SOCIAL ASSESSMENT
for
the IDA assisted ICDS-IV/Reform Project

Sponsored by DFID, India

Final Report

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Acronyms and Abbreviations

ANC	Antenatal care	NFHS	National Family Health Survey
ANM	Auxiliary Nurse Midwife	NGO	Non Governmental Organization
APERP	Andhra Pradesh Economic Restructuring Project	NHD	Nutrition and Health Day
ASCI	Administrative Staff College of India	NIPCCD	National Institute of Public Cooperation and Child Development
ASHA	Accredited Social Health Activist	NREGA	National Rural Employment Guarantee Act
AWC	Anganwadi Centre	NRHM	National Rural Health Mission
AWH	Anganwadi Helper	NSS	National Sample Survey
AWW	Anganwadi Worker	NSSO	National Sample Survey Organisation
BRGF	Backward Regions Grant Fund	OBC	Other Backward Caste
CBO	Community Based Organisation	PHC	Primary Health Centre
CDPO	Child Development Project Officer	PRI	Panchayati Raj Institution
CMO	Chief Medical Officer	PSE	Pre-school Education
CSO	Civil Society Organisation	RACHNA	Reproductive and Child Health and Nutrition Program
DFID	Department for International Development	SCs	Scheduled Castes
ECE	Early Childhood Education	SEWA	Self Employed Women’s Association
FGD	Focus Group Discussion	SHG	Self- Help Group
FOCUS	Focus on Children Under Six	SN	Supplementary Nutrition
GoI	Government of India	SNP	Supplementary Nutrition Programme
ICDS	Integrated Child Development Services	SSA	Sarva Shiksha Abhiyan
IDI	In-depth Interviews	STs	Scheduled Tribes
INHP	Integrated Nutrition and Health Project	THR	Take home ration
JSY	Janani Suraksha Yojna	TINP	Tamil Nadu Integrated Nutrition Programme
M&E	Monitoring and Evaluation	UoI	Union of India
MDM	Mid-day Meal	WB	World Bank
MWCD	Ministry of Women and Child Development	WCD	Women and Child Development
NAC	National Advisory Committee	WFP	World Food Programme

1 Summary

1.1 Background

PricewaterhouseCoopers and CARE India were assigned the task of conducting Social Assessment study by the UK Department for International Department (DFID) for the proposed International Development Association (IDA) assisted ICDS Reform/ICDS- IV Project of the Ministry of Women and Child Development, Govt. of India.

The main objectives of the social assessment study were to:

- Provide relevant social analysis and operationally relevant recommendations that promote equity and social inclusion in ICDS.
- Provide qualitative inputs for evaluation of the performance of the ICDS.
- Identify considerations that may impact the WB operational policies related to Social Safeguards.

Field data was collected in 32 villages across four states in India: Andhra Pradesh, Jharkhand, Rajasthan and Uttar Pradesh. Beneficiaries, state and local governments, community based organisations (CBOs) and civil society organisations (CSOs) were consulted. Special efforts were made to identify vulnerable groups including scheduled castes, scheduled tribes, backward classes and other ethnic or religious minority groups. Secondary qualitative and quantitative data over the last 5 to 7 years was collated through a desk review and was triangulated with the field data. The findings in our report are presented in the form of a national overview along with an analysis and a linked set of strategic recommendations.

1.2 Summary of Findings

The findings of the study are classified into three sections: Service provider's perspective on exclusion, community's perspective on exclusion and community's expectation of the ICDS.

1.2.1 Service provider's perspective on exclusion

Caste based discrimination by Anganwadi Workers (AWW) was observed. The findings included evidence of:

- Caste based discrimination in provision of services.
- Self exclusion based on caste by the community.
- AWWs belonging to one caste group not visiting the homes of women belonging to other caste groups.
- A reduced participation and attendance of children belonging to disadvantaged groups due to differential attitudes of AWWs and AWHs from higher caste groups.

The AWWs reported that they faced the following challenges when dealing with the communities:

- Lack of cooperation from the community, attributed to their low levels of education and awareness and a rigid belief system.
- Poor help seeking behaviour of the community and their dependence on the AWW to provide a door-step service.
- Lack of support of the community to support the AWC with essential material resources that they have at their disposal.

It was observed that the following factors influence the motivation of the AWWs:

- Perception that they are underpaid and are also overburdened with so much work that they have inadequate time to complete all the tasks assigned to them in time.
- Evidence that the AWW's involvement in other government programmes impacts her work in the ICDS services.

According to the Service providers lack of cooperation and coordination existed with other departments such as the Department of Health and Family Welfare (DoHFW) resulting in:

- Poor convergence with the DoHFW because of poor planning at the district level.
- Poor follow-up of cases referred to by the AWW to the ANM/ PHC.
- Competition for financial incentives for referrals among the ANMs, ASHAs, AWWs and TBAs.

The findings on supervision include:

- Poor supportive supervision for AWWs from Supervisors (for quality service delivery).
- No assessment on the access of vulnerable groups to ICDS services.
- Lack of targeted interventions to deserving groups like malnourished mothers and children.
- Insufficient supervisors due to vacancies and their limited mobility in the field.
- Absence of a Management Information System to monitor the progress of the ICDS services.

Service delivery mechanism at Anganwadi Centre (AWC) includes:

- Evidence of untimely release of funds for the procurement of food therefore excluding certain groups from access to food.
- Insufficient budget for supplementary nutrition due to rising costs of food resulting in poor quality food distributed and to limited number of beneficiaries.

Issues of training include:

- Perception that AWWs needed more refresher trainings.
- Training institutes for lower and middle level functionaries are seriously deficient in resources like manpower.

- Uptake of ICDS services will improve if communities are trained to understand their entitlements and the challenges of service provision.
- Training for AWWs lack key components such as counselling methods, building community participation and consensus building etc.

The findings on the role of Anganwadi Helpers (AWHs) include:

- AWHs from the same village are much more proactive in ensuring that information about the ICDS services reaches the community.
- Evidence of some discrimination against lower caste group children if the AWH belongs to a higher caste group.

The findings on the role of the Accredited Social Health Activist (ASHA) include:

- A lack of clarity of roles between the AWW, AWH and ASHA even though there was evidence that the three functionaries work closely with each other.
- The ASHA being responsible for filling important service delivery gaps in the ICDS services because of her close proximity to the communities.

1.2.2 Community's perspective of ICDS Services

Our findings cover the communities' perception on AWWs, the role of Panchayats and specific findings on the six ICDS services.

The community's perceptions of the AWWs include that:

- Marginalised communities perceived that upper caste AWWs were callous towards their complaints related to access.
- Communities distrust the AWW because she is a political appointee and she is often untrained to provide the ICDS services.
- Low caste beneficiaries have reported the high-handed and callousness of high-caste AWWs towards their problems.
- In UP and Jharkhand, there is a strong community perception that AWWs are corrupt.
- AWWs have a poor understanding of health and nutrition concepts and are unable to provide effective counselling to communities.

The communities' perceptions on the role of Panchayats in ICDS include:

- Criticism on the caste and power dynamics that impact the appointment of the AWW and affect ICDS service delivery.
- The need for the democratization of AWW selection and AWC location selection keeping in mind excluded groups to improve their access.
- The perception that Panchayats need to monitor the AWC.

Detailed findings on the six ICDS services including those on the AWC are discussed below.

Findings on the AWC include:

- The farther the AWC is from the home of the beneficiary the less it is accessed by them.
- Temporary migrant families cannot access AWCs.
- AWC based in the homes of AWWs of a particular caste are generally poorly accessed by women and children of other castes.
- AWCs located in religious places affect access by other groups.
- Escort services improve the access of young children to AWCs. Physical and social barriers like open wells and hostility and violence compromise access.
- Poor infrastructure of the AWC deters parents from sending their children.
- Urban centres are marginally better accessed by vulnerable groups.

Findings on immunisation include:

- Awareness of immunisation is high in communities but there is little knowledge of the diseases prevented by vaccination.
- Evidence that the immunisation programme has been a successful example of effective convergence between Department of Women and Child Development (DoWCD) and the DoHFW.
- Self exclusion from Muslim communities from receiving vaccinations due to their belief system.
- Exclusion of poor migrant families from receiving timely immunisation.
- Evidence in UP of shortage of vaccines and disposable syringes hampering service delivery.

Findings on supplementary nutrition (SN) include:

- Poor understanding of malnourishment.
- Poor access to SN by SC and ST communities. Muslims access SN the least among religious groups.
- Migration of poor families in search of employment excludes them from regular SN.
- Universalisation of ICDS is difficult because SN is not sufficient to cover all the beneficiaries in a village.
- Mothers-in-law are important influencers of mothers and their children in accessing the SN service.
- No evidence of identification of malnourished children. Further, there are no special interventions or health referrals undertaken for such children.

Findings on preschool education include:

- Poor access to preschool education where distance of the AWC from the beneficiary group is large.
- Poor attendance, retention and tracking of children especially girl children.

- Perception that the quality of education in the AWC is poor.
- Evidence that younger children accompany their older siblings that attend government schools.
- Perception that AWWs are inadequately trained to teach and engage young children.
- Evidence that poor infrastructure of the AWCs, erratic timings of the AWC and location of ECE in the houses of the AWWs negatively affects the access of children to the AWC especially SC and ST children.

Findings on Growth monitoring, health and nutrition education, health check-ups and referral services include:

- Evidence that growth promotion of children below 3 years is not consistently undertaken. This adversely affects the targeting of specific activities aimed at malnourished children.
- Grading of children is rarely communicated to mothers during the Nutrition and Health Days and advice on health and nutrition is not provided.
- Limited evidence of health-education and health referral services happening at the field level.
- Evidence that AWWs devote insufficient time to outreach services.

1.2.3 Community's expectations of ICDS Services

The communities had the following expectations from the ICDS:

- Regular, improved quality and equal amounts of SN should be provided to all beneficiaries including adolescent girls.
- That the amount of food they are entitled to should be publicly available information.
- Take home rations should be delivered to the homes of those who cannot come to the AWC.
- Demand for a wider variety of cooked foods to break the monotony of SN.
- Timings of the AWC should be fixed and that an AWH escort for children should be provided.
- Suggestions that AWW should make regular home-visits and use attractive IEC material.
- Counselling during NHD should be improved and that there should be a better health referral service.
- Increased community based monitoring of ICDS services.
- Better quality teaching in the AWC and a stimulating learning environment for children.
- Well equipped AWCs and AWC 'outposts' in remote habitations.

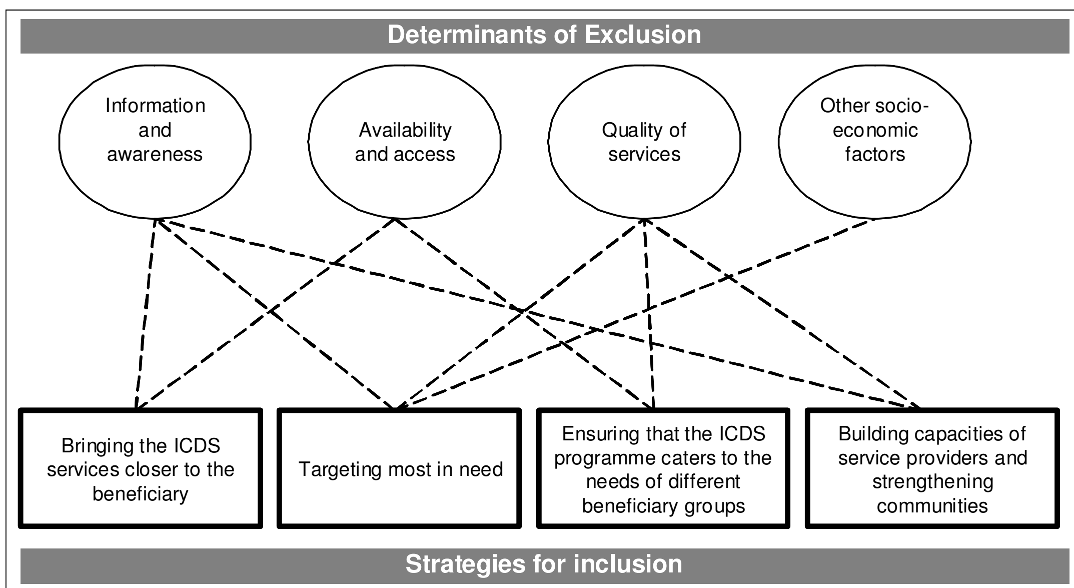
1.3 Analysis and Recommendations

Our analysis of the findings from our field research and additional desk based research concluded that there are 4 keys determinants of exclusion in ICDS services.

- **Availability and access of ICDS services:** This refers to: physical access to the AWC with respect to distance and timing; social accessibility (e.g. non religious buildings); eligibility for services (e.g. migrant workers); and availability of resources (e.g. SN).
- **Information and awareness of ICDS services:** This refers to: insufficient awareness of benefit of ICDS services; lack of information on timings of service provision and entitlements; and traditional beliefs which influence health seeking behaviour.
- **Quality of ICDS services:** This refers to the fact that poor quality of the six services deters communities from accessing them.
- **Other socio- economic factors:** This refers to: Caste dynamics (e.g. caste based discrimination or inter-caste rivalry); exclusion of girl child; and self exclusion due to religious or traditional beliefs.

Recommendations based on how exclusion can be addressed in ICDS have been developed based on these 4 determinants of exclusion. Addressing the issues social exclusion coupled with improved quality in ICDS can potentially have a significant impact on the reach and impact of the programme.

The diagram below maps how the determinants of exclusion are addressed by the 4 strategies identified in this report to improve inclusion in ICDS.



The 4 strategies and associated detailed recommendations to address inclusion and social equity in ICDS are detailed below. They have been developed bearing in mind the ICDS IV/Reform principles. Please note these are presented for consideration

only and implementation will depend on local contexts. The main report classifies these between ‘quick wins’ and longer term recommendations.

1.3.1 Strategy 1 - Bringing the ICDS services closer to the beneficiary

The recommendations in this section aim to improve the reach of services and access to ICDS.

- Introduce a home planner for AWW to record important service delivery milestones.
- Provide crèche facilities for vulnerable working women’s children.
- Establish Mini – AWCs in remote habitations.
- Temporary access to ICDS services for migrant families.
- Outsource ICDS through PPPs.
- Commission special outreach workers, especially from marginalised communities to maximise outreach to vulnerable groups.
- Encourage AWWs to contextualise messages to local traditions and customs to improve the community’s participation.
- Establish mobile training teams to conduct refresher training for field staff for both AWWs and ASHAs.
- Mandatory institution of the NHD in each AWC.

1.3.2 Strategy 2- Targeting those most in need

These recommendations are based on identifying the most vulnerable groups and providing specific interventions with the ICDS for them.

- Conduct social mapping exercises to ensure that the AWW, AWH and ASHA have a complete understanding of all beneficiary groups and their needs.
- Create a comprehensive complaint and grievance redressal mechanism for marginalised groups.
- Consider a conditional cash-transfer and financial incentive mechanism within the ICDS.
- Use print and electronic media more effectively to improve awareness of the ICDS services.
- Institute social audits by the Panchayat as a community based monitoring system within the ICDS.
- Strengthen the existing Management Information System to collect and analyse disaggregated data on the progress of women and children from different social groups.

1.3.3 Strategy 3: Ensuring that ICDS caters to the needs of different beneficiary groups

These set of recommendations focus on addressing discriminatory factors like caste, religion and gender.

- Secure independent buildings for AWCs.
- Seek the help of religious leaders to improve the immunisation uptake by their communities.
- Effectively use the NREGS to build AWCs and involve communities in their upkeep and maintenance.
- Give special emphasis to the participation of the girl child by educating communities and involving CBOs and NGOs to address gender based discrimination.
- Form adolescent girls groups and involve them in delivering targeted interventions for girl children.
- Establish 'Beacon' AWCs to act as 'role-models' for other centres.
- Develop IEC material specific to secondary care-givers in order to influence health and nutrition seeking behaviours of eligible women and children.
- Undertake Geographical Information Systems (GIS) mapping within regions to identify AWCs and beneficiaries (especially vulnerable groups). This will help to plan interventions, deploy manpower and monitor progress of beneficiary groups.
- Create nutritional rehabilitation facilities for children suffering from Grade 3/4 malnourishment.

1.3.4 Strategy 4 - Building capacities of service providers and strengthening communities

The recommendations here are aimed towards the training of functionaries and improving transparency and accountability.

- Establish a special innovation fund to create opportunities for communities to foster inclusion.
- Train AWHs and build her capacity to convey key messages and motivate the community to access the services.
- Establish Open Black Boards based on the RTI principles to display service delivery milestones of the AWC and to provide contact information of the redressal officer.
- Involve Panchayats to fund infrastructure improvements.
- Train service providers on issues of exclusion and the rights of marginalised groups.
- Enlist SHGs to monitor and facilitate certain ICDS services in the AWC.

2 Introduction

2.1 Background

Combating child and maternal malnutrition and mortality are two key Millennium Development Goals (MDGs), and its reduction will contribute to achieving the remaining MDGs. The Integrated Child Development Services (ICDS) Program has been India's primary response to the challenge of breaking the vicious cycle of malnutrition and impaired development among children. It aims to address both the Nutrition and the ECE aspects through an integrated program. It was launched as a Centrally Sponsored Scheme (CSS) in 1975 in 33 development blocks and currently covers 5,829 development blocks through about 850,000 village level *anganwadi* centers. The program reportedly covers 58 million children below 6 years of age and 12 million pregnant and lactating mothers[1].

After the closure of the ICDS-III/WCD Project, the Government of India (GOI) has expressed an interest in having the World Bank continue to support the ICDS program. In this context, the Ministry of Woman and Child Development (MWCD), of the Government of India and the World Bank are in the process of preparing a new project for IDA financing, the ICDS Reform/ICDS-IV Project. The project would span the period 2008/09 to 2012/13. To strengthen the design and implementation of the proposed project by providing relevant social analysis that promotes equity and social inclusion at all levels of the program, a Social Assessment study has been planned with support from DFID. The study focuses on identifying community needs, practices and preferences, and problems currently being experienced with the ICDS program. This would help determine what the project must do to effectively reach out to the socially and economically disadvantaged sections of the community to meet their nutrition, health, and pre school goals.

The Social Assessment exercise will enable the improved effectiveness of ICDS through a Rights Based Approach. It will provide an understanding of how to achieve equity in outcomes with a key focus on utilisation of quality services by Scheduled castes (SCs), Scheduled tribes (STs), minorities especially Muslims, the economically backward and other groups. It will provide recommendations to deliver accountable and responsive services to the poorest and the most vulnerable children and women, who are often excluded.

The key findings of the social assessment will help the GoI and eight selected State Governments design Project Implementation Plans (PIPs) by addressing issues of outreach to the excluded and most vulnerable. The results will also feed into the M & E component of the Central and State Project Implementation Plans (PIPs) enabling monitoring of outcomes on the social dimensions of the project. The Social Assessment focuses on the most pertinent issues and come up with operationally relevant recommendations.

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[1] ICDS QPR 31 March 2007

PricewaterhouseCoopers and CARE India were assigned the task of conducting Social Assessment study by the UK Department for International Department (DFID) for Ministry of Women and Child Development, Government of India.

2.2 Objectives of the Study

The specific objectives of the study are:

- To strengthen the design and implementation process of the proposed project by providing relevant social analysis and operationally relevant recommendations that promote equity and social inclusion.

- To suggest steps for institutionalising effective use of social appraisals at the national and state level implementation processes.

- To suggest concrete strategies to ensure operational relevance of the recommendations made through the social assessment.

- To provide necessary qualitative inputs for evaluation of the performance of the ICDS with regard to health and nutrition improvements, changes in the perceptions of the service providers and the beneficiaries of the scheme, their access to services, changes in the attitudes, needs, behaviours, knowledge & practices of the community in general and the excluded groups in particular.

- To ensure compliance of the ICDS Reforms project with applicable World Bank Operational Policies related to Social Safeguards (OP 4.10 on Indigenous Peoples and OP 4.12 on Involuntary Resettlement).

2.3 Study Methodology

The study was conducted in four states: Andhra Pradesh, Jharkhand, Rajasthan and Uttar Pradesh. The data was collected from key stakeholders including mothers with children from 0 to 3 and 3 to 6 age groups, mother-in-laws, fathers, state and local government, community based organisations (CBOs) and civil society organisations (CSOs). Special efforts were also made to identify vulnerable groups susceptible to exclusion including scheduled castes, scheduled tribes, backward classes and other ethnic or religious minority groups.

A team of investigators led by a Supervisor and Team Leader was constituted in each state for data collection, consolidation and documenting information through focus groups and in-depth interviews.

Two high-burden districts [2]were selected for the study from each of the four states out of 8 identified States under ICDS-IV. The selection was based on the criteria that one of the districts would represent the overall ICDS coverage and the second would provide specific insights into the more excluded communities within the state. Further, one block and two sectors were selected from each chosen district. Data collection covered the household at the community level/AWC level, functionaries at

[2] A mapping study was undertaken which ranked India's 548 districts[2] on a composite index based on two parameters: Weight-for-Age: (-2SD) for children below six years of age, and Anaemia level among pregnant women of age 15-44 years:(Moderate = 5-7.9 gm/dl of haemoglobin level).The data was drawn from the nationwide survey (District level household survey-DLHS; RCH 2002-04). The worst 200 districts were identified through this mapping exercise and States were ranked on the basis of the number of districts in the "worst 200 list" that fell within their boundaries. 145 districts from these 200 worse-off districts from seven States with the highest number of high-burden districts were selected for the ICDS-IV project.

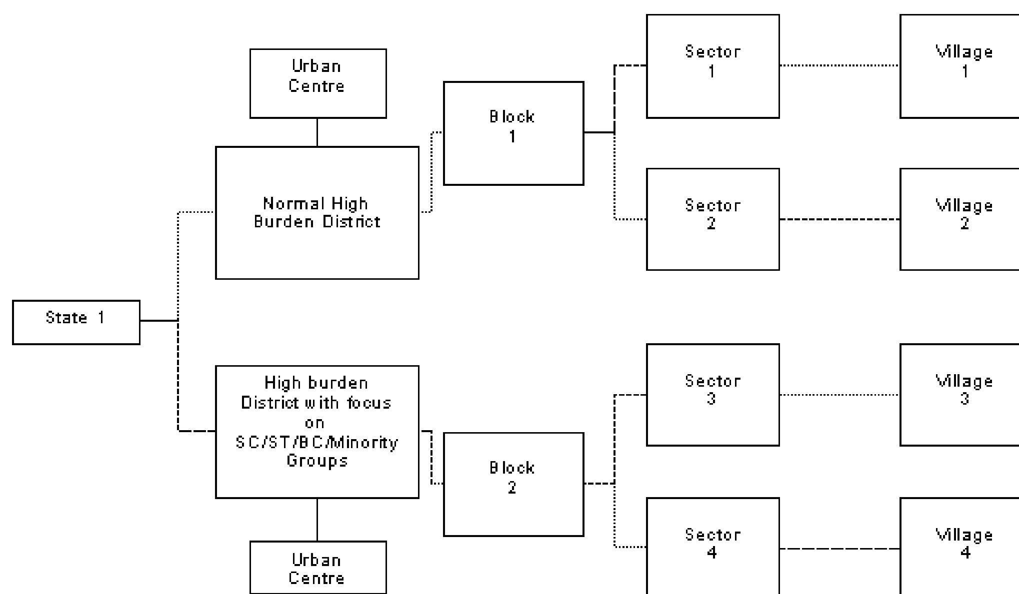
the Sector and block level, including supervisors, CDPOs, BDOs, MOs and other key officials.

2.3.1 Sampling Method and Sample size

Purposive sampling technique was employed to understand social exclusion among Scheduled Castes, Scheduled Tribes, Other Backward Castes and minority groups. From each of the four sampled states two high burden districts were selected. One was randomly picked having a heterogeneous population and the other district was purposively selected with a concentration of Scheduled Castes, Scheduled Tribes, Other Backward Classes and minorities.

One block was selected from each of these districts from each block two sectors were studied with at least one sector having a high concentration of villages with SC, ST, OBC or other minority population. A single village from each sector was studied for the social assessment study. In addition, for each district, one urban ICDS centre was also studied to understand the implemented mechanism in these areas and to draw comparisons with their rural counterparts. Figure below gives a diagrammatic view of the sampling methodology taken up in the study.

Figure: State sampling methodology



Data was collected from beneficiaries, decision makers and service providers. For the purpose of the study, all those stakeholders at the local level who directly benefited from the services and those decision makers at the local level who influenced the uptake of the services were studied. The key informants at this level included mothers of children from 0-3 and 3-6 age groups, their husbands and mother-in-laws, community based organisations (e.g. self help groups) civil society organisations (CSOs) and Panchayats. Besides the community's perception, the study also captured institutional and other systemic issues underpinning the programme. However, given the limited timeframe and resources, the scope of the study was limited to understanding field level service delivery issues and the challenges it posed. Key informants therefore included AWWs and ANMs. However to correlate issues of convergence, monitoring and motivation, Supervisors, CDPOs, Medical Officers and Block Development Officers were also consulted. A conscious

effort was made to interview as many beneficiaries as possible from marginalised and vulnerable groups in every village. Some beneficiaries from the general population were also interviewed to understand their perspective and provide a useful comparison of perspectives.

A major portion of the data collection depended on the use of focus group discussions with the different segments of the community and key stakeholders at the community level, in-depth interviews were also conducted with mothers and other key informants within the village. At different levels of enquiry (i.e. the district, the block, village and urban centres) various mix of tools were used with different segments as appropriate, which included:

- Focus Group Discussions (FGD).
- In-depth Interviews (IDI).
- Desk reviews including examination of public records.
- Systematic observation of services including free-listing.

The tables below give the sampling details of the four states. The geographic details related to districts where the study was conducted is shown in Table 1. Table 2 gives the description of sample size at the community level and Table 3 describes the sample size at the service provider's level.

Table 1: Geographic Sampling Details

State	District	Block	District	Block
	1		2	
Andhra Pradesh	Mahabubagar	Achampeta	Kadapa	Rayachoti
Jharkhand	West Singbhum	Sonua	Dhanbad	Gobindpur
Rajasthan	Udaipur	Kherwara	Jhunjhunu	Bhuhana
Uttar Pradesh	Allahabad	Kaurihar	Hardoi	Ahirohi

Table 2: Community Sampling Details

	SC	ST	OBC	Religious Minorities	General
Andhra Pradesh					
Mothers	16	10	13	5	
Grandmothers	7	3	4	1	
Fathers	10	3	5	1	
Jharkhand					
Mothers	3	11	10	15	3
Grandmothers	1	4	7	10	0
Fathers	2	6	9	4	4
Rajasthan					
Mothers	15	10	10	3	6
Grandmothers	6	4	1	0	9
Fathers	4	3	5	0	8
Uttar Pradesh					
Mothers	12	0	6	5	9
Grandmothers	6	0	5	1	4

Fathers	5	0	6	2	3

Table 3: Sampling Details of Service Providers

Service Providers	Description	Nos.
Traditional Birth Attendant	1 per village for 4 villages	4
Anganwadi Worker	1 per centre for 4 centres in 4 villages	4
Auxiliary Nurse and Midwife	1 per centre for 4 centres in 4 villages	4
Lady Health Visitor	1 per block in 2 blocks	2
Medical Officer in Charge	1 per block in 2 blocks	2
Child Development Project Officer	1 per block in 2 blocks	2
Supervisor	1 per block in 2 blocks	2
Block Development Officer	1 per block in 2 blocks	2
District Programme Officer	1 per district in 2 districts	2
Chief Medical Officer	1 per district in 2 districts	2
District Collector/Magistrate	1 per district in 2 districts	2

2.3.2 Desk Review

A Desk review was simultaneously undertaken to compile and collate the key findings related to issues of social exclusion and community perceptions of the ICDS from the main studies, reports and evaluation documents of the ICDS over the last seven years.

2.3.3 Data Analysis

The data collected from the states and desk based reviews were analysed for similarities and differences to gain deeper insights into the dynamics that are at work within the different geographical scenarios.

2.4 Study Context

The Social Assessment study was informed by the experiences from other studies and a number of developments in the policy and programme environment. Prior to the study an extensive programme analysis was undertaken based on primary and secondary available information along with review of existing policies and programmes. Presented below is a brief overview of the problem analysis that contributed to the design of the social assessment study.

Problem Analysis

Using information from various sources, problems relevant to the programme were analyzed under following two broad heads: issues related to child nutritional status on India and access and utilization of ICDS services.

2.4.1 Child Nutrition Status in India

An analysis of the NFHS-2 data by HNP discussion paper (Gragnolati et al, 2005) revealed that the underweight rates were much higher among scheduled castes (53.2%) and scheduled tribes (56.2%) than the non-scheduled groups (44.1%.). Similarly the underweight rates were shown as high as 60% in the lowest quintile, but are also present in 33% of children in the wealthiest quintile. Gender differentials were also observed with girls exhibiting higher prevalence of underweight (48.9%), than boys (45.5%). Looking at the trend, widening disparity between various social

groups was observed. The rate of reduction in under-nutrition in the last decade (1992/93 to 1998/99) had been relatively slower among girls, children in lower wealth quintile groups and SC/ ST groups, than other social groups. It is dismal to note that the discriminatory outcome is stronger in the case of children facing severe under-nutrition in these social groups.

The Sachar committee report (GoI, 2006) based on NFHS-2 also showed disparities in nutritional status based on religion and caste. Muslim children showed the highest rates of stunting and those belonging to STs had the highest rate of underweight. The report also indicated regional differences with a clear differential status of Muslim children in northern region comprising of Jammu and Kashmir, Himachal Pradesh, Punjab, Haryana, and New Delhi and eastern region including, Bihar, Orissa, and Uttar Pradesh.

Figure 1: Child Nutrition based on religion (NFHS 3)

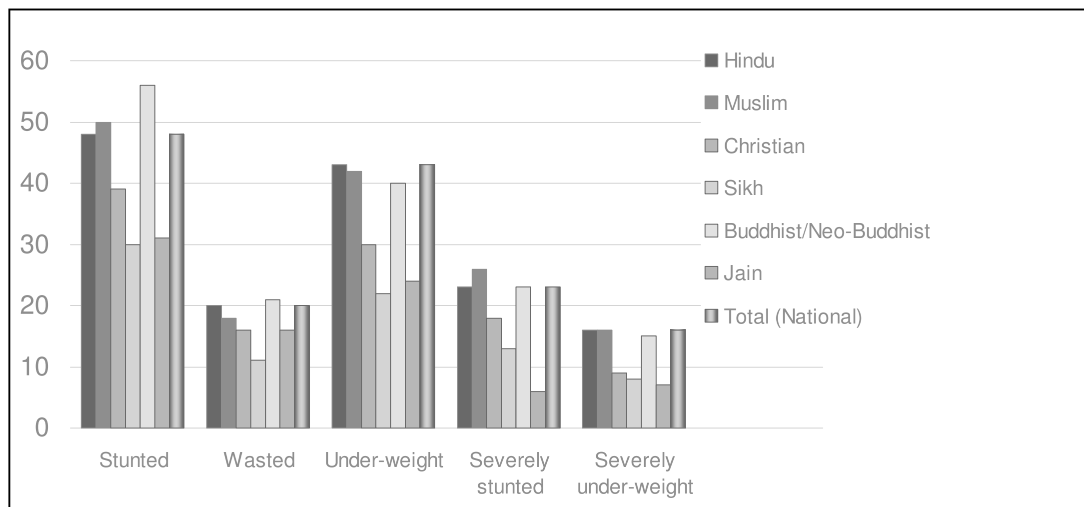
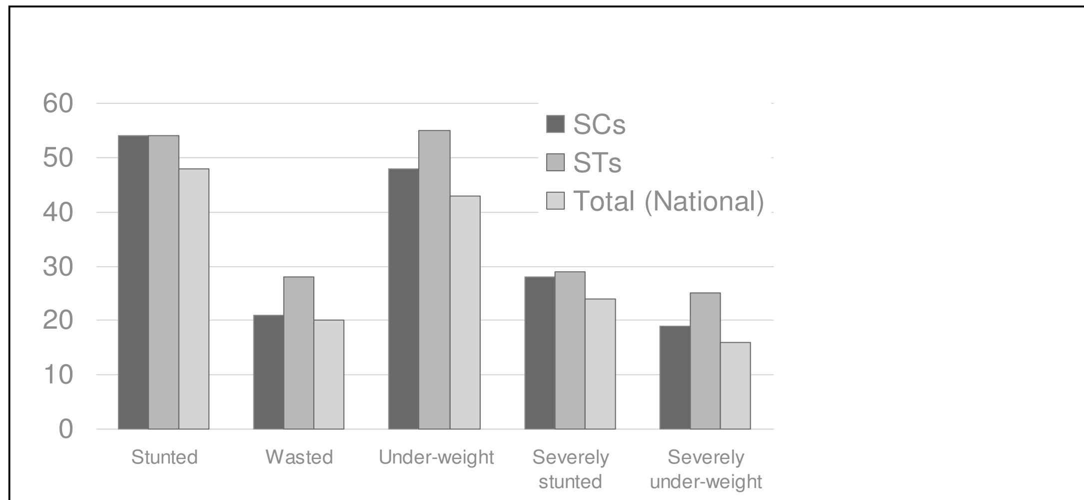


Figure 2: Child Nutrition based on Caste/Tribe (NFHS 3)



Comparison of nutritional status across various social groups between the two rounds of data between round 2 (1998-99) and round 3 (2005/06) of National Family

Health Survey indicated that stunting and wasting in children has worsened among ST, SC and OBC communities. Even though weight-for-age status has shown improvements between the two rounds, the extent of improvement among Scheduled Castes and Scheduled Tribes was much less and still continues to fall below country average of 43%. The infant mortality rate registered a significant decline from 146 per 1,000 live births in 1951 to 58 per 1000 births in 2004 (SRS 2006), but the progress during the last decade was not significant.

From the perspective of one of the major impact objectives of the ICDS is to improve the nutritional and health status of children in the age group of 0-6 years, a continued role and support is required in addressing the prevalent issues and finding out ways to fill these gaps. The Social Assessment study was thus conducted to find out such gaps in the community and service delivery system and thus inform the system about various mechanisms needed for effective service delivery.

2.4.2 Access and utilisation of ICDS Services

The NFHS 3 collected information on access to supplementary food, immunisation, health check-ups, preschool education, growth promotion of children (counselling service provided to mothers at different stages) and access to services by pregnant and lactating women in 29 states. It was found that SC and ST children and groups in the lower wealth index were able to access these services relatively greater than other groups. Key findings based on caste and wealth index were:

- While the coverage of children by an AWC is relatively high at 72% across India, only 32.9% of children between 0 to71 months had received any service from an AWC in the year preceding the survey. This proportion does not vary greatly by sex of the child, but generally the percentage of females attending is greater than males.

- Utilization of AWC services is higher in rural (35%) than in urban (23%) areas served by an AWC.

- 50% of scheduled-tribe and 36% scheduled-caste children received at least one of the ICDS services, compared with 28% from non – scheduled groups or other backward classes. Children of Muslim and Sikh communities received ICDS services the least amongst religious groups.

- 70% SC children and 56% ST children did not receive any supplementary nutrition from an AWC. This figure was significantly higher in children not belonging to any caste/tribe/group (77%). Muslim and Sikh communities received SN the least amongst religious groups.

- The highest proportions of children to have received vaccinations in the past 12 months from an AWC are Buddhist/Neo-Buddhist children (49%) and scheduled-tribe children (33%). Proportion of Muslim and Sikh communities who received any vaccination from an AWC was the least.

- 21% ST children had a health check up done at least once a month, compared with only 13% among SC-children and 10% of children not belonging to any caste/tribe/group. Muslim communities had a health check up done the least (7%).

- Among ST children, 21% approx were weighed at least once a month, compared with 13% SC-children and less than 10% other children. Muslim and Sikhs accessed this service the least.

A recent evaluation by NIPCCD showed that the largest proportion of beneficiaries were from backward castes (29.6%) followed by scheduled castes (26.3%), other castes (21.4%) and scheduled tribes (20.4%). Data from NFHS-III highlighted differential access of minority religious groups, wherein Muslim and Sikh communities accessed ICDS services significantly lesser than other religious group.

The graphs below illustrate the utilisation of ICDS services based on religion according to the NFHS 3:

Figure 3: Utilisation of ICDS services based on Religion (NFHS 3)

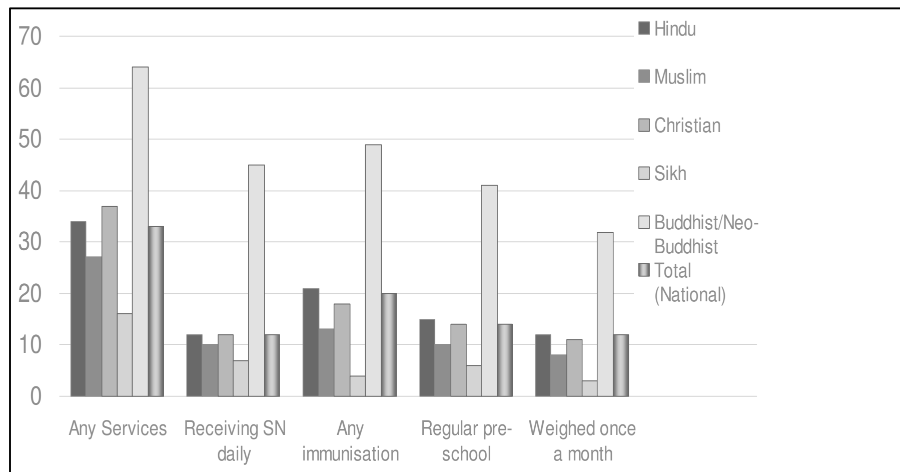
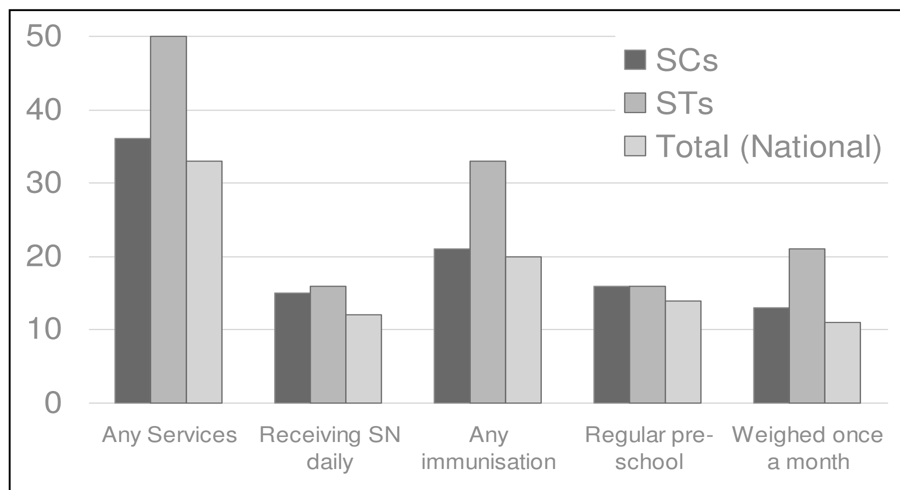


Figure 4: Utilisation of ICDS services based on Caste/Tribe (NFHS 3)



The NIPCCD study also showed that only 0.83% of the beneficiary children were disabled. Apart from these groups, children of migrant labour, urban slum dwellers

and urban homeless were not covered by ICDS (Supreme Court Appointed Food Commissioner's 6th report). Some of these groups such as disabled children, migrant labour and urban homeless are excluded at the policy level. The desk review could not find studies which suggest strategies for inclusion of these groups in ICDS. Similarly, as the exclusion of minority groups (NFHS-3) and urban slum dwellers (6th Report of Supreme Court Appointed Food Commissioners) is a recently recognized issue, studies discussing strategies, experiences and best practices to address the exclusion of these two groups are not available.

2.5 Health and Nutrition Profile of the sampled States for Social Assessment Study

Indicators for neonatal mortality, routine immunization coverage, and recognition and response to common childhood illnesses (diarrhoea and pneumonia) suggest that these areas need urgent attention. The table below summarizes key health and nutrition indicators for four ICDS IV states selected for the Social Assessment study. Mortality in most states is well above the all India average that is already unacceptably high. Malnutrition levels are likewise very high with over half the children suffering from malnutrition in all states except AP. Proven interventions are available in India, but coverage is very low and highly variable. While national policies exist to support many of these interventions, they are not systematically implemented in India. ICDS IV with its strategies aims to fill this gap by taking cues from other successful approaches of various other programmes.

Profile of selected four states and national averages (NFHS 3)

Indicator	India	AP	JH	RJ	UP
Infant Mortality rate	57	53.5	68.7	65.3	72.7
Weight-for age (% below –2 SD)	42.5	32.5	56.5	39.9	42.4
Neonatal Mortality Rate	39	40.3	48.6	43.9	47.6
DPT3 coverage %	55.3	61.4	40.3	38.7	30.0
Measles coverage %	58.8	69.4	48	42.7	37.5
Vitamin A coverage % (at least 1 dose in < 6 months)	21.0	21.4	23.3	13.2	7.3
Early Breastfeeding % (within 1 hour of birth)	23.4	22.4	10.9	13.3	7.2
Exclusive BF % (Children 0-3 months)	46.3	62.7	57.8	33.2	51.3
Complementary Feeding (% 6-9 m. who receive BF+CF)	55.8	63.7	65.3	38.7	45.5
Children with anemia (%)	79.2	79	77.7	79.6	85.1
Tetanus Toxoid coverage(% receiving ≥2)	76.3	85.3	67.6	65.2	64.5
Iron and Folic Acid coverage (% Received supply for 3+ months during pregnancy)	22.3	39.3	14.6	12.8	8.7

3 Findings of the Study

3.1 Introduction

The findings of the study are based on data collected and observations made during field visits to 2 districts each from the 4 selected states of Andhra Pradesh, Jharkhand, Rajasthan and Uttar Pradesh. Secondary data collection was also undertaken based on the desk review simultaneously, the details of which are presented in the next section.

The focus of these observations and recommendations has been on understanding the challenges of access of vulnerable and marginalised communities especially SC/STs/OBCs and other minority communities to the services provided under ICDS Scheme. These issues have been dealt at three levels:-

- Service providers perspective on exclusion
- Community's perspective of the ICDS
- Community's expectation of the ICDS services

Based on the findings, a set of recommendations has been proposed to address the challenges faced and gaps identified in the ICDS programme.

3.2 Service Providers Perspective on Exclusion

Anganwadi Workers (AWWs), Anganwadi Helpers (AWHs), Auxiliary Nurse and Midwives (ANMs) and Accredited Social Health Activists (ASHAs) were interviewed to gain useful insights about their perspective on exclusion within the community. Government health and nutrition programmes in India have near universal presence. Between the programs of the Ministry of Health and Family Welfare (i.e. RCH-II and National Rural Health Mission -NRHM and the ICDS program of the Ministry of Women and Child Development), their outreach extends to virtually every rural habitation in the country. There is at least one doctor for every thirty thousand people, two skilled multipurpose health workers for every three to five thousand, and an Anganwadi worker for every one thousand people.

The primary objective of these functionaries is to provide nutrition and health services at the grassroots level. Their perception of the various schemes, their interactions with the members of community and their relationship with the bureaucracy are important to the success of the delivery of these programmes - especially the ICDS. In this section both direct and indirect factors related to these workers especially AWWs, which impact the ICDS services are observed. Observations of other service providers who complement the AWW's role in service provision have also been made where necessary.

3.2.1 Caste based discrimination

Caste was found to be one of the major determining factors in service delivery. It was found that communities of one caste often excluded themselves from accessing the ICDS services if the AWW did not belong to their own caste. Outreach was also found to be severely affected in many places where the AWWs did not make home visits to women belonging to other caste groups.

Secondary data has noted that there is reduced participation of children belonging to disadvantaged groups due to differential attitudes of AWWs and AWHs from higher caste groups. The social exclusion in ICDS study by Harsh Mander (2006) ('*Social exclusion in ICDS: A sociological whodunit*?' CARE India) has found that the AWH did not collect children from the low caste hamlets, and often these children and their guardians were scared about how they would be treated by the AWW if they defecated or were naughty at the AWC, although parents of children from more advantaged backgrounds did not harbour such fears. Another 2004 report, *'Reflections on the ICDS'.* (Ramchandran, Vimla -2004) confirms this – where in two districts of Uttar Pradesh over 70% of AWWs were from the forward castes or the OBC community. Similarly the same study in Andhra Pradesh found that 74% AWWs from the sample AWWs were from non-scheduled groups.

Besides the obvious caste differential, language was seen as the other deterring factor for effective service delivery. The difference in language of the service provider and the community as evident especially in the tribal dominated areas in the study, affected effective communication of key messages.

Observation: Discrimination based on caste was observed as a common feature of the social relationships existing in the villages in Andhra Pradesh. In one of the villages of Mahabubnagar district, it was observed that the study team instead of being escorted by the AWH, within the community in the ward dominated by the Scheduled Caste, via a shorter route, was taken through a parallel longer route. When enquired it was found that she belonged to a lower caste and it was perceived socially unacceptable for her to walk through a higher caste neighbourhood.

3.2.2 AWW's perception of the community

Most communities consulted during the field study expressed distrust and anger towards the AWWs (as described later under the head 'community's perception'). Similar feelings were reciprocated by the AWWs who felt frustrated due to the lack of cooperation received from the community to the extent that despite best efforts, their advice on health and nutrition was mostly ignored. They attributed this to the low awareness levels and age-old beliefs and customs prevalent within the community that deter any positive behaviour change. This was especially true in respect of the poor and marginalised communities.

Few AWWs expressed lack of participation of the community members in the activities at the AWC... Some of the demands by the community such as delivering the supplementary nutrition to their homes, make the tasks of AWWs all the more difficult.

Even though the Government has made provisions for supplies of utensils, fuel and water connection for preparation of hot cooked food at the AWC, often shortages happen. Under such circumstances, many AWWs stated that no help was received either from the community members or from other influential people/PRI members in the village.

3.2.3 Motivation

District and block level officials pointed out lack of motivation among the AWWs was one of the key factors for their underperformance. Majority of the AWWs consulted lack motivation in delivering services because they feel overburdened with work,

underpaid and have too much to do in a limited time. They were of the opinion that their workload needs to be rationalized based on the population they cover and the distances they have to travel.

Even the AWWs who performed better felt less motivated to work harder because there was no system of financial incentives or recognition for their good work. A general dissatisfaction prevailed among the workers with the kind of honorarium they get. The District officials also felt that this leads to a tendency of malpractice, resulting in making money through dishonest and corrupt practices.

Many a times, the engagement of AWWs in other government programmes also over- burdened them. In Jharkhand, AWWs were expected to be involved in various development schemes, which also involved conducting time consuming surveys. As a result, her responsibilities especially awareness building and outreach services were affected. Due to lack of time, they also failed to cover habitations and clusters that are far away from the AWC.

3.2.4 Lack of coordination and co-operation with other departments

ICDS Scheme aims to improve nutritional and health status of children by providing a package of six services comprising of supplementary nutrition, ECE, nutrition and health education, immunization, health checkups and referral services. Out of these, immunisation, health check-ups and health referrals can only be delivered successfully if there is inter-departmental convergence between the Department of Health and Family Welfare, Department of Education (DoE) and Department of Women and Child Development (DoWCD). The departments have overlapping goals, yet complementary programming is a challenge. It was observed that in all the states efforts were made at both district and block levels to build convergence by organising joint monthly meetings of staff from all these departments. However limited coordination was observed at higher levels, thus affecting service delivery at the village level.

High motivation levels of functionaries both at the field level and at higher levels were found to be a key factor to successful implementation of the entire package of services. Also, ICDS supervisors, LHVs, and ‘helpers’ were found under-utilized resources and thus it was important to determine long-term motivation and support mechanisms for them. Strong leadership is important to keep the field workers motivated

In some states, initiatives have been taken by non-governmental organizations like CARE-India to constitute Block level Advisory Committees (the members of this committee include staff from the Health department, ICDS, ANMs, Cluster Coordinators, Lady Health Supervisors, CDPO and NGO organizers). These BLACs serve as a platform where various stakeholders meet to discuss issues and solutions to implementation challenges. While this has led to some impact, it is seen as a CARE initiative and there is a fear that with the withdrawal of CARE’s support, these meetings may be difficult to organise. In some states, the district officials were of the opinion that ICDS operates as a completely independent programme and that no effort is made to engage other stakeholders. The health and district administration officials felt that there is an urgent need to break this isolation of the ICDS and to integrate it to other district programmes.

Though limited coordination was observed at district and block levels, efforts of convergence were seen among the frontline workers. Synchronization of the distribution of supplementary nutrition from the AWC with antenatal care and immunization services provided by the ANM was promoted through the Nutrition and Health Days (NHDs) on a predetermined day of the month. This was found to be highly effective and once instituted; it had the potential of becoming the focal point in the village for involvement of local organizations, including women's and panchayat bodies, and conceivably for health awareness and education sessions. The NHD is based on a formal agreement between the ICDS and the health departments to ensure that the ANM's visit and the food distribution occurred on a a fixed day, fixed time and place.

Coordination with education department

Most of the AWWs felt an urgent need for better co-ordination with the Department of Education (DoE). Many 5 to 6 year olds eligible for attending the early childhood education at the AWC were seen attending primary government schools. The parents preferred sending them to private and government schools as they perceived that the quality of education imparted there was better than education provided in the AWC. They also expressed that children preferred the quality and variety of food provided in these schools under the Mid Day Meal (MDM) programme. Another problem faced by the AWWs was that often the older sibling took the younger one to the primary school as their parents did not want to leave the younger one unattended at the AWC. Parents who had to go out of their homes for economic reasons early in the morning found the AWC timings inconvenient if they had to accompany their child to the AWC.

Few AWWs suggested that the primary schools should not give admission to 5 to 6 year olds without the production of a graduation certificate from the AWC.

Coordination with the Health Department

In order to ensure effective service delivery at the field level for immunisation, health check-ups and referral services, both the AWWs and ANMs need to work in tandem. It was observed that wherever the relationship between the AWWs and the ANMs is strained, their performance was affected and both functionaries achieved less in terms of targeting and outreach. The problem is complicated because the two departments work with different lines of management. Under such circumstances both AWWs and ANMs do not feel obliged to cooperate with one another. Given the lack of coordination between the two departments, there are no external factors which force the two to work together despite their differences.

In Rajasthan it was found that the AWWs felt that they were asked to assist the ANM in what is clearly the ASHAs role. The AWWs however felt that since that was an additional responsibility, they should be financially rewarded.

Differences between the frontline workers were a common occurrence. A few ANMs reported that they did not receive adequate support from the AWWs. They felt that lack of dedication of AWW to outreach activities affected services like immunisation, health check-ups and referrals. The AWWs on the other hand reported that the referrals made by them to the PHC were either not attended to by the Medical Officers or by the ANM or that the quality of services was so poor that the referred women chose to access private healthcare services instead.

Often other government schemes were found to be affecting service delivery in ICDS. In Uttar Pradesh, it was found that AWWs, ANMs, ASHAs and even Traditional Birth Attendants competed for financial incentives under programmes like the Janani Suraksha Yojna (JSY) which provided financial incentives to the service providers who motivate women for institutional delivery and immunisation. This results in unavoidable conflict between these functionaries.

3.2.5 Supervision

It has been found that lack of supportive supervision by Supervisors/CDPOs was a major contributing factor leading to poor performance of the AWC. Monitoring and evaluation were arguably seen as the weakest links in the ICDS implementation. Besides monitoring of the performance of AWWs, no mechanism exists to find out the access to various services by vulnerable groups. Even the regular monitoring system fails to capture these nuances. It thus becomes difficult to judge the progress made or to know about the areas where the problems exist. There is no evidence of targeted programme delivery and no means of ensuring that malnourished children are effectively reached. Poor staffing and vacancies in the position of supervisors and also the large coverage area which each supervisor has to cover, limits the quality of her supervision. Her limited mobility, issues of her safety and the remoteness of habitations are the commonly cited reasons by supervisors because of which they are unable to perform field visits and conduct meetings at the field level with the AWWs. In Andhra Pradesh it was found that some AWWs who got promoted as Supervisors were perceived as less educated and capable as compared to those who were recruited directly as Grade I supervisors. The quality of supervision also differed among the two as Grade I supervisors were able to mentor and support the AWWs better than the latter.

AWWs across the study states have expressed that they receive very little support from the supervisors whom they describe as high- handed and incapable of offering practical advice. AWWs also stated that even when they approached supervisors to seek their advice on problems of accessibility by vulnerable groups, their problems were not addressed and the supervisors failed to give them any specific advice.

The lack of a robust MIS in many districts severely hampers the supervisor's ability to monitor progress. The Supervisors struggle to provide basic monitoring support to the AWW. They also have a poor understanding of how services are accessed in their operational area and there is no mechanism of collecting and using information excluded groups. In one of the interviews, the District Magistrate of Jhunjhunu stated *"the people that AWCs are currently reaching out to do not require them but the ones who require them do not have the courage and are unable to collectively demand AWC services. At present there is no evidence or mechanism in place to ensure that the ICDS reaches those who are marginalized in terms of caste, class, gender and geography"*.

3.2.6 Service Delivery Mechanism at AWCs

AWWs expressed that service delivery at the AWC is a challenging responsibility. Besides providing direct services to the beneficiaries, they are also responsible for the procurement and storage of SN. The two activities in which the AWW is involved in especially the ECE and provision of nutrition requires two separate skill sets, moreover, targeting of these activities also involves interaction with two different age

groups. Thus time management coupled with greater skill orientation to manage both is in itself a challenging task.

Where food procurement is decentralised to the AWC, AWWs are responsible for procuring raw food from the market and ensuring that it is cooked for the children attending pre-school. The un-timely-release of funds to buy food affects the quality, quantity and frequency of the feeding programme. The AWWs have to also ensure that fuel is available to prepare food. Procurement of grains and pulses is a cumbersome task and involves submission of bills, for which AWWs have to travel distances and this eats into their service delivery time.

AWWs have also expressed their dissatisfaction over the allocated budget which is sufficient only for 100 beneficiaries. They are forced to turn away some beneficiaries or reduce the quantity or quality of food given to each. This food management by the AWWs is often perceived by the community as being an act of corruption and dishonesty. It has a bearing on her credibility and influences her relationship with the community. Where pre-packed feed is supplied to the AWC, the AWWs are supposed to ensure timely indenting and collection of stocks from the block warehouse. Any delays in procurement may result in the expiration of the commodity and renders it unfit for consumption.

Despite the rise in costs of rice and pulses and universalization of ICDS, the government has yet not revised the allocated budget for supplementary nutrition. The quality of rice and pulses supplied to the beneficiaries forms part of the take home ration and is largely dependent on their availability in the market and their fluctuating price. In more open and transparent service delivery systems, it has been observed that, the community realises that the AWWs have to compromise on the quality of the food because the funds made available to them do not take into account the price of food in the market. However, some beneficiaries have expressed their dissatisfaction about the quantity of dry rations they received.

Overall the AWWs felt that the community was unaware of the challenges they had to face in managing resources at the AWC. Also, because of the poor awareness of their entitlements unreasonable demands are being made from the community members. For example few residents of the village demanded that the THR should be given to every member of the household.

Vacancies due to administrative problems of timely recruitment or at places where the centre covers more than 1,000 population, management of greater number of beneficiaries by single AWW pose a challenge. But with the current policy of gradual universalisation this is being addressed.

3.2.7 Training

An evaluation of the Udisha training project (2006-07) of the World Bank assisted ICDS III Project revealed that the training backlog of personnel had been cleared. The evaluation recommended that among the three sets of training – Induction, job training and refresher training, the refresher training needed more attention. This study found that AWWs who were promoted as Supervisors needed special refresher training so that they can provide better monitoring and evaluation support to the programme. A majority AWWs expressed that their educational status or the duration of their service had no bearing on the relevance of the training they received to the

operational mechanisms of their job responsibility. The Udisha report also indicated that the level of knowledge of the AWWs on growth monitoring, pre-school education and immunisation was quite low, yet this did not necessarily mean that the functions related to these services suffered.

The functionaries reported that the training improved their job performance but that this improvement was not uniform across all components of the ICDS services. Growth monitoring, health and nutrition education and community participation were the areas which still needed improvement. The evaluation report also mentioned the deficit in resources and manpower of training institutes for lower and middle level functionaries.

Field level workers expressed that though it was crucial to build the capacities of the service providers, it was equally important to create awareness among the beneficiaries and CBOs. Once this awareness is created, the communities through their CBOs would be empowered to understand their entitlements which would lead to better uptake of the ICDS services. This would also enable the creation of demand for services in the community and trigger off local mechanisms of accountability led by women's groups and local youth cells.

The AWWs and their supervisors also expressed that training was not sufficient enough for them to address the challenges of teaching young children. They found it difficult to actively engage children and reduce dropouts. Non- participation by parents in parent-teacher meetings at the AWCs was another problem faced by the AWWs. They expressed a desire to have interactive sessions with the parents of small children, to make them aware of the challenges they face in running the centres.

From the interviews with several service providers it was found that their training did not cover are a number of areas. These included:

- Counselling methods.
- Building community participation and consensus.
- Improving child education.
- Improving convergence between the DoHFW and the DoWCD functionaries in the field.
- Ways of addressing myths, misconceptions and traditional beliefs of communities that hinder service delivery; thus improving their health and nutrition seeking behaviour.
- Involving CBOs in the AWC activities.
- Leadership training.

3.2.8 Role of the Anganwadi Helper (AWH)

In all the states, the AWH was seen as an important resource to the AWC who was strongly connected to the community. In many states, where the position of AWW

was not filled, it was the helper who managed the centre. In many centres, she was seen collecting children, looking after them, cooking food for them and conducting pre-school activities. Since she belonged to the community, she was found to be much more proactive in providing information to the community about any change in AWC timings or in ensuring timely immunization schedule.

Even though most of the AWHs were found to be aged and illiterate, the community had high regard and appreciation for their role. However, wherever the helper was either economically sound or belonged to a higher caste, they were found to be uncooperative, did not clean up the centre or went to the houses of lower caste families (especially SCs) to get their children to the AWC.

3.2.9 Role of the Accredited Social Health Activist (ASHA)

In most of the States, NRHM has created a cadre of women voluntary health worker, - ASHAs at the village level, who would assist ANM and AWW. Despite a lack of clarity of roles between the AWW, the AWH and ASHA, there has been evidence that the three functionaries have worked together. Two of the four states studied demonstrated distribution of work related to the ICDS– the AWW was responsible for procuring rations, running the early childhood education and record keeping; the AWH is responsible for cleaning the centre, food preparation and feeding the children; the ASHA is expected to conduct at least 10 home visits every day, inform women about vaccination schedules and collect them on the day of immunisation and also helped in the promotion of institutional deliveries.

3.3 Community's Perspective of the ICDS Programme

In the study the community is defined as being a subset of the primary users of the ICDS services and their influencers (mothers, fathers and mothers-in law, panchayats and Community Based Organisations (CBOs).

3.3.1 Community perception of the AWWs

Most communities perceived the AWW as a government functionary and a political appointee who did not feel accountable to them in anyway. The AWWs did not consider it important to conduct home-visits and provide door-to-door counselling. They also felt no need for dissemination of information for awareness building about the ICDS services. The community also stated that in many instances, she visited only those homes which were closest or most easily accessible by her. In fact the community was of the view that she operated the centre according to her convenience. General distrust about her prevailed within the community. In UP and Jharkhand it was found that communities were of the opinion that AWWs were involved in mismanagement of funds and this perception was found to be very strong. In another case, one of the women members from the community in Pacheri Kalan (Rajasthan) when questioned on ways to improve AWC services, responded that "*When we do not know what goes on in the AWC and what services we are entitled to then how can we be expected to comment on the ways of improving them*?"

From the individual interviews and focus group discussions across states, caste based discrimination was also prevalent in the community. Marginalised communities reported that AWWs of upper caste were callous towards their complaints regarding ICDS services. When asked about how their children were treated in the AWC, no

mother belonging to any caste or social groups complained about the differential treatment given to their children by the AWWs. None of the beneficiaries from any group reported an up-front denial of services at the AWC.

When asked about ways of improving access to ICDS services, many mothers of Scheduled Caste community in a FGD in Kadapa district (AP) quoted that, *"Awareness and access to the ICDS services would be greatly enhanced if the AWW was from our own village and community. She would understand the problems faced by the women and children and ensure that information and services reach the community on time"*

Communities across states also felt that many AWWs were incompetent to provide the ICDS services and therefore did not feel the need to take her advice. This study as well as the secondary research also pointed towards the poor understanding of AWWs on health and nutrition concepts which affected counselling.

Most communities were unaware of any mechanism through which their grievances could be redressed. Many marginalized communities expressed their frustration about the lack of feedback mechanisms or systems to lodge complaints about the quality of CDS services provided to them. One such case came across the study team which visited Sadiapur (Hardoi); where a local woman told the team that when she lodged a complaint about the malpractice of AWWs in the AWC, she was badly beaten by the AWW's family members who belonged to a powerful family in the village.

Community based monitoring mechanisms were also sought as suitable solutions for increasing the AWWs accountability towards the community. Few communities had expressed disciplinary action against non-performing AWWs. They suggested that the responsibility of enforcing disciplinary action should be vested with the Gram Sabha.

3.3.2 The Role of Panchayats

Though the role of Panchayat in the functioning of the AWCs was acknowledged by majority of the district officials, AWWs and the communities, there was general feeling that over involvement of panchayats in some of their activities caused difficulties. There were certain processes where the functionaries desired not to engage the panchayat. One such process under strong criticism is the selection of the AWW. The common perception is that the selection of the AWW is a political process which is not indicative of the need of the community and more importantly not based on the competency of the candidate. The selection of AWW through the Panchayat also meant that when some other faction came into power, the AWW's work was obstructed due to political rivalry.

Across states many stakeholders felt the need to democratize the selection process of the AWW and appoint them on the basis of specific criterion. The district administration also felt that the community should be involved in her appraisal which should be based entirely on her performance. This would not only improve her accountability towards community but will also lead to her increased efficiency. .

While the role of the Panchayat in selection of AWW was debatable, a clear role for the Panchayat in monitoring of the activities at AWCs was considered desirable. It

was suggested that Panchayats as part of their responsibilities should also be provided training to supervise the functioning of the AWC. They should have an advisory and supportive role in the running of the centre to ensure that all groups belonging to their villages are covered and that none are excluded from ICDS services. The Panchayats in some parts of Andhra Pradesh have been found to be proactively involved in providing funds for the construction of AWCs and mini AWCs. One such case came up during the field work in Kalyanpur (UP). In one of the AWCs where the team visited, it was found that the AWC functioned from a room allotted in the primary school. The ration was stored and cooked in same room as a result it was not only unhygienic but also left very little space for ECE activities. The AWW requested the Panchayat to build a separate space where the food can be stored and cooked. She was promised by the Panchayat members that a separate kitchen would be constructed from a provision in their flexi-fund.

District health and ICDS officials have recommended that a special fund allocation should be made to train Panchayats on maternal and child health and nutrition issues. This coupled with the PRIs focus on other rural development issues will have a positive impact on health and nutrition indicators of their communities.

3.3.3 Infrastructure and Access to Anganwadi Centres

The AWC is the nerve-centre of the ICDS where health/nutrition and ECE activities are undertaken for mothers and children. Distance to the AWC is a major determining factor for beneficiaries to access the AWC services. Distance thus is an exclusion factor and a barrier among vulnerable groups like lower castes and tribal populations who live in habitations at the periphery of the village or far away from the AWC. It was observed that in all states there were many instances where the centre was established in locations which were generally more easily accessible to higher caste groups. It was found that wherever the services were perceived to benefit the community, the AWC was located in an area dominated by the upper castes. Wherever the ICDS services were not perceived to be important, the AWC was located in decrepit and derelict structures making it unsafe for the AWWs to travel and work there and for beneficiaries to access services. Under such circumstances the AWC was considered non-functional – which mean there were no service providers or beneficiaries to avail of the services. For example some of the Tribal families residing in forest areas in Mahabubnagar district of Andhra Pradesh quoted *“The AWW excludes 5 households from the forest colony from all ICDS services. We are neither visited by her and nor told about our entitlements”.*

Accessibility to services of the AWC was also affected by communal tensions within the community. The lower caste and minority groups expressed concern about sending girl children to far-off AWCs fearing any untoward incident occurring on the way. Poor infrastructure for example open wells in the village was also cited by some as a reason why they did not prefer sending their children to the AWC unaccompanied.

Observation: It was observed that both caste and location of the AWCs affected access to the ICDS services. In both districts of Uttar Pradesh, marginalised communities especially SCs faced exclusion. In Mubarakpur, which is a Muslim dominated village, the Pasi community could not avail the benefit of ICDS services because (1) their hamlet was located on the outskirts of the village far from the AWC

(2) due to ongoing rivalry between the two groups, families feared sending women and children (3) they belonged to a lower caste.

The need for proper AWC infrastructure with enough space, proper toilets and provisions for drinking water was expressed by everyone across the states. The AWC is a place where antenatal checkups are provided to pregnant women and ECE activities are conducted for children, it thus becomes essential to have enough space for the two groups. Most of the leased out structures provided by the local governments are cramped and ill designed to cater to the needs of the two groups. Wherever the AWC was located in the AWW's homes, caste politics, religious differences and lack of space were cited as major exclusionary factors. District level functionaries have indicated that local governments can contribute resources to those buildings where AWC activities can be undertaken especially in inaccessible habitations. In Andhra Pradesh, mini-centres have been established in habitations far away from AWCs which provide ICDS services to marginalised groups. These centres have been established with the help of assistance provided by Panchayats and Zilla Parishads from their funds.

Both qualitative and quantitative data indicate that infrastructure and the availability of toilets, cleanliness of the centre, drinking water and educational materials impact access to services at the AWC. Families are less likely to send their children for pre-school education to AWCs without basic facilities. They instead prefer sending them to either government schools or private schools where all these facilities are available and where they perceive their children can receive better education. Many parents complained that the AWCs functioned erratically. The centres did not start early enough as a result parents who needed to leave for the fields early could not drop their children to the centre. Often, the centres would shut down earlier than expected, which again left the parents worried about their child being left unattended.

The Panchayat plays a very important role in deciding the location of the AWW. In areas where the Panchayat is dominated by the upper castes, the centres are inevitably placed in locations that benefit them. In some places like in Andhra Pradesh, ICDS services are conducted within Hindu temple precincts, thus excluding or making it difficult for Muslims and Dalits to access these services.

From the field evidence it was found that urban centres across all four states were marginally better accessed by mothers and children than in rural AWCs. Their proximity to the AWC was probably a reason why access was perceived to be better. Most of the urban centres which were observed catered largely to socio-economically disadvantaged groups like slum dwellers and children of migrant labourers. Families from better socioeconomic status in urban areas did not prefer sending their children for pre-school education to the AWC. They instead chose to enrol them in private schools and nurseries. However, these groups did occasionally access the SNP and immunisation programmes from the centre. The Urban centres were found to have slightly better materials for pre-school education than their rural counterparts. Urban areas have a higher population density. This was cited to be the reason why AWCs there were found to be much more cramped and hygiene and cleanliness were observed to be a major cause of concern for the community.

Seasons too play an important role in determining who accesses the AWC and when. Harsh environmental conditions and difficult terrain affects the functioning of and

access to the AWC. Fewer women and children reported visiting the AWCs in the peak of summer. In some states, the AWC's pre-school remains closed because the class rooms are too hot and children have to walk back home in the scorching heat. During the monsoons, the poor structure of the building makes it difficult to keep the rain water out of the centre, resulting in closing down of these AWCs. The quality of dry rations and food packets stored in the AWC also suffers.

Secondary evidence studied points out that pre-school Dalit children did not go to the ICDS centre but instead accompanied their older siblings to school where there were Dalit teachers and informally shared their mid day meals. In these cases the distance of AWCs and schools was similar. This information also hints at the important service need of picking up and dropping the children at home by AWHs.

3.3.4 Access to ICDS services

Immunisation

The immunisation component of the ICDS package of services reported a high recall in all the states studied. The pulse polio campaign and its sessions have been able to create a significant impact on the psyche of the communities – for them immunisation is synonymous with pulse polio. They attributed the success of the polio campaign to the wide spread use of media. Even district and block level officials have commended the coverage of the immunisation component as being the best among all other ICDS services. Various reasons were cited for the success of the immunization programme. The District Immunization Officer of Kadapa district (AP) quoted *"good immunization coverage is achieved in the district by conducting the sessions in places where they will be accessed the most. In our district, we take the immunisation sessions not only to the AWCs, but to the PHCs and schools as well"*.

Though all sections of the community seemed aware of other immunisations like TT and other vaccinations, not many of them were able to describe what diseases these vaccines prevented. There is evidence that when knowledge of immunisation and its benefits are higher, the probability of seeking these services from private healthcare providers is also high because it is generally perceived that they use better quality vaccines and syringes. Separate vials and disposable syringes used by the private healthcare providers as opposed to the larger multi-dose vials and glass syringes are perceived by the community to be more desirable and effective.

The immunisation programme has been described as the best examples of inter-departmental convergence in most states. While the ANM plays an important role in the actual vaccination of women and children, the AWW and the ASHA played a crucial role in informing mothers and motivating them to access this service. In many states these three functionaries came together on a NHD in the village/AWC, schools, temples etc to provide fixed day services and especially immunisation. District officials commended the role of the ASHA worker in following up and motivating the mothers and stressed that her role needs to be strengthened especially where the AWCs are yet to be established.

Access to immunisation camps is largely determined by the information communities received of the timings of these sessions at the AWC or any other place on a NHD. It has been observed that SCs/STs and OBCs who lived far away from the centre were largely ill informed about the timings and thus could not access the services. Distance from the AWC also played a very important role in their access. When

immunisation sessions were held in the AWCs, only those women and children living closest to the AWC accessed these services. Immunisation sessions held in the habitations of these marginalised groups were well attended but the turn out of SC and ST women and children was poor in the main AWCs. Where immunisation sessions were held at the homes of AWWs, the caste of the AWW; her relationship with the ANM and the size of her dwelling also determined the access.

Caste and gender also played an important role in accessing immunization services. Muslims did not receive immunisations services because they thought it was against their religious beliefs and established set of practices. A woman interviewed in a village in Uttar Pradesh quoted that she *"does not see the use of immunising a girl child"* – indicating gender based discrimination and ignorance at the beneficiary level. Some respondents also expressed because of fear of pain from the immunisation they did not want to get the immunization done.

Migration is another excluding factor preventing the poor and marginalised who have to move away from their homes in search of employment from accessing immunisation services. These groups are usually the most ill informed about the sessions. District and block level functionaries have confessed that this highly mobile population has been difficult to track and monitor. In states where the health card which records immunisations received have been discontinued, it is suggested that they be revived and cards be handed over to migrant mothers so that they can access immunisation wherever they go.

In Jharkhand, there is evidence of shortage of supplies of vaccines and disposable syringes. Mothers were asked to pay for them and wherever mothers were not able to bear the cost of the disposable syringes, regular syringes often unsterilized were used.

Supplementary Nutrition

In the course of the field work, it was found that communities in general and the SC/ST and other vulnerable communities had a very poor understanding of concepts of nutritional status. Their knowledge was limited to the understanding that poor eating habits would lead to 'weakness'. Though the supplementary nutrition component is among the top two most accessed components of the ICDS services, the beneficiaries have a moderate understanding of their entitlements. They are not sure of the quantity of the food they are supposed to receive and how often. The desk review has found evidence that SC and ST groups have poorest access to the SNP .Dalit children have been reported to face exclusion on the counts of distance of the AWC from them, a preference for enrolling local/ closest living children over those who stay far away and feeding in an AWC based in the home of a high caste AWW. There is also secondary evidence that Muslims also access the SN the least among the religious groups. Migration of the poor in search of employment also excludes their women and children from accessing the SN.

It is worthwhile in this section to mention that the AWC is the service point from where all cooked meals are prepared and where dry rations and food packets are stored for the SNP component of the ICDS. Where food is cooked in the AWCs, improper ventilation, lack of sufficient space for cooking and unavailability of water for cooking and cleaning utensils are cited as common problems. In a few villages, it was noticed that the village head insisted that the dry rations be stored in their

houses and the meal prepared from their kitchens so that it would seem that they were responsible for the feeding of children and women and thus gain political mileage. This together with the cooking of food at the AWW's house has been largely perceived as excluding certain sections of the community who do not belong to same caste group as the AWW or the village leaders.

AWHs are the key functionaries responsible for the cooking and distribution of food to the children within the AWC. There is no evidence that children coming to the centres have been discriminated against where provision of hot cooked meals is concerned. Neither is there evidence that children have been segregated on the basis of the caste while feeding them.

AWWs are mandated and provisioned to provide SNP for a maximum of 100 beneficiaries per AWC. The change in quantity and quality of take home rations is perceived by the community as a measure of corruption of the AWW. There is evidence that beneficiaries who received dry THR of grain and pulses mix these with their household rations and these in turn were consumed by the entire family. In many states AWWs are challenged by the community and its leaders to provide SN to everyone who wants it. These unreasonable demands by the community lead to the AWW avoiding confrontation by staying absent.

There is no evidence of rationalization of the 100 beneficiary-norm at the district level where the number of beneficiaries in a certain village is clearly much higher. In such cases, the AWW follows a rotation policy of providing SN to alternating sets of beneficiaries every month. In other cases AWWs have adopted distribution of SN to those who they consider the most deserving and poor. The field study shows evidence that pregnant mothers and children from 0 to 3 years received better SN than lactating mothers, 3 to 6 year old children and adolescent girls. Across the states studied, it was observed that adolescent girls received SN the least among all other groups.

Mothers-in-law are the most important influencers of mothers and children accessing the SN service. In communities where the 'Indiamix' (a locally-produced, low-cost, micronutrient- fortified food) has been provided to mothers and children, mothers-in-law have complained about how this causes diarrhoea in young children and have dissuaded children under their care from eating this mixture. District and local functionaries have expressed how mothers in law should be educated about the benefits of the mix.

District and block level functionaries have also expressed that there is a need to improve the shelf life of the mix so that it can be utilised by the communities well before its expiry date. They also commented that it is not the food that causes diarrhoea in children but the poor hygiene and sanitation in the AWC and the failure to motivate children to eat with clean hands and from clean plates. Some communities have expressed the need that take home rations (THRs) and feed packets should be home delivered wherever possible because it was difficult for beneficiary women who were engaged in household chores and who worked in the field to visit the AWW everyday.

Pre-school Education

Access to pre-school education is found to be largely determined by the distance of the AWC from the beneficiary groups. Children who lived closer to the AWC attended the pre-school more frequently than children who stayed more than a distance of 1 km. As documented earlier in this section, the SC/ST groups lived farthest from the AWC. Distance to the AWC coupled with the availability of the AWH to help pick and drop children are the two important deciding factors considered by parents who desire to send their young children to the AWC. Where parents needed to go early to or far away for work, they citied the need for the AWH to pick up their children early and drop their children back home after they returned from work. There is evidence from the field that when this was not possible, these groups voluntarily excluded their children. Inevitably, these children have been from poor and marginalised groups.

In most of the AWCs visited as part of the study, parents of children attending pre-school complained about the poor quality of education imparted by the AWW. There is a general perception by parents in the community that the AWWs are not qualified enough or trained sufficiently to provide pre-school education to their children. According to them the teachers in the government and private schools are much more educated and trained than the AWW. Frequent absenteeism of the AWWs and the dependence on the illiterate AWHs to engage their children is also another reason why parents prefer to send their children to private ‘convent’ schools. They perceive that these private schools provide the following benefits over the AWC:

- Better facilities for teaching: more qualified teachers and good quality teaching material.
- Better infrastructure in terms of more spacious and cleaner classrooms, toilet facilities and the provision of safe drinking water.
- Provision of uniforms for children: lack of appropriate clothing especially for older girl children is a serious deterring factor why parents exclude their children from pre-school education.

In all the states studied, many families show preference for the male child over the female one and send the boys to AWC for pre-school education. There is also evidence that in certain districts, younger children are left in the care of their older siblings who attend government schools. The younger children are encouraged to attend school with these older children and share the midday meal with them. In many instances, the midday meal was perceived by the parents as being better than the irregular supply of SN.

Few parents in the Alwal urban centre, Andhra Pradesh stated that *“they like sending their children to the AWC because the teacher was very proactive in teaching new things to their children. She teaches the children in the centre the English alphabet and nursery rhymes. It is motivating to see our children speak a few sentences and sing songs in English”*

The poor infrastructure of the AWCs, erratic timings of the AWC and conducting of pre-school education in the houses of the AWWs all affect the enrolment of the children to the AWC especially from the SC and ST community. Often, children were marked as present by the AWWs even though they did not attend ECE. There were also examples of poor retention of children as AWWs were unable to hold the child’s

interest. In the absence of any tracking mechanism it became difficult to follow-up on dropout children especially girls

Observation: Problems were faced by those who were involved in agriculture or worked as labour. In Ramnagar many children did not go to the AWC for pre-school education. Being agriculturalists/labourers they were required to leave early in the morning making it difficult for them to send their children for ECE

Growth Promotion, Health and Nutrition Education and Health Check-ups and Referral Services

Growth promotion of children below 3 years is a severely neglected intervention within the ICDS. Mothers and functionaries in both urban and rural centres displayed ignorance on the growth grades of their children though urban mothers perceived that growth promotion was important in the care of the child. One of the most commonly cited reasons for poor growth -promotion are the absence of weighing scales in the AWC and the poor skills of the AWW to counsel the women. There is evidence however that even where weighing scales are available and functioning, many AWWs were unable to weigh and grade children properly due to lack of training.

In the absence of weighing scales and with the lack of understanding of malnourishment, children who falter in nutrition grades cannot be identified and thus counselling of such cases also suffers. There is a provision of double ration for these children, who fall in Grades III and IV, but since they cannot be identified due to reasons quoted above, they are deprived of double rations as well as proper counselling. In fact the Nutrition and Health Education sessions also lacked proper counselling and advice given to the mothers on such issues.

There is no strong evidence that nutrition and health education and referral services are delivered at the field level. This is attributed to the fact that AWWs have not devoted sufficient time to outreach services restricting their mobility to the AWC and back to their residences. AWWs depend highly on the ANM and ASHA worker to fulfil these roles.

3.3.5 Community's expectation of the six ICDS services

In the study along with community's perspective on ICDS services, they were also asked about their expectations of ICDS. They were questioned about their expectations especially in the light of minimizing exclusion and ensuring maximum access. They provided a wide range of suggestions on the various components of the ICDS services. These expectations have been tabulated below:-

ICDS Component	Community Expectations
Supplementary nutrition	▪ Regular distribution of SN. ▪ Increase in quantity of SN. ▪ All eligible beneficiaries including adolescent girls should be given SN. ▪ Home delivery of THR to working women and to those who cannot attend the NHD ▪ Standardisation in the measuring / weighing devices during distribution of THR. ▪ Greater variety in the cooked food provided to children to attract them

ICDS Component	Community Expectations
	to the AWC for pre-school education. ▪ Community should be made aware of their entitlements under the SN programme.
Pre-school education	▪ Regularise timings of the AWC. The timings should be displayed in a prominent place for the community. ▪ An escort service to pick up and drop children to the AWC should be provided. Ideally this should be the AWH. Pick up should be before parents leave for work and children should be dropped after parents get home. ▪ Improve the quality of teaching in ECE. Train the AWW to engage he children more effectively. ▪ Improve the environment of the AWW so that children can learn better and are motivated to stay. ▪ Provide playing toys for children in the AWC.
Nutrition & health education	▪ Improve and regularise home visits by the AWW. ▪ Use attractive dissemination and IEC materials to convey the messages effectively. ▪ Provide advice on health and nutrition to mothers during immunisation sessions and THR distribution. Focus key messages on pregnant women, lactating women and malnourished children.
Immunisation	▪ Create awareness on the different illnesses prevented by immunisation.
Capacity building	▪ Educate communities about their entitlements under the programme and train them to create a demand for the ICDS services.
Referral services	▪ Improve the AWWs capacity to coordinate with the health department to create an effective referral system. ▪ Create awareness among the community about the health referral services.
Service delivery	▪ Improve and regularise outreach activity in far-flung areas. ▪ Increase accountability of the AWW to the community instead of to local politicians. ▪ Improve monitoring and supervision of the AWW to stem corruption and ensure quality services. ▪ Build independent AWCs with basic facilities and create mini- AWCs in far-flung habitations. ▪ Increase involvement of CBOs in monitoring the AWCs.

Note: Many suggestions made by the community are documented here and are based on their understanding of their entitlements. However many of these demands are outside the scope of the ICDS programme and sometimes even untenable. While studying these recommendations, we suggest that the reader bear in mind that the sample size for this study was not representative of the coverage area of the ICDS scheme.

4 Alternative and Innovative Service Delivery Strategies in ICDS

Comprehensive details on some of the main innovations and alternative service delivery mechanisms that address social exclusion are included in Annex 3 of this report. The annex includes a brief overview of the impact of each of the approaches, the practices involved, the extent of impact on excluded groups and the corresponding sources of evidence. A summary of these initiatives are detailed below.

4.1 Innovative Service Delivery Strategies in ICDS

4.1.1 Andhra Pradesh Economic Restructuring Project (APERP).

The Andhra Pradesh experience of establishing Mother's committee in APERP project was positive. The programme was initiated in 1999 and finished by 2005 with coverage of around 11 million beneficiaries. Evaluation shows that it was successful in decreasing severe under nutrition from 2.9% to 2.1% and moderate malnutrition from 13.3% to 12.9%. An important role played by Mother's committee.

The formation of Mother's committee was initiated in 1998 and a social assessment carried out in 149 villages during 1999 showed non-functional or poor performing Mothers committee. The assessment found that Mother's committees were formed in hurry as less time was given to supervisors and the committees were formed more due to efforts of staff rather than participation of people.

However latter evidence showed that they turned out to be performing certain useful roles. Gragnolati et al (2005) shows that out of 50, 000 Mother's committee formed 40% were involved in ICDS work. Around 31% of surveyed mothers reported to have heard about its functioning. The awareness was quite higher in tribal areas (49%). Similarly, three-quarter of AWWs found that the functioning of Mother's committee as good and 11 % of AWW found it to be satisfactory. These mother's committees were originally involved in the civil works components of the World Bank-assisted ICDS I project - selecting construction sites for anganwadi centres, monitoring construction and releasing funds to cover construction costs. Latter the government added a range of new functions for mother's committee. "*The range of responsibilities of AWW today includes recruiting AWWs and AWHs, paying honoraria, community-based monitoring for AWCs*". This approach seems to be genuinely empowering, where the AWW manage many aspects of ICDS. This model of ICDS could be helpful in giving poor and marginalised women the control of monitoring the scheme.

4.1.2 CARE-RACHNA- Integrated Nutrition and Health Project

The $160 million Reproductive and Child Health, Nutrition and HIV/AIDS Programme (RACHNA) is CARE India's programme that consists of two projects. The first, the Integrated Nutrition and Health Project (INHP II) targeted pregnant and lactating women and children less than two years to improve child survival and nutritional status. Interventions include supplementation with food (using Title II food aid and local food), vitamin A, iron and folic acid, immunisation, antenatal care, and improved practices for safe delivery, newborn care, breastfeeding and complementary feeding. The project strives to provide an integrated delivery of packages that cross the ICDS

and RCH schemes and foster convergence between them. The programme works in 78 districts in nine states.

Mechanisms such as Nutrition and Health Days, Take-Home Food Rations, Change Agents (CA), Block Level Resource Mapping (BLRM) and Community-based monitoring systems (CBMS) helped address issues related to social exclusion in the target groups.

4.1.3 Tamil Nadu Integrated Nutrition Programme I and II

The project had a focused design to target biological vulnerable period for children. **TINP-I** (1980-89) followed a strategy of **restricting its scope of intervention to children under 36 months and pregnant and lactating mothers**. It managed to bring down the target group to approximately 30 pregnant and lactating women and 100 to 120 children. However only the severely and moderately undernourished children were targeted therefore the actual number of children and women needing the attention of the AWW became manageable. After a detailed and time consuming review process based on progress in weight gain (growth faltering criterion), on average 25 to 25 children in 0 to 3 age group and 9 to 12 pregnant and lactating women, were found to be eligible. These children and mothers were given short term supplementary nutrition and counselling for appropriate feeding practice.

In TINP-II, the programme was broadened to include children in 0 to 72 month age group while retaining the focus on children in 0-36 months and pregnant and lactating mothers. Here a two worker model was followed whereby one worker exclusively concentrated on the children between 0-36 months and pregnant and lactating mothers.

Evaluation studies of TINP-I show that during the programme period severe malnutrition declined by a third and a half among in 6-24 months old children and by about half among 6-60 months old children. However, moderate malnutrition decreased by 14% in the 1st project areas and increased in 2nd and 3rd phases.

There is no rigorous evaluation undertaken for TINP- II. However the independent survey data suggested a decline in severe malnutrition by about 44% over a five years period of TINP II.

The first strategy of TINP, i.e. targeting based on growth faltering has received support (see Final evaluation report of RACHNA) as well as wider criticism (see Goplan, 1982). However the two worker model which allows for concentrated efforts including outreach on children in 0-3 age group and pregnant and lactating women have received wider support (NAC recommendation on ICDS, (2004), Sinha, Dipa (2006). This was included in the recommendation of the Planning Commission's working commission's sub group on child nutrition but was not found in the final working group recommendations. The success of TINP is also ascribed to changes in behaviour of mothers' which had positive impact of children's health and nutritional status (WB, 1998).

4.1.4 World Bank assisted ICDS- III Project (1999-2006)

The World Bank assisted ICDS-III/WCD Project ended on March 31, 2006 after 6.5 years of implementation. The project was made effective in October 1999, in five States of Kerala, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. During

2002-03, the project was restructured to include the states of Madhya Pradesh, Bihar, Chhattisgarh, Jharkhand, Orissa and Uttaranchal. Some of the innovations in this programme that had a positive impact on the inclusion of socially excluded groups in the programme are:

- Biannual Child Health and Nutrition Months (Bal Swasthya Poshan Mah) in Uttar Pradesh.
- Adolescent Girls' Clubs in Kerala.
- Malnutrition Eradication campaigns in the Pune District of Maharashtra.
- Anganwadi Kala Jattha campaigns in Uttar Pradesh.
- *Poriawadi* implementation - mini-AWCs placed in villages with populations starting from 300 people helped to increase the access of tribal people.

Further details of these innovations are included in the appendix.

4.1.5 World Food Programme support to ICDS

Since 1963, WFP has provided approximately US$345 million to ICDS. In 2006 the ICDS under WFP was operational in 19 districts in Madhya Pradesh, Orissa, Rajasthan and Uttaranchal.

The major strategy included the provision of Indiamix to beneficiaries for 25 days a month, through THRs and on-site feeding. Pregnant women, lactating mothers and children between six months and three years received a double take-home ration (160 g. of Indiamix), in order to account for sharing at home, while children between three and six years received 80 g. of Indiamix in the form of a cooked mid-morning snack, six days a week.

Apart from Indiamix the following strategies were included in the programme with varying degrees of success:

- Adolescent girls were to be recruited as volunteers to deliver take-home rations, assisting in other efforts to improve outreach to targeted women and children, and to achieve identified programme objectives. Each volunteer received a monthly food ration of 10 kg in return for her assistance.
- Closer coordination and, eventually, joint programming with other agencies, donors and NGOs such as UNICEF, WHO, CIDA, CARE and UNFPA.
- Technical support provided to improve nutrition and health services, including NHED and health care, through partnership arrangements with district officials in the DoHFW.
- Teachers received training and material support aimed at improving the quality of pre-school teaching and learning in AWCs.
- Strategies for enhancing community participation and ownership devised and implemented.

- Uptake of micronutrient fortified blended food in the ICDS in Uttar Pradesh, Madhya Pradesh, Orissa, and Uttaranchal.

Evaluations of the programme recognized that social exclusion was a main barrier in performance of ICDS. In Madhya Pradesh and Rajasthan, one of the main reasons of ICDS having poor attendance was the frequent migration of ICDS beneficiaries' families. Follow-up of absent children by the evaluation team revealed that families had left for several days to work in distant fields. Without alternative care options or money to leave with relatives to cover food purchases, children accompanied their parents, and missed ICDS. The evaluations reasoned that the most food insecure households may have been excluded for reasons such as lack of awareness of the programme's existence or its benefits, distance from the centres, reluctance to join others of higher castes or social classes, etc.

4.1.6 Mitanin Programme

The experience of the Mitanin programme of Chhattisgarh provides some useful lessons in achieving convergence between ICDS and health system through the use of community volunteers. An interim internal evaluation with 1,200 Mitanins from 240 villages as respondents found good coordination between the health and ICDS. Mitanins reported that they were engaged in distribution of SNP (57 %); promoting child attendance (48 %); weighing children (45%); diagnosing malnutrition and counselling (36 %) and immunisation (46 %); (Mitanin Evaluation Report, State Health Resource Centre, July 2004, Quoted in Sudaraman, T, 2006).

Further the study found that the assistance was most critical in the hamlets without AWC. The main perquisite for the success of the programme was noted as careful selection of Mitanins based on community choice.

Other experiences, like that of Mitanin in Chhattisgarh show that community workers could be used effectively. In Chhattisgarh a Mitanin (community volunteer) in each hamlet is selected by the community, with approval of the Panchayat. More importance is placed on selection process with three-to six-month process of selection where the interests of the weaker sections within the community are facilitated by a trained 'prerak'.

Mitanins are trained for around 18 months including 18 days of camp-based training and 30 days of on the job training in the village. After this, support is provided in her work with close coordination with the ANM and AWW.

The crucial part of the programme is its attempt to maintain a balance between the twin role performed by Mitanin; (a) as a partner of AWW and ANM in provision of services and addressing the gap between them and (b) as a representative and community leader who monitors and demands accountability. This balance in the role is also considered an important motivating factor which gains respectability for the Mitanins (Sundarajan, T, 2006)

4.1.7 Dular strategy of UNICEF

The UNICEF supported Dular strategy is implemented in Bihar and Jharkhand covering 8 million people. Designed to complement ICDS and build upon its infrastructure, one of the major goals of the Dular strategy is to capitalize and develop community resources at the grassroots level. The emphasis of the Dular

strategy is to establishing a community-based tracking system of the health status of women and of children 0 to 36 months of age by neighbourhood-based local resource persons. Methods such as: group of community volunteers; tool for community level monitoring and counselling and village contact drives have been used. Evaluation of the project highlighted that the poor in Dular strategy performed better than poor in other areas, especially in feeding behaviour and cleanliness. They also indicate that programmatic overlays to the ICDS have the potential to transform into a cost-effective instrument for reducing child malnutrition in India, with implications for women and children in India.

4.1.8 Self Employed Women's Association (SEWA) Crèches

The experiences of SEWA in Gujarat highlights that providing crèche facilities and linking livelihood programmes with the ICDS increases the contact as well as participation of working women. SEWA started to set up crèche facilities due to the demand for child care from its members. It first developed crèche services and subsequently engaged with the State government in ICDS. The crèche facility and ICDS complemented each other well. Specific features of the crèche services operated by SEWA, include (a) engaging a paid crèche worker, (b) flexible timing according to the needs of the actual workers and (c) ownership and contribution from users for services provided by the crèche services. The RACHNA final evaluation also includes a recommendation on integrating micro finance activities with ICDS. Today such approaches would be useful for working with poor communities as suggested through the strategy of Day Care Centres (Sinha, Shantha 2006).

Further details on each of the above programmes including further information on best practices and the findings of programme evaluations can be found in Annex 3.

4.2 Approaches to address social exclusion in other government programmes

4.2.1 Lessons from Sarva Shiksha Abhiyan

Approach

The aim of Sarva Shiksha Abhiyan (SSA) is to ensure that by 2015 all children in India receive eight years of basic education of acceptable quality, regardless of sex, caste, creed, family income or location. SSA places special emphasis on vulnerable groups, earmarking funds for their specific needs. In SSA terminology the vulnerable groups are referred to as 'special focus groups' or 'SC/ST and minorities'. SSA also ensures that every child with special needs (CWSN), irrespective of the kind, category and degree of disability, is provided meaningful and quality education. Hence, SSA has adopted a zero rejection policy. This means that no child having special needs should be deprived of the right to education and should be taught in an environment, which is best, suited to his/her learning needs. SSA combines a dual thrust on enrolment and equity with an emphasis on quality.

Apart from filling human resource and infrastructure gaps, important strategies of SSA included promoting community ownership of school based interventions through effective decentralised involvement of women's groups, Village Education Committees (VECs) members and members of Panchayati Raj institutions. The programme envisages accountability to the community through cooperation between teachers, parents and PRIs. These mechanisms were expected to focus on the girl

child and special groups including, children from SC/ST, religious and linguistic minorities, disadvantaged groups and disabled children.

The SSA framework sought to institutionalize this in the planning process through participatory methods. Several State Governments have taken steps, through legislation, to empower mechanisms such as School Management Committees (SMCs), Parents Teachers Association (PTA), and VECs. These committees or associations should in turn monitor, among other things, the provisions made in SSA for vulnerable groups such as:

1. Free text books for girls, SC/ST students.
2. Special coaching/remedial classes for girls SC/ST children and a congenial learning environment.
3. Teacher's sensitisation programme to promote equitable learning opportunities.
4. Community engagement and ownership of the school.
5. Special focus for innovative projects related to girls' education, SC/ST children.
6. NPEGEL in blocks that have at least 5% SC/ST population and where SC/ST female literacy is below 10% in 1991 census.

Performance

Community based monitoring is gradually becoming the prime strategy in SSA. The interface of communities with PRIs is also developing, with at least 15 states showing various degrees of involvement, ranging from participation of PRIs in school monitoring to active participation in teacher recruitment, performance monitoring, and payment of salary (as in Nagaland and Kerala). A total of 23.8 lakh people have undergone community participation and supervision related training. The trend towards community participation bodes well for local ownership of schooling initiatives and the sustainability of community involvement.

A key theme of SSA is the involvement of communities in school management, including construction of all of the civil works supported by SSA through School management Committee (SMC) or the Village Education Committee (VEC).

While evaluation of the actual impact made by community level monitoring of the programme is still limited (Govinda, R. and Madhumita Bandyopadhyay, 2007), lessons suggest that focusing on backward area would benefit tribal groups, who are concentrated in these regions and not Dalits who are scattered and found in small and excluded hamlets in most villages (CAG, 2006). Similarly, the empowerment of members from vulnerable groups within the monitoring communities remains a major challenge.

Apart from community monitoring, SSA stresses on local flexibility in relaxing norms and promoting innovation. The local dynamics of exclusion would vary depending on the electoral equations, livelihood dependence and control over resources. One of the main recommendations of the review of SSA in 2006 promotes the greater use of Innovation Funds to boost the performance of first generation learners, especially SC and ST children and older girls. The innovation funds should be managed locally and

based on an analysis of the barriers faced by SC/ST children within the household, the community and in the school and the interplays among these (Department of Education, 2006).

4.2.2 Lessons from RCH-II Vulnerable action group plan

RCH-II since inception had clear goals to reach the vulnerable groups. It prepared a detailed programme implementation plan for vulnerable groups under RCH II (MOH/HFW, 2004) and recommended the state governments to modify and operationalising it to suit the local conditions.

The overall objective of the Vulnerable Plan was to:

- Improve their accessibility, availability and acceptability of health services, by (a) strengthening infrastructure (b) training and skill development of service providers, (c) improving supply of equipment, drugs etc in an integrated and participatory manner
- Bring vulnerable groups at par in this respect with rest of the population, and thus improving the aggregate indicators towards achieving the expected results set under RCH Phase II by the end of 2010.

Approach

The first step suggested for the states in this action plan was to identify the vulnerable group and strategies to prioritize these groups under RCH-II.

The state governments were to focus on (a) convergence of health activities with other departments such as water and sanitation. (b) Partnership with the Private. Sector and NGOs, (c) ensuring participation of elected representatives of Panchayati Raj Institutions in planning, implementation and monitoring at different levels and (d) forming committees at village, block and district level (involving Gram Pradhan, ANM, AWW, Link workers and two members of the Gram Sabha).

The state governments were also asked to prepare three separate specific plans for reaching (a) tribal population in notified tribal blocks, (b) Urban slum dwellers and (c) SC/ST and poor living in urban and rural areas (not covered by Urban and Tribal Projects).

Once the plan of action was implemented continuous monitoring of the progress in reaching vulnerable groups was made. In the first three years, process indicators were used to assess the performance of the states. In the later years of the Programme, output and outcome indicators will be used to show the benefits received by vulnerable communities.

Specific indicators for vulnerable groups were given to states for documenting as part of their Monitoring & Evaluation exercise at regular intervals. For technical assistance a National Health Resource Centre was established in New Delhi. The Centre also has a unit for promoting best practices in addressing the needs of the vulnerable, carry out needs analysis, design services and management and monitoring systems.

Performance of the Vulnerable Action Plan

There is very little information publicly available on the performance of these plans in their respective states. Joint reviews for three states, Chhattisgarh, Uttar Pradesh and Assam were reviewed; however these reviews are still focusing on process indicators infrastructure, manpower and other technical aspect of the plan.

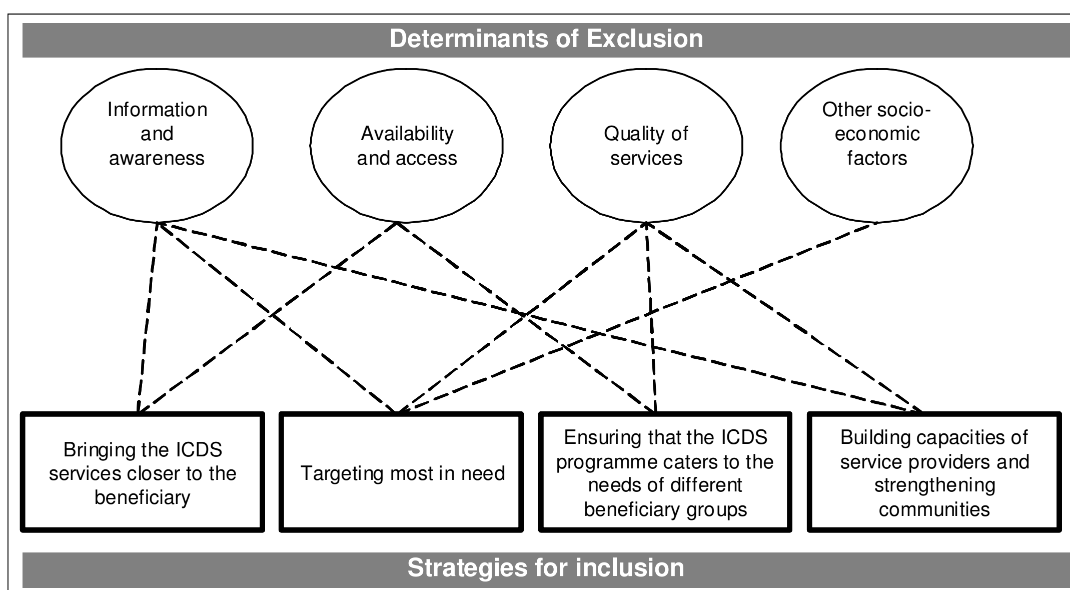
The review could not trace any inference on the performance of village level committees or on impact or process indicators related to vulnerable social groups, apart from discussion on covering backward regions.

5 Analysis and Recommendations

Our analysis of the findings from our field research and additional desk based research concluded that there are 4 keys determinants of exclusion in ICDS services.

- **Availability and access of ICDS services:** This refers to: physical access to the AWC with respect to distance and timing; social accessibility (e.g. non religious buildings); eligibility for services (e.g. migrant workers); and availability of resources (e.g. SN).
- **Information and awareness of ICDS services:** This refers to: insufficient awareness of benefit of ICDS services; lack of information on timings of service provision and entitlements; and traditional beliefs which influence health seeking behaviour.
- **Quality of ICDS services:** This refers to the fact that poor quality of the six services deters communities from accessing them.
- **Other socio- economic factors:** This refers to: Caste dynamics (e.g. caste based discrimination or inter-caste rivalry); exclusion of girl child; and self exclusion due to religious or traditional beliefs.

These determinants of exclusion have been linked to specific strategies to address them as shown in the diagram below:



The recommendations presented have been developed taking into account the 5 key reform principles of ICDS IV, namely: better targeting; flexibility of management and implementation; a simple evidence and outcome based programme design; stronger convergence, and a strong monitoring and evaluation approach.

Based on the findings from the state social assessments and the desk review, recommendations that address exclusion and social equity have been identified. These recommendations are not exhaustive but attempt to address the major challenges in provision of and access to the ICDS services.

These recommendations will enable states to strengthen their Project Implementation Plans (PIPs) both at the state and district level. However the applicability of these recommendations will largely depend on the regional and local differences within those states.

Indicative time periods for each of the recommendations have been provided. These are based on the following the periods.

- Short term - 0 to 6 months.

These recommendations are quick-wins and consist of simple activities and processes which can be easily implemented sometimes even at the district and block level. They can be considered to be of immediate priority

- Medium term - 6 to 12 months.

The medium term recommendations need a higher level of planning than their short-term counter parts. They also require a significant budgetary commitment. They may involve two or more steps before being operationalised at the local level.

- Long term – greater than one year.

This set of recommendations requires a deeper commitment at the state and national level in order to be fully operational. They may need a series of steps (often complex) including policy level decisions followed by district level planning and field level implementation. These recommendations maybe considered the most challenging to implement because they need to be embedded into the programme design.

5.1 Recommendations for inclusion of marginalized and vulnerable groups

Strategy 1: Bringing the ICDS services closer to the beneficiary ***Action: Improving reach of services and access by beneficiaries***	
Recommendations	**Similar experience**
<u>Short term</u>	
1. A home planner should be introduced for the AWW so that she can plan and prioritize her visits to different households. This diary like book should contain a checklist of **health and nutrition communication messages** that she should give to the women she is visiting. The planner will also serve as a record book to record growth grades of children and the referrals made to PHC and other health facilities.	The RACHNA experience covers home visit tools as well as other programme implementation tools.

Medium term

Recommendation	Experience
1. An important way of addressing policy based exclusion of working women and their children from vulnerable families would be to provide **crèche facilities**. The existing crèche facility provision under the Rajiv Gandhi crèche scheme should be strengthened. Pilots should be started for crèches for 0-3 and day-care for older children. Where possible Panchayats should be roped in to build and maintain these crèches.	The SEWA experience of their micronutrient initiative in 2007 suggests that 70% of the children went to school for the first time after crèche facilities were started in their village. These facilities also achieve social cohesion and inclusion.
2. **Mini AWCs** should be established in hard to access habitations where women and children have to travel more than say 30 minutes on foot where the main AWC is located. This Mini AWC can provide at least 3 of the 6 in-house AWC services including SNP, ECE and Immunisation. As the population in these habitations increases, these mini AWCs can be **upgraded into full fledged AWCs.**	The Andhra Pradesh experience of setting up mini AWC in hard to reach habitations with the help of BRGF funds is a noteworthy example of bringing ICDS services closer to communities.
3. Women and Children of **migrant families should be provided with temporary access** to all ICDS services if they have moved out more than a particular distance from their parent village. In order to monitor and track these families, they should be given a health and nutrition card where their access of different services is recorded wherever they go. AWWs should maintain a separate register to monitor and track these families and services should not be denied to them.	Experiences in some states like Jharkhand and Bihar to issue a card on the lines of ration cards would be useful.
4. **Outsourcing some of the ICDS services** like ECE to local NGOs to improve the value of the services provided should be explored.	Naandi Foundation experience of running AWCs in remote tribal hamlets of AP is an important lesson of partnership with NGOs. They have been able to turn around attendance to this AWC by children introducing joyful methods of learning thus ensuring that these children will smoothly transition into school. The Ramakrishna Mission in Chhattisgarh also runs AWCs based on similar model. In Karnataka and AP, PHCs have been outsourced through a PPP model. They aim to provide better quality services to communities accessing them.

	Recommendation	Evidence
5.	Home based care and monitoring remains a very important component of tracking women and children and referring them to higher levels of care if necessary. It is recommended to use **special outreach workers** from marginalised communities to communicate important health and nutrition information and identify and refer cases to the ANM or PHC. These outreach workers will also motivate these women and their children to access the ICDS services from the AWC. Where these outreach workers from marginalised communities cannot be identified, trained and deployed, the use of ASHA workers and AWHs should be maximized. A concrete way of eliminating exclusion due to language and dialect barriers would be to appoint AWWs, AWHs and outreach workers who speak the language of the communities they work with.	Involving community volunteers is considered as highly desirable as it could (a) increase community involvement and ownership; (b) lead to reduction in work burden of AWW and (c) expansion of services despite infrastructure bottleneck. Further this strategy in itself could be a promising monitoring mechanism .As Sharma, Adarsh (2007) notes that the recent changes in health and ICDS strategy of the Government of India, including the provision of ASHA in NRHM and adolescent girls of Kishori Shakti Yojna in ICDS, there is a possibility of having a band of volunteers who could effectively participate in the programme. There is evidence that the ASHA sahayoginis in Rajasthan have been used successfully to conduct home visits.
6.	Successful IEC strategies like local folklore and art can be used to improve the participation of the community and to convey key messages to them. AWWs should be trained to mobilise such activities like door to door contact rallies, folk songs, group discussions etc. This will improve the credibility of the AWW among the community and help her reach marginalised groups.	Anganwadi Kala Jathas in UP were found to improve the interpersonal communication of the AWWs. It helped them deliver key messages to the community in a socially relevant way. It helped them develop confidence and increased their ability to reach marginalised communities. The Mitanins of Chhattisgarh are used to communicate to communities the value of the AWW in their village. They help validating their credibility and improving their acceptance.
7.	The quality of in-field training is proven to be much more effective that those based in headquarters. This kind of training affords much more real-time practice for AWWs, AWH and is contextually more relevant. It is recommended to set up **mobile training teams** to conduct refresher training courses for ICDS field level functionaries. Where possible, local MOICs and ANMs should join these teams and couple ASHAs refresher training as well. This will help in convergence of the services at both villages as well as block level.	The DULAR – UNICEF project introduced a District Mobile Monitoring Training team (DMMTT) which was able to fill the gap of 80% vacancy at the supervisory level
8.	It should be mandatory for the NHD to be held on a fixed day and at a fixed site. Over and above these, where communities have been identified who do not access these services; the NHD should be conducted in	CARE has extensive experience in 8 states in conducting the NHD and improving field level convergence efforts.

those habitations and communities.

Strategy 2: Targeting those most in need *Action: Identifying most vulnerable groups and providing specific interventions within the ICDS for them*	
Recommendations	**Similar Practice**
<u>Short term</u> 1. An initial **social mapping** exercise should be conducted in all the villages together by the AWW, AWH and ASHA to get a better understanding of their operational area. The social mapping exercise is also a very important community based monitoring tool. This map would be the focal point of all the AWC's intervention in the village. The map would identify most vulnerable groups and especially those not accessing critical services. Together with the AWH and ASHA, the AWW will develop an outreach calendar and travel plans to reach out to these groups.	Community based monitoring systems (CBMS) were found to be very useful in identifying left out hamlets and houses in the CARE Rachna experience.
2. An effective **complaint and grievance redressal mechanism** that deals with grievances of marginalised groups should be in place. A complaint book should be kept at the block level. This could be in the form of vigilance committees or even pre paid post cards that are available with the Panchayat addressed to the Project Director (or equivalent senior position). In tandem an enforcement mechanism is required to ensure that the complaints are satisfactorily addressed.	The use of postcards to report unusual trends in spread of disease or epidemics in villages has been used in the health department for a number of years. The use of social audit and RTI can also be cited as examples of similar experiences.
<u>Medium term</u> 1. Each child under six should have a **Bal Adhikar patra** combining birth certificate with immunisation details, weight at various ages, AWC registration, health check-up and sickness records etc. Essential NHE messages could also be printed on this card. The card would be kept by the parent but, the Gram Panchayat would be responsible for updating it regularly with the assistance of the AWW. Create awareness in these communities about the ICDS services.	
2. Based on the experience of conditional cash transfers in other programmes, a self referral financial incentive mechanism should be introduced into the ICDS. This will motivate the poor participate to in the programme.	The JSY Scheme in the RCH II programme is a good programme analogy for this recommendation.

3. Self monitoring exercise can be used as they have been seen working successfully as innovations within the SSA. The older children can monitor their own attendance on the walls by putting stars for those days they attend classes. They can then be used to motivate their peers and siblings to improve their attendance.	Similar progress charts have been used in Naandi Foundation's endeavour to monitor learning outcomes in school going children.
4. The ICDS should leverage its services to reach marginalised groups by the extensive use of socially relevant print and electronic **media**, for example radio information programmes in local dialects to create awareness in these communities about the ICDS services.	The success of "community radio" in promotion of health and nutrition related messages have been well documented.
5. Community based monitoring mechanisms such as **social audits** or involvement of the Panchayat. This social mapping tool can also be incorporated into a social audit exercise by the community.	
Long term	
1. A comprehensive **MIS system** should be put in place that collects **disaggregated data** on the progress of women and children from **different socio-economic groups**. This will be critical in understanding nutrition and health deficits and addressing those problems within the ICDS and the RCH. The data coming in should be timely, relevant, easily accessible and of high quality. It should shift focus from inputs to results, outlays to outcomes and create a mechanism of accountability for performance based on their ability to minimize exclusion.	
Strategy 3: Ensuring that the ICDS caters to the needs of different groups **Action: Addressing discriminatory factors like caste, religion and gender**	
Recommendations	**Similar Practice**
Short term	
1. The mandate for independent AWC should be enforced. As a first priority, AWCs should be in **secular buildings** and ICDS services such as SN and immunisations should not be delivered in temples or other religious locations because of the implicit discrimination and exclusion against lower caste and minority groups. Ideally, the AWC should not be located in the AWW's house either.	
Medium term	

1. Muslim communities are averse to receive immunisation because they believe that it is ‘haraam’. This can seriously compromise the ICDS immunisation component of the programme and its universalization. It is recommended to constitute district level **representations of Muslim clerics** to create information material for such communities so that they are better informed on the benefits of immunisation.	Several Islamic clerics in Uttar Pradesh are coming together to educate Muslims on the necessity of vaccinating against polio to prevent crippling and disability in their community. Lucknow maulanas under the aegis of Rotary International have been closely involved with the polio eradication programme.
2. The use of **NREGS** scheme to help build AWCs and mini AWCs should be positioned in such a away so as to demonstrate how different caste and social groups come together to establish and build the AWC. Parents groups can also be included to plant trees, prepare ECE teaching material, decorate the centre and contribute resources like utensils, plates, jars for storing drinking water etc.	
3. Special emphasis on including girl children in the programme should be laid. Here **change agents play a very important role in reshaping the community's perception of the girl child** and the need to rescue her from the cycle of exclusion and marginalization – poorly nourished girl children will go on to become mothers in poor health and so on. It is also recommended to select these change agents from excluded groups and use them to address larger issues of exclusion. Local NGOs and CBOs should be roped in to support the change agents in their ministry. This will go a long way in bringing excluded groups into the programme and improving the participation of girl children.	The CARE RACHNA experience of the change agents is a noteworthy one. Their use of social mapping to address challenges like exclusion has been documented. Similarly mother's committees in AP has a mandatory provision of including people from low socio economic groups Improving infrastructure by constructing toilets and providing safe drinking water has shown to improve the participation of girl children in schools.
4. **Adolescent girls groups** with about 20-30 girls in each village should be established - these should include both school dropouts and those in school. Targeted interventions should be undertaken by AWWs to improve the awareness levels regarding the symptoms of anaemia and food sources rich in iron among these girls. An adolescent-girl-card should be provided to all girls which tracks their IFA tablet intake and provides key information health, hygiene and nutrition issues.	School going adolescent girls such as those tribal areas of MP and Chhattisgarh have also been successfully recruited to serve as change agents and assist AWWs the villages.

5. **Beacon AWCs** in each state identified by the ICDS Project Directors office that act as 'role models' for other centres. Staff from these centres could share good practice and be used to support other neighbouring centres in improving their services.	The CARE RACHNA experience of 'Demonstration site' is a useful example for these proposed beacon AWCs. In Jharkhand and Bihar, the good practice of cluster coordinator who fill the gap of supervisors on one hand and promote peer learning among AWWs on the other.
6. A focus on **secondary caregivers** of children and pregnant women including fathers and mother-in-laws. They should be encouraged to visit the AWC for at least one antenatal care session or met during home visits so that important health and nutrition information can be given communicated to them as well. They will play a very important role in influencing the health and nutrition behaviour of the woman and child.	The establishment of Ballika Mandals in the APERP intervention has shown that these groups were useful in creating awareness not just among themselves but also among younger girl children. The Dular –UNICEF project introduced this card to serve as a community level monitoring and counselling tool.
Long term	
1. Introduction of a **specific mapping system of districts**, blocks and villages for **nutritional grades** of children registered in AWCs. This grade mapping will allow for identification of regions with vulnerable children in grade 3 and 4 and will aid in planning of intervention, deployment of manpower and monitoring of progress. It is assumed here that the registering of children in every village will be a comprehensive and inclusive exercise and that all malnourished children identified will inevitably be from marginalised groups. In urban centres, clusters should be identified listing all slums and prioritization of outreach based on access to facilities rather on just income surveys.	NIN in Hyderabad conducted a study using GIS information of nutritional grades of children in some blocks and found that the information from the AWCs thus mapped helped in the block and village planning to reach out to severely malnourished children.
2. Rehabilitation facilities like **nutritional rehabilitation centres** should be available at PHC level for children suffering from Grade 3 and Grade 4 malnourishment as well as their mothers. AWWs should be responsible for identifying such children and referring them to these facilities. These children and mothers should be entitled to an enhanced nutrition supplementation plan along with a financial grant during the period of rehabilitation. This should be done in convergence with the health department to prevent severe malnourishment and hunger deaths. A self referral financial incentive mechanism should also be introduced.	Under the Janani Surakasha Yojna, women who opt for institutional delivery are incentivized with a grant. This experience should be adopted by the ICDS as well for women and children opting to visit the nutritional rehabilitation centres.

Strategy 4: Building Capacities of Service Providers and Strengthening communities *Action: training field level functionaries and improving transparency and accountability*	
Recommendations	**Similar Practice**
Short term	
1. A **special innovation fund** should be made available to the community to take forward **innovations** that promote inclusion. Financial responsibility for these funds can be maintained by the CDPO.	SSA has introduced innovation funds to boost the performance of first generation learners, especially SC and ST children and older girls. The innovation funds are managed locally and based on an analysis of the barriers faced by SC/ST children within the household, the community and in the school and the interplays between them.
2. Special emphasis should be paid on the training of AWH who are the closest to the communities they work in. Their capacities should be built to increase the scope of their work to be communicators of key messages to women.	
3. Special **open blackboards** should be introduced in the AWC based on the **RTI principles** (including the contact information for their respective RTI officer) that will improve the transparency of the AWC and bring accountability in service provision. This black board will display the timings of the AWC on any particular day, the number of beneficiaries receiving services, the number of children attending ECE, the amount of SN distributed, the number of malnourished children identified, no of referrals made, days when the AWW is absent and dates for the NHD. This board could be updated by anyone in the village including parents, Panchayat members, and school teachers or visiting officials.	This experience is drawn from Naandi Foundation's experiment with the Open black board in primary schools in its national education initiative.
4. The Panchayat should be involved in building and/or funding the necessary infrastructure where required. For example, the provision of toilets, drinking water and gas supply which has shown evidence to **improve the participation of girl children** in schools.	

Medium term	
1. There is a need to **train service providers** especially AWWs and sensitizing them on issues of social exclusion, migration and caste based discrimination. They should be trained in specific interventions to identify and reach out to those excluded and those who do not access the ICDS services.	
2. **SHGs** should be enlisted to help **monitor** the quality of hot cooked meals and food provided by the AWW. Where necessary, they could help plan the menus for the AWC and assist in the distribution of food packets to women and children who are unable to come to the centre. They should also be involved in monitoring the administration of the AWCs (for example by ensuring that all the AWC registers are filled up regularly by the AWW.)	In some states like MP, preparation of hot cooked meals by local women groups has made it more attractive to the community. Under SSA in some instances there is evidence that cooked meals can increase attendance particularly of girls and they reduce caste barriers and gender inequality because all children eat together.

5.2 Recommendations on the improvement of the quality

While the aim of this report is to identify recommendations to address issues of social exclusion in ICDS, it is important to recognise that an improvement in the overall quality of services delivered through ICDS in general will have a significant impact on increasing the utilisation of ICDS services. Our field work re-emphasized the overall and general dissatisfaction of communities with the services, especially the marginalised groups and also found that dissatisfaction with ICDS services was a key reason why people, including those from marginalised groups, did not access ICDS services.

The scope of this report is not to identify a long list of generic recommendations on ways of improving ICDS services. Many studies have been conducted in the past that have given specific recommendations on improvement of ICDS services (such as the FOCUS report (2006), The World Bank Project Appraisal Document on a Proposed Interim Trust Fund Credit (1998), The World Bank Implementation Completion Report-WCD/ICDS-III Project (2006) and various reports between 2004-2008of Commissioners of the Supreme Court). Detailed below is an indicative list of some of the issues identified through our field research with regards to the functioning of AWCs that require improvement. These include:

- **Location of AWC and Staff recruitment:** For example the introduction of AWC to areas where at present they do not exist and appointment of AWWs to vacant positions.

- **Monitoring and accountability:** Better quality of supervision for AWCs. Better quality monitoring information with specific focus on excluded children.

- **Performance management:** For example, better incentives (both financial and non-financial) for AWWs, AWHs and Supervisors.

- **Resources:** Better quality of educational material. More and better quality grain. Better infrastructure including independent buildings which are equipped with minimum infrastructure including toilets, clean water, mats etc. Adequate health equipment including weighing scales, BP apparatus etc.

- **Streamlined processes:** Maintaining registers. Less corruption so that more supplementary nutrition can reach beneficiaries gets to the front line.

- **Capacity of staff:** Appropriately qualified staff with the right skills to deliver the range of services under ICDS. Adequate training programmes to improve capacity. Adequate training to address discrimination and exclusion.

- **Better convergence:** With other government programmes, in particular the health and education departments and tribal welfare departments.

A critical point to mention when considering improvements and interventions at the national level is that in order to ensure social exclusion is truly addressed in ICDS then it should be included in all aspects of the planning and development of the programme (similar to gender mainstreaming that takes place in other programmes). Examples of where this is relevant include implementing an MIS system and marketing and awareness raising in ICDS. In the case of an MIS system it is

important that information on socially excluded groups can be disaggregated. When developing communication messages for ICDS services it is important that these are tailored to different communities in terms of media, dialect and specific means. Also, enhancing the awareness of the AWWs and sevikas to recognise caste bias and addressing such exclusion is important.

5.3 Monitoring in ICDS

5.3.1 Existing monitoring mechanisms

Vandana Kullar's *'ICDS – A critique of evaluation techniques'*, is an extensive discussion on the monitoring systems within the ICDS. The ICDS has a built-in monitoring system for assessment and analysis at different levels at which data is generated. The Ministry of Women and Child Development (MWCD) at the central level has the overall responsibility of monitoring, collecting and analysing periodic work reports. Based on this, programme strategies are supposed to be refined and timely interventions made. Each state government has a Management Information Systems (MIS) co-ordinating cell. Districts with more than five projects also have a monitoring cell. MIS ensures the regular flow of information and feedback between different levels, through a monthly progress report (MPR) and a monthly monitoring report (MMR). Anganwadi workers compile standardised monthly and half-yearly reports based on their register data. These reports are forwarded through supervisors to CDPOs who in turn forward the reports to state and central ICDS cells. MPRs quantify the status of key import indicators pertaining to the major scheme components. But assessment and analysis have not led to action in a sustained manner, because of the poor quality of reporting from lower levels and the poor feedback from higher levels.

The computerisation process seems to be restricted to compilation of data and sending it to the central government, not to the processing of data and extracting useful information such as the project-wise performance of health indicators.

The report emphasises the means, not the ends, thereby unintentionally giving the message to functionaries that it is important to be seen to be working, to hold meetings of women and to conduct home visits, but not so important to see whether the incidence of child morbidity and mortality has fallen. In fact, it would be unrealistic to expect short-term monthly data to reflect any changes in health indicators. However, even biannual or annual reports of CDPOs fail to reflect these changes, and are simply a compilation of the relevant 6 or 12 monthly reports. The project staff thus fails to see the connection between measures taken and results obtained, with the latter mostly invisible and hence failing to motivate the staff to perform better.

The government has also introduced the collection of beneficiary data about SC, ST and OBC. However this data is not being integrated into information and is not being used in an ongoing and meaningful way to understand under-nutrition in these groups. However, this data is useful in understanding the coverage of ICDS in the high burden districts.

An attempt has been made in Orissa to improve the monitoring, coverage and quality of services such as identification of at-risk children so that supplementation could be provided to them, assessing how they are responding to supplementation and referring such children to health care if they are non-responsive. Data on a three

monthly moving average of children with severe under-nutrition in the selected blocks over two years showed a decline in the severe grades and reduction in the seasonal variation in the prevalence of severe grades of under nutrition.

A study was conducted in Andhra Pradesh by the NIN to improve the monitoring of nutritional component of ICDS at district level. ICDS functionaries were trained to improve the quality and timeliness of reporting. Analysis of the data and discussions on the implications of the reports with these service providers facilitated the implementation of midcourse corrections.

Even though there is a perception that this kind of information may not be robust enough, this data generated by the AWW is useful for monitoring of the block and district situation and could over time be useful for building up a database for nutritional surveillance. Based on this data, appropriately targeted interventions could be initiated. An increasing use of the data would encourage workers to correctly file their monthly reports. The data produced by this technique could also be triangulated with other information collected through social audits, periodic surveys, grievance forums etc.

As long ago as in 1983, it was realised that preschool education needed to be strengthened A monitoring and evaluation cell was set up in National Institute of Public Cooperation and Child Development (NIPCCD), to look into the ways and means of monitoring of preschool education and community participation in ICDS projects. The monitoring schedules have now been modified to include these aspects as well. Some effort has also been made to reinforce the preschool education component through revision of training syllabi and organisation of short-term refresher training in this area. Attempts to select and produce core material for distribution to AWCs, and to the supervisory personnel to further strengthen their monitoring and guiding capabilities are being made as well.

5.3.2 Proposed qualitative and quantitative indicators

In order to monitor exclusion, the monitoring data collected under ICDS should be reported on the basis of sex, caste, disability and other socio- economic characteristics. Similarly data on the caste and education qualification of AWWs and AWHs and the coverage and functioning of SC/ST hamlets, outreach in these hamlets etc should be an integral part of ICDS monitoring system.

The availability of such indicators would help to monitor the improvement in lower socio-economic groups; this is evident from the CARE-RACHNA experience.

Surveys and social assessments should be conducted at regular intervals for assessing social exclusion and special surveys for specific social groups such as disabled children, children of migrant labour, single women, and children whose family members are affected by stigmatized or debilitating diseases could also be undertaken.

Care should be also taken to monitor rights based processes such as formation of marginalised people's groups, their representation in committees and action taken to access ICDS services by them. Participatory Rural Appraisal tools could be used effectively to monitor the improvement in rights based processes followed by marginalized groups and its impact.

The table below summarizes the quantitative and qualitative indicators that can be used to monitor the extent of social exclusion in ICDS. The list is prepared based on the strategies identified in the desk based review we undertook. It should be noted that all data collected should be disaggregated based on caste, religious minorities, age, sex and socio-economic category.

Table: Indicators to monitor the progress of social exclusion in ICDS

	Quantitative	Qualitative
Outputs to be achieved by the social development strategy	**Nutritional status** • Severe as well as moderate underweight prevalence	**Nutritional status** • Perception of improvement in nutrition status of children
	Access to services • Beneficiary profile • Awareness of different services among beneficiaries • Supplementary Nutrition Programme coverage – cooked/ Take Home Ration • Timings and regularity of ICDS centre • AWH picks up and drops the child • AWW informs about different services • Contacts made by AWW and ANM • Services for severely undernourished children • Services which focus on 0-3 children and their mothers • Percentage of ICDS centres located in SC/ST hamlet • Uncovered hamlets and households in the intervention area • Distance of AWC from home	**Access to services** • Adequacy, Taste and quality of SNP • Non-users perspective on reasons for not using/ not being covered • Users perspective on discrimination • Perception of community on role of ICDS (focus on 0-3 children, SNP, Feeding practices, Health etc) • Reasons for hamlet not getting covered • Behaviour and attitude of service providers • Did they get convince with the counselling • Importance of child growth and nutrition • Perceived benefit of each service
	Coverage of backward areas • Socio-economic characteristic of newly selected areas and its comparison with other areas which were not selected in the state	**Coverage of backward areas** • Perceptions of officials in different government departments • Perception on local NGOs
Measures of stakeholder participation	• Number of Volunteers • Number of committees • Number of Members in committees • Number of PRI members in committees • Number of meetings by the committees in SC and ST tolas • Participation of Volunteers, NGO, PRIs, Supervisors, ANMs	• Perception of men on child growth, nutrition and ICDS • Volunteers perception regarding their role and responsibility • Villagers perception of volunteers and AWW • Perception of members of Committees, PRI and NGO functionaries on their role

	Quantitative	Qualitative
	CDPOs in committees • Participation of Volunteers, NGO, PRIs, Supervisors, ANMs CDPOs in NHDs • SC/ST representation in all the above including NGOs • Function performed by Community volunteers	• Perception of role of other functionaries • AWWs perception of usefulness of participating stakeholders, including supervisors • Do villagers agree on selection of change agent • Is change agent seen as part of government or as representative of their village/ caste/religion etc.
Measures of implementation and institutional reform	**Adequate and quality infrastructure** • Presence of dedicated quality buildings, drinking water, weighing machines, Nutrition & Health Education Kits, Display Board, play materials and baby friendly toilets, etc. • Location of AWCs and their infrastructure facilities	**Adequate and quality infrastructure** • Perception on Infrastructure facilities
	Human resource and monitoring structure • Staff Vacancies at different level • Timeliness of monitoring reports • Visit by supervisory structure (CDPOs and supervisors) • Education, residence and Caste, of AWW • Gender and Education of Supervisor and CDPO • Number of Pre-service and In-service training • Years/ months since last training • Number of training days • Number of Specialised training	**Human resource and monitoring structure** • AWW's perception of her work load • Perception on effectiveness of training • Perception on role played by supervisor and CDPO • Relative time taken by AWC for different activities (PRA) • Perception of AWW and ANM on cooperation in activities
	Health-ICDS convergence • Number of joint visits by AWW and ANM • Participation in NHDs • Nearest sub-centre and PHC • Nearest functional sub-centre and PHC	

6 World Bank Operational Policies related to Indigenous Peoples and Involuntary Resettlement

6.1 Indigenous (Tribal) Peoples (Operational Policy 4.10)

With reference to paragraph 4 (b) of the World Banks operational policy on Indigenous Peoples it is not envisaged that any indigenous groups will lose collective attachment to any geographically distinct habitats or ancestral territories in the project areas for ICDS IV.

6.1.1 Socio cultural and Political Context of Tribal Communities

According to the 2001 census, the population of STs in the country is approximately 84.3 million constituting 8.2%of the total population of the country. Out of this, males total 42.6 million and females 41.7million, accounting for 8.01% and 8.40%of the total population of their respective groups. The ST population varies among states in India. The main concentration of tribal population is in central India and in the North-Eastern States. Nine states together account for about four-fifths of the total tribal population of the country, but the tribal percentages of these states' population vary from about 5.5 to 31.8%. Also, several smaller states, most notably in the northeast of the country, have much higher percentages (ranging from 64 to 95 per cent), but account for a smaller proportion of tribal people in the country as a whole.

There are 698 tribes (with many over lapping communities in more than one State) as notified under Article 342 of the Constitution of India, spread over different States and Union Territories of the country. Each one of the tribes is associated with a specific geographic area, some more dispersed than other. Most have their own language, which is generally different from the 'mainstream' language of the state in which they live. While some tribal communities have adopted a mainstream way of life, at one end of the spectrum are 75 Primitive Tribal Groups (PTGs), who are characterized by:

- A pre-agriculture level of technology.
- A stagnant or declining population.
- Extremely low literacy.
- A subsistence level of economy.

Tribal people tend to live in two main types of situations: (a) in 'mixed'(tribal and non-tribal) rural communities, within reach of educational and other opportunities and resources, and (b) in habitations that are small in size and located in relatively inaccessible hilly or forested areas of the country. The majority of these habitations have less than 200 persons. The distribution of tribal people in these two types of settlement varies markedly by state, district and even block. As a result, different strategies need to be used in different areas to reach and provide ICDS services tribal children. Demographically tribal habitations are small in size, scattered, and are sparsely populated. Because of this, most of these villages are bereft of basics infrastructural facilities like transport and communication.

6.1.2 Nutritional Status Overview of Scheduled Tribes (STs)

Children belonging to scheduled tribes have very poor levels of nutrition according to the three key measures: children being stunted, under weight and wasted. Analysis of NFHS II (1998-99) and NFHS III (2005-06) highlights the following trends.

1. The high prevalence of wasting in the ST group is 28% compared to overall India rate of just 19% (as per NFHS III).

2. NFHS II reported 54% children less than 3 years as under weight which has gone up to 56% in NFHS III. Under weight children from scheduled tribes have shown only a marginal decrease from 56% to 55% between NFHS II and III.

3. 53% of ST of children under- 3 years were found to be stunted in NFHS II compared with 46% in the general population. During NFHS III 48% children under 5 years were stunted, compared with 54% ST children in the same age group

The NFHS III data indicates that the feeding practices are worst among scheduled tribes, with only 14% children (6 to23 months) receiving 3+ food groups and minimum number of breastfeeds, compared to 25% of children in the general population. The data also revealed that women and men from scheduled tribes have a relatively poor diet that is particularly deficient in fruits and milk or curd.

Prevalence of anaemia among children in the age group of 6 to 59 months in India is high, with 77% of children in this group having some form of anaemia (mild, moderate or severe) in 2005/06. There is almost no difference in the anaemia level in these children and those from other social groups like SC/ST/OBC. However, research in NFHS III indicates that disadvantaged groups such as the scheduled tribes are somewhat less likely than others to give their young children supplements and de-worming medication. 68.5% women among scheduled tribes suffer from any form of anaemia, compared with 55% in India as a whole. The nutritional status of women has deteriorated since NFHS II which recorded 64.9% and 48% for tribal women and any woman, respectively.

6.1.3 Summary of findings from field research in relation to tribal communities

Information and Awareness

Awareness of the ICDS tended to be limited to the immunisation and the supplementary nutrition components of the programme. Awareness levels regarding five cleans was found more amongst the general community compared to ST category.

The traditional belief system on ST communities can have an impact on the uptake on the immunisation services of ICDS. A greater emphasis is placed by these communities on the customary home remedies and there is a fear of injections through their own set of misconceptions and beliefs. .

It was generally noted that AWWs did not receive any specific training in order to reach out to vulnerable communities such as STs. For example training for field staff on subjects like RCH and HIV/AIDS has been conducted but it was found lacking in ways of reaching out to vulnerable and hard to reach communities.

Availability and Access

It was observed from our field visits that households closest to the AWCs utilized the services more readily than those further away. In villages that are divided by caste lines ST populations are often located on the outskirts of the communities with limited means of transportation they are often the most adversely affected. ST communities cite the long hours they have to spend walking to the AWC and the time they have to spend waiting for the services as a major factor that deters them from using ICDS services. Extensive travel to AWCs can result in the loss of wages and impacts other important household chores like fetching of drinking water. Parents are also concerned about hazards on route to the AWCs such as open wells or busy roads; therefore prefer the children to e accompanied by an adult.

In addition women from ST localities on the outskirts of villages complained that immunisation sessions were not conducted within their vicinity.

There does not appear to be any special plans or training provided to the AWW to help her reach uncovered marginalised communities under ICDS (including STs). As growth monitoring is not regular, undernourished children are not tracked making it difficult for the AWW to reach out to and target malnourished children effectively.

In rural families where both the parents of the child work, the women will often take her child along with her while she is working in the field as she is often there for the whole day. As a result neither the mother nor the child is able to reap the benefits of ICDS.

Another factor that has a direct impact on the update of services by STs is migration. For those ST communities that have to migrate to other regions due to economic reasons, it is very difficult for them to access ICDS service whilst travelling. The ICDS does not allow for temporary participation in the scheme.

The caste of the AWW is an important deciding factor that parents consider when deciding to send their child to the AWC. STs and SCs are hesitant to send their children to the AWC when the worker is from another community and vice versa. STs sometimes feel that higher caste AWWs are unwilling to visit their homes due to caste prejudices.

Quality of Services

Due to the low awareness among certain SC and ST pockets of communities, they are not in position to demand for quality services. They are not aware of their entitlements under the ICDS. Also, outreach to these areas by the AWW is poor and home visits are conducted sporadically or sometimes not at all, therefore counselling and referrals also suffers.

In rural centres, SC and ST mothers spoke of the irregular timings of the AWCs and poor quality of education inputs prompted parents to pull their children out and put them into other forms of schooling where the quality of education was better and the timings were longer. They were of the opinion that the AWCs run for too short a time and should run for as long as the government schools.

The quality and amount of food provided was cited as an important factor in ST groups not accessing utilising ICDS services. Inadequate facilities at the AWC

including the lack of clean drinking water, limited electricity, limited space and poor seating arrangement were cited as reasons for non attendance.

Exclusion

As mentioned previously ST communities that live on the outskirts of villages utilise the services of ICDS less than those communities that live nearer to AWCs. Groups located more than half a kilometre away from the AWC expressed their discomfort of accessing the AWC, and AWWs and ANMs are less motivated to visit remote habitations.

In Andhra Pradesh one ST family in the forest colony said that the AWW excludes 5 households from the forest colony from all ICDS services. This ST community is not visited by the AWW and they are unaware of their entitlements.

Our field visits highlighted limited evidence to suggest that extra food supplements were being provided to SC/ST children in any of these villages.

In those villages which are not divided along caste lines and where communities are mixed, problems with regard to exclusion are less, however where you have villages with ST communities on the outskirts (it is often the case) then exclusion is more of an issue.

There was no evidence of services for ICDS not being delivered equitably within the AWC itself. There were no instances of parents feeling that children AWWs were treating their children differently to other children. However, there was concern with regard to the regularity of the services provided and erratic opening hours.

Grievance procedures

The grievance procedures within the current ICDS are limited. Observations from the field visits undertaken highlighted that the majority of the time, no proper system for the redressal of public grievances existed under the ICDS. Community members complained that they had lodged complaints against the service providers but with no response from ICDS officials at the block level.

Mechanisms for marginalized groups including STs to give feedback on the quality of services received from ICDS do not exist. Observations from the field visits noted that PRI representatives have been approached to use as a channel to provide feedback, but was not effective.

Women’s Self Help Group forums formed for Micro Credit initiatives have been used to share grievances on AWC performance and issues. However as there is no organic linkage of ICDS with SHG forum this has not proven to be effective.

6.1.4 Monitoring information

A comprehensive list of indicators that can be used to monitor the extent of social exclusion in ICDS is included in section 5.5 of this report. In order to measure the extent of exclusion by different groups these indicators should be disaggregated based on caste, religious minorities, age, sex and socio-economic category.

6.2 Involuntary Resettlement (Operational Policy 4.12)

Matters relating to significant involuntary resettlement were not identified through our state level field investigations or the desk based research undertaken.

MWCD does not foresee any major involuntary resettlement as there will be limited small construction taking place in ICDS IV (for AWCs only).

SOCIAL ASSESSMENT
for
the IDA assisted ICDS-IV/Reform Project

Sponsored by DFID, India

Annexes

July 2008

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Annex 1: Summary of State Findings[1]

Andhra Pradesh Findings

1. Causes of Exclusion

a. Information and awareness
- Communities are not aware of all six services of the ICDS programme.
- Communities are aware of Indiamix and its benefits. The mix was used by other family members besides beneficiaries.
- Communities aware of their entitlements with respect to SN.
- Some reports that Indiamix was used to feed livestock.
- SC/ST communities had limited knowledge of the timings of the AWCs.
- Families closer to AWC knew timings of the AWCs and were more aware of the other services.
- Awareness of services more in urban than rural AWCs.
- Urban mothers knew more about ECE, SN and immunization than rural mothers.
- Poor knowledge of roles and responsibilities of AWC functionaries.

b. Availability and access
- Access to SN and ECE was found to be poor. Poor demand for the other services.
- AWH played an important role in improving access by providing information about the services.
- Greater the distance from the AWC, lesser the access. SC/ST communities lived farthest away from the AWC.
- Groups located more than half a kilometre away found it difficult to access the centre.
- SN, immunization and ECE had better recall than the other services.
- There is no caste based discrimination of services provided in the AWC.
- Poor growth monitoring leads to poor tracking of malnourished children who come from socio-economically weaker sections.
- No special plans to reach out to uncovered SC/ST populations.
- Caste of AWW plays important role in access. Self exclusion by certain groups if AWW belongs to a different caste observed.
- AWWs of one caste do not visit homes of women belonging to a different caste group.
- Marginalised groups complained about callousness of AWW in addressing their problems of access.

c. Quality of services
- SC/ST communities not aware of their entitlements under the ICDS services.
- Limited outreach to SC/ST communities resulting in poor health promotion and health referral services.
- AWW does not feel accountable to the community and feels no ownership.
- Community perceives her to be a political appointee.
- Poor participation of parents for ECE meetings and NHDs.
- Poor ECE facilities for children.
- Irregular timings of AWCs.
- Parents chose putting their children in government/convent schools over AWCs.
- Urban centres cramped and unhygienic, but found to be better equipped in terms of IEC and ECE material.
- Communities satisfied with promptness of immunisation services.
- SC/ST communities found it hard to reach immunisation services if located far away

[1] State specific recommendations are suggestions that have been documented from dialogue with stakeholders and the community. They are useful in understanding the expectations of the community and should be taken into consideration if relevant by the ICDS IV

from their homes.
- Health referral services enhanced due to 108 emergency services.
- Growth monitoring and grading of children is very irregular.
- High regard for the ANM.
- No mechanism for marginalised communities to provide feedback about the quality of the ICDS services. They however sometimes approach their respective Panchayats.

d. Other Socio-economic factors
- Lack of awareness of the ICDS and distance excludes Dalit communities.
- Self exclusion by Muslims of immunisation services observed.
- Poverty in the region contributes to migration. Migrant families cannot access ICDS services.
- SC/ST communities live on the fringes of villages and thus far away from the AWC.
- The caste of the service provider determines which caste group beneficiary accesses the ICDS services.

2. State specific recommendations

- Start smaller AWCs in remote habitations.
- Enhance follow up by AWW and AWH to reach excluded groups.
- Create awareness of entitlements for each of the services. Adjust the timings of the AWCs to suit the needs of daily wage workers.
- Improve escort services for children.
- Improve the targeting of excluded groups.
- Improve the participation of other community members in the ICDS.
- Involve local women's groups to monitor AWCs.
- Improve coordination of services and information flow between AWWs and ANMs.

Jharkhand Findings

1. Causes of Exclusion

a. Information and awareness.
- General awareness on health and nutrition is poor among mothers.
- OBC mothers had a higher level of health and nutrition awareness.
- Poor knowledge of the timings of immunisation schedules and the purpose of vaccinations.
- Awareness of the SNP but ignorance of the entitlement.
- Poor knowledge of the timings of the AWCs and the role and responsibility of the AWW.
- Difference in awareness between different clusters of villages. Further the cluster, poorer the awareness.
- Immunisation had highest recall among all the six services.
- AWW does not facilitate information dissemination and awareness of the services in the community.

b. Availability and access
- SN most accessed of the ICDS services.
- Due to insufficient SN, AWW only distributes SN for children below 3 and pregnant women and neglects lactating women and adolescent girls.
- THR mixed with home rations. Beneficiary has no direct benefit of SN.
- Greater the distance from the AWC, the poorer the access. Communities excluded themselves because they did not want to travel long distances.

c. Quality of services
- AWWs have poor understanding of health and nutrition concepts.
- AWWs are reluctant to make home visits to far-off clusters.
- Community expressed little faith in the capability of the AWWs.

- SN quality and quantity affected by fluctuating price of food grains. Community realizes that fluctuating food prices affect quality of SN
- Funds for SN not released on time.
- ICDS Supervisors too few and have large areas to cover.
- Quality of cooked food is poor and the menu is monotonous.
- AWWs are perceived to be incapable of running ECE centres.
- AWCs lack basic facilities such as toilets.
- Women asked to pay for disposable syringes. Those who could not afford have immunized using non-disposable syringes.
- Shortage of vaccines.
- Poor condition of IEC and ECE material at the AWC.
- AWW called to do other government tasks like surveys thus overburdening her.
- AWW dissatisfied with honorarium and work load.
- AWWs do not have time to conduct outreach services.
- Most centres run in the homes of AWWs.
- Remote postings affect quality of services provided by the AWW.
- Community perception that AWWs are corrupt.
- AWH does not cooperate with the AWW when both of them belong to different castes.
- Poor convergence and coordination between AWW and ANM.

d. Other Socio-economic factors
- Muslim communities exclude themselves from vaccinations.
- Muslims most excluded groups in the ICDS services followed by STs.
- Fear of injections and other local misconceptions affect access to immunisation.
- Women do not want to lose wages for the day so they are unwilling to travel long distances or wait in long lines to receive ICDS services.
- Migrant families find it hard to access the ICDS services.
- Adolescent girls did not get SN.
- SN for is provided for one woman in the household though many eligible beneficiaries live together. E.g. Muslim families.

2. State specific recommendations

- Build capacity of communities to enable them to demand better services.
- Democratize selection of AWW. Empower communities to take disciplinary action against AWW.
- Create greater awareness of entitlements in the community.
- Community opinion should be sought to improve quality of the ECE.
- Encourage community to make voluntary contributions to the AWC.

Rajasthan Findings

1. Causes of Exclusion

a. Information and awareness
- Poor awareness of the importance of the ICDS and role of AWW.
- Communities unaware that SN was also meant for lactating women.
- Poor knowledge of immunisation and its benefits.
- Mothers not informed about the reactions or mild fevers that commonly occur after vaccinations thus deterring their subsequent use.
- Communities had poor knowledge of the NHDs.
- AWC primarily perceived as an immunisation centre.
- Poor understanding of health and nutrition.
- Poor community knowledge of their SN entitlements.

- No effort by AWW to create awareness or provide information to far flung communities.
- Many of the AWCs opened recently in the last year, so some mothers are still not aware of their entitlements under the ICDS.

b. Availability and access
- Irregular opening hours of the AWCs leads to poorer access to the services.
- Beneficiaries closer to the AWC accessed the services more than those who did not.
- Communities visited AWCs mostly for SN and immunisation.
- Women from better-off families hardly accessed SN from the AWC.
- Tribal communities found it most difficult to access the ICDS services.

c. Quality of services
- Home visits and health referrals are the weakest activities of the ICDS.
- Irregular timings of the AWCs. Frequent absenteeism of the AWWs.
- Poor quality of ECE in the AWCs. Government primary schools and private schools preferred over the AWC.
- Communities satisfied with cleanliness of the AWC and with equitable seating arrangement of children from all backgrounds.
- Coordination and convergence of ANM and AWW is seen.
- Existing supervisors have large area to cover and this affects monitoring..

d. Other Socio-economic factors
- No obvious evidence of caste based discrimination was identified.
- Mothers had no complaints of differential treatment of their children in the AWCs.
- Daily wage labourers and their children rarely access the ICDS services.

2. State specific recommendations:

- Women want AWW and ANM to make more home-visits.
- Improve the quality of food given in the AWC.
- Regular immunisation services.
- Proper training of AWWs and ANMs.
- Timely information about ICDS services and entitlements.
- Regular timings of the AWC.
- More AWWs for larger villages.
- Disclosure of expiry date of food packets.
- Better IEC and ECE material

Uttar Pradesh

1. Causes of Social Exclusion

a. Information and awareness
- Community not aware of the term ICDS.
- Poor understanding of the concept of malnourishment and its consequences.
- Instant recall of polio but no familiarity of diseases prevented by other vaccines.
- Knowledge that ANM and AWW coordinate with each other for immunisation services.
- SN not recognized as an intervention to address malnourishment but rather as an incentive for children to attend ECE.
- Recall of ECE, SN and immunisation more than other ICDS services.
- AWWs do not inform communities about of the services and their entitlements under the ICDS.
- SC communities were not aware of the health referral services.

b. Availability and access
  - SN is provided to all beneficiaries who access the centre without discrimination.
  - Communities on the outskirts of the village or far away from the AWC rarely access the ICDS services.
  - No effort by AWW to reach out to SC communities in far-flung habitations.
  - AWH facilitates the access of children to AWC even in the absence of the AWW.

c. Quality of services
  - AWCs have irregular timings.
  - Quality of weaning food is poor and communities believe that they are not being given their due.
  - Communities believe that some AWWs are corrupt and poorly trained.
  - Growth monitoring does not take place.
  - Shortage of vaccines reported.
  - PSE children receive cooked food only 5 -6 times a month.
  - Nutrition and health education does not take place.
  - Health checkups and health referrals do not happen.
  - High absenteeism of AWW affects quality of services.
  - Good monitoring and supervision during immunisation campaigns.
  - Poor PSE material.
  - AWH opens centre and animates children when AWW is absent.
  - AWCs had poor facilities.
  - AWWs complained of excessive workload and poor compensation.

d. Other Socio-economic factors
  - Caste based discrimination observed when upper caste AWWs do not visit lower caste households.
  - Women who are daily wage labourers find it hard to access ICDS services.
  - Newly married women not allowed access to AWCs because of social restrictions
  - Religious based rivalry and animosity prevents access to the ICDS services.
  - Political factionalism hinders access of ICDS services and prevents AWWs from doing her job.

2. Community expectations

  - Better quality and regular SN.
  - Better quality IEC and ECE material.
  - Improved AWC physical infrastructure.
  - Strong monitoring and supervision of AWWs.

Annex 2: State Reports

The detailed findings from our field visits in the following sates are included in this annex:

- Andhra Pradesh
- Jharkhand
- Rajasthan
- Uttar Pradesh

A. Andhra Pradesh

The two high burden districts of Mahabubnagar and Kadapa were studied. From these districts, Achampet, Sundupalli and Sambepalli blocks were selected. The villages from Achampet were Marripalli and Balmooru; the village from Sambepalli was Boggulavaripalli and from Sundupalli the village selected was T. Sundupalli. Two urban centres were also selected, one from Rangareddy district – the Alwal urban project and from Kadapa district, the Shastrinagar II project.

Community Perceptions of the ICDS programme

Information and Awareness

There is a lack of comprehensive knowledge of child malnourishment as a problem. The awareness on the importance of immunization is high among all selected groups of the population. They however, showed poor awareness of the schedule and purpose of the vaccines.

Across the communities studied, the stakeholders interviewed were aware of the supplementary powdered feed provided as part of the ICDS programme and were aware that it was prepared to be a nutritious supplement for pregnant women, lactating women and children. Though the respondents who received the feed expressed that they were aware it was meant for lactating, pregnant mothers and children, they confessed that the supplement was being used by other members of the family as well. Some communities also complained how some beneficiaries used the feed for their livestock.

The community in general and SC and ST communities in particular had limited knowledge of the timings of the AWCs as well as the roles and responsibilities of the AWW. They were however well informed about their entitlement to the SNP and the pre-school programme.

It was observed that groups, who were of higher socio-economic status and who generally lived closer to the AWC, accessed the available services at the centre more often than those who lived on the fringes of the villages. The groups that lived farthest away from the centre tended to belong to SC/ST. The groups closer to the centre were also better informed of the services and their schedule rather than those who lived further from the centre.

While they were aware of some of the services in the ICDS programme, when interviewed, the respondents showed poor awareness that the programme constituted of six essential services. This lack of awareness was more acute in rural centres studied compared to the urban centre. More **urban mothers** interviewed displayed knowledge of immunization, pre-school education and health education and growth monitoring rather than their rural counterparts. Both groups however said that they were aware about the SNP and their entitlements.

Mothers across the sampling spectrum expressed that awareness could be generated by:

- **Involving parents** closely with the centre and its functioning through meetings.
- **Providing material** like pamphlets or booklets to all villagers about the ICDS services in rural areas.

- SC/ST mothers and mother-in laws emphasized that improving the **frequency of home visits** by the AWW would also improve awareness.

- Use the support of community groups like **youth groups** and women's groups to dissemination information.

Quote: *'Awareness and access to the ICDS services would be greatly enhanced if the AWW was from our own village and community. She would understand the problems faced by the women and children and ensure that information and services would reach the community on time"* - SC mothers during a FGD in Kadapa district.

Availability and Access

In spite of reasonable awareness about the importance of pre-school and SN provided to pregnant and lactating mothers, access to the services was found to be poor. There was little evidence of demand for other ICDS services. It was found that the intervention of the AWW in improving access was limited whereas the **Ayah played a greater role** in informing mothers about the timings for immunization and improving the community's access to the ICDS service. It was observed that households closest to the AWCs utilized the services more readily than those further away. Incidentally the remotest households belonged to the SC and ST communities. All groups located more than half a kilometre away from the AWC expressed their **discomfort and difficulty** in accessing the AWC.

Observation: Caste based prejudices and discrimination are a common feature of the social relationships in villages in Andhra Pradesh. In one of the villages visited in Mahabubnagar district, the study team were guided by a local anganwadi helper to the SC wards from the AWC. They noticed that she did not walk through a certain street which was a shorter route to the destination and instead took the long route on the main road. The investigators were then informed that she was from a low caste and that it was socially unacceptable for her to walk through a high caste neighbourhood.

Among the six services; SN, immunization and pre-school education services had the **highest recall** in the communities observed as compared to referral services, growth monitoring and health education. These services are poorly provided in some villages and not provided at all in others.

All members of the community have articulated that **where services are provided and accessed in the AWC, they were offered equally to SC and ST beneficiaries**. They however expressed that **no special plans existed to reach out to other uncovered SC/ST communities**. Because growth monitoring is not regular, undernourished children are not tracked, this makes it difficult to reach out to and target malnourished children effectively. No evidence of providing extra SN to either malnourished or poorly faring malnourished children was found.

The field investigators also identified that the **caste of the AWW** plays a very important role in the **access and provision of services**. Communities of one caste often exclude themselves from accessing the ICDS services if the AWW belongs to another caste. Outreach is also severely affected by this form of **discrimination and self exclusion** because in many places, AWWs from one caste group do not visit homes of women of other caste groups.

Most groups interviewed mentioned that the services when informed to them were conducted as per schedule. However, the women from SC and ST localities complained that immunization sessions were **not conducted in their localities primarily due to the greater distance the ANM and AWW have to travel.**

Though there is no overt discrimination and up-front denial of services to any particular group, marginalised communities have registered with this study, the **callousness of the worker** in ensuring that their communities be adequately covered by the ICDS programme.

Some of the factors identified that affect the access to the ICDS services are listed below:

- SC and ST communities emphasized that **Geography and terrain** play a very important part in access. The further the habitation from the AWC, the lower is the awareness and accessibility to the services.

- Large scale **migration** is observed in the landless poor due to lack of economic opportunities in the village. Also, **daily wage labourers** are unable to access the AWC because the centre's timings clash with their work schedule. Children of daily wage labourers are also unable to attend pre-school, because the **timing of the Ayah** is not suitable for the working parents.

- **The belief systems of some minority groups** result in their limited access to ICDS services. This was particularly the case for Muslim groups.

- **Mothers-in-law, discouraged** mothers and children from accessing the SNP because they are of the opinion that the feed causes bowel problems and is not easily digested. They are generally unaware of the **benefits of the SNP**

- Traditionally expectant mothers move to their **maternal homes** during their confinement and thus are denied services in her village.

The communities studied shared their ideas through the focus group discussion on how access and availability of services can be enhanced. These include:

- SC and ST communities emphasized that mini centres should be established where SNP, immunization and pre-school education can be accessed by groups located far away from the main centres. They were of the opinion that modifying the timings of the AWCs to coincide with government school timings and the pick up time of the Ayah to earlier in the morning would greatly enhance the uptake of services especially by those who are the poorest in the community.

- Most stakeholders felt that involving parents and village institutions like youth groups and Mahila Mandals to take up a monitoring role would help bring an improvement to the AWC and thus improve the demand for services by the community.

Quality of Services

Based on the findings from the field, the issues related to quality have been classified as follows:

- **Awareness of services and low demand for quality services:** Due to the **low awareness** among certain SC/ST pockets of communities, they are not informed

of their entitlements under the ICDS programme and are thus not in a position to demand quality services. Distance limits outreach to these communities by the AWW and **home visits** are conducted sporadically or sometimes not at all. As a result, counselling and referrals also suffers.

- **Accountability and Transparency:** From most interviews and discussions across different community members, it was found that the AWW has little or **no accountability** to the community because her **appointment is a political** one. She does not feel responsible to the community and her **ownership** of the programme is low. This however was not seen in the urban centre where the AWW was more accountable to the community. The community also confessed that **poor participation of parents for meetings and NHDs** and other village groups in the activities of the AWC was a reason why transparency was lacking.

- **Quality of pre-school education:** Parents of eligible children in rural areas commented on the **poor facilities** available in the AWC. SC/ST parents also complained about the **irregular timings** of the AWC and the poor quality of education inputs. These factors contributed to parents removing their children and putting them in convent schools instead where the quality of education was better and the timings were as long as government schools.

In the urban context, the centres were well provisioned but too **cramped and unhygienic.**

Quote: *"We like sending our children to the AWC because the teacher is very proactive in teaching our children new things. She teaches the children in the centre the English alphabet and nursery rhymes. It is motivating to see our children speak a few sentences and sing songs in English"* – Parents of AWC children in the Alwal urban centre

- **Quality of the immunization services:** The data from the field reveals that communities near the AWC were in general satisfied with the promptness of the immunization programme. However SC and ST groups, who found it hard to reach the AWC, noted that they felt that there was no adequate coverage of their habitations.

- **Quality of Referral Services:** The community expressed that the referral services were greatly enhanced because of the **Emergency Management and Research Institute (EMRI) service**[2] under the Arogyashree Programme. The convergence of the emergency service provided by Satyam Foundation to the health and the ICDS department has increased the speed of provision of critical care to mothers and children.

- **Quality of information material and study aids used for awareness generation:** It was observed that the information material and the pre-school study aids in the rural AWCs were not adequately used in pre-school teaching. Most of the material was in poor condition. The **urban centres were observed to be better equipped** and teaching learning material was prominently displayed and used. In a subjective assessment, where mothers were asked to rate the AWCs, the urban mothers rated their centres higher than mothers in villages.

[2] 108 Emergency Response Service is 24X7 emergency service for medical, police and fire emergencies. It is a free service for any Emergencies involving people. The service is available 24x7 in the entire state of Andhra Pradesh

- **Capacity building programme for service providers in addition to service seekers such as mothers:** The communities were of the opinion that while the service providers were adequately trained for the limited services that they received, they commented on **how their capacities need to be built** –especially the CBOs and PRI; so that they can be more involved in the better functioning of the AWC and in the monitoring of the AWW. They expressed their belief that the community as a whole can influence better service delivery if they are given the appropriate support.

- **Effectiveness of service provision by AWW, ANM, AWH and TBA:** The majority of the mothers expressed that the **growth monitoring service** is very irregular and the **grading of children is not recorded** by the AWW. As a result follow up activities like referrals and targeting of malnourished children of poor families is limited. The **absence of weighing scales** is the primary reason for this. The community appreciated the work of the ANM in complementing the work of the AWW. They were aware that the quality of services especially those of immunization and prompt referrals can be enhanced if the ANM and AWW work together.

Both urban and rural communities reported that the sanitation facilities of the AWCs were poor and that often, drinking water in the AWC was not provided. They also commented on how all children in the AWC are encouraged to eat together where spot feeding was conducted.

The SC and ST beneficiaries expressed that there were no opportunities available for marginalised groups to provide feedback about the quality of the services in the ICDS programme. There were not aware of any mechanism or functionary through whom their grievances could be redressed. They however mentioned that they approach their local Panchayats to voice their concerns. The local Panchayats in turn feel they have no control over the AWW or the activities conducted by her. The role of the Panchayat is at present only restricted to participation in the special programmes like the health day. One of the suggestions from the communities was to link SHGs and other village level groups to the ICDS programme so that feedback from marginalised groups can be registered in a timely and effective way.

Exclusion

Of the different groups studied, SC/ST women in Mahabubnagar and the Dalits from Ambedkar colony in Kadapa expressed that they felt excluded from the programme because of their lack of awareness about the programme and their distance from the AWC. Minority groups like Muslims on the other hand expressed that they excluded themselves from services like immunization and family planning because of their set of beliefs and customs.

Some other reasons ascribed to exclusion of vulnerable groups include:

- **Poverty and the lack of employment opportunities** push a large population of landless families out of the district into other states for as long as three years. They are unable to access the ICDS services when they are travelling.

- SC and ST communities live on the fringes of the villages and are thus excluded from services. ANM and AWWs are not motivated to visit these **far-off habitations.**

- **Minority communities** like Muslims exclude themselves from services like family planning because of their belief system and traditional practices.

- **Caste** also plays an important role in exclusion of certain groups of the ability of services to reach a particular community.

Some suggestions made by the community to improve inclusion of marginalised communities in the ICDS programme include:

- **Recruitment** of AWW from the excluded community.

- Initiating new or **mini- AWC** in excluded habitations in order to make it easier for SC/ST and marginalised groups located far away from the AWC to access the ICDS services.

- Repeated or **enhanced follow-up** by the AWW and Ayah to reach out to excluded groups.

- Enabling the excluded communities to be aware of their entitlements and can create a demand for the services ensured under the ICDS.

- **Reworking timings** of AWCs to suit the needs of daily wage workers.

- **Improve the pick up of children** by the Ayah. Parents are usually concerned about the open wells along the way and roads that need to be crossed by children and thus are dependent on the ayah for this.

It was observed in the study and reported that where cooked meals are served, all children in the AWC eat their meals together and that there was no discrimination in this regard.

It was also reported that no extra efforts besides general persuasion are made to encourage parents to send their girl children to the centre.

Programme Expectations

The community expectations have been categorized in this table:

Table 3: Community Expectations of the ICDS

ICDS Component	Community Expectations
Supplementary nutrition	▪ Regular distribution of SN. ▪ Increase in quantity of SN. ▪ All eligible beneficiaries should be given SN. ▪ Adolescent girls should not be left out. ▪ Those who cannot take THR on the NHD should be given THR later as per their convenience and availability. ▪ Standardisation in the measuring / weighing devices during distribution of THR. ▪ There should be more variety in the spot feeding for children to attract them to the AWC for pre-school education. ▪ Community should be made aware of the actual entitlements under the SN programme.

ICDS Component	Community Expectations
Pre-school education	▪ Opening up and closing down of the AWC by the AWW on time at fixed times. ▪ Someone should be given the job of fetching and dropping the children from their door step. ▪ Improvement in the quality of teaching in pre-school education. ▪ Training of the AWW in this context. ▪ More attractive and conducive environment for children to learn through joyful methods. ▪ Better foods for children in spot feeding under PSE. ▪ Availability of innovative TLMs and playing kits for children in the AWC.
Nutrition & health education	▪ Regular home visits by the AWW. ▪ Use of attractive dissemination and IEC materials. ▪ Advice during immunisation sessions and THR distribution. ▪ Special counselling sessions for pregnant women, lactating women and malnourished children.
Immunisation	▪ Awareness generation regarding the various kinds of immunisations.
IEC materials	▪ User friendly and attractive materials. ▪ AWW should make these materials available to the beneficiaries for their ready reference.
Capacity building	▪ Regular and quality training for community groups and AWWs.
Referral services	▪ AWW's capabilities have to be increased to make this effective. ▪ Community should be made aware of this service.
Service delivery	▪ AWW should conduct outreach activities in far flung habitations. ▪ AWW should be made accountable to the community. ▪ Strong monitoring and supervision system to prevent any corrupt practices at any level. ▪ Building with all basic facilities for AWC. ▪ Mini-AWC for far off clusters. ▪ Increased involvement and role of women SHGs and Mahila Mandals in the functioning of the AWC.

Good Practices

Observation: We noticed many villages in Andhra Pradesh access to certain services was influenced by social status and caste affiliation, however the village of Marripalli was different. The villagers of Marripalli practice 'Rachabanda' during the Nutrition and Health Days to promote greater access for immunization and other services. The concept of Rachabanda is to provide a common place in the village where all caste groups can come together to access a particular service without discrimination or fear of reprisal.

Service Provider's Perspective of the ICDS

General perception of service providers

The general perception of the service providers is that there is **good coverage** of the services of the ICDS programme. They however agree that there is poor uptake of services like health education and pre-school education. The uptake among all communities of SNP, immunization and antenatal care was the highest. The pre-prepared SNP powder was well received well by the community.

Quote: *"The fixed day service is a successful model of convergence because the functionaries from the WCD and health department are able to work together on the field. As a result more beneficiaries are able to access the ICDS services. Also, the 104 services have augmented the fixed day service by reaching otherwise inaccessible areas and the 108 services have improved the responsiveness to emergency care thus strengthening the referral system. A regular monitoring by the district collector to check on services like immunization sessions and other programmes will ensure that the programmes are well accessed".* – CDPOs in the FGD in Mahabubnagar district.

Quote: *"The overall health and nutrition of the poor has increased significantly. With the National Rural Employment Guarantee Scheme the poor are able to find employment within their village. There is much more ready cash in the villages to spend on food and healthcare"* – A village elder from Mahabubnagar district in Andhra Pradesh. *"Distress migration has also significantly reduced because of the ERGS and this has allowed pregnant and lactating mothers to stay back in their villages and access health and nutrition services"* – An ICDS supervisor from a village in Mahabubnagar..

The service providers have expressed that they find no difficulty to reach all the people in the community with the exception of minority communities like Muslims where they have been challenged to work with their belief systems and traditional practices.

Quote: *"Good immunization coverage is achieved in the district by conducting the sessions in places where they will be accessed the most. In our district, we take the immunisation sessions not only to the AWCs, but to the PHCs and schools as well"*. The DIO of Kadapa district.

Outreach services are highly dependent on the ability of the health and ICDS service providers to come together – the AWW, ANM and ASHA; however the **AWH is a key motivator** of communities and her scope of responsibilities needs to be broadened to engage communities better.

There are a **large number of vacancies** for AWWs in many areas, depriving communities of important services in the ICDS programme. Many of the functionaries interviewed were of the opinion that as part of a larger plan, the **educational status of excluded and vulnerable communities** should be enhanced so that AWWs from within the community can be identified to serve them.

Implementation problems are generally resolved at the village level and supervisors support in problem solving. A few innovations like the **home delivery of SN** are being worked out where

beneficiaries are unable to come to the centre. The present Supervisor to AWW ratio is low. As the PD ICDS observes, there is a need to strike the ratio of supervisors: AWW to at least 1:30. Besides their regular tasks, AWWs and supervisors are also expected to conduct surveys for other departments and this impacts the quality of their work.

Resources

The service providers have expressed that it was essential that the AWC have its own building. They mentioned that with the increasing participation of the PRI through the Indira Kranti Patham, new constructions of mini AWCs are being encouraged. However within the AWCs, the dearth of weigh scales, Blood pressure apparatuses and a separate space for health checkups is seriously lacking. There is also no evidence of positive discrimination to provide services to those who need it the most.

The block level functionaries have said that the short shelf life of the feed is a cause for some concern. At present, the shelf life is about 20 days. There is a significant time lag between the time an indent for the feed is made up to the time it is distributed to the respective AWCs. There is risk that expired feed will be distributed to the beneficiaries.

Capacity

It was observed that the number of Grade 1 supervisors was much less than Grade 2 supervisors. Senior AWWs are usually promoted to Grade 2 supervisors and their training and qualifications is much less than the Grade 1 supervisors. Both Grade 1 and **Grade 2 supervisors felt that the training of Grade 2 supervisors needs to be enhanced.** It has been suggested that more direct recruitment in Grade 1 supervisors take place. These personnel will help mentor the Grade 2 supervisors.

Training for field staff on subjects like RCH and HIV/AIDS has been conducted but did not specifically include methods of **reaching out** to vulnerable and remote communities like SC/STs and minority groups. Though these issues are considered by the AWW, there is no planning and thus no activity to address this gap in implementation. There have been gender based training but the respondents emphasized that **training on the rights of disadvantaged groups** would be helpful.

It was felt that the AWWs and supervisors need a special component of training on **communication and leadership skills**. Most of them felt that they were constantly called upon to resolve issues in their day to day tasks and that a training to build their capacity in communication and leadership would help them.

They suggested that the training should also include the following components

- Effective **targeting** of excluded groups.
- Ways of improving and incorporating the **community's feedback**.
- Improving the **participation** of the community.

Information

There is no exclusive mechanism to monitor and supervise services to vulnerable groups. But common mechanisms like **checking Health Cards** for immunization coverage & ANCs, SNP register helps in identifying gaps in coverage of SN service. This will help to identify vulnerable

groups who are not receiving SN and thus plug the gaps. Supervisors also use this register to identify what gaps in coverage exist and advise the AWW on ways to bridge them.

The district level functionaries felt that **decentralization** would eventually help the ICDS programme by bringing the AWC and the AWW under the purview of the communities. They were of the opinion that this system would be self correcting because it would be a democratic process and issues like corruption and bad performance would be suitably addressed. The Panchayati should institute **women's groups** who will monitor the AWCs and thus improve the accountability of the ICDS.

Institutional convergence and motivation

Immunisation and ANC services are administered by the ANM, AWW and PRI who converge at the local level so that the maximum number of beneficiaries can be covered. The following measures were suggested at the district level to improve institutional convergence:

Regular Meetings

- Sector level meetings with ANMs, AWWs and Supervisors of ICDS and supervisors of Health programmes should be conducted regularly and reports should be shared and problems of implementation should be shared

- PHC review meetings which include CDPOs and Supervisors should be conducted regularly and continuing medical education should be provided to them to improve their skills

- Policy level integration at planning and implementation level should occur between health, WCD, RD, tribal welfare, and education so that the services for and coverage of vulnerable are taken up more effectively.

Service Delivery

- AWWs should ensure that women's LMP are registered and they should ensure that they make post natal visits and make prompt referrals through the 104 service

- There is also a need to create awareness among the ANMs, ASHA and AWW about the need for convergence and its benefits

- ANMs and AWW should compare information of left-out communities and use this information to plan ways to reach out to these communities.

Community Participation

- There has been an improved involvement of the CBOs through IKP. It has been possible to construct new centres in new habitations and ensure that self owned centres are constructed. This should be further encouraged.

- Mothers groups, youth groups, NGOs, Village Organisations, CBOs and farmer organisations should be more proactive in monitoring service provision, especially to marginalised groups.

Motivation

In many cases it is observed that AWW and Ayahs find it difficult to reach out to geographically remote communities. Reports from both districts indicate that service providers find distance the major challenge in reaching remote areas (Ambedkar colony in Sambepalli of Kadapa and SC colony in Marripalli of Mahabubnagar). In three of the rural AWCs studied, the **Ayahs are too old to walk** and reach out the remote communities.

It is widely felt that there is a need to promote a **system of incentives & rewards** to ICDS staff. As District Collector himself remarked, “The quality of leadership of the CDPO, supervisors need to be improved. They need to be motivated and they need to grow within the system and be duly incentivized and rewarded”.

B. Jharkhand

The two high burden districts of West Singhbhum and Dhanbad were studied. From each of these two districts, Sonua and Gobindpur blocks were selected. The villages which were selected from Sonua block were Madhupur and Tunia, whereas the villages selected from Gobindpur block were Daldali and Chandudih. Besides these, one urban centre was studied from each of the districts. These were Mary Tola in West Singhbhum and Herapur- Bawri Tola in Dhanbad.

Community Perception of the ICDS Programme

<u>Information and Awareness</u>

It was found that the general awareness about health issues was very poor. This is especially true for the mothers. It was also observed that the level of awareness about these issues was higher in OBCs as compared to the other sections of the community. The scheduled tribes were the most ill informed among those that we spoke to.

The community in general across all groups were aware of the supplementary nutrition and immunisation components of the ICDS programme. However, they showed poor awareness about the timings and purpose of each of the immunisations. Though the different members of community are aware of the fact that children and pregnant and lactating mothers are entitled to SNP, they do not know the quantity and norms governing that **entitlement.** They are therefore unable to demand these from the AWW.

All members of the communities were found to be unaware of the following issues:

- The time when the AWC was opened everyday.
- The funds available to the AWCs to run the different programmes.
- The detailed roles and responsibilities of the AWW.
- The number of beneficiaries the AWW is supposed to cover as part of her intervention.

It was observed that the **difference in awareness** varied between clusters of villages and hamlets rather than based on caste or class. The further the villages/ clusters or hamlets are located from the AWCs/ block head quarters, the lower the levels of awareness about the ICDS programme and its components.

Among the different ICDS components, the supplementary nutrition programme, pre-schooling and immunisation have the **highest recall** as compared to other services. This is especially true in the case of ST populations who are only aware of the SNP and immunization programmes of the ICDS. The nutrition and health education component was observed to be the **most neglected component** of the 6 ICDS services being provided. The reasons for this have been identified as follows:

- The AWWs have a poor understanding of health and nutrition concepts and thus they are found incapable of providing effective counselling and creating awareness in the community.

- The AWWs are reluctant to make house visits and there is very little supervision to ensure that these happen regularly.

- Some communities expressed that they have little faith in the capability of the AWW and that they rarely take her advice.

The study also identified that the AWWs **role in information dissemination** and in creating awareness in the community is severely neglected. She is more focused on the actual delivery of the services as opposed to ensuring that awareness is built and demand for the services is enhanced among all beneficiaries.

Observation: The Nutrition and Health Day (NHD) is designed to converge all the ICDS services at a fixed date, place and location every month and especially to reach out to beneficiaries who do not currently access the ICDS services, however it was noticed that the AWW and her 'Sahaika' in certain villages did not go to the remote clusters to inform these communities of the programme and therefore these scattered and remote habitations remained excluded from the programme. The AWW and the Sahaika would only meet with the communities in their own tolas or habitations.

Availability and Access

Of the six ICDS services, it was observed that the **SNP was the most accessed** service and that health and referral services were the **least accessed** services. All sections of the community access the SNP component the most and the health education and referral services the least. The reasons for poor access are linked to poor awareness of the services provided as seen in the previous section. Other observations on access are listed below:

- Muslim communities showed **reluctance in being immunized** because they perceived vaccines as 'haraam' and thus against their faith. The reasons attributed include the fear of pain, misconceptions about vaccines and immunizations and their own belief system.

- It was observed that the AWW prioritises her nutrition supplies to children below 3 years and pregnant women. Adolescent girls **accessed supplementary nutrition the least** and this group was followed closely by lactating women.

- Availability of supplementary nutrition is considerably **affected by the price** of rice and pulses in the market. AWWs are bound by providing nutrition to a fixed number of 100 beneficiaries for whom they have been allotted funds. They are therefore challenged when they have to make these services available to more than 100 beneficiaries.

- These take home rations (THR) are mixed with household rations and thus it is not possible ensure that the target beneficiary has **exclusive access to the SNP.**

- There is very little attention paid to the pre-school component by the AWW. As a result of this parents are not motivated to send their children to the AWC. It was observed that access to pre-school education was inversely proportional to the **distance of the AWC from the target group**. It was also observed that no AWC had an attendance of greater than 20 children at any given time. Member from

marginalised groups from the community indicated that apart from exclusion created by remoteness of certain habitations, **voluntary exclusion** was also a reason why the pre-school service was so poorly accessed. These reasons have been highlighted below:

- The AWC does not open on time and often closes before the scheduled time.
- The centres are poorly-maintained with insufficient facilities and are not conducive to learning. Therefore parents who have the available resources are not motivated to send their children and chose to send their children to private institutions instead.

- In terms of coverage, the findings indicate that the **most excluded community** with respect to immunization are the Muslim communities in the area followed by the STs. This is seen in the minority clusters of Parwatpur, Dhatki and Chandudih. The fear of injections and their own set of misconceptions and beliefs prevent Muslim groups accessing the immunization service. Besides these reasons, habitations located far away from the AWC are less likely to use the services provided by the AWC. Communities cite the long hours they have to spend walking to the AWW and the time they have to spend waiting for the services to be made available to them. This often results in loss of wages and impacts other important household chores like collecting of drinking water.

- **Migration for work** especially among the ST communities also severely affects the community's access to the ICDS services. Entire households migrate to brick kilns during the agricultural lean period for as long as 6 months. Thus the children miss their immunisations and both children and women lose out on the SNP. It was expressed by the community that no special effort was made to reintegrate these beneficiaries into the programme once they returned.

- The **knowledge, attitude and behaviour** of the community also play a vital role in determining their access to various services from the AWC. The table below illustrates the community's attitude and their practices in the highlighted areas. These have been drawn from findings and experiences of mothers and children between 0-6 years.

Table 1: Practices amongst communities

Observation: The field investigators noticed that though the NHD is an occasion for the ANM and AWW to weigh children below three years and monitor their growth, the growth of children who were unable to attend the NHD was not monitored. The ANMs and AWWs agreed that it was possible that there were many malnourished children among those who miss out on growth monitoring and whose malnourished status is not recorded. The AWWs did not have a clear understanding of the concept of growth monitoring and how it should effectively followed up. They also admitted that the target beneficiaries were identified as malnourished (mothers and children) were not given any extra SNP or other enhanced services from the AWC.

Quote: *"The supplementary nutrition for women and spot feeding from children in ECE has not been regular for the last 3 months. During the same month we were given two qualities of rice (one was much inferior to the other). Those who came on*

the NHD got a better quality of rice than the others, who were not present on that day and took THR a few days later" – Community members of Madhupur village

Quality of Services

Based on the findings from the field research, the issues related to quality have been classified as follows:

- **Quality of food grains supplied under the supplementary nutrition component:** The quality of the rice and pulses supplied to the beneficiary groups form part of the take home ration and is largely dependent on their **availability in the market and their fluctuating price.** It has been observed that the community realizes that the AWW has to compromise on the quality of the food because the funds made available to her do not take into account the price of food in the market. Where spot feeding is undertaken, it is said that the food is monotonous and does not motivate the children to come or parents to send their children.

- **Quality of education imparted to children under the pre-schooling component:** All members of the community perceive that the AWW is **incapable of providing quality pre-school education.** It is also perceived that as compared to private institutions, the AWC **lacks basic facilities** such as toilets.

- **Quality of counselling provided to the pregnant and lactating women:** It was observed that AWWs **rarely conduct home visits**, especially in clusters and habitations that are far away from their parent villages. It was also felt that the ANMs and AWWs do not give explicit suggestions during the immunization sessions of the NHD because they are busy trying to achieve their respective targets.

- **Coverage of immunization:** All the mothers indicated that on some occasions they have been **asked to pay** for using disposable syringes. If the beneficiary was unable to pay the amount, they use non-disposable syringes. The community also observed that there is often a **shortage of vaccines** and many beneficiaries are therefore left out. **Poor coordination** between the ANM and AWW leads to the exclusion of many beneficiaries. AWWs do not take the responsibility of informing communities about the immunization timings and this affects coverage of those to be immunized.

- **Quality of IEC materials:** The 2- 3 different types of educational material like posters and flash cards used for awareness generation were observed to be in **poor condition** and seldom used. It is perceived that there is a **shortage** of attractive, effective and good quality educational material used for the programme.

- **Capacity building for the community:** The communities indicated that training should not only build the capacity of the service provider but should enable the beneficiary to demand better services.

- **Effectiveness of service provision by AWW:** Many members of the community have indicated that they are displeased with the rude and arrogant behaviour of the AWWs. This probably stems from the fact that AWW are not appointed by the communities and therefore feel **no sense of accountability** to the community. There have also been complaints of **misappropriation of funds**.

Because the AWW is a government employee, like government school teachers, they are **called to do other duties** such as conducting surveys as well. They therefore do not have sufficient time for awareness building and information dissemination related tasks. They also fail to cover habitations and clusters that are far away from the AWC. CBOs and Panchayats have expressed that **their participation is not sought** and therefore they do not have a role to play in the implementation of the ICDS programme.

It was found that poorer families still preferred home delivery. Besides a few OBC and general category family who are more educated are opting for institutional delivery. Therefore, TBAs are the most important service provider for home-based deliveries. The poor in the community prefer the local TBAs because it is an affordable option. The TBA is easily available and is perceived to be more knowledgeable. The TBA does not tend to interact with the AWW.

- **Inadequate infrastructure:** Only a few AWCs have their **own buildings. Most** of the centres are run from the homes of the AWW which are small and inadequate for conducting immunization, health checkups and pre-school education.

  Though drinking water is available in all the AWCs, the **absence of a toilet** poses a challenge for children and is a deterring factor when parents are deciding to send their children to AWCs.

- **Limited ownership:** It has also been observed that the quality of the programme is compromised because the community feels **no ownership** for the programme. Their participation is not sought in a way that will allow the programme to be responsible, transparent and all inclusive.

The community has suggested the following recommendations to render the programme more effective:

- **Democratize** the selection process of the AWW through the Gram Sabha and therefore increase her accountability to the community. The community should be empowered to take disciplinary action against an AWW if she does not deliver the ICDS programme effectively. She should present all financials to the Gram Sabha for scrutiny from time to time.

- The community should be made **more aware** of the programme components and their entitlements.

- The **community opinion** should be taken in improving the quality of pre-school education through the AWC.

- Community should be encouraged to make **voluntary contributions**. The fund so generated should be utilised for improving the quality of services in the AWC.

Exclusion

As previously mentioned, exclusion in the ICDS programme is linked more to the distance of a cluster/habitation from the AWC than it is to class or caste groups. The status of exclusion in the study villages can be better understood from the table

below, based on interviews with community stakeholders who were asked about their perception of which groups they felt were excluded from the six ICDS services.

Further reasons ascribed to exclusion from the communities consulted include:

- **Poor awareness** of the ICDS programme and its scheduled services. THR and immunizations are therefore missed because the information on their distribution is not communicated to the communities on time.

- **Limited home visits were undertaken** by the ANM and AWW to remote clusters/ habitations.

- **Migrant families are** unable to access the ICDS services while travelling.

- Some areas are affected by **extremist activity**, making it dangerous for health and nutrition service providers to reach these pockets.

- **Adolescent girls** did not get supplementary food in most of the study villages as first preference for food is always given to the first 100 beneficiaries who constitute children and pregnant women.

- In Muslim communities we consulted, the fertility rate was higher therefore the possibility of having **more than one eligible woman in every household** is greater. However the AWW only provides supplementary nutrition to one beneficiary per household. As a result many are excluded in this system.

Programme Expectations

The community expectations of ICDS services in Jharkhand have been collated in this table below:

Table 3: Community Expectations of the ICDS

Community Expectations
Supplementary nutrition
▪ Regular distribution of SN. ▪ Increase in quantity of SN. ▪ All eligible beneficiaries should be given SN. ▪ Adolescent girls should not be left out. ▪ Those who cannot take THR on the NHD, they should be given THR later as per their convenience and availability. ▪ Standardisation in the measuring / weighing devices during distribution of THR. ▪ There should be more variety in the spot feeding for children to attract them to the AWC for pre-school education. ▪ Community should be made aware of the actual entitlements under the SN programme.
Pre-school education
▪ Opening up and closing down of the AWC by the AWW on time at fixed times. ▪ Someone should be given the job of fetching and dropping the children from their door step. ▪ Improvement in the quality of teaching in pre-school education. ▪ Training of the AWW in this context.

▪ More attractive and conducive environment for children to learn through joyful methods. ▪ Better foods for children in spot feeding under PSE. ▪ Availability of innovative TLMs and playing kits for children in the AWC.
Nutrition & health education
▪ Regular home visits by the AWW. ▪ Use of attractive dissemination and IEC materials. ▪ Advice during immunisation sessions and THR distribution. ▪ Special counselling sessions for pregnant women, lactating women and malnourished children.
Immunisation
▪ Awareness generation regarding the various kinds of immunisations. ▪ Immunisation sessions should be done twice a month so that if someone misses out on one then they can attend the next and would not have to wait for the next month.
IEC materials
▪ User friendly and attractive materials. ▪ Use of pictorial methods for generating awareness. ▪ AWW should make these materials available to the beneficiaries for their ready reference.
Capacity building
▪ Regular and quality training for community groups and AWWs. ▪ Training for TBAs.
Referral services
▪ AWW's capabilities have to be increased to make this effective. ▪ Community should be made aware of this service.
Service delivery
▪ AWW should conduct outreach activities in far flung habitations. ▪ AWW should be made accountable to the community. ▪ Strong monitoring and supervision system to prevent any corrupt practices at any level. ▪ Building with all basic facilities for AWC. ▪ Mini-AWC for far off clusters. ▪ Increased involvement and role of women SHGs and Mahila Mandals in the functioning of the AWC.

Service Provider's Perspective of the ICDS

General perception of stakeholders

The number of centres is not always proportional to the population they are meant to serve/cover. The AWW finds it challenging to provide comprehensive ICDS services to the often increasing population under her charge. The reasons including remoteness of certain habitations have been stated in the former sections. AWWs **lack motivation in delivering services as t**hey feel they are overburdened with work and have too much to do in a very short time. When asked about which service was the most difficult to implement, the most common response of the AWW has been the pre-education activities. The reasons cited by the AWW were as follows:

- The parents prefer sending their children to private and government schools because they perceive that the **quality of education** is better than that of the AWC. They also expressed that their children like the quality and variety of food provided in these schools under the midday meal programme. These schools also provide scholarships for the children and provided an attractive study environment.

- The AWWs are not well trained to conduct the pre-school education classes and they are therefore unable to hold the **child's interest** for long periods of time.

It was observed that often the AWWs do not refer eligible women and children to the ANM. It is perceived that there is **no formal system** for effectively implementing the referral service at the grassroots level. The block and district officials recommended the revival of the health referral card/immunization card which help track the immunizations and health services received by women and children. They can also be taken with the woman whenever they move to another a village.

Another challenge that AWWs face is in the **procurement and distribution of supplementary nutrition.** The AWW's concerns include:

- **Funds are not released on time** to buy the supplementary nutrition. Also, the funds released to their accounts are only for 100 beneficiaries and this is often insufficient for their centre. In this circumstance, they have to follow a rotational norm – some women are covered in the next round of SNP distribution. This norm creates discontent in the community and affects the AWW's reputation and credibility and ultimately her relationship with the community.

- Despite the rise in costs of rice and pulses in the open market, the government has not revised the funds released to the AWWs for supplementary nutrition.

- The AWWs believe the community is unaware of the challenges in **managing resources of the centre** and they often face criticism from the community. Because of poor awareness of their entitlements the community often make unreasonable demands including providing THR to every member of the household.

- The AWW also discussed how the **THR is not necessarily consumed by the target beneficiary** for whom it is meant for. It is pooled with the household's provisions and is consumed by the entire family.

In the case of immunization the biggest barrier is the **existing beliefs and myths** associated with these immunisations. The fear of pain is also an important reason why the service is not availed by certain groups of people. They also agreed that remoteness of some clusters/habitations negatively impact immunization coverage.

Some of the major challenges cited by the block and district level service providers are listed as follows:

- The lady supervisor is responsible for and has to **supervise a large area**. Her **mobility** in this area is limited because she is not provided any transportation. Issues of safety also hamper her from visiting remote areas where regular public transport is unavailable.

- The coverage of the ICDS programme suffers from a large number of **vacancies** both in the health department as well as in ICDS. The service providers also expressed that **remote postings** affects the motivation and thus the efficiency of the block level staff.

- The monitoring and supervision is poor at the field level and this problem is compounded because there is **no robust MIS** at the block and district level to monitor progress. Computers are not available at the block level office of the ICDS which makes reporting and documentation cumbersome and slow.

- The officials expressed that **inter–departmental coordination** is required both at the field as well as the block and district level. This coordination does not always happen. It is largely dependent on the motivation and leadership of the heads of both departments.

- Institutional delivery is poorly accessed in these districts because most of the **doctors in the PHC are male** and the women feel uncomfortable in seeking services.

Resources

Only 15 to 20 % of the AWCs have independent premises. All the other centres are run in the homes of the AWW and these spaces are too small to provide all the services under the programme. This constraint affects the quality of the service provided and causes inconvenience to the beneficiaries.

There is no physical provision for the health checkups for pregnant women even in AWCs where sufficient space is available – the basic requirements like a screen, bed etc are not available. ANMs often complain that they cannot conduct these checkups because the AWC is poorly equipped or that the AWW does not make these arrangements in advance. The only service that is conducted on the NHD is the weighing of children below three years and monitoring of their growth.

There are three routine tests that need to be recorded for pregnant women – weight, blood pressure and urine test. The AWCs however do not have weighing machines for adults and thus weights of pregnant women are not recorded by the AWW The Urine test strips are also in short supply and this is also a neglected test. In some centres, blood pressure apparatuses are either not functional or not available at all.

The distribution of accurate amounts of THR to the beneficiaries is a cause of concern in the communities. Standard measuring devices are not available to measure precise entitlements to beneficiaries THR.

This is especially true in villages with minority groups especially Muslims, where the fertility rate is very high and therefore the eligible population is more. In this scenario, adolescent girls are given the last priority for SNP. Also, it has been observed that the AWW follows a system of positive discrimination favouring the 'poorest' among the eligible women for the SNP. This has been observed to be problematic because the identification is arbitrary and subjective.

Capacity

The service provider's interviews have expressed that there are a number of areas not covered in the training under ICDS. These include:

- Counselling methods.
- Building community participation and consensus.
- Improving child education through a joyful learning pedagogy.
- Improving convergence between the health department and the ICDS on the field.
- Ways of addressing myths, misconceptions and traditional beliefs of communities that hinder service delivery; thus improving their health and nutrition seeking behaviour.
- Involving CBOs in the AWC activities.
- Leadership training.

<u>Information</u>

There are a number of problems in relation to the data that needs to be collected at the AWC:

The problem associated in this concern has three dimensions:

(i) The quality of documentation is not standardized across centres, making it difficult to compile data across a region.

(ii) There is no compilation of this information on a regular basis at the block and district level

(iii) The information documented is not suitable for converting into an analysis for the purposes of monitoring and evaluation.

<u>Institutional convergence and motivation</u>

The ICDS programme can only run smoothly and successfully if there is inter-departmental convergence, especially between the health department, education department and ICDS department. Presently efforts are being made to build some convergence strategy at the block level through block level meetings of the health and ICDS functionaries once a month. However this is not sufficient and does not result in improved service delivery at the village level.

Observation: The field team came across a classic case of village level conflict in the village of Madhupur where the AWW and ANM are at loggerheads. Each of them does not allow the other to work and this affects the convergence of the programme. The AWW does not allow the ANM to organize immunization sessions in the AWC, which is also incidentally the AWW's home. In FGDs the community said *"because of the rivalry in the village between the AWW and the ANM we don't get CDS services"*.

Under the Janani Suraksha Yojna, financial incentives are given to the service provider who bring women for institutional delivery and immunisations. This

sometimes creates a conflicting situation between Sahiya, Sahaika, AWW and TBA when more than one of these service providers (or health linkers) claims to have brought the women to the PHC for referral.

Motivation

The motivation level of the AWW is low due to the following reasons:

- The community attitude towards the AWW is one of distrust and scepticism because they feel they are not getting what they are entitled to. There is also a general impression that the AWW is involved in misappropriation of funds and corruption.

- The rigid customs and traditions of communities frustrate the efforts of the AWW who try and improve the health and nutrition seeking behaviours of the communities.

- The AWW is also dissatisfied with the honorarium that is being paid. They believe that they are not adequately financially rewarded for the work they undertake. This also often leads to a tendency of making extra money through dishonest and corrupt practices.

- There is evidence that AWW feel that they are not receiving adequate mentorship and support from their supervisors.

- The motivation level of the ANM is affected by the non-cooperative attitude of the AWW or Sahaika in some cases. They are outsiders for the village and cannot achieve the target coverage without the assistance of the AWW or Sahaika.

C. Rajasthan

Two high burden districts of Jhunjhunnu and Udaipur were selected for the field study. From these two districts Buwana (in Jhunjhunnu) and Kherwara (in Udaipur) blocks were identified and 2 villages in each of these blocks Pacheri Kalan and Gadli (in Buwana) and Garaja and Kalyanpur (in Kherwara) were selected for field work. Besides the four villages, two urban centres, ward 3 urban AWC located near the district collectorate office in Jhunjhunnu and the Nimach Mata AWC scheme C in the Udaipur district were also identified for field work.

Community perception of the ICDS programme

Information and Awareness

In almost all the villages and urban centres consulted, the community was aware of the AWC and its location, but there was no clarity about the purpose of AWCs and the role of the AWW. In predominantly tribal villages, the AWC were seen as centres for distribution of supplementary nutrition and education for children. Most of the interviewees were unaware of supplementary nutrition for pregnant and lactating women.

In other villages, AWCs were primarily seen as centres for immunisation, supplementary nutrition for children and pregnant and lactating mothers and to provide pre school education. Community members in general had poor knowledge of the Nutrition and Health Days that take place in the village.

Quote: "We do not know what goes on in the AWC and what services we are supposed to receive. How do you expect us to comment on ways of improving the services?" - A woman from Pacheri Kalan in Rajasthan.

Availability and Access

In most of the villages the AWC was primarily identified as an immunisation service. In fact many of the respondents mentioned that the biggest advantage of the AWC was that vaccination had become very easy and accessible. While there was general awareness and acceptance of vaccination, the vaccination coverage in the tribal villages was very low. The parents (grandmothers, fathers as well as mothers) accept that vaccines are generally good for the children, but the lack of vaccination among children in the village was the result of non availability of vaccination services rather than ignorance. There were complaints that no ANMs were posted in their village or even if there was an ANM they rarely visit the AWC. There were also complaints about irregular opening hours of the AWC and even that the AWW does not open the centre on occasion.

The community cited that no effort was made by the AWW to reach out to those who live far away from the AWC. Those who live close to the centre are able to avail the limited services the AWC provides as it is easier for them to know when the AWW has opened the centre. However those who live in far away hamlets find it impossible to visit the centre due to the irregularity of the opening hours.

After vaccination, supplementary food was the main reason why the beneficiaries visited the AWC. By supplementary food, most of the respondents referred to "hot meals" for children. In the predominantly tribal village, most of the mothers consulted

were not aware of the provision of supplementary food to pregnant women as there was no AWC in the village when they were pregnant. Despite the AWC being operational for a year, there is still a general lack of knowledge amongst mothers about the availability of supplementary food for pregnant and lactating women. In other villages in Rajasthan, taking supplementary food from the AWC depended on the socio-economic status of the women. Those from economically better families rarely took supplementary food from the AWC.

The main incentive for children who go to AWC for ECE is to receive SN. There was general agreement amongst the respondents that the quality of education at the AWC was not good. Those who sent their children to the AWC did so mainly because they could not afford to send their child to the private school. The only advantage of sending the child to the AWC according to the respondents was that children learned to go to school and sit in the class for a couple of hours. Those who could afford to preferred to send their children to the private school in the village.

In villages where the AWCs were comparatively more accessible respondents cited an increase in the institutional deliveries that took place as a positive benefit.

Quality of Services

Home visits, referrals and dissemination of health related information by the AWW is the weakest component of the AWCs work. On the occasions that the AWW or the ANMs do visit village households, they do so either for survey purposes or to inform them of the immunisation schedule. Most of the mothers interviewed stated that they would like it if the AWW or the ANM were to visit them regularly and give them health advice.

While there is general acceptance that vaccines are good for children, no respondent was able to explain how many vaccines should be given to a child or their associated reasons. The mothers were also not informed about the adverse reactions of vaccines such as swelling at the site of injection, or fever after vaccination.

Quote: "I did not take my child for the next vaccination because my child's arm began to swell after the first dose. I took my child to the AWC to complain to the AWW and she advised me to visit the doctor in the PHC. I felt that the ANM and AWW showed little concern for my child's wellbeing and my distress" – A woman beneficiary in Rajasthan.

The opening hours of the AWC are not regular and the AWW does not open the centre according to the scheduled hours. The perception was that for the AWW the main purpose of collecting the children at the AWC was to provide them with food and that the education component was not a priority.

Most mothers were not happy with the quality of education given at the AWCs and some of the children who were 4 or above were sent to the primary schools instead as it was felt the quality of the education in these schools are better.

The mothers were however generally satisfied with the cleanliness at the AWCs and the seating arrangement for children, with children from mixed backgrounds sitting together. Most AWCs had access to drinking water in the form of hand pumps.

However, the mothers felt that there was scope for improvement in the quality of food given to the children.

Exclusion

From the interviews and focus group discussions, no obvious evidence of caste based discrimination was identified. Mothers had no complaints about the treatment given to their children in AWCs and believed that all children were treated similarly by the AWW and the AWH and received a similar quantity and quality of food.

Similarly there was no evidence that there were select houses in the villages that the AWW did not visit or ignored based on background reasons, however it was identified that community members (especially those living further away from the AWCs) are not aware of the activities of the centre, therefore do not send their children.

The main criteria for mothers accessing the services of the AWC were closeness to their homes and general convenience in terms of timings. However, problems occur due to the irregular opening hours of the centres which deter mothers sending their children to the AWCs.

Little attempt is made by the AWWs to reach out to the homes further away from the AWC. Similarly, families where the parents work as casual/daily workers are unable to access the services as the centre opens only for limited hours and too sporadically to ensure that children can be looked after while parents are working.

Another problem that inadvertently excludes the beneficiaries from taking advantage of the AWC services is the shortfall in the number of AWCs that actually exist. This leads to indirect exclusion of those who need the services. For example, in one predominantly tribal village where houses are spread out over a large area there was one AWC which was established a year ago, but was unable to cater to the high demand for services from the village as the norms for the provision of services did not cover the entire village.

Programme expectations

The community's expectations of ICDS are detailed below:

Immunisation

- This service was liked by the entire community as they felt that it protected the mother and the child against many diseases.
- Regular and routine immunisation sessions.
- Timely dissemination of information about the sessions.
- ANM and AWW to do outreach with regard to immunisation. In far off and remote villages, people have no information about immunisation and its uses.

Health Check-ups

- Proper training of nurses / ASHA workers/ ANMs and AWWs regarding delivery. In complicated cases and even in many simple delivery cases, villagers prefer going to the referral hospital or those in the town or the city.
- Adequate and timely supply of medicines and proper storage facilities.
- Provision of qualified doctors at least for a couple of days in a week who can cater to complicated and emergency cases since all the cases cannot be handled alone by ANMs and AWWs.
- Proper and timely information regarding health (check-up) camps.
- Regularized timing of the AWCs (10 am to 5 pm) on all working days and more staffing for the AWCs to deliver services.
- Emergency services and basic first aid facilities in the AWC.

Nutrition and Health Education

- Regular home visits by the AWW.
- Information on other health related issues besides vaccination.

Supplementary Nutrition

- Better quality of nutritious food for children and pregnant and lactating mothers.
- Regular change in the food menu. Milk, groundnuts, biscuits be provided to incentivise children to come to the AWC.
- Good infrastructural facilities at the AWC like electricity, fans, proper sitting facilities, toys, and potable drinking water.
- Disclosure of the date of expiry on food packets given to the mothers and children.

Referral Services

- Better medical facilities, qualified doctors and life saving drugs should be made available at the referral hospital.
- Doctors should be available any time in order to handle complicated cases.

Service Provider's perspective of the ICDS programme

General Perception of stakeholders

The performance of ICDS varied in the two districts of Rajasthan where the field study was carried out. While the service providers in Jhunjhunnu feel that the coverage and performance of the ICDS is very good in the district, in Udaipur ICDS lags behind.

The difference in performance is mainly due to the general composition and socio-economic background of the population in Jhunjhunnu. The district has a very high literacy rate with the majority of the population working in the service industry with agriculture as a secondary business. There are only 30,000 families below the poverty line out of a population of 23 Lakh. The need for ICDS is not as intense as in Udaipur. Compared to Jhunjhunnu, Udaipur has a higher percentage of tribal population and almost 90% of the tribal families are below the poverty line.

Coverage of ICDS is poor in Udaipur due to a number of factors:

- Tribal dominated areas are spread out and difficult to access, bad roads and lack of transport facilities make it difficult for the service providers to be mobile and reach remote areas.
- The lack of health as well as ICDS staff makes it more difficult to generate awareness in the area.
- The traditional beliefs and practices of the tribal families come in direct conflict with those of the health department. Garasia, Meena and Bhil communities are left out due to their inaccessibility, and conflicting cultural practices.

Even within Jhunjhunnu, the feeling among the district level officials is that there is a need to improve coverage among BPL families and the marginalised.

Quote: *"The people that AWCs are currently reaching out to do not require them but the ones who require them do not have the courage and are unable to collectively demand AWC services. At present there is no evidence or mechanism in place to ensure that the ICDS reaches those who are marginalized in terms of caste, class, gender and geography"* - The district magistrate of Jhunjhunnu.

The district officials from both the districts felt that universalization had dispersed the focus of the program and service providers away from those who are most in need. In Jhunjhunnu for instance, the majority of the district population that is reasonably well off in socio-economic terms including education does not require ICDS services. There is a need for the program to improve services and its quality for those that are marginalized only.

However the one component in ICDS that generally seems to have worked in Jhunjhunnu is the IEC component. It has raised the awareness about nutrition and health among general population and has enabled the health department and district administration to keep local data updated and also support other social welfare programs.

While overt caste discrimination was not recognised as an issue in the functioning of the AWCs by either the service providers or the community and beneficiaries do not appear to be left out on the basis of caste, language can be a problem amongst groups. This can be the case particularly in tribal dominated areas.

Quote: *"I find it difficult to communicate to the women in the village because I do not understand their dialect and cannot speak it"* – An AWW serving in a tribal dominated village.

There is also some confusion regarding the division of work and responsibilities between the various workers in the AWC. The community members have no idea about their respective roles.

The number of children registered at the centre is much more then those who regularly attend the centre – there was very poor attendance of children in the centre and no follow up of drop outs by the AWW. Complaints against AWWs are generally not taken up by the higher authorities.

The AWCs are expected to form SHGs in the village and hold 3-4 meetings in a month. These meetings are also meant for disseminating information. However, our observation was that these meetings are not convened on a regular basis. In fact some of the AWWs mentioned that they did not enjoy the SHG aspect of their job as they have to go house to house to collect money as part of the SHG contribution.

While no cases of discrimination based on social group or religion were identified, there have also been no cases of positive discrimination either. The consensus was everyone is treated on a par with others.

Monitoring

There are no clear indicators to gauge the success in fighting malnutrition in the district. The registers that the AWW complete each day provides details of the children fed, weekly THR distributed to pregnant and lactating mothers, immunization etc.. However information on programme coverage is not available as the Supervisors or AWWs do not have the appropriate skills to collate and analyse village level information.

While there is no institutional mechanism to know whether the services are reaching the marginalized, the MPR has indicators which do provide an indication. In the district of Jhunjhunnu there are no children in the severely malnourished category, though there are children in the other three growth chart categories. However, the accuracy of growth monitoring undertaken by the AWW is not reliable. The Supervisors also complained that surveys are not completed properly by the ANM and AWW, as they do not actively seek to identify new children; they merely base the survey on the previous register.

District officials stated that a computerised tracking system that could capture details from pregnancy to delivery including miscarriages, abortions, still births, caesareans and normal delivery cases would be useful. It would also help monitor the female foeticide issue in Rajasthan.

Another issue is that there is no gender disaggregated data available to show the extent to which services are benefiting girls and boys.

There was general agreement among the officials that the AWC has had a significant impact on immunisation coverage and has also had an impact on reducing the IMR.

Resources

The majority of buildings from which the AWCs are operational from are rented. They keep changing due to the landlord's demands.

The lack of good quality educational material was pointed out as a major barrier to delivering the IEC component of the ICDS programme by some AWWs. For example, there were complaints that posters/charts that gave details of nutrition were not available in the right quantity. There were also no alphabet charts or toys for children. Blackboards are required urgently. Not all AWCs have access to electricity, fans or even chairs.

A major barrier to growth monitoring is the absence of weighing scales which was the case in many of the AWCs visited.

Some of the AWCs visited cover a population of more than a 1000 often spread over 4-5 Kms. This makes outreach difficult, particularly in the tribal areas of Rajasthan where houses are dispersed due to the Dhadhi system. The large distance that these tribal communities have to travel to access the AWCs deters them from sending their children to the centres.

Quote: Mothers often do not see the value in travelling long distances to sporadically collect packets of SNP. One mother who was interviewed pointed out that, *"Women are not motivated to walk more than a kilometre in the heat to collect just a packet of dry ration."*

A shortage of staff in the health department also creates problems. In some cases ANMs have been given charge of more then 2-3 SCs. This leads to delays in immunisation. There are also no facilities for safe deliveries at the SCs.

Many of the respondents complained about the quality of food received in the AWC.

The AWW and the ANM felt that the community had an important role to play in ensuring the resources of the AWC are sufficient either through donations of resources or through user fees.

There were some cases of the AWW involving the CBOs and the Panchayat to help improve the facilities of the AWC.

Observation: Field investigators visited an AWC in Kalyanpur where the AWC runs from a room allotted to it in a primary school. The ration is stored and cooking is done in the same room. This left very little space to accommodate the children and conduct ECE activities.

Institutional convergence and coordination

There seems to be better convergence across different government departments and agencies in Jhunjhunnu. As the DM of the district pointed out, "There is convergence between health and the water and sanitation department under the Public Health and Environment Department (PHED) in Jhunjhunnu. ANMs receive some funds from PHED to perform department related tasks. Also the health department is paying the ASHA worker an incentive to achieve immunization targets. NRHM also has provisions of paying ASHA in helping it achieve institutional deliveries".

There is a District Health Society which is chaired by the DM but involves all key officials from all departments. Information is exchanged during these convergence meetings. However there is a general feeling that convergence can be improved further. One of the suggestions has been to make it essential for all block and district level officials of various programs to sit at least together once in a month to discuss the integrated planning and monitoring and evaluation. A regular block level Health and Sanitation committee is also another way of converging services.

There was also general consensus that with the start of the National Rural Employment Guarantee Act, the BDOs and SDOs are too busy to be involved in any other tasks than their own.

While the district administration feels there is a need to improve convergence between the AWW and the ANM, the interviews with the ANMs and AWWs do not reflect this need. In their interviews, the ANMs and AWWs were generally happy with the support they received from each other. It is important to mention here that there was a clear understanding among the health workers about the distribution of work between them. The AWW was responsible for procuring ration, running the ECE and general record keeping. The Helper was responsible for cleaning the centre, cooking and feeding the children. The ASHA was expected to survey 10 households every day, inform women about vaccinations and collect them on the day of immunisation. However, there were instances of conflict between the AWW and the ANM which had a direct impact on the delivery of the programme.

The ANMs are only allowed to give vaccines at the SC or AWC. Given the remoteness of some of the hamlets, she felt that if she was given the appropriate support and permission that it would be more effective if she were to travel to the hamlets to ensure the children were immunized.

The aim of involvement of Panchayats in ICDS was to ensure community ownership, partnership and accountability of program staff to community. However the actual impact has been negative as the 'vote bank politics' of Panchayats has impacted the appointment of AWWs, their attendance verifications, their non-performance and accountability to public due to influential links with PRIs or any other influential personnel. There were mixed feelings among those consulted with regards the involvement of the Panchayats in ICDS.

The involvement of the Panchayats in the selection of AWWs has led to a number of problems. The Panchayat members can sometimes insist on selecting women who are not be qualified to be an AWW. Because the selection of AWW has become political, when the opposition members come to power, they tend to create problems for the serving AWWs. When food is in short supply there were instances where the AWW has given preference to those who are closer to the Sarpanch than to those who are marginalized.

The service providers felt that Panchayats were not suitably trained to monitor and supervise the functioning of AWW. Their lack of capacity in assessment, supervision and even planning was cited as issues. The service providers believed the involvement of the Panchayats should only be in an advisory capacity.

Motivation

Excessive paper work and responsibility of work in other programmes in addition to poor financial incentives were the two main reasons for poor motivation cited by the AWWs and AWHs.

The number of Supervisors that exist to monitor the programme is insufficient. One Lady Supervisor has to look after more than 30-40 AWCs and therefore she is unable to visit all of the AWCs under her jurisdiction.

The supervisors feel that given the number of AWCs they have to cover, it is imperative that they should be given some kind of transport facility, particularly when basic infrastructure in the area is underdeveloped.

Many large villages have only one or two AWCs which affects their coverage reaching out to agricultural labourers and in particular seasonal migrants -which is very difficult.

Innovations

Efforts are being made in the tribal dominated areas to improve the situation. For example the Tribal Welfare Department (TWD) has started Maowari Centres for the excluded population in the areas where ICDS is unable to reach or where the AWCs are present but non functional. The role of these centres is to supplement the functioning of the AWC and ensure that the gaps left by ICDS are breached. There is one Maowari centre for every 30 children and the major activities are pre school education, health and nutrition. Besides this the TWD also provides basic training to the AWWs to help them understand tribal cultural and behavioural practices. The decision to open these centres was taken in consultation with the ICDS department. Funds are released by the TWD to construct AWC, health centres or PHC, wherever required.

D. Uttar Pradesh

The two high burden districts of Allahabad and Hardoi were studied. From each of these two districts, Kaurihar and Ahirohi blocks were selected. The villages which were selected from Sonua block were Mubarakpur and Ramnagar, whereas the villages selected from Kaurihar block were Rajpar and Sadiapur. Besides these, one urban centre was studied from each of the districts. These were Teliaganj in Allahabad and Allothok in Hardoi.

Community Perception of the ICDS Programme

<u>Information and Awareness</u>

The study team observed that not all the respondents were familiar with the term ICDS and that the programme was largely recognized by the term 'dariya' – dalia being the supplementary food provided at the AWCs. The mothers interviewed did not understand what malnourishment or 'kuposhan' was or its consequences. However, they showed concern about 'weakness', repeatedly falling ill and infections manifested as diarrhoea and fever seen in mothers and children.

All the respondents interviewed were familiar with the concept of immunization and that they can prevent diseases. Most members of the community immediately recalled the polio immunization that has been undertaken. However they were unable to recall the names of other diseases preventable by vaccine. All members of the community consulted acknowledged that during pulse polio rounds, both the ANM and AWW undertook this activity together.

The entire community used the term "dariya" for weaning food and "khana" for cooked food distributed at the AWCs in both Allahabad and Hardoi districts. The concept of supplementary feeding was not well understood by the community. They recognised it as an incentive to attract children to come to the AWC rather than an attempt to bridge the nutritional gap in women and children.

None of the beneficiaries consulted were able to identify all of the 6 services delivered through the AWC. Indeed During one focus group discussion an AWW was unable to list the services provided through ICDS. Most beneficiaries including marginalised communities recognized pre-school education, supplementary nutrition and immunization out of the six services. The nutrition and health education components of ICDS were completely unknown by all of the community respondents.

In both the districts the community acknowledged that ANM visits the households along with AWWs but this situation was generally only for polio immunisation rather than for other services such as IFA, TT, health check-ups and advice to pregnant mothers.

All the respondents felt that the AWWs do not inform them of the services they are entitled to receive and therefore they feel that they are being deprived of essential services which are their right. Member of most groups of the community were not certain of the quantity of food that they were entitled to receive and were completely unaware of referral services through the AWW. This was more so in the case SC groups.

The respondents also communicated the following issues related to the ICDS in their villages:

- The AWCs do not have regular opening and closing hours. The AWW appears to open the AWC according to timings that are convenient to her rather than the community.
- That they suspect that some AWWs sell the food meant for women and children to traders who in turn purchase it as feed for animals.
- Preschool children receive cooked food 5 – 6 times a month.
- There is no feedback to mothers about the nutritional status of their children.
- The session on nutrition and health education at the AWC is not taking place.
- There is no system of referrals by the AWW.

Availability and Access

The study team observed that there is little interaction between the SC community members and the AWWs in Rajpar and Ramnagar. They are less informed than other groups about the timings of different ICDS services. The mandatory home visit by the AWW does not occur within these groups. Because the AWWs do not live in the villages they service, the centres are effectively managed by the AWH.

The community in general and marginalised communities in particular are of the opinion that the AWCs are not located far away from their habitations and that they are to far away for pregnant women and children to access

There was evidence that the three services (provision of SN, conduction of pre-school education and immunization) did occur in the villages studied. However, even though pre-school education is provided to under-six children, the provision of this service is largely dependent on the AWH and not the AWW. High absenteeism of the AWW affects the quality of this service because the AWH is illiterate and untrained, therefore not capable of delivering the services that the AWW should deliver. Supplementary food is however provided to all the communities that attend the AWC either as weaning food or hot cooked food. All the beneficiaries admitted to having poor knowledge about the use and importance of certain foods for pregnant and lactating mothers.

There was no evidence of other services such as nutrition and health education, regular health checkups and referrals being delivered. Some individual instances have been reported where the health provider has delivered these services but these have not been institutionalized through the AWC. The study team found that the AWW or AWHs call women and children from nearby places for immunization or pre-school activities but those families that reside in the outskirts of the village are left out. As the SC populations generally live on the fringes of the villages they remain excluded. The significant number of SC respondents in both districts expressed that no effort is made by the AWW to reach out to their community.

Community members especially from the SC groups in both districts felt that the AWWs do not visit their homes because she is usually from a higher caste. The only time she visits them is when she has to survey or motivate them to access the polio immunization. This they believe is because the monitoring and supervision of the AWW during the polio immunization sessions is much more intensive and stricter. These communities were unanimous that there was no discrimination of women and children who visited the AWC to access the services there. They agreed that the AWH visits them to take children occasionally to pre-school and this happens even in the absence of the AWW. The community also believed that the AWH was their link to the ICDS programme and that she conveyed important information about the programme to them.

Observation: The data collection team observed that in both districts, marginalised communities especially from SCs faced exclusion. In Mubarakpur, a Muslim dominated village, the Pasi community did not receive any of the ICDS services because they live on the outskirts of the village and the AWC is far from their homes. Also, due to ongoing rivalry between the dominant Muslim groups, families do not send their women and children to the AWC to avoid any kind of incident while travelling. Rajpar, a village in Hardoi is SC dominated. Because the AWW is from an upper caste, community members believe that she behaves differently towards them. In Ramnagar the Muslim population has reservations about accessing ICDS services because the AWC is run in the precincts of a temple. In Sadiapur, the community does not dare complain about the functioning of the AWC because the AWW is close to the henchmen of political groups who terrorize the villagers.

Some of the common reasons ascribed to the community for not accessing ICDS services are listed below:

- The community is not adequately informed about the nature and timings of the activities in the AWC. Panchayat members are also unaware of the package of services provided by the ICDS.

- The activities are scheduled at inconvenient times when women are tending to household chores or in the field.

- Newly married women are not allowed to the AWC as it is unacceptable for them to leave the house. This is a traditional belief across castes in the villages we visited.

- There is a misconception in the community that the ICDS programme is meant to provide a door to door service.

Observation: The children of Ramnagar do not go to the AWC for pre-school education. Their mothers are agricultural labourers and are required to leave early in the morning to work in the fields. They find it difficult to send their children for ECE because there is no one to take their children to the centre.

Quality of Services

Quality of Pre School Education: Because of the high absenteeism of the AWWs, the AWH runs the pre-school education sessions in place of the AWW. In the absence of the AWW, the AWH who is illiterate manages to retain the children and keep them engaged. She also provides them with SN. The community across caste groups appreciates the efforts of the AWH. However, they are of the opinion that she should receive further training to ensure she can run the centre better. The pre school material is insufficient and replenishment of material takes a long time. Most of the AWCs have received pre-school educational material only once.

Quality of Supplementary food: All the communities consulted believed that the quality of the weaning food supplied at the AWCs is poor. They complained that it is sticky and children find it difficult to swallow. The hot cooked food prepared at the AWC is more acceptable. Due to fluctuating prices, the cost of raw materials for cooked food has gone up. This has severely compromised the quality and quantity of food provided. Due to lack of sufficient information about their entitlements, the community believes that they are given less than they are due. Furthermore, they expressed that SN does not take place regularly. All members of the community believe there to be extensive corruption in the ICDS system and therefore the quantity of their entitlements is reduced. The formation of mother's committees in the region has also failed to address this problem.

Effectiveness of service provision: Most community members and SCs in particular do not believe that the AWWs give the feedback they provide to them to their respective supervisors. When the community wants to meet the supervisor and make representations, the supervisors are difficult to contact. The community has reported infighting, high handedness of family members of the AWWs and sectarian politics – all of which affects the quality of services of the ICDS programme. The community therefore has very little regard for the effectiveness of the AWW and the AWC. The team observed that the community and especially marginal groups had a number of complaints about the functioning of AWCs and prevalent malpractices but they were unwilling to provide detailed information. It was observed that the members of the mother's committees only performed a signatory function and they were neither concerned nor capable of bringing any change into the functioning of AWCs. The community is not optimistic about the participation of PRIs in the monitoring of the AWCs. The community as a whole has complained that their village leaders are indifferent to the programme and that no PRI based monitoring system exists.

Most of the weighing machines in the AWC were broken and as a result growth monitoring cannot take place. In the absence of the mandatory and prescribed home visits by ANMs, mothers are not counselled and appropriate referrals are not made. Mothers are also not informed about the growth grades of their children and health and nutrition education is not provided.

The role of the ASHA worker as a local helper for the ANM has greatly enhanced the health service delivery in the villages. This is true for the immunization programme as well. She plans the immunization schedule, prepares an advance list to check for the availability of vaccines and advises mothers on the possible side effects of the vaccines. However, many villages have expressed that there has been a shortage of IFA tablets and that they prefer to receive the TT injections through private medical practitioners.

Discrimination against girl children was found to be rampant in both districts. This was observed not only in aspects of health and education but in nutrition as well.

Quote: "We do not see the use of immunising a girl child" – A woman consulted in a village in Uttar Pradesh indicating gender based discrimination

Exclusion

Our study identified a number of instances of exclusion in the villages we visited. In Mubarakpur (Allahabad) the Pasi community does not receive ICDS services as they are fearful of powerful Muslim groups who dominate the village and who terrorize them and control all the village resources. There has been no attempt by the block and district level functionaries to rectify the situation. The Ramnagar Muslim women are agricultural labourers who take their children with them to work as they have to go to work very early. They are therefore excluded from the AWC services. Muslim groups have expressed concern that some AWCs run in temple precincts and that it is unacceptable for them to enter these AWCs. Some Muslim communities also excluded themselves from the immunization programme because they believe it to be against their faith. The community believes that there has been no attempt by the ICDS to address this issue.

Observation: The team visiting Sadiapur (Hardoi) came across an AWW and her family members belonging to a powerful family. When a local woman complained about malpractice in the AWC she was badly thrashed by the AWW's family members.

Programme Expectations

Table 3: Community Expectations of the ICDS

ICDS Component	Community Expectations
Supplementary nutrition	▪ Regular distribution of SN. ▪ All eligible beneficiaries should be given SN. ▪ Adolescent girls should not be left out. ▪ Standardization in the measuring / weighing devices during distribution of THR. ▪ There should be more variety in the spot feeding for children to attract them to the AWC for pre-school education. ▪ Community should be made aware of the actual entitlements under the SN programme.
Pre-school education	▪ Opening up and closing down of the AWC by the AWW on time at fixed times. ▪ Someone should be given the job of fetching and dropping the children from their door step. ▪ Improvement in the quality of teaching in pre-school education. ▪ Provision of uniforms and scholarships. ▪ More attractive and conducive environment for children to learn through joyful methods. ▪ Availability of innovative TLMs and playing kits for children in the AWC.

Nutrition & health education	▪ Regular home visits by the AWW. ▪ Use of attractive dissemination and IEC materials. ▪ Advice during immunization sessions and THR distribution. ▪ Special counselling sessions for pregnant women, lactating women and malnourished children.
Immunisation	▪ Awareness generation regarding the various kinds of immunisations. ▪ Immunisation sessions should be done twice a month so that if someone misses out on one then they can attend the next and would not have to wait for the next month.
IEC materials	▪ User friendly and attractive materials.
Capacity building	▪ Regular and quality training for community groups and AWWs. ▪ Training for TBAs.
Referral services	▪ AWW's capabilities have to be increased to make this effective. ▪ Community should be made aware of this service.
Service delivery	▪ AWW should conduct outreach activities in far flung habitations. ▪ AWW should be made accountable to the community. ▪ Strong monitoring and supervision system to prevent any corrupt practices at any level. ▪ Building with all basic facilities for AWC. ▪ Supervisors should interact with the community directly to register their feedback about the programme.

Service Provider's Perspective of the ICDS

General perception of stakeholders

The majority of the AWCs visited in this study were located in the house of the AWWs. Parents are reluctant to send their children to the centres based in the AWW's home because of caste differences, social and political rivalries, their own domestic work load and fear of safety of their children. The number of children attending pre-school education in the AWCs is therefore reduced.

AWWs have expressed that the quality and quantity of available pre-school education material was very poor. They also complained that when these materials became un-usable due to wear and tear no replenishment was made. AWWs believe that parents prefer to send their children to government schools by concealing their age. These schools offered scholarships and better facilities in terms of food and education to the children.

AWWs do not find it easy to cover all the eligible women and children under the programme because some habitations are located far from the main village and are difficult to reach. However they mentioned that the immunization coverage of the population did not suffer because of the appointment of ASHA workers in all habitations. They believe that communities do not access the health component services from ICDS and prefer to use private services because they perceive them to be of better quality. Even though the AWWs refer women and children to the ANM,

the ANMs poor follow up results in communities choosing private health services instead.

AWWs also stated that they found it difficult to communicate health and nutrition messages to the women. They indicated that they needed to be trained in order to communicate these messages more effectively. They also complained that the workload was high compounded with a large amount of time spent maintaining registers.

The health service providers informed our data collection team that there were no formal meetings with the AWWs. They complained that the AWW did not involve them in their activities. They also mentioned that the AWH do not support the ANMs. If the AWH come from well off families, they look down upon and shirk their responsibilities of activities like cleaning the centre and picking up the children.

Because of the sectarian politics present in the villages, the AWWs expressed difficulties in getting PRIs involved in the monitoring of the programme. This becomes more challenging when the AWW belongs to one political faction and the village head to another.

The formation of mother’s groups to monitor the activities of the AWCs has not resulted in improvement in the provision and access of ICDS services. From consultation of the mother’s groups capacity was poor and they had a limited understanding of their role in the monitoring of the services of the AWC. However the district and block functionaries commented that these institutions were new and needed some incubation time before results could be seen.

In the two communities who are not accessing the ICDS services (the Mubarakpur SC community and the Ramnagar Muslim community), there is limited effort by the AWWs to bring these communities closer to these services. In addition there was little evidence of the supervisors and CDPOs being actively involved in the supervision of these AWCs or providing support to provide solutions to the challenges the AWCs face.

AWWs confirmed that beneficiaries have a poor understanding of supplementary nutrition. They identified the following challenges they encounter in the provision of supplementary nutrition:

- Women do not come to AWCs to collect their SN due to their domestic chores at home.
- Hot cooked food requires the use of fuel and utensils which they have not provided with.
- AWWs need bills to submit to the CDPO when they procure food. However, these bills are not available in the village, it therefore makes it hard to purchase and cook food at the AWC.
- Beneficiaries show resentment about the limited quantity of raw food they receive.

The CDPO felt that the most important hurdle in the service delivery of the ICDS programme was the absenteeism of the AWWs. She expressed that it was very

difficult to use disciplinary action against absent AWWs because of their strong unions.

The district programme officer informed the study team that there were vulnerable pockets within the communities who were not accessing the ICDS services and that there was ignorance among the district and block level functionaries about these groups of people.

Resources

The majority of AWCs visited were situated in Panchayat bhavans or in AWW's residence. Some evidence of AWCs being constructed did exist, but this was limited in number. The AWCs visited were in a state of disrepair and lacked basic facilities like electricity and water. The district level functionaries also complained about the acute shortage of medicines like IFA tablets and TT vaccines available to them in the districts.

The unavailability of weighing machines was another major problem that hampers the ability of the AWW to monitor the growth of children in the AWC. The AWWs also complained of the shortage of pre-school education material available in the AWCs.

Capacity

The AWWs and CDPOs interviewed stated that they only received training on joining the programme and that there was no provision for refresher courses whilst performing their jobs. AWWs specifically expressed the need for health communication training and training on community mobilization and engaging harder to reach communities. It was also suggested that the curriculum of training for AWCs needs to be modified to include more technical training.

The AWWs were of the opinion that their work load needs to be rationalized based on the population they cover and the distances they have to travel. If this is not addressed they believed any additional training efforts will be wasteful.

Information

According to district and block level functionaries, the AWWs surveys and summaries are the most authenticated source of village level information. Other government department functionaries have used this data for their developmental work. The health department is also reliant on this data to reach out to women and children and to provide them services such as immunization and referrals to higher levels of care.

Institutional convergence and motivation

Some basic convergence between ICDS and the Health Department was observed during the field investigations. This was particularly the case during the pulse polio immunization rounds. AWWs stated that on occasion, when the AWW gives a mother a referral card asking her to seek the advice of the medical doctor at the PHC, the doctor sometimes disregards this intervention of the AWW. The block and district level officials stated that they are attempting to increase the number of meetings between the ICDS and health staff. They believed that in order for these meetings to be effective, they should be convened by the district magistrate.

One CDPO felt that the ICDS functions in isolation and that there was no attempt to integrate the programme with services of other departments (for example the education department) which would improve convergence. He laid the onus of initiating and maintaining convergence on the MWCD.

The functionaries who were interviewed stated that the frequent fights between the community and the AWW also compromised convergence efforts at the field level. These clashes of political rivalry between ANMs and AWWs also severely hamper service delivery to the communities.

Motivation

The AWWs felt that their motivation could be improved if they had regular, good quality, encouraging supervision. They complained that the excessive workload and the non-cooperation of the supervisors was a serious barrier to improving their performance. They also mentioned that in order to function efficiently, they would need the support of the community and their leaders. Without this support, they would not be able to reach out to vulnerable populations.

Annex 3: Innovations in ICDS

<table>
<tr><th>NAME OF THE INTERVENTION:
ANDHRA PRADESH ECONOMIC RESTRUCTURING PROJECT (APERP)</th><th colspan="2">OPERATIONAL AREA:
Total: 40,000 AWCs
1999 to 2005, in Andhra Pradesh</th></tr>
<tr><td>OVERALL IMPACT</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>• Decreased severe under nutrition from 2.9% to 2.1% and moderate malnutrition from 13.3% to 12.9%.
• Around 50, 000 Mother’s committee were formed 40% were involved in ICDS work. Around 31% of surveyed mothers reported to have heard about its functioning. The awareness was quite higher in tribal areas (49%). Similarly, three-quarter of AWWs found that the functioning of Mother’s committee as good and 11 % of AWW found it to be satisfactory.</td><td>Baseline and endline survey.</td><td></td></tr>
<tr><td>IMPACT ON EXCLUDED GROUPS</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>No data to show the impact.</td><td></td><td></td></tr>
<tr><td>BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS</td><td colspan="2">BEST PRACTICES WHICH HAD IMPACT OF SOCIALLY EXCLUDED GROUPS</td></tr>
<tr><td>Mothers committees
50,000 committees have been formed. Each group has a bank account for management of community funds. These mother’s committees were originally involved in the civil works components of the World Bank-assisted ICDS I project - selecting construction sites for anganwadi centres, monitoring construction and releasing funds to cover construction costs. Latter the government added a range of new functions for mother’s committee. “The range of responsibilities of AWW today includes recruiting AWWs and AWHs, paying honoraria, monitoring and community-based monitoring for AWCs”. This approach seems to be genuinely empowering, where the AWW manage many aspects of ICDS. This model of ICDS could be helpful in giving poor women the control of monitoring the scheme.</td><td colspan="2">No (best) practice which seemed to work for addressing social exclusion was documented in APERP project reports and state annual reports.</td></tr>
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Balika Mandals (adolescent girls groups) There are 11,340 Mandals in the state. There were around 250,000 girls who acted as change agents. A "Balika Mandal" is formed with 25-30 Adolescent Girls in the age group of 11-18 years in a village both with school dropouts and school going girls. AWW conducts awareness sessions to all Adolescent girls regarding the symptoms of anaemia and food source of Iron Rich foods among other nutritional issues. These trained girls in turn conduct the session to the rest of the girls in the village. First time these groups were formed in ICDS. This has been replicated in other states	4211 mini AWC are operating in thinly populated slums and tribal areas. This would have led to the inclusion of target tribal populations living in small (with 150 to 300 populations) and geographical dispersed location. However could not identify any documentation regarding this in APERP project reports and state annual reports.
	An academic study based on a qualitative study in Andhra Pradesh on Village Education Committees and Mothers' Committees found that poor and disadvantaged increased participation in public affairs and which brought about some improvements in service quality, inclusive and meaningful participation. However, illiteracy and lack of information, as well as caste, gender, and socioeconomic inequalities still proved to be considerable barrier. There were considerable tensions between inclusive participation and committee effectiveness as members need skills, status, and resources in order to have a meaningful impact on service provision (Jones, Nicola, 2007)

<table>
<tr><th>NAME OF THE INTERVENTION:
WORLD BANK ICDS- III PROJECT</th><th colspan="2">OPERATIONAL AREA/
In five states since 1999 and further 6 states from 2003. Project completed in 2006.
1999- Kerala, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh.
2003 – Madhya Pradesh, Bihar, Chhattisgarh, Jharkhand, Orissa and Uttaranchal.
Approx. 26 million beneficiaries.</th></tr>
<tr><td>OVERALL IMPACT</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>• On average reduction in severe and moderate malnutrition in 0-36 month old children (<-2SD, NCHS Growth Standards) by 8.95 percentage points in 5 years.
• Uttar Pradesh achieved a maximum reduction of 13.4 percentage points, followed by Tamil Nadu with a reduction of 11.4 percentage points. Next is Maharashtra with a reduction of 9.2 percentage points, followed by Kerala with a reduction of 7.83 percentage points and Rajasthan with a reduction of 7.6 percentage points.
• Substantial improvement in certain indicator including: (a) proportion of children age 6-36 months consumed Vitamin-A rich food, (b) Proportion of children age 12-36 months who received Vitamin A dose, (c) Proportion of AWWs reporting regular (monthly) growth monitoring of under 3 children, (d) Proportion of children over 12 months that have ever been de-wormed, (e) Proportion of children weighed at birth.</td><td>Based on baseline (2000) and end line surveys (2005) and evaluation in Kerala, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh.
No controls were used.</td><td>Reductions in the proportion of severely malnourished children (0-36 months; <-3SD) is only 1.7 percentage points in 5 years
Results of feeding practices are mixed. The proportion of 0-6 children who were exclusively breastfed actually decreased during the project period.</td></tr>
<tr><td>IMPACT ON EXCLUDED GROUPS</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>• No statistically significant difference in the participation rates of boys and girls, either among the group that attends the ICDS centres on a daily basis or among those who attend at least once a month.
• In all states the attendance rates of scheduled caste and scheduled tribe children are in line with or slightly better than that of other castes. In Maharashtra, Madhya Pradesh and Chhattisgarh, the percentage of scheduled tribe children attending the AWC is higher than any other caste, while in Kerala, Rajasthan and Uttar Pradesh.</td><td>Based on baseline (2000) and end line surveys (2005) and evaluation in Kerala, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh.
No controls were used.</td><td>The data is based on those beneficiaries who live in villages with AWCs and not children from excluded hamlets.</td></tr>
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• Little variation was found in children's participation rates across wealth quintiles – not much more than a 10 percentage point. • Difference. However in Kerala and Madhya Pradesh, attendance is particularly regressive, with higher attendance rates in the upper quintiles.		

BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS	BEST PRACTICES WHICH HAD IMPACT OF SOCIALLY EXCLUDED GROUPS
Biannual Child Health and Nutrition Month (Bal Swasthya Poshan Mah) in Uttar Pradesh: Under the BSPM strategy, two months (May and November), six months apart, were identified as health and nutrition months. During these months, ANMs and other functionaries in the PHC are assigned with the task of providing immunization and other services to the beneficiaries while ICDS sector is responsible for mobilizing beneficiaries for using the services by organizing intensive social mobilization and IEC activities. "The activities of these biannual months have been linked with the routine immunization days of ANM (Wednesdays & Saturdays). Since its inception, these months are being organized in June and December because of frequent Pulse Polio rounds. BSPM months also focus on severely malnourished children towards which a fixed a day is organized as "Shishu Aahar Samaroh" for prevention and management of severe malnutrition.	An innovation identified in ICDS II (Implementation completion report, 2003) was continued in ICDS III. Here poriawadi," a mini-AWC placed in villages with populations of as little as 300 people helped to increase the access of tribal people. A database on tribal groups was developed in Bihar and Jharkhand and was used to plan the location of the new AWCs. Does not report any data. The ICDS IV concept note includes this as a main strategy for Targeting SC/ST/Minorities Does not identify any other specific best practice which helps to reach socially excluded groups either in Implementation completion report or borrower's evaluation report. Did a comprehensive web search to locate the best practices which helped in reaching the excluded group in ICDS. However could not find it. This in despite Banks' specific objective to target poor and marginalized. Off course the Banks' attempt to reach marginalized and uncovered region as part of universalisation would have helped.
Adolescent Girls' Club (Kerala): Adolescent Girls clubs were formed in each ICDS centre. Each AG club consists of not less than ten members and they select representatives from among them and convene meeting twice in a month and various activities are carried out regularly. The total number of clubs formed is 12060 and the number of members is estimated to be 350,055. Adolescent Girls Club activities gave a boost to ICDS with greater concern to the community in adolescent issues.	

Malnutrition Eradication Campaign (Pune District, Maharashtra): District level Panchayat Body of Pune in Maharashtra in collaboration with the local Rotary Club and SNDT College, launched 'Malnutrition Eradication Campaign' to ensure that no child in Pune District remains malnourished. Under the programme, all Zilla Parishad officials "adopt" malnourished children and then work towards making then healthy by putting them on right diet and ensuring all other necessary services to them. The campaign has been successful in mobilizing the local community members to support the ICDS and create awareness among them on the nutrition and health issue of women and children.	
Anganwadi Kala Jattha (Uttar Pradesh): The objective of Anganwadi Kala Jattha was to strengthen interpersonal communication of ICDS workers, so that they can target the community with specific messages repetitively. A resource organization having required communication and folk skills was identified for developing a module for this campaign. The AWWs, after acquiring required skills, have been able to run this awareness and social mobilization campaign in an effective and sustainable manner. A series of activities like rally, door-to-door contact, wall writings, folk songs, Phad Presentation & Discussion, Nukkad Natak, group discussion and quiz were conducted to mobilize and sensitise the community. At the end, feedbacks were discussed in an open forum in a large group. By performing live in front of a large audience, AWWS have gained immense confidence, which has reflected in a positive improvement in their routine work of running AWCs. Extra remuneration was paid for being part of the performing team.	

<table>
<tr><th>NAME OF THE INTERVENTION:
CARE-RACHNA- INTEGRATED NUTRITION AND HEALTH PROJECT</th><th colspan="2">OPERATIONAL AREA
Over 102 million people in the 9 states Andhra Pradesh (AP), Bihar (B), Chhattisgarh (CH), Jharkhand (JK), Madhya Parse (MP), Orissa (O), Rajasthan (RAJ), Uttar Pradesh (UP), West Bengal (WB). 2001 - 2006. 94,592 AWCs.</th></tr>
<tr><td>OVERALL IMPACT</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>• During 2001 and 2006 the reduction in weight for age malnutrition was from 61% to 53% for children in 12-23 months age group across all programme areas (based on baseline and end line)
• Impressive increases in the use of RCH health services, including measles immunization which nearly doubled and improvement in Tetanus Toxoid immunization, micronutrient supplementation with vitamin A, iron and folic acid.
• Improved contacts and home visits by ANMs and AWWs.
• Impact on increasing antenatal check-ups was mixed.
• The use of ICDS nutrition services also increased, including supplementary feeding for pregnant women, lactating women and children in 6-23 months age group.</td><td>(a) program-wide results from 2001 Baseline and 2006 End line representative household surveys in all states except Bihar (without having control).
(b) rigorous pre-test, post-test, controlled, quasi-experimental Evaluation Research studies on (i) newborn health and survival in one intervention vs. a comparison district in UP (2003 and 2006) and (ii) nutrition in one intervention vs. a comparison district in UP and AP states.
(c) Three annual rapid assessments between 2003 and 2005 in one panel district each in eight states.</td><td>(a) No data on severe under nutrition

(b) The indicators for exclusive breastfeeding showed little improvement. Research using control in U.P. and A.P showed decline in exclusive breast feeding. RAPS results showed that exclusive breast feeding until 6 months increased in four states and remained similar in three states and fell in one state. The INHP-II baseline did not have this indicator to enable comparison with end line results.</td></tr>
<tr><td>IMPACT ON EXCLUDED GROUPS</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>Evidence of inclusion
• Beneficiary profile disaggregated by lower and higher socio-economic groups, shows the programme is benefiting the lower socio-economic groups more.

• Ongoing Gender Analysis of Rural RACHNA data reveals an absence of any significant gender differentials in the child care practices measured. The ER on nutrition interventions does not reveal any pattern of gender discrimination.</td><td>Three annual rapid assessments between 2003 and 2005 in one panel district each in eight states.</td><td>The relative position/gain was more for High in coverage of Vitamin A and DPT doses, and more prominently in exclusive breast feeding and feeding of semi solid food, the exclusionary process were at work.</td></tr>
</table>

<table>
<tr><td>Impact was higher for lower socio economic groups (SC/ST and low income house holds) in the following indicators and states:
• Improvement in % of women delivering at home (AP, CG)
• Improvement in use of all five cleans at birth (WB, MP)
• Treatment of the cord or umbilicus (CG, WB)
• Delay in bathing (WB)
• Early breastfeeding (SG and WB)
• Initiating breastfeeding on the first day (AP, CG, WB)
• % of newborn babies not given pre-lacteal feeds (MP, UP)
• Receipt of a minimum of 90 tablets during pregnancy (CG)
• Improvement in mean number of tablets (RAJ, JK)
• Increasing % of women consuming 90 tablets min. (WB, JK)
• Improvement in % of children consuming half the recommended quantity (CG, MP)
• Coverage with measles vaccine (WB)
• Improvement in overall, complete immunization coverage (WB, JK).</td><td></td><td></td></tr>
<tr><td>BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS</td><td colspan="2">BEST PRACTICES WHICH HAD IMPACT ON SOCIALLY EXCLUDED GROUPS</td></tr>
<tr><td>Nutrition and Health Day (NHD) and Take-Home Food Ration (THR)
The programme aims at increasing access of all the eligible children below three years, pregnant women and lactating women and bringing convergence in service delivery of ICDS and Health services at community level to enhance reach of both programs.

Each month, on a fixed day take home rations are distributed to the participants and the ANM visits the AWC and provides immunization and/or antenatal care services. The mother can access the Services at a convenient timing on the particular day.</td><td colspan="2"></td></tr>
<tr><td>Change Agents(CA)
One community volunteers (CA) for every 15-25 households, or multiple change agents per village were used. Change agents was one of the three best practice</td><td colspan="2">Change Agents
Qualitative assessments showed that change Agents from every hamlet in the village and representing different castes and social groups were good mechanism</td></tr>
</table>

identified by INHP-I, and were present in 48% of village as found in End line survey by 2005. However during continuous monitoring using RAPS data it was noticed that Change Agents were not useful in making home visits and then the whole programme stopped recruiting and training more Change Agents and tried to strengthen AWW home visits and supervision. The problem could have been in the selection process as hinted by the final evaluation.	to deal with exclusion. They were important bridge between the systems and the community in terms of being able to positively influence both, behaviour change and service delivery and uptake.
Block Level Resource Mapping (BLRP) BLRP was used as a tool for participatory planning and monitoring in order to focus on nutrition and health issues at the block level with the objective of promoting convergence between ICDS and MOHFW through joint problem identification, problem solving, and action planning. Participants varied from state to state and generally included staff from the health department and ICDS, ANMs, cluster coordinators, lady health supervisors, the CDPO, NGO organizers, and members of the INHP District team. This was first adopted as best practice but did not prove useful. The impact was not much and it depended upon the Government in charge on its successful functioning.	
Community-based monitoring systems (CBMS) CBMS included (a) self-monitoring tools (SMTs) for families and (b) social mapping (SM) Community-based monitoring systems (CBMS). The CBMS was identified as a best practice is to mobilize, empower and facilitate the engagement of community leaders and groups, institutions, and individuals to monitor their own AWCs. However it was found that the use of family-based self-monitoring tools, usually visual depictions such as wall drawing/writing etc were not find widespread. Though social maps were found in 97 % AWCs, they were not used as empowering monitoring tools.	**Social mapping** Qualitative assessments showed that Social were very useful in identifying left-out hamlets and houses. The social map was important for delineating the boundaries of the village and enumerating the catchment area to increase participation by excluded hamlets/ neighbourhoods. The SM was helpful for selecting Change Agents to ensure full coverage excluded hamlets/ neighbourhoods. However it could not track either behaviours or dropouts from services. Social maps were seen as mechanisms easily scalable and user-friendly.

NAME OF THE INTERVENTION: WORLD FOOD PROGRAMME ICDS - INDIAMIX	OPERATIONAL AREA: Two million beneficiaries. 4 States: Rajasthan, Orissa, Madhya Pradesh and Uttaranchal	
OVERALL IMPACT	**METHODOLOGY/ BASIS OF EVIDENCE**	**SHORTCOMINGS**
Improved performance (statistically significant) in relation to government programming in two indicators: • children receiving supplementary food • participation of women The proportion of the underweight children was higher in the General ICDS blocks (60%) than the WFP ICDS blocks (54%). Madhya Pradesh assessment showed that 20 months of the intervention showed improvement in several indicators in populations benefiting from Indiamix compared to those receiving non-fortified food, such as reduced anaemia, reduction in Bitot's spots, and higher serum retinol levels. Rates of severe and moderate malnutrition were reduced from 54 to 46 percent in the sample of children who had consumed Indiamix, compared to a reduction from 63 to 47 percent in children who had only received non-fortified food there was a greater decline in severe malnutrition amongst those who consumed most of the Indiamix and those who consumed only 50 – 75 percent (6.9 percent compared to 9.4 percent).	Baseline (2001-02) and End line survey (mid term) (2006) in 300 randomly selected anganwadi centres in 3 states. Survey comparing areas with WFP supported ICDS and no-WFP ICDS. (2006). Assessment of the Impact of ICDS Food Fortification in Madhya Pradesh carried out by the National Institute of Medical Statistics.	Baseline and End line survey not strictly comparable. Underweight increased from 49.6% to 56.3% and severely malnourished from 19% to 24.5%. The proportion of the severely malnourished children was almost identical in the General (24.3) % and WFP ICDS blocks (24.6%). There was little difference between WFP and government programming, in attendance by children, receipt of supplementary nutrition by women, prevalence of nutritional deficiency among women, the proportion of severely malnourished children, and several indicators related to improved child and self-care practices. There were a number of other child and self care practices where control groups were found to have performed better than WFP, and there was also a lower level of children with severe and moderate anaemia in non-WFP areas.
IMPACT ON EXCLUDED GROUPS	**METHODOLOGY/ BASIS OF EVIDENCE**	**SHORTCOMINGS**
No impact indicators.		

BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS	BEST PRACTICES WHICH HAD IMPACT OF SOCIALLY EXCLUDED GROUPS
Significant higher participation among Children in SNP was cited due to Indiamix, the blended micronutrient fortified food provided by WFP in its ICDS programme. Efforts were made to make the fortified food suitable to local taste and resources. In Uttaranchal the use of locally-grown, organic finger millet in ICDS is considered a major success. WFP has linked the Uttaranchal State Organic Board with relevant government ministries, and at the time of the mid term evaluation, 25 percent of the ICDS meal for six months of the year were made from finger millet. District Model Resource Centre (DMRC) in MP established together with the NIPCCD, DWCD, and the GoMP. The DMRC is equipped with audio-visual aids and resources aimed at motivating ICDS staff to improve the impact of NHED.	Though no best practices were identified by the organization, the Evaluation team recognized that social exclusion was a main barrier in performance of ICDS. The evaluation team which interviewed WFP staff, GoI staff, and international agency staff; carried out extensive interviews with state level government and NGO staff; interviewed 700 beneficiaries in 35 villages and assessed the results of baseline/endline survey results noted that dispersed locations of hamlets made coverage of excluded groups more difficult. In MP and Rajasthan, one of the main reasons of ICDS having poor attendance was the frequent migration of ICDS beneficiaries' families. Follow-up of absent children by the evaluation team revealed that families had left for several days to work in distant fields. Without alternative care options or money to leave with relatives to cover food purchases, children accompanied their parents, and missed ICDS. It reasoned that the most food insecure households, may have been excluded for reasons such as lack of awareness of the programme's existence or its benefits, distance from the centres, reluctance to join others of higher castes or social classes, etc.

<table>
<tr><th colspan="2">NAME OF THE INTERVENTION:
TAMIL NADU INTEGRATED NUTRITION PROGRAM I AND II</th><th colspan="2">OPERATIONAL AREA:
TINP-I 9 million, 1980 – 1989
TINP-II 11 million, 1990 – 1998 (Tamil Nadu).</th></tr>
<tr><td>OVERALL IMPACT</td><td colspan="2">METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>Evaluation studies of TINP-I show that during the programme period severe malnutrition declined by a third and a half among in 6-24 months old children and by about half among 6-60 months old children.

There is no rigorous evaluation undertaken for TINP- II. However the independent survey data pointed out a decline in severe malnutrition by about 44% over a five years period of TINP II.</td><td colspan="2">Baseline and end line. No controls.</td><td>However, moderate malnutrition decreased by 14% in the 1st project areas and increased in the areas in 2nd and 3rd phases.</td></tr>
<tr><td>IMPACT ON EXCLUDED GROUPS</td><td colspan="2">METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>Severely malnourished children were mostly from disadvantaged and low income families. Therefore reduction in severe under-nutrition would have benefited the excluded groups more.</td><td colspan="2">To conform this a study was conducted on at-risk families and correlation to income and literacy</td><td>However, TINP failed to reach those living in hamlets outside TINP's service areas in the main villages. Around 20% of the population lived in such hamlets, and because the hamlets were mainly populated by people from the scheduled castes, whose nutrition was considerably worse than average.</td></tr>
<tr><td colspan="2">BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS</td><td colspan="2">BEST PRACTICES WHICH HAD IMPACT OF SOCIALLY EXCLUDED GROUPS</td></tr>
<tr><td colspan="2">Two worker model in TINP –II, whereby one worker exclusively concentrated on 0-36 months and pregnant and lactating mother.</td><td colspan="2">Wherever possible AWWs were chosen from women who were both poor and who had healthy and well nourished children. Such women had no social barrier between themselves and their poorer clients,</td></tr>
<tr><td colspan="2">Focus on intensive growth monitoring based identification of undernourished was promoted as best practice. However this method is also widely criticized.</td><td colspan="2">Choosing community workers who are residents of the village. They are socially acceptable as well as available at the right time--usually early morning and late afternoon, when poor clients are most likely to be available.</td></tr>
</table>

NAME OF THE INTERVENTION: MITTANIN PROGRAMME	OPERATIONAL AREA: Chhattisgarh rural population, approximately 18 million people. Programme running since 2002.	
OVERALL IMPACT	**METHODOLOGY/ BASIS OF EVIDENCE**	**SHORTCOMINGS**
An interim internal evaluation with 1,200 Mitanins from 240 villages as respondents found good coordination between the health and ICDS programmes. Mitanins reported that they were engaged in distribution of SNP (57 %); promoting child attendance (48 %); weighing children (45%); diagnosing malnutrition and counselling (36 %) and immunisation (46 %);	Evaluation report is part of interim evaluation is of based upon the data collected from 1200 Mitanins and 240 villages in 25 blocks during the period June to August of the year 2004.	No data on perception of beneficiaries, nutrition status, coverage under ICDS services and critical feeding practices.
IMPACT ON EXCLUDED GROUPS	**METHODOLOGY/ BASIS OF EVIDENCE**	**SHORTCOMINGS**
No data available		

BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS	BEST PRACTICES WHICH HAD IMPACT OF SOCIALLY EXCLUDED GROUPS
In Chhattisgarh a Mitanin (community volunteer) in each hamlet is selected by the community, with approval of the Panchayat. More importance is placed on selection process with three-to six-month process of selection where the interests of the weaker sections within the community are facilitated by a trained 'prerak'. Mitanins are trained for around 18 months including 18 days of camp-based training and 30 days of on the job training in the village. After this, support is provided to her in her work with close coordination with the ANM and AWW. The drop out rates among Mitanins was very low.	The assistance of Mitanins was most critical in the hamlets without AWC. The main perquisite for the success of the programme was noted as careful selection of Mitanins based on community choice.
Mitanins were able to help AWW considerably. Mitanin also acted as a as a representative and community leader who monitors and demands accountability from the state. 75.72 % of Mitanins reported a hamlet level committee in their hamlet which is linked to this programme and supports it. This includes 63.66% who had a self help group in the hamlet which functioned as the committee or was there in addition to the health committee. A 34.62% of hamlets reported a third	The Mitanins in different places as organized community leaders are working together with NGO and right to food campaign. Studies in academic journal documents such initiative in around six districts in Chhattisgarh. With help of a district case study Gargh (2006), shows that the campaign emerged slowly as issues raised by the Mitanins were not getting addressed by the supervisory mechanism. This experience also shows the potential of extending the monitoring

committee that was functional and assisted the programme. The crucial part of the programme is its attempt to maintain a balance between in the twin role performed by Mitanin; (a) as a partner of AWW and ANM in provision of services and addressing the gap between them and (b) as a representative and community leader who monitors and demands accountability. This balance in the role is also considered as important motivating factor which gains respectability for the Mitanins.	and accountability structure which in a sustainable way links grass roots action to state, national and international level. Further such participation at multiple levels also has potential to address the problem of exclusion at local level as the campaign here focused on three marginalised primitive tribal groups, who were suffering from worst levels of malnutrition and morbidity.

NAME OF THE INTERVENTION: DULAR STRATEGY- UNICIEF	OPERATIONAL AREA: Bihar, Jharkhand- 8 million, Since 1999	
OVERALL IMPACT	**METHODOLOGY/ BASIS OF EVIDENCE**	**SHORTCOMINGS**
In Jharkhand, after three years the prevalence of severe underweight in Dular areas is roughly half that in regular ICDS. In Bihar, the prevalence of underweight among Dular children is now 10 percentage points lower than in regular ICDS, and the prevalence of wasting among 0-3 Dular children is less than two-thirds that of children in the normal ICDS program. Children in Dular households that had contact with Volunteer groups in the course of a month were more likely to be normal than those	Rigorous surveys over three year period (2003, 2004 and 2005) on 1500 children. Had controls over these years in Dular and non Dular area.	The information could not be triangulated with the large scale rapid survey information.
IMPACT ON EXCLUDED GROUPS	**METHODOLOGY/ BASIS OF EVIDENCE**	**SHORTCOMINGS**
No discriminatory outcome between non-poor and Poor households in Dular area. Poor in Dular area performed better than poor in non-dular area, especially in feeding behaviour and cleanliness.	Rigorous surveys over three year period (2003, 2004 and 2005) on 1500 children. Had controls over these years in Dular and non Dular area.	
BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS	**BEST PRACTICES WHICH HAD IMPACT OF SOCIALLY EXCLUDED GROUPS**	
Group of community volunteers Introduced a new cadre of volunteers named Local Resource Persons (LRPs) to assist the AWW. They are specially trained to disseminate information and to encourage healthy behaviours and practices in the places where they live With supportive and supervisory District Mobile Monitoring Training Team (DMMTT), which was able to fill the gap of 80% vacancy at	Could not be identified.	

supervisory level?	
Community Level Monitoring and counselling tool: Community-based tracking system of the health status of women and of children 0 to 36 months of age by local resource persons (LRPs). At the household level a Dular Card is provided to caregivers to monitor progress of their children. An adolescent card is provided to adolescent girls which tracks IFA tablet intake and provides information on key health, nutrition and hygiene issues. Dular also has developed a Dular Kit consisting of 10 flash cards that is used by the LRPs and AWW to counsel households and for training purposes. A specific folder on IDD has also been developed.	
Home contact drive: Special two-day village contact drive where the whole community participates.	

<table>
<tr><th colspan="1">NAME OF THE INTERVENTION:
SELF EMPLOYED WOMENS ASSOCIATION (SEWA)-CRÈCHES-AWCs</th><th colspan="2">OPERATIONAL AREA:
Gujarat: Around 9000 infants and children in 5 districts.</th></tr>
<tr><td>OVERALL IMPACT</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>70% of children went to school for the first time after Crèche facilities were started in their village</td><td>Not available. The study is quoted in (Mirai Chatterjee, 2006) (Focus, 2006) and (Micronutrient initiative, 2007). However they do not discuss the methodology.

The actual study could not be located despite a comprehensive internet search.</td><td></td></tr>
<tr><td>IMPACT ON EXCLUDED GROUPS</td><td>METHODOLOGY/ BASIS OF EVIDENCE</td><td>SHORTCOMINGS</td></tr>
<tr><td>The benefited group is children of poor working women.</td><td>Many academic studies including, Swaminathan, Mina (1996), Das, Deepa, (2003), S. Anandalakshmy (2005), (Mirai Chatterjee, 2006) (Focus, 2006), quote this as best practice.</td><td></td></tr>
<tr><td>BEST PRACTICES WHICH LED TO OVERALL IMPACT INCUDING IMPACT ON SOCIALLY EXCLUDED GROUPS</td><td colspan="2">BEST PRACTICES WHICH HAD IMPACT OF SOCIALLY EXCLUDED GROUPS</td></tr>
<tr><td></td><td colspan="2">Crèche services operated by SEWA, include:
• involving paid worker
• flexible timing according to local needs of workers and
• ownership and contribution from users for services provided by the crèche services
SEWA has also been the first to turn it into a cooperative of child care workers. The caregivers are drawn from the same group as the mothers and given minimal training, and the management is non-hierarchical in nature. Though SEWA has moved far towards financial self-reliance, it raises the question of the extent to which social services can be expected to be self-supporting in developing societies.

The strong demand from parents for these services meant that SEWA could be firm in their approach to addressing caste class prejudices and to help achieve cohesion.</td></tr>
</table>

Annex 4: Desk Research Findings

Evidence from surveys

Nutrition Status Indicators

The analysis of NFHS-II data by HNP discussion paper (Gragnolati et al, 2005) shows that the underweight prevalence is much higher among scheduled castes (53.2%) and scheduled tribes (56.2%) than among non scheduled groups (44.1%.). Similarly the underweight prevalence is as high as 60% in the lowest quintile, but is also present in 33% of children in the wealthiest quintile. The prevalence of underweight is slightly higher among girls (48.9%), than among boys (45.5%).

Looking at the trend, the discussion paper notes the widening disparity between different social groups. The rate of reduction in under-nutrition in the last decade (1992/93 to 1998/99) is relatively slower in girl child, children in lower wealth quintile groups and SC/ ST groups, than other social groups. The worrying fact is that the discriminatory outcome is stronger in the case of children facing severe under nutrition in these social groups.

The Sachar committee report (GoI, 2006) based on NFHS-II shows that Muslims suffer from the highest rates of stunting and the second highest rates of underweight children among all social groups, including SC, ST, OBC and OC. STs have the highest rate of underweight children. Further, the committee concludes that Muslim children are at a slightly higher risk of child malnutrition than other Hindu children. However, they are less likely to be underweight or stunted than SC and ST children. The report also indicates that the regional differences show a clear differential status of Muslim children in northern region comprising of Jammu and Kashmir, Himachal Pradesh, Punjab, Haryana, and New Delhi and eastern region including, Bihar, Orissa, and Uttar Pradesh, where the rate of low birth-weight babies among Muslims increased sharply between 1992-93 and 1998-99.

Analysis of NFHS III (2005/06) across the main social groups indicates that stunting and wasting have worsened across the 2 surveys among ST, SC and OBC communities. Weight for age has improved between NFHS II and NFHS III, but the extent of SC and ST improvement has been less at 55% and 48% respectively and still continues to fall below country average of 43%.

Stunting has worsened across all religious groups between NFHS II and III (except in the Sikh community). Muslims and Buddhists have the highest stunting rates across these groups. Wasting has also deteriorated further among children from all religious groups. Weight for age has improved between the 2 surveys among the major religious groups. The Hindu community has the highest percentage of under-weight children (43%) in NFHS III, apart from those under 'other' religious groups.

The Nutritional Intake in India, 2004-05, NSS 61st round, Jul 2004 to Jun 2005 report found that the percentage share of food expenditure in total expenditure by the Indian population was 55.0% in the rural areas and 42.5% in the urban areas. Relative to their comparable survey results for 1993- 94, the share of food expenditure has dropped by 8.2% and 12.2 % in rural and urban areas respectively. The average daily intake of calories by the rural population has dropped by 4.9 % from 1993-94 to

2004-05 and by 2.5% in the urban areas in the same period. The average daily intake of protein by the Indian population has decreased from 60.2 to 57 grams in the rural area between 1993-94 and 2004-05 and remain stable around 57 grams in the urban area during the same period. A significant rise in per capita daily average intake of fat is observed during both surveys in both rural and urban areas - 13% in both rural and urban areas.

Access and utilisation of ICDS by different social groups

The NFHS-III survey collected information on access to supplementary food, immunizations, health check-ups, preschool education, weighing service, counselling service provided to mothers at different stages and access of services during breastfeeding and pregnancy in 29 states. Evaluating access to these services based on a caste and wealth index, the report shows that SC and ST children and groups in the lower wealth index were able to access these services relatively better than other groups. More specifically:

- While the coverage of children by an AWC is relatively high at 72% across India, only 32.9% of children between 0-71 months had received any service from an AWC in the year preceding the survey. This proportion does not vary greatly by sex of the child, but generally the percentage of females attending is greater than males.
- Utilization of AWC services is higher in rural (35%) than in urban (23%) areas served by an AWC.
- 50% of scheduled-tribe and 36% scheduled-caste children received at least one ICDS services, compared with 28% of children who do not belong to any scheduled caste, scheduled tribe, or other backward class. Muslim and Sikh children receive ICDS the least amongst religious groups.
- 70% SC children and 56% ST children did not receive any supplementary nutrition from an AWC. This figure was significantly higher in children not belonging to any caste/tribe/group (77%). Muslim and Sikh communities received SN the least amongst religious groups.
- The highest proportions of children to have received vaccinations in the past 12 months from an AWC are Buddhist/Neo-Buddhist children (49%) and scheduled-tribe children (33%). Muslim and Sikh communities received any immunization from an AWC the least.
- 21% ST children had a health check up at least once a month, compared with only 13% among SC-children and 10% of children not belonging to any caste/tribe/group. Muslim communities had a health check up the least at 7%.
- Among ST children, 21% approx were weighed at least once a month, compared with 13% SC-children and less than 10% other children. Muslim and Sikhs accessed this service the least.

A recent evaluation in NIPCCD showed that the largest proportion of beneficiaries were from backward castes (29.6%) followed by scheduled castes (26.3%), other castes (21.4%) and scheduled tribes (20.4%).

However NFHS-III highlighted differential access of minority religious groups, wherein Muslim and Sikh communities have significantly lower access to ICDS services compared to other religious group.

The NIPCCD study also showed that only 0.83% of the beneficiary children were disabled. Apart from these groups, children of migrant labour, urban slum dwellers and urban homeless were not covered by ICDS (Commissioners, 6th report). Some of these groups such as disabled children, migrant labour and urban homeless are excluded at the policy level. The scheme guidelines do not attempt to make special provisions for these groups such as allowing temporary access in nearby ICDS for children with their migrant labour parents and homeless parents.

The desk review could not find studies which suggest strategies for inclusion of these groups in ICDS. Similarly, as the exclusion of minority groups (NFHS-III) and urban slum dwellers (6th Report of Commissioners) is a recently recognized issue, studies discussing strategies, experiences and best practices to address the exclusion of these two groups are not available.

ICDS Coverage

Much of the problem in ICDS in India is diagnosed as a failure to provide an integrated package of services including immunisation, health check-ups, referral services, growth monitoring, nutrition and education services.

This concern is confirmed by the latest NFHS –III data which states that the percent of 0-6 children who have received services is as low as 20.0 % (immunisation); 15.8 % (health check-ups); 22.8 % (pre school education) and 18.2 % (weighing).

Monitoring and accountability

Another widespread problem in ICDS is lack of supervisory structure. As on 30.09.2006, 37.3% and 39.9% of sanctioned posts of CDPOs and supervisors were vacant (Commissioners, 7th report). State wise data shows high disparity between states with more than 50 % vacancies in some states (Commissioners, 6th report).

The lack of supervisory structure was so prevalent that in Bihar and Jharkhand funds were directly put into the bank account held by the anganwadi worker. In Uttar Pradesh and Rajasthan, 83% and 86% of ICDS projects respectively, did not have the requisite supervisory structure, leaving the ICDS virtually without supervision and monitoring (Commissioners 6th report). A NIPCCD survey found that despite the guidelines of the scheme 32.7% of CDPOs were males and there were evidences of frequent transfers of CDPOs.

Evidence from field studies

Access and utilisation of ICDS by different social groups

While the larger national trend continues to show poor coverage, field based studies however have not addressed this issue of social exclusion at the AWC level in any significant manner. The Health Nutrition and Population discussion paper, using ICDS baseline/end line survey data of 2000-2002 conducted in six states, shows that AWCs are attended more or less equally by male and female children in different

caste groups and wealth quintile groups in Kerala, Maharashtra, Rajasthan, Uttar Pradesh, Madhya Pradesh and Chhattisgarh. The FOCUS survey (2004) which made random surprise visits to 200 AWCs and interviewed 500 mothers of children under six, confirmed this for Maharashtra, Rajasthan, Uttar Pradesh, Chhattisgarh, Tamil Nadu and Himachal Pradesh. Among the surveyed mothers, only 1% of SC/ST mothers felt that their child had faced caste discrimination.3 Further the share of SC and ST children enrolled in the AWCs visited was found to be 40% compared to 27% in the general population. These two reports however did not assess differential access for Muslim children.

User and non user perspectives

A good way to assess discrimination and exclusion in ICDS is to get the perspective of the users and non-users of the services. We were only able to identify one study which collected large scale survey data on user's perspective – Focus on Children under Six (the FOCUS survey). This study did not show significant evidence of discrimination based on income, caste and gender. The result of the study is contrary to expectation in a patriarchal and caste ridden society in rural India. The result is more surprising when the surveys from the Midday meals scheme did provide strong evidence of discriminatory practice (Mathur, Kanchan, Shobhita Rajagopal and Pradeep Bhargava, 2004) within the programme. A recent survey by the Institute of Dalit studies, in 531 villages from 30 districts in Rajasthan, Uttar Pradesh, Bihar, Andhra Pradesh and Tamil Nadu showed that the percentage of users who reported discrimination in access to services that include Public Distribution System and mid-day meal ranged from 24 percent to 52 per cent (Thorat, Sukhdeo and Joel Lee, 2005). Further studies in primary education (Geetha B. Namsissan, 2007) and primary health care (Sanghmitra S. Acharya, 2007) also corroborate the evidence of discriminatory practice based on caste.

In light of the overwhelming evidence of discrimination in public services, the insignificant evidence of discrimination in ICDS as revealed through just one study, viz., the FOCUS study, may be treated as an outlier.

Exclusion as evident in programme evaluations

Evaluation reports of the CARE India's RACHN project and the World Bank-ICDS-III programmes both attempted to assess the extent of exclusion in ICDS. The mid-term evaluation of RACHNA, notes that there is no evidence of discrimination between boy and girl in matters of child care. The final evaluation notes that "analysis of rapid assessment survey data disaggregated by lower and higher socio-economic groups, as well as the small studies from the panel districts, indicate that the RACHNA program is benefiting the lower socio-economic groups more". The final evaluation of RACHNA confirms this and states that gender integration and social equity concerns were addressed successfully by CARE in the rural RACHNA project.

Similarly, the implementation completion report of ICDS-III, noted that the end line data shows no discrimination between girls and boys.

[3] However, field investigators perceived that 16% of the village observed any evidence of caste discrimination.

Experiences of the Mitanin programme in Chhattisgarh, SEWA in Gujarat, MV foundation in Hyderabad and ICDS in Tamil Nadu, shared through a series of articles in Economic and Political Weekly also felt that the scheme was useful in reaching the vulnerable groups. However they do not report any evidence in the form of studies to substantiate their experiences.

Despite this positive evidence, most of these studies identify addressing exclusion as an important priority. The World Bank's Implementation Completion Report (November 2007) and Health Nutrition and Population discussion paper, states this concern in terms of the need to increase coverage of vulnerable groups and to target them effectively.

The evidence indicates that ICDS has the potential to address social exclusion, and large scale surveys show that a large proportion of SC/ST and poor children are accessing ICDS services. However the larger development process in India is still discriminatory (see Throat et al, 2007 for socio-economic difference between SC/ST and other social groups) and in the absence of any evidence of discrimination in ICDS services, the widening differential outcomes in terms of nutritional status among different social groups is probably triggered by these larger socio-economic and cultural processes at the national and local level. However the fact that there is no evidence to suggest social exclusion in ICDS does not necessarily mean that the problem does not exist as studies have not been performed that address the issue. This is a matter of concern, as coverage of the ICDS programme is low and those that are left out or excluded are generally the most marginalised and vulnerable groups in society. ICDS therefore has an important role to ensure that the difference in nutritional status is addressed.

Barriers to inclusion in ICDS

Location of ICDS centres

The FOCUS and IDS qualitative studies found that location of AWC played an important role in excluding people from the disadvantaged castes. An intensive field study in 14 villages in 4 states of Andhra Pradesh, Chhattisgarh, Jharkhand and Uttar Pradesh, which purposively selected those ICDS centres which were perceived by decision makers to be well performing, gives evidence of this in all of its sample villages. The ICDS centres were always found to be located in hamlets belonging to the dominant caste in a mixed caste village. This led to the exclusion of Dalit and Tribal children in two ways. Firstly, due to distance and secondly, due to being denied enrolment in favour of children in the immediate locality in light of limited SNP provision available.

A social assessment of ICDS in Eastern Uttar Pradesh (GEAG, nd) which had 24 villages in 6 districts as its sample, noted that the location of an AWC restricted access of children and women from disadvantaged groups. Children from SCs who were living in distant hamlets, were the one whose access was hampered most. The location of the AWC was mostly in upper caste localities as the AWC was generally located in AWW's house. The study further noted that it was mainly the influential and economically prosperous/ high caste people who have gained access to pre-schooling services whereas the actual target groups have not benefited. The factors which strengthen exclusionary tendencies such as shortage of space and limited

SNP provision, where children do not get enough to eat, were found in the study area. The study also noted that male children had relatively more access to AWCs.

Another study, part of the Andhra Pradesh Economic Restructuring Project (APERP) project (ASCI, 1999), confirmed that the location of ICDS centre was a main barrier. The study which also documented the perceived needs of people found that people were appreciative of services and demanded AWCs for disadvantaged castes.

The seventh report of the Supreme Court Commissioners notes that the Inter Ministerial Task Force has recommended that an AWC "should be so located that the beneficiaries should not have to walk more than one kilometre". However the Commissioner's comment that though the introduction of a distance norm may be welcomed, it may be noted that children below the age of 6 years, pregnant women and nursing mothers cannot be expected to walk a one-kilometre distance on a daily basis. Hence, they recommend that the distance norm should be reduced to half a kilometre for each AWC at the most. Further against the required 14 lakh AWCs required in the ICDS programme only 8.4 lakh AWCs have been established and are operational.

Studies have noted that the service gap and under coverage is severe in poor states and in backward districts within them with concentration of marginalized social groups. (Sinha, 2005 and Gragnolati et al, 2005). Further, the shortage in coverage is likely to affect the settlements with Dalit and tribal population most (Commissioners, 6th report).

Therefore, any attempt to improve coverage will necessarily benefit the socially excluded groups. However special provisions should be made to monitor the progress of expansion to check its role in decreasing social disparity in access (Commissioners, 6th Report).

AWW and local political patronage

Mander, Harsh et al., 2006 also noted that next to location the other important factor determining access to AWC is the service provider. They found that differential attitudes of the AWW and AWH to children of different castes and economic backgrounds played a major role in discouraging the participation of children from disadvantaged castes. The helper did not collect children from the low caste hamlets, and often these children and their guardians were scared about how they would be treated by the ICDS staff if they defecated or were naughty (accidentally or otherwise), although parents of children from more advantaged backgrounds did not harbour such fears. The study also found villages where pre-school Dalit children did not go to the ICDS centre but instead accompanied their older siblings to school where there were Dalit teachers and informally shared their mid day meals. In these cases the distance of AWCs and schools were similar. This information also hints at the important service need of picking up and dropping the children at home by AWHs.

Despite the inherent discrimination resulting from the caste background of the AWW, most of the AWWs in the study villages were from non-scheduled groups. Ramachandran, Vimala (2004) confirms this by quoting a study in two districts of Uttar Pradesh which showed that over 70% of AWWs were from the forward castes

or the OBC community. Similarly, the study in Andhra Pradesh found that 74% AWW in the sample AWWs were from non-scheduled groups

These studies found that not only were the AWWs from upper castes, they were mostly appointed under the patronage of local political leaders belonging to Upper castes. Often the AWWs were from the families of powerful people in the village. There were also some instances of such appointment where AWWs lived in other villages (in-laws home), reported in Mander et al (2006), IDS (1996), and GERG (nd). This created extreme power imbalance and people from disadvantaged sections would not demand accountability for the AWW who operated ICDS services at irregular timings, for limited time and made the AWH to do most of her work.

Working parents and ICDS

Mander, Harsh et al 2006 found that another consistently excluded group was of daily wage casual workers and migrant workers. In areas when both parents had to set out daily to look for uncertain, erratic and poorly paid work, the opportunity cost of taking their children to the ICDS centre was too high. Even slightly older pre-school children were sometimes required to tend their infant siblings at home, because their mothers had to look for work. In some cases, children could not be spared because they had to work at home making bidis. The problems of exclusion were aggravated in cases where they had to migrate to other places for work.

Similarly, Ramachandran, Vimala et al (2004) notes that many working women had to take their children to the working place. They could not leave and fetch children from ICDS centre as they would leave early and come late.

Outreach services and social exclusion:

Though most of the studies discussed above focus on social exclusion in the SNP component in ICDS, evidence of exclusion also exists in the outreach services of AWW and ANM. For instance, in the CARE India's RANCHA experience indicators for exclusive breastfeeding and feeding practices were skewed against households with low socio-economic status. This could be due to the difficulty faced by working women in finding time to devote to these practices.

Annex 5: Methodology for Field Studies

Overview of Methodology

The data collection part of the social assessment study focused on two main source groups for information.

Community Perceptions of the ICDS programme

The study recognised that the community's perception of the ICDS programme and its 6 core services influences uptake and is important in making the programme contextually relevant. For the purpose of the study, we have defined "community" as all those stakeholders at the local level who directly benefit from the services and those decision makers at the local level who influence the uptake of the services. The key informants at this level included mothers of children from 0-3 and 3-6, their husbands and mother-in-laws, community based organisations (e.g. self help groups) civil society organisations (CSOs) and Panchayats. The mothers groups were divided into three sub groups to capture the specific aspects of their needs and concerns relevant to their condition. Pregnant and lactating women were covered in focus groups. While key health, nutrition and growth related issues were discussed in detail with these mothers with particular regard to pre and post natal care, specific focus was also be placed on early child education among the mothers of the older children.

The areas we covered under community perceptions are detailed below. They were categorised into 5 themes. We used both semi-structured questionnaires and focus group discussion guides in order to collect the required information.

Themes	Issues
Information and Awareness	• Is there awareness of child malnutrition as a problem? Do different sections of the community have different perceptions and understanding of child malnutrition? • Are people aware of their rights and entitlements such as access to different services? Does this differ between different groups or marginalised groups? • Is there sufficient awareness about the ICDS programme and its six key services? Does this vary in different groups and areas? Are SC/ST groups less aware of entititlements? • Is there information available to the community on how these services are availed and who provides these services? Are they equally available to all groups? • How can better awareness be created? What should be done/who should be involved in creating awareness? Who can best ensure that those who need the services are aware of them? (e.g. should Anganwadi workers come from SC/ST communities?)
Availability and Access	• Are all the 6 services under the ICDS programme provided to all the community members? Is there a bias in which services are provided to which groups? • Are the services provided adequately, equitably and regularly? Do SC/ST children who are recorded as having the worst nutrition rates provided with more food and services to re-balance the services? • Is there sufficient coverage of the programme across the community? Is everyone in the community covered under this scheme? Would you know of anyone left out for whatever reason? What could be the reasons? • Are the services available on time/at the time when they are needed? Has the community that most needs the services been consulted about when and how

Themes	Issues
	the services should be provided and located? i.e. in the poorer part of the village/ whilst mothers are working. • What are the factors that affect access to the services (discrimination, geographic, domestic and economic)? Does caste and gender affect access to services? How are 0-2 year olds brought to the services or given supplemental food? How is explicit and implicit discrimination playing a part? • Is distance or other factors responsible for low access and utilization of ICDS services? • Do community members have any suggestions for improving coverage and accessibility of these services?
Quality of Services	• What are the issues around the quality of ICDS that concern the community? How can these be improved? • What are the concerns from dis-advantaged groups about the quality of staff providing ICDS services (if any)? How can the community help improve the services? What is the credibility of the AWW among the community? • Are there mechanisms and opportunities for marginalised groups or SC/STs to give feedback about the quality of the services provided? • Do the children with the most severe nutrition problems or those who have at some point dropped to Grade II/III and especially IV benefit the most from services? Are these children specifically followed up? • Are there other service providers in the community who complement/ offer better services to marginalised groups? Why are they better? • What role can the community play in improving the services? • Do you think the programme has contributed to an improved health, nutrition and education status for families with sick/malnourished children in the community? If 'yes' how? And if 'not' then why? • Are common habits such as washing hands, sanitation etc. part of the services/information provided? • Do the anganwadi centres have facilities such as clean toilets, safe drinking water, and a place for children to wash their hands at the right height etc? • Are children encouraged to eat together? • Will improved participation/accountability to the community and other service providers enhance the quality of services? How? • Does the local Panchayat have a role in implementing the ICDS?
Exclusion	• Are there groups or individual households in the community who are excluded from the ICDS program? Give examples. • Who are these groups and are there other social, economic and topographic reasons why they are excluded? • What are the barriers that exclude these groups? • What are the additional inputs required from AWCs or other community organisations needed for these groups in order to access the ICDS services? • What role can the PRIs and CBO play in exclusion or inclusion of different vulnerable groups? • What extra efforts have been made to include children form socially disadvantage groups. What extra effort is being made with regard to girls? • Do people from ST/SC and other marginalised groups find it difficult to access the service and why? • Does religion play a part in restricted access to services?
Programme expectations	• Which of the ICDS services are considered most important to the groups that need the services most - those with malnourished children/babies? • What are the ST/SC and other marginalised groups' expectations from the ICDS and the service providers?

Themes	Issues
	• To what extent are these expectations met by the current services? • How can existing services be improved to increase uptake of services and/or improve quality? • Are the voices and grievances of the community (in particular marginalised groups) adequately addressed? Are there effective mechanisms in place for quick action?

Service Providers Perspective

Besides the community's perception, the study also captured institutional and other systemic issues underpinning the programme. How effectively the institutional mechanisms work at every level within the organisation is critical to the success of the ICDS. However, given the limited timeframe and resources, this study will limit its scope to understanding field level service delivery issues and the challenges it poses. Our key informants therefore included AWWs and ANMs. However to correlate issues of convergence, monitoring and motivation we also consulted supervisors, CDPO, medical officers and block development officers. The key areas of investigation among these institutional representatives are included in the table below:

Themes	Issues
Training	• Is the training given to the field level staff to deliver services sufficient to address issues of social exclusion? Does it explain that poorer people, SC/ST groups have the worst indicators for nutrition in India and how to address this? • Does the training address issues facing women and girls, socially disadvantaged groups' rights etc? Does it cover discrimination and how to provide non-discriminatory services? • How does the existing training methodology address social exclusion issues? • How can training of key personnel in the field be enhanced to address issues of social exclusion?
Resources	• What are the physical resources that are lacking at the field level that impede service delivery and can lead to exclusion of groups? • Are there any experiences of positive discrimination? i.e. providing more services for those who need them most.
Information	• What are the mechanisms for monitoring and supervision that document services provided to vulnerable groups? What impact do these have on services? • How is this information used to plan the coverage of services at the field level? How can it be used more effectively? • Would it help to introduce community level mechanisms for monitoring the programme? What should these look like?
Institutional Coordination/ convergence	• What local level institutional mechanisms are necessary for effective service delivery for vulnerable groups?
Motivation	• Are field staff sufficiently motivated (particularly in reaching out to geographically remote communities or over difficult terrain or to excluded groups)? • What problems are faced in reaching out to the most remote and excluded communities? What can be done to ensure full coverage? • Do field staff receive supervisory and mentorship support? • What are the existing incentives (both financial and non-financial) to reach out to the marginalised girls, boys and women?

Methods and instruments

While a major portion of the data collection depended on the use of focus group discussions with the different segments of the community and key stakeholders at the community level, in-depth interviews were also conducted with mothers within the village community. In-depth interviews were also conducted with the key informants within the village.

An extensive desk review was undertaken to supplement information on the major focus areas of this study such as, innovations within the ICDS, factors hindering and supporting the effective implementation of the ICDS, reasons of social exclusion and problems and possible solutions of appropriate targeting, etc.

The tools and instruments for this study were developed based on key questions we were trying to answer detailed above. The tools were translated into the local language. At each different levels of enquiry (i.e. the district, the block, village and urban centres) the team used a mixture of tools with different segments of the community as appropriate. These included:

- Focus group discussions (FGD).
- In-depth interviews (IDI).
- Desk reviews including examination of public records.
- Systematic observation of services including free-listing.

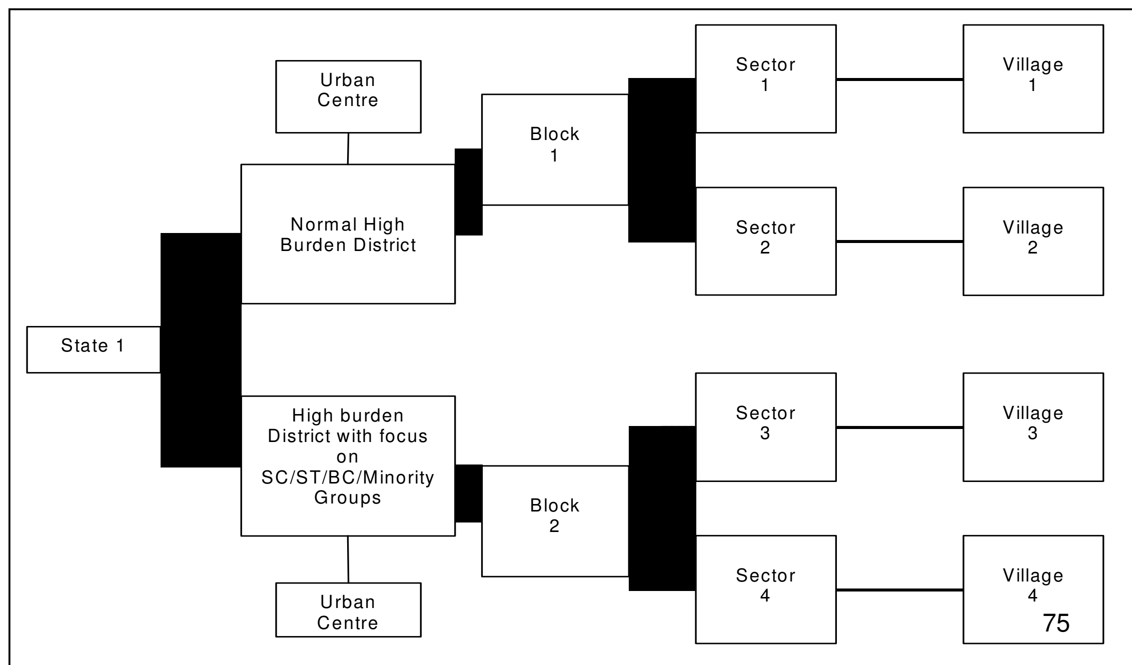
Separate FGD and IDI guides were developed for each different set of informants. Informants from SC/ST and other marginalised groups will be consulted in addition to other member of the community. Both users and non users of ICDS services were consulted.

Data was collected from both rural and urban AWCs of the district.

Sampling

The figure below illustrates how we undertook sampling within each state.

Figure: State sampling methodology



In each of the four sample states (Andhra Pradesh, Uttar Pradesh, Jharkhand and Rajasthan), 2 high burden districts were selected. One of these districts was a normal randomly selected high burden district that had a heterogeneous population while the other district was selected such that special focus on scheduled castes, scheduled tribes, other backward classes and minorities can be emphasised. From each of these blocks, two sectors were identified. One village from each of these sectors was then included in the sample under study.

In addition, for each district, we studied one urban ICDS centre to better understand how the services are implemented and perceived differently from their rural counterparts.

Data Collection

Data Collection Team

The data collection teams were constituted in the four states. These teams were responsible for collecting information at the local level (i.e. village or urban centres). The teams included 4 primary investigators, 2 of whom were responsible for facilitating focus group discussions among the stakeholders and two who were responsible for conducting in-depth interviews with other key informants. They were also responsible for collecting structured observations during their visits to Anganwadi centres. They were supported by a supervisor checked for the accuracy and quality of the data being collected and monitor the data collection processes in the field. The supervisor and/or writer were responsible for collating, consolidating and analysing the field information gathered within each state.

Training and orientation for the teams was delivered at the state level. Micro plans for data collection were also prepared during these workshops.

Study coordinators for each of the states were responsible for collecting information at the district level as required for their respective states and also undertook the interviews with the CDPO at the block level. In addition, they interviewed 2/3 NGOs that worked on issues of social exclusion within each of their states to build upon the information gathered by the data collection team.

The desk reviews was undertaken by a dedicated consultant. The review was used to identify best practices (in addition to our field visits) as well as to triangulate qualitative findings for the national overview of findings.

Data Collection Process

Data was collected from both the community and from the service delivery institutional level. We undertook data collection from Village, Urban Centres, Blocks and Districts. The tables below highlight the stakeholders which were consulted for both the community perception and service delivery dimensions of this study and the tools we used to collect this information.

Community stakeholders

Stakeholder groups/	Tools/ instruments used
Mothers with children from 0 - 3 years	FGD, IDI (caste wise)
Mothers with children from 4 – 6 years	FGD, IDI (caste wise)
Mothers in law	IDI
Husbands	IDI
Traditional birth attendants	IDI
Community Based Organisations (Self Help Groups, mothers groups etc)	FGD

Institutional stakeholders

Stakeholder groups/	Tools/ instruments used
Members of the local Panchayat	FGD
Anganwadi Workers (within the sector)	FGD, IDI
Anganwadi Helpers (within the sector)	IDI
ASHA workers	FGD, IDI
Supervisors, ICDS	FGD
CDPOs, ICDS	IDI
Auxiliary Nurse and Midwife, Sub centres	IDI
Lady Health Visitors, PHC	IDI
Medical Officers, PHC	IDI
Block Development Officer, ITDA	IDI
District Magistrate/ District Collector	IDI
Chief Medical Officer	IDI
PO, ITDA	IDI

Besides the above mentioned stakeholder groups and key informants, the team also visited Anganwadi centres, observed the activities and did on the spot interview/discussion with mothers or family members who came to drop or pick up their children. They also visited the Integrated Nutrition and Health Programme's (INHP) Nutrition and Health Day (NHD) to observe the fixed day services in the villages and conduct on the spot interviews.

Annex 6: Sample Size and Coverage

Beneficiaries and Decision Makers

Geographic Sampling Details

District	Urban Centre	Block	Sector	Village
Mahabubnagar	Alwal Project	Achampeta	Balmuru	Balmuru 3
			Uppunuthala	Marripalli
Kadapa	Sastry Nagar	Rayachoti	T Sundupalli	Sundupalli
			Sanbepalli	Bogullavari palli

Community Sampling Details

Stakeholder	SC	ST	OBC	Religious minorities
Mothers	16	10	13	5
Grandmothers	7	3	4	1
Fathers	10	3	5	1

<u>Jharkhand</u>

Geographic Sampling Details

District	Block	Villages – Urban Centre
West Singhbhum	Sonua	Madhupur
		Tunia
		Mary Tola (UC)
Dhanbad	Gobindpur	Daldali
		Chandudih
		Herapur-Bawri Tola (UC)

Community Sampling Details

Stakeholder	SC	ST	OBC	Religious minorities	General
Mothers	3	11	10	15	3
Grandmothers	1	4	7	10	0
Fathers	2	6	9	4	4

Rajasthan

Geographic Sampling Details

District	Urban Centre	Block	Sector	Village
Udaipur	Neemach Mata, Udaipur city	Kherwara	Kalyanpura	Kalyanpura
			Bawalwara	Gareja
Jhunjhunu	Jhunjhunu city, ward 3	Bhuhana	Khuhadwas	Gadali
			Pacheri	Pacheri Kalan

Community Sampling Details

Stakeholder	SC	ST	OBC	Religious minorities	General
Mothers	15	10	10	3	6
Grandmothers	6	4	1	0	9
Fathers	4	3	5	0	8

Uttar Pradesh

Geographic Sampling Details

District	Block	Villages – Urban Centre
Allahabad	Kaurihar	Mubarakpur
		Ramnagar
		Teliaganj (UC)
Hardoi	Ahirohi	Rajpar
		Sadiapur
		Aloothok (UC)

Community Sampling Details

Stakeholder	SC	ST	OBC	Religious minorities	General
Mothers	12	0	6	5	9
Grandmothers	6	0	5	1	4
Fathers	5	0	6	2	3

Service Providers

The respondents at the village, block and district level are detailed in the table below.

Service Providers	Description	Nos.
Traditional Birth Attendant	1 per village for 4 villages	4
Anganwadi Worker	1 per centre for 4 centres in 4 villages	4
Auxiliary Nurse and Midwife	1 per centre for 4 centres in 4 villages	4
Lady Health Visitor	1 per block in 2 blocks	2
Medical Officer in Charge	1 per block in 2 blocks	2
Child Development Project Officer	1 per block in 2 blocks	2
Supervisor	1 per block in 2 blocks	2
Block Development Officer	1 per block in 2 blocks	2
District Programme Officer	1 per district in 2 districts	2
Chief Medical Officer	1 per district in 2 districts	2
District Collector/Magistrate	1 per district in 2 districts	2

Annex 7: References

1. ASCI (nd) Beneficiary/Social Assessment for ICDS II, AP - Final Report, ASCI, Hyderabad (Nov, 1999)
2. Alur, Mithu (2000): Abstract- Invisible Children: A Study of Policy Exclusion, International Special education congress2000, Including the Excluded, University of Manchester, 24th to 28thg July, 2000. http://www.isec2000.org.uk/abstracts/papers_a/papers_indexa.htm
3. Behrman JR, H. Alderman and J. Hoddinott. (2004). "Copenhagen consensus - challenges and opportunities: hunger and malnutrition". Copenhagen Consensus Challenge Papers. May 7, 2004
4. CAG (2006) Performance audit report on SSA, Report No. 15 of 2006
5. CARE (2008) India's Approach to Social Exclusion (draft note)
6. CARE , Final evaluation of RACHNA, 2008 ftp.info.usaid.gov/in/Pdfs/Annexure_A_Care_Rachna_ER.pdf downloaded on April 07
7. CARE India, Rights in Health - Module
8. CARE, Reflections on a Journey - Rachna Midway, CARE India
9. Chatterjee, Mirai (2006) Decentralised Childcare Services: The SEWA Experience
10. Commissioners of the Supreme Court (2004): 'Fifth Report Submitted in Supreme Court: PUCL vs. UoI Civil writ 196 of 2001', 2004
11. Commissioners of the Supreme Court (2006): 'Sixth Report Submitted in Supreme Court: PUCL vs. UoI Civil writ 196 of 2001', 2006
12. Commissioners of the Supreme Court (2008): 'Seventh Report Submitted in Supreme Court: PUCL vs. UoI Civil writ 196 of 2001', August 2008
13. Department of Education (2006) Sarva Shiksha Abhiyan: Fourth joint Review Mission. Aide Memoire, New Delhi
14. Drèze, Jean and Shonali Sen (2004): 'Universalisation with Quality: An Agenda for ICDS', report prepared for the National Advisory Council, available at www.nac.nic.in
15. Examining Conditional Cash Transfer Programs: A Role for Increased Social Inclusion? Bénédicte de la Brière and Laura B. Rawlings
16. EPW, pp 3660-3664
17. Financial and Economic Analysis of ICDS programme in India - Final Report (21/05/2007)
18. Focus on children under six (2006): 'Citizen initiative for rights of the children under six', New Delhi
19. Garg, Samir (2006)Grassroot Mobilisation for Children's Nutrition Rights, EPW August 26, 2006,pp-3694-3700
20. GEAG (nd) Draft Report Based on Social Assessment in Eastern Uttar Pradesh for WCDP, PRA Resource Centre, Gorakhpur
21. Ghosh, Shanti (2006).Food Dole or Health, Nutrition and Development Programme? Economic and Political Weekly August 26, 2006, 3664-3666

22. GoI (2006), Social, economic and education status of Muslim community in India, 2006
23. Goplan, (1982) Choosing 'beneficiaries' for feeding programme, NFI Archives
24. Govinda, R. and Madhumita Bandyopadhyay (2007), Access to Elementary Education in India: Country Analytical Review, August 2007, NUEPA
25. Gragnolati, Michele, Meera Shekar, Monica Das Gupta, Caryn Bredenkamp and Yi-Kyoung Lee (2005) India's Undernourished children: A call for reform and action, August 2005, HNP discussion paper.
26. Gupta, (2006) Infant and Young Child Feeding An 'Optimal' Approach, EPW, 2006
27. Heaver, Richard, (2002) Improving Nutrition - Issues in Management and Capacity Development, HNP discussion paper, World Bank
28. ICDS IV Project – A Handbook (2008-09 to 2012-2013)
29. IDS (1996) Strengthening Quality and Access to Services in ICDS Programme: A Social Assessment of select districts in Rajasthan, Draft, IDS, Jaipur
30. Joint Review Mission- RCH-2, Uttar Pradesh, January 16-20, 2007
31. Joint review of RCH-II, Chhattisgarh State Report, 14-18 Feb 05
32. Kullar, Vandana (1998), 'Integrated Child Development Services – A critique of Evaluation Techniques' Economic and Political Weekly, 7 March 1998
33. Mander, Harsh, ICDS in cross roads- CARE India
34. Mander, Harsh, and M. Kumaran (2006): 'Social exclusion in ICDS: A sociological whodunit?', CARE India
35. Micronutrient Initiative (2007) Review of Best Practices in ICDS, Micronutrient Initiative (31/05/2007)
36. Namsissan, B, Geeta (2007): 'Exclusion, inclusion and education: Perspective and experiences of Dalit children', paper presented at National conference on social exclusion and inclusive policies, IIDS, New Delhi
37. National Family Health Survey II and III
38. NSSO 61st round 2004-05
39. Project implementation plan for vulnerable groups under RCH II
40. Radhakrishna, R; Rao, K Hanumantha; Ravi, C; Reddy, B Sambi (2004), 'Chronic Poverty and Malnutrition in 1990s' Economic and Political Weekly, 10 July 2004
41. Rajivan, Anuradha Khati (2006): 'ICDS with a difference- Tamil Nadu', EPW, pp 3684- 3688
42. Report of the visit of the Common Review Mission team to Chhattisgarh (nd)
43. Report: State visit to Assam, RCH-II Joint Review Mission – February 2006
44. Sanghmitra S. Acharya (2007): 'Health care utilization among Dalit children: Understanding social discrimination and exclusion', paper presented at National conference on social exclusion and inclusive policies, IIDS, New Delhi
45. Saxena, NC, ICDS in Bihar

46. Shariff, Abusahel (1999), ‘women’s status and child health’, in maithreyi Krishnaraj, ranta M., Sudharshan and Adusaleh, Shariff (eds) Gender, Population and development. New Delhi; OUP, pp-185-291
47. Sharma, Adarsh (2007) ‘Replication of Integrated Nutrition and Health Project Approaches in Non-CARE Assisted ICDS Areas: Operational Guidelines’ Washington, DC: the Food and Nutrition Technical Assistance (FANTA) Project, Academy for Educational Development (AED), September 2007
48. Singh, K Amarendra (nd) ICDS in a Right's Perspective – Some thought, Draft document
49. Sinha, Dipa (2006): ‘Rethinking ICDS: A right based perspective’, EPW, pp 3689- 3684
50. Sinha, Sachidanand (2005): ‘Reaching out to undernourished children: social inequalities and policy perspectives’, Journal of health and development, Oct-Dec Vol 4, pp 71- 90
51. Sinha, Shantha (2006): ‘Infant survival: A political challenge’, EPW, pp 3657-3660
52. SRS 2006
53. Srinivasan. K, Chander Shekhar, Arokiasamy. P (2007): ‘Reviewing reproductive and child health programmes in India’, EPW, July 14, pp. 2931- 2939
54. Sundaraman, T, (2006) ‘Universalisation of ICDS and Community Health Worker Programmes Lessons from Chhattisgarh’ EPW August 26, 2006, pp-3674-3679
55. Tandon, Monica, and Umesh Kapil (1998), Integrated Child Development Services Scheme: Need for Reappraisal, INDIAN PEDIATRICS VOLUME 35-MARCH 1998
56. Thorat, Sukhdeo and Joel Lee (2005), Caste Discrimination and Food Security Programmes , EPW, September, 2005
57. Thorat. S, Lee, Joel (2007): ‘Discrimination in food security programmes- Mid-day-meal and PDS’, National conference on social exclusion and inclusive policies, IIDS, New Delhi, pp 146,192
58. WB (1998)Project Appraisal Document on a Proposed Interim Trust Fund Credit, WB (27/05/1998)
59. WB (2006) Implementation Completion and Results Report (IDA N0420), WB (27/11/2006)
60. World bank, Tribal development plan for SSA
61. Working Group on Child Development for the 11th Five Year Plan (2007-2012) - Final Report on ICDS and Nutrition

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