NATIONAL COMMISSION FOR PROTECTION OF CHILD RIGHTS

Shivpuri (Pohri block) Visit Report

Madhya Pradesh

Submitted By: Dr. Dinesh Laroia, Dr. Sunil S. Raj & Shaifali Avasthi

15th -16th Jan. 2011

Table of Contents

Introduction

District visited : Shivpuri, Madhya Pradesh

Dates of Visit : 15th - 16th Jan, 2011

Purpose :

1. To observe the efficacy of Anganwadi Centres (AWC) and Nutrition Rehabilitation Centres (NRC)
2. To investigate into the alleged malnutrition deaths in Pohri block of Shivpuri district.

Number of places visited on :

AWCs

- Nahargada
- Jarian Kalan and
- Dangebarbe

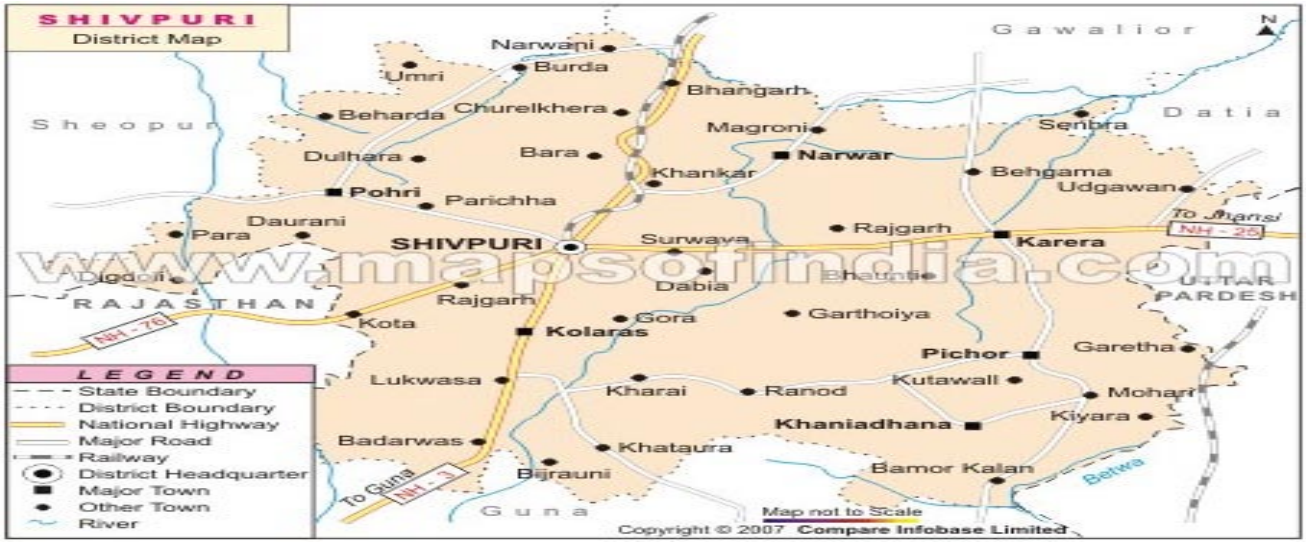
NRCs

- Pohri block
- Shivpuri

Team Members :

1. Dr. Dinesh Laroia, M.D. (Pediatrics) Member, NCPCR
2. Dr. Sunil Sakxena Raj, Associate Professor, IIPH-Delhi
3. Ms. Shaifali Avasthi, Consultant, NCPCR

Shivpuri Map



Madhya Pradesh has a total population of 60,385,118 and under 6 population of 10,782,214[1]. Major Child Health Indicators *vis a vis* national averages are as below:

	Madhya Pradesh		India	
	NFHS 2 (1998-99)	NFHS 3 (2005-06)	NFHS 2 (1998-99)	NFHS 3 (2005-06)
Neonatal Mortality Rate	54.9	44.9	43.4	39.0
Post Neonatal Mortality Rate	31.2	24.7	24.2	18.0
Infant Mortality Rate	86.1	69.5	67.6	57.0
Child Mortality Rate	56.4	26.5	29.3	18.4
Under 5 Mortality Rate	137.6	94.2	94.9	74.3

The Child Health Indicators are far below the National average.

MP is one of the poorest state with 32.4% of its population living below poverty line as compared to the national average of 21.8%[2]. The state has a sizeable Scheduled Tribe population (21.4%) and Scheduled Caste population (17.9%)[3].

Shivpuri is one of the district of Madhya Pradesh having population of 1,440,666[4] with 0-6 population of 248804[5].

Total no. of blocks	8
Total no. of villages	1459
Total no. of *panchayats*	605
Total no. of AWCs	1850
Total no. of NRCs	8

**Office of Programme Officer, WCD*

[1] Census of India, 2001
[2] NSS, 2007
[3] NFHS 3 (2005-2006)
[4] Census of India, 2001
[5] Office of Programme Officer, WCD

Chronology of Events

NCPCR is tracking and keeping a strong vigil on the issues of malnutrition and associated deaths in Madhya Pradesh;

In Feb, 2009

First Public Hearing on malnutrition was held in Satna and Bhopal. The State Administration was advised accordingly.

In July, 2010

Second Public Hearing was held in Bhopal wherein 10 cases of deaths of malnutrition from Shivpuri district were reported out of which 3 were presented at the Public Hearing. Complaints of other 7 deaths were also notified. Commission took these cases with the District Administration. However, the directives had already been sent to the District Administration, but the District Administration denied of the allegations in 6 cases from this district. In 5 death cases it has been stated that the reason of child death is high fever and the AWCs are running efficiently in this district.

In Dec, 2010

On the complaints of increasing incidence of malnutrition and deaths thereof received by the Commission, District Administration was again consulted and response was sought. The letter was sent to the District Collector, Shivpuri to explain the situation and the response have also been received from the District Collector dated 13/01/2011 ***(Annexure 1)***.

In 15th Jan, 2011

However, because of the serious differences between the administrative response and the complaints, the Commission decided to physically verify the facts and so a team was sent to Shivpuri, Madhya Pradesh to enquire into the facts.

The team was entrusted upon the responsibility of finding the facts, the efficacy of the AWCs, the referral systems from AWC to NRC and follow up pattern and overall status of health in the AW beneficiaries.

Findings during the field visits

At Nahargada

Demographic profile

Total Population of the village	:	450
Total no. male children at the AWC	:	61
Total no. of female children at AWC	:	47
Total no. of children registered at the AWC	:	109
Children between the age group of 6mths- 3 yrs	:	47
Children between the age group of 3- 6 yrs	:	61
Total no. of Pregnant Women	:	10
Total no. of Lactating Women	:	13

About the Centre

Nahargada is a remote village accessible only through *kuchha* road and *approx*. 7-8 *kms* from the main road, constituting mainly of Sahariya tribe and Yadav community. AWC was easily approachable to the community. The building of AWC was sanctioned by the government and was a *pucca* building. General hygiene of the Anganwadi premises appears to be fair. Source of drinking water was Handpump. This village does not have the facility of toilets. The plates for meals were being provided by the centre. The plates appeared to be clean and recently purchased. Place of the storage of the raw materials was unsatisfactory. Availability of the space for outdoor activities was enough. Room size of the AWC was inadequate and the children were being compactly adjusted.

Comments

As per the villagers and administration version the AWC has recently been shifted to this premises following the visits of dignitaries. Initially it was being run from a very dingy place, despite of relocation, the room size was not enough to accommodate the kids.




About the AW Supervisor

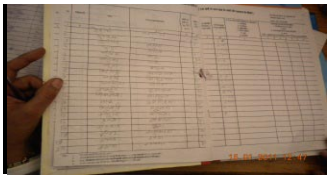
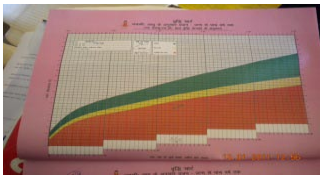
The AWC at Nahargada was running without regular AWW under the guidance of Anganwadi supervisor with the assistance of AWH thereby, affecting the functioning of AWC adversely. AW Supervisor who is supposed to look after the AWC resided at a distance of 8 *kms* and visits the centre once or twice a week and had attended reorientation programme 5 yrs back. Citing her own problems of transport, non-availability of the AWW, public apathy, she seemed like an unmotivated team member. The record maintenance by the staff was extremely impecunious. Attendance register for the staff, record for the enrolled children, weight and MUAC, Growth Charts, Malnutrition indices, raw material registers were being poorly maintained at the AWC. Plotting of Growth Charts was not been properly done. Food quality at the time of visit was good. The weighing machines were almost new and with new plates, toys and accessories.

Comments

The entire scenario looked like it has been recently done in haste. The team believed that all the records were freshly made. The glaring lacunas were there, despite of this particular AWC being in lime light. The inappropriate record keeping speaks in itself.

The process of early identification of SAM kids, their timely referral and follow up of the kids who have received NRC care was totally missing. There was no concept for pre-school education. The authorities and the AW staff was putting the entire blame on the poor health seeking behavior of the community. However, the villagers were strongly denying the fact and were reacting to this cooked up situation. On direct interaction with the kids, they had mixed reactions, most of them admitting the irregularity, apathy and discrimination at AWC.



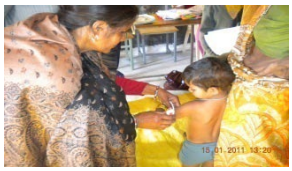
About the Beneficiaries

There were *approx.* 8-10 kids with pot bellies and wasted limbs but not falling in Grade III or Grade IV. Overall referral process from the AWC is a major stumbling block. 3 children were found with physical deformities including inability to listen and speak. This particular child was

not allowed for schooling and no attempt has ever been made by the AWW to refer him to the higher centre and to bring him to the main stream. District Administration in last few months has arranged 2-3 health camps in this particular village and had identified six SAM kids and has referred them to the NRC, Pohri.

Comments

The functioning of the AWC, the health monitoring system, its food distribution system and its results were far below the desired level. The AWWs have a very myopic view. Kids with other problems and physical handicaps were totally neglected. The motivation level of the AWH and the Supervisor was very low. It was functioning more as a food distribution centre.





Overall Comments

Regarding reported deaths of 4 children with malnutrition, the team personally interacted with the 3 parents. All the three reported of one or the other illness as a preceding cause of death. They were also admitted to the CHC but they died within a week of discharge from CHC. AW Supervisor blamed the non- cooperation from the families as the main cause.

While interacting with the children and their parents of the village, the team was told that all this has been arranged in a hush and after the frequent visits of the dignitaries. The villager's version seems to be true. As all the accessories arranged were either new or very sparingly used. Overall satisfaction level of the children and the services provided at the AWC was not good.

At Jarian Kalan

Demographic profile

Children between the age group of 6mths – 3 yrs	:	73
Children between the age group of 3- 6 yrs	:	76
Total no. of Pregnant Women	:	5
Total no. of Lactating Women	:	11

About Infrastructure

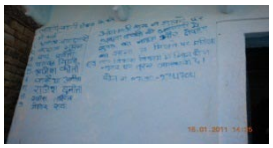
This AWC was also easily approachable and accessible to the community. The building was a *pucca* building and rented. General hygiene of the premises appeared to be good. Non- availability of fresh water in the premises and no measures were being taken for water purification. There was no toilet facility in the premises. Cleanliness of the kitchen appears to be good. Food was served in the plates brought by the children and were clean. The AWC was having adequate space for the storage of the food material. Space for the outdoor activity was enough for the children.

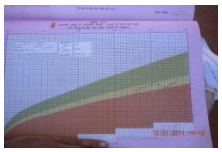
AWW is qualified upto 8th class. Personal hygiene of the AWW appeared to be clean and the children were fairly clean. AWC was also approachable to the AWW and was at the distance of maximum 1 *km*. In the absence of AWW, the AWH runs the AWC. She was having good knowledge about plotting of Growth Charts. She was also assisting the PHC staff in immunization, health check ups, antenatal and post natal check ups. She was also assisting in the *Kishori Shakti Yojana,* organizing the health camps, supporting in the Pulse Polio Programme, organizing supplementary nutrition feeding for the children (0-6 yrs) and expectant and nursing mothers, assisting in the implementation of Nutrition Programme for the children and Pre-school education to the children were being provided at this AWC.

Administration and AWW have put in their efforts for the record keeping, maintenance of hygiene and overall status of the AWC. The food is cooked at the kitchen which was not very far of the place. No extra efforts are to be made to call the children to the AWC. The children comes by their own after hearing the bell in the morning at 09:00. Referral to NRC found to be very weak. At least 5 girls with dipping growth chart line were found in record and many more at the borderline for which no action has yet been taken.

Comments

In sharp contrast to Nahargada this AWC was managed in a proper way with well maintained records. While interacting with the children, parents and the villagers, the response was good for this particular AWC and the AWW. They seem to be satisfied with the services provided by her. However, the factor of early identification and timely referral was missing.

At Dangebarbe

Demographic Profile

Total no. of children	:	150
Children between the age group of 6 mths- 3 yrs	:	57
Children between the age group of 3-6 yrs	:	78
Total no. of Pregnant Women	:	8
Total no. of Lactating Women	:	18

The situation at Dangebarbe appeared to be deplorable.This AWC was easy to approach and accessible. The building was rented. Source of drinking water was handpump and the well. AWW stays very close to the AWC. She was of Adivasi community. She appeared to be fairly clean. Being illiterate she was dependent on other Supervisors for filling of the records and despite of administration knowing this fact, we were not informed of any remedial measures intended so far. AWW was not been able to recall and understands the important nutritional concepts and basic information required for the functioning of Angawandi systems. Immunization status of the children was very poor. Freshness appeared in the records. Only one time training on the nutrition was been attended several years ago by the AWW and they were rarely been involved in any capacity building initiatives. Size of the AWC was not sufficient for the total number of the children.

Comments

Ill kept food ration, unhygienic surroundings, poor health status of the children, illiterate AWW, very poor record maintenance, weak referrals to NRCs, no follow ups, total absence of involvement was clearly visible. Contradictory responses appeared between males and females regarding the distribution of the nutritious food at the AWC. The male population denying of the proper distribution of the food while the females accepting the regular distribution of the food at the AWC.

At Zakhnore

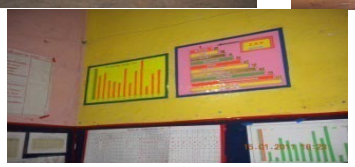
This village has not been investigated physically, but the records were called and investigated. Again the distressful situation was noted in the maintenance of the records, basic concepts of plotting of the graphs, nutritional aspects, referral systems *etc.* on the part of AWW.

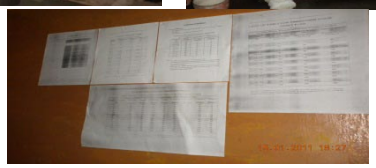
Nutrition Rehabilitation Centre at Pohri Block

The NRC was 10 bedded. Surroundings and premises of the NRC was clean. This NRC was having one Nutrition cum Counselor, one cook and 2 helpers. Infrastructure at the NRC was good. The records of patient register, counseling sheets, monthly report of children admitted to NRC, dietary history sheets, monthly reporting formats, follow up charts appeared to be genuine. Records and dedicated work done at NRC Pohri by the team especially by the Food Counselor was admirable. This NRC was also maintaining hygiene and sanitation in and around the premises. The centre was organizing Health Camps after the interval of six months.









It has been reported that many a times the children in the category of SAM are refused or postponed admission to NRC due to unavailability of bed which is believed to be a lost opportunity. Such cases should always be referred to other NRC under supervision.

Comments

The overall impression and service provided at the NRC was good because of the proper maintenance of the records, feeding system, cleanliness of the area, the counseling provided to the affected children. But the high LAMA and Premature discharge rate of the SAM children was alarming.

Nutrition Rehabilitation Centre No. 1 and 2, Shivpuri

This centre was running with the association of Mangalam, Shivpuri. The main feature which came out was high dropout rate. The combined rate of drop outs, non responders and deaths was more than 35% from Jan. to May, 2010 and no attempt has ever been made to locate these lost children. There are the kids who are more at the risk of die, if left untreated. Administration should do something to track them down and respond accordingly at all NRCs. There are 3 kids with HIV positive parents. No effort has been done to refer the children and to diagnose their status of HIV which should be done at the earliest. 45.4% and 30.9% of the children were the defaulters at the NRC No. 1 and 2 from Jan. – May, 2010 respectively.

Comments

More efforts are required in letter and spirit to be made by the Administration in trying to resolve this issue after it came to light. Laps were found in the maintenance of the records, building, other infrastructure. Apathy of the food distributing lady was obvious. The system of transferring to PHC for treatment of associated ailments was not very effective. The high LAMA and Premature discharges and irregular follow ups plagues this NRC also. No efforts for identification of other ailments was being made at the NRC.

Conclusion

The Integrated Child Development Scheme is predominantly dependent upon the efficient delivery of the services by the AWW. They are the key persons and peripheral health service providers. Her involvement, education level, dedication, motivation is important for the smooth functioning of the entire system. Out of 4 AWCs visited 3 were found to be grossly lacking in providing the desired ICDS services to the beneficiaries.

AWWs and AWHs were blaming the community's social taboos, higher work load, meager salaries, poor promotional avenues and lack of reorientation courses for suboptimal functioning of the AWs. Some of them were found to be critical of the existing system of promotion of AWW who have worked for more than 10 years, despite providing appropriate services to the supervisor's satisfaction.

There is a system of point grading for the appointment of AWWs, but because of the unavailability of the desired level of AWW at every village, the entire ICDS programme suffers.

Enroute to Gwalior team had a chance to interact with 2 AWWs at Mohana village who were working for more than 20 yrs and were post graduates but because of domestic reasons could not appear in the promotional exams and hence were deprived of being supervisors, extreme demotivation was seen in them regarding the existing system.

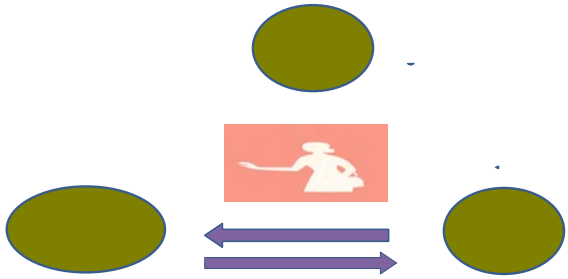
The AWCs were running from places which are inadequate to house the total no. of children. Food storage, food distribution, regularity of AWC, quality of water, methods for filtering water/ chlorination, pre-school education and health records was not satisfactory.

Inadequate charting of growth on the growth card and poor record maintenance is responsible for very low referral rate of malnourished children to the NRC. There is also a concern that children with falling parameters are not detected in time because of the NRC criteria that the kids with MUAC less than 115 mm can only be referred to NRC. The early fall in parameters even if detected are never intervened, so the vital stage of intervention is lost.

AWCs besides providing food should also facilitate early detection and referral of disabled kids and kids with other medical problems and should work on the principal of high index of suspicion only then the entire purpose of ICDS will be solved.

Even when the SAM kids are detected, the families are not adequately counseled for admission in **NRC.** There was no data to suggest that families have ever been advised for NRC admission except for verbal assurance.

Because of the late referral or no referral to NRC, SAM is quite prevalent in this area. There is no system of tracking the kids who have either left NRC or have not attended the follow ups. These are the kids who are more likely to fall again in the clutches of malnutrition.



Main reasons stated for not attending NRC were job days lost, family pressure, poor health seeking behavior, lack of knowledge regarding- malnutrition, possible outcomes, large family sizes *etc.* However, the increasing number of admissions in NRC suggests that if persuaded well most of the children can be successfully referred at NRC where the support system is in place.

District Administration was aware of the situation and as a knee jerk reactions tries to hold the health checkups, camps in these areas without necessary follow up. This appeared to be a mere eye wash.

Effectiveness of food distribution was seen in the Take Home Ration. The provision of supplying of RTE food is more effective than serving hot cooked meal in terms of easy distribution and maintaining the quality of the food. However, the end utilization of RTE is always questionable.

On Verbal Autopsies and after interacting with the parents of the children who have died, it is difficult to assign malnutrition, as the sole cause of death. However, it cannot be denied that malnutrition must have played a significant role making the body more prone to the diseases or leading to the ultimate disaster. The overall health status of majority of the children was below average.

The issue of Malnutrition deaths at Nahargada village cannot be ignored as the statistics of malnutrition is not declining expectedly in this area. However, poor health seeking behavior should not become an excuse for not offering them appropriate services and care.

Enroute to Gwalior the team also interacted with the Chittoriya Adivasi community, tikula village at Gwalior district, Mohana Highway Road. This community is the follower of Maharana Pratap. The population of 111 people registered in the voters list out of 150 *approx*. Approx. 25- 30 families residing there and having second hand mini bus. Only 2-4 names were registered in the AWC and the AWC was on the other side of the road. No help has been provided to this

community in terms of the education by the AWW, as she hardly used to visit them. This community was staying in the tents. This community stays in this area for more than 6-8 months in a calendar year and migrates taking the whole family to associate them for work. The State Unit WCD has been requested to arrange for AWW and enroll the children in the nearby AWC.

Recommendations

Some simple solutions based on our discussions/observations with the community and the state authorities have made to explicit these recommendations to the concerned departments in power which are at the level of AWC/AWW, NRC and District Administration.

AWC

1. Immediate appointment of AWW at Nahargada village at the end of January, 2011. However, the AWW should be diligent, well trained and dedicated and should be in place within stipulated time frame and same may please be notified.
2. Good deed awards and competitions to be held for the AWWs at frequent regular intervals.
3. An appropriate human resource policy needs to be implemented to ensure promotional avenues for AWW.
4. Need of intervention for frequent refresher training courses for building the capacity of the AWWs and concepts in Nutrition. Also, on their roles and responsibilities in understanding of the reporting and linkage systems. Clear cut knowledge about the technical concepts of the nutrition, maintenance of the growth charts and records needs to be cleared to them.
5. Early detection of malnutrition cases and other illness should also be looked for on high index of suspicion and timely referral should be made.
6. Identification of the children with disabilities at the early stage in order to prevent the severity of the problem so as to bring them to the mainstream. AWW should also maintain a separate record of Disabled children and referral made.
7. Increase in the no. of supervisor visits to AWC. Record checking by the Supervisor should be mandatory.
8. For ensuring the health of the children the number of supervisors have to be increased.
9. Procurement of locally available food produced by village communities, women SHGs, mahila mandals or the most appropriate decentralized village forum and they should be made accountable for it.
10. Nutritious and carefully designed THR based on locally procured food both palatable and acceptable to the society should be provided as “supplementary nutrition” for children in this age group.
11. Process of transport of raw food material/ THR from the block to the AWCs should be made more friendly for the AWWs.
12. Adequate access to skilled counseling and support for early initiation of breastfeeding and exclusive breastfeeding.

13. Discrimination among children on the basis of caste or otherwise must always be avoidant and District Administration should act immediately on such issues by taking proper action.

14. AWCs which are having illiterate AWWs and cannot be replaced because of procedural issues, educated member of the village/Panchayat should be designated for the purpose of record maintenance along with the support of Supervisor.

NRC

1. HIV status of the children of parents found to be positive at the NRC No. 1 and 2, Shivpuri, must be confirmed and referred to the nearest ART centre, if found positive at the earliest.

2. Children in the category of SAM, discharged from NRC and lost to follow up, need to be traced and followed up. Otherwise their chances of reverting back to the same condition of SAM are acceptably higher.

3. NRC after the mandatory physical follow up of the discharged point should continue to maintain and obtain health record from AWC for another 4-6 months so as to prevent relapse.

4. Whenever there is fall in weight even if the child has not landed in SAM. NRC should intervene at AWC level to boost up the health.

5. Basic investigative and treatment facilities should be boosted at CHC/PHC level.

6. NRCs are again plagued with high drop outs and poor follow up. The system of follow up for 2 months, every fortnightly is practiced. But the kids recovering from SAM need extra nutritional care even after 14 days of the referral when they are just out of the category of SAM to prevent the relapse. Hence, adequate and different provisions should be made at the level of AAW to improvise the nutritional status of the children immediately after their discharge from NRC.

District Administration

1. Sahariya community are not to be treated as the only affected community from malnutrition. So, no discrimination is to be done in this context. Remedial measures are to be taken to improve the health status of all the affected children.

2. For monitoring of AWs falling under malnutrition affected area the model of SHP Gujarat can be considered in the District. A Pulse intensive Programme running for 2 months in a year including physical verification of all the AWCs can be undertaken.

   Resource planning including team members, Date of visit for a particular AWC should be done in advance.

   It should be a 3-5 days Programme in each AWCs.

   Day 1 should be for village tour, verification of records and other amenities and interaction with the villagers and beneficiaries.

Day 2 should be for Growth monitoring and health checkups and distribution of medicines along with the referrals

Day 3 should be for Group Discussions, imparting health and nutrition education, arranging competitions and prize distribution and awarding efficient AWW/AWH.

Resource mobilization of medical personnel's can be done from Government Hospitals, Recognized Medical practitioners. Medical colleges including interns and local medical councils and for further details SHP of Gujarat can be contacted as a reference.

3. Health Cards and AAY cards need to be issued to all the beneficiaries and adequate availability of fresh water supply for the villagers of all the communities needs to be ensured.
4. Issuance of Job cards and providing the jobs to all the beneficiaries who comes under MGNREGA.
5. Some official from the *panchayat* must monitor the training and functioning of AWW and the Supervisor by checking the records at the anganwadi and referrals to NRC.
6. Medicine kits and Pre-School kits should be procured locally. Monitoring and evaluation should also be carried out at the block and district level with the active involvement of PRIs.
7. ***List of all malnourished and severely malnourished children*** should be part of MIS system by putting the list of children on the department website.

Assurance from the Administration

1. District Administration assured of appointing the new AWW at Nahargada village, by the end of January, 2011.
2. Regular visits by supervisor and additional hand pumps for community.
3. Special Health Camps and New BMO has been advised to ensure regular medical services to Sahariya tribe and similar measures have been assured for other AWW.
4. Monitoring of the PDS, and to supply prescribed quantity of the ration to the beneficiaries.
5. Resolving of the problem of not delivering the Breakfast at the AWCs under Sanjha Chulha scheme due to the constraint in the timings of the school and AW timings differences in school and AWC timings.
6. Responses from the public are always be welcomed for filing the loopholes in the existing system. SHGs are also putting in their hard. They are working for the Nutrition purpose and benefitting the AWCs.
7. CEO Gram Panchayat said that the pilot project has been implemented with the support from UNICEF for Antenatal check ups. The pregnant mothers are being timely referred to the District Hospitals by Janani Express. Institutional delivery increased to 92%. Immunization is effectively being done. SNUs have been set up for inpatients and outpatients services. Training of ASHA workers is very effective at IMNCI. Set up of 2 NRCs at Shivpuri district are in process.
8. State government is in the process of implementing supply of fortified wheat flour in the district.

Abbreviations Used

NCPCR	National Commission for Protection of Child Rights
WCD	Women and Child Development
IIPH- D	Indian Institute of Public Health- Delhi
UNICEF	United Nations International Children's Emergency Fund.
SHP	School Health Programme
ICDS	Integrated Child Development Scheme
PDS	Public Distribution System
AAY	Antodaya Anna Yojana Scheme
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
RTE	Ready to Eat
NFHS	National Family Health Survey
NSS	National Sample Survey
THR	Take Home Ration
AW	Anganwadi
AWC	Anganwadi Centres
AWW	Anganwadi Worker
ASHA	Accredited Social Health Activists
AWH	Anganwadi Helper
PHC	Primary Health Centres
NRC	Nutrition Rehabilitation Centre
CHC	Child Health Centres
SHG	Self Help Group
SAM	Severely Acute Malnutrition
MUAC	Mid Upper Arm Circumference
LAMA	Left Against Medical Advice
PRI	Panchayati Raj Institutions
CEO	Chief Executive Officer
BMO	Block Medical Officer
SNU	Special Nutrition Unit
IMNCI	Integrated Management of Neonatal and Childhood Illness
HIV	Human Immunodeficiency Virus
MIS	Management Information System

****

Annexure - 1

Office of the Collector, Shivpuri (M.P.)

No... Shivpuri, Dated 13-01-2011

To,

Shri Lov Verma
Member Secretary
N.C.P.C.R. Delhi

Subject Visit of a team from N.C.P.C.R. for 14-16 Jan 2011
Ref: Later no 13014/19484/2010-11/comp/15494 Dated 03/01/2011.

Sir,

With reference to the above subject the under signed is ensuring the compliance of the suggestions given by N.H.R.C. A follow up programme is being ensured by all the concerned departments at Nehargudha and at other Aagan wadies of Saharia tribal situated in Scattered villages of Pohari block of District Shivpuri.

After my visit to Nehargudha, I have understood the problems and ensuring the follow up programme.

1- P.H.E

1. In Nehargudha Mazara, the total population of saharias is 500 and the department as per norms, is maintaining two hand pumps for 500 peoples.
2. There is no community well. The other two wells are of Shri Badami Yadav and Shri Harpal Yadav respectively. The Sodium Hypo chloride solution has been poured two times during rainy season.
3. One more hand pump has been recommended by the Department. It will be sanctioned very soon.

2- FOOD & SUPPLY

1. There are 43 Antyodaya Ration cards of Saharias in Nehargudha.
2. Prior to Dec-10, the wheat grain 33 kg and 34 kg was distributed but onwards Dec-10, now 35 kg wheat grain is distributed.
3. Rice quota is not allotted.
4. The salesman is directly related to Sarpanch and it is taken in to consideration. He will be removed very soon after completing the due formalities.
5. The enquiry was conducted regarding Bhalla and Rajveer. It is said that Bhalla alias Balla s/o Navlu is holding one A.A.Y. card but Rajveer has not even submitted the application for his Antyodaya card.

3- W.C.D.

1. In Nehargudha 127 children have been reported, registered. There are 22 children below average weight.

2. The children above 6 months to 6 yrs have been vaccinated. Health department organized three special camps.

3. The Aaganwadi workers have been already removed. The process of appointment is on; it will be completed by the end of January.

4. The Nehargudha Aaganwadi has been already shifted to Govt. building.

5. The visits of supervisors are being ensured regularly.

Nov 10=> 2/11, 9/11, 16/11, 30/11

Dec 10=> 7/12, 14/12, 21/12, 25/12, 28/12

Jan 11=> 1/1, 3/1, 4/1, 11/1, 12/1

6. Aaganwadi workers will be posted very soon as process is completed.

7. Special package proposals for Saharias tribals have been submitted to Govt.

8. The NRC Pohari is now being run by BMO Pohari, which was run by one NGO.

9. The CDPO of Pohari has been asked to monitor the follow up programme to Saharias Aaganwadies regularly.

4- TRIBAL DEPT

1. Saharias Development Authority Shivpuri has identified the certain area where special attention is needed. These identified villages have been put under CCD plan, which will be run by one NGO called Gram Bharati Mahila Mandal.

5- C.E.O. ZP

1. The job cards are being hold by the family head of the saharia family. In Nehargudha one Pipalwala Nistar tank has been sanctioned and the work was run from 21st June, 2010 to 26th June, 2010 and 10th December 2010 to 15th December, 2010. The job card holders shared the work of Nistari tank in groups of 60, 32 and 92 respectively.

2. The information of work opened was put into the knowledge of villagers and who else ever have returned for work, the work has been provided.

3. Each and every job card was found in the hands of the head of family.

4. Fifteen families have been registered under Mazdoor Suraksha Yojana.

5. In Nehargudha three works were opened which are under progress and every day on an average 15-20 peoples are getting regular job.

6. In Nehargudha other than the Gram Van, one Nistari tank and one Kharanza work is opened. A community well has been also taken under MNREGA.

7. No complaint has been received till now against the corrupt practices of Sarpanch of the Panchayat. But even a proper enquiry will be conducted and it will be ensured that no Saharia family is being exploited by the Sarpanch of the village.

6- HEALTH DEPT.

1. Average 20 patients are being examined at PHC Pohari and sub centre Bairad.

2. ANM/MPW were asked to hold special camps in Nehargudha on 1st, 4th and 12th January 2011.

3. The vaccination to the children of Nehargudha was done on 30th March 2010, 1st November, 2010, 8th November, 2010, 3rd December, 2010 and 7th January 2011 respectively.

4. The medical officers along with Para-medical staff have organized the health camps at Nehargudha on following dates

Oct 10=> 8/10, 9/10, 10/10, 14/10,16/10, 25/10, 29/10 and 30/10
Nov 10=> 1/11
Dec 10=> 1/12, 4/12
Jan 11 => 12/1 and every first Friday of the month.

5. The Medical officer has been transferred and Dr. Vyas has been posted a new BMO Pohari to ensure the regular medical services to Saharias in Pohari Block of District Shivpuri.

Collector,
District Shivpuri MP

C.C TO,
(1) P.S. WCD Bhopal
(2) Commissioner, Helth, Bhopal.
(3) Commissioner Gwalior Division Gwalior.

for CEO Z.P
SHIVPURI (M.P)