Delhi Visit Report

National Commission for Protection of Child Rights

Submitted By: Dr. Dinesh Laroia, Dr. U.C. Bajpai & Shaifali Avasthi

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Introduction

Place visited : Delhi

Dates of Visit : 19-21 & 26-27, April, 2011

Purpose:

1. NCPCR visited 16 AWCs, 2 Hospitals Hindu Rao and Kasturba Hospital to know the status of realization of Right to Health and Nutrition in Pre- School children and one kitchen utilized to prepare food for AWCs, Bhatti Mines project.

Number of places visited on :

1. **On 19.04.2011- North East Delhi**
   a. Nand Nagari
   b. Seemapuri
2. **On 20.04.2011- East Delhi**
   a. Ramesh Park Juggi
   b. Mandawali
3. **On 21.04.2011- West Delhi**
   a. Pankha Road JJ Colony
   b. ICDS Nazafgarh
4. **On 26.04.2011- South Delhi**
   a. Maidangarhi
   b. One Kitchen
5. **On 27.04.2011- Hospitals**
   a. Hindu Rao Hospital
   b. Kasturba Hospital

Team Members :

1. Dr. Dinesh Laroia, M.D. (Pediatrics) Member, NCPCR
2. Dr. U.C. Bajpai, Consultant, NCPCR
3. Ms. Shaifali Avasthi, Consultant, NCPCR

About ICDS

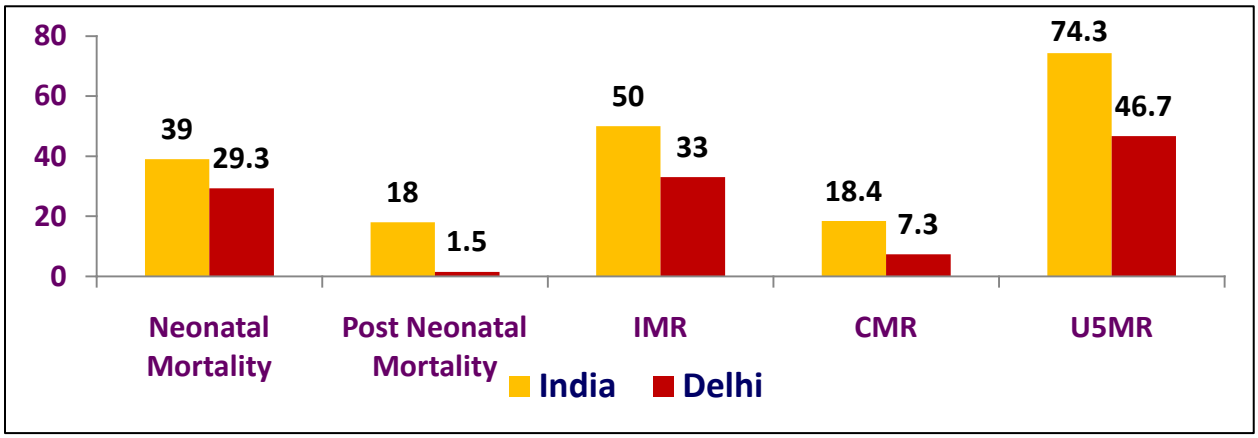
India's Integrated Child Development Services (ICDS) programme is established in 1975 is the world's largest early child development programme. The programme approaches child health holistically and comprises health, nutrition, and education components for pregnant women, lactating mothers, and children under six years of age. The programme is implemented through a network of community-level *anganwadi* centres. The range of services targeted at young children and their mothers include growth monitoring, immunization, health check-ups, and supplementary feeding, as well as nutrition and health education to improve the childcare and feeding practices that mothers adopt. Preschool education is provided to children between three and six years of age. The coverage of ICDS has steadily increased since its inception in 1975. According to a recent report, the programme is operational in almost every block, and the country currently has more than 14 lakhs *Anganwadis* covering over 19,70,510 (0-6 kids).

Features specific to Delhi

Total population of Delhi	1,67,53,235
Total 0-6 yrs population of Delhi	19,70,510
Total no. of Operational AWCs	6,606
Total no. of AW beneficiaries (0-6 yrs)	6,07,957 (approx. 30% of the total)
Total no. of children left out	1,362,553

Source: Census of India- 2011 for total population of Delhi and 0-6 yrs population & Ministry of WCD for total no. of Operational AWCs and total no. of AW beneficiaries.

Child Health Statistics of Delhi



Source: NFHS 3 for Neonatal Mortality, Post Neonatal Mortality, CMR, U5MR & SRS, Jan. 2011 for IMR

Enrolment Profile of AWC Visited

	Total no. of Beneficiaries 6mths-6 yrs (as per the AWW Survey)	Total no. of children enrolled	Total no. of left out children
North East Delhi			
AWC 1	167	109 (65.26%)	58 (34.73%)
AWC 2	190	105 (55.26%)	85 (44.74%)
AWC 3	144	102 (70.83%)	42 (29.17%)
AWC 4	230	114 (49.57%)	116 (50.43%)
East Delhi			
AWC 5	223	93 (41.70%)	130 (58.29%)
AWC 6	190	80 (42.11%)	110 (57.89%)
AWC 7	65	65 (100%)	0
AWC 8	172	95 (55.23%)	77 (44.77%)
AWC 9	150	102 (68%)	48 (32%)
West Delhi			
AWC 10	150	123 (82%)	27 (18%)
AWC 11	145	89 (61.38%)	56 (38.62%)
AWC 12	106	79 (74.53%)	27 (25.47%)
South Delhi			
AWC 13	149	93 (62.42%)	56 (37.58%)
AWC 14	160	99 (61.87%)	61 (38.12%)
AWC 15	154	99 (64.28%)	55 (35.71%)
AWC 16	145	101 (69.65%)	44 (30.34%)0
Total % age	**2540**	**1548 (60.94%)**	**992 (39.05%)**

Status of AWCs Visited

	Infrastructure	Growth Monitoring	Maintenance of Records	Referral System	Pre-Education School
AWC 1	▲	▲	▲	♦	♦
AWC 2	▲	▲	▲	♦	♦
AWC 3	▲	▲	▲	♦	♦
AWC 4	▲	▲	▲	♦	♦
AWC 5	▲	▲	▲	♦	♦
AWC 6	▲	▲	▲	♦	♦
AWC 7	■	●	■	■	■
AWC 8	■	●	■	■	■
AWC 9	●	●	■	■	■
AWC 10	●	●	●	▲	■
AWC 11	●	●	●	▲	■
AWC 12	●	●	●	▲	■
AWC 13	●	▲	■	▲	▲
AWC 14	■	▲	▲	▲	▲
AWC 15	▲	▲	▲	▲	▲
AWC 16	■	▲	▲	▲	▲
♦	Very Poor				
▲	Poor, Not approachable, Not accessible, Inadequate, Insufficient, Not available				
■	Fair				
●	Good, Approachable, Accessible, Adequate, Sufficient, Available				

Findings

1. **Infrastructure:** Most of the AWCs were having poor infrastructural facilities.

   Common Infrastructural issues were:

   - Shortage of Space
   - Difficult approachability
   - Ill ventilated – suffocating rooms
   - Cramped unhygienic places
   - Adjustment of the kids in the room already full of living furniture
   - No play area
   - Few AWCs are being run from the first floor having steep high-rise steps with no protective railings making the children vulnerable to accidents
   - At one place the AWC was running at the Junk store area
   - All the AWCs visited were not having enough space to accommodate the kids enrolled. However, they are running because of the fact that more than 50% of the enrolled kids come to the AWCs just to collect food
   - Non- availability of functional electric fans in the scotching summer months

Other basic amenities like:

a. Safe Drinking water

At most of the places the water was stored in the earthen pots and at one AWC we were informed that due to some procedural delays, it was bought by the donations provided by the parents. The quality, procurability and storage of water at most of the places was questionable.

b. Floor carpets/ Darris

It was either not available or worn out. At most of the places kids were sitting directly on the bare floor.

c. Availability of toilets/ facilities for hand washing

None of the AWCs was having any provisions for strengthening basic health practices like washing of hands before meals. Though the toilets were available in the AWCs, as these centres were running from the residential houses but they were not clean and rarely the children were allowed to use them.

2. AWWs/Supervisors/CDPO:

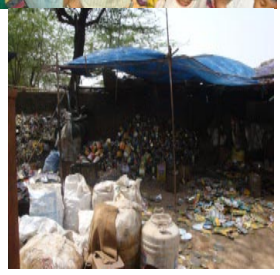
Most of the AWWs, the team visited were qualified for the job and were present on the duties at the time of visit. However, the spirit of AWs, the dedication and motivation level was very low at many places. Administrative and functional gaps, delays in procuring the basic items, lot of paper work, poor promotional chances were the few causes listed for their sub – optimal performance.

Extremes of the levels of functioning and involvement was seen at the Supervisor and CDPO's level during the visit. On one hand, neither the supervisor nor the CDPO was knowing, where the AWC is and have to repeatedly call AWWs to a prefixed point, so that she can guide to the Centre and on the other hand Supervisors were directly involved with the minutest of details of each and every AWC in their jurisdiction.

Supervisor claimed that lot of paper work detains them from going to field. While the Project Officer is handling more than one project at a time. Hence, it is not possible for her to visit all AWC even in one year. CDPOs have to manage all the administrative issues which keeps them occupied most of the time and the field visits suffer.








Out of the six major objectives of the ICDS

1. **On the Supplementary nutrition front:**

The availability of cooked food, its quality, its timing, its acceptability, its taste was satisfactory in the AWCs visited. However, the process of distribution of food among the kids varied from AWCs to AWCs, The infrastructural issues, the squeezed spaces restricts the physical presence of beneficiaries and hence the concept of collecting the cooked food from the AWC is fast picking up. And unfortunately most of the AWWs are deliberately promoting this. The feeding time is a time to inculcate the basic hygienic health practices like hand washing at a tender age but this practice was not seen in any of the AWCs.

The THR is being provided once in a week but the quality of THR, the potential stability of the contents, its packaging is variable. We feel that all the packaged food items distributed from the AWCs should be packed in a hygienic way and should have label showing the date of manufacturing and contents.


2. **Immunization:**

The immunization services provided to the AW beneficiaries was satisfactory; however, records were available only at few places.

3. **Health Check Up:**

Though most important but one of the weakest part of the AWCs is the Growth monitoring.

a. Non- availability of weighing machines
b. Sharing of the weighing machines between 3-4 AWCs
c. Faulty machines
d. Non- availability of new Growth Chart Booklets
e. Apathetic attitude of the AWW

were the main reasons.

The responsibility of bringing the weighing machine to the centre, rest with the AWW which is preferably overlooked. Most of the AWW claimed that they can pick up malnutrition by their sheer

experience only. At one or two centres the weight recording was done only once in a year and weight registers were not available at the time of visit or were not maintained properly.

There was no uniformity in the maintenance of records. The range varied from meticulously maintained records to non- availability of records.

Facilities for distribution of medicines for common ailments, deworming etc. was barely available.

4. **Referral Services:**

Though most of the AWWs claimed that they have been regularly referring children with various ailments and with different levels of malnutrition to higher centres but at none of the place any referral register/ referral slips were available to confirm their claims. Moreover, it seems that its all a verbal communication between the AWW and Community.

5. **Pre- School Education** was existing only on papers. The AWWs does not have time for providing pre-school education to the children. Few worn out toys and soiled charts completed the responsibility of the Pre- school education.

6. **Nutrition and Health Education:**

Imparting health and nutrition education is one issue which is totally dependent on the dedication and sincerity of AWW. However it was grossly lacking in most of the centres. Excess of paper work was cited as the most common reason.

Conclusion:

Despite of 36 yrs of existence, ICDS is catering to just *appox.* 30% of the total 0-6 yrs of population of children in Delhi. .

Out of the six major functions attributed to AWC, we strongly feel that except for Nutrition/Supplementary Nutrition and Immunization (both of which are reinforced because of Community awareness and demand) rest four (Health Check- Up, Referral Services, Pre- School Non-Formal Education and Nutrition and Health Education) needs to be overhauled for maximum and effective utilization of resources.

The Referral Hospitals

Though 25 beds have been created in 14 hospitals of Delhi and separate IYCF (Infant and Young Child Feeding) clinic have been started in a child friendly manner. But still due to lack of dedicated registration counter for children referred from AWC. The optimal utilization of services is lacking.

The given data suggests 225 admissions in last 3 months. It is a sizable number. Four to six beds in each hospital have been created to attend SAM patients only but there is no separate cubicle or room for them. Hence, they are sharing their cots with patients having infectious and contagious diseases. In one of the hospital SAM patients was placed in a room having 2-3 TB patients thus making them vulnerable for getting infected.

The team was told by the attending doctor that separate food is being cooked in the hospital kitchen for them. Dietician and Doctors take care of them. Mortality in both the hospitals is significantly less.

On interaction with the mothers of SAM kids, we were told that none of the child was an Anganwadi beneficiary though they were staying in Delhi for few years, some of them have not heard of AWCs and none of them has ever been surveyed by AWW.

Facilities provided by the hospital and team of doctors were satisfactory as both the hospital are in a position to provide tertiary care to these children and have to full-fledged backup of specialist and diagnostic facilities.


Recommendations:

A. FACILITIES IN AWCs:

1. The spaces for AWCs should be earmarked considering the no. of beneficiaries. The utilization of AW premises which is already being used for living purposes should not be allowed. School buildings, Community Halls, Corporate assistance, Barat Ghar. Public spaces can be utilized but cramping of kids in a non- ventilated room (already full of living furniture) should be avoided at all cost.

2. The AWCs should not be allowed to run from 1st floor but if it is unavoidable then safety provision on the stairs should be made so as to avoid accidents.

3. The AWC should be weather friendly and must have all basic amenities like drinking water, electric fans, floor carpets, first aid kits. All non- functional items should be immediately replaced.

4. Provision of functional weighing machines should be urgently made in all AWCs.

5. THR which is supplied should have a label depicting: Date of manufacturing and best used before and the description of content.

6. The packaging of THR should be in leak proof, tamper proof packets which are easy to handle and store.

B. FUNCTIONS OF AWW AND TRAINING:

1. The usefulness of filling the weight charts needs to be reinforced. Their interpretation in the light of new WHO weight Charts has to be explained.

2. Availability of Growth Chart booklets at all AWCs is urgently required.

3. The paper work of AWW should be reduced, as most of the time AWW keep on filling the records during her duty time and leaves the responsibility of kids on the Helper. Thus, jeopardizing the Pre- School, 'Health and Nutrition Education front.

4. Reorientation and Refresher courses for AWW should be initiated at the earliest preferably hands on training in their centres only will be more beneficial.

5. Project Officer should not be allowed to handle more than one project and they should be made accountable for poor functioning of AWC in their Jurisdiction. Mere producing statistics and creating charts will not suffice their responsibilities.

C. HEALTH AND REFERRALS FOR SAM:

1. Dedicated registration counter for children referred from AWC should be set up in the referral Hospitals.

2. Hospitals catering to SAM patients should have a separate cubicle or room and all measures should be taken to avoid hospital acquired infections in these children.

3. The statistical process should be reviewed the distinction between nomenclature of SAM, PEM, Grade III & IV should be clarified so as to minimize under reporting of SAM and detailed protocol of diagnosis and management with proper follow up should be maintained in the Hospitals.

4. Managing SAM should be the joint responsibility of the Nutritionist under the supervision of Pediatrician/ Medical officer.

5. The Follow up of SAM kids should be strictly done till the time they attain normalcy and AWW should be made responsible to ensure their follow up visit to the hospital.

6. AWC network should be broadened to include more and more beneficiaries and visibility of AWC should be enhanced and made more child friendly.

Meeting with the State concerned officials after the visit

On this issue the Commission conducted a meeting with the Officials from the Department of Health and Family Welfare, Department of Social Welfare and WCD and the Director, Mission Convergence, Government of NCT of Delhi on 17.06.2011 at NCPCR Conference Room at 03.00 p.m. New Delhi, wherein following issues were discussed and inputs from the officials were taken:

1. Regarding the high number of children who are still out of the ambit of Anganwadi system, the Commission was informed that another more than 4000 centres have been approved but still this no. will not suffice for entire 0-6 population of Delhi.

2. Regarding the space of the AWCs, the officials informed that the AWCs are rented on a meager monthly rent of Rs. 750/- per month, as per the existing provision of the government and in place like Delhi. It is difficult to procure reasonable space for running the AWCs with such small rental amount for procuring the building of AWCs. Hence nothing much can be done, except for careful selection of space.

3. Non- availability of weighing machines- During the discussion Commission was informed by the officers of the Department of WCD that the weighing machines were brought by the NRHM and were sent to the ICDS, but as those weighing machines were faulty. Those were returned back. Shortage of funds was given as a main reason by the officials of the department of WCD for not procuring enough weighing machines.

4. The Commission handed over a loose packet of *Panjiri* collected from one of the AWCs which was distributed as THR to the officers of WCD and Health and Family Welfare department. The sample did not contain the labeling like Date of Manufacturing etc. and was packed in loose polyethene bag. Tied with hair rubber band on the top. The officers accepted that it was happening in some of the AWCs and promised to take urgent steps, so that the properly packed THR is made available and to prevent such things in future.

5. During discussion on referral system the Department of WCD and Department of Health and family Welfare accepted that there was total lack of coordination between the health delivery system and ICDS. When the query was made by the Commission for opening dedicated counters in the hospitals referred from the AWCs, the officers of WCD and Health department expressed their inability to execute the same with the given circumstances.

6. As far as the separate cubicle or ward for SAM is concerned, the shortage of beds and the overcrowding was cited as a main reason and the Commission was told that this is not practically feasible at this point.

7. The treating hospital should have defined no. of AWC attached to them and the name and address of the Hospital should be mentioned falling with their catchment area on the referral slips of AWC, so that on admission the hospital management is aware of the referring AWC and while discharging the child can be referred to the same AWC and

follow up can be maintained through AWW. Thus facilitating the connectivity of AWW with the Tertiary care centers.

8. During the meeting the ICDS and health officials started shifting responsibilities on each other but later on agreed that the synchronization between the two is the need of an hour. They also wished to involve MCD Hospitals for the same and decided that this type of meeting should be organized more often, so that future plan could be made. However inclusion of MCD Hospitals and Central government run hospitals was also desired.

Abbreviations Used

NCPCR	National Commission for Protection of Child Rights
ICDS	Integrated Child Development Scheme
CDPO	Child Development Project Officer
WCD	Women and Child Development
THR	Take Home Ration
AW	Anganwadi
AWC	Anganwadi Centres
AWW	Anganwadi Worker
IYCF	Infant and Child Feeding
TB	Tuberculosis
SAM	Severely Acute Malnutrition
PEM	Protein Energy Malnutrition
IMR	Infant Mortality Rate
CMR	Child Mortality Rate
U5MR	Under 5 Mortality Rate
NCT	National Capital Territory of Delhi
WHO	World Health Organization
NFHS	National Family Health Survey

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