Integrated Child Development Services

Time and Work Study of Anganwadi Workers

Main Report

(Devendra B. Gupta)

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Costing of Two Worker Model

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Section 1

1. Introduction:

The Government of India has recently undertaken an expansion of ICDS program to cover all habitations across the country and improve coverage of children based on India's census. At present all the services envisaged for various age category of beneficiaries – children under six years, pregnant and lactating women and adolescent girls - are provided by a locally recruited non-government woman worker called the anganwadi worker (AWW) supported by another woman worker designated as anganwadi helper (AWH). This entire structure is supported through a government supervisory structure that goes up to the block, district and state levels. The existing system based on single service worker to provide both nutrition and ECCE services is found to suffer from severe limitations on the quality of service delivery. This limitation is said to stem from the fact that (a) the target groups for both components are different with nutrition component primarily catering to under 3-years children and ECCE to children between 3-6 years, and (b) the content and mode of implementation for both components are qualitatively very different. In order to address this limitation it is being suggested to have two separate service delivery channels for the two components with some common areas of overlap. The operational implication of this is to have two separate specialized workers at the village level, one addressing the nutrition needs of under three year old children and the other addressing the early childhood education program for children in the age group 3-6 years. One of the workers would focus on communication with community and care givers, with the other worker concerned with planning and conducting a developmentally appropriate ECD program. In order to implement the two-worker model, with adequate quality assurance, certain additional inputs in the form of institutional and financial provision for training, resource support and capacity building of workers would be needed. As there are some other models with innovative features tried out earlier, it is quite possible for states to opt for one of these tried out models but which proved successful and which can be scaled up. This is particularly relevant in India's context, which indicates the existence of wide socio-cultural variations among various regions and states.

1.1 **Objectives:**

The overall focus of the study is to 'envisage the institutional and financial requirements of the proposed two worker at the local level in three different settings and estimate the costs involved'. The three settings broadly relate to (i) stand-alone habitation based model, (ii) NGO based model, and (iii) school based model. As we proceed we would see that each model has some strengths and some weaknesses.

In this paper an attempt is made to examine the cost implications of introducing an additional specialist worker parallel to the existing anganwadi worker. As mentioned above, the underlying rationale for introducing a two worker model arises from the *inability* of the existing ICDS delivery system, which is based on one anganwadi worker supported by one anganwadi helper, to deliver effectively all the services under the ICDS program. In a few states, however, some innovative features have been introduced that were not part of the national ICDS to partly overcome this problem.

Specifically the study has thus focused on (i) time management of the AWWs with reference to the prescribed job responsibilities with a view to examining the need for an additional worker (which means a two worker model), and (ii) the consequential financial implications of such a measure.

1.2 Structure of the Paper:

The paper is organized as follows.

- Section II briefly outlines the methodology used in achieving the objectives of the study.
- Section III provides a brief description of the ICDS program in the country indicating (a) the main components of the services provided under the program, and (b) job profile of the functionaries entrusted with the delivery of these services
- Section IV provides a review of the functioning of the ICDS program in the country. The review is based on the four-states survey specifically undertaken for the present study and comparing its findings with the findings of two earlier studies carried out by the NCAER and NIPCCD.
- Section V is devoted to analysing the tasks and responsibilities of ICDS functionaries. First, an idea about the tasks assigned to anganwadi workers is provided. We then

indicate the activities actually carried out by them as well as the time devoted on each of these activities. This description is based on the findings of the four-states survey.

- Section VI presents the salient features of select delivery models created through introducing certain, distinct, innovative features that are not part of the national ICDS. Inter alia the section contains a brief description of the implications of these alternative models in the context of a two-worker model.
- Section VII gives an idea of the costs incurred by select states on the ICDS program at the state, district, project, and village/habitation (AWC) levels. It also attempts to indicate the financial and institutional implications for a two worker model.
- Section VIII concludes with indicating some major concerns/issues in the context of a two worker model.

Section II

2. Methodology:

In this section an attempt is made to describe the methodology used for carrying out (a) a sample survey of anganwadi centres in the four study states (that is, Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh, being some of the most backward states of India), (b) focus group discussions with women beneficiaries, and (c) case studies of good Practices. In addition the study has also made use of secondary information. This largely comprise of (i) government documents brought out from time to time during the implementation of ICDS program in the country, (ii) Nationwide Concurrent Evaluation of ICDS by NCAER (2001) and Three Decades of ICDS - An Appraisal by NIPCCD (2006). The last two studies are largely used for comparing the findings of the four-states survey, where ever such comparisons are possible.

2.1 Sample Design of Four-States Survey: The survey covers four EAG states, namely, Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh. From each of the four study states, one district was chosen. The choice of both states and districts was made in consultation with the Bank. The criterion for choosing a particular district was its backwardness. From each selected district, two blocks were selected, with one of the blocks being not so well performing block. In the selection of anganwadi centres from each block an attempt was made to give representation to each gram Panchayat. Then a sample of 25% of the AWCs in each of the selected block was drawn, with the proviso that there would at least be 25 AWCs from each block. The following table gives the number of AWCs selected for survey.

State	Bihar	Jharkhand	Madhya Pradesh	Uttar Pradesh	Total sample size
AWCs #	60	60	50	53	223

A structured questionnaire, which was shared with the Bank and the MoWCD and pre-tested, was used to collect the required information. A distinguishing feature of the survey was that the investigators were advised not to prompt the respondents when inquiring about the type of activities performed during the day. They were asked to recall the activities carried out by them at the AWC. The investigators were also advised to personally observe the activities being actually carried out by the AWW during the day while recording the information.

Similarly the investigators were advised to record the actual time spent on various activities in the sample AWCs. As the findings provided below would show that certain activities like nutrition health education and growth monitoring hardly found any mention when the AWWs were not prompted. However in a later question, it was revealed that they did not ignore these activities altogether, indicating that only those activities get a mention which are relatively more important.

2.2 Focus Group Discussions: The focus group is a qualitative research method for eliciting descriptive data from population sub-groups, usually the stakeholders. Usually, a group of eight to twelve persons are gathered together for a group interview or discussion on a focused topic. In focus group research, reasoning proceeds from observations of a series of particular facts to a general statement or hypothesis. The strength of focus group as a qualitative method is that it generates rich, detailed, valid processed data that usually leave the study participants' perspective intact.

Thus, in addition, two focus group discussions with women beneficiaries were conducted in each of the eight selected blocks in the four states. The focus group has examined a narrowly focussed topic of anganwadi functioning. The emphasis is placed on interaction among group members. Groups of eight women comprising pregnant women, mothers of children 0-3 years and mothers of children 3-6 years were included in the discussion. The participants were selected from varying background. While conducting focus group, the facilitator created a non-evaluative environment in which group members felt free to express their opinion without concern for either agreement or disagreement of others in the group. The primary emphasis in group discussion was on stimulating interaction among the participants, the facilitators responsibility was to guide the direction of the respondent's comments so that the discussion did not become tangential to the study's established focus.
The details of selected anganwadis, where FGDs were conducted, is presented as under:

State	District	Anganwadi
Bihar	Kishanganj	Phutaniganj
		Sarsel
		Kumhar Tola
		Kalabgara Basti
Jharkhand	Giridih	Ghutiya
		Kadam Tola
		Dumar Ghutio
		Sonbad
Madhya Pradesh	Dhar	Pindarbodi
		Indira Colony
		Ghatgara
		Chhokla
Uttar Pradesh	Sonebhadra	Maldeva
		Bijri (Harhua)
		Beedar III
		Koora (Masohi)

2.3 Case Studies of Good Practices: As far as case studies of good practice states, which had/have incorporated certain innovative features that are not part of the nation ICDS program, are concerned we have largely relied on our discussions with program managers at the state, district, and block levels followed by field visits to 2 to 3 AWCs in each selected state. The selected states are: Andhra Pradesh, Chhatisgarh, Gujarat, Tamil Nadu and Rajasthan. For instance, under the Andhra Pradesh Economic Restructuring Project, Mothers Committees were used as support groups in the ICDS Program in AP. In Chhatisgargh, on the other hand, the institution of Mitanin (a kind of community health volunteer) are currently assisting the AWW in the delivery of ICDS services. In Gujarat, SEWA, an NGO, was implementing the national ICDS in select AWCs in Gujarat, mainly in Ahmedabad by using the services of three workers and extending the working hours of the AWC. Tamil Nadu is a classic case where the success of TINP in reducing the level of malnutrition is well documented and recognized. Rajasthan had in 2004 introduced an additional worker, Sahyogini. Recently however after the launching of NRHM, Sahyogini has been redesignating as ASHA-Sahyogini. The new worker would largely be responsible for health and nutrition related functions. This makes Rajasthan virtually a two plus one worker model. While discussing the salient features of each of this good practice, an attempt is made to briefly indicate the strength and weakness of each model in the context of a two worker model. Inter alia financial implication of each model is examined.

Section III

3 The ICDS Program

The national ICDS which was launched on October 2, 1975 in 33 blocks initially now covers all the blocks in the country, but some of them are yet to become functional/operational. It covers children under 6 years of age, adolescent girls 11-18 years, pregnant and lactating women. In the following paragraphs, we briefly outline the main features of the ICDS program.

3.1 Package of ICDS Services: The ICDS program provides six services at the anganwadi centre (AWC) by an anganwadi worker supported by a helper. The following table gives an idea of the package of services provided at the AWC.

Range of Services that the ICDS seeks to provide to Children & Women

	Children under 6	Pregnant Women	Lactating Women
Health check-ups, and treatment	Health check-ups by AWW, ANM, LHW Treatment of diarrhea Deworming Basic treatment of minor ailments Referral of more severe illness	Ante-natal check-ups	Post-natal check-ups
Growth Monitoring	Monthly weighing of under threes Quarterly weighing of 3-6 years old Weight recorded on growth cards		
Immunization	Immunization against poliomyelitis Diphtheria, pretties, tetanus, tuber-culosis and measles	Tetanus toxoid Immunization	
Micronutrient Supplementation	IFA and Vitamin A supplementation for malnourished children	IFA supplementation	
Health & Nutrition \Education		Advice includes infant feeding practices, child care and development, utilization of health services, family planning and sanitation	Advice includes infant feeding practices, child care and development utilization of health services, family planning and sanitation
Supplementary Nutrition	Not meal or ready-to-eat snack providing 300 calories and 8-10 g protein Double ration for malnourished children	Hot meal or ready-to-eat snack providing 500 calories and 2-25 g protein	Hot meal or ready-to-eat snack providing 500 calories and 2-23 g protein
Pre-school education	Early childhood Care and Preschool Education (ECCE) consisting or "early stimulation" of under-threes and education "through the medium of play" for children aged 3-6 years.		

Source: DWCD, 2004.

In addition, the MoWCD has recently added adolescent girls as a new component in the package of services. The following table gives an idea about the new package of services under the ICDS program:

ICDS package of Services

Beneficiary	Composition of Package
Children (6-12 months & 1-3 years)	Supplementary Nutrition, Health check-up, Immunization, Referral Services, Growth promotion, Vitamin A drops, Iron and Folic supplement
Children (3-6 years)	Supplementary Nutrition, Health check-up, Immunization, Referral Services, Growth promotion, Vitamin A drops, Iron & Folic acid supplement, Non-formal pre-school education
Adolescent Girls (11-18 years)	Supplementary Nutrition, Health check-up, Referral Services, Growth promotion, Vitamin A tablets, Iron & Folic acid supplement, Nutrition and Health Education, Literacy, recreation and skill development
Women (15-45 years)	Supplementary Nutrition, Health check-up, Immunization, Referral Services, Growth promotion, Vitamin A tablets, Iron & Folic acid supplement, Nutrition & Health Education, Ante-natal and Post-natal care.

Note: In practice, not all of these services are necessarily provided at every AWC.

It can be seen that the ICDS program has adopted a multi sectoral approach to child well-being, incorporating health, education and nutrition interventions, and is implemented through a network of AWCs at the community level. The emphasis on the life-cycle approach by the Government of India implies that malnutrition is fought through interventions targeted at unmarried adolescent girls, pregnant women, lactating mothers and children under 6 years of age. Over the period, ICDS has expanded its range of interventions to include components focused on adolescent girls' nutrition, health, awareness, skill development, as well as income generation schemes for women.

3.2 Eligibility Criteria: Both AWW and AWH are honorary workers, usually drawn from within the local village/community. AWW is expected to be acceptable to the local community and be in the age group of 18-44 years. As far as education eligibility criterion is concerned, initially the AWW was expected to be matriculate, but this condition was seldom adhered to, and this has much to do with the availability of women with appropriate education. On the other hand there is no such eligibility criteria for helpers except hat they are local women with some literacy. These workers are normally supposed to put in about 4 hours of work for six days a week. In the choice of AWWs and AWHs, it was suggested that preference be given to recruit SC/ST and other weaker sections. However there are several state governments which pay additional honoraria for some additional hours of work. AWCs in Tamil Nadu, for example, is open from 8/9 am to 4.30 pm but the AWWs and helpers are

paid almost twice the honoraria sanctioned by the GoI, the additional financial burden is met through state resources.

It may be mentioned that there are cases when anganwadi workers, not fulfilling the minimum prescribed eligibility conditions, have been appointed. The reason may be non availability of women with requisite qualification and experience or on extraneous grounds, perhaps related to political patronage or caste considerations etc. This is so because these workers exert great deal of influence on the local community.

3.3 Compensation Package: The following table shows the honoraria as sanctioned by the Government of India from time to time for AWWs and AWHs under the national ICDS.

Table: Honorarium/Benefits extended to Anganwadi Worker and Helper since 1975

Figures in Rupees

Qualification/year	1975-76	1.4.78	1.7.86	2.10.92	16.5.97	1.4.02
ANGANWADI WORKER						
Non-matriculate	100	125	225	350	438	938
Matriculate	150	175	275	400	500	1000
Non-matriculate with 5 years experience			250	375	469	969
Matriculate + 5 years experience			300	425	531	1031
Non-matriculate + 10 years experience			275	400	500	1000
Matriculate + 10 years experience			325	450	563	1063
ANGANWADI HELPER						
	35	50	110	200	260	500

In addition the following benefits are currently available:

3.3.1 Leave – They have been allowed paid absence on maternity at par with women emploees in the organized sector.

3.3.2 Insurance Cover - The Government of India has introduced Anganwadi Karyakarti BimaYojana for AWWs and AWHs with effect from 1.4.2004 under theLIC Social Security Scheme

3.3.3 Award – In order to motivate the AWWs and give recognition to good voluntary work, Scheme of Award for Anganwadi Workers has been introduced, both at the national and state

level. The award comprises Rs. 25000 in cash and a Citation at Central level and Rs. 5000 cash and Citation at State level.

It would be noted from above that since the inception of the ICDS program in the country, measures have been taken to improve the compensation package of both AWW and AWH, not only through increase in the quantum of honoraria to take care of price rise, but also by providing additional benefits and incentives.

3.4 Job Profile:

Given the range and diversity of services that AWWs and AWHs have to perform it would be relevant to know clearly what their assigned roles and responsibilities are and the extent to which they are capable to discharge their duties efficiently. Annexure 1 gives the range of responsibilties assigned to the AWW. A close examination of these assigned tasks would clearly indicate the enormity and diversity of work that an AWW is expected to perform. For instance, an AWW is responsible for pre-school education, nutrition and health education, growth monitoring promotion, assisting ANM in health checks and immunization, record keeping and many other administrative duties besides assisting in other non-ICDS duties, and all this as an honorary workers in four hours. All these services require different skills as well.

It is true of course that as far as some health functions are concerned, the ANM and PHC doctor provide the necessary support. The following matrix gives a broad idea of the services delivered by each functionary type.

Services	Target Group	Services Provided by
Supplementary Nutrition	Children under 6 years; pregnant and lactating mothers (PLW)	AWW and AWH
Immunization•	Children under 6 years; PLW	ANM/MO
Health Check up•	Children under 6 years; PLW	ANM/MO.AWW
Referral	Children under 6 years; PLW	AWW/ANM/MO
Pre-School education	Children 3-6 years	AWW
Nutrition & Health Education	Women (15-45 years)	AWW/ANM/MO

*AWW assists ANM in identifying and mobilizing the target group.

Given the background and the skills as well as the diverse tasks that AWWS/AWHs are expected to perform in a short time and cover almost 200 households could indeed be very

• AWW assists ANM in identifying and mobilizing the target group

trying for any one. Besides the compensation package offered to them is regarded as quite measly, although these packages have improved over time. It is however worth pointing out that, since most anganwadi workers are from within the village, any income that they earn is usually an additionality to their family income. Besides it also brings in certain amount of recognition.

In another section we deal with this aspect in greater detail by analysing the activities actually carried out by the AWW. The time management aspect is also examined with the help of the findings of the survey of four districts conducted specifically for the present study as well as the findings of an earlier evaluation.

Section IV

In this section we present the findings of the survey of AWCs and Focus Group Discussions of Women beneficiaries in the four study states. The findings of the survey, where ever possible, are compared with the findings of two earlier evaluations conducted by NCAER (2001) and NICCD (2006). The focus of the section is on service provision and utilization.

4.1 Survey Findings:

4.1.1 Service Provision and utilization

Anganwadi Infrastructure: Appendix Tables 1 provide an idea about the availability of infrastructure facilities at the sample anganwadis in the four study states.

Location of AWCs: Overall a quarter of the sample anganwadi centres (AWC) were co-located with school buildings and nearly 30% in the house of the anganwadi worker (AWW). There are however wide inter state variations. For example, in Uttar Pradesh (UP) over 83% AWCs were located within the school building, and in Bihar almost 78% AWCs were operating from AWW's own homes.

According to the NCAER evaluation, about 33% AWCs operated from own buildings, 13.8% from AWWs house and 9.5% were located in school buildings. According to NIPCCD (200^), 13.8% AWCs were located in school buildings, 19.7% operated from rented preimises, and 24.5% AWCs were owned by the state governments. All survey findings indicate that a fairly sizeable proportion of AWCs functioned from community/Panchayat owned buildings.

Space: A little under 80% sample AWWs reported having adequate space for carrying out ICDS related activities in the AWCs**.** Some of the anganwadis were operating in the open as well (68% of the 47 AWCs which responded to the question).

According to NCAER's evaluation nearly 50-60% AWCs reported adequate space in respect cooking (49%), storage (56%), outdoor playing (59%) and indoor playing (49%). The NIPCCD evaluation found nearly 50% AWCs to have adequate outdoor and outdoor space and space for storage. The FGDs also suggest that space availability at the AWCs was not a problem.

Building Structure: Of the AWCs surveyed, while less than 7% reported poor structure of buildings, 59% found condition of AWC buildings to be satisfactory, with 34% finding the buildings to be in good condition.

Rental Paid: Nearly 50% of the AWCs were operating from rented buildings, this percentage being lower for Uttar Pradesh most AWCs were located within the primary school premises. Also a larger percentage of the sample AWCs in Bihar and Jharkhand were operating from rented buildings. Nearly 75% of the AWCs paid rents between Rs.100 and Rs.200 per month. Also about 16% of AWCs paid a rent of Rs.300 and more (all those which paid a rent of more than Rs.300 were urban AWCs).

Amenities: As far as access to amenities like water and power is concerned, nearly 80% AWCs reported to have provision for water. This is not true in regard to availability of electricity where the situation is rather dismal.. Only about one fifth of the households reported to have access to power, with Uttar Pradesh and Bihar indicating much lower percentage (3.8% and 16.7%, respectively). The situation in regard to toilet facilities at the AWCs is somewhat better, with nearly 50% AWCs reporting the availability of toilet facilities. In Jharkhand, however, only 11.7% AWCs had toilet facilities. A heartening feature is that of those which had toilet facilities, almost 85% were reported to be in working condition. The NCAER evaluation had however given a very different picture, according to which only 16.2% had toilet facilities of one kind or the other. In fact the women beneficiaries during FGDs complained about lack of toilet facilities.

Accessibility: With regard to the location of anganwadi centre, across all the four states it has been revealed that anganwadi centre is 'conveniently located'. Except for the fact that during rainy season, approach to anganwadi became a problem in Jharkhand and Bihar.
The NCAER evaluation also found most AWCs across the country located within accessible distance (100-200 meters) from beneficiary households. A majority of beneficiary households was within 100 meters of the AWC. Another 10 per cent were about 150-200 meters away. The rest were beyond 200 meters. Thus, the factor of distance of beneficiary households from the AWC was unlikely to affect attendance at the AWC during inclement weather.

4.1.2 Equipment and Supplies:

Apart from the existence of functional infrastructure, availability of necessary equipment and aids, furniture and fixtures and other materials, including the essential medicines, is critical for the ensuring the quality delivery of services. Tables 11 shows the situation in regard to the availability of various materials.

Utensils and Furniture: First except Bihar, the availability of various such equipment as almirah, bucket, cooking vessels and chair, etc. is reasonably satisfactory.

Toys, Charts, Slate: Also over 80% AWCs reported availability of toys, charts/poster and slate. The availability of charts/poster is however low in Bihar (31.7% AWCs). Somewhat satisfactory situation in regard to toys/slate etc. may be associated with the fact that these materials are supplied in kind. It was revealed during the FGDs that in Jharkhand, sand toys were provided as a part of PSE material. We may however point out that having toys does not necessarily ensure that they are being used. The NIPCCD evaluation indicates a much lower availability of toys (25-27 per cent).

Weighing Scales: As far as availability of weighing scale is concerned only 53.8% of AWCs had the scales for children and 56.5% for adoloscent girls and women. None of the AWC in Jharkhand reported having a weighing scale. In Bihar the percentage of Aws having weighing scales is around 50%. The NIPCCD evaluation showed between 85% to 95% of AWCs having scales, with nearly 90% of hem in working condition.

Possession of scales is not enough unless it is used. Most women during the FGDs reported that routine weighing was done once a month, but sometimes once in two months. Women in Jharkhand were unable to recall when weights were last taken. There were however varying responses. For example in Bihar, it was reported that AWWs weighed children at birth o at the time of illness. In Madhya Pradesh weighing of children was done once a month during Bal Sanjivini Drive.

Medicine Kits: The situation in regard to the availability of medicine kits is quite disturbing with only about one third of the AWCs reporting to have the medicine kits. There are very wide inter-state variations in the availability of medicine kits. Except Madhya Pradesh with 96% AWCs having medicine kits, all the other three study states reported very low

availability (8.33% Jharkhand and Bihar and 26.4% Uttar Pradesh). Of the AWCs having medicine kits, a little over three fourth of them received medicine within couple of days.

4.1.3 Profile of Anganwadi functionaries: Education, background and Training

Education: Contrary to the popular view, the majority of the anganwadi workers in the sample AWCs had education upto intermediate or above (over 85%) (Tables 2). Even the anganwadi helpers were reasonably well educated with almost 50% AWHs having education above the junior middle level. According to the NCAER evaluation one out of two AWWs was found to be educated at least up to matriculate level across the country. According to NIPCCD (2006) around 76% AWWs were matriculates or had higher education. All the surveys show that there were hardly any illiterate workers (less than 1%).

Caste: A majority of AWWs belonged to SC (14.8%), ST (8%), other backward classes (35.4%) and minority communities (16.6%); only a quarter of the AWWs came from general category. As far as AWHs are concerned, a much larger proportion belonged to the deprived communities (almost 88%). However there are wide inter-state variations, with both Madhya Pradesh and Bihar having a larger percentage of AWWs from the general category (40% and 38.3% respectively). In Jharkhand there was no worker from the general category, and OBC dominated with 70%.

Residence: 82% AWWs and 87% AWHs working in the sample AWCs lived within the village, although one third of the AWWs in Uttar Pradesh and Madhya Pradesh lived outside the village. According to NCAER (2001), while 22% AWWs lived within the population they served, about 56% lived in the vicinity of their respective AWCs.

Age and Experience: Most anganwadi workers, both AWW and AWH, were below the age of 40 years (with more than 60% AWWs and 50% of AWHs below 35 years of age). According to NICCD (2006), almost 77% of AWWs were in the age group of 25-45 years and NCAER evaluation found nearly 44% of AWWs in the age group 31-40 years.
Further nearly half of the anganwadi workers (both AWWs and AWHs) were with the AWCs for less than 5 years. The NIPCCD study found less than 10% of the workers with experience of 5 years and less. The NIPCCD study figures are for the country as a whole, and it is possible that many of the AWCs in our sample are relatively new.

Training: All anganwadi workers reported to have received training which they found useful (Table 3). A breakdown of various trainings shows that only 66% received induction training, 97% received job training and 92% had received joint training. As far induction training only 15% of AWWs in the sample had received induction training; this percentage was 50% for Madhya Pradesh. 63% of AWWs reported to have received refresher training. However both Uttar Pradesh and Bihar indicate a lower percentage (28% and 38% respectively). 53% AWWs said they had received all the three training. Most AWWs found these training useful. However many AWWs expressed their keenness to receive further training, especially in pre-school education, inter-personal communication skills and maternal health. As per the NCAER evaluation about 84 per cent of the functionaries reported to have received training but that was largely pre-service training. Further, in-service training according to NCAER evaluation, had remained largely neglected.

4.1.4 Beneficiaries:

The following table gives an idea about the number of beneficiaries registered as a percentage of the eligible women and children.

State	Percent of Beneficiaries Registered				
	0-3 years	3-6 years	Pregnant womenn	Lactating women	Adolescent girls
Uttar Pradesh	66.35	73.48	88.05	84.63	3.69
Madhya Pradesh	56.75	58.94	90.84	85.62	10.40
Jharkhand	35.80	48.55	75.30	54.15	14.02
Bihar	55.12	61.90	52.52	49.59	4.89
Total	53.93	61.10	75.09	65.90	7.29

Overall, nearly 54% of the children under the age of 3 years were registered, with a low of around 35% in Jharkhand. The percentage of registered children in the age group 3-6 years and those of pregnant and lactating women (PLW) is much higher. However the percentage of registered PLW is relatively lower in Jharkhand and Bihar. As far as adolescent girls (AG) are concerned, the percentage of AGs registered is pitifully small (7.2%).

4.1.5 Utilization of Services:

Let us now examine the utilization of various services by the beneficiaries. (Tables 4).

Pre School education: Only about 61.5% of the registered beneficiary children were present for pre school education on the day of the visit, their number being lower in Uttar Pradesh (52%) and Madhya Pradesh (55%). Both Bihar and Jharkhand showed higher attendance (over 70%).

Supplementary Nutrition: As far as supplementary nutrition is concerned the following table gives the distribution of children who received SNP on the day of the survey.

State	Number of Children given SNP on the day of Survey					
	number	15-30	31-45	46-60	61-75	76-90
UP	53	30.19	43.40	24.53	0	1.88
MP	50	70.00	28.00	2.00	0	0
Jharkhand	60	58.33	41.67	0	0	0
Bihar	60	0	0	15.00	71.67	13.33
Total	223	38.57	27.80	10.31	20.63	2.69

The above table that in about 38% of the AWCs, the number of children who were present for SNP was between 15-30. Almost in one quarter of the AWCs the number of children present for SNP was as high as 61-75. There are wide inter-state variations with MP and Jharkhand showing a smaller number of children benefiting from SNP. In Bihar children taking advantage of SNP is very high.

4.1.6 Convergence and Interaction with other Workers:

During the course of her work, the AWW comes in contact with several other functionaries, and also have occasions to work together. Thus in response to a question about such interaction, and the nature of work performed, including the time spent, three main workers were mentioned – teacher, the ANM and the ASHA worker.

Interaction with Teacher: As far as interaction with the teacher is concerned, it was mostly in the areas of admission work at the primary schools, organizing annual functions, and child surveys, besides providing some assistance in teaching when required. As far as assistance in teaching is concerned this was confined to Uttar Pradesh where most AWCs are co-located with primary schools. Nearly 50% of AWWs received such assistance from the school teacher who spent almost 1.5 hours daily (!). AWWs provided assistance in admission work.

This was however an annual ritual only at the time of admissions. The time spent was between 1.5 hours to 4 hours annually. Some assistance was also received from the teacher in record keeping.

Interaction with ANM: As far as AWW's interaction with the ANM is concerned, it is fairly well defined. The AWW helps in immunization and health check up. Besides she also participates in counseling PLWs. The AWW normally spends 4 hours in a month with the ANM.

Interaction with ASHA: As far as interaction with ASHA is concerned, it is confined to Uttar Pradesh and Madhya Pradesh (Rural). As ASHA is a health worker, the interaction was mainly in the area of health and that too at the moment it was mainly confined to immunization, health check up and ANC/PNC for PLW. While in Uttar Pradesh, an AWW spent about four hours once in a month with the ASHA worker, the time spent in Madhya Pradesh was about six hours once every month (Tables 7)

4.1.7 Role of Community-based organizations and Self-help Groups

It is generally well recognized that self-help groups, mahila mandals and other community based organizations, including the panchayats have an important support role towards the successful functioning of the AWCs. It would be seen that overall only about 35% of the AWCs received any help from CBOs. There are wide inter state variations with 84% AWCs in Madhya Pradesh reporting such assistance. In Uttar Pradesh only 45.3% AWCs received such assistance. The CBOs and other similar groups did not seem to be active at all in Bihar and Jharkhand where only an insignificant percentage of AWCs received any assistance. Among the various community groups active in the field, mention may be made of Mahila Mandals and Mothers Committees, besides self help groups. Most AWWs were keen to solicit the support of these organizations, particularly in activities related to immunization, adolescent girls and NHE.

The NCAER study found community leaders generally showing a positive attitude towards the functioning of the AWCs with more than 70 per cent finding the program to be beneficial to the community. According to NIPCCD evaluation, community leaders extended support (67.7%) in the form of supervision, solving personal problems of AWWs, and protecting them from undesirable elements. Further they (44.6%) also supported AWWs as an when the

same was needed. The community leaders helped in several other ways to promote the cause of ICDS by motivating parents to send children to AWCs, providing assistance in record keeping, and assisting AWC-leaving children to get admission to class I in primary schools.

4.1.8 Supervision:

It is generally asserted that close and regular supervision improves the outcomes of the program. Therefore a set of questions on supervision were asked. Under the ICDS, both supervisors and the CDPO are expected to make supervisory visits to the AWCs under their respective jurisdictions. In practice, however, this task is seldom taken seriously. Indeed TINP's success is usually attributed to close supervision built into the system. According to Tables 12, it is observed almost two third of the AWCs were supervised at least once in a month, with nearly 13% being never visited by the Supervisory staff. In Jharkhand, almost half of the sample AWCs were never visited, and only 13% of the AWCs were visited once in a month by the supervisor. The supervisory visits to the AWC by the CDPOs however is seen to be less frequent, although they on the average visited almost one quarter of the AWCs at least once in a month. In Bihar, the CDPO had visited the AWCs only once in a year. The frequency of visit by the DPO to AWCs was almost conspicuous by its absence, though the DPO did visit some AWCs once in a year or once in six months. The frequently supervised activities included checking of children's attendance and record keeping and maintenance of registers (including stock position). Other aspects of supervision included checking of general hygiene and providing guidance in areas where such advice was sought.

4.1.9 Role of ASHA

In the context of a two-worker model, it is useful to understand the possible role of ASHA and her potential areas of cooperation with the AWW. Alternatively one would like to understand the extent to which ASHA would be able to take on some of the workload of the AWW. Tables 13 show that it is only in Uttar Pradesh that one could comment on the role of ASHA, although a quarter of the AWCs in Madhya Pradesh reported the existence of ASHA. Only about half of the AWWs admitted some reduction in the burden of their current workload. For the moment at least two third of the AWWs believed that ASHA would be able to help them in their work. We explore this further later in this paper.

4.1.10 Service Delivery

Pre school Education Activities:

PSE activities comprise of numerous sub activities, and hence a question was included to list the activities carried out under the PSE component in the AWC. The method adopted was to observe selectively the PSE activities when they were being actually carried out at the centre. Tables 18 provide the necessary information. Prayers, games, color recognition, poetry and story, PT/exercise, hygiene, numbers and alphabet were among the major PSE activities (around 50% or more AWCs). Some variations among the study states were observed. The following figures culled out from table give some idea of such inter-state variations.

PSE Activity	% AWCs (Mean)	High State with %	Low State with %
Payer/National Anthem	79	95 (Jharkhand)	56 (MP)
Action Songs	39	74 (UP)	24 (MP)
Story telling	52	92 (MP)	27 (Jharkhand)
Conducting Games	82	92 (Jharkhand)	62 (Bihar)
About Colors	57	84 (MP)	12 (Jharkhand)
Poetry	51	85 (Bihar)	12 (Jharkhand)
About Animals	38	70 (UP)	0 (Jharkhand)
PT Exercise	49	83 (Jharkhand)	20 (Bihar)
Hygiene-related	52	63 (Bihar)	45 (UP)
Drawing	38	64 (MP)	22 (Bihar)
Alphabet	57	78 (MP)	17 (Jharkhand)
Fruits/Vegetables	34	60 (MP/UP)	0 (Jharkhand)
Language	21	30 (MP/Jharkhand)	5 (Bihar)
Social Relationships	19	25 (Bihar)	16 (MP)

Note: All percentages have been rounded off.

A very large proportion of AWWs (nearly 92%) did set aside some time for planning and preparation of material for PSE. While on average AWWs spent nearly 8 minutes daily on planning and preparation of PSE material, but more time was spent on it either once a week (54 minutes) or once in a month (37 minutes on average). The breakdown of AWWs by time spent on these activities is given in Table 18.1b.

According to the four states survey findings, almost 150 minutes to 190 minutes were devoted to PSE activities in a day, the NCAER's study showed that on average 104 minutes (range being 70 minutes to 156 minutes) were spent on PSE activities. Indeed in most backward districts, most time was seen to be devoted to PSE activities, a large part of which may indeed be on SNP, as was observed during the field visits.

With regard to provision of pre-school education (PSE) at the anganwadi centre, findings of FGD imply that across all the four selected states anganwadi worker provides PSE to children in the age of 3-6 years. However, the duration of PSE varies across states. The duration of PSE on an average is four hours in Bihar and Jharkhand and 2.5 hours in Madhya Pradesh and Uttar Pradesh.

State	Time spent on PSE (hrs)	PSE material provided to children
Bihar	4.0	Slate, pencil, toys, pictures of animals and birds.
Jharkhand	4.0	Only sand toys.
Madhya Pradesh	2.5	Toys, charts, ball.
Uttar Pradesh	2.5	Slate, chalk, colored beads, plastic toys and plastic vegetables

IMPACT OF PSE: The women were further probed whether any improvement among children was indicated as a result of PSE activities at the anganwadi centres? Across states, women felt that PSE activities had only limited impact. The improvement in Bihar was visible mainly in terms of knowledge enhancement, change in food habits, learning alphabets, intermingling with peers and smooth transition to school. In Jharkhand, women felt that child learned mixing with peers, and also learned speaking etc. In Madhya Pradesh, women stated that child learns manners, alphabets and become habituated to formal environment. In Uttar Pradesh, women have said that children learn mixing with peers, develop habits and manners and PSE facilitates smooth transition of children from anganwadi to school.

The following tabulation from NCAER study makes an interesting reading in the sense it shows that despite almost two hours to three hours on PSE activities, not many children were able to perform various PSE activities

	% children who could perform
Recognize alphabets	32.6
Count numbers	37.4
Write alphabets/words	26.3
Distinguish colors	31.3
Distinguish objects	29.4
Recognizing pictures	26.7

Nutrition and Health Education Activities:

Once again like numerous activities under the PSE component, there are several sub activities under the NHE component. We therefore wanted to get an idea of the NHE activities actually carried out by the AWW at the AWC. Table 19 gives the percentage of AWCs where these services were being delivered. While almost 88% of the AWWs reported providing nutritious meals, this percentage is lower for immunization (about 75%) and iron tablets (45%), other NHE services were either neglected or received less attention. For instance breast feeding percentage was a little under 25%, colostrum feeding (19%) and child growth monitoring (16%).

On average 74% mothers of the 25% mothers (who were reported to breastfeed) breastfeed either on the same day or immediately, 21% mothers 2-3 days and remaining after a week or so.

Growth Monitoring and Counseling:

A number of questions were asked in the context of GMP. Functional weighing scale is a pre-requisite to GM. Only about 45% of the AWWs reported these scales to be in working condition (Table 20.1). Also only 54% of the AWCs were reported to have growth monitoring cards, and an identical percentage were in a position to prepare GM charts and do proper marking on them. Almost 70% AWWs reported to convey the importance of GM to mothers. Also a large percentage (82%) held counseling sessions with mothers.

Weighing is still a taboo, and we asked whether there was any resistance to the weighing of children. Almost two third of the parents did not offer any resistance. However nearly 18% did resist. In such cases the AWWs explained the positive aspects of weighing.

The NCAER survey found that only 41% AWCs reported preparing/maintaining community growth chart and 44% mothers reported observing child's growth chart.

4.2 FEEDBACK FROM WOMEN BENEFICIARIES

4.2.1 HEALTH CHECK UP

If we take a look at the state-wise findings, it reveals that in all the four selected states, usually all pregnant women go to anganwadi centre for ante-natal check-up. It seems that awareness regarding ante-natal check-up is prevalent among pregnant women across four states. On probing the role of anganwadi worker in ante-natal check-ups, pregnant women of Bihar claimed that anganwadi worker inform them regarding the visit of ANM at the anganwadi centre. The worker makes an entry in the concerned register indicating that ante-natal check-up is conducted on the specified date. Further anganwadi worker tells ANM about the duration of each pregnancy. The group also agreed that in case of illness of pregnant women, anganwadi worker takes the women to a doctor for check-up or treatment. The group reported that anganwadi worker tells about the importance of tetanus injection during pregnancy. The worker insists on institutional delivery, as institutional delivery is considered as 'safe' compared to non-institutional delivery. In Jharkhand, anganwadi worker advises pregnant women regarding the type of food to be consumed during pregnancy, cleanliness to be maintained at all the time, necessity of adequate rest, timely consumption of food, importance of tetanus-toxoid injection and harmful effects of lifting heavy load during pregnancy. If we view the role of worker during antenatal check-up in Madhya Pradesh, we find that worker advises only regarding the tetanus-toxoid injection and mandatory three antenatal check-ups for each pregnant women. If we observe the group findings in Uttar Pradesh, we find that role of anganwadi worker is restricted to telling the importance of TT injection during pregnancy, routine interaction with pregnant women and providing prior information to pregnant women regarding delivery.

4.2.2 HOME VISITS AND NUTRITION HEALTH EDUCATION

Another indicator probed during FGD was whether anganwadi worker visits the house of each pregnant women and lactating mother? The findings reveal that in all the four states, anganwadi worker do visit the house of each pregnant women and lactating mother. During the 'home visits', the worker in Bihar advises pregnant women regarding importance of consuming nutritious food, importance of green leafy vegetables, timely vaccination, iron tablets and avoid lifting heavy load during pregnancy. Lactating mothers are briefed about exclusive breast-feeding of child, introducing semi-solid food at the age of six months, importance of maintaining birth interval, regular weighing of children, use of ORS and tips

about successful motherhood. In Jharkhand, women accept that anganwadi worker informs about TT, importance of consuming green leafy vegetables, fruits and routine check-ups during pregnancy. Lactating mothers are advised regarding exclusive breast-feeding, child immunization and overall child-care. If we view the findings in Madhya Pradesh, we conclude that anganwadi workers advises pregnant women regarding consumption of food at least thrice a day, TT injection, iron and folic acid tablets, calcium, fruits, vegetables, milk, importance of institution delivery and avoid lifting heavy weight. Lactating mothers are told about exclusive breast feeding and child immunization. The women group of Uttar Pradesh indicated that anganwadi worker advises for TT injection, fresh fruits, adequate rest, iodized salt, colustrum feeding, vitamins and against bottle-feeding.

4.2.3 INSTITUTIONAL DELIVERY

On probing the place of delivery, the women group of Bihar, Jharkhand and Uttar Pradesh have claimed that place of delivery in majority of cases is ‘home’, whereas women of Madhya Pradesh have opined that place of delivery at most of times is a ‘hospital’.

On asking, who usually helps/attend the delivery in case of ‘domicile births’, women of Bihar recognized that it is local Dai, neighborhood women, mother-in-law, sometimes ANM and Nai. In Jharkhand, only local Dai and mother-in-law attends the delivery at home. However, in Uttar Pradesh, women have agreed that untrained Dai, ANM, mother-in-law and elderly women attend the delivery at home.

On investigating the role of anganwadi worker in domicile births, women of Bihar have reiterated that anganwadi worker visits the house at the time of delivery, in case she is unable to attend, she deputes helper. Worker remains at the place of delivery till the child is delivered. She insists for a new blade too. A few women in Bihar have also reported that there is no role for anganwadi worker in domicile birth. Women in Jharkhand have said that anganwadi worker simply inquired the status of pregnancy and insist for institutional delivery. Women of Uttar Pradesh have categorically stated that there is no role of worker, in case of delivery at home.

Contrary to the above, the women were further asked to clarify the role of anganwadi worker in ‘institutional delivery’. It has been observed that women of Bihar have revealed that anganwadi worker arranges a vehicle up to the hospital, she accompanies the women to

ensure safety and if need arises, she refer the case to an appropriate doctor. Women of Jharkhand have reported that worker simply recommends the hospital for delivery. In Madhya Pradesh, women consider institutional delivery as ‘safe’. At many times, anganwadi worker reimburses the travel expenses incurred by the women for reaching the hospital. In Uttar Pradesh, anganwadi worker accompanies the women up to the hospital, interacts with the doctor and infuses confidence in the women.

4.2.4 NUTRITIONAL SUPPORT

During the FGD, women were asked whether they received nutritional supplement at anganwadi centre? If yes, how much quantity of food supplement is received and what is its quality rating? In all the four states, it has been observed that women do receive nutritional supplement at the anganwadi centre.

State	Frequency of receiving supplement	Quantity of supplement	Quality of supplement
Bihar	Daily	One thali khichdi	Satisfactory (tasty, easily digestible)
Jharkhand	Once a month	2 kg. Rice & 1 kg pulse	Satisfactory
Madhya Pradesh	Daily	One bowl soybean (sweet & salty alternate)	Satisfactory
Uttar Pradesh	Weekly	12 glass sweet corn-Soya blend on every Saturday.	Satisfactory

It can be observed that frequency of food supplement varies from ‘daily’ in Bihar and Madhya Pradesh to ‘weekly’ in Uttar Pradesh and ‘monthly’ in Jharkhand. In Bihar, women have also highlighted that non-registered pregnant/lactating women are not eligible for receiving food supplement. Sometimes, raw material and khichdi (i.e. rice & pulse) is provided to women once a month. All women have reported that quality of food supplement is ‘satisfactory’. With regard to the nutritional supplement provided to children at anganwadi centre, the women said that supplement is provided. The state-wise details are as under:

State	Frequency of Supplement	Quantity of supplement	Quality
Bihar	Daily	One bowl khichdi + one toffee	Satisfactory
Jharkhand	Daily	Khichdi+suji (as per requirement)	Satisfactory
Madhya Pradesh	Daily	Soybean (as per requirement)	Satisfactory
Uttar Pradesh	Daily	Sattu (as per requirement)	Satisfactory

It can be seen that frequency of nutrition supplement is ‘daily’ for children. However, the type of nutrition supplement varies across states.

4.2.5 MOTHERS MEETINGS

With regard to the women meetings arranged at the anganwadi centre, the focus group discussion has brought out that across all the four states, such meetings are organized 'once in a month' by the anganwadi worker for pregnant women and lactating mothers. However, some women in Bihar have informed that they could not attend such meetings due to their pre-occupations in domestic chores.

On probing the issues normally discussed in these meetings organized by anganwadi workers, women in Bihar have stated that topics include – type of food recommended during pregnancy, consumption of iron/folic acid tables, TT injection, ante-natal and post-natal checks, importance of colustrum feeding, exclusive breast-feeding, timely immunization, family planning, consumption of green leafy vegetables and eating fresh food. Women of Jharkhand have reported that anganwadi worker normally discusses about family planning, child care practices, cleanliness, iron-folic acid tablets, post-natal check-ups, breast feeding and immunization. In Madhya Pradesh, FGD has revealed that issues like age at marriage, importance of education, family planning, breast feeding, institutional delivery, hygiene, colustrum feeding, iron-folic acid tablets and calcium needed during pregnancy are discussed during these meetings. In Uttar Pradesh, women have informed that they are briefed about colustrum, immunization, cleanliness, hygiene and institutional delivery.

FGDs further tried to bring out the advantages of such meetings as perceived by the women. Women in Bihar have acknowledged that they learned about good food habits, child-care practices, and other health related issues. Women of Jharkhand claimed that their knowledge was enhanced, in addition to knowing about the child rearing practices. In Madhya Pradesh, the participants agreed that they came to know about preventive measures. In Uttar Pradesh, the group of women accepted that after such meetings women preferred institutional deliveries and also the use of ORS has become a common practice in the households.

4.2.6 IMMUNIZATION

On asking their awareness and knowledge regarding immunization, they were probed to state for which preventive illness immunization is provided to children? The findings revealed that accurate knowledge regarding child immunization is lacking among women. If we examine the state-specific findings, we note that women of Bihar reported that immunization to children is provided for measles, chickenpox, polio, BCG, diarrhoea, DPT, tetanus, typhoid, TAB and blindness. A few of them could not tell any one of these. In Jharkhand, women

informed that child immunization is basically meant for Diarrhoea, Small pox, Polio, Measles and Tuberculosis. In Madhya Pradesh too, women said that immunization is provided for polio, measles, BCG, DPT, Jaundice, Malaria and Tetanus. In the state of Uttar Pradesh, the scenario is similar. Women have stated that child immunization is provided for Tetanus, Polio, Goiter and Measles.

On enquiring about the place of immunization, the inter-state observations show that in Bihar, Jharkhand and Madhya Pradesh the place of immunization is usually the anganwadi centre within the village. In Jharkhand, some women have claimed that they sometimes availed immunization facilities from the government hospital also. However, in Uttar Pradesh the place of immunization is nearby primary school. The response is similar across all the four states with regard to 'who administers the vaccines'. It is usually the Auxiliary Nurse Midwife (ANM), who administers the vaccines (at anganwadi centre).

During the course of FGDs it has been revealed that role of anganwadi worker is diverse during the process of immunization. In Bihar, women have acknowledged that anganwadi worker assists/facilitates ANM, visits door to door to collect children, does entry in immunization register, send prior information to households and explains the importance of immunization. In Jharkhand, women have opined that anganwadi worker simply deputes the anganwadi helper to mobilize children for immunization. In Madhya Pradesh, women have reported that anganwadi worker sends information to households, bring children to anganwadi centre and make entries in immunization register. In Uttar Pradesh, women have expressed that anganwadi worker collect children for immunization, remind households and send advance information across the village.

4.2.7 GROWTH MONITORING AND WEIGHING OF CHILDREN

If we take a look at the findings of FGD with regard to awareness among women for growth monitoring parameters, we came to know that women in Bihar have indicated that growth-monitoring parameters are simply weight and height. In Jharkhand, women could not tell any growth monitoring parameter and said that anganwadi worker interacts with doctors. In Madhya Pradesh, women informed 'weight' and 'diet' as two growth monitoring parameters. In Uttar Pradesh, women reported 'weight' and 'height' as two key growth-monitoring parameters.

The issue of weighing of children at anganwadi centre was probed in FGD. The findings confirm that in the selected anganwadis of Madhya Pradesh and Uttar Pradesh, women have claimed that weighting of children in undertaken at anganwadi centre. However, in Bihar and Jharkhand the scenario is reverse. Women have acknowledged that weighing of children is ‘not undertaken’ at anganwadi centre due to non-availability of weighing scale.

The knowledge of women was tested in FGD by asking them the advantages of weighing children. In Bihar, women agreed with the view that weighing was done for monitoring the growth of child, to identify illness and to take necessary interventions. Some of the women expressed their inability to list the advantages of weighing children. In Jharkhand, women agreed that weighing was primarily for identifying illness, for assessing development of child and for assessing overall health. In Madhya Pradesh, women have claimed that weighing is for assessing weakness, for diagnosing illness and to know the weight gain over a period of time. In Uttar Pradesh, women have informed that weighing is simply to monitor growth, and to identify weakness and illness.

When does the anganwadi worker weigh children? The findings imply that in Bihar, women reported that anganwadi worker weigh children at birth, weigh child at the time of illness, after illness and during weakness. They further added that routine weighing is ‘once in a month’ and sometimes ‘once in two months’. Some women could not recall when exactly the weighing is done. In Jharkhand, women responses were varied. Some women reported that weighing of children in undertaken ‘every month’, ‘once in two months’ and ‘once in six months’ and some women said ‘don’t know’. In Madhya Pradesh, women accepted that weighing of children in done ‘on a monthly basis’, during the ‘Bal Sanjivani’ drive. In Uttar Pradesh too, women said that weighing of children is undertaken ‘once in a month’.

4.2.8 DIFFICULTIES IN UTILIZATION OF SERVICES

During the course of FGDs, it was asked that why some women do not prefer to approach anganwadi centre? In Bihar, the main reasons for not approaching anganwadi centre are illiteracy and unawareness among women. In Jharkhand, women felt that the main reasons for not approaching anganwadi centre are ‘ignorance’ and ‘shyness’. In Madhya Pradesh, due to their pre-occupation in domestic chores, some women do not visit anganwadi centre. Other women who do not visit anganwadi centre are either ‘well-off’ or they ‘do not have confidence’ in the services provided at the anganwadi centre. In Uttar Pradesh, almost all women of selected anganwadi villages do consult anganwadi centre.

4.2.9 SUPERVISION; Women are cross-checked whether anganwadi centre opens 'daily' or not? Across all the four selected states, women have acknowledged that anganwadi centre opens daily. They have also reiterated that in case of absence of anganwadi worker, helper opens the anganwadi centre.

4.2.10 OVERALL SATISFACTION

With regard to the satisfaction with the anganwadi services, women across states have recognized that they are 'satisfied' with the services provided at the anganwadi centre. The reasons of satisfaction cited by women of Bihar and Jharkhand are care of children at anganwadi centre, facility of immunization, health awareness created by the worker and usefulness of home visits by anganwadi worker.

While delivering the services at anganwadi centre, behaviour of anganwadi worker and helper plays a pivot role. Therefore, it was discussed in FGD that whether women are satisfied with the behaviour of anganwadi worker and helper. The findings of FGD across states reflect that women have expressed their 'satisfaction', with the behaviour of anganwadi worker as well as helper. Reasons cited for satisfaction are – co-operation from anganwadi worker and helper, their skills, easy mixing with villagers, hard work, their way of functioning, regard for villagers, and their politeness. Women are really impressed with their behaviour.

4.2.11 IMPACT OF ICDS

During the conduct of FGDs, it was investigated that is there any improvement in the health status of women and children as a result of anganwadi services? The qualitative findings imply that women have expressed that health status of women and children has definitely improved as a result of services provided at the anganwadi centre. The reasons cited for health improvement are that anganwadi centre/worker has imparted nutrition and health education to women which has resulted in consumption of balance diet, consumption of iron & folic acid by women and use of ORS in case of diarrhoea. All these factors have finally led to reduction in morbidity, mortality, family size and enhanced childcare. Thus, resulting in improvement of overall health status.

Across selected states, women have expressed their 'satisfaction' with the services provided at anganwadi centre. Probably due to their enhanced health & nutrition awareness, which has lead to overall development of children and human resources.

Suggestions for improving AWC services based on Feedback

Bihar: Provide chairs, dress, educational posters, toys, PSE kit, utensils, variation in food supplement, own building for AWC, drinking water, increased frequency of ANM visit, availability of toilet, availability of medicines.

Jharkhand: Provision of a doctor, regular supervision, improvement in immunization services, availability of basic medicines and at least one women meeting a month.

Madhya Pradesh: Own building for AWC, PSE kit and 'jhulas' for children.

Uttar Pradesh: Replace 'sattu' with 'gram', 'groundnut' or 'jaggery', provision of new slates, durries, supply of vitamins and iron tablets.

Section V

5 Activities at the Anganwadi Centres and the Time Management:

In this section we focus on the activities carried out by the AWWs and the time spent on various activities. While according to the prescribed norms in respect of roles and responsibilities of angawadi functionaries, an AWW is expected to perform numerous activities, in practice however this is seldom followed, partly because of the shortage of prescribed working hours of the centre and also because AWW's own preferences and priorities.

5.1 Time Management: An idea of the time spent on various activities would also help in assessing the activities receiving greater attention and emphasis. Table 5 provides some idea about these aspects. It may be mentioned that while ascertaining from the AWW about the various activities carried out by her at the centre, we first allowed the AWW to recall the activities carried by her during the day and then proceeded to record her replies. Expectedly the three activities mentioned were - Pre-school Education (PSE), Supplementary nutrition (SNP), and home visits (Jharkhand reported high percentage of home visits). Now looking at the time spent on these activities, it is seen from the figures that almost 150 minutes to 190 minutes alone were devoted to PSE-related activities, followed by about half an hour to one hour on supplementary nutrition. The ones reporting home visits, about half an hour to one hour was spent on home visits.

Another concern frequently expressed in the context of the functions discharged by the AWWs is about their participation in activities other than those assigned under the ICDS mandate. When confronted with this question, almost 80% of AWWs confirmed of having worked in programs not related to the ICDS. In Uttar Pradesh, however, this percentage was relatively small (22%). These activities range from pulse polio program to school chalo abhiyan and vertical diseases, etc.

When specifically asked about the purposes of home visits, three major purposes mentioned were – nutrition and health education (NHED), health check up and immunization. A smaller proportion of AWWs mentioned growth monitoring (8%) and referral services. Some had even mentioned PSE activities. Most anganwadi workers visited homes for four to six days in a week. On the average, in a day an anganwadi worker spent nearly 10-20 minutes on one home visit.

In terms of the workload, a majority of the AWWs thought they were given too much work. This, they said, was largely due to such duties as survey work, report preparation, and cooking SNP food (ICDS related), and pulse polio and survey work for other departments (non ICDS work).

When asked which activity the AWW believed could be performed without much difficulty, pre school education and supplementary nutrition (overall 82% and 54% respectively) were the two major activities which they thought they could perform easily. Other activities like immunization (24%) and home visits (11%) were also indicated but their percentage was too low. Some of the activities which the AWWs have had problems in performing, particular mention may be made of field based survey work and preparation of reports.

It would be instructive to compare the findings with those of the NCAER evaluation in regard to the time management and the number of non-ICDS related activities assigned to the AWWs. The following table gives the relative emphasis placed on various ICDS services as indicated by the time devoted to them.

State	**AverageTime spent per day (minutes)**		**Percentage of time spent on specific activity to total time devoted by AWW**			
	AWC activities	**Other assigned work**	**Feeding %**	**PSE %**	**Record Maintenance %**	**Others %**
Andhra Pradesh	**258.9**	**56.2**	**32.2**	**34.2**	**15.5**	**18.1**
Bihar	**228.0**	**40.0**	**39.3**	**45.7**	**13.4**	**1.6**
Gujarat	**276.7**	**67.6**	**37.2**	**29.5**	**13.7**	**19.7**
Madhya Pradesh	**212**	**27.6**	**43.1**	**31.9**	**14.6**	**10.4**
Orissa	**236.0**	**20.0**	**42.2**	**37.2**	**14.0**	**6.6**
Rajasthan	**231.0**	**7.0**	**50.9**	**32.1**	**13.8**	**3.2**
Tamil Nadu	**374.3**	**31.5**	**44.7**	**30.9**	**16.6**	**7.8**
Uttar Pradesh	**228.0**	**33.0**	**23.3**	**42.8**	**19.9**	**14.0**
All India	**232.8**	**26.1**	**39.8**	**36.3**	**15.6**	**8.9**

Source: NCAER (2001)

The following table gives an idea of various government departments outside the purview of ICDS which also tend to use the services of the AWWs. These departments keep changing. For example currently the AWWs are helping the Total Sanitation Campaign of the

Government of India. It may also be mentioned that some of the departments even compensate the AWWs for the services rendred by them.

Percent Anganwadis assigned other Work by type/program

Description	% AWW assigned other work	Type of Work/Department/Program					
		IRDP	FLAW	Physical Disability	NFE	FWP	Others
India	**22.7**	**25.9**	**16.3**	**32.1**	**15.3**	**16.7**	**52.7**

Source: NCAER (2001)

Coming back to the activities expected to be performed at the AWC, the AWW was asked to check each activity one by one. This question is quite different from earlier question on activities at the centre where prompting was not permitted. It would be seen from Table 9.1 that the AWW was aware of all the services in the ICDS package. The exception was growth monitoring and referral services in Jharkhand and growth monitoring in Bihar. Postnatal care was there but in about 80% of the cases. This contrasting picture does raise questions as to whether the AWCs are delivering all the services, and maintaining the quality. We would come back to this aspect when we take of the focus group discussions.

While discussing the work load of AWWs, it is usually asserted that the number of registers that an anganwadi worker is supposed to maintain are too many, and if the task of maintaining the registers is taken seriously the workload would be such that other activities related to child development would be neglected. Table 10 gives the distribution of the number of registers maintained at the AWC. It may be mentioned that not all the registers are expected to have daily entries. Some are daily, while others are to be filled less frequently say once a week or once a month, and sometimes even once in six months. Tables 10.1 give a clearer picture of the more frequently used registers in the four study states. As record keeping is a tedious task and not quite within the comprehension of many anganwadi workers, we were keen to know whether any assistance was taken from others to maintain the registers, and if so whether any payment was made. Table 10.2 shows that nearly 35% of the AWWs took help from others, but only 9% paid for the help (Table 10.2a).

5.2 Anganwadi Workers priority Activities:

We were keen to know the views of AWWs in regard to the ICDS activities which in their judgement were high on their priority list. We are not surprised to find that the overwhelming response was in favor of supplementary nutrition and pre school education, both activities focusing on 3+ years children. Such activities as nutrition and health education, child growth monitoring, vaccination, hygiene and games for children have had few takers (Table 16). There are some inter-state variations, but these are too insignificant. In fact this conclusion is no different from the one that we inferred from our earlier question where we had asked the AWW to recall the ICDS activities carried out at the AWC. It may be added these priority activities were also the ones, which they recalled without prompting.

5.3 Distribution of Time Spent by the type of beneficiary:

Tables 17 provide an idea about the time devoted by the AWWs on various categories of beneficiaries. These have been classified into children under 1 year, children between 1-3 years, children in the age group of 3-6 years and adolescent girls. The time spent by the AWW on major activities shows that, while there are some variations among the study states, on average an AWW devoted about 45 minutes weekly on children under 1 year. The two major activities for this group comprised of (i) weekly SNP distribution to their mothers and (ii) monthly immunization sessions. Bihar did not respond. For children between 1-3 years, AWWs on average spent nearly 46 minutes weekly. The activities included mainly SNP distribution, although some AWCs reported of conducting NHED sessions as well as some on action-songs/games. The sample AWCs carrying out these activities on the average spent nearly 36 minutes weekly on NHED. Those responding to the latter question were very few. The time spent on 3-6 years children was clearly the maximum, almost 150 minutes a day. The major activity consisted of PSE during which SNP was also distributed. Adolescent Girls is the other important segment of beneficiaries in the life cycle approach. Here we found that on average the AWWs spent 36 minutes weekly on the activities related to AGs. The following figures based on table 17 gives a clearer picture about the way AWW distributes her time on various activities:

Target Beneficiary	Average Time Devoted (minutes)	Daily/Weekly/ monthly	Standard deviation	Activities
Children under 12 months	45.6 (no response from Bihar)	weekly	24.2	SNP distribution and immunization
Children 12-36 months	46.3	weekly	24.1	SNP distribution
Children 12-36 months	36.0	weekly	12.7	NHED for mothers of children 12-36 months
Children 3-6 years	149.1	daily	64.7	PSE
Adolescent girls	36.6	weekly	19.7	NHED

Before concluding this section it would be interesting to give an idea of some of the activities which were mentioned by the AWWs as the ones they performed during the course of week before the survey, and the time devoted on them. The following information culled out from Tables 6 provide the necessary details:

Activity	Average time spent by AWW in minutes by state			
	UP	MP	Jharkhand	Bihar
PSE	176	149	191	193
SNP	29	24	37	29
NHED	Hardly any response			
GMP	Hardly any response			
Immunization	Hardly any response			
Home visit	34		63	
Record Keeping	23	12	18	14
General upkeep & mobilization	18	24	13	16

It is very difficult to reconcile various kind of information – since each information is collected with different methodologies. However one fact emerging from preceding analysis is that both PSE and SNP related activities receive considerable attention of the Aa conclusion also indicated by the question on priority activities by the AWWs. It does not however imply that other activities are grossly neglected as indeed was evident from FGDs. The problem is that not enough time is devoted on them. The analysis also shows considerable inter state variations in emphasis. The above analysis is unable to clearly bring out the service quality. For example while adequate time is given to PSE related activities most available research is unable to vouch for the service quality. Same is true of other

components, particularly NHED and Growth monitoring. Both appear to be weak components, receiving little attention from the AWWs, partly because of time limitations, and also because of the diverse nature of various activities – each requiring different skills.We also find that only about 10% of the time was spent on non-ICDS activities. Even the quality of PSE is indicated to be poor.

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Section VI

Case Studies of Good Practices

This section contains a brief description of the working of ICDS program in a few select states where certain innovative features have been introduced in the national ICDS program to supplement the single anganwadi worker. In addition we also describe the experiences of Tamil Nadu where Tamil Nadu Integrated Program (Phase I and Phase II) was implemented and of SEWA, an NGO, in Gujarat. The other states are Chhatisgarh where Mitanin actively helps in the ICDS activities, and Andhra Pradesh where under the A.P. Economic Restructuring Program (APERP), Mothers Committees were formed to support the functioning of the anganwadis. The description, which is based on existing literature on the subject, is supplemented by observations based on short field visits. Also, based on existing literature, we provide the working of ICDS in Rajasthan where Sahyogini supports the work of the anganwadi worker. This, as we would see later, is virtually a two-worker model.

6.1 Mitanin - Community Health Volunteer: The Case of Chhatisgarh

6.1.1 Background: Given the prevailing cultural practices of people in rural areas in Chattisgarh and poor health education has led to high levels of disease and a low utilization of health services. In order to address this problem, a state-wide Community Health Volunteer (Mitanin) Program was launched in 2002. The Community Health Volunteer, also called Mitanin, is a married woman worker from the same community, not necessarily formally educated but with a background in social work. She is selected by the community and endorsed by the panchayat. By definition Mitanin is bonded with the local community and she is a friend of the community. She is a selfless worker – but not a whole time worker. Minanin is active in AWCs and actively supports the work of AWW.

Specifically they are expected to involve actively on:

- Day 1 Visit on Child birth and delivering essential neonatal care messages
- Planning for the expected deliveries and facilitate for proper ANCs; Prompt referral for complications and inst. delivery
- Regular Health Education, awareness and initiatives for health entitlements through women's groups: 75 messages
- Identification of malnourished children- refer the severe cases and counseling for common cases
- Mobilize community for public health services- find out gaps and help the health worker to fill them
- Early detection, first contact care and referral- focus on common but critical illnesses-fever, cough-colds, and diarrhea.
- To act as community interfaces for health & related programmes- national health programmes, epidemic control, education, food security, watsan etc.
- To lead the hamlet level initiatives under Panchayat Health Planning & health related development.

Mitanins work on a purely voluntary basis and no remuneration is envisaged under the program, except that she would be compensated for missing the work for attending training and some performance incentives. An important aspect of this program is that it is integrated with the entire range of health sector reforms that aims to strengthen the supply side rather than work on demand generation and community health aspects in isolation. They are generally not engaged in activities other than those related to health and nutrition.

6.1.2 Working of Chhatisgarh Model with Mitanin as another worker: Field Observations

The following description is based on our observations during the field visit to some of the AWCs in Chhatisgarh, and the discussions with ICDS functionaries including the Secretary (WCD) and the Director (ICDS), Government of Chhatisgarh.

The focus of the field visits was to understand the contribution that Mitanin has been able to make (and has the potential) to support the AWW in the activities of the AWC. In Chhatisgarh, apart from Mitanin, the self-help groups are actively supporting the anganwadi activities, especially in the area of nutrition and health. These are described in the following paragraphs.

- **Self help groups:** The SHGs of women (or Mahila Samoohs) are very active in Chhatisgarh. These are formed for almost each of the activity separately. For instance there was a self help group for public distribution. All PDS related activities were managed by these groups. In fact these activities generate substantial income some of which is devoted to the welfare activities of the AWC, including upgradation of infrastructure. Similarly there was a self-help group to whom the responsibility for noon meals activity was entrusted. Again this group was able to provide not only wholesome nutritious food to the children but each day menu was varied and attractive to the children. There was also a self-help group of women formed for the rearing of goats. They had fairly large income from this activity, and thus able to contribute to the activities and infrastructure of the AWC.

- **Mitanin:** Mitanin worked closely with the AWW, given her greater commitment to health related activities, it is not entirely difficult to induct Mitanin as a specialist second worker at the AWC. Indeed in Chhatisgarh, Mitanin is being asked to play the role of

ASHA. Mitanin was reported to be paid Rs.50 per month for assistance in immunization work. She is also paid Rs.200 per delivery, besides Rs. 400 for transportation costs. Other tasks in which Mitanin assisted included early detection of pregnancy, mobilization of women and children for immunization, weighing of women and children. Having said that Mitanin can be supplement to existing AWW, we envisage a major problem in this. As we know Mitanin is an honorary worker, working on voluntary basis, it is difficult to assume a long term relationship with her, besides problems associated with a voluntary worker. As we would see while discussing the Rajasthan model that Mitanin may indeed serve as a specialist worker provided a regular cadre for Mitanins is created as was done in Rajasthan where a regular payment is made to Sahyogini, an equivalent of Mitanin.

- **Nutrition Health Education:** Using the local traditions, the AWCs organize regular meetings once a month of various self help groups, other village women, adolescent girls, and women beneficiaries to convey NHE messages. At this gathering the pregnant women for the *goad bharai* ceremony and mothers with their six-month children for *annaprashan ceremony* (or when weaning food is given) are invited. The pregnant women are given food platter comprising of food items which they should eat for their health and for the health of the child in the womb. Then there is the *aart*i and folk songs through which messages of dos and don'ts are conveyed. For instance they are told about the schedule for immunization for self and to-be-born child, the importance of exclusive breast feeding and vitamins as iron and vitamin A etc., merits of providing colustrum to the newborn and other precautions they ought to take for the good health of mother and child. The whole ceremony, in which Mitanin actively participated, seemed to have great impact on the target groups. The presence of adolescent girls on this occasion helps in sensitizing them. They are indeed to-be-mothers and early sensitization is clearly helpful. Through songs etc. they are also provided with messages about the disadvantages of early marriage. Indeed there were instances cited when these adolescent girls were able to stop marriages of girs below 18 years of age. The adolescent girls were found to practice personal hygiene, which they learnt during their training.

- **Schedule of Activity at the AWC:** In our visits to select AWCs we found that AWCs in Chhatisgarh worked on the average for four hours a day out of which only one hour was devoted to pre-school activities, 15 minutes on average for adolescent girls, 30 minutes

per day on the average for record keeping and related activities, and 10-15 minutes per day on total sanitation campaign. In addition other regular activities on which AWW spent time were – packing of take home food and its distribution, and work associated with self help groups. In addition the AWW was reported to make regular home visits to counsel PLW. On the average an AWW was said to visit 4-5 homes in a day and spend 20-25 minutes on each home. The total time on home visits was indicated to be around 90 minutes per day.

As far as one could see from the field visits, the role of Mitanin and that of various self-help groups seems to be largely confined to nutrition and health related activities. Even a large part AWW's time seems to be taken away by feeding related activities. The pre-school education seemed to receive very little attention. This to an extent is understandable, given the fact that both Mitanin and self-help groups are voluntary, and their accountability is limited except to the extent of their commitment to community service. The sustainability of such a model is suspect. Mitanin in her present Avatar or the community based groups can hardly be a substitute for another dedicated worker whose roles would be well-defined and enforceable at the same time. There is however some hope now with Mitanins being asked to also act as ASHA workers, with the consequence tat they would be able to financially benefit to the extent they actually discharge the functions of ASHA. However the loyalty would largely remain with the health department, unless strong convergence is forged between WCD anf Health departments. There are already some positive signs on this account.

6.1.3 Expenditure on ICDS: In Chhatisgarh, a total expenditure of Rs. 69.37 crores was incurred on 163 ICDS projects giving a unit project cost of Rs. 42.55 lakhs. The unit cost of an AWC (operational) is around Rs. 26900. If we net out the overhead costs on account of expenses of DPO/State Cell, the unit cost (operational) of an AWC would work out to be around Rs. 23,300. These costs do not include the expenditure incurred on Mitanins, which is currently estimated at Rs. 750 per Mitanin per annum. These costs relate to cost of training Mitanins. Also, in Chhatisgarh we learnt that Mitanins are being recruited as ASHA by the health department under the NRHM, and accordingly they would receive compensation for the actual work they would perform.

6.2 SEWA/Sangini: an NGO Model

6.2.1 Background: At the outset it may be mentioned that Sangini (Sangini is a SEWA-sponsored women's cooperative), which was entrusted with the task of implementing ICDS program in select AWCs in Ahmedabad, is currently not involved with this program, as recently, for some unexplained reasons, the responsibility of implementing the ICDS program was withdrawn from Sangini. It would however be instructive to document Sangini's experience with the implementation of the ICDS program. It may be mentioned that when Sangini was entrusted with the implementation of the ICDS program, it met with several problems. Some of these hurdles encountered are listed below alongwith the manner in which SEWA overcame these problems.

- The ICDS program has a number of rules, which pertain to the principles of the program such as reaching beneficiaries below an income limit, which matched well with Sangini's objectives. However there were a number of rules which did not pertain to basic issues, but which due to inflexibility, caused problems in the start up phase. For example

- The rule for three years existence before the project could be granted: Sangini, had been in independent existence for two years, although earlier as a project of SEWA, it had a good track record of sic years. However, since the three-year rule was inflexible, the Ahmedabad Municipal Corporation (AMC) refused to hand over the project to Sangini. Finally, SEWA intervened to step in and the project was handed over to SEWA, which handled it, although Sangini actually did the work. This was a major setback to Sangini as a co-operative.

- The ICDS requires an AWW to have studied up to tenth class (exception is provided in situations where matriculates are not available). However, Sangini was started by and for poor women and so only 10 of the 25 women were 10th class pass. All the teachers had undergone a number of intensive training programs in childcare, and had at least six, and in some cases more than ten years of experience. However, the rules remained inflexible. Finally, a compromise was reached that the teachers could remain, but they would be paid only Rs. 225 per month as compared to Rs. 325 for the more educated women. (These were the remuneration rates at that time – these have since been revised)

- Another major hurdle was related to the jurisdiction of the ICDS program. Since this program was to be handled by the AMC, its jurisdiction remained Ahmedabad city.

However, the jurisdiction of Ahmedabad Municipal Corporation is confined only to certain parts of Ahmedabad, the rest is under the Ahmedabad Urban Development Authority. In particular, some of the industrial areas where there were large concentrations of the workers, and which had 7 Sangini centres, were outside the jurisdiction. Sangini therefore faced the painful choice of either closing down the centres, or shifting them into the AMC's jurisdiction.

- The other major problem experienced by Sangini related to delay in formal sanction this was the most difficult period as far as Sangini teachers were concerned as, although the agreement had been reached, the actual sanction took almost one and half years.

  Madhuben Parmar, the then president of the co-operative explains how Sangini members got through those years.

> "I was a paper picker when I became a member of SEWA in 1980. Once we were having a meeting in SEWA and I came to know that SEWA is going to start childcare centres. I am very fond of children so I offered to start one. I have a one-room kuccha house with a verandah, where I would gather the children of the neighborhood. I would collect Rs. 5 from each parent, SEWA would send us Nashta and room rent. I took a number of training's and the parents were happy with me and readily gave fees.
>
> Later we all formed a co-operative, and I was elected President. Then, the grant from SEWA got finished so we applied to the AMC for ICDS program. It was agreed, but then for one & half years it was not sanctioned.
>
> It was the hardest time in my life. I did not want to shut the creche, but the children had got used to the nashta and would not come without it. I explained the situation to the parents and mothers began sending some nashta, but it was rarely enough. So I used the fee I collected for nashta. I was spending 6 hours a day in the creche, but earning nothing. My family members were upset, earlier I used to pick paper and feed my children, but now I was contributing nothing to my household. But I felt that if I bear this hardship for a few days all will be well.
>
> Sangini teachers would meet every month, somehow we gave each other strength. We felt SEWA is also with us, and we have come so far, built our own co-operative, we should not give up now. Finally, the ICDS program was sanctioned."

- An extremely serious problem in the context of an NGO implementing a wholly owned government program but seldom realized at least initially relates to differing environments and cultures in which these two types of agencies operate. For instance initially the program began with lot of good will but soon there was discomfort on both sides due to a clash of cultures and work environment. The ICDS personnel, CDPO and doctors, while used to a hierarchical, official culture, the Sangini members were used to a more informal culture. This clash could be seen, for example, when the CDPO was invited to sit on the floor along with the teachers. This did not go well with the CDPO and

she thought that she was being insulted. On the other hand, the teachers felt equally hurt as if they were inferior.

The other aspect related to the issue of flexibility. While the teachers felt that their first priority were the children and their needs, the ICDS personnel thought otherwise and felt it was their duty to run a good program according to rules. Over the years, however, both sides had got adjusted to one another. While the ICDS personnel had become more friendly and informal, the Sangini teachers started respecting the rules and constraints under which they operated. However, for Sangini, the inflexibility and the priority to rules and paperwork had remained a major constraint.

- Another major problem arose from the emphasis the two collaborating institutions place on various activities needed for child development. Due to a clash of objectives the Sangini had lost some of its previous vitality. The centres earlier operated by Sangini spent a lot of time in such child development activities as songs, group activities, toy play etc. However, after taking up ICDS in practice they hardly found any time for these activities mainly because of ICDS program's high focus and emphasis on feeding of both children and pregnant and lactating mothers, weighing, immunization and health, filling registers and home visits. All these activities taken together took more than five hours.Given the low payments under the ICDS it was difficult to expect the teachers to put in more work, although in practice they did put in almost upto 6 hours a day.

- The low education of workers under the Sangini run centres posed yet another problem. This was related to record keeping and the maintenance of registers as was required under ICDS program. These workers found it quite difficult to fully comprehend the task of record keeping. They had not had any experience in register filling, found it difficult to do, extremely time consuming and could not see the significance. However eventually after almost three years, they were able do realize the significance of some of the registers particularly the ones concerning the growth of a child and indeed took steps accordingly. Despite this they always thought this task of many registers too consuming time and which they thought could be better spent on the children's welfare.

Overall, despite all these problems and hurdles, the Sangini – ICDS collaboration was unique in several ways. First, it was part of the on-going experiment of de-Governmentising the

program. Second, and more important, Sangini being an organisation of the beneficiaries themselves it was thus a step further towards the process of decentralization and empowerment of the people, and especially of women.

Based on an evaluation study, 'Implementation of ICDS through the Sangini Child Care Workers Cooperative: An Alternative Model' carried out by Renana Jhabvala, Mirai Chatterjee and Mita Parikh at SEWA Academy with the objective of examining, analysing and documenting the impact of Sangini a workers co-operative, in providing holistic, integrated child care to self-employed women workers and their families, through the ICDS program, a number of issues emerged. These are contained in the following Box..

Box: Some Major Issues

The issues emerging from the Sangini co-operative taking up the ICDS program reflect the concerns arising from the objectives of Sangini, SEWA and ICDS. Although the objectives are overlapping, there are differences in emphasis and in focus. Though the target for both is the poor mother and child, Sangini, was set up to serve the childcare needs of SEWA members. The focus is therefore on the working women and her child. ICDS, on the other hand, is a comprehensive survival and child development scheme. The focus is on the malnourished child and it's mother.

This difference in focus has resulted in differing emphasis; with Sangini's emphasis more on child development and caring for the child in order that the mother can work better and increase her income, and ICDS emphasis on nutrition, and identification and targeting of the malnourished child.

The complementary of objectives has resulted in a program where both the needs of the working mother and of the malnourished child are given equal weightage. The urban poor families receive a mix of services, with the result that the emphasis of ICDS moves away from only nutrition to a more holistic, community-based approach.

However, given the limited resources and rather restrictive rules, the provision of all-round services have not been as complete as would be desirable.

6.2.2 Observations based on Field visits to NGO-run AWCs in Ahmedabad

This section is based on a field visit to some of the anganwadi centres which were earlier imoplementd by Sangini, a cooperative of SEWA as well as those which were not run by Sangini. In addition, we were able to hold discussions with Mirai Chatterjee of SEWA and other representatives of Sangini who were concerned with the implementation of ICDS program in Ahemdabad. We also met briefly with the Director and Commissioner, Incharge, ICDS program in the State Government.

Sangini was already running creches for children, and when the opportunity came to utilize the ICDS resources, it went in for upgrading these creches into AWCs. These creches were child care centres and worked according to working hours of women. When Sangini started AWCs under ICDS model, they found that two workers were not adequate to provide the services envisaged under the national ICDS program. They therefore decided to have three workers whom they called Sevikas since under their thinking this classification was not conducive to the dignity of workers. Also these Sevikas were generally drawn from poorest families, irrespective of caste/religion/regional considerations. Of the three sevikas, two were essentially care takers and one was an anganwadi worker

The Sangini run AWCs had about 35-45 children under 6 years, but Sangini ensured that in urban AWCs, there would at least be 15 children under 2 years, and in rural areas about 10-15 children. This was essentially done on the assumption that this class of children needed considerable attention. Another district feature of Sangini-run AWCs was the involvement of fathers, as they thought that fathers had an important role and responsibility towards their children. Why mothers alone should be accountable as far as children were concerned. Also instead of mothers meetings, the meetings were given a new nomenclature - Parents meetings. In these meetings almost 30-40% of the members present were fathers. Another significant emphasis placed in the working of the AWCs was the policy of consciously encouraging children of all the communities to join the AWCs. It was mentioned that earlier in the beginning there was considerable opposition for this mix of children from various religions and castes. However the uncompromising stance paid, and the entire idea became acceptable. This proved also conducive to creating harmony as at the parents meetings there were persons present from all communities and castes. Yet another interesting idea but related to this was the practice of holding morning prayers of all religions.

6.2.3 Working of the AWCs: The AWCs under Sangini were run on full time time basis and the hours matched the working hours of mothers. Each child was charged a fees, unlike in the national ICDS. The fee ranged from Rs. 10 pm per child to Rs. 30 pm per child. Sometimes it could be Rs. 40 pm per child. In addition, the mothers contributed in kind by bringing vegetables and other foodstuff for the children in the Centre. The fee was deposited with the cooperative and a proper fee receipt was provided. Sangini had introduced longer working hours (9 am to 5 pm) in some of the AWCs run by it, and in the remaining AWCs the ICDS pattern of four hours was adopted.

Recruitment of Sevikas: The recruitment of AWWs/Sevikas was done jointly by ICDS (WCD) and Sangini. Because of the insistence of Sangini/SEWA, the educational qualifications as prescribed under the national ICDS for AWWs were not adhered to as mentioned earlier. However, before recommending a woman for the sevika job, it was ascertained that the woman would love to work with small children, had a sense of responsibility, was willing to take up leadership role, and belonged to poor background. What community she belonged was immaterial while recruiting a sevika. Normally an elected local union leaders or Agyavans would make a recommendation to Sangini with those personal traits. The Committee of the ICDS and Sangini with CDPO in the chair did the final selection. As far as dismissal is concerned, Sangini could dismiss a worker but with the concurrence of the government.

The monthly remuneration the sevikas was between Rs 2200-2800 p.m. with more than 15 years experience, and Rs. 1500-2400 for sevikas with less than 15 years experience. In practice this could vary.

Training: The training to the Sevikas was imparted by the WCD/ICDS. In addition SEWA had developed its own modules/tools for training which focused on child nutrition and health education. Child development was a gap, and the activities focused on stories, songs and painting. These related to different stages of a child. The emphasis was on cognitive and brain development including spiritual development.

Supervision: Three supervisors who were taken as whole time workers were paid Rs. 3000 pm.(or Rs. 80 per AWC). They were entrusted with task of supervision and providing guidance to the Sevikas. They were also trained. CDPO had also participated in supervision and consultations.

Services:

GMP: It was reported Growth Monitoring Promotion was a problem and relatively a weakly implemented component

Nutrition: The food prepared was reported to be nutritious and was generally liked by children. Every day dishes conforming to local food habits was served.

PSE: 10 modules specifically prepared for the purpose were used.

Space: This was a major problem. Attempts were made to get space for AWCs within the primary schools. In Anand and Kheda, success was reported in getting space in municipal schools but elsewhere this was not permitted. Panchayat Ghars was another alternative.

6.2.4 Visit to an AWC run earlier by Sangini:

This AWC located at Sankar Bhawan was earlier working from 9am to 5 pm, but the timings have now been curtailed to 11am to 2 pm. Earlier Rs. 30 per child was charged as fees but now no fees is charged as per the ICDS norms. The sevikas were paid Rs.2650 and Rs.2340 pm, but now they are paid Rs.1060 and Rs.500 pm. Earlier two hot foods were served, but now only one prepared food was served. The Parents' Committees which existed earlier have now been replaced by Mothers Committees.

6.2.5 Visit to Two other AWCs located in a Mosque and a Dargah:

Here the timings have remained from 9 am to 5 pm as earlier. There were three sevikas in each, the payment to them was made according to experience. Currently they were paid Rs. 1200 (for the two sevikas) and Rs. 1900 for the main sevika. Students were charged Rs. 40 pm as fees, although some were allowed to pay between Rs. 10 to Rs.30 pm., depending upon the economic circumstances of the family. These AWCs were unable to meet all the costs and thus faced deficit, but the same was met through donations from the community, temples, mosques, parents - both in cash and in kind.

6.2.6 Dialogue with Director/Commissioner (ICDS, Government of Gujarat)

The Commissioner apprised of the new measures being taken for the ICDS program in Gujarat. The state government was in the process of providing various types of fortified food to children and PLW. He referred to the fact that children under three years and PLW were not visiting the AWCs.He therefore suggested the need for a nutrition worker for a group of AWCs (mark not for every individual AWC). Children in age group 6-36 months would be provided with fortified ready to eat food, while children 3-6 years would be getting meals prepared with fortified atta. For AWCs in tribal areas, the Commissioner favored a two-worker model.

The Director informed that currently 10% or about 4000 AWCs are being run by NGOs. He lamented the poor quality of services being delivered under the ICDS, thus requiring proper management of quality related issues. He was not in favour of the staff being involved in logistics and supplies, and wanted the strengthening of NHE component. In Gujarat at the moment there was no ASHA worker. He did not complain of ICDS infrastructure. He said government was adding to the stock of pucca AWCs by about 3000-4000 per year to the already 20000 pucca AWCs out of about 38,000 AWCs in the state. According to the Director even the PSE component was poor in the state. This he thought was largely because of low payment to the AWC workers. He informed that the state's health department has agreed for payment of a token honorarium to AWWs.

6.2.7 Unit Cost: Apart from fees from children, SEWA received a grant of Rs. 5663 per AWC per month from the state government (ICDS). It was reported that on average SEWA/Sangini incurred an expenditure of nearly Rs. 10,000 to Rs. 11,000 per AWC per month. The entire deficit was met by Bernard van Lear Foundation (Netherlands). SEWA had also solicited donations from both private and religious institutions/persons.

6.2.8 Summarizing the SEWA experience, one would first like to underline the approach adopted by SEWA to the Projects implemented by it. As far as possible, SEWA's underlying philosophy is to ensure that people pay for the services they receive so that the clients take the activities seriously. Secondly, as an NGO they make efforts to raise funds from the community and other sources to ensure that quality services are provided. Third, SEWA tends to design their projects in such a way that they are demand driven. The levy of fee, raising of donations to meet the deficits, and matching the timings of the AWCs so that mothers also benefit are some of the distinctive features of SEWA-Sangini initiative..

As far as lessons for a two-worker model are concerned, SEWA model clearly demonstrates the utility of such a model. They were able to ensure high attendance, reduce levels of malnourishment among children and provided both PSE and NHE. There were however weaknesses too, and it is difficult to say that an additional worker who is semi literate can be of much use in effectively delivering quality services. It is also not a highly cost-effective model. Such models can perhaps be advocated on a limited scale where NGOs have strong presence in a particular location. On their own, these models are not scaleable, except to the extent they adequately serve the purpose of a creche. An idea thrown up by the Secretary

(WCD) is worth considering. This is to explore the possibility of having an additional worker for NHE for a "manageable" group of AWCs. Tis is worth piloting and hhas high chances of success where population densities are reasonably high.

6.3 The Tamil Nadu: The TINP Model

6.3.1 Background: The Tamil Nadu Integrated Nutrition Program (TINP) was established in 1980 by the State Department of Social Welfare in collaboration with the Department of Health and with financial assistance from the World Bank. It was later absorbed by the national Integrated Child Development Services Program (ICDS) in 1997. The project provided integrated nutrition and primary health care services at the community level by a team of Community Nutrition Workers (CNWs) and Multipurpose Health Workers (MPHWs).

The main features of TINP were universal growth monitoring for children 6-36 months, a group hardest to reach; early identification of growth failure and its treatment by a fixed term (90 days), on-site food supplementation; primary medical care of and remedial nutrition instructions for the mother. On resumption of normal growth, food supplementation was discontinued and treated children were reverted to home care. Long term malnutrition was achieved by a comprehensive IEC system and direct health measures as immunization, vitamin A, iron and folate, ORT and routine deworming. The other target group was the PLW for ANC and PNC including IFA, food supplementation for nutritional risk and health education.

As would be seen, TINP and ICDS adopted different approaches in regard to food supplementation. For instance while TINP served children a slightly sweetened snack food early in the morning, which was seen by mothers as a supplement, rather than a meal the ICDS feeding is at lunchtime, and so almost a substitute for a meal at home. The ICDS timing suits older children, who can walk to the feeding center. TINP’s early morning supplementation was at a time when mothers could bring children under three – the most nutritionally vulnerable – to the nutrition center before they went to work.

As indicated earlier, a very distinctive feature of TINP was its selective approach to feeding, that is, it supplemented only children who were malnourished or whose growth was faltering; they “graduated” from supplementation when their growth was back on track. ICDS on the

other hand provides supplementary nutrition to all the eligible children every day, irrespective of their nutrition status or growth faltering. Since the same children are fed every day, food is seen as an entitlement, rather than a temporary supplement designed to get the child back on track and to show mothers how they can prevent or treat malnutrition at home by feeding small, affordable amount of extra food.

The TINP strategy in principle was both more effective in terms of reducing malnutrition, and cheaper, because on the average 25 per cent of children were supplemented on a given day, in comparison to ICDS's 40 per cent. But, because different children came into TINP supplementation as and when their growth faltered, 75 per cent of TINP children got supplementation at different times, thus encouraging broad community acceptance of the program*

Apart from selective feeding, which was more cost effective as well as efficient in dealing with malnourished children, there were certain other distinctive features of TINP which focused on certain micro-management and capacity related issues and which made it a successful program*

The first one was concerned with the recruitment process as well as recruitment criteria criteria: The outreach workers were taken from their local community. Usually, and perhaps importantly, as far as possible, they were chosen from women who were not only poor, but whose children were also well nourished. The underlying rationale for the choice was to demonstrate to the target community that their poverty did not necessarily stood in the way of good nutrition. Indeed this improved the credibility of the workers in their task of counseling on nutrition and health related aspects.

Selection Criteria for CNW in TINP I &TINP II

- Residence in the Village
- An elementary school education (eight years of schooling)
- Leadership potential
- Acceptability to the community

Half way of TINP II, the local residence criterion was not strictly adhered to. One consequence of relaxing the condition of residence during TINP II was the adverse impact on centre's activities. This is because non resident CNWs were least likely to be present when

TINP services were either delivered in early mornings before mothers left for the farms or in late afternoons after they just returned.

The w*ork routines* were clearly defined on a daily, weekly, and monthly basis. Growth monitoring, for example, was conducted on the same three day every month, so women knew when to bring their children to the nutrition center. This cut down the number of home visits that the workers had to make to monitor children. Further, of prime importance in TINP was investment in human resources. The training system was innovative in that the Community Nutrition Instructress (CNI) was also the pre-service and in-service trainer of the workers in her area. This meant training could be tailored to workers' individual needs and cut out the expense of maintaining a network of training institutions. Yet another positive aspect was the system of *Supervision.* There was a field supervisor for every 10-community workers, and a senior supervisor for every 60-70 workers. Apart from routine supervision, the CNS was

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* Based on a review of TINP by Richard Heaver (2002).

responsible for making joint home visits with CNW to families with special problems. CNS were supervised by CNIs.

The other major strength of TINP was its monitoring system which generated timely, good quality data that was available to both CNWs , client communities and program managers. Every month, data showing the proportion of children weighed and the number malnourished were posted on a chalkboard outside the nutrition center. This helped communities monitor progress. And every month, the data for all centers were analyzed by computer, and poor-performing centres were identified for special attention by supervisors. A weakness of the MIS pointed out was with collecting much more information than was actually needed or utilised (especially during TINP I). (Richard Heaver 2002)

Now that the TINP has merged with ICDS, a change was needed from a two worker to a one worker model. However as we point out in the field notes, the state government is continuing with three workers, with enhanced honoraria to the helpers. This is discussed in greater detail, bringing out its implications for ICDS.

6.3.2 TINP and the ICDS

- TINP resulted in reducing malnutrition rates between 1.5% to 2.4% annually, TINP II led to a decline in malnutrition by 44% over the five-year period. It may be noted this is based on routine data, and there was no control.
- In TINP there was an extra support through provision of one additional worker for 3-6 year olds
- The institutional training of village workers was provided at the Block level as opposed to a more central level to provide on the job training to workers on a regular basis.
- Because of the additional worker in TINP, it was possible to devote time for providing services for bringing about behavior change. IN ICDS this is not possible as neither AWW nor AWH has the necessary skills or the time.

6.3.2.1 Some Lessons Learned from TINP I:

- Selectivity and targeting - limited range of interventions targeted to limited number of beneficiaries with clear *entry* and *exit* criteria. SNP was confined to children in Grade III and IV, and to those children who were faltering after three consecutive months. For

children 6-12 months, feeding was initiated when a child failed to gain 300 grams per month for two months. For children in the age group of 12-36 months, 4 months of failure to meet the criteria were required. All children in Grades 3 and 4 were fed with double ration. Once begun, feeding continued once per day for a minimum of three months or until the age of 36 months. If a child gained 500 grams or more by that time, feeding ceased – otherwise the child was referred to a health sub centre.

- Staffing and clearly defined job activities – the CNW needed a minimum of grade 8 education level and she had a limited number of activities to perform.

- Training and Supervision – Along with pre-service training, supervision and in-service training was a high priority. At the Block level a Community instructress was placed to provide on the job training. Also important was the ratio of supervisor to CNWs which was 1:10 as compared to the current ICDS norm of 1:20/25

- Monitoring – timely, accurate data that was used by the CNWs and made available to the community and managers. However sometime too much information was collected.

6.3.3 Observations from field visits to ICDS facilities in Tamil Nadu:

The following is a brief description of the field visits to some of the AWCs, in Tamil Nadu.

6.3.3.1 Visit to an AWC in Chennai District: This was an AWC in Chennai, and it worked from 8 am to 4.30 pm. The day usually begins spot feeding sessions. The first session is from 8 am to 9-45 am. The underlying rationale is to ensure avoidance of food sharing. Timings were fixed and well defined.

Daily Time Table of a Typical AWC

Time	Activity
8-9.45	Spot Feeding insisted to avoid sharing with others

Mothers come to the Centre to collect Laddoo for children under 3 years. For children in grade I and II, the weight of Laddoo is 100 gms and is given for 300 days in a year. For children Grade III and IV the weight of Laddoo is 150 grams. Weaning food is given from children of 7 months onwards. Exclusive Breast Feeding is advocated upto six months, and

after that for next two years extended breast feeding is advocated. .ANC/PNC mothers are also given Laddoo (weighing 100 gms.per day for 300 days)

Since mothers come every day to the AWC, interactive counseling sessions are held every day. Notes are exchanged on various aspects of mutual interest

A counseling booklet is provided to the AWWs. Meetings are held with the mothers and through counseling booklet, the AWW explains to the mothers the correct method of breast feeding the child, besides other related issues. Also if the child is not gaining weight according to the age of the child (brain milestones), the ANM is contacted, and the child is referred to PHC.

After the morning session is over, the children are collected for prayers. The following is the schedule of activities from 9-45 am onwards. The timings were reported to be strictly adhered.

9.45-10.0	Prayers
10-10.40	Exercise and imaginative play
10.40-11.0	Intellectual Development (counting/color recognition, etc)
11- 11.30	Break
11.30-12 noon	Creative work e.g painting etc.
12-12.15	Life activity (e.g. cleaning the floor, etc.)
12.15- 1.00 pm	Feeding
1.00 – 2.00	Sleep
2.00-4.0	Play

It was said that on the average an AWW devoted nearly 60 minutes every day on record keeping and about 120 minutes on PSE..

Services provided at the AWC

The following services were provided at the Centre.

Pre-school education	Daily
Supplementary Nutrition	
3-6 years	daily
under 3 years	weekly distribution (take home) collect from AWC
Immunization (mobilization)	Once a month
NHED	Weekly (linked with SNP under 3 yeas)
Referral Sevice	Infrequent
Growth Monitoring and health check up	
Under 3 years	once a month
3-6 years	once in three months
P & LW	SNP, Immunization, NHED
Home visits	
Record Keeping	
Adolescent Girls	Weekly NHED
Survey of Beneficiary	Once in six months

Home Visits by AWWs (between 2.00 pm-4.00 pm during which time the AWHs manage the children). The following is the time table for home visits

Monday, Tuesday and Thursday – AWWs meet the mothers at their home

Wednesday – Mothers meeting at the AWC, also collect take home food

Home visit are made in the case of high risk mothers and children. These high risk cases are identified by the ANM. Both ANM and AWW make joint visits. While for the entire neo-natal period 3 home visits are made – once every trimester, these can be more frequent in case these are needed. Another home visit is made one or two weeks before the expected date of delivery. The purpose of this visit is to decide the type of delivery. It was said that on the average it took 60 minutes. The survey register was filled once in six months. Record keeping work was generally carried out when children slep.

Record Keeping

In all it was mentioned that 20 registers were kept but daily only 10 were filled. Among the important registers maintained at the AWC, mention may be made of registers for attendance, supplementary feeding, stock register, cash register, daily register and MMR REGISTER

Convergence:

One visit every week with ANM

Monday Antenatal Clinic

Wednesday: Immunization

Thursday: Health Check up at AWC

Friday: Adolescent Clinic

Tour Program of ANM to AWC is fixed in advance for joint activities.

For water Supply liaison is maintained with the Rural Development Department.

For PSE contact is kept with Education Department

Supervision:

There was joint supervision, but over the period it has weakened.

Self help Groups as informers and support group.

Training:

Tamil Nadu does not have Anganwadi training Centres (AWTC) unlike other states. It has a team of trainer per block/project and has adopted decentralized pattern of training and

supervision. There are several advantages. For instance close monitoring of the problems faced and their solution is possible. Most trainers are home science graduates who have undergone training in numerous aspects relevant to ICDS related services. They are also provided with 15 days special training in pre-school education. At the state level there is a Communication and Training Centre where both job and refresher training are provided. The advantage of training at the block level is that the training takes care of the region specific problems.

The AWW worker receives one month (26 working days) job training. There is a refresher training for 15 days once every two years, but in Tamil Nadu it is split into two – 7 days in the first year and 8 days in the second year. GoI is not in favour of this split.

Other innovations in training include joy of learning training (5 days), women empowerment (5 days), IMCI (2 days) and Infant and young Child feeding (5 days). There are special modules for these training. It may be noted that this special training is confined to certain selected districts of the state.

In addition there is joint training with the health department. AWW and VHN at the AWC level and Supervisor (ICDS) and SHN (Sector Health Nurse) at the sector level are provided joint training.

It is estimated that Rs. 55,000 per month is on the average annual expenditure for a block on ICDS training.

Kishori Shakti Yojane is provided Rs. 1.10 lakhs per annum

Compensation Package:

The anganwadi workers, because of extended hours of the AWC are given higher honoraria. The additional financial burden on this account is borne by the state government out of its own resources. The current honoraria are:

AWW – Rs. 2600 per month

AWH – Rs. 1300 per month

AWH Additional) – Rs. 1000 per month (earlier this was Rs. 800)

(only a few centres have additional helper)

Job responsibility of AWW;

These include

- early identification of disability/defectiveness
- detection of malnutrition
- teaching basic methods
- how to maintain registers,
- take weight of children
- participation in UIP and other health programs(with health department)
- ANC/PNC
- Weaning food distribution and food to PLW
- Growth Monitoring Charts for children under 6 years
- Faltering in growth/disease etc. - referral

One of the two AWHs is largely responsible for maintaining cleanliness in the AWC. She is also responsible for cooking the hot meals. The AWH assists the AWW in mobilizing children, weighing of children distribution weaning food and food to PLW. This senior AWH also assists in some of the PSE activities like exercises, etc. In addition, she compliments AWW in making home visits.

Impressions

Strengths

- **Selective Supplementary Feeding: Hot cooked meals served to children 3-6 years with varying menu every day. Two meals a day.**
- **Spot Feeding for children under three years and ANC/PNC women**
- **Intensive Training Drill**
- **Interaction with mothers almost every morning when problems relating to health and nutrition discussed**
- **AWW and AWH well paid, and in some AWCs one additional helper – thus making it possible to have extended hours for the AWC**
- **Block Training Team with joint Training Mechanism**

Deficiencies:

- **Much time spent on record keeping**
- **Take home weaning food may be shared**
- **Almost 15-20% of time of AWW devoted to non-ICDS activities**

As perceived by the author

6.3.3.2 Visit to AWCs in Vellore in Tamil Nadu

The visits to AWCs in Vellore district were extremely interesting. Here the community is deeply involved with the activities of AWCs, and have made significant contributions. For example in one of the AWCs, a SHG has contributed tumblers and plates, the Panchayat took the responsibility of reflooring the AWC, the polishing and painting (as well as fans) by the local community. In addition the Panchyat pays for electricity bills of the AWC. The AWC is

rent-free. AWWs regularly make home visits, and provide NHE to mothers. Mothers assist in mobilizing the community for immunization and bring vegetables etc.

The AWC has a specified timetable for various activities during the day and work between 7 am and 4 pm. Morning begins with spot feeding and interaction with mothers (7-9 am), between 10 am and 12 noon PSE activities are conducted. Feeding is done by AWW/AWH during 12 noon to 1 pm. From 1 pm to 3 pm children sleep during which AWW completes the records. 3 pm-4 pm is the play time. On average AWW spends 45 minutes on record keeping. Some home visits are also made between 1-3 pm when children sleep. There are fixed days for health, immunization and co-ordinated activities with PHC (AWW/VHN).

The AWCs have had two helpers, the AWW receives Rs. 2673/- pm whereas AWHs were paid Rs. 1320/- and Rs. 1010/-. Earlier AWW and AWH received additional honoraria of Rs. 50 and Rs. 25 respectively from SSA, but this is now withdrawn.

Summarizing the Tamil Nadu experience, it would be fair to assert that where there is political commitment, irrespective of which party runs the government, resources could be found. The relatively high compensation, and engagement of an additional worker, although at the helper level, has ensured that both PSE and NHE component are well managed. All the target beneficiaries, PLW, children under 3 years and between 3-6 years are able to adequately access various services. The community including families of beneficiaries are forthcoming to contribute to the activities of the AWC. To what extent an additional helper would be helpful in a backward, poor district is difficult to say. The significant factor contributing to superior performance of ICDS in Tamil Nadu may be found in the concept of trainers team at the district level. Such a system provided effective monitoring.

6.4 Mother's Committees: The Andhra Pradesh Case

The Andhra Pradesh Economic Restructuring Project supported by the World Bank as part of the project had identified six major components to meet the priority need in human development and in the maintenance economic assets affecting the rural poor. While the APERP primary education and nutrition/ICDS components of were designed as parts of the ongoing national centrally sponsored, nevertheless certain innovations, that were not part of the national ICDS program were introduced. This innovation consisted in creating *Mothers*

Committees at each AWC, thus institutionalizing community approach. The basic concept for the creation of mothers committees is to

- Promote sense of ownership
- Ensure contextuality and sustainability of the initiative
- Generate demand for improved quality delivery services
- Mobilize community Involvement
- Bring about advancement, development and empowerment of women
- Change social attitude and community practices

The Mothers Committee is a core group of mothers of beneficiaries of ICDS who are expected to effectively monitor the functioning of the anganwadi centre. The core group is selected by convening meetings of representatives of local NGO, IGA, Self help groups, elected women members of Panchayat, Sarpanch and Upa Sarpanch of the village. The core group consists of eight members with a president and secretary. It may be noted that in practice the Mothers Committees are informal groups, except in specific situations which demand undertaking responsibility for the construction of AWC building in which case these committees get registered. The basic objectives of Mothers Committees are:

- To improve the nutrition and health of young children, women (especially pregnant and lactating women) and adolescent girls by increasing the quality and cost effectiveness of ICDS through involvement of mothers in the programme.
- To provide support in the activities in the reduction of IMR to 55, low birth rate to 18% , severe malnutrition (that is Grades III and IV) to 4%.

As far as the responsibilities of Mothers Committees are concerned, they are broadly as follows:

- Identification of sites for AWCs and hand pumps under civil works
- Supervision in construction of AWC buildings
- Selection of masonry groups
- Supplementary feeding with local foods, entrusted responsibilities of receipt of food stocks supplied to AWCs and assist in preparation and distribution of food to all eligible beneficiaries
- Motivation of adolescent girls to get them enrolled for bridge course, skill development and workshops and exposure visits as proposed under women empowerment activities and HB test.

Another innovation introduced in AP's ICDS is the upgradation of AWCs into Model Early Childhood Development Centres (ECDs).(see annexure describing the concept of model AWCs). Another major initiative in Andhra Pradesh concerns the co-location of the AWC with enhanced infrastructure within the premises of the primary schools.

6.4.1 Field Visit to AWCs – Medak in Andhra Pradesh

We visited some of the AWCs in Andhra Pradesh. The following is a brief description of what we observed during the course of these visits.In AP, AWCs have extended working hours and are generally between 8-30 am to 3-45 pm.The following is the time table of a typical AWC in AP.

Time Table of a Typical Anganwadi Centre in Andhra Pradesh

Time	Activity/Service
8.30 am – 9.00 am	Prayers
9.00 –9.30	Personal Hygiene
9.30 – 10.00	Action Songs
10.00 –111.30	Story Telling
11.30 – 12 noon	SNP
12 noon – 1.00 pm	Sleep hour
1.00 –2.30	Scientific experiences (PSE)
2.30 – 3.45 pm	Games/ Exercises (Physical)
Afternoon	Home visits, NHE Counseling

In addition to the daily activities as indicated above, there are some other activities as well. These are:

- One day for Nature work
- Every second Saturday for NHED (also weighing/immunization, etc.)
- Home visits
  -Neonatal: : Twice in first week (breast feeding/colustrum feeding)
  -Last trimester
  -III – IV grade children

- **Recruitment:**
  Normal ICDS related guidelines are followed
- **Honoraria:**

Enhanced honoraria is provided to compensate longer hours of work. The rates are:

AWW – Rs. 1400 per month
AWH – Rs 700 per month
(The additional honoraria of RS. 400 and Rs 200 to AWW and AWH over and above the central contribution is met out of state budget)

- **Training:**
  Job Training as per ICDS guidelines
  Two Refresher Trainings
  Sankalp Training
  Exclusive Breast Feeding Training
  HIV/AIDS Training
- **Overall Strategy adopted for behaviour change:**
  Four strategies are adopted in the district (Medak)

- Exclusive Breast Feeding and colustrum feeding
- All girls to be enrolled in schools upto class X
- Washing hands before and after food
- Compulsory intake of iodized salt

- **Other activities**

  -Folk Songs and Drama for BCC are organized for two hours by NGOs. These are attended members of the PRIs and ICDS officers. Rallies of adolescent girls, mothers, and school children are organized in the evenings to create awareness
  - Evening Sessions with Gram Sabha
  - Convergence with other departments

- **Monitoring System:**
  Through continuous feedback at all levels – Block –to Sector ---to village – to AWC

6.4.2 The Mothers Committee in Practice:

The mothers committee is an informal group consisting of eight members out of whom one is designated as President and the other as secretary. These are mothers of the children attending the AWCs and hence they are there only so long as their children are in the AWC. Their term is for a period of two years. The members of the Committee receive training in several rounds for six days in the first phase. Each time two members attend the training by turn. Subsequently each round of training is for two days. The training is provided in various components of the ICDS. There are variations in the duration of various rounds of training from one block to another.

Over the period the role of mothers committee has changed. In the initial phase for instance some of the MCs were registered, as they were involved in the construction-related activities in the district. They were also entrusted with choosing the masonry groups and the department provided training. They also played a key role in the choice of functionaries, in fact they were the disciplinary authority and also had a say in hiring and firing of AWW/AWH.. This we were told has changed now. They also have no financial role and are not provided with any funds.

In matters of monitoring and other activities of the AWC, mothers committees play an important role. For instance in implementing GMP, MCs alert mothers and community to send children to AWC and counsel the mothers and the community about any negative aspect indicated in growth monitoring**.** Further when SNP is provided to children, at least one member of the MC would be present. They also help AWW/AWH in collecting green vegetables for nutritious food. MCs are the designated authority to certify for the quality and quantity of the materials supplied to the centre. Of course CDPO's certification is needed as well. The MC members also participate in PSE related activities, especially in songs, story

telling and games. MCs also help in mobilizing children for immunization.. The members of MC generally ensure their presence in most function held in the centre.

MCs act as pressure group to ensure proper functioning of the AWC. MC is also the right forum to identify the target beneficiary like adolescent girls, pregnant and lactating women, children under 6 years, besides also keeping track of births and deaths.

On the whole the presence of Mothers Committee assists in greater community involvement in the activities of AWC. The members of these Committees being both practitioner and conveyor of messages are more effective in greater acceptability of messages for bringing about changes.

It may be mentioned that when MC selected AWW/AWH at the recruitment level, we were told the functioning of the Centre was better, mainly because of the local presence of MC members, which kept the functionaries on their toes. A positive aspect of members of MC being permitted to be part of other SHGs is that it fosters links between the MCs and SHGs.

AS far as supervision is concerned, it may be mentioned that MCs are neither replacing nor lessening the role of the supervisor who is mandated to check records and registers, certification of quality of supplies, and performance of the functionaries.

Overall impression that one gets from the visit is the positive contribution made by Mothers Committees in terms of acting as not only support groups but also as effective monitoring and supervisory institution.

6.4.3 Adolescent Girls

These girls were given prescribed training and assisted the AWWs in their work. They were familiar with the disadvantages of early marriage and took to advocacy work on this account. Also they were familiar with personal hygiene, including preparation of pads etc. They were also actively participating in other activities and functions of the AWC as and when required.

Panchayats

One very heartening feature of this Centre was whole hearted support from the Sarpanch and through him the media. He contributed personally to the cost of construction of a toilet for AWC children.

Digitization of beneficiary houses

As a part of modernization of the Centre, an innovative step taken was to paint a map of the village indicating all the location of the houses in the village with labeling of different kinds, like whether a house had malnourished children, whether a house had a pregnant or lactating woman etc., and other related details. These were constantly updated. One advantage of this mapping exercise was that each household was keen not to see itself in bad light.

Visit to other AWCs in Ranga Reddy district in AP

Typical working hours for AWCs in this district are similar to those in Medak. The AWCs work between 8.45 am to 3.30 pm.

Activities and time devoted:

About one to one and half-hour is devoted to PSE, record keeping on average 30 minutes every day, nutrition related work 60-90 minutes daily. Good deal of time is spent on home visits, mobilizing children, spot feeding, distribution of take home food to mothers and children under 3 years.

Mothers Committees:

Two members of the MC would come by rotation and would stay at the AWC for some time, or longer when required. They would help in conducting some of the PSE activities e.g. songs, stories, etc.) and other related activities. They are also authorized to certify for the quality and quantity of supplies. Also assist in supplying nutritive food to children. On NHE day, ANM is expected to come to AWC and check pregnant women (weight). NHE counseling is also done on that day. IFA tablets and ANC check also done on the same day. The presence of members of MCs make considerable difference to the quality of services delivered at the AWC.

Adolescent Girls:

These girls go to school but on second Saturday they visit AWC, and assist in weighing. These girls were aware of the problems associatd with early marriage and on occasions actually took out protest march and succeeded in stopping early marriage.Well aware of the need for personal hygiene and practiced. Knew how to prepare pads. Received trainings.

Panchayat:

Full cooperation from GP, with Sarpanch providing money and assistance with food provisions. There is also full involvement of the community.

Functionaries:

Well educated – AWW with intermediate pass. Received all the trainings, satisfied with her work.

AWC run by an NGO

This was an NGO run AWC. It receives grants from various sources apart from ICDS. Recently it received Rs. 54000 from World Vision, an NGO which permitted the centre to acquire tables, chairs, water filter. The Sarpanch of local GP provided fans and almirahs

The mothers committee is active, and motivate/bring mothers to the centre for meetings. Also assist in bringing children to AWC, and help in weighing them. Apart from bringing sweets etc, help in teaching songs and telling stories. However this assistance .is not forthcoming regularly. AS in other AWCs, here too MC certifies for quality and quantity of supplies/materials. MC members had received two rounds of training of two days each.

The community involvement was much greater here. Apart from contributing to getting the centre white washed and painted, prizes are also given. Take active part in organizing exhibitions at the AWC. Sarpanch also helped in organizing baby shows and promoting breast feeding.

Little time is given to PSE activities – about 60 minutes a day.

Visit to a poor performing AWC.

This was a revelation. The AWC was located in a small room without any cross ventilation, and no fan. The temperature was perhaps around 39/40C. The children were sweating. While MC existed and community support said to be good, the whole experience was depressing. Can a mothers committee be a substitute to a proper institutional support. There was hardly any infrastructure except a pucca room. There was no other facility like toilet/water etc. The AWW was well educated, but that is not enough. No explanation, except helplessness!

Summarizing the experience of A.P. where Mothers Committees were acting as support to the activities of AWC. AP has adopted the national pattern of ICDS with one AWW and one AWH. However AWC has extended hours of work, generally from 9a.m. to 3.30, and for that some additional honoraria are provided to AWW and AWH. It was seen that the success of an AWC depended on the availability of various inputs in the form of a package. If any one input is missing, the system breaks down. This is precisely what we observed with one AWC almost non-functional because of the inadequacy of the infrastructure. In contrast, another AWC located within the premises of a primary school building with active support of sarpanch and Mothers' Committee functional in an exemplary manner. Part of the reason was the fact that AWW was proactive and showed leadership in mobilizing the support of key stakeholders. Whether this model could be scaled up is suspect, except in situations where all key stakeholders have full ownership of the project.

6.5 ASHA SAHYOGINI: The Rajasthan Case

In 2004, recognizing the limitations of the one worker model of ICDS to deliver effectively the package of services envisaged under the national ICDS program, especially those directed at women and under three years old children, the state government introduced yet another worker called *sahyogini* at the AWC level. The addition of a new worker gave enough time to the existing AWW to focus on pre school education and supplementary nutrition for children between 3-6 years. The new worker was largely utilized for home visits to target beneficiaries. However while this was being done, the state government's health department began implementing the National Rural Health Mission which provided for an honorary health worker, called ASHA, at the village level. The underlying rationale of appointing ASHA or Accredited Social Health Activist can be traced to the fact that the ANM who wass responsible for covering three to five villages comprising of a population of 3000-5000 found it difficult to provide services at door steps. Thus to fill the gap arising from difficulties experienced by the AWW and AWH on the one hand and the ANM on the other, it was decided by the Department of Health and Family Welfare and the department of Women and Child Development to give a new nomenclature to Sahyogini. As both ASHA and Sahyogini were envisaged to perform similar health and nutrition related functions, this joint HFW and DWCD initiative is now given a new name, namely ASHA-Sahyogini.

Unlike appointment procedures adopted for AWW, AWH and ASHA, the recruitment procedure for ASHA-Sahyogini is slightly different.First in the recuitment of ASHA-Sahyogini, the minimum qualification of class VIII is strictly adhered to, and there is no relaxation of it unlike for AWW/AWH/ASHA where such relaxation in minimum qualification was made. This is evident from the fact that a large percentage of AWWs are illiterate or just Class V pass. These AWWs are inadequately equipped in effectively deliver the services. Also perhaps at the time that ICDS was launched, the education among women was low and not many women who had some education were available. However, the female literacy has gone up substantially and it is now possible to get adequate number of women workers with the requisite education, and hence insistence on minimum education level could be sustained. Another rationale for this insistence is to ensure that the selected ASHA-Sahyogini is able to absorb the training content and enabled to effectively deliver the services with quality. The other distinctive feature of the selection procedure is insistence on satisfactory performance at the training. The prescribed age 21-45 years the process is as follows: The Gram Sabha identifies a local woman for the job of ASHA-Sahyogini and her name is recommended for the work of ASHA-Sahayogini. Once her name is received, she is asked to attend a 10-day training by DWCD. Each potential worker attending the training is assessed and in case she makes either grade A or Grade B, she is asked to begin work as ASHA-Sahyogini. In case she is unable to make the required grade, her name is sent back to Gram Sabha. In case Gram Sabha insists on her candidature, the 'failed' woman is asked to again go through a training course, and in case she makes either grade A or grade B she is allowed to work as ASHA-Sahyogini; otherwise she is not taken. Thus while ensuring the competence of ASHA-Sahyogini to effectively deliver the services, the procedure ensures the involvement of the community. It may be mentioned that in the appointment of ASHA-Sahyogini preference is given to SC/ST. single/widowed/divorced woman.

ASHA-Sahyogini is paid Rs.500 per month by the Department of Women and Child Development. The training expenses are met up by the Department of Health and Family welfare. In addition the DWCD Rs. 30 per quarter for attending the meeting. The HFW pays only incentive money to ASHA-Sahyogini which is at prescribed rates under NRHM. The incentive payments are according to the work actually executed. In all ASHA-Sahyogini can make almost the compensation received by the AWW.

In addition to ASHA-Sahyogini, the department (WCD) has encouraged the formation of Mothers Samitis which help in the distribution and monitoring of SNP Component of ICDS services. The Committee comprises of five members – one mother of under three years children, one mother of 3-6 years child, one pregnant and one lactating women, besides the anganwadi worker. If the sarpanch is a woman, then she is the chairperson of the Committee, otherwise the vice chairman of Gram Sabha. Also in case no such women is available then the oldest member becomes the chair person. The AWW is the member secretary. This is an informal group, The Mothers Committee is provided an advance of Rs. 4000, and it is deposited with the Bank. The AWW and one of the members operate the account. The MS is given Rs. 2.38 per beneficiary child for SNP

AWW	AWH	ASHA_Sahyogini
Phase 1 – all activities at AWC were conducted by AWW	AWH helps AS on MCHN and weighing. Days AS Accompanies	Undertakes home visits and conducts all work related to behavior change, MCHN and weighing days

Note: ASHA-Sahyogini is given Rs. 150 p.m. for mobilization.

The following matrix shows the division of work amongst ASHA Sahyogini (AS) and AWW

S. No.	Service	Target Beneficiary	Worker
1	Immunization	PW, children under 3 years	AS (mobilization), ANM
2	Health Check up	PW, severely malnourished children	As in 1
3	Counseling safe delivery, breast feeding, weaning food to 6 months+ children	Pregnant women	AS, community
4	Complementary feeding	Children completing 6 months	AS visits home and ensures instructions are follows instructions
5	Deworming	2-6 yrs. Children every six months	AS (medicine)
6	Use of iodine salt	Counseling women for presence of iodine	AS/AWW
7	Meeting of mother samiti	SNP quality and quantity	AWW/AS
8	IFA tablets	AGs	Community (MC)
9	SNP distribution	3-6 yrs children and PLW	AWW/AS/MC

Main AWC Worker	Support worker	Target Beneficiary	Service
ASHA-Sahyogini	ANM	Pregnant Women (PW), children under 3 yrs.	Immunization
ASHA-Sahyogini	ANM	PW and severely malnourished children	Health Check up
ASHA-Sahyogini		Children completing 6 months	Complementary feeding (Home visits)
ASHA-Sahyogini	Community	Pregnant Women	Counseling safe delivery,breastfeeding Weaning food
ASHA-Sahyogini		2-6 yrs children	Deworming
ASHA-Sahyogini	AWW	Women beneficiary	Counseling on use of iodine salt
AWW	ASHA-Sahyogini	Meetings of Mothers Committee	SNP quality and quantity
Mothers Committee		IFA tablets	Adolescent girls
AWW	ASHA-Sahyogini, Mothers Samiti	3-6 years children, and PLW	SNP distribution
AWW	AWH	PSE	Children between 3-6 years
AWW			Record Keeping
AWH			General Cleanliness of AWC
AWW			Record Keeping

Unit Costs: The average operation cost of a Project was around Rs. 52 lakhs and was responsible for 121 AWCs, thus the average unit cost of an AWC is around Rs. 47,000 (excluding SNP). In contrast, the AWC gets under Rs. 70,000 p.a.

The ASHA-Sahyogini model seems to be working well as was evident from a visit to some of the AWCs in the State. There were well defined areas of work for AWW and ASHA-Sahyogini, with the former focussing on PSE and SNP for children 3-6 years old and distribution of take home food. In all these activities AWW has the support of AWH. ASHA-Sahyogini has been entrusted with home visits where she consoles mothers on nutrition and health related aspects. Unlike Mitanin, who is an unpaid worker, ASHA-Sahyogini has the necessary education and training, and thus well equipped for the nutrition and health component of the ICDS package of services. As ASHA is a paid worker, there is accountability attached to it, and she has the scope to earn more by way of performing functions assigned to ASHA. The additional cost is marginal, about Rs. 500 p.m. and some expenditure on training.

Section VII

7. Expenditure on ICDS – Select Illustrations

This section is devoted to providing brief details about the actual expenditures incurred on ICDS from the state cell level to the Anganwadi Centre in some of the select states in the country. It also indicates the norms adopted by the GOI in reimbursing its share on ICDS. There are however some states in the country, as indicated earlier, which have introduced certain additional features to the national ICDS. Among the important ones mention may be made of an additional worker at the AWC level, payment of higher enrolments, extended working hours of AWC, and formal/informal involvement of the community and/or Panchayats/ women groups to support one or the other activity at the AWC. They have impacted differently on the functioning of AWC.

We have, in the concluding section, attempted to capture the impact of some of these innovative features. Inter alia, we have also indicated the likely additional expenditures needed to support one or the other desirable features including the additional cost of a two workers model. This section is mainly confined to providing information on expenditure on ICDS at typical facility levels.

Before presenting various costing illustrations on ICDS, a word about the funds flow and the structure of ICDS program in the state would be in order. At the top is a state cell (ICDS) with an IAS official as a Director. The state cell is responsible for disbursement of funds to AWCs through its network of District Project Offices, and the Block Level offices. Each Project office at the block level manages several AWCs, usually 125 to 200. Their number can however vary considerably. At each level considerable sum of funds is spent on administration etc. and these eventually are reflected in operational unit cost of an AWC. The costs incurred at various levels can be very high, almost 25-30% of the direct costs incurred. It is for this reason that in the unit cost illustrations we provide costs of typical State cell/District Project office/CDPO/AWC. The Central Government meets most of the operational expenditure on ICDS as per the prescribed norms and certain upper limits on expenditure. The funds are transferred by the Union Government through its Ministry of WCD to the State Governments. Each state government has an ICDS cell, either as a separate department or as a part of the social welfare department. The State Cell transfers the

funds to the ICDS cells at the District Level (called the District Project Office) which in turn transfers funds to various Project Offices, under their respective jurisdiction, at the Block level (CDPO). Each CDPO has a number of anganwadi centres under its administrative control, the number of such AWCs in a block is determined by its population. The CDPO in turn transfers funds to AWCs. There are prescribed norms for staffing pattern at each level, although the state governments may choose to appoint a larger number of functionaries, provided the state governments meets the additional expenditure from their own funds. As we would see some administration expenses are incurred at each point of transfer of funds. The extent of such expenditure varies from one state to the other.

We begin by presenting some illustration of the actual expenditures incurred by some of the states on ICDS. The choice is based on the availability of the information as well as on the distinctiveness of the model.

7.1 Project Cost: Illustrations from Tamil Nadu:

(a) Unit Cost of a Project; The case of Vellore in Tamil Nadu withOne AWW and two Helpers

As mentioned in an earlier section, AWCs in Vellore have a staff of one AWW and two AWHs. It has a strong community support. The community has provided funds in some cases, have financially helped in meeting the cost of painting the walls. Some have even gifted saucers etc. The following statement provides the necessary details of expenditure at the district level, CDPO level and at the AWC level.

Table: Staffing and Expenditure pattern of ICDS Cells

Typical Structure of a *District Project Office* staffing/salary, etc	
Staff/Head	Monthly Expenditure (Rs.)
DPO	20849
DCO	16748
Superintendent	17155
Supervisory Team	
Nutritiom	15108
Health	15108
Education	15108
Accountant	9302
Assistant	10577
Junior Asst.	6923
Driver	13124
OA	7722
Rent	4500
Electricity	700
Telephone	700
POL	6500
Contingency (per annum)	10000
Stationery (per annum)	5000

Illustrative Salary Expenditure at CDPO office at Block Level	
Description	Monthly expenditure (Rs.)
CDPO	16000
Grade I Supervisor	15000
Grade II Supervisor	12000
Superintendent	16000
JA	7000
OA	6500
Illustrative Expenditure of an AWC	
AWW	2673
AWH	1320
AWH additional	1010

(b) CDS Expenditure at the State Level - Tamil Nadu

The following table gives in detail the operational costs incurred by a state (Tamil Nadu) on ICDS activities in a year. An interesting feature to note is that whether it is a state or an NGO, only 50% of the operational expenditure is contributed by the Central Government. Here in both cases there are three workers with extended hours of work for the AWC.

Tamil Nadu - Consolidated Expenditure by broad heads on ICDS			
Description	State share (Rs.Lakh)	Central share (Rs.Lakh)	Total (Rs.lakh)
World Bank assisted ICDS (general) for 434 projects (Rs. Lakh)	18292	16173	34465
Kishori Shakti Yojana (Rs. Lakh)		469	469
National Program for Adolescent Girls (Rs.lakh)		240	240
SNP (Rs. Lakh)	50% of total expenditure by GoI		3118
ICDS Trg (Rs. Lakh)		234	234
Total (Rs. Lakh)			38526
Physical Parameters - Tamil Nadu			
No. of AWCs			45726
No. of ICDS project			434
Average AWCs per Block			105.36
Unit Costs based on State Data			
Unit operational cost for one Block (rs lakh.)			**79.41**
Unit operational cost of AWC (Rs.)			**75372**
Unit Cost of Training per block (in Rs. lakh)			**0.54**
Unit Cost of Training per AWC (Rs.)			**515**
Unit Cost basef on district level data for Vellore in Tamil Nadu			
Actual GOI Cost of Vellore DPO 2006-07 (Rs lakh)			**741**
Cost of one block in Vellore with 23 blocks			**32.22**
Actual State Cost Vellore DPO (Rs.lakh)			**708**
State's share on one Vellore block (Rs. Lakh)			**30.78**
Unit cost of one block in Vellore (Rs.Lakh)			**63**
Unit Cost of one AWC in Vellore			**53194**

The operational cost of one ICDS Project inclusive all costs on administration at the level of state cell and the district cell is over Rs. 79 lakhs. However when the unit cost of a block is estimated from the district cell financial information, the unit operational cost of an ICDS block is lower, being Rs. 63 lakhs. Clearly the difference is accounted for by various expenses that the State cell incurs in kind besides administrative expenses, and expenses on IEC, etc. As far as the training cost is concerned it works out to be Rs. 0.54 lakh per block annually or Rs. 515 per AWC.

© Expenditure and Staffing Pattern of a Typical Anganwadi Centre in Tamil Nadu:

It would be interesting to provide item wise statement of allocations for a typical Anganwadi Centre in Tamil Nadu, including the sharing arrangement between the Central Government and the State government in respect of the costs incurred on the ICDS.

Unit Cost of one AWC in Tamil Nadu excluding meal cost (in Rs.)			
Description	State Share	Centre Share	Total
Hon. AWW	18840	12756	
Hon. AWH	10080	6000	
Transportation Cost	312		
Rent		9000	
Contingency		600	
Registers/Formater		200	
PSE kit		500	
Medicine kit		600	
Total	29232	29656	58888
State Contribution %		49.64	
Overhead Expenditure Per AWC (75372 - 58888)			15464
Non Recurring Expenditure on one AWC (in Rs.)			
(Expenditure met by Central Government)			
Play Materials		1000	
Vessels		1500	
Baby weighing scale		450	
Adult weighing scale		550	
Furniture		1500	
Total (Rs.)		5000	

The above table suggests that the average unit cost of an AWC would be around Rs. 60,000. This is because of the fact that the government of Tamil Nadu is paying Rs. 28,920 per annum from its own funds compared to Rs. 18756 which the Central Government reimburses for the purpose. And in case we take account of the additional helper which some of the AWCs in Tamil Nadu have, an additional Rs. 12120 annually would need to be added to the total outflow from state treasury.

7.2 ICDS Project Cost Estimates: The Case of Andhra Pradesh

The following table contains item wise financial data in respect of the expenditure incurred in the state of Andhra Pradesh on ICDS program during the year 2006-07. As mentioned in an earlier section the State Government gives additional honoraria to AWWs and AWHs on account of the extended hours of work. This is captured in the total honoraria indicated in the statement below.

Table: Expenditure on ICDS in Andhra Pradesh during 2006-7:An Illustration		
Basic Physical Data		
Numver of District Cells	23	
Number of ICDS Projects Operational	376	
Number of AWCs operational	61241	
Financial Data:		
(Consolidated Expenditure excluding SNP	**Rs. Lakh**	
Salary to regular/contract emploees	4910.60	
Honorarium to AWWs/AWHs	11143.56	
POL	147.10	
Medicine Kit	307.27	
Pre school kit	330.01	
Rent	783.30	
Contingencies	599.54	
Others - details		
TA	1824.07	
FTA	115.36	
Adv. & Publicity	81.80	
Hiring of vehicles	200.97	
Motor Vehicles	57.16	
Training Programme and GIA	1093.69	
Equipment & furniture per new AWC/Project	810.02	
Total Expenditure on ICDS	22404.45	
THE UNIT COST AT DISTRICT/PROJECT/ANGANWADI levels		
Unit Cost of a District Cell (Rs. Lakh)	974.11	
Unit Cost of a Project (Rs. lakh)	59.59	
Unit Cost of an AWC (in Rupees)	36584	
Overall increase under scenario (b)	11413.31	

It may be noted that the unit costs in the above table include the cost of training which comes to Rs. 2.91 lakh per block in a year, and the unit cost of training per AWC is Rs. 1785. For comparison purposes due adjustments for training cost would need to be made.

7.2.1 Expenditure on a district Project Office - The Case of Ranga Reddy District in A.P:

The following table for a district in Andhra Pradesh which broadly follows national ICDS model, except with enhanced payment to AWW and AWH with some extended hours of work shows that the state contributes about 25% of the operational expenditure on the program.

Illustration of State -Centre Share based on monthly expenditure statement of RR District in AP	
Description	Expenditure (Rs.)
State share	1298676
Central share	3566967
Total (Rs.)	4865643
% State Share	26.69074

7.3 ICDS Project Cost Estimates for ASHA Sahyogini model: The Case of Rajasthan

The following table gives the estimate of costs of a typical project in Rajasthan, which employs one additional worker at the AWC level, ASHA Sahyogini who is paid an honorarium of Rs. 500 per month. The training costs are excluded which approximates Rs. 2500 per participant for a 10 day course.

Costing of a Block - The case of ASHA-Sahyogini in Rajasthan

Item of Expenditure	Expenditure (in Rs. Lakh)
Salaries	24.46
TA/DA	0.49
Medical	0.14
Petty office expenses	0.29
POL	0.71
Building Rent	0.57
Nutrition+transport	20.9
KSY	0.43
sub total 1	47.99
Expenses of AWCs	
Salaries	21.73
TA	0.2
Contingency	0.75
ASHA Sahyogini	4.48
TA	0.02
Rent	0.13
sub total 2	27.31
Unit Cost of a Project(Total 1 & 2)	75.3
Number of AWCs	121
Unit Cost of AWC (Rs.)	62231
Unit Cost Excluding nutrition(Rs.)	44959
Unit Cost of a Project excluding Nutrition (RS.Lakh)	54.4

In the above cost estimates, only the actual number of ASHA-Sahyoginis have been accounted for. However, if all the AWCs had ASHA-Sahyogini in place, the project expenditure would have been a little higher (by nearly Rs. 3 lakh) and so also the unit cost of an AWC by nearly Rs. 2480.

7.4 ICDS Project Cost Estimates: The Case of Uttar Pradesh

The following statement presents the expenditure on ICDS in Uttar Pradesh for 2006=07, and based on that the unit cost estimates of a ICDS Project. The cost estimates are also provided for Sonebhadra District in Uttar Pradesh as well as of one Project within the district of Sonebhadra. Incidently this infirmation relates to the block which was surveyed for the study.

Expenditure on ICDS 2006-07 - The Case of Uttar Pradesh

Particulars	Central Contribution (Rs. Lakh)	State Contribution (Rs. Lakh)	Total (Rs. Lakh)
Total Expenditure on ICDS at state level excluding SNP	32890.00	12111.00	45001.00
Sonebhadra District Cell			
Total Expenditure of District Office on ICDS excl. SNP	249	116	365
Number of CDPOs under DPO: 8, Unit Cost of CDPO			45.63
Number of AWCs: 1179, Unit Cost of AWC			30958.44
CDPO Level - a block in Sonebhadra			
Total Expenditure of CDPO on ICDS (excluding SNP)			24.94
Number of AWCs in the Block -79, Unit Cost of AWC			31569.62
AWC level information (a typical AWC)			
Total expenditure of AWC on ICDS (excluding SNP)			0.19

The above table shows that the unit cost of a District Project Office comprising of 8 ICDS Projects is Rs.365 lakhs, giving an average unit cost of an ICDS Project as Rs. 45.63 lakhs and average unit cost of an AWC as Rs. 30958. The unit cost of the sample study Project comprising of 79 AWCs is Rs. 24.94 lakhs or Rs. 31570 per AWC. The AWC however received Rs.19000 excluding SNP and supplies in kind.

It may be remembered that this particular block had most AWCs located within the schoolpremises.

7.5 Cost of a Project in Chhatisgarh:

The total expenditure incurred by the State of Chhatisgarh on ICDS Program during 2006-07 was reported to be Rs. 6937 lakhs. It currently had 158 ICDS Projects and 29437 operational AWCs. This gives a unit cost of a project as Rs. 43.91 lakhs and Rs. 23566 as the unit cost of an AWC. Till now the state has followed the national ICDS pattern, but proposes to enhance the honoraria of both AWW and AWH by Rs.200 and Rs. 100 per month respectively. These unit costs exclude the cost of training.

7.6 Summary Estimates of Project Costs:

The following table contains a summary of the above-mentioned cost estimates of ICDS Project.

Total Expenditure on ICDS for select States

*State	Projects number	AWCs number	Total Expenditure (Rs. Lakh)			Unit Cost of Project (Rs Lakh)	Unit Cost of AWC (Rupees)	% State Share
			State	Centre	Total			
Andhra Pradesh	376	61241			22404	59.59	36583	26.7
Chhatisgarh	158	29437			6937	43.91	23566	*
SEWA /centre/month (in Rs.)				5663	10500		55000-60000	45
Tamilnadu (2006-07)	434	45726	18292	16173	34465	79.41	75372	53.1
Uttar Pradesh - Sonebhadra dist.	8	1179	116	249	365	45.63	30958	31.8
Rajasthan	1	121				54.4	44959	

- The state has recently agreed to give additional honoraria of Rs. 200 and Rs. 100 to AWW and AWH.

7.6.1 Discussion:

- Andhra Pradesh, which broadly follows the national ICDS pattern (except the payment of higher honoraria to AWW/AWH for extended working hours of AWCs) with the innovative feature of Mothers Committee providing support to the activities of the AWCs, spent nearly Rs. 59.6 lakhs on an ICDS Project at the block level. The corresponding unit cost of an AWC worked out to be Rs.36583. If we assume that the direct cost of one AWC is about Rs. 30,000 then nearly Rs. 6000 (or about 15-20%) is towards the administrative and supervisory costs (including materials in kind).

- Tamil Nadu (loosely a two-worker model) has a high cost of Rs. 79.4 lakhs per ICDS Project or Rs. 75373 per AWC. The main reason for these high costs is to be found in the

high honoraria paid to the anganwadi workers compared to the ones paid as per the national ICDS normsl because of the extended working hours of AWCsIn Tamil Nadu.

- SEWA which had adopted a 3 worker model (1 AWW + 2 helpers, all called Sevikas) shows a much higher unit cost. It may be noted that unit cost for SEWA included cost of meals which is almost 50%. If we exclude the cost of meals, then SEWA model would suggest a unit cost of around Rs. 55000 to Rs. 60,000 for one AWC.

- The operational unit cost of an ICDS Project in Chhatisgarh which receives active support of Mitanins and SHGs is Rs. 43.91 lakhs or Rs. 23566 per AWC. The Chhatisgarh model is pretty close to the national ICDS in terms of staffing and cost norms. Recently, kit was learnt that the state government was proposing to enhance the honoraria of both AWW and AWH by Rs. 200 and Rs. 100, respectively.

- Rajasthan's ASHA-Sahyogini model entails an additional annual expenditure of Rs. 6000 per ASHA-Sahyogini on her honorarium and one time expenditure of about Rs.2500 on her training , and a an expenditure of Rs. 300 per annum on contingency, the total additional financial burden for Rajasthan model may not be more than Rs. 6500 per annum. We analyse these costs later in the report.

7.7 Estimated costs of a hypothetical two-worker Model (based on national ICDS norms)

Using the current cost norms of the Central Government which are rather conservative, and 5 supervisors per project of 140 AWCs and treated at par with the existing supervisors, the total cost of a project works our to be around Rs. 58.07 lakhs as shown below. The unit cost for an AWC is therefore Rs. 41479 approximately excluding the cost of meals. The preceding cost analysis of other states show that this cost estimate is not significantly different from cost estimates for most states. The current unit cost of a project is around Rs. 37.5 lakhs. If we work with only one AWW as at present, the unit cost of ICDS Project is seen to be Rs.41.27 lakhs or Rs. 29479 for one AWC.

The costs given above excludes the costs of training. However if we include the communication cost of Rs. 1 lakh per annum for one project, then the unit cost of a project for a two worker model would be Rs.59 lakhs.

Item/per month	Number	Cost norm (Rs.)	Monthly Cost	Annual Cost
Staff Salary and Honoraria				
Project Staff				
CDPO	1	12000	12000	
ACDPO	1	10000	10000	
Assistant	1	8500	8500	
Statistical Assistant	1	8500	8500	
Supervisor	5	8000	40000	
Clerk Typist	1	5000	5000	
Driver	1	5000	5000	
Peon	1	4500	4500	
sub total (A)			93500	**1122000**
Field Staff				
Anganwadi Worker (PSE etc.)	140	1000	140000	
Anganwadi Worker (Nutrition)	140	1000	140000	
Anganwadi Helper	140	500	70000	
sub total (B)			350000	**4200000**
Other recurring Expenses				
Rent for AWCs (per month)	140	50	7000	84000
Medicine Kit (once a year)	140	600	84000	84000
PSE materials (once a year)	140	500	70000	70000
POL per annum		50000	50000	50000
Contingency for AWW (per month)	140	50	7000	84000
Contingency for Project Office pa		30000	30000	30000
IEC per annum		25000	25000	25000
Stationery per month	140	200	28000	28000
Rent (Block Office) annual		30000	30000	30000
sub total (C)				**485000**
sub total (A+B+C)				**5807000**
Cost after withdrawing one AWW				**4127000**

Mobility	140	600	84000	84000
Communication Strengthening	140	250	35000	35000
NHE material	140	100	14000	14000
Training Cost of additional AWW	140	750		105000
Hand Pumps	20	40000	800000	800000
Nutrition Instructor per block	1	12000		144000
M & E	140	200	28000	28000
Non recurring (furniture/equipment)				
AWC		5000		
CDPO		91700		
DPO/Dist.ICDS cell		91700		
State/UT cell upto 50 projects		60000		
State/UT cell above 50 projects		120000		

Contingency (norms)				
AWC		600		
CDPO		30000		
DPO		50000		
State/UT cell upto 50 projects		60000		
State/UT cell 50-200 projects		80000		
State/UT cell above 200 projects		100000		
Petrol,Oil & lubricants (norms)				
CDPO		50000		
DPO		50000		
State/UT ICDS cell		60000		
IEC (norms)				
Project		25000		
District		50000		
District ordinary cell		10000		
District - Technical Cell		25000		
State/UT cell upto 50 projects		50000		
State/UT cell above 50 projects		100000		
Medicine kit per AWW per annum		600		

It may be mentioned that the various unit costs of ICDS Projects given above are not comparable because of the fact that in practice each ICDS Project has varying number of AWCs under its jurisdiction. In order to make the unit costs comparable, we have reworked these on the assumption that each ICDS project would have 100 AWCs under its jurisdiction. The following recalculated unit cost of an ICDS Project comprising of 100 AWCs is given below:

State/Project	Unit Cost of ICDS Project with 100 AWCs (Rs. Lakh)	Type of Model
Andhra Pradesh	36.8	School/habitation based
Chhatisgarh	23.5	Habitation based
Rajasthan	44.96	Habitation based
Tamil Nadu	75.6	Two worker/ habitation
Uttar Pradesh	31.04	School based
SEWA-Sangini	55-60	NGO based
Hypothetical - Two workers	41.48 (1)	Two worker suggested/ habitation based
Hypothetical- National ICDS	29.48 (1)	Current costs as per current ICDS model

(1) Do not include overhead costs unlike other models

In the two worker model the cost of training and that of communication would have to be also included.. If we take Rs.1500 per AWW as the cost of training in a year and an

additional Rs. 1 lakh for IEC/communication, the total unit cost of an ICDS project based on a two worker. Model would be Rs.45.48 lakhs (Rs. 3 lakh per annum for training component and Rs. 1 lakh for IEC). If we add 15% as overhead costs, the final unit cost of two worker model at the Project level would be Rs.52.3 lakhs. The ASHA-Sahyogini which is close to a two worker model (with half the honorarium for the second worker) is Rs. 44.96 lakh (excluding training cost). Even NGO model (SEWA-Sahyogini) is not much different from the pure two worker model.

While the unit cost of a two worker model does not appear to be much different from the cost of other existing models (having some innovative features) a significant advantage of ASHA-Sahyogini model over the other models appears to be the strong convergence between the health department and the department of women and child, as the second worker (namely the ASHA-Sahyogini) is common to both and thus in a position to effectively perform nutrition and health related functions better. In one sense it also obviates the need to search for yet another worker in a village which seems to be difficult given the low levels of rural literacy.

Section VIII

Concluding Observations

In this concluding section, an attempt is made to summarize the main findings of the study based on desk review and fieldwork. Inter alia an attempt is made to indicate the main issues and concerns emerging from the preceding analysis especially in the context of a two worker model.

8.1 Work Load and Time Management: The preceding analysis of the roles and responsibilities of ICDS functionaries has clearly brought out the fact that the tasks assigned to the AWW are highly diverse and numerous. It is highly unrealistic to expect that one single worker, with little educational qualifications, would be in position to deliver all the services prescribed in the ICDS package within a span of four hours in a day. All the past evaluations, as well as our own analysis seem to confirm this finding. In such an environment, while it is possible to have large enrolment of children, the actual attendance is expected to be low as indeed was observed during the survey. Whatever little attraction is there for AWCs, it is largely associated with SNP for children 3-6 years old. There is however one positive feature of the ICDS in that the AWWs have been able to mobilize women and children for immunization. Record keeping is another aspect which seems to keep worrying the AWWs, although in actual practice only about 30-45 minutes are devoted to record keeping. Finding record keeping difficult, some of AWWs are forced to take help from others, and sometimes even pay for the help. As far as PSE component is concerned, although almost 60 minutes to 150 minutes are devoted to PSE activities, except for some prayers and songs, counting and story telling much of the PSE related time is taken away by feeding related activities. NHE component including promotion of growth monitoring is not given adequate attention. Recently, however, more and more women are becoming aware of the need for exclusive breast-feeding and colustrum. Some awareness in regard to improved food habits was evident. The following table gives some idea of how the AWW organizes her time on various ICDS services.

Time Devoted on various activities at a typical AWC under national ICDS

Activity	Average Daily Time in minutes
Pre-school education	120-150 minutes
SNP distribution & Nutrition Supplements	45 minutes
Home Visits - Nutrition Health Education & Health related	30-45 minutes
Record keeping, other administrative, survey, identification of beneficiaries	45 minutes

8.2 Role of Community: It is worth noting that some of the AWCs which are reported to be working well in terms of the delivery of services are the ones receiving active support from the community including the Panchayats. The participation of the community (whether mothers committees or women's self help groups) in AWCs' activities ;wherever this has happened, has made a positive impact on the functioning of the AWC, especially in relation to health and nutrition related activities. In one sense it has also been able to release some pressure on the AWWs and has permitted them more time for other activities including the PSE. Further it was seen that whenever the sarpanch has taken interest in the ICDS program, the functioning of the AWC has seen distinct improvement. Another factor, although well known and fully recognized is the role of the Manager (here CDPO, DPO, etc.). Whenever CDPO/DPO have shown vision and taken personal interest the AWWs have been motivated to provide quality services with the same resources.

Another significant contribution of the community involvement is related to the monitoring aspect. Thus we saw that the presence of mothers committees or similar groups ensured that the AWWs took their work seriously. The community was also seen to contribute significantly in improving the infrastructure and upkeep of the AWC (a la Vellore, Medak)

8.3 Additional Support: It was also seen that, apart from community support, AWCs with three workers (e.g ASHA-Sahyogini in Rajasthan, one AWW plus two helpers in Tamil Nadu, three Sevikas in SEWA-Sangini) were found to have better attendance. We also found that the incidence of malnourishment amongst the children was lower, as was evident from the records. Both PSE and NHE components in such an environment received adequate attention from the AWWs. The use of additional worker has also helped in giving adequate attention to both nutrition and health aspects, particularly for children under three years.

8.3.1 ASHA' Role: As far as the involvement of another worker from a related sector (e.g. ASHA, Mitanin) or of the community in ensuring better delivery of services in the ICDS package is concerned, while there are successful examples, these are isolated, and are not scaleable. While both Mitanin and/or ASHA are honorary workers, they are able to effectively support the activities (largely health related) of the AWC, it is difficult to assume that they would always continue to lend such support. One should not ignore the fatigue factor which might begin operating after some lapse of time. Indeed their commitment can not be taken for granted. Also as far as ASHA is concerned, her role is more related to RCH activities, which are somewhat different in their concept from the ones under the ICDS program. The community's role is also contextual and cannot be taken for granted. There is also the question of accountability. It is well known their commitment is contextual, and they may withdraw from the program without sufficient warning.

The recent measure to induct Mitanin as ASHA workers in Chhatisgarh and the assignment of ASHA's functions to Sahyogini (in addition to her WCD related functions) seemed to have reopened the issue in regard to ASHA also assuming the role of a second specialist worker under the ICDS program. The success of such a measure would largely depend upon the way the institution of ASHA is integrated with the ICDS. The limited experience with ASHA-Sahyogini does seem to suggest a positive future for such a model, particularly because of (i) strong convergence between the departments of health and Women and Child Development because of the new worker assuming the role of both health and nutrition, (ii) the model being highly cost effective and (iii) the model obviating the need to search for yet another literate worker when there are already problems in finding properly educated AWWs/ASHA/Sahyoginis in the rural setting. Perhaps an alternative model for urban areas may be appropriate (for example SEWA-Sagini type)

8.3.2 The Need for Additional Worker- options: The current evidence suggests that the design of national ICDS is inadequate with its one AWW performing all the tasks requiring diverse skills. The rich experience with both TINP, and SEWA (and even limited experience of ASHA-Sangini) suggests the advantage of working with two specialist-AWWs, or some variation of it at least in some of the most backward districts in terms of their nutrition and education levels. A major issue in the context of a two worker model (or some variation of it) would be the availability of additional funds for the purpose. The extent of additional resources needed to implement a two-worker model may be in the range of 25-30% of the

current allocations. However to overcome this problem, we may consider implementing two-worker model only in those blocks/districts which are nutritionally and educationally most backward. In the urban context where there is demand from working mothers one might consider levying some fee (a la SEWA-Sangini). This latter model of fee would considerably improve the attendance at the AWCs (a la SEWA-Sangini) which at the moment is generally low. This is also leading to leakage in food rations by showing higher attendance than actual. This would also have other positive aspects. For example it would lead to greater accountability as was evident in SEWA's case where parents censured the sevikas if the children were not provided palatable food. Parents also ensured that the AWCs actually functioned for the prescribed hours. The exit and entry system adopted by TINP in respect to feeding has some merits, but how far this would be workable in practice particularly in a situation when some children are provided food while others are deprived of it.

8.4 Role and responsibilities of Additional Worker: In case we adopt a two worker model the following division of responsibilities is suggested.

Suggested Framework for a Two Worker Model

Main worker of AWC	Support System	Services
AWW (1)	AWH	Pre-school Education
AWW (1)	Support mothers committes, community, AGs, Primary school teacher	Food supplementation (3-6 years)
AWW (II)	AWH	Registration of ANC/PNC
AWW (I)	ANM	Health checkup
AWH	ANM	Immunization
AWW (II)	ANM	Nutrition Education
AWW (II)	Media	Home visits
AWW (II)		EBF and Colustrum
AWH (II)	ANM	Growth Promotion
AWW (II)	Mothers, Self Help Groups	Spot Feeding & take home food
AWW I & AWW II	AWH	Survey work
AWW I	AWH, AWW (II)	Record keeping
AWW I & AWW II	ANM & Supervisor	IEC Activities, MCHN days & Weighing days
AWW II		Micronutrient supplement
AWW II		Identification of disabilities
AWW I	AWH	Supplies & Materials
AWH		Upkeep of AWC
AWW I		Other administrative work/activities

It would be seen from the above matrix that while one of the two AWWs would focus on the needs of children in the age group of 3-6 years, the second AWW would concentrate on providing services to children under the age off three years and the pregnant women and lactating mothers (PLW). Thus the first worker would be concerned with PSE and SNP

related activities, the second worker would focus on health and nutrition related activities, including antenatal and postnatal care. The first AWW is also entrusted with record keeping and other administrative work. There are some common areas where both AWW 1 and AWW II would work together. The AWH would work under the supervision of AWW 1, and would be responsible for the upkeep of the AWC and assisting in cooking, etc. It would be seen from the above matrix that the community has been assigned a role, because whenever the community has taken active interest, the results have been very positive. Also the participation of Community and SHGs where they exist can contribute significantly to their ownership, and contribute to improving the delivery of quality services.

8.5 Alternative Models -overall assessment

In an earlier section we had outlined the experiences in regard to the working of ICDS Program in select states. The main purpose of the exercise was to examine their relevance in the context of a two-worker model. In this section an attempt is made to document some of the distinctive features of the various ICDS models studied as a part of the present study, and identify their strengths and weaknesses. We have also attempted to provide our own assessment in the scale of 1 to 5 stars, with one star as a low ranking and 5-stars a very high ranking.

Table: SWOT of Alternative ICDS Models

ICDS MODEL	Distinctive Features	Strengths	Weaknesses	Overall Assessment
ASHA-Sahyogini (Rajasthan)	• Extra paid worker at village level, ASHA –Sahyogini • Convergence between WCD and Health • Village contact days fixed/implemented at the start of the program to mobilize the community e.g. MCHN day (immunization/vit A supplementation, etc.) and Fixed weighing and Counseling Day (a week before MCHN day) • Mata Saminits assist AWW in supervising preparation and distribution of food • Provision of training manuals and booklets to AWWs • Strict adherence to minimum qualification for Asha-Sahyogini	• Responsibilities of workers well defined • Committed worker with full accountabilityHighly cost effective • Obviates the need for searching yet another educated worker	• Limited evidence about the working of ASHA-Sahyogini model	****
Mitanin (Chhatisgarh)	• Honorary Community Health Volunteer- traditionally bound to local community • Strong Support of Mahila Samitis/SHGs • Use oftraditional ceremonies to convey NHE messages	• The recent move to recruit Mitanin as ASHA workers may work as incentives are in-built • Adequate attention to children under 3 years age	• Mitanin being voluntary worker, her commitment can not be taken for granted • Much time devoted feeding related activities, with PSE a victim • Accountabilit y of Mitanin an issue	**

NGO-run (SEWA-Sangini)	• Three paid workers with extended time • Community Donations raised, fee charged • Insistence on a certain minimum percent of children under 3 years, • Adherence to prescribed minimum education • All Mothers contribute regularly in various ways – cash contribution, bring vegetables and other foodstuff to help in providing nutritious food • Participation of Fathers	• Demand driven and hence high attendance • Community donations create community ownership • High chances of success in urban or semi urban setting with concentration of working mothers	• More of a creche rather than ECCD centre • Requires high management capacity, • not suitable for rural area	**** (rural) **** (Urban AreaS)**
Mothers Committees (Andhra Pradesh)	• Pioneered Community approach active support from Mothers Committees, especially in supervising the preparation of food, bring food/vegetables, assist in weighing, immunization and awareness creation • Mothers' Committees have bank accounts, members provided training in various ICDS service components • Role of the leader - Active Project Officer • Upgradation of AWC to Model ECD	• Adequate time left with AWWs for other activities, help in provision of nutritious and clean food • MCs have helped in vigorous community involvement • Community participation has contributed to improvement in service quality	• The proactive nature of MCs suspect in the long run • Single worker design has limited ability to deliver desired outcomes and MCs can not act as a substitute for another	***1/2

	Centres to effect improvement in service quality- included physical colocation of AWC with enhanced infrastructure within the primary school complex, additional space for health convergence, extension of AWC timings • Primary school teachers and model ICDS officers counseled parents on enrolment and retention in ICDS and primary schools as part of jint monitoring • Introduced vocational and educational training module for selected number of adolescent girls • IEC-support fixed day strategies e.g. MCH days, communication workshops, development of materials and media services • Digitization of beneficiary homes for monitoring	• In certain situations, high chances of success • Digitization helps in better monitoring of malnutrition, ANC/PNC, etc	worker • Benefiting mostly pre-school children but need to increase its focus on children under 3 years old • Members of mothers committees cancontinue only so long as they have their child in AWC. This in effect means loss ofher experience to AWC	
TINP (Tamil Nadu)	• Decentralized training at block level – institutional training of village workers is provided at the block level and an instructress placed at the block level to provide job training on a regular basis • Targeted feeding, hot food, insistence on spot feeding • extended anganwadi working hours with clearly defined job opportunitues • Extra worker for 3-6 year olds, all workers paid over the prescribed honoraria under national ICDS • Selectivity and Targeting- limited interventions confined to limited number of beneficiaries with clear exit entry criteria	• Highly successful because of extra worker and adoption of targeted approach • Nutrition component highly successful, • High cost Project, but in the long run cost effective to deal with nutritionally high risk children	High Cost Project -funds could be problem PSE receive less emphasis	**** (Recommended where funds are available)

As pointed out earlier, from the viewpoint of sustainability, both ASHA-Sahyogini and the Tamil Nadu Models have an edge over other models described here. However, given the general shortage of funds with states, ASHA-Sahyogini model to be the one which has a decisive advantage over all the other models. The only problem here however is the lack of evidence of the working of ASHA-Sahyogini model in practice. The SEWA-Sangini model is perhaps more appropriate for urban areas or relatively better off rural areas where there is the dominance of working mothers. Even the Tamil Nadu model in its old AVATAR as the TINP may be appropriate in situations and areas where there is the dominance of malnourished children. The models which largely rely on community support and participation have suspect sustainability. While community participation, as a support system is highly desirable, stand-alone community support based models are not likely to succeed in the long run.

Annexures and Appendices

Annexure 1
Role and Responsibilities of AWWs

i. To elicit community support and participation in running the programme.

ii. To weigh each child every month, record the weight graphically on the growth card, use referral card for referring cases of mothers/children to the sub-centres/PHC etc., and maintain child cards for children below 6 years and produce these cards before visiting medical and para-medical personnel.

iii To carry out a quick survey of all the families, especially mothers and children in those families in their respective area of work once in a year.

iv. To organize non-formal pre-school activities in the anganwadi of children in the age group 3-6 years of age and to help in designing and making of toys and play equipment of indigenous origin for use in anganwadi.

v. To organize supplementary nutrition feeding for children (0-6 years) and expectant and nursing mothers by planning the menu based on locally available food and local recipes.

vi. To provide health and nutrition education and counseling on breastfeeding/infant & young feeding practices to mothers. Anganwadi workers, being close to the local community, can motivate married women to adopt family planning/birth control measures.

vii. AWWs shall share the information relating to births that took place during the month with the Panchayat Secretary/Gram Sabha Sewak/ANM whoever has been notified as Registrar/Sub Registrar of Birth & Deaths in her villages.

viii. To make home visits for educating parents to enable mothers to plan effective role in the child's growth and development with special emphasis on new born child.

ix. To maintain files and records as prescribed.

x. To assist the PHC staff in the implementation of health component of the programme viz. Immunization, health check-up, ante natal and post natal check etc.

xi. To assist ANM in the administration of IFA and Vitamin A by keeping stock of the two medicines in the Centre without maintaining stock register as it would add to her administrative work which would effect her main functions under the Scheme.

xii. To share information collected under IVDS Scheme with the ANM. However, ANM will not solely rely upon the information obtained from the records of AWW>

xiii. To bring to the notice of the Supervisors/CDPO any development in the village which requires their attention and intervention, particularly in regard to the work of the coordinating arrangements with different departments.

xiv. To maintain liaison with other institutions (Mahila Mandals) and involve lady schoolteachers and girls of the primary/middle schools in the village which have relevance to her functions.

xv. To guide Accredited Social Health Activists (ASHA) engaged under National Rural Health Mission in the delivery of health care services and maintenance of records under the ICDS Scheme.

xvi. To assist in implementation of Kishori Shakti Yojana (KSY) and motivate and educate the adolescent girls and their parents and community in general organizing social awareness programmes/campaigns etc.

xvii. AWW would also assist in implementation of Nutrition Programme for Adolescent Girls (NPAG) as per the guidelines of the Scheme and maintain such record as prescribed under the NPAG>

xviii. Anganwadi Worker can function as depot holder for RCH Kit/contraceptives and disposable delivery kits. However, actual distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANM or ASHA as decided by the Ministry of Health & Family Welfare.

xix. To identify the disability among children during her home visits and refer the case immediately to the nearest PHC or District Disability Rehabilitation Centre.

xx. To support in organizing Pulse Polio Immunization (PPI) drives.

xxi. To inform the ANM in case of emergency cases like diahorrea, cholera etc.

Role and responsibilities of Anganwadi Helpers

i) To cook and serve the food to children and marchers.
ii) To clean the Anganwadi premises daily and fetching water.
iii) Cleanliness of small children
iv) To bring small children collecting from the village to the Anganwadi.

The ICDS Functionaries

Level of functionary	Functional responsibilities
Ministry of Human Resource Development (Department of Women and Child Development)	Nodal Ministry responsible for budgetary control and administration of the scheme from the centre.
Department of Social Welfare or nodal Department for the scheme as decided by the State Government	Nodal Department responsible for overall direction and implementation of the programme at the State level.
District level officer/District Women and Child Welfare Officer, etc.	Responsible for coordination and implementation of the scheme at the district level.
Child Development Project Officer – incharge of each project	Responsible for implementation of the programme at each block/project. He/she supervises and guides the supervisors and anganwadi workers in the delivery of services within the block.
Supervisor or Mukhya Sevika	Responsible for supervision and guidance to anganwadi workers of 17-25 anganwadis approximately. She provides on the job training to anganwadi workers and assists them in recording home visits and other activities conducted at the anganwadi centre, organising community meetings and visits of health personnel.
Anganwadi worker	A community based voluntary frontline worker of the programme responsible for delivery of all services under the scheme to the beneficiaries. She also surveys the village and keeps a record of the entire population falling under her anganwadi centre. She needs to maintain a record of all her activities in various registers prescribed by the programme.

Source: Meera Priyadarshi (2007).

Current Roles and responsibilities of AWW and ASHA workers and options for team work

MCHN & ECD	AWWS (current assignments) (paid, 4-6 hrs., 6 days a week)	ASHA (current assignments (no fixed payment, flexible hrs., 4 days a week)
Program Planning	Rapport Building with the Community, Village Mapping (annual enlisting of all HHs)	
	Survey and Enlisting Beneficiaries- (0-6 children, 'at risk' children, expectant and nursing mothers, adolescent girls) (enlist all under threes in a village)	Register all pregnant women, assist in urin and Hb test, BP and 3 abdominal examinations
	Birth and Death Registration	
Service Delivery	Preparation and Distribution of Supplementary Food	
	Growth Monitoring	Weigh newborns
	Assisting Health Staff in Immunization and Health Check-up	Assist immunization, Provide ORS, IFA, Vitamin A, and contraceptives
	Referral Services	Refer malnutrition, complicated pregnancies, minor ailment to PHC, referral for IUD or terminal methods
	Detection of Disability among Children	
	Providing Treatment for Minor Ailments	
	Management of Childhood Illness	Treatment of minor ailment
	Health and Nutrition Education	N&H education
	Organizing Pre-school	
IEC	Communicate with and Counsel Parents, Families/Communities	Family planning motivation, follow up on side-effects to contraception methods
	Use Traditional and Folk Media	
	Organize Awareness Campaigns, Street Plays	RTI/STI education
	Prepare Communication and Education Materials	
Community Contact	Mobilize Community and elicit Community Participation	Conduct three post-natal visits
	Maintain liaison with Panchayat, Primary School, Mahila Mandals, Health functionaries	
Management and Administration	Management of AWC	
	Maintenance of Registers	
	Preparation of Reports	

Source: the new pre-service training module 2003, NIPCCD;
Cited in Meera Priyadarshi (2007)

Team Design A: Independent worker from primary education or NGOs for ECD within or outside ICDS
AWW, ASHA and upgraded ICDS Helper deliver MCHN

Team Design B: AWW to be the main ECE worker
ASHA and the upgraded ICDS Helper deliver MCHN

Systems Support in ICDS

Table 1. Revised responsibilities of ICDS Supervisors

Planning and administration	Activities at the centers, inventory of supplies, food, medicines, pre-school materials,
	Assisting in preparation and collection of monthly reports, verifying accuracy of data, other records (administrative), honoraria distribution
	Organizing sectoral meetings
	Training inventory, personnel issues, arrangements for food transfer, storage
Supervision and continuing education	Supportive visits to centers, verifying enrolment and identification of severely malnourished
	Assist in pre-school education, distribution of food
	Continuing education to workers about family surveys, organizing women's meetings
	Joint home visits with worker for counseling and interaction with caregivers
Training	Planning and organizing training of workers and helpers
Service delivery	Assisting in growth monitoring, management of childhood illness, referral services, prevention and early detection of disabilities
Monitoring and Evaluation	Assessing functioning of centers
	Analyzing skills and performance of workers
	Preparation of quarterly plans, compiling monthly reports, interpretation of data, assessing shortfalls in achievements, reporting to project officers with remedies
Coordination liaison and linkages	With health and family welfare, education, information and broadcasting (field publicity, and song and drama division)
	Coordination with primary health center, and sub-center, liaison with health staff
Note: insufficient numbers of supervisors mean each in charge of more than 20 centers (up to 50 in some cases), each center sometimes waits for months for a supervision visit, most supervisors stay at district headquarters, mobility is an issue for her visits to remote centers, her administrative functions are predominant, very few examples of ideal trainer roles are documented (see Tamil Nadu).	

Source: Meera Priyadarshi (2007)

ANNEXURE - Mitanin

Some of the major objectives of the Mitanin Programme are

- Improve awareness of health and spread health education
- Improve utilization of existing public health care services and advocacy for equitable access and its effectiveness
- Provide local measures of immediate curative and preventive relief to health problems of society
- Organize community ,especially women and weaker sections on health and health related issues
- Sensitize panchayats and build up its capabilities in planning and imparting health-placing health on panchayat's agenda.

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* To be included in final version.

The underlying approach to the Mitanin Program may be summarised as:

- Launched as result of a process of state-civil society consultation.
- Placed at demand side to point out/fill in the supply side gaps
- Not to replace public health systems, but to strengthen them
- Conceptualization of the program and selection of Mitanins done through a community processes- also build on local traditions
- The Program is built up on camp based training followed by on the job training and supportive supervision on an enabling environment
- Ongoing Course correction measures as a consolidated response to field level issues
- Innovative institutional mechanism: State Health Resource Centre- to act as an additional technical capacity, to take the reform processes forward and to Bridge state and civil society
- Was instrumental in design of ASHA Scheme under NRHM

The Mitanin is trained (20 days of camp-based training and 30 days on the job training) and supported by a block training team and the ANM and AWW.

The Training inputs

λ Initial set of training covering all

- Understanding of health and health services and Community Monitoring of Health services
- Managing critical Child Health Issues and prompt referral
- Health Issues of Women/Adolescent Girls
- Community Control of Malaria
- First level Contact Care using Mitanin Dawapeti
- Assisting Disease Control Programmes
- Assisting the Panchayat level health status assessment and health planning

λ Subsequent Training Rounds

- Food & Social Security: community roles
- Home based Herbal Remedies- Jadi buti Le karein Ilaj

λ A Special training on Integrated Neonatal and Child Survival has been initiated recently, aiming to fill in all the gaps at community level care and to improve referral linkages in common childhood illnesses- Based on IMNCI and home based neonatal care approaches.

As a result of training the Mitanins are expected to play an important role in several areas.

In order to enhance outcomes, a number of measures are contemplated; These are:

- Supportive visit to every mitanin by Trainers to be ensured so as to improve Mitanin activity levels
- Cluster (Panchayats) meeting of mitanins with trainers/DRPs to Assess this
- Fortnightly Trainer meeting to Review Mitanin Status
- Field Visits by DRPs to assess this
- DRP meeting to review block/trainer status
- Analytical look at data and improving measures at all levels- Built in evaluation processes
- The Monitoring strategy is tailored into these steps

Because of the design of the program, it has certain inherent merits. First being a state sponsored scheme, Mitanin Program enjoys political patronage at the highest level. Another positive aspect of this program is the fact that Mitanins come from within their own communities which they serve and are more committed to their jobs. This indeed is borne out by a mid term evaluation which shows less than 5% drop out rate. They are supported by high quality training material as well as have the advantage of continuing training and support further enhances the sustainability of the program. The program is fortunate to have the civil-state partnership at all levels which ensures ownership and cooperation. Despite all these merits of the Mitanin Program, there are certain threats. For example unless both government and political patronage is forthcoming, it would have little chance for success.

The program would have little chance of success unless the community is reasonably convinced about the continuance of the institution of Mitanin. Also the community should be fully involved in the selection of Mitanins and should not be left entirely to the judgement of ANM/AWW. Yet another aspect is false promises made to Mitanin about the possibility of their getting government jobs.

The sustainability of the program is questionable. Whether the funds and other support on a sustainable basis would be available for the Mitanin Program at least for three to five years is anybody's guess.

Annexure 3:

Recently under the NRHM there is a provision for the appointment of yet honorary worker, ASHA to act as health time worker.

The accredited Social Activist (ASHA) is envisaged to be a trained female voluntary Community Health Worker in the eight EAG states, Assam and Jammu & Kashmir. Others states also have the flexibility to adopt it under RCH-II. ASHAs would reinforce community action for universal immunization, safe/institutional delivery, other Reproductive & Health related Services newborn care, prevention of water-borne and other communicable diseases, nutrition and sanitation. ASHAs would be chosen by the Panchayat and be fully accountable to them. Though she would not be paid any salary she would be entitled for performance linked incentives under different programmes. Fully anchored in the Anganwadi system, ASHAs would work in close coordination with the ANM and AWW. ASHAs would be provided with a basic drug kit including AYUSH drugs. She would also be a depot holder for contraceptives and IEC materials developed for villages. So far the selection of more than 1 lakh ASHAs has been completed and the training process is on.

The Accredited Social Health Activist (ASHA) would work as a link health worker between the poor pregnant women and public sector health institution in the ten low performing states. ASHA would be responsible for making available institutional ante-natal as well as post natal care. She would also be responsible for escorting the pregnant women to the health centre.

The Scale of Assistance under the Scheme would be as follows:

Category	Rural Area		Total	Urban Area		Total
	Mother's package	ASHA's package		Mother's package	ASHA's package	
LPS	500-200	600	1300	500-100	200	800
HPS	500-200		700			

LPS: Low performing States HPS: High Performing States

All BPL pregnant women would be eligible to get cash benefits of Rs. 500/- per live birth on registration. However, the disbursement would be done at the time of delivery, irrespective of the place of delivery.

Such eligible beneficiaries who deliver in health institutions would get an additional cash benefit of Rs. 200/- if they belong to rural areas and Rs. 100/- if they belong to urban areas of above mentioned ten low performing States.

For the services provided by ASHA, in rural areas of all the ten low performing states a package of assistance of Rs. 600/- has been provided. The package is towards meeting the cost of transportation for the pregnant women and the ASHA to reach the health centre, transactional expenses for ASHA for her stay with the expectant mother in the health centre ASHA. However, in urban areas the package of assistance for ASHA will be restricted to Rs. 200/- because of availability of better transport facilities, in comparison to the rural areas.(For detailed fnction expected of ASHA, please see Annexure).

Integrated Child Development Services

Time and Work Study of Anganwadi Workers

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Executive Summary

In this study, an attempt is made to carry out a study of select anganwadi centres to assess the work load of anganwadi workers and the time spent by them on various activities assigned to them under the ICDS program as well as on other activities assigned to them by other departments from time to time. The assessment is supplemented by focus group discussions with women beneficiaries and case study of states which have introduced certain innovative features to the existing design of the national ICDS program. The study has also documented the unit cost of ICDS facilities in study states at various levels, namely anganwadi centre, block, district and the state. Inter alia an attempt is made to indicate the main issues and concerns emerging from the analysis especially in the context of a two worker model.

Work Load and Time Management: In the context of time management, two aspects are important. One is concerned with the manner in which an anganwadi devotes her time to various ICDS related activities, and the second one is the way she gives her time to various categories of beneficiaries. First an analysis of the roles and responsibilities of ICDS functionaries has clearly brought out the fact that the tasks assigned to the AWW are highly diverse and numerous. It is highly unrealistic to expect that one single worker, with little educational qualifications, would be in position to deliver all the services prescribed in the ICDS package within a span of four hours in a day. The following table gives some idea of the way an anganwadi worker distributes her time on various ICDS related services:

Time Devoted on various activities at a typical AWC under national ICDS

Activity	Average Daily Time in minutes
Pre-school education	120-150 minutes
SNP distribution & Nutrition Supplements	45 minutes
Home Visits - Nutrition Health Education & Health related	30-45 minutes
Record keeping, other administrative, survey, identification of beneficiaries	45 minutes

All the past evaluations, as well as our own analysis seem to confirm this finding. In such an environment, while it is possible to have large enrolment of children, the actual attendance is expected to be low as indeed was observed during the survey. Whatever little attraction is there for AWCs, it is largely associated with SNP for children 3-6 years old. There is however one positive feature of the ICDS in that the AWWs have been able to mobilize women and children for immunization. Record keeping is another aspect, which seems to

keep worrying the AWWs, although in actual practice, as indicated in the above table, only about 30-45 minutes are devoted to record keeping. Finding record keeping difficult, some of AWWs are forced to take help from others including fellow AWWs, and sometimes even pay for the help. As far as PSE component is concerned, although almost 60 minutes to 150 minutes are devoted to PSE activities, except for some prayers and songs, counting and story telling much of the PSE related time is taken away by feeding related activities. NHE component including promotion of growth monitoring is not given adequate attention. Recently, however, more and more women are becoming aware of the need for exclusive breast-feeding and colustrum. Some awareness in regard to improved food habits was evident.

As indicated a related but an important concern is in regard to the time devoted to various categories of beneficiaries, especially in regard to children under three years of age who are alleged to receive less attention. The following table based on the sample survey of four nutritionally deficient states gives an idea about the relative time devoted to various categories of beneficiaries:

Table: Distribution of Time Spent by AWWs by type of Beneficiary

Target Beneficiary	Average Time Devoted (minutes)	Daily/Weekly/ monthly	Standard deviation	Activities
Children under 12 months	45.6 (no response from Bihar)	weekly	24.2	SNP distribution and immunization
Children 12-36 months	46.3	weekly	24.1	SNP distribution
Children 12-36 months	36.0	weekly	12.7	NHED for mothers of children 12-36 months
Children 3-6 years	149.1	daily	64.7	PSE
Adolescent girls	36.6	weekly	19.7	NHED

The time spent by the AWW on major activities shows that, while there are some variations among the study states, on average an AWW devoted about 45 minutes weekly on children under 1 year. The two major activities for this group comprised of (i) weekly SNP distribution to their mothers and (ii) monthly immunization sessions. Bihar did not respond. For children between 1-3 years, AWWs on average spent nearly 46 minutes weekly. The activities included mainly SNP distribution, although some AWCs reported of conducting NHED sessions as well as some on action-songs/games. The sample AWCs carrying out

these activities on the average spent nearly 36 minutes weekly on NHED. Those responding to the latter question were very few. The time spent on 3-6 years children was clearly the maximum, almost 150 minutes a day. The major activity consisted of PSE during which SNP was also distributed. Adolescent Girls is the other important segment of beneficiaries in the life cycle approach. Here we found that on average the AWWs spent 36 minutes weekly on the activities related to AGs.

Survey Findings on the Profile of AWWs and the AWC Infrastructure: The four study states survey revealed that almost 25% AWCs are co-located with school buildings and 30% in AWWs' own homes. While many of these have water and toilet facilities, most AWCs lack electricity provision. They are conveniently located and generally accessible. In regard to equipment and supplies, regularity is a problem. Major problem is also with availability of medicine kits and weighing scales. There is also the problem of scarce use of weighing scales even when they are there.

As far as the profile of AWWs is concerned, the literacy levels are generally satisfactory. Over 80% live close to the AWCs where they work. A very large proportion of AWWs is below the age of 40 years. While most AWWs have received both induction training as well as refresher training, most AWWs indicate a desire to receive further training. The in-service training is a neglected area. Most AWWs are satisfied with the content of training.

In regard to utilization of ICDS services, except SNP component, other components are reported to be weak, especially the quality aspect of PSE. Perhaps, it is only in the SEWA-Sangini model, that PSE is taken quite seriously.

Survey results also indicate growth monitoring and nutrition and health education (NHE) as weak components. While almost 88% of the AWWs reported providing nutritious meals, this percentage is lower for immunization (about 75%) and iron tablets (45%), other NHE services were either neglected or received less attention. For instance breast feeding percentage is a little under 25%, colostrum feeding (19%) and child growth monitoring (16%).

The FGDs with women beneficiaries, however, indicate the positive role that the AWWs have played in various aspects of their reproductive life, especially in terms of the importance of institutional delivery, early breast feeding, and nutritious food. There are however areas of concern like lack of accurate knowledge about child immunization and growth monitoring and weighing of children. There are certain cultural banners in the delivery of services.

Shyness and ignorance are two important factors. Also some women do not have enough confidence in the competence of AWWs to deliver quality services.

Role of Community: The study has shown that some of the AWCs which are reported to be working well in terms of the delivery of services are the ones receiving active support from the community including the Panchayats. The participation of the community (whether mothers committees/samitis or women's self help groups) in the activities of the AWC (wherever this has happened) has made a positive impact on the functioning of the AWC, especially in relation to health and nutrition related activities. One positive externality of this is the release of at least some pressure on the AWWs which in turn has permitted them to be able to devote more time on other activities including the PSE. Further it is seen that whenever the sarpanch has taken interest in the ICDS program, the functioning of the AWC has seen distinct improvement. Another factor, although well known and fully recognized, is the role of the Manager (here CDPO, DPO, etc.). Whenever CDPO/DPO/DM etc. has shown vision and taken personal interest in the activities of AWC, the AWWs are seen motivated to provide quality services with the same resources.
Another significant contribution of the community involvement is related to the monitoring aspect. Indeed the presence of mothers committees or similar groups is seen to ensure that the AWWs take their work seriously. The community is also found to contribute significantly to improving the infrastructure and upkeep of the AWC (a la Vellore, Medak)

Additional Support: The study also shows that, apart from community support, AWCs with three workers (e.g ASHA-Sahyogini in Rajasthan), one AWW plus two helpers in Tamil Nadu, three Sevikas in SEWA-Sangini in Ahmedabad) have generally indicated higher attendance of child beneficiaries. Further the incidence of malnourishment amongst the children under these models is generally lower, as most records reveal. Both PSE and NHE components in such an environment received adequate attention from the AWWs. The use of additional worker has also helped in giving adequate attention to both nutrition and health aspects, particularly for children less than three years.

ASHA' Role: As far as the involvement of another worker from a related sector/department (e.g. ASHA, Mitanin) or of the community in ensuring better delivery of services in the ICDS package is concerned, while there are successful examples, these are isolated, and are not scaleable. While both Mitanin and/or ASHA, who are honorary workers, are able to

effectively support the activities (largely health-related activities) of the AWC, it is difficult to assume that they would always continue to lend such support. One should not ignore the fatigue factor, which might begin operating after some lapse of time. Indeed their commitment can not also be taken for granted. As far as ASHA is concerned, her role is more related to RCH activities, which are somewhat different in their concept from the ones under the ICDS program. The community's role is also contextual and cannot be taken for granted. There is also the question of *accountability*. It is well known their commitment is at best limited and contextual, and they may withdraw from the program without sufficient warning as there are no conditions/penalties/disincentives prescribed in case they decide to give up their current role as ASHA/Mitanin or for that matter even the so called self help groups including the members of mothers committees.

The recent measure to induct Mitanin as ASHA worker in Chhatisgarh and the assignment of ASHA's functions to Sahyogini (in addition to her WCD related functions) seemed to have reopened the issue in regard to ASHA also assuming the role of a second specialist worker under the ICDS program. The success of such a measure would largely depend upon the way the institution of ASHA is integrated with the ICDS. The limited experience with ASHA-Sahyogini does seem to suggest a positive future for such a model, particularly because of

- Strong convergence between the departments of health and Women and Child Development because of the new worker assuming the role of both health and nutrition,
- The model being highly cost effective, and
- The model obviating the need to search for yet another literate worker when there are already problems in finding properly educated AWWs/ASHA/Sahyoginis in the rural setting. Perhaps an alternative model for urban areas may be appropriate (for example SEWA-Sangini type)

The Need for Additional Worker- options: The current evidence suggests that the design of national ICDS is inadequate with its one AWW performing all the tasks requiring diverse skills. The rich experience with both TINP and SEWA (and even limited experience of ASHA-Sangini) suggests the advantage of working with two specialist-AWWs, or some variation of it in, at least, some of the most backward districts in terms of their nutrition and education levels. A major issue in the context of a two-worker model (or some variation of it) would be the availability of additional funds for the purpose. The extent of additional resources needed to implement a two-worker model may be in the range of 25-30% of the

current allocations. However to overcome this problem, we may consider implementing two-worker model only in those blocks/districts which are nutritionally and educationally most backward. In the urban context where there is demand from working mothers one might consider levying some fee (a la SEWA-Sangini). This latter model of fee would considerably improve the attendance at the AWCs (a la SEWA-Sangini) which at the moment is generally low. This would also have other positive aspects. For example it would lead to greater accountability as is evident in SEWA's case where parents censured the Sevikas if children are not provided with palatable food. Parents also ensure that the AWCs actually functions for the hours/timings prescribed for the purpose. Unlike other ICDS programs with innovative features, SEWA-Sangini model is unique and rests on cost sharing arrangement between the beneficiary community, community at large, NGOs and the government. Clearly close participation of all the key stakeholders has a much greater chance of success in terms of the key nutrition, health and education indicators.

The exit and entry system adopted by TINP in respect to feeding has some merits, but how far this would be workable in practice particularly in a situation when some children are provided food while others are deprived of it. One major advantage of TINP model is the role of supervisors as trainers. The continual feedback from AWWs helps supervisors in making training more purposeful and close to ground reality. Supervisor is also able to understand the specific problems of each anganwadi worker receiving training.

Role and responsibilities of Additional Worker: In case we adopt a two-worker model, our analysis suggests the following division of responsibilities:

Suggested Framework for a Two Worker Model

Main worker of AWC	Support System	Services
AWW (1)	AWH	Pre-school Education
AWW (1)	Support mothers committees, community, AGs, Primary school teacher	Food supplementation (3-6 years)
AWW (II)	AWH	Registration of ANC/PNC
AWW (I)	ANM	Health checkup
AWH	ANM	Immunization
AWW (II)	ANM	Nutrition Education
AWW (II)	Media	Home visits
AWW (II)		EBF and Colustrum
AWH (II)	ANM	Growth Promotion
AWW (II)	Mothers, Self Help Groups	Spot Feeding & take home food
AWW I & AWW II	AWH	Survey work
AWW I	AWH, AWW (II)	Record keeping
AWW I & AWW II	ANM & Supervisor	IEC Activities, MCHN days & Weighing days

AWW II		Micronutrient supplement
AWW II		Identification of disabilities
AWW I	AWH	Supplies & Materials
AWH		Upkeep of AWC
AWW I		Other administrative work/activities

It would be seen from the above matrix that, while one of the two AWWs would focus on the needs of children in the age group of 3-6 years, the second AWW would concentrate on providing services to children under the age off three years and the pregnant women and lactating mothers (PLW). Thus the first worker would be concerned with PSE and SNP related activities, the second worker would focus on health and nutrition related activities, including antenatal and postnatal care. The first AWW is also entrusted with record keeping and other administrative work. There are some common areas where both AWW 1 and AWW II would work together. The AWH would work under the supervision of AWW 1, and would be responsible for the upkeep of the AWC and assisting in cooking, etc. It would be seen from the above matrix that the community has been entrusted with a role, because whenever the community has taken active interest, the results have been very positive. Also the participation of Community and SHGs where they exist can contribute significantly to their ownership, and contribute to improving the delivery of quality services.

Alternative Models -overall assessment

In the context of a two-worker model we evaluated the working of ICDS Program in select states which have introduced certain specific, innovative features to the national ICDS program. As a part of this assessment the study has attempted to document some of the distinctive features of the various ICDS models studied. Inter alia it identifies their respective strengths and weaknesses. The assessment is done on the scale of 1 to 5, with one star indicating a low ranking and 5-stars a very high ranking in terms of their suitability for adoption.

Table: SWOT of Alternative ICDS Models

ICDS MODEL	Distinctive Features	Strengths	Weaknesses	Overall Assessment
ASHA-Sahyogini (Rajasthan)	• Extra paid worker at village level, ASHA –Sahyogini • Convergence between WCD and Health • Village contact days fixed/implemented at the start of the program to mobilize the community e.g. MCHN day (immunization/vit A supplementation, etc.) and Fixed weighing and Counseling Day (a week before MCHN day) • Mata Samitis assist AWW in supervising preparation and distribution of food • Provision of training manuals and booklets to AWWs • Strict adherence to minimum qualification for Asha-Sahyogini	• Responsibilities of workers well defined • Committed worker with full accountabilityHighly cost effective • Obviates the need for searching yet another educated worker	• Limited evidence about the working of ASHA-Sahyogini model	****
Mitanin (Chhatisgarh)	• Honorary Community Health Volunteer- traditionally bound to local community • Strong Support of Mahila Samitis/SHGs • Use of traditional ceremonies to convey NHE messages	• The recent move to recruit Mitanin as ASHA workers may work as incentives are in-built • Adequate attention to children under 3 years age	• Mitanin being voluntary worker, her commitment can not be taken for granted • Much time devoted feeding related activities, with PSE a victim • Accountability of Mitanin an issue	**

NGO-run (SEWA-Sangini)	• Three paid workers with extended time • Community Donations raised, fee charged • Insistence on a certain minimum percent of children under 3 years, • Adherence to prescribed minimum education • All Mothers contribute regularly in various ways – cash contribution, bring vegetables and other foodstuff to help in providing nutritious food • Participation of Fathers	• Demand driven and hence high attendance • Community donations create community ownership • High chances of success in urban or semi urban setting with concentration of working mothers	• More of a creche rather than ECCD centre • Requires high management capacity, • not suitable for rural area	**** (rural) **** (Urban AreaS)**
Mothers Committees (Andhra Pradesh)	• Pioneered Community approach active support from Mothers Committees, especially in supervising the preparation of food, bring food/vegetables, assist in weighing, immunization and awareness creation • Mothers' Committees have bank accounts, members provided training in various ICDS service components • Role of the leader - Active Project Officer • Upgradation of AWC to Model ECD	• Adequate time left with AWWs for other activities, help in provision of nutritious and clean food • MCs have helped in vigorous community involvement • Community participation has contributed to improvement in service quality	• The proactive nature of MCs suspect in the long run • Single worker design has limited ability to deliver desired outcomes and MCs can not act as a substitute for another	***1/2

	Centres to effect improvement in service quality- included physical co-location of AWC with enhanced infrastructure within the primary school complex, additional space for health convergence, extension of AWC timings • Primary school teachers and model ICDS officers counseled parents on enrolment and retention in ICDS and primary schools as part of jint monitoring • Introduced vocational and educational training module for selected number of adolescent girls • IEC-support fixed day strategies e.g. MCH days, communication workshops, development of materials and media services • Digitization of beneficiary homes for monitoring	• In certain situations, high chances of success • Digitization helps in better monitoring of malnutrition, ANC/PNC, etc	worker • Benefiting mostly pre-school children but need to increase its focus on children under 3 years old • Members of mothers committees cancontinue only so long as they have their child in AWC. This in effect means loss ofher experience to AWC	
TINP (Tamil Nadu)	• Decentralized training at block level – institutional training of village workers is provided at the block level and an instructress placed at the block level to provide job training on a regular basis • Targeted feeding, hot food, insistence on spot feeding • extended anganwadi working hours with clearly defined job opportunities • Extra worker for 3-6 year olds, all workers paid over the prescribed honoraria under national ICDS • Selectivity and Targeting- limited interventions confined to limited number of beneficiaries with clear exit entry criteria	• Highly successful because of extra worker and adoption of targeted approach • Nutrition component highly successful, • High cost Project, but in the long run cost effective to deal with nutritionally high risk children	High Cost Project -funds could be problem PSE receive less emphasis	**** (Recommended where funds are available)

Overall from the viewpoint of sustainability, both ASHA-Sahyogini and the Tamil Nadu Models have an edge over other models studied here. However, given the general shortage of funds with states, ASHA-Sahyogini model appears to be the one which has a decisive advantage over all the other models. It has the added advantage of introducing an element of accountability. The only problem here however is the lack of sufficient evidence with the working of ASHA-Sahyogini model in practice. The SEWA-Sangini model is perhaps more appropriate for urban areas or relatively better off rural areas where there is the dominance of working mothers. As mentioned above, the SEWA-Sangini model is the only one with cost sharing arrangements between various key stakeholders. In terms of nutrition, health and education indicators this should be the one model, which should be further, experimented with. It is indeed unfortunate that the whole SEWA-Sangini model was abandoned too early for reasons we were unable to comprehend. It is highly desirable that there should be a revival of this model at least in certain well off areas with some tradition of good working NGOs. Even the Tamil Nadu model in its old AVATAR as the TINP may be appropriate in situations and areas where there is the dominance of malnourished children. TINP's feature of training at the Block level has certain distinct merits as pointed out before. The models, which largely rely on community support and participation, have suspect sustainability. While community participation, as a support system is highly desirable, stand-alone community support based models are not likely to succeed in the long run.

Project Costs:

An attempt is also made to estimate the current costs of implementing ICDS program at State/district/block/anganwadi centre levels. These estimates have been made for a few states. The following table contains a summary of the cost estimates of ICDS Project at various levels.

Total Expenditure on ICDS for select States

*State	Projects number	AWCs number	Total Expenditure (Rs. Lakh)			Unit Cost of Project (Rs Lakh)	Unit Cost of AWC (Rupees)	% State Share
			State	Centre	Total			
Andhra Pradesh	376	61241			22404	59.59	36583	26.7
Chhatisgarh	158	29437			6937	43.91	23566	*
SEWA /centre/month (in Rs.)				5663	10500		55000-60000	45
Tamilnadu (2006-07)	434	45726	18292	16173	34465	79.41	75372	53.1
Uttar Pradesh -	8	1179	116	249	365	45.63	30958	31.8

Sonebhadra dist.									
Rajasthan	1	121				54.4	44959		

- The state has recently agreed to give additional honoraria of Rs. 200 and Rs. 100 to AWW and AWH.

7.6.1 Discussion:

- Andhra Pradesh, which broadly follows the national ICDS pattern (except the payment of higher honoraria to AWW/AWH for extended working hours of AWCs) with the innovative feature of Mothers Committee providing support to the activities of the AWCs, spent nearly Rs. 59.6 lakhs on an ICDS Project at the block level. The corresponding unit cost of an AWC worked out to be Rs.36583. If we assume that the direct cost of one AWC is about Rs. 30,000 then nearly Rs. 6000 (or about 15-20%) is towards the administrative and supervisory costs (including materials in kind).

- Tamil Nadu (loosely a two-worker model) has a high cost of Rs. 79.4 lakhs per ICDS Project or Rs. 75373 per AWC. The main reason for these high costs is to be found in the high honoraria paid to the anganwadi workers compared to the ones paid as per the national ICDS normal because of the extended working hours of AWCs in Tamil Nadu.

- SEWA which had adopted a 3 worker model (1 AWW + 2 helpers, all called Sevikas) shows a much higher unit cost. It may be noted that unit cost for SEWA included cost of meals which is almost 50%. If we exclude the cost of meals, then SEWA model would suggest a unit cost of around Rs. 55000 to Rs. 60,000 for one AWC.

- The operational unit cost of an ICDS Project in Chhatisgarh which receives active support of Mitanins and SHGs is Rs. 43.91 lakhs or Rs. 23566 per AWC. The Chhatisgarh model is pretty close to the national ICDS in terms of staffing and cost norms. Recently, kit was learnt that the state government was proposing to enhance the honoraria of both AWW and AWH by Rs. 200 and Rs. 100, respectively.

- Rajasthan's ASHA-Sahyogini model entails an additional annual expenditure of Rs. 6000 per ASHA-Sahyogini on her honorarium and one time expenditure of about Rs.2500 on her training , and a an expenditure of Rs. 300 per annum on contingency, the total additional financial burden for Rajasthan model may not be more than Rs. 6500 per annum. We analyze these costs later in the report.

Estimated costs of a proposed two-worker Model (based on national ICDS norms)

Using the current cost norms of the Central Government which are rather conservative, and 5 supervisors per project of 140 AWCs and treated at par with the existing supervisors, the total cost of a project works our to be around Rs. 58.46 lakhs as shown below. The unit cost for an AWC is therefore Rs. 41757 approximately excluding the cost of meals. The preceding cost analysis of other states show that this cost estimate is not significantly different from cost estimates for most states. The current unit cost of a project is around Rs. 37.5 lakhs. If we work with only one AWW as at present, the unit cost of ICDS Project is seen to be Rs.39.03 lakhs or Rs. 27879 for one AWC. These costs exclude the costs of training.

Item/per month	Number	Cost norm (Rs.)	Monthly Cost	Annual Cost
Staff Salary and Honoraria				
Project Staff				
CDPO	1	12000	12000	
Assistant/Statistical Assistant	1	8500	8500	
Supervisor	4	8000	32000	
Clerk Typist	1	5000	5000	
Peon	1	4500	4500	
sub total (A)			62000	744000
Field Staff				
Anganwadi Worker I	140	1000	140000	
Anganwadi Helper	140	500	70000	
sub total (B)			210000	2520000
Other recurring Expenses				
Rent for AWCs (per month)	140	100	14000	168000
Medicine Kit (once a year)	140	600	84000	84000
PSE materials (once a year)	140	500	70000	70000
Transport (only hiring)				120000
Contingency for AWW (per month)	140	50	7000	84000
Annual Contingency for Project Office		30000	30000	30000
IEC per annum		25000	25000	25000
Stationery per month	140	200	28000	28000
Rent (Block Office) annual		30000	30000	30000
sub total (C)				639000
Sub Total D = Total of sub totals (A+B+C)				3903000
Additional Cost for Two Worker Model				
Anganwadi Worker II (additional)	140	1000	140000	1680000
Communication Strengthening Additional)	140	250	35000	35000
NHE material	140	100	14000	14000
Additional Training Cost for AWW II	140	500		70000
Nutrition Instructor per block	1	12000		144000

Sub total E				1943000
Total F = Total of sub totals (D+E)				5846000
Secondary Computations & Summary				
Percentage Increase in Additional Cost				49.78
Average Cost Per AWC with one AWW				27879
Average Cost per AWC with two AWWs				41757
Unit Cost of a Block of 140 AWCs with				
(a) One AWW as at present (Rupees)				Rs. 39.03 lakhs
(b)Two AWWs as proposed (Rupees)				Rs. 58.46 lakhs

It may be mentioned that the various unit costs of ICDS Projects given above are not comparable because of the fact that in practice each ICDS Project has varying number of AWCs under its jurisdiction. In order to make the unit costs comparable, we have reworked these on the assumption that each ICDS project would have 100 AWCs under its jurisdiction. The following recalculated unit cost of an ICDS Project comprising of 100 AWCs is given below:

State/Project	Unit Cost of ICDS Project with 100 AWCs (Rs. Lakh)	Type of Model
Andhra Pradesh	36.8	School/habitation based
Chhatisgarh	23.5	Habitation based
Rajasthan	44.96	Habitation based
Tamil Nadu	75.6	Two worker/ habitation
Uttar Pradesh	31.04	School based
SEWA-Sangini	55-60	NGO based
Two workers Model as proposed	41.75 ***(1)***	Two worker suggested/ habitation based
One worker model as at present	27.86 ***(1)***	Current costs as per current ICDS model

(1)Does not include overhead costs unlike other models

While the unit cost of a two worker model does not appear to be much different from the cost of other existing models (having some innovative features) a significant advantage of ASHA-Sahyogini model over the other models appears to be the strong convergence between the health department and the department of women and child, as the second worker (namely the ASHA-Sahyogini) is common to both and thus in a position to effectively perform nutrition and health related functions better. In one sense it also obviates the need to search for yet another worker in a village which seems to be difficult given the low levels of rural literacy.