दिल्ली सरकार

आप की सरकार

सत्यमेव जयते

Assessment of Effectiveness of ICDS Scheme

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Delhi Commission for Protection of Child Rights
DCPCR
दिल्ली बाल अधिकार संरक्षण आयोग

दिल्ली सरकार
आप की सरकार

Foreword

सत्यमेव जयते

The first six years of children's life decides how the next few decades would unfold for them.

There is substantial empirical evidence to suggest the early experiences and care shapes the child's cognitive development. This becomes even more important since nearly 90% of the brain development happens before the child turns five. It is this age group when the child's brain develops more than at any other time period in life.

This is also a crucial time period for physical growth of the child. One in three children is malnourished in India. Nearly 12 lakh children die every year before they turn five years because of deaths that are easily avoidable. This calls for serious reorganising of governance priorities.

Periodic monitoring and evaluation is one significant manner in which governance priorities are reorganised. Systematically carried out evaluations can be insightful helping the good practices amplify, and breakdowns pinned down enabling further improvement.

The Commission For Protection of Child Rights Act 2005 casts the obligation of monitoring the implementation of the children's related schemes, legislations and policies. Therefore, under the able leadership of Shri Ramesh Negi, the then Chairperson, the DCPCR commissioned the study to understand the status of implementation of Integrated Child Development Services (ICDS), one of the most important policies for children. The report also identifies key areas of improvement and makes several recommendations to the Government of NCT of Delhi for the same.

I am glad that DCPCR has sought to bring stakeholders attention to this important time period in a child's life and sincerely hope that the Department of Women and Child Development takes note of this report, and finds it useful as it strives to provide every child a positive early childhood experiences where children grow cognitively, healthily, and in happiness.

Anurag Kundu

Chairperson, DCPCR

सत्यमेव जयते

Acknowledgment

The report is dedicated to all the children of India; nutrition is necessary for proper growth and development of a child and it is the right of children that they have access to proper nutrition. In addition to aforementioned it also showcases the efforts of Anganwadis and NGO who put time and energy into assessing children's health.

I am highly indebted to Shri Ramesh Negi (Former Chairperson, DCPCR) for his constant guidance and effective leadership throughout and also thankful for the constant support of current Chairperson Shri Anurag Kundu. I would like to express my sincere gratitude to Rakesh Bhatnagar (Member Secretary) for ensuring smooth functioning of the administration and Shri B C Narula (Senior Consultant,DCPCR) for his valuable recommendations.

My sincere appreciation Dy. Director - (ICDS), District Officers, CDPOs, Anganwadi Workers and Anganwadi helpers of ICDS project in North East Delhi who participated and coordinated in this study and Matri Sudha NGO who initiated this study "Status report of Anganwadi Services Scheme- a study on assessment/effectiveness of ICDS projects in North East Delhi".

I am thankful to the entire team and staff of the Commission, Mr. P. Nitayichand (Sr. Assistant), my team; Ms. Sunita Rodhiya (Consultant, DCPCR) and Ms. Sarita Rawat (Steno, DCPCR) who's conscious effort finished this project in its present form and worked dedicatedly and performed the important role of co-ordination and liasoning.

Ranjana Prasad

Member, DCPCR

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Preface

Children are supremely important asset, the statement which we find in our document was brought into the national picture in 70's, and the document was National Policy for Children. A year later, the largest programme for children below six years was launched integrating health, nutrition and early childhood development, commonly known among us Integrated Child Development Scheme.

To my understanding over the years the ICDS scheme has been implemented as a nutrition supplementation and school readiness programme. Moreover, not gathering much evidence through age-appropriate interventions is its biggest limitation. Although, an attempt was made in 2012 to restructure ICDS by bringing back the focus on children below two years and to address the problem of malnutrition in early childhood years, had remained a distant dream.

On the other hand various developments at the international level also played an important role to mainstream early childhood development into the national programmes by seeking commitments from national governments. Two major developments happened in 2000, first, the millennium development goals and second, ECD actors increased. The remarkable publication by The LANCET, Child Development in Developing Countries, the global support with the SDGs and Nurturing Care Framework not only amplified to work in a life-cycle approach but at the same time bringing back the discussion to focus on 'windows of opportunity' i.e. the first 1000 days and subsequently build on it.

The Assessment of Anganwadi Services Scheme evaluates the functioning of anganwadi centres in NCT of Delhi by taking sample from three districts – North-East, East and Shahdara. We will find more details about the study in successive chapters.

On behalf of the entire team of Matri Sudha I am very thankful to Delhi Commission for Protection of Child Rights for giving us an opportunity and all the esteemed personalities who have shared their valuable time to give final shape to this study.

Lastly, through this research report I would like to make an appeal to all to come together and extend your support in favor of young children of Delhi. Your feedback and suggestions will not only enrich the discussion but guide us to draw the roadmap.

Arvind Singh

Advisor, Health & Nutrition

Matri Sudha – A Charitable Trust

Content

Contents

Foreword 2

Acknowledgment 3

Preface 4

List of Chapters 7

List of Tables 8

List of Figures 9

List of Images 10

Abbreviations 11

A. Executive Summary 13

B. Introduction 16

1) Nurturing Care & SDGs 19

2) Forty-Five Years of ICDS 27

3) Status of Children Under-Six 44

4) Anganwadi Services Scheme in NCT of Delhi 61

5) Literature Review 75

C. About the Study 80

D. Results & Discussions 97

E. Conclusion 169

Annexures 203

Appendix 215


Ankur
Rhymes
&
गीत
A
KINGFISHER
DRAUGHT
Applications
MODEL NO
TPOS7

List of Chapters

A. Executive Summary

B. Introduction

   1) Nurturing Care & SDGs
   2) Forty-Five Years of ICDS
   3) Status of Children Under-Six
   4) Anganwadi Services Scheme in NCT of Delhi
   5) Literature Review

C. About the Study

D. Results and Discussion

E. Conclusion

F. Key Recommendations

List of Tables

Table 1: The SDG Index, India 26
Table 2: The SDG Index, NCT of Delhi, 2019 27
Table 3: Services and beneficiaries of Anganwadi Services Scheme 30
Table 4: Population Norms for AWC 31
Table 5: Expansion of Anganwadi Services Scheme (1975-2019) 32
Table 6: Coverage under Anganwadi Service Scheme (March 2013 to March 2019) 33
Table 7: Cost sharing ratio between Centre & States/UTs 34
Table 8: Budgetary Allocation under the Anganwadi Services Scheme (in Crore) 34
Table 9: Component-wise expenditure on Anganwadi Services Scheme 35
Table 10: POSHAN Abhiyaan Targets 40
Table 11: PMKVY Benefits 42
Table 12: Developmental Needs of Children Under-Six 47
Table 13: Health & Nutrition Status Children Under-Six & Women in India 49
Table 14: Anganwadi Centres in Delhi 59
Table 15: District-wise child population (0-6 years) 60
Table 16: No of AWCs & Population of Children Under-Six in Delhi 61
Table 17: Number of Beneficiaries and AWCs in Delhi 62
Table 18: Registered Beneficiaries of ICDS 63
Table 19: ICDS Budget, 2019-20 (in thousands), GNCTD 65
Table 20: Composition of Population 78
Table 21: District-Wise List of ICDS Projects Covered in the Study 82
Table 22: Project-Wise Distribution of AWCs 82
Table 23: Distribution of Sample Population 83
Table 24: Distribution of Sample: A Comparison of Different Studies on ICDS in Delhi 84
Table 25: Topics Covered in the Scheduled Interviews 85
Table 26: Distribution of AWCs Covered in Sample ICDS Project 93
Table 27: Socio-economic and demographic indicators of AWWs 98
Table 28: Official Visits by Supervisors and CDPOs 101
Table 29: Inputs by AWWs 104
Table 30: Space inside & outside the AWCs 111
Table 31: Nutritional Standards of Supplementary Nutrition 117
Table 32: Status of Weighing Machines in AWCs 123
Table 33: Frequency of Growth Monitoring 124
Table 34: Coordination of AWWs & ASHAs 129
Table 35: Socioeconomic & Demographic Characteristics of Beneficiaries 150
Table 36: Awareness among Beneficiaries about Anganwadi Services 151

List of Figures

Figure 1: Multi-sectoral framework for development of children under-six 24
Figure 2: GoI Approvals for ICDS **Error! Bookmark not defined.**
Figure 3: National Stunting levels for under-five children in South Asia 49
Figure 4: Health & Nutrition Status Children Under-Six & Women in Delhi 50
Figure 5: Prenatal and Delivery Care in Delhi 53
Figure 6: Post-Natal and Early Childhood Care in Delhi 55
Figure 7: Percentage of Beneficiaries Receiving Supplementary Nutrition 64
Figure 8: Nutritional Status of Children in North-East District 78
Figure 9: Pre-Natal & Delivery Care in North-East District 79
Figure 10: Post-Natal & Early Childhood Care & Nutrition in North-East District 79
Figure 11: Nutritional Status of Children in East District 80
Figure 12: Prenatal & Delivery Care in East District 81
Figure 13: Post-Natal & Early Childhood Care & Nutrition 81
Figure 14: Data Collection Stage I 88
Figure 15: Data Collection Stage II 88
Figure 16: Actual Number of AWCs Covered 93
Figure 17: Education Qualification of AWWs **Error! Bookmark not defined.**
Figure 18: Work Experience as AWW & in Current Project 97
Figure 19: Enrollment of Beneficiaries in AWC (In Percentage) 109
Figure 20: Location, Accessibility & Other Features of AWCs 115
Figure 21: Awareness w.r.t serving supplementary nutrition to Severely Underweight Children 119
Figure 22: Potential Means of Contamination of Food 121
Figure 23: Nutritional Status of Children in AWC – Weight-for-Age (In Percentage) 126
Figure 24: Frequency of meetings 127
Figure 25: Possible Changes noticed in ICDS in past few years 140

List of Images

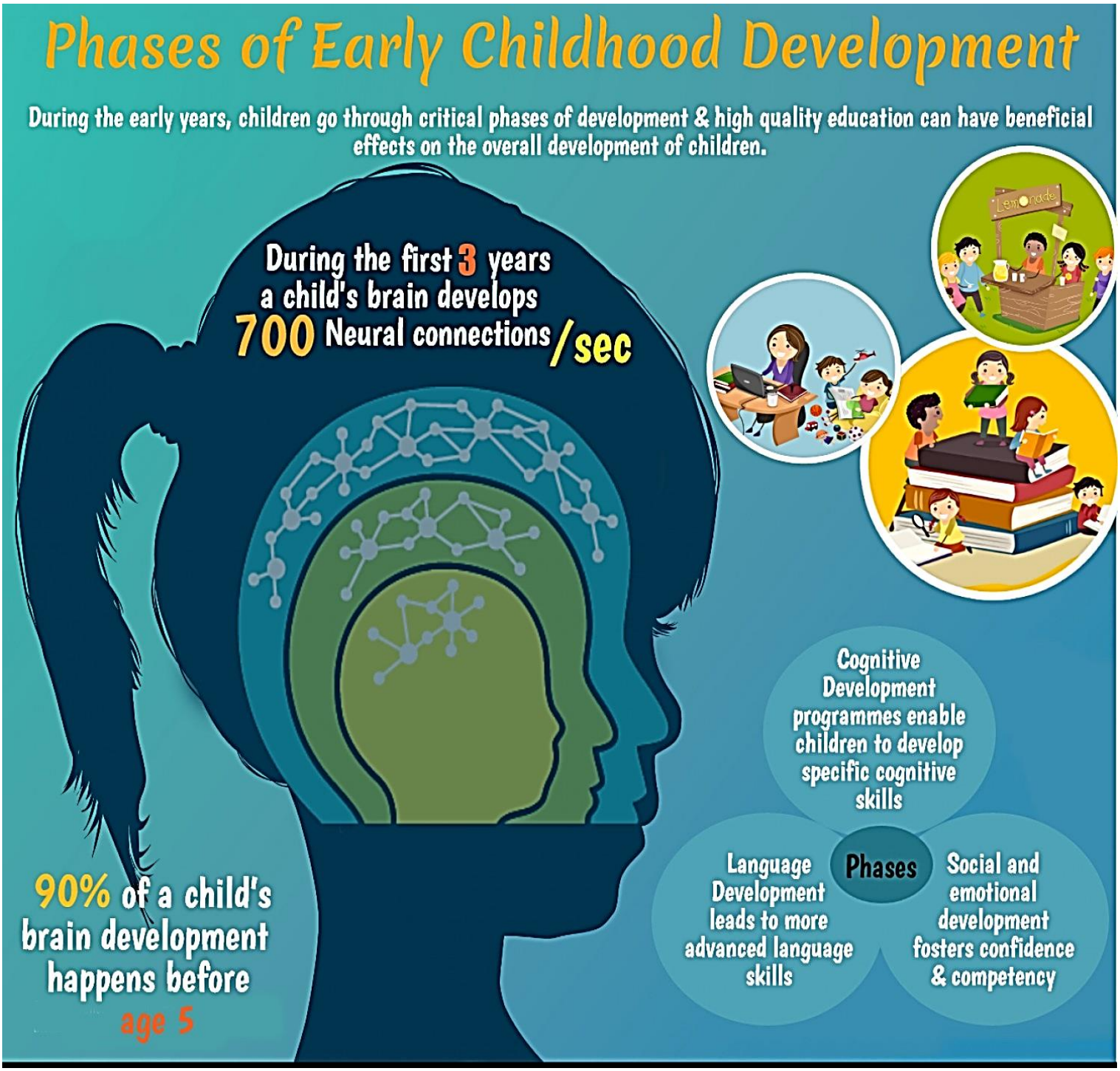
Image 1: Image taken from an AWC in Sample Districts **Error! Bookmark not defined.**
Image 2: Sustainable Development Goals (sustainabledevelopment.un.org/?menu=1300) **Error! Bookmark not defined.**
Image 3: Image taken from an AWC in Sample Districts **Error! Bookmark not defined.**
Image 4: Role of Different Stakeholders at State & District Levels **Error! Bookmark not defined.**
Image 5: Role of Different Stakeholders at Central Level **Error! Bookmark not defined.**
Image 6: Sleepers of Children, the Helper and Worker in an AWC in Sample Districts **Error! Bookmark not defined.**
Image 7: Image taken from an AWC in Sample Districts **Error! Bookmark not defined.**
Image 8: Revenue districts covered for research **Error! Bookmark not defined.**
Image 9: Sample Distribution **Error! Bookmark not defined.**
Image 10: Visit Records 102
Image 11: Image taken from an AWC in Sample Districts **Error! Bookmark not defined.**
Image 12: Children found sitting in the AWC in Seelampur 108
Image 13: Children and Women Sitting in AWC for Immunization **Error! Bookmark not defined.**
Image 14: Toilet in AWC in Sunder Nagari **Error! Bookmark not defined.**
Image 15: A child playing inside the AWC **Error! Bookmark not defined.**
Image 16: Children in HUB Centre, Mandawali **Error! Bookmark not defined.**
Image 17: ECCE Kit in AWC **Error! Bookmark not defined.**
Image 18: AWW conducting activity with children in AWC **Error! Bookmark not defined.**
Image 19: Leftover Food in an AWC **Error! Bookmark not defined.**
Image 20: Meeting Minutes Register in AWC, Trilokpuri **Error! Bookmark not defined.**
Image 21: AWW Telling a Story to Children in AWC, Geeta Colony 133
Image 22: A well-decorated Hub Centre in Sonia Vihar ICDS Project 135
Image 23: Image taken from an AWC in Sample Districts **Error! Bookmark not defined.**
Image 24: Image taken from an AWC in Sample Districts **Error! Bookmark not defined.**
Image 25: Surrounding in front of AWCs in Sunder Nagari & Shahdara 166
Image 26: Image taken from an AWC in Sample Districts **Error! Bookmark not defined.**

Abbreviations

ANM	Auxiliary Nurse Midwife
ASER	Annual Status of Education Research
ASHA	Accredited Social Health
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CABE	Central Advisory Board of Education
CDPO	Child Development Project Officer
CECED	Centre for Early Childhood Education & Development
DCPCR	Delhi Commission for Protection of Child Rights
ECCD	Early Childhood Care & Development
ECCE	Early Childhood Care & Education
FGD	Focus Group Discussion
ICDS	Integrated Child Development Scheme
IYCF	Infant Young Child Feeding
P&LM	Pregnant and Lactating Mothers
MHU	Medical Health Unit
MO	Medical Officer
MHRD	Ministry of Human Resource Development
MWCD	Ministry of Women and Child Development
NCAER	National Council for Applied Economic Research
NCERT	National Council for Educational Research and Training
NFHS	National Family Health Survey
NHED	Nutrition and Health Education
NHP	National Health Policy
NHRM	National Rural Health Mission
NIPCCD	National Institute of Public Cooperation and Child Development
NNP	National Nutrition Policy

NPA	National Plan of Action
NRC	Nutrition Rehabilitation Centre
PSE	Preschool education
POSHAN	Prime Minister Overarching Scheme for Holistic Nutrition
SCERT	State Council for Educational Research and Training
SDG	Sustainable Development Goals
THR	Take Home Ration
UNESCO	United Nation Education Social and Cultural Organization
UNICEF	United National Children Emergency Fund
VHND	Village Health and Nutrition Days
WHO	World Health Organization

A.Executive Summary



Executive Summary

a. Contextualization

The first 6 to 8 years of a child's life are globally acknowledged to be the most critical years for lifelong development since the pace of development in these years is extremely rapid. Recent research in the field of neuroscience, particularly on the brain, has provided convincing evidence of the 'critical periods' located within these early years for the forming of synaptic connections in the brain and for the full development of the brain's potential. Research has also indicated that if these early years are not supported by, or embedded in, a stimulating and enriching physical and psychosocial environment, the chances of the child's brain developing to its full potential are considerably, and often irreversibly, reduced[1].

Survival, growth and development in the earliest years of life are fundamental for the future of every individual and for the future of the societies into which those individuals are born. However, these crucial formative years remain a time of peril and loss – disease and malnutrition not only claim the lives of millions of children throughout the world, but they also damage their growth and development, diminish their quality of life in the present and compromise their future[2].

Keeping in view of its commitment to provide an integrated programme related to survival, health, care, and development, Integrated Child Development Services (ICDS) as a Centrally Sponsored flagship Scheme was launched in 1975. The scheme aims at holistic development of children below six years and providing nutritional and health support to pregnant and lactating mothers. It provides for a package of six services viz. supplementary nutrition, immunization, referral services, health check- up, pre-school non-formal education, health and nutrition education[3].

Objectives

The present research report aims at evaluating the Anganwadi Services Scheme under the Umbrella Integrated Child Development Services. The objectives of the research: (a) To evaluate the Anganwadi Services Scheme under the Umbrella ICDS Programme; (b) To identify key areas

[1] NCERT 2006
[2] WHO 1999
[3] Integrated Child Development Scheme

of improvement in the services; (c) To understand the utilization and awareness about the Anganwadi Services; and (d) To make suitable recommendations to Govt. of NCT of Delhi.

Methodology

The present study uses a mixed-method technique that looks into the views of the service providers and the beneficiaries. The study is designed to give a holistic overview of Anganwadi Services Scheme which includes in-depth interviews of Anganwadi Workers, the Supervisors, the CDPOs, the beneficiaries and communities from East and North-East districts of NCT Delhi. The scheduled interviews of the Anganwadi Workers, the beneficiaries, the Supervisors, Child Development Project Officers and focus-group discussion in communities have been the primary source of data collection.

The study has done secondary research and compiles information from the Census, NFHS-IV, NRHM, and Rapid Survey on Children (2013), Children in India (2018), NITI Aayog, budget documents, information available on government websites, NIPCCD, existing literature.

Limitations

The present study is conducted in two districts which cannot be generalized to all Anganwadi Centres in NCT Delhi. Therefore, the findings of the research are limited to the data collection sites covered during the field work. The availability of data with respect to adolescent girls were found in very few anganwadi centres, hence, it was difficult to assess the benefits of the scheme for this group.

B.Introduction

Nurturing Care & Sustainable Development

Forty-Five Years of ICDS

Status of Children Under-Six

Literature Review


Every young child deserves to thrive
A child's brain develops fastest in the first 2-3 years
Nurturing Care:
Nutrition
Safety and security
Health
Responsive care
Early learning
The Foundation for Children's Development
Cost of Inaction
About 250 million children under 5 are at risk of not reaching their full potential
About 25% reduction in average adult earning potential
Countries may lose up to 2 or 3 fold what they now invest in health or education
Early childhood development pays off
Better health and learning capacity
Increased adult earning
Poverty reduction
Fewer inequalities
More peaceful societies
Nurturing care means supporting parents and caregivers to:
Breastfeed and provide nutritious food
Maintain good health during conception, pregnancy and in the postnatal period
Provide a nurturing and safe environment
Give their children opportunities to explore and learn
The Lancet Early Childhood Development Series 2016

Abstract

In this chapter the writers of this report have started with a new paradigm for early childhood development at the global level in the form of Nurturing Care Framework which has brought back the focus from pregnancy to children below 3 years. The nurturing care framework means giving young children opportunities for early learning, through interactions that are responsive and emotionally supportive. Then the chapter moves on the progress toward sustainable development goals and its progress in India and NCT of Delhi.

The constant changes in the situation of children below six years, particularly, the situation of malnutrition in the country, the chapter further touched upon multi-disciplinary issues and how ICDS schemes have progressed in the last few years. The last two sub-chapters in this section have brought the existing studies on ICDS in the form of literature review and concluded with the situation of children below six years in NCT of Delhi.

1) Nurturing Care & SDGs

Chapter I

Image SEQ Image * ARABIC 1: Image taken from an AWC in Sample Districts

1. Nurturing Care and Sustainable Development

There can be no equality of opportunity without… appropriate stimulation, nurturing, and nutrition for infants and young children. Conditions of poverty, toxic stress and conflict will have produced such damage that they may never be able to make the best of any future opportunities. If your brain won't let you learn and adapt in a fast changing world, you won't prosper and, neither will society."

World Bank Group President Jim Yong Kim, Oct 1, 2015

It is a well-known fact that a very large number of children are at risk of poor development as undernutrition continues to exert a heavy toll globally. In 2018, almost 200 million children under the age of 5 years suffered from stunting or wasting while at least 340 million suffered from hidden hunger i.e. deficiencies of vitamins and minerals. The triple burden of malnutrition – undernutrition, hidden hunger and overweight – threatens the survival, growth and development of children, young people, economies and nations. The greatest burden of all forms of malnutrition is shouldered by children and young people from the poorest and most marginalized communities, perpetuating poverty across generations[4].

An adverse environment harms development of children both in the short term and more importantly, the longer term. One of the most sensitive to ensure the growth of a child starts from pregnancy to the first three years after birth. The adversity during pregnancy may lead to low birth-weight or preterm birth; this raises the risk of developmental difficulties and chronic disease in adulthood. Other factors that threaten early childhood development include maternal nutrition, suboptimal breastfeeding, malnutrition, limited stimulation, neglect, maltreatment, disabilities and violence at home and in communities. This is compounded by factors including teenage pregnancy, disability, family violence; discrimination and substance abuse. Threats to early child development tend to cluster together, often in conjunction with lack of services and social exclusion. So being exposed to one risk usually means being exposed to many. Therefore, we need more resilient families and communities to promote development of young children and it is possible only when

[4] UNICEF 2019

different groups across sectors come together to bring back the focus on children below three years[5].

Various researches have shown that window of opportunity for addressing a child's nutritional needs, not only for short-term growth, but also for the generation of health and productive adults in long term, lies between the duration when the child is conceived to age 2[6]. Also dimensions of under-nutrition and its cumulative impact are reflected in stunting (low height for age), wasting (low weight for height), undernourishment and micronutrient deficiencies of iron, Vitamin A, zinc and iodine, which adversely affect growth, cognitive development, increase chances of disease and infections, and in worst cases, even lead to death[7].

In Indian context, the world's largest community-based outreach programme to promote the early development of children, ICDS offers a package of health, nutrition and education services to the children below six years and pregnant and nursing mothers[8]. An attempt was made in the 12th Five Year plan to transform the ICDS programme with a vision to ensure holistic physical, psychosocial, cognitive and emotional development of children under 6 years of age in nurturing, protective, child friendly and gender sensitive family, community, programme and policy environments with greater emphasis on children under 3 and promotion of optimal early childhood care, development & learning including maternal care[9].

The nurturing care framework provides strategic directions to support the development of children from pregnancy up to 3 years. These conditions enable communities and caregivers to ensure children's good health and nutrition, and protect them from threats. Nurturing care also means giving young children opportunities for early learning, through interactions that are responsive and emotionally supportive[10].This multi-sectoral framework (Fig-1) is viewed as the heart in nurturing care of young children, provided by parents, families, and other caregivers. Nurturing care also comprises of a caregiver's sensitivity to fulfill children's physical and emotional needs, as well as ensure protection from harm, provision of opportunities for exploration and learning, and

[5] Nurturing Care for Early Childhood Development 2018
[6] Marrie Ruel and John Hodinott John 2008
[7] WHO
[8] M C Sandhyarani and Dr C Usha Rao 2013
[9] ICDS Mission Document
[10] Nurturing Care for Early Childhood Development 2018

interactions with young children that are responsive, emotionally engaging, and cognitively stimulating[11].

Figure 1: Multi-sectoral framework for development of children under-six

It is time to act and to work toward realization of a vision where every child is able to develop their full potential and no child is left behind. The Sustainable Development Goals have embraced young children's development, seeing it as key to the transformation that the world seeks to achieve by 2030. Embedded in the SDGs on hunger, health, education and justice are targets on malnutrition, child mortality, early childhood learning and violence – together with others, outline an agenda for improving early childhood development[12]. India along with other countries signed the declaration on the 2030 Agenda for Sustainable Development, comprising of seventeen Sustainable Development Goals (SDGs) at the Sustainable Development Summit of the United Nations in September 2015[13].

Explicit mention is made in SDG Target 4.2 which states that by 2030 countries should: 'ensure that all girls and boys have access to quality early childhood development, care and pre-primary

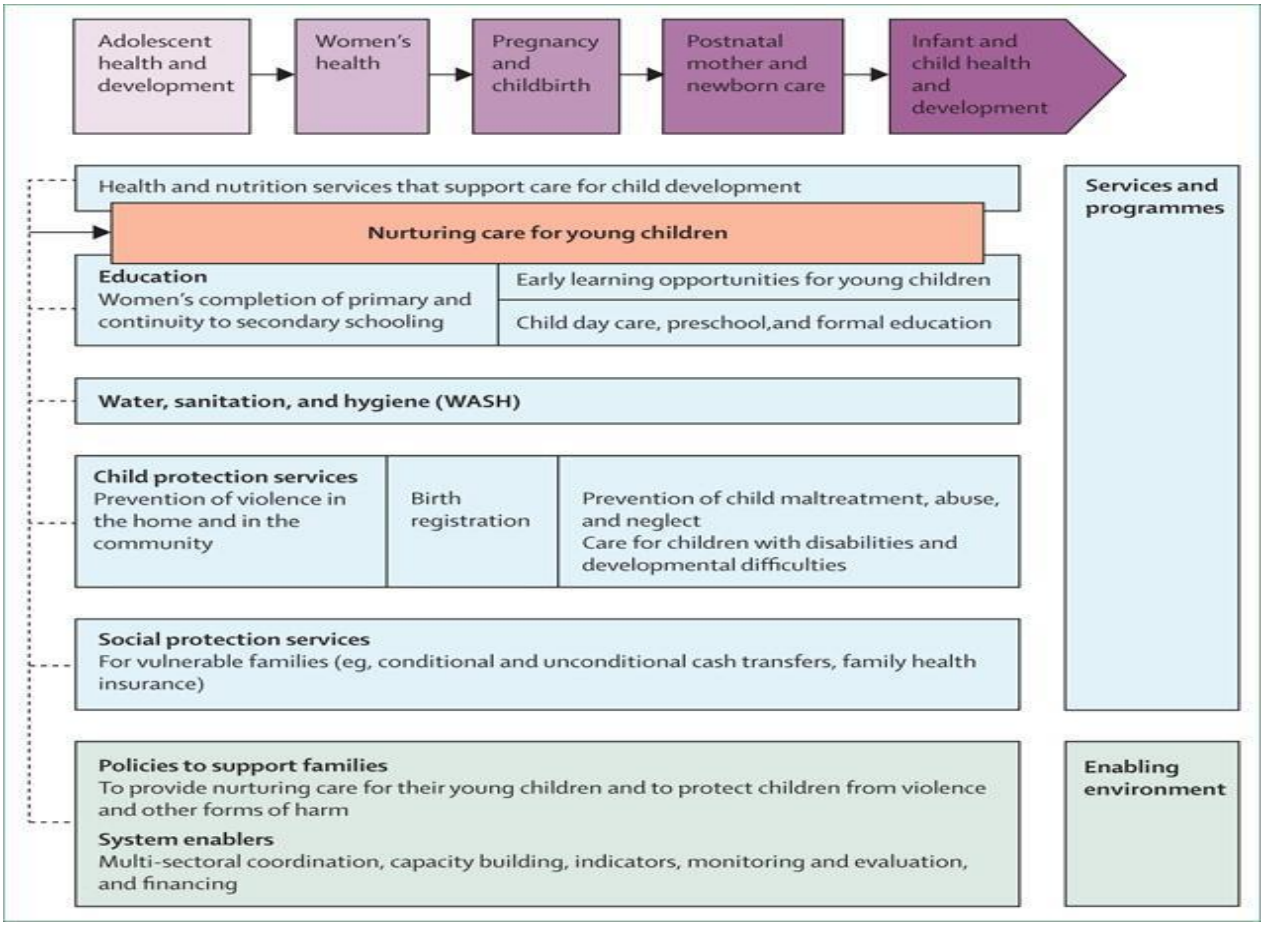
[11] LANCET 2018

[12] Nurturing Care for Early Childhood Development 2018

[13] India and Sustainable Development Goals: The Way Forward 2016

education so that they are ready for primary education'. But SDG commitments to early childhood development are much broader than this education-focused target.

Strengthening early childhood development is the key to achieving at least seven of the SDGs, on



poverty, hunger, health (including child mortality), education, gender, water and sanitation and inequality[14].

[14] Early Childhood Development in the SDGs 2016

Image SEQ Image * ARABIC 2: Sustainable Development Goals
(sustainabledevelopment.un.org/?menu=1300)

The Anganwadi Services Scheme could play a major role in achieving goal 2 of zero hunger which requires a qualitatively higher order of planning, budgetary allocations, and interdisciplinary coordination at the national, state and local level[15].

Table 1: The SDG Index, India

The SDG Index, India[16]							
Country: India		**Region: East and South Asia**		**Rank: 115**		**Score: 61.1**	
Goal 1 No Poverty	Goal 2 Zero Hunger	Goal 3 Good Health & Well-Being	Goal 4 Quality Education	Goal 5 Gender Equality	Goal 6 Clean Water & Sanitation	Goal 7 Affordable & Clean Energy	Goal 8 Decent Work & Economic Growth
71.4	**42.6**	**58.8**	**80.2**	**33.2**	**56.6**	**65.4**	**83.2**

[15] Special Commentary - Sustainable Development Goals: An India Perspective 2017
[16] Sustainable Development Report 2019

Goal 9 Industry, Innovation & Infrastructure	Goal 10 Reduced Inequalities	Goal 11 Sustainable Cities & Communities	Goal 12 Responsible Consumption & Production	Goal 13 Climate Action	Goal 14 Life below water	Goal 15 Life on Land	Goal 16 Peace, Justice & Strong Institutions	Goal 17 Partners hips for the Goals
28.7	**49.0**	**51.1**	**94.5**	**94.5**	**51.2**	**51.1**	**61.3**	**65.7**

NITI Aayog on 30th December 2019 released the second edition of the Sustainable Development Goals (SDG) India Index, which comprehensively documents the progress made by Indian States and Union Territories towards achieving the 2030 SDG targets. The SDG India Index score has been categorized as follows:

- Aspirant: 0-49
- Performer: 50-64
- Front Runner: 65-99
- Achiever: 100

The indicator set for SDG India Index 2019-2020 is large (100 indicators) as compared to SDG India Index 2018-19 (62 indicators) and thereby two indices are strictly not comparable. There are 40 indicators that are common across SDG India Index 2018-19 and SDG India Index 2019-2020.

The SDG Index (Among UTs)[17]								
Country: India	**NCT of Delhi**			**Rank: 5**			**Score: 61**	
Goal 1 No Poverty	Goal 2 Zero Hunger	Goal 3 Good Health & Well-Being	Goal 4 Goal 4 Quality Education	Goal 5 Gender Equality	Goal 6 Clean Water & Sanitation	Goal 7 Affordable & Clean Energy	Goal 8 Decent Work & Economic Growth	
54	**56**	**54**	**64**	**27**	**61**	**96**	**60**	
Goal 9 Industry, Innovation & Infrastructure	Goal 10 Reduced Inequalities	Goal 11 Sustainable Cities & Communities	Goal 12 Responsible Consumption & Production	Goal 13 Climate Action	Goal 14 Life below water	Goal 15 Life on Land	Goal 16 Peace, Justice & Strong Institutions	Goal 17 Partnerships for the Goals
100	**69**	**63**	**39**	**30**	**-**	**82**	**64**	**-**

[17] SDG Index Among UTs 2019

Table 2: The SDG Index, NCT of Delhi, 2019

Among the Union Territories, Chandigarh ranks first with a score of 70 followed by Puducherry (66 score) and Dadra & Nagar Haveli (63 score) in 2019. The NCT of Delhi ranks 5 with a total score of 61 in 2019-20 against 62 in 2018-19.Therefore, as per the classification of scores, the NCT of Delhi is the front-runner in achieving the SDGs (Table 2).

Similarly, among the states, Kerala stands 1st (70 score) which is then followed by Himachal Pradesh (69 score) and Andhra Pradesh (67 score). The states which stand last in the list are Jharkhand at 26th position (50 score) and Bihar 28th position (50 score).

2) Forty-Five Years of ICDS

Chapter II

2. Forty-Five Years of ICDS

2.1. Introduction

In 2019, the world's largest programme for children below six years completed the 45th year of its implementation covering 8.4 crore children of age below 6 years and 1.91 crore pregnant and lactating mothers through 7,066 projects and 13.42 lakh operational AWCs[18].The programme has expanded tremendously in over four decades of its journey to cover almost all the development blocks in the country[19].

It offers a wide range of health, nutrition and education related services to children, women and adolescent girls. ICDS is intended to target the needs of the poorest and the undernourished, as well as the age groups that represent a significant window of opportunity for nutrition investments (i.e. children under three years of age, pregnant and lactating mother)[20].

Very recently it was renamed as Anganwadi Services Scheme under the umbrella ICDS programme by the Ministry of Women and Child Development, the nodal agency to oversee its implementation. This chapter discusses in detail about this centrally sponsored scheme right from its conception to till date. The key challenges and gaps in its implementation at the national level is discussed in the last section of this chapter and its status in the national capital territory of Delhi in coming sections of this report.

2.2. The Background

The foundations for the introduction of ICDS programme were laid with the organized support to childcare, which was an objective promoted by the National Planning Committee appointed during the freedom struggle in 1939-40. The Constitution of India affirmed the State's commitment to the welfare of children in its Directive Principles of State Policy. Based on the Directive Principles, the Central Social Welfare Board was set up on August 13, 1953 which in turn started schemes for

[18] NITI AAYOG 2015
[19] ibid
[20] ibid

providing care and medical attention to children and pregnant women and for setting up child welfare centres under the Community Development Blocks[21].

Though many welfare schemes for children were being implemented through various agencies and departments even then a study conducted by the Planning Commission brought to light that the benefits reached only a small percentage of the target groups at the local level. As a response to the weakness brought out by the Planning Commission study, a National Policy for Children was adopted by Government of India in August 1974 declaring children as, "supremely important asset." It was felt that it should be the policy of the state to provide adequate services to children, before and after birth, and through the period of growth, to ensure their full physical, mental and social development[22].

On the other hand the average under-five mortality rate was 202 in 1970[23]. Also, during 1975, the maternal mortality rates (MMR) and infant mortality rates (IMR) were extremely high (MMR – 853 per 1, 00,000 live births and IMR – 134 per 1,000 live births) due to the severe drought the country faced[24].

Based on the recommendations of the Planning Commission and keeping in consideration the state of maternal and child health, ICDS was inaugurated in 33 blocks[25] across the country on 2nd October, 1975. The **objectives** of the services are[26]:

1. To improve the nutritional and health status of children below the age of six years;
2. To lay the foundation for proper psychological, physical and social development of the child;
3. To reduce the incidence of mortality, morbidity, malnutrition and school dropout;
4. To achieve effective coordination of the policy and implementation amongst the various departments to promote child development; and
5. To enhance the capability of the mother to look after normal health and nutritional needs of the child through proper nutrition and health education.

[21] Planning Commission 2011
[22] ibid
[23] Suresh Sharma 2008
[24] Planning Commission 2011
[25] A development block is an administrative unit covering about 115 villages on average. The administrative structure of India consists of states and Union Territories (UTs), districts, and blocks, in decreasing order by size.
[26] Planning Commission 2011

2.3. Services and Programme Norms

The ICDS programme provides an integrated package of health, nutrition and education services targeted to children aged below 6 years; pregnant and nursing mothers; and in some blocks, adolescent girls. The programme aims to cover economically or socially marginalized sections of women and children as primary beneficiaries (Planning Commission, 2011).

Table 3: Services and beneficiaries of Anganwadi Services Scheme[27]

Services	Target Group	Service provided by
Supplementary Nutrition	Children below 6 years, pregnant women and lactating mothers	AWW and AWH [MWCD]
Immunization	Children below 6 years, pregnant women and lactating mothers	ANM/MO [MHFW]
Health check-up	Children below 6 years, pregnant women and lactating mothers	ANM/MO/AWW [MHFW & MWCD]
Referral services	Children below 6 years, pregnant women and lactating mothers	ANM/MO/AWW [MHFW & MWCD]
Pre-school education	Children age 3-6 years	AWW [MWCD]
Nutrition and health education	Women (15-45 years)	AWW/ANM/MO [MHFW & MWCD]

Source: Evaluation Report on Integrated Child Development Services Vol. I, Planning Commission, 2011

2.4. Population norms

On November 28, 2001, the Supreme Court of India directed the central and state governments to universalize the ICDS programme. Universalization of ICDS means that every hamlet/settlement should have a functional AWC, and that the coverage of ICDS should be extended to all children below 6 years and all eligible women (Planning Commission, 2011).

The prevailing coverage norms are: The scheme covers rural areas, tribal areas and slums in urban areas. In non-tribal areas each AWC covers 40 beneficiaries in case of 0-3 years and for 3- 6 years category, and the coverage is 20 beneficiaries in case of pregnant and lactating mothers (P&LM) (including 4 being those recommended by the Auxiliary Nurse Midwife (ANM)/Doctor on medical

[27] Annexure 1

grounds). The coverage per AWC for Tribal Areas is as follows: In tribal areas each AWC covers 42 beneficiary in case of 0-3 years and 3-6 years category, and the coverage is 25 in case of P&LM (Planning Commission, 2011).At present the population norms are:

Table 4: Population Norms for AWC

	For AWCs in Rural/Urban Projects
For Rural/Urban Projects	
Population	**Number of AWC**
400-800	**1**
800-1600	**2**
1600-2400	**3**
Thereafter in multiples of 800	**1**
For Mini Anganwadi Centre	
Population	**Number of AWC**
150-400	1
For Tribal /Riverine/Desert, Hilly and other difficult areas/ Projects	
Population	**Number of AWC**
300-800	1
Mini Anganwadi Centre For Tribal /Riverine/Desert, Hilly and other difficult areas/ Projects	
For Mini Anganwadi Centre	
Population	**Number of AWC**
150-300	1

Source: Chapter 3, Child Development, Annual Report 2019-20, Ministry of Women and Child Development

2.5. Expansion and the coverage

Integrated Child Development Services (ICDS) Scheme, now renamed as Anganwadi Services, was launched in 1975[28] with 33 projects and 4891 Anganwadi Centres (AWCs) and was gradually expanded to 5652 Projects and 6,00,000 sanctioned AWCs in the country, by the end of IX Plan (1997-2002). The coverage of Anganwadi Services Scheme, till IX Plan, was not universal as it covered only 42% of the 14 lakh habitations[29]. Following the Honourable Supreme Court's order dated 13th December 2006 to sanction and operationalize a minimum 14 lakh AWCs in a phased and even manner starting forthwith and ending December 2008[30]. The services scheme today operates through a network of 7075 fully operational projects and 13.73 lakh AWCs[31].

Table 5: Expansion of Anganwadi Services Scheme (1975-2019)

Year	Projects	AWCs
1975	33	4,891
2002	5,652	6,00,000
2019-20	7,075	13,72,872

Source: Chapter 3, Child Development, Annual Report 2019-20, Ministry of Women and Child Development

2.6. Coverage under ICDS

There has been significant progress in the implementation of Anganwadi Services under the Umbrella ICDS[32](Annexure 2) Scheme both during X, XI and XII Plans (as on 31.03.2019) in terms of increase in number of operational projects and Anganwadi Centres (AWCs) and coverage of beneficiaries as indicated below[33]:-

[28] Press Information Bureau 2018
[29] MWCD Annual Report 2019-20
[30] PUCL vs Union of India and others, Civil Writ Petition 196 of 2001
[31] MWCD Annual Report 2019-20
[32] Annexure 2
[33] ibid

Table 6: Coverage under Anganwadi Service Scheme (March 2013 to March 2019)

Year ending	No. of operational projects	No of operational AWCs	No. of Supplementary Nutrition Beneficiaries (in Lakh)	No. of Pre-school education beneficiaries (in Lakh)
31.03.2013	7,025	13,38,732	956.12	353.29
31.03.2014	7,067	13,42,146	1,045.09	370.71
31.03.2015	7,072	13,46,186	1,022.33	365.44
31.03.2016	7,073	13,49,563	1,021.31	350.35
31.03.2017	7,074	13,54,792	983.42	340.52
31.03.2018	7,075	13,63,021	892.77	325.91
31.03.2019	7,075	13,72,872	875.61	301.92

Source: Chapter 3, Child Development, Annual Report 2019-20, Ministry of Women and Child Development

i. The number of operational AWCs/ mini AWCs increased from 13,04,611 on 31st March, 2012 to 13,72,872 on 31st March, 2019.

ii. Number of beneficiaries for supplementary nutrition, children (6 months to 6 years) and pregnant & lactating mothers, were reported to be 972.49 lakh on 31st March, 2012 and 875.61 lakh on 31st March, 2019.

iii. Number of beneficiaries for pre-school education were reported to be 358.22 lakh on 31st March, 2012 and 301.92 lakh on 31st March, 2019.

2.7. Cost-sharing Norms and Budgetary Allocation

For the Anganwadi Services (AS) scheme, the Government of India releases grants-in-aid to the States/UTs presently on the following cost sharing ratio between Centre and States/UTs[34]:

[34] ibid

Table 7: Cost sharing ratio between Centre & States/UTs

	AS (General)	Salary	SNP
States/UTs with Legislature	60:40	25:75*	50:50
NE/Himalayan States	90:10	90:10	90:10
States/UTs without Legislature	100:0	100:0	100:0

*From 1st December, 2017, remuneration under Anganwadi Services Scheme is allowed only for selected staff of Anganwadi Services.

The details of budget allocation and expenditure for the year 2013-14 to 2019-20 in respect of Anganwadi Services are presented in Table 8. One can see from the table that the gradual expansion of the scheme is linked to increased budgetary allocation. Although there is an increased revised budgetary estimate in 2018-19 in comparison to 2013-14, however, the increased allocation amounted to Rs. 1567 crores in six financial years. One can also see that the expenditure in 2019-20 is the lowest in comparison to previous five financial years.

Table 8: Budgetary Allocation under the Anganwadi Services Scheme (in Crore)

S. No	Years	Budget Estimate (BE)	Revised Estimates (RE)	Expenditure	Percentage w.r.t RE
1.	2013-14	17,770.00	16,312.00	16,267.00	99.73
2.	2014-15	18,195.00	16,561.00	16,581.00	100.12
3.	2015-16	8,335.77	15,483.77	15,438.93	99.70
4.	2016-17	14,000.00	14,560.60	14,430.31	99.11
5.	2017-18	15,245.19	15,245.19	15,155.34	99.41
6.	2018-19	16,334.88	17,879.17	16,811.71	94.03
7.	2019-20	19,834.37	17,704.50	14,269.46	80.59

Source: Chapter 3, Child Development, Annual Report 2019-20, Ministry of Women and Child Development

The component wise-expenditure as presented in Table 9 shows that the revised estimate is Rs. 1544.29 crore more than the budget estimate, however, the total expenditure is Rs. 1068 crore lesser than the revised estimate. The expenditure on training is only 0.528 percent of the total expenditure on the scheme, while 50.41 percent of the total expenditure is spent on supplementary nutrition[35].

Table 9: Component-wise expenditure on Anganwadi Services Scheme

	Details	Amount (in Crore)
a.	BE 2019-20	19,834.37
b.	RE 2019-20	17,704.50
c.	General Components	7,597.39
d.	Supplementary Nutrition Programme	6,457.78
e.	Swachhta Action Plan	1.39
f.	Food & Nutrition Board	11.10
g.	Training	6.33
	Total Expenditure (c+d+e+f+g)	**14,073.99**

Source: Chapter 3, Child Development, Annual Report 2019-20, Ministry of Women and Child Development

[35] Annexure 3

2.8. Administering Anganwadi Services Scheme

The Anganwadi Services is a Centrally-sponsored scheme which is administered at different levels. At the Central Level the Ministry of Women and Child Development is administering the Anganwadi Services along with National Institute for Public Cooperation and Child Development and Food and Nutrition Board[36]. (Please see Annexure 4: Main Actors of Anganwadi services scheme).

[36] NIPCCD 2006

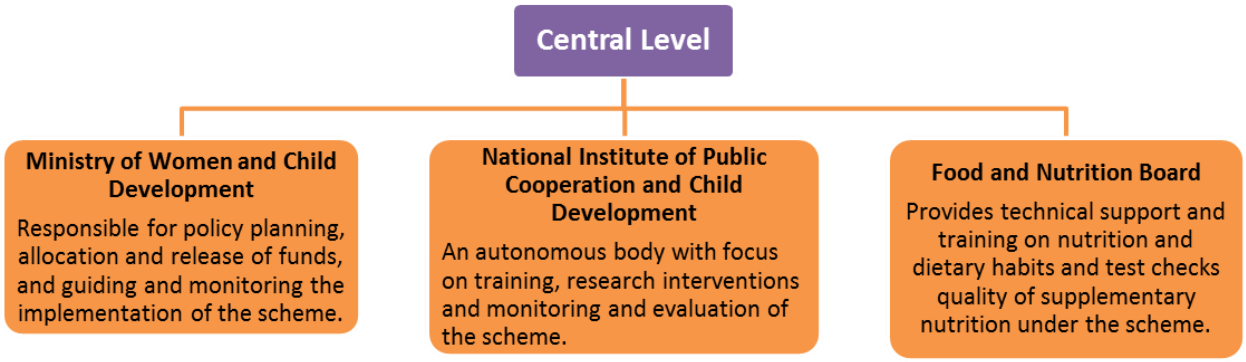


Image SEQ Image * ARABIC 5: Role of Different Stakeholders at Central Level

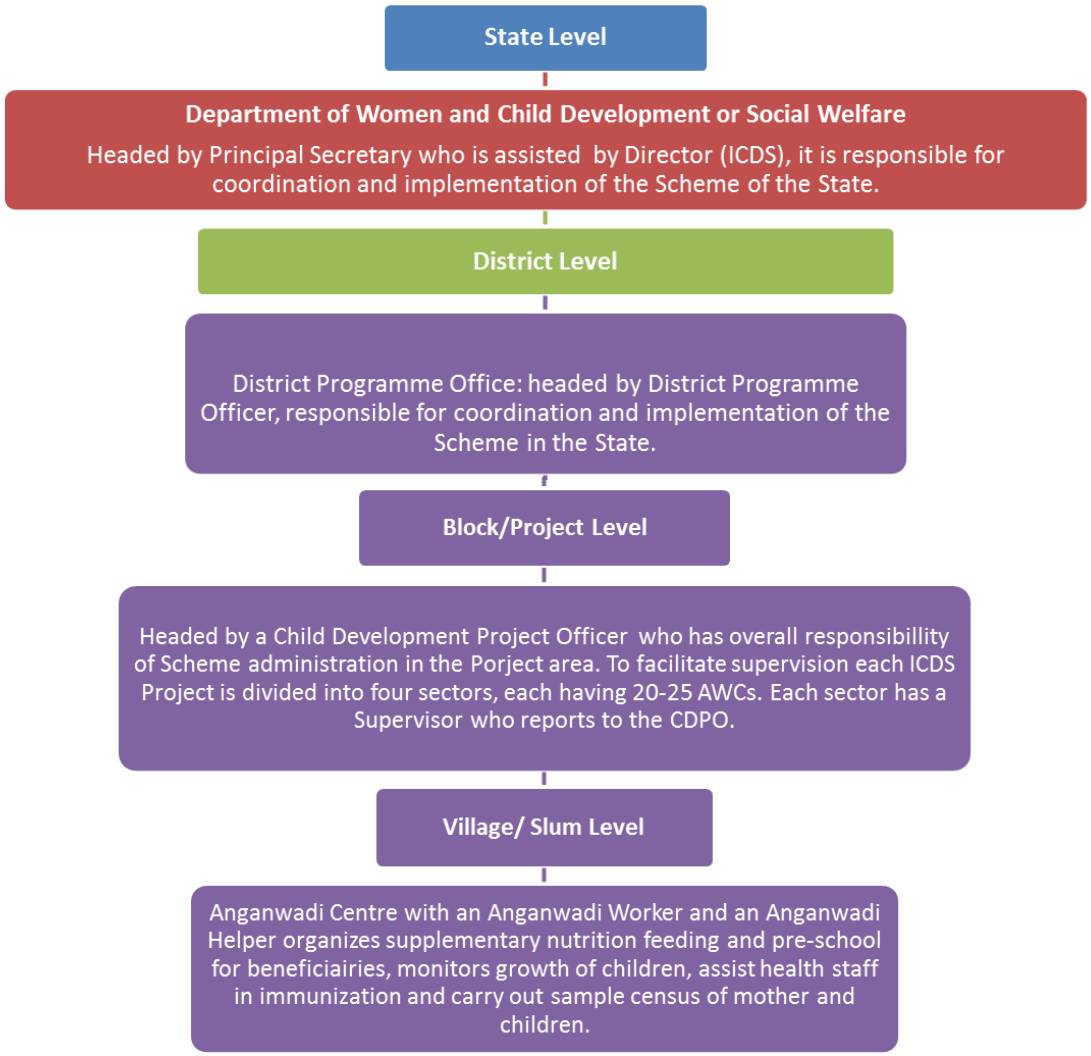


Image SEQ Image * ARABIC 4: Role of Different Stakeholders at State & District Levels

2.9. Budget Brief: Integrated Child Development Services: 2019-20 (ICDS)

The budget brief for Integrated Child Development Services is prepared by Centre for Policy Research[37] for the financial year 2019-20. The budget brief shows that the Government of India allocated Rs. 29,165 crore for the Ministry of Women and Child Development in the financial year 2019-20 in which Rs. 19,834 crore was allocated for Anganwadi Services (ICDS Core) in the same financial year.

₹ 29,165 cr

GoI allocations for Ministry of Women and Child Development (MWCD) in FY 2019-20

₹ 19,834 cr

GoI allocations for ICDS Core (Anganwadi Services) in FY 2019-20

Summary and Analysis

- The allocation for Anganwadi Services increased by 11 per cent from `17,890 crore in Financial Year (FY) 2018-19 to `19,834 crore in FY 2019-20 (IB).
- The Supplementary Nutrition Programme (SNP) accounts for the largest share of the total GoI approved budget and has increased from 45 per cent in FY 2015-16 to 51 per cent in FY 2018-19.
- The number of children receiving SNP and Pre-School Education (PSE) has been falling over the years. Between March 2014 and January 2019, the number of children (6 months - 6 years) receiving SNP fell by 17 per cent from 849 lakh to 705 lakh. Similarly, between March 2014 and January 2019, there was a decline of 14 percent in the number of children availing PSE.
- There are a large number of vacancies in posts for Child Development Project Officers (CDPOs) and Lady Supervisors (LSs). As of June 2018, 25 percent of sanctioned positions for CDPOs and 32 percent of sanctioned positions for LSs were vacant across the country.
- Disability-Adjusted Life Years (DALY's) attributable to child and maternal malnutrition fell from 36 per cent in 1990 to 15 per cent in 2016. However, it continues to be India's leading risk factor for health loss in 24 out of 30 states for which data was available.

[37] Centre for Policy Research 2019-20

Trends in Demands and Allocations

- In FY 2019-20 (IB), GoI allocated `29,165 crore to MWCD. This is an 18 per cent increase from the previous financial year.
- Anganwadi Services is the largest scheme run by MWCD. The share of Anganwadi Services out of total MWCD budget has decreased year on year. In FY 2014-15, the scheme accounted for 89 per cent of MWCD budget. This decreased to 68 per cent in FY 2019-20 (IB).
- In FY 2019-20 (IB), `19,834 crore was allocated to Anganwadi Services. This was an increase of 11 per cent from FY 2018-19 when revised allocations stood at `17,890 crore. As with the entire MWCD budget, allocations for Anganwadi Services remain below the projected demand made by MWCD. In FY 2017-18, MWCD projected a demand of `18,007 crore, of which 85 per cent was allocated. Similarly, in FY 2018-19, 85 percent of MWCD's projected demand of `21,101 crore for Anganwadi Services was allocated.

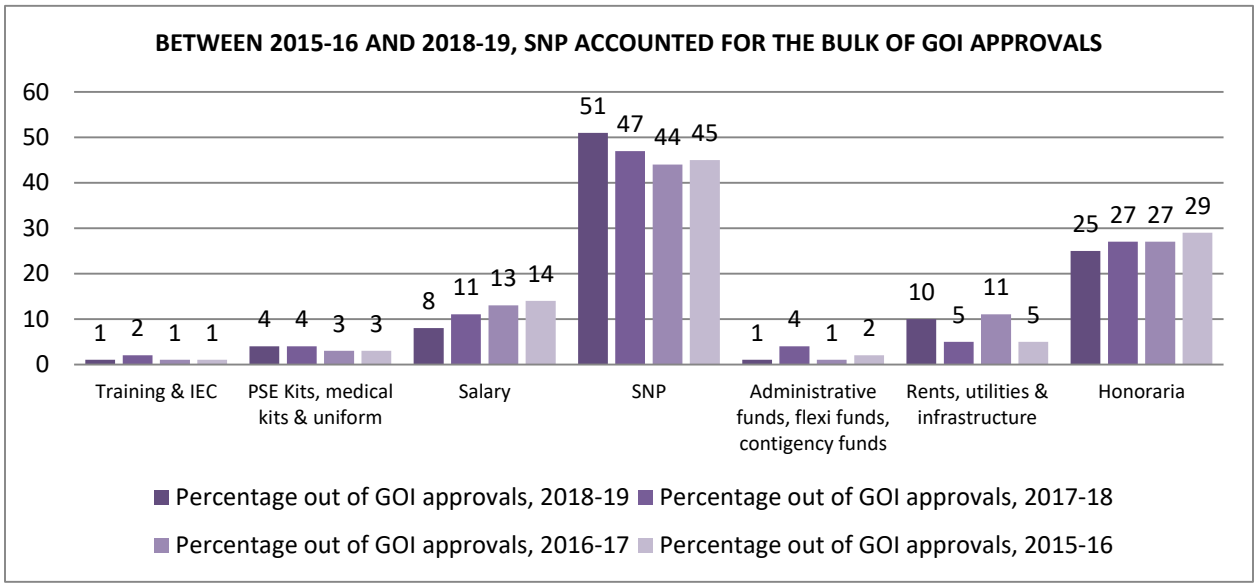


Figure SEQ Figure * ARABIC 2: GoI Approvals for ICDS

Source: Centre for Policy Research, Budget Brief 2019-20: Integrated Child Development Services (ICDS).

2.10. Key challenges and issues

In the previous chapter it was discussed that there has been decline in the population availing Anganwadi services, despite increase in budgets and provisions which is attributable to several factors[38]. The key constraint on its effectiveness is that its actual implementation deviates from the original design. There has been an increasing emphasis on the provision of supplementary feeding and preschool education to children four to six years old, at the expense of other components that are crucial for combating persistent undernutrition[39].

Because of this, most children under three – the group that suffers most from malnutrition – are not reached, and most of their parents do not receive counseling on better feeding and child care practices. To conclude, greater clarity and focus is needed if ICDS program is to make a substantial dent in the problem of persistent undernutrition in India. In particular, the three mismatches identified earlier need to be resolved so that a nutrition intervention is implemented that:

i. it provides the most effective services to address the most important determinants of malnutrition;
ii. it reaches the younger children and the most vulnerable segments of the population; and
iii. it is well targeted to areas where the prevalence of undernutrition is highest[40].

[38] NITI AAYOG 2015
[39] The World Bank 2006
[40] ibid

2.11. Other Interventions under Umbrella ICDS

2.12. POSHAN Abhiyaan

The Government of India has set-up POSHAN Abhiyaan (PM's Overarching Scheme for Holistic Nutrition) erstwhile the National Nutrition Mission which was launched on 8th March, 2018 from Jhunjhunu, Rajasthan, with an overall budget of Rs. 9,046.17 Crore (50% from Government source and 50% from International Bank for Reconstruction and Development)[41].

The programme through use of technology, a targeted approach and convergence strives to reduce the level of stunting, under-nutrition, anemia and low birth weight in children, and also focuses on Adolescent Girls (AGs), Pregnant Women and Lactating Mothers (PW&LMs), thus holistically addressing malnutrition[42].

To ensure a holistic approach, all Districts under the 36 States/UTs have been covered. The Abhiyaan empowers the frontline functionaries i.e. Anganwadi Workers and Lady Supervisors by providing them with smartphones. The software application, ICDS-Common Application Software (ICDS-CAS), especially developed for this purpose, enables, data capture, ensures assigned service delivery and prompts for interventions wherever required[43].

Table 10: POSHAN Abhiyaan Targets

S. No	Objective	Target
1.	Prevent and reduce Stunting in Children (0-6 years)	By 6% @ 2% per annum.
2.	Prevent and reduce under-nutrition (underweight prevalence) in Children (0-6 years)	By 6% @ 2% per annum.
3.	Reduce the prevalence of anemia among Young Children (6-59 months)	By 9% @ 3% per annum.
4.	Reduce the prevalence of anemia among Women and Adolescent Girls in the age group of 15-49 years.	By 9% @ 3% per annum.
5.	Reduce Low Birth Weight (LBW).	By 6% @2% per annum.

Source: POSHAN Abhiyan Jan Andolan Guidelines, Ministry of Women & Child Development, Government of India

[41] Press Information Bureau 2018

[42] POSHAN Abhiyaan

[43] ibid

POSHAN Abhiyaan ensures convergence of various programmes i.e. Anganwadi Services, Pradhan Mantri Matru Vandana Yojana, Scheme for Adolescent Girls of Ministry of Women & Child Development; Janani Suraksha Yojana (JSY), National Health Mission (NHM) of MoH&FW; Swachh Bharat Mission of Ministry of Jal Shakti and other line ministries.

Under the POSHAN Abhiyaan Anganwadi Workers are provided Rs. 500 per month for using ICDS-CAS on achieving certain parameters like opening of Centres, Home Visits and Weighing of Children. As on 20th November, 2019, Rs. 4,183.58 lakh has been provided to Anganwadi Workers for using ICDS-CAS. Similarly, in order to strengthen processes for community engagement, empowerment of beneficiaries and increased social accountability of ICDS, the POSHAN Abhiyaan provides for the organisation of Community Based Events (CBEs) twice in a month on a fixed day of week at each anganwadi centre.

The Ministry of Women and Child Development (MWCD) in 2017-18 sanctioned Rs. 945.95 lakh, in 2018-19 Rs. 2,206.88 lakh and in 2019-20 (till 31.03.2019) sanctioned Rs. 0.00 under the POSHAN Abhiyaan to Government of NCT of Delhi[44].

2.13. PMMVY

Using the anganwadi platform, the government of India in 2017 officially approved the pan-India implementation of a centrally sponsored scheme i.e. PMMVY (Pradhan Mantri Matru Vandana Yojana) under which the grant-in-aid is being released to States/UTs on a cost sharing ratio basis. The ratio between the Centre and the States/ UTs with Legislature are 60:40, for North-Eastern States and Himalayan States it is 90:10 and is 100% for UTs without Legislature.

The Scheme envisages providing cash incentive amounting to Rs. 5,000 in three installments directly to the Bank/Post-Office Account of pregnant women and lactating mother (PW&LM) in Direct Beneficiary Transfer Mode during pregnancy and lactation in response to individual fulfilling specific conditions as given below:

[44] https://wcd.nic.in/sites/default/files/WCD_AR_English_2019-20.pdf

Table 11: PMMVY Benefits

Cash transfer	Conditions	Amount (in Rs.)
First installment	Early registration of pregnancy	1,000
Second installment	Received at least one antenatal Check-up (Payment after 6 months of pregnancy)	2,000
Third installment	Child birth is registered Child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/ Substitutes	2,000

The beneficiary also receives benefits under Janani Suraksha Yojana so that on an average a beneficiary gets Rs. 6,000 under PMMVY. All eligible pregnant women for the first living child of the family are entitled for benefits under the Scheme. All Government/PSU (Central and State) employees or those who are in receipt of similar benefits under any law for the time being are excluded from the Scheme[45].

As on 31st December 2019 the Ministry of Women and Child Development received 3,45,49,525 applications from 1,37,59,405 beneficiaries from all 37 States/UTs on PMMVY-CAS. The maternity benefits amounting to Rs. 4,938.29 crore have been released to 1,21,13,044 beneficiaries.

In NCT of Delhi a total 1,34,443 beneficiaries were enrolled out of which 1, 23,958 beneficiaries were paid the benefits of the scheme as on 31.12.2019.

[45] Annexure 5

3) Status of Children Under-Six

Chapter III

Image SEQ Image * ARABIC 6: Sleepers of Children, the Helper and Worker in an AWC in Sample Districts

3. Introduction

Before jumping into this section, wherein the writers of this report have discussed in detail about the status of children under-six years, an attempt has been made to bring key information for the readers, especially the first time readers who keep interest in child rights, with special focus on children under-six years. This chapter discusses certain essential Articles of the Constitution which upholds the rights of children and women and acted as the source of key legislations in the country. As one moves ahead, the national policies and government of India's commitment to uphold child rights find their place in the chapter.

3.1. Constitutional Obligations

The Constitution of India guarantees Fundamental Rights to all children in the country and empowers the State to make special provisions for children. The constitutional obligation starts from Article 14 which states that "the state shall not deny to any person equality before the law or the equal protection of the laws within the territory of India". More importantly, Article 21 ensures that "no person shall be deprived of his life or personal liberty except according to procedure established by law". Article 39 (f) states that "child are given opportunities and facilities to develop in a health manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment[46]".

Maternity benefits finds its relevance in Article 42 which enjoins the State to secure just and humane conditions of work and maternity relief. In context to children below six years Article 45 is central to all discussion, wherein the state shall endeavor to provide early childhood care and education for all children until they complete the age of six years. Lastly, Article 47 puts to raise the level of nutrition and increase the standard of living, and to improve public health[47].

3.2. National Policies

The first policy on children in the country rightly pointed out that "it shall be the responsibility of the State to provide adequate services to children, both before and after-birth, and throughout the period of growth". The State progressively increases the scope of such services so that, within a

[46] Constitution of India
[47] ibid

reasonable time, all children in the country enjoy optimum conditions for their balanced development[48].

Carrying forward the balanced development of children, the National Policy for Children, 1986 specially emphasizes "investment in the development of young child, particularly children from sections of the population in which first generation learners predominate"[49]. It was found that the investment in early years of childhood required state commitments to achieve the goals and developing strategies in a time bound manner, as a result the national plan of action was formulated which was followed by the formulation of the state plan of action for children (SPAC) which aimed at the protection, survival, development, and growth of children[50].

To meet the international goals and standards, the national policy for Infant Young Child Feeding practices was formulated to advocate the cause of infant and young child nutrition and its improvement through optimal feeding practices nationwide. IYCF has the potential to improve child growth and development in India. As a result the role of frontline workers in the largest supplementation programme for children below six years in India, play a vital role in promoting young child feeding practices and embedded it in the ICDS system[51].

Another important service in the ICDS pertains to universal immunization of children against all major preventable diseases, and addresses the unmet needs for reproductive rights. The national policies on health takes care of this provision by declaring 'health for all' through universal provision of primary health services with principal feature of extending the coverage of immunization[52]. The policy for empowerment of women laid out the provision of support services for women like childcare facilities, including crèches at work places, educational institutions and homes[53].

In 2005, the government came with a national plan of action for children with a focus on twelve identified areas keeping in view the intensity of the challenges that require utmost and sustained

[48] National Policy for Children 1974
[49] National Policy for Children 1986
[50] National Plan of Action 1992
[51] National Policy for Infant Young Child Feeding Practices 1993
[52] National Health Policy 2000 and 2002
[53] National Policy for Empowerment of Women 2001

attention at each stage of childhood. Out of the twelve identified key areas, the one which promote early childhood survival, care and development are reducing infant and maternal mortality rates, reducing malnutrition among children, achieving 100% civil registration of births, universalization of early childhood care and development and quality education for all children including pre-schools[54].

Almost four decades after the first policy for children paved the way for formulation of the New National Policy for Children in 2013. The new national policy for children reaffirmed and recognized that childhood is an integral part of life with a value of its own. The guiding principle laid out that every child has universal, inalienable and indivisible human rights; that every child has the right to life, survival, development, education, protection and participation. Right to life, survival and development goes beyond the physical existence of the child and also encompasses the right to identity and nationality. The mental, emotional, cognitive, social and cultural development of the child is to be addressed in totality[55].

In the same year (2013) the government brought a new National ECCE policy to reaffirm the commitment of the Government of India to provide integrated services for holistic development of all children, along the continuum, from the prenatal period to six years of age. The Policy lays down the way forward for a comprehensive approach towards ensuring a sound foundation, with focus on early learning, for every Indian child[56].

3.3. Commitment to Uphold Child Rights

The Government of India echoed its commitment to secure the rights of its children by ratifying the United Nations Child Rights Convention on 11th December 1992[57]. In 2007, the government of India formally ratified the United Nations Convention on the Rights of Persons with Disabilities[58]. This was followed by accepting the Hague Convention on Protection of Children and Cooperation in respect of Inter-Country Adoption in 2008[59]. Another significant feat achieved

[54] National Plan of Action for Children 2005
[55] National Policy for Children 2013
[56] National Early Childhood Care and Education Policy 2013
[57] Convention on the Rights of the Child 1989
[58] Convention on the Rights of Persons with Disabilities 2006
[59] Hague Conventions

by the Government of India was signing and hence, ratifying the United Nations Convention on 5th May 2011, against Transnational Organized Crime which includes the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially women and children, supplementing the United Nations Convention against Transnational Organized Crime[60].

In 2017, the Government of India ratifies two fundamental ILO Conventions concerning the elimination of child labor, the Minimum Age Convention, 1973 (No. 138) and the Worst Forms of Child Labor Convention, 1999 (No. 182)[61].

3.4. Development Needs of Children Under-Six

Various national and international literature have described early childhood as the period from conception to eight years of age. These early experiences are largely determined by supportive family and community care practices, proper nutrition and health care, learning opportunities, which in turn are dependent on enabling policies and investments for young children and families. Further, early childhood education positively impacts attendance, retention, and learning of children in elementary and higher education[62]. Children below six years of age need good nutrition, education and care in order to meet their full potential of health, well-being and capacity for the rest of their lives[63].

Investing in the early years is one of the smartest things a country can do to eliminate extreme poverty, boost shared prosperity, and create the human capital needed for economies to diversify and grow.

[60] United Nations Convention against Transnational Organized Crime
[61] International Labor Organization
[62] UNICEF
[63] Strategies for Children Under Six

Table 12: Developmental Needs of Children Under-Six

S. No	Age Group	Development Needs
1.	Pre-natal to birth	Maternal health and nutrition Parental and family education Safe motherhood Maternal support services
2.	Birth to six months	Maternal health-postpartum care Exclusive breastfeeding Infant health Nutritional security Responsive care Early stimulation/play Safety and security Support services
3.	Six months to three years	Infant health Nutritional security, responsive care Early stimulation/play and learning opportunities Safety and security
4.	Three to six years	Child health and nutrition Adequate nutrition Day care Play-based preschool education Responsive care Safety and security

Source: World Bank, 2004 as cited in The Right Start: Investing in Early Years of Education, Save the Children, 2018

Yet today, millions of young children are not reaching their full potential because inadequate nutrition, a lack of early stimulation, learning, and nurturing care, and exposure to stress adversely affect their development[64]. An estimated 45 percent of deaths of children under the age of 5 are linked to malnutrition[65]. It results from the interaction of poor-quality diets and poor-quality health and care environments and behaviors, which are shaped in part by a host of underlying factors[66]. So, a question is raised as to why development needs of children under-six is not reached to its potential?

[64] The World Bank 2006
[65] The Lancet 2013
[66] Global Nutrition Report 2015

The coming section of this chapter discusses the status of children under-six both in India and in the National Capital Territory of Delhi.

3.5. Status of Children Under-Six

3.5.1. Demography & Population

India with a population of 121.1 crore, has 158.8 million children under-six which constitute 13.1% of the total population respectively[67]. Of these, 74.1% (117.6 million) children (0-6 years) live in urban areas where as the rural population constitute 25.9% (41.2 million) of the India's population[68].

The Census 2011 recorded a decline of 5.0 million children between 2001 and 2011. This decline was largely due to the sharp decline of 8.9 million children in the child population in rural areas. The trend was reverse in urban area where the child population during the same period increased by 3.9 million children[69].

The child sex ratio in the country in Census 2011 has recorded the lowest since 1961 Census whereas it has declined by 13 points from 927 in 2001 to 914 in 2011. In rural areas the fall is significant (-15 points) from 934 in 2001 to 919 in 2011 whereas in Urban areas the decline is limited to 4 points from 906 in 2001 to 902 in 2011[70].

Delhi is the national capital territory of the country. After Mumbai (18.41 million), Delhi (1.67 million) is the second largest populous city, followed by Kolkata (14.11 million) and Chennai (8.70 million). The child-sex ratio in Delhi stands at 871 females per 1000 males[71]. On the other hand it boasts of a high literacy rate of 86.34 per cent[72]. The birth rate is 15.2 and infant mortality rate is 16 per 1000 live births[73].

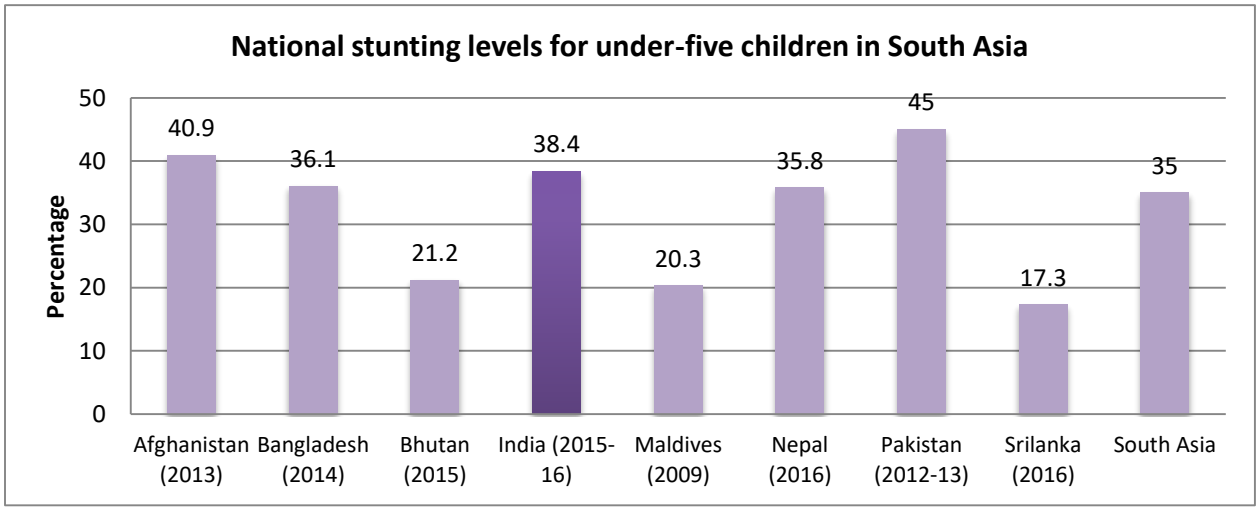
[67] Census of India 2011
[68] ibid
[69] Ibid
[70] The Hindu
[71] Wikipedia
[72] Census of India 2011
[73] SRS Bulletin 2019

3.5.2. Health and Nutrition Status of Children Under-Six

The data captured in Figure-2 is related to stunting i.e. chronic malnutrition in eight South Asian countries. India stands at 6th level in terms of total percentage of children who were chronically malnourished in 2015-16[74].

At the national level the percentage of children who were stunted has declined from 48 percent in 2005-06 to 38.4 percent in 2015-16 (Table 13). As per NFHS IV (2015-16) the figures given in the table 12 shows that India has made progress in reducing the percentage of stunted or chronic malnutrition and underweight children, but less in wasting or acute malnutrition.

Figure 3: National Stunting levels for under-five children in South Asia



Source: National surveys (Demographic and Health Surveys and National Nutrition Survey, various years) and UNICEF/WHO/World Bank Group Joint Child Malnutrition Estimates, 2018

Table 13: Health & Nutrition Status Children Under-Six & Women in India

Status of children below six years	NFHS-III (2005-06)	NFHS-IV (2015-16)
Children under five years who are underweight (%)	42.5	35.7
Children under five years who are wasted (low weight for height) %	19.8	21
Children under five years who are stunted (low height for age) %	48	38.4
Children age 12-23 months fully immunized %	43.5	62

[74] Stunting in South Asia 2018

Children age 6-35 months who are anemic	69.4	58.4
Infant Mortality Rate	57	41
Non-pregnant women age 15-49 years who are anaemic	53.1	55.2
Pregnant women age 15-49 years who are anaemic	57.9	50.3
Women whose Body Mass Index (BMI) is below normal	35.5	22.9

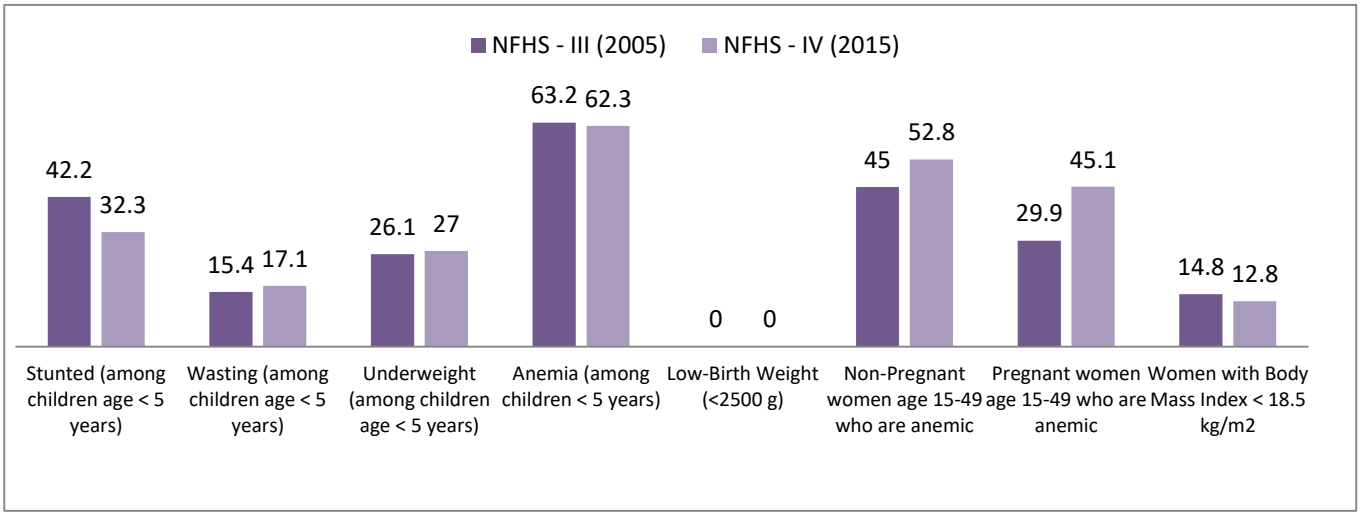
Source: National Family Health Survey-IV, Fact Sheet (2015-16)

Similar efforts have been put by NCT of Delhi in reducing the burden of malnutrition. The percentage of children who are stunted declined from 42.2 percent in 2005-06 to 32.3 percent in 2015-16. However, there is no improvement in the percentage of children who are underweight.

The NITI Aayog in its report Nourishing India stated that overall there has been a 16% decrease in the underweight prevalence among children below 5 years. Underweight prevalence in children under 5 years (composite indicator of acute and chronic undernutrition) has declined in all the States and UTs (except Delhi), although absolute levels are still high[75]. The level of severe wasting has increased in most of the States/ UTs and only 10 States/ UTs (Meghalaya, Madhya Pradesh, Tripura, Delhi, Himachal Pradesh, Bihar, Mizoram, Nagaland, Tamil Nadu and Jharkhand) have witnessed a decrease in the levels of severe stunting. It is important to understand that "nutrition is central to the achievement of other National and Global Sustainable Development Goals, therefore, it is critical to prevent undernutrition, as early as possible, across all lifecycle, to avert irreversible cumulative growth and development deficits", the report further states.

[75] National Nutrition Strategy 2014

Figure 4: Health & Nutrition Status Children Under-Six & Women in Delhi



Source: NCT of Delhi, Key Indicators, NFHS: 2005-06 & 2015-16

On the other hand, births with a reported birth weight less than 2.5 kg regardless of gestational age is called a low-birth weight (LBW). The causes of Low Birth Weight multifactorial which includes the key factors like adolescent pregnancy, maternal weight less than 50 kg, malnutrition during pregnancy, maternal gestational weight gain below 7 kg and certain other factors (World Health Organization). Therefore, key statistics with respect to Low Birth Weight would be an asset for early intervention.

The NFHS-IV India fact sheet (2015-16) finds that seventy-eight percent of live births in the five years preceding the survey had a written record of the child's weight at the time of birth or the mother was able to recall the child's weight. Eighteen percent of these births had a low birth weight (less than 2.5 kg), down from 22 percent in 2005-06[76]. However, NFHS-IV fact sheet for States and Union Territories does not provide information on low-birth weight.

Anemia among young children and pregnant women is a serious global public health problem. It is a condition characterized mainly by low blood hemoglobin concentration, which decreases the capacity of the blood to carry oxygen to tissues and results in symptoms such as fatigue and

[76] NFHS 4 Report 2015-16

reduced capacity for physical work[77]. World Health Organization estimates that 42% of children less than 5 years of age and 40% of pregnant women worldwide are anemic[78].

Anemia in pregnancy has been associated with negative outcomes, including maternal mortality, low birth weight and premature birth[79]. It is seen that overall, the levels of anemia among women and girls has not improved over the last decade from 45% in NFHS-3 to 53% in NFHS-4 in national capital territory of Delhi. In terms of percentage points, states which have witnessed maximum decrease in the levels of anemia are Sikkim (24.6), Assam (23.3), Mizoram (15.6), J&K (11.7), Tripura (10.6) and Chhattisgarh by 24.6 (10.5). Alternatively, 8 States/ UTs (Punjab, Himachal Pradesh, Meghalaya, Delhi, Haryana, Uttar Pradesh, Tamil Nadu and Kerala) have seen an increase in the prevalence of anemia, the same report stated[80].

There is vast regional variation in nutritional status in India.In certain cases geographic location, environmental condition may influence health condition.The children of Bihar, Madhya Pradesh, Jharkhand, Mizoram etc. are found to be affected most as far as nutritional levels are concerned. Parents with no education have children with the worst nutritional statuses but this improves progressively as parents gain higher levels of education. Illiterate parents are not aware of the necessities and ways and means of providing nutritionally balanced food to children. Likewise, the wealth index too plays its significant role in nutritional status. Nutritional status becomes better as one goes from lower wealth index to higher. This is justifiable because in higher wealth index children have better access of food, environment which largely characterizes into socio-economic, cultural and demographic indicators

3.5.3. Prenatal and Delivery Care

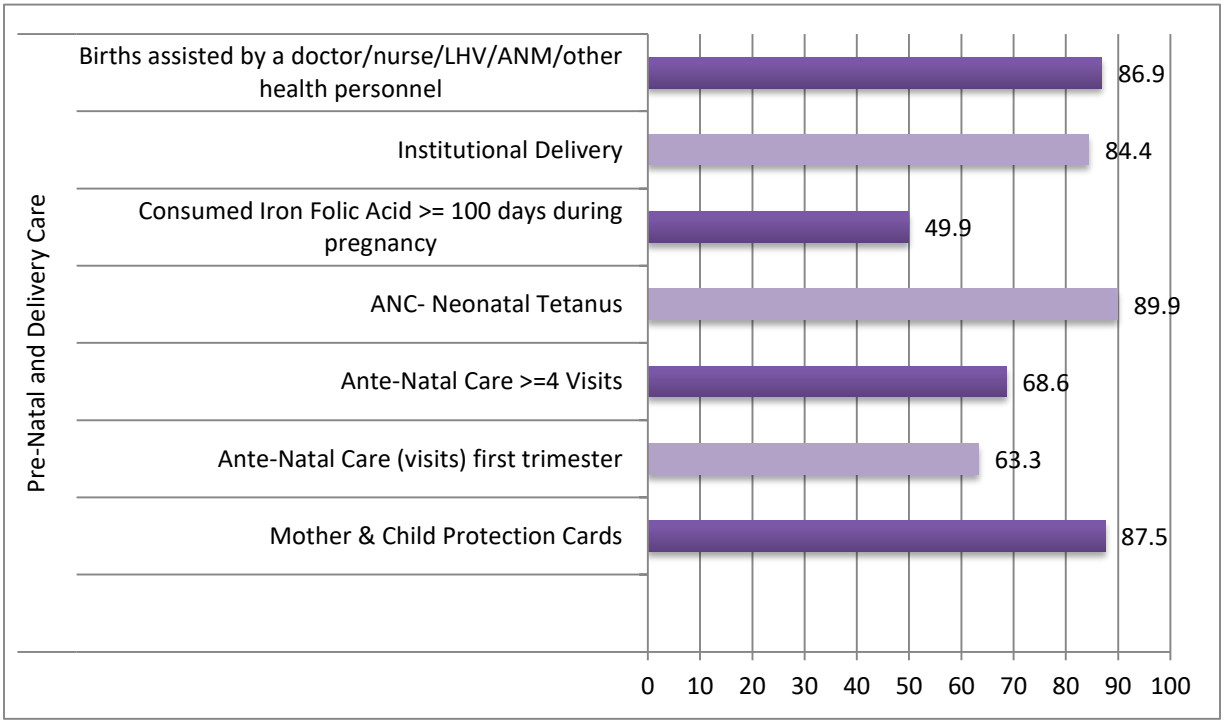
The time of birth is critical to the survival of women and their babies, as the risk of morbidity and mortality could increase considerably if complications arise (World Health Organization).It is envisioned that every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and postnatal period. It could be seen from Figure 5, that 63.3 percent women

[77] WHO 2018
[78] Information on Anemia
[79] WHO 2018
[80] National Nutrition Strategy 2014

had ante-natal visits in the first trimester while 68.6 percent women had four or more ante-natal visits throughout their pregnancy.

It is recommended that at least four ante-natal check-ups are essential for a pregnant woman; the first ante-natal check-up is conducted within three months of detecting the pregnancy. Birth-assisted by a skilled health-care professional (86.9 percent), birth taken place in a health institution (84.4 percent), ANC-Neonatal Tetanus (89.9 percent), availability of Mother and Child Protection Cards (87.5 percent) are quite progressive in Delhi. However, efforts should be made to improve the consumption of weekly iron & folic supplementation (49.9 percent) and ante-natal care registration in the first trimester and visits throughout the pregnancy.

Figure 5: Prenatal and Delivery Care in Delhi



Source: NCT Key Indicators, NFHS, 2015-16

Post child birth, infant and young child feeding, is a key area to improve child survival and promote healthy growth and development. The first 2 years of a child's life are particularly important, as

optimal nutrition during this period lowers morbidity and mortality, reduces the risk of chronic disease, and fosters better development overall[81].

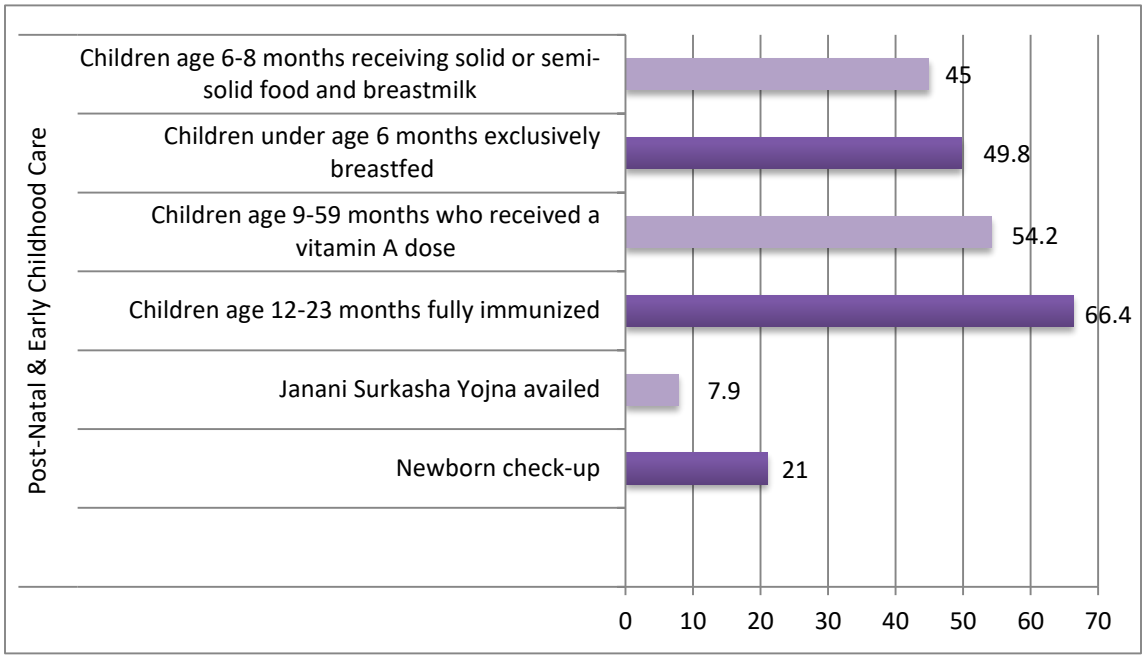
3.5.4. Post-Natal and Early Childhood Care

Early initiation of breastfeeding, within one hour of birth, protects the newborn from acquiring infections and reduces newborn mortality. The risk of mortality due to diarrhea and other infections can increase in infants who are either partially breastfed or not breastfed at all. Additionally, breast-milk is also an important source of energy and nutrients in children aged 6–23 months. It can provide half or more of a child's energy needs between the ages of 6 and 12 months, and one third of energy needs between 12 and 24 months. Breast-milk is also a critical source of energy and nutrients during illness, and reduces mortality among children who are malnourished[82].

Still, around 50 percent of children aged 6 months are exclusively breastfed and 45 percent children aged 6-8 months received semi-solid food and breast milk in Delhi. Although there has been a major push to compulsory vaccination of children aged 12-23 months, still, 66.4 percent children completed their vaccination, while only 54.2 percent children aged 9-59 months received Vitamin A supplementation. The Janani Suraksha Yojna which was launched on 12th April 2005 is a 100 percent Centrally Sponsored Scheme integrating cash transfer with delivery and post-delivery care. The key objective of the scheme is to reduce maternal and neonatal mortality by promoting institutional delivery among the poor pregnant women[8384]. The data shows that around 8 percent eligible women in Delhi received the benefits of the scheme.

[81] Infant and young child feeding
[82] ibid
[83] Janani Suraksha Yojana (JSY)
[84] Annexure 6

Figure 6: Post-Natal and Early Childhood Care in Delhi



Source: NCT Key Indicators, NFHS, 2015-16

In 2017 the government of India started a new maternity benefit programme (PMMVY) to provide partial compensation for the wage loss in terms of cash incentives so that the woman can take adequate rest before and after the delivery of the first child and to improve health seeking behavior amongst the pregnant women and lactating mothers. The eligible beneficiaries would receive the incentive given under the Janani Suraksha Yojana (JSY) for Institutional delivery and the incentive received under JSY would be accounted towards maternity benefits so that on an average a woman gets Rs. 6000[85]. The department of Women and Child Development, Government of NCT of Delhi is the nodal agency for implementing the scheme to benefit pregnant women and lactating mothers using ICDS platform.

[85] Pradhan Mantri Matru Vandana Yojna 2017

Quality antenatal care will:

Encourage women to seek **skilled care at childbirth**

Reduce stillbirths, childbirth complications and newborn deaths

Help women get care and counselling for HIV, malaria, TB and other conditions

Quality antenatal care should be available for all women to ensure a positive pregnancy experience.

World Health Organization

3.5.5. Pre-school education

It is important to understand that pre-school education in ICDS does not impart formal learning but develops in the child desirable attitudes, values and behavior patterns and aim at providing environmental stimulation. Good pre-school education increases cognitive abilities, school achievements and improve class behavior among children[86].

The National Policy on Education (2013) has given a great deal of importance to ECCE. It views ECCE as an important input in the strategy of human resource development, as a feeder and support programme for primary education and as a support service for working women of the disadvantaged sections of society.The significance of play and activity approach and the need for child-centeredness in the programmes of ECCE and early introduction of the 3 R's is required for early care and stimulation of children[87].

The Rapid Survey of Children, 2013 shows that 61.7 percent children age 3-6 years attending pre-school education in NCT of Delhi. The children in urban areas (62.2 percent) and in rural areas (37.8 percent) attending the programme in anganwadi centres. Among the social category, children belong to Schedule Caste (71.4 percent), OBC (47.2 percent) and others (55.9 percent) attending pre-school education in AWC[88]. The segregation of children attending pre-school education based on their economic status is not available at the state level.

However, at the national level, the survey shows that around 52 percent children coming from lowest wealth quintile attending preschool education in ICDS, whereas children in highest wealth quintile (16.0 percent) attend the least[89]. Similarly, out of 96.6 percent children under-six covered in the survey, 40.1 percent girls and 37.5 percent boys attended pre-school education in ICDS.

It is important to note that the Anganwadi services scheme is the world's largest integrated programme for children below six years and covers 8.4 crore children of age below 6 years through

[86] Sarabjit Singh Kular 2014
[87] National Policy on Education 1986 & 1992
[88] Rapid Survey of Children 2013
[89] Rapid Survey of Children 2013

7,066 projects and 13.42 lakh operational AWCs. This is against a total number of 16.45 crore children in the age group 0-6 years in the country[90]. The decline in the population availing Anganwadi services, despite increase in budgets and provisions made of universalization since 2001 is attributable to several factors, ranging from problems with implementation, lack of political will as well as a result of changing aspirations among parents, particularly with respect to pre-school education[91].

[90] NITI AAYOG 2015

[91] Save the Children 2018

4) Anganwadi Services Scheme in NCT of Delhi

Chapter IV

4. Introduction

Of the 33 ICDS projects started in 1975 while launching the programme, the Jama Masjid was the milestone project for the state of Delhi[92]. The major impetus to expansion of programme in the country was received after the Supreme Court orders on ICDS in 2006 which states that "government of India shall sanction and operationalize a minimum 14 lakh AWCs in a phased manner"[93] to universalize the programme.

4.1 Background

The Supreme Court of India in its order dated 13th December 2006 stated that "the universalization of ICDs involves extending ICDS services (Supplementary nutrition, growth monitoring, nutrition and health education, immunization, referral and pre-school education) to every child under the age of 6, all pregnant women and lactating mothers and all adolescent girls[94].

As on 31st March 2019, there are 10,897 operational anganwadi centres out of 10897 sanctioned[9596] by the Ministry of Women and Child Development. These anganwadi centres are distributed in 95 ICDS Projects providing supplementary nutrition, health services, vaccination, preschool activities, health and nutrition education and referral services to children (up to the age of 6 years) and pregnant and lactating mothers.

Table 14: Anganwadi Centres in Delhi

S. No	District	Sanctioned AWC	Operational AWCs	No. of ICDS Project
1.	North West I	2,098	2,073	19
2.	North West II	977	977	8
3.	East	607	607	5

[92] Department of Women and Child Development, Govt. of NCT of Delhi
[93] PUCL Vs Govt. of India and Others, Civil Writ Petition 196 of 2001
[94] PUCL vs Govt. of India and Others, Civil Writ Petition 196 of 2001
[95] Press Information Bureau 2019
[96] It is to be noted that the Ministry had sanctioned 11,250 AWCs for NCT Delhi but in 2018, the Department of Women and Child Development (ICDS) had surrendered 253 AWCs which is accepted in Ministry vide order no11-33/2015-CD-I dated 16 November 2018

4.	West	1,973	1,745	18
5.	North-East	1,819	1,819	15
6.	South West	579	579	4
7.	Central Delhi	491	491	4
8.	North	547	547	5
9.	South	2,059	2,059	17

Source: Annual Programme Implementation Plan of ICDS, 2018-19, Govt. of NCT of Delhi

It is important to note that the responsibility to open an Anganwadi Centre (AWC) in rural/urban/tribal/hilly areas including the far flung areas rests with the States/UTs who assess their requirement on the basis of the prescribed population norms and send the proposal to the Government of India. The proposals received from the States/UTs are, in turn, examined by the Government of India and the new AWCs/Mini-AWCs demanded by the States/UTs are sanctioned, if found, meeting the criteria and subject to availability of AWCs/Mini-AWCs. Coverage of all habitation/hamlets in the block and cover all the eligible beneficiaries lie with the Child Development Project Officer at the Block or Project Level and the overall implementation of the programme[97].

The Court further said "Government of India shall ensure that population norms for opening of AWCs must not be revised upward under any circumstances. While maintaining the upper limit of one AWC to a population of 1000 people, the minimum limit for opening of a new AWC in a population of 300 people may be kept in view. Further, rural communities and slum dwellers should be entitled to an "Anganwadi on demand" (not later than three months) from the date of demand in cases where a settlement has at least 40 children less than six years but no Anganwadi Centre"[98]. The Table-15 shows the district-wise population of children below six years in NCT of

[97] Press Information Bureau 2013
[98] ibid

Delhi which clearly shows that North-West District has the highest population while New Delhi has the least.

Table 15: District-wise child population (0-6 years)[99]

Revenue Districts	Police Districts	Population of children (0-6 years)
South	South	3,31,043
Central	Central	6,27,39
West	West	2,88,421
North	North	1,03,304
North-east	North-east	3,01,947
South-west	South-west	2,67,989
East	East	1,94,357
North-west	North-west	4,49,894
New Delhi	New Delhi	12,760
Source: Census 2011[100]		

While, the district-wise number of anganwadi centres presented in Table-16 shows that the North-West District has the highest number of anganwadi centres. This could be attributed to the population norms per anganwadi centre. Based on the population criteria, one could easily see that the total number of children per anganwadi centre is highest in the South-West district and least for the Central District.

Therefore, the policy makers have to keep into consideration the fact that the population has increased since 2011, therefore, either the number of anganwadi centres should be proportionately increased or revisit the population criteria for anganwadi centres.

[99] Shahdara & South-East Districts were formed in 2011 hence no Census Population is available for these two districts.
[100] Cenus of India 2011

Table 16: No of AWCs & Population of Children Under-Six in Delhi

District	Population of children < 6 Years			Number of AWCs	Total number of children per AWC
	Male	Female	Total		
South	1,75,592	1,55,451	3,31,043	2,059	160
Central	32,928	29,811	62,739	491	127
West	1,54,088	1,34,333	2,88,421	1,745	165
North	55,155	48,149	1,03,304	547	188
North-East	1,60,583	1,41,364	3,01,947	1,819	165
South-West	1,45,285	1,22,704	2,67,989	579	462
East	1,03,902	90,455	1,94,357	607	320
North-west	2,41,169	2,08,725	4,49,894	3,050	147
New Delhi	6,738	6,022	12,760	-	-

Source: Census 2011[101]&Annual Programme Implementation Plan of ICDS, 2018-19, Govt. of NCT of Delh

4.1. Expansion of ICDS Projects in Delhi

While the ICDS programme has expanded over the years across the country so in the NCT of Delhi (Kindly see table 16), the number of registered beneficiaries of ICDS in Delhi has shown a sudden decline post-2015. In April 2012 there were 10,72,226 registered beneficiaries of ICDS which has reduced to 8,37,942 registered beneficiaries in January 2016. The number of registered beneficiaries has declined by 51.4 percentage points to 551310 as on 31st March 2019 (see Table 17). However, the exact reason for such decline in the overall number of registered beneficiaries is yet to be explored.

[101] Census of India 2011

Table 17: Number of Beneficiaries and AWCs in Delhi[102]

	Total number of ICDS Projects	Total number of Anganwadi Centres (Operational)	Total number of registered beneficiaries (in Lakhs)
As on March 2011	55	6,606	7,19,266
As on March 2012	94	10,577	10,71,931
As on March 2013	95	10,874	10,79,062
As on March 2014	95	10,897	10,83,128
As on January 2015	95	10,897	10,19,203
As on January 2016	95	10,897	8,37,942
As on January 2017*	No data is available for 2017-18 and 2018-19 on http://www.wcddel.in/icdsmpr.html		
As on January 2018**			
As on March 2019***	95	10897	5,51,310

Source: Monthly Progress Report of ICDS (2011-2016) and ***Press Information Bureau https://pib.gov.in/newsite/PrintRelease.aspx?relid=191997

[102] Monthly Progress Report (2011-2016), ICDS, Department of Women and Child Development, Govt. of NCT of Delhi. No Monthly Progress Report for 2017 and 2018 available on the website Department of Women and Child Development. Data for March 2019 received received through https://pib.gov.in/newsite/PrintRelease.aspx?relid=191997

Table 18: Registered Beneficiaries of ICDS[103]

Month/Year	Registered Children Beneficiaries			Registered Women Beneficiaries	Total Registered Beneficiaries
	6 months to 1 year	1 year to 3 years	3 years to 6 years		
April 2012	1,07,690	4,21,466	3,74,613	1,68,457	10,72,226
April 2013	1,03,093	4,27,176	3,78,332	1,67,595	10,76,196
April 2014	1,02,341	4,22,750	3,76,352	1,72,233	10,73,676
April 2015	96,337	3,98,823	3,45,895	Not Available	8,41,055
January 2016	82,142	3,49,166	2,62,949	1,43,685	8,37,942
2017*	No data is available for 2017-18 and 2018-19 on http://www.wcddel.in/icdsmpr.html				
2018**					
March 2019***	3,02,812		1,34,234	1,142,64	5,51,310

Source: Monthly Progress Report of ICDS (2011-2016), ***Press Information Bureau: https://pib.gov.in/newsite/PrintRelease.aspx?relid=191997

Budget Briefs of ICDS (2019-20)[104] compiled the data between March 2014 and March 2018 shows that at the national level percentage beneficiaries receiving supplementary nutrition fell by 16 percent. The report further mentioned that states with the largest fall in the number of SNP beneficiaries were Goa (54 per cent), Bihar (56 per cent), Delhi (49 per cent), Punjab (33 per cent) and Uttar Pradesh (25 percent).

Whereas the number of beneficiaries receiving supplementary nutrition increased in Jammu and Kashmir (87 per cent), Mizoram (77 per cent), Tripura (10 per cent), and Madhya Pradesh (10 per

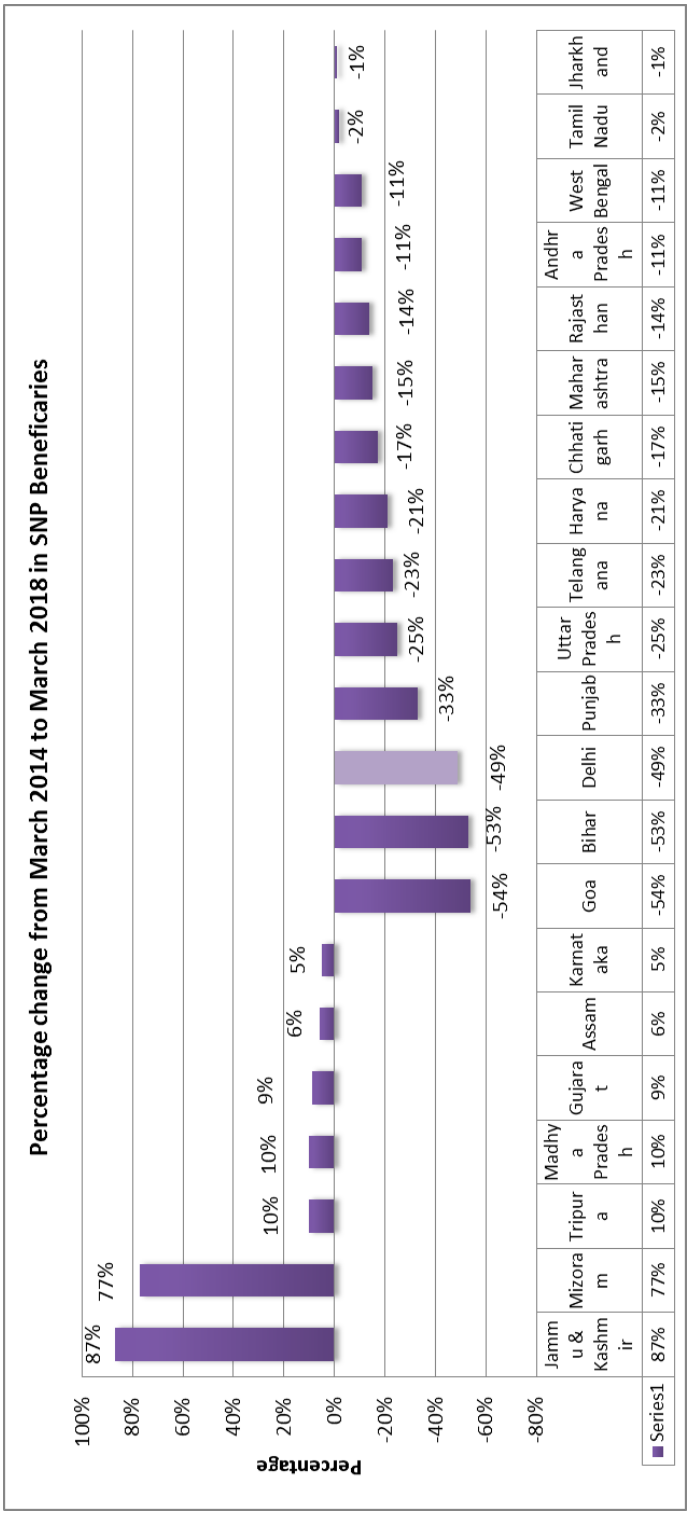
[103] ibid

[104] Centre for Policy Research 2019-20

cent)[105]. Although, the analysis has not quoted the exact causes of decline in receiving supplementary nutrition by beneficiaries; however, the trend is worrisome.

[105] ibid

Figure 7: Percentage of Beneficiaries Receiving Supplementary Nutrition



Source: Centre for Policy Research, Budget Briefs, ICDS, GOI 2019-20, VOL11/ISSUE 3

4.3 ICDS Budget

ICDS is a centrally-sponsored scheme implemented through the State Governments/UT Administrations. Prior to 2005-06, 100 percent financial assistance for inputs other than supplementary nutrition was being provided by the Government of India. It was decided in 2005-06 to support the States up to 50 percent of the financial norms or to support 50 percent of the expenditure incurred by them on supplementary nutrition, whichever is less. From the financial year 2009-10, the Government of India has modified the funding pattern of ICDS between Centre and States for all other components of ICDS as 90:10 (100% central assistance earlier)[106].

Since 2012, approved budgets under ICDS are based on state-wise plans known as Annual Programme Implementation Plans (APIPs). These APIPs are prepared following a decentralized planning process wherein blocks, districts and other key stakeholders are consulted before finalization. These APIPs are then submitted to the Government of India for approval.

The government of NCT of Delhi has started incentivizing anganwadi centres. The incentivized approach to Anganwadi Upgradation (see annexure 7) has planned to ensure uniform, systematic and informed rising of the bar across all anganwadis in Delhi[107]. Another component for which there is a provision of budget is the installation of CCTV cameras in AWCs.

Table 19: ICDS Budget, 2019-20 (in thousands), GNCTD

2019-20		
		(Rs. in thousands)
Major Budget Heads	Budget Estimate	Revised Estimate
SNP	1511400	1280000
Incentivized Anganwadi Upgradation Scheme	250000	70000
Training	6000	0
CCTVs in AWC	200000	0
Procurement of Aadhar Enrollment Kit	42750	0

Source: Allocation of Revised Estimates for the FY 2019-20, Govt. of NCT of Delhi

4.4. Previous Research on ICDS in Delhi

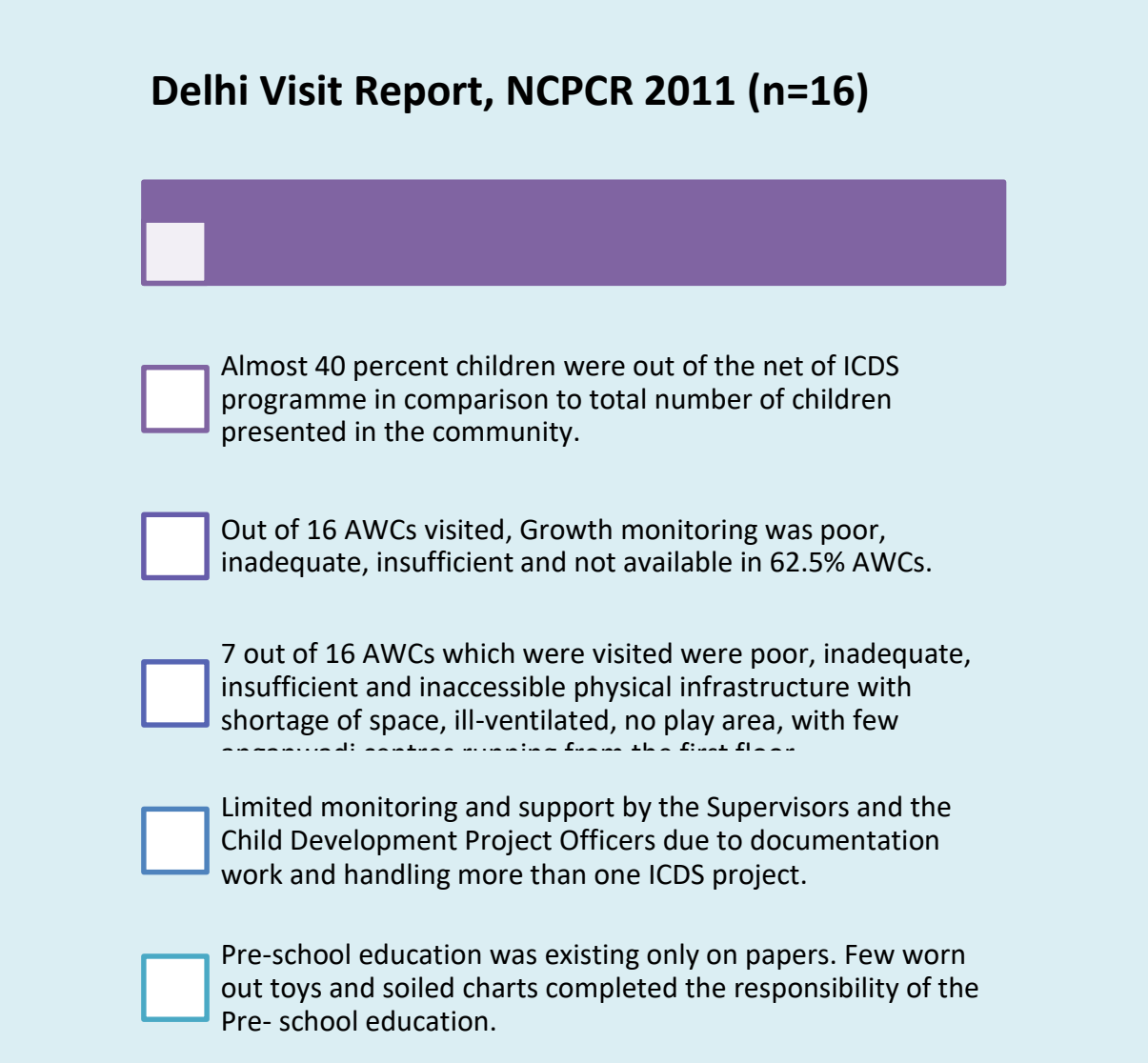
In order to deeply understand the situation of the Anganwadi services scheme in Delhi, in this chapter, the findings of three research works undertaken by different agencies have been

[106] Department of Women & Child Development, Govt. of NCT of Delhi

[107] Transforming Delhi Anganwadis, Initiatives & Innovations

summarized for the readers. The findings in these research works may also help the reader to co-relate them with the present research work.

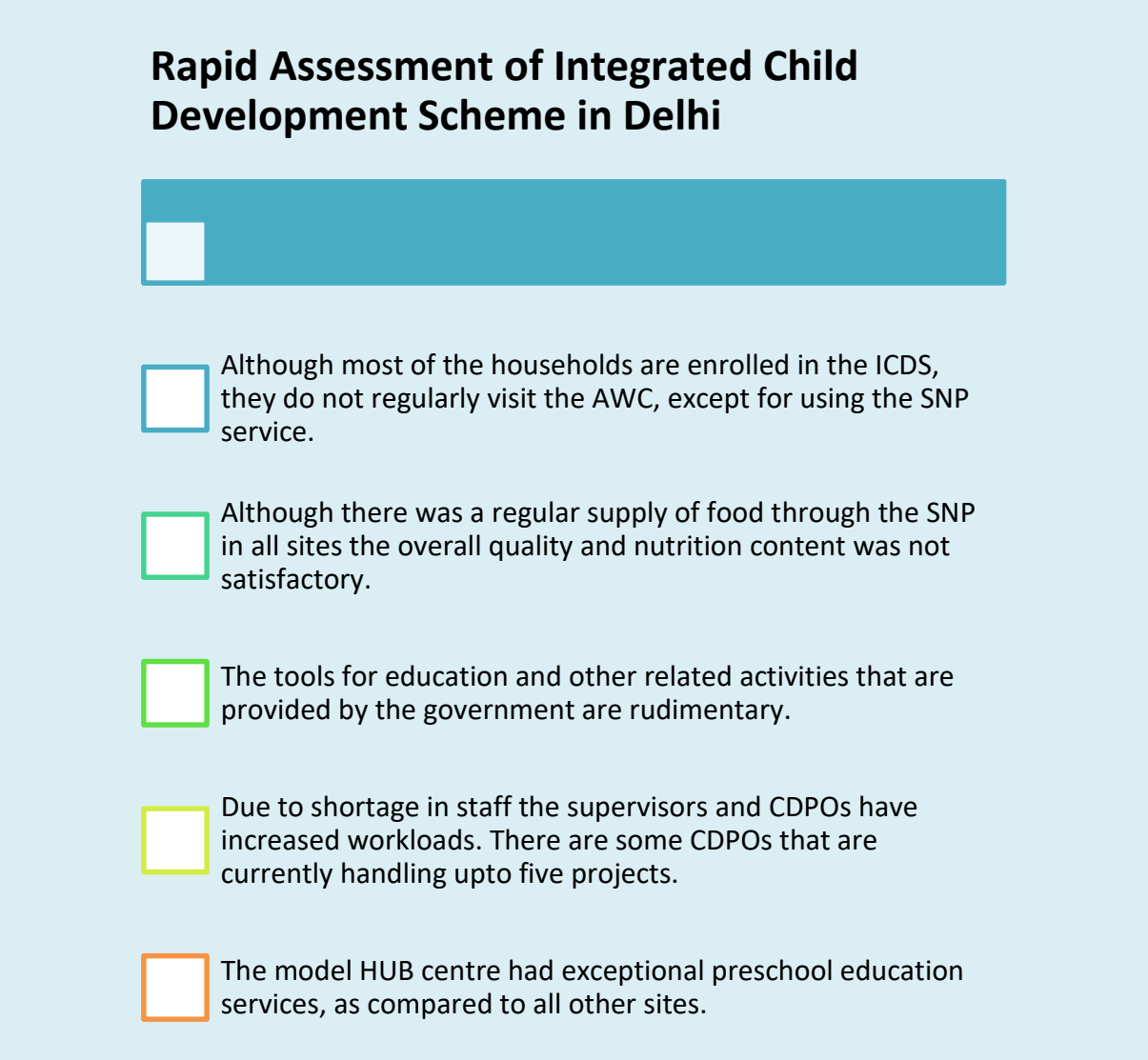
The first assessment was done by the National Commission for Protection of Child Rights (NCPCR) in 2011 when the commission visited 16 AWCs in different locations. The key points of the research report are summarized as:



Source: Delhi Visit Report, NCPCR, 2011

The second assessment of Anganwadi services scheme was done by Institute of Human Development which was published as Rapid Assessment of Integrated Child Development Scheme in Delhi (2014-15). The pilot study to explore the functioning and gaps of the ICDS from the viewpoint of the service providers was conducted in the National Capital Territory (NCT), India,

within 16 distinct Anganwadi Centres (AWCs). The key points of the research report are summarized as:



Source: Rapid Assessment of Integrated Child Development Scheme in Delhi, Institute of Human Development

NITI Aayog had conducted a national level research on ICDS in 2015 in which it had taken a sample of 30 anganwadi centres from NCT of Delhi. The key points of the research report are summarized as[108][109][110]:

A Quick Evaluation Study of Anganwadis under ICDS

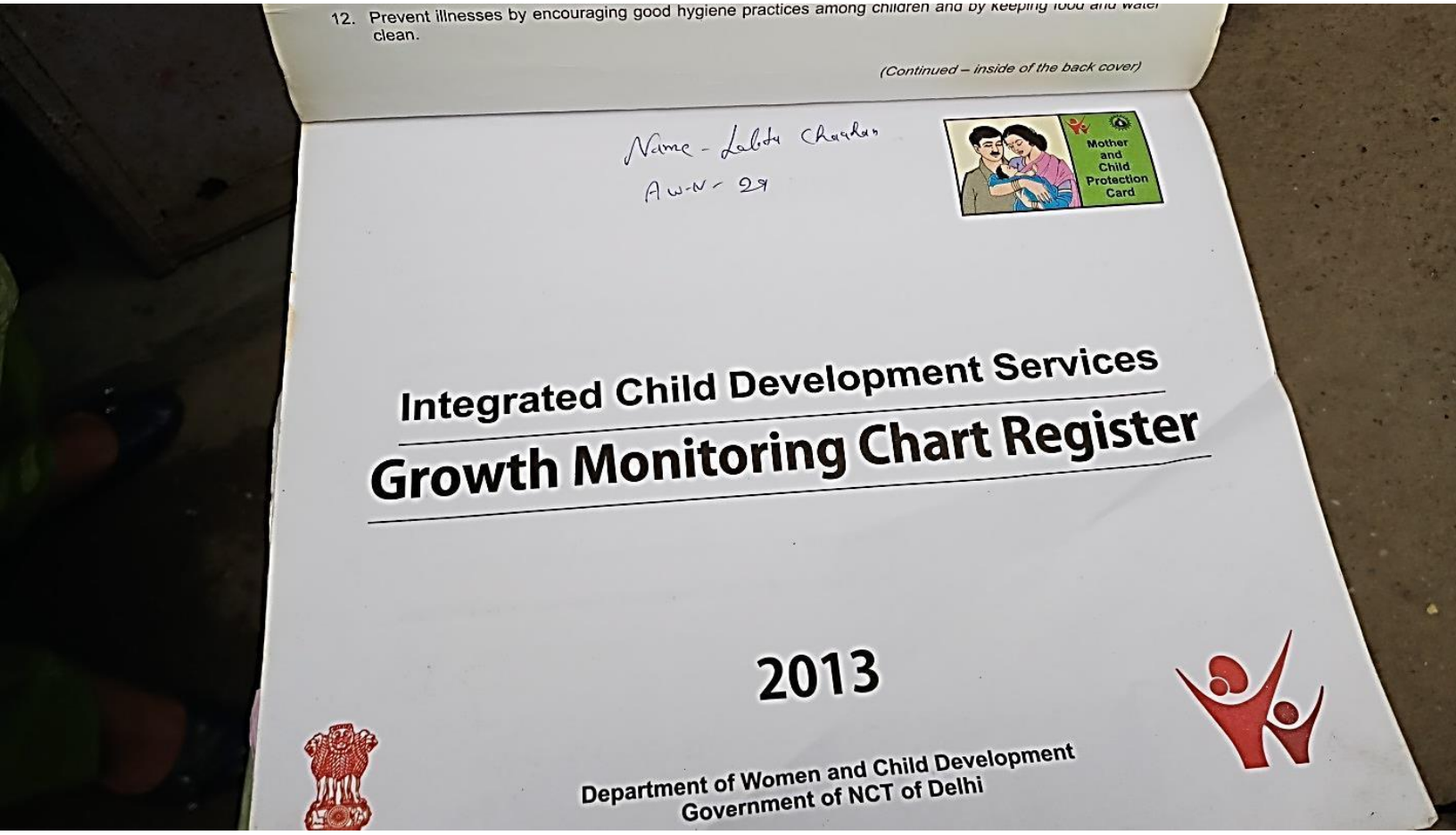
- Out of 30 AWCs visited only 6 AWCs were found to have the adequate space for children while 27 AWC had the drinking water facility.
- Out of 30 AWCs only 19 AWCs were found to have good hygiene and sanitation condition.
- Due to shortage in staff the supervisors and CDPOs have increased workloads. There are some CDPOs that are currently handling upto five projects.
- In rural Delhi 49.8% children were in Normal Grade (Green Zone), 26.2% were Moderately Underweight (Yellow Zone) and 24.0% were Severely Underweight (Red Zone).

[108] NITI AAYOG 2015
In NCT of Delhi the Sample district was South Delhi and the sample size was 30 AWCs.
[109] NITI AAYOG 2015
[110] NITI AAYOG 2015

There are certain issues which were presented in all of the above three studies like functioning Anganwadi Centres, infrastructure, quality of cooked meal, Take Home Ration, Growth Monitoring are similar to the present study. However, the limitations in above studies that the sample size was too small, response of the beneficiaries with respect to the scheme were not taken, convergence and coordination with the health frontline workers (ASHAs and ANMs) which is an important component of ICDS scheme need special mention.

5) Literature Review

Chapter IV



5. Literature Review

The present chapter deals with review of literature related to studies on ICDS across different states in the country, topics which have already been covered, their conclusions as well as gaps in previous researchers that could be further examined.

Health and nutrition

A study conducted with 610 children who received no, partial or full services through the ICDS. The results of the study indicated that those children that were fully utilizing the services showed significant improvements in their nutritional status that was measured by stunting, wasting and weight, whereas those with partial utilization had significantly poorer results[111]. Further, it has been seen that most growth faltering occurs during the first two years of life, and continues to negatively affect children's development all through their lives; therefore, it is essential that children under the age of three years are effectively reached with ICDS interventions[112]. It has been seen that the presence of an ICDS centre was associated with a 5% decrease in the probability of being underweight for boys, but not for girls[113].

Further, women's health during pre and post-pregnancy, as well as her knowledge on issues regarding feeding practices and care directly and indirectly impact their children's health outcomes. Inadequate food, illnesses, family planning knowledge, lack of safe prenatal and postnatal care, poor knowledge regarding self and child health, and overall healthy living practices, have a significant impact on children's health[114][115]. The future demographic dividend which is expected to be enjoyed by India after 2025 largely depends on the quality of the future human resources. But major health challenges posed by the specific phases of the demographic transition that India is going through is related to lower status of reproductive health and child malnutrition causing higher incidence of mortality among children[116].

[111] Sayed and Seshadri 2000
[112] Allen and Gillespie 2001
[113] AB Deolalikar 2005
[114] L. C. Smith et al. 2003
[115] G Kent 2005
[116] Bhattacharya and Haldar 2014

The proper implementation of ICDS services through local anganwadi centre might result in health and nutritional benefits. Unfortunately, most of the services are poorly implemented, and a majority of households only use nutritional supplements[117]. AWWs spend up to 40 per cent of their time on supplemental nutrition-related activities and a further 39 per cent on preschool education which does not leave much time for other important ICDS activities such as growth-promotion, health and nutrition education, home visits, referral services and meeting with the community[118].

In the long run health-human capital is severely affected, if the individual does suffer from malnourishment which may cause an intergenerational vicious cycle, hence, a worse health capital stock may be passed from adults to their children[119]. Keeping in mind the direct and indirect factors leading to child malnutrition, India's largest child nutrition programme i.e. Integrated Child Development Scheme provides a multi-sectoral approach that not only targets availability of food, but also factors such as immunizations, health care facilities, maternal health amongst other social and environmental factors[120].

Pre-school education

Bloom in his book "Stability and Change in Human Characteristic"[121] has argued that major changes in the personality characteristic are not possible after the child has reached a high level of stability. Thus, the major objective in the early childhood stage should therefore be to help children in developing basic concepts which would lead them towards logical reasoning.

Pre-school education is a very crucial component of the package of services envisaged under ICDS as it seeks to lay the foundation of physical, psychological, cognitive and social development of children. More importantly, it is envisaged as an essential component for children who are at the verge of going into the formal education system. The main objective of the preschool education component is to stimulate and satisfy the curiosity of a child, rather than following any rigid learning curriculum. In a non-formal setting preschool education forms the backbone of ICDS programme as its all services converge at the anganwadi[122]. It is to be imparted to children in the

[117] Kandpal 2005
[118] NCAER 2001
[119] N Singh and P Gupta 2015
[120] Ministry of Women and Child Development 2014
[121] B S Bloom 1966
[122] N Shabnam 2003

age group of 3-6 years at anganwadi center especially to children from socio-economically deprived sections of the society. Preschool education imparted through anganwadi centres under the ICDS scheme emerged as a single most important factor in the better performance of attenders, even many years after having attended anganwadi, thus indicating its sustainability[123]. However, it remains one of the weakest component as the anganwadi worker possess limited skills to conduct preschool education in a holistic manner and are less favorably inclined towards children[124]. There are further challenges to implementation of pre-school education due to limited infrastructure facilities in anganwadi centres[125].

Good-quality holistic ECCE programs encapsulate early learning as well as health, nutrition, hygiene, safe water, sanitation, affection, care and protection of children. Enhancing service delivery in these areas can promote human capital development and ensure long term growth. Compromising this may lead to adverse effect on the education and development of the children[126].

Convergence & Coordination

Keeping in view the objectives of ICDS, one may find that nutrition strategy for reducing child malnutrition hinges on convergence between health and nutrition. The ICDS program has been in operation now for 36 years, but unfortunately, many studies that have reviewed its implementation have highlighted the failure of convergence between the nutrition and health sectors around ICDS as a barrier to reducing child undernutrition[127].

The ICDS frameworks and strategies do not, therefore, go beyond articulation of convergence, possibly partly because the ministry overseeing the program has little authority over other ministries that play a role in nutrition. On the ground, the nucleus of ICDS – the AWC – is a potential, and in many cases an actual, convergence ground for many programs, including public health programs such as vaccination. However, there is little that an Anganwadi Worker or even her Supervisors at block and district levels can do to ensure maternal or child health services,

[123] NIPCCD 2006
[124] Aroral et al 2006
[125] Dhingra and Sharma 2011
[126] Reetu Chandra, Renu Gulati & Adarsh Sharma, 2017
[127] Gragnolati et al 2005

which are very much in the realm of the service delivery framework of the health department. The guiding principles for implementation of the National Health Policy are laid out in the project implementation plan of the RCH-II program and in the implementation framework of the NRHM. Both documents are explicit about the institutional mechanisms for convergence of actions on the ground[128].

One of the key processes that can assess the outcomes of convergence is monitoring. Continuous monitoring of program implementation, of supervisory systems, of feedback loops, and of performance indicators is critical to know not just if overall outcomes are being achieved but also if convergence is enabling the achievement of outcomes. Unfortunately, effective monitoring is one area that was not integrated into ICDS even in its early days, resulting in an ineffective monitoring and evaluation system, limited in its ability to measure nutrition outcomes and certainly not equipped to assess whether or not convergent actions were taking place. Overall, the monitoring of the ICDS program continues to focus substantially on the food component; there is little reporting of health indicators beyond growth monitoring. A recent publication, developed jointly by the nodal departments of health and nutrition, does contain a comprehensive monitoring framework. However, it is too early to tell if this is really being implemented in letter and spirit[129].

[128] Rajni Ved and Purnima Menon 2012
[129] MWCD/MOHFW 2010

C.About the Study

Rationale for the study

Objectives of the Study

Methodology

Sampling Framework

Population and Sample

Criteria of the Sample Selection

Data Collection Stages

Geographical Coverage

ICDS Projects

Research Tools for Data Collection

Methods & Approaches for Data Collection

Organizing the Data & Analysis

Ethical considerations

Limitations of the study

Abstract

This chapter discusses in detail about the study, the methodology, the population and sample, data collection stages, coverage of ICDS projects, methods and approaches for data collection, taking into the account the ethical considerations for conducting the research and certain limitations of the research work.

1. About the Study

1.1. Rationale for the study

Early years in a child's life are the period of rapid physical and mental growth wherein the foundation for the child's development is laid and therefore, these years are considered extremely critical for the overall development of the child[130]. Further, a larger majority of children in India do not have optimal learning conditions largely due to poverty. Majority of parents are not able to give much stimulation to their child because of their own limitations. Health, nutrition and wellbeing disparities in urban India are stark[131].

Children less than six years in the most vulnerable sections of the urban poor are 2.5 times more undernourished than the urban rich. And their mortality rate is significantly higher than the urban aggregate. The urban poor are in fact far less likely to avail ICDS and other schemes than the rural poor[132]. Given that a child's future well-being (in terms of health, nutrition and education) is determined substantially in this period, the ICDS is a very important programme[133].1

There is extensive research evidence which indicates the positive impact of early intervention and both short-term and long-term gains of an early childhood programme. However, mere participation in an early childhood programme is not sufficient. The quality of the programme attended by the children at this stage is also crucial.

Given the complex need of this age group the present research study has been undertaken with the following objectives.

1.2. Objectives of the Study

1. To evaluate the anganwadi services scheme under the Umbrella ICDS programme
2. To identify the areas of improvement in implementation of the scheme.
3. To understand the utilization and awareness about anganwadi services.
4. To make suitable recommendations to the Govt of NCT of Delhi.

[130] N Chopra 2012
[131] Qadiri and Manhas 2010
[132] Siddharth Agarwal 2014
[133] Reetika Khera 2015

1.3. Methods

A mix-method descriptive survey method is applied to evaluate the various aspects of ICDS scheme in the sample districts of Delhi which is discussed in the coming section. The research adopted qualitative as well as quantitative approach to meet the requirements of the study. The various methodology steps followed to fulfill the objectives of the research are described as follows.

1.4. Sample Districts for the Study

At the time of drafting the methodology a lot of discussions were held about the districts to be covered for this research study. Initially, it was decided to cover five districts from all across Delhi with a homogenous sample. Eventually, it was decided to cover East Delhi and North-East Delhi to get a fair picture of functioning of AWCs in these two districts and to draw certain conclusions to strengthen the services of ICDS in NCT of Delhi.

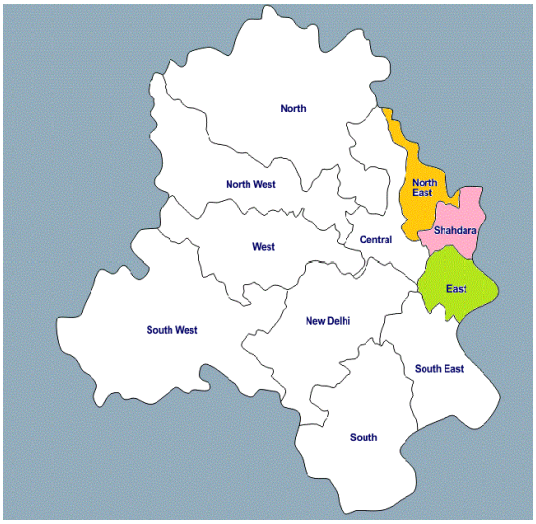


Image SEQ Image * ARABIC 8: Revenue districts covered for research

However, during the data collection process, one of the CDPOs informed that the Shahdara ICDS Project falls under the Shahdara district; as a result, three districts had to be covered. The writers of this research report have tried to bring certain facts about the two districts for the readers from the existing literature on district profiles.[134]. These draw on diverse sources of data to compile a set of indicators on the state of nutrition and its cross-sectoral determinants. The districts data are intended to be conversation-starters at the district level and to enable discussions about why undernutrition levels are high, and which factors, at multiple levels, might need to be addressed to improve nutrition.

[134] District Nutrition Profile, IFPRI

North-East District

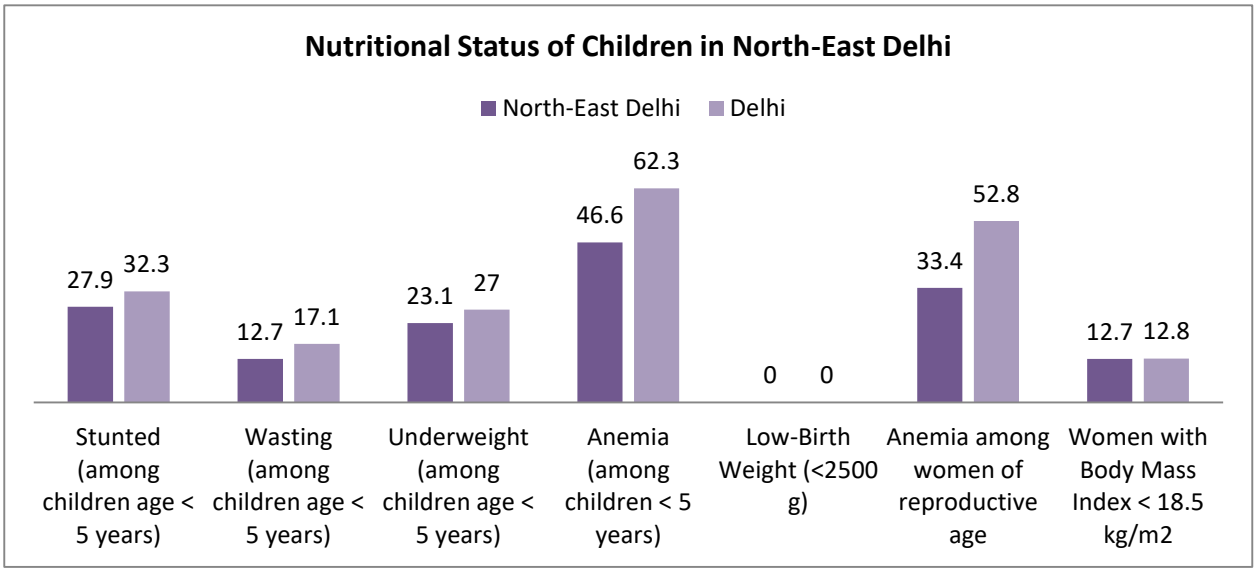
The North-East Delhi comprises a total population of 22, 41, 624 in which male comprises 53 percent and female comprises 47 percent of the total population. The district is largely an urban agglomeration and 16.7 percent population belongs to scheduled caste.

Table 20: Composition of Population

Male: 53 percent	**Female: 47 percent**
Urban: 99 percent	Rural: 1 percent
Schedule Caste: 16.7 percent	Others: 83.3 percent

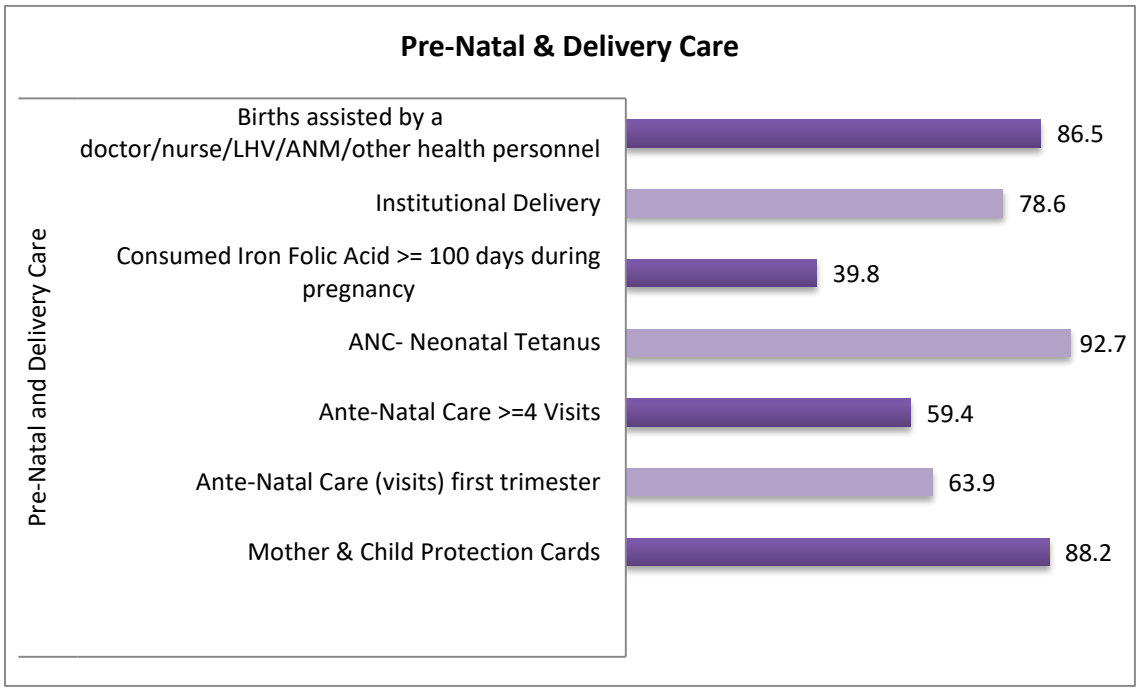
The health and nutritional status of children below five years in the district shows that 46.6 percent children are anemic and 27.9 percent children are chronic malnourished (stunted).

Figure 8: Nutritional Status of Children in North-East District



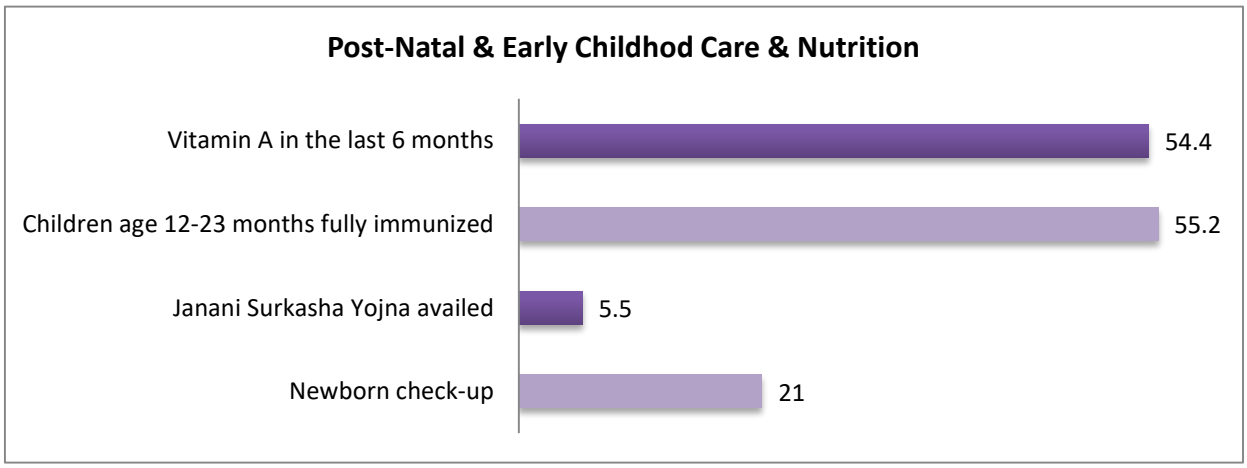
The figures show that 33.4 percent women are anemic while only 39.8 percent consumed the iron and folic acid tablets in 100 days during the pregnancy period. The institutional birth in the district is quite progressive with 78.6 percent births taken place in health institutions (institutional delivery). However, only 59.4 percent women had four or more visits during ante-natal check ups.

Figure 9: Pre-Natal & Delivery Care in North-East District



In comparison to pre-natal period, the postnatal health indicators show that multiple steps would have to be taken to improve the existing situation in the district. Only 55.2 percent children in the age group of 12-23 months were fully immunized while only 5.5 percent women availed the benefits of Janani Suraksha Yojna.

Figure 10: Post-Natal & Early Childhood Care& Nutrition in North-East District



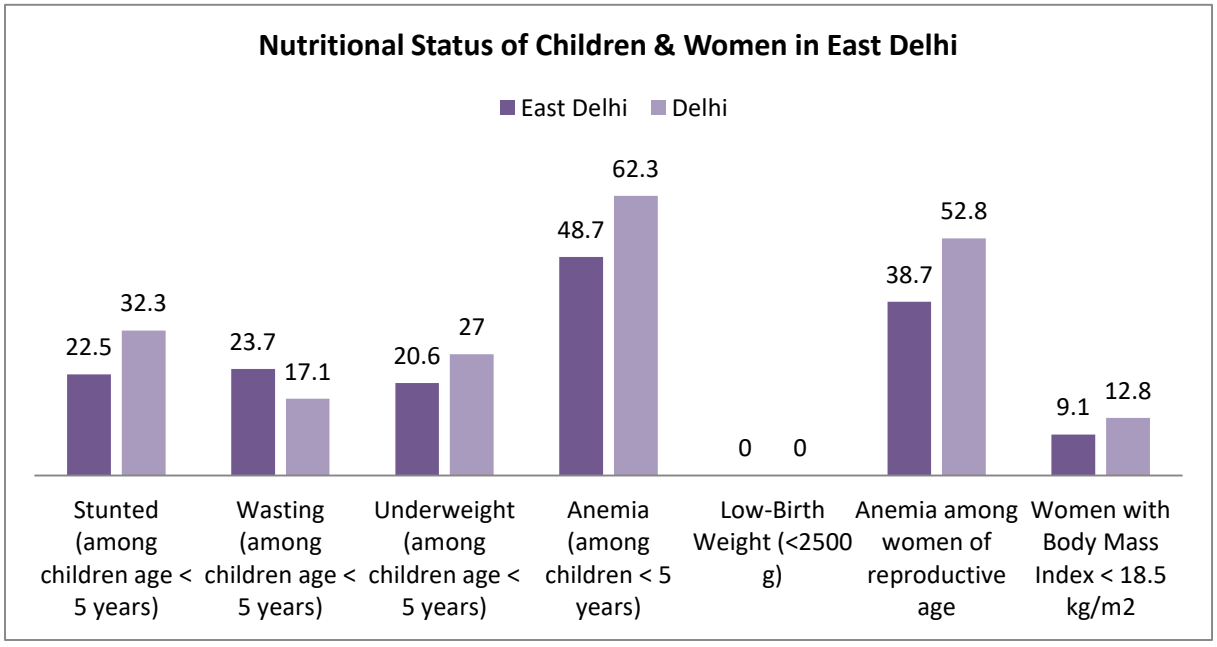
East District

The East Delhi comprises a total population of 17, 09, 346, in which male comprises 53.1 percent and female comprises 46.9 percent of the total population. The district is largely an urban agglomeration and 16.5 percent population belongs to scheduled caste. The demographic indicators are similar to the North-East District.

Male: 53. Percent	**Female: 46.9 percent**
Urban: 99 percent	Rural: 1 percent
Schedule Caste: 16.7 percent	Others: 83.3 percent

The health and nutritional status of children below five years in the district shows that 48.7 percent children are anemic which is higher than North-East Delhi and 22.5 percent children are chronic malnourished (stunted).

Figure 11: Nutritional Status of Children in East District



The figures show that 38.7 percent women are anemic while only 41.9 percent consumed the iron and folic acid tablets in 100 days during the pregnancy period. In comparison to the North-East District, the institutional birth in the district is quite high with 85.2 percent births taking place in health institutions (institutional delivery). However, only 56.2 percent women had four or more visits during ante-natal check ups which is still lower than East-Delhi.

Figure 12: Pre-Natal & Delivery Care in East District

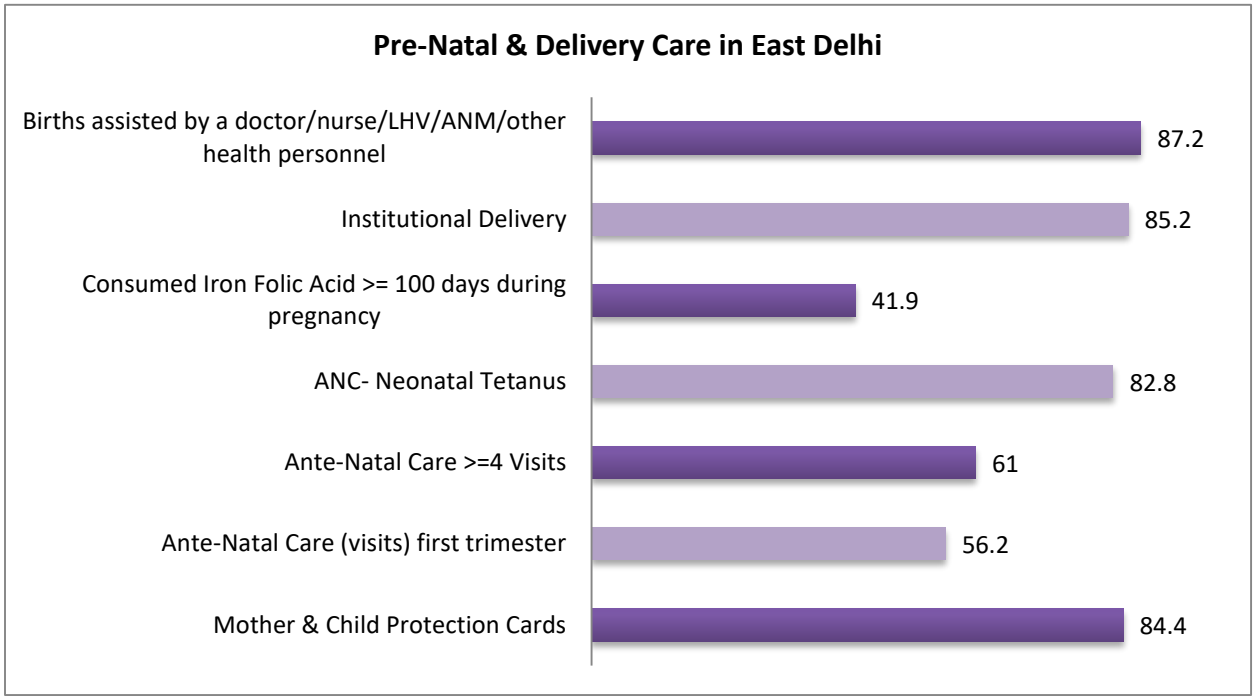
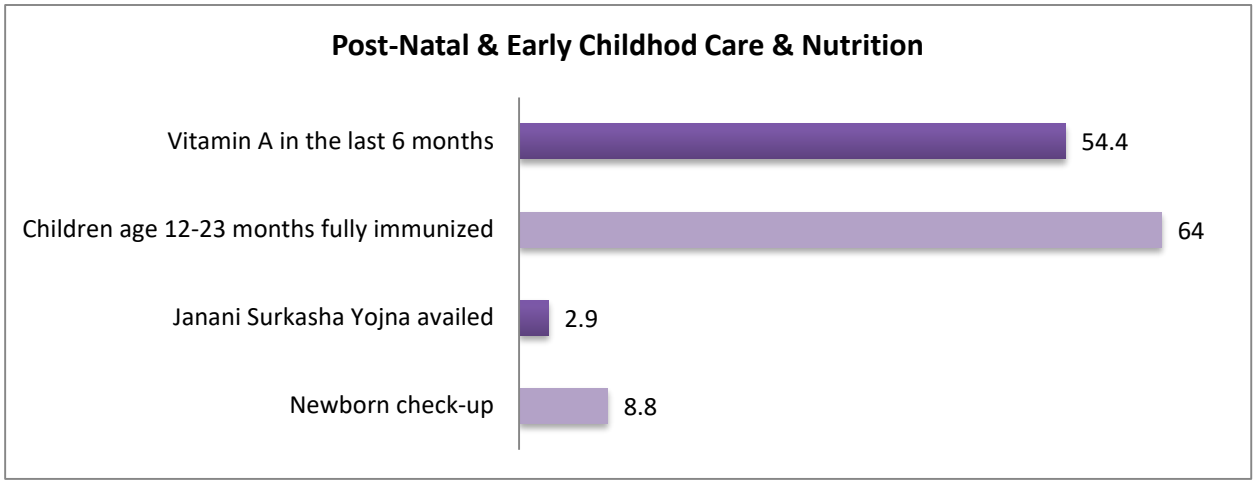


Figure 13:Post-Natal & Early Childhood Care & Nutrition



In comparison to pre-natal period, the postnatal health indicators show that multiple steps would have to be taken to improve the existing situation in the district. 64 percent children in the age group of 12-23 months were fully immunized which is again higher than North-East District while only 2.9 percent women availed the benefits of Janani Suraksha Yojna.

1.5. Sample ICDS Projects

As mentioned earlier, in this report, there are 95 operational ICDS projects in NCT of Delhi having 10,897 operational AWCs. This research study has randomly selected 10 operational ICDS Projects from both the sample districts which are as follows:

Table 21: District-Wise List of ICDS Projects Covered in the Study

East District	North-East District	Shahdara
1. Trilok Puri	1. Sunder Nagari	1. Shahdara
2. Geeta Colony	2. Seemapuri	
3. Shakarpur	3. Nand Nagari	
4. Patpatganj	4. Seelampur	
	5. Sonia Vihar	

Table 22: Project-Wise Distribution of AWCs

S. No	Name of ICDS Project	Number of Anganwadi Centre in ICDS Projects	Number of Anganwadi Centre Selected for the study
1.	Trilok Puri	113	28
2.	Sunder Nagari	105	26
3.	Seemapuri	131	33
4.	Geeta Colony	152	38
5.	Nand Nagari	130	33
6.	Shakarpur	100	25
7.	Patparganj	94	24
8.	Seelampur	115	29
9.	Shahdara	147	36
10.	Sonia Vihar	113	28
	Total	**1,200**	**300**

Source: Department of Women and Child Development, Govt. of NCT of Delhi

1.6. Sample Population for the Study

The sample of the study consists of AWWs, the Supervisors, the Child Development Project Officers, mothers of children below six years, pregnant women and adolescent girls who are registered beneficiaries of ICDS. The total population comprises an anganwadi worker from each AWC, one registered beneficiary randomly selected from each AWC, two supervisors from each project and a child development project officer representing the ICDS Project (please see Table 23).

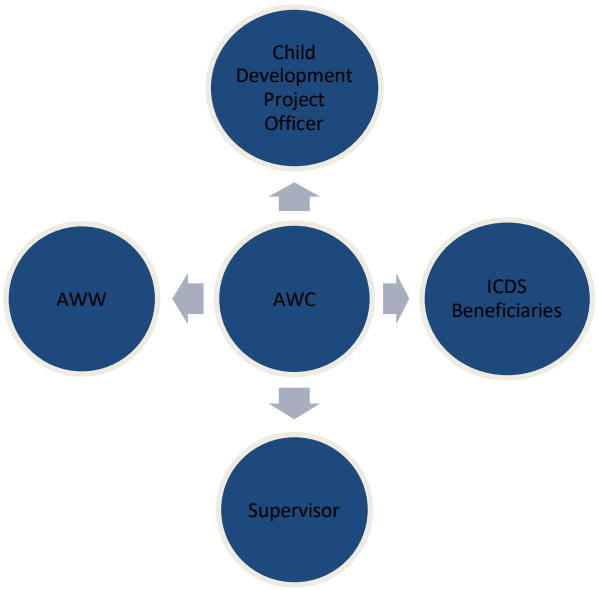


Image SEQ Image * ARABIC 9: Sample Distribution

Table 23: Distribution of Sample Population

Categories			
Child Development Project Officer	**Supervisors**	**AWWs**	**ICDS Beneficiaries**
One from each ICDS project	Two Supervisors from each ICDS project	One AWW from each AWC	One beneficiary randomly selected from each AWC
10	20	300	300
Total Sample from 10 ICDS Projects: 600			

Table 24: Distribution of Sample: A Comparison of Different Studies on ICDS in Delhi

Research Study Name	**Organization conducted the research**	**Year**	**Projects Covered**	**Sample Size**
Delhi Visit Report, NCPCR, 2011	National Commission for Protection of Child Rights	2011	7 (Nand Nagri, Seemapuri, Mandawali, Ramesh Park Jhuggi, Pankha Road JJ Colony, Najafgarh and Maidangarhi).	19 Hospitals=2 AWC=16 Kitchen=1
Rapid Assessment of Integrated Child Development Scheme in Delhi (Pilot Study)	Institute for Human Development	2014	4 (Geeta Colony, Kirti Nagar, Najafgarh, Mehrauli).	49 AWW=16 AWH=16 Supervisors=6 CDPOs=5 Officials=4 NGO officials=2
Assessment of Anganwadi Services under Umbrella ICDS Scheme in Delhi	Delhi Commission for Protection of Child Rights & Matri Sudha	2019	10 Trilokpuri, Geeta Colony, Shakarpur, Patpatganj, Sundernagari, Seemapuri, Shahdara, Seelampur Nand Nagari and Sonia Vihar.	730 AWW=300 Beneficiaries=300 Supervisors=20 CDPOs=10 FGD=100

1.7. Research Tools for Data Collection

- ✓ Structured in-depth interviews (IDIs) have been used to gather information from anganwadi workers (AWC), mothers of children age below six years, pregnant women who were registered as beneficiaries of ICDS programme, the Supervisors and the CDPOs.
- ✓ Focus group discussion (FGD) with the general population including men and women at the study locations about the functioning of AWCs in their geographical locations.

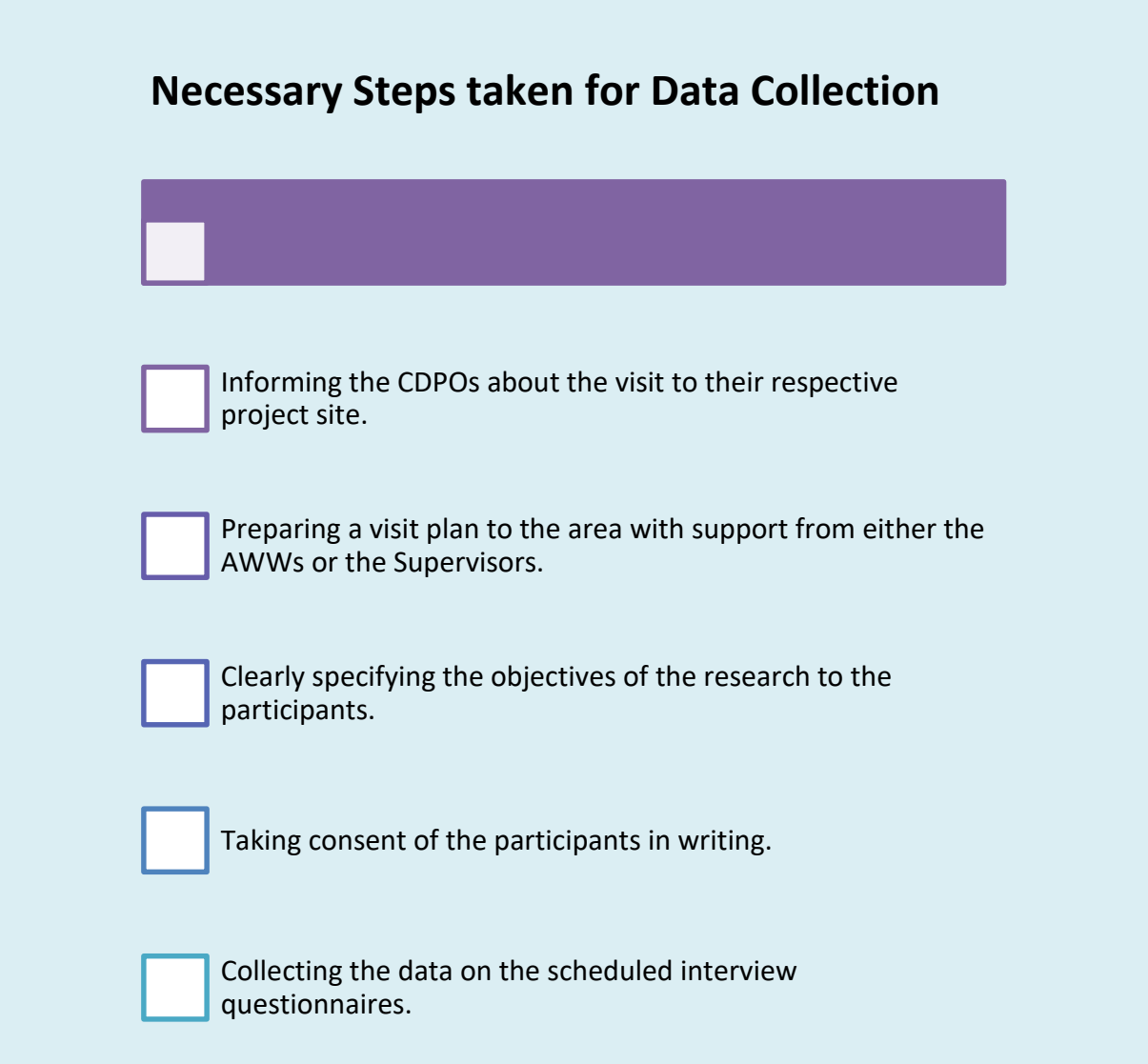
1.8. Methods & Approaches for Data Collection

The observation schedule devised by NIPCCD and other allied agencies in previous research studies were referred for preparing the data collection tools for this research study (please see table . All the researchers personally visited the Anganwadi centres between 9:30 am to 1:30 pm to collect the information. The scheduled interviews of Supervisors and CDPOs were conducted at their respective project offices. In order to get valid information from the registered beneficiaries (mothers of children age less than six years, pregnant women and in fewer cases the adolescents) the visits were made at their homes. In certain cases, the beneficiaries were called in the AWCs.

Table 25: Topics Covered in the Scheduled Interviews

Topics Covered in the Scheduled Interviews	
Anganwadi Workers	1. Supply of supplementary nutrition and its quality. 2. Availability of weaning food for pregnant women. 3. Growth monitoring and availability of operational weighing scales. 4. Availability and utilization of teaching-learning material 5. Assessment of nutritional status of children 6. Observation of physical presence of children in AWC 7. Any existing best practice and positive case study.

Beneficiary	1. Awareness and utilization of Anganwadi Services. 2. Taste and quality of Supplementary Nutrition 3. Usefulness of pre-school education. 4. Suggestions for improving the Anganwadi Services.
Supervisors & CDPOs	1. Monitoring of Anganwadi Centres 2. Changes noticed in ECCE 3. Steps taken to improve the Anganwadi Services 4. Challenges in Growth Monitoring 5. Notable gaps in existing Anganwadi Services 6. Kitchen inspections 7. Key suggestions to improve the Anganwadi Services



1.9. Data Collection Stages

To maintain the heterogeneity and uniformity of information during the data collection process, major emphasis has been given on sample distribution so that every group is equally represented. The study has used the mixed method research technique to collect the data. The following steps have been taken for data collection:

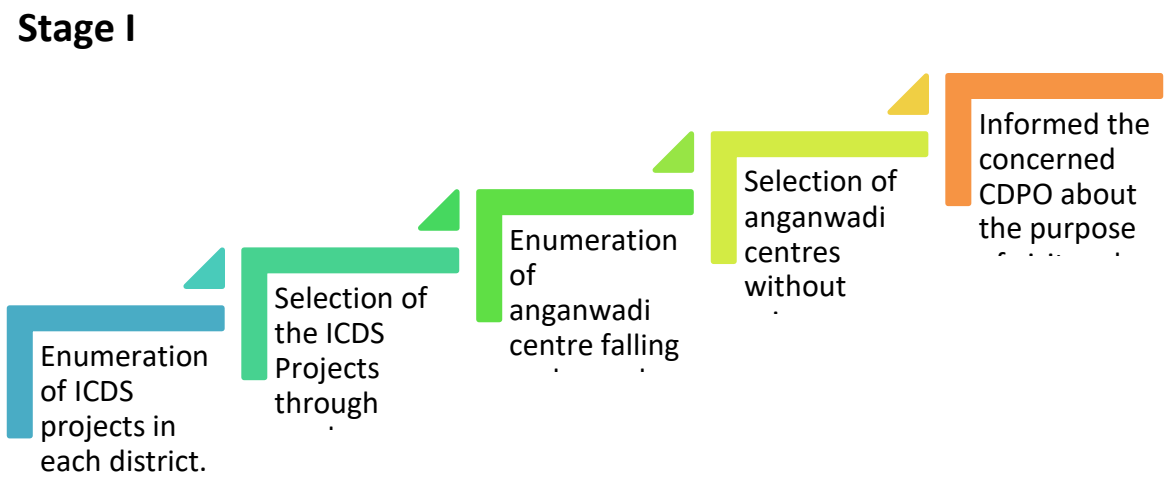


Figure 14: Data Collection Stage I

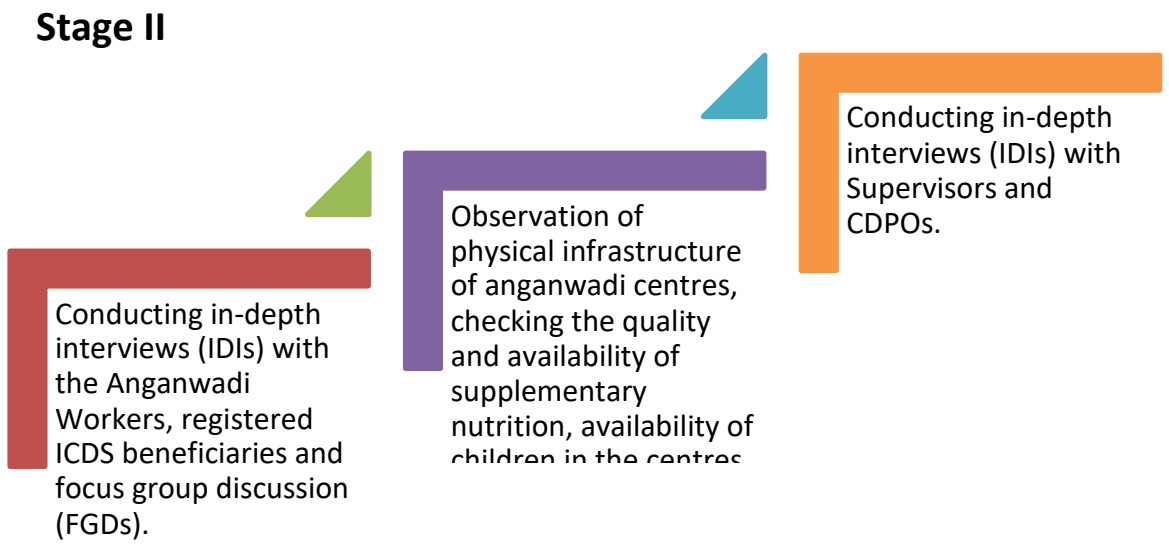


Figure 15: Data Collection Stage II

1.10. Organizing the Data & Analysis

In order to arrive at conclusion it is very important that the data that has been gathered by the researcher is organized properly and systematically. The quantitative response was coded, tabulated for preparation of tables and charts using advanced Excel Techniques. The qualitative response was written separately and the data analysis has recorded all similar responses.

1.11. Ethical considerations

1. This assessment tool is developed for field investigators as a part of a research study named 'Assessment of Integrated Child Development Scheme in Delhi' supported by Delhi Commission for Protection of Child Rights, Govt. of NCT of Delhi.
2. The Institutional Ethics Committee of Matri Sudha – A Charitable Trust (December 2018, MS/-IEC-01/18), reviewed the protocol and approved the study.
3. Delhi Commission for Protection of Child Rights also granted ethical approval to the study.
4. Data collector's took the informed consent and recorded it on paper (signed by all participants) after explaining the purpose of the study.
5. In case if any participant is apprehensive about giving anything in writing, though they agreed to participate in the study, verbal consent could be taken from a few participants.
6. Confidentiality of all participants would be assured during the data collection and analysis.
7. The assessment tool will be used solely for collecting information from Anganwadi Workers based in North-East and East Districts.
8. The information collected during the field visits will be kept confidential and all personnel assigned the task of collecting the data and supervising the work will adhere to the guidance and policies of Matri Sudha - A Charitable Trust.

1.12. Limitations of the study

1. The findings of the research are limited to the data collection sites covered during the field work.
2. Although out of school adolescent girls are covered by the Anganwadi Services through a scheme called as Scheme for Adolescent Girls (SAG), previous known as SABLA, a very limited number of adolescent girls were found registered with the Anganwadi Centres, which restricted the scope to understand the impact of the programme on adolescents.

D. Results & Discussions

Status of ICDS Services

In-depth Interviews of CDPOs: Major Highlights

In-depth Interviews of Supervisors: Major Highlights

In-depth Interviews of Beneficiaries: Major Highlights

Abstract

This chapter has covered three different sections in which the first part has discussed the status of ICDS in NCT of Delhi. The ICDS status has further elaborated the coverage of AWCs, socio-economic & demographic characteristics of anganwadi workers, the issues in capacity building, status of anganwadi centre, major challenges in ICDS and improvements observed by the workers.

The next section of the report has covered the issues narrated by the CDPOs, the Supervisors and the Beneficiaries of ICDS programme during their in-depth interviews.

1. Status of Anganwadi Services Scheme

Coverage of AWCs

Socio-Economic & Demographic Characteristics of Anganwadi Workers

Honorarium of Anganwadi Workers

Supervision of AWWs by Supervisors and CDPOs

Capacity Building of AWWs

The Anganwadi Centre

ICDS Services

Community Support

Major Challenges in ICDS as per AWWs in Delhi

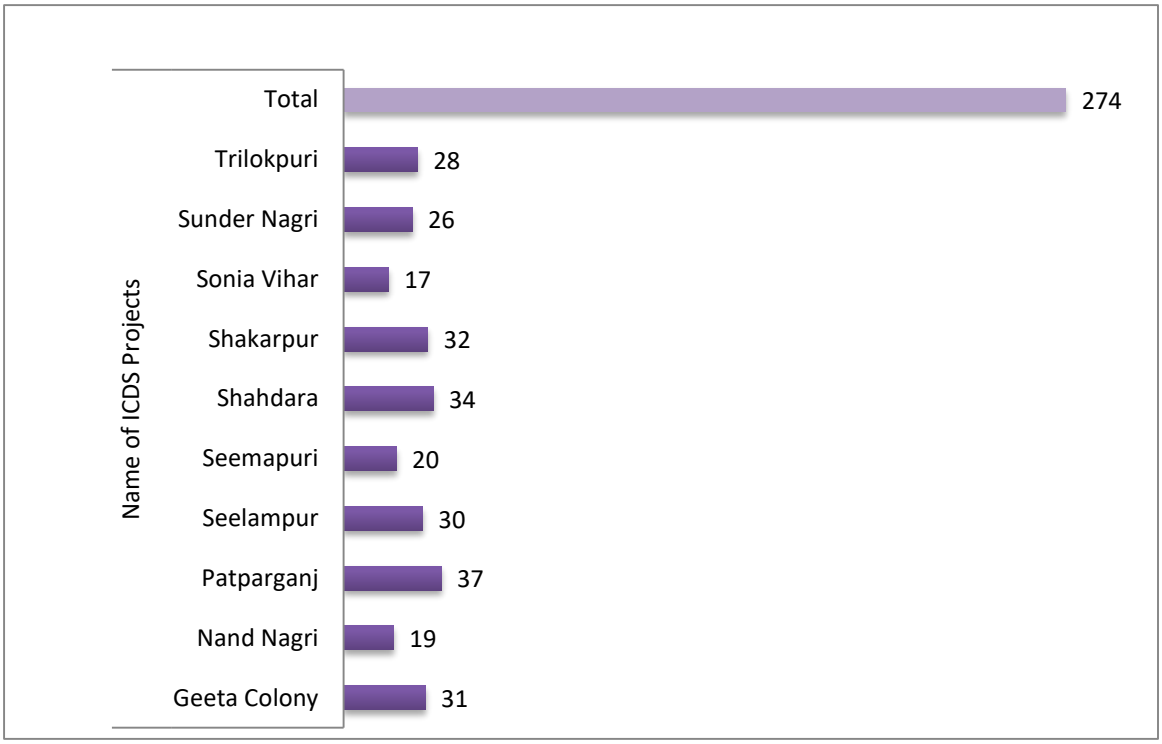
Improvements observed by AWWs in ICDS

1. Coverage of AWCs

1.1. Actual number of AWCs Covered

Out of 300 AWCs, where the scheduled interviews were to be conducted with AWWs and the beneficiaries, 274 centres[135] were covered for data collection. Further, out of these 274 centres, the position of anganwadi workers in 7 centres was vacant. The number of anganwadi centres has been distributed across slums, resettlement colonies, unauthorized and authorized colonies as per the information given by the anganwadi worker and the beneficiaries.

Figure 16: Actual Number of AWCs Covered



[135] In 26 Anganwadi Centres, either the AWW was not available or the centre was closed.

Table 26: Distribution of AWCs Covered in Sample ICDS Project

S. No	Name of ICDS Project	Number of Anganwadi Centre Selected for the study	**Total Number of AWC Covered in ICDS Project**
1.	Trilok Puri	28	28
2.	Sunder Nagari	26	26
3.	Sonia Vihar	28	17
4.	Shakarpur	25	32
5.	Shahdara	36	34
6.	Seemapuri	33	20
7.	Seelampur	29	30
8.	Patparganj	24	37
9.	Nand Nagari	33	19
10.	Geeta Colony	38	31
	Total	**300**	**274 (91.3%)**

Anganwadi workers are the backbone of ICDS programme and their unavailability may risk the efficiency of the programme in short-term as well as in long term. Unavailability of AWW in few anganwadi centres was one of the concerns shown by the AWHs who informed that they are able

to provide only supplementary nutrition. There is a provision of additional charge given to another AWW, who is being given monthly Rs. 200 to come on alternate days to look after the AWC. This arrangement reduces the quality of services of AWC as well.

1.2. Socio-Economic & Demographic Characteristics of Anganwadi Workers

Various research studies in the past have talked about the socio-economic and demographic characteristic of anganwadi workers in implementing the ICDS programme[136]. The socio-economic and demographic characteristics include age, education and work experience of anganwadi workers[137].

It is important to understand an anganwadi which is the focal point for delivery of ICDS services to children and mothers. An Anganwadi normally covers a population of 1000 in both rural and urban areas and 700 in tribal areas. Services at Anganwadi center (AWC) are delivered by an Anganwadi Worker (AWW), who is a part-time honorary worker. She is a woman of same locality or resided at a different location, chosen through a process of selection decided by the government, having a minimum secondary school educational qualification. She is assisted by a helper who is a local woman and is paid a monthly honorarium.

Not only she has to reach a variety of beneficiary groups, she has to provide them with different services which include nutrition and health education (NHE), non-formal preschool education (NFPSE), supplementary nutrition, growth monitoring and promotion, and family welfare services. She also coordinates in arranging immunization camps and health check-up camps. Her functions also include community survey and enlisting beneficiaries, primary health care and first-aid, referral services to severely malnourished, sick and at risk children, enlisting community support for Anganwadi functions, organizing women's groups and Mahila Mandals, enrolment of children for Aadhar cards, pension of old-age persons, identifying eligible beneficiaries in PMMVY[138] and linked them to the scheme, and maintenance of records and registers. The work of the AWW is to be monitored by the Supervisor which will be discussed in the next section of

[136] Dhingra and Sharma 2011
[137] Meenal M. Thakare et al 2011
[138] Annexure 7

the report. Under the proposed Restructured ICDS Scheme, minimum qualification for selection of Anganwadi Worker has been fixed as Matriculation and the age as 18-35 years[139].

1.3. Age of Anganwadi Workers

In the present research study, out of the total 267 AWWs which were interviewed, 72.2 percent were in the age group of 35-50 years which is quite similar with other studies. The critical assessment of AWCs observed that 32% of AWWs were below 30 years of age[140]. Three decades of ICDS (2006), a comprehensive assessment of the programme at national level undertaken by National Institute of Public Cooperation and Child Development (NIPCCD) made an observation that 30% of AWWs were in the age group of 25-35 years. In another study on ICDS it was found that 36.92% (127) of workers were in the age group of 30–39 years and 27.62 percent workers (95) were in the age group of 40-49 years[141].

1.4. Education Qualification of Anganwadi Workers

It has been found through this research study that 44.9 percent workers have completed their matriculation, 14.9 percent completed their higher secondary school i.e. in total 59.8 percent completed their higher secondary education.

Around 26.2 percent of AWW's have completed their graduation while 13.8 percent are post-graduate which shows that 40 percent AWWs are well qualified. A study on ICDS on the knowledge of anganwadi workers found that 15 percent AWWs were graduates while only 3% were post-graduates[142]. The similar findings were there in another study in which it was found that

[139] Press Information Bureau
[140] Seema et al 2001
[141] Sondankar et al 2014
[142] Kalpana Joshi 2018

more than half of AWWs were matriculate[143]. Therefore, as far as the qualification of Anganwadi Workers is concerned, it is quite progressive in NCT of Delhi.

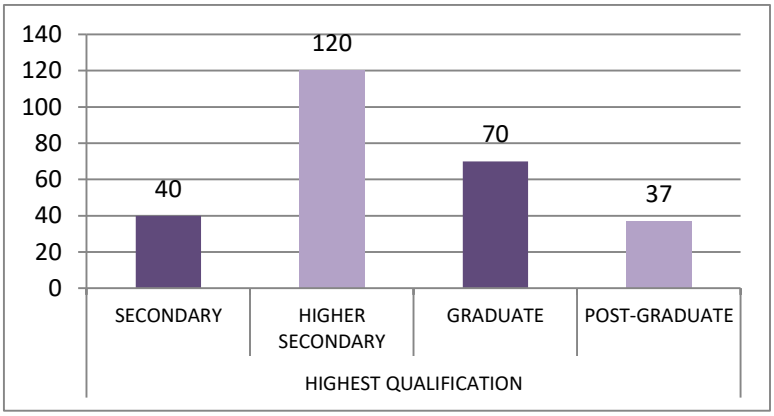
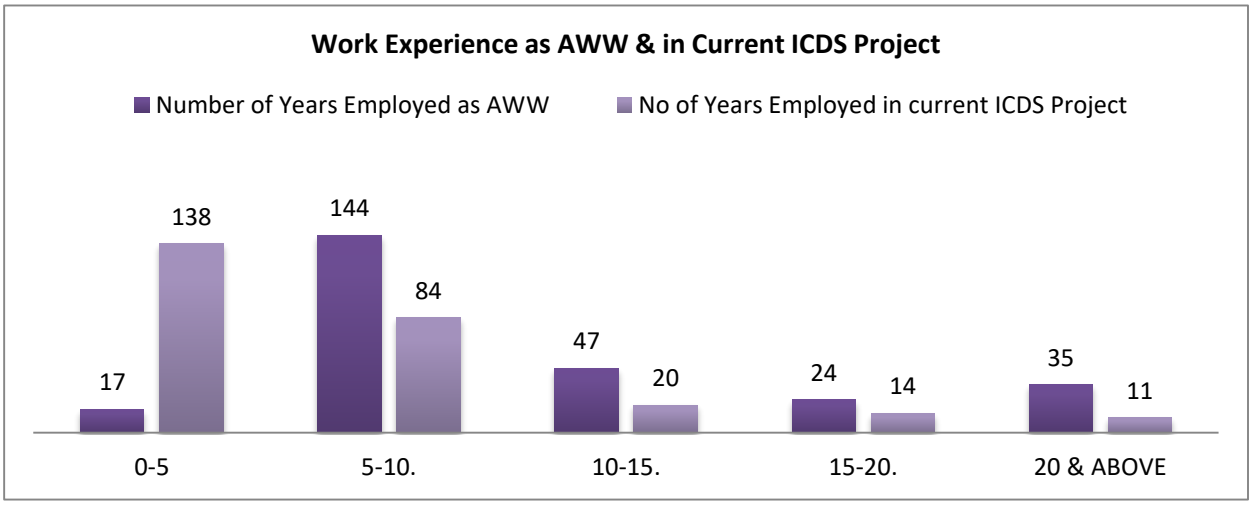


Figure SEQ Figure * ARABIC 17: Education Qualification of AWWs

1.5. Number of working years & resident status of AWWs

In terms of total number of working years for the Anganwadi Workers, around 40 percent workers have more than 10 year of experience and of these around 83 percent anganwadi workers have been employed in the current ICDS projects from the last ten years.

Figure 18: Work Experience as AWW & in Current Project



A study on Integrated Child Development Scheme in Jammu found that 25% of anganwadi workers were having a work experience of 0-10 years, while 65% of them had a work experience of 10-20 years and 10 % of them had a work experience of 20-30 years[144]. Another study on

[143] Patil and Doibale 2013
[144] Manhas et al. 2012

anganwadi workers found that 69.38% had work experience of more than 10 years[145]. The findings of profile of anganwadi workers and their knowledge conducted in 2014 found that 36.35% (125) AWWs had more than 10 years of work experience[146]. Therefore, one can conclude that the work experiences of Anganwadi Workers are quite similar with the present study.

With respect to the resident status of AWWs, this research study finds that 34 percent respondents are from the same locality, whereas the rest of them come from different geographical locations. As a result few AWWs find difficulty to commute to the present location as reported during the survey. It is suggested by the policy makers that the Anganwadi Worker should be from the local community. Few research studies substantiates this aspect like one study conducted in Vadodara district of Gujarat finds that almost 87% Anganwadi workers covered in their study were from same village where the anganwadis were located[147]. A study of Urban Blocks in Sundargarh District of Odisha found that 96.7% of the AWWs in the research study were resident within the same area where the Anganwadi centres were located and only 3.3% were staying outside the village[148]. Another research study in Mizoram on community participation in ICDS found that all the AWWs covered in the study were residing in the locality same to that of location of AWCs and none of them had faced difficulty in commuting to the AWCs[149]. Therefore, one can consider the aspect that Anganwadi Worker can be either from the same locality or she is posted at the location near to her residence.

Table 27: Socio-economic and demographic indicators of AWWs

Parameters		Number of Respondents	Percentage
Age	Less than 35 years	74	27.8
	35-50 years	193	72.2
Qualification	Secondary	40	15
	Senior Secondary	120	45
	Graduate	70	26

[145] Patil and Doibale 2013
[146] Sondankar et al 2014
[147] Desai et al 2012
[148] Prasanti Jena 2013
[149] RL Bawitlung 2015

	Post-Graduate	37	14
Years of Experience	0-5 years	17	6
	5-10 years	144	54
	10-15 years	47	18
	15-20 years	24	9
	20 years and above	35	13
Resident Status	Within the community	91	34
	Outside the community	176	66

1.6. Fixed Honorarium to Anganwadi Workers

Inadequate and untimely disbursal of honorarium to Anganwadi workers reported in various studies in the past. The study on the knowledge and problems of anganwadi workers describes that 75% workers complained about inadequate honorarium[150]. Problem and Prospects of Anganwadi Workers (2019) states that the problems of anganwadi workers is the inadequate honorarium and when a majority of the Anganwadi workers belong to low-income groups, the timely and adequate amount of honorarium will sympathize their concerns.

Similarly, a study of anganwadi workers in North Karnataka (2019) found that in case of benefit plans like vacation, retirement, medical facilities and honorarium AWWs expressed moderately to extremely dissatisfaction[151]. They felt that in case of the honorarium they receive is not in proportion to their job performance.The study on changing role of anganwadi workers state that the anganwadi worker and helper, who are the basic functionaries of the ICDS, are not treated on a par with other government employees, but are called “workers" or "voluntary workers". They are not paid "wages" (which would provide them with some minimum service conditions) but only an "honorarium"[152].

The AWWs and AWHs are paid fixed honorarium per month as decided by theGovernment from time to time. The Government of India enhanced honorarium to AWWs from Rs. 3,000/- to Rs.

[150] Meena et al 2011
[151] Surekha and Akshatha 2019
[152] Desai et al 2012

4,500/- per month; at miniAWCs from Rs. 2,250/- to Rs. 3,500/- per month; to AWHs from Rs. 1,500/- to Rs. 2,250/- per month; and introduced performance linked incentive of Rs. 250/- per month to AWHs effective from 1st October, 2018. Further, the AWWs are allowed a performance linked incentive of Rs. 500/- per month for using ICDS-CAS under POSHAN Abhiyaan. In addition to the honorarium paid by the Government of India, the respective States/UTs are also giving monetary incentives to these workers out of their own resources for additional duties assigned to them under other Schemes[153].

The anganwadi workers in NCT of Delhi are now paid Rs. 9,678 and anganwadi helpers get Rs. 4,839 per month as the fixed monthly honorarium[154] which is progressed from previous findings on ICDS scheme in Delhi by the Institute of Human Development which mentioned that the AWWs were getting Rs. 5000 as the fixed monthly honorarium. The same report, further, mentioned about the irregularity in receiving the honorarium by the anganwadi workers which is not similar to the findings of this research study[155]. Elaborating more on the status of fixed monthly honorarium, the AWWs, except four, reported timely disbursal of payments to them which is, according to them, has improved in the last few years, especially, after the strike by the Anganwadi Workers. It is to be noted that in 2017 the Delhi State Anganwadi Workers and Helpers Union staged protest for more than 40 days to increase their fixed monthly honorarium for workers from Rs. 5000 to Rs. 16,182 and from Rs. 2500 to Rs. 14,698 for helpers in accordance with the minimum wages set by the government[156]. The anganwadi workers still feel that there is mismatch in the monthly honorarium they receive and the volume of work is being done. The workers said "their monthly honorarium is yet to match the scale of minimum wages in Delhi".

Quoting one of the Anganwadi Workers from the study that was going to retire in few months:

"I have been employed for more than 30 years in the ICDS programme, when I would retire from my position, I would reach the same position where I started from with no pension, no gratuity,

[153] MWCD Annual Report 2019-20

[154] http://timesofindia.indiatimes.com/articleshow/59712351.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

[155] Institute of Human Development 2015

[156] Hindustan Times, https://www.hindustantimes.com/photos/india-news/photos-anganwadi-workers-fair-pay-protest-enters-40th-day-in-new-delhi/photo-EtR99jzjHxYdK1H9nIWpAL.html

even not health insurance. We are the backbone of the ICDS programme, and we are the marginalized one".

Although, anganwadi workers (AWWs)/ Anganwadi Helpers (AWHs) in the age group of 18-50 years are covered under Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) for life cover of Rs.2.00 Lakh (covers life risk, death due to any reason); those in the age group of 18-59 years are covered under Pradhan Mantri Suraksha Bima Yojana (PMSBY) for accidental cover of Rs. 2.00 Lakh (for accidental death and permanent full disability)/Rs. 1.00 Lakh (for partial but permanent disability) and those in the age group of 51-59 years are covered with the modified Anganwadi Karyakarta Bima Yojana (AKBY) for life cover of Rs. 30,000/- (covers life risk, death due to any reason). However, the response received from the anganwadi workers in this research study was quite surprising as none of them have reported to be covered by any insurance scheme.

2. Supervision and Support to AWWs by the Supervisors and the CDPOs

A study on anganwadi workers in ICDS Blocks in 2013 reported about inadequate supervision is one of the problems reported by anganwadi workers[157]. The present research found that 11 percent (29) anganwadi workers reported that in last three months no Supervisor made official visit[158] to their centre, whereas 64 percent (170) anganwadi workers reported that no visits were made by the project heads i.e. CDPOs during the same time period. There was dissatisfaction with inadequate supervision by the CDPOs. The results of another study conducted in 2014 on Anganwadi Workers in Rural ICDS Blocks of Punjab showed that nearly half 46.66% AWWs viewed that inadequate supervision from Supervisors and CDPOs was one of the main problems faced by the anganwadi workers[159].

[157] Patil and Doibale 2013

[158] Official visit means when the attendance is recorded on the visitors register maintained by the Anganwadi Worker.

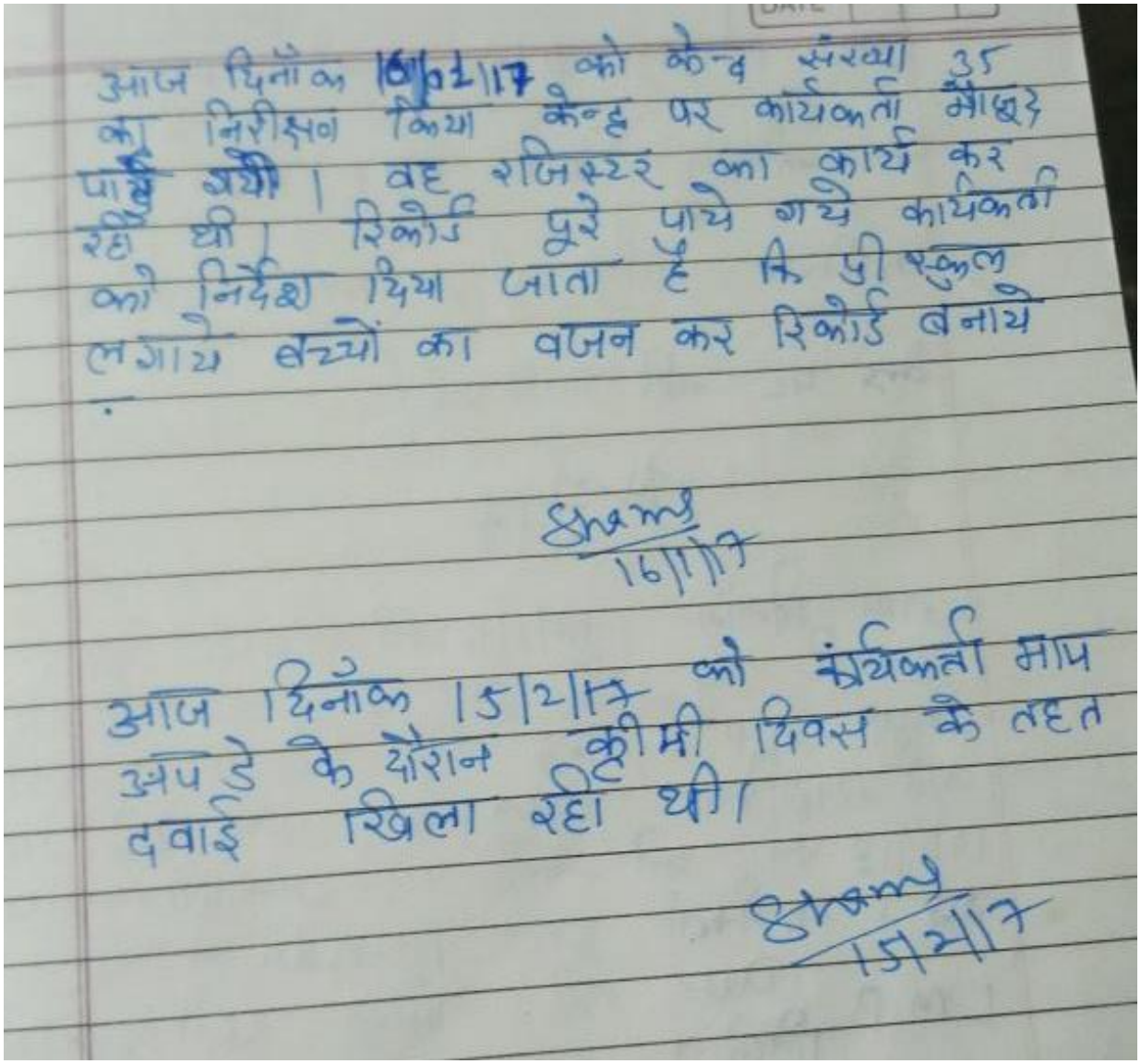
[159] Sarabjit Singh Kular 2014

Table 28: Official Visits by Supervisors and CDPOs

			Yes	No
Official visit by Supervisor to AWCs three months prior to this research			238 (89%)	29 (11%)
Official visit by the CDPO three months prior to this research			97 (36%)	170 (64%)
Visits	No Visits	Less than 3 visits	4-6 visits	More than 7 visits
Number of times the Supervisor visited to AWC	29	127	91	27
Number of times the CDPO visited to AWC	170	80	22	2

In order to understand the visits made by either the Supervisors or the CDPOs, visit records of previous years were also noted in many cases, similar trend was found across every project with little variation with respect to the official visits made by the CDPOs and the Supervisors.

Image 10: Visit Records


आज दिनांक 16/2/17 को केन्द्र संख्या 35 का निरीक्षण किया केन्द्र पर कार्यकर्ता मौजूद पायी गयी। वह रजिस्टर का कार्य कर रही थी। रिकॉर्ड पूरे पाये गये कार्यकर्ती को निर्देश दिया जाता है कि पी स्कूल लगाये बच्चों का वजन कर रिकॉर्ड बनाये

Shanti
16/2/17

आज दिनांक 15/2/17 को कार्यकर्ता माप अपडेट के दौरान कीमी दिवस के तहत दवाई खिला रही थी।

Shanti
15/2/17

Some of the reasons quoted by the anganwadi workers on visits made by the CDPOs and the Supervisors were noted which include:

a) CDPO madam forgets to mark their signature on the register.
b) Due to more volume of work in handling multiple projects, visits are less frequent by the CDPO madam.
c) Most of the workers are unaware about the reasons while some of them has quoted that the Supervisor has a vast area of work so does not get much time to visit all anganwadi centres.
d) Some supervisors have newly joined.

The trend of continued support from the Supervisors is being reflected from the response recorded which shows that AWW receive possible help in improving the services of ICDS, finding the location and room for AWC, quality of meal, on the job-training, induction training and improving the physical environment in the AWC.

3. Capacity Building of AWWs

Training constitutes a basic concept in human resource development as it is concerned with developing a particular skill to a desired standard by instruction and practice'. Training is a highly useful tool that can bring an employee into a position where they can do their job correctly, effectively, and conscientiously. Training is the act of increasing the knowledge and skill of an employee for doing a particular job. AWWs play a key role in delivering the benefits of the ICDS scheme. The efficacy with which they discharge their responsibility, largely depend upon the inputs invested in their training[160]. The training component of the ICDS Programme has now been recognized as the most important key to achieving the aims and objectives of ICDS, with the ultimate aim of moldings the ICDS functionaries into "Agents of social and behavioral change"[161]. An assessment on role of training in enhancement of knowledge of anganwadi workers found that AWWs who had received reorientation training for more than one time had better knowledge of growth monitoring[162]. It has been documented that proper training improves AWWs performances[163].

[160] Shivani Sharma 2017
[161] NIPCCD 2010
[162] Anuradha Davey, Sanjeev Davey and Utsuk Datta 2008
[163] Chudasama et al 2012

In present research study, except 10 AWWs who did not receive any kind of training, the remaining AWWs received the induction training, on the job training and refresher training. During field visits to collect data for this research study many anganwadi workers at study locations were enrolled for training programmes on ECCE.

As reported by anganwadi workers about the training they received on ECCE, they informed that the training has helped them to enhance their capacity to work, changed working method, and learned new methods of conducting pre-school education in anganwadi centers, more awareness with respect to dealing with children, better delivery of services, documentation work can be done easily, taking care of children, engaging children through some activity and teaching method has been improved.

The evaluation study on anganwadi centres during 1996-2001 reported that though 84% of the functionaries had received training; it was largely pre-service in nature and in-service training remained largely neglected[164]. Regular refresher training courses are extremely essential as they keep the AWWs abreast with the recent trends and changes in their field. Therefore, evolving a package of coordinated and joint training program for various health functionaries with provision of practical field oriented training is needed[165].

In the present study AWWs provided their inputs based on their experiences in the ongoing training on ECCE and the previous training. Their inputs are:

Table 29: Inputs by AWWs

Issues	Inputs by AWWs
Topic coverage	More than one topic should not be covered in one day training. It creates problems to understand.
Training Days	Number of training days should be increased to reduce the daily burden of covering the topics.

[164] NCAER 2001
[165] Dixit et al 2010

Methods of Training IEC material	Activity based learning should be organized and proper IEC material should be provided.
Trainers	Expert trainers should come to take the training
Coverage of different themes	Limited training has been provided on health, nutrition, growth-monitoring which must also be the preference.

Miles to Go Before I sleep today…Would be I able to?

Today, I left my home at 7 am to reach to AWCs which were around 30-35 Km from my home. I was quite sure that I would meet my all team members who have put their all efforts to carry out the research work which may lay stone for strengthening of ICDS system in Delhi. There have been some common metro stations on the Rithala-Dilshad Garden line and are in our memories every time when we think of the anganwadi centres in the area.

Finally, I reached to the AWC. There was a smile on my face, seeing anganwadi worker sitting with few children, accurately 5-7 children of different age groups, but less than six years of age. To my surprise, the anganwadi worker also had her son sitting with other children in the centre.

The main road cuts into narrow lanes in this Basti where this anganwadi centre was located, the room size should be 10*8 (10 feet by 8 feet) or less. Perhaps, I would be carrying a measuring tape to have the accurate measurement.

This centre had one 100 watt bulb which was smiling like me from one side and another LED bulb was looking at me from the other side. I had to be cautious since the ceiling fan was just over my head, luckily, it was not switched on.

Few charts were hanging on the wall, some were pasted and some of them were finding their way towards dustbin.

Thank God!! There was no dustbin. Looking at the condition of the room, I did not have the courage to go and see the condition of toilet, but somehow I managed to open the door. It could be used but it required more courage than I had.

Anganwadi worker was in hurry. She had to go. I asked where you had to go. She replied ‘for immunization’. What time you all go for the vaccination drive, I asked. Sir, it is12 ‘0’ clock. We all knew that vaccination schedule starts at 1:00 PM.

Few children who were sitting also started leaving, as they had received their share of meal for the day, rest was left in the container.

The picture on the next page might speak more than what I have spoken of.


मुक्ति दिवस

4. The Anganwadi Centre

The handbook for anganwadi workers emphasized that infrastructure is the basic physical and organized structure that facilitates the delivery of services and also improves the quality of a programme. The development and expansion of infrastructure is an essential prerequisite for the prosperity of any programme. It has been perceived that link between infrastructure and development is not a once-for-all effort. It is a continuous process and progress in development has to be preceded, accompanied and followed by development in infrastructure[166].

The report further states that adequate space for children inside the anganwadi centre with proper lighting and ventilation, outdoor space for activities with children, availability and usage of teaching and learning material, availability of drinking water and toilet facilities constitute the basic infrastructural arrangements of an anganwadi centre.

The activities organized at the AWC starts from reciting prayer, free conversation, making children feel comfortable and safe in the centre, teaching alphabets, recitation of poems and songs, physical activities like jumping and playing, necessary for stimulation and development of motor skills[167].

The first and the foremost thing starts with a room conducive to function as the anganwadi centre. The moment it is decided to run the anganwadi centre in that space, it turns into a space, largely seen as the centre for early childhood care and development. A space of 10*10 or more which seems to lay the foundation stone for children is largely neglected with little or inadequate facilities for children. Anganwadi centre is the focal point of intervention and implementing ICDS services to children and women. Optimum utilization of the services requires adequate infrastructure facilities.

4.1. Enrolment in Anganwadi Centres

The enrollment in AWCs usually happens through different processes: survey of the area by the AWW and registering the name of the beneficiary; self-enrollment; information given by ASHA workers in certain cases; community support in getting the beneficiary registered with AWC.

[166] NIPCCD 2006

[167] Institute for Human Development 2015

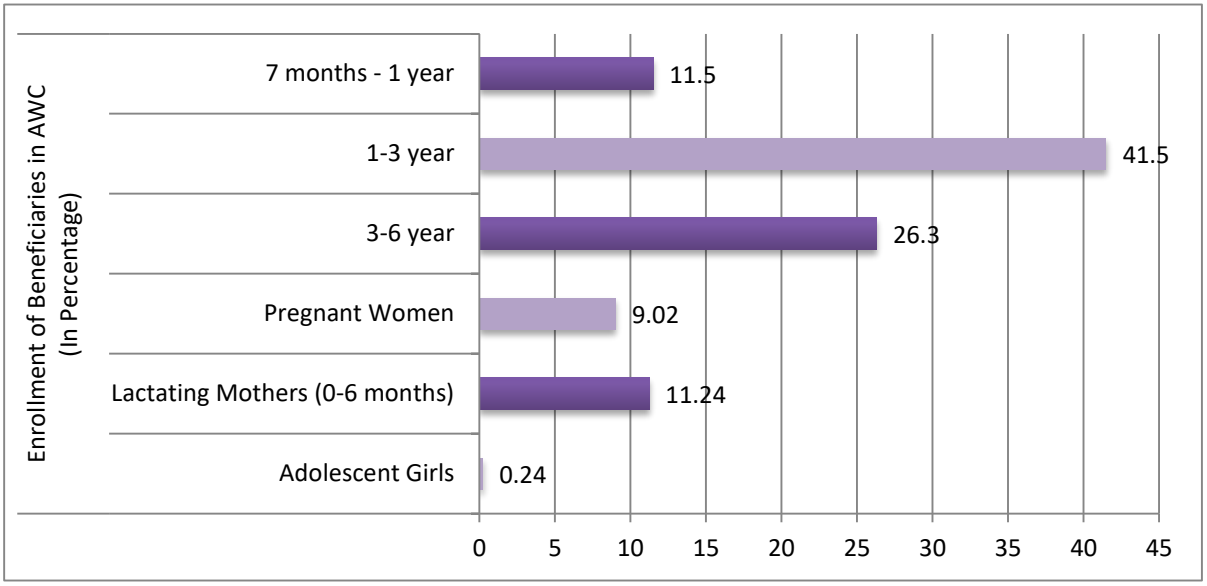
Image 12: Children found sitting in the AWC in Seelampur

Eighteen thousand one hundred and nineteen children and women have found to be registered in 274 AWCs across 10 ICDS Projects covered in this research work which means that on an average 66 beneficiaries per anganwadi centre have found to be registered which is higher than the state average of 51 beneficiaries per Anganwadi Centre.

The enrollment rate of the beneficiaries such as children, mothers and pregnant women is presented in figure 19. The enrollment of beneficiaries' and their physical presence in anganwadi centre may show the utilization of ICDS services in the respective projects. Besides being one of the objectives of ICDS, it is important for lactating mothers to attend AWCs as they create linkages with pregnant women, counsel them about care during pregnancy period, linking them with AWCs, sharing their experiences as how to look after their babies and importance of vaccination.

Children age less than three years constitute 54 percent of the total enrolled beneficiaries in the AWCs which is quite encouraging in terms of utilization of supplementary nutrition, counseling and awareness of their mothers to prevent them from being malnourished.

Figure 19: Enrollment of Beneficiaries in AWC (In Percentage)



The study did not capture the total number of beneficiaries (eligible women and children) registered in the AWC out of total eligible children and women in the catchment area. However, the observation of data collectors and other team members found an average 8-10 children sitting in AWCs.

In many AWCs no children were found sitting and closed during the survey which is mentioned in the coming section in this report. At various places children who were not registered in the AWC were also found sitting at the time of data collection. These observations are similar to the findings

of an independent evaluation of ICDS undertaken by the Planning Commission which found that less than half of eligible children were covered by the ICDS[168].

However, there were exceptions to this observation, and children were found in good numbers (more than 40) in Model HUB centres and 20-25 children per anganwadi centre (there were only 8-10 such centres) where the AWWs were found active and availability of adequate infrastructural facilities like sitting space for children, availability and accessibility to toilet facility, drinking water and active use of pre-school education kit.

4.2. Space in AWCs

The ecological surroundings play an important role in the development of children. There is a direct link between healthy children and learning as is also reflected in a popular saying that a healthy mind lives in a healthy body. A good quality time is being spent by children in AWC and, therefore, should be clean, hygienic and stimulating to promote the learning abilities.

The present study found that all AWCs were operating through rented accommodation. The physical space was more in the Model Hub Centres as 4-5 anganwadi centres were merged together to get bigger space. These Hub Centres were in Patparganj and Sonia Vihar ICDS Projects. The physical space in anganwadi centres is largely congested in urban slums of Delhi.

With respect to the physical space in anganwadi centres, it was found that 65.6 percent of the AWCs had adequate space for conducting activity with children while 34.4 percent had lesser space for sitting and conducting any kind of activity with children. Similarly, out of the total AWCs visited only 24 percent of AWC had space outside the centre for conducting activity with children and 18.2 percent centre were found to have adequate space inside and outside the centre for conducting activity with children. Therefore, one can properly utilize the space in anganwadi centres having adequate physical space to conduct activities with children and on the other hand

[168] Planning Commission 2011

finding an alternate space like porta-cabins at a specified location in the urban slums to increase the footfall of children and women to access the anganwadi services.

Image SEQ Image * ARABIC 13: Children and Women Sitting in AWC for Immunization

The present study found that 74.9 percent Anganwadi Centres has proper ventilation due to availability of good size windows on the wall. The remaining Anganwadi Centres are congested with no windows on the wall as discussed earlier due to shortage of space within the AWCs and narrow lanes inside the slums/basti where such centres are located. 91 percent AWCs were found properly clean which gives a stimulating feeling not only to children but also the anganwadi staff who run the centre on a daily basis. In terms of requirement of any repairing work there were 23.2 percent AWCs which required some kind of repairing work.

Anganwadi workers engage children in doing activities like reciting of prayers, jumping, yoga, poems with actions. However, variations had been found at different locations as the unavailability of adequate space and basic facilities was a major challenge to them. Moreover, outdoor activity with children was limited to few AWCs due to unavailability of any adequate space outside the centre.

Table 30: Space inside & outside the AWCs

	Adequate		Inadequate	
	Numbers	%	Numbers	%
Space inside the AWC		65.6		34.4
Space outside the AWC		24		76
Space outside and inside the AWC		18.2		81.8

4.3. Monthly Rent of AWCs and its Disbursal

The present study found that 88 percent anganwadi centre receive rent on time while 12.3 percent and 2.3 percent AWWs reported sometime and very often delay in disbursal of rent of AWCs. The Anganwadi workers felt that due to workers strike, there have been improvements in disbursal of rent; otherwise, it used to be delayed for many months. However, still, there are gaps in disbursal of rent and it does not come on time from the department. However, no clear indications were given by the anganwadi workers that reported delayed disbursal of rent.

The department of women and child Development, in 2015 had revised the monthly rent norms (see annexure 9). The data shows that 51.6 percent AWCs operate from a room whose monthly rent is Rs. 1500 or less. While monthly rent of 34 percent AWCs fall between Rs. 1,500-Rs. 2,000 and 16.7 percent AWCs has monthly rent above Rs. 2000.

The anganwadi workers reported the challenges in getting the adequate space for running the anganwadi centres and this was especially for Anganwadi Centres located in urban slums. They uniformly raised the concern of lesser rent for anganwadi centres, especially in a city like Delhi where fifteen hundred rupees is too less to get an appropriate space.

4.4. Basic Amenities in AWCs

4.4.1. Toilet facilities

A study to assess the performance of Anganwadi workers in both urban and rural areas, found that toilet facilities were available in 69.6 percent centers[169].

The availability of proper toilet facilities means it should have the dedicated space for toilets, availability of clean toilet sheets and easily accessible to children and AWWs. Additionally the toilets have proper water facility with bucket, mug and soap for hand washing.

In the present study 72.9 percent AWCs had proper toilet facilities. In AWCs where proper toilet facility was found available, it was available for use for both children and the AWWs. Out of the total number of AWCs where toilet facilities were available, it was found that only 78.5 percent AWCs had availability of soaps for hand-washing, in 88.5 percent AWCs buckets and mugs were available.

Image SEQ Image * ARABIC 14: Toilet in AWC in Sunder Nagari

In 27.1 percent AWCs where proper toilet facilities were not found suitable were largely inaccessible for children as shown in (Image 14). The image was taken in the Sunder Nagari ICDS Project; the toilet was available in a backside of a shop adjacent to the AWC. Children in this anganwadi centre had to walk down to this shop to access the toilet, since the anganwadi centre does have the toilet of its own in the same premises.

In some centres the toilets were available at first floor or some had western toilet sheets which were not accessible for children. In that situation either a child goes to their home or the anganwadi worker makes them sit in an open drain outside the anganwadi centres. The workers either use the landlord`s toilet or any other community toilet.

4.4.2. Drinking Water and Hand Washing Facilities

There were 89.4 percent AWCs in which the water facility was found available both for drinking purpose and hand washing. Out of total AWCs the water for drinking purpose was available in

[169] Chudasama et al 2012

91.6 percent centres whereas in 90.8 percent AWCs water was available for hand-washing, respectively. The drinking water was largely found in jars with water filled inside it and placed at one corner of the room while water for hand washing was found in buckets filled with water and a mug inside it.

The present study found that there were 11 percent anganwadi centres where no proper water storage facility, water taps for hand washing were found satisfactory in place. In such case the either the anganwadi worker would have to find an alternate option like children taking water bottles with them or children or visiting the homes to fulfill the requirement of water for drinking purpose and hand washing.

4.4.3. Sitting facilities in AWWs

The AWC needs a basic infrastructure like pre-school kits, proper sitting facilities and first-aid kits for children. Majority of the AWCs had mat or durries which were getting used, but the quality of mat or durries were rough and in many cases uncomfortable for children. At some places the quality of the mat or durries was in poor condition which was pointed out to the AWWs to get them replaced. In the majority of the AWCs, only one chair and in a few cases a table was provided to the anganwadi worker.

Image SEQ Image * ARABIC 15: A child

Image SEQ Image * ARABIC 17: ECCE Kit in AWC

Image SEQ Image * ARABIC 18: AWW conducting activity with children in AWC

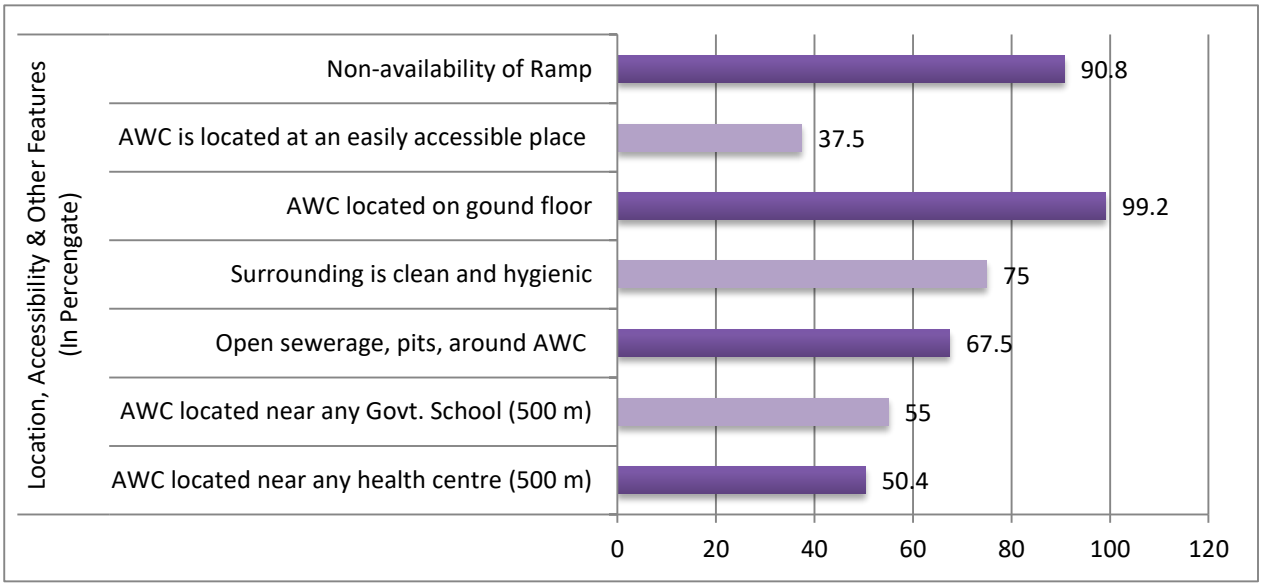
Image SEQ Image * ARABIC 16: Children in HUB Centre, Mandawali

4.4.4. Location & Accessibility of AWCs

The attraction toward an AWC starts from it surrounding where it is located and how easy it could be accessed by children. This section of the report deals with certain prominent features of AWCs like their location, accessibility, cleanliness and surrounding environment, presence of any government dispensary and school near AWC.

In terms of accessibility, it was found that 62.4 percent of the AWCs could be easily accessed in terms of its location, 98.9 percent centres are located on the ground floor, 75.1 percent had clean and hygienic surrounding environment while only 67.5 percent had no open sewerage, open pits around the AWCs. However, ramps for children were disabilities were found in limited anganwadi centres for availing the ICDS services.

Figure 20: Location, Accessibility & Other Features of AWCs



Further, 50 percent of the AWCs were located near to a government health centre while 55 percent were located near to a government school (<=500 m). both the institutions (government school and dispensary) which have a strong relationship in enrollment of children in the school, immunization of children, and referral to the dispensary which is discussed later in the report.

There is a strong relationship between adequate infrastructure, location and surroundings of AWCs and the quality of services provided by the AWWs which lay the foundational stone for children.

The results of the present study found that the infrastructure of the AWCs was satisfactory, but there was a requirement of teaching learning material in adequate quantity in sample AWCs. The absence of adequate pre-school kits restricts the AWWs to conduct preschool education activities, discharging their duties properly, distributing SNP, organizing nutrition and health education sessions with community women.

Similar studies in the past by many researchers across the country established a direct relationship between the adequate infrastructure and activities in the AWCs, particularly, pre-school education (Anuradha and Kamala, 2003; Sinha, 2008; Qaidri and Manhas, 2009; Population Research Centre,2009; Vijayanti, 2010; Dixit et al, 2010; Bashir,2011, Rajni Dhingra & Iesha Sharma, 2011).

5. ICDS Services

5.1. Supplementary Nutrition

The persistent high levels of child undernutrition in India are the consequence of a complex interaction of basic, underlying and immediate factors[170]. While any single intervention cannot address such a complexity of determinants, the package of services provided by ICDS is well-suited to addressing the immediate causes of undernutrition, namely, inadequate dietary intake and childhood infection. It is a well-designed intervention and is an appropriate response to the problem of under nutrition in India[171].

The beneficiaries of the ICDS in the reported projects are provided with nutritious meals between 11:00 AM-12.00 PM through the Supplementary Nutrition Programme (SNP) with little variations in timings. The supplementary nutrition (see annexure 3) is one of the key components of ICDS bridging the calorific gap between the recommended and average intake of children and women, especially, the underserved communities[172].

Table 31: Nutritional Standards of Supplementary Nutrition

S. No	Category	Type of Meal	Calories (Kcal)	Protein (g)
1.	Children (6 months to 3 years)	Take Home Ration	500	12-15
2.	Children age (3-6 years)	Morning Snack and Hot-Cooked Meal	500	12-15
3.	Children (6 months to 6 years who are malnourished)	Take Home Ration	800	20-25
4.	Pregnant Women and Lactating Mothers	Take Home Ration	600	18-20

Source: Schedule II: Nutritional Standards, National Food Security Act, 2013

[170] Theoretical frameworks of Mosley and Chen 1984 and UNICEF 1990

[171] ICDS and Persistent Under nutrition 2006

[172] Annual Programme Implementation Plan, ICDS, Govt. of NCT of Delhi, 2018-19

Food helps in mental and physical growth of all human beings during developmental stages of life (new born child, pre-school child, growing adolescent, pregnant women, or elderly persons). Three parameters which are of utmost importance and are major issues in undermining nutrition and health of people are[173]:

- Food Security
- Food Quality
- Food Safety

At the study sites, 99.2 percent respondents (AWWs) informed that hot-cooked meals come daily, while 98.5 percent informed that it comes on time as well. Providing food to young children was considered as the yardstick to measure the performance of anganwadi by most of the communities[174]. With respect to the quality of supplementary nutrition (SNP), 98.9 percent responded that the meal is freshly prepared and hot-cooked. During the physical observation in anganwadi centres, very few anganwadi workers were found to taste the supplementary nutrition before being served to children. Contrary to this, 89.4 percent Anganwadi Workers reported that they taste the food on a regular basis before serving it to children and women which shows that there is difference in their existing practices and the responses they had given during the interviews.

With respect to the menu of the supplementary nutrition, this research study found that 64.96 percent workers wanted to get the menu of the meal changed, since they were dissatisfied with the preparation techniques, lack of flavor and nutritious values in Halwa, Daliya, Pulao and Khichdi. Also, they felt that it has been more than a decade since the menu was changed. Children and women are less enthusiastic to receive the same food every day.

The workers reported that Halwa is the least preferred item by children as it does not taste good and is prepared in a very poor manner. It looks like the water is mixed in flour with little sugar in it and cooked haphazardly. Studies that focus on poverty and nutrition indicate that although people are poor, that does not mean they should be deprived of food with flavor[175].

[173] NIPCCD 2016
[174] Asha et al 2014
[175] Institute for Human Development

Further, probing into the quality of supplementary nutrition, the anganwadi workers reported that during summers Moong Dal Khichdi start leaving water, if it gets very late in reaching out to AWCs, since, according to them, it must have been prepared very early in the morning. Khichdi if properly prepared and served well in time; it is highly beneficial during summers. Rice is easy on digestion and is high in water content alongside being wealthy in vitamin B complex, iron, and a good source of healthy carbohydrates. Moong has a cooling impact on the body and is simple on the liver too. The customary rice with a mix of moong is Khichdi, is also known as the Ayurveda remedy for resting the digestive system, improving the liver and to evade conditions like ulcers and acidity[176]. Therefore, some anganwadi workers suggested that addition of vegetables and certain spices may add taste to it, while few other anganwadi workers suggested to change khichdi with any other nutritious item like seasonal fruits.

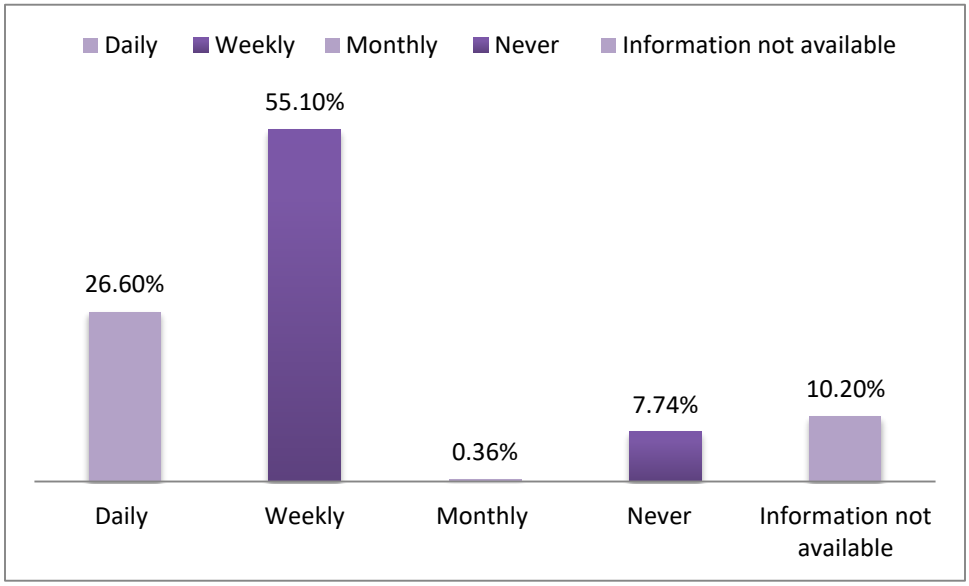
The anganwadi workers suggested to provide eggs and daliya alternately as both are the known source of protein and calcium. It is to be noted that wheat dalia is rich in fiber, protein, calories and carbohydrates whereas eggs are a rich source of protein, fat, iron, vitamins, minerals and carotenoids. The egg is a powerhouse of disease-fighting nutrients like lutein zeaxanthin which can protect your eyes from harmful high-energy light waves like ultraviolet rays in sunlight[177].

The present research study also tried to understand the knowledge level of the AWWs with respect to the frequency of supplementary nutrition being served to children and women. There was uniformity among anganwadi workers with respect to distribution of supplementary nutrition to children, pregnant women, lactating mothers and moderately underweight children. The variations in AWWs knowledge and awareness were noted in case of serving meals to severely underweight children by the researchers. As mentioned previously in (Table 31), that severely underweight children are to be provided 800 Kcal and 20-25 g of protein, therefore, one needs to ensure that proper mechanisms are in place to ensure that nutritional standards are met. Moreover, it is very important to identify severely underweight children so that they receive their entitlements.

[176] NDTV Food: https://food.ndtv.com/

[177] https://www.webmd.com/eye-health/lutein-zeaxanthin-vision

Figure 21: Awareness w.r.t serving supplementary nutrition to Severely Underweight Children



It is to be noted that the Supplementary Nutrition Programme under ICDS has become a legal entitlement under the National Food Security Act (NFSA), 2013 which has been enacted on 10.9.2013. Section 4, 5 and 6 of the National Food Security Act 2013 pertain to nutritional support to pregnant and lactating mothers, nutritional support to children and prevention and management of child malnutrition.

Further, the anganwadi workers were more concerned about the contamination of food during summers, as the kitchens are located at distant locations and non-availability air-conditioned transportation facilities might lead to higher chances of food being spoiled. If they come across any instance of food being spoiled, they bring into the notice of their respective Supervisors. The anganwadi workers further suggested that at certain places, there is availability of space to develop on-site kitchens for preparation of supplementary nutrition. This may reduce the time of transporting food to anganwadi centres and lesser chances of food being contaminated. Therefore, according to them, the department should think on these lines to save food from being wasted.

The facilitators guide book on food, food safety and hygiene measures in ICDS (2016), acknowledged that supplementary nutrition of ICDS is one of the most pivotal interventions addressing child malnutrition in India and also a key service addressing food security. However, the safety issues in care of handling supplementary nutrition have been highlighted from time to time and therefore it is extremely important to take precautions and manage quality checks at regular intervals at the centres and the kitchens to ensure that safe and nutritious food are delivered to children and women[178]. NIPCCD acknowledged the potential means of contamination of food in its guide which is shown in Figure 22.

Figure 22: Potential Means of Contamination of Food

[178] NIPCCD 2016

5.2. Growth Monitoring

5.2.1. Status of weighing machines in AWCs

The present study found that that 25.9 percent Salter-Weighing scale and 58.3 percent Adult-Weighing scales were found working in the AWCs, while 15.8 percent anganwadi centres did not have either. The availability of working weighing machines was found to be higher in this research study than a similar study on ICDS in district Amritsar of Punjab where only 45 percent weighing

Image SEQ Image * ARABIC 19: Leftover Food in an AWC

scales were found in working condition in urban areas. A study conducted in Aurangabad city also showed that weighing machine was present in 93 percent of anganwadi centres but 86 percent

anganwadi centres had weighing machines in working condition[179]. Another study on quality of infrastructure of anganwadi centres conducted in West-Bengal reported that weighing machine was adequate in 56.5 percent anganwadi centres wherein at national level, it was 69 percent[180].

The present research study found that out of the total percentage of adult weighing scales available in working conditions in the AWCs, only 58.9 percent of those weighing scales were found to be used by the AWWs. Anganwadi workers reported that weighing tools or weight machines are being used on a rotational basis i.e. one AWC completes the growth monitoring and then it gives the weighing tools to another AWC, since not every anganwadi centre has been allotted the weight machines. One weight machine rotates among five anganwadi centres as reported by anganwadi workers. However, this research study has not found out the number of anganwadi centres having allocated weight machines specifically for a particular centre.

Table 32: Status of Weighing Machines in AWCs

	Salter Weighing Scales (for children age < 1year)		Adult Weighing Scales (for children age >1 year)	
Weighing Scales in Working Condition	Yes	No	Yes	No
	71 (26%)	203 (74%)	160 (58%)	114 (42%)

5.2.2. Nutritional & Health Status of children

It is one of the objectives of the anganwadi programme to know the nutritional and health status of children below six years for which they organize monthly growth monitoring. In examining the ability of the respondents to monitor the growth of all the registered children in the center, 36 percent of the AWWs reported that they were unable to monitor the growth of children in the AWCs due to unavailability of weighing tools in last three months from the date of conducting the study, while 37.1 percent AWWs reported that they organized growth monitoring for more than 3

[179] Meenal M Thakare et al 2011
[180] B Paul, B Biswas and A Ghosh 2017

times, 4.7 percent and 22.2 percent AWWs had organized the growth monitoring one time and two times in last three months respectively.

The findings in the study is similar to the findings conducted in an urban block of Odisha in which the AWWs were not aware of the importance of growth chart instead they were maintaining the growth charts as per the requirement of their job profile only[181].

Table 33: Frequency of Growth Monitoring

Number of times AWWs conducted Growth-Monitoring in three months	None	One Time	Two Times	Three Times
	98 (36%)	13 (4.7%)	61 (22.2 %)	102 (37.1%)

There had been inconsistency among the anganwadi workers to monitor the growth-pattern of children and their attitudes were largely found casual. The inadequacy of workers to plot the growth of children on Growth Charts was seen when the majority of children were left out without any classification of their nutritional status.

The qualitative analysis of the responses given by AWWs in this research highlights the major challenges to map the nutritional status of children among which some of the notable reasons are:-

1. **Non-availability of growth charts** for many years, in majority of AWCs the growth chart book handed over to the AWW in 2013 was in use, few AWW received the growth chart book in 2017, while some of them had received growth charts (single sheet separately for boys and girls), the practice of plotting the growth on a register made themselves by the worker which only shows the grading – normal, moderately underweight and severely underweight
2. Most of the centres **did not have weighing tools** and in some centres **weighing tools were not in working condition**. The workers **borrow weighing machines on a rotation basis** from other centers for growth monitoring. The **weighing machines** which were available in some centers **did not show correct weight measurement.**

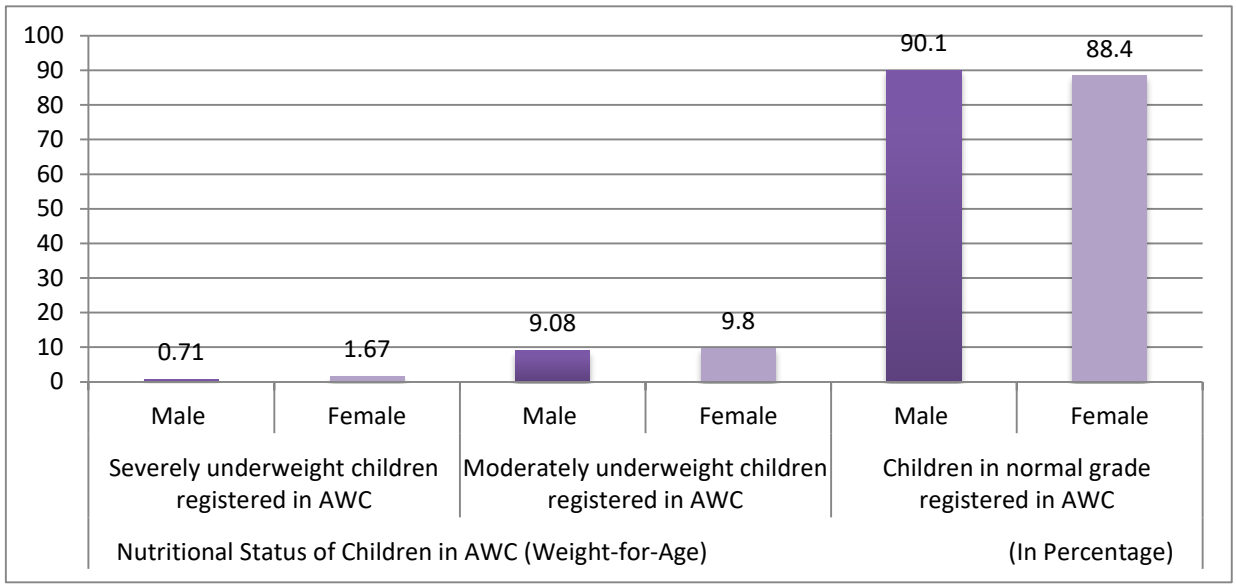
[181] Prasanti Jena 2013

3. AWWs were also dissatisfied and demotivated due to lesser response of senior officers **for procuring new weight machines and no training on growth-monitoring, health and nutrition by the department.**

NCPCR in its study (2011) highlighted 'growth monitoring' as the weakest part in the ICDS system in a pilot research conducted by visiting 16 AWCs which included centres in Seemapuri and Nand Nagri which are also covered in the current study. The report states that 'though most important but one of the weakest parts of the AWCs is the Growth monitoring. The Commission stated non-availability of weighing machines, sharing of the weighing machines between 3-4 AWCs, faulty machines, non-availability of growth chart booklets and apathetic attitude of the AWW in their findings. The Commission further mentioned that the responsibility of bringing the weighing machine to the centre, rests with the AWW which is usually overlooked. Most of the AWW claimed that they can pick up malnutrition by their sheer experience only. At one or two centres the weight recording was done only once in a year and weight registers were not available at the time of visit or were not maintained properly.

The present study also found that due to inconsistency in plotting the nutritional status of children on growth charts it had been very difficult for the researchers to assess the exact number of malnourished children registered in the AWC, hence, it could be seen in figure 23 that out of total children found registered in AWCs only 2.38 percent children were found to be severely underweight.

Figure 23: Nutritional Status of Children in AWC – Weight-for-Age (In Percentage)



In order to ensure reduction in malnutrition and under-five mortality rates, there is need to refocus the programme on the issue of food and nutrition security of children and pregnant, lactating and nursing mothers, rather than broadening the goals of the programme to include other services. This would ensure that all present resources are directed towards improving the nutritional status of the beneficiaries[182].

An editorial on Restructuring of ICDS research study highlighted that the foremost barrier in improving nutrition and ECD services through Anganwadi centre is the poor capacity of Anganwadi workers. As a result she emphasized on improving the quality of training provided to anganwadi workers. Moreover, hands-on training needs to be designed which help the Anganwadi workers acquire required skills. The best approach for this could be by developing ICDS project at block level as hub for continuing training of AWWs[183].

[182] Institute for Human Development 2015
[183] Subodh Sharan Gupta 2013

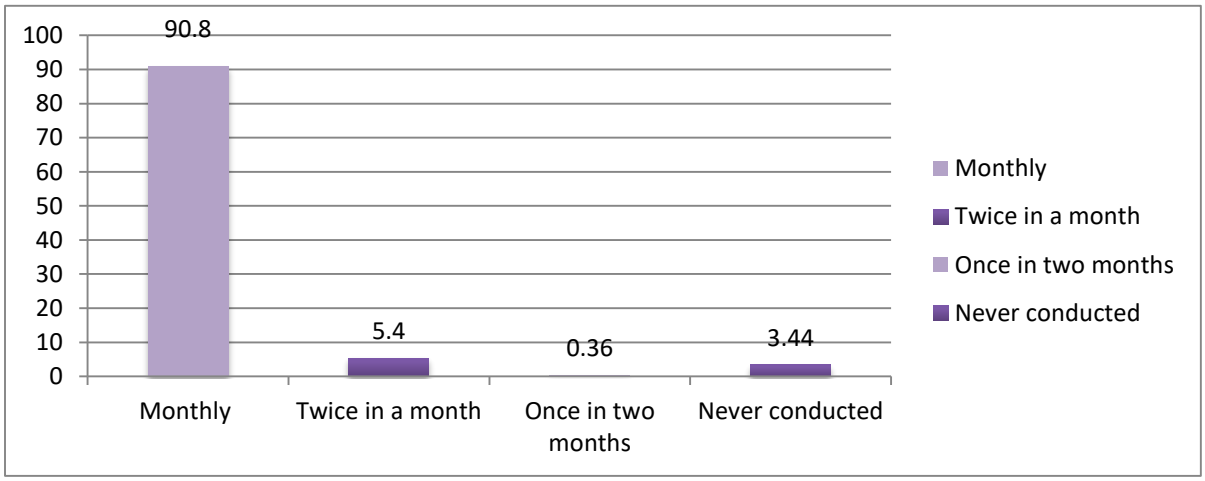
5.3. Health Services

5.3.1. Health and Nutrition Education

With respect to health and nutrition education, the AWWs help mobilize the community and spreads awareness with regard to importance of sanitation, nutritious diet, immunizations, family planning, prenatal and postnatal care for women, and general welfare of adolescent girls[184].

The present research study found that 96.7 percent AWWs reported that they conduct meetings with community women, of these 90.87 percent AWWs reported about organizing monthly meetings, 5.76 percent organize it either twice and once in a month, while 3.44 percent AWWs reported that no meeting conducted in past few months.

Figure 24: Frequency of meetings



[184] Institute for Human Development

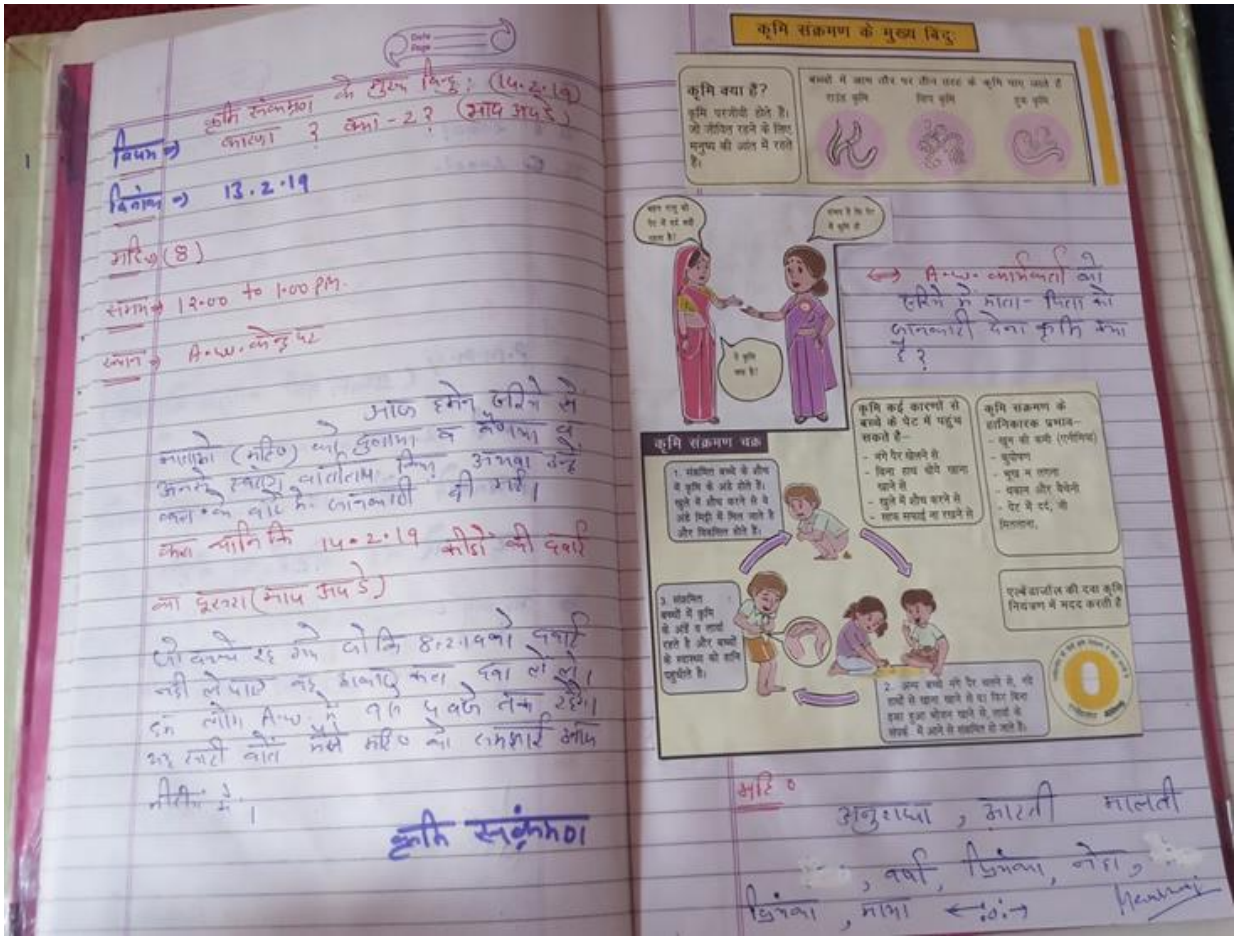


Image SEQ Image * ARABIC 20: Meeting Minutes Register in AWC, Trilokpuri

A copy of meeting minutes found in one of the AWCs in Trilokpuri, is the suitable example, as to how well the minutes could be made and presented. The anganwadi worker of this centre was very active and had taken the researchers to almost all the beneficiaries of its anganwadi centre.

However, the key challenge she used to face is finding an appropriate space for running the anganwadi centre since she was recently shifted to a new place which according to her was much better than the previous one. In light of the challenges the anganwadi workers face in context to limited space in anganwadi centres, she suggested that the government should increase the rent of the anganwadi centre which has adequate space with all amenities. Meetings with community women on health and nutrition and other related subjects would only be successful, if the anganwadi centres have adequate space to accommodate them. She reported that recently, an Anganwadi Hub centre is opened in their project.

5.3.2. Convergence of AWWs and ASHA Workers

ICDS envisages convergence of nutrition and health programmes. The concept of package of nutrition and health-related services under the ICDS is based primarily on the consideration that the overall impact will be much more if the different services are delivered in an integrated manner. The task expected of ASHA requires that she works in close coordination with ANM and AWW for effective delivery of services. The present study covered a section on inter-sectoral convergence between the frontline workers in order to understand the coordination of health and ICDS services at the community level to fulfill health and nutrition services.

The findings of the present study revealed that 73.35 percent AWWs reported that they work jointly with ASHA workers, 24.08 percent reported they do not work with ASHA workers and 2.57 percent reported that they work sometime with ASHA workers. The joint work of AWWs and ASHA workers happens 10.09 percent on a daily basis, 50 percent on weekly basis, 17.7 percent twice in a week and 22.11 percent once in a month.

In terms of joint visits to the beneficiaries of health and ICDS, the AWW and ASHA workers, in last three months, visited to Pregnant Women (54 percent) during ante-natal period, 39 percent reportedly visiting the women during lactation in post-natal period while in 9 percent cases they made visit to a child who was severely underweight. However, these findings are limited to the responses given by anganwadi workers only, with limited or no formal records of such joint visits.

Table 34: Coordination of AWWs & ASHAs

AWWs work jointly with ASHA Workers	**Yes**		**No**		**Sometimes**	
	Numbers	%	Numbers	%	Numbers	%
	201	73.35	66	24.08	7	2.57

Meetings between AWWs& ASHAs	Everyday		Once a week		Twice a week		Once a month	
	Numbers	%	Numbers	%	Numbers	%	Numbers	%
	21	10	104	50	37	18	46	22

Visits made by AWWs ASHAs	Pregnant Women		Lactating Mothers		Severely underweight children	
	Numbers	%	Numbers	%	Numbers	%
	163	54	117	39	22	7

Further, the findings of present study found that the meetings of AWWs and ASHA workers were regular where both the workers were available in the community for a longer period of time. The leading factors was non-availability of either AWW or ASHA workers i.e. the positions were vacant; ASHA worker had newly joined as a result no linkages were established; communication gap between both the workers; while at many places ASHA workers not recruited e.g. in Seelampur ICDS Project, the AWWs reported that due to non-availability of ASHA worker they had to face various problems in vaccination of children, ante-natal check-up of pregnant women and referral services to the nearest health centre. In many cases, the either the worker or the helper accompany a pregnant woman to the nearest health centre.

The coordination and convergence between frontline workers is central to successful implementation of health and nutrition services under the ICDS. The anganwadi centre is identified as the hub reproductive and child health services under National Health Mission. The programme activities are primarily focused on early registration, identification and referral of high risk children and pregnant women[185]. One such platform for coordination at the grass roots level is organizing Village Health and Nutrition Days (VHNDs), however, VHND is restricted mainly to incentivized activities like ANCs and immunization activities with no nutrition education[186]. VHND can be an effective platform for provision of comprehensive primary care to the beneficiaries at their doorstep if organized with full involvement from the community[187].

Based on the discussion with ASHAs and Anganwadi Workers, the VHNDs in Delhi, have largely focused on providing vaccination services to children by Auxiliary Nurse Mid-Wife with support from ASHA and AWWs. Whereas the VHND has been designed to promote the coordinated functioning of frontline workers from health and ICDS, increase predictability and improve the

[185] Sanghamitra et al 2016

[186] Dinesh Paul, Shanta Gopalakrishnan and Priyanka Singh 2013

[187] Kabita Barua, Rupali Baruah and Moni Anku Saikia 2015

coverage of health and ICDS services delivered on the same day and same site. Detailing out more information on ‘nutrition’ as the missing component in the VHNDs, the workers reported that all the frontline workers (AWWs, ASHAs) and ANMs need to be properly oriented and re-oriented from time to time on the various services being offered under the ICDS since they have to serve as effective links between AWWs and the community. Secondly, in order to gain the expected maximum dividends, there is a need to consider joint training of ASHAs, ANMs and AWWs on ICDS and related activities with much focus on nutrition intervention. Few workers, who would know about VHNDs rightly pointed that the day VHND is organized in any particular community; there is no intervention with severely underweight children, who have to be linked or referred to the nearest government health centre.

Collaboration between ICDS and the health delivery system has improved in recent years, one consequence of which has been better immunization coverage. However, the partnership between the AWWs and the ANM has been less successful with respect to identifying high-risk pregnancies, providing prenatal and postnatal care, and conveying adequate health and nutritional messages to women.The objectives of the Reproductive and Child Health (RCH) programme and ICDS are intertwined and, so, the promotion of linkages between the activities of the two would be mutually beneficial.

Further, in order to deeply understand the role of AWWs and ASHA workers during prenatal, post-natal and early years of childhood, particularly, in the first two years of life of a child after birth in Delhi, few more research are required to be undertaken.

5.4. Pre-School Education

Non-formal pre-school education of ICDS scheme provides stimulating experience to children which facilitate optimal cognitive development and brings about an improvement in various inter related dimensions of child development such as social, emotional, and cognitive development. Mere exposure to pre-school education is not enough to result in positive development aspects, hence, the inputs should be of good quality, to develop and demonstrate the competencies intended to be promoted through pre-school education[188].

Various researches, however, have pointed out that the crucial aspect of pre-school education, demonstrating that child development outcomes are greater through combined interventions in all aspects of development. Poor care, health and nutrition impact educational outcomes through impaired cognitive and behavioral capacities, depression, mental retardation and poor concentration, while early health and nutritional interventions have also been shown to directly contribute to improved school attendance and achievements. Quality pre-school education is one that integrates education, health and nutrition.

The present study found that out of the total registered children beneficiaries in the anganwadi centres 26.3 percent children were in the age group of 3-6 years. The AWWs were following a prescribed syllabus for conducting the pre-school education and were given training as well to strengthen the ECCE component. Many AWWs reported that their level of understanding to conduct the pre-school has been enhanced due to recent training which was under progress at the time of this research study. However, this research study has not come across any innovation or success stories on pre-school education in anganwadi centres and what has been the impact of ECCE training on the existing practices on pre-school education in the anganwadi centres.

[188] Samridhi Arora, Shaveta Bharti & Sarita Sharma 2007

Image 21: AWW Telling a Story to Children in AWC, Geeta Colony

Further, the present study found that the availability of ECCE Kit was available in 72.2 percent AWCs and was getting used in 70.07 percent AWCs. A common trend was seen across the majority of the AWCs for imparting pre-school education, books in Hindi and English which were found hanging across the walls using a thread. Different charts including alphabets, numbers, birds, animals etc. found pasted on the walls could be commonly seen in any anganwadi centres but largely seemed unutilized by AWWs.

Although the anganwadi workers were satisfied with the quality of training on ECCE, however, they informed that irregular flow of teaching-learning material from the department is one of the challenges they faced while trying to ensure successful execution of pre-school education. Further, describing the challenges to pre-school education, the anganwadi workers informed that AWWs and AWHs prepare the teaching-learning materials by using local material and in many cases purchase material from their own pocket which is never being reimbursed. Majority of the teaching-learning material prepared by the AWWs were the charts having colors name, birds name, vegetables name, in some cases toys.

For a successful pre-school education programme the anganwadi workers require constant support in terms of supportive supervision, adequate teaching-learning material and adequate space in anganwadi centres for children. Importantly, the workers also need self-motivation to conduct pre-school education.

Recently, the government of NCT of Delhi inaugurated 101 Model Hub Centres in different parts of Delhi to ensure larger space for children in the Anganwadi Centres. In one of the reports in print media mentioned that "these hub centres are larger space for children to play and learn — that's the big change workers at Delhi's new anganwadi 'hub-centres' are most excited about[189].

The workers running the Hub-Centre in Sonia Vihar had a similar story during our visit to this centre. **'The workers informed that now they have around 20 children aged 3-6 years from each centre which come daily for pres-school education. In total 80-100 children aged 3-6 years can sit together for pres-school education. Parents themselves come to drop their children. The worker further informed that the main reason is the larger, more colorful space. It looks like a play school and parents can see that there are many of us teaching. It is very positive for us as well'.**

It is a well known fact that lesser physical space in anganwadi centres directly impacts the ICDS services, particularly, preschool education for children aged 3-6years. These Hub Centres have been able to address this problem. However, there are certain key issues which lies with the HUB centres is that not all children under the age of six years of the same location are able to come to HUB centres, the population criteria is changed from one AWC per 1000 people to one AWC per 2500 people, broken chairs, non-availability of weighing scales and limited teaching-learning material. Therefore, the anganwadi workers in the Hub Centres suggested that the government should address the operational challenges to make this innovation in ICDS a successful model in NCT of Delhi.

[189] The Indian Express

Image 22: A well-decorated Hub Centre in Sonia Vihar ICDS Project

6. Community Participation in ICDS Programme

The government has made considerable investments in improving the nutritional status of its citizens, through laws, policies and programmes. The central piece of this response is the nationally funded anganwadi services scheme. Initially available to the poorest families in chosen blocks of India, the Supreme Court of India mandated universalization of the scheme in 2001 in response to the case by the People's Union for Civil Liberties[190].

With a few exceptions, ICDS remains a highly standardized intervention that follows rules and regulations set centrally. The programme is also run in a very top-down fashion, with all the logistical and implementation inefficiencies and rigidities that such an approach entails. A programme to provide daily services to young children and pregnant women requires active participation and supervision by the community. There does appear to be some empirical association between those states (and areas) in which AWCs have been identified as being better performers and those in which community support for ICDS have been forthcoming[191].

In order to understand the status of ICDS in Bihar a study in 2005 identified community support and participation as a major force for success of pre-school education in ICDS. Referral and health checkups were the weakest link of ICDS due to lack of community participation and health staff[192]. Similarly, a study on efficiency of anganwadi centres in Kerala found that support from health department, inter-sectoral coordination, and community participation were found to be statistically associated with efficiency of anganwadi centres[193]. Further, poor citizen knowledge of service entitlement has resulted in serious governance failures, including limited control of people over ICDS functioning[194].

[190] Biraj Swain and Priti Dave Sen 2009
[191] Brendkamp & Akin 2004
[192] Gupta A et al 2013
[193] Asha et al 2014
[194] LANSA Research Brief 2017

The present study found involvement of women in meetings on health and nutrition education, however, mere participation of women without much focus on involving them in their day-to-day functioning of AWCs may not be much useful to bring the desire outcomes. During the discussion with anganwadi workers and through our own observations, it had been seen that people largely helps in identifying appropriate space for running anganwadi centres and in certain cases their unused items like furniture, toys were donated, but the retention of people to enhance the quality and coverage of anganwadi programme was found limited.

Although, an attempt had been made to enhance the participation of people in supervision and monitoring of anganwadi programme, through formation of anganwadi level support and monitoring committees (See Annexure 8), however, only 1056 committees had been formed in Delhi[195], till this study is completed. While reflecting more on the issue of community participation and the key challenges to it, the anganwadi workers reported, that the programme has been limited to cater people of very low-income group or people who has limited opportunity to send their children to a good pre-school, largely due to weak financial status, as a result, only their parents get involved in its anganwadi functioning. The other challenge for limited participation of people and lesser ownership in the programme is the quality of services, particularly, the food which is served.

The workers accepted the fact that the onus of participation in the ICDS programme largely comes to women, since, in the majority of cases men go out for work. While few other workers added that, in areas where women also go out for work, there is limited opportunity for women to participate in meetings. Moreover, there are certain restrictions from families which are largely related to their social, cultural and religious biases towards women participation in community meetings or social gatherings. For instance, as per the anganwadi workers, women in areas like Shahdara and Seelampur largely belong to religious minority groups which are politically active and exercise their voting rights, they still are conservative and if asked to participate in meetings in anganwadi centres they do not show much interest and seem less motivated. After much persuasion, very few women participate in the meetings organized at anganwadi centres.

[195] Annexure 8

Interestingly, while discussing community participation in anganwadi programme, few workers felt that the programme is not much successful as far as the participation of men are concerned which they believe is an equally important social group to support and supervise its functioning. They further detailed out that there is a general perception among men that anganwadi programme is managed by women i.e. the anganwadi workers and helpers, for children and women in different geographical locations. As a result men do not feel much connected to the programme and, hence, this is seen as another limitation toward active community participation.

In the context of foregoing analysis, it is important to increase involvement of community people in managing and organizing AWC activities in urban settings; need for proper capacity building and skill development of ICDS staffs in the context of urban challenges; need for convergence and coordination and multi-sectoral partnership and need for co-micro planning with multi-sectoral agencies to implement and monitor the scheme.

7. Improvements observed by AWWs in ICDS

In recent years various studies have been conducted to evaluate the services of ICDS which have resulted in numerous changes to achieve the objectives of ICDS. Although there had been vast expansion of ICDS programme since its inception in 1975 in Delhi but there have been two extreme ends with closed centres to barely functional ones.

This research report has captured the progress of ICDS based on the responses given by AWWs and have been categorized on the basis of five major indicators – Infrastructure, Salaries, Awareness among community on ICDS, Training of AWWs, Inspection and Monitoring. These indicators were mapped against four responses – improvements i.e. there are improvements in Anganwadi Services; no difference i.e. things are similar like before; worsening i.e. things was better before and now has weakened; and cannot say i.e. workers have not noticed any change in the anganwadi services.

Around 60 percent anganwadi workers realized that the inspection and monitoring has been increased in the last few years at all levels. The earlier practice of skipping the field work by the senior officials has reduced and now both Supervisors and CDPOs engage actively with us. The workers believe that the practice of taking a ‘Selfie with Anganwadi’ to mark their attendance has brought more transparency in opening the anganwadi centre.

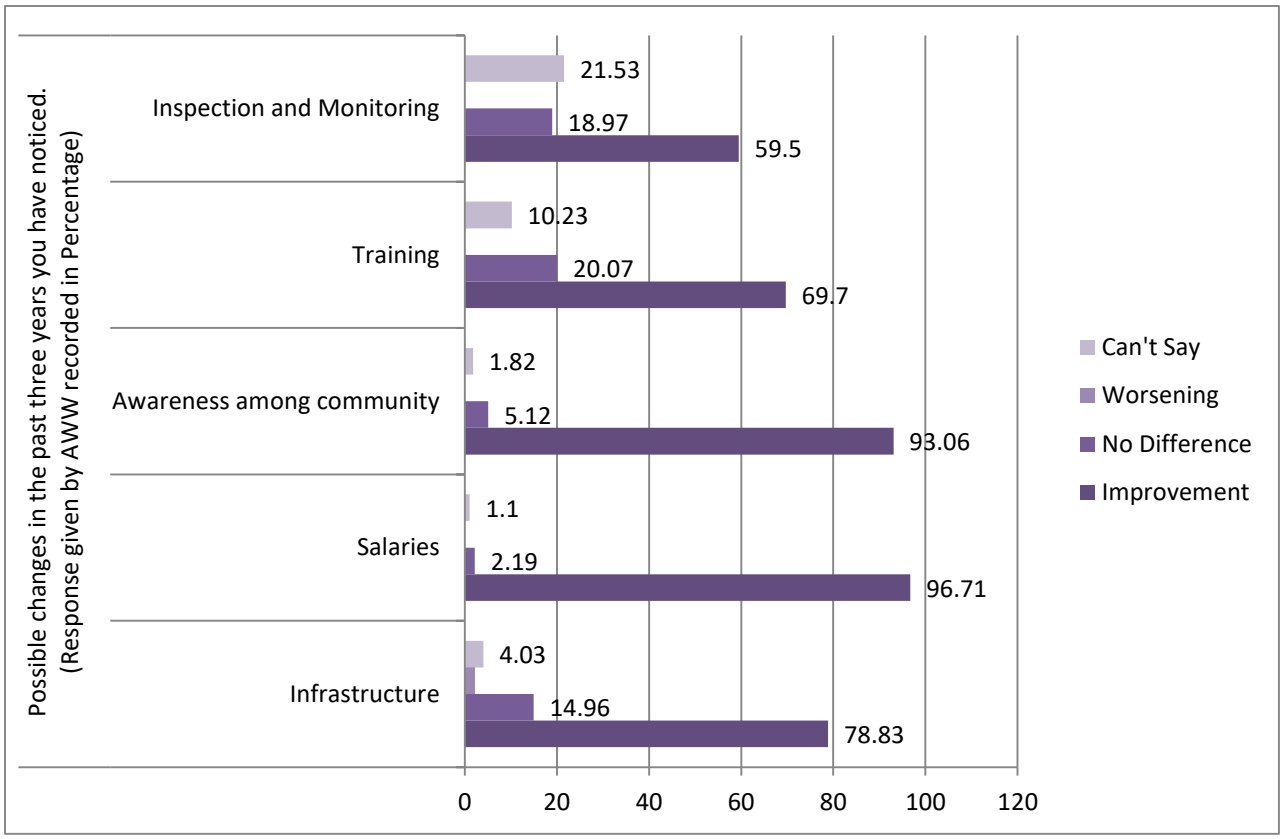
Another indicator which has shown improvement is the disbursal of salaries of the workers and the helpers. However, the workers do not hesitate to acknowledge the peaceful demonstration organized by them in wake of increment in their salaries. Similarly, the workers give due recognition to government for improving the physical infrastructure in anganwadi centres but they felt that lots of work needs to be done to ensure that every anganwadi centre is developed into a vibrant early childhood learning centre so that they compete with low-cost pre-schools in their areas which, according to them, are a major threat for successful execution of pre-school education in anganwadi centres.

One of the key components which require further strengthening is capacity building of ICDS functionaries. The workers and ICDS officials emphasized the need to have constant training programmes. There is a demand to have a separate state level training centre for the ICDS functionaries and this training centre assess the training needs and oversee its implementation.

A major attraction towards the anganwadi programme in recent years is also attributed to conditional cash transfer under the PMMVY programme. This has also helped the ICDS functionaries to create awareness in their geographical locations. It is very important to understand that during our analysis 1473 eligible women were found registered in all the AWCs under PMMVY programme out of which 890 women completely received incentive of Rs. 5000 from through ICDS till date. The remaining women were still in the different stages of receiving the incentive amount.

The workers believe that due to more information and communication by the government, people are now more informed about various government schemes and approach the anganwadi centre for any help.

Figure 25: Possible Changes noticed in ICDS in past few years



2. In-depth Interviews of ICDS Officials

In-depth Interviews of CDPOs: Major Highlights

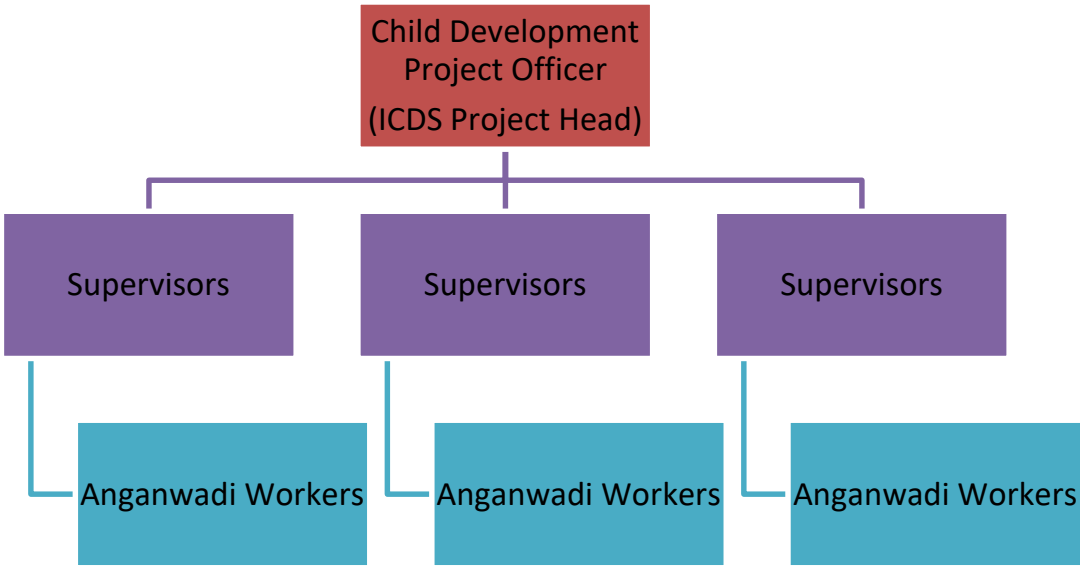
In-depth Interviews of Supervisors: Major Highlights

1. In-depth Interviews of CDPOs: Major Highlights

Background

Administratively, the ICDS is a 'centrally sponsored scheme' which implies that it is largely designed by the central government, implemented by the state government and funded by the central and state governments jointly. The ICDS project is the basic administrative unit of the ICDS as it is the smallest entity of the programme that receives and manages funds. It is often considered to be co-terminus with the community development block, the smallest unit in the administrative structure of India, comprising of approximately 115 villages[196].

Each ICDS project is managed by a Child Development Project Officer (CDPO). A rural and urban project usually has 5-8 Supervisors reporting to the CDPO. Anganwadi centres are organized into beats/circles/sectors of 20-25 for the purposes of supervision with each beat monitored by a Supervisor[197].



[196] Sreerekha 2017

[197] Planning Commission 2011

In the present research three CDPOs were interviewed who were managing ICDS Projects in Sonia Vihar, Patparganj, Seemapuri, Trilokpuri and Kondli. The CDPOs were the current duty charge officers. All the officers were having more than 25 years of experience in the ICDS programme, however, they have 1-3 years of experience as child development project officers.

The foremost discussion with the CDPOs started with their field visits, as in the previous chapters, it was seen that the officers were found less available. The CDPOs informed that the field visits are done either daily or based on the requirement of the work in the anganwadi centres. The majority of the work during field visits includes taking reports from the Supervisors, organizing monthly coordinating meetings and checking enrollment of beneficiaries in the registers. The reporting formats are the same: every Supervisor has to submit their monthly reports. The CDPOs suggested that the Supervisors should make field visits on rotation basis i.e. their field area should keep changing which may enhance their knowledge and understanding among different geographical locations and status of anganwadi centres.While discussing about the field visits, the CDPOs reported few challenges like unviability of any transportation facility by the department for monitoring AWCs which are located in difficult geographical location like Yamunna-Khaddar area. Therefore, they also suggested that necessary transportation facilities should be provided to CDPOs, especially, for field visits for distant locations.

Moving ahead to the discussion with CDPOs, it was found that there are different grades of Supervisors in the ICDS in NCT of Delhi. The CDPOs reported that there are 3-grades of Supervisors i.e. Regular, Contractual and Outsourced and all three have different salary structure and other benefits, whereas the level of work is same for everyone. The outsourced Supervisors do not get travelling and daily allowances, while the Supervisor who is recruited through DSSSB examination has the highest salary than the other two. Therefore, they suggested that there should be no distinction in the salary of the supervisors, especially, when there is no difference in their level of work. Further, they specifically mentioned that the training of outsourced supervisors should be done immediately as soon as they are recruited by the department, as the CDPOs are not able to give them training.

As mentioned in the previous sections of this report regarding community participation in the ICDS programme, the government of NCT of Delhi constituted anganwadi level support and monitoring committees which require people's participation. The CDPOs discontented with the constitution of committees since, according to them it is not beneficial for the people to become a member owing to voluntary participation. They mentioned that ALSMCs have seen to be active in the geographical locations where there is any non-profit organization involved to constitute and functioning of such committees. However, they also agreed that it is for the first time that such an attempt has been done by the government to formalize the structure of community participation and other stakeholders in monitoring and supporting the functioning of ICDS programmes.

Kitchen visits is one of the important duties of CDPOs to supervise the quality of food for distribution through anganwadi centres. The officers informed that the Supervisors make visits to kitchens on alternate days and the major focus is to ensure that the owners maintain the kitchen in hygienic condition. That the drainage system is functioning well, safety measures are properly undertaken, use of pesticides control, kind of raw material used in cooking the supplementary nutrition are some of the key domains as part of supervising the kitchens. The CDPOs agreed with the viewpoint of anganwadi workers with respect to their dissatisfaction with supplementary nutrition. They suggested that the government should review the menu and add meals which have more nutritional values in it.

The discussion with the Child Development Project Officers concluded on the challenges which they face while implementing the scheme. The constraints in adequate space for the anganwadi centres were common to all CDPOs which became more difficult owing to low rental norms. The rental norms for anganwadi centres do not match the market value of the rented space available for anganwadi centres with toilet facilities, adequate space, location and safety for children. Therefore, they wanted that the government should bring changes in the norms[198]. Further, they agreed to the point that slums have limited space as rooms are very small, sometimes measuring 8 feet by 10 feet and in such cases there are no other alternates and hence, this problem does not seem to be resolved. But there was a general feeling among all that, the government may think to create some temporary structures like Porta-Cabins and affix them at certain locations.

[198] Annexure 9

The other challenge which the CDPOs brought into the picture was vacant positions at the level. They were the current duty charge (CDCs) and fulfilling the responsibilities of a child development project officer. They would have to take approval of DDHO since they are CDC's for any expenses, organizing any community based event etc. Vacant positions of CPDOs may lead to monitoring of multiple ICDS projects which, they believe, are sometimes non-feasible. This is followed by the poor conditions of CDPOs offices, particularly in Trilokpuri and in Seemapuri areas. The walls were broken, the almirahs, the windows, the wall paint seemed not repaired and painted for many years. Working environment is not conducive due to poor infrastructure in CDPOs offices. Only one computer is given to a Supervisor for filling data and reporting. Therefore, they suggested that The CDCs should be delegated powers of CDPOs at the same time the government should take appropriate steps to fill-in the vacant positions of CDPOs.Improving the infrastructural facilities in CDPO offices including proper work space, computers etc. is required to increase the efficiency of work. The non-availability of weighing scales in anganwadi centres was another challenge which they felt should be addressed at earliest.

Amid these challenges the CDPOs referred severely underweight children from Yamuna-Khadar area to nutrition rehabilitation centres. In East and North-East Delhi, the anganwadi centres now organize similar activities as per the schedule given to them for e.g. they organize growth monitoring on 5th and 20th of every month.

2. In-depth Interviews of Supervisors: Major Highlights

Background

The CDPO is assisted by 'Supervisors', who make regular visits to the Anganwadis. The supervisors are supposed to check the registers, inspect the premises, advise the Anganwandi Worker, enquire about any problems she may have, and so on.

In the present research only seven Supervisors were interviewed from ICDS Projects – Sonia Vihar, Patpatganj and Seemapuri. Of the total Supervisors interviewed, two hold the permanent position, one is contractual and four are outsourced supervisors. Out of seven Supervisors only one was recruited through DSSB exam and did not have any prior experience of working in ICDS system.

Out of the total Supervisors three are having less than five years of experience while others have four above five years respectively. For the last five years all of them have been employed with the same ICDS projects. One Supervisor has studied till Matric level, one has studied till graduation and other five are post-graduates. All of the Supervisors reported that in the last one year they have not attended any orientation and workshop. However, they have been given training on ECCE, PMMVY and deworming. Out of seven Supervisors, two informed that they visit AWC once in a month while the other five visit twice in a month.

All seven Supervisors agreed to the point that growth monitoring and identifying severely underweight children is a challenge in their area. This is largely due to non-availability of growth monitoring machines and grade cards in AWCs. They reported that functional weight machines are lesser in number and many machines are not in working conditions. As a result one weight machine which works properly is being used on rotation basis among 5 AWCs.

They also felt that there is a lack of knowledge among the AWWs regarding weight charts as there have been fewer training sessions on it. Hence, according to them, the department should organize training for anganwadi workers on managing severely underweight children and preventing malnutrition through community based activities. To strengthen the health and nutrition activities in the anganwadis the supervisors realized that they should engage themselves in health and nutrition education meetings, expanding the coverage of health services in coordination with Health Workers, identifying malnourished children where the functional weighing scales and grade cards are available and referring them to health centres

Improvement in pre-school education is one of the driving forces for the community to send their children to AWCs. Hence, recent training of anganwadi workers on ECCE may add value while discharging pre-school education in anganwadi centres. They have noticed that children are more participatory in pre-school hours; the books which are given to the anganwadi workers are used to certain extent to organize activities with children.

They believe that the supervisors may help AWWs in developing innovative teaching-learning material with support from the Department for proper execution of preschool activity. Therefore, a corpus fund should be created by the department for preparing the material. Notwithstanding the fact that efforts have been put in place to attract children toward anganwadi centres by improving

pre-school education, still the anganwadi which have lesser space, conducting pre-school education is a challenge. Attendance has been improved and children have developed interest for learning but this is not applicable for all areas and efforts would have to be made to improve anganwadi services.

Three Supervisors reported that there is a gap in the quality of meal served to children and women, monthly rent and community support. Sometime when they find the quality of food is bad, they return it to the kitchen. For example, one Supervisor reported that once she checked the quality of food the amount of salt was much, grams and peas were not well cooked and the food was spicy which was not found fit for children to eat, so she returned the food. She further informed that during her visit to Kitchens she first checks the quantity of the food containers, the kitchen is properly clean and hygienic and pest-control is used to disinfect the kitchen area. The Supervisors in their interview suggested that the government should form a committee which includes Supervisors, AWWs and few people from the community on rotation basis to check the quality of food prepared in kitchens.

All Supervisors report that there is no lack of awareness about ICDS services in the community. They themselves should lead the community meetings to encourage AWWs to fulfill their job responsibilities properly. They believe that Supervisors should encourage parents to send their children regularly to AWCs which could be done through field visits and community meetings. In the last few months the awareness campaigns on safe drinking water, health and hygiene in their areas have taken place. Regular awareness among the community to get children enrolled for pre-school education in AWCs is taking place.

On average a Supervisor monitors 42 AWCs against the norms of 20 AWCs which hampers their supervisory work. Space for AWCs is a big challenge, if this gets improved, it may solve problems related to pre-school education, and community meetings may improve the quality of ICDS programmes. At many locations the Supervisors admit that toilets are not in good conditions and are unhygienic. Further no option is available for reimbursing the payment to anganwadi workers for stationery items which they purchase for their centres. Five Supervisors reported that space of AWC is still a challenge to ICDS services. While one Supervisor reported that there is a notable gap in infrastructure of AWCs, location of AWCs and lack of support from the senior officers are some other issues which need to be addressed properly. The Supervisors informed that monthly

reporting has increased in the last few months as a result a good quality time of Anganwadi Workers goes in preparing these reports. Therefore, the documentation and reporting should get minimized and to limit the list of additional work for AWWs.

Despite having these challenges while discharging their responsibilities, the Supervisors seemed quite enthusiastic to improve the ICDS services and suggested that if given an opportunity and support by the department they would like to improve the infrastructure of the AWC like making appropriate seating arrangements for children and anganwadi workers as well. The Supervisors reported that in many AWCs there are plastic mats which are not fit to use in winters as children feel cold. During their interview the Supervisors brought the focus on anganwadi centres which have proper space for children. They emphasized that these centres can be converted like Hub Centres with little investment into them. Development of AWCs having big spaces should be taken on priority as they may also be acted as model AWCs. On the other hand they suggested that Swings can be installed in Hub Centres for children to play. At last they suggested that there is a need for awareness on family planning in the communities and more work on this subject is required.

3. In-depth Interviews of ICDS Beneficiaries

Socio-Economic & Demographic Characteristics of Beneficiaries

Knowledge and Awareness about ICDS

Utilization of Supplementary Nutrition by Beneficiaries

Maternal & Child Health Services

Health and Nutrition Meetings

Preschool Education

Community Support

1. Socio-Economic and Demographic Characteristics of Beneficiaries

The total number of beneficiaries covered in this research study was 264 in which 37.5 percent were women who were pregnant, 25 percent were mothers of children age less than 1 year, 14.01 percent were mothers of children aged 1-3 year and 23.5 percent were mothers of children aged 3-6 years. No adolescents were being covered in this study due to absence of data in AWCs.

The results tell us that 67.04 percent beneficiaries come from Hindu families, 32.5 percent come from Muslim families and 0.46 percent was Sikh family. Among the beneficiaries covered, 37.6 percent belonged to Schedule Castes, 5.6 percent belonged to Other Backward Classes (OBC), and 23.8 percent were in the General Category, while 33 percent were Minorities.

As far as the qualification of the beneficiaries are concerned only 4.5 percent were illiterate, 17.80 percent were studied till primary class, while 24.62 percent upper primary, 14.77 percent were secondary school, 24.24 percent were senior secondary, 10.98 percent were graduate and 3.03 percent were post-graduate. 45.07 percent were living in nuclear families while 54.92 percent were living in joint family structure. 45.83 percent beneficiaries were between the age group of 19-25 years, 81.70 percent were in the age group of 25-35 years while only 3.4 percent were above 35 years of age.

Among the total women covered during the research 99.6 percent were married while only 0.4 percent women were found to be widows. 67.8 percent families had their own accommodation while 32.2 percent were living on rented accommodation. 85.60 percent families had Pakka accommodation (concrete wall plastered with cement), 10.6 percent were Semi-Pakka houses (limited use of bricks and cement) while only 3.8 percent were found living in Kaccha accommodation.

Majority of the beneficiaries (80 percent) were the permanent residents of Delhi and had been living for more than 10 years in Delhi while 20 percent were the temporary residents who shifted to Delhi 2-3 years before. While trying to know the states where they migrated from, few names were Bihar, Gujarat, Jharkhand, West-Bengal, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh.

Table 35: Socioeconomic & Demographic Characteristics of Beneficiaries

Beneficiaries							
Women (Pregnant)		Mother of children (Age 7 months to 1 year)		Mother of children (Age 1 - 3 year)		Mother of children (Age 3-6 year)	
Numbers	%	Numbers	%	Numbers	%	Numbers	%
99	37.5	66	25	37	14	62	23.5
Religion							
Hindu		Muslim		Others			
Numbers	%	Numbers	%	Numbers	%		
177	67.04	86	32.5	1	0.46		
Categories							
Schedule Caste		OBC		Minorities		General	
Numbers	%	Numbers	%	Numbers	%	Numbers	%
99	37.6	15	5.6	63	23.8	87	33
Education Qualification							
Illiterate		Primary		Upper-Primary		Secondary	Higher Secondary
Numbers	%	Numbers	%	Numbers	%	Numbers %	Numbers %
12	4.5	47	17.8	65	24.6	39 14.7	64 32
Graduate		Post-Graduate					
29	10.98	8	3.03				
Type of Accommodation		Own-Accommodation		Rented			
		Numbers	%	Numbers	%		
		179	67.8	85	32.2		
Type of House		Pucca		Semi-Pucca		Kutcha	
		Numbers	%	Numbers	%	Numbers	%
		225	85.6	28	10.6	11	3.8
Residential Status		Living permanently (> 10 years)		Migrated 2-3 years before			
		Numbers	%	Numbers	%		
		211	80	53	20		

2. Knowledge and Awareness about ICDS

The present research study found out that most of the beneficiaries were aware about the anganwadi center either through AWWs, mother in law`s or neighborhood. In majority of the cases similar responses were mentioned by the beneficiaries, which were related to supplementary nutrition given to children, time spent by children in anganwadi centre during pre-school sessions. In few cases the beneficiaries mentioned that AWWs have filled PMMVY form to get the eligible benefits to community women. These were the common responses from the beneficiaries.

It came out during the discussion with the beneficiaries that AWWs create awareness about the healthcare during pregnancy, motivate them to attend meetings and to understand about health and nutrition issues, bringing food from the AWC, administration of vaccination of children at the nearest AWC, getting their children enrolled for Aadhar Card and submitting PMMVY forms. It was observed that information about the benefits of PMMVY was quite common among the beneficiaries. The AWWs also reported that the percentage of enrollment of pregnant women eligible for PMMVY benefits have increased since the implementation of the scheme has taken place. A separate and in-depth study on PMMVY may be needed to understand the impact on overall enrollment of pregnant women in anganwadi centres in the NCT and other parts of the country.

Table 36: Awareness among Beneficiaries about Anganwadi Services

Services at AWCs	Beneficiaries Response
Know about PMMVY	✓
Aware about the location of AWC	✓
Aware about pre-school education in AWCs	✓
Awareness on health and nutrition issues	✓
Supplementary Nutrition for women and children	✓

Weight measurement of children in AWCs*	▪
Plotting of weight of children**	▪

(*Less awareness) (** Very less awareness)

The responses received from the registered beneficiaries of ICDS to some extent contradict the information provided by the service providers with respect to the awareness about ICDS services. Equal awareness about the each service of ICDS should be provided to people living within the catchment area of each anganwadi centre using different mediums of communication like nukkad natak, poster-campaigns, wall paintings, community meetings.

3. Utilization of Supplementary Nutrition

Supplementary Nutrition Programme focuses on improving nutritional intake by providing 'spot feeding' and 'take-home rations' (THR) or weaning food to the registered beneficiaries, i.e., women and children. The beneficiary of the ICDS is provided hot-cooked supplementary nutrition every morning for 300 days in a year. The cost of supplementary nutrition has been revised twice in the last one decade of the ICDS programme. The menu of supplementary nutrition is decided with the help of key experts from the field of nutrition subject to the allocation of budget. The study has found out that 80.7 percent beneficiaries take supplementary nutrition (SNP) on a regular basis while 15.5 percent take it sometimes and 3.8 percent beneficiaries either take it once a week or never. Although the data suggests that 8 out of 10 children take SNP on a regular basis, the research has not been able to find out the extent to which the food remains unutilized by the beneficiaries.

As a result responses from the beneficiaries were recorded with respect to the quality of food. They reported about semi-cooked food being served many a time at the AWCs and they do not find quality of food as fit for consumption as food smells very bad. Majority of children do not like Halwa, Daliya and Khichdi which was common across all ICDS projects covered in the research study. The previous research study on ICDS in Delhi mentioned that foods such as daliya, khichdi and rice pulao are high in carbohydrates and do not contain other essential food groups including protein, minerals, vitamins and fiber. Therefore, while the participants might be meeting their required caloric intake, they are falling short of essential nutrients required for optimal growth.

The beneficiaries further stated that since there are no alternate arrangements to get a hot-cooked meal; the beneficiaries take it the way it comes and their feedback about the quality of food largely remains with AWWs itself. The responses received from the beneficiaries support and validate the request of Supervisors and CDPOs to bring changes in the existing food of ICDS.

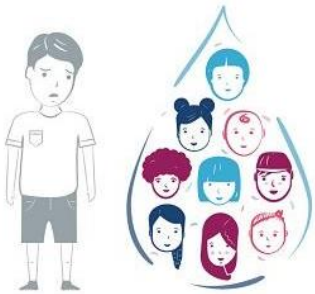
Weaning food for pregnant women and mothers of children aged 7 months - 1 year comes on every Monday across all project sites where the data was collected for this research study. There were limited instances when the weaning food was found to be distributed to the registered beneficiaries on Mondays. For e.g. in Seemapuri ICDS project the weaning food was received after two-weeks, as reported by the AWWs and the distributor. The distributor informed that due to personal problems of the supplier, it could not be delivered. The present study found out that 72 percent beneficiaries have been informed to receive the weaning food whenever it came to AWCs in the past while 28 percent inform that they either received it sometime or never.The distribution of weaning food is largely entrusted with the AWWs. The in-depth analysis of the responses of the beneficiaries from the project location sites stated the facts for not receiving the weaning food for two major reasons (1) due to irregular supply of weaning food by suppliers (2) the beneficiaries were not properly informed about availability of weaning food and its availability in the anganwadi centre.

Food distribution is a major component of ICDS, and SNP is the largest feeding programme focused on improving the nutritional status of children and women in India. As of September 2016, there were 1.35 million ICDS centres in the country, catering to an average of 75 beneficiaries per centre under SNP.SNP under ICDS is a major social protection measure that reaffirms the states' commitment to improving the nutritional outcome of children and their mothers[199].

4. Maternal and Child Health Services

a. Vaccination & Health Check-up

[199] LANSA 2018



The present study found out that immunization cards were available with all mothers of children less than one year which shows the level of awareness among the community about immunization. As per the immunization records available with the beneficiaries 39.4 percent had received Vitamin A and Measles supplementation while 88.9 percent women who were pregnant had Tetanus Toxoid doses. An assessment of children under-six in 2006 found that found that 66.6% children were fully immunized for age[200]. In another study conducted in Tamil Nadu, Delhi and Maharashtra mentioned that immunization services are well-integrated with ICDS[201]. In another evaluation on ICDS it was found that health checkups are provided by nearly 70 percent and referral by around 50 percent anganwadi centres across the country. To improve the health services and the convergence of health and women and child development departments are needed to have a well-integrated district plan of action[202].

b. Childhood Illnesses

Additionally the present research study captured the history of childhood illnesses like Pneumonia, Diarrhea and Jaundice among children registered with AWCs. Among all the beneficiaries, 11.4 percent mothers informed about the previous and current history of childhood pneumonia, 1.5 percent informed about the incidence of diarrhea while 4.9 percent about Jaundice. This analysis requires further in-depth research as there had been assumptions of more incidences of diarrhea due to poor sanitation facilities and the quality of drinking water. Out of the total cases of pneumonia and diarrhea reported by the beneficiaries, in 27.7 percent cases the child was referred by AWW to the nearest government health centre and in 84.61 percent cases, the child was taken to the health centre (govt. or private). In cases where the AWW were not able to refer the child to the health centre, parents preferred to take the child to the hospital.

c. Awareness and utilization about growth monitoring

[200] Handbook for Anganwadi Workers 2006
[201] NITI AAYOG 2015
[202] Planning Commission 2011

With respect to awareness about growth monitoring and its implementation by the AWW, the research report found that 50.4 percent beneficiaries informed that weight of their child was taken in a month and in few cases mothers also remembered the weight of their child taken recently by the AWWs. While 20.4 percent beneficiaries reported that the weight was taken every 3 months. However, there was a lack of uniformity in terms of regularity of weight measurement of all registered children in anganwadi centres. Further, 16.7 percent were not aware about this kind of activity in the AWCs while 12.5 percent reported that weight of the child was never measured in AWCs.

To understand the information available among the beneficiaries about plotting of children weight on growth-chart in 80.3 percent cases there was no awareness about this activity in the AWCs while in 9.84 percent cases weight of the child was plotted on the growth chart and similar number of beneficiaries reported that it was not plotted on any growth chart, respectively.

Table 37: Awareness & Utilization (Growth Monitoring)

Awareness & Utilization (Growth Monitoring)							
Once a month		Once in three months		Not aware		Never Taken	
Numbers	%	Numbers	%	Numbers	%	Numbers	%
	50.4		20.4		16.7		12.5

Similar studies on evaluation of ICDS conducted in Jammu & Kashmir, West Bengal, Madhya Pradesh and Uttar Pradesh in 2009 reported that children were not weighed regularly and less than 60 percent coverage of supplementary nutrition[203].

5. Health and Nutrition Meetings

Rapid Assessment of Integrated Child Development Scheme in Delhi mentions that with respect to care and nutrition counseling, the AWW helps mobilize the community and spreads awareness with regard to importance of sanitation, nutritious diet, immunizations, family planning, prenatal and postnatal care for women, and general welfare of adolescent girls. In addition to this

[203] NIPCCD 2008

community mobilization and awareness building tactics are used to keep a record of any new pregnant mothers or infants in the community. Mahila mandals are held once a month, where pregnant and lactating mothers, as well as mothers of children between 0-6 years voice their concerns and are made aware of issues such as birth registration, immunizations, malnutrition, and nutritious food, amongst others.

The present study found that 70 percent of beneficiaries responded that they attended meetings in the AWCs while 30 percent did not attend any such meetings which generate knowledge and awareness among community women. The nature of meetings were related to immunization, breastfeeding, deworming, HIV/AIDS, complementary feeding, care during pregnancy.

The present report further captures the responses from beneficiaries who did not attend the meetings in AWC which are summarized as:

a) 11 percent of women would never be informed by the AWW about any meetings organized by them in the AWC.
b) 9 percent of women reported that the center is far from home.
c) 8 percent of women reported that they have to take care of their other children at home.
d) 9 percent of women reported that due to domestic work they do not get time to attend the meetings.
e) 11 percent of women reported that they do not go outside of the home.

6. Pre-School Education (PSE)

Since pre-school education is one of the important components of the ICDS programme, the study also reveals the awareness among all categories of beneficiaries about this activity. In the present study it has been found that 94.6 percent beneficiaries reported that preschool activity is useful for children if it is conducted regularly and properly and provided their suggestions to improve the preschool activities in AWCs while 5.4 percent beneficiaries were not aware about this activity.

The beneficiaries who know the usefulness of pre-school education in AWC reported that it is better than costly private play schools, saves money and is a place where the child first starts to sit and learn. Children learn to speak, read and write, sit and eat properly at the AWC. At the AWC

the beneficiaries further reported that, whatever children learn in the AWC, they come and narrate it to the parents and children remain close to their home while visiting the AWC. This service recognizes the importance of early childcare and education. It is focused towards providing early childhood education services to children between the ages 3–6 years at the AWCs.

7. Community Support

Community support is quite pertinent for successful implementation of anganwadi scheme. During the study, it was found that 97.3 percent assist the AWC by sending their children, 89.3 percent by attending meetings, 10.2 percent by volunteering their time in AWC, 87.5 percent by taking supplementary nutrition, 88.2 percent by getting their child vaccinated, 3.7 percent by donating materials like mat, fan, board, learning material, 20 percent by helping AWWs to find appropriate space for AWC, and 20 percent assist AWWs in solving the problems related to women and children. These were the responses when the beneficiaries were asked what are the possible ways of assisting the activities of anganwadi centre in the area.

Image SEQ Image * ARABIC 23: Image taken from an AWC in Sample Districts

E. Conclusion

Image SEQ Image * ARABIC 24: Image taken from an AWC in Sample Districts

Abstract

Before moving forward into the chapter which discusses key recommendations, this section is the concluding part of the research study discussing in detail that ICDS now has a substantial presence in urban areas, particularly in poor slum settlements, resettlement colonies and unauthorized colonies. AWCs are increasingly playing a crucial role in providing health and nutrition services to children and women in the urban landscape. The limited space in anganwadi centres in an urban city like NCT of Delhi is not a new subject when one deals with the challenges in implementing the largest programme for children below six years. The outcomes of pre-school education are largely dependent upon the robust infrastructure of anganwadi centres. The Model HUB-Centres have seemingly played an important role to bring back the focus in improving the bottlenecks in the infrastructure of anganwadi centres. On the other hand, the anganwadi workers underwent training on ECCE which improved their soft skills in pre-school education. The anganwadi workers seemed enthusiastic to prevent malnutrition in their respective areas which is a priority issue to the Supervisors and the CDPOs. However, the first challenge to prevent malnutrition is lesser awareness among people. Overall, the utilization of ICDS services seemed limited at all study sites which are also substantiated with reports of the department in terms of coverage of its beneficiaries in the last few years.

Conclusion

The nutritional status of children has become an important indicator of the development status of the country. Today, ensuring good nutrition is a matter of international law. This is being fully expressed in the Convention on Rights of Child (1989) which specifies that States must take appropriate measures to reduce infant and child mortality and to combat malnutrition through the provision of nutritious foods. Though originally designed to reach rural communities, ICDS now has a substantial presence in urban areas as well, particularly in poor slum settlements, resettlement colonies and unauthorized colonies. Thanks to the Honorable Supreme Court of India, which in its order of April 29, 2004 and December 13, 2006, has inter-alia directed the Government of India to sanction and operationalize a minimum of 14 lakh AWCs in a phased and even manner, so as to cover all habitations.

AWCs are increasingly playing a crucial role in providing health and nutrition services to children and women in the urban landscape. However the constraints of space, proper infrastructure, sanitation, town planning without giving adequate provision for childcare plague the functioning of urban ICDS. It has rightly put that "the ICDS runs very poorly in urban slums areas, the urban Anganwadis are in terrible conditions. Whether winter or summer, they make the kids sit on a paper-thin durrie and even if they soil themselves they are made to sit like that for hours. All they get is a meal but no personal touch. He further stated that most women here who go out for work leave their children with private care providers. In urban slums, the problem of appallingly low rent allocations for hiring of spaces and non-availability of government buildings needs to be addressed urgently to fill the gap in universalizing services for slum populations"[204].

Broadly, as with delivery and other public funded programmes, ICDS has been plagued with implementation problems, many of which relate to weak management systems and oversights, such as poor planning and budgeting, non-transparent procurement and financial systems, and weak or no engagement of the community.

The MWCD during deliberations recognized and acknowledged that urban ICDS is faced with a multitude of constraints and further noted that "in view of multidimensional challenges there is

[204] NC SAXENA 2012

pressing need for identifying the key issues and to arrive at workable solutions along with short and long term strategies for ICDS programme in urban areas"[205].

The limited space in anganwadi centres in an urban city like NCT of Delhi is not a new subject when one deals with the challenges in implementing the largest programme for children below six years. Many reports in the past also highlighted the similar concerns. There is some progress, but, largely, the scenario is the same to the majority of the anganwadi centres, as limited options have been explored.

There is an existing challenge related to adequate space in AWCs at many locations, availability of safe drinking water and functional toilets. Mainly, there were constraints of space in places like Seelampur, Seemapuri, and Sundernagari where the concentration of slums was found in plenty. The poor ventilated rooms do not provide a healthy environment for development of children. In JJ clusters and slums like these, it becomes a tedious task for the anganwadi workers to find proper space to run AWCs. Although the department had revised the rent-norms for anganwadis in 2015, but, the existence of old rental norms is a matter of concern and should be looked into as quoted by many workers.

Further, in colonies like Geeta Colony, the facilities of separate toilets and drinking water come at a higher rate. Hence, landlords demand for an increase in their rent as reported by anganwadi workers and ICDS officials. Quite interestingly, at Trilokpuri, it was found that the anganwadi centres were still running at a monthly rent of Rs. 750.

Adequate space for anganwadi centres to provide ICDS services is a difficulty for the ICDS officials as at many places there are small rooms at higher prices. The existing situation poses a challenge to the ICDS officials like the CDPOs and the Supervisors to find appropriate places to run the anganwadi centres owing to increase in rental rates in colonies, slums and JJ clusters in the last few years. As a result, the anganwadi workers keep looking for new rooms on a periodic basis to match the existing rental norms.

The Model HUB centres which were visited in Mandawali area and Sonia Vihar were well-equipped in terms of space and other infrastructural facilities to provide good quality pre-school

[205] MWCD 2012

education to children. In both the areas few AWCs were merged together and allotted a bigger space. The discussion with AWWs tells us that challenges related to growth monitoring, unavailability of growth-charts and other existing challenges remain the same in the HUB Centres. They inform that earlier they had to cover a population of 1000 people as per the norms of ICDS and now they have been directed to cover a population of 2500 people within the same resources. The anganwadi workers feared that it might lead to drop-out of children and exclusion from the benefits of ICDS as people preferred to send their children to the anganwadi centre located near their residence. At many other places like in Geeta Colony, there were bigger anganwadi rooms which could be converted into model AWCs.

The outcomes of pre-school education are largely dependent upon the robust infrastructure for anganwadi centres. One such factor is the availability of adequate space for the workers to carry out the activities with children. This is followed by continuous supply of teaching-learning material in accordance with the need to build social, cognitive, psychological behavior and analytical aptitude among children coming to anganwadi centres. The anganwadi workers accept the fact that poor infrastructure of anganwadi centres poses a serious challenge to compete with unauthorized private pre-schools in their areas. Parents prefer to send their children to these schools due to their perception of getting a good education and environment for children.

There might be the possibility that education in these private pre-schools may not be much stimulating, as they are supposed to be, the pre-school education in anganwadi centres do not meet the quality standards as well. There are thin durries for children to sit in all the anganwadi centres. These parents ask the anganwadi workers how children would sit on these paper-thin durries.

The anganwadi workers have undergone a thorough training on ECCE, which is conducted by the department of women and child development. However, there was a broader discussion that training would help to build their skills, but these trainings require teaching-learning material in adequate quantities every month. Due to the insufficient availability of teaching-learning material, AWWs and helpers prepare the TLM (Teaching Learning Material) themselves by using local material and in many cases purchase material from their own pocket which is never being reimbursed. Majority of the teaching-learning material is prepared by the AWWs where the charts have vegetables name, color name, toys, animal name and bird name but it was not utilized by the worker as the material was limited according to the number of children. Moreover, the insufficient

material supplied by the department also remains unutilized leading to improper implementation of educational support for children.

The anganwadi workers seemed enthusiastic to prevent malnutrition in their respective areas and this subject seemed a priority issue to the Supervisors and the CDPOs. However, the first challenge to prevent malnutrition is lesser awareness among people and its consequences on development of children below six years. As mentioned in the previous chapter, there was a lack of uniformity among the mothers in terms of regularity of weight measurement of all registered children in AWCs. Further, 16.7 percent were not aware about this kind of activity in the AWC while 12.5 percent reported that weight of the child was never measured in AWC. Similarly, in 80.3 percent cases there was no awareness about plotting the weight of children on growth-charts. Based on the observation of few anganwadi workers, they felt that the number of malnourished children seemed to have increased in their areas, particularly in Sunder Nagari and Seemapuri areas.

The AWWs were found less trained to plot the weight of children on growth charts to classify the nutritional status. A very simple and genuine reason which came out during the discussion is that growth charts were not available for long. The growth chart book that was handed over to the AWWs in 2013 was still in use, few AWWs received the new growth chart book in 2017 while some of them had received growth charts (single sheet separately for boys and girls). The practice of plotting the growth on a register made by the workers themselves shows the grading – normal, moderately underweight and severely underweight. The AWWs were found less informed with respect to the Standard Deviations which is mentioned on the growth growth chart in the form of (-3 SD, -2 SD, -1 SD) as no proper training was given to them. There was inconsistency in measuring the growth of children and plotting them on a growth chart, and was found in the majority of the AWCs. Most of the centres do not have weighing tools and some centre`s weighing tools are not in working condition. The workers borrow weighing machines on a rotation basis from other centers for growth monitoring. The weighing machines which were available in some centers also do not show correct figures.

Further weight measurement tools were not in working conditions which in addition to non-availability of growth charts make things more complex for the workers. As a result severely underweight children are not properly identified, their linkages with the health centre and to recommend the extra diet is not done properly. Consequently the nutritional rights of severely

underweight children are completely overlooked as such children are not being reported in their reports. As reported earlier that village health and nutrition days are limited to vaccination, except one case of Yamunna-Khadar area, no other instances were reported, where the severely underweight children were linked to the appropriate health facilities like the government health centre or to the Nutrition Rehabilitation Centres. It was also brought into the notice that many AWWs also do not possess the skills and are not trained on health and nutrition issues. Similar issue was there with the Supervisors as well.

The supplementary nutrition under the anganwadi services programme is entitled to every pregnant woman, lactating mothers till six months after birth and every child in the age group of six months to six years (including those suffering from malnutrition). The supplementary nutrition in ICDS bridges the gap between Recommended Dietary Allowance and Average Daily Intake. Supplementary nutrition in ICDS may lead to fulfillment of the deficiencies of calories, proteins, minerals and vitamins in the existing diets, if cooked properly. However, the nutritional content of the food provided to children and women were the concern.

Without keeping into consideration the diversity and food choices, the same menu is followed for many years. There is low acceptability of food in the existing menu of ICDS as mentioned previously in the report, owing to their taste and preparation techniques, therefore, it is difficult to validate the objective of supplementary nutrition to improve the nutritional status of children rather than just feeding them.

The supply of take-home ration for pregnant women and mothers who breastfeed their children was found irregular with no proper checks and balances to ensure that it is reached out to the actual beneficiary. The packaging of take-home ration is highly dissatisfactory when the packets were found unsealed at one site in Seelampur. The low quality of food may affect the image of anganwadi workers and place a negative impact on community support and participation. The contamination of food, especially during summers, was a fear among the anganwadi workers. Further, there is no mechanism in place to prevent food from being contaminated while transporting them from the kitchen to the anganwadi centres.

The UN Convention on the Rights of the Child, under Article 24, commits state parties to ensure the highest attainable standard of health for every child. This includes providing clean drinking

water and eliminating the dangers of environmental pollution. Unsafe water, poor sanitation and unhygienic conditions claim many lives each year. Without sufficient access to safe drinking water and an adequate water supply for basic hygiene, children's health suffers. Thus, improving access to basic services remains vital for reducing child mortality and morbidity.

In ICDS, sanitation in and around AWCs is an important component as this is a centre where children below six years, pregnant & lactating mothers are offered health & nutrition services. According to a Parliamentary panel report tabled in the Parliament (2018) a third of total 13.6 lakh anganwadi centres have neither toilets nor drinking water facilities. Nearly 25 percent of anganwadi centres do not have drinking water facilities and 36 percent of these do not have toilets. Out of 10897 anganwadi centres in Delhi, 9643 centres are having toilet facilities i.e. 88.49 percent[206].

Bal Swachhta Mission was launched in 2014, with an aim to support the Swachh Bharat Mission. The key focus of Bal Swachhta Mission is related to anganwadis which are: clean anganwadis, clean surroundings, clean drinking water, clean food, clean toilets and clean self. However, the anganwadi centres which are located in slums and JJ Clusters are largely prone to unhygienic surroundings with garbage dumps, overflow of water from sewerages and thus there seemed limited impact of the mission at the grassroots. Poor water, food hygiene and personal hygiene contribute to a high incidence of diarrhea with a loss in body weight and nutrients. Poor availability of water both in terms of quantity and quality and poor use of toilets are increasingly recognized as contributing causes of undernutrition[207].

The sustainable development goal 6 is related to Water and Sanitation with target 6.1 is related to universal and equitable access to safe and affordable drinking water for all. The indicator to achieve this target is the proportion of people using safely managed drinking water services. Similarly, target 6.2 relates to access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the special needs of women and girls and those in vulnerable situations. The indicator against this target is a proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water. Therefore, it

[206] UNICEF 2019
[207] NIUA 2016

is indispensable that anganwadi centres have water and sanitation facilities which are crucial for a child's survival, health, nourishment, adequate facilities for drinking water and sanitation facilities with hygienic conditions in and around the anganwadi centres.

Image 25: Surrounding in front of AWCs in Sundernagari & Shahdara

A special intervention for adolescent girls was devised in the year 2010 using the ICDS infrastructure with an aim at breaking the intergenerational life-cycle of nutritional and gender disadvantage thus providing a supportive environment for self-development of adolescent girls. It is a well-known fact that adolescence is a crucial phase in the life of a woman. This stage is intermediary between childhood and womanhood and it is the most eventful phase for mental, emotional and psychological well-being. The life-cycle approach for holistic child development

remains unaddressed if adolescent girls are excluded from the developmental programmes aimed at human resource development[208].

Realizing the multi-dimensional needs of out of school pre-adolescent girls (11-14 years) and with an aim to motivate these girls to join school system, the Government approved implementation of restructured Scheme for Adolescent Girls (SAG) to focus on out of school adolescent girls in the age group of 11-14 years. With expansion of the scheme to all the districts of the country, the Kishori Shakti Yojana has been phased out. Scheme for Adolescent Girls - SAG to be implemented using the platform of Anganwadi Services of Umbrella ICDS Scheme through Anganwadi Centers (AWCs). SAG being implemented in 205 districts has been expanded in phased manner. The expansion is taken in two phases:-

1. Phase-1: In 2017-18, the scheme was extended with revised financial norms to additional 303 high burden districts identified under National Nutrition Mission
2. Phase-2: In 2018-19, the scheme was extended with revised financial norms to all the districts of the country w.e.f. 01.04.2018.

The package of services in the programme is:

1. Nutrition provision
2. Iron and Folic Acid (IFA) supplementation
3. Health check-up and Referral services
4. Nutrition & Health Education (NHE)
5. Mainstreaming out of school girls to join formal schooling, bridge course/skill training
6. Life Skill Education, home management etc.
7. Counseling/Guidance on accessing public services[209].

It is to be noted that the Government of India and States/ UTs with legislation share the cost of supplementary nutrition in a ratio of 50:50.

[208] Scheme for Adolescent Girls: https://wcd.nic.in/schemes/scheme-adolescent-girls
[209] Scheme for Adolescent Girls https://wcd.nic.in/sites/default/files/letter%20and%20guideline_0.pdf

The Ministry of Women and Child Development released a grant of Rs. 20,403.88 lakh to 36 states and union territories against which 9,623.80 were spent. Similarly, in 2019-20 (up to 30.11.2019) a grant of Rs. 10,233.24 lakh was released against which Rs. 2,459.65 lakh was spent[210].

In NCT of Delhi three districts were among 205 districts which include North-East, East and North-West for implementation of schemes for adolescent girls. Further in 2018-19 as part of the expansion of the programme, two more districts were included which were Central and West districts. In 2018-19, the Ministry of Women and Child Development released a grant of 320.48 lakh against which only 14.19 lakh was spent. Further, in 2019-20 (up to 30.11.2019), only 12.84 lakh was released by the ministry against which no expenditure was reported by the state government[211]. The report further mentions that in 2017-18 there were 3,383, in 2018-19 there were 2,280 and in 2019-20 there were 2,268 registered beneficiaries of the programme in Delhi[212].

Therefore, one of the major challenges which have come across through this research is that the eligible beneficiaries of these scheme i.e. adolescent girls were not found registered in majority of anganwadi centres in the sample districts, hence, limited opportunity to understand the impact of anganwadi programme on these girls. Few attempts were made to contact the registered adolescents but due to their unavailability no concrete information could be taken from them.

Similarly, there is another scheme under the Umbrella ICDS programme known as Pradhan Mantri Matru Vandana Yojna (PMMVY) which is implemented through anganwadi centres. AWWs were finding difficulty to enroll the newly migrated pregnant women who is eligible to get enrolled in PMMVY scheme due to non-availability of complete documents. In majority of cases, the non-availability of their bank account poses a challenge to anganwadi workers. Secondly, the present residential address does not match with the details mentioned on their bank account passbook and the Aadhar card; hence it takes a lot of effort to get it corrected. This sometime leads to exclusion of women who are eligible to avail the benefits of the programme. Similarly, the anganwadi workers and anganwadi helpers as well reported non-reimbursement of allowances for filling the PMMVY forms.

[210] MWCD, Annual Report, 2019-20,Page 232
[211] Ibid
[212] MWCD, Annual Report, 2019-20,Page 234

Apart from these there are existing challenges and gaps with respect to availability of adequate human resources and structuring of staff in the anganwadi programme. There are multiple positions of CDPOs which are laying vacancy in Sunder Nagari and Shakarpur as a result of which the person who is employed in the ICDS as the Current Duty Charge (CDC) have been designated as the CDPO. Such CDCs reported that there is limited power among the persons holding the post of CDPO which is originally with the DDHO. They are designated-CDPO and thus do not have the authority to make expenses in their ICDS projects which is not the case with a person who is a CDPO on records with the government.

On the other hand, each CDPO manages at least three ICDS projects as a result of the increased workload; the quality of service that is being provided at each level is being affected. The supervisors and CDPOs are overworked and therefore are unable to effectively supervise and manage the AWCs. This, as a result impacts the quality of work of the AWWs and AWHs as well as the overall implementation of ICDS.

The different categories of Supervisors to monitor the implementation of the scheme are another problematic area which needs to be sorted out. Three different categories of Supervisors manage the same quantity of work in different pay-scale. Similarly, at certain locations AWW positions were found vacant due to the fact that the other anganwadi worker gets the additional workload of one more center. Further, the non-availability of ASHA workers at certain locations was the key challenge for child vaccination coverage, PMMVY scheme enrolment, referral of malnourished children to health centres.

Overall, the utilization of ICDS services seemed limited at all study sites which are also substantiated with reports of the department in terms of coverage of its beneficiaries in the last few years. There may be multiple factors to these challenges like unchanged food in ICDS, availability of low-cost pre-schools in communities and congested space in anganwadi centres. Further there is a limited community outreach service like organizing village health and nutrition days, perception among parents that in this age group children learn, write and read and AWCs are not well-equipped in terms of quality standards to make children ready for school. Lesser involvement of CDPOs and the Supervisors to mobilize people for sending their children to AWCs acted as another key factor for limited utilization of anganwadi services.

Key Recommendations

Image SEQ Image * ARABIC 26: Image taken from an AWC in Sample Districts

Abstract

Based upon the findings of the report as discussed in previous chapters which include the interviews of ICDS officials, the status of ICDS scheme in NCT of Delhi and to a large extent the issues brought into the limelight through descriptive information by people who receive primary benefits of the scheme have allowed the writers of the report to put forth certain recommendations in order to carry forward the wave of transformation for children below six years and women in NCT of Delhi.

Key Recommendations

With a strong government commitment and political will, the anganwadi services scheme has emerged as India's flagship nutrition programme. Many of its components are well-designed to address the immediate causes of malnutrition. However, there are certain challenges particularly, little focus on children below three years, limited physical space in urban slums, quality of the cooked meal and lesser coordination of line departments (i.e. department of women and child development and health and family welfare) creates a bottleneck to achieve its goal. Therefore, substantial shifts in focus and improvements in implementation will be necessary if the programme is to realize its potential[213].

1. Timely identification of malnourished children & their linkages

There is ample evidence to support that investment in early years of childhood particularly on health and nutrition; there are more chances of survival and contributing productively later when children turn into adults. There is a limited focus on children below three years when malnutrition establishes its roots. The present study finds that not only the children are excluded to cover in monthly and quarterly growth monitoring to understand the nutritional status of children but also there is no proper mechanism to monitor the growth movement. The study found a lack of coordination among AWW and ASHA workers to jointly work at the community level to identify the child and provide appropriate support like joint visits to their homes, referral to health centres, NRCs etc. Therefore, a pool of dedicated budget within ICDS or separately must be created to address this issue.

Also at many places, there were no ASHA workers which again a problematic area to increase the coverage of health interventions at the community level particularly among children and women. Therefore, the Health department should fill in the vacancies of ASHA workers and place them accordingly. The linkages of severely underweight children with medical complications have always been a tedious task for frontline workers especially due to limited number of Nutrition Rehabilitation Centres in Delhi. Therefore, it is highly necessary to increase the coverage of nutrition rehabilitation centres in Delhi.

[213] Brendenkamp and Akin 2004

There is another opportunity which could be explored along with increasing the coverage of Nutrition Rehabilitation Centre. The opportunity lies in Mohalla Clinics which could play a vital role by acting as the first referral unit to severely underweight children with medical complications like pneumonia, diarrhea or any other childhood illnesses.

2. Develop Infrastructure of all AWCS at par with HUB Centres

There is a kind of feeling that the AWWs who are shifted to Model HUB are working in a better working environment than those who run the AWCs in the existing limited resources. This may lead to dissatisfaction among the AWWs and may further demotivate them to deliver their work efficiently and effectively. There are 102 HUB centres created across Delhi at different locations which has increased the enrollment of children for pre-school. The HUB centres run at various places having adequate space with proper ventilation, floor mats instead of paper thin durries as found in AWCs and teaching-learning material for children to play. The physical infrastructure of all the AWCs must be created on the same parameters so that every child has access to learning opportunities in early years of childhood.

3. Supplementary Nutrition Menu & Quality Standards

The package of services provided by ICDS is well-suited to addressing the immediate causes of undernutrition, namely, inadequate dietary intake and childhood infection. It is a well-designed intervention and is an appropriate response to the problem of under nutrition in India as mentioned previously in this report as well.

As reported earlier in this report that around 65 percent workers are in favor of revising the existing supplementary nutrition menu, since they are dissatisfied with the preparation techniques, lack of flavor and nutritious values in certain items like Halwa, Daliya, Pulao and Khicchdi. Children and women are found less enthusiastic to receive the same food every day. Hence, the department could explore in this direction to revise the existing menu by adding items like Poha, Fruits, and Boiled Eggs in the menu for children and enriching the quality of Panjiri by adding Millets and Nuts in it.

Further, the anganwadi workers were more concerned about the contamination of food during summers, as the kitchens are located at distant locations and non-availability air-conditioned transportation facilities might lead to higher chances of food being spoiled. The anganwadi workers further suggested that at certain places, there is availability of space to develop on-site kitchens for preparation of supplementary nutrition. This may reduce the time of transporting food to anganwadi centres and lesser chances of food being contaminated. Therefore, according to them, the department should think on these lines to save food from being wasted.

4. Extend the Timings of AWCs for conducting age-appropriate ECCE Activities

The initiatives and innovations in Delhi anganwadis require further strengthening of the programme by bringing focus on children below three years. This could be done by developing age-appropriate pre-school education activities by bringing focus on health, nutrition and early psycho-social stimulation through free play and a lot of adult-children interactions in the form of games, introduction to story-telling, drawings etc. For this the anganwadi centre should be safe, spacious and have a clean environment. The anganwadi workers may also involve the parents in these age-appropriate learning techniques in order to enhance their capacity and skills on child care. The intervention in this age group with children may establish a strong foundation of socio-psychological aspects as children grow with age.

Similarly, children in age 3-4 years require a planned play based programme for at least 2-3 hours, opportunities to listen to stories, learn rhymes, create and indulge in imaginative play, simple problem solving, interactive learning and developing a self-positive image. Although the writing readiness may start a little early, children in the age group of 4-5 years may develop reading readiness, hence the pre-school education programme in ICDS may focus on picture–sound matching, shapes, phonetics; increasing vocabulary; verbal expression, developing bond with and interest in reading through picture books, storytelling, charts etc. The concept of school readiness falls in the age-group of 5-6 years; hence, the ECCE component should focus on sentence comprehension, numbers and space concepts, giving words for letters, early numeracy and literacy.

The execution of age-appropriate pre-school activities require an additional time as existing two-hour duration for pre-school education in anganwadi centres is inadequate; therefore, the

government should consider to extend the timings of anganwadi programme by two hours i.e. from 9 am to 4 p.m.

5. Providing adequate Teaching-Learning Material for Pre-school Education

To increase the efficiency of pre-school education, the government provided training to AWWs on ECCE. It is highly appreciated that the department felt the need to develop the soft skills of AWWs on one of the key components of ICDS i.e. pre-school education. Supplementing the soft skills with teaching learning material may further enhance the quality of the programme once it is being executed at the anganwadi level. Therefore, in order to increase the outcomes of pre-school education, there should be a regular arrangement of providing the material to every AWC. The department may create a Flexi Fund of Rs. 500 per anganwadi centre per year for Teaching Learning Material at each ICDS Project level. The respective CDPOs may disburse the amount to each AWW who may use this fund for purchasing the teaching learning material for implementing the pre-school education.

6. Capacity Building

It is an accepted fact that efficacies, with which ICDS functionaries discharge their responsibility largely, depend upon the inputs invested in their training. The training component of the ICDS Programme has now been recognized as the most important key to achieving the aims and objectives of ICDS, with the ultimate aim of molding the ICDS functionaries into agents of social change.

However, training of the field level ICDS functionaries, viz., AWWs, AWHs and Supervisors, is mostly conducted through AWTCs/MLTCs and continuation of these training centres is made on a year-to-year basis. NIPCCD is responsible for training of CDPOs/ACDPOs and also Training of Instructors of MLTCs. It is found that the existing infrastructure for training is inadequate to cater the emerging needs of training and capacity building, especially in view of the huge backlogs that are accumulated due to universalization of the ICDS Scheme and also introduction of new schemes like PMMVY, Scheme for Adolescent Girls, Poshan Abhiyaan which are implemented using AWC platform. Therefore, it is advised to the government of NCT of Delhi to establish its own State Training Institute to cater the needs of training ICDS functionaries.

The discussion with ICDS functionaries again re-emphasized the urgent need to conduct training for them on health and nutrition issues. As mentioned earlier in the report anganwadi workers have limited understanding on malnutrition, role of frontline workers during prenatal and postnatal. The CDPOs which were covered in the interviews suggested to conduct training for all functionaries and accordingly the intervention plan is prepared through anganwadi centres, Further, the training programme should also include certain indicators which could be assessed to evaluate the impact of training during implementation of anganwadi programme.

For frontline workers the training should evolve as a package of coordinated programme for both the AWWs and the ASHAs with provision of practical field orientation and on ground support.

Lastly, the training programme should also bring the aspect of developing key resource persons from among the anganwadi workers. This may help in sustaining the training programme for longer duration and may also provide an opportunity to workers to enhance their skills on critical aspects of health and nutrition. The Commission could assist in developing a package of training modules for the ICDS functionaries.

7. Revise the existing Rental Norms for AWCs

Presently, an anganwadi centre runs in a single shift of 5 hours (9 AM – 2 PM). The order for revising the rental norms in Delhi anganwadis came in May 2015 which segregated the monthly rent rates based on the size of the room and facilities like drinking water, toilet and electricity. However, under any circumstances, if the designated room does not have any of the given facilities but a minimum size of 18-25 sq. yards, an anganwadi centre could run in this room.

There is a possibility that segregation of rental norms must have been done on the basis of the fact that there are space crunches in slums and JJ clusters which lack facilities of drinking water and toilets. Even during this research, these kinds of anganwadi centres are operational to provide services to children and women.

The highest rent to get a room for an anganwadi centre is Rs. 5000 per month for a room size of 56-66 sq. yards with all facilities in place. But, in a city like Delhi, even a small room of 10 ft-12 ft. comes at a monthly rent of Rs. 2500-3000; hence, it becomes difficult for anganwadi workers to find an appropriate space to run anganwadis. During the discussions with both the CDPOs and

the Supervisors, they brought this issue into focus and emphasized the need to revise the existing rental norms of AWCs so that they get adequate space with all facilities to run these centres.
At certain locations where there are space crunches, the department may think to create temporary structures like the Delhi Government has done to create the structures of Mohalla Clinics using Porta-Cabins. This may improve the existing size of anganwadi centre with an opportunity to run a HUB Centre in these cabins.

8. Implementation of Scheme for Adolescent Girls

In the previous chapters it has been highlighted that some of the districts in NCT of Delhi are covered under the scheme for adolescent girls (SAG), but due to absence of any registration data, this research report has been not been able to find out the exact impact of anganwadi programme on adolescent girls.

The line department should look into gaps in implementation of SAG in the respective districts of Delhi so that the benefits of the scheme could be reached out to them. On the basis of this report, it is also recommended to further explore the impact on health and nutrition status of adolescent girls eligible to be benefitted by the programme.

9. Issues of ICDS Functionaries

There are vacant positions of AWWs at certain locations which limits the coverage of services of ICDS to provide supplementary nutrition to children and women. The difference in salary structure and other statutory benefits given to Supervisors has also been found during the study. The office of the need urgent attention for e.g. the office of the CDPO of Trilokpuri, Seemapuri and Sonia Vihar does not have appropriate infrastructure in place. The designated CDPOs do not have the authority to make expenses in her project location in improving the infrastructure of AWCs. None of the AWWs were found to have any health insurance card and do not have statutory benefits of pension or gratuity. The outsourced Supervisors do not have the privilege to claim travelling and daily allowances while visiting the community and every expense is included in their salary. Therefore, the existing positions of AWWs, Supervisors and CDPOs must be filled which may prove to increase the supervision, sharing of existing load of work and better implementation of the scheme.

10. Expanding Anganwadi Level Support & Monitoring Committee

The constitution of Anganwadi Level Monitoring Committee finds its first reference in 2011 when the Ministry of Women and Child Development proposed a five-tier monitoring framework from National to the Anganwadi level to review the progress of implementation of ICDS scheme. This framework was further strengthened in the proposed restructured ICDS Programme or the ICDS Mission under the institutional arrangements. Although in 2012 district level committees were constituted but they largely remain defunct due to problems in channelizing the role of its members in the committee.

Under the regime of the new government in Delhi on lines of empowered SMCs in schools, Anganwadi Support and Monitoring Committee -- ASMC aka Anganwadi Samiti was notified. A considerable amount of work has been done by these committees which are constituted in 1056 AWCs in different ICDS Projects. To further strengthen the anganwadi programme in Delhi, it is highly recommended to expand the bandwidth of these committees all across Delhi.

School Management Committees in Delhi have played a remarkable role in successful execution of Mega PTMs and the similar model could be replicated at anganwadi level in two different groups. The one group comprises parents of children below three years and another with parents of children age 3-6 years. These meetings could be called as PAMs – Parents-Anganwadi-Meetings. The anganwadi committee could play a vital role in mobilizing the parents to participate in these meetings.

11. Creating Clean and Healthy Environment around AWCs

The study finds that surroundings outside the AWC at many locations were not clean and there were plinths of garbage, blocked drainages and overflowing of water. The ICDS Department should work in coordination with Municipal Corporation of Delhi to make sure that surroundings around AWC are clean by creating more awareness on health and sanitation issues. Even if the AWC is providing the services adequately in terms of supplementary nutrition, meetings with community women, conducting pre-school education, the unhygienic environment around the AWC may reduce the results of ICDS scheme.

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Annexures

ANNEXURE 1: Best Practices in ICDS

It is widely recognized that ICDS is a well-designed programme having a wide outreach; bottlenecks in service delivery hamper harnessing full potential of the programme. Considering the fact that better service delivery is a pre-requisite for inclusive growth, variations in implementation of specific components of ICDS, as a response to local needs, are being adopted in States and some of the initiatives have been found to be more effective than the prescribed guidelines[214].

Tamil Nadu: While many states must have taken initiatives to improve ECE programme in ICDS, it has been one of the first states to have given importance to ECE and formed a working committee for the development of curriculum which is called 'Odi Vilayadu Paapa' through a consultative process. The curriculum is intrinsically linked with Activity-Based Learning (ABL), the pedagogy currently practiced in primary classes in Tamil Nadu.The diverse recipe which includes three egg and banana is being given every week in Tamil Nadu.

Rajasthan: To strengthen Early Childhood Care Education (ECCE) in Rajasthan, the State has established a State level Coordination Committee having linkages with SCERT, NCERT, UNICEF and some reputed NGOs. The initiatives include establishment of a child media/resource laboratory for material development, operational research, advocacy and strengthening of ECCE at grassroots level through community ownership.

Andhra Pradesh: In Andhra Pradesh the state has developed a preschool kit for each AWC by engaging Andhra Mahila Sabha. The kit consists of child-friendly and developmentally appropriate play and learning material, story cards, flash cards, puppets etc.

[214]MWCD & NIPCCD 2013

Uttarakhand: In Uttarakhand, the hot cooked meal is provided by mother's committee and fund is directly transferred to their bank account.

Odisha:A Jaanch Committee is formed at the village level, which has greater involvement of PRI and community. Standardized packaging of THR with details of date of manufacture, ingredients, method of use etc. is being implemented in Odisha and Rajasthan. Village Health and Nutrition Day (VHND), Mamta Diwas, a concept for interdepartmental convergence having desirable health outcomes of children below five years, is being introduced in the State of Odisha by the Department of Health and Family Welfare. The programme is organized once a month in every Anganwadi Centre on a fixed day basis (either Tuesday or Friday) with joint efforts of ANM, AWW and ASHA.

Delhi & other Urban Areas in Rajasthan, A.P. Gujarat: In case of select cities and sub-urban areas in meals by private sector several States/UTs, ICDS has involved non-government organizations to provide hot cooked food to feeding centres on a daily basis.

Madhya Pradesh: An incentive of Rs. 100 is paid to AWW for identification of severely undernourished children with medical complication and accompanying child and caregivers to Nutrition Rehabilitation Centres (NRCs) at the district or block level. Mangal Divas are observed in ICDS.

Maharashtra: The AWW conducts feeding sessions for 30 days providing three additional meals apart from the routine SNP. Antibiotics and micronutrients are given under supervision of the health department.

ANNEXURE 2: Umbrella ICDS Scheme

- ***Anganwadi Services Scheme***

  Launched in 1975, Integrated Child Development Scheme (ICDS) is a unique early childhood development programme, aimed at addressing malnutrition, health and also development needs of young children, pregnant and nursing mothers[215].

- ***Pradhan Mantri Matru Vandana Yojana (PMMVY)***

  PMMVY is implemented using the platform of Anganwadi Services scheme of Umbrella ICDS under Ministry of Women and Child Development in respect of States/ UTs implementing scheme through Women and Child Development Department/ Social Welfare Department and through Health system in respect of States/ UTs where scheme is implemented by Health & Family Welfare Department. Under PMMVY, a cash incentive of ` 5000/- is provided directly to the Bank / Post Office Account of Pregnant Women and Lactating Mothers (PW&LM) for first living child of the family subject to fulfilling specific conditions relating to Maternal and Child Health[216].

- ***National Crèche Scheme***

  The Rajiv Gandhi National Crèche Scheme has the objectives: i) to provide day-care facilities for children (6 months to 6 years) of working mothers in the community; (ii) to improve nutrition and health status of children; (iii) to promote physical, cognitive, social and emotional development (Holistic Development) of children, and; (iv) to educate and empower parents /caregivers for better childcare. The scheme focuses on children of 6 months to 6 years, of working women in rural and urban areas who are employed for a minimum period of 15 days in a month, or six months in a year.As on January 2015, there are 23,293 functional crèches. This Scheme will continue as a Central Sector Scheme in rural and urban areas[217].

- ***POSHAN Abhiyaan***

  The programme through the targets will strive to reduce the level of stunting, under-nutrition, anemia and low birth weight babies. It will create synergy, ensure better monitoring, issue

[215] https://icds-wcd.nic.in/
[216] https://wcd.nic.in/sites/default/files/FINAL%20PMMVY%20%28FAQ%29%20BOOKELT.pdf
[217] https://wcd.nic.in/sites/default/files/Revised%20RGNCSScheme_210515.pdf

alerts for timely action, and encourage States/UTs to perform, guide and supervise the line Ministries and States/UTs to achieve the targeted goals[218].

❖ ***Scheme for Adolescent Girls***

Realizing the multi-dimensional needs of out of school pre-adolescent girls (11-14 years) and with a aim to motivate these girls to join school system, the Government approved implementation of restructured Scheme for Adolescent Girls (SAG) to focus on out of school adolescent girls in the age group of 11-14 years. With expansion of the scheme to all the districts of the country, the KSY has been phased out. Scheme for Adolescent Girls - SAG to be implemented using the platform of Anganwadi Services of Umbrella ICDS Scheme through Anganwadi Centers (AWCs)[219].

❖ ***Child Protection Scheme***

The Integrated Child Protection Scheme (ICPS) is a centrally sponsored scheme aimed at building a protective environment for children in difficult circumstances, as well as other vulnerable children, through Government-Civil Society Partnership[220].

[218] https://icds-wcd.nic.in/nnm/NNM-Web-Contents/UPPER-MENU/AboutNNM/PIB_release_NationalNutritionMission.pdf
[219] https://wcd.nic.in/sites/default/files/Letter%203rd%20on%2031%20August%202018%20.pdf
[220] http://wcd-icps.nic.in/

ANNEXURE 3: Revised Norms for Supplementary Nutrition

The Cabinet Committee on Economic Affairs chaired by the Prime Minister on 20th September 2017 approved the proposal for revision of cost norms with annual cost indexation for Supplementary Nutrition (SN) for the beneficiaries of Anganwadi Services and Adolescent Girls (out of school 11-14 years) under the Umbrella ICDS Scheme. The revised Supplementary Nutrition cost norms for the beneficiaries of Anganwadi Services and for Adolescent Girls (11-14 years out of school) under the Umbrella ICDS Scheme, as approved by the Government are as under[221]:

S. No	Categories	Pre-revised rates (in Rupees per day per beneficiary)	Revised rates (in Rupees per day per beneficiary)
1.	Children (6-72 months)	6.00	8.00
2.	Pregnant Women & Lactating Mothers	7.00	9.50
3.	Severely Malnourished Children (6-72 months)	9.00	12.00
4.	Adolescent Girls (11-14 years out of school)	Rs. 5.00	Rs. 9.50

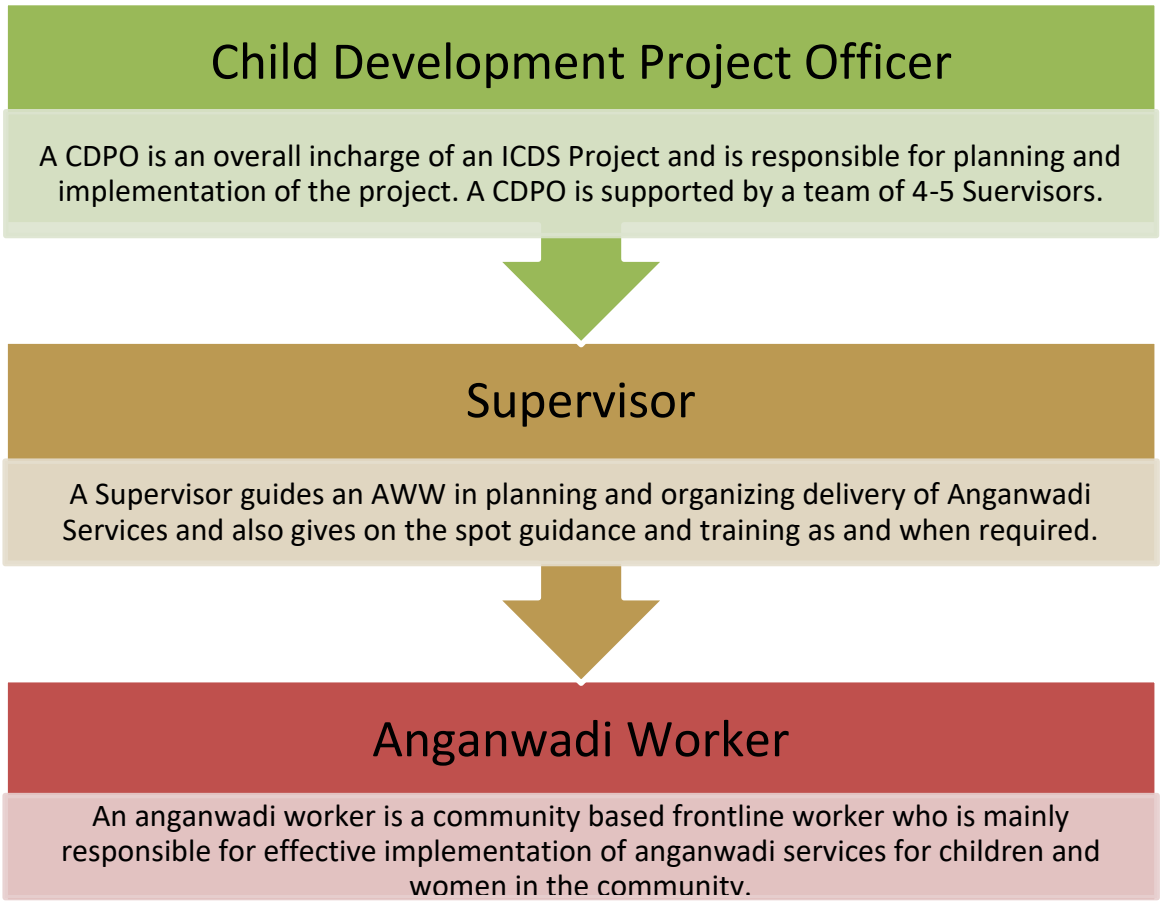
Source: Cabinet Committee on Economic Affairs, Government of India, 20th September 2017

The revision of cost norms for SN for beneficiaries of Anganwadi Services would cost additional expenditure of Rs.9,900 crore and for beneficiaries of Adolescent Girls, it would cost Rs.2,267.18 crore as GoI share for a period from 2017-18 to 2019-20.

The revision in the cost norms of SN for the beneficiaries of Anganwadi Services and Adolescent Girls would impact the health and nutritional status of about 11 crore beneficiaries per annum.

[221]Cabinet approves increase of cost norms for Supplementary Nutrition provided in Anganwadis and in the Scheme for Adolescent Girls, https://pib.gov.in/newsite/PrintRelease.aspx?relid=170953

ANNEXURE 4: Main Actors of Anganwadi Services Scheme[222]



[222] NIPCCD 2006

ANNEXURE 5: Pradhan Mantri Matru Vandana Yojana

From 01.01.2017, the Maternity Benefit Programme was implemented in all the districts of the country. The programme is named as 'Pradhan Mantri Matru Vandana Yojana' (PMMVY). Under PMMVY, a cash incentive of ` 5000/- is provided directly to the Bank / Post Office Account of Pregnant Women and Lactating Mothers (PW&LM) for the first living child of the family subject to fulfilling specific conditions relating to Maternal and Child Health.

PMMVY is implemented through a centrally deployed Web Based MIS Software application and the focal point of implementation would be the Anganwadi Centre (AWC) and ASHA/ ANM workers[223].

PMMVY Eligibility Conditions

Installment	Conditions	Documents	Amount (In Rs.)
First Installment	Requires mother to:- Register her pregnancy in the MCP card along with required documents within 150 days from LMP	• Duly filled Application Form 1A • Copy of MCP Card • Copy of Identity Proof • Copy of Bank/ Post Office Account Passbook	1,000
Second Installment	• At least one Ante Natal Check Up • Can be claimed post 180 days of Pregnancy	• Duly filled Application Form 1 B • Copy of MCP Card	2,000
Third Installment	• Child Birth is registered • Child has received first cycle of immunizations of BCG, OPV, DPT and Hepatitis B • Aadhaar is mandatory in all states except for J&K, Assam, Meghalaya	• Duly filled Application Form 1C • Copy of MCP Card • Copy of Aadhaar ID • Copy of Child Birth Registration Certificate	2,000

[223] For more details: https://wcd.nic.in/schemes/pradhan-mantri-matru-vandana-yojana

ANNEXURE 6: Janani Suraksha Yojana

The scheme focuses on poor pregnant women with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir. While these states have been named Low Performing States (LPS), the remaining states have been named High Performing states (HPS)[224].

Cash Assistance for Institutional Delivery (in Rs.)

The cash entitlement for different categories of mothers is as follows:

Category	Rural Area		Total	Urban Area		Total
	Mother's package	ASHA's package		Mother's package	ASHA's package	Amount in Rs.
LPS	1400	600	2000	1000	400	1400
HPS	700	600	1300	600	400	1000

*ASHA package of Rs. 600 in rural areas include Rs. 300 for ANC components and Rs. 300 for facilitating institutional delivery.

**ASHA package of Rs. 400 in urban areas include Rs. 200 for ANC components and Rs. 200 for facilitating institutional delivery.

[224] For more details: https://nhm.gov.in/index1.php?lang=1&level=3&lid=309&sublinkid=841

ANNEXURE 7: Incentivized up gradation of Anganwadi Scheme[225]

S. No	Anganwadi Feature	Incentive points scored
1.	Room size min 225 sq feet (equal of 15 ft X 15 ft), devoid of any land lord furniture (for some areas, like say JJ Clusters where pukka accommodation is not available, this criterion will have to be customized to reflect the best possible accommodation available in the catchment area of the Anganwadi)	1
2.	Clean Toilet facility (with daily cleaning)	1
3.	Clean Drinking Water facility	1
4.	Interior cleanliness, painted walls	1
5.	Natural light and ventilation	1
6.	Adequate Electrical Lighting	1
7.	Working Fan	1
8.	Clean, clear and safe approach to Anganwadi	1
9.	Min 20 children (2.5 yrs and above) attending anganwadi regularly (6 days a week, 3.5 hrs/day) for ECE (with regular, timely and full duration operation of anganwadi by both Worker and Helper)	1
10.	Fully functional Anganwadi Samiti (with complete membership structure and regular meetings)	1

[225] For more details: https://www.prathamdelhi.org/pdf/Transforming%20Delhi%20Anganwadis%20(Innovations%20&%20Initiatives).pdf

ANNEXURE 8: Anganwadi Level Support & Monitoring Committee

S. No	Composition	Nos.	Roles
1.	Graduate Woman from the community (a criterion which is laxed where such member is not available)	1	Chairperson
2.	Woman Beneficiary (pregnant lady/nursing mother)	2	Member
3.	Social Workers from the community/Community Teacher/Retd. Govt. Oficial	2	Members
4.	Parent of beneficiary children	3	Members
5.	ASHA Worker	1	Member
6.	Sakhi under Sabla Program (if any)	1	Invitee
7.	Kishori under KSY Program	1	Invitee
8.	Representative of MLA	1	Member
9.	Anganwadi Worker	1	Convener

ANNEXURE 9: Enhancement of under ICDS SchemeRent of AWC

DEPARTMENT OF WOMEN & CHILD DEVELOPMENT
GOVT. OF NCT OF DELHI
1 CANNING LANE; K.G. MARG,
NEW DELHI-110001

F.No. 76(13)(Revised rate of rent)/DWCD/ICDS/2014-15/ 5163-282 Dated: 07 MAY 2015

OFFICE ORDER

In reference to the Office Order No. F.76(Revised rate of rent)/DWCD/ICDS/2014-15/ 17651-748 dated 21 August 2014 regarding enhancement of rent of AWCs under the ICDS Scheme, It is hereby clarified that shifting of Anganwadi centres should be done on the basis of following categorization of rental norms:

AREA	FACILITIES	RENTAL NORMS
18-25 sq. yards	Without toilet, drinking water and electricity facilities	Rs. 1000/-
18-25 sq. yards	With toilet, drinking water and electricity facilities	Rs. 1500/-
26-35 sq. Yards	Without toilet, drinking water and electricity facilities	
26-35 sq. Yards	With toilet, drinking water and electricity facilities	Rs. 2000/-
36-45 Sq. yards	Without toilet, drinking water and electricity facilities	
36-45 Sq. yards	With toilet, drinking water and electricity facilities	Rs. 3000/-
46-55 Sq. yards	Without toilet, drinking water and electricity facilities	
46-55 Sq. yards	With toilet, drinking water and electricity facilities	Rs. 4000/-
56-66 Sq. yards	Without toilet, drinking water and electricity facilities	
56-66 Sq. yards	With toilet, drinking water and electricity facilities	Rs. 5000/-

The following standards must be followed while shifting of AWCs in the ICDS Projects by the CDPO concerned:----

a) AWC should be on the ground floor.
b) Safety of children from fire, traffic, water tank etc. must be ensured.
c) AWC be easily accessible for the ICDS beneficiaries.

Further, A Committee comprising of the concerned Nodal Officer, concerned CDPO and concerned Supervisor is to inspect the location and submit a Certificate in r/o every shifted AWC on the prescribed format and the certificate must be kept in a separate file in the Office of the concerned ICDS Project, which may be called for by the HQ at any point of time.

(RAKESH BALA)
Deputy Director-ICDS II

ALL CDPOs, ICDS Projects

F.No. 76(13)(Revised rate of rent)/DWCD/ICDS/2014-15/ 5163-282 Dated: 07 MAY 2015

1) PA to Director-DWCD.
2) PA to Additional Director-DWCD.
3) All Nodal Officers under the ICDS Scheme

(RAKESH BALA)
Deputy Director-ICDS II

Appendix

Registered Beneficiaries in AWCs			7 Months to 1 Year children		1-3 Years		Children 3-6 Years		Children with Disability (Less than 3 years		Children with Disability (3-6 Years)		Total no. of Children registered (7 months to 6 years)		Registered women in AWC		Maternity benefit (PMMVY)	
Sr. No.	Name of the Area	ICDS Project Name	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	PW	LM	Total no. of women registered	Total number of women received benefits till date
1	Sunder Nagri	Sunder Nagri	3	3	15	17	9	8	0	0	0	0	27	28	4	6	4	1
2	Sunder Nagri	Sunder Nagri	3	3	15	19	6	8	0	0	0	0	24	30	3	6	2	0
3	Sunder Nagri	Sunder Nagri	3	3	14	17	7	9	0	0	0	0	24	29	5	6	6	0
4	Sunder Nagri	Sunder Nagri	1	9	28	18	25	28	0	0	0	0	54	55	7	6	3	0
5	Sunder Nagri	Sunder Nagri	3	4	16	22	7	9	0	0	0	0	26	35	5	7	4	1
6	Sunder Nagri	Sunder Nagri	5	5	11	30	9	11	0	0	0	0	25	46	8	10	4	3
7	Sunder Nagri	Sunder Nagri	7	6	19	18	8	15	0	0	0	0	34	39	4	13	2	1
8	Sunder Nagri	Sunder Nagri	4	4	30	27	15	9	0	0	0	0	49	40	6	8	4	3

9	Sunder Nagri	Sunder Nagri	4	2	17	12	11	12	0	0	0	0	32	26	4	14	0	0
10	Sunder Nagri	Sunder Nagri	3	3	14	13	13	11	0	0	0	0	30	27	8	10	8	3
11	Sunder Nagri	Sunder Nagri	4	2	19	13	7	14	0	0	0	0	30	29	6	10	6	3
12	Sunder Nagri	Sunder Nagri	6	5	14	16	3	14	0	0	0	0	23	35	4	10	5	2
13	Sunder Nagri	Sunder Nagri	5	6	17	17	10	7	0	0	0	0	32	30	6	11	6	1
14	Sunder Nagri	Sunder Nagri	2	2	13	16	12	9	0	0	0	0	27	27	4	4	4	0
15	Sunder Nagri	Sunder Nagri	3	4	17	23	8	10	0	0	0	0	28	37	4	14	9	1
16	Sunder Nagri	Sunder Nagri	4	3	14	14	7	15	0	0	0	0	25	32	7	11	3	1
17	Sunder Nagri	Sunder Nagri	4	5	2	3	14	12	0	3	0	0	20	20	8	9	5	4
18	Sunder Nagri	Sunder Nagri	4	2	16	12	12	19	0	0	0	0	32	33	6	7	0	0
19	Sunder Nagri	Sunder Nagri	7	1	17	14	15	12	0	0	0	0	39	27	5	9	6	2
20	Sunder Nagri	Sunder Nagri	2	3	12	10	10	12	0	0	0	0	24	25	7	3	5	3
21	Sunder Nagri	Sunder Nagri	3	2	21	20	0	0	0	0	0	0	24	22	5	1	5	1
22	Sunder Nagri	Sunder Nagri	1	6	24	19	0	0	0	0	0	0	25	25	6	12	3	1
23	Sunder Nagri	Sunder Nagri	4	7	5	2	13	13	1	0	0	0	22	22	4	11	2	0
24	Sunder Nagri	Sunder Nagri	1	2	14	8	8	16	0	0	2	0	23	26	2	8	4	1

25	Sunder Nagri	Sunder Nagri	4	4	5	4	5	7	0	0	0	0	14	15	5	7	2	0
26	Sunder Nagri	Sunder Nagri	2	3	12	13	0	0	0	1	0	1	14	16	6	4	0	0
27	Seelampur	Seelampur	1	2	18	14	8	7	1	0	0	0	27	23	6	9	3	2
28	Seelampur	Seelampur	6	4	5	7	7	9	0	0	0	0	18	20	11	10	13	13
29	Seelampur	Seelampur	5	2	26	19	8	8	0	0	0	0	39	29	8	7	0	0
30	Seelampur	Seelampur	1	3	18	26	7	6	0	0	0	0	26	35	7	4	1	0
31	Seelampur	Seelampur	5	2	19	19	9	9	0	0	0	0	33	30	5	7	3	2
32	Seelampur	Seelampur	8	4	17	13	6	10	0	0	0	0	31	27	10	10	2	0
33	Seelampur	Seelampur	6	4	11	18	7	6	0	0	0	0	24	28	7	15	1	0
34	Seelampur	Seelampur	6	2	13	15	8	9	0	0	0	0	27	26	5	11	1	1
35	Seelampur	Seelampur	3	5	14	15	12	11	0	0	0	0	29	31	6	6	0	0
36	Seelampur	Seelampur	4	8	16	13	7	12	0	0	0	0	27	33	2	2	2	1
37	Seelampur	Seelampur	7	10	16	15	5	9	0	0	0	0	28	34	4	8	12	8
38	Seelampur	Seelampur	1	2	14	13	7	8	0	0	1	0	22	23	4	5	0	0
39	Seelampur	Seelampur	8	4	13	12	6	6	0	0	0	0	27	22	5	5	5	4
40	Seelampur	Seelampur	4	5	12	13	10	11	0	0	0	0	26	29	7	5	2	1
41	Seelampur	Seelampur	9	12	18	18	6	10	0	0	0	0	33	40	12	13	8	7
42	Seelampur	Seelampur	10	8	15	13	13	9	0	0	0	0	38	30	5	9	6	5
43	Jafrabad	Seelampur	3	3	21	13	12	5	0	0	0	0	36	21	9	7	1	0
44	Welcome	Seelampur	2	7	14	11	9	12	0	0	0	0	25	30	2	9	9	8
45	Seelampur	Seelampur	3	3	11	14	8	8	0	0	0	0	22	25	5	7	2	1
46	Seelampur	Seelampur	3	1	9	19	8	11	0	2	0	0	20	31	5	3	7	7
47	Seelampur	Seelampur	1	3	13	8	5	11	0	0	0	0	19	22	4	5	2	1
48	Seelampur	Seelampur	2	1	7	12	9	9	0	0	0	0	18	22	1	5	0	0
49	Seelampur	Seelampur	6	3	21	17	9	14	1	0	0	0	36	34	10	9	18	14
50	Seelampur	Seelampur	8	18	4	8	8	9	0	0	0	0	20	35	6	5	1	1
51	Seelampur	Seelampur	3	5	14	16	13	11	0	0	0	0	30	32	6	10	3	1

52	Seelampur	Seelampur	4	3	9	18	13	11	0	0	0	0	26	32	5	12	7	5
53	Seelampur	Seelampur	6	11	14	23	7	7	1	0	0	0	27	41	8	8	4	0
54	Seelampur	Seelampur	6	6	17	15	10	11	1	0	1	0	33	32	4	3	2	0
55	Seelampur	Seelampur	4	2	8	15	13	10	0	0	0	0	25	27	8	6	1	0
56	Seelampur	Seelampur	4	1	13	15	14	9	0	0	1	0	31	25	10	7	4	0
57	Seelampur	Shahdara	15	10	8	6	7	10	0	0	0	0	30	26	7	15	0	0
58	Seelampur	Shahdara	5	5	15	14	7	9	0	0	0	0	27	28	14	7	4	0
59	Seelampur	Shahdara	5	4	18	16	5	6	0	0	0	0	28	26	7	9	2	2
60	Seelampur	Shahdara	1	3	26	14	11	13	1	1	0	0	38	30	5	5	2	0
61	Seelampur	Shahdara	4	4	21	21	10	13	0	0	0	0	35	38	7	7	0	0
62	Seelampur	Shahdara	4	1	10	12	6	10	0	0	0	0	20	23	4	6	1	1
63	Seelampur	Shahdara	3	4	16	15	11	8	0	0	0	0	30	27	4	9	0	0
64	Seelampur	Shahdara	5	4	15	18	10	6	0	0	0	0	30	28	9	8	0	0
65	Seelampur	Shahdara	2	3	16	14	9	9	0	0	0	0	27	26	5	4	4	0
66	489/22 Zafrabad	Shahdara	5	9	22	21	10	10	0	0	0	0	37	40	7	7	2	0
67	Gali no. 18 Zafrabad	Shahdara	5	1	23	14	12	13	0	0	0	0	40	28	10	10	2	0
68	Gali no. Zafrabad	Shahdara	3	4	21	19	12	9	0	0	0	0	36	32	6	8	5	0
69	Gali no. 20, Zafrabad	Shahdara	4	0	20	20	14	11	0	0	0	0	38	31	9	8	6	0
70	Gali no. 10, Zafrabad	Shahdara	6	5	13	12	6	6	0	0	0	0	25	23	6	6	2	1
71	Gali no. 10, Zafrabad	Shahdara	0	7	18	16	10	4	0	0	0	0	28	27	7	2	7	4
72	Gali no. 10, Zafrabad	Shahdara	3	5	11	15	0	0	0	0	0	0	14	20	5	7	7	4
73	Gali no. 10, Zafrabad	Shahdara	5	4	0	6	11	14	0	0	0	0	16	24	7	9	4	0

74	Gali no. 10, Zafrabad	Shahdara	5	4	22	14	11	13	0	0	0	0	38	31	5	6	7	5
75	Gali no. 10, Zafrabad	Shahdara	6	2	21	12	7	8	0	0	0	0	34	22	4	5	4	1
76	Gali no. 10, Zafrabad	Shahdara	3	4	17	16	10	7	0	0	0	0	30	27	5	10	3	3
77	Gali no. 10, Zafrabad	Shahdara	6	8	21	18	7	10	0	0	0	0	34	36	10	10	7	1
78	Gali no. 10, Zafrabad	Shahdara	7	5	23	14	9	11	1	0	0	0	39	30	7	14	4	0
79	Gali no. 10, Zafrabad	Shahdara	4	0	16	10	7	6	0	0	0	0	27	16	5	7	1	1
80	Gali no. 10, Zafrabad	Shahdara	4	3	13	14	7	11	0	0	0	0	24	28	9	11	6	3
81	Gali no. 10, Zafrabad	Shahdara	5	3	18	23	5	9	0	0	0	0	28	35	7	10	2	0
82	Gali no. 10, Zafrabad	Shahdara	3	7	27	22	5	15	0	0	0	0	35	44	8	10	13	11
83	Gali no. 10, Zafrabad	Shahdara	4	2	27	14	7	9	0	0	0	0	38	25	8	6	9	5
84	Gali no. 10, Zafrabad	Shahdara	4	4	13	18	0	0	0	0	0	0	17	22	4	5	2	0
85	C-1/51, New Seelampur	Shahdara	7	7	19	16	11	12	0	0	0	0	37	35	9	8	4	0
86	E-1, New Seelampur	Shahdara	6	5	17	12	7	11	0	0	1	0	30	28	5	4	4	0
87	E-1, New Seelampur	Shahdara	5	2	13	13	7	9	0	0	0	0	25	24	4	11	2	0
88	C- Block	Shahdara	2	3	15	15	13	13	0	0	0	0	30	31	3	9	0	0
89	B-Block Hub center	Shahdara	3	3	10	12	6	6	0	0	0	0	19	21	2	6	6	4

90	B-Block Hub center	Shahdara	1	2	18	17	10	11	0	0	0	0	29	30	4	7	2	1
91	B-Block Hub center	Sonia Vihar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
92	D-3/90, G. No. 7 3rd Pusta	Sonia Vihar	5	3	14	15	5	11	0	0	0	0	24	29	11	8	2	0
93	D-block, D-1/32, G. no. 1 3rd pusta	Sonia Vihar	5	5	18	16	7	8	0	0	0	0	30	29	7	9	2	0
94	C-2/754, Gali no 12	Sonia Vihar	2	5	17	14	13	6	0	0	0	0	32	25	9	9	2	0
95	C-3/368, Gali no . 3, 2nd Pusta	Sonia Vihar	3	3	5	19	14	7	0	0	0	0	22	29	10	8	5	4
96	A-block, Gali no. 11, H no. 759	Sonia Vihar	3	3	15	19	11	10	0	0	0	0	29	32	7	10	4	2
97	A-Block, Part 1, 0 Pusta	Sonia Vihar	9	3	13	16	9	10	0	0	0	0	31	29	9	9	9	8
98	A Block Part 1	Sonia Vihar	4	1	15	17	7	7	0	0	1	0	26	25	9	9	12	7
99	A Block, Part 1	Sonia Vihar	5	3	16	17	8	15	0	2	0	0	29	35	10	5	15	10
100	C-Block	Sonia Vihar	4	2	19	12	7	9	0	1	0	0	30	23	4	11	10	5
101	D-Block	Sonia Vihar	12	4	16	10	6	9	1	0	0	0	34	23	4	7	11	9
102	D-Block	Sonia Vihar	3	5	19	19	10	14	0	0	0	0	32	38	5	13	12	8
103	D-Block	Sonia Vihar	3	3	15	15	4	14	0	0	0	0	22	32	11	9	15	9
104	D-Block	Sonia Vihar	3	4	14	17	11	10	0	0	0	0	28	31	10	8	9	4
105	Nand Nagri	Sonia Vihar	1	3	16	16	13	13	0	1	0	0	30	32	10	10	16	12
106	Nand Nagri	Sonia Vihar	6	3	12	19	9	12	0	0	0	0	27	34	7	6	7	3

107	Nand Nagri	Sonia Vihar	10	3	23	14	16	12	0	0	0	0	49	29	10	6	11	8
108	Nand Nagri	Nand Nagari	1	2	20	8	6	7	0	0	0	0	27	17	7	3	3	0
109	Nand Nagri	Nand Nagari	2	6	10	20	6	11	0	0	0	0	18	37	11	3	3	0
110	Nand Nagri	Nand Nagari	2	2	13	11	5	8	0	0	1	0	20	21	6	11	1	0
111	Nand Nagri	Nand Nagari	3	2	17	15	7	9	0	0	0	0	27	26	7	8	0	0
112	Nand Nagri	Nand Nagari	4	3	18	14	7	8	0	0	0	0	29	25	4	6	2	2
113	Nand Nagri	Nand Nagari	2	2	12	14	10	9	0	0	0	0	24	25	2	4	0	0
114	Nand Nagri	Nand Nagari	6	12	24	28	10	13	0	0	0	0	40	53	7	11	14	1
115	Nand Nagri	Nand Nagari	3	5	18	7	14	14	0	0	0	0	35	26	6	11	9	3
116	Nand Nagri	Nand Nagari	1	1	16	15	7	8	0	0	0	0	24	24	7	5	9	1
117	Nand Nagri	Nand Nagari	4	4	14	12	8	7	0	0	0	0	26	23	4	4	13	2
118	Nand Nagri	Nand Nagari	6	5	13	14	10	6	0	0	0	0	29	25	5	6	5	3
119	Nand Nagri	Nand Nagari	3	3	15	11	14	6	0	0	0	0	32	20	4	7	2	0
120	Nand Nagri	Nand Nagari	4	4	14	12	6	15	0	0	0	0	24	31	1	7	1	1
121	Nand Nagri	Nand Nagari	5	5	15	14	9	6	0	0	0	0	29	25	6	8	1	0
122	Nand Nagri	Nand Nagari	4	5	14	14	0	0	0	0	0	0	18	19	6	12	2	0

123	Nand Nagri	Nand Nagari	3	2	21	13	11	9	0	0	0	0	35	24	4	6	10	5
124	New Seelampur	Nand Nagari	3	4	13	12	7	10	0	0	0	0	23	26	5	10	4	1
125	New Seelampur	Nand Nagari	2	4	17	21	7	9	0	0	0	0	26	34	6	8	12	8
126	New Seelampur	Nand Nagari	1	3	14	23	14	7	0	0	0	0	29	33	5	6	12	4
127	Trilokpuri	Trilokpuri	3	5	4	5	4	8	0	0	0	0	11	18	10	10	7	4
128	Trilokpuri	Trilokpuri	4	2	11	14	9	3	0	0	0	0	24	19	6	6	16	14
129	Trilokpuri	Trilokpuri	2	2	14	13	8	6	0	0	0	0	24	21	6	6	14	14
130	Trilokpuri	Trilokpuri	4	2	13	13	9	4	0	0	0	0	26	19	5	7	11	10
131	Trilokpuri	Trilokpuri	6	5	7	3	10	9	0	0	0	0	23	17	4	5	12	12
132	Trilokpuri	Trilokpuri	2	2	12	12	5	6	0	0	0	0	19	20	4	5	5	5
133	Trilokpuri	Trilokpuri	5	2	12	13	11	10	0	0	0	0	28	25	12	11	5	2
134	Trilokpuri	Trilokpuri	2	3	17	13	7	9	0	0	0	0	26	25	5	13	1	1
135	Trilokpuri	Trilokpuri	3	2	20	16	5	7	0	0	0	0	28	25	4	8	0	0
136	Trilokpuri	Trilokpuri	2	2	8	15	3	13	0	0	0	0	13	30	5	8	1	0
137	Trilokpuri	Trilokpuri	3	4	16	8	7	6	0	0	0	0	26	18	6	11	1	1
138	Trilok Puri	Trilokpuri	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
139	Trilok Puri	Trilokpuri	1	4	7	16	3	8	0	0	0	0	11	28	8	9	14	14
140	Trilok Puri	Trilokpuri	1	2	14	17	7	5	1	0	0	0	22	24	8	7	2	2
141	Trilok Puri	Trilokpuri	5	0	11	14	7	7	1	0	0	0	23	21	6	7	4	3
142	Trilok Puri	Trilokpuri	4	5	13	10	9	13	0	0	0	0	26	28	5	9	3	3
143	Trilok Puri	Trilokpuri	4	5	19	10	9	16	0	0	0	0	32	31	6	6	1	1
144	Trilok Puri	Trilokpuri	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
145	Trilok Puri	Trilokpuri	5	2	16	12	9	14	0	0	0	0	30	28	9	10	10	10
146	Trilok Puri	Trilokpuri	2	5	12	18	4	8	0	0	0	0	18	31	7	6	6	4
147	Trilok Puri	Trilokpuri	4	2	17	11	11	10	0	0	0	0	32	23	4	10	30	8
148	Trilok Puri	Trilokpuri	3	4	12	10	10	6	0	0	0	0	25	20	5	8	10	9

149	Trilok Puri	Trilokpuri	3	2	10	12	5	8	0	0	0	0	18	22	4	12	21	17
150	Trilok Puri	Trilokpuri	2	6	11	14	6	9	0	0	0	0	19	29	9	7	11	9
151	Trilok Puri	Trilokpuri	1	3	13	10	8	5	0	0	0	0	22	18	7	5	3	2
152	Trilok Puri	Trilokpuri	1	7	14	7	14	7	0	0	0	0	29	21	8	4	7	5
153	10-block	Trilokpuri	7	3	20	12	4	7	0	0	0	0	31	22	7	10	7	3
154	Gol Baithak	Trilokpuri	5	2	13	12	4	10	0	0	0	0	22	24	4	11	11	11
155	Sema Puri	Seemapuri	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
156	Seema Puri	Seemapuri	4	5	17	18	8	14	0	1	0	0	29	37	7	11	8	5
157	Seema Puri	Seemapuri	5	3	16	18	7	7	0	0	0	0	28	28	7	6	1	0
158	Seema Puri	Seemapuri	3	4	0	0	13	14	0	0	0	0	16	18	7	7	7	1
159	Seema Puri	Seemapuri	2	5	19	10	0	0	0	0	0	0	21	15	9	8	13	8
160	Seema Puri	Seemapuri	2	3	16	12	0	0	0	0	0	0	18	15	5	11	10	7
161	Dilshad Garden	Seemapuri	3	4	16	11	0	0	0	1	0	0	19	15	6	2	11	9
162	Seema Puri	Seemapuri	4	1	0	0	0	0	0	0	0	0	4	1	4	8	3	1
163	Seema Puri	Seemapuri	5	5	3	2	10	18	0	0	0	0	18	25	7	10	3	3
164	Seema Puri	Seemapuri	3	10	0	0	0	0	0	0	0	0	3	10	4	1	0	0
165	Seema Puri	Seemapuri	2	6	20	16	10	10	0	0	0	0	32	32	4	11	0	0
166	Seema Puri	Seemapuri	3	2	16	6	15	14	0	1	0	0	34	22	6	8	6	4
167	Seema Puri	Seemapuri	4	0	19	10	10	17	0	0	0	0	33	27	4	11	7	6
168	Seema Puri	Seemapuri	3	1	26	13	0	0	0	0	0	0	29	14	10	9	2	0
169	Seema Puri	Seemapuri	6	0	12	23	5	17	0	0	0	0	23	40	7	11	7	2
170	Seema Puri	Seemapuri	4	3	15	13	0	0	0	0	0	0	19	16	6	8	6	4
171	New Seema Puri	Seemapuri	4	1	12	13	0	0	0	0	0	0	16	14	5	4	0	0
172	New Seema Puri	Seemapuri	6	4	9	9	3	1	1	0	0	0	18	14	4	7	2	1
173	New Seema Puri	Seemapuri	4	3	15	13	1	2	0	0	0	0	20	18	8	7	11	8

174	New Seema Puri	Seemapuri	7	3	3	4	15	17	0	0	0	0	25	24	7	9	0	0
175	New Seema Puri	Patparganj	2	4	12	14	7	11	0	0	0	0	21	29	4	13	5	3
176	papadganj	Patparganj	1	1	12	13	7	12	0	0	0	0	20	26	4	3	3	2
177	papadganj	Patparganj	3	4	22	25	11	13	0	0	0	0	36	42	10	8	2	2
178	Patparganj	Patparganj	4	6	18	18	8	10	0	0	0	0	30	34	11	8	4	2
179	Patparganj	Patparganj	4	3	16	14	6	7	0	0	0	0	26	24	3	10	18	18
180	Patparganj	Patparganj	6	1	10	10	13	17	0	0	0	0	29	28	9	7	8	2
181	Patparganj	Patparganj	4	1	15	10	13	16	0	0	0	0	32	27	5	9	2	0
182	Patparganj	Patparganj	3	4	19	9	13	12	0	0	0	0	35	25	5	10	8	5
183	Patparganj	Patparganj	1	4	13	9	11	8	0	0	0	0	25	21	7	6	5	3
184	Patparganj	Patparganj	8	5	14	14	14	9	0	0	0	0	36	28	6	17	2	1
185	Shashi Garden Jawahar mohallah	Patparganj	4	3	11	16	6	9	0	0	0	0	21	28	4	7	0	0
186	Patparganj	Patparganj	3	5	10	18	11	17	0	0	0	0	24	40	5	11	8	6
187	Patparganj	Patparganj	3	1	15	6	9	10	0	0	0	0	27	17	6	4	2	2
188	Patparganj	Patparganj	2	6	8	12	7	9	0	0	0	0	17	27	3	1	3	1
189	Patparganj	Patparganj	4	5	12	11	5	11	0	0	0	0	21	27	4	9	8	6
190	Patparganj	Patparganj	1	4	10	13	6	13	0	0	0	0	17	30	5	5	6	4
191	Patparganj	Patparganj	6	2	12	12	11	9	0	0	0	0	29	23	6	8	10	8
192	Patparganj	Patparganj	2	4	15	7	12	11	0	0	0	0	29	22	1	7	4	3
193	Patparganj	Patparganj	2	4	14	16	12	10	0	0	0	0	28	30	9	7	22	20
194	Patparganj	Patparganj	7	4	20	21	12	16	0	0	0	0	39	41	11	6	12	12
195	Lalita Park	Patparganj	6	3	18	16	16	13	0	0	0	0	40	32	8	8	15	8
196	Laxmi Nagar	Patparganj	5	2	12	16	6	5	0	0	0	0	23	23	6	6	13	10
197	Ramesh park	Patparganj	6	4	15	16	9	2	0	1	0	0	30	22	4	9	4	3

198	Ramesh park	Patparganj	3	6	13	16	10	9	0	0	0	0	26	31	7	5	13	11
199	Ramesh park	Patparganj	1	5	11	14	9	11	0	0	0	0	21	30	10	10	9	5
200	Ramesh park	Patparganj	9	6	7	10	6	6	0	0	0	0	22	22	6	6	15	13
201	Kishan Kunj	Patparganj	2	3	12	12	9	9	0	0	0	0	23	24	7	8	2	0
202	Lalita Park	Patparganj	5	2	11	11	7	7	0	0	0	0	23	20	4	9	2	0
203	Shastri Nagar	Patparganj	5	3	17	17	12	11	0	0	0	0	34	31	4	4	0	0
204	Shastri Nagar	Patparganj	2	3	15	11	8	8	0	0	0	0	25	22	3	9	6	5
205	Patparganj	Patparganj	5	3	13	10	3	9	0	0	0	0	21	22	5	9	8	6
206	Patparganj	Patparganj	2	4	12	12	8	7	0	0	0	0	22	23	7	7	4	2
207	Patparganj	Patparganj	4	5	14	16	6	7	0	0	0	0	24	28	5	10	3	0
208	Patparganj	Patparganj	3	2	10	10	5	5	0	0	0	0	18	17	5	5	2	0
209	Patparganj	Patparganj	8	3	12	11	3	9	0	0	0	0	23	23	8	5	8	2
210	Sarojini Park	Patparganj	2	4	13	9	3	9	0	0	0	0	18	22	4	8	1	0
211	Sastri nagar	Patparganj	3	3	13	11	8	4	0	0	0	0	24	18	5	8	8	7
212	Sastri nagar	Geeta colony	3	2	9	8	10	18	0	0	0	0	22	28	5	5	8	5
213	Geeta colony	Geeta colony	4	1	13	18	8	7	2	0	0	0	25	26	6	5	5	2
214	Geeta colony	Geeta colony	2	3	7	13	8	9	0	0	0	0	17	25	8	10	2	0
215	Geeta colony	Geeta colony	2	4	12	13	11	15	0	0	0	0	25	32	7	12	2	0
216	Geeta colony	Geeta colony	3	0	12	9	11	10	0	0	0	0	26	19	9	6	0	0
217	Geeta colony	Geeta colony	1	2	9	10	7	9	0	0	0	0	17	21	4	3	3	0
218	Geeta colony	Geeta colony	3	6	14	13	5	5	0	0	0	0	22	24	9	6	10	4
219	New Chand Mohalla	Geeta colony	5	3	11	9	12	9	2	0	0	0	28	21	2	7	5	5

220	Multani Mohalla	Geeta colony	1	4	13	4	5	7	0	0	0	0	19	15	4	6	1	1
221	Multani Mohalla	Geeta colony	3	0	9	2	6	9	0	0	0	0	18	11	5	6	1	1
222	Multani Mohalla	Geeta colony	1	2	11	13	7	7	0	0	0	0	19	22	6	3	1	0
223	Multani Mohalla	Geeta colony	3	1	11	11	4	8	0	0	0	0	18	20	7	10	8	3
224	Geeta colony	Geeta colony	3	3	15	21	21	20	0	0	0	0	39	44	6	11	3	1
225	Geeta colony	Geeta colony	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
226	Geeta colony	Geeta colony	3	4	14	13	3	8	0	0	0	0	20	25	4	6	0	0
227	Geeta colony	Geeta colony	3	3	11	14	7	15	0	0	0	0	21	32	10	4	7	0
228	Delhi	Geeta colony	4	3	12	12	8	9	0	0	0	0	24	24	5	7	8	6
229	Delhi	Geeta colony	1	3	20	20	4	7	0	0	0	0	25	30	5	4	8	4
230	vishwas nagar	Geeta colony	1	4	17	14	7	11	0	0	0	0	25	29	6	6	3	0
231	vishwas nagar	Geeta colony	4	3	12	13	8	5	0	0	0	0	24	21	0	0	0	0
232	Vishwas Nagar	Geeta colony	3	4	11	12	6	4	0	0	0	0	20	20	3	5	0	0
233	Nakul Gali, Vishwas Nagar	Geeta colony	4	0	12	25	6	6	0	0	0	0	22	31	6	8	2	2
234	Trilok Puri	Geeta colony	7	3	28	27	0	0	0	0	0	0	35	30	4	10	10	5

235	Geeta Colony	Geeta colony	2	4	21	19	21	20	0	0	0	0	44	43	7	6	10	6
236	Shakarpur	Geeta colony	13	11	4	4	6	10	0	0	0	0	23	25	3	7	3	1
237	Shakarpur	Geeta colony	22	10	22	11	7	8	0	0	0	0	51	29	3	4	4	0
238	Shakarpur	Geeta colony	4	3	23	15	10	11	0	0	0	0	37	29	2	10	14	12
239	Shakarpur	Geeta colony	2	5	21	18	4	7	0	0	0	0	27	30	2	7	2	0
240	Shakarpur	Geeta colony	21	18	4	7	10	4	0	0	0	0	35	29	2	7	2	0
241	Shakarpur	Geeta colony	5	6	10	9	5	7	0	0	0	0	20	22	4	11	8	6
242	gali no.-2, Railway colony, mandawali	Geeta colony	3	3	25	19	8	4	0	0	0	0	36	26	7	6	12	10
243	Saket, Block no.-3, Faizal pm village mandawali	Shakarpur	3	5	15	10	7	9	0	0	0	0	25	24	4	6	5	5
244	hub centre	Shakarpur	2	3	11	12	9	8	0	0	0	0	22	23	6	4	6	2
245	Geeta colony	Shakarpur	5	3	14	12	15	9	0	0	0	0	34	24	5	5	5	1
246	Geeta colony	Shakarpur	1	7	18	12	14	22	0	0	0	0	33	41	6	5	2	1
247	Dram valli Juggi 17/192	Shakarpur	3	3	10	13	7	8	0	0	0	0	20	24	8	5	1	1
248	Geeta colony	Shakarpur	2	4	10	8	12	4	0	0	0	0	24	16	5	4	1	0
249	Geeta colony	Shakarpur	5	3	10	10	11	9	0	0	0	0	26	22	6	8	5	4
250	Geeta colony	Shakarpur	2	2	11	12	12	9	0	0	0	0	25	23	6	9	1	0
251	Geeta colony	Shakarpur	5	2	14	10	11	12	0	0	0	0	30	24	4	8	3	0

252	Geeta colony	Shakarpur	3	3	15	12	18	15	0	0	0	0	36	30	8	5	4	0
253	mandawali school block	Shakarpur	5	5	21	12	13	6	0	0	0	0	39	23	5	10	8	5
254	Shakarpur	Shakarpur	3	2	11	11	11	9	0	0	0	0	25	22	5	8	3	2
255	Shakarpur	Shakarpur	5	0	13	13	5	13	0	0	0	0	23	26	5	7	3	0
256	Shakarpur	Shakarpur	4	2	10	16	13	11	0	0	0	0	27	29	5	12	22	20
257	Shakarpur	Shakarpur	5	4	14	14	13	12	0	0	0	0	32	30	6	7	16	15
258	Shakarpur	Shakarpur	4	4	15	12	10	10	0	0	0	0	29	26	8	8	5	0
259	Shakarpur	Shakarpur	2	5	8	5	5	6	0	0	0	0	15	16	9	1	2	2
260	Shakarpur	Shakarpur	5	2	15	21	7	10	0	0	0	0	27	33	3	8	10	8
261	East School Bloack	Shakarpur	4	4	21	11	6	13	0	0	0	0	31	28	12	5	5	5
262	westvinod Nagar	Shakarpur	4	3	11	16	8	14	0	0	0	0	23	33	9	8	6	5
263	Sakarpur	Shakarpur	6	8	19	20	16	19	0	0	0	0	41	47	7	7	4	4
264	Sakarpur	Shakarpur	2	4	11	13	10	12	0	0	0	0	23	29	10	4	1	1
265	Sakarpur	Shakarpur	4	3	11	13	5	14	0	0	0	0	20	30	6	7	6	0
266	Chandra vihar	Shakarpur	2	2	2	14	8	11	0	0	0	0	12	27	6	6	2	1
267	Sakarpur	Shakarpur	5	5	16	16	10	10	0	0	0	0	31	31	8	7	5	5
268	Sakarpur	Shakarpur	1	6	14	13	7	11	0	0	0	0	22	30	6	8	11	9
269	Sakarpur	Shakarpur	1	7	15	16	24	20	1	0	0	0	40	43	9	9	5	0
270	C-141 Cauder Vihar	Shakarpur	7	5	13	13	8	10	0	0	0	0	28	28	5	6	4	4
271	D-14 Galino.-6 Ucheepar Maudawati	Shakarpur	2	3	11	16	8	9	0	0	0	0	21	28	6	9	15	25
272	B-166, Chandre Vihar gali no.-10	Shakarpur	1	6	13	13	8	7	0	0	0	0	22	26	6	7	6	6
273	407, Gali no.-2, Maudwali	Shakarpur	5	4	13	12	12	8	1	0	0	0	30	24	6	10	2	0
274	Sakarpur	Shakarpur	3	3	14	14	6	7	0	0	0	0	23	24	8	6	11	9

End notes

DELHI COMMISSION FOR PROTECTION OF CHILD RIGHTS
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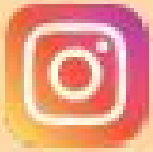

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