
  
- 2. Conducting Regular Immunization Services:** Immunization clinics are to be conducted in such a place which is acceptable to all people of the habitation. These services are to be planned in such a way that all pregnant mothers and children are covered with good quality vaccines without missing a single dose. The mothers should be educated regarding vaccine preventable diseases and also the importance of immunization in such a way that the mothers are enabled to demand quality and timely immunization services.
  
- 3. Nutrition and Health Education:**
  - Educating the mothers and family members on the consumption of low cost and locally available foods like groundnut, *jaggery*, egg, milk, green leafy vegetables, legumes etc.
  - Mere education to mothers alone is not sufficient but health education has to be given, for it to be effective, to the decision makers in the family such as the husband / mothers in law / whoever is the head of the family.
  - Importance of male participation in family welfare programme.
  - Imparting Health Education on maintenance of Environmental Sanitation which can be defined as control of all those factors which exercise or may exercise a deleterious effect on man's physical environment, health and survival.
  - Health education on personal hygiene.
  
- 4. Adolescent Girls Education**
  - Education on personal hygiene and menstrual hygiene.
  - Nutrition Education.
  - Right age at marriage, which is the deciding factor for healthy parenthood.
  
- 5. Evaluating indicators for quality of services delivered by the Department of Health and the DWDCW:**
  - A.** Regular hemoglobin checkups.
  - B.** Height and weight measurement of pregnant mother and children.
  - C.** Full immunization of children



15. The other related Departments like Indira Kranthi Patham (IKP), Panchayati Raj, Rural Water Supply, Education etc., and N.G.O.'s who work in the area of Health may also have to be involved in support to the convergence of health and ICDS efforts for achieving common goals like the reduction of IMR and MMR.

**16. Measures to be taken at various levels for convergence of the efforts of the Department of Health and DWDCW:**

- District Officers like the DM & HO; the Project Director, ICDS and the Project Director IKP may have to meet at the district level frequently and discuss the measures to be taken from time to time to achieve the common goals.
- Every month departmental review meetings and training sessions are held at District and Divisional levels and these offer the best opportunity to the other department to attend, address and convey the implementation requirements of their programmes, especially in regard to the achievement of the common goals like reduction of IMR and MMR.
- Similar convergence meetings should be organized at the Mandal level by exchanging information on the dates of such meetings by the Departments dealing with Health, ICDS and IKP.
- At habitation level where actually the programme is implemented, the key functionaries, namely the ANM, ASHA Worker, Anganwadi worker and the IKP Grama Samakhya Members should interact with each other and involve themselves in the planning, implementation, evaluation and the monitoring of the programmes to reach the planned goals. Instructions need to be issued to institutionalize these meetings.

**17. Role of the ANM:**

She has to inform the date of her visit and the type of services she would deliver such as antenatal care, postnatal care, immunization etc., well in advance to the ASHA worker, Anganwadi worker and IKP members seeking their co-operation, and co-ordination with her work.

**18. Role of the AWW:**

The Anganwadi worker has to inform all the beneficiaries, namely, the pregnant mothers, children and the adolescent girls well in advance of the ANM's visit so as to assemble them in a place for providing the designated services - a place, which is acceptable to all the people in that particular habitation.

**19. Sparring the Services of One PHC Doctor to the ICDS Programme:-**

- If one Medical Officer of the PHC is exclusively spared for health services i.e., the field activities in the ICDS, school health services and epidemic control; and another Medical Officer is allotted exclusively for provision of medical care at the PHC i.e. attending to O.P. and emergencies; treatment of minor ailments; provision of MCH services and attending to chronic illness cases, the ICDS Services will ultimately be greatly strengthened.
- Utilizing the services of **108, 104 services** by the Health and ICDS staff to the maximum extent in their work areas will also make these programmes more effective.

**20. Conclusion:**

The convergence of health, ICDS and IKP functionaries right from the state to the district and to the grass root levels will lead to meeting the felt needs of the community effectively in the areas of mother and child health, nutrition and immunization services and thus achieve the expected results.

**21. Introduction of a Dual System in the Health Department:**

At present the PHC doctor has to discharge the medical care and health care service needs at the PHC. He has to attend O. P. and also health care services at field level which, realistically, is not practicable. According to the expectations of the people this single doctor has to attend to the OP, minor and chronic ailments at the PHC and he also has to be available all the day at the centre. However, the importance of public health demands of the same doctor, on the same day, to attend to epidemic control measures and other field activities assigned to him to achieve the goals under the various National Health Programmes. According to the guidelines, the PHC doctor

has to tour 20 days in the month. If so, the doctor cannot be available at the PHC Head Quarters to deliver medical care which is considered to be the most important service by the public. This is the main reason for the dissatisfaction of people and also for the complaints made against the doctors by the public. It also needs to be mentioned that the PHC doctor is implementing the National Health Programmes viz., the Family Welfare programme; Immunization; Epidemic Control (Water, Food and Vector Borne Diseases) and attends medical camps in the field during fairs and festivals; arranges the First Aid Centres when and wherever a public gathering takes place such as during VIP visits; seeds distribution campaign; and SSC, Intermediate, Degree, PG and other APPSC, EAMCET examinations. It is high time we bring about radical changes in the Health and Medical Care Services Delivery System to meet the felt needs of the people through a dual system for Medical and Health Services, which may be implemented as detailed below:

- To perform all duties effectively at the PHC according to public expectations one doctor with supporting staff like Staff Nurse, Pharmacist, Lab Technician, MNO, Ward Boy, Dresser, Sweeper, Office Subordinates etc., may exclusively be identified to deliver the Medical Care Services at the PHC. This doctor may be designated as CAS and may be assigned drawing and disbursing powers to his supporting staff as well.
- Another doctor may be designated as Medical Officer to deliver all the field services. He should be provided with sufficient mobility for effective implementation of field level activities and should be the Drawing and Disbursing Officer for the field level staff (supervisory staff and MPHAs, Male & Female etc.) This Medical Officer can be assigned the work to coordinate the services concerned with the common goals of the Health Department and the ICDS scheme.

## **22. Sub - Divisional Level Supervision:**

For effective supervision of this dual system of Medical and Health Services an administrative wing may be set up at the Sub-divisional level covering 6 to 8 PHCs. The sub-divisional level officer will have the task of closely monitoring and supervising both the PHC and field level activities. He can be a Deputy Civil Surgeon,

preferably with a DPH. If a DPH person is not available, an MBBS doctor with training for 6 months in Public Health may be posted.

**23. Inter Sectoral Co-ordination:**

Health of the community depends upon environmental sanitation i.e., provision of protected drinking water supply, socio cultural habits of the people and the economic status of the people. Availability of water and power which are the deciding factors to supply safe and protected water is also important. Educational status of the people will contribute to the good health habits of the community. All these have to be addressed holistically. For this, we need certain measures:

- to involve all the related departments like Health, DWDCW, Education, Panchayat Raj, Revenue and Veterinary and other relevant line departments in provision of good health services to the community. The present Public Health Act may also have to be revised for the effective implementation of holistic health programmes.
- A special Nodal Officer may be identified and given powers to co-ordinate with Health, DWDCW, and other line departments like Panchayat Raj, Rural Water Supply, Indira Kranthi Patham, Veterinary and Revenue Department for the better running of the Health Care Delivery system.
- **Introduction of Solar Energy** to provide sufficient water and power as an alternative source of energy. Solar power may be introduced as it could be cheaper than any other source, over a period of time.
- **Introduction of the Indian Medical Service (IMS):** An Indian Medical Service (IMS) may be introduced on par with the other All India Services. The IMS members will be medical doctors with the basic qualification of MBBS who should appear in a competitive examination (Civil) with Medicine and Public Health as optional subjects. They should be trained in the administrative aspects of work as well, and will be positioned as the District Health Authority with over all responsibility for implementing all the medical and public health activities in the District in an effective manner.

## **24. Cold Chain Maintenance of Vaccines.**

For effective and qualitative immunization services, Cold Chain maintenance is necessary.

Maintenance of required temperature of vaccines from the point of manufacturing to the beneficiary is called cold chain.

## **25. Maintenance of Cold Chain**

- From the manufacturer to the State Vaccine Stores, vaccine is transported by air or through railways in a specially designed transport system of air conditioned vehicles. After reaching the State head quarters the vaccine is preserved in separate, specially designed vaccine stores, which have walk-in-coolers with specific levels of temperatures maintained by specially trained technical staff. Special cold chain equipment is installed in the vaccine stores with a continuous temperature monitoring system, with automatic power generators to combat the power failures backed by a temperature alarm system. These measures help keep the vaccine always at the required temperatures to avoid loss of potency.
- From the State Vaccine Stores, the vaccine is loaded in vaccine boxes (Cold Boxes ) with frozen ice packs, and these cold boxes are transported to the Regional Vaccine Stores through a specially designed vaccine carrier vehicle. The cold boxes with ice packs will maintain the required temperature upto 48 hours. The vaccine is kept at Regional Vaccine Stores in Walk-In-Coolers maintained by specially trained technical people. The Regional Stores is also equipped with automatic generators and a continuous temperature monitoring system round the clock.
- From the Regional Vaccine Stores to the District Vaccine Stores the vaccine is again transported, loaded in the cold boxes with ice packs and transported through vaccine carrier vehicles. At the District Stores the T Series vaccines (DPT, TT, DT, Hepatitis B) are kept in ice lined refrigerators, which have a holding time of 18 to 24 hours. BCG, Measles and Polio vaccines are kept in deep freezers at  $-20^{\circ}$  c. The Dist. Vaccine Stores is also provided with automatic generators and

maintained by technically trained people who will regularly monitor the temperatures.

- To store the vaccines at required temperatures at the PHCs and CHCs, each institution is provided with ice lined refrigerators and deep freezers. Ice lined refrigerators are to preserve vaccines and the deep freezers are for preparation of ice packs.
- From the District Stores to the PHCs and CHCs, the vaccine is transported through vaccine carrier vehicles. Each District will have its own vaccine distribution plan through vaccine routes. A vaccine vehicle will cover 6 to 8 PHCs / CHC per day on a route. The dates and time of arrival of the vaccine vehicle to the institutions will be informed to the concerned well in advance, so as to enable them to wait and receive the vaccine and to preserve it in ILRs. At PHC / CHC level the Pharmacist / Staff Nurse will look after the cold chain maintenance and stock and issue vaccines.
- From PHC / CHC to vaccine session where the vaccine is given to the beneficiaries, the vaccine is carried through vaccine carriers with 4 ice packs. The holding time of the vaccine carrier is 24 hours. The concerned health staff will collect the vaccines from the PHC by 8<sup>00</sup> clock in the morning, take them to the habitations and complete the immunization by 1.00 PM.

Each PHC will have immunization session plans i.e., organization of the Immunization Day on every Wednesday at the PHC and Sub Center Head Quarters and on every Saturday in the other habitations. These sessions are planned to cover 1000 to 1500 population on every immunization day so that the population and the habitations of the concerned ANM will be covered once in every month.

- 26. Injection Safety:** To provide complete aseptic injection methods and also to ensure exact dosage of vaccine, each beneficiary will be administered the vaccine with a specially designed Auto Disabled Syringe, which cannot be re-used. All these used syringes are again disposed in a safe manner.
- 27. Vaccine vial monitor:** In addition to all the precautions taken to maintain the cold chain for vaccines, each vaccine vial is provided with a Vaccine Vial Monitor, which indicates whether the potency of the vaccine is being maintained or not.

## **SOCIAL AUDIT - ICDS**

### **WORK BOOK**

1. Name of the Mandal:
2. Name of the Grama Panchayat:
3. Name of the Habitation:
4. No. of the AWC:
5. Name of Supervisor:
6. Name of AWW:
7. Name of AWH:
8. Names of the SA Team members:
9. AWC is functioning from the year:
10. Is the AWC location easily accessible to the beneficiaries? If not, describe the problem:
- 11.1 Building: Own building/Panchayat building/Government School/AWW's or Helper's house/rented building
- 11.2 Type of building: Pucca/tine shed/tiles/thatched
- 11.3 Condition of the building
- 11.4 Area of the building
- 11.5 Open space available

### **12. Facilities Available at the AWC**

(Registers to be scrutinized: Other Stock (Asset) Register)

No.	Issues to be examined	Summary of findings
1	Drinking water	
2	Toilet	
3	Medical Kit	
4	Toys	
5	Teaching aids	
6	Weighing Scale	
7	Are the equipment kept in good condition?	

### 13. Supplementary Nutrition

(Registers to be scrutinized: Anganwadi Survey Register, Register of Services for Pregnant Women and Lactating Mothers, Register for Supplementary Nutrition and Pre-School Education, Births and Deaths Register, Anganwadi Food Stock Register )

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	No. of children in the village in the 0-3 years age group	
2	No. of children enrolled in the 0-3 years age group	
3	If there is variation between 1 and 2, explanation for the same	
4	No. of children in the village in the 3-6 years age group	
5	No. of children enrolled in the 3-6 years age group	
6	If there is variation between 4 and 5, explanation for the same	
7	No. of Pregnant women in the village	
8	No. of Pregnant women Enrolled	
9	If there is variation between 7 and 8 explanation for the same	
10	No. of Nursing Mothers in the village	
11	No. of Nursing Mothers Enrolled	
12	If there is variation between 10 and 11 explanation for the same	
13	Verification of SN stock register as on 31 <sup>st</sup> Aug.08	
	Stock received:	
	Stock distributed:	
	If there are discrepancies explanation for the same:	
14	Are the timings for distribution of SN followed strictly? If not reasons for the same.	
15	During the last 30 days for how many days SN was not distributed:	
	Reasons for the same:	
16	Are all the enrolled children in 0-3 age group given SN regularly? If not, reasons for the same:	
	Are all the enrolled children in 3-6 age group given SN regularly? If not, reasons for the same:	
	Are all the enrolled pregnant women given SN regularly? If not, reasons for the same:	
	Are all the enrolled nursing mothers given SN regularly? If not, reasons for the same:	
17	Are the severely malnourished children identified? If yes, how many? What are the extra quantities of SN provided to them?	

	Are the anemic pregnant women identified? If yes, how many? What are the extra quantities of SN provided to them?	
	Are the anemic nursing mothers identified? If yes, how many? What are the extra quantities of SN provided to them?	
18	Are there any complaints on the quality of SN during the last 12 months? If yes, details:	
19	Did children fall sick after eating SN? If yes, details:	
20	If there are problems in taking delivery of SN and its distribution, explain:	

#### 14. Growth Monitoring of Children

(Registers to be scrutinized: Growth Chart Register, Health Checkup Register, Mother and Child Card.)

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	How often are the weights of the 0-3 year old children?	
2	When was the latest weights recorded for children in 0-3 year age group?	
3	Are the weights of all enrolled children in 0-3 year age group recorded?	
4	If not, reasons for the same:	
5	How often are the weights of the 3-6 year old children?	
6	When was the latest weights recorded for children in 3-6 year age group?	
7	Are the weights of all enrolled children in 3-6 year age group recorded?	
8	If not, reasons for the same:	
9	No. of children in Grade I:	
	No. of children in Grade II:	
	No. of children in Grade III:	
	No. of children in Grade IV:	
10	Are the Grade III and IV children provided additional support?	
11	Are the disabled children being identified?	
12	If yes, no. of children identified	
	What treatment being given to them?	

#### 15. Immunization

(Registers to be scrutinized: Register of Immunization, Iron & Folic Acid Tablets and Vitamin – A Supplementation.)

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	Was the time/day for immunization fixed in advance and publicized?	
2	Who has administered vaccine?	
3	At which place are the vaccines administered?	
4	Are vaccine vials brought in cold box?	
5	If vaccines are not administered according to the schedule, reasons for the same.	
6	If vaccines are not administered to all the enrolled children, reasons for the same.	
7	Are all the enrolled pregnant women given tetanus vaccine according to schedule? If not, reasons for the same:	

## 16. Health Check-up

(Registers to be scrutinized: Health Checkup Register, Supervision-cum-Visitors' Book, Register of Services for Pregnant Women and Lactating Mothers, Mother and Child Card)

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	How often was health checkup of children done?	
	In the last 6 months how many health checkups were undertaken?	
	When was the last health checkup done?	
2	In the last 6 months how many children were identified with health problems?	
	What were the health problems identified?	
	What was the treatment given to them?	
3	How often was antenatal checkup of pregnant women done?	
	When was the last checkup done?	
	Whether given schedule was followed.	
	Important observations coming out of health checkups.	
4	How often was postnatal checkup of nursing mothers done?	
	When was the last checkup done?	
	Whether given schedule was followed.	
	Important observations coming out of health checkups.	

5	Who has done health checkups?	
6	Where were the health checkups done?	

### 17. Referral Services

(Registers to be scrutinized: Health Checkup Register, Register of Services for Pregnant Women and Lactating Mothers)

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	Is AWW giving treatment for minor ailments?	
2	Are the referral slips available with the AWW?	
3	In the last three months how many sick children and women approached AWW for medical help?	
	What help did they receive from the AWW?	
4	In the last three months how many pregnant women were referred to hospitals for institutional delivery by AWW?	
5	Is the AWW attending to follow up care of treated cases? If yes, experiences:	

### 18. Medicine Distribution

(Registers to be scrutinized: Register of Immunization, Iron & Folic Acid and Vitamin – A Supplementation, Medicine Distribution Register.)

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	Details of medicines and their quantities received during the last 6 months:	
	Details of medicines and their quantities distributed during the last 6 months:	
	Are the medicines at the AWC adequate? If not, reasons for the same:	
2	How many children were given Vitamin – A dose?	
	If all the children did not receive the dose, reasons for the same:	
3	How many enrolled women and adolescent girls were given IFA tablets regularly?	
	If all the enrolled women and adolescent girls did not receive the tablets, reasons for the same:	

## 19. Nutrition and Health Education

(Registers to be scrutinized: Minutes of Meetings on Nutrition and Health Education, Daily Diary)

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	How frequently are meetings on NHE held?	
2	When was the last meeting held?	
	What was discussed at this meeting?	
3	Are these meetings held only at the time of SN distribution?	
4	Who is conducting these meetings?	
5	Who and how many are attending these meetings?	
	And how regular is the attendance?	
6	What was the duration of these meetings?	
7	What are being discussed at these meetings? (contents & methods)	
8	Are these meetings useful?	
9	Are fixed day house visits followed?	

## 20. Pre-school Education

(Registers to be scrutinized: Register of Supplementary Nutrition and Pre-School Education.)

No.	Issues to be examined	Summary of Findings / Differences between Records and Personal Verification
1	What are the timings for Pre-School classes?	
	Are these timings convenient to the children and their mothers?	
2	How many enrolled children are not regularly attending the pre-school?	
	Reasons for not regularly attending	
3	What is being taught?	
	How it is being taught?	
	Is the AWW trained in using teaching aids?	
	Are teaching aids being used?	
4	Performance. (Elicit through interaction with the children)	3-4 years
		4-5 years
		5-6 years
5	If mothers are not satisfied with the teaching at the AWC as well as performance of their children, reasons for the same:	



7	Referral services	
8	Medicine distribution	
9	Nutrition & Health Education	
10	Pre-School Education	
11	Adolescent Girls	
12	Record keeping	
13	How often did ANM, ASHA, Supervisor and CDPO visit AWC?	
	When was the last time each of them visited AWC?	
	What support did AWW receive from ANM, ASHA, Supervisor and CDPO?	
14	Is the AWW satisfied with the facilities available at the AWC?	Yes                      No
	If no, explanation:	
15	Is the AWW receiving any support from the village community/GP/Mothers' Committee?	
16	During the last one year, is the AWW mobilized by the govt. to perform any duty other than the AWC work?	Yes                      No
	If yes, details of the works entrusted to the AWW	
	Duration of these works:	
	Whether AWC was run during these days?	
	Did AWW receive additional remuneration for this work?	
17	The problems faced by the AWW in discharging the duties at the AWC.	
18	What suggestions AWW has to improve the performance of the AWC?	

#### **24. Discrimination:**

(If instances of discrimination are reported, record the same with details)

#### **25. Report on the Gram Sabha**

(Including the decisions taken and follow up planned)

**K. R. VENUGOPAL IAS (RETD.)**  
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