Final report

Analysis of positive deviance in the ICDS programme in Rajasthan and Uttar Pradesh

Qualitative study commissioned by World Bank

Educational Resource Unit
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Table of Contents

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Section I: Analysis of positive deviance

1. Framework of the report

India is a country of tremendous diversity. It has a staggering range of development programmes with equally staggering degrees of success. There are pockets of excellent performance in almost all the regions, and there are people at all levels working against all odds. The challenge for administrators, planners, donors and practitioners is how to expand this circle of excellence. How to turn around the system to, work more efficiently and with a greater degree of commitment? The objective of this study is to tease out factors that contribute to positive deviance in the ICDS programme.

At the outset it is possible to identify factors that can potentially promote positive deviance in specific areas and pockets. The following list has been drawn from both documented evidence of best practices in social sector programmes as well as hands-on experience of the research team in managing and evaluating programmes in child development, primary education and maternal and child health programmes (MCH) in India.

- Administrative history of the state, district and block;
- Leadership (the human factor) – at the state, district, block, cluster and panchayat levels;
- Giving primacy to the core objectives and goals, thereby not losing focus;
- Formulation and communication of appropriate guidelines that facilitate context specific adaptation, rather than tie down people to a set of rigid rules and regulations;
- Creating structures that facilitate action, such that do not stifle frontline workers, coupled with accountability systems that work both ways – upwards and towards the beneficiaries;
- Presence of other programmes, projects, non-governmental institutions and social movements that have increased awareness in the community and improved the utilisation of government facilities, programmes and schemes;
- Appropriate selection of service providers, keeping in mind their social access to the poor, aptitude, commitment and location followed by rigorous training and regular follow-up and refresher workshops to maintain motivation;
- Tight monitoring systems and ability to use periodic meetings to not only provide learning opportunities but also to motivate, affirm and reward good performance and censure indifference and inefficiency;
- Vibrant and sensitive local self-government institutions (such as panchayats), women's and youth groups;
- Overall improvement in transport and communication in the area leading to greater mobility and access to health care services for women and children; and
- Homogeneity in the population – this reduces tension and competition between different communities for control and access to resources.

This report attempts to systematically unpack some of the above issues using the qualitative information gathered in the course of this research study. **At this juncture it is important to note that the effort is to understand and not evaluate**. Every experience we encountered – positive or negative – has been used to analyse and understand why something does or does not work in a given environment.

2. Scope of the study

The specific purpose of this study was to investigate "the reasons for the observed good performance of the ICDS and propose interventions to replicate the features of the programme

elsewhere" (Concept Note, World Bank, January 2004). To this end, it was agreed that the World Bank, in consultation with central and state governments would identify the study area in two states: Rajasthan and Uttar Pradesh (See Annexure 1 for Methodology and selection os study area).

This was done by using the baseline study information and ICDS data to identify the blocks associated with high participation among poor groups and low prevalence of malnutrition among regular attendants. It was decided that in-depth interviews would be carried out to assess the perception of the ICDS among the staff, at the administrative levels of the programme (central DWCD, state DWCD, districts, blocks, and Aanganwadi Centres) and the programme's beneficiaries (communities and households) to identify some of the information gaps and implementation bottlenecks.

These findings were to be framed in the context of the World Bank's support to the ICDS programme in the last 10 years.

- Within the above scope, the specific issues to be explored in the study were:
- Targeting (inclusion of poor communities and households and coverage of children under 3 years);
- Worker-related factors (selection, remuneration, training, job responsibilities, ongoing support, caste and other variables that influence efficiency);
- Nutrition inputs - growth monitoring (GM), Supplementary Nutrition Programme (SNP), regularity of supplementary feeding, health programme (immunisation and active referral systems);
- Centre-related factors (location, regular operation, timings, growth promotion activities);
- Programme implementation factors - high-performing CDPO, clear policy directives from state, monitoring and supervision (supportive supervision, especially the role of the trainer supervisor), training;
- Community-related factors (interface with or support from mothers' groups, panchayats, youth groups, adolescent girls groups).

An in-depth qualitative study was done in one block each in the two states. Eight Aanganwadi Centres (AWCs) in each block were selected to capture the proximate as well as distal factors that contribute towards or impede the attainment of the goals of the ICDS programme. In a recent qualitative study by the Educational Resource Unit for the World Bank (on factors that facilitate or impede successful primary school completion – case profiles of children in diverse poverty situations, April 2003) we came across an energetic and creative ICDS centre in Bellary district of Karnataka. This centre was re-visited with a view to documenting best practices.

2.1 Recapturing objectives and package of services of ICDS:

The goals of the ICDS programme can be broadly categorised into three areas:

- Addressing the problem of malnutrition among children, (appropriate height and weight for age) through provision of supplementary nutrition, monitoring the growth of children and educating families (mother / primary care giver) to adopt better feeding practices – better nutrition during pregnancy, breast feeding, weaning foods and balanced nutrition in the early years of the development of children (up to 6 years);
- Ensuring freedom from intermittent diseases and better health of children through timely and complete immunisation for vaccine-preventable diseases, regular de-worming, providing Vitamin A & iron supplements, facilitating referrals in case of illness through convergence with the health sector, and raising health awareness levels amongst the target population;

- Promoting holistic child development through pre-school education – with focus on motor and concept development, acquiring language and social skills and preparing the child for schooling.

The three inter-related objectives are addressed through a range of AWC-based as well as home-based services and awareness activities. As programmes go, the ICDS is, perhaps, one of the better-conceived and designed programmes. The package of services offered by the ICDS is elaborated in Table 1.

Table 1: Package of services offered by the ICDS programme

Children 6-12 months & 1-3 years	Children 3-6 years	Women (15-45 years), pregnant and lactating	Adolescent girls 11-18 years
Health check-up Immunisation Growth promotion Supplementary feeding Referral services Vitamin and iron supplement	Health check-up Immunisation Growth promotion Supplementary feeding Referral services Pre-school education Vitamin A and iron supplement	Health check-up Immunisation Referral services Registration of ante / post natal care Vitamins and iron supplements Nutrition and health education	Health check-up Referral services Vitamin A and iron supplement Health and nutrition education Self-development, recreation, skill formation

Source: Based on the Annual Report of the DWCD, GOI 1999

3. Positive deviance observed in 16 AWCs visited[1]:

This section of the report summarises the main observations of the study – we have documented only what we observed and culled from documents/data available and recorded in the field. There were many other factors that could have contributed to positive deviance, but are not included here because we did not find evidence on the ground. The accent here is on processes and real outcomes observed in the field (see Annexure 1 and 2 for centre-wise assessment). The information is presented in three categories, namely:

- Strongly positive aspects of the programme;
- Mildly positive aspects of the programme; and
- Negative aspects.

[1] **Challenge faced in UP**: We commenced work with the understanding that we were visiting the best performing blocks in the two states. The research tools were designed to specifically capture positive deviance. We presumed that supply of supplementary nutrition was regular in a positive deviance block. Unfortunately, just as we commenced fieldwork in Uttar Pradesh, the district office informed us that nutrition supplements had not been received since September 2003. The data on supply of SNP to AWCs given in the Quarterly Progress Report for Q II ending 30 September 2003 (CPMU, DWCD, GOI, November 25, 2003) reports 100 percent AWCs received SNP supply in the quarter ending September 2003. While this was indeed the case according to AWC records (the last time SNP was supplied was in August 2003), the reality was that there has been no supply since then. At this point, we were not sure whether to proceed with the study or select another area. Further enquiry revealed that the SNP supply had been disrupted all over the state. Weaning food was being supplied in most districts for children in 0-3 age group under the Prime Minister Gramodaya Yojana (PMGY) – a central scheme of the GOI. We were also informed that districts covered under the WFP and CARE nutrition supply were not covered under the PMGY. Therefore, Sultanpur district was not covered under the PMGY. We discussed our predicament with the World Bank and it was decided that we should go ahead despite the fact that a critical component of the nutrition programme was missing.

3.1 Strongly positive inputs and outcomes:

Two important input variables that stand out are:

- The Aanganwadi worker:
    - The educational level of the AWW
    - Her caste and community affiliation
    - Her dynamism and leadership qualities; and
    - Her place of residence (if she belonged to the same village)
- Location of the AWC
    - Own building or located in a public space (Primary School, Panchayat)

We found strongly positive deviance in the AWCs where these qualities converged. Where the AWC was located in a public space the community leaders and women were aware of its timings and the services they provided. Such AWCs presented a safe and secure place where mothers could leave their children for a few hours every day, even when there was no regular supply of nutrition supplements (Uttar Pradesh is a case in point). The rapport between the AWW and the ANM, schoolteacher and panchayat made considerable difference – in communicating with women, ensuring repair and maintenance of the centre (through the panchayat) and, most importantly, in facilitating immunisation, referrals and school enrolment.

Inputs		Outcomes
Worker related:		
Worker educated (class 8 upwards) Worker from the same village or hamlet Worker from poor community – shows empathy and concern, does not exhibit caste prejudice Young and dynamic worker Young and dynamic helper Highly motivated and has good rapport with the community (good community outreach) Worker has leadership qualities Workers have credibility in all sections of the community, especially women Makes home visits Good rapport with schoolteacher and ANM	⇒	Aware of the goals of the ICDS programme – nutrition, growth monitoring and pre-school education Conducted yearly house-to-house (HH) survey and identified children from target groups Maintains growth chart of all children Good records Centre opens regularly and on time SNP distributed regularly and cooked with care Children fed at 10.30 am and again at 12.30 Neat and clean environment – children's cleanliness check every day (nails, hair, face washed, hair combed) Pre-school education happening IEC and pre-school materials displayed well Record (age, weight, immunisation) of 0-3 year olds available Distributes IFA tablets Facilitates referrals through ANM Facilitates enrolment in school 4 of 8 AWCs in Rajasthan used referral services for children through ANM
Centre-related:		
AWC has its own building Located in the centre of the village or close to the target population Adjacent to primary school or located in it– centre is a part of a well-functioning school	⇒	Accessible to target population AWC in public view, possible for panchayat and community to check if it opens daily and functions for the stipulated hours Children bring their younger siblings when they come to school – ensures regularity of

Hand pump and drinking water source on the premises Painted and attractive Cooking and storage utensils available		attendance of 3-6 year olds SNP stored with care
Community related:		
Community values pre-school education Community values nutrition supplement and monthly health check-up Awareness of the scope of the ICDS programme (nutrition, health, immunisation, pre-school education) – result of social mobilisation of a women's development and empowerment programme AWW meets with mothers regularly in the AWC	⇒	Children sent to the AWC, even when there is no SNP Mother's come to AWC for medicines, immunisation, to make contact with ANM Women feel confident to approach AWW for advice and help Contributes jaggery (gur) to make SNP more palatable
Monitoring visits of LS, CDPO, DPO		
LS visits regularly, visits families in their homes – surprise visits made Makes home visits and talk to mothers Good rapport with panchayat leaders	⇒	Worker on her toes Community, mothers and panchayat leaders come when the LS visits; they view it as an opportunity to voice appreciation, problems and grievances, feel they have someone to turn to
Other related factors:		
Refresher training for pre-school education AWC, AWW received awards Primary health centre (PHC) located in the village	⇒	Uses child-friendly and play-way methods for pre-school education (songs & rhymes) Community appreciative and also proud of their centre- thereby takes more interest Facilitates ready referrals through ANM

3.2 Mildly positive inputs and outcomes

While the educational level of the worker and her location was important, we also found centres with less educated (primary level education) or illiterate AWWs who were highly motivated and committed to their work. We also learnt that while location of the centre on the main road contributed to better monitoring by the LS and the CDPO, it was a deterrent for children for two reasons. One, it was not considered safe and two; access was a problem for very small children if it is far from the village. Daily wageworkers and women who went out to work in the forest (for collection of forest produce) or in their fields were not able to escort their children to the centre. It depended on the ability of the Aanganwadi Helper (AWH) to go and fetch the children. The degree of heterogeneity / homogeneity of the community made a difference to the functioning of the AWC. For example in UP where the communities (SC, OBC, minority and FC) compete for resources, then access depends on the caste and community of the AWW and her commitment to reach out. On the other hand, in a situation where nutrition supply is very irregular (seven months' break at a time) the mainstay of the ICDS programme is pre-school education. Schooling has become a social norm among the OBC and forward castes (FCs). As a result, parents make it a point to send their children to the AWC. This, however, is not the case with the SC community, which is generally poor and migrates for work for several weeks, or even, months at a time. If the AWW is also from the OBC or forward caste, she makes little effort to reach out to the SC children even when they live close to the AWC.

Inputs		Outcomes
Worker related:		

Not educated or literate but motivated (husband or children help with records) Empathetic to the poor – herself poor or widowed woman From the target group (SC or ST) but not literate Elderly but caring (low energy levels, poor understanding of programme, tired) Commutes from nearby village, reaches on time ANM visits only on health day, essentially for immunisation	⇒	Aware of the goals of ICDS programme, can repeat it. Not sure if she understands the link between nutrition, health and overall development of children House-to-house survey done, but incomplete Growth monitoring record updated but not analysed and used for growth promotion AWW does not understand importance of growth monitoring Poor records but trying hard - takes help (even pays Rs 100/month for maintaining records) Depends on ANM for distribution of IFA tablets Caring environment SNP cooked with care and distributed Difficulty tallying names and records in different registers – but AWW knows most children by name or father's name
Centre related:		
Has own building, but located on the main road (Janawari) Located in a panchayat building, not very accessible to children from all hamlets Located inside the primary school, but does not have its own space / building	⇒	Regular monitoring and supervision possible for LS and CDPO since the centre is accessible – even though it may not be very safe or accessible for children, depends on AWH to fetch or escort children Monitoring by School Teacher ensures regularity, but not very accessible to women with small babies
Community related		
Heterogeneous community and schooling a social norm among the OBC and other forward castes (UP) Relatively homogeneous tribal community where the forward caste groups or richer sections (who are a minority) do not access supplementary nutrition for their children (Rajasthan)	⇒	Dominant community takes interest in pre-school education – as schooling has become a social norm (UP) Self selection leads to greater access for the tribal groups (Rajasthan)
Monitoring visits of LS, CDPO, DPO		
LS visits only on fixed days; no surprise visits, predictable schedule CDPO visit also with prior information Checks records, spends time in the centre – does not make regular home visits	⇒	Records updated for monitoring visits When LS visit confined to a fixed day (health day), focus is on immunisation and records only; home visits take the back seat
Other related factors		
Supply of SNP fairly smooth Regular immunisation by ANM Target for forming 2 self-help groups (SHGs) in the village	⇒	Regular distribution of SNP, daily as well as weekly rations for children in 0-3 age group and pregnant and lactating women (sometimes irregular) – cooked, but is tasteless and dry. Children's access to immunisation near-total – but do not have access to other child health services

		Good rapport with women who are members of the SHG

3.3 Negative outcomes and processes responsible for it:

When we commenced work on this project, an official in the WCD directorate in Rajasthan said that the human factor made a considerable difference, both positive and negative. Half the battle was won, he said, with the selection of the right people. Training and motivation can make a difference. But technique and system can do little if the people involved lack empathy. During the fieldwork, we often came across high- caste and influential AWWs who had little interest in or commitment towards their work, lacked empathy and, most importantly, were supremely confident that nobody could dislodge or transfer them from their present positions. This smugness was all pervasive.

Equally important was the regular supply of SNP, pre-school education kits and medicine kits in the absence of which the AWW couldn't do very much. This affected her credibility in the community. Commitment at higher levels was mandatory to ensure timely supply and support where poor quality supplies affected the functioning of the AWC.

Inputs		Outcomes
Worker related:		
Unmotivated worker who has been around for over 20 years From the dominant community, forward caste or OBC Lives a fair distance from the village Related to an important leader or office bearer in the village - indifferent to the goals of the programme, targeting the poorest and malnourished children AWC located in the school Long gaps between refresher training for workers AWW and AWH not trained	⇒	Little understanding or appreciation of the goals of the ICDS House-to-house survey erratic or not done Enrolment on the basis of accessibility – confines her work to the immediate surroundings Does not make home visits Enrols children who comes to the AWC – self-selection a norm Helper opens the centre and starts cooking and worker comes late – if at all Class 1 and AWC children sit together, the AWW minds both groups (UP) Children do not stay for very long at the centre and run home No growth monitoring done. If the children are weighed, the AWW claims to have given the figures on a piece of paper to the LS Cannot tally the names of the children in different registers or the children actually present with those enrolled in the registers
Centre related:		
AWC located in the home of the worker (Shahgarh 1, UP) AWC located in the house of rich upper-caste worker (Paniyar, UP) No hand pump, water fetched from afar Poorly maintained building, broken floor and unsecured doors (Wanka, Rajasthan) Next to an open drain – safety of children a big issue (Afoiya in UP)	⇒	Irregular timings Centres that run in the homes of AWWs do not have an identity Where the centre is located in the house of the upper caste worker, children from SC and minority community do not have access Low access to water implies that children are given SNP unhygienically on pieces of

No measuring cup available in the centres (All)		paper and in plastic bags – Storage of SNP a problem – AWW takes it home to keep it safe Environment not child friendly SNP not measured during distribution – worker gives one spoonful to all, well below the stipulated amount.
Community related		
Tension between the social groups in the village, SC community 41.7 percent but AWW is OBC (Hardoiya, UP)	⇒	Worker has little rapport with the poor and targeting suffers Poorest community keeps away
Monitoring visits of LS, CDPO, DPO		
Remote – therefore, visits by the CDPO and other higher ups problematic LS visit timed with health day only	⇒	Probability of dysfunctional AWCs more in remote habitations that are not visited As LS visit is pre-determined (health day) the centre does not open daily
Other related factors		
Long gaps in SNP supplies. Poor quality of SNP supplied Weighing scales not calibrated Weighing machine damaged Long breaks in the supply of medicine kit Irregular ANM– comes only on Pulse Polio days AWW gives SNP to anyone who comes to the centre – even children who are 6+, old destitute women. Says she cannot refuse when people are so poor. Irregular supply of medicine kit (no supply since 2002) No specific training chart / guide the use medicine kits Family planning targets Target to form self-help groups	⇒	Nutrition distribution affected, leading to waning interest and, in UP, apathy. Weighing, if done at all, is done using incorrect scales. Saw erratic measures in records Children do not get adequate measure of food supplements. No distribution of IFA, de-worming and Vitamin A. Medicine kit not used, expired drugs Alienation from young mothers and their families, especially when they are not yet ready for the sterilisation operation (family planning). AWW not interested in reaching out to very poor women who cannot participate in SHG due to poverty or lack of access to money.

4. Factors that explain positive deviance or the lack of it:

4.1 The human factor:

4.1.1 State level

The first, and a central, factor that seems to affect the performance of the programme is the way in which its broad national goals are understood and articulated by officials at the state level. Detailed interviews with programme leaders at the state and district levels revealed that this is, indeed, a critical variable.

In Rajasthan, the state level leadership was fairly clear that the primary objective of the programme is to promote better nutrition and health of children. As a result, the programme was geared for regular procurement of nutrition supplement and its distribution. Discussions revealed that procurement and supply of SNP was given top priority, followed by organising a monthly "Health Day" at each AWC to forge convergence with the health department. Clarity about the objectives of the programme, coupled with support from the political leadership in the state, resulted in timely procurement, though not-so-timely supply, of SNP by the contractor. The talks also revealed that a concerted effort was made, especially since 1999, to

streamline procedures for procurement even though there are some glitches still with respect to regular supply by the contractor. Collection, compilation and analysis of data appear to be an equal priority. The ability of the PMU in Jaipur to retrieve data on the number of children surveyed, growth monitoring data and SNP distribution was quite impressive.

Another important factor that may explain the relatively better performance in Rajasthan is the state leadership's belief that the primary beneficiaries of the programme are poor children. As a result, targeting is taken seriously. Government orders issued in the last five years emphasised the importance of "proper selection" of the AWWs and proper identification of beneficiaries. ICDS guidelines specify the following:

Based on house-to-house surveys, weights (the only growth indicators being used) of children in the age group 0-6 years should be taken; identification of malnourished (grades 1 and 2) and severely malnourished (grades 3 & 4) children is to be done.

- Such children are to be enrolled – on a priority basis – at the AWC.
- Targeting of the poor is to be done in the following order:
    - BPL families;
    - IRDP families;
    - Landless labour or small and marginal farmers;
    - SC and ST families

The situation in Uttar Pradesh was different. Discussions with the leadership of the ICDS (Secretariat and Directorate) revealed considerable ambiguity about the primary objective of ICDS. While the officials interviewed agreed that nutrition and health were important objectives, all of them gave precedence to pre-school education. This could, perhaps, be attributed to the overall administrative and political environment in the state where the last five years have witnessed considerable political instability. Officials admit that floating and finalising tenders that run into millions of rupees is not easy. Equally, ensuring quality and regular supply of the approved quantity has never been smooth.

Selection of AWWs is also wrought with problems – a significant proportion of workers come from the upper castes and relatively better of families due to the fact that they are related in some way to panchayat leaders or officials. Also because 20 years ago educated women were available only from FC families. Workers who are influential and well connected have little empathy for the marginalized poor. Unlike in Rajasthan, where the upper caste families shun public feeding programme, in Uttar Pradesh benefits meant for the poor are cornered by the powerful and, often, find their way to the market. In a recent study done in the state, researchers were able to purchase the SNP meant for free distribution under the ICDS programme at local shops! (Ramachandran et al, 2003). It is, therefore, important to factor in the larger governance issues in the design, delivery and management of social sector programmes.

It emerged from the discussions that the unstable political climate contributed to apprehensions in taking decisions on awarding tenders for procurement and supplies. The inability of successive administrations to streamline procurement and supplies could have contributed to re-articulating the objectives of the programme itself. Also, the streamlining process did not appear to be a priority for the government. This could, theoretically, be resolved by policy reform [moving away from ready-to-eat to locally available food (rice, wheat, dal) that is procured at the block / panchayat level] or by streamlining procurement at the state level by making it transparent and above board. But the important issue here is that political will at the highest level is necessary to transform the programme into a pro-poor programme.

A significant positive factor in Uttar Pradesh was the government order to shift all AWCs running in the homes of AWWs to primary schools or panchayat buildings. Explaining the reason for this important initiative, Secretary, WCD, said the move had ensured regular

functioning. In the past, the AWCs running in the homes of AWWs were found to be dysfunctional. Also, in the event of the AWW being a forward caste woman, access of poor children was constrained by socio-cultural practices. Given that it is physically impossible to constantly monitor the AWC, shifting it to the school premises ensured some degree of accountability. AWWs admitted that this initiative made them more regular and also enhanced their status: they were seen as teachers and not merely as child-care workers.

Pre-school education has, thus, received a lot of attention in the state. Many AWWs felt this to be their primary responsibility.

The downside of this move was that the AWWs had to manage not only the AWC children but were often asked to take charge of Class 1 children as well, because most of the schools are short of staff. The AWH was seen cleaning the school. Another problematic area was that location of the AWC in the school restricted access to pregnant and lactating women – except on days when the ANM visited the centre for immunisation. AWWs also reported that they handed over IFA tablets and other medicines to the ANM for distribution. Convergence of the ICDS with primary schools was quite beneficial but the same could not be said for its convergence with the health department.

4.1.2 District and Block levels:

Functionaries at the district and block levels in Rajasthan and Uttar Pradesh echoed the views of the state officials. In fact, they took their cue from the Directorate. The Deputy Director (District Project Officer) in Banswara listed the factors that make for a good AWC:

- Where village survey has been completed and data of malnourished children and poor families is available,
- Where poor and malnourished children are enrolled at the centre
- Where PSE happens
- Where health day is observed seriously once a month
- Where record keeping is satisfactory and of acceptable level
- Where the relationship between AWW and the villagers and panchayat officials (patwari, gram sewak, sarpanch, panchayat secretary) is good
- Where mothers' and SHG groups are functioning and effective; credits are arranged and utilised
- Where there is cooperation with the Health and Education Departments in the block, panchayat, village;
- Where AWW motivation level is higher than average – which, in turn, depends on the proper selection of workers.

The DPO or Deputy Director is expected to provide leadership and vision. A fair share of the credit for the Banswara success story goes to the dynamic and empathetic Deputy Director and District Project Officer. We were informed that she worked as the Project Director of WDP Rajasthan in Banswara district. She held monthly review meetings and was quite particular about targeting, nutrition supply and record keeping – in that order. We were informed that Garhi block was considered the "best performing block" by the district administration. We decided to make a brief trip to the block and observe a few AWCs and interview the CDPO and Lady Supervisors. While this was not strictly within the scope of this study, the research team felt a rapid assessment would add value to this study. Box 1 below captures the essence of what we observed.

Box 1: Positive Deviance in Garhi block of Banswara district

The ICDS was launched in Garhi on a pilot basis in 1975.

- The CDPO, LS and AWWs interviewed were clear about the three objectives of ICDS – nutrition, health and pre-school education. This could be attributed to the quality of training given in the pilot phase of the project. They worked as a team and seemed to be highly

motivated.

- VIHAN – an NGO specialising in early childhood development provided continuous training and resource support in the block, not only in the ICDS programme but also in the ECCE component of the Lok Jumbish Project.
- Despite the fact that most of the AWWs were barely literate, they visited homes, took nutrition education seriously and elicited the support of the panchayat to arrange for jaggery / other condiments to make the food palatable to children. Overall cleanliness of AWCs was impressive and AWWs aware of the importance of good hygiene.
- Self-help groups were fairly active and reportedly, the uptake of credit was among the best in Rajasthan. The SHG programme also received support from ASEFA – a NGO that specialises in this field. We came across fairly aware and active mothers' groups, who were also a part of the SHGs. Women's groups in the villages worked with the AWCs and performed the role of an aware and active community forum. Grain banks were organised in some villages to promote nutrition security.
- The CDPO was authorised by the Deputy Director to permit AWWs and Lady Supervisors to purchase pre-school education materials up to Rs 600 per annum. As a result the AWCs were bright and colourful.
- We were also informed that the CDPO motivated the administration to use famine relief work to undertake repairs of the AWCs, a fact borne out by our visit to four centres, which were in excellent condition.
- The adult education programme was launched here in the 1980s followed by the Total Literacy Campaign. While this may not have meant to total literacy, community leaders admitted that it had led to higher awareness among the poor – especially women.
- Interface with education was impressive. Garhi was among the first blocks taken up under Lok Jumbish. Micro planning and school mapping carried out in the block also contributed to greater awareness about education, including pre-school education.

Source: Field visit from 13 to 15 March 2004.

Taking a cue from the Directorate, the system for tendering of the SNP transportation contract in Rajasthan (from block offices to the AWCs) was detailed (Table 2)[2]. A committee consisting of the CEO, Zila Parishad, the District Accounts Officer, and the Deputy Director, ICDS, adjudicated tenders. Separate transporters were selected for each block. This system seemed to work but with some delays, with the average time lag between the receipt of SNP at the block office and distribution to the AWC being a week to 10 days or more (Table).

Table 2: Nutrition supply to the Block and AWC in Rajasthan 2003-04

Demand from Block	Orders to the transport company	Date of arrival	Supply to the centre
First week of June 2003	16 June 2003	24 June 2003: 15 metric tonne	25 June, 2003
Same as above	Same as above	27 June 2003: 20 metric tonne	Next day
14 July, 2003	6 August 2003	16 August 2003: 15 metric tonne	Next day
27 August, 2003	6 September 2003	11 September 2003: 20 metric tonne	15 September 2003
13 October 2003 Reminder 1 November, 2003	5 November 2003	12 November 2003: 15 metric tonne	14 November, 2003
3 December 2003	15 December 2003	26 December 2003: 15 metric tonne	3 January, 2004
27 January 2004	22 January 2004	4 February 2004: 15 metric tonne	9 February 2004
26 February 2004	No information	Supply had not arrived when we visited the centre on 15 March, 2004	

Source: DPO, Banswara

[2] Average size of the contract is Rs 0.2 to 0.25 mi

Conversely, we could not ascertain the exact procedure / time lag in Sultanpur lock. Comparing the date of receipt of SNP at the block level with delivery in the AWC, we noticed that there was no consistent pattern (Table 3). The CDPO was not well versed with logistical issues and she was fully dependent on the office accountant. In Rajasthan also, the CDPO was not conversant with the logistics of supply, and she depended completely on the office clerical cadre. Lady Supervisors in both states had little to do with supply. At best, they reported inordinate delays or poor quality of SNP.

Table 3: SNP supply from block to the AWC in Shahgarh, Uttar Pradesh

Receipt of SNP at Block HQ 357 Sacks x 25 kg each	Delivery of SNP at AWC 7 sacks x 25 kg each / per month
26 April 2003	No supply
13 May 2003	23 May 2003 (14 sacks)
15 June 2003	26 June 2003 (7 sacks)
5 July 2003	5 August 2003 (7 sacks)
11 August 2003	29 August 2003 (7 sacks)
No supply from September 2003 to March 2004	

Storage of SNP was not given due attention. The stock was kept in the storeroom of the block office till it was distributed. Given the relatively short time lag between receipt and supply, this may not be a big issue in Rajasthan. But it is an important matter in Uttar Pradesh. Storage in an unsecured space may lead to deterioration in quality, especially if the floor is damp or cracked. The block office in Sultanpur was spacious, but the floor was cracked and windows unaligned. The larger compound was unkempt – home to rats. AWWs and schoolteachers admitted that the quality of SNP was inconsistent in Uttar Pradesh unlike in Rajasthan where, we were informed, that the quality was fairly consistent.

The finance and administrative staff of the district and block offices were not included in training and orientation programmes. As a result, they did not understand the importance of timely supply or easing supply bottlenecks. With the exception of the Statistical Assistant in Banswara, the rest of the administrative staff in both states did not work with the CDPO and LS as a team. They were, at best, aloof, and in the worst case they saw themselves as gatekeepers. The CDPO had little control over them as they reported directly to their supervisors at the district level. Equally, the CDPO did not appear to have adequate capability to manage or supervise finance and administration. Many of the officials were promoted from the ranks and though accounting and administration are part of their training, these are not emphasised enough. They confined themselves to monitoring targets / data. For example, the CDPO in Rajasthan was not even aware of a directive issued from the DPO's office for the purchase of jaggery and had marked it without reading it to the office accountant. There also seemed to be a gender division here. Most finance and administrative staff was men while the programme staff constituted women. Therefore, even a highly motivated and committed CDPO may feel powerless to control her finance and administrative staff. There is little devolvement of financial powers to the block level and very few discretionary powers, apparently to prevent misuse.

The CDPO (in the case of UP, the Assistant CDPO) plays a critical role in managing the project. The contrasting situation in the two states is revealing.

- In UP, the ACDPO was given a lump sum of Rs 4000 for travel and conveyance per annum. She did not have a vehicle to make field visits and had to request someone for a lift. She had to pay for the fuel. Despite that she goes on field visits and has already visited 25 centres in the short tenure. Though the ACDPO is motivated and committed she is still struggling in the cross currents of unmotivated Supervisors. All the Lady Supervisors reported to the CDPO office every afternoon, but there was no formal system of monthly monitoring meetings among themselves.

- The agency of the CDPO and DPO - in creating a supportive environment and ensuring tight monitoring - is, perhaps, the key to relatively higher prevalence of good practices in Banswara district of Rajasthan. To begin with, the CDPOs had vehicles for monitoring visits. As a result, they were motivated and in close contact with both the district office as well as their supervisors. They had visited many centres (except the ones in remote areas) and were fairly well informed about all the aspects of the programme. They also attended the quarterly state level meetings on a rotation basis – thereby coming in direct contact with the Directorate. These quarterly meetings at the state level were used to communicate guidelines, provide training (the one held in February 2004 was on linking SHGs to banks and growth monitoring) and get feedback on operational issues / problems.

4.1.3: AWC and cluster or sector level:

As discussed in Section 3, workers and personnel are, perhaps, among the most crucial factors that determine performance. As most of the AWW-related factors have been discussed at length in that section, the key issues are flagged here. The social background of workers is an important determinant. Appointing workers from upper castes and/or relatively well-off communities is a barrier to the participation of the socially and economically disadvantaged. If the worker also happens to be well connected –wife, daughter or daughter-in-law of the village head (pradhan, sarpanch) - then enforcing discipline / accountability is difficult. While educational status makes a difference, especially in understanding concepts and keeping records, high motivation levels and quality support from the LS can compensate well, as was evident in Garhi block (Box 1).

Training makes a difference. Discussions with AWWs in Garhi block (Box 1) - one of the pilot districts - revealed that training was more rigorous and holistic in the late 1970s and early 1980s. However, as the programme went to scale, it was diluted. Discussions with trainers at NIPCCCD and officials who were involved with the ICDS during the early stages revealed that training programmes then focused on child development as a holistic process, where nutrition and stimulation were given greater importance. However, as the programme became institutionalised, record keeping became more significant. The workers took their cue from the issues that were prioritised in the training programme and from monitoring indicators that emphasised aggregate data. Little effort was made to put a face or a name to the data. This, perhaps, explains why the tabulated data with Lady Supervisors could not always be tallied with AWC registers (See paragraph 3.3 above).

Important learning!

Another issue that emerged during the fieldwork was the status of the AWW in the system. She is at the bottom of the ladder and it is not surprising that workers in UP are happy when the AWC is located in the school. This appears to enhance her status in the eyes of the community. She is seen as a teacher and not as a child-care worker. Three AWWs said that they even had a chair to sit on! This, perhaps, also explains why AWWs prefer to focus on the 3-6 years and ignore home-based care of children under 3. Home visits are not considered important to them or the Supervisors.

In view of the fact that the AWW is possibly the only female village level worker available on site, she is given a range of tasks. For example, in Rajasthan she still received family planning targets, SHG targets, immunisation responsibilities and almost any programme that dealt with women and children sought to involve the AWW. The importance of a given campaign or programme of the government at a point of time determines the seriousness with which her routine work is monitored. For example, in Uttar Pradesh, the Pulse Polio campaign has been on the priority list of the government for valid reasons. According to AWWs their interaction with under-3s and pregnant women last year was mostly linked to the campaign. Supervisors of AWWs and, most importantly, the district level administrators do not pay much attention

to nutrition and growth monitoring. This is not surprising given seven-month long breaks in nutrition supply.

On the positive side, a nurturing and caring administration can, indeed, spur the workers. The situation in Rajasthan (Talwara and Garhi blocks) and Karnataka (Bellary) shows that proper selection, tight monitoring and regular encouragement and affirmation (through awards, regular visits by CDPO, DPO) can make a difference – even where three of the eight AWWs are untrained (Table 4).

The role of the Lady Supervisor in providing on-the-spot training emerged as an important factor. On the other hand, the UP scenario demonstrated that mechanical or routine induction training without regular follow-up and / or refresher courses is of limited value. The AWWs of the study sample were selected and trained in 1984 with the exception of one. They took standard training of three months, which was later reduced to 52 days in the 90s. At that time, the selection process was simple. Applications were invited and interviews held for selection. The AWWs had to be from the village and educated women in the villages were largely from forward caste communities. Of the 51 AWWs, all but one was trained. This untrained one had been retained on compassionate grounds even though she was not mentally sound and could not perform her routine tasks and responsibilities. Another AWH had been appointed on compassionate grounds because she had lost her husband and was supporting four daughters. However, she was the daughter of the AWW (forward caste), and was employed in the same centre as her mother! AWWs had not received any refresher trainings or new inputs since 1993. Whatever they had learnt during induction and other trainings in 1984 and other short trainings in 1992-93 had been lost over the years.

Table 4: Profile of AWWs

	Talwara Rajasthan	Shahgarh Uttar Pradesh
Age group		
Below 40	4/8	2 of 8
40 to 50	4/8	5 of 8
50 plus	0/8	1 of 8
Educational level		
Illiterate	1/8	0/8
Primary School	1/8	0/8
Middle School	4/8	0/8
High School	2/8	5/8
Intermediate	0/8	3/8
Graduate and above	0/8	0/8
Caste of AWW		
Upper caste	2/6	6/8
OBC	0/6	2/8
SC/ST	6/8	0/8
Training		
Untrained	3/8	0/8
Received pre-service training	4/8	8/8
Received additional training	1/8	0/8

The Lady Supervisor (LS) is a crucial link in the ICDS programme. Her motivation level, age, training, years in service and in the sector, her capability and leadership qualities can energise the programme. A competent Lady Supervisor can make a difference in her sector. We found

that if she is energetic and earnest about her work, a Lady Supervisor can achieve a lot regardless of whether she has been directly recruited to the post or promoted from the position of AWW. Similarly, educational qualifications do not seem to make much difference.

Five out of the eight LSs interviewed in Rajasthan were post-graduates, only one was a graduate and the remaining two were matriculates. We did not see any significant difference in their performance, understanding or commitment. Their monitoring report was fairly standardised. They recorded the number of children present, conducted some pre-school activities, and met a few mothers, and so on. However, what was certainly impressive was that all the eight LSs were familiar with each of the AWCs under their supervision and could grade them quite accurately.

The scenario in UP was not so rosy. Monthly visit reports made at the AWC level (with copies to the block office) were routine recording mundane issues such as attendance of children, activities conducted with them, cleanliness of the centre and children, growth monitoring data (not a single demonstration had been recorded), status of immunisation, meetings of Mahila Mandals (women's groups) and status of SNP distribution (when available). There was no evident follow-up on the previous month's report of the Supervisor's visit to a particular centre. The LSs saw their role as one of "checking the centre" rather than providing support. All the 3 LS were resided at the block HQ and were familiar with all the 51 centres. Their motivation level was low. Out of the three – two were intermediate pass and promoted to the level from AWW. The third one was B.Ed. and Post Graduate and had been recruited as Supervisor directly 25 years ago. She was promoted to the level of CDPO (in another district) and then reverted to this position due to legal case regarding recruitment of an AWW. She was the major demotivating factor in the entire block office set up. –

It was observed that had the supervisors been adequately motivated, their guidance to B grade centres would have highly improved the quality of functioning of these centres. For instance in Sevai village the AWW required inputs for record keeping and data collation, which could have easily been rendered by the supervisor had she given some time and showed some initiative

Notwithstanding the above, three factors have the potential of creating positive deviance in the sector:

Important learning!

- The ability of the LS to establish a good rapport with the workers at the AWC, the CDPO, and government service providers at the panchayat, village and block level is a big help. We came across a few LSs in Talwara, who were able to access panchayat resources to improve the building, install a hand pump, arrange for jaggery and recommend their centres for awards. One particularly motivated LS had been deputed to work as Pracheta (cluster level worker) in WDP, Rajasthan. She was a skilled communicator and highly energetic trainer.
- Distance between the place of stay of the Lady Supervisor and her cluster is also crucial. Living in close proximity enables her to reach her centres on time and also come unannounced. On the other hand, Lady Supervisors who commute from afar have a predictable schedule – bus timings, schedule of health days and Pulse Polio dates.
- The motivation of the Supervisor is equally crucial for proper functioning of centres and for positive deviance.

Interestingly, we observed that a group of proficient Lady Supervisors in Rajasthan could easily offset an unresponsive or unmotivated CDPO while the reverse was true in UP.

4.2 Formulation and communication of operational procedures:

In the last five years, the Rajasthan Government has formulated and issued a wide range of orders and guidelines. These are essentially procedures meant to guide the day-to-day functioning of the programme. A gist of some of the important ones is as follows:

i. AWCs to operate in their own buildings failing which, near or in a primary school or in health sub -centre (HQ of ANM), or, as a last resort, from rented locations. The centres will not function from the residences of the AWWs. Consequently, nearly all the AWCs have their own building in Talwara block.

ii. Village Panchayat Committees will undertake construction of AWC buildings at convenient locations identified or made available by the panchayat, in consultation with the LS or CDPO. The panchayat will also be responsible for the maintenance of the building.

iii. Appointment of AWW and AWH
   a AWWs should be, as far as possible, married and residents of the same village (or locality, in the case of urban centres), residing not more than 1 km away from the AWC. They should be between 21 and 45 years of age (some relaxation is possible in specified cases), and should have studied till at least Class VIII (Class X in the case of urban AWCs).
   b Widows divorcees or separated women, or those from SC / ST (in that order) should get preference.
   c The Gram Panchayat should select the AWWs in the presence of the LS, and the CDPO must endorse their candidature. Exceptions can be made in the event of the non-availability of suitable candidates from the village, but with the consent of the CDPO. In such cases, selection should be made on the condition that the earlier appointment would be cancelled in case suitable candidates are found at a later date. The period of such an appointment will be one year, extendable on an annual basis.
   d Retirement age has been fixed (September 2003) at 58 years. In exceptional cases, a committee comprising the CEO, Zila Parishad; DD, ICDS; the Panchayat Development Officer concerned, and the CDPO can grant extension till the age of 62. .
   e AWHs are required to have cleared at least Class V, failing which, they should be at least literate.
   f Only one woman per family can be appointed for the positions of AWW or AWH; AWWs and AWHs are not transferable from their place of appointment.

iv. With effect from 1 April, 2002, honoraria payable to the AWW and AWH are Rs 1,000 per month and Rs 500 per month respectively.

v. AWCs must open for four hours per day (8am till 12noon in summer, and 9am till 1pm in winter).

vi. For every 1000 population, the target number of beneficiaries are 100:
   a 40 children in age group 0-3 years,
   b 40 children in age group 3-6 years,
   c 10 pregnant mothers, eight lactating mothers, and
   d Two adolescent (11-15 year olds) girls from very poor and needy families.

vii. Based on HH surveys, where weights (the only growth indicators being used) of children in the age group 0-6 years are also taken, malnourished (grades 1 and 2) and severely malnourished (grades 3 & 4) children must be identified. Such children must be enrolled at the AWC.

viii. Target number for pregnant women is 10 and lactating mothers is eight – they must be selected from economically weaker sections.

ix. Targeting of the poor is to be done in the following order: BPL families; IRDP families; landless labour or small / marginal farmers and SC / ST families.

x. SNP distribution at each AWC is should be broken up into:

a "Carry home" rations, to be given every Monday @ 160 gm per day to pregnant and lactating mothers, as well as to malnourished adolescent girls;
b Ration to be distributed daily in cooked form @ 80 gm to Grade I & II children, and @160 gm to Grade III & IV children in the age group 3-6 years (target of 40 children). Salt and jaggery to be also supplied.
c A weekly menu for cooked SNP must be followed at each centre.

xi. All enrolled children must be weighed every quarter. Growth charts must be maintained and LSs are required to review these during their monthly inspection visit to the AWC. The LS will assist an AWW who is not adequately trained or is unable to conduct this activity due to lack of or lower literacy.
xii. SNP is to be distributed at each AWC six days a week, barring holidays. It is expected that this activity will be conducted for an average of 300 days per year. Stainless steel utensils of excellent quality and in reasonable quantities have been made available to all ICDS III AWCs.
xiii. Procurement activity for SNP is done at the state level, and orders are placed on for delivery at the Block H/Q. Contractors, chosen through an established tendering procedure at the district level (members of the tender committee are the DD, ADM - Admin and District Treasury Officer) will be responsible for SNP transportation from the block headquarters to the doorstep of the AWCs. .
xiv. Pre-school education (PSE) activity with the 3-6 year olds must be conducted every day. Most AWWs / AWHs have received some training for this. The Directorate of ICDS supplies PSE kits annually, and procurement is done on tender basis[3].
xv. Health awareness / check up, as well as immunisation activity is conducted in co-ordination with the ANM (Health Department) on one pre-specified health day per month, when the LS is also expected to be present at the AWC. No physical targets are given to AWWs / LSs.
xvi. Medical kits (as per GOI norms) with one medical box (cabinet) are provided at AWCs. Replacements of over-the-counter (OTC) drugs etc. are to be obtained from the health sub-centres via ANMs.
xvii. IFA (large size, meant for adults) and de-worming tablets are being arranged (though the supply is sporadic) at the state level through tender. Pulse Polio drops and Vitamin A is dispensed in campaign mode with the assistance of ANMs.
xviii. Target for number of home visits:
a Twenty per month for AWW ;
b Five per AWC and minimum 100 per month for LS; and
c Five per AWC, and minimum 75 per month for CDPO / ACDPO.
xix. Training is based on the norms / curriculum specified by the state, and is normally conducted for LSs by the Home Science Institute in Udaipur and for AWWs by Rajasthan Vidyapeet (Dabok in Udaipur) / Rajasthan Mahila Vidyalaya (Udaipur) / Vidya Bhawan (Udaipur). District-level training programmes are occasionally organised, for both the AWWs as well as AWHs (the research team actually visited one residential training programme for AWHs). The DPOs / CDPOs receive training either at RIPA (Jaipur) or NIPCCD (Lucknow).
xx. Goals for the formation of SHGs (at least two per AWC) with savings targets (normally Rs 50 to Rs 100 per member per month), mothers' committees (one per centre), and family planning cases (two per year) have been given to the AWWs.
xxi. With the assistance of their LSs, AWWs are expected to do the following:
a Maintain 15 / 16 registers;
b Prepare their monthly progress reports; and
c Attend one sector meeting every month at their sector headquarters.
xxii. LSs are expected to visit every AWC at least once a month, as also attend meetings at the CDPO office.

[3] Quality of ESE kits available at AWCs was observed to be quite poor.

xxiii. DPOs and CDPOs are expected to visit nearly 20 AWCs per month, for which they have been provided jeeps.
xxiv. AWWs are expected to assist their counterparts – *Sathins* – in dealing with cases of child marriage and women's exploitation in their villages.
xxv. With effect from July 2003, AWCs will operate under the direct supervision of the village panchayats. The CDPOs, LSs and other staff are under the overall administrative control of the Panchayat Samiti, which is ultimately answerable to the Zila Parishad, with technical assistance and guidance of the DD ICDS and DPO. AWWs must attend four panchayat meetings– on the 5th, 12th, 20th, and 27th of every month. Daily attendance monitoring is the responsibility of the panchayat.
xxvi. An AWW can be promoted as LS provided she has at least 10 years of continuous service, is a matriculate, and is less than 45 years of age.[4]
xxvii. A system of monetary awards has been instituted at the state level as impetus for the staff.

The significant point here is that there has been a concerted effort, at least in the last five years, to streamline the programme and eliminate contradiction that may have existed in guidelines issued over a period of time. Notwithstanding the positive impact of the streamlining, the downside of the programme in is that the AWWs have been given family planning (four sterilisations a year) and SHG targets (formation of two groups per centre). Similarly, Lady Supervisors and the CDPO have also been given specific targets with respect to family planning and linking SHGs to banks. In addition, workers at all levels are expected support the *Sathin* in her efforts to prevent child marriages and also respond to the needs of women in distress and / or victims of domestic violence. A compendium of guidelines is available at the state and district levels in Rajasthan.

However, we could not access such a document in Uttar Pradesh. Responding to the need to clarify the appointment procedures for AWWs, the Directorate issued an amendment on 16 December 2003 to the appointment guidelines of 1991. The significant changes in this government order includes retirement age of 60 for AWW, ensuring that the AWW is a resident of the village (not panchayat), priority to be given to widows / deserted / separated women / those from below-poverty line families. The order also stipulates a procedure for the selection of the AWW by a committee that includes the CDPO, Panchayat Samiti members, and the village *pradhan*.

Important learning!

The most important learning from the Rajasthan experience is that a cohesive set of guidelines and operating procedures creates a positive environment for the project, it minimises ambiguities and facilitates clarity of roles and responsibilities among each and every functionaries. This complemented by motivated and efficient leadership at the state and district levels provides tremendous scope for positive deviance. Particularly noteworthy are the fairly regular supply and distribution of SNP, appropriate selection of workers and targeting poor children for the programme.

4.3 Procurement, supply and distribution:

Supplementary nutrition (SNP) is being arranged in Banswara under the World Food Programme. At present, nutrition being supplied is "India Mix" in 25 kg HDPE bags. We were informed that the nutrition supply to the centres has been fairly smooth – even though some of the centres we visited recorded up to 30 days' break in supply (see Table 5).

[4] It is understood that the maximum age criterion is now being slightly relaxed for very meritorious cases.

Table 5: Pattern of Distribution of SNP in 3 AWCs, June 2003 – March 2004

Name of AWC	Date on which SNP was over	Date of supply of SNP	Quantity received	Gap – Number of days
Barisiatalia	21 June 2003	30 June 2003	250 kg	9 days
	8 August 2003	27August 2003	100 kg	19 days
	10 August2003	17 August 2003	150 kg	8 days
	10 October2003	16 November 2003	100 kg	32 days
	2 December 2003	5 January 2004	225 kg	33 days
	-	10 February 2004	100 kg	-
	28 February 2004*	Supply not received	-	Over 17 days (15 Mar 04)
Janawari	18 August2003	26 August2003	125 kg	8 days
	18 October 2003	17 November 2003	125 kg	30 days
	20 December 2003	6 January 2004	200 kg	18 days
	-	10 February 2004	100 kg	-
	15 March, 2004*	Supply not received	-	-
Wanka	27 June 2003	1 July 2003	250 kg	4 days
	8 August 2003	21 August 2003	125 kg	13 days
	12 September 2003	17 September 2003	150 kg	5 days
	15 October 2003	17 November 2003	125 kg	34 days
	21 December 2003	6 January 2004	200 kg	17 days
	6 February 2004	10 February 2004	100 kg	4 days
	-	-	-	10 kg stock available March 15, 2004*

* Take home ration has not been given on March 8 and 15, 2004

Source: Registers at the AWCs and interviews with AWWs and LSs.

Since there has been no supply of SNP in UP since September 2003, the research team could not observe or record any positive deviances. It was, hence, decided to observe some AWCs where PMGY/sponsored nutrition ("baby mix" or weaning food) is currently available. In consultation with the DWCD, Lucknow, the team visited three AWWs in Jarwal block of Bahraich district, selected on a random basis. The AWWs told us that the Supervisors had asked them to distribute the weaning food among the 3-6 year olds to ensure regular attendance at the centre. But in the stock register, the entries were against distribution to 0-3 years olds! Printed registers meant to record the details of every child enrolled in a consolidated form with columns for parents' names, date of birth, attendance, immunisation, distribution of supplementary nutrition etc. were being maintained. Out of the three AWCs visited, two were functional, while the third (functioning from the residence of the AWW) appeared to be dysfunctional. The AWW here claimed to be ill on the day of the visit, possibly to get away from explaining why no children were visible during the working hours the AWC. Even at the two functional centres, we saw poor and malnourished children.

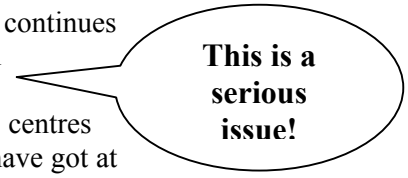
The key issues pertaining to supply and distribution are:

Important learning!

- Adequate and uninterrupted supply must be ensured. This is entirely in the hands of the state government. Larger governance issues determine the ability of the WCD directorate to ensure timely procurement. The Rajasthan scenario is much better.
- Streamlining of supply from the block to the AWCs is within the purview of the district and block officials. Evidently, two important factors influence this in Rajasthan:
- Tight monitoring at the state level to minimise the time lag between the receipt of supply and its distribution;
- Financial and administrative authority devolved to the CDPO's office to ensure monitoring.
- Distribution of adequate quantity to targeted children. This depends on the quality of training, tight monitoring and the availability of a vessel to give the stipulated amount

to the target beneficiaries and not to every child who happens to come to the AWC or, in some cases, to destitute women (mostly elderly). Some best practices observed in Rajasthan are:

- Distribution of the cooked meal twice – at 10.30 am and again at 12.30 pm – just before the children go home;
- Village contributes to jaggery supplies;
- Palatability of the food is contingent on the availability of sugar or jaggery. This is a weak area even in Rajasthan, with the exception of two centres. The quality of preparation leaves much to be desired.
- Home-based support or monitoring of feeding practices for 0-3 years to promote weaning food, monitor the growth of grade 3 and malnourished children is necessary if the programme is serious about reaching out to this age group.



We observed a casual approach to nutrition education, which continues to be a weak area. Discussions with mother's and older women in the community revealed that they are not sure if the supplementary feeding actually makes a difference. In several centres of Rajasthan, the meal in the AWC substituted what they may have got at home. The take home rations for children who are below 3 years is merged into the general household food kitty. In the specific context of the practices that we observed on the ground, we were left wondering if nutrition supplements actually make a difference to the children from very poor families. **This is a serious issue**.

4.4 Targeting beneficiaries:

This section starts with a concise socio-economic profile of the two selected blocks. It, then, analyses the issue of targeting keeping the specific situation of the area as the backdrop. This section covers four issues:

- Socio-economic profile of the area;
- Profile of Aanganwadi workers (AWWs), their caste and/or community;
- Identification and enrolment of children in AWCs
- The situation with respect to children under 3.

4.4.1 Talwara block, Banswara district, Rajasthan:

Talwara is a development block in Banswara tehsil (sub-district unit), therefore census data is available only for Banswara tehsil. Talwara has a fairly homogeneous population and is covered under the Tribal Sub-plan, with 61 percent of the population being scheduled tribes. In rural areas, the number goes up 76.8 percent. The SC population is insignificant at 4.4 percent in Banswara district as a whole, with only 3.7 percent in rural areas. *Bagri* is the largest tribe is and the spoken dialect of the district is also *Bagri.* Other tribes living in this region are *Bheel, Ninama, Maida* and *Garasia* - the most deprived group among the tribals. The female literacy rate for the entire tehsil is 36.6 percent, and only 23.5 percent in rural areas. The total number of children between 0-6 years in Banswara is 72,918 with a sex ratio of 941. (Census 2001)

There are eight blocks in the district, with a total of 1,234 operating AWCs. Banswara district falls in the command area of the Mahi Multipurpose Project. Unlike most of Rajasthan, the land here is fertile and yields good returns to farmers. With the exception of the severe drought years, people grow a variety of food as well as commercial crops. This is also an important marble mining area. So, non-farm employment is also available at the mining sites.

The ICDS survey data indicate that the district has a total of 206,406 children in the 0-6 age group, and 28,266 women either pregnant or lactating[5]. Corresponding figures for Talwara block are 25,013 children in the 0-6 age group and 3,620 pregnant or lactating mothers.

[5] Source: CDPO Office, January 2004 data

Table 6: Demographic profile of Banswara and Sultanpur

Census 2001	Rajasthan		Uttar Pradesh	
	Banswara District	Banswara Tehsil (Talwara)	Sultanpur District	Gauriganj Tehsil (Shahgarh)
Population,	1,500,420	3,71,320	3,214,832	326,723
Sex Ratio	978	959	980	977
Juvenile sex ratio	972	941	941	948
Female Literacy	27.86	36.6	40.9	34.4
SC Population	4.3	4.4	22.2	26.8
ST Population	72.3	61.0	0	0

Banswara is a tribal majority area and most of the children enumerated and enrolled are STs (Table 6). Figures available in the district reveal that 39,298 children (19,709 boys and 19,589 girls) are enrolled in the AWC against a target of 49,400. The corresponding numbers in Talwara block are 4,944 children (2,506 boys and 2,438 girls) enrolled against a target of 5,500. The block or district does not maintain centre-wise data of beneficiaries based on social groups because it has a predominantly ST population. Six of the eight AWWs were from SC and ST communities. During the field visits, we noticed that nearly all the children were from poor tribal households. We were informed that the relatively well-off families or those from forward castes did not send their children to the AWC as they considered it below their social standing to avail of free nutrition. As against this, children from almost all communities enrolled in the primary school partook of the mid-day meal.

It is evident from Table 6 that a fixed number of children are enrolled in the AWC and the programme does not cater to all the children in the village – especially, larger villages. Some big villages have two AWCs but this is more an exception than a norm. The proportion of enrolled girls and boys is commensurate with the prevailing sex ratio in the district (978) and the tehsil (959). It is in this context that targeting assumes significance.

Discussions with the community (mothers' group, panchayat) revealed that AWCs primarily catered to tribal children. Unfortunately, the centres do not think it important to collate available information disaggregated by social groups – even though the enrolment registers records social groups.

4.4.2 Shahgarh block, Sultanpur district, Uttar Pradesh:

Sultanpur district is a part of Faizabad division of Uttar Pradesh. The geographic area of the district is 4436 sq km. It may be called an agrarian area because agriculture is the main occupation of the people. The district headquarter are in Sultanpur, the only town with a municipality. Other town areas are Amethi, Musafirkhana, Dostpur, Kadipur and Koeripur. The district is divided into 22 development blocks under six tehsils or subdivisions: Sadar (Sultanpur), Kadipur, Musafirkhana, Amethi, Gauriganj and the newly formed Lambhua. Shahgarh block comes under Gauriganj tehsil.

Sultanpur is an agriculturally rich district with fertile soils and good irrigation facilities. This has resulted in higher area under food grain production and yields, placing the district in the first quartile of high food production districts in the state (Source: CMIE, U.P. February 2004). The social composition of the population in Shahgarh block is interesting, with almost 75 percent comprising general and OBC categories while only 18percent percent belong to scheduled castes (See Table: 7 for social composition of the Shahgarh development block).

Table 7: Social composition of Shahgarh block, Sultanpur district.

	Males	Females	Total	percent
General	15657	14930	30587	37.3
SC	8097	7484	15581	18.0
OBC	16381	16456	32837	40.0
Minority	1527	1510	3037	3.7
Total	46662	40380	82042	

(Source: SSA 2001-2002, Department of Education, GoUP)
Note: SSA Survey data pertains to the Shahgarh development block, located in Gauriganj tehsil.

Members of the OBC community – Yadav, Muraos, Kurmis, Lodhs and Gararíyas - are known to be hardworking cultivators and vegetable growers. Even though the land holdings are small, people cultivate food grains and vegetables for the local markets and their own consumption. During the visits to the village in the evening, we saw many women collecting vegetables from the fields for their dinner. We did not come across abject poverty in this dominant community. The SC population is generally poor, with landless farmers who do share cropping for a living. The research team came across several cases where the SC families had migrated to Lucknow and other neighbouring cities for work.

One of the important issues pertaining to targeting is the low enrolment of children from socially disadvantaged families. The AWWs conduct half-yearly surveys. The last one was done in October 2003. The Aanganwadi workers admitted that they were not sure why this survey was done. They could not connect enumeration of children with their enrolment. During interaction sessions with the community, especially the SCs, we found that the poorest of the poor were invariably left out, and children who lived in the vicinity of the AWC enrolled first. Out of the 559 children (all categories) enrolled in the AWCs visited, 49 percent were OBC, 27 percent were SC, 20 percent were GC and 3 percent were Muslims. With the exception of Hardoiya (where the AWC is located in an SC hamlet), the enumeration of SC children was not commensurate with the 0-6 population. The OBCs were the dominant social group in the block, which was evident in the enrolment statistics (Table: 8 on AWC data by social group). The SC community, comprising 26.8 percent (Census 2001), was under-represented in the centres under study. Only 31 percent of the children from this community had enrolled.

Equally important is the profile of the AWWs. Out of the 51 AWWs in Shahgarh block, eight were OBC and five SC. The remaining 39 AWWs were from forward castes. However, most of the AWHs were either SC or OBC, with a few exceptions. Workers from forward caste admitted that their home visits were irregular in SC hamlets.

While exploring the reasons for low enrolment of SC children, we found that OBC and FC families greatly emphasised primary education. In the last five years primary schooling had emerged as the social norm among these castes. This was not, however, true for the families of the ST community – many of whom migrated on work to other areas (in UP and outside) for several months a year. This could also partially explain under-representation in the AWCs.

4.4.3 Identification of beneficiaries

The link between HH survey (including measurement of weight for age) and enrolment of children in AWCs was tenuous in Uttar Pradesh, even though AWWs reported that they had covered all the habitations in seven of the eight centres visited. Discussions with the workers and women in the community revealed that all the children brought to the centre were enrolled. We found that AWWs did not appreciate the necessity of a HH survey in enrolment. It was seen a mechanical process to collect information and send it up. As a result, self-

selection of beneficiaries was more a norm than an exception. AWWs in UP reported that they first enrolled children (3-6 years) who were already registered with them (0-3 age) and only then looked for more children to meet the target. They did not consciously target poor families. We could not ascertain any pattern in the enrolment of 0-3 age group.

The situation in Rajasthan was somewhat different. The AWWs reported that they enrolled children after the HH survey. The survey covered all the habitation in five of the eight centres and only partially covered all the habitations in three of the eight centres (Table: 8). As Banswara is a predominantly tribal area, an overwhelming majority of the children in the district were not only tribal (given that they constitute 61 percent of the population in the area), but also they were from very poor households. The better off (both upper caste and tribal) did not avail of supplementary nutrition, probably because of social prestige.

Table 8: Household survey and identification of beneficiaries

	Talwara	Shahgarh
Household survey		
HH survey done (full)	5/8	7/8
Survey done (partial)	3/8	1/8
Not done at all	0/8	0/8
Identification of beneficiaries		
By weight (Grade 1 - 4)	1/8	0
The poor	8/8	0
The poorest	0	0
By social group	0	0
By proximity to AWC / accessibility	7/8	8/8

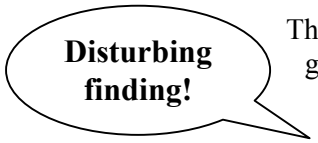
4.4.4 Targeting under 3s:

Despite clear policy directives from the GOI, especially under the aegis of ICDS III, the ability of the programme to reach out to children under 3 remains a problem, even though, technically, they are enrolled in the AWC.

Firstly, nutrition supplement to this group is distributed only once a week. Given that the AWWs do not make regular home visits, their ability to monitor the growth of children in the age group is problematic. The situation is rather bleak in Uttar Pradesh where there was a seven-month break in the supply of SNP. We did not come across any positive practices with respect to growth monitoring or health / nutrition education. The only service made available was immunisation and occasionally, Vitamin A (through ANM in UP) distribution. This is a very serious issue because the overall health and nutritional status of children we visited was quite poor. The findings in this study reaffirm those made in an earlier study (Ramachandran et al, Report submitted to the World Bank, 2003):

- Nearly all the children visited received polio drops in Rajasthan and Uttar Pradesh. However, mothers could not recall any other vaccine given to their children;
- Awareness about the importance of vaccines in disease prevention was low, as was knowledge about the link between clean drinking water, proper sanitation and disease;
- Children between 6 and 18 months received very little weaning food. They were primarily breastfed. The practice of feeding soft and mushy food was not common, especially among the very poor;
- AWWs admitted that the weekly rations given to children and pregnant / lactating mothers were often consumed by the entire household in very poor families.
- Children suffered frequent bouts of diarrhoea or other communicable diseases. On enquiring about the low weight of children, mothers invariably said the child had just recovered from a bout of diarrhoea or fever;

- Mothers admitted that that the AWWs, especially in Rajasthan, asked them to give solid food to their children. However, they could not recall the exact nutrition advice given by the workers. The reason for this could partly be because nutrition and health education is disseminated infrequently and casually. Even though the AWWs in UP said they took up nutrition education with mothers during home visits, interaction with the latter belied the workers' claims. They only met the mothers if and when they brought their children to the centres for immunisation. *We did not come across <u>even a single</u> instance where the AWW had monitored a grade 3 or 4 malnourished child and used the opportunity to demonstrate the effectiveness of supplementary feeding*.
- In Rajasthan, the AWWs showed us the counterfoil of referral slips given to mothers for severely malnourished or ill children (unlike in Uttar Pradesh where we did not come across any referral services). We were informed that the ANM visited the villages fairly regularly – especially for immunisation services. We were pleasantly surprised to see that the Block PHC in Talwara had a resident doctor couple. Notwithstanding the positive impact of a functioning primary health care programme, families seemed to use the services only for specific illnesses. Incidentally, malnutrition was not seen as an illness. Discussions with mothers' groups in Rajasthan and Uttar Pradesh revealed that the mothers felt their children would "catch up" after the age of three when they would be able to eat the food cooked for adults. They were not aware of the long-term health implications of severe malnutrition in early childhood.
- Equally, while most of the AWWs in Rajasthan provided supplementary nutrition to pregnant and lactating mothers, they took little interest in finding out whether the mother was registered with the ANM and receiving any antenatal care. There was almost no nutrition education for pregnant women.
- The Lady Supervisors and CDPO did not discuss these issues during field visits.



The absence of positive deviance with respect to monitoring the growth of children under 3 is a cause for concern. Aanganwadi workers find it easier to manage older children and are not motivated to provided home-based care or services. Monitoring systems currently used do not capture this aspect of the ICDS programme. This may, perhaps, explain the absence of positive deviance even in relatively well-performing projects.

Table 9: Children in 0-6 age group and those enrolled in AWC, Talwara, Rajasthan

AWC	AWW Caste	Banswara Sub-division						ICDS data from Talwara development Block									
		Population Census 2001			0-6 Population Census 2001			6-12 Months Enrolled in AWC			1-3 Years Enrolled in AWC			3-6 Years Enrolled in AWC			Total 6 months to 6 years enrolled in AWC
		Total	ST	SC	M	F	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
Wanka	SC	1135	513	25	130	77	207	8	9	17	25	20	45	20	20	40	102
Janawari	FC	1003	1000	0	107	110	217	4	4	8	16	12	28	20	20	40	76
Kushalpura	FC	2420	2119	5	288	256	544	7	3	10	16	10	26	23	18	41	77
Warlipada	ST	1066	1066	0	116	113	229	10	7	17	11	15	26	20	19	39	82
Barisia Talai	SC	1068	850	0	135	127	262	7	2	9	16	17	33	22	14	36	78
Malwasa 1	SC	2884	2655	15	356	328	684	10	11	21	12	12	24	18	18	36	81
Saga Garnawat	ST	1950	1849	15	214	211	425	10	10	20	4	4	8	18	17	35	63
Gamdi 1	ST	1823	896	137	186	171	357	2	2	4	14	8	22	10	14	24	50
TOTAL		13349	10948	197	1532	1393	2925	58	48	106	114	98	212	151	140	291	609
Percent of Total			82.01	1.48						17.41			34.81			47.78	

Note: Talwara Development Block is located in Banswara subdivision. Census 2001 data pertains to the sub-division. Data for Malwasa (1 & 2) and Saga Ganawat (Leemthan panchayat) in Census 2001 is of the larger village – the AWC caters to a set of hamlets of the village and do not always cover the entire village.

Table 10: Children enumerated and enrolled by social group, Shahgarh, UP

AWC	Census 2001 Gauriganj Tehsil		Survey Data														
	Percent Scheduled Caste	0-6 Population	AWW Caste	Scheduled caste			OBC			General			Muslim			All social Groups	
				Enum	Enrolled	percent	Enum	Enrolled	percent	Enum	Enrolled	percent	Enum	Enrolled	percent	Enum	Enrolled
3 to 6 Yrs																	
Soraon	8.0	165	Brahmin	13	5	38.46	75	22	29.33	10	10	100	7	3	42.86	105	40
Chilbili	31.7	192	OBC	52	12	23.08	53	20	37.74	19	8	42.11				124	40
Shahgarh 1	17.9	489	Thakur	30	2	6.67	50	32	64.00	30	1	3.33	20	5	25.00	130	40
Paniar	16.2	295	Brahmin	36	12	33.33	41	17	41.46	35	11	31.43				112	40
Purabgaon	13.6	339	Brahmin	28	5	17.86	34	22	64.71	30	12	40.00				92	39
Sewai	33.3	400	OBC	30	13	43.33	16	20	125.00	10	7	70.00				56	40
Afoiya	36.6	366	Brahmin	38	24	63.16	30	8	26.67	30	8	26.67				98	40
Hardoiya	41.7	323	Thakur														40
All				227	73	32.16	299	141	47.16	164	57	34.76	27	8	29.63	717	319
0 to 3 Yrs																	0
Soraon	8.0	165	Brahmin	18	5	27.78	80	34	27.00	7	5	71.43	5	4	80.00	110	48
Chilbili	31.7	192	OBC	41	19	46.34	44	15	34.09	27	5	18.52				112	39
Shahgarh 1	17.9	489	Thakur	39	2	5.13	93	30	32.26	55	3	5.45	28	5	17.86	215	40
Paniar	16.2	295	Brahmin	41	16	39.02	48	11	22.92	34	13	38.24				123	40
Purabgaon	13.6	339	Brahmin	34	4	11.76	28	21	75.00	18	14	77.78				80	39
Sewai	33.3	400	OBC	37	11	29.73	39	17	43.59	19	6	31.58				95	34
Afoiya	36.6	366	Brahmin	45	22	48.89	41	7	17.07	36	11	30.56				122	40
Hardoiya	41.7	323	Thakur														34
All				255	79	30.98	373	135	36.19	196	57	29.08	33	9	27.27	857	314
Total 0-6		2569		482	152	31.54	672	276	41.07	360	114	31.67	69	17	28.33	1574	633

Source: Data from AWC registers, February 2004 and Census 2001. Hardoiya AWC did not have the required information.
Shahgarh Block is located in Gauriganj Tehsil / Sub Division. Census 2001 data pertains to Gauriganj Tehsil / Sub Division

4.5 Growth monitoring:

At the outset, ICDS data reveals a relatively positive picture (as compared to the state in general) with respect to the nutritional status of children attending AWC (see Table 1 on Baseline data used for Block selection and Table 11 below). Growth monitoring data collected in the project reveals that almost 40 percent of children are "normal" and only 0.55 percent in UP and 0.28 percent in Rajasthan are in grades 3 and 4. The nutrition profile of the 2 blocks selected for this study appears to be better than the state average as revealed in NFHS II (Table 11).

Table 11: Growth monitoring data of the ICDS compared to NFHS II data

Growth monitoring data of children 6 months to 6 years attending AWC								
	Shahgarh, UP (51 AWCs)				Talwara, Raj (138 AWCs)			
	Boys	Girls	Total	Percent	Boys	Girls	Total	Percent
Normal	420	418	838	41.65	1885	2110	3995	40.28
Grade 1	376	342	718	35.69	1624	1549	3173	31.99
Grade 2	220	225	445	22.12	1394	1329	2723	27.45
Grade 3 & 4	7	4	11	0.55	12	16	28	0.28
Total	1023	989	2012	100.00	4915	5004	9919	100.00

NFHS II (1998) - Percent children in 0-35 months						
	Uttar Pradesh			Rajasthan		
	Boys	Girls	Total	Boys	Girls	Total
Percent Children < 3 SD	19.8	24.2	21.9	20.6	21.0	20.8
Percent Children < 2 SD	49.6	53.9	51.7	49.2	52.2	50.6

Source: ACDPO/DPO, Sultanpur and Banswara, February 2004, NFHS II (IIPS, 1998)

It is not possible to say whether the nutrition status of children is actually much better than the state average or whether this can be attributed to faulty weighing scales and poor weighing practices followed in the AWCs observed in this study. Anyway, the only growth-monitoring indicator is weight, which too, is being measured using faulty and uncalibrated weighing machines. Children between 3-6 years are being weighed on adult weighing machines. As a result, the growth monitoring charts (wherever maintained) are certainly not accurate. In the course of this study, we weighed roughly 25 percent of the children in this age bracket who were present on the day of the fieldwork. We tried to crosscheck this information in the registers. One, we could not tally the names of children in almost 60 percent of the cases. Two, where the weights were recorded there was no mention of the age of the children. Three, in most cases even the names did not tally with the actual children. The AWWs said most children had two or more names. The ones recorded in the enrolment register were not always the same as ones used at home. We were not able to record the GM data in most of the AWCs. Either the Lady Supervisor gave us this information from her notebook or we got it from the CDPO's office. They had aggregate numbers of children in each grade and the LSs could not name the children who were recorded as being grade 3 or 4 level malnourished. Every centre in Rajasthan had two children recorded as receiving double rations. Once again, the AWW could not give us their names.

This is a critical issue. Equally important is that the registers are not designed to track each child by name and indicators. Given this scenario on the ground, the growth monitoring data that is fed in the system may well be incorrect.

What was fairly evident during the fieldwork is the relative agricultural prosperity of the two blocks as compared to the overall scenario in the respective states. As discussed in the section on the socio-economic situation in the research area, both districts have plenty of water and

agricultural productivity is high. In particular, the dominant community (OBC) that avails of the AWC in Shahgarh, are vegetable growers. Nutrition is not a big issue in this community. However, the economic situation of scheduled caste families is precarious. Being landless daily wage labourers or possessing very small land holdings, their access to food is not assured. This is especially true for families that migrate for short periods for work. Similarly, the overall economic situation of Banswara has also been highlighted earlier in the section on socio-economic profile of the study area. An inference one can draw from the information on the two identified blocks is that some of the positive deviance observed can be attributed to agricultural development and the availability of water for irrigation.

However, during the visits to the villages, we met several families living in abject poverty. Many of them reported that their children were not enrolled in the AWC and they did not avail of the supplementary nutrition provided. On exploring the reasons for non-participation, we found that daily wagers did not have the time to bring their children to the AWCs and pick them up in the afternoon. So, most of them took their children with them.

But really, there were no surprises here. The existential reality of very poor households is well known. The exclusion of the poorest of the poor from a range of government services is well documented. The issue is one of identifying strategies to reach out to them and provide nutritional security to their children.

Another issue that repeatedly surfaced during group discussions and individual interactions was the adequacy of the nutrition supplement in tackling persistent hunger among children. While the quality of SNP supplied was fairly good in Rajasthan, it was not as tasty. In six of the eight centres visited, the fortified flour was cooked badly – it was dry and salty. Small children could hardly be expected to eat more than a handful. Almost all the children spilled some, packed some in old newspapers and only ate a small portion in the presence of the AWW. Two centres had used jaggery to make "*halwa*" (semi-solid porridge) which the children relished.

The message was loud and clear. It was not enough to ensure the supply of fortified flour alone. Supplying jaggery or sugar and other condiments was essential if the SNP was to be made more palatable to children. The AWC re-visited in Bellary district of Karnataka is an excellent example of positive deviance. Rice, broken wheat, pulses, jaggery and salt were supplied and vegetables and condiments were procured locally. The meal served to the children was wholesome and palatable to children and pregnant and lactating mothers. (See Section II of this report)

Another area of concern was the quantity given to each child (Table 12). Given the milieu in the villages, the AWW distributed the supplements to any child who came to the centre. In two AWCs of Rajasthan, we also observed old women (who had little or no family support) and men coming to the centre for food. We did not come across any child who was officially getting double rations even though nearly all the registers recorded two to four children as being given double rations. The AWWs were at a loss trying to name the children who were identified as the recipients of double rations. When we tried to explore this issue further, the Lady Supervisors and AWWs said that they distributed what was cooked among those who came to the centre. Almost all the AWWs admitted that the AWHs took some cooked SNP to home. In some cases, even the AWWs carried some SNP home. We were informed that they added the fortified supplement to wheat flour to make *rotis* (flat bread) or cooked it as porridge for the entire family. In UP too, the AWWs reported that nutrition was not distributed as per the stipulated amount as there were often more children than those enrolled at the centres. In the AWCs located in school premises, children of class 1 were also fed along with those of the centre.

Table 12: Nutrition and growth monitoring in AWCs visited

	Talwara Rajasthan	Shahgarh Uttar Pradesh
Distribution of supplementary nutrition		
6-36 months	Yes	No since September 2003
3-6 years	Yes	
Pregnant mothers	Yes	
Lactating mothers	Yes	
Regularity	7 out of 8	Could not be observed
Getting correct measures	3 of 8	
Small quantities to all	5 out of 8	
Palatable SNP	2 out of 8	
Growth monitoring		
Weighing only	8 of 8	1 of 8
Erratic weighing	8 of 8	7 of 8
Weighing and filling charts	7 of 8	1 of 8
Tracking	1 of 8	1 of 8
Health & immunisation		
Check-up	7 of 8	0 of 8
Immunisation	8 of 8	7 of 8
Vitamin A	8 of 8	Through ANM
Iron and Folic Acid Tablets	Through ANM	Through ANM
De-worming	N A	N A
Referral services	Exist	No
Availability of medicine kits	3 of 8	0 of 8

Almost all the AWWs in Rajasthan reported that they spoke to mothers (casually, when they met them) the importance of supplementary nutrition to children. And that they also urged pregnant and lactating mothers not to share their rations with the family. They used religious and cultural superstitions to explain to the women that it is a "paap" (sin) to share with the family what is meant for the unborn child. However, it was difficult to say whether the women actually adhered to the advice given.

Important learning!

The most important learning from this study is that the nutrition and growth monitoring of under-3s is a neglected area. Home-based care and support is practically nonexistent. The AWWs find it easer to manage the 3-6 age group and limit their interactions with mothers and under-3s to weekly distribution of nutrition supplements in Rajasthan. The AWWs have almost no interaction with under-3s in UP – with the exception of immunisation-related work during the Pulse Polio campaign.

4.6 Pre-school education:

Observations at the centres revealed that pre-school education comprised reciting rhymes, singing songs and repeating the alphabets. Children in UP used slates (white slate with liquid chalk) and were expected to copy numbers and alphabets. The AWH was seen singing to the children in some centres. In some others, the children were seen sitting around and playing by themselves. The AWCs located in the schools functioned from 9 am to 1 pm in winter and 8 am to 12 pm in summer. In two AWCs, the children were sitting with class 1 students, with the AWW minding the entire group. Given the high pupil-teacher ratios in UP (in one school there were over 240 children and one teacher) the AWW were elevated to the status of a teacher and given the responsibility of class 1. During group discussions, a mother said, "Children must go to the AWC to learn how to sit and behave. At home they play in the dirt

and are up to mischief. There they learn some discipline and move on to the school." Parents believed that children must be learning something if they are going to school. During the various discussions/interaction at all levels PSE emerged as the key objective of ICDS in UP. Under Udisha (ICDS III Training programme) PSE training for AWWs are conducted across the state in 50 district level training centres through NGOs. However according to the Secretary DWCD there is a considerable backlog of training.

Table 13: Pre-school education kits

Pre-school education	Talwara, Rajasthan	Shahgarh, UP
Availability of PSE kits	6 of 8	No
Play way (songs etc)	8 of 8	2 of 8
Alphabets / numbers	N A	7 of 8
Merged with Class 1 children	No	2 of 8

According to the DPO, the number of PSE beneficiaries in the district (enrolled children in the age group of 3-6 years) was 39,298 (19,709 boys and 19,589 girls) against a target of 49,400. In Talwara block, the number was 4,944 (2,506 boys and 2,438 girls) against a target of 5,500. All the AWCs in Rajasthan had been supplied with PSE kits – they were available in six of the eight centres in Rajasthan but not even one centre in UP had them. The seesaw was used but toys and charts were brought out only during inspection days and for the duration of this study.

It is noteworthy that pre-school education has received considerable attention in Rajasthan in the last few years. Most refresher training programmes organised in the recent past have been on pre-school education. Under the Udisha scheme (ICDS III), training modules have been prepared in Rajasthan. A retired official from the education department (Shiksha Karmi Project) has been hired to develop the training modules and organise training. It is too early to say whether this intervention has been effective.
We went unannounced for the second time to most of the 16 centres and found the PSE kits had been put away.

Table 14: Status of Pre-School Education

	1: Very poor; 3: average; 5: excellent							
Rajasthan	AWC 1	AWC 2	AWC 3	AWC 4	AWC 5	AWC 6	AWC 7	AWC 8
Display of PSE material	4	5	4	2	1	2	2	3
Availability and usage by children	3	5	4	1	2	1	1	2
Generation of own PSE material by AWW	3	5	3	1	1	2	1	2
Involvement in school enrolment	4	4	3	1	2	4	2	3
Attraction of children to the AWC	5	5	4	4	3	4	3	2
Uttar Pradesh								
Display of PSE material	1	2	2	1	1	2	1	1
Availability and usage by children	2	2	2	1	1	1	1	1
Generation of own PSE material by AWW	1	1	2	1	1	1	1	1
Involvement in school enrolment	5	3	5	3	2	2	3	3
Attraction of children to the AWC	5	1	4	2	1	1	1	1

Important learning!

An important learning from this study is that the AWWs like to see themselves as teachers who are responsible for pre-school education and record keeping. The responsibility of nutrition distribution is given to the helper. They prefer to focus on the 3 to 6 age group and are ambivalent when home-based case for 0-3 is

discussed.

4.7 Convergence with health and education

One of the strong positive findings in Uttar Pradesh was that convergence, though limited, was visible with the Education Department. This was facilitated by the decision to move AWCs to primary school premises. Thirty six of the 51 AWCs in the block were located in primary schools. This ensured regular attendance of the workers and fixed timings of the centres. Almost 70 percent of children between 3 and 6 years were present in most of the AWCs even though the nutrition component was absent. This was a huge step forward. Teachers admitted that children were now able to make a smooth transition from the AWC to the primary school. In the last year 48 out of the 93 children who moved from these eight AWC to schools were from the three centres located within schools. The teachers saw the AWC as part of the school and functioned under the overall supervision of the schoolteacher. Some of the AWWs were resentful that they were being paid far less than the teacher, and even the Shiksha Mitra (para teachers). Discussions with women in the community revealed that many children above 6 years continued to avail of the supplementary nutrition when distributed and also got 3 kilograms of wheat (in lieu of the mid-day meal) from the school[6].

Convergence with the health sector was not as promising. The ANM visited the AWC for immunisation every month. However the CHC, PHC and Sub Centres almost dysfunctional as a result of which referral services were almost nonexistent. People went to Government Hospital in Musafirkhana or the Sanjay Gandhi Hospital (Private) in Amethi (the electoral constituency of the Gandhi family). The block CHC did not have adequate qualified staff or infrastructure to cater to out-patients. In one of the villages, the ANM had not visited for the last three-four months as she was on sick leave!

The situation was quite encouraging in Rajasthan.

- We came across a functioning block PHC in Talwara where a doctor couple was available round the clock. In view of the priority assigned by the state government to maternal and child health in the 100-day programme of the new government, ANMs visited the villages and the block PHC provided back-up support.
- The Women's Development Programme (WDP) was introduced in this block in 1984. As a result there is a group of highly motivated *Sathins* that has been working with women on a range of developmental and empowerment issues. This has created an environment where the uptake of government services by poor women is relatively high. Several ICDS functionaries were deputed to the programme and were sensitive to the problems of poor women. The DPO and several Lady Supervisors reverted to the ICDS and brought with them the work culture of the WDP programme.
- The Public Health Department (PHED) supplied portable water from tube wells and hand pumps.
- The government has introduced a system known as *Mini Sachivalaya* (mini secretariat) where in all panchayat level workers meet four times a month (on the 5th, 12th, 20th and 27th) to address inter-departmental convergence. The sarpanch and panchayat secretary conduct these meetings. AWWs complain that they have to "waste" an entire day in these meeting. While this takes them away from their centres four times a month, this forum has tremendous potential. It is bound to be effective, if workers are trained to use this forum to address the shortfalls in the programme, namely access to sugar and jaggery to make the food more palatable and can facilitate referral services for women and children's health.

[6] Uttar Pradesh has not yet complied with the directive of the Supreme Court of India to provide cooked mid-day meals. Dry rations of 3 kilograms of wheat are distributed every month.

The work of Lok Jumbish (Education for All project which functioned in the district from 1992 to June 2004) has also reinvigorated primary education. We visited primary schools in all the eight villages and found them functioning. The teacher-pupil ratio was encouraging (1:25- 40). Schooling is gradually becoming a social norm and there is a demand for pre-school education.

While the full potential of good inter-departmental convergence is yet to be realised, the overall environment in Banswara is encouraging.

The important learning here is that the ICDS programme does not and cannot stand-alone. Its effectiveness is influenced by the larger development scenario in the village, cluster and block – in particular the functioning of primary healthcare, primary education, women's empowerment programmes, rural roads and communication and a well-functioning panchayat. Proactive Sathins and an energised primary education system have made people confident about accessing government education and awareness programmes. When programme uptake goes up, the pressure on the worker to provide services also increases. The converse is also true. The ICDS cannot shine by itself if the health system is dysfunctional, primary schools over-crowded, teachers indifferent and there is no independent forum for women to come together.

4.8 Record keeping, information flow and monitoring:

A great deal of energy was expended on record keeping, compiling data and feeding information up the line. This was evident at all levels. The database and information retrieval system at the state and district level was quite impressive in Rajasthan and fairly good in Uttar Pradesh. But as we got closer to the AWC the situation became fuzzy. The data fed into the system was recorded in 15 or so registers. We found considerable variation in the number of registers maintained from centre to centre. The following registers were being used:

- Survey (house-to-house) register, to be updated every quarter
- Enrolment register and daily attendance register
- Growth charts register
- Mamta Cards
- IFA register
- Immunisation register maintained by the ANM but kept in the AWC
- Referral services diary
- MS-4 form register: recording receipts, distribution and stock position of supplementary nutrition
- Stock register of permanent and semi permanent assets
- Birth and death records register
- Visit books to record the observations of the person(s) inspecting the AWC
- SHG groups register recording savings and credit records of members (Rajasthan)
- Mahila Mandal meetings register
- Mothers' committee meetings record register
- Jaggery and salt register (Rajasthan)

Discussions with AWWs revealed that there was little clarity especially at the AWC level about the purpose for which data was collected. One common problem encountered was in tallying the names of children in different registers. While the enrolment and attendance registers mentioned the data of birth of the child and in most cases the father's name, the growth chart register or the loose sheets recording the weight of children did not include their date of birth even though there was a slot for age. AWWs explained that parents used different names for the same child. Often the name of the children in the loose sheets of paper recording weights did not tally with those in the register. The most relevant and critical information, the names of children in grades 2, 3 and 4 levels, was not readily available with

either the LSs or the AWWs. But the LSs could give us monthly aggregate data on children at different levels from their notebook. *Perhaps this explains why the LS and CDPO have access to aggregate numbers but the AWW cannot identify children in different nutritional grades by name*. It is this data that is fed upwards in the system. The validity of this information is therefore questionable. Another complication we encountered was that not all enrolled children attended. Children living near the AWCs came, while officially children from target groups were enrolled.

In Uttar Pradesh we were informed that the directorate had made an effort to streamline and simplify registers. We came across one such register in Bahraich district (see Box 2). The AWW concerned admitted that this format was indeed easier and all relevant information, enrolment onwards, about the child was recorded on one page. It was, therefore, easy to track the child by attendance, nutrition supply, weight and immunisation status. Discussions at the block, district and state levels revealed that the state government and the directorate had little say on the format of the registers. This had been decided by the GOI.

Box 2: Innovative registers in Uttar Pradesh

On a random visit to three AWCs in Jarwal block in Bahraich district (covered under ICDS III), the team came across a printed register meant to record details of every child enrolled in a consolidated form. It had columns for parents' name, date of birth, attendance, immunisation and distribution of supplementary nutrition etc. Such registers could replace the multiple registers being maintained. But here too it was not being put to proper use.

Source: Field visit, 28 February 2004

Important learning!

The most important channel for monitoring the information flow is the monthly meeting held at the sector, block and district levels. The meeting dates are fixed and workers at each level are expected to bring the tabulated data for submission. This data is then compiled by the district office and sent up to the directorate. This activity takes precedence over all other activities and the quality of a project is often judged by the regularity of information flow. Unfortunately no effort was made to authenticate the data and put a face to the numbers. Almost all the AWCs in Rajasthan reported the malnourished children (3 & 4 level) given double rations between grades 2 and 4. But seven out of eight AWWs could not readily offer the names of the children.

4.9 Community interface:

This is perhaps one of the most important factors that can potentially make a big difference on the ground. Yet this was found to be the weakest link in the programme. We encountered some interesting situations – an active panchayat leader who took personal interest in the AWC; a *Sathin* who visited the centre daily to check on it and also helped the AWW; and a local teacher who kept an eye on the children. We did not see an effective functioning formally constituted Mother's Committee. These committees, at least the ones we met and interacted with, comprised of women who came to the AWC for supplementary nutrition either for themselves or their children. There were conflicting accounts on whether they were a formally constituted group and whether they met regularly. The record of meetings was fairly standard. The attendance of 5- 8 women was recorded and with a mention of the AWWs advice on nutrition followed by thumb impressions of the women. There was little difference across centres over a period of time.

A disturbing phenomena was the degree of community apathy towards the AWC in UP. While discussions on nutrition supplies were spirited, the poorest were resigned to the fact

that the supplies would not reach them. The situation was better in Rajasthan, especially in villages where the *Sathins* were active and women were aware of the services provided in the AWCs. Active community involvement in the day-to-day functioning of the centre was missing.

4.10 Governance holds the key:

Any commentary on the relative success or failure of the ICDS programme invariably leads to comparisons between Tamil Nadu on one end of the spectrum and Bihar and Uttar Pradesh on the other end. During our travels in Tamil Nadu in 1999-2000 for the fieldwork of a study on gender and social equity in primary education (Ramachandran (ed), 2002) we saw a number of pre-election meetings in rural areas. The message was fairly simple – the major political parties in Tamil Nadu claimed credit for the successful mid-day meal (primary school) and supplementary nutrition programme (ICDS). Local community leaders were vociferous in their support to one party or the other on count of the two programmes.

Child nutrition is a big political issue in Tamil Nadu and a priority. Officials admit that corruption and misappropriation of funds meant for the nutrition programme is taboo. Successive chief ministers have monitored them closely.

The situation in Andhra Pradesh in 2002-03 was quite similar. Following the directive of the Supreme Court, the Andhra Pradesh government planned to introduce a hot mid-day meal programme. Women's groups (DWCRA) were mobilised to cook and serve the meals to children in schools. This, we are told, was a big election issue for the incumbent political party.

The new chief minister of Rajasthan started her 100-day programme with a focus on health, nutrition and primary education. We saw the hectic activity at the district level. The ICDS programme and primary education is now under the spotlight. It is too early to say which way the wind will blow. But the officials we met in Jaipur and in Banswara were trying their best. They were not afraid of political censure, in procurement and supply-related issues and in following the procedures laid down for appointment of functionaries.

In contrast with the scenario in Uttar Pradesh, child health and nutrition are nowhere on the political radar of the political parties. A great deal has been written about caste and community-based mobilisation during elections for the appointment of service providers and distribution of "goodies" in the form of contracts and services. Yes, primary education has slowly become an important issue among the people. As a result, we see a sudden increase in the number of private schools and teaching shops. When people become aware of safe healthcare, they move from traditional or informal providers to the private sector. Uttar Pradesh has seen a gradual decline in most social sectors and the ICDS programme is no exception. Committed officials are often helpless – the fear of being targeted is genuine when huge sums of money are involved in tenders for procurement.

But why blame the political leaders alone? Another important difference between Uttar Pradesh and Karnataka or Tamil Nadu is the absence or presence of positive stakeholders. NGOs, civil society groups, the media and business community make a difference. We have seen remarkable progress on the primary education front in the last five to seven years – even in Uttar Pradesh and Bihar. There is now a groundswell in primary schooling. It is fast emerging as a social norm and people want their children to go to school. When the voice of the people gets louder, the political leaders and administrators cannot afford to remain apathetic. The issue is not only about client voice and client power. It is about the voice of the ordinary people who dare to ask what has happened to the millions of rupees allocated for child health and nutrition or for that matter maternal and child health, primary education and

so on. This voice is audible in Karnataka, Tamil Nadu and, at times, even in Rajasthan. Unfortunately, it is silent in Uttar Pradesh.

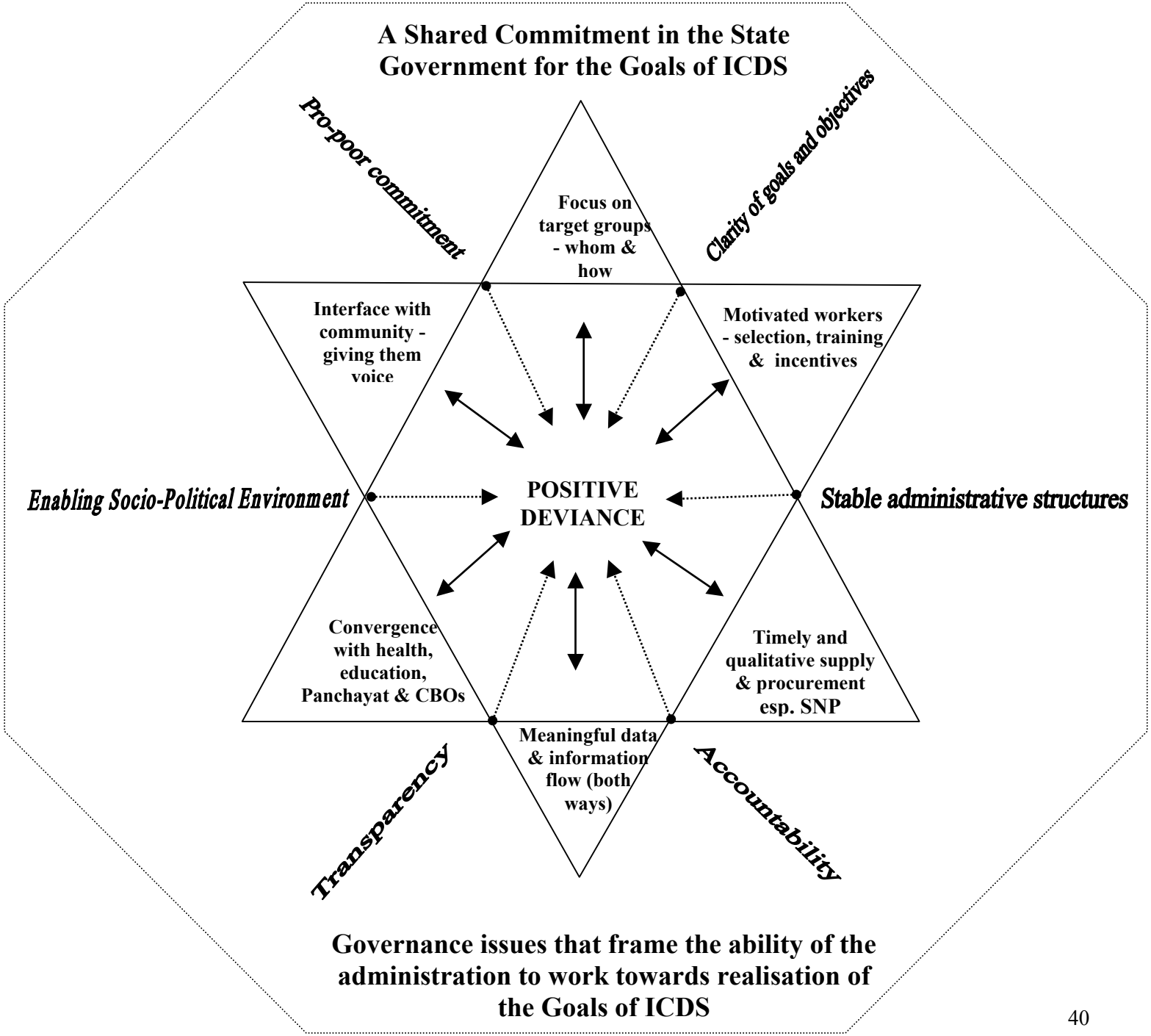
The overall development scenario is Banswara district could, perhaps, be attributed to the several decades of care given by important leaders from the district that led the child ministry for a decade or more. Senior officials also admit that Banswara (which is in the south extreme of Rajasthan bordering Gujarat and Madhya Pradesh) is seen as a punishment posting. As a result people who get posted in the district are those who either do not have clout or cannot afford to pay for a plum posting. A positive outcome of this situation is that the tenure of officials in the district is fairly long. The current DPO of the ICDS has been in the district for 23 years – long enough to strike deep roots and also get involved with the people. Frequent transfers, insecurity of tenure and interference can dampen the spirits of even the most committed of workers.

5. Summarising factors that contribute to positive deviance:

Exhibit 1 below summarises the factors that can potentially lead to positive deviance in the ICDS programme. As evident, the overarching environment in the state makes a big difference to the way in which the programme is administered in the state. The most important issue that influences the success of any programme is whether everyone – up and down the line – have a shared understanding of the goals of the programme, how these goals broken down the line into tasks, outputs and monitoring indicators. Equally significant is the fact is whether the government is able to enforce full implementation. Once the key actors understand the larger policy context in which the ICDS programme was launched in the mid-1970s and its relevance in their own geographical area today, it becomes possible for the rank and file to meet expectations of the programme

State level:

- High-level political and administrative commitment given to health, nutrition and education of children.
- The ICDS flagged as a priority programme of the government.
- Interest taken in communicating guidelines in a consistent manner, no contradictory messages, no time lag between order or directive and implementation.
- Ensuring deployment of personnel, right up to the AWC level:
- Negotiating of local factors that may inhibit proper selection and working to see that AWWs are selected with care.
- Ensuring regular supply of SNP and other supplies, right to the AWC.
- Close monitoring of the supply chain, with an eye on the quality of storage and transporting procedures
- Training to use the medical kits etc. Ensure regular supply of kits and IEC materials.
- Approach to training: to see not only if it happens or the training curriculum but also pay attention to motivating and supporting workers.
- Close tracking of targets with qualitative inputs and insulating AWWs from extraneous responsibilities and tasks (SHG, FP targets).
- Periodic meetings of DD, DPO, CDPO, ACPO, LS etc to discuss the specific aspects of the programme – especially tracking every single malnourished child.
- Create structures and forums to give the lower level staff a voice, to include them in planning, training and contributing ideas.


A Shared Commitment in the State Government for the Goals of ICDS
Pro-poor commitment
Clarity of goals and objectives
Focus on target groups - whom & how
Interface with community - giving them voice
Motivated workers - selection, training & incentives
Enabling Socio-Political Environment
POSITIVE DEVIANCE
Stable administrative structures
Convergence with health, education, Panchayat & CBOs
Timely and qualitative supply & procurement esp. SNP
Meaningful data & information flow (both ways)
Transparency
Accountability
Governance issues that frame the ability of the administration to work towards realisation of the Goals of ICDS

District level:

- The agency of the DD in regularly monitoring and supporting the programme, travelling across the district.
- Smooth supply – of SNP, medical kits, PSE and IEC materials.
- Close monitoring of supply chain – with an eye on the quality of storage and transporting procedures.
- Close tracking of the given targets and insulating AWWs from extraneous responsibilities and tasks (SHG, FP targets).
- Presence of individuals with commitment, those who have not had to lobby for the post in the district. This is particularly important because officials who have managed their posting through lobbying or payment are not as dedicated and are also prone to corruption.
- Culture of work built over several years and by successive officials.
- The ICDS does not stand-alone. The presence of other programmes that contribute to creating an overall environment for (a) service delivery and (b) uptake of services by people is must:
- A cluster of programmes linked to each other like the WDP, PHC, and primary education. There is a positive ripple effect of a good programme on other similar or related programmes.
- The ICDS is also influenced by the effectiveness / interest taken by PRI institutions – in supporting and encouraging and giving the programme some importance.

Block and cluster (sector) level:

- Individuals, the agency of the LS and her team of AWWs, make a lot of difference. The most important factor that influences the functioning of an AWC is the Lady Supervisor. Her role is critical to the operation of the AWC.
- The ripple effect of good quality services -particularly important in the regular supply and provision of SNP to children. People get used to availing of services and a break leads to sustained and gradually increasing pressure on the service providers.

AWC level:

- The educational level of the AWW influences her ability to understand and appreciate the various aspects of the programme.
- Her ability to grasp concepts (not necessarily related to the educational level), and see the connections between them – malnutrition and weight linkage, holistic approach to nutrition etc is crucial.
- Whether she is local and also from the appropriate social group to reach out to the community seems to be quite important, at least from the point of view of the panchayat.
- Additional responsibilities given to the AWW (SHGs, FP targets) take her away from her primary responsibility – SNP, GM and PSE. Too many responsibilities affect quality of work.
- Presence of a *Sathin* and any other highly motivated or socially active agency or service provider
- AWW's rapport with women in the community.
- AWW's rapport with the panchayat and her ability to access additional resources from the community – jaggery, vegetables, sugar, butter milk etc to make SNP tasty as well as nutritious.
- Infrastructure and facilities.
- Distance of the AWC from the main road appears to be a critical factor:
- The AWCs in the interior areas were much worse. It is detrimental for the programme when the workers are not from the village. All the AWCs we visited in the remote areas were not functional.
- Distance from the centre of the villag
- Younger children cannot come – location needs greater attention.

Panchayat / community level:

- The panchayat marks the attendance of the AWW and also controls resources like building maintenance. A vibrant, vigilant panchayat makes a difference.
- Presence of strong women's groups can be a big help, especially if poor women are mobilised and organised to not only access the services but also to wield pressure on the service providers. This gives them a voice and also a forum to make themselves heard.

6. Role of Government of India in the realisation of the core objectives of ICDS

While the ICDS programme is a central Sector Scheme, with Government of India assuming the leadership and making a significant financial contribution to the programme, the State Government from its own non-plan resources finances the food component. Equally significant is the fact that external assistance by way of loan from the World Bank or as grant from other multilateral agencies like UNICEF (except the WFP) is channelled for geographical expansion of the programme and for infrastructure development, personnel, training and monitoring. The World Bank Supervision Mission of September-December 2003 notes: " The CPMU and the World Bank agree that it is now necessary to improve the quality of execution of the ICDS III project and the general ICDS program by focusing on the execution of all the activities that need to accompany the investment in infrastructure development for ICDS to have an impact on children's and women's well-being, including their nutritional status". Yet, despite repeated mention of slow / irregular procurement in states like Uttar Pradesh and despite recommending adoption of local procurement of supplements, not much headway has been made in this direction[7].

As a result, ensuring regular supply of nutrition is within the purview of the state government. Discussions with DWCD and NIPCCD reveal that their role is one of compiling the data and monitoring the programme through quarterly reports. DWCD, GOI issues guidelines from time to time on almost all aspects of the programme. These guidelines are communicated to the state and an exhaustive compendium of these guidelines is available. NIPCCD provides guidance with respect to training and has in the past conducted detailed studies on the impact of the programme. GOI's ability to ensure regular supply of SNP is limited. Equally important is the fact that the external agencies are also not in a position to make their support conditional on regular procurement and supply of nutrition supplements.

7 "Progress in implementing the quality improvement components of the project shows some improvements from the June 2003 (expenditure from 20% to 29%). However, there is a need to speed up the process of implementation particularly in the problem states like U.P. and Maharashtra where expenditure levels are merely 16% and 12% respectively. Some sub components like Training for IEC (3%), action research, continued social assessment (14%), Monitoring Information Systems (4%), and Mobility for field supervision (4%) need more attention as overall expenditures are reported very low…. During the national consultation for the mid-term review (MTR) in May 2003, it was agreed with GOI and the states that there in an urgent need for speeding up the implementation of specific quality improvement components for achievement of project development objectives. It was recommended that community based multi-sectoral "best practices" that support the core guiding priciples of restructuring, such as the UNICEF supported "Anchal Se Angan Tak" - Rajsthan, "Dular" - Bihar, "Bal Sanjeevni" - Madhya Pradesh, INHP, CARE, will be scaled up in project blocks under innovative funds. However, there is no progress on this…Based on the analysis of the project survey data, it became evident that the ICDS program needs to improve some of its structural features if is to be used as the vehicle to reduce the problem of malnutrition in India successfully. In particular, problems of targeting and service quality were identified even in the areas were the ICDS program has succeeded in reaching most, if not all, households" (Aide Memoire, December 2003)

Given this situation, it is not clear to what extent the GOI can actually ensure the realisation of the core objectives – reduction in malnutrition, targeting poor households, targeting under 3s and behaviour change communication. Given the federal structure of the country and given uneven development across the social sectors, national designs and national norms make little sense. Perhaps the only answer is to move towards state specific norms and state specific Memorandum of Understanding between GOI, the external donor agency and the State Government. Such an approach could lend itself to more intensive technical support and monitoring in the more difficult regions and a more hands-off approach in those states where the programme is functioning well.

7. Recommendations:

7.1 **State-by-state visioning exercise**: A state-by-state re-visioning exercise can be explored to revisit the objectives of the ICDS programme – within the agreed ICD conceptual framework (Annexure 5). This is essential to secure the commitment of the state leadership to the core objectives of the programme. This may be followed by stakeholders' meetings at the state and district levels, with political leaders and with other important opinion makers in the state. A draft vision document that is circulated widely could help involve a larger number of people in re-shaping the programme. This will also provide an opportunity to engage the political leadership in an informed debate on the importance of a child health and nutrition programme in the larger development strategy. Such a process will, hopefully, throw up positive stakeholders who can, then, be involved in a periodic social audit of the programme. It will also enable greater participation of the corporate and business community, who can be invited to contribute in cash or kind. State level agencies or individuals could be involved in independent monitoring of processes and their outcomes.

7.1.1 It is important that GOI and the World Bank take on board governance issues while designing the ICDS programme. Given the political sensitivity of the issue, it is often overlooked in the design and mentioned as a "risk factor". Global experience has shown that development practitioners have not alternative but to address these issues squarely. If the ICDS programme is meant for the poorest of the poor, then all efforts should be made to ensure that it reaches them. Appropriate checks and balances are necessary to enforce proper targeting. This is where larger civil society institutions (not just NGOs, but corporate, media, eminent people) have to be involved in monitoring targeting.

7.1.2 Given the situation with respect to procurement and supply, the World Bank can also explore (where necessary) localised procurement of rice, wheat, and dal etc through the panchayat and move away from ready-to-eat nutrition supplements. Alternatively, the DWCRA and other women's groups can be give per-child budget for procuring and feeding children in the village. While appreciating fears about misappropriation of funds, given the abysmal supply situation in Uttar Pradesh, such a shift may not lead to greater leakages. Needless to add, the situation with respect to supplies needs to be reviewed for each state and appropriate systems designed to suit the specific administrative and political situation in the state concerned.

7.1.3 Since not all poor children have access to the ICDS centre (especially in UP and Rajasthan where most villages have only one centre), the government should consider making it a universal programme for all children in the appropriate age group as also all pregnant and lactating mothers in the catchment area of the ICDS centre. It is important to emphasise that provision of dry rations to pregnant and lactating mothers' defeats the very purpose of supplementary nutrition. Given the precarious economic situation of the households studied, the supplement goes into the food kitty of the family. Educating the women / adolescent about the importance

of iron supplements and how it impacts on the overall health and well-being of women in the reproductive age group needs serious attention[8].

7.1.4 Learning from the successful polio campaign in many parts of the country, the programme should be geared to promote better and accessible nutritional practices. Existing women's programmes and other environment education programmes are not paying much attention to nutrition and health of children. Public education has received a setback in the last 30 years. It may be worthwhile re-visiting earlier nutrition education and preventive health programmes. One disturbing feature is that every new programme introduced tends to diminish the validity of earlier efforts. It was rather disconcerting that basic public health and nutrition messages have been lost in the din of family planning and now HIV and AIDS control. While not challenging the importance or validity of the new focus, simple messages (kitchen gardens, eating leafy vegetables, universal planting of common fruits like guava / berries, nutritional value of coarse grains etc.) that enable people to harvest whatever local resources they have to improve their nutritional status of children. This aspect needs strengthening.

7.1.5 There is today a multiplicity of village level groups and committees with competing goals and overlapping roles. To seriously address crucial factors that facilitate / impede the overall development and growth of children, it is vital to re-examine the roles / mandate of these committees and look for ways to empower specific groups of people to play a more positive interventionist role in ensuring that benefits accrue to those most in need. The enthusiasm with which these committees are constituted is rarely matched by resources / activities to educate and empower them. It is thus necessary to pay special attention to the process of constitution of committees and strengthen training / capacity building activities that are necessary to give them the teeth – to make the difference. This applies to all the committees established for primary education / child development at the village level.

7.1.5.1 Monitoring of ICDS centres and workers needs an urgent review. It may be worthwhile considering the involvement of the Panchayats or educating and empowering the women's committee to play a more effective monitoring role to ensure that programme meets its stated objectives / goals. In particular, that women's groups like *Mahila Samakhya*, *Swashakti* or self-help groups are educated and empowered to play a proactive role in ensuring effectiveness of the ICDS programme. It is a matter of concern that these groups, though aware of the problems and the mandate of the ICDS programme, are not playing any significant role in the villages surveyed.

7.2 **Splitting the ICDS programme**: Analysing the situation on the ground, especially with respect to targeting under 3s, it is recommended that the World Bank discuss the possibility of splitting the ICDS programme into two: (a) a dedicated home-based programme to promote health and nutrition of children in the 0-3 group; health and nutrition of adolescent girls and pregnant and lactating mothers; (b) a centre-based nutrition and pre-school education programme for 3-6 years. This is absolutely essential if we are serious about reaching out to this very important segment of our population. Poor health, malnutrition and frequent bouts of illnesses at this stage have an irreversible impact on the overall health and well being of children.

7.2.1 The additional workers being envisaged in the programme could be trained to provide home-based care. We were informed that there is a proposal to appoint an additional worker in Rajasthan. This welcome addition provides a golden opportunity to re-design the programme and gear it to meet the needs of infants and children up to the age of 3.

[8] Many of the recommendation in 7.1 (7.1.3 to 7.1.5) were made in an earlier study commissioned by the World Bank (Vimala Ramachandran, 2003)

7.2.2 Drawing upon the positive experiences of a pre-school section attached to primary schools, it is recommended that this section be linked to the primary school and be located inside schools. Such a restructuring can enable children to access the mid-day meal programme and also gain from pre-school education. The WCD can contribute to the mid-day meal budget for the 3-6 age group.

7.3 **Specific recommendations with respect to the management of AWCs**:

7.3.1 It is proposed that growth monitoring be done through demonstration. Children, who are identified as being at grades 2, 3 and 4, need to be tracked by name. The AWW should be made to report on the progress of each child to the mothers' committee or a panchayat committee on a monthly basis. Equally the Lady Supervisors should track them over a period of 12 to 18 months and report on the progress.

7.3.2 Aanganwadi registers need to be rationalised and simplified. All relevant information about the child should be recorded on the same page. Separate registers can be maintained for stock and supplies. The 15 or 16 registers need to be reduced to a maximum of three or four.

7.3.3 Lady Supervisors should be given the responsibility of monthly weighing of children in the 0-3 age group using regularly calibrated scales. The programme should explore the possibility of taking the help of an educated youth (preferably female) to assist the LS in this task. The AWW can do the same for 3-6 year olds – again with the help of a local educated youth.

7.4 **Specific recommendation with respect to Aanganwadi Workers**:

7.4.1 As noted in the analytical sections above, the AWW is at the bottom of the chain of government functionaries – not only is she a part-time "honorary" worker, but the work she does, i.e., child care, is not valued by society. Over and above this, she is perhaps the only woman worker available at the village level. As a result she is involved in almost all programmes for women and children. In Rajasthan, she still gets family planning targets, despite GOI directive that non-health department functionaries should not be given FP targets. So we have a situation where the AWW is not monitored on her core responsibilities but on a range of additional duties – which are often given more importance. It is therefore recommended that DWCD negotiate with other departments and free the AWW of additional duties. Equally, set in motion processes whereby the core responsibilities of the AWW are monitored regularly (as spelt out in 7.3.1).

7.4.2 Greater accountability systems have to go hand-in-hand with empowerment, one without the other would not be effective. State-by-state strategies need to be evolved to empower the AWW and improve her status in the administrative machinery and also her status in the community. Again, there are no national solutions. The mother's committee, as it operates now is ineffective – therefore existing women's groups (Mahila Samakhya, WDP, SHG, Water User's Committee, JRM committee) should be linked to the ICDS programme. These groups could both support as well as monitor the AWW.

7.4.3 The retirement age of AWWs and AWHs should be enforced and all new appointments made from the hamlet or village where the AWC is located. Specific guidelines should be issued from the DPO's office stipulating the social background and other essential characterises that are appropriate to the area. Villages with significant SC population must have a worker from that community only.

8. Feedback from dissemination workshop (June 2004):

8.2 The World Bank convened a workshop on 21 June 2004 on "Accelerating Nutrition and Development Outcomes in ICDS – Moving Forward" to share the findings of the study (along with related studies commissioned by the W Bank) with the government

and other stakeholders of the ICDS programme. The recommendations discussed in paragraph 7 above were discussed at length and also placed in the larger context of the ICDS programme in the country. Several recommendations were endorsed in the meeting and some of them were noted but not accepted. The overwhelming message from the dissemination meeting was that given the diversity in the country state specific strategies need to be negotiated with each government under a broad national umbrella.

8.3 Reaching out to under-3s:

8.3.1 The workshop recognised the need for more concerted efforts to reach out to children below the age of 3 and taking a cue from recent policy level decision of the Rajasthan Government to introduce an additional worker with specific responsibilities for 0-3. This implies that there will be a separate worker to manage children in the 3-6 age group.

8.3.2 The workshop underscored the importance of strengthening the nutrition and health component of the ICDS programme. Improving care practices was flagged as being of critical importance. To this end, the participants were of the opinion that the community, mothers and other care providers need to be sensitised and that the skills of the AWWs need to be enhanced to manage nutrition and health issues of under-3s.

8.3.3 Workshop participants were unanimous in their call for greater attention to nutrition counselling – a job that could be specifically assigned to the LS and not be the job of AWWs. This may warrant a fresh round of training and capacity building of LS.

8.3.4 The workshop was unanimous in recognising that demonstration could play a important role in sensitisation of the community and enhancing the confidence of care givers. To this end, a few suggestions were listed, namely: complementary feeding demo session every quarter for 6-12 months children, create awareness about low cost nutritious diet, documenting and demonstrating growth-monitoring through mothers meetings, greater community participation in addressing nutrition related activities in order to promote greater awareness nutritional issues – especially for children below 3 years.

8.3.5 Given the worrisome nutrition situation of children, the participants agreed that there should be on AWC for every 1000 population for urban and rural areas – thereby ensuring full coverage.

8.3.6 The importance of proper nutrition in early childhood needs to become an important focus of communication activities through mass media as well as location specific programmes and activities, notably demonstration of the effectiveness of proper nutrition in improving the health of severely malnourished children. This could influence behaviour and practices of caregivers and the family.

8.3.7 Acknowledging the role of the nutrition component of PMGY scheme for 0-3 yrs, the participants were of the view that this can be used for improving nutrition education in the families through home visits by the AWWs – to this end the AWW could be paid an additional honorarium through PMGY funds to make home visits in the evening – especially in states where an additional worker is not envisaged.

8.4 One the ICDS programme in general:

8.4.1 The participants felt that there should be a uniform retirement age for AWW and AWH and that some kind of retirement benefit may be considered – this was seen as being of particular importance in the light of the home based care needed to improve the nutrition and health situation of under-3s.

8.4.2 Another unanimous recommendation was to reduce the number of registers and streamline the system so that the information gathered is not just sent up for compilation but is also used at the AWC level and by the LS.

8.4.3 Reviewing the data on immunisation and participation in the ICDS programme the workshop participants underscored the importance of improved targeting of the programme to reach the lowest quartile of the population, i.e., make sure the programme actively reaches out to the poorest of the poor in rural and urban areas.

This in turn is influenced by the social profile of AWWs as well as the location of the centre.

8.4.4 The ICDS programme needs to take a life-cycle approach starting from pregnant mothers right up to adolescents. While the need for such a holistic approach has been recognised by the programme, its implementation on the ground remains an area of concern.

8.4.5 There was widespread consensus on the need to not only streamline supply by adopting strategies that is best suited to the specific situation of a given state but also the need to ensure that the SNP supplied is of good quality, is transported and stored hygienically. In this context ensuring allocation of funds in the first quarter of every financial year was underlined as being critical to ensure smooth and uninterrupted supply of SNP.

8.4.6 The need for grassroots management and monitoring of the quality and distribution of SNP was highlighted. In this context the workshop explored ways to enhance the participation of community groups like the mother's committee, SHGs and other women's groups in the area.

8.4.7 What should one monitor? Moving from input and supply indicators to output and outcome indicators was discussed. A lot more work needs to be done on how the nutrition status of children could be monitored and who is best positioned to monitor them. While community based monitoring is perhaps the best way forward, one cannot ignore the need for qualitative and quantitative data that can be used by the government and donor partners to gauge the impact of the programme.

8.4.8 In the above context there were several suggestions on introducing performance based incentives into the programme – for example by announcing rewards for Panchayats / AWCs that are able to demonstrate reduction in child malnutrition.

8.4.9 Showcasing and documenting best practices received considerable attention in the workshop.

8.5 **Concluding observations:** The June 2004 workshop provided an opportunity for the researchers, administrators, nutrition specialists and the World Bank to discuss factors that have the potential to promote positive deviance. While this qualitative assessment tried to explore factors that have the potential to promote positive deviance – the important point that emerged through the study and experience sharing in the June 2004 workshop is that stand-alone interventions in any one dimensions is not enough. A holistic approach that addresses all aspects of the ICDS programme starting from policy level directions to ground level monitoring of impact on the lives of poor children are of equal importance. Equally, attention to related programmes of the government, notably health, sanitation, elementary education and basic infrastructure contribute towards creating an environment where child development interventions have a positive impact on the overall health and nutrition of children. The June 2004 workshop reinforced most of the findings and recommendations of this study.

SECTION II: A GOOD PRACTICE CASE STUDY
(AWC IN HOLAGUNDI VILLAGE OF BELLARY DISTRICT IN KARNATAKA)

Chimnalamma, promoted as a supervisor a month ago, is quick to list the characteristics of a good AWC. "It should be a spacious place with clean surroundings, the building should have good ventilation, enough play materials and teaching aids, a mirror for the children to come and have a look, a small garden in front of the centre, and they should be received with love…" she pauses a while and continues with a grin. "Of course, most of these things are not there in my centre but children attend regularly in good numbers." She elaborates that it is the relationship with children, good pre-school component and food, which attract the children towards the centre.

Chimnalamma's confidence in her centre is borne out by some happy reality. Forty seven children were present when we visited the centre unannounced. This was true for all the three days we visited the centre. By about 10.30am all the children would troop in, some marching in confidently, others brought in crying by grandmothers or older siblings. We were intrigued by the fact that the attendance continued to be high even after Chimnalamma had left to take over her new role as supervisor and the centre was being run by the helper. It seemed as if the centre had acquired a status on a par with the school, where parents sent their children regularly.

The Picture at the Taluka Level

Holagundi village is in Hoovinahadagali taluka of Bellary district, which seems to have a reasonably well-functioning ICDS programme in general. The CDPO of the taluka assesses the centre of Holagundi village as one the better AWCs in his Hoovinahadagali. His criteria for assessing AWCs is:

- Regularity of the AWW and AWH
- Regular attendance of children
- Tasty and well-cooked food
- Use of teaching aids
- Children capable of replying to the simple questions
- Aanganwadi worker and helper handling the children well

The CDPO rated 10 out of the 150 AWCs in this block as excellent (the Holagundi centre being one of them) and 25 as very good. Between 25 and 30 centres, he said, were not functioning well at all.

The CDPO was quick and eager to share data on his taluka and to establish its claim to having a better functioning ICDS programme.

Table II.1: Coverage

Age group	Target	Achievement	% Coverage
6 months to 2 years	3090	2644	86
2 to 3 years	2316	1921	85
3 to 5 years	3894	3874	99
5 to 6 years	1739	1701	97
Pregnant women	955	787	82
Nursing women	855	840	98

Source: Women and Child Department at taluka level. Data as on February 2004

Table II.2: Status of buildings

Status of buildings	Aanganwadi centres
Own building	117
Panchayat building	5
Community building	1
Youth association building	5
Mahila mandal building	2
Temples	6
School buildings	9
Rental buildings	5
Total	150

Source: Women and Child Department at taluka level.
Data as on February 2004

Table II.3: Health status of children

Status	Number of children
Normal	3978
1st grade	4386
2nd grade	3213
3rd grade	80
4th grade	15

Source: Women and Child Department at taluka level.
Data as on February 2004

The near universal reach and coverage of the 3-5 year olds in the taluka is a pattern that one has observed in the other AWCs as well. The pattern repeats itself in the case of Holagundi village as we shall see. The CDPO was emphatic that the number of severely malnourished children in his taluka had come down dramatically because of close monitoring and follow-up by the AWC workers, as well as the provision of regular nutrition supplement. He, however, had no clear plan on how to tackle the fairly large number of children still below normal nourishment levels, nor did he consider this as a major problem.

Profile of Holagundi Village

Holagundi in Hoovinahadagali taluka is a very large village. It has seven schools and six AWCs. The village schools and centres are segregated on caste lines. Chimnalamma's AWC is for the SCs.

Table II.4: Demographic profile of the village

Particulars	Population	Male	Female
SC	1748		
ST	249		
OBC	2782		
Muslims	315		
Total	5094		
0 to 3 children	248	142	106
3 to 6 children	269	146	123
6 to 14 children	1342	689	653

Source: School records and AWC records. As on November 2003

Chimnalamma's centre serves 218 children (0-6yrs) who live in the SC locality. Ninety percent of these children belong to the SC community.

Table II.5: Profile of 0-6 years children belonging to study area.

Social Group	Age	Boys	Girls
SC	0-3	54	50
	3-6	43	48
ST	0-3	2	3
	3-6	2	1
Minority	0-3	3	1
	3-6	2	2
Others	0-3	2	1
	3-6	2	2

Source: Aanganwadi Centre's survey records (03-04)

Table II.6: Profile of the children registered in the AWC.

SC			
Age	Boys	Girls	% of total population
0 to 3	13	20	32%
3 to 6	28	26	59%
Total	41	46	45%

Source: Aanganwadi Centre's survey records. (03-04)

As Table II.6 clearly shows the AWC caters only to the SC community, and even here not all the eligible children of the community access the centre. As in the case of the taluka as a whole, a lot more children (59 percent) between 3 and 6 years attend the Aanganwadi as opposed to about 32 percent in the 0-3 years age group.

Asked why other children did not come, Chimnalamma was quick to point out that one centre would be inadequate if all the eligible children came. Nevertheless, we persisted on understanding why children from the other social groups did not come to this centre. And we found that the AWC was seen as a centre for SCs. Though caste discrimination was not specifically articulated, it was clear that traditional caste boundaries prevented children of other communities from using this centre.

But this was a not seen as a major area of concern as some of the children from the other communities went to other AWCs in the village. Further, short and long-term migration prevented children from accessing the service. Focus group discussions with women revealed that some of the parents did not look at the Aanganwadi Centres as an important service for their children and, hence, did not bother to send their children there. But one cannot say for sure that the poorest have been denied access to the AWC in the case of the Holagundi centre. It needs further exploration.

The Women Who Run the Centre

The AWW, Chimnalamma, and helper Barmavva have been working for the past 14 years. Both belong to the SC community and live close to the centre. While Chimnalamma has studied up to the PUC level, Barmavva is illiterate. Both have been trained for the work at the centre. According to Chimnalamma, the trainings were very helpful in understanding the concept of the programme and to learn some activities, which she could use with the children. After Chimnalamma was promoted as supervisor a month ago, Barmavva has been managing the centre with the help of two adolescent girls from the village and standing in for the AWW as well. Even though, she cannot handle the pre-school component Barmavva keeps the children engaged with songs and games. The teacher from the nearby school comes every morning and takes the children to school after marking their attendance. Chimnalamma and

Barmavva have good understanding and work well together. The community has a lot of appreciation and respect for both of them.

The Aanganwadi Centre

The AWC is located amidst the residential area of the SC community and is easily accessible for the children. It has its own building. The classroom is a 12 x 20 room. In addition, it has a storeroom and a kitchen. Food is made in the kitchen. There are enough vessels for cooking and serving. There is a water tank very close to the centre , but the water supply is not consistent. In such cases, water has to be brought from a bore well nearby. A toilet has been built recently, but no one has yet begun to use it. The children's plea is that they find it difficult to use the toilet in the absence of regular water supply. . But the fact is they are just not used to it. It is, perhaps, a cultural mindset or habit that stops them from using the toilet. Unfortunately, nobody even encourages using this facility.

In the focus group discussion mothers said going to the toilet was dirtier than going to the open field. The other AWCs in the village also have toilets, which were built recently. But they have started using them. Drinking water is kept in the pot in the corner of the hall. Children dip the tumbler in it and take the water on their own. However, the same vessel is used for the purpose of toilet also.

The conditions in which drinking water was used appeared very unhygienic. The surroundings of the centre were unclean but the community did not seem to be conscious of the concept of cleanliness.

Nutrition Supply and Logistics

According to the CDPO, the food materials were delivered to the AWC without any delays. The AWW also said in her 14 years of service she had never experienced any major delays in the supply of food. Barring a couple of times when the delay occurred for a few days and only once for a week, the AWW couldn't recount any other occasion of a time lag in the supply of the SNP. Even so, the children attended regularly.

Even when the occasional delay occurred in the supply of certain kind of food materials, there was always something or the other for the children. For instance, if there was a delay in the supply of rice, there would be sprouted green-grams or energy food ready for the children. This was reconfirmed in the focus group discussion with the mothers. When we asked the women whether there were days when the children were not provided food, one of them immediately responded with, "Yes! on Sundays."

Nutrition Inputs / Malnutrition

The AWCs followed a detailed menu that is decided for the week by authorities at the state level.

Table II.7: Menu of the week.

Monday	Pongal made of rice and jaggery
Tuesday	Chitranna (rice seasoned with oil and Bengal gram dhal)
Wednesday	Eggs (not consistent) / Chitranna
Thursday	Chitranna
Friday	Energy food-mixed dal ground with jaggery.
Saturday	Chitranna
Once in a few days.	Along with the above sprouted green-gram

Source: Aanganwadi Centre records

Every child gets around 65 to 70 grams of rice. This is lunch, according to the children. It is, obviously, an important meal as the children eat a morsel of rice and dal or a chapatti in the mornings before coming to the centre.

Both Chimnalamma and Barmavva said food for 0-3 year olds was sent to their houses. But this did not seem to be a regular feature. Usually the energy food (which comes in the packet) was distributed at homes for the 0-3 kids. But we did not get a clear picture of the regularity of such distribution.

Food is cooked with care. Some attempts are being made to teach personal hygiene to the children. They are made to wash their hands before they start eating. (In the other AWCs of the same village, they even use soap to do so.) Once they have washed their hands, the children are constantly reminded to not touch the floor, or anything else before eating.

Table II.8: Nutritional status

Status as on November 2003 of children in the centre			
Nutritional status	**Number of boys**	**Number of girls**	**Total**
Normal	7	9	16
1st grade	21	19	40
2nd grade	11	9	20
3rd grade	1	2	3
4th grade	0	1	1
Status as on February 04 of children in the centre			
Normal	12	8	20
1st grade	11	13	24
2nd grade	7	17	24
3rd grade	0	1	1
4th grade	0	1	1

Source: Aanganwadi Centre records, March 2004.

Children are weighed every month and their nutritional status is measured. As Table 8 shows, malnutrition among grade 4 children is fairly small, but several children are still below the normal range. The CDPO and the Aanganwadi teacher told us that several efforts had been made to improve the nutritional status of the children. Mothers were informed about the status of the child and advised on how to improve the food intake of the child. The local health assistant also provided a tonic in some cases. We were also told that efforts had been made to provide extra food, both at home and at the centre - a fact that was not easy to establish.

A case of a grade 4 malnourished girl child came to light, she has remained in the same situation for more than two years. The child is five now and has become totally immobile. Despite consultations with several doctors, there's been little improvement. A boy of grade 3 recently died when the family moved away from the village. The cause of death is not known.

But the silver lining to the cloud is a few mothers we met were aware of the weight of their children in the previous month and the subsequent improvement that came about with consistent care. For example, a child recovered from the 4th grade to normal and another case from 3rd to 1st grade.

Our perception is that the nutritional status of children between 3 and 5 years stand a better chance of being addressed as this age group accesses the centre. The situation is not as clear or hopeful in the case of the 0-3 year olds. In one case, a 2–month old baby was underweight and the mother was advised to get a tonic for the child. But she could not – such was the poverty she faced. As things stand, the AWW feels she has fulfilled her responsibility by

identifying the problem, referring the child to the health centre and guiding the mother on what needs to be done. But the question of who is going to help this child begs an answer.

Reaching out to Pregnant and Lactating Women

According to our survey in 2003, there were 25 pregnant and 25 lactating women. Among them, 15 pregnant and 11 lactating women accessed the nutritional facilitates at the AWC. The AWW spent enough time with the mothers, either in small groups or individually, educating them on various aspects of health, nutrition, foods provided in the centre, importance of breast-feeding and health and hygiene. Both the AWW and the health assistant felt that there had been a considerable improvement in reaching out to and educating this group.

Pregnant women are being provided iron tablets regularly. While women confirm that they receive the tablets, some don't consume it. They are not convinced of its importance and worry that the newborn would be overweight and the delivery difficult. The issue of malnutrition of pregnant women is still a major concern area.

Convergence with Health Services

The primary health centre with a doctor, junior health assistant and a peon is situated in the same village. The centre seems to be functioning with a fair degree of regularity. We did not hear any complaints against the doctor or the health assistant. There is good co-ordination between the AWW and the health unit. In case of major problems the cases are referred to the PHC. Previously the AWC were provided with a medical kit, which contained tablets, syrups and first aid material. For two years there has been no such provision. The AWWS have to coordinate with the health unit for such support. In case of this village there is no problem because the health unit is close to the centre. It is reported that there are regular monthly health check ups. Common children's ailments are cold, cough, running nose and skin diseases. People here have not yet realised the connection between health and hygiene, said the doctor. The AWW said she could make a difference to the children and the community but hygiene is still a problem area.

According to the health assistant and the AWW the coverage of immunisation is fairly good. Mothers bring the children voluntarily to the centre. This is a visible change. When we asked women whether they knew the immunisation cycle they said they did not remember the names but took the children to the AWC on the day of immunisation.

Table II.9: Immunisation

Age	Immunisation	AWC		Village	
		B	G	B	G
0-1	DPT	12	12	54	60
	BCG	20	24	61	70
	Polio	12	12	54	60
	Measles	10	15	54	60
18-24 months	DPT, polio booster dose	11	10	74	88
	Vitamin A (1st dose)	9	18	54	60
	Vitamin A (2nd dose)	53	27	45	60
	Vitamin A (3rd to 5th dose)	22	36	80	97

Source: PHU and AWC records (Apr 03 to Mar 04)

In 2002 a special survey was done on children with disability. Some of the physically handicapped have been provided with aids, but we could not get a complete picture of what other support was being provided.

Table: II.10 Details of disability among children.

Disability	Boys	Girls	Total
Hearing disability	3	5	8
Visual impairment	3	4	7
Orthopaedic handicap	21	10	31
Mentally retarded	1	3	4
Multiple disability	-	2	2

Source: Aanganwadi Centre's records 2002

Box 3: Community and Panchayat Involvement

There is no visible, formal or regular involvement of the community with regard to this AWC. The panchayat ward member from the SC colony once got the premises cleaned and provided a couple of chairs to the centre. Panchayat members and the community respect and appreciate the work of the AWW and the helper. Women often visit the centre to informally interact with the AWW. For her it is these informal interactions that help in communicating children, health and other issues with the women.

Monitoring and supervision

Monitoring and supervision has been very limited in this taluka as there were no supervisors. Only recently 7 supervisors were appointed and sent for training. The lone CDPO could only make limited visits to the AWCs. It is in the monthly review meetings that some monitoring was done based on the self-reporting of the AWWs themselves.

Despite limited monitoring, the 25 or so centres in the taluka were functioning well and the CDPO emphatically credited this to the individual workers and their motivation. An equally important factor was the selection process where the right women have been put in charge.

What insights does the Holagundi AWC provide?

- The regular supply of the nutrition supplement directly at the AWC meant that children were consuming food supplement in a sustained way. The supply was not dependent on an individuals having to go and collect the foodstuffs from a centralised centre. This also implied there was a commitment at the state level to the ICDS programme and by implication to the needs of children. That additional efforts were made to provide variety in the weekly menu was ample proof. Regular supply has had a direct bearing on ensuring regular attendance of children. In the absence of longitudinal monitoring of children it is difficult to conclusively establish the impact on the child's health status. However, as children reported, the nutrition provided at the AWC forms a major part of their daily intake.
- Coverage continues to be a problem. In the case of our study nearly 50 percent of the children in the catchment area of the centre remain outside its purview. While there may be several caste and attitudinal reasons why children are not sent, it would help if the programme were universal in its approach to reach out to all children. This would mean that issues such as space needed to be addressed.

- Other issues of coverage remain a problem area. While 3-6 age group children are covered efficiently for nutritional inputs and health services, the 0-3 age group remains ignored.
- The overall environment of the centre remains unappealing. Though the AWC has a pucca building with good ventilation, a playground and a toilet, no efforts have been made to make the environs child friendly so children could be trained in the use of toilet and personal hygiene.
- Having said the above, a good AWW and helper make all the difference. The human touch is crucial. Children are often shouted at and given a whacking, but the overall approach is one of love and care. Close coordination between the two has made the centre efficient. Their personal commitment to maintaining regular timings has ensured that even though there is no regular teacher currently, children continue to come.
- Both the AWW and the helper seem better equipped to handle the 3-6 year olds than younger children. The AWW for instance handled the pre-school component with interest and ability. It raises some questions on the focus of their training.
- The coordination with health services has resulted in better immunisation of children and pregnant women. While mothers visiting the AWC seem to have understood the dimensions of malnutrition, the relation between age and weight and health status, there is still a long way to go. An understanding of nutrition among pregnant woman and its impact on the child seems limited, highlighting the need for a more focused and effective health education strategy.
- Holagundi showcases that the selection of appropriate people is critical for the functioning of the AWC so that it serves the children. Though monitoring and supervision mechanisms are weak, for Chimnalamma and Baravva, it is a matter of pride that they run the centre regularly, provide food, sing songs, tell stories and thereby draw children to the centre.

ANNEXURE

Annexure 1: Methodology and selection of study area

Block selection by the World Bank in consultation with the Government of India:

Using the data on malnutrition among children attending or not attending AWCs generated during the baseline survey of the World Bank-assisted ICDS III project in UP and Rajasthan (done by ORG-Marg, Lucknow, in UP and by IIHMR, Jaipur, in Rajasthan, 2001), ICDS blocks covered in the sample survey were ranked using three indicators (Table 1):

Levels of malnutrition among children in the 0 to 6 age group in the general population – an overall indicator of the general well-being of children;

Percentage difference in malnutrition levels between children in the 0 to 6 age group attending and not attending the AWC – a proxy indicator for targeting poor households;

Under-3s who attend AWC as a percent of the total under-3s in the sample.

Table 1: Baseline data used for block selection

	Under weight: Weight for age (< 2 SD) of children in the 0-6 age group			Percent Difference	Targeting under-3s	Targeting poor households
	General population	Attending AWC	Not attending AWC			
Rajasthan						
Chittorgarh, Chittorgarh	56.9	58.1	56.3	-1.8	14.1	18.0
Khandar, Sawaimadhopur	53.3	58.5	52.3	-6.2	13.4	14.4
Pratapgarh, Chittorgarh	72.8	78.8	71.9	-6.9	13.3	18.2
Sajjangarh, Banswara	66.7	60.7	67.5	6.8	11.2	15.4
Simalwara, Dungarpur	46.7	46.0	47.0	1.0	15.6	20.7
Siwana, Barmer	61.4	74.4	60.5	-13.9	9.4	15.7
Talwara, Banswara	52.2	61.3	48.5	-12.8	22.1	29.6
Uttar Pradesh						
Banki, Barabanki	47.7	55.1	44.2	-10.9	30.9	44.1
Chitaura, Baharaich	54.2	57.7	53.7	-4.0	6.9	10.3
Chitrakoot, Chitrakoot SJM	59.9	60.0	58.8	-1.2	12.0	14.8
Haswa, Fatehpur	54.4	53.2	54.2	1.0	22.7	25.4
Naugarh, Chadauli	39.2	40.7	38.7	-2.0	22.2	22.9
Pharenda, Maharajganj	43.4	34.3	45.1	10.8	12.8	17.6
Shahgarh, Sultanpur	36.3	42.1	33.3	-8.8	31.7	33.0

Source: Himani Pruthi, World Bank, January 2004

This data was shared with the GOI and the ICDS Directorate in Uttar Pradesh and Rajasthan. In Rajasthan, the information generated in the baseline survey was fairly consistent with project MIS. While the ICDS Directorate felt that Garhi in Banswara could qualify to be one of the best performing projects, given that this block was not included in the baseline sample survey, the government selected Talwara block of Banswara district for this study (vide letter dated 30 January 2004 sent to the Educational Resource Unit by the Directorate of the WCD, Government of Rajasthan). In Uttar Pradesh, the baseline survey pointed towards Banki block of Barabanki district. This information, perhaps, did not match the available project MIS and monitoring reports. Therefore, the Secretary, Shri K L Meena, recommended that Shahgarh block of Sultanpur district be selected (telephone and e-mail communication between the ICDS Project Directorate in Lucknow and the World Bank, February 2004).

The selection of AWCs for the in-depth study was done at the commencement of the fieldwork. In a group exercise with the ICDS project team in the blocks, the CDPO and Lady Supervisors (LS) were asked to categorise the AWCs in their block on a four-point scale (A, B, C & D). They were asked to list out the indicators they used for categorisation. Given the difference between Rajasthan and UP on the perceived priorities of the ICDS programme, the criteria used in the two states to categorise the AWCs were different.

It must be noted that supplementary nutrition had not been supplied in Uttar Pradesh since September 2003, and the project functionaries reported that there had been a six to seven-month break in the preceding two years also. Therefore, distribution of nutrition and the related growth monitoring activities could not be used as a criterion for assessing performance.

The criteria used for grading the AWCs in Uttar Pradesh were:

- Location of the AWC - primary school, panchayat bhavan, own building, home of Aanganwadi worker (AWW) etc;
- Regular attendance of children (3 to 6 age group);
- Pre-school education (this was given significant weightage);
- Motivated, trained and confident AWW;
- Growth monitoring –weighing children once a month;
- Community support to the AWC;
- Meeting targets for immunisation;
- Proper maintenance of records.

In view of the fact that there were no serious disruptions in the supply of SNP, the criteria used for categorisation of the AWCs in Rajasthan were:

- Punctuality of the worker and adherence to official timings of the AWC ();
- Regular opening and functioning of the AWC;
- Quality and adequacy of pre-school education;
- Rapport of the AWWs with the community;
- Implementation of immunisation and health-related guidelines of the ICDS;
- Involvement of the panchayat in monitoring and supervision of the AWC;
- Observance of the monthly Health Day; and
- Timely and accurate record keeping.

Within each category, we picked the sample by lots. Initially we had decided to select three each from categories A and B, and two from category D to explore why certain centres under-performed in an otherwise better performing block. It was also felt that as many sectors as possible should be represented in the sample in order to be able to capture the variations in the

block – especially, the distance from the main road and remoteness of the area. Given the size of Talwara block and the number of AWCs functioning in it (138) we had to select one AWC from category D instead of B in order to ensure better representation. In Uttar Pradesh, there was only one centre identified as "D" category, and this was completely dysfunctional; therefore the sample was selected from categories A, Band C only.

Table 1.1: Selection of AWC for in-depth study

Category	A	B	C	D	Total
Talwara, Rajasthan	41	42	37	18	138
AWCs selected	Janawari* Kushalpura Gamdi I	Wanka Malwasa I	Nil	Warli Pada Bari Sia Talai Saga Garnawat	
Shahgarh, Uttar Pradesh	18	17	15	1	51
AWCs selected	Soraon Chilbilli Shahgarh I	Paniyar Purabgaon Sevai III	Hardoiya I Afoiya I	Nil	

Methodology

Given the research mandate of the study, the focus was on fleshing out the factors that explain positive deviance, if any, as also on exploring factors that hamper optimal performance of the AWC. Being a qualitative study, the accent was on detailed interviews, observations and group discussions. The following tools were used at each level:

National level: Open-ended interviews with Director, ICDS in DWCD - GOI, Director of NIPCCD, Assistant Director CPMU of ICDS III and perusal of guidelines issued by the GOI from time to time.

State level: Detailed open-ended interviews with Secretary, WCD and the ICDS project team; perusal of guidelines or government orders issued in the last five years.

District level: Detailed open-ended interviews, followed by a group discussion with the District Project Officer and her team (the district team includes statistical assistant, procurement and supply in-charge and those managing training)

Block and sector (one sector made up of 18 to 25 AWCs) levels: Detailed open-ended interviews followed by group discussions with the CDPO and her team (the block team includes procurement and logistics in-charge and Lady Supervisors)

AWC level: Observation, perusal of records, detailed interview with AWW, focused group discussion with mothers' committee, open-ended interaction with community leaders, panchayat leaders, measurement of weight of a select number of children, and open-ended interaction with women in the poorest hamlet of the village.

* Janawari was specially selected as this AWC was considered the best in the block – in fact, the AWW had earlier received an award at the state level for her performance. It was felt that a detailed study of this centre would, probably, reveal some positive deviance.

Annexure 2: Centre-wise positive deviance matrix, Rajasthan

	Strongly Positive	Positive	Negative
Wanka	Own building Located in the centre of the village	AWW not literate but committed AWH old but caring Drinking water (hand pump) available nearby Cooking and storage utensils available Careful storage of SNP Relationship of AWW with the children interactive IEC and PSE materials well displayed ANM visits only on health day Good use of toys, see-saws and swings (although broken)	Building in need of urgent repair Children not clean / bathed. Erratic growth monitoring, weighing scales give incorrect reading No proper measurement of SNP Records not properly maintained (only done with the help of LS) No community contribution Medical kit not available Pre-school education limited to reciting just a couple of poems everyday
Janawari	Own building IEC and pre-school materials very well displayed Overall environment at the AWC neat and clean. As this AWC has received an award, it was recently painted AWW literate (matriculate), highly motivated and dedicated. She has leadership qualities. Community outreach very good Primary school is adjacent to the centre Centre opens regularly and on time AWC given the ideal centre award AWWis president of the Aanganwadi Workers Association of Banswara	Efforts are made to ensure cleanliness of children. For example, making them wash hands Some gaps in supply and quantity of SNP. But when SNP is available, it is cooked with love and care and given to the children. Drinking water (hand pump) located on the primary school premises – within 15 metres of the AWC. IFA tablets for pregnant and lactating mothers given by the ANM regularly Community survey carried out in January 2004, as per the requirement of the Project Office. Targeting of grade 3 and 4 children good. Records well maintained and growth monitoring done meticulously ANM visits regularly of– on health day Community immunisation regular AWH (ST) residing in the village Cooking utensils available Toys such as see-saws and swings Regular monitoring and supervision –possible since the centre is right on the highway to Udaipur.	Location right on the Udaipur highway (away from the centre of the village), two road accidents have taken place during the Pulse Polio campaign. Location of AWC prevents children from a distant hamlet from coming to the centre Not all enrolled pregnant and lactating mothers come on Mondays to take home rations as they have to go to work early morning Building in need of repair with broken floors Medical kit not available Non availability of jaggery. No variety in the taste of the supplement. Children do not like the salty taste of SNP all six days of the week Weighing scales give inaccurate readings – they have not been calibrated ever since they arrived at the AWC.

		AWH old but active and caring. Convergence with health and education departments good Availability of storeroom for SNP etc. Home visits of AWW are regular	
Kushalpura	Own building Located near the main road	Drinking water (hand pump) facility PHC centre located in the village and very good contact with the AWC ANM visits regularly, even comes on days other than the health day Regular immunisation Convergence with education and watershed departments AWC also the place of continuing education centre. Therefore, AWW able to use some of their material like durries and furniture AWW and AWH both from the same village - motivated and have a good rapport with the children Children fairly clean AWW involved with mothers and SHG group activities Good use of toys, see-saws, swings by children	Improper measurement for SNP SNP not well cooked, very salty SNP given to even school going children. Of them, many belong to the 6+ age group Weighing scale gives incorrect reading
Warlipada	Own building (though in a bad state) Located in the centre of the village	AWW and AWH both from the village	Lack of cleanliness, standards of attending to children poor Records not properly maintained (outsourced to some literate person in the village – for a fee!) Survey data not available, a few far away hamlets not included No community contribution Medical kit not available Pre-school education limited to reciting poems (the same two poems everyday); PSE kits lying unused as the AWW fears that the children will take away the toys etc Weighing scale gives erratic reading Only very few children come to the AWC

			regularly Drinking water comes from an open well which has dirty water Lack of storage facility for SNP PSE materials, the flooring on the side room at the AWC are in a bad state.
Barisiatalai	Own building	Community contributes jaggery and other items Open space, neat and clean environment Comparatively literate AWW –able to maintain her own records. Is also able to understand concepts like targeting	Storage of PSE materials at the home of the AWH (adjacent to the AWC) No supply of medical kit AWW untrained (she was appointed only two years ago) Standards of cleanliness of children poor
Malwasa		AWC located in the school building -school support in form of basic infrastructure Availability of medical kit AWW from nearby hamlet; AWH is local Drinking water from a nearby hand pump Involvement of AWW in school enrolment Motivated AWW, AWH old but caring	No proper measurement of SNP distribution Weighing scales faulty Records maintained with the help of teenaged daughter of the AWW.
Saga Garnawat		Centre moved to the present building a few days ago; building right on the main road. Hence, better monitoring possible	Limited supply of medical kits No proper measurement of SNP to the children and take-home rations No proper growth monitoring – weighing scale not working Data not filled with care, incomplete; AWW appears incompetent to handle extensive record-keeping required by the establishment Reports from the community suggest that the AWC opens irregularly
Gamdi - I	Own building and good condition Location near the panchayat and primary school building	AWW (physically challenged) but motivated and committed AWH active AWW is from a nearby hamlet, but the AWH is from the village itself. Mothers' committee active; AWW has a good rapport with the community. Involvement of AWW in school enrolment	Limited supply of medical kits Limited contribution from the community Poor response from ANM; she is irregular even for the monthly health day Quite a few 6+ children and old, poor women of the village regularly get SNP meant for the 3-6 year olds

		Neat and clean environment Records very well maintained; community survey complete PSE material being displayed and used regularly by the children. Continuing education centre runs from the same location, and some basic infrastructure items (furniture and durries) etc are, hence, available to the AWC also	

Annexure 3: Centre-wise positive deviance matrix, Uttar Pradesh

	Strongly Positive	Positive	Negative
Soraon	Location in primary school adjacent to a road School environment is encouraging – AWC is part of a well-functioning school Synergy between teachers and AWW Children of the centre neat and clean as they were also checked for the routine health / hygiene exercise (nails, hair, dress etc.) with the school kids Surroundings of the school / centre clean Drinking water (hand pump) and toilet facility available. Toilet kept locked unless children want to use it	AWW is motivated and committed ANM comes regularly to the centre, location of the school is convenient for the ANM and the community, immunisation regular AWH (SC) old but caring	Poor community contact and targeting (Caste of AWW may be a factor – she is a Brahmin) Enrolment on the basis of accessibility Erratic growth monitoring Pre-school education of AWC kids combined with classes for class 1 children
Chilbilli	Young, dynamic and highly motivated AWW Location in the primary school adjacent to a road Record-keeping meticulous AWW has credibility in all sections of the community, specially women Activity-based PSE Home visits / contacts regular Drinking water facility in school	Caste of AWW helps in her relationship with community Support from school in the form of infrastructure Children clean Weight measurements regular Immunisation regular – ANM visits every month Locally-based AWH (SC) in charge of centre when AWW not there AWW involved actively with mothers and women for SHG activities	Targeting poor – AWW from OBC community Space of school is restricted - children sit is an un-cemented veranda, this gets difficult in the rains Weighing machine damaged Class 1 children sit with the AWC children
Shahgarh	Highly motivated, elderly yet active AWH (SC) Location near the block HQ Activity based PSE	AWW quite motivated and has rapport with mothers Supportive husband assists her in record keeping Contact with ANM and PHC which is nearby	Targeting is not appropriate even though centre is located near SC community – can be attributed to the caste of AWW (forward caste) Growth monitoring is erratic Most children are irregular Centre is located in AWW's house
Poorabgaon	OBC community valued PSE	Location in school - school support in the form of infrastructure and record keeping Drinking water from HP in school	AWW and AWH (latter not trained) mother-daughter duo (upper caste) Lack of motivation found in both Community contacts weak – AWW does not visit

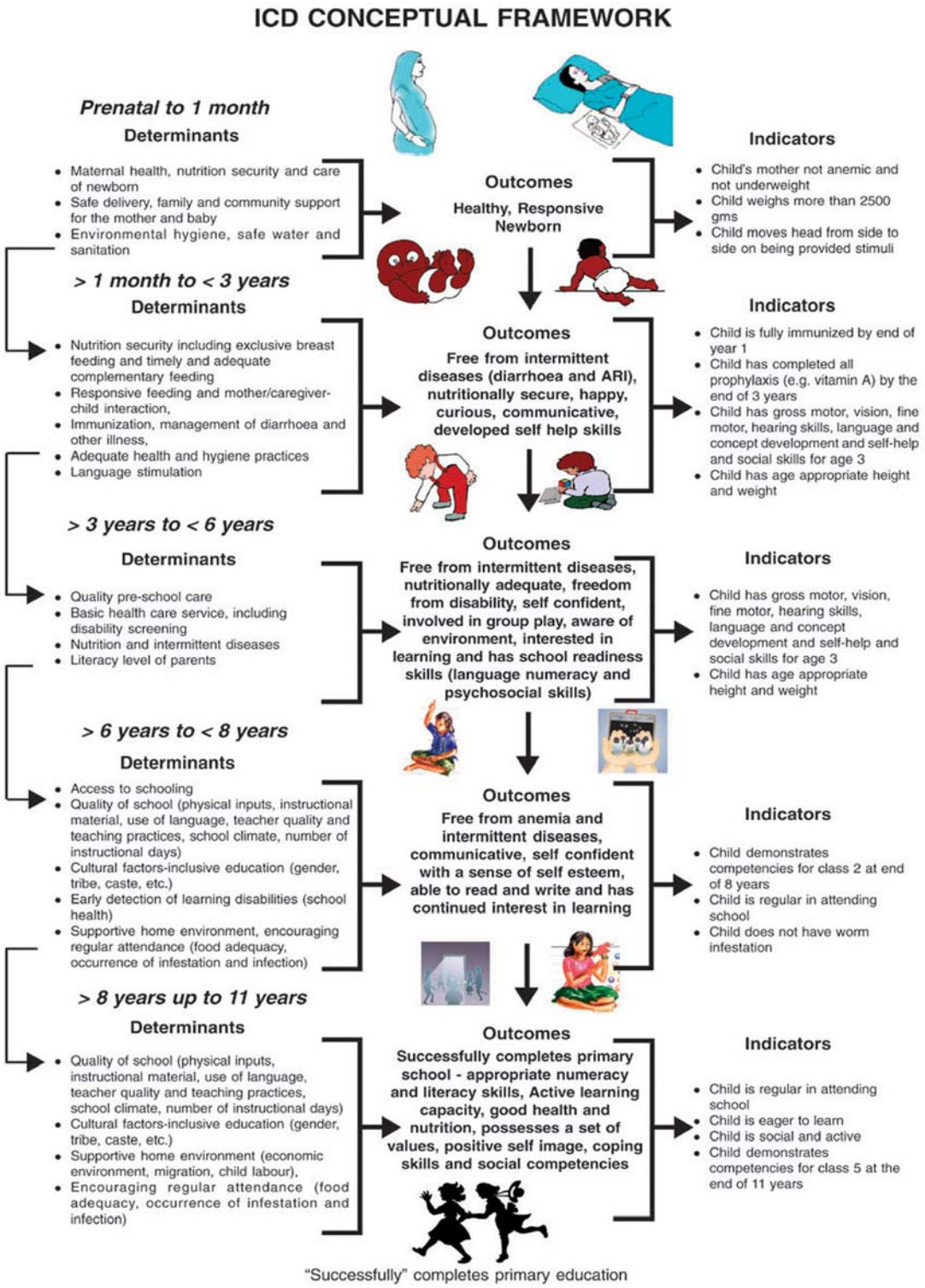
			SC hamlet. Poor targeting and rare home visits reflect caste bias Attendance of children irregular AWC children sit with class 1 children – AWH minds class 1 and 2 Poor growth monitoring Space unfriendly for children in monsoon and summer- treeless, exposed environment Rare visits of ANM- people to the Block for health services.
Paniyar	Located in a clean and open space, closer to road	Records maintenance average AWW (upper caste) well-versed and seasoned with good family connections	AWC located in rich upper caste house AWH unmotivated Upper caste attitude of AWW (brahmin) leading to poor community contacts Children unkempt and dirty Erratic and poor growth monitoring ANM does not visit the AWC and people go to PHC for immunisation No hand pump or toilet facility for centre AWC remains shut when AWW is away because AWH does not have the capability to do so on her own.
Sevai	Good community support from SC / OBC groups ANM from the same village: Therefore, immunisation regular Mothers involved, visit the AWC periodically as it is located in panchayat building	Motivated AWW from OBC community, teaches children poems from a register in which she has collected them Timings of centre regular Hand pump near the centre Location in the vicinity of homes but not among them Old AWH from SC community - basically a good, responsible woman though illiterate	Space restricted – only a verandah available Poor guidance for record keeping, at times husband helps AWW Poor growth monitoring No toilet facility Centre remains shut when she is on leave Space for children not congenial in extreme weather conditions
Hardoiya	Highly motivated and educated AWH from the SC community, runs the AWC de-facto	Centre moved to (two years ago) own (ICDS) building from residence Some PSE being done by AWH	Unmotivated AWW, (Thakur), faces caste opposition as village is dominated by SCs. She has major attitudinal problem, very obvious caste bias AWW has little information about children

			enrolled Records incomplete Children irregular in attendance Timings of centre irregular Centre not child-friendly and empty No growth monitoring / weighing is being done No visit of ANM for four months, status of immunisation low No drinking water facility (hand pump) or toilets for children
Afoiya	Nothing strikingly significant	Centre runs in Panchayat Bhavan, AWW can draw support from the panchayat because husband is pradhan (village head) Drinking water from hand pump but no toilet	Location and space of AWC unsafe for children. Centre in the middle of field, away from the villages. Open, low-level well is next to the veranda where children sit AWW has little idea about the children who attend Upper caste attitude and social status of AWW is barrier Badly maintained records No community rapport Erratic growth monitoring Children irregular in attendance and not clean ANM visits randomly No PSE visible - some PSE material brought out on the day of visit

Common denominators in Uttar Pradesh:

- All AWWs had received induction training for three months, a refresher course of 18 days and a three- day training course on family planning. No trainings happened after that. One AWW was inducted in 1996, while the others had been inducted in 1984. For seven of them, there had been no training at all since 1993. They had no printed materials to refer to in everyday work.
- Seven AWHs were trained in this group but could recall little.. Two of them had studied till class 5 and and the other had cleared class 9.
- The centres had last received medical kits in June 2002, utensils in 2001, PSE material in 2002 and nutrition supply in September 2003.
- All AWWs had conducted the survey in September/October last year, but data was not consistent.
- All AWWs lived locally, within half to 2 km from the AWCs.
- Homes of AWWs served as stores for SNP, PSE materials, utensils and medicines.
- Though Supervisors visited each centre at least once a month – there was, apparently, no guidance

Annexure 5: ICD Conceptual framework:



Annexure 6: Glossary

ACPO	Assistant Child Development Project Officer
ANM	Auxiliary Nurse Midwife
AWC	Aanganwadi Centre – ICDS Centre
AWH	Aanganwadi Helper
AWW	Aanganwadi Worker
Basti	Settlement
BPL	Below Poverty Line
CARE	An International NGO that provided SNP to ICDS
CDPO	Child development Project Office
CHC	Community Health Centre
Chitranna	Coloured rice
CPMU	Central Project monitoring Unit
Dal	Lentils
Dalia	Porridge
Dalit	SC groups listed in IX Schedule of the Constitution of India
DD	Deputy Director
DH	District hospitals
DPEP	District Primary Education Project
DPO	District Project Officer (ICDS)
Durries	Colourfully woven cotton or woollen floor mats
DWCD	Department of Women and Child development
ECCE	Early Childhood Care and Education
ECE	Early Childhood Education
FC	Forward Caste
FP	Family Planning
GM	Growth Monitoring
Gram sabha	Assembly of all the people
HH survey	Household or House-to-house survey
ICDS	Integrated child development scheme
IEC	Information Education and Communication
IFA	Iron and Folic Acid Tablets
IRDP	Integrated Rural Development Project
Kuccha	Unpaved
LS	Lady Supervisor
MIS	Monitoring Information System
Nalla	Open drain
NFHS	National Family Health Survey
NSS	National Sample Survey
Panjeeri	Granular nutrition supplement
PHC	Primary Health Centre
PHED	Public Health Education Department
PHU	Primary Health Unit
PMGY	Prime Minister's Gramayodaya Yojana
PMU	Project Monitoring Unit
PRI	Panchayati Raj Institutions
PSE	Pre School Education
Rava	Semolina

RMP	Registered medical practitioner
Sarpanch	Elected leader of the village
SHG	Self Help Group
SNP	Supplementary Nutrtion
Taluka	Administrative unit – often used along with Block
Tehsils	District subdivision
Tola	Locality / Settlement
Uppittu shale	Feeding centre
Uppitu	Sprouted green gram
VEC	Village Education Committee
WCD	Women and Child Development
WDP	Women's Development Programme (Rajasthan)
WFP	World Food Programme