

33333 Quick Review of Working of ICDS in Rajasthan

Sponsored by

**Department of Women and Child Development
Ministry of Human Resource Development**



2005

Conducted by

**Society for Economic Development and Environmental
Management
(New Delhi)**

Contents

| | Page No |
|--|----------------|
| The investigating team | 7 |
| Map | 8 |
| Abbreviations used and local terms | 9-10 |
| Executive summary | 11-18 |
| Chapter 1 Statement of the problem | |
| 1.1 Statement of the problem | 19 |
| 1.2 Terms of reference of the study | 19-21 |
| 1.3 Problems in the field | 22 |
| 1.4 Structure of the report | 22 |
| Chapter 2 The implementation process | |
| 2.1 Combating malnutrition through life-cycle approach | 23 |
| 2.2 Programme components and target | 24 |
| 2.3 Structure for implementation | 24 |
| 2.4 Sources of assistance | 24 |
| 2.5 Tasks and responsibilities | 25-28 |
| 2.6 The core issue | 28-30 |
| 2.7 Coordination with ANM | 30-31 |
| 2.8 Reporting | 31-32 |
| 2.9 Supply and Distribution of SN and medicines | 32-34 |
| 2.10 Record of other activities at district level | 34 |
| 2.11 Conclusion | 34-35 |
| Chapter 3 The beneficiaries | |
| 3.1 Sampling | 36 |
| 3.2 Features of the sample | 36-37 |
| 3.3 Premature deaths in the family and causes | 37 |
| 3.4 Social and cultural practices | 37-38 |
| 3.5 Awareness among women | 38-39 |
| 3.6 Interaction with Anganwadi centre | 39-40 |
| 3.7 Facilitators of information dissemination | 40 |

Quick review of the working of ICDS programme

| | | |
|------|---|-------|
| 3.8 | Services received during pregnancy | 40-41 |
| 3.9 | Facility utilised for pre-natal check up | 41-42 |
| 3.10 | Tetanus vaccination | 42 |
| 3.11 | Services immediately after childbirth | 42 |
| 3.12 | Supplementary nutrition | 43 |
| 3.13 | Awareness about diseases and action taken | 25 |
| 3.14 | Home management of children's diseases | 44-45 |
| 3.15 | Exclusive breast-feeding | 45 |
| 3.16 | AWC services to children | 45-46 |
| 3.17 | Immunisation of children | 46-47 |
| 3.18 | Conclusion | 47 |

Chapter 4 The Village Leaders

| | | |
|------|--|-------|
| 4.1 | Reason for interviewing village leaders | 48 |
| 4.2 | Selection of subjects | 48 |
| 4.3 | Background of respondents | 48-49 |
| 4.4 | Perception of three most important responsibilities of AWW | 49-50 |
| 4.5 | Perception of the performance of ANM | 50 |
| 4.6 | Information dissemination | 50 |
| 4.7 | Critical health related problems | 51 |
| 4.8 | Need for small family | 51 |
| 4.9 | Food production | 51-52 |
| 4.10 | Implication for ICDS programmes | 52-53 |
| 4.11 | Conclusion | 53 |

Chapter 5 Working Of Anganwadies

| | | |
|------|--|-------|
| 5.1 | The purpose of AWCs | 54 |
| 5.2 | Number of working centres and beneficiaries | 54 |
| 5.3 | Stocks, supplies and equipment at surveyed centers | 55-56 |
| 5.4 | Essential records | 56-58 |
| 5.5 | Anganwadi worker (AWW) | 58-61 |
| 5.6 | Quality of physical facilities | 62-63 |
| 5.7 | Other observations | 63 |
| 5.8 | Observations of senior investigators | 63-64 |
| 5.9 | Exceptional AWC | 64-65 |
| 5.10 | Inter-institutional conflicts | 65-68 |

Chapter 6 Coordination of ICDS with health services and Auxiliary Nurse Midwife

| | | |
|-----|--|-------|
| 6.1 | Working of ANMs and ICDS | 69-70 |
| 6.2 | Community perception of ANMs | 70 |
| 6.3 | Investigators' observations of working of ANMs after meeting with elected members of GP / village elders | 71 |

Quick review of the working of ICDS programme

| | | |
|------|--|-------|
| 6.4 | Background of ANMs | 71-72 |
| 6.5 | Training under ICDS programme | 72 |
| 6.6 | Availability of basic supplies | 72-73 |
| 6.7 | Interaction with AWW | 73 |
| 6.8 | Interaction with other health worker | 73 |
| 6.9 | Interaction with elected members of Panchayats | 73-74 |
| 6.10 | Referral cases | 74 |
| 6.11 | Immunization cover (Children) | 74-75 |
| 6.12 | Immunization cover (Women) | 75 |
| 6.13 | Convergence of ICDS and RCH programmes | 75-78 |
| 6.14 | Managing convergence | 78-81 |

Chapter 7 Problems and weaknesses

| | | |
|-----|--|-------|
| 7.1 | Summary of findings | 82 |
| 7.2 | Strategies for tackling malnutrition and problems | 82-85 |
| 7.3 | The nutrient drain: major findings from recent studies | 85-93 |
| 7.4 | The systemic problems | 93-96 |
| 7.5 | Structural and processual weaknesses | 96-99 |
| 7.6 | Conclusion | 99 |

Chapter 8 Suggestions and recommendations

| | | |
|------|---|---------|
| 8.1. | Suggestions | 100-104 |
| 8.2. | Sustainable food security and nutritional sufficiency | 104-106 |

List of tables used in the chapters

| | Table numbers | Page No |
|-----------|----------------------|---------------------|
| Chapter 1 | 1.1. | 21 |
| Chapter 2 | 2.1. to 2.4 | 24-27 |
| Chapter 3 | 3.1 to 3.93 | 108-132 |
| Chapter 4 | 4.1 to 4.14 | 48, 133-137 |
| Chapter 5 | 5.1 to 5.20 | 54, 55, 59, 138-143 |
| Chapter 6 | 6.1 to 6.16 | 69,77,79, 144-154 |
| Chapter 7 | 7.1 to 7.4 | 85,85,86,89 |

Quick review of the working of ICDS programme

Charts

| | | |
|-----------|--|----|
| Chapter 2 | 2.1. Structural and processual issues from district to village level | 29 |
| Chapter 3 | 3.1. Age at marriage | 36 |
| | 3.2 Cause of death (Children) | 37 |
| | 3.3 Comparative awareness | 39 |
| | 3.4 Utilization of facility of checkup during pregnancy | 41 |
| | 3.5 Not vaccinated (basis: mothers' recall) | 46 |
| Chapter 4 | 4.1 Critical tasks of AWW | 49 |
| | 4.2 Adequacy of food production | 51 |
| Chapter 5 | 5.1 Adequate stocks of given items at sample AWCs | 55 |
| | 5.2 % of AWCs having the listed records | 56 |
| | 5.3 Educational level of Anganwadi Worker | 59 |
| | 5.4 Number of training programmes attended | 61 |
| Chapter 6 | 6.1 Availability of basic supplies with ANM | 73 |
| | 6.2 Immunization coverage of children (from ANM records) | 74 |
| | 6.3 TT vaccination (from ANM's records) | 75 |
| | 6.4 Awareness of health centers | 78 |

Boxes

| | | |
|-----------|--|----|
| Chapter 4 | 4.1. Average changes in the mineral content of some fruits* and vegetables*, 1963-1992 | 52 |
| Chapter 6 | 6.1. Reproductive & child health programme | 51 |

Figures

| | | |
|-----------|--|----|
| Chapter 2 | 2.1 Inter-generational cycle of malnutrition | 23 |
|-----------|--|----|

Quick review of the working of ICDS programme

Photographs

| | | |
|-----------|--|----|
| Chapter 1 | 1.1 Young soldiers brave the heat and sand | 20 |
| Chapter 5 | 5.1 Poorly equipped AWC at Sikar | 62 |
| | 5.2 Will the road pass them by? | 63 |
| | 5.3 Adarsh AWC, Tilara, Ajmer | 66 |
| | 5.4 AWC at Tausar | 67 |
| | 5.5 Something for me too? | 67 |
| | 5.6 Gathinlasar, Nagaur district | 68 |
| | 5.7 Adarsh Abganwadi Kendra | 68 |

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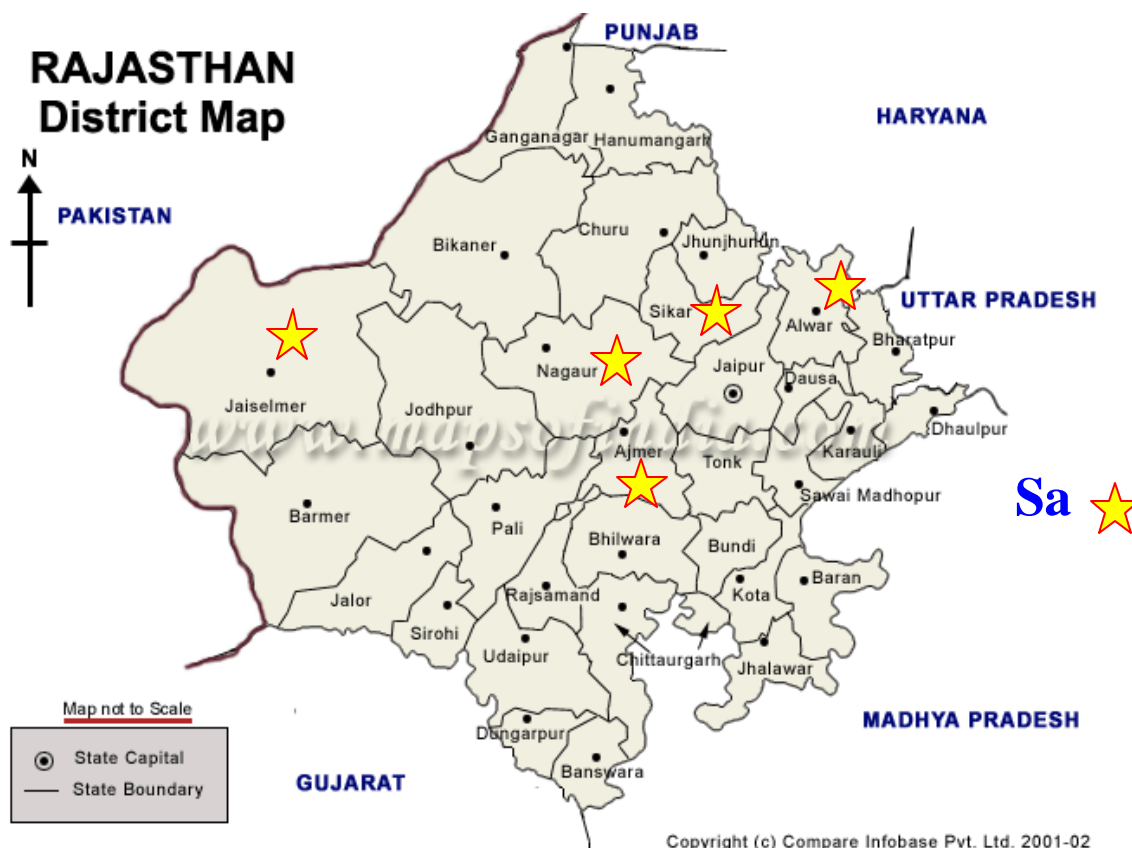
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Quick review of the working of ICDS programme



Sample districts: Alwar, Ajmer, Nagaur, Sikar, and Jaisalmer. Four districts form a major cluster around Jaipur urban along with Jaisalmer, being a desert district, would capture major variability. All sample Anganwadies were selected from midway and remote areas.

Subjects sampled

1. Benefit agency (Key officials)

State Government Directorate/ICDS (Jaipur)

Districts: Regional Deputy Directors of all five districts

Projects CDPOs of 10 projects, selected randomly from five districts

2. Implementing agencies

Anganwadies 50 Anganwadies

Subcentres 50 ANMs, serving the respective Anganwadi

3. Stakeholders, influencers, and facilitators

Gram Panchayats 50 Panchayat Pramukhs

Mahila Mandals Wherever found to be effective stakeholders

Self Help Groups Selection criteria same as Mahila Mandal

4. Beneficiaries

Users (women) 5 users per Anganwadi, total 250

5. Cases

A mix of well and poorly managed Anganwadi

List of Abbreviations used

| | | |
|---------|---|---|
| ANC | : | Ante Natal Check up |
| ANM | : | Auxiliary Nurse Midwife |
| AWC | : | Anganwadi Centre |
| AWW | : | Anganwadi Worker |
| BPL | : | Below Poverty Line |
| CBO | : | Community Block Officer |
| CBR | : | Crude Birth Rate |
| CDPO | : | Child Development Project Officer |
| CE | : | Continue Education |
| CHC | : | Community Health Centre |
| CM & HO | : | District Chief Medical & Health Officer |
| CNAA | : | Community Needs Assessment Approach |
| CSS | : | Centrally Supported Schemes |
| CSSM | : | Child Survival and Safe Motherhood |
| DM | : | District Magistrate |
| DWCD | : | Department of Women and Child Development |
| ECO | : | Economic |
| FGD | : | Field Group Discussion |
| FRU | : | First Referral Unit |
| GP | : | Gram Panchayat |
| ICDS | : | Integrated Child Development Service |
| IEC | : | Information Education Communication |
| IFA | : | Iron Folic Acid |
| IUD | : | Intra Uterine Device |
| JMJ | : | Jan Mangal Jora |
| LBW | : | Low Birth Weight |
| LHV | : | Lady Health Visitor |
| MHD | : | Monthly Health Day |
| MPR | : | Monthly Progress Report |
| MT | : | Metric Tonne |
| NFHS2 | : | National Family Health Survey 2 |
| NGO | : | Non Governmental Organisation |
| NHD | : | National Health Day |
| NHED | : | National Health Education Day |
| PDS | : | Public Distribution System |
| PHC | : | Public Health Centre |
| PLP | : | Post Literacy Programme |
| PNC: | | Post Natal Check up |

Quick review of the working of ICDS programme

| | | |
|--------|---|--|
| RCH | : | Reproductive and Child Health |
| RCS | : | Rajasthan Civil Service |
| RDD | : | Regional Deputy Director |
| RTI | : | reproductive tract infection |
| SC | : | Scheduled Caste |
| SN | : | Supplementary Nutrition |
| SoL | : | Standard of Living |
| ST | : | Scheduled Tribe |
| STD | : | sexually transmitted diseases |
| THR | : | Take Home Ration |
| TLC | : | Total Literacy Campaign |
| TT | : | Tetanus |
| UN-FPA | : | United Nation- Population Fund |
| UN-WFP | : | United Nation- World Food Programme |
| USDA | : | United State Department of Agriculture |
| WFP-CG | : | World Food Programme – Canadian Grant |
| WSHGs | : | Women’s Self Help Groups |
| ZSS | : | Zila Saksharata Samiti |

Executive brief

1. Statement of the problem

The Government of India through its Department of Women and Child Development (DWCD) within the Ministry of Human Resource Development (MoHRD) is implementing one of the most critical programmes to break the inter-generational cycle of malnutrition through specific interventions. Rajasthan, Uttar Pradesh, Bihar, and Madhya Pradesh are the focus of a major effort of ICDS programmes comprising of (i) supplementary nutrition, (ii) Pre-school service, (iii) Dissemination of health and nutrition awareness, (iv) Health check-up, (v) Immunisation, and (vi) Referral services. Whilst services (i) to (iii) are key tasks of ICDS functionaries, services (iv) to (vi) are to be provided jointly through a coordinated effort of Health Department and ICDS. In order to understand the working of these programmes, a quick review was undertaken in the state of Rajasthan.

2. Terms of reference of the study

(a) Objectives of the quick review: The review was undertaken with the following objectives:

- I. Detailed system's analysis of the working of ICDS programme including analysis of distribution of supplies (SN and medicines)
- II. Analysis of the working of Anganwadies against given tasks and documenting key problems, including reasons thereof
- III. Documenting case studies on positive and proactive roles of any CBO (WSHGs and Mahila Mandals) and its impact on the working of Anganwadies
- IV. Documenting the quality of coordination between Anganwadi Worker and ANMs at Anganwadies and participation of beneficiary women in NHD/MHD
- V. Documenting the perception and awareness of users, chiefly nursing mother and pregnant women
- VI. Documenting the role of Gram Panchayat Pradhans as a key stakeholder
- VII. Identification of Key factors for success by analysing the strengths and weaknesses of documented working of sample Anganwadies and projects
- VIII. Document alternative sustainable strategies for health & nutrition observed during the fieldwork in any village especially through convergence of, and synergy through, other complementary programmes, and
- IX. Present the findings and recommendations for greater effectiveness, efficiency and sustainability of ICDS intervention

(b) Methodology: A comprehensive methodology covering organisational working and sampling of key stakeholder was adopted.

Quick review of the working of ICDS programme

A team of senior management consultants conducted detailed study of systems and processes through which ICDS programmes are implemented at Alwar district. At each district discussions were conducted with the following: Regional Deputy Director, CDPOs, Supervisors, Anganwadi worker, Panchayat Pradhan and ANMs. Discussions centred on systems and processes of working, practical problems encountered, problems of coordination and control, and solutions arrived at.

(c) Sample survey provided the backdrop against which organisational decision variables were studied and strength and weaknesses documented.

(d) Sample districts: Five districts were selected for the study: Alwar, Ajmer, Nagaur, Sikar and Jaisalmer.

(e) Subjects: In all 475 subjects were to be sampled but at a few places ANMs and GP Pradhans were not available. The actual sampling is detailed in Table 1.

| <i>Districts</i> | RDDs | CDPOs | Supervisors | AWCs | ANM | Users | Pradhans | TOTAL |
|------------------|----------|-----------|-------------|-----------|-----------|------------|-----------|------------|
| <i>Alwar</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Ajmer</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Nagaur</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Jaisalmer</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Sikar</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| Target | 5 | 10 | 10 | 50 | 50 | 250 | 50 | 475 |
| Sampled | 5 | 10 | 10 | 50 | 43 | 250 | 47 | 466 |

Several attempts were made to contact absent ANMs and Pradhans but when they could not be contacted at the location, investigators were recalled. The reason for their absence has been recorded.

The study team allowed the CDPOs to select the best Anganwadies for sampling subject to the condition that they were located at least 10 kilometres from the city limit and at least 5 kms from block headquarter.

(f) Data collection instruments: The following data collection instruments were employed: (i) Beneficiary schedule, (ii) AWW schedule, (iii) GP Pradhan schedule, and (iv) ANM schedule. In addition to this records were studied and entries checked for stocks, weighing events, immunisation, NHD/MHD, etc, not only at AWCs but also at CDPO's office. The consulting team collected data in long hand on systems and

Quick review of the working of ICDS programme

processes from various control documents supplied by the investigating team after in-field discussions with ICDS functionaries. Supervisors, CDPOs and RDDs were asked structured questions given to the field investigators to collect their perceptions of the problems and prospects. Thus, in all seven sets of structured questionnaires were administered.

(g) Testing of knowledge and awareness: The knowledge and awareness of pregnant women and nursing mothers was tested on 67 points arranged around 22 questions. Simple questions were framed based on the information given in NHED book, charts, posters that one would expect to find in any Anganwadi centre. The same questions were administered to Anganwadi workers as well to find whether AWWs have significantly more knowledge as compared to beneficiary women or are equally ill informed.

(h) Selection of investigators and training: A team of investigators with experience in ICDS and similar surveys in Rajasthan were selected from Delhi, Rajasthan and Himachal Pradesh. They were given a three-day training with one day in-field training at Alwar. The investigating team was then briefed extensively and sent to the field.

(i) Total time and constraints: The total time for the project was 75 days to draft report. A presentation was made on 1st June and the structure of the draft report was finalised. Two districts could not furnish data as required: Nagaur and Jaisalmer. Other districts furnished the required data but comparability was a problem.

After repeated visits and persistent telephone calls these districts have released some data. These were required to complete the report.

3. Main findings

3.1. Weaknesses in the structure for implementation

(a) CDPOs

- ? 45% holding additional charge
- ? 88% Male
- ? 12.2% posts vacant
- ? 44 CDPOs supervising 18,666 staff (1:424)
- ? Each CDPO supervising 161 AWC

(b) Supervisors

- ? Nearly 28% posts are vacant
- ? 98% supervisors are female
- ? They are supervising from 20 (Ajmer) to 44 (Sikar) AWCs
- ? One supervisor to (average) 28 AWCs in the five sample districts

Quick review of the working of ICDS programme

? Marginal role in capacity building of AWW

(c) AWW

? All AWC sampled had an AWW in position. In general nearly all AWCs has a AWW in the five sample districts

? AWWs have participated in on average 6 training programmes, yet their awareness level is only marginally better than that of the women beneficiaries

? Inability to ensure community based participative healthcare planning with ANM. Two reasons for this situation: (a) CNAA is still not operational, and (b) Ad-hoc system of coordination with ANM

? Training and capacity building leaves a lot to be desired. Supervisors come to the centre to set the records in order, not to build the capacity of AWWs.

(d) Sahyogini

? ICDS Rajasthan has decided to appoint Sahyogini, one at each GP, to ensure that women take medicines regularly and come for health check up, that adolescent girls are not left out, and that generally to mobilise the community to take benefits under ICDS programme.

? Between 60 to 80% Sahyoginies have been appointed. The CDPOs say that educated women are not available, which is a bit hard to believe.

3.2. Performance on key indicators

(a) **Supplementary nutrition programme:** Nearly 92% women are getting supplementary nutrition benefits from AWC; supply has improved; storage of SN is a problem; some women do not like SN because they are stale; women share SN with family members; children enjoy murmure, even non-beneficiary children come for it; data on supplies from CDPOs to AWWs not made available, therefore average quantities supplied per AWC or per beneficiary can't be calculated.

(b) **Pre-schooling:** Children are coming to the crèche. In majority of centres in the sample AWCs, children were present at the time of survey (9AM to 12 AM). There are some officially designated "Adarsh" (Model) AWCs; on the other hand there examples of excellent initiatives taken by AWWs to set examples in setting up crèche in their village. The latter are better run because of community-based and community supported initiative. Although there is provision for 40 children per crèche, in none of the centres there was a register of enrolled children. SN yes, but not a separate register for crèche.

Quick review of the working of ICDS programme

(c) **Awareness creation:** Over 90% women report of NHD/MHD in their AWC every month. Yet awareness was below 50% of the facts contained in NHED books. On the other hand, even AWWs scored an average of about 60%. Both groups were tested on a set of 67 questions that they should know the answer to. AWWs are expected to know at least 90%+ having attended on average over 6 training programmes. It was also observed that literacy and awareness have weak positive correlation, meaning that literacy level is generally not a determinant of awareness. Some notable points are:

- 📖 100% EBF is yet to be achieved
- 📖 99% do wash their hands before eating
- 📖 Majority has made use of health facility for treatment of various illnesses
- 📖 All the sample women do not take IFA tablets
- 📖 Generally women do not go to the AWCs on their own

(d) **Immunization:** The study team collected data from three sources AWC records, ANM records, and From women on recall basis. The findings are:

📖 **From AWC records:** 38% AWC have record of immunization of children and 40% have records on children;

📖 **From ANM records:** DPT 1 and 2 records show over 100% achievement. On all other vaccination the records show less than 100% coverage. Even OPV ranges from 97.7% (OPV-O) to 93% (OPV-3). Common records are not available with ANMs and AWWs. Majority of ANMs have given a signed statement as to the veracity of their records. It indicates that:

- i. 100% coverage even in case of Polio is not achieved;
- ii. 93.8% children have measles vaccination;
- iii. Achievement for DT shots is below 90%

📖 **Beneficiary women:** On recall basis it was also found that all the children of sample beneficiaries have not been immunised.

(e) Health check up: Only **14% AWCs** have records on number of women and children given health check up. However, women do remember that NHD/MHDs take place every month in majority of sample AWCs.

(f) Referral services: Only 6% AWCs sampled has record of referred cases.

4. Discussion

The various approaches to combating malnutrition are not new; they have been in existence since 1910. The four basic approaches to combating malnutrition have been critically examined in chapter 6. The ICDS is following SNP with regular heavy dose of critical micronutrients. The study team has further discussed that this is not a

Quick review of the working of ICDS programme

sustainable solution. The study team has referred to the fact that food grown in farms using modern industrial methods of farming is already terribly deficient in nutritive content. Reference has been made to serious studies conducted by leading scientists worldwide that raise questions as to whether we, as a society, can go on feeding ourselves nutrient-deficient food? And if not, what are the possible strategies available to combat malnutrition? The second area of focus is the coordination between ANM and AWW. One chapter has been devoted to analysing the central issue of the working of RCH programme through the tool of Community Needs Assessment Approach (CNAA), and also failure of CNAA. Now, it must be noted that RCH programme (of the Ministry of Health and Family Welfare) assumes that community needs shall be assessed through a “participatory process” at Gram Panchayat level. A Gram Panchayat may have one to five AWCs, depending upon its population density. If an ANM is not in a position to visit each AWC and assess community needs, it is a moot question as to how she is achieving her targets? It is yet another moot question as to why ANMs are setting targets when the entire RCH programme is to follow Target-Free Approach, which is the basis of RCH and its planning tool CNAA? When a major programme like RCH has such critical weaknesses, how can the programme achieve synergy with ICDS programme? The issue of convergence of RCH and ICDS has been extensively dealt with in Chapter 6 and 7.

5. Suggestions

Suggestions have been discussed within the overall context of breaking the inter-generational cycle of malnutrition.

The suggestions are in three parts: (a) Suggestions for immediate improvement in ICDS performance leading to powerful impact at grass-roots level, (b) Improving coordination between RCH and ICDS programmes, and (c) combating malnutrition through a concerted effort through Women’s SHGs to grow their own green

vegetables to achieve 80% nutritional sufficiency for a family of five from just 50 square metres of land.

Suggestions for immediate improvement in ICDS performance leading to powerful impact at grass-roots level was mentioned in point (a):

- 🏠 Rajasthan-ICDS/WCD should immediately **develop parameters** to measure the performance of AWWs, Supervisors, and CDPOs;
- 🏠 They should **appraise the performance** of each level of functionaries immediately in a transparent manner;
- 🏠 **Promote** high performing AWWs to Supervisor level and fill the 28% vacancies that currently exist;

Quick review of the working of ICDS programme

- 🏠 Promote high performing Supervisors to the level of CDPOs, with a clear instruction that their job is to continuously **build the capacity of lower level functionaries**;
- 🏠 **Remove all CDPOs holding additional charge**, except those who have expertise in areas of convergence, like agriculture, healthcare, or natural resource management;
- 🏠 If ANMs want to join at supervisor level, it should be encouraged, provided they have the minimum qualifications for being ANMs as well as **demonstrable performance of coordination with AWWs**;
- 🏠 Supervisors must realise, and they should be formally trained to realise the fact, that it is not their job to fill the registers and record books;
- 🏠 All RDDs, CDPOs, Supervisors, and AWWs must have a shared concern of breaking the intergenerational cycle of malnutrition. It is not their job to prevent premature death of women and children; that is the job of the health department. It is not the job of ICDS to ensure 100% immunization but it is the job of AWC and ANM to jointly ensure that 100% immunisation takes place. There must be a shared concern down the line from the Directorate to the AWCs that the purpose of ICDS is to break the intergenerational cycle of malnutrition and to reverse it.
- 🏠 The areas of convergence must be clearly demarcated. These are agriculture, and health. They are primary focus of convergence. Secondary foci include watershed management (because Rajasthan is water deficient), sanitation, rural development, etc. Once areas of convergence have been demarcated, ICDS programme managers have to work out a foolproof method of coordination with complementing departments to achieve synergy. This is the crux of sustainable development and also a primary focus of Common Minimum Programme of the present government.

Coordination between ANM and AWW is critical to the success of ICDS programme. Thee weaknesses have been outlined and extensively discussed in Chapter 5 and 6. It is suggested that:

- 🏠 Every household is issued a **family card** with name of each member, vaccination given, date of vaccination, batch number of vaccine, name of ANM, and signature of ANM. This card should remain in the AWC for all villagers, rich or poor. Panchayat Pradhan should issue the card. If a household is well off enough to get private medical attention, even then they must have a card with the AWC. This would enhance the image of AWC and also ensure 100% vaccination.
- 🏠 The name of every beneficiary of ICDS must be recorded in Gram sabha meeting and endorsed by the Gram sabha. This should become the basis of SNP
- 🏠 Every ANM must have a designated day, at least once a week, in the AWC.

Quick review of the working of ICDS programme

And, lastly, people **must learn to grow nutritious food**, especially green vegetables, because foods that people eat are nutrition-deficient. No amount of SN and micronutrients can supplement a diet that is essentially deficient in micronutrients. It must be mentioned here that one tomato of 1960 had ten times more nutrition as compared to today's tomato. One 100 gm helping of spinach had all the iron required by a woman. Not today.

Concerted effort of WSHGs is critical in combating malnutrition. Women's SHGs have been successful in empowering women. The first task of WCD should be to focus their attention to growing **"food for the family"**: green vegetables, lentils, tubers, egg and meat, and, if they can afford through their SHGs, honey and mushroom. Growing food for the family, ***growing nutritious food must be promoted like a religion***. The methodology for growing nutritious food has already been tested, tried out and it works. It does not require any investment in research. It simply requires one to convince women and men in the household to allocate 50 square metres of land to grow "food for the family".

Chapter 1

The study

1.1. Statement of the problem

The Government of India through its Department of Women and Child Development (DWCD) within the Ministry of Human Resource Development (MoHRD) is implementing one of the most critical programmes to break the inter-generational cycle of malnutrition through specific interventions. Rajasthan, Uttar Pradesh, Bihar, and Madhya Pradesh are the focus of a major effort of ICDS programmes comprising of (i) supplementary nutrition, (ii) Pre-school service, (iii) Dissemination of health and nutrition awareness, (iv) Health check-up, (v) Immunisation, and (vi) Referral services. Whilst services (i) to (iii) are key tasks of ICDS functionaries, services (iv) to (vi) are to be provided jointly through a coordinated effort of Health Department and ICDS. In order to understand the working of these programmes, a quick review was undertaken in the state of Rajasthan.

1.2. Terms of reference of the study

(a) Objectives of the quick review: The review was undertaken with the following objectives:

- X. Detailed system's analysis of the working of ICDS programme including analysis of distribution of supplies (SN and medicines)
- XI. Analysis of the working of Anganwadies against given tasks and documenting key problems, including reasons thereof
- XII. Documenting case studies on positive and proactive roles of any CBO (WSHG's and Mahila Mandals) and its impact on the working of Anganwadies
- XIII. Documenting the quality of coordination between Anganwadi Worker and ANMs at Anganwadies and participation of beneficiary women in NHD/MHD
- XIV. Documenting the perception and awareness of users, chiefly nursing mother and pregnant women
- XV. Documenting the role of Gram Panchayat Pradhans as a key stakeholder
- XVI. Identification of Key factors for success by analysing the strengths and weaknesses of documented working of sample Anganwadies and projects
- XVII. Document alternative sustainable strategies for health & nutrition observed during the fieldwork in any village especially through convergence of, and synergy through, other complementary programmes, and
- XVIII. Present the findings and recommendations for greater effectiveness, efficiency and sustainability of ICDS intervention



Image 1.1. Young soldiers brave the heat and sand. March 2005.

A group of children of Anganwadi Centre at Brahmsar GP Jaisalmer saluting the study team

(b) Methodology: A comprehensive methodology covering organisational working and sampling of key stakeholder was adopted.

A team of senior management consultants conducted detailed study of systems and processes through which ICDS programmes are implemented at Alwar district. At each district discussions were conducted with the following: Regional Deputy Director, CDPOs, Supervisors, Anganwadi worker, Panchayat Pradhan and ANMs. Discussions centred on systems and processes of working, practical problems encountered, problems of coordination and control, and solutions arrived at.

(c) Sample survey provided the backdrop against which organisational decision variables were studied and strength and weaknesses documented.

(d) Sample districts: Five districts were selected for the study: Alwar, Ajmer, Nagaur, Sikar and Jaisalmer.

(e) Subjects: In all 475 subjects were to be sampled but at a few places ANMs and GP Pradhans were not available. The actual sampling is detailed in Table 1.1.

Quick review of the working of ICDS programme

Table 1.1. Sample subjects and size (target and actually sampled)

| Districts | RDDs | CDPOs | Supervisors | AWCs | ANM | Users | Pradhans | TOTAL |
|------------------|----------|-----------|-------------|-----------|-----------|------------|-----------|------------|
| <i>Alwar</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Ajmer</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Nagaur</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Jaisalmer</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| <i>Sikar</i> | 1 | 2 | 2 | 10 | 10 | 50 | 10 | 95 |
| Target | 5 | 10 | 10 | 50 | 50 | 250 | 50 | 475 |
| Sampled | 5 | 10 | 10 | 50 | 43 | 250 | 47 | 466 |

Several attempts were made to contact absent ANMs and Pradhans but when they could not be contacted at the location, investigators were recalled. The reason for their absence has been recorded.

The study team allowed the CDPOs to select the best Anganwadies for sampling subject to the condition that they were located at least 10 kilometres from the city limit and at least 5 kms from block headquarter.

(f) Data collection instruments: The following data collection instruments were employed: (i) Beneficiary schedule, (ii) AWW schedule, (iii) GP Pradhan schedule, and (iv) ANM schedule. The schedules are appended here as Annex I to IV. In addition to this records were studied and entries checked for stocks, weighing events, immunisation, NHD/MHD, etc, not only at AWCs but also at CDPO's office. The consulting team collected data in long hand on systems and processes from various control documents supplied by the investigating team after in-field discussions with ICDS functionaries.

(g) Testing of knowledge and awareness: The knowledge and awareness of pregnant women and nursing mothers was tested on 67 points arranged around 22 questions. Simple questions were framed based on the information given in NHED book, charts, posters that one would expect to find in any Anganwadi centre. The same questions were administered to Anganwadi workers as well to find whether AWWs have significantly more knowledge as compared to beneficiary women or are equally ill informed.

(h) Selection of investigators and training: A team of investigators with experience in ICDS and similar surveys in Rajasthan were selected from Delhi, Rajasthan and Himachal Pradesh. They were given a three-day training with one day in-field training at Alwar. The investigating team was then briefed extensively and sent to the field.

1.3. Problems in the field

(a) Quality of records: At many AWCs records were incomplete or had not been maintained properly. Crucial data was missing. It may also be noted that all districts do not follow a uniform format for data management. Maintenance of records on a rolling basis should be available at Anganwadi itself especially on events, immunisation, etc., but these were not available.

(b) Non-cooperation of officials: Despite a formal letter of introduction and authorisation, many CDPOs/their staff were not able to give critical data on stocks and supplies under one pretext or other. In general it was observed that a non-serious attitude permeates district level and below. Because of this reason, the movement of stocks could not be traced. Overall the record keeping is deficient.

(c) Travelling: In general this was a major problem. Because sample anganwadies were selected primarily from remote areas, travelling to the village and back to base station was a major hurdle. In these places generally a bus leaves the village for district headquarter early in the morning and returns by 4 PM and vice versa. Thus, to cover each village, the investigating team had to make several visits and at places had to hire a jeep.

1.4. Structure of the report

The report is in two volumes. Volume 1 is the basic report with tables and other details.

Volume 1 is structured as follows:

- Chapter 1: Introduction
- Chapter 2: Implementation process
- Chapter 3: The beneficiaries
- Chapter 4: The village leaders
- Chapter 5: Working of Anganwadies
- Chapter 6: Coordination with healthcare system
- Chapter 7: Problems
- Chapter 8: Suggestions

Volume 2 contains photographs of each of the 50 Anganwadies visited. This volume is under preparation and will be submitted with the final report.

Chapter 2

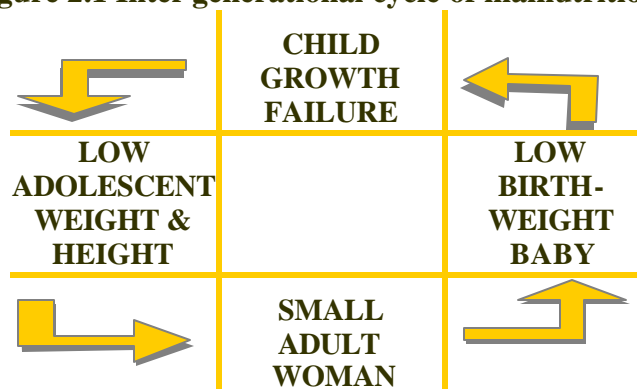
The implementation process

2.1. Combating malnutrition through life-cycle approach

Malnutrition that occurs during childhood, adolescence and pregnancy has an accumulative negative impact on the birth weight of the newborn. Low birth weight (**LBW**) babies, having suffered intra-uterine growth retardation as a foetus, are effectively born malnourished and risk of death during neonatal period or later infancy is quite high. Many **LBW** babies do survive this period but they are unlikely to catch up the lost growth later and will eventually experience a variety of developmental deficits. By age five, an infant is most likely to be stunted, a condition that will probably persist through adolescence and adulthood. Although the adolescent growth spurt does offer a chance to compensate for earlier growth failure, such potential is limited. The stunted child is likely to become a stunted adolescent and later a stunted adult. Stunted pregnant women are more likely to give birth to low birth weight babies. And so the cycle goes on (Figure 2.1).

Figure 2.1 Inter-generational cycle of malnutrition

Supplementary feeding is one amongst many strategic options for combating malnutrition. There are other approaches- such as food-for-work programmes (i.e. SGRY) that target the household as its focal unit. In addition to these, many programmes explicitly seek poverty alleviation than malnutrition reduction. But the fact that continued



malnutrition causes permanent cognitive deficits in children must surely imply that breaking the cycle is the most critical task if the future quality of India's population is to be seriously addressed.

However, given the role of inter-generational cycle in the downward spiral of general health, it is essential to attack all the inter-related causal factors such as low productivity of land, inadequate nutrition, poverty, poor access to healthcare and educational facilities, gender discrimination, low socio-economic status of women, etc. Some (viz. Sarah Stimson) believe that women's lower status could be the single most critical determinant of persistent malnutrition among women and children. But there is a general consensus that the dominant effect of malnutrition is the loss associated with cognitive deficits in children (Susan Horton and Jay Ross of Micronutrient Initiative, 1998) In the matrix of solutions for malnutrition, each of the causal factors is being

Quick review of the working of ICDS programme

addressed by Governments-State or Central- at least in theory. In this matrix the purpose of ICDS is to ensure *that the cycle is broken and reversed*, and this **is the central concern of ICDS programmes**.

2.2. Programme components and target

In practice ICDS programmes comprise of (i) Distribution of supplementary nutrition, including micronutrients, (ii) Pre-school (crèche) services, (iii) Dissemination of essential information through NHED books/charts, (iv) Health check-up including maintenance of growth chart, (v) Immunisation, and (vi) Referral services. These services are given to targeted beneficiaries at Anganwadi centre, established for a cluster of 1000 persons. Targeted beneficiaries are: pregnant women, nursing mothers, adolescent girls, children 0-3 and 3-6 age groups. Thus, the bouquet of services seeks to extend a protective shield from the time a woman conceives to birth, growth of the infant, pre-school services through to the level the child starts school, and then to adolescents and nursing mothers. In accordance with the programme objectives, ICDS has the structure to pull rural population out of the scourge of malnutrition.

2.3. Structure for implementation

The WCD-ICDS directorate is located at Jaipur from where the statewide operations are directed, supervised and controlled. At district level there is one Regional Deputy Director. CDPOs, heads of projects, supervise, direct and control the activities of Supervisors. The supervisors, in turn, oversee the functioning of Anganwadi centres. The ANM, reports to Health Department but in matters of immunisation, health check up and referral services is expected to closely coordinate her activities with that of the Anganwadi worker to extend healthcare services under RCH programme to the population in general and to the identified beneficiaries in particular. The structure at district level is shown on the left hand side of Chart 2.1.

2.4. Sources of assistance

There are two types of projects in five sample districts: (a) Centrally Supported Schemes (or CSS) and (b) World Bank supported. Table 2.1 shows the distribution of AWCs based on source of assistance. It would be clear that roughly 51% of AWCs are World Bank supported and another 49% supported by the central government. Jaisalmer does not have any World Bank supported project. However, the study team did not observe any marked qualitative difference between the two types of projects.

| Districts | CSS | WB assisted | Total |
|-----------|------|-------------|-------|
| Alwar | 860 | 1219 | 2079 |
| Jaisalmer | 327 | 0 | 327 |
| Nagaur | 1454 | 386 | 1840 |
| Ajmer | 692 | 636 | 1328 |
| Sikar | 159 | 1350 | 1509 |
| Total | 3492 | 3591 | 7083 |

2.5. Tasks and responsibilities

2.5.1. Anganwadi centre (AWC)

Anganwadi Worker

Of the listed six main tasks of ICDS given to an Anganwadi centre, tasks (i) to (iii) are to be performed exclusively at the AWC by AWC functionaries while tasks (iv) to (vi) are performed by ANM with AWW acting as facilitator. It is AWW's responsibility to maintain records. The main concern of AWW is to ensure that children, adolescent girls and women get proper SN, medicines, and information to break the cycle of malnutrition. However, majority of AWWs feel that their main concern is distribution of SN.

Sahyogini

The State government has appointed one "Sahyogini" for each Gram Panchayat. The Sahyogini's responsibility is to ensure that (a) adolescent females and beneficiary women take SN and micronutrient doses in their presence, (b) every potential target is included in ICDS. They are further supposed to contact ten households every day and advise

every pregnant, nursing mother and adolescent girls on best practices for healthcare and nutrition. At present 60-80% Gram Panchayats have Sahyogini. The short fall in recruitment is ascribed to inability of ICDS to find 8th pass females. Hence at many places even barely primary school pass women have been appointed.

| District | Number | AWC/ CDPO | AWC/ Supervisor |
|--------------|-------------|------------|-----------------|
| Alwar | 2079 | 139 | 24 |
| Jaisalmer | 327 | 109 | 30 |
| Nagaur | 1840 | 167 | 34 |
| Ajmer | 1328 | 121 | 20 |
| Sikar | 1509 | 377 | 44 |
| Total | 7083 | 161 | 28 |

"Sahayika"

She is a helper. Her job is to help the AWW maintain cleanliness, distribute SN and medicines, and look after the children.

Manpower at AWCs

In all there are 7,083 AWCs in the five districts, maximum at Alwar (2079) and minimum at Jaisalmer (327). These centres have in all about 14166 persons, plus another 4000-4500 Sahyoginies, 100% appointments have not been made as yet. Thus the total number of functionaries would be about 18,000.

Supervision of AWCs

Each supervisor has to supervise between 20 to 44 AWCs. The normal target is that a lady supervisor should be able to visit one AWC per month and given that there are about 22-25 working days in a month, 22-25 AWCs should be supervised. However, supervisors at Sikar have to supervise 44 (highest), while the lowest was observed at Ajmer was 20. The average number of AWCs supervised is about 28.

Similarly CDPOs at Sikar have to supervise 377 AWCs (highest) but around 109 at Jaisalmer. The average number of AWCs supervised by CDPO is 161. (Table 2.2.)

2.5.2. Lady Supervisors/Supervisors

The responsibility of supervisors is to physically visit each AWC under her/his charge at least once a month to ensure that all records are properly maintained, that medical kits and SN are supplied as per the needs to each AWC, and that all planned events are held as planned.

| | Sanctioned posts | In Position | Vacant | Male | Female |
|--------------|------------------|-------------|-----------|----------|------------|
| Alwar | 100 | 86 | 14 | 2 | 84 |
| Jaisalmer | 17 | 11 | 6 | 0 | 11 |
| Nagaur | 91 | 54 | 37 | 1 | 53 |
| Ajmer | 65 | 65 | 0 | 1 | 64 |
| Sikar | 74 | 34 | 40 | 1 | 33 |
| Total | 347 | 250 | 97 | 5 | 245 |

Main concern: As per discussions with supervisors, the majority feels that their main concern is (i) to stop child death and (ii) pre-mature death of women. And majority feels that they have failed in addressing these concerns because the needy are not getting assistance and there is too much political interference.

Under-staffing: Of the 347 sanctioned posts of supervisors in the sample districts, 250 are placed while 97 (nearly 28%) are lying vacant, many for more than one year. Majority is female. (Table 2.3.) Under these circumstances, AWCs are placed under charge of available supervisors, which adds to the workload and the required monthly supervision becomes well nigh impossible.

2.5.3. CDPO

As head of a project, a CDPO has the overall responsibility of ensuring that the objectives of ICDS are met. In practice, this level is inadequately staffed.

There were 49 sanctioned posts in five sample districts, 44 persons were in position. However, 23 CDPOs (out of 44 in position, or 52%) are either on deputation or holding additional charge. In fact 20 out of 44 (45%) are holding additional charge. Majority of these officers are revenue officials (Tehsildars), or officers from Agriculture, Education, and other departments. It may also be noted that majority of CDPOs (88%) is male. At executive management level of CDPO, women are nearly absent from decision-making process in these five districts. (Table 2.3)

Quick review of the working of ICDS programme

Duties and responsibilities: CDPOs' responsibility is to ensure that

- ✍ The functionaries perform their duties and responsibilities as defined,
- ✍ Their salaries and expenses are paid (CDPOs office directly disburses salaries and expenses of functionaries under his/her charge),
- ✍ AWCs get all the essential supplies and facilities,
- ✍ All records are maintained at AWC level and properly compiled on monthly basis at CDPO's office,

- ✍ Concerned departments effectively coordinate their efforts (chiefly health, occasionally education department)
- ✍ Sets sub-targets for AWCs (for instance the target for each AWC in Rajasthan is 9 pregnant women, 9 nursing mother, 2 adolescent girls, 40 under 3 year old children and 40 3-6 year old children, totalling 100. If there are more than 9 women, the CDPO decides who should get benefits. The criteria used is BPL status, caste, etc)

Main concerns: Nearly all CDPOs believe that their main concern is “to prevent premature death of women and children.” Few could elaborate upon intergenerational cycle of malnutrition or its impact on cognitive deficits of children.

Table 2.4. Deployment of CDPOs at project level

| | Total sanctioned | In position | Vacant | On deputation | Additional charge | Male | Female |
|--------------|------------------|-------------|----------|---------------|-------------------|-----------|----------|
| Alwar | 15 | 15 | 0 | 1 | 6 | 14 | 1 |
| Jaisalmer | 3 | 3 | 0 | 0 | 0 | 3 | 0 |
| Nagaur | 11 | 11 | 0 | 1 | 5 | 11 | 0 |
| Ajmer | 11 | 11 | 0 | 0 | 5 | 7 | 4 |
| Sikar | 9 | 4 | 6 | 1 | 4 | 4 | 0 |
| Total | 49 | 44 | 6 | 3 | 20 | 39 | 5 |

This gap in perception is probably the single most critical factor in sub-optimal quality of implementation of ICDS programmes. Preventing premature deaths is the responsibility of the Health Department that is implementing RCH programme. ICDS programme focus is to break the intergenerational cycle of malnutrition but this is not clearly understood at project level by CDPOs or Supervisors.

2.5.4. Regional deputy director (RDD)

They have secondary role in ICDS programmes in Rajasthan. Primary role belongs to CDPOs. But the RDDs are responsible for other critical programmes such as women's empowerment, formation of SHGs, awareness campaign against child marriage, “Jajam Baithak,” etc. They work through “Pracheta” at block level and the Prachetas work through “Sathin” at Gram Panchayat level.

Quick review of the working of ICDS programme

Four out of five RDDs were from Rajasthan civil service cadre and one from ICDS cadre. Majority of RCS officers could not discuss the details of ICDS programme for various reasons (short tenure was the main reason cited). One lady RDD at Alwar was not available for detailed discussion. Thus, the practical problems faced at district level by RDDs could not be documented.

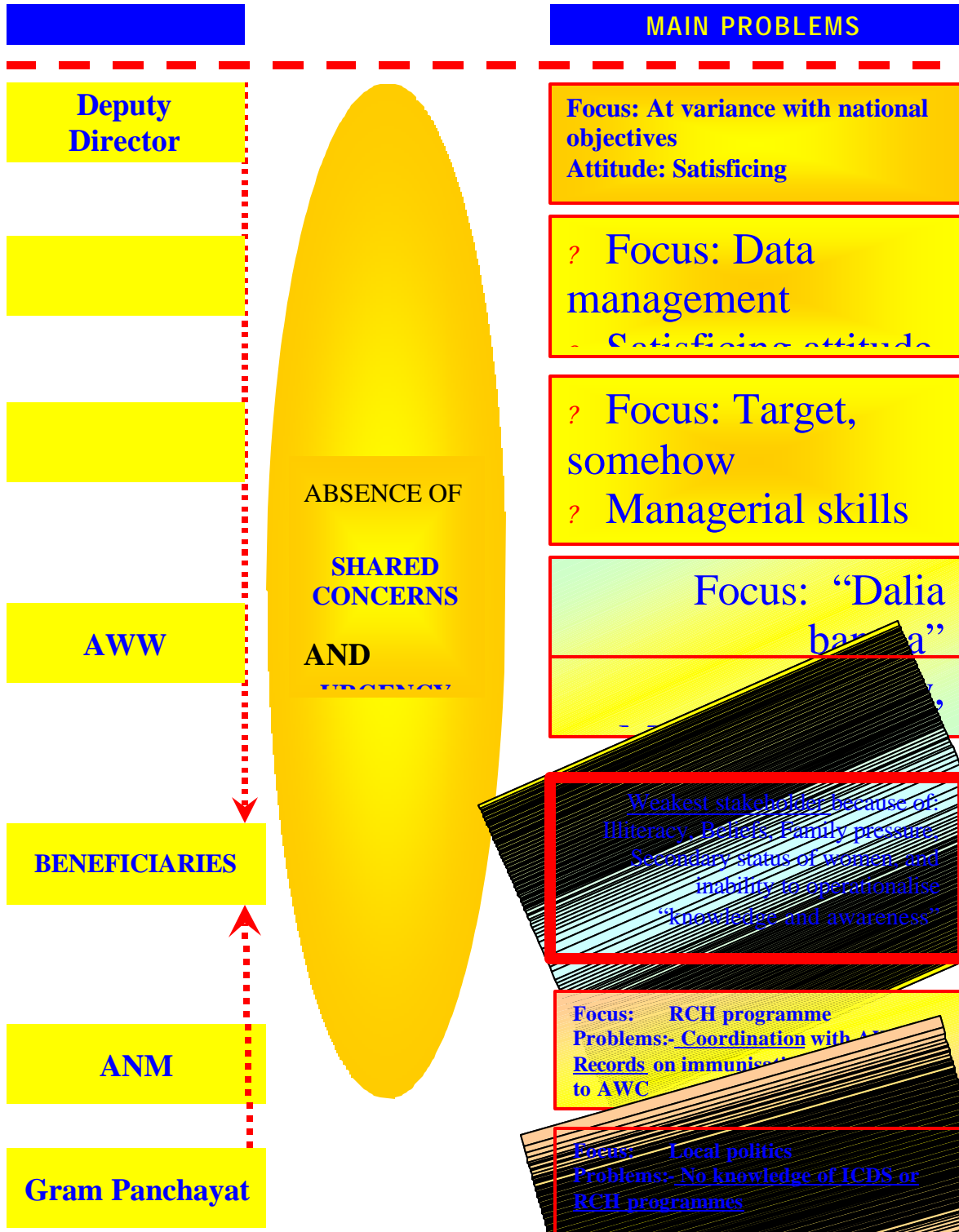
In the absence of substantive discussion, the study team relied on data given by various CDPOs and district level staff at RDD offices. The main problems at CDPO level, as seen by district level officers/staff are:

- ✍ The RDDs receive feedback from CDPO that clubs data on malnutrition related activities with empowerment related activities, in a single control document.
- ✍ The record sheets on analysis were found to be inadequate to take executive management decisions. They are merely records of numbers and do not convey any specific information. For example it is impossible to estimate what quantity of SN was given for how many days to how many beneficiaries at a given AWC.
- ✍ There are no records of wastage.
- ✍ Many non-beneficiaries also collect SN (children like *Murmure* and AWWs do not stop them from having a handful)
- ✍ CDPOs are supposed to physically visit 45 AWCs per month, or about 540 field visits per year. Even if he/she can visit three centres per day, it would take him 180 days on the year to complete the target. But because of shortage of CDPOs and many holding additional charge, proper supervision of supervisors and AWCs is virtually impossible.
- ✍ In all there are an estimated 18,000+ staff at project level in the five districts. These functionaries are being supervised by 44 CDPOs, or on average one CDPO looks after the performance of 424 personnel.
- ✍ Poor administration of a project implies poor control over supervisors, anganwadi workers, sahyoginies, and helpers.

2.6. The core issue

The central issue that emerges from this empirical study is absence of “shared concerns” from RDD level right down to AWC level. *Therefore, the focus and urgency is missing*. The situation is sustained because of faulty record keeping and poor data processing reducing the scope for effective managerial or administrative intervention. This is clearly illustrated in Chart 2.1.

Chart 2.1. STRUCTURAL AND PROCESSUAL ISSUES



Quick review of the working of ICDS programme

There are following core issues in structural terms:

- (a) There is no shared concern and focus at district level on the priority area of ICDS programme, which is to eliminate inter-generational cycle of malnutrition;
- (b) Supervision of AWCs is weak because of understaffing. 28% Supervisor's posts are lying vacant.
- (c) There is no motivation for AWC, other than self-motivation. Only 7 AWWs have been promoted to Supervisor level in Alwar, none in Nagaur, 4 in Sikar, and 7 in Ajmer.
- (d) The concept of "Adarsh" AWCs has certain parameters like the ideal centre should be located in government building or own premises, should have listed furniture and fixtures, with proper staffing and training. But on all these counts, the supportive structure is weak.
- (e) Whilst community leaders including elected members of Gram Panchayats are concerned about working of AWC and Sub-centre, they are not clear about the focus of ICDS and RCH programmes. This debilitates AWC because AWC is actually supposed to be a community based, community centred organisation. If community leaders and elected members of Gram Panchayats are not able to offer community level supervision, a major building block is missing.

2.7. Coordination with ANM

2.7.1. The processes through which the two co-ordinate their activities are quite complex. Data on community healthcare needs are collected during NHD organised at AWCs. AWWs and their Sahyoginies are supposed to be in touch with pregnant women and nursing mothers and keep the ANM updated. When information comes to ANM she arranges for ANCs, PNCs, immunisation, or referral. If she observes any major health problems, she refers the case to a PHC or CHC or First Referral Unit (FRU). She arranges vaccinations through the **Sub-centres** (cold chain equipment and vaccines are kept here). Data and information given by AWWs are aggregated at sub-centre level and collated at PHCs and CHCs. **Annual healthcare, family welfare, and immunisation plans are prepared at CHC level based on this data.** Thus, the AWW provides information to ANM that helps formulate block-level health plan. Based on assessment of health of the population, the CM&HO advises appropriate intervention. ICDS acts accordingly.

Thus, the ANM is responsible for ANCs, PNCs, all vaccinations, health check-up, special camps, and co-ordination with AWWs to ensure that no woman or child is left out. An ANM is responsible for early detection of serious health problems among children (RTIs, growth faltering, etc) and recommends appropriate action. All these activities are part of RCH project of MoFHW/GoI, a priority programme launched after ICPD-Cairo (1995).

Quick review of the working of ICDS programme

On the other hand, the main task of AWW, a volunteer, is to run pre-school and monitor growth of pre-school children. They are *also* responsible for maintaining records- of anaemia among women and children, vaccinations, children's growth-based on which they distribute supplies and discuss remedial actions with ANM.

2.7.2. Quality of coordination

Interaction: Whilst about 31% ANMs say that they meet AWW everyday, 69% interact with AWWs strictly as per their own schedule (once a week, once a fortnight or once a month). On the other hand 46% of AWWs say that they interact with ANMs everyday, others strictly on days of events. Thus, in about 23 AWCs (46%) there is fairly regular interaction. Majority of these are World Bank funded.

Immunisation: AWWs do not have record of immunisation. ANMs do not easily reveal the data. It is virtually impossible to identify which child has had all the required vaccinations. In actual fact, it is difficult for AWW to say how many children have full complement of vaccinations. It does not reflect upon AWW as much as it reflects upon failure of CNA and RCH programme.

Health check up: Data on health check-up events held at AWCs are difficult to collate because of variations in recording. At some places number of events is given, at others number of boys and girls is mentioned. Thus it is difficult to say whether there is a consistent pattern of health check up or not. In fact the quality of coordination can only be commented upon from the number of events held in the past and beneficiary-wise but it can't be done.

Referral services: There have been complaints. (a) Referred cases are not given priority at CHCs/PHCs as is expected by AWWs, which lowers their prestige amongst villagers. (b) Cases have been reported where some complications occurred, at the time of removal of suture, leading to bleeding. The ANM left the patient and refused to accompany AWW to the nearest PHC. It is understandable that ANMs have their own priorities and compulsions, yet it's her responsibility to serve the identified villages.

2.8. Reporting

2.8.1. Normative process: Rigorous reporting is essential to ensure that distribution of micronutrients is regular, to ensure that regular information on related activities reach planners and decision makers, to ensure that shortages do not occur; and to ensure timely re-ordering of supplies, thereby speeding up the procurement process and effective control of the project.

2.8.2. Actual Reporting: One of the primary causes in unsatisfactory (sub-optimal) performance of ICDS programmes is widespread failure in reporting. Documents collected by the study team show that records were entered for the sake of filling up

Quick review of the working of ICDS programme

columns. In most of the reports, columns were left blank, and basic calculation errors, cuts, and over-writing reduce the sanctity of reporting protocol. It is also worth mentioning that Nagaur district authorities refused to release any data to the study team.

2.8.3. Main observations

(a) Wrong entries: If the summary data for March 2005 for Ajmer district is added up, the total beneficiaries comes to 2,88,739 (World Bank assisted AWCs showing 117344 children and 16813 women and CSS projects showing 134548 children and 20034 women, adding up to 2.88 lakhs. In other words 217 beneficiaries per centre.) But if the data from another monthly report is taken, the number of beneficiaries comes to 131553, or about 99 beneficiaries per centre. Both records are prepared by ICDS office.

(b) All districts are not compiling data on malnutrition by grades (Grades I, II, III and IV).

(c) All districts are not compiling data by number of SN beneficiaries, quantity received and quantity distributed. Present stock position could not be calculated. Average distribution of SN per beneficiary also can't be calculated.

(d) Number of SN days varies from 21 to 80 per year, which reflects poorly on some of the districts;

(e) Number of weighing events is not recorded in many districts;

One may conclude that the required care in data management is absent in most of the projects. Control documents are poorly designed. They are designed to record data but give no information on quality of services. Summary tables may be seen in the statistical abstract under relevant chapter.

2.9. Supply and Distribution of SN and medicines

2.9.1. Normative distribution of SN: The normative distribution of SN (Rajasthan mix and corn-soya mix) is 75 grams per day (single ration) and 150 grams per day (double ration) per child under age 3. For children going to pre-school the same norm for murmure is followed (75 grams single and 150 grams double ration). For woman (pregnant or nursing) 125 grams of THR per day is the norm, single ration, and 250 grams per day for double ration. It implies that average 25-day ration for women should be 3.125 kgs single ration and 6.25 kgs double ration. Similarly, for pre-school children the norm is 1.875 kgs of murmure per child per month. For infants (Baby mix) 2.25 kg per month is given as single ration, double in case of serious growth faltering.

The normative distribution of medicines is: (a) One packet of IFA tablets in 10x10 blister packs each per pregnant woman and nursing mother once a year; (b) for

Quick review of the working of ICDS programme

children (3-6 years) 20mg of elemental iron plus 0.1 mg of folic acid; (c) One bottle of IFA syrup per child under 3 years of age; (d) 5 ml of Vitamin-A per child administered twice a year (e) De-worming tablets are given as single dose but its distribution depends upon supplies coming from Jaipur.

The quantity of SN and medicines to be supplied to each AWC is based on predetermined target of beneficiaries in each category: children under 3 years, children affected by moderate or severe malnutrition, number of pregnant women, and number of nursing mothers. Distribution ideally takes place six days a week but many AWCs are not open on all days.

2.9.2. Actual distribution: Essentially three problems were observed

- (a) Quantities delivered per AWC vary, although stock position has improved as per the statement of AWWs.
- (b) Children from villages simply walk in and ask for murmur. The AWW does not stop them but distributes SN to them also, which implies that
- (c) At many places the normative quantities may not be reaching the beneficiaries

2.9.3. Actual supplies received by beneficiaries:

SN received by women: There are two statements from women. (a) 59.6% women have not received THR at the AWC. Only 40.4% have received SN at AWC. (b) But when another question was asked “have you received supplementary nutrition along with IFA tablets and Vitamins, etc?” (The terms they understand are “anupurak ahar” and “khoon banane ki goli”) 92.4% women said yes, they have. It indicates that majority of sample women are receiving SN but it may be collected by some one else in the family. However, because of paucity of data, it is not possible to say whether they are getting the normative quantities.

IFA tablets: 92.8% say that they have received IFA tablets.

Vitamin A syrup: 10.8% women say that they have received Vitamin A supplements, 89.2% have not. This is consistent: Vitamin A is administered twice a year to children up to five years of age to prevent night blindness. Vitamin A is not supplied to women from AWC. It is possible that they have consumed other vitamin supplements given by ANM.

Perception of SN: Whilst 84.1% women like SN given at the centre, 15.8% do not like them. The 16 owmne (15.8%) who do not like SN, do so because (i) bad taste (7), (ii) makes them sick (3), old stale stock (1) and don't know, can't specify (5). (Tables 3.48 and 3.49 pg.13) As mentioned in para 2.8, because of poor record keeping it is not possible to calculate whether beneficiaries are receiving the normative quantities of SN and medicines or not.

Quick review of the working of ICDS programme

Thus it can be seen that the programme delivery is weak, although majority of AWWs have said that there has been substantial improvement in supply of SN and medicines.

2.10. Record of other activities at district level

National Health Day: Jaisalmer and Nagaur have not given the data. However, from Tables 6.13 and 6.14; pg. 40 it is clear that women know that a health day event is held once a month in their AWC. This implies that health days are regularly organised.

Immunisation: Few districts have records of all the essential data on children's and women's immunization. Merely numbers are recorded not the type of immunization. At AWC level, these records are available only at 38% AWCs, in many cases the records are incomplete (Not entered against beneficiaries name). At ANM, some have released their records and these records clearly show that even registered beneficiaries have not been given all required immunization cover. Statements of registered women show that all have not received the full complement of vaccination. (Tables 3.91 and 3.92; pg. 23-24)

TT Vaccination: 23.3% women have not received TT vaccination as per their statement (Table 3.39; pg 11). Even ANM records show that two shots of TT vaccination were not given to some registered women. Therefore, the data on TT vaccination prepared by district level also does not make sense.

Weighing of children: All districts have not given data on children weighed. Records were not given even after repeated physical visits and telephone requests. 59.39% women say that their newborn was weighed at the time of birth; 36% say that their newborn was not weighed.

Other events: Records of health awareness sessions are rare at district level.

2.11. Conclusion

The programme suffers from inadequate staff, absence of common shared concern and weak control systems. Record keeping is extremely lax.

The **centre level** was observed to be the weakest link between programmes and the target communities for the following reasons:

Absence of structured co-ordination between AWW and ANM, which is mainly due to non-operationalisation of Community Needs Assessment Approach. This fact is known to health experts in the Ministry as well as UN-WFP, UN-FPA and other agencies, including the Planning Commission. Yet, no alternative method has been designed.

Quick review of the working of ICDS programme

The programme seeks to change perception and healthcare practices of women but the main point of contact is AWC. It is unrealistic to expect an *illiterate or semi-literate* AWW to win the confidence of a rural community in sample districts to bring about culture change.

At AWC level, there must be a list of items they are supposed to have at all times. None has a normative list. Records are incomplete which weakens control process. Cases referred by AWW are not given due importance by ANM and FRUs which lowers the prestige of AWW in her village. If the health functionaries just accord some importance to AWW, women will show more respect and will have more confidence in the AWC. Panchayat Pradhans, in their ignorance, also dilute the importance of AWW. They can at least invite her in General Body meeting of Panchayats but that rarely happens.

The **tactical level, (which is the project level under ICDS)**, in any strategic intervention, requires competence, continuity and commitment (**3Cs**). It is this level that transforms strategic initiatives (planned at Ministerial level and state directorate level) into realistic operational possibility. The tactical level comprises of CDPOs and Supervisors.

Frequent transfers, additional charge given to functionaries with little or no understanding of ICDS related activities have played havoc. Many officials at district and block levels, on secondment from other departments, have no idea of nutritional intervention. Placement of ill-equipped persons in crucial positions causes discontinuity in supervision, monitoring, and control. Even if they are highly motivated, have the necessary commitment and application, in the absence of deep understanding of key issues they find it difficult to focus their effort.

The main focus of Supervisors should be training and capacity building of AWWs and Sahyoginies. Instead, they come to the centre and fill up registers and forms. AWWs can build a solid structure for programme delivery but because of lack of direction from supervisors, they are also groping in the dark. Consequently, planned events are seldom organised. In the end only forms get filled-up to ensure that no one questions the functionaries.

Thus a well designed programme is significantly weakened at operational and tactical levels.

Chapter 3 The beneficiaries

3. Women and children

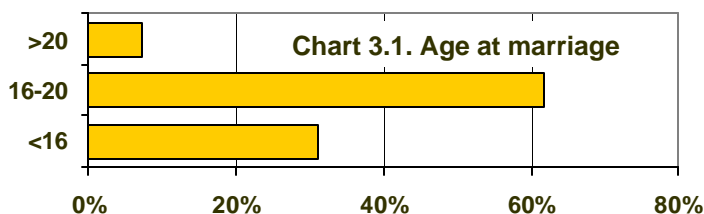
3.1. Sampling

250 women (pregnant and nursing mothers) were sampled: 5 from each centre. All women are registered beneficiaries. Sample comprises of 40.8% pregnant, 43.2% nursing mothers, and 16% adolescent females. (Table 3.1; pg.108)

3.2. Features of the sample:

Age at marriage: Of the 210 married women, 30.95% got married before they were 16, 61.9% were married off between ages

16 and 20. Only 7.14% got married at age over 20. Nearly 50% of the females were married off before the legal age. (Chart 3.1)



(Table 3.2; pg.108)

Education and literacy: 46.8% has attended school, 53.2% has not; thus over 50% of sample is illiterate. Some of the 53.2% who have not been to school are barely literate, can sign their name. 22% has completed primary school, 13.6% middle school, and 9.2% high school. 5 have been to college or completed technical education. It implies that 62 women have completed middle or higher level of formal education. It further implies that while some villages may not have literate women to run AWC or become Sahyogini or Sathin, majority of villages has at least a small pool of literate women who can be motivated to take up this type of work. (Table 3.3 & 3.4; pg.108-&109)

Occupation: 77.2% is housewife. 14.8% are occupied as daily wager or unskilled worker but they work outside their home. 8% are either self-employed or otherwise occupied in gainful occupation (farming, dairying, etc). (Table 3.5; pg. 109)

Caste and religion: 14.4% belong to general castes. 40.8% are from OBC communities, 27% are from the Scheduled Castes, and 0.8% from the Scheduled Tribes (mainly Gujjars). 14.4% belong to the minority communities; others are all Hindu. (Tables 3.6 & 3.7; pg. 109&110)

Type and size of households: Whilst 66% live in joint family, 34% are nuclear family. 13.2% have 4 or fewer members, 54.8% have between 5 to 7 members, and

Quick review of the working of ICDS programme

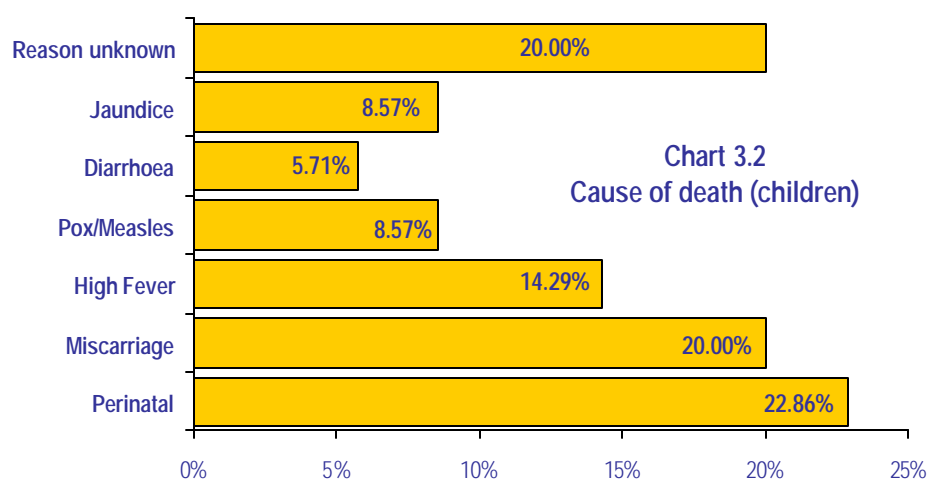
32% have more than 7 members. It indicates that nearly 87% households are large. (Table 3.8 & 3.9; pg. 110)

Number of children: Between 210 women there are 499 children, on average 2.3 per woman. This is an encouraging sign. (Table 3.10; pg. 110)

Standard of living: Asset based analysis (designed by ICMR) shows that 44.4% women come from low standard of living households, 37.6% from medium and 18% from high. (Table 3.11; pg.110)

3.3. Premature deaths in the family and causes:

14% women have lost at least one child (Chart 3.2 below).



It may be seen that **perinatal causes account for 22.8% deaths**, followed by unknown reason (20%), Jaundice (8.57%), Diarrhoea (5.71%), Pox/Measles (8.57%), high fever (14.29%), and miscarriage (20%). This pattern is consistent with past studies conducted in Rajasthan by this agency and indicates that substantial impact of ICDS intervention is yet to be seen in remote rural areas. (Table 3.12 & 3.13; pg. 111)

Death of women (age 15-45): Furthermore, there have been 2 deaths of women in reproductive age group (15-45) and both died during pregnancy, which indicates poor access to healthcare services. Both CDPOs and Supervisors in majority of projects have stressed that they are unable to prevent premature deaths and that ICDS programmes in this sense are not showing substantial impact. (Tables 3.14 & 3.15; pg. 111)

3.4. Social and cultural practices

Eating together: Whilst 42% say they eat together as family, 58% do not. There could be many factors for this (time, different working hours, needs, etc) but social practices have a role in family members not eating together. (Tables 3.16; pg. 112)

Quick review of the working of ICDS programme

Males eat first: In 64.4% household men still eat first, which implies that women eat later, often whatever is leftover. (Tables 3.17; pg. 112)

Can a woman eat as much as she wants: Over 99% says yes, they can. 98% also say that daughters can eat as much as they want. However, subsequent questioning on dietary practices during environmental stress, pregnancy, etc., reveals that women can eat as much as they want provided sufficient food is available to the household. (Tables 3.18 & 3.19; pg. 112)

Washing hands before eating: Over 99% say that they wash hands before eating. This is a positive sign and indicates that awareness campaigns have had some impact on hygiene. (Tables 3.20; pg. 112)

These responses together suggest that women are aware of basic issues. However, it also indicates that knowledge and awareness alone are not sufficient; operationalisation of knowledge has a long way to go. But if women begin to operationalise knowledge it'd alter power structure within the family. Hence it suggested in Chapter 8 that men should also attend AWC.

3.5. Awareness among women

Section 4 of the questionnaire was actually a test of awareness of basic healthcare facts that a registered woman should learn at AWCs. One of the main jobs of AWW is to disseminate essential healthcare and child care and nutrition related information, including home management of diseases. All women as well as AWW were administered the test of awareness. Chart 3.3 shows comparative score of beneficiary women and AWW and the results are discussed below.

Quick review of the working of ICDS programme

For each correct answer one mark was given and the total score was compiled for each woman and AWW. The mean score for total sample of women (250 beneficiaries) comes to 46.67% and 59.85% for Anganwadi workers. Thus, there is a difference in the mean score of 13-percentage point in knowledge and awareness of AWW (service provider) and women (service takers or beneficiaries). Both beneficiary women and AWW in Ajmer scored the highest (50.96% and 63.73%, respectively). Lowest score was achieved by women in Jaisalmer (43.82%) and by AWWs in Alwar (55.97%).

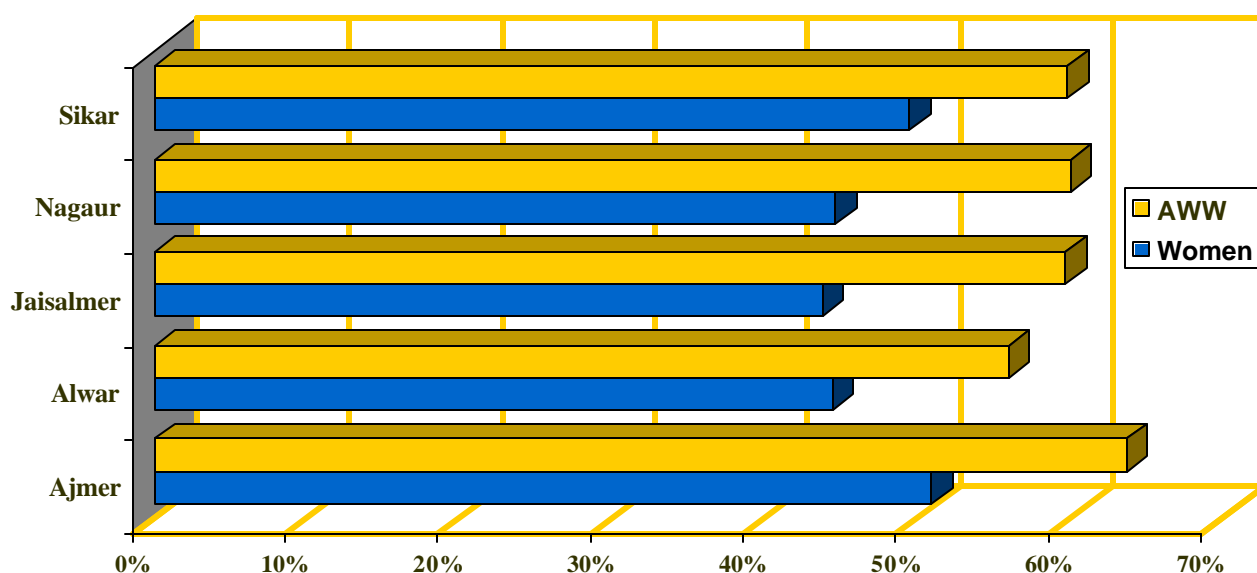
Correlation between literacy and awareness is 0.195379 for women and 0.191349 for AWWs, meaning that literacy and awareness has a weak positive correlation. It implies that in this sample, awareness does not have significant correlation with literacy. An illiterate woman could possess high awareness level but a literate woman would not necessarily have high awareness level. Several conclusions can be drawn from this analysis:

- (i) AWWs, despite participation in training programmes, have marginally high awareness level as compared to the awareness of women.
- (ii) None has shown full knowledge of the basic facts they are expected to know.
- (iii) It is not surprising that beneficiaries trust ANMs more than they trust AWW.
- (iv) Training and capacity building of AWWs leaves a lot to be desired.

3.6. Interaction with Anganwadi centre

3.6.1. Participation in meetings

Chart 3.3 Comparative awareness



Since all respondents are registered at AWC, it is expected that they use AWC facilities. However, 20.8% said they have not been invited /called to the AWC. 79.2%

Quick review of the working of ICDS programme

said that they have been invited. It shows that not all AWWs are proactive and there are reasons why registered beneficiaries are not invited. (Tables 3.21; pg. 113)

Of the 198 who were called to the centre, 54% (136) did go to the centre and participated in the meetings held there. (Tables 3.22; pg. 113)

Regularity of meetings at AWCs: 95% AWCs hold regular meeting, at least once a month, while 2% hold a meeting once in two months. A small percentage is irregular in holding meetings. (Tables 3.23; pg. 113)

3.6.2. Proactive involvement of women in centre-level activities

17.2% women visit AWCs to help the centre with various tasks/activities. (Table 3.24; pg. 114) Those who actively participate in centre-level activities perform such tasks as cleaning the centre (27.5%), preparation of SN meal (25%), distribution of SN (28.75%), send adolescent girls to the centre (13.75%) and getting community support for nursing mothers (1.25%). (Table 3.25; pg. 114)

3.6.3. Awareness and participation in NHD/MHD (Swasthya divas)

35.2% know of NHD/MHD (Tables 3.26; pg. 114) Maximum awareness is in Ajmer and Sikar and minimum in Jaisalmer. NHD/MHDs are regularly held

in all AWCs. In the last three months, 3 NHDs have been held (Tables 3.27 & 3.28; pg. 114). This shows that at least majority of AWCs are holding health days at least once a month.

36.36% women have attended the NHD held last month (month previous to the survey), while 63.64% have not. (Tables 3.29; pg. 115)

Convenience: 16.4% would like to have SN distribution on same day as NHD, while 41.6% want the two events organised separately. 42% did not answer this question. Working women in general want the two events organised the same day. This decision should be left to the community to be decided jointly by ANM, AWC and Supervisor. (Tables 3.30; pg. 115)

3.7. Facilitators of information dissemination

Presence of JMJ: 18% women say that there is a “jan mangal jora” in their village. 82% say that there is none. Of the women who know of the presence of JMJ, 95.5% know the JMJs personally and 93% say that JMJs freely discuss and share information with them. (Tables 3.31(a-b); pg. 115)

3.8. Services received during pregnancy (Tables 3.32 & 3.33; pg. 116)

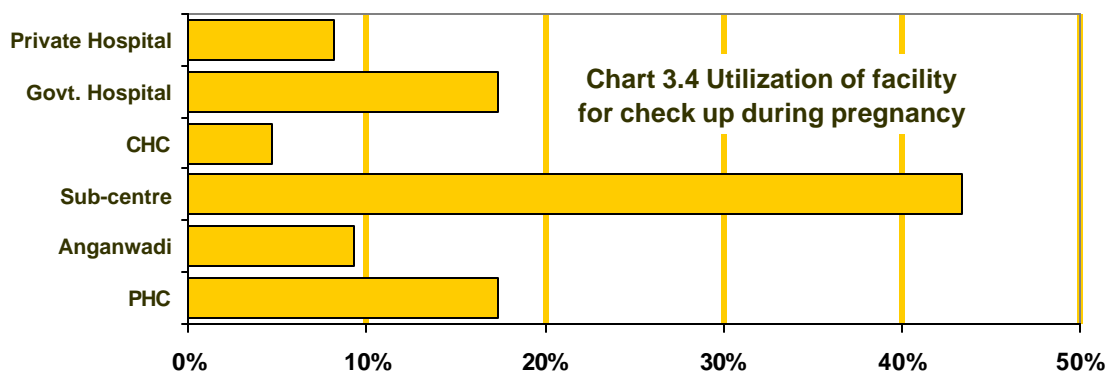
82.38% women, out of 210, went for a health check up during their last pregnancy. 37 did not go for various reasons such as: there was no problem (43.24%), don't know-

Quick review of the working of ICDS programme

can't say (27%), and can't go alone (8.11%). Some did not go because of superstition, and others because of poverty.

Of those who went for medical check up, 97.1% are registered with AWC, 2.89% are not (Tables 3.34; pg. 116), which indicates poor record keeping.

Frequency of medical check up: 27.75% went for check up once, 43.93% twice,



20.23% thrice and 8.09% more than three times. (Tables 3.35; pg. 116)

3.9. Facility utilised for pre-natal check up:

43.35% women went to a sub-centre for check up, 17.34% went to a PHC, 17.34% to any government hospital (could not name the type of facility), 9.25% went to AWC, and 4.62% went to CHC. About 8% went to a private hospital. Thus over 82% have gone to a proper place for pre-natal check up. This is a healthy trend and indicates that even rural women now prefer to go to an accredited place for basic health check up

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|-------|-------|-----------|--------|-------|-------|---------|
| No problem | 3 | 3 | 2 | 3 | 5 | 16 | 43.24% |
| DK/CS | 2 | 3 | 2 | 3 | 0 | 10 | 27.03% |
| Can't go alone | 0 | 2 | 0 | 0 | 1 | 3 | 8.11% |
| 1st time pregnant | 0 | 1 | 1 | 0 | 1 | 3 | 8.11% |
| Superstition | 0 | 1 | 0 | 0 | 0 | 1 | 2.70% |
| Nurse came home | 0 | 1 | 0 | 0 | 0 | 1 | 2.70% |
| AWC closed | 0 | 2 | 0 | 0 | 0 | 2 | 5.41% |
| Because of poverty | 0 | 1 | 0 | 0 | 0 | 1 | 2.70% |
| TOTAL | 5 | 14 | 5 | 6 | 7 | 37 | 100.00% |

before childbirth. (Tables 3.36(a); pg. 117)

Who performed diagnostic check up?

28.9% say that a doctor gave them check up, 55.49% say it was nurse, and 15.03% say that it was ANM. Two women went to AWW for check up. Essentially, majority, i.e. nearly 99% have gone to a competent person for check up. (Tables 3.36(b); pg. 117)

What sort of check up was given?

Not all women remember all the tests given to them but a picture emerges that shows that there is growing awareness of what sorts of signs should be observed by women and that they should be observed. Table 3.37;page 117 summarises the things that women remember that was observed by the person giving them check-up. Not all remember everything, but some remember many important observations.

Apprising the patient of danger signs

38.15% were told of the danger signs during pregnancy, 61.85% were not. This is an important issue that should be raised with the Health Department. (Tables 3.38; pg. 118)

3.10. Tetanus vaccination

Of the 210 mothers/pregnant women, 76.67% have received TT vaccination, 23.33% have not. (Tables 3.39; pg. 118)

Of those who have received TT vaccination, 17.14% have received once, and 76.67% have received twice. (Table 40& 3.41; pg. 118)

3.11. Services immediately after childbirth

Birth weight: 59.39% say that their child was weighed immediately after birth. 36.04% say that no such event took place. This is a serious matter and should be raised with the Health Department. Unless every newborn is weighed immediately after birth, Rajasthan Government won't know the extent of underweight children and they can't take any meaningful action to break the cycle of malnutrition. (Table 3.42; pg.119) It also needs to be stated here that the investigating team found that 80% of AWCs did not have a working weighing machine at the time of the survey.

First feed: 86.7% women have said that the newborn was breast-fed immediately after birth. 13.3% did not breast feed the child immediately after birth. (Table 3.43; pg. 119)

However, this data is contradictory. Table 3.84; pg. 129 shows that only 33.51% women breast fed their newborn within 30 minutes of birth. It is suspected that something else was given to the child.

3.12. Supplementary nutrition

40.40% women have received SN after pregnancy, 59.6% have not. This equates to 101 women who have received SN. Main observations are: (Table 3.44; pg.119)

- ≈ 98% women share SN with other members of the family, particularly children. (Table 3.45; pg.119)
- ≈ 21.78% take SN in lieu of main meals, the rest take it in addition to the main meals. This implies that roughly one in five is taking SN as the main meal. (Table 3.46; pg.120)
- ≈ The SN given at AWC is THR as stated by 32.94%, and pre-prepared (55.29%). Others don't know or could not say what it is. (Table 3.47; pg.120)
- ≈ 84.16% like the supplements given at AWC. Of those who do not like SN, 43.75% do not like it because of taste, 18.75% say that it makes them sick and the remaining say that it is stale. There is truth in each of these statements. Most significantly, six to ten months old stocks have been found that are kept open in plastic bags. (Table 3.48-3.49; pg.120)
- ≈ 10.8% say that they have received Vitamin A supplements. This could not be verified from records. (Table 3.50; pg.121)
- ≈ 92.8% have received IFA tablets and over 93% of them have taken the tablets as per advice. Majority has taken the complete dose. (Table 3.51-3.52; pg.121)
- ≈ 92% say that have received total complement of SN, IFA and medicines from AWC. (Table 3.53; pg.121)
- ≈ Only 7.6% has received de-worming tablets. On crosschecking, it was observed that de-worming tablets are not supplied regularly. Whenever it comes, these are distributed. But the distribution is rare. This is confirmed from the responses tabulated in table 3.54; pg.121.
- ≈ But only about one in four take de-worming tablets when given. 68.4% say that sometimes they ingest it, implying that they often throw it away. (Table 3.55; pg. 122)

3.13 Awareness about diseases and action taken

Measles: 61.6% women do not know what causes measles. 14.4% say that it is due to some infection. 15.2% believe that it is due to some deficiency. 8.8% believe that it is due to some curse. Thus nearly 85% do not know what causes measles. 25.2% do not know what to do when measles strikes. 47.6% would go to a doctor, 18.4% would use Neem leaves and other traditional medicines, while 3.6% would go to Shitla Mata. 5.2% said they would go for vaccination. It shows that about 52.4% are not sure about managing measles. 5.6% have also said that they would be prevented from seeking proper medical advice. (Table 3.56 to 3.58; pg 122-123)

Night blindness: 9 (3.6%) women have suffered night blindness. 4 were treated with dose of Vitamin A; other 5 were treated at hospital. 2 had obtained medicine from pharmacy without consultation; doctors or ANM treated others. (Table 3.59; pg. 123)

General debility: 23.6% has suffered from non-specific debility. 57.63% were treated by doctors, 35.5% by ANM, and 1.69% at AWC itself. 52.54% were told that the weakness is due to low HB count, 32.20% because of inadequate diet, 13.56% due to excessive workload, and 1.69% due to unspecified reason. This indicates that women are taking non-specific debility/persistent weakness, usually precursor of serious health problems, seriously. It is also worth noting that they remember what the health officer told them: 28.57% were told to take medicines regularly, 44.29% were told to take proper diet, 15.7% were told to take nutritious food. There was one serious case where the woman was given drip. (Table 3.60 to 3.63; pg. 123 –124)

Anaemia: 16.4% (41) women were diagnosed of anaemia. 48.78% were diagnosed by doctor and 43.9% by ANM. 7.32% do not remember. While 5 do not remember of having been given a test, others do. 34.15% were tested at PHC, 17.07% at CHC, 17.07% at Sub-centre, 17.07% at district hospital, and 2.44% at a private clinic. It implies that nearly 88% went to a proper health facility for essential diagnostic tests. 12.2% were diagnosed of mild, 78.05% moderate, and 9.76% severe anaemia. (Table 3.64 to 3.67; pg. 124-125)

Iodine deficiency: 5 women (2% of sample) were diagnosed of iodine deficiency. Two were told to take iodine rich salt, others do not remember. (Table 3.68-3.69; pg.125)

Diarrhoea: Ten women (4%) have suffered from diarrhoea. 4 were treated at government facility, one at AWC. Others could not say where they were treated. 60% were given ORS, 20% were given some medicines. 20% do not remember the medication received. (Table 3.70 to 3.72; pg. 126)

3.14 Home management of children's diseases

Cough and fever: 23.94% women reported that their child had suffered from fever, and 18.09% reported cough. 88.24% reported that their child had rapid breathing during cough. 91.18% treated their child for cough. (Table 3.73 to 3.76; pg.127)

Diarrhoea: 10.11% (19) women reported their child having suffered from diarrhoea. 3 had observed blood in urine (which is actually a sign of poor hygiene and can lead to serious problems later). 84.21% women gave normal diet to the child during diarrhoea. 94.74% did seek proper treatment and all of them (100%) gave the prescribed medication. All the mothers gave ORS solution. 52.63% obtained ORS packets from

Quick review of the working of ICDS programme

AWC, 21.05% each from PHC and Sub-centre, and 5.26% from a pharmacy. (Table 3.77 to 3.82; pg. 127 –128)

In general, the indications are that when a woman realises or knows that it is in her interest to seek medical advice, she is going for that option, rather than wait and do nothing. Indications are that traditional beliefs and remedies are slowly being discarded in favour of more rational approach to management of diseases.

3.15 Exclusive breast-feeding

All mothers have breast fed their children. (Table 3.83; pg.129) This is a general response and quite correct.

Whilst 33.51% mothers have breast-fed their child within 30 minutes of birth, 44.15% did so after one hour. About 6 % breast-fed their child between 2-6 hours later. 29 women (15.43%) breast-fed their child after one day. It indicates that while breast-feeding is practiced but the recommended EBF is not. (Table 3.84;pg. 129)

Colostrum: 80.32% mothers say that they did feed colostrum to the child (Table 13.4) but 14.36% said that threw away. (Table 3.85 –3.86; pg. 129)

78.19% are still breast-feeding their child. (Table 3.87; pg. 129)

46.34% said that they have breast fed their child for about one year, 24.39% for up to two years. 7.32% have breast-fed their child for six months, 9.76% for 7 to 9 months. (Table 3.88; pg.130)

Several conclusions may be drawn from these tables:

- ✍ **EBF is not the norm**
- ✍ Women are still persisting with the practice of throwing away colostrums
- ✍ Other food and drinks are introduced before six months when it is not recommended

All this points to a major failure of AWCs in performing their basic task: to popularise EBF.

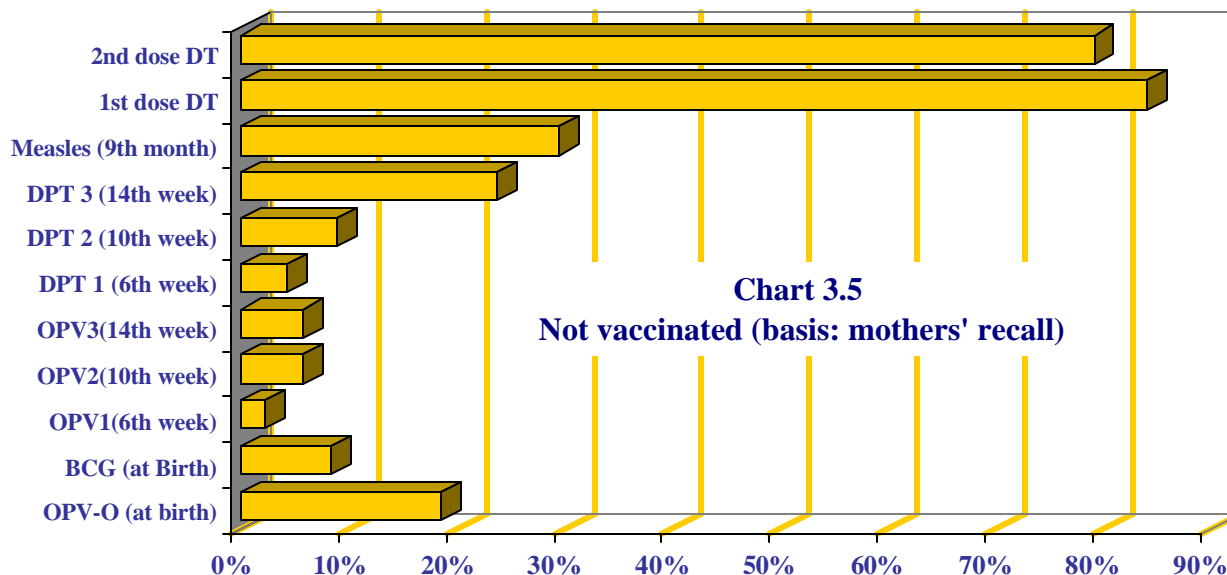
3.16. AWC services to children

According to mothers, 63.83% children were weighed or regularly weighed. (It may be noted that 80% of weighing machines in sample AWCs are not in working condition) (Table 3.89; pg.130)

94.29% of women say that their child received any Vitamin. 11.43% of mothers say that their children have received Vitamin A.

None has received referral service from AWC, in general mothers have received ORS packets. The accuracy of this data is questionable because women do not know what they should be getting.

3.17. Immunisation of children



The data is based on recall basis. It appears that none of the children have received 100% immunisation as recommended. Between 210 mothers there are 292 children below 6. 281 have had vaccination, possibly polio shots. Majority remembers polio shots. 11 children have not had any vaccination. (Table 3.90 to 3.92; pg. 130- 132)

The ANMs say that women frequently refuse vaccination. It may be true for a small minority of women but in general women are not afraid of getting their children immunised. This is where coordination between AWW and ANM can play a decisive role.

On further questioning, it appears that as the child grows older, the incidence of required vaccination drops. It could be that ANMs don't cover all vaccination as a mission, like Polio vaccination has become.

69.54% women say that children were vaccinated on NHD/MHD, while 24.71% say that the event took place any day. 5.75% do not know. (Table 3.93; pg. 132)

Quick review of the working of ICDS programme

Chart 3.5 plots the statement of mothers based on recall. It may be seen that majority do not remember of DT, 30% do not remember measles vaccination administered to their children. Even in case of Polio shot at birth, about 18% could not recall.

This indicates a major problem. The Rajasthan Health Department data shows that about 90% children have been covered under RCH programme and that the children have received the required shots. However, the responses from registered mothers show a different picture. **It is for this reason that effective ANM-AWW coordination is necessary.**

3.18 Conclusion

Registered women come from all sorts of background, including about 18% with high standard of living, which is encouraging. In one urban centre (sampled just for comparison purpose) the AWW had told the study team that well-off women do not use AWC facilities, only children of BPL families and weaker section go there. However, in rural areas, even women from upper caste higher standard of living utilise AWC services.

The women were interviewed on **13 major indicators**: socio-cultural practices, Awareness, interaction with AWC, participation in NHD/MHD, services utilised during pregnancy, Tetanus vaccination, services received after child birth, supplementary nutrition, awareness of diseases and action taken, home management of children's diseases, EBF, services utilised for children, and immunization of children. These indicators cover the entire range of services, which either AWC provides or are jointly provided by ANM and AWW.

The positive performance of AWC is reflected in the fact that 99% women now wash hands before eating; their awareness is marginally below that of AWW, which is good; participation in NHD camps is satisfactory; and majority of women are utilising health facilities located around their village. However, 100% immunization coverage and 100% exclusive breast feeding-two critical indicators of healthcare-show that results are not satisfactory. The positive indication is that if ANM and AWW coordination is strengthened, it will definitely show dramatic improvement on all indicators.

Chapter 4

The Village Leaders

4.1. Reason for interviewing village leaders

Ever since Panchayati Raj became a reality, gram panchayats have been elected and the village sarpanch, up-sarpanch, and ward members have a role in the development of their village, including provision of basic services such as AWCs, Sub-centres, water, sanitation, construction and maintenance of community assets such as roads, village pathways, water storage system, Panchayat Bhavans, Mahila Mandal Bhavans, sarai, etc. They are actively involved in selection of Anganwadi worker, Sahyogini, Sathin, and helper. It has been observed that village headmen are taking keen interest in these appointments and some have even taken steps to get an AWC started in their village. However, all is not well: caste and religious politics has vitiated the environment that has seriously debilitated the working of AWCs at many places.

4.2. Selection of subjects

Whilst every attempt was made to interview sarpanch or up-sarpanch, or ward member (if woman), when efforts failed to contact them the school principal or a village elder was interviewed. As can be seen from Table 4.1 that only 7 out of 47 available responsible

Table 4.1. Designation of responder

| District | Sarpanch | Up-sarpanch | Ward panch | Others | Total |
|--------------|-----------|-------------|------------|----------|-----------|
| Ajmer | 4 | 1 | 4 | 0 | 9 |
| Alwar | 8 | 1 | 0 | 0 | 9 |
| Jaisalmer | 5 | 1 | 1 | 2 | 9 |
| Nagaur | 6 | 1 | 2 | 1 | 10 |
| Sikar | 3 | 2 | 1 | 4 | 10 |
| Total | 26 | 6 | 8 | 7 | 47 |

persons were not elected members of the Panchayats but were mainly school principals. In three Panchayats no one could be traced to discuss village level issues and running of AWCs, one each in Ajmer, Alwar and Jaisalmer.

4.3. Background of respondents

Gender: 68.09% of respondents are male, 31.91% female. (Table 4.2; pg. 133)

Religion: Whilst 87.23% is Hindu, 10.64% is Muslim, and 2.13% Sikh. (Table 4.3; pg.133)

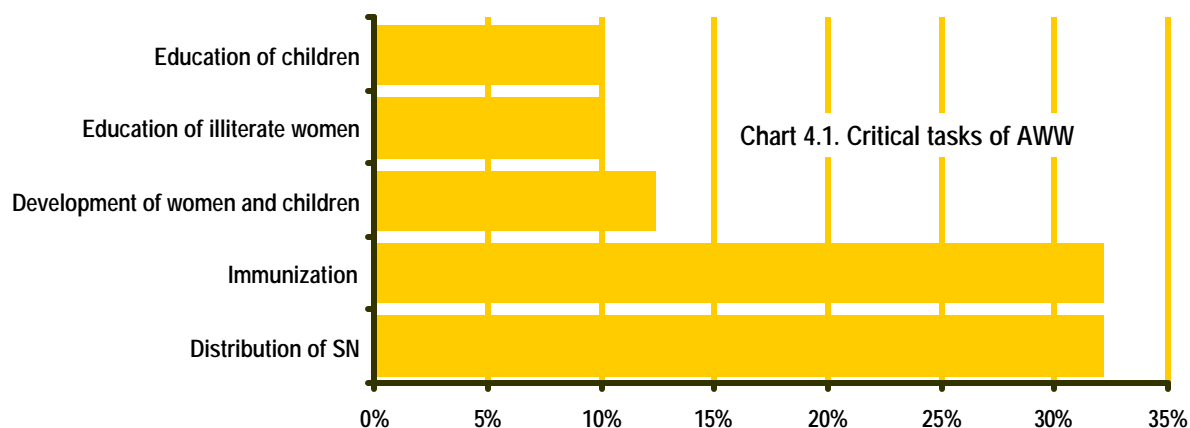
Caste: 29.79% is from the upper castes, 12.77% from the Scheduled Castes, 4.26% from the Scheduled Tribes, 40.43% from Other Backward Communities and 12.77% are either Muslims or Sikhs, the latter did not specify his caste. (Table 4.4; pg. 133)

Educational status: 8.33% is illiterate, 14.58% barely literate (can sign his/her name), 18.75% has completed primary school, 22.92% middle school, 16.67% high school, and 18.75% college. (Table 4.5; pg. 134)

Quick review of the working of ICDS programme

It is notable that in the last Panchayat elections, many educated young men and women have been elected. Discussions with them reveal that they are keen to learn their duties and responsibilities and work for local area development.

On the other hand there are caste and religious leaders who want to retain their hold



over local communities. Especially the religious leaders are the ones who are negating attempts to keep family size down lest they lose out on numbers.

4.4. Perception of three most important responsibilities of AWW

4.4.1. Dominant perceptions

Discussions with respondents reveal a critical information gap. Multiple responses were summarised in Table 4.6. page 134, Chart 4.1 above represents the information in graphical form. It can be seen that 39 out of 47 responsible persons in the Panchayats believe that the role of AWW is to distribute supplementary nutrition (SN) and help with immunization. About 12% believe that second most important task is “development of women and children” without having clear understanding of what the most critical issues are. Next in rank is the perception that key tasks of AWW is education of illiterate women and children from poorer households.

4.4.2. Absence of shared concerns

The sheer ignorance can be gauged from Table 4.7; pg.134: nearly 98% believe that AWW is performing her duties and responsibilities properly, none stated any deficiency.

The objective of ICDS programmes is to break the intergenerational cycle of malnutrition and to stop and reverse downward spiral of women’s health and the permanent cognitive deficits in children born of rural women, rich or poor is not a

consideration here. **Now, acknowledgement of this fact does not appear even once anywhere.**

Many elected Panchayat members are themselves from weaker sections or BPL families. If they are not aware of the thrust of ICDS programmes, how can they monitor the performance of ICDS in their own villages? The weakness can be directly ascribed to the fact that million of rupees were disbursed for training of elected representatives of PRIs to nodal NGOs but remain unspent, wrongly spent, or have been used for something else, but not for training. There is no need to blame representatives of PRIs as incompetent or ignorant. They simply don't know what their duties and responsibilities are.

Unless local leaders and representatives of local people know of the main concerns that are known in the Ministry, they can't become effective stakeholders. Unless they become effective stakeholders, ICDS programmes can't succeed in spite of the fact that it is one of the best-designed programmes.

4.5. Perception of the performance of ANM

89.5% feel that ANMs are doing their job properly. Four have complained that they do not for various reasons: (a) one is frequently absent, (b) ANM does not stay in the village that causes problems in times of emergency, and (c) one ANM charges money for services. Three out of four complaints are from Jaisalmer. (Tables 4.8 to 4.9; pg. 135)

4.6. Information dissemination

In order to effectively disseminate information among rural communities the government has an elaborate network of officers/volunteers like Jan Mangal Jora, village health worker, Sathin, Sahyogini, Lady supervisor, and Lady Health Visitors. In the opinion of village elders with the exception of ANM/AWW and Doctors (whenever they visit) none is seriously engaged in information dissemination. (Table 4.10; pg. 135)

Here it is important to remember that in the minds of the people a doctor is the only one qualified to treat patients and proffer proper advice. Other than the doctor, people look up to ANM. This is clear from this survey as well as earlier surveys carried out by this agency.

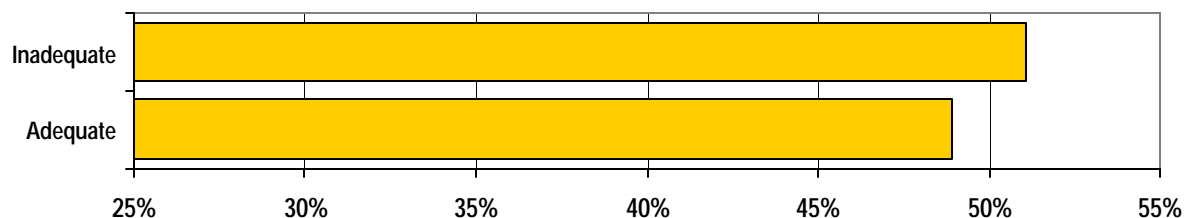
Hence, people expect doctors and ANMs to disseminate information and educate the people. When that does not happen, they complain. It is, furthermore, worth noting that few village elders have clear understanding of the role of various functionaries. Therefore, it is understandable that a realistic appraisal of the role of key functionaries is missing.

4.7. Critical health related problems

Table 4.11 page 136, summarises the critical health related problems faced by the villages. Ranked in order of responses, it appears that the fact that there is no dispensary in the village is perceived as a major problem, followed by shortage of doctors, quality of drinking water, and lack of awareness.

Actually, it is not even the lack of awareness as would be clear from data from women and AWW on awareness of basic healthcare issues. The crux of the problem lies in the inability of women to practice the knowledge and awareness in daily life because of social and cultural constraints, and the fact is that men formulate *the constraints*. It is men who frame the rules of social mores and practices, not women. And it is men who prevent changes. Therefore, lack of awareness is not the cause for sub-optimal performance of ICDS programme; it is the mind-set of men, to a large extent, that

Chart 4.2 Adequacy of food production



prevents desirable changes of traditional practices.

4.8. Need for small family

Majority, 46 out of 47, feel that family size needs to be small. Even women want small families, implying fewer children. (Table 4.12; pg. 136) Yet village elders want to retain political control over the village and that control can only come from numbers from their caste/religious groups.

4.9. Food security

4.9.1. Food production

A major factor in the battle against malnutrition is the ability of a community (or village) to produce adequate quantity and quality of food for its people. This issue was discussed at length at all sample villages.

About 49% of village leaders feel that their village can feed its population but 51% (24 villages) feels that the village does not enjoy food security. (Table 4.13 page 137)

4.9.2. Natural calamity

Quick review of the working of ICDS programme

46 villages have suffered a drought in the last five years. (Table 4.14 page 137) Only 16 villages have taken steps to prevent its recurrence and the results have yet to be seen. (Table 4.15 page 137)

4.10. Implication for ICDS programmes

4.10.1. Growing healthy food is essential to combating malnutrition: Unless rural people produce healthy food, particularly vegetables, SN and medicines are unlikely to resolve the central issue of malnutrition and its long-term consequences.

It is possible for any household to produce healthy vegetables and fruits all year round and earn enough money to exchange surplus produce to buy good quality cereals and essential goods and services. But the farmers have become so heavily dependent on artificial means for fertigation that

our soils are now devoid of critical micronutrients (sulphur, magnesium, boron, etc., to name just a few). These micronutrients are critical for soil health. Without healthy soil it is impossible to produce healthy crop. Without healthy crop people can't maintain good health.

Enough evidence has already piled up that show that conventionally grown food is deficient in critical nutrients and micronutrients. (Box 4.1)

Box 4.1. Average changes in the mineral content of some fruits* and vegetables*, 1963-1992

| Mineral | Average % Change |
|------------|------------------|
| Calcium | -29.82 |
| Iron | -32.00 |
| Magnesium | -21.08 |
| Phosphorus | -11.09 |
| Potassium | -6.48 |

* Fruits and vegetables measured: oranges, apples, bananas, carrots, potatoes, corn, tomatoes, celery, lettuce, broccoli, iceberg

Healthy life depends upon healthy food but the deficient food that people have been eating since conventional agriculture was adopted is now held to be directly responsible for major diseases like cancer, sclerosis, diabetes, premature ageing, poor bone density, obesity, and malnutrition throughout the world. About 500 papers are available with SEDEM that convincingly prove that India is fast moving into substantial dietary inadequacy regime. Conventional farming has seriously affected the quality of milk, meat, egg, fruits, and pastures. Medical journals like Lancet, British Journal of Medicine and life style magazines such as Life Extension, and others have published countless research papers recommending that only chemicals-free foods should be given to children, nursing mothers, pregnant women and patients of cancer, hypertension, diabetes, and other degenerative diseases. One US study has demonstrated that children who eat conventional foods purchased from super markets ingest as much pesticides by age 5 as is permissible over the entire life of a human being. Long-term (longitudinal) studies from Scandinavia, Australia, Japan and the US prove that organic foods are superior on every nutritional parameter. Hence, a major contingency is to grow nutritious food through sustainable management of farms.

Quick review of the working of ICDS programme

The USDA (United States Department of Agriculture) commissioned a series of studies in 2001 and similar studies were commissioned in European Community countries that prove that conventional farming is causing dramatic fall in nutritive content of foods. Micronutrient Initiative has produced authoritative data that population in even developed economies is facing malnutrition. Therefore it is critical that India moves into a food security regime that addresses the question of nutritive content of food grown on land. In fact USDA is on record for stating that one tomato produced in 1960 had sufficient nutrition that even 10 tomatoes can't give in 2003, i.e. the nutritive content has come down to 10% of what it used to be in 1960.

4.10.2. Villagers and Gram Panchayats must realise the fallacy of producing quantity at the expense of quality: For far too long villagers have believed that producing quantity by artificial means will ensure higher income and food security for their family. None of the farmers has achieved this. Instead, they have moved into debt trap and are producing food that is short of nutrition.

4.11. Conclusion

The central issues of malnutrition are not clearly understood by village leaders. They have rather vague understanding of the role of key functionaries. Nearly 50% of the villages surveyed are food scarce region. The quality of food being produced is nutrition deficient because majority of farmers follow conventional methods of farming.

It must however be acknowledged that there are complex issues involved in progressive decline in land productivity and the decline in nutritive content of foods that we eat. But the study team did not meet even one person who had even some idea of the magnitude of problem facing rural communities.

The current thinking at village level is unlikely to help local communities move toward nutritional adequacy.

Under the circumstances, a Gram Panchayat will be unlikely to play a significant role in reversing the intergenerational cycle of malnutrition.

Chapter 5

Working Of Anganwadies

5.1 The purpose of AWCs

The AWCs are community-based organisation with main focus on breaking the cycle of malnutrition. Hence Anganwadies serve four groups: (a) pregnant women and nursing mothers (b) Infants (c) pre-school children and (d) adolescent girls. Socialisation of children begins here at the crèche. AWCs also act as distribution point for supplementary nutrition and essential micronutrients to registered beneficiaries in designated clusters.

Essentially, all the critical health and nutritional programmes converge at community level to be managed at AWCs through a coordinated effort of Anganwadi and Sub-centre functionaries. It is their joint responsibility to create awareness about healthcare, sanitation, hygiene, childcare, and to provide the first point of contact to a villager in need of healthcare and family welfare services. The RCH programme of Health Ministry seeks to prepare village, block, district and state level participatory health plan through Community Needs Assessment tools. The AWC and Sub-centres are the bedrock for the entire planning exercise. Hence, it would not be incorrect to say that India's efforts to control population, eliminate malnutrition and provide high quality healthcare services rest squarely on AWC and Sub-centre functionaries.

5.2. Number of working centres and beneficiaries

There are 7083 approved AWCs in the five districts. The target for each centre is: 9 nursing mothers, 9 pregnant women, 2 adolescent girls, 40 infants (0-3 years), and 40 preschool children (3-6 years). Thus the target is to reach out to 100 beneficiaries per centre. However, numbers vary from village to village.

When the actual number is higher than the target, the CDPO uses his discretion to select the beneficiaries giving priority to BPL, SC/ST, or minority households.

| District | Period | Approved AWC | Working AWC | Total Beneficiaries | Average Per AWC |
|------------------------------|-----------|--------------|-------------|---------------------|-----------------|
| Ajmer | March, 05 | 1328 | 1328 | 131,553 | 99 |
| Alwar | March, 05 | 2079 | 2079 | 203,075 | 98 |
| Jaisalmer | March, 05 | 327 | 327 | 32,309 | 99 |
| Nagaur | March, 05 | 1840 | 1840 | 175,214 | 95 |
| Sikar | March, 05 | 1509 | 1509 | 149,991 | 99 |
| Total for 5 districts | | 7083 | 7083 | 692,142 | 98 |

5.3. Stocks, supplies and equipment at surveyed centres

5.3.1. Stocks of SN

From the above data it can be calculated that if all beneficiaries are given single ration only, the monthly stock of SN should be 150 kgs of baby mix, 62.5 Kg of Rajasthan mix, and 75 kgs of *murmure* per AWC. Normally, SN is supplied in 20 kg plastic sacks and stored in the centre, within the crèche. Some spoilage does take place but many non-beneficiary children also come here and take ration. The control over distribution is generally lax. The main point is that 7083 centres are supplying at least 442 MT of Rajasthan mix, 531 MT of *Murmure*, and 1062 MT of baby mix, every month, without proper records of stock in hand, spoilage, etc., at project (CDPO) office.

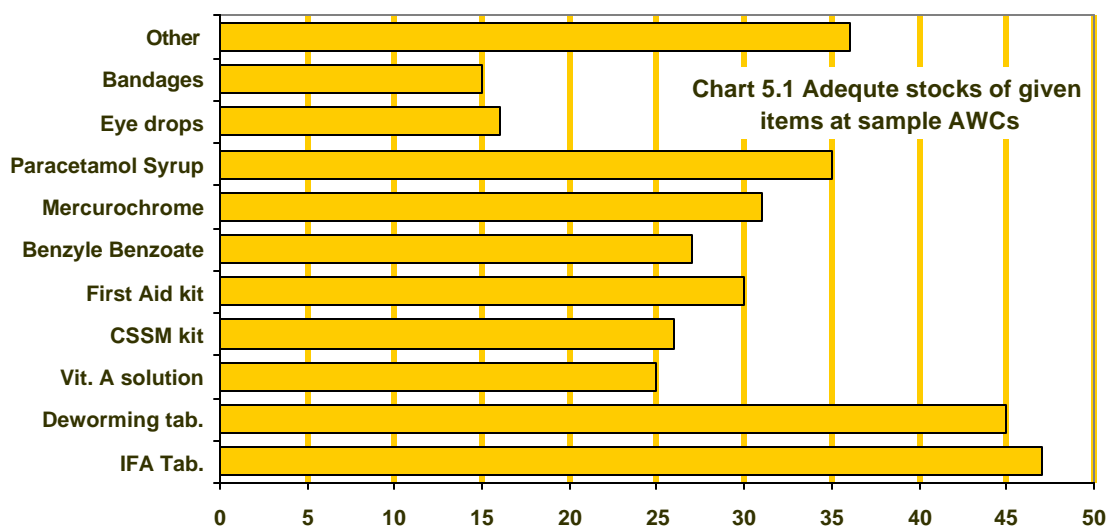
Table 5.2 Required stocks of SN (only on single ration basis)

| | Monthly ration | | Target | Monthly stock |
|--------|----------------|--------|--------|---------------|
| | Single | Double | | Single ration |
| Women | 3.125 | 6.25 | 20 | 62.5 |
| Child | 1.875 | 3.75 | 40 | 75 |
| Infant | 3.75 | 7.5 | 40 | 150 |

Due to paucity of data on supplies made to AWCs it is impossible to analyse and arrive at whether adequate quantity of SN is reaching the centres or not. There is reluctance to share data on stocks received from suppliers, requisitioned by projects, issued to AWCs, and transported to the AWCs. The entire distribution logistics is shrouded in mystery. However, all AWCs have reported that they have adequate stocks of SN.

5.3.2. Essential medicines and supplies:

The investigating team collected data on availability of medicines and equipment from all the 50 centres. From Chart 5.1 it would be clear that in 47 centres sufficient



Quick review of the working of ICDS programme

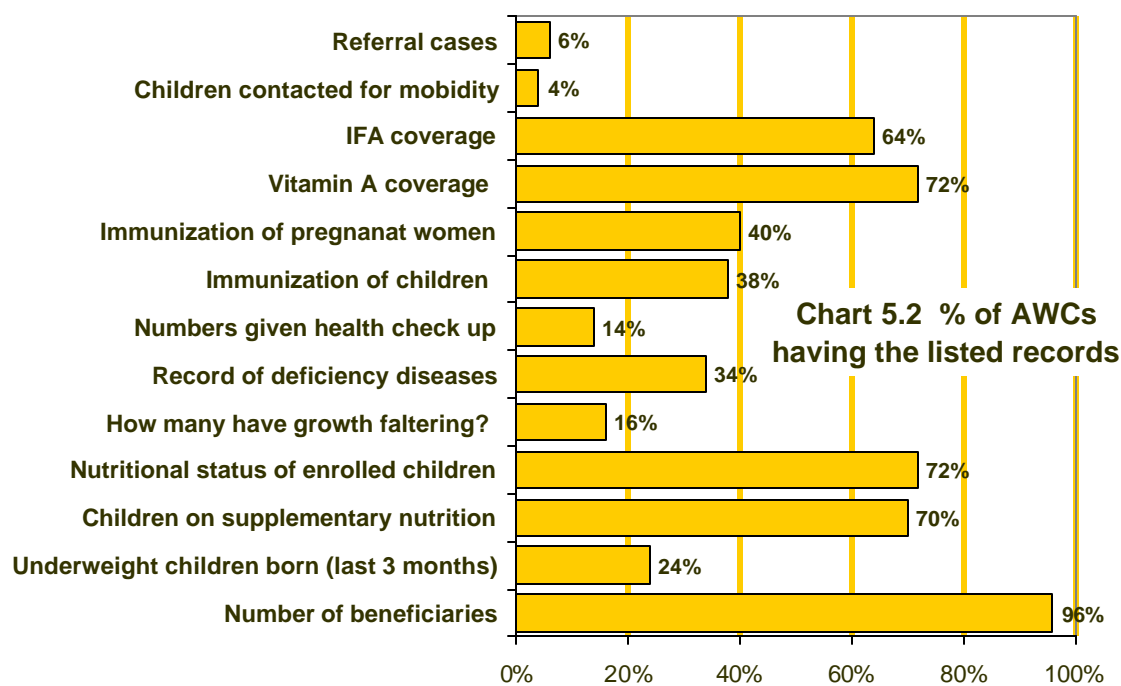
quantity of IFA tablets is available, in 45 centres there is sufficient de-worming tablets, 25 centres have sufficient stock of Vitamin A, and so on. For some time, it has been the policy to keep CSSM (Child survival and safe motherhood) kit at AWCs and it can be seen that 26 centres had this kit. An important observation is that all AWCs do not have all the essential stocks of medicines, supplies and equipment. The investigating team was also told that many supplies are not sent regularly.

5.3.3. Essential equipment

The investigating team observed that in 40 centres, weighing machines are non-functional. It implies that 80% of weighing machines were non-functional at the time of survey and it is natural that regular weighing events are not held in these centres.

In addition to these, each centre should have cooking utensils, stove, kerosene, steel plates and saucers for serving SN, water pot, tumblers, soap, towels, black board, table, chairs, rug/mat for children to sit, colourful charts, etc. All the AWCs do not have all the essential equipment as per the requirement.

5.4. Essential records



The investigating team checked the method and quality of record keeping in respect of 12 key data items that are supposed to provide the basis for state records. These were: number of beneficiaries, number of underweight children born, children on SNP, nutritional status of children, numbers with growth faltering, record of deficiency diseases (Bitot's spot, pigeon chest, etc), numbers given health check up, immunization of women and children, Vitamin A and IFA coverage, children contacted for morbidity and referral

Quick review of the working of ICDS programme

cases. Chart 5.2 shows the number of AWCs that have proper records against the listed item. The remaining has either no record or partial record, partial in the sense that there is no consistency.

It can be seen that there is not a single AWC that has all the records. Even on most basic services that AWCs provide, records are complete on number of beneficiaries at 96% centres, nutritional status of children at 72%, Vitamin A coverage at 72%, **children on SNP at 70%**, and IFA coverage at 64%. In most other matters less than 50% AWCs have records. In certain critical matters like numbers given health check up, only 14% has proper records.

It implies that majority of AWCs do not have proper system of record keeping. The next logical questions are: (a) how do ICDS Projects generate management data for their own control and administration purposes? For example, if data on nutritional status of children is not available at 28% AWCs, how are the controlling projects determining the needs for SN, medicines, etc? And (b) if corresponding data is not maintained at AWC, how are ANMs preparing Sub-centre level health plan? It is the aggregate of sub-centre plan that eventually becomes the district health plan for coming months. More crucially, on what basis the district health authorities are compiling data on immunization, ANC, PNC, TT vaccination, all critical components of RCH programme?

Implication for Supervisory level: What are the supervisors and CDPOs doing? As mentioned in Chapter 2, sub-sections 2.5 to 2.10, nearly 9 out of 20 CDPOs are holding additional charge and they have no time to oversee the working of Supervisors. 28% posts of Supervisors are vacant because of which fewer supervisors are available to oversee the working of centres under their charge. In many centres months pass by before a supervisor visits them. Since many AWWs are barely literate, it is natural that record keeping is shoddy. Yet, data is reaching the district headquarters. The Management Consulting team observed that the first thing a Supervisor does on her visit to the AWC is update the AWC records. She marks and signs the attendance sheets, fills up the columns of children under SNP, etc. She is supposed to do this once a month but in many projects the turn of an AWC comes after at least 60 days. In majority of cases the records remain incomplete and in some cases they are fudged. At CDPO, i.e. at project level, the numbers are “*churned*” and transmitted to the district headquarter and on to the state directorate.

Implication for ANM and sub-centre level health planning: An ANM is supposed to work with AWW to assess, for example, the needs for health check-up, immunization, etc, i.e. all the components of RCH programme. Suppose 7 women are pregnant, she has to plan for 7 x 2 TT vaccinations, and at least three ANCs per woman, or 21 ANCs, and this data is sent to PHC, from PHC to CHC and then on to the District Hospital where it is entered as target, although under RCH programme targets are not to be set. In other words, a target is one that correctly reflects

Quick review of the working of ICDS programme

“Community needs” not what the ANM feels, observes and/or records. Now if the ANM has record of only 5 women out of 7, she would plan for 10 TT shots. If she gives 10 TT shots she has achieved 100% target, without realising that two women were not included. If perchance she includes the sixth woman, then automatically she achieves more than 100% target, which is technically incorrect. Also, suppose 4 women are on record and 4 are left out. 8 TT vaccinations are given. The ANM may record 100% target achieved but in fact she may have given one TT shot to each of the 8 women. From ANM’s own record, these facts have been confirmed.

On the other hand, when one correlates the number of children with full complement of vaccination, the data shows that not one child is 100% vaccinated. This is based on mother’s recall and statement based on recall cannot be totally dependable because majority of women are illiterate. Then the basic questions are: If all the ANMs are ensuring 90%+ immunisation, where is the record of beneficiaries? On what basis they set their RCH target if record of community needs is not available within the community? There is no evidence that suggests that target was set through a properly coordinated community based participative planning at AWC?

5.5. Anganwadi worker (AWW)

AWWs form the bedrock on which performance of ICDS programmes squarely rests.

They represent the concerns of the state within the community or cluster of

households. In this section data from structured interview schedules administered to 50

AWWs are summarised.

(a) Background of AWWs

34% belong to Upper castes, 50% is from OBCs, 16% from the Scheduled Caste communities; 94% is Hindu, 6% Muslim; 48% live in nuclear family, 52% in joint family; 46% has more than 7 persons to the household, 38% has 5 to 7, and 16% has 4 or fewer.

(Tables 5.4 to 5.7; pg.138-139) 54% has high, 38% has medium, and 8% has low standard of living. Computation of SoL data is based on ICMR protocol.

(Table 5.8; pg. 139)

(b) Literacy and awareness

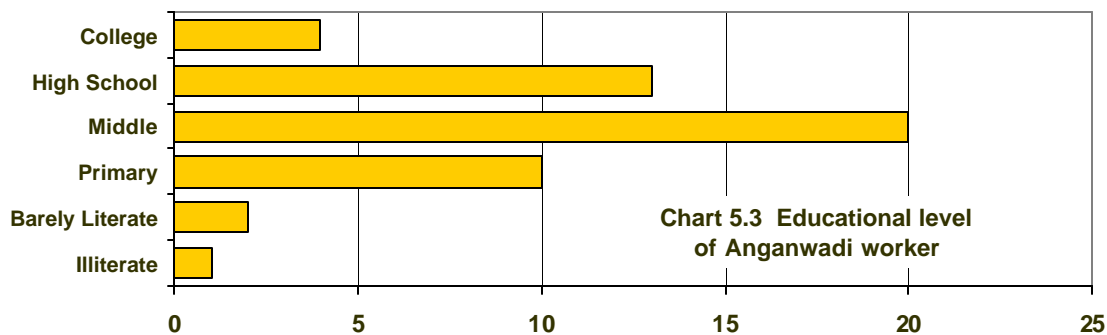
Quick review of the working of ICDS programme

(i) **Literacy:** Of the 50 AWWs interviewed, 40% are middle pass, 20% are Primary pass, 26% have completed high school, 8% has gone to college. 6% is illiterate or barely literate. Thus it can be said that about 74% (middle and above) are formally literate and can manage the activities of AWCs. (Chart 5.3)

(ii) **Awareness:** The 50 AWWs were given a test of awareness, same as beneficiary women were given. The scores are summarised and discussed below.

| District | Mean score Women | Mean score AWW | % Difference (AWW-women) | Mean literacy Women | Mean Literacy AWW |
|-----------|------------------|----------------|--------------------------|------------------------------------|-------------------|
| Ajmer | 50.96% | 63.73% | +12.78 | Between barely literate to primary | Middle |
| Alwar | 44.45% | 55.97% | +11.52 | Between barely literate to primary | Middle |
| Jaisalmer | 43.82% | 59.70% | +15.88 | Barely literate | Primary |
| Nagaur | 44.63% | 60.00% | +15.37 | Barely literate | Middle |
| Sikar | 49.49% | 59.85% | +10.36 | Between barely literate to primary | Middle |

The above table shows that the percentage difference between beneficiaries and AWW in the five districts varies from 10.36% to 15.88%, implying that AWW are relatively



more aware of the facts that are given in NHED book. But not one AWW scored over

Quick review of the working of ICDS programme

70%, implying that even they do not know all the facts as required. **It further implies that their training and capacity building is deficient.**

The table also shows that mean literacy level of beneficiary's lies between barely literate to primary whereas the mean literacy level of AWW is at least primary in Jaisalmer and middle in other districts. **But the correlation between literacy and awareness is weak** (+0.19), implying **that literacy is not a determinant of awareness.**

Low awareness of AWW indicates lack of commitment, seriousness, poor training and capacity building, and poor supervision by supervisors. *All AWWs believe that they are in a government job, all the more reason for them to learn their tasks.* It is, therefore, important to look at their training and capacity building.

(c) Training and capacity building

Programmes attended: All AWWs have received training (100%). Majority has attended more than 2 programmes. (Chart 5.4)

30% of AWWs have attended more than 11 programmes, 12% has attended 8 to 11 programmes, 16% has attended 5 to 7 programmes, and 36% has attended 2 to 4 programmes. The mean number of programmes attended by AWWs is 6.5. (Table 5.9; pg. 139)

Convenience of location: 88% feel that the programmes were at a location that was convenient to them. (Table 5.10; pg. 140)

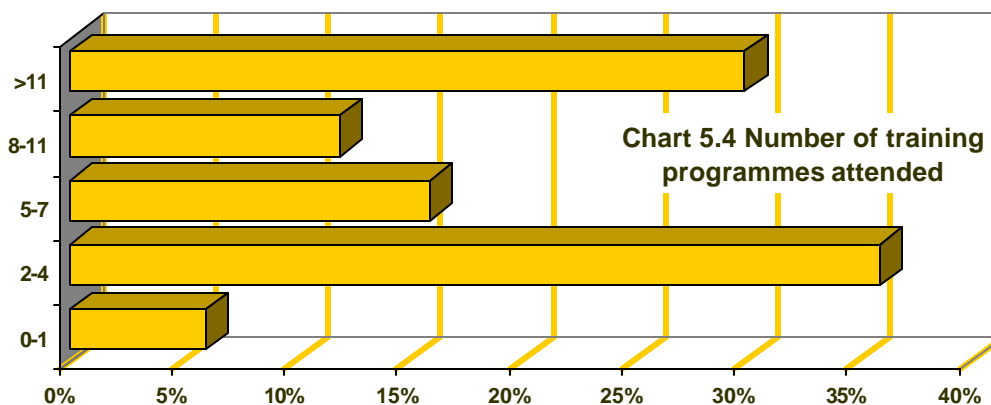
Training materials: 98% say that training and reading materials were given to them. The materials included various items like register, pen, booklet, paper, etc. 62% has received NHED book. 60% showed the investigating team the book, 40% did not. (Table 5.11 to 5.12; pg. 140)

Use of training material: 56% use the book, others don't. It may be noted that this book is supposed to be the basis of information dissemination within the registered women. (Table 5.13; pg. 141)

Perception of training material: 80% feel that the training material is good. (Table 5.14; pg. 141)

Quick review of the working of ICDS programme

Batch size: It appears that average training batch size was quite large. 38% say that 100-130 AWWs were trained in one batch, 46% say that 32-60 were trained, 10% say that 16-31 were trained. It implies that average trainee batch was about 65, too large to be effective. On the contrary, only 2% of the AWWs feel that a typical batch size was



too large. 20% feel that it was large and 68% feel that it was adequate. In any well-designed training programme the ratio is 20 trainees to 1 trainer. It implies that organisers have not taken training programmes seriously. The AWWs being largely semi-literate have not been able to understand the seriousness of training and capacity building. (Table 5.15 to 5.16; pg. 141 –142)

Perception of training programmes: All (100%) believe that the training programme has helped them perform their tasks better. 6% observed some weaknesses in the programme. (Table 5.17 to 5.18; pg. 142)

Perception of trainers: 90% believe that trainers were good, 82% believe that they were qualified and experienced. 94% discussed their weak areas (problems) with the trainers and all of them received proper response from the trainers. (Table 5.19 to 5.21; pg. 143)

Summary on training: One may conclude that many training programmes have been organised in past and majority of AWWs has attended about six of them. The batch sizes have been large, over 65 per batch, which has reduced the effectiveness of the programmes. In general, AWWs believe that trainers were good, training materials were useful. But only about 6 out of 10 make use of the training material. It implies that training programmes will have to be strengthened, followed by effective capacity building.

5.6 Quality of physical facilities

An “Adarsh” AWC is one that has its own government building, furniture & fixtures, essential supplies, AWW with 10 years experience, and at least primary pass.

Around 42% facilities are good; the remaining vary from poor to extremely decrepit. Majority has serious storage problem. The photograph of one poorly equipped AWC is given below.

The main problems in many AWCs are: availability of water, shortage of storage



Image 5.1 A poorly equipped AWC at Sikar

Quick review of the working of ICDS programme

space, and basic tools for pre-schooling. Some Adarsh AWCs have painted their walls black, which is bad for growing minds. (See Image 5.8)

Majority of AWCs had a number of posters and charts giving information on healthcare, vaccination, mother and child care, sanitation, nutrition, importance of ANCs, etc. Even if the centres were run from homes, they had these basic information posters. However, few are properly equipped to run as crèche or pre-school



Image 5.2 “Will the road pass them by?” Young soldiers with Akshar Kumar, who headed the investigating team. Akshar died in an accident on 20th May 2005.

5.7 Other observations

Lack of awareness of expired medicines

Whilst the number of AWCs keeping expired medicines is small, the fact that they were found in unopened boxes suggests that they do not maintain stocks properly. One urban AWW was asked as to what she does with expired medicines. She said she throws them by the wayside. It may be noted that this is not the way expired medicines should be disposed off. They are supposed to be destroyed.

5.8. Observations of senior investigators

At all 50 AWCs the study team had the required time to make independent in-depth assessment of AWWs by observing their work. This summary is based on observations of senior investigators and feedback from village elders along pre-determined parameters.

Quick review of the working of ICDS programme

In so far their **inter-personal skill** is concerned, 33 can work with the community with women of varied socio-economic background. Others (17) do not have these skills. Caste, social perception and literacy are the main barriers.

30 were observed to be committed workers. **Commitment** was missing in nine; they believe that their job is to distribute SN. Others are simply there because they were appointed to the post.

So far as **knowledge and competence** is concerned, 15 (30%) were found to be knowledgeable and competent, others were not so. It must be pointed out that many do not remember the technically correct answers to many questions.

Honest and hardworking: 35 (70%) are honest and hardworking. Feedback on six was that they are not. 35 of the 50 are **healthy and physically fit**. Two are frequently down with illnesses. In remote rural areas this is a serious constraints.

Majority **regularly** attend to their work. “Attend to work” does not imply that they keep the Anganwadies working as planned. They are efficient in distributing SN and about 39 run the crèche properly within the obvious constraints.

5.9 Exceptional AWC

Anganwadi centre, Dahalwas, GP and PO Dajalwas, Umrain Block, Alwar

AWW: Mrs Uma Devi

Uma Devi is a Bengali lady, who divorced her first husband because of his drunkenness, got married to a Rajasthani army man serving in her village in West Bengal and, upon his discharge, is now settled in her second husband’s village. She has completed primary level of education through Bengali medium but can’t read or write Hindi or English. She speaks Hindi, though. She has been running the centre, from her house, for about 16 years now.

She requested the study team to put in a word with the local Bank Manager to fund her Anganwadi Centre. With her own resources she has managed to complete the plinth and raise the walls up to the window level. The construction is of random rubble and local materials, quite suitable for this remote village. She has participated in Tarun Bharat Sangh’s water movement and was quite active in her village. She has attended programmes on water management, critical for survival in these parts.

The village is about 18 kilometres from Umrain CDPO office and is the last village on the road. Beyond this village there is no road. The village is surrounded by hills on

Quick review of the working of ICDS programme

three sides. There is a river by the village, which is usually dry in summer but full of water during the monsoon.

About 35 children attend the pre-school. Uma Devi has a natural talent for teaching children with the help of oral tradition of stories, jokes, and fables. Children and adolescent girls love her. It is for them that she has made the effort to construct her own AWC.

Uma Devi organises, on average 20 WSHG meetings per month. This is remarkable. It was observed that women come to centre at all hours during the day and Uma Devi attends to them in the best possible manner.

Possibility of public-private partnership

It is suggested that Uma Devi is given some assistance with building materials and some financial assistance for her to meet the labour cost of construction of her partially complete centre. It will encourage other AWWs to take initiative and construct their own permanent structures through a public-private-community partnership. It has been observed that motivation and commitment of AWWs is the key determinant of utilisation of Anganwadi facility. Hence, this lady should be rewarded with support for what she wants to do for her centre.

Unfortunately neither Uma Devi nor her AWC could be photographed. Senior members of the consulting team had visited this centre when they heard of Uma Devi's achievements on the spur of the moment. Actually this was 52nd AWC covered.

5.10. Inter-institutional conflicts

An Anganwadi centre in Jaisalmer was using one room of a primary school as crèche. When schoolteachers were present, the children of this primary school would not disturb the AWC. When teachers were absent, children would disrupt AWC functioning, demanding murmure and baby mix.

The AWW complained to the school headmaster. The headmaster found out that the Supervisor and CDPOs were recording the number of days the primary school teachers were absent. This got the headmaster worried.

He ordered the AWC out. And the District Primary Education office, which took the plea that AWC's presence is a hindrance in maintaining discipline of the Primary School, supported him.

Quick review of the working of ICDS programme

Field investigators' observation

Akshar Kumar (now deceased), senior investigator of SEDEM, investigated the event and his observations are that many primary schools have surplus space that can be shared between AWC and the Primary School. At least some of the SN stocks can be stored here.

But two departments are involved here: the education department and ICDS. Hence it is suggested that as far as practicable, AWCs should not be located in other schools.



Image 5.3 Adarsh AWC, Tilora, Ajmer. One of the World Bank assisted AWCs.

Quick review of the working of ICDS programme



Image 5.4 AWC at Tausar (Gujjar ki Dhani), Nagaur district. The AWW is giving information on vaccination to women (TT, children’s vaccination, etc)

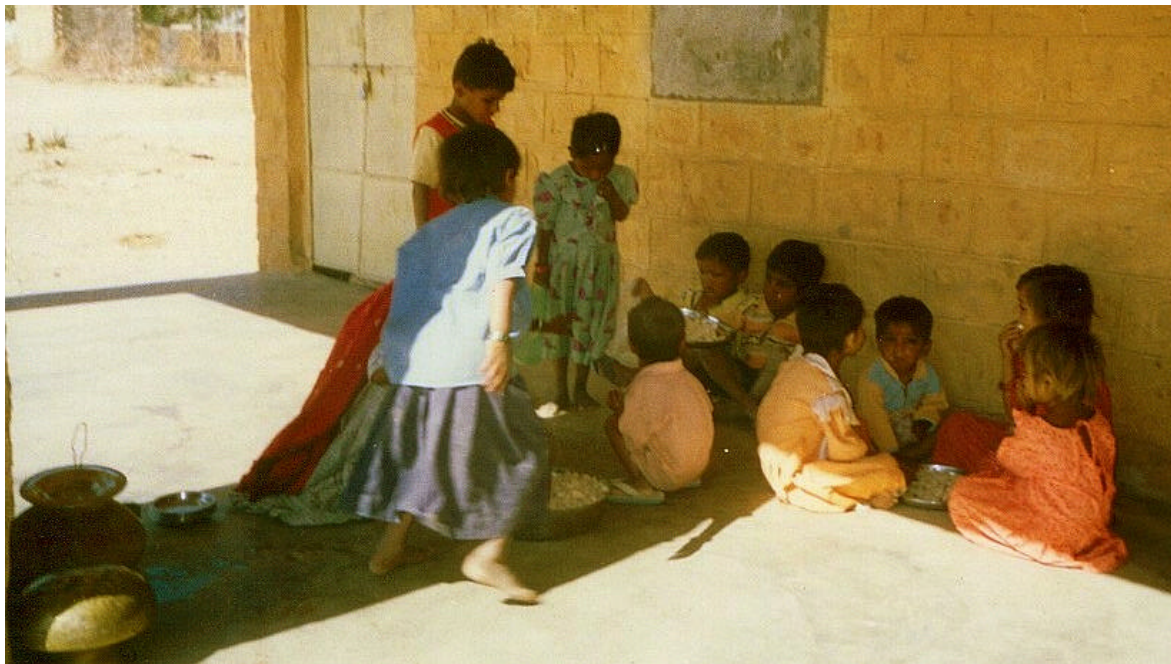


Image 5.5 “Something for me too?” Children sharing murmure at AWC at Chandan village, Jaisalmer.

Quick review of the working of ICDS programme



Image 5.6 Gathinlasar, Nagaur district: distribution of supplementary nutrition.



Image 5.7 Adarsh Anganwadi Kendra, Gangwana, Ajmer District-a group of preschool children. This is one of the better-managed centres in Ajmer.

Chapter 6

Coordination of ICDS with health services And Auxiliary Nurse Midwife

6.1 Working of ANMs and ICDS

The study team could meet with 43 ANMs in the five districts. Seven were on leave, two on maternity leave, two were absent or not available, one village did not have an ANM. A senior investigator made a second visit to track down absent ANMs in April but to no avail. He could meet only two in Jaisalmer. The final tally is shown in Table 6.1.

| | |
|-----------------------|-----------|
| ANMs interviewed | 43 |
| On leave | 1 |
| On Maternity leave | 2 |
| Absent /Not available | 4 |
| Total attempted | 50 |

Mean distance of AWC from ANM's residence: The mean distance of sample AWC from the residence of ANM is 1.95 kilometres. The farthest an ANM comes from is one about 13 kilometres (Ajmer), one in Alwar from 11 kms and one in Sikar from 10 kms. (Table 6.4; pg. 144)

Type of facility near sample AWC: According to ANMs, 74% of AWCs have a Sub-centre nearby, 20.9% has a PHC and 2.3% has a CHC. 2.3% has an ISM&H centre. Thus 43 ANMs say that there is a government health facility near AWC sampled. (Table 6.5; pg. 144)

Awareness of ICDS and its objectives: 97.67% is aware of ICDS programme; one ANM in Jaisalmer (2.33%) is not. (Table 6.6; pg. 144) Those who are aware have variously responded that project objectives are (a) Check up of pregnant women and family planning (35.37%), (b) Distribution of SN (32.93%), (c) Vaccination (15.8%), (d) Health education (7.3%), and women and child development (6.1%). (Table 6.7; pg. 145) It can be seen that the main focus of ICDS-to break the inter-generational cycle of malnutrition-has not been mentioned by any.

Main responsibilities under ICDS: Those who know of ICDS have variously described their responsibilities as: (a) Vaccination (45.6%), (b) Health check up (17.2%), (c) Family Planning (22.2%), and SN distribution (3.7%). Issues such as better co-ordination with AWW to prevent deficiency diseases, 100% coverage for vaccine preventable diseases, and prompt referral were not even mentioned. It indicates that ANMs know something about the ICDS but the focus of ICDS and integrative responsibilities under RCH are not mentioned and not known. (Table 6.8; pg. 145)

Job satisfaction and complaints: 93.2% appear to be satisfied with their job. Their three main complaint pertains to (a) distance, travel time and lack of transport, (b)

Quick review of the working of ICDS programme

shortage of a few critical supplies like vaccines, (c) Lack of awareness of women. Thus, problems facing ANM can be classified under three heads: (a) the responsibility to cover scattered villages and user groups without any transportation facility, (b) lack of awareness and non-co-operation of user/target groups, and (c) poor facilities. These are genuine complaints for some. (Tab 6.9 page 145)

Suggestions from ANMs to improve healthcare: Different districts have different problems and this is reflected in the responses of ANMs. The four most suggestions from ANM are (a) Dissemination of information and awareness creation, (b) transportation facility to enable her to cover four or five AWCs under her charge, (c) one helper or assistant and (d) Support of GP. The last point has been mentioned in the passing by many ANMs. (Tables 6.10-6.11; pg. 146)

Responsibility for providing healthcare: 42 out of 43 believe that it is their responsibility to provide quality healthcare and 40 of them believe that the centres under them are getting good quality service. (Tables 6.12 to 6.13; pg. 147) It indicates that they understand their responsibilities under RCH programme and within the constraints they believe they doing the best for the local communities.

Critique facilities: The ANMs have extensively discussed their constraints in terms of infrastructure, supplies, stocks of medicines, availability of working equipment, etc. These constraints have been summarised in Table 6.14 page 147. It can be seen that their main problem is poor infrastructure including lack of residential facility, followed by equipment not in working conditions, etc. Availability of stocks of medicines and essential supplies has improved but still about 6.98% have complaints on this count.

6.2. Community perception of ANMs

People trust ANMs and the latter are respected members of the community. If ANMs say something, people take it more seriously and many follow the suggestions in practice.

Of the 47 village elders and GP representatives interviewed, 43 have no complaint against ANM. Four have serious complaints as to (a) Absence, (b) Living away from village and (c) demand for financial compensation (Suvidha shulk mangti hai) This equates to about 8.5% having serious complaints against ANM. However, it must be stressed here that this sample is small to make generalisation against ANMs. (Tables 9 and 10)

According to community leaders key role in information dissemination is played by AWW and ANM (27.6% say this), while another 27.6% say that it is doctors. The worst district in these terms was Ajmer and best Jaisalmer in this sample.

The four most critical health related problems facing the sample Gram Panchayats were: (a) No dispensary, (b) Shortage of doctors, (c) drinking water, and (d) lack of awareness.

6.3. Investigators' observations of working of ANMs after meeting with elected members of GP / village elders

Commitment to work: 30 were reported to be committed to work, three not committed for various reasons; there was no observation on others. Investigators have also reported that one ANM was present in the village but refused to meet the study team despite several visits to her house.

Ability to work with women of varied background: Majority can work, two can't work (one because of language problem; ANM from non-Hindi speaking regions have this problem). The investigating team has not found caste based discrimination among this sample of ANMs.

Knowledge and competence: Majority is reportedly knowledgeable and competent. No observation on two. One ANM in Jaisalmer is too young (about 16 or 17) and questions have been raised on her appointment.

Dependable in emergency: 36 are reportedly dependable: they have responded well in times of emergency. Seven were weak on this count and this is based on observations of villagers. ("Nahin ati hai," "Paisa mangti hai", etc.) Demand for a fee has been reported against two ANMs.

Hardworking and honest: Ten were observed to be hardworking and honest. Four were not.

Sickness among ANMs: Majority is healthy. A major problem is that some are on maternity leave that leaves many AWCs unserved for long periods.

Attendance: This is again based on reports, not on records or attendance register. The general observation is that majority does attend to duty regularly.

6.4 Background of ANMs

Age and age at marriage: It can be seen from Table 6.15 that 44.19% are 36 years or older, 23.26% are 31 to 35 years of age, 27.91% between 26 and 30, and 4.66% 25 or below. Thus majority of ANMs are young women. 32.5% got married when over 20, 39.53% when they were between 16 and 20, and 27.9% when they were under 16. Like AWW, under-age marriage is still prevalent even among ANMs. (Tables 6.15 to 6.16; pg. 148)

Type of family: 67.4% live in nuclear household, others in joint households. (Table 6.17; pg. 149)

Caste and religion: 44.19% are from upper castes, 9.3% from the Scheduled Caste communities, 9.3% from Scheduled Tribe communities, 23.26% from OBCs, and 11.63% are from other communities. 81.4% is Hindu, 4.65% Christians (a few from Kerala, a reason for language problem), and none from the Muslim community. (Table 6.18 to 6.19; pg. 149)

Quick review of the working of ICDS programme

Literacy and schooling: Over 97% has been to school. One has not cleared primary school. 46.5% has gone to college and 44.18% has completed high school education. Thus, in general, ANMs have the basic educational level, except four. How these women got admission in nursing school and how they got appointed leaves certain unanswered questions. (Tables 6.20 to 6.21; pg. 149-150)

Household size: 42% have fewer than 4 members to the household, 33% has 5 to 7, and 23% has over 7 members to the household. In comparison to AWW, ANMs have smaller family. Between 43 ANMs there are 95 children, on average 2.2 children per ANM. (Table 6.22; pg. 150)

Premature deaths in the household: 7.94% has lost a child prematurely. 4 were male and 1 female child. Deaths were caused by poor management of child's disease (pneumonia and heat stroke) and one died because it was premature. It indicates that some ANMs can't handle their own near and ones when they fall ill. (Table 6.24 to 6.26; pg. 151)

Standard of living: 81% has high standard of living, 14% has medium and 5% low. It indicates that over 80% ANMs have basic assets required in a modern living. (Table 6.27; pg. 151)

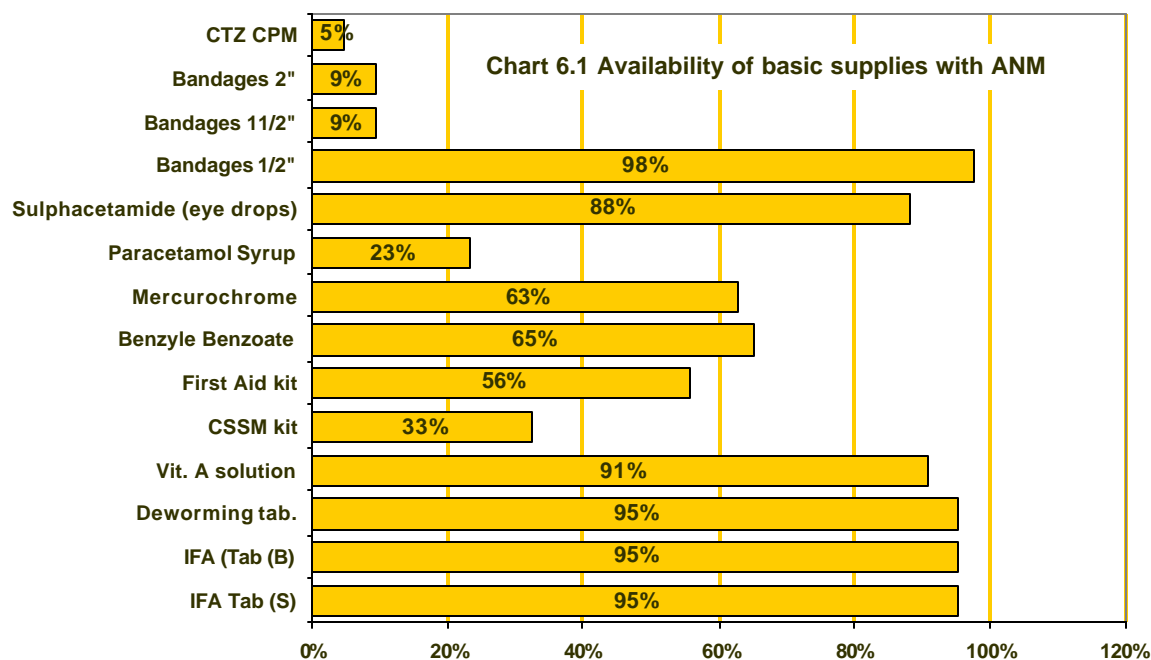
It can be seen that majority of ANMs comes from relatively well off households that do not lack basic comforts and means. They are much better educated and have smaller families.

6.5 Training under ICDS programme

53.49% has attended a training programme under ICDS; others have not. 60.8% has attended between 2 to 4 training programme. 39.05% attended a programme of up to 3 days, 21.74% attended a programme lasting 4 to 6 days, 8.7% attended programmes lasting 9 to 12 days, and 26% attended programmes lasting 12 to 15 days. Majority had to attend the programme outside their place of residence. 44.19% has received a copy of NHED book; 53.49% has not. Over 94% use the booklet regularly. (Tables 6.28 to 6.31; pg. 152)

6.6. Availability of basic supplies

It can be seen from Chart 6.1 that none of the ANMs has all the essential supplies that they are supposed to have at Sub-centre. However, in respect of IFA, de-worming, Vitamin A solution, and Bandages etc, over 90% has them. CSSM kit, an essential kit supposed to be available at all Sub-centres is available at only 33% Sub-centres. It implies that even the Sub-centres are not fully equipped in terms of RCH requirements



6.7. Interaction with AWW

Frequency of meeting with AWW: 30.95% meet the AWW every day, 28.5% once a week, 9.5% once a fortnight and 30.95% once a month. It implies that nearly 40% ANMs meet AWW once in 15 days or more. It may also be noted that there is no laid down rule as to the visit of ANM to an AWC. They do it as per their convenience, which seriously affects three components of ICDS programme. (Table 6.32; pg. 153)

During these interaction the ANMs discuss various issues such as need for IFA, deworming tablets, health check-up, growth of children, etc. (Table 6.33; pg. 153) 93% say that they get all the help from AWW.

6.8. Interaction with other health worker

79% say that there is a JMJ in the village, and the ANMs know them. Apart from JMJ, there are no health worker in the village. ANMs say that JMJs have helped in raising the level of discussion on malnutrition by associating at various levels in the village (with Panchayats, talking to women, etc) (Table 6.34; pg. 153)

6.9. Interaction with elected members of Panchayats

Over 90% ANMs regularly meet with Sarpanch and other elected members of Panchayats. Of those who meet with GP members, over 79% meet with them regularly. (Tables 6.35 and 6.36; pg. 153 & 154) As per the main concerns of GP members are: hospital facilities, need for awareness, need for medical personnel, etc. (Table 6.37; pg. 154) 76% discuss health problems with GP members, especially

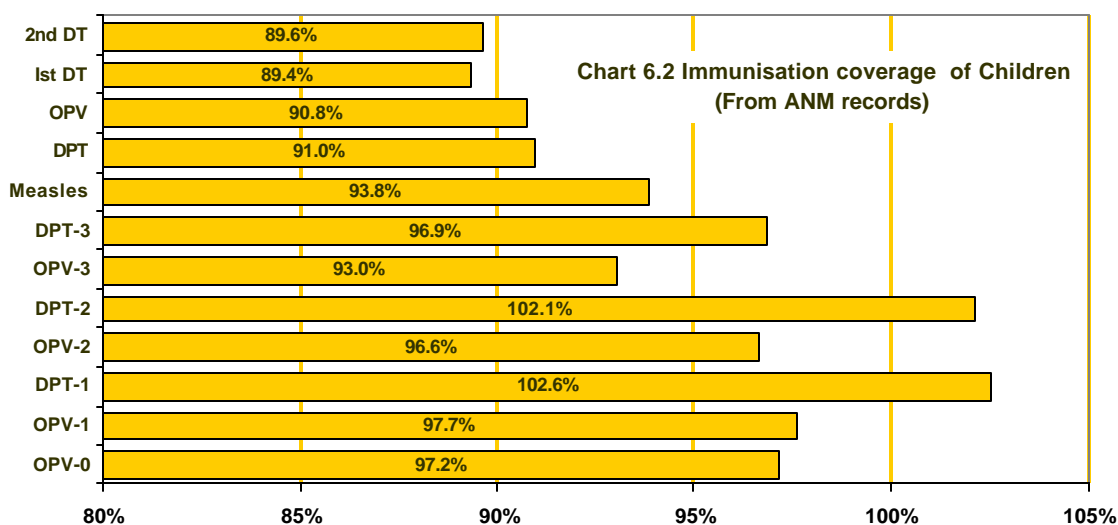
Quick review of the working of ICDS programme

concerning sanitation, family planning etc. (Tables 6.38; pg. 154) 67% say that GP members do take action when concerns are raised. (Table 6.39; pg. 154)

6.10. Referral cases

48.8% ANMs say that AWWs do refer cases to them, others don't. Details of cases as per the records of ANM is tabulated in Table 6.40; pg. 154

6.11. Immunization cover (Children)



From the records available with ANMs the above chart was plotted to show immunization coverage. It can be seen that in case of DPT 1 and 2 there is more than 100% coverage, in all other cases the coverage is below 100% of registered children.

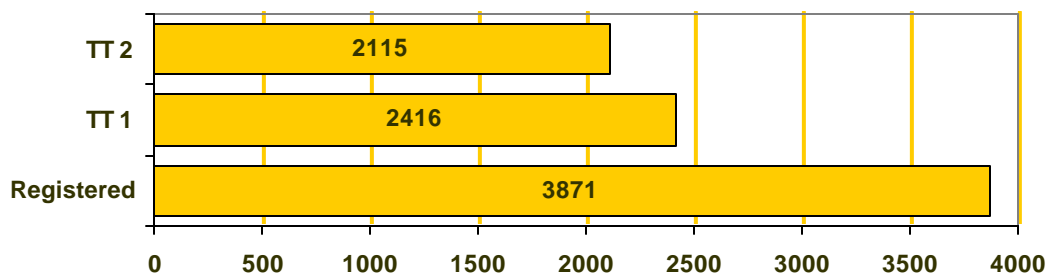
Majority of ANMs have given a signed statement as to the veracity of their records. It indicates that:

- ? 100% coverage even in case of Polio is not achieved;
- ? 93.8% children have measles vaccination;
- ? Achievement for DT shots is below 90%

It may be noted that the 50 AWCs surveyed have 50x100=50,000 target beneficiaries of which children under 3 constitute 40%, or 20,000. The registered persons with ANM are far less than this number.

Quick review of the working of ICDS programme

Chart 6.3 TT vaccination (From ANM's records)



6.12 Immunization cover (Women)

The 43 ANMs had total registered women for TT vaccination numbering 3,871. Of this 2416 (62.41%) were given first shot and 2115 (54.63%) second shot of TT.

The total number of pregnant women is not known because of poor record keeping. Given that 9 pregnant women are targeted at each AWC, there should be 450 in all the 50. Assuming that each ANM looks after 5 AWCs from her Sub-centre that adds to 2250 pregnant women to be given TT shots. The data with ANMs show 3871 registered women.

It implies that AWCs and ANMs are working with two sets of data and two sets of targets. In the process, both ICDS and RCH programmes are suffering. Despite these anomalies 95% believe that the AWCs under their charge are giving good services. Very few have mentioned that women do not want vaccinated or to take essential medication.

It is for this reason that the mechanism of coordination and the importance of convergence of the two programmes need to be discussed.

6.13 Convergence of ICDS and RCH programmes

6.13.1 Women and Child Development Department, established in 1985 by the Government of Rajasthan, was the nodal agency for implementing supplementary nutrition programme. Now implements two programs:

1. Integrated Child Development Service Program (ICDS) and
2. Women Development Program that includes formation of Self Help groups for social and economic empowerment, including prevention of violence against women, etc.

Quick review of the working of ICDS programme

The main focus of ICDS is to break the inter-generational cycle of malnutrition. In practice, this focus translates into Supplementary nutrition programme, distribution of IFA tablets, vitamin supplements for infants and children, growth monitoring of children from birth to age six, distribution of supplements to adolescent girls as well as dissemination of information, dissemination of knowledge about basic healthcare and hygiene to women especially pregnant women and nursing mothers, regular health check up of women and children, immunization, and referral services and pre-schooling for 3-6 year old children.

Three of the ICDS programme components (i) health check up (including dissemination of health related information and advocacy of family welfare), (ii) immunization, and (iii) referral services are actually provided by Health department from its Sub-centres. Each Sub-centre has a designated First Referral Unit (known as FRUs) where an ANM is supposed to refer problematic cases before a medical case becomes an emergency case. In order to prevent a simple case becoming a medical emergency case, an ANM is supposed to conduct regular health check up, ensure that the health of vulnerable women and children are regularly monitored, and timely action is taken at sub-centre level itself. Thus AWC and Sub-centres together establish what may be called the first level of preventative and social medicine through their respective facilities.

6.6.2 RCH programme: India, being a signatory to ICPD, adopted RCH programme in 1996. It integrated various components of health and family welfare, including IEC into this umbrella programme. The main components of RCH programme are about 14, being implemented throughout the country without differentiation (See Box 6.1).

The programme has led to strengthening of facilities throughout the country. Every district now has District Hospital headed by Chief Medical Officer (designated as CMHO in Rajasthan). Block level hospitals have been re-designated as Community Health Centres or CHCs. Under CHCs, there are Primary Health Centres, the lowest level where qualified MBBS doctors with training in RCH are placed. Each PHC is connected to a number of Sub-centres, normally around 6 in plains areas. The population covered under different levels of facility is also fixed: one sub-centre for 5000 persons (3000 in hilly areas), one PHC for 30,000 (20,000 in hilly areas), one CHC for 120,000 (80000 in hilly areas). Depending upon the availability of facilities and functionaries, each district designates a number of PHCs and CHCs as First Referral Units (FRUs).

These facilities have been provided with essential infrastructure (including OT, ambulance, water tank, generator, etc) staff (doctors, technicians, male/female nurse, etc), supplies (stocks of medicines, chemicals and reagents, IUD kits, condoms, etc) and equipment (such as surgical instruments and kits, test facilities, cold chain, etc). Whilst all facilities are not optimally equipped to provide the full range of RCH

Quick review of the working of ICDS programme

services, on a rough and ready basis, facilities in Rajasthan are about 60% equipped and operating with about 80% functionaries.

Sub centres in Rajasthan: Since this agency had conducted the Facility Survey under RCH programme in Rajasthan, a few critical sub-centre level data can be given to exemplify the degree of preparedness at sub-centre level. The data pertains to 2003 (January to June).

- ? About 45% sub-centres were operating from a government building
- ? About 15% posts of ANMs were vacant
- ? Less than 20% had own water supply
- ? About 35% had residential quarter for ANM

(Source: Facility Survey, 2003, SEDEM, consolidated district data for 20 sample districts)

The above data shows that the Sub-centres have yet to be fully equipped and staffed for proper functioning of RCH programme. Consequently, it is bound to impact ICDS programmes as well.

Status of FRUs in a few districts: The Facility Survey was conducted in 20 randomly selected districts. Only three districts under this **Quick review** were included in the facility survey of 2003. The status of FRUs in these districts is summarised in the above Table 6.2.

Technically, referred cases are to be sent to the designated FRUs only, a system that creates a structure for command and control as well as even distribution of load across the facilities. Otherwise, there would be over-crowding in the district hospital and surplus capacity in many.

It can be seen that in 2003, none of the FRUs were 100% equipped in terms of infrastructure, staff, supplies and equipment. However, it has been observed that Rajasthan state is progressing rapidly towards having adequate facilities under RCH programme.

Table 6.2 Status of FRUs in terms of percentage availability, Facility survey, 2003

| Districts | Infrastructure ¹ | Staff ² | Supply ³ | Equipment ⁴ |
|-----------|-----------------------------|--------------------|---------------------|------------------------|
| Nagaur | 73.0 | 96.0 | 56.0 | 67.0 |
| Alwar | 84.0 | 88.0 | 48.0 | 83.0 |
| Sikar | 89.0 | 95.0 | 57.0 | 71.0 |

¹ Includes water facilities, electricity, vehicle, labour room and laboratory.

² Includes medical officer, male health assistant, female health assistant and lab technician.

³ Includes the general kits like IUD insertion, Delivery Kit, Obstetric Care Kit, mounted lamp, stock of oral pills, vaccine stock, IFA tablets and ORS packets.

⁴ Includes deep freezer, vaccine carrier, BP instrument, functional autoclave, MTP suction aspirator and labour room equipment.

6.6.3. Type of health facilities located near sample AWCs

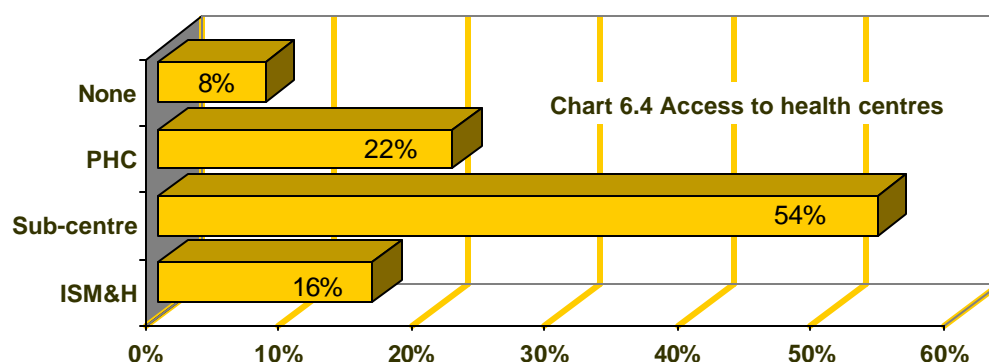


Chart 6.4 shows the availability of health centre by type in the village where Anganwadi is located. It can be seen that 54% AWCs have a Sub-centre in the village itself, 16% has a Indian Systems of Medicine and Homeopathy (ISM&H) dispensary (Ayurved, Unani, or Homeopathy), and 22% has Primary Health Centre in the village itself. 8% has no facility in the village. It implies that at least 76% villages, with the presence of qualified personnel in modern medicine, the quality of ICDS service should have no reason to be deficient.

Accessibility: It implies that 92% of the villages where AWCs are located in this sample has at least **one government health facility**. All sample villages are connected to the First Referral Unit (FRU) by all-weather road.

It further implies that referred cases from AWC/Sub-centres can be easily transported to the designated FRUs.

Utilisation of facilities: The fact that women beneficiaries of ICDS programme have stated that in case of any problem they do visit the doctor or nurse for advice and treatment implies that *facilities are being utilised*.

ISM&H centres are also expected to provide preventive treatment as well as healthcare and IEC services. But there are two problems: (a) ISM&H doctors trained in RCH programme are few and (b) As yet, there is no evidence of an initiative from ICDS to utilise their services in ICDS programme. None of the CDPOs could shed light on this aspect. There is a third problem: many ISM&H practitioners are using allopathic medicines, a practice that is unethical and a problem that Health Secretaries of Rajasthan have been worried about.

6.14. Managing convergence

6.14.1. The structure of two crucial departments that provide healthcare and nutritional support to rural communities is shown in Table 6.3. At the level of a

Quick review of the working of ICDS programme

cluster, both departments converge. The AWW co-ordinates with her *senior partner* ANM to serve a community. Since one ANM serves many villages, she divides her time across many clusters under her jurisdiction. Inter-personal relationship, communication skills, some leadership quality, emotional bonding, ability to network with AWWs, and commitment to local community are not just essential but critical skills. Same skills are required of an AWW also because she is closest to the community and these skills have played a role.

Table 6.3 Shows that at district level there is district hospital, CHC, PHC and Sub-centre, headed by CMHO, MO-In charge of CHC and PHC followed by ANM at Sub

| WCD/ICDS | | Health Department | |
|--------------------------|--|--------------------------|--|
| Programme and level | Functionary responsible | Facility | Functionary responsible |
| WCD | Regional Deputy Director (Has a parallel structure to ICDS but different foci) | District Hospital | District Chief Medical & Health Officer (CMHO) |
| ICDS Projects | Child Development Project Officer (CDPO) | CHC | Medical Officer In-charge CHC |
| 'Sectors' | Supervisors | PHC | Medical Officer in-charge PHC |
| AWC | Anganwadi worker (AWW) and a Helper plus one Sahyogini at each GP | Sub-centre | ANM, LHV, assistants etc |
| Population served | One AWC to about 1000 persons but one Sahyogini per Gram Panchayat | | One sub-centre to about 5000 persons |

centre. The ICDS has a RDD that is directly responsible for WCD programmes through a structure at block and village level. This has nothing to do with ICDS programme. The CDPO is directly responsible for ICDS programme and in fact CDPO receives funds directly from the Directorate in Jaipur.

While Anganwadi centre serves about 1000 persons, one sub centre serves about 5000 persons. In general, therefore, the ratio of AWC to Sub centre should be about 5 to 1.

6.7.2. Convergence and community-level plan: Under RCH programme a planning tool called "Community Needs Assessment Approach" (or CNAA) was designed to help assess the needs at Sub-centre level and consolidate the data at PHC, CHC and DH levels. The key role in CNAA was assigned to ANM through a coordinated effort at AWC between three entities: the people, the AWW and ANM, ideally under supervision of the Gram Panchayat. (see Box 6.1 point.3, pg 62)

None of the sampled Gram Panchayats has detailed knowledge of ICDS and RCH programmes. The reason is that CNAA has all but failed to be properly utilised.

Quick review of the working of ICDS programme

Under RCH programme, service providers are not supposed to set targets. When “target free approach” was implemented, service providers thought that since there is no target, they failed to show any performance. This was eventually replaced by CNAA late in 1999. Under the approach every DH was provided with computer hardware and software to help them with planning. Even in 2002, very few districts had installed the systems and fewer still were reporting to the Ministry. Effectively, CNAA is a dead horse.

Hence, ANMs are working in whatever manner they can. They are not supposed to set targets, yet they are setting targets. How they are setting targets is a mystery because the AWC level coordination is weak and this point has been dealt with under Paragraph 5.3.4.

Box 6.1. Note on REPRODUCTIVE & CHILD HEALTH PROGRAMME

Universal Immunisation Programme was started in 1985-86. Various other programmes under Maternal and child Health were also implemented during the VII Plan. As the objectives of all these programmes were convergent, during the VIII Plan, these programmes were integrated under CSSM programme and was implemented from 1992-93. This process of integration of related programmes was taken a step further in 1994 when the International Conference on Population and Development (ICPD) in Cairo recommended that the participant countries should implement unified programmes for RCH. Accordingly, the CSSM and related programmes have been reorganised into RCH package of programmes by adding components on sexually transmitted diseases (STD) and reproductive tract infection (RTI).

There exists variations in different parts of the country as well as within States in health infrastructure and staffing, as well as in technical and management capacity and in programme development. This has led to an identification of differential strategy whereby some states and districts will give higher emphasis to Mother and Child Health Care as against spacing issues, while districts/states with a more comfortable hospital based delivery record and lower CBR could begin on the larger Reproductive Health package. The districts have been classified into three categories viz., A,B and C on the basis of available CBR and female literacy rates.

INTERVENTIONS WITHOUT DIFFERENTIATIONS (i.e. throughout the country)

1. Child Survival interventions (as available under CSSM Programme)
2. Safe Motherhood interventions (as available under CSSM Programme)
- 3. Operationalisation of Community Needs Assessment Approach ?**
4. Institutional Development
5. Modified Management Information sub-System
6. IEC activities & counselling on health, sexuality & gender.
7. Urban & Tribal Areas RCH package
8. District sub-projects under Local Capacity Enhancement
9. RTI/STI Clinics at FRUs in a phased manner.
10. Facility for Safe abortions at PHCs by providing equipment, contractual Doctors etc.
11. Enhanced community participation through Panchayats, Women's Groups and NGOs.
12. Minor civil works
13. Provision for Lab Technicians for laboratory diagnosis of RTI/STI & EOC.
14. Adolescent health and reproductive hygiene.

Source: RCH programme, policy document, 2001, MoHFW

Chapter 7

Problems and weaknesses

7.1. Summary of findings

The survey data shows some change on most of the indicators, the changes are not as pervasive and widespread as expected of a three-decade-old programme. Illiteracy remains a major stumbling block. Whilst awareness of healthcare issues has gone up, women have yet to effectively operationalise the knowledge. Specifically, the practice of squeezing out and throwing Colostrum persists, although on a reduced scale, and immunization cover is still far from 100%. These two practices alone are jeopardising the future of many children. This section highlights core issues and paves the way for recommendations that are based on this analysis of the study team.

There appears to be significant changes in delivery mechanism as well but the limit of 100 beneficiaries per AWC implies that all potential needy persons are not covered. Having said this, it must be acknowledged that record keeping, data management and reporting system is seriously flawed. And many AWCs have failed to reach the target.

Any strategic programme must *achieve its stated objectives within 7 years*. If it takes longer either the strategy is flawed or its implementation is weak, or both as this study has documented in Rajasthan.

7.2. Strategies for tackling malnutrition and problems

Researchers tend to hold two contrasting views on the question of causes of malnutrition. Economists blame slow GDP (gross domestic product) growth and low incomes, although this postulate has now been effectively challenged and dismissed because even in the USA about 40% of its adult population is malnourished. High GDP does not correlate with good health. Nutritionists point to insufficient calories or protein, poor nutrition knowledge, micronutrient deficiencies, poor basic hygiene, and infection. This is a better postulate but it ignores the fundamental cause of malnutrition discussed later in this chapter.

Malnutrition in its severe and not- so-severe forms still remains a significant cause of maternal mortality, short- and long-term morbidity, and permanently lost productivity and intellectual capacity in societies which can ill afford such losses and costs. The position now is that nearly every country is suffering from severe crisis of malnourishment leading to malnutrition: developed or developing.

Despite the devastating consequences, the range of methods by which micronutrient deficiencies and general malnutrition are addressed have remained much the same and almost consistently fall into one of the following categories.

Food diversification: It is achieved through diversifying household and/or regional food production strategies to ensure that foods rich in the nutrients identified as deficient become available. In some cases the desirable changes occur by increasing overall food intake while in other cases it comes about through behavioral change that increases the consumption of nutrient rich foods.

Food fortification. The deliberate addition of a specific nutrient to a food vehicle which is identified as being widely consumed in adequate quantities by populations at risk of the deficiency. The classic examples being the iodization of salt, fortified crisps (*murmure*), and fortified cereals (Rajasthan mix and baby mix).

Medicinal supplements. The strategy comprises of (a) periodic administration of large doses of a specific micronutrient, such as vitamin A or iodine, which either provide some protection from a prolonged period of deficient intake or treats a deficiency which has already resulted in clinical symptoms, or (b) medicinal amounts far above the RDA for the nutrient, for example iron and foliate supplements during pregnancy, or following diagnosis of anaemia through clinical means.

Dietary supplements: Micronutrient dietary supplements offer a fourth approach, and one that can control deficiencies using a single intervention. This approach is unique since it delivers micronutrients that fill the nutritional gap via a vehicle that is, or becomes well accepted by the target group. The supplementation of diets with a specific food substance high in one or more micronutrients recognized as potentially deficient in the regular diet is not a new concept.

These methods are technically easy, easy to administer and believed to be cost-effective given the economic gains that can be achieved. Significant achievements in reducing micronutrient malnutrition have been made using them *although their sustainability is a big question mark.*

Disadvantages and limitations: Each of these four standard approaches has its disadvantages and limitations. Most people agree that food diversification offers the best long-term approach that is likely to be sustainable. But often it requires major changes either in agricultural production, including home gardens, or in higher incomes for the poor, allied with nutrition education. So in many under-developed rural regions of Rajasthan (as well as India) progress is slow. A serious problem is that under *conventional farming method*, followed widely in Rajasthan as well as India, food diversification is unlikely to substantially reduce micronutrient deficiencies in the near future, unless alternative and radical farming systems are adopted on a wide scale. It must also be pointed out that Agricultural Ministry's main focus is to enhance production, to help farmers grow more food. Up until now food quality has not been its focus and a uniform food standards-from seeds to packaging, storing, and distribution-is yet to be developed, which, to say the least, **is the central problem behind poor health and nutrition of Indians.**

Quick review of the working of ICDS programme

Fortification requires food processing. Conditions for fortification vary depending on the nutrient and the foods eaten in a region. In some regions several commonly eaten foods do pass through commercial processing where fortification is feasible. Salt iodination, has virtually eliminated iodine deficiency disorders in India and greatly reduced its impact in many countries. But in many non-industrialized regions, nutritionists say, it is difficult to find a suitable food vehicle to fortify with iron or Vitamin A. A suitable food has to be consumed regularly by those at risk of the deficiency, who are invariably children and women in poor illiterate families. Especially in rural areas those suffering from micronutrient deficiencies may purchase very few manufactured or processed foods. This strategy suffers from two fundamental weaknesses: (a) Processed food is invariably "devitalized". For example processed wheat loses much of its roughage and essential vitamins. Processed vegetables lose much of its micronutrients; the longer they are stored before ingestion, the greater is the nutrient losses. (b) The supply of Rajasthan mix and baby mix free of cost is not a sustainable solution, although at present there appears to be no alternative. Its main weakness is the weak delivery system and controls and process losses of nutrients.

Medicinal supplements are of two kinds. First there are those taken in pharmacological doses daily or at frequent intervals, and second those prescribed to be consumed in large doses at intervals of 4 to as long as 24 months. Ferrous sulfate and foliate are examples of the former, and vitamin A and lipiodol (containing iodine) are examples of the latter. Medicinal supplementation is also (like food supplementation) dependent on a delivery system which is often relatively costly if the supplement is to reach those at risk. Other problems include poor compliance that is common with iron prescribed during pregnancy, and low participation rates when massive dose of vitamin A supplements are offered every month over long periods.

Thus two common problems arising from the implementation of any or all of these strategies are: (i) the lack of appropriate delivery infrastructure with adequate access for poor women and isolated populations; and (ii) the lack of honest, efficient and technically competent project delivery mechanism that ensures implementation of all the inter-related sub-components of strategy to combat malnutrition. There are two further issues that need to be considered: (i) the lack of demand for these products because of lack of awareness, and (ii) enforcement of a quality system for food fortification.

Quick review of the working of ICDS programme

| Common vegetables | Vitamin C | Vitamin A | Calcium | Potassium | Magnesium |
|-------------------|-----------|-----------|-----------|-----------|-----------|
| Spinach | -45% | -17% | +6.45% | +18.72% | -10% |
| Corn | -41% | -29% | -33% | -3.5% | -22% |
| Beets | -50% | +90% | No change | -10% | -8% |
| Collard greens | -61% | -41% | -28% | -51% | -84% |

Source: Life Extension Magazine, 2001, cover story; Researched by Alex Jack and findings discussed with USDA subsequently.

7.3. The nutrient drain: major findings from recent studies

Before one can discuss possible solutions, it is also axiomatic to refer to some major studies that suggest that all four strategies may be seriously flawed.

7.3.1. The vitamins and minerals drain

The National Academy of Sciences has issued an alert that it takes twice as many vegetables to get the daily requirement of vitamin A as previously thought. Carrots and pumpkin are exempt from the caveat. Despite the apparent increase of vitamin A in carrots, most vegetables are losing their vitamins and minerals.

Nearly half the calcium and vitamin A in broccoli, for example, have disappeared. Collards are not the greens they used to be. If one seeks minerals and vitamin A from them, the caveat is that the vitamin A content has fallen from 6500 IUs to 3800 IUs. Their potassium has dropped from 400 mg to 170 mg. Magnesium has fallen sharply-57 mg to 9. Cauliflower has lost almost half its vitamin C, along with its thiamine and riboflavin. Most of the calcium in pineapple is gone-from 17 mg (per 100 grams raw) to 7.

The second important study was quoted here is by Paul Bergner and findings were presented in his book, "The Healing Power of Minerals, Special Nutrients and Trace

Table 7.2. Average changes in the mineral content of some fruits and vegetables*, 1963-1992 (From Paul Bergner's)

| Mineral | Average % Change |
|------------|------------------|
| Calcium | -29.82 |
| Iron | -32.00 |
| Magnesium | -21.08 |
| Phosphorus | -11.09 |
| Potassium | -6.48 |

* Fruits and vegetables measured: oranges, apples, bananas, carrots, potatoes, corn, tomatoes, celery, romaine lettuce, broccoli, iceberg lettuce, collard greens, and chard

Elements" 1997, Prima Publishing, Rocklin. Table 6.2 summarizes his key findings. It shows that on average calcium loss is about 29%, Iron 32%, magnesium 21%, phosphorus 11% and potassium 6.4%. It essentially implies that one would have to eat *substantially more vegetables* to achieve the recommended daily average dosage than is normally recommended in nutritionists' textbooks.

Quick review of the working of ICDS programme

The third major study being quoted here is by Anne Marie-Meyer, 2003. Anne's results are summarized in Table 6.3.

Table 7.3 Average ratio of mineral content and dry matter (new/old) for vegetables and 20 fruits*

| | Ca | Mg | Fe | Cu | Na | K | P | M. |
|-----------------|-------|-------|-------|-------|-------|-------|------|------|
| Vegetable ratio | 0.81* | 0.65* | 0.78 | 0.19* | 0.57* | 0.86 | 0.94 | 0.97 |
| Fruit ratio | 1.00 | 0.89* | 0.68* | 0.64* | 0.90 | 0.80* | 0.99 | 0.91 |

Her findings show a consistent decline of critical nutrients ranging from 19% to 97% in 20 popular fruits and vegetables. The study was conducted at Columbia University, USA.

Three longitudinal studies are going on in Denmark, the US and Britain and the results are due later this year, to independently corroborate the above three findings. However, about 300-350 studies conducted in the last five years all consistently demonstrate loss of critical nutrients. No such study has been commissioned in India as yet.

For a complete listing of all research papers compiled by SEDEM, please visit:

www.soilandhealthlibrary.org

Click Ag-library and then browse down to "A case for organics" compiled by Arun Shrivastava.

The implication for combating malnutrition is obvious: the strategy of micro nutrient supplementation will have to continue for some more time, until food production methods consistently achieve high nutritive content as well as quantity.

7.3.2. The relationship between energy and nutrient

The Government of India in 1972 defined poverty as a person who ingests less than 80% recommended daily requirement of calories. This definition came to be known as the "Calorie norm." This calorific need was converted into monetary equivalent to estimate the amount of money required to ensure that the 80% of daily-recommended calorie intake is available to a poor person. If the monetary equivalent of required calorie norm was below the threshold, that person was classified as poor.

This theory still remains unchallenged although poverty measurement now includes income, expenditure, assets, and access to human development facilities as indicators. However, the calorie norm is yet to be refuted decisively.

Quick review of the working of ICDS programme

Majority of India's rural population is barely surviving. Suppose we lived on say potatoes- plain potatoes, roasted, baked, fried, and boiled potatoes – potatoes all day, every day, every month, every year. And suppose that we could digest and burn no more than 2000 calories per day. Suppose, further, that Indians could eat 11% potato micronutrients or 5% potato micronutrients, depending upon how potato is grown, but that either way an Indian is getting 2000 calories. Now, if we lived on nutritionally – poorer potatoes, we'd be shorter – in height, and in lifespan – and overall, less healthy.

Steve Solomon, a well-known American scientist-farmer, writer, thinker, and philosopher, who has studied the problem of nutrition and health for over 40 years, has invented a little equation to express this (not intended to be numerical equivalency), which is

$$\text{Health} = \text{Nutrition} / \text{Calories}$$

(This is copyright, not to be quoted without the permission of the author, Steve Solomon, Tasmania, Australia)

“This simple viewpoint may not serve as the explanation of specific individual health problem; it is however the explanation for overall social health versus overall degeneration.” (Steve Solomon, “Growing Vegetables South of Australia, 11th Print, January 2005, page 7) The equation established a fundamental relationship between factors that cause health or disease, through the route of malnourishment. To simplify the matter, one should take "Nutrition" as the combined total of protein, amino acids, enzymes, minerals, vitamins and other nutritional factors but EXCLUDING carbohydrates. And take "Calories" as all the carbohydrates, sugars, fats and other food factors that are readily convertible into glucose during digestion. Proteins may be converted to calories if there should be an excess of them in the system but is irrelevant.

All the equation is saying is that if we get lots of nutrition relative to the amount of energy fuel we are consuming then we will be (relatively) *healthy*. If we get lots of energy fuel and little nutrition, *then we will become unhealthy*. The ultimate in “good” food is a raw green leaf-virtually no calories, lots of protein, minerals, vitamins, etc.

Average mass health of a community equals the total of all the nutrition they can obtain from the entire dietary intake divided by the total number of calories that have to be eaten to obtain it. If Rama Devi, for instance, can get 2000 units of nutrition contained within 2000 units of calories, then her health comes out to be “1” but if she

Quick review of the working of ICDS programme

gets only 1000 units of nutrition in her 2000 calories/day diet, then her health comes out as "one-half" or 50% of the "ideal."

If a group of people ate such that their nutritional intake was high compared to the calories they were consuming, then that group would be incredibly healthier if compared to what people consider "normal" health these days.

Food production by conventional methods

Conventional farming has poisoned the masses. It has destroyed the environment. It has caused severe loss of bio-diversity and water scarcity. And it has destroyed millions of acres of once fertile agricultural lands. In short, conventional farming has destroyed **nutritious food producing capability** of the entire world. It seeks to enhance the weight of food produced, ignoring the nutritive content of food grown. The food processing industry seeks to process food, without ensuring that nutritive content is retained. The industrialization of food production is the main cause of malnutrition throughout the world. It is this basic fact that has to be factored-in in any strategy to resolve malnutrition problem in India.

Faced with an estimated 800 million hungry and an estimated 2 billion malnourished people in the world, cheerleaders for our social order have an easy solution: "we will grow more food through the magic of chemicals and genetic engineering". For those who remember the original "Green Revolution" promise to end hunger through miracle seeds, miracle chemicals, miracle pesticides, miracle immuno-modulators, miracle of cheap oil, miracle of unending water resource, this call for "Green Revolution II" should ring hollow. Yet Monsanto, Novartis, AgrEvo, DuPont, and other chemical companies who are reinventing themselves as biotechnology companies, together with *international agencies*, would have the world's anti-hunger energies aimed down the path of *more agrochemicals and genetically modified crops*. This second Green Revolution, as the cheerleaders tell us, *will save the world from hunger and starvation* if we just allow these various companies, spurred by the free market, to do their magic.

The Green Revolution **myth goes like this**: the miracle seeds of the Green Revolution increase grain yields and therefore are a key to ending world hunger. Higher yields mean more income for poor farmers, helping them to climb out of poverty, and more food means less hunger.

The Green revolution truth goes like this: a typical farmer has lost his ability to produce his own seeds and now buys at a price from transnational firms, he needs fertilizers to artificially enhance nutritive content of soil to remain productive, he needs pesticides because the soils are so depleted of nutrients that plant diseases and

Quick review of the working of ICDS programme

pest can destroy any crop, he needs huge amounts of water because he has forgotten how to grow crops without wasting water, he has gone for mono-crops to maximize his yield and income from one crop. But all his input costs nullify all the productivity gains. He remains where he was 50 years ago, on the verge of starvation and indebtedness. But he is at the mercy of local moneylenders and the transnational corporations, without any guarantee of survival. In 2030, when petrol and diesel supplies run out, as predicted, Green revolution will also collapse, leading to mass hunger and starvation deaths. This is too serious a matter not to be addressed immediately.

Nutrition enhancing farming methods

Dealing with the root causes of poverty that contribute to hunger and malnutrition would take time. That is not the focus of ICDS programme. However, it is worth pointing out that non-conventional farming has consistently shown higher nutritive content of foods grown

Table 7.4. Average difference in nutrient levels

***Biodynamic, non-biodynamic and all organic crops compared to similar conventional crops**

| Nutrient | Biodynamic % difference | Other organic % difference | All organic % difference |
|-----------------|------------------------------------|---------------------------------------|-------------------------------------|
| Vitamin C | +47.6% | +11.9% | +22.7% |
| Iron | +33.9% | +15.6% | +17.2% |
| Calcium | +07.4% | +38.4% | +30.8% |
| Phosphorus | +06.6% | +14.3% | +12.5% |
| Sodium | +20.3% | +19.3% | +19.6% |
| Potassium | +07.9% | +16.2% | +14.1% |
| Magnesium | +13.2% | +28.3% | +24.4% |
| Beta-carotene | +14.0% | -09.2% | -00.3% |
| Nitrates | -49.8% | -30.9% | -33.9% |

Source: Virginia Worthington; "Nutrition and Biodynamics: Evidence for the Nutritional Superiority of Organic Crops; Biodynamics v.224, Jul/Aug 1999.

Dr Worthington compared the nutritive content of foods grown under conventional, organic and biodynamic management and found that the enhanced nutrition is significant. How soon farmers, especially rural household can transit to sustainable farming is, therefore, a moot question. **But the transition has to occur. It is a compulsion; there is no choice now.**

While the Green Revolution buys the time, Rajasthan and India desperately need to deal with the underlying social causes of poverty, gender disparities, soil degradation, and to cut birth rates. Here ICDS has a powerful role: it can galvanize women's SHGs to take up biological farming, health and nutrition related issues, and enhance income from higher productivity. In any case, outsiders-like the scientists and policy advisers behind the Green Revolution-can't tell a poor people to reform their perceptions and

Quick review of the working of ICDS programme

values, but they can contribute invaluable expertise in food production *honestly*. While the first Green Revolution may have missed poorer areas (Bihar, UP, Rajasthan, Orissa, Andhra, and MP) with more marginal lands, one can learn valuable lessons from that experience to help launch a ***second Green Revolution through Women's SHG led biological farming*** to defeat hunger and malnutrition once and for all, sustainably.

GM foods are no solution: The potential health effects of GM foods are unknown, probably acutely dangerous. A paper in Nutrition and Health (UK) states that there have only been ten published studies of the health effects of GM food and that the quality of some of these was inadequate. Over half were done in collaboration with companies (fully or partially), and these found no negative effects on body organs. The others were done independently and looked more closely at the effects on the gut lining; in several, **evidence of harmful effects was found which remain unexplained.**

Similar effects on the gut lining were found in an unpublished animal feeding study on a GM tomato. In addition, a study by Newcastle University sponsored by the FSA found that the transgenes (genetically modified organisms) transfer into gut bacteria at detectable levels after only one GM meal. The health effects of these transgenes are unknown and until they have been properly tested GM food should not be promoted at all, especially for combating malnutrition.

7.3.3. The puzzle resolved

What is the solution? Vitamin pills? Iron-fortified food? Or supplements containing the required minimum level of micronutrients? This is one solution. But technical solutions need to be backed up by a food production and dietary regime that progressively takes people to health. Medicines alone can't make a person healthy.

Integrating *micronutrient-rich foods* in the diet is the only way to solve this problem, and vegetables are the cheapest source of these nutrients. After the thorough review of policy options one is constrained to say that increased consumption of micronutrient-rich foods in general, and **vegetables in particular,** is the only sustainable solution. As much raw vegetables and fruits as one person can eat, provided it is not produced with the help of chemicals because all agriculture chemicals, with the exception of few fertilizers, are poison. If fruits are not available, or can't be grown, or unaffordable, vegetables alone can provide sufficient micronutrients in Rajasthan.

This solution fits with the new concept of "food security" debated during the International Conference on Nutrition held in 1992. The Rome conference defined food security as ***"a balanced and safe diet for an active life."*** Thus, in addition to macronutrients, such as food energy and protein, micronutrients, especially vitamin A,

Quick review of the working of ICDS programme

iron, and iodine, are necessary ingredients in a balanced diet and hence, are an integral part of food security.

Data from many countries suggest that the prevalence of micronutrient deficiency now far exceeds protein-energy malnutrition in Asia. Despite substantial increases in cereal supply, which has contributed to increased intake of calorie and protein-rich foods, the supply and consumption of commodities rich in micronutrients, such as provitamins and minerals have not increased proportionally. Fast foods in urban areas and chemical laced food in rural areas have made matters worse.

Vegetables and micronutrient availability

Vegetables are a major and efficient source of micronutrients considering both per unit of land occupied and per unit production cost. They have an advantage over cereals, legumes, and livestock in producing vitamins A and C. In India spinach, cabbage, onion, tomato, and capsicum produce 13, 3, 3, 3, and 2 times more iron, respectively, compared to cereals, from a given piece of land per day. And mungbean sprouts can provide 45% more protein than cereals per unit of land per day. Ditto for *chana*, various types of rajma, etc.

In terms of micronutrient supply per unit of production cost (i.e., variable and fixed costs), Cole crops and onion are 3.6 and 2 times more cost-efficient, respectively, compared to cereals, in providing iron. Cabbage is 92% more efficient than any red meat in supplying iron. And cabbage, sweet pepper, mungbean sprouts, and tomato are 3.8, 3.1, 4.8, and 2.8 times more efficient, respectively, than chicken when it comes to protein as well. Moreover, increased vitamin C consumption from vegetables enhances iron bioavailability from other foods. This symbiotic relationship also must be understood.

Despite these advantages, agriculture production data shows that vegetable supply in most regions is far below the 200 grams per capita per day recommended level. This is aggravated by seasonal and annual fluctuations in vegetable production and consumption.

Micronutrients and vegetable processing and handling

Micronutrient availability is very sensitive to the way vegetables are handled, stored, and cooked. For instance, boiling vegetables substantially improves their iron bioavailability in most cases. Iron bioavailability in cabbage is normally enhanced from 5 to 18% through cooking but reduced from 18 to 12% when the cooked cabbage is kept in the refrigerator at 4⁰C for 3 days, a reason why urban middle classes also suffer from malnutrition.

Quick review of the working of ICDS programme

Provitamin A, such as beta-carotene, is degraded after treatment with acid, heat, and even light. Thus, the bioavailability of nutrients in processed products is generally lower than in fresh vegetables. Thus a lot of fresh vegetables straight from kitchen garden is absolutely essential to remain healthy.

Research on cooking and processing methods has substantial scope to improve bioavailability of micronutrients in vegetables. Thus, social scientists and nutritionists need to work together to understand cooking and food processing habits, and the acceptability of interventions for enhancing micronutrient availability.

Production for feeding family

It is important to understand that one can feed a family of five, highly nutritious vegetables all year round from just 50 square metres of land. And this sort of productivity can be achieved anywhere, even in wastelands (except deserts), within about two years. There are farmers achieving extremely high level of productivity from average quality of lands without using any chemicals by a process called biological farming. A farmer can achieve this productivity by following simple stage-wise process of total recycling of agricultural, human and animal waste through vermicomposting thereby improving soil tilth and micronutrient availability in soil. Vegetable production drains soil nutrients while cereal production (rice) enriches soil. Thus a combination has to be used. In difficult lands, vegetables can be grown all year round as has been demonstrated by hundreds of radical farmers in India and elsewhere by careful enrichment of soil micronutrient availability. Along with production of vegetables farmers can easily add production of honey, free-range poultry and egg, etc. This will ensure variable and nutritious diet, as well as enhanced income.

Instances of extraordinary successes

Dagar Farm, Akbarpur Barota, Sonapat, Haryana:** Ramesh Chandra Dagar, 10th pass, runs a model farm that has achieved **a turnover of Rs 13.3 lakhs per hectare**, about Rs 5 lakhs per acre. He can achieve this consistently. His is an integrated biological farm, using minimum inputs. Vermicompost fertigates his lands, apiary boosts production by another 15-20%, and all wastes are internally recycled to produce vermicompost. Whilst he has yet to install drip irrigation to save water, use of solar pump means he does not require electricity for irrigation. **He has proved that small farms can be very profitable and can sustainably produce healthy food.

***Tarun Bharat:** Rajendra Singh's Tarun Bharat has revived long dead water bodies in Alwar district. He has virtually eliminated water scarcity in a number of villages of Alwar leading to improved production of food and incomes. The revitalization of water bodies can take from 2 to 5 years, after which it becomes sustainable. Thus the contention that Rajasthan has a major problem of irrigation is true but misleading. Water problem can be resolved, including problem of salinity, because these are man-made problems. If Rajendra Singh's solutions are combined with afforestation on wastelands in Rajasthan and use of low cost drip irrigation for growing food, water can become a plentiful resource everywhere and food can be grown anywhere.*

East Asian experiments to combat malnutrition and poverty: A series of field trials were conducted in Thailand, Indonesia and Malaysia on very small kitchen gardens following a successful experiment carried out by Thailand Outreach Programs, Kasetsart University, Kamphaeng Saen, Nakhon Pathom, Thailand from November 10, 1988 to February 15, 1989. The total garden area was 50 square metres or about 475 square feet.

The total yield obtained from the garden under normal operating condition was 63.9 kg *without using radical methods*. The overall performance of some crops was much better. The home garden supplied significant percentage of protein, calcium, iron, vitamins A and C of the RDA for a family of 5 and supplied vitamins A and C more than the family requirement. In terms of economic returns, growing vegetables proved to be profitable as well. The experiment period was one season or roughly 95 days.

Please note that under radical conditions (vermicomposting, intensive raised beds, drip irrigation, total internal waste recycling, honey and mushroom cultivation) the yields can be easily increased by four times. Having said this, farmers will have to be trained in radical farming: it is not easy. Poverty and malnutrition can be eliminated provided we stop the unholy exploitation of land and natural resources.

7.4 The systemic problems

The seriousness of malnutrition and its strategic significance was identified in “the Asian Enigma,” (Dr V Ramalingaswami, former head of AIIMS) and the study paved the way for a major nutritional intervention in India. A major cause of malnutrition was found to be the secondary status of women in relation to “in-laws” and “the husband.” Childcare comes third in a household’s order of priorities, and women last.

It was essentially to address these problems that two departments were created, namely ICDS (for children) and WCD (for women). The Health department serves the community through a coordinated effort of ANM and AWWs in addition to SC-PHC-CHC-DH system of healthcare under RCH programme.

At macro level (state or central government) programmes are implemented through structures that are sectorally organised. At micro level, (the level of a community) all these programmes converge. For example, women’s empowerment is sought to be achieved through WSHGs, which is a major programme of the DWCD/MoHRD as well as Ministry of Rural Development. There is 33% reservation for women in the PRIs, a policy that seeks to enhance participation of women in the political processes. ICDS runs community based Anganwadies, and through these ANMs extend healthcare, RCH, CNAA and IEC activities. IEC activities are further reinforced through JMJs (volunteers) and LHVs, both controlled by the Health Department. NHD is a mechanism to reach out to rural communities under the RCH programme. **However, a systematic and concerted strategy is absent and synergy is missing.**

Failure to achieve synergy stems from (a) the failure to integrate sectoral programmes at community level. Community based organisations are perceived as “cost effective implementing agencies,” a sort of intermediate structure that would implement departmental programmes; the powers of dispensing must remain with the departments; (b) different departments view their area of activities as “domains” not to be transcended or trespassed by others, least of all the PRIs; (c) each main functionary feels responsible only to his/her boss, none to the people for whom they exist; (d) weak community based organisations, made so by their continued dependence on grants and assistance from donor agencies, chiefly government departments. Consequently, communities, more specifically “the user groups” (pregnant and nursing women and pre-school children) remain weak stakeholders and marginalized.

This negates the provisions of 73rd Constitutional amendment. PRIs are the third level of government. Indeed an emerging notion within various Ministries is to transfer central grants and assistance directly to PRIs, bypassing the state government and its departments. (In fact one state- Himachal Pradesh- even amended its own PR act, consistent with the Amendment, and transferred ANMs and AWWs to be supervised by PRIs. This small structural adjustment led to a statewide strike) PRIs are perceived

Quick review of the working of ICDS programme

as implementing agencies, not the third tier of government. In Rajasthan, particularly, the power to appoint AWW and Sahyogini is now vested in Gram Panchayats. But in these appointments the Panchayat members are promoting their own relations and friends, ignoring the purpose. The CDPOs are faced with a serious situation at grass roots level.

Malnutrition is the result of many wider problems such as poor resource base, degraded environment causing periodic or persistent food shortages, social oppression of women, population growth, indifferent quality of health services, weak civil society organisations, etc. This was not so two hundred years ago. During the colonial period the strong local, village level structures were systematically dismantled, and replaced by departments through which the colonial government came to control natural resources: land, water, forests, and other resources. That “control” orientation is the dominant and core cultural value within government departments even today: these issues have seldom been discussed. Consequently, even well conceived programmes have failed to show any tangible and sustainable result.

Today, poverty and malnutrition is not a cultural but systemic problem. For each of the factors that cause malnutrition there is a programme and a department to implement those programmes. Each year targets are achieved but the number of potential beneficiaries increases, not merely due to population increases but because of slippages. When sanitation programme fails, water pollution problems accentuate, directly causing serious health problems. Poor implementation of irrigation projects is responsible for poor land productivity, water scarcity, food shortages, and malnutrition. There is little or no co-ordination, no seriousness to finally eliminate a problem. This is the central cause of failure of social, educational, and economic development programmes.

In the present study, it was observed that presence of JMJs has played a crucial role in bringing about culture change, wherever they are pro-active. Pro-active community participation in AWCs, wherever observed, has also led to major changes in perceptions and practices. These changes have occurred where key functionaries were of similar or same caste. But in majority of Panchayats JMJs are not pro-active and community participation is poor.

Caste is a reality, a powerful force in the villages of sample districts. For reasons of secularism, the bureaucracy believes that all castes should be the target of intervention, a major systemic weakness within benefit agencies. In practice, at community level, caste is invariably a basis for resource allocation. When agents of benefit and beneficiaries are “samjatiya” (same caste) changes occur fast. This indicates that homogenous caste based communities can be more effectively used as a unit of intervention. In fact, the study team believes that recognising this reality and turning them into competing groups can speed up culture change. Also, by using a

Quick review of the working of ICDS programme

homogenous caste group as unit of intervention, beneficiaries can stand up to the pressures of lower level departmental officials.

If people fail to get benefits as planned, or government officials do not behave responsibly, it is primarily because each household is a fragmented entity whereas the department acts as “self-satisfying” and an organised “satisficing” entity.

The purpose of this discussion is to demonstrate that it is possible for even the most stagnant community to transit to vigour, under certain conditions. The state government should create conditions that facilitate the transition, and in Rajasthan, the government departments will require to put more emphasis on proper management of intra and inter community discords. It has also been discussed that caste as a force must be accepted officially and should be used as structures for modernisation. Every political party, every social organisation, and every department of every government works on its understanding of caste factor. Therefore, denial of its existence in matters of “programme dispensations” may even be taken as root cause of *dysfunction*. However, it can be said here without fear of contradiction that this “denial”, this ostrich like behaviour, has caused sub-optimal performance of ICDS programmes.

The core substructure: beliefs and habits

Awareness should ideally lead to better perception of the reality and positive action (changed behaviour). And there is a belief among planners that information, education, and communication would cause the required change. Between the “source” and “sink” there are initiators, influencers, gate-keepers, and deciders; the hapless “users” of the body of knowledge come last in the pecking order. All these intervening obstacles are usually wished away, not even discussed; they are the main constraint to bringing about socio-cultural changes. They are the main constraint to dissemination scientific thinking within a community. For example “in-laws” are powerful “gate-keepers” as well as “deciders” of what information must flow to the “users”, so is the “husband,” who in rural Rajasthan *believes in husbanding his wife*. The “local “thakur” is a great “influencer” as well as “potential initiator” of change; but his power base is perpetuated by ignorance. Therefore, even he acts as “gate-keeper”.

Many women in this sample know that newborn babies must have Colostrums but they would give “Janam ghunti”. The reason given was, ‘it has been the custom followed by ancestors, therefore, I do the same.’ Villagers know that water harvesting can be done by community action yet they believe that “Thakur saheb will give us water.”

Social practices are a composite of awareness, habits, customs, beliefs and values. These variables do not change easily *even after observed empirical evidences*. If this were not true, societies would quickly become “logical” and “rational.”

Perception is associations in the mind, possibly for the mind and of the mind as well. Perceptions, grounded in beliefs, customs, and values, ensnare people into a web of illusions; like skins of an onion one may keep peeling one layer after the other, till nothing remains. We all tend to swear by our perceptions of reality and try to influence others just the same: few of us are prepared to do an exercise in demystifying our own perceptions and beliefs. It requires the presence of powerful influencers, the social engineers and change agents to alter beliefs and practices. **ICDS projects do not have the benefit of change agents in any of the sample village who can demystify beliefs and perceptions.**

7.5. Structural and processual weaknesses

At Anganwadi Level

? **Illiterate AWWs:** Because many Anganwadi workers are illiterate, they cannot communicate the usage pattern and benefits of nutritional supplements or explain the importance of healthcare to the communities. Because the names and instructions for taking micronutrients and medicines are written in English language, their usage is not understood properly, by the AWWs. Therefore, beneficiaries do not trust them.

Quick review of the working of ICDS programme

? **Too much expectation:** The AWWs are expected to achieve what even the ANMs and doctors find it difficult: to change beliefs and values within a rural community is not difficult but with current level of competency of AWWs it is well nigh impossible.

? **Poor incentives for the AWWs:** The AWWs get a monthly wage of about Rs 900/-. The helpers get much less. The poor incentives add to the woes of the workers, who in some cases are forced to make money out of the project supplies. In some AWCs the rent of the building for running the centre provided by the government is inadequate (Rs 50/- p.m.), and the AWWs at places face difficulty with the landlords. These problems divert their attention from their main function. They say that they are volunteering for childcare and distribution of SN, not to sort out problems of tenancy and, as mentioned earlier, transportation.

? **Poor record keeping:** Health check up and immunisation records are kept by ANMs, while SN distribution, crèche, and registration of pregnant and nursing mothers is to be kept at AWC. But majority of AWCs do not have well maintained records.

? **Distances of facilities:** The facilities such as PHCs, FRUs, Project offices, Public Call Office or Banks are located at quite a distance from the AWCs. It entails cost and time in commuting in order to serve the beneficiaries efficiently. Even the Lady Health Visitors have to request two/three wheeler drivers to go to a centre. Many ANMs stay far away from AWCs under their charge because of distances, which is a reason for poor attendance at some of centres.

? **Social Structure:** Social class and caste play a powerful role in participation of rural women in healthcare and nutrition programmes. ICDS must attack these forces at the root by demystifying them. The problem also arises when people from higher caste do not mingle with the lower caste and vice-versa and as a result, AWW of a particular caste cannot distribute supplies to members of other castes.

Due to the '*Dhani*' homes/habitat being followed by most inhabitants in Jaisalmer district in the State, communication and knowledge sharing among the community members is a problem.

There are many instances where the elderly lady usually a mother-in-law does not permit her daughter-in-law to participate in the meetings for her to get vaccinations and health check-ups.

Although state level decision makers know of these weaknesses, these are seldom addressed at CDPO level. In all future projects the role of caste, class and religion needs to be addressed and key functionaries must know how to resolve these issues. There has to be a contingency plan to cover the target population.

At the Regional Office Level (Project offices and Regional ICDS offices)

? Many critical positions are vacant.

? Another problem is the casual attitude of functionaries; the urgency is missing.

Quick review of the working of ICDS programme

? In many offices, people are holding additional charge for long duration as detailed in Chapter 2. The responsibility and accountability of the concerned person thus gets divided and he or she is not able to do justice to his/her work. Apart from CDPOs other vacant positions include Additional CDPOs, UDCs, LDCs, SA's, Drivers etc. Adequate staffing must be a key feature of the programme.

At the State Government

? Being the implementing authority, the initiative of proffering encouragement and motivation should be the prime concern, which unfortunately is missing. The benefits of the program and its direct effect on the beneficiaries need to be strongly enthused among the masses. Although there has been effort on part of the State government in devising policies and framework, implementation is poor because policies, focus and guidelines are not clear to everyone.

? The major causal factor for not achieving its objectives and goal is poor supervision, monitoring and control. There are documents that clearly indicate field visits, surprise checks and proper monitoring of many project areas are done as laid down. Though there are several such schemes and programs operational in the State, if the concerned authorities do not monitor the developments either themselves or by appointing people to do the same, projects that involve money and materials are unlikely to achieve objectives.

Problem of coordination between AWW and ANM

Data clearly points toward a failure of proper coordination at community level. This is affecting two programmes: RCH and ICDS. Under RCH programme 100% immunisation coverage is the objective. Records show that under RCH programme ANMs are not achieving 100% target. In fact there is an urgent need for inter-Ministerial coordination between Family Welfare Department and DWCD in Delhi to sort out the problem of coordination. The same problem is with health check up, and regular growth monitoring. These are not done as required.

Problem of integration of services at community level

The one single cause of failure of coordinated effort is lack of understanding of CNAA. CNAA was supposed to be a planning tool as well as the mechanism for implementing RCH programme of MoHFW/GoI. Till today there is no clarity as to what is CNAA. The Ministry has one view, State Governments find it simply a method for data collection, the CMHOs at District Hospitals find it an added administrative burden, the software has not been installed in many districts. Equipment malfunction, poor electricity supply, lack of seriousness to regularly update data are added problems.

Quick review of the working of ICDS programme

But most importantly, CNAA presumes that community needs shall be decided by the communities at up-gram panchayat or gram panchayat level. These needs shall be compiled by ANM at sub-centre level and transmitted to PHC for PHC level annual health plan preparation. All PHC health plans are to be consolidated at CHC for preparation of block level health plans. And all CHC plans are consolidated at District level to prepare annual district health plan.

But there is hardly any district in India that has successfully implemented this “bottom-up” approach. Targets are set at district level by CMHOs based on past data and conveyed to ANMs through the normal administrative channel, exactly as ICDS sets up a target of 100 beneficiaries.

CDPOs say that target for family planning comes from Collectors or DMs when the latter have no role within RCH programme. When DMs/Collectors set target, they distribute the targets to CDPOs. CDPOs distribute the targets to supervisors. Supervisors off-load the targets to schoolteachers, AWWs, ANMs, Sathins and Sahyoginies. Thus, while a system under RCH programme does exist, instead of making it effective, the district administration has to intervene for achieving family planning targets. Most surprisingly RCH programme is built on the premise of “target-free approach,” meaning that targets shall not be set by the administration but people shall be so motivated that they themselves set a target for small families. Under the present method of working, all sorts of pressures are brought on the people that vitiate major programmes of the Government of India.

If ICDS, WCD and RCH programme were effectively integrated at AWC level through proper controls and feedback, the synergy would help achieve ICDS objectives as well.

Lack of shared concerns at operational level

It needs to be noted that RDD, CDPO, Supervisors, AWWs, elected representatives of Panchayats and ANMs, none has clear understanding of the main thrust of ICDS programmes. Therefore, shared concern is missing. Consequently, there is no seriousness at implementation level.

7.6. Conclusion

Essentially three problems need tackling: (a) Nutritionless food production, (b) structural and processual weaknesses in management of ICDS programme, and (c) absence of effective coordination between complementary programmes at strategic, tactical and operational levels. These can be effectively resolved without any additional cost.

Chapter 8 Suggestions

8.1. Suggestions for overall improved performance

8.1.1. Suggestions for immediate improvement

(a) ICDS, like health services, must have strong cadre, from AWW to district head.

All AWWs should be appraised immediately. Those who are competent and at least middle school pass, with 10 years of experience and proven competence, should be promoted to Supervisors level to the extent that all vacant posts are filled. The vacancies created at AWCs should be filled with at least Middle school pass women, thereby creating a system of induction of educated AWWs.

Supervisors' performance should be appraised immediately and those found suitable should be promoted to the level of CDPOs.

(b) Organization-wide focus and shared concerns on intergenerational cycle of malnutrition is absolutely critical. The entire structure must have one single focus: to break the cycle. Within that single focus, people may perform various tasks, but the focus remains common to every one, including community leaders.

(c) Capacity building of AWWs and Sahyogini: should be the focus of Supervisors and CDPOs. Every officer must be appraised on the basis of his or her performance on capacity building. All great organizations develop potential leaders on the basis of how they supervise and develop the innate abilities and competencies of people working under them. This is the basic principle of running a good organization. A person who harasses his or her subordinate to achieve targets should have no place in any organization, particularly one that is implementing a critical programme like ICDS.

(d) Training: RDD to AWW need focused training in order to create shared concerns. They should be trained together. Common training with the presence of senior most to junior most operative helps dissolve psychological barriers, creates team spirit, creates conditions for information sharing, and transparency. These are all at present missing in ICDS. A CDPO behaves like a feudal lord, Supervisors like junior lords. And the fact remains that both need the performance of AWW to achieve their own respective targets. A joint training programme will demystify the aura surrounding the supervisory level of CDPOs and Supervisors, so pervasive in BIMARU states.

(e) Structure for coordination between ANM and AWW should be fool-proof. RCH and ICDS programmes have common spheres of concern. CNAAP planning tool

Quick review of the working of ICDS programme

remains un-utilized. Two structures must work together in a symbiotic relationship to achieve synergy. Each can help the other achieve 100% coverage. But the structure has to be fool-proof. The starting point for creating a fool-proof structure is (i) Consistent and uniform record keeping, (ii) rigorous checks on records, including surprise checks, (iii) a community-based consultative process under supervision of the Gram Panchayat, where targets are set and voted for in a gram sabha meeting, and (iv) Mother and Child card on SNP and immunization. Every rural household must have a health card wherein record of immunization is entered and endorsed by a competent authority.

8.1.2. Suggestions for superior performance

Only identified people should be trained and placed for ICDS-projects: There should be a clear agreement with the state government that trained personnel would not be transferred for at least five years. This is particularly true for CDPOs and RDDs. Specialisation must be accorded top most priority. If Rajasthan Civil service officers do not want to work in ICDS/WCD, they should not be placed there. There is no point in placing a person who is not concerned about a particular problem. On the other hand, those who perform well should be given powerful and visible recognition that would attract the best officers to ICDS.

Culture change: One of the key components of any training programme should be “culture change”. Merely training people, in performing tasks such as record keeping or growth chart maintenance, although crucial, is not enough. Key functionaries-from CDPOs to AWWs- must understand the purpose of the intervention, which is “to bring about changes in traditional practices in order to break the intergenerational cycle of malnutrition.” The ability to “demystify” beliefs is the starting point in culture change strategy. Training must focus on changing the mind-set of benefit agency, before they can be expected to bring out changes in the mind-set of beneficiaries.

Coordination at strategic level: The following departments are implementing programmes that have a major bearing on healthcare, nutritional adequacy and food security:

| <i>Department</i> | <i>Responsibilities</i> |
|------------------------|---|
| ICDS | Early childhood care, immunization, supplementary feeding |
| Agriculture department | Sustainable management of farms and scientific storage |
| Health department | Immunization and IEC activities |
| Irrigation department: | Watershed management and irrigation |
| Rural Development | Livelihoods, housing, sanitation, drinking water |
| Environment & Forest | Biodiversity supporting food security through bio-synergy |
| Civil supplies | Management of PDS particularly in rural areas |

Quick review of the working of ICDS programme

The first three must have a monthly coordination meeting at district, block and panchayat levels. The seven departments should have at least a quarterly co-ordination meeting to ensure that maximum synergy is achieved at community level, preferably at district and block levels.

8.1.3. Suggestions for improved delivery

Selection of beneficiaries: Gram sabha should do this. In gram sabha meetings, attendance is highest when the community knows that something is being distributed (SN or medicines or anything). ANMs should attend these meetings; explain the purpose of SN, NHD, growth monitoring, etc, to men, women and children. The list of women and children identified by ANM or AWW or the gram sabha should be endorsed in gram sabha meeting signed by at least 2/3rd members present and voting. This list should become the master list; modifications should only be allowed in subsequent gram sabha meeting.

Distribution of SN and medicines and reporting: Distribution from CDPOs downward to AWCs need to be more closely monitored by senior officials in terms of quantity and periodicity, with regular monitoring of adequacy of supplies. There is scope for improvement by ensuring that MPRs are regularly monitored (i.e. read and acted upon by officer in-charge, and not merely filed as a piece of paper). Gram panchayat can ensure proper reporting. The study reveals that sarpanches are only marginally involved in nutritional programmes; majority do not even monitor the presence of AWWs and ANMs on NHD, etc. Activities of each AWW should be discussed in a gram sabha meeting. Secondly, MPRs sent by ICDS must be a summary statement based on aggregation of endorsements from each gram panchayat where SN programme is operational. This will prevent CDPOs to fill in the forms. Thirdly, there must be a single reporting format. If any district wants additional information, that report must be additional to basic reports.

Attendance of AWWs and Supervisors: The AWWs themselves maintain attendance, which implies that there is no effective control. Supervisors do check this but those checks are most cursory. ICDS should install a system that the attendance register is maintained by community-based “health sub-committee” comprising of user groups. There is no harm in having a representative from each caste/ minority group. (The Forest Department in Haryana has a Village Forest Committee with one representative from each Caste and one woman. The same can be tried in ICDS)

Awareness: Illiteracy of AWWs is *one of the main causes* of poor awareness level. If AWWs are illiterate it is the responsibility of Zila Saksharta Sammittee and CE committee to mop-up the illiterates, especially women. The performance of ZSSs has been pathetic. Because literacy programmes have a bearing on nutritional programmes, healthcare, and childcare, failure of TLC/PLP/CE programmes needs to be brought to

Quick review of the working of ICDS programme

the notice of the state government because one department does not know what the other is doing and how it affects major projects and strategic interventions. If the state government cannot ensure that ZSSs perform, ICDS should remove all illiterate AWWs and replace them with literate and committed workers. There is no shortage of qualified people in the villages surveyed but casteism on part of ICDS staff and nepotism at Panchayat level are hindrances.

Managing convergence of healthcare and AWC: The Health Department, WCD, and ICDS have to decide on a more effective co-ordination at community level. People trust doctors and ANMs, not AWWs. Therefore, involvement of doctors and nurses in community based health awareness events such as NHD/MHD must be built into the programme structure. Involvement of NGOs should also be explored: NGOs can act as initiators, facilitators, even deciders of priorities. However, whatever structural and processual devices are selected for government-community contacts these must be written down and codified rather than left to the initiatives of illiterate AWWs, ill-equipped ANMs, and indifferent medical professionals in Rajasthan. This will improve performance of several programmes through synergy.

Interaction with JMJs and AWWs: It has been established that close interaction with pro-active AWWs and JMJs has resulted in changes in practice. Therefore, it is important that these informal interactions are strengthened. It can be done by ensuring that JMJs are made active participants on NHDs/MHDs, and are regular attendees in women's meetings (Mahila Mandal or otherwise). This sort of linkage will go a long way towards awareness creation.

8.1.4. Suggestion for enhancing stake of local communities

ICDS programmes are being implemented throughout Rajasthan. Therefore, a small experiment may be tried in a few districts:

- ✚ The needy should be identified in a gram sabha meeting. Only these beneficiaries should be supplied SN and medicines. The quantity of nutritional supplements should be recorded against the names of beneficiaries;
- ✚ A gram-sabha sub-committee can be co-opted to oversee the functioning of ICDS programmes. Members of this committee can be trained just as well as the AWWs. This committee should include AWW, ANM, Sarpanch, Sathin, Sahyogini, and two nominated women members. The proceedings should be recorded in a register. This committee must oversee that the identified beneficiaries are getting the required services. This committee should regularly monitor the working of AWW, ANM and Supervisors.
- ✚ Community control over the working of AWCs and ANMs can be informally exercised; formally it may not be acceptable to the controlling departments.

Quick review of the working of ICDS programme

Thus, MPRs and reports on other activities should be endorsed by village panchayats.

- Each gram sabha can send its own monitoring report to the Directorate on a standard format and cost of reporting may be borne by Gram Panchayat.

There are **several advantages** in working through the village panchayats:

- Arbitrary selection of beneficiaries by CDPOs will stop. The problem may not be fully resolved but at least the majority of the needy will get enlisted;
- Greater stake of the community may put pressure on ANMs, JMJs, LHVs, and elected members of the panchayats to work together and perform;
- Pressure will mount on politicians to perform; consequently
- There will be greater pressure on departments and officials to be responsive.

The disadvantages, quite a few, need to be mentioned as well:

- Panchayat functionaries lack skill and experience in managing their work;
- The role of local dominant coalitions varies from panchayat to panchayat. They play both positive as well as negative roles, which are exploited by the lower level bureaucracy, and this is detrimental to communities' interest; and
- Participation in gram sabha meetings is generally poor in many panchayats. Consequently, clever functionaries in league with local government servants, misuse programme funds and resources.

However, implementing programmes through effective involvement of communities will reduce the scale of slippages. Therefore, this approach can and should be tried.

8.2. Suggestions for sustainable nutritional adequacy

8.2.1. Goals and scope

The goal should be to increase vegetable supplies through sustainable farming methods to make at least **vegetables** available during all the seasons to all sections of the rural society. **This is absolutely essential**. Both self-consumption and income-enhancement strategies should be considered to achieve these goals. The production strategy should focus on soil health and effective natural resource management regime so that more farmers can grow vegetables with progressively lower input cost, especially during the difficult season, like summer and monsoon. Programmes should focus on enhancing overall supply of appropriate vegetables along with increasing diversity in vegetable production.

Sustainable income-enhancement strategy can and should be taken up by WSHGs. (SEDEM can demonstrate the effectiveness of this strategy at selected Gram

Quick review of the working of ICDS programme

Panchayats at no cost to DWCD/MoHRD. Two Panchayats will be selected at Alwar in the beginning)

The benefits of these strategies include increased food and income security, new jobs, diversity in food, and enhanced sustainability of the agricultural production systems that result from diversification of these systems.

8.2.2. Strategy

Please bear in mind that the strategy proposed here is a bare outline based on over 3000 research papers, actual field level results and extensive discussions with leading scientists worldwide on sustainable farming methods. It works, it is simple, but the science behind this is extremely complex. It involves six inter-related activities:

Raising earthworms: WSHGs can be trained to raise earthworms (*Eisenia foetida* specie). These worms, if fed properly and kept in shade, multiply 35 times in one year and produce their body weight of vermicompost. Starting with just 10 kilograms, costing Rs 2000, the worm population will become 350 kgs, producing 350 kg of high quality compost every day. These composts should be diluted with common soil and spread over the farm. Earthworm casts not only add critical nutrients to the soil, they also add about 40 friendly bacteria that helps improve soil fertility.

Intensive raised beds: vegetable growing areas should be divided into 8 feet by 4 feet by 1 feet high raised beds, separated by 2 feet wide pathway, for intensive cultivation. Raised beds prevent damage to growing crops and separate traffic areas from growing areas. Raised beds also bring work up, thereby reducing drudgery of de-weeding, irrigation, planting, and harvesting. As the soil gets more and more nutrient rich, production will start booming. In about two years it would be possible to grow vegetables all year round.

Rainwater harvesting and drip irrigation: production will become optimum only when rainwater is harvested and stocked and low cost drip irrigation is installed. A low cost drip irrigation system can be set up for as little as Rs 1200 per acre. Rainwater harvested can be used for irrigation through drip method, thereby putting more water than is extracted. The system can achieve optimum results in 2-5 years.

Apiary: Each SHG can start with 4 boxes, costing Rs 2000 each. It will provide about 40-60 kgs of honey per box and add a critical synergy to the agriculture production. Each Kg of honey sells for about Rs 60 ex-farm. Thus 4 boxes can achieve a sale of Rs 9600 per year and cost of boxes can be achieved within two years.

Mushroom cultivation: Oyster mushroom can be grown anywhere in India using low cost substrate and ordinary thatched house for growing the crop. It can also be set up with as low as Rs 2000 initial investment. The first year women may lose some crop and earn a modest income. But the real gain is the substrate. The pasteurised weed free substrate is a rich feed for the earthworm and the worm casts is far superior and weed free. From year two, mushroom would not only provide nutritious diet but also additional income. The spent substrate can go towards enriching the farmland.

Quick review of the working of ICDS programme

Quail rearing: Quail is easy to keep, can be fed surplus worm, and quail meat and egg is richer in protein and micronutrients as compared to chicken meat and egg. Quail wastes can be recycled to be fed to earthworm. Quail meat sells for Rs 125 ex-farm and eggs are an excellent source of protein and nutrients.

This integrated farm, if installed over 10 acres-through a farmers Self-Help Group, or even WSHGs- can achieve powerful biological synergy leading to production of vegetables, meat, egg, honey, vermicompost, and earthworm for domestic consumption as well as to generate additional income. The only initial investment is in worms and mushroom seeds: other activities can be integrated sequentially. By integrating these systems, farmers can add about 200 beneficial bacteria to the soil, maintain soil nutrient level at peak level and produce vegetables and food all year round. This farming method does not require tilling, hence no need for tractors, tillers and petrol/diesel.

The best return would be from availability of nutritious food all year round: it will resolve malnutrition problem within about 2 to 3 years. It is worth trying out in Rajasthan and all the BIMARU states. The following outcomes are guaranteed:

- 🏠 65-70 kg vegetables per 50 square metres of land all year round from year 2 onwards;
- 🏠 80% micronutrient needs satisfied from the suggested activities within 2 years;
- 🏠 100% micronutrient and dietary needs satisfied from Year 3 onwards.

Subject to the condition that irrigation facility is available in the village. This does not mean that SEDEM will run away from water-scarce villages. It will take some time, another 3-4 years to build irrigation and water harvesting structures to achieve water security. Then, any village can move on to food security and nutritional adequacy.

SEDEM is starting demonstration projects in 7 centres in North India. It is an international project. It is for the farmers to observe and learn.

Last word: it must be noted that micronutrient deficiency is a modern phenomenon. As societies moved into processed food and industrial farming, they lost the beneficial and critical micronutrients.

Unfortunately, outlandish theories, like biotechnology and genetic engineering, are being promoted to solve food problem. There is no conclusive scientific evidence that these strategies are harmless. There are conclusive evidences that both biotechnology and GM foods are potential killers. Going back to the basics is the only sustainable way to resolve malnutrition problem. The choice is with the decision makers.

STATISTICAL TABLES

Tables for Chapter 3

Features of the sample

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------------|-------|-------|-----------|--------|-------|-------|---------|
| PREGNANT | 20 | 22 | 20 | 20 | 20 | 102 | 40.80% |
| LACTATING | 20 | 28 | 20 | 20 | 20 | 108 | 43.20% |
| Adolescents | 10 | 0 | 10 | 10 | 10 | 40 | 16.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| Years | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| <16 | 17 | 10 | 10 | 15 | 13 | 65 | 30.95% |
| 16-20 | 22 | 33 | 29 | 22 | 24 | 130 | 61.90% |
| >20 | 1 | 7 | 1 | 3 | 3 | 15 | 7.14% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |

| Blocks | Yes | No | Total |
|------------|--------|--------|---------|
| Ajmer | 27 | 23 | 50 |
| Alwar | 24 | 26 | 50 |
| Jaisalmer | 17 | 33 | 50 |
| Nagaur | 15 | 35 | 50 |
| Sikar | 34 | 16 | 50 |
| Total | 117 | 133 | 250 |
| Percentage | 46.80% | 53.20% | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-----------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| Illiterate | 18 | 15 | 33 | 30 | 12 | 108 | 43.20% |
| Barely Literate | 5 | 10 | 2 | 5 | 5 | 25 | 10.00% |
| Primary | 15 | 7 | 8 | 8 | 15 | 55 | 22.00% |
| Middle | 12 | 8 | 2 | 3 | 9 | 34 | 13.60% |
| High School | 0 | 7 | 5 | 3 | 8 | 23 | 9.20% |
| College | 0 | 2 | 0 | 1 | 1 | 4 | 1.60% |
| Technical | 0 | 1 | 0 | 0 | 0 | 1 | 0.40% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------------------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| House Wife | 42 | 36 | 40 | 35 | 40 | 193 | 77.20% |
| Daily Wage | 3 | 7 | 4 | 5 | 2 | 21 | 8.40% |
| Skilled Labour | 0 | 1 | 0 | 0 | 0 | 1 | 0.40% |
| Unskilled Labour | 1 | 6 | 3 | 6 | 0 | 16 | 6.40% |
| Self Employed | 1 | 0 | 0 | 1 | 0 | 2 | 0.80% |
| Others | 3 | 0 | 3 | 3 | 8 | 17 | 6.80% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|----------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| General | 9 | 6 | 11 | 4 | 6 | 36 | 14.40% |
| Schedule Caste | 5 | 7 | 28 | 22 | 6 | 68 | 27.20% |
| Schedule Tribe | 0 | 0 | 2 | 0 | 0 | 2 | 0.80% |
| OBC | 29 | 20 | 6 | 12 | 35 | 102 | 40.80% |
| Other | 7 | 17 | 3 | 12 | 3 | 42 | 16.80% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| Hindu | 43 | 38 | 48 | 38 | 47 | 214 | 85.60% |
| Muslims | 7 | 12 | 2 | 12 | 3 | 36 | 14.40% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| Nuclear | 18 | 18 | 19 | 20 | 10 | 85 | 34.00% |
| Joint | 32 | 32 | 31 | 30 | 40 | 165 | 66.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| Less than 4 | 6 | 8 | 10 | 2 | 7 | 33 | 13.20% |
| 5 to 7 | 29 | 24 | 29 | 24 | 31 | 137 | 54.80% |
| Above 7 | 15 | 18 | 11 | 24 | 12 | 80 | 32.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|-----------|------------|-----------|------------|-----------|------------|----------------|
| Boys | 39 | 51 | 52 | 58 | 38 | 238 | 47.70% |
| Girls | 46 | 64 | 45 | 61 | 45 | 261 | 52.30% |
| TOTAL | 85 | 115 | 97 | 119 | 83 | 499 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| Low | 15 | 22 | 41 | 26 | 7 | 111 | 44.40% |
| Medium | 24 | 17 | 6 | 22 | 25 | 94 | 37.60% |
| High | 11 | 11 | 3 | 2 | 18 | 45 | 18.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 6 | 4 | 12 | 5 | 8 | 35 | 14.00% |
| No | 30 | 46 | 21 | 36 | 29 | 162 | 64.80% |
| NA | 14 | 0 | 17 | 9 | 13 | 53 | 21.20% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|----------------|-------|-------|-----------|--------|-------|-------|---------|
| Perinatal | 2 | 1 | 4 | 0 | 1 | 8 | 22.86% |
| Miscarriage | 0 | 1 | 3 | 0 | 3 | 7 | 20.00% |
| High Fever | 3 | 0 | 1 | 1 | 0 | 5 | 14.29% |
| Pox/Measles | 0 | 1 | 2 | 0 | 0 | 3 | 8.57% |
| Diarrhoea | 0 | 0 | 0 | 2 | 0 | 2 | 5.71% |
| Jaundice | 1 | 0 | 0 | 1 | 1 | 3 | 8.57% |
| Reason unknown | 0 | 1 | 2 | 1 | 3 | 7 | 20.00% |
| TOTAL | 6 | 4 | 12 | 5 | 8 | 35 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 1 | 1 | 0 | 0 | 0 | 2 | 0.80% |
| No | 49 | 49 | 50 | 50 | 50 | 248 | 99.20% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|------------------|-------|-------|-----------|--------|-------|-------|---------|
| During Pregnancy | 1 | 1 | 0 | 0 | 0 | 2 | 100.00% |
| During Birth | 0 | 0 | 0 | 0 | 0 | 0 | 0.00% |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0.00% |
| TOTAL | 1 | 1 | 0 | 0 | 0 | 2 | 100.00% |

Quick review of the working of ICDS programme

Social and cultural practices (impact)

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 30 | 12 | 28 | 18 | 17 | 105 | 42.00% |
| No | 20 | 38 | 22 | 32 | 33 | 145 | 58.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 25 | 39 | 29 | 32 | 36 | 161 | 64.40% |
| No | 25 | 11 | 21 | 18 | 14 | 89 | 35.60% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 50 | 50 | 48 | 50 | 50 | 248 | 99.20% |
| No | 0 | 0 | 2 | 0 | 0 | 2 | 0.80% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 50 | 49 | 46 | 50 | 50 | 245 | 98.00% |
| No | 0 | 1 | 4 | 0 | 0 | 5 | 2.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 50 | 49 | 50 | 50 | 50 | 249 | 99.60% |
| No | 0 | 1 | 0 | 0 | 0 | 1 | 0.40% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

Quick review of the working of ICDS programme

Interaction with AWWs

| Blocks | Yes | No | Total |
|-----------|--------|--------|---------|
| Ajmer | 46 | 4 | 50 |
| Alwar | 31 | 19 | 50 |
| Jaisalmer | 33 | 17 | 50 |
| Nagaur | 43 | 7 | 50 |
| Sikar | 45 | 5 | 50 |
| Total | 198 | 52 | 250 |
| % | 79.20% | 20.80% | 100.00% |

| Blocks | Yes | No | Total |
|-----------|--------|--------|---------|
| Ajmer | 26 | 24 | 50 |
| Alwar | 24 | 26 | 50 |
| Jaisalmer | 21 | 29 | 50 |
| Nagaur | 32 | 18 | 50 |
| Sikar | 33 | 17 | 50 |
| Total | 136 | 114 | 250 |
| % | 54.40% | 45.60% | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|-------|-------|-----------|--------|-------|-------|---------|
| once in one month | 29 | 23 | 29 | 29 | 33 | 143 | 95.33% |
| once in two months | 0 | 0 | 0 | 3 | 0 | 3 | 2.00% |
| once in six months | 0 | 1 | 0 | 0 | 0 | 1 | 0.67% |
| No meeting | 0 | 0 | 2 | 0 | 0 | 2 | 1.33% |
| DK/CS | 1 | 0 | 0 | 0 | 0 | 1 | 0.67% |
| Total | 30 | 24 | 31 | 32 | 33 | 150 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 6 | 9 | 11 | 7 | 10 | 43 | 17.20% |
| No | 44 | 41 | 36 | 43 | 31 | 195 | 78.00% |
| DK/CS | 0 | 0 | 3 | 0 | 9 | 12 | 4.80% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------------------------------------|-------|-------|-----------|--------|-------|-------|---------|
| Call children | 5 | 4 | 5 | 3 | 5 | 22 | 27.50% |
| Cleaning | 2 | 4 | 6 | 4 | 4 | 20 | 25.00% |
| Prepare SN | 4 | 5 | 6 | 4 | 4 | 23 | 28.75% |
| Distribute SN | 0 | 2 | 5 | 2 | 2 | 11 | 13.75% |
| Send adolescents to AWC | 0 | 2 | 0 | | 1 | 3 | 3.75% |
| Community support to Nursing mother | 0 | 0 | 1 | 0 | 0 | 1 | 1.25% |
| Total | 11 | 17 | 23 | 13 | 16 | 80 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 29 | 13 | 8 | 15 | 23 | 88 | 35.20% |
| No | 21 | 37 | 42 | 35 | 27 | 162 | 64.80% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

Table 3.27 When does NHD take place in your village?

Once in a month

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 5 | 9 | 6 | 8 | 4 | 32 | 36.36% |
| No | 24 | 4 | 2 | 7 | 19 | 56 | 63.64% |
| TOTAL | 29 | 13 | 8 | 15 | 23 | 88 | 100.00% |

Quick review of the working of ICDS programme

| Blocks | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------------------------|-------|-------|-----------|--------|-------|-------|---------|
| Health checkup with SN distribution? | 3 | 18 | 6 | 3 | 11 | 41 | 16.40% |
| Separate health checkup and SN | 25 | 22 | 11 | 21 | 25 | 104 | 41.60% |
| DK/CS | 22 | 10 | 33 | 26 | 14 | 105 | 42.00% |
| Total | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

Information dissemination process

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 10 | 11 | 3 | 13 | 8 | 45 | 18.00% |
| No | 40 | 39 | 47 | 37 | 42 | 205 | 82.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 10 | 11 | 3 | 11 | 8 | 43 | 95.56% |
| No | 0 | 0 | 0 | 2 | 0 | 2 | 4.44% |
| TOTAL | 10 | 11 | 3 | 13 | 8 | 45 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 10 | 11 | 3 | 10 | 6 | 40 | 93.02% |
| No | 0 | 0 | 0 | 1 | 2 | 3 | 6.98% |
| TOTAL | 10 | 11 | 3 | 11 | 8 | 43 | 100.00% |

Quick review of the working of ICDS programme

AWC services during pregnancy

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 35 | 36 | 35 | 34 | 33 | 173 | 82.38% |
| No | 5 | 14 | 5 | 6 | 7 | 37 | 17.62% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|-------|-------|-----------|--------|-------|-------|---------|
| No problem | 3 | 3 | 2 | 3 | 5 | 16 | 43.24% |
| DK/CS | 2 | 3 | 2 | 3 | 0 | 10 | 27.03% |
| Can't go alone | 0 | 2 | 0 | 0 | 1 | 3 | 8.11% |
| 1st time pregnant | 0 | 1 | 1 | 0 | 1 | 3 | 8.11% |
| Superstition | 0 | 1 | 0 | 0 | 0 | 1 | 2.70% |
| Nurse came home | 0 | 1 | 0 | 0 | 0 | 1 | 2.70% |
| AWC | 0 | 2 | 0 | 0 | 0 | 2 | 5.41% |
| Because of poverty | 0 | 1 | 0 | 0 | 0 | 1 | 2.70% |
| TOTAL | 5 | 14 | 5 | 6 | 7 | 37 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 35 | 34 | 35 | 32 | 32 | 168 | 97.11% |
| No | 0 | 2 | 0 | 2 | 1 | 5 | 2.89% |
| TOTAL | 35 | 36 | 35 | 34 | 33 | 173 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|---------------|-------|-------|-----------|--------|-------|-------|---------|
| Once | 3 | 12 | 18 | 9 | 6 | 48 | 27.75% |
| Twice | 21 | 10 | 10 | 17 | 18 | 76 | 43.93% |
| Thrice | 7 | 14 | 7 | 5 | 2 | 35 | 20.23% |
| > Three times | 4 | 0 | 0 | 3 | 7 | 14 | 8.09% |
| Total | 35 | 36 | 35 | 34 | 33 | 173 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| PHC | 3 | 7 | 9 | 8 | 3 | 30 | 17.34% |
| AWC | 2 | 3 | 2 | 6 | 3 | 16 | 9.25% |
| SC | 21 | 12 | 13 | 14 | 15 | 75 | 43.35% |
| CHC | 1 | 2 | 3 | 2 | 0 | 8 | 4.62% |
| Any Govt. Hospital | 8 | 11 | 7 | 4 | 0 | 30 | 17.34% |
| Private Hospital | 0 | 1 | 1 | 0 | 12 | 14 | 8.09% |
| Total | 35 | 36 | 35 | 34 | 33 | 173 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|-----------|-----------|-----------|-----------|-----------|------------|----------------|
| Doctor | 8 | 6 | 12 | 11 | 13 | 50 | 28.90% |
| Nurse | 20 | 30 | 17 | 15 | 14 | 96 | 55.49% |
| ANM | 7 | 0 | 5 | 8 | 6 | 26 | 15.03% |
| AWW | 0 | 0 | 1 | 0 | 0 | 1 | 0.58% |
| Total | 35 | 36 | 35 | 34 | 33 | 173 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|------------|------------|------------|------------|------------|------------|----------------|
| Stomach | 29 | 27 | 27 | 31 | 27 | 141 | 22.31% |
| Blood | 23 | 5 | 8 | 7 | 7 | 50 | 7.91% |
| Urine | 17 | 11 | 5 | 10 | 13 | 56 | 8.86% |
| BP | 4 | 6 | 3 | 4 | 3 | 20 | 3.16% |
| Pulse beat | 17 | 14 | 14 | 12 | 16 | 73 | 11.55% |
| Throat | 8 | 4 | 6 | 5 | 2 | 25 | 3.96% |
| Eye | 16 | 9 | 16 | 17 | 20 | 78 | 12.34% |
| Lips | 3 | 1 | 6 | 4 | 5 | 19 | 3.01% |
| Palm/hand | 11 | 6 | 8 | 10 | 11 | 46 | 7.28% |
| Teeth & gums | 10 | 0 | 4 | 7 | 9 | 30 | 4.75% |
| Face | 7 | 9 | 12 | 11 | 5 | 44 | 6.96% |
| Skin | 1 | 3 | 0 | 3 | 3 | 10 | 1.58% |
| Nail | 4 | 12 | 16 | 6 | 0 | 38 | 6.01% |
| Bone/muscles | 1 | 0 | 1 | 0 | 0 | 2 | 0.32% |
| Total | 151 | 107 | 126 | 127 | 121 | 632 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 13 | 21 | 13 | 8 | 11 | 66 | 38.15% |
| No | 22 | 15 | 22 | 26 | 22 | 107 | 61.85% |
| TOTAL | 35 | 36 | 35 | 34 | 33 | 173 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 35 | 36 | 28 | 33 | 29 | 161 | 76.67% |
| No | 5 | 14 | 12 | 7 | 11 | 49 | 23.33% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-----------|-------|-------|-----------|--------|-------|-------|---------|
| Not taken | 0 | 6 | 0 | 1 | 2 | 9 | 4.29% |
| Once | 11 | 8 | 6 | 5 | 6 | 36 | 17.14% |
| Twice | 29 | 35 | 31 | 34 | 32 | 161 | 76.67% |
| Thrice | 0 | 1 | 3 | 0 | 0 | 4 | 1.90% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|------------------------|-------|-------|-----------|--------|-------|-------|---------|
| SN | | | | | | | |
| Yes | 40 | 43 | 37 | 40 | 38 | 198 | 94.29% |
| No | 0 | 7 | 3 | 0 | 2 | 12 | 5.71% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |
| Iron/Folic Acid | | | | | | | |
| Yes | 35 | 43 | 38 | 40 | 37 | 193 | 91.90% |
| No | 5 | 7 | 2 | 0 | 3 | 17 | 8.10% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |
| Vitamin A | | | | | | | |
| Yes | 0 | 12 | 3 | 3 | 6 | 24 | 11.43% |
| No | 40 | 38 | 37 | 37 | 34 | 186 | 88.57% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |
| Deworming | | | | | | | |
| Yes | 1 | 6 | 5 | 5 | 5 | 22 | 10.48% |
| No | 39 | 44 | 35 | 35 | 35 | 188 | 89.52% |
| TOTAL | 40 | 50 | 40 | 40 | 40 | 210 | 100.00% |

Quick review of the working of ICDS programme

Immediately after child birth

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|--------|
| Yes | 28 | 21 | 24 | 16 | 28 | 117 | 59.39% |
| No | 8 | 25 | 9 | 20 | 9 | 71 | 36.04% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 95.43% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-----------|-------|-------|-----------|--------|-------|-------|---------|
| Colustrom | 34 | 30 | 32 | 34 | 33 | 163 | 86.70% |
| Other | 2 | 16 | 1 | 2 | 4 | 25 | 13.30% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

Availability and consumption of SN and medicines

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 16 | 31 | 15 | 17 | 22 | 101 | 40.40% |
| No | 34 | 19 | 35 | 33 | 28 | 149 | 59.60% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| Districts | Share it will all | Share it with children | Do not share | Total |
|-----------|-------------------|------------------------|--------------|---------|
| Ajmer | 13 | 3 | 0 | 16 |
| Alwar | 5 | 25 | 1 | 31 |
| Jaisalmer | 11 | 5 | 0 | 16 |
| Nagaur | 9 | 7 | 0 | 16 |
| Sikar | 14 | 7 | 1 | 22 |
| Total | 52 | 47 | 2 | 101 |
| % | 51.49% | 46.53% | 1.98% | 100.00% |

Quick review of the working of ICDS programme

| Districts | In lieu of normal meal | Additional | Total |
|-----------|------------------------|------------|---------|
| Ajmer | 4 | 12 | 16 |
| Alwar | 12 | 19 | 31 |
| Jaisalmer | 1 | 15 | 16 |
| Nagaur | 1 | 15 | 16 |
| Sikar | 4 | 18 | 22 |
| Total | 22 | 79 | 101 |
| % | 21.78% | 78.22% | 100.00% |

| Districts | THR | Pre-prepared | DK/CS | Total |
|-----------|--------|--------------|--------|---------|
| Ajmer | 7 | 8 | 2 | 17 |
| Alwar | 6 | 7 | 0 | 13 |
| Jaisalmer | 4 | 12 | 0 | 16 |
| Nagaur | 6 | 11 | 0 | 17 |
| Sikar | 5 | 9 | 8 | 22 |
| Total | 28 | 47 | 10 | 85 |
| % | 32.94% | 55.29% | 11.76% | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|------------|-----------|-----------|-----------|-----------|-----------|-----------|---------------|
| Yes | 15 | 23 | 13 | 14 | 20 | 85 | 84.16% |
| No | 1 | 8 | 2 | 3 | 2 | 16 | 15.84% |
| TOTAL | 16 | 31 | 15 | 17 | 22 | 101 | 100.00% |

| Districts | Bad taste | Makes me sick | Old/ stale | Dk/CS | Total |
|-----------|-----------|---------------|------------|--------|---------|
| Ajmer | 1 | 0 | 0 | 0 | 1 |
| Alwar | 1 | 1 | 1 | 5 | 8 |
| Jaisalmer | 0 | 2 | 0 | 0 | 2 |
| Nagaur | 3 | 0 | 0 | 0 | 3 |
| Sikar | 2 | 0 | 0 | 0 | 2 |
| Total | 7 | 3 | 1 | 5 | 16 |
| % | 43.75% | 18.75% | 6.25% | 31.25% | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 0 | 10 | 9 | 4 | 4 | 27 | 10.80% |
| No | 50 | 40 | 41 | 46 | 46 | 223 | 89.20% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 46 | 44 | 46 | 49 | 47 | 232 | 92.80% |
| No | 4 | 6 | 4 | 1 | 3 | 18 | 7.20% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 41 | 41 | 43 | 47 | 45 | 217 | 93.53% |
| No | 5 | 3 | 3 | 2 | 2 | 15 | 6.47% |
| TOTAL | 46 | 44 | 46 | 49 | 47 | 232 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 50 | 40 | 43 | 49 | 49 | 231 | 92.40% |
| No | 0 | 10 | 7 | 1 | 1 | 19 | 7.60% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 1 | 1 | 7 | 5 | 5 | 19 | 7.60% |
| No | 49 | 49 | 43 | 45 | 45 | 231 | 92.40% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

Quick review of the working of ICDS programme

| Blocks | When needed | 1 time | 2 times | 3 times | 4 times | Not needed | Total |
|---------------|-------------|----------|----------|----------|----------|------------|----------|
| Ajmer | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Alwar | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Jaisalmer | 0 | 4 | 1 | 1 | 0 | 1 | 7 |
| Nagaur | 0 | 4 | 1 | 0 | 0 | 0 | 5 |
| Sikar | 0 | 3 | 1 | 0 | 1 | 0 | 5 |
| Total | 1 | 12 | 3 | 1 | 1 | 1 | 19 |
| % | 5.26% | 63.16% | 15.79% | 5.26% | 5.26% | 5.26% | 100.00% |

Disease management and utilization of services

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|-------|-------|-----------|--------|-------|-------|---------|
| Sankraman | 5 | 3 | 11 | 7 | 10 | 36 | 14.40% |
| Lack of Some Thing | 7 | 10 | 9 | 5 | 7 | 38 | 15.20% |
| Abhishap | 5 | 6 | 4 | 2 | 5 | 22 | 8.80% |
| DK / CS | 33 | 31 | 26 | 36 | 28 | 154 | 61.60% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| Blocks | Go to Doctor | Neem ka patha & Imli ka chaya | Shital mata | Vaccination | DK/CS | Total |
|-----------|--------------|-------------------------------|-------------|-------------|--------|---------|
| Ajmer | 30 | 2 | 7 | 0 | 11 | 50 |
| Alwar | 6 | 32 | 2 | 2 | 8 | 50 |
| Jaisalmer | 17 | 3 | 0 | 8 | 22 | 50 |
| Nagaur | 31 | 3 | 0 | 3 | 13 | 50 |
| Sikar | 35 | 6 | 0 | 0 | 9 | 50 |
| Total | 119 | 46 | 9 | 13 | 63 | 250 |
| % | 47.60% | 18.40% | 3.60% | 5.20% | 25.20% | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 3 | 8 | 1 | 1 | 1 | 14 | 5.60% |
| No | 47 | 42 | 49 | 49 | 49 | 236 | 94.40% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 1 | 3 | 2 | 0 | 3 | 9 | 3.60% |
| No | 49 | 47 | 48 | 50 | 47 | 241 | 96.40% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

Non-specific debility

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 13 | 25 | 8 | 8 | 5 | 59 | 23.60% |
| No | 37 | 25 | 42 | 42 | 45 | 191 | 76.40% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Doctor | Nurse | AWC | NR | Total |
|-----------|--------|--------|-------|-------|---------|
| Ajmer | 9 | 4 | 0 | 0 | 13 |
| Alwar | 13 | 8 | 1 | 3 | 25 |
| Jaisalmer | 4 | 4 | 0 | 0 | 8 |
| Nagaur | 6 | 2 | 0 | 0 | 8 |
| Sikar | 2 | 3 | 0 | 0 | 5 |
| Total | 34 | 21 | 1 | 3 | 59 |
| | 57.63% | 35.59% | 1.69% | 5.08% | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|-------|-------|-----------|--------|-------|-------|---------|
| Low Hb count | 10 | 10 | 5 | 4 | 2 | 31 | 52.54% |
| Inadequate diet | 2 | 8 | 3 | 4 | 2 | 19 | 32.20% |
| Excessive workload | 1 | 7 | 0 | 0 | 0 | 8 | 13.56% |
| Other reasons | 0 | 0 | 0 | 0 | 1 | 1 | 1.69% |
| Total | 13 | 25 | 8 | 8 | 5 | 59 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|-------|-------|-----------|--------|-------|-------|---------|
| Regular medication | 5 | 3 | 5 | 7 | 0 | 20 | 28.57% |
| Proper diet | 2 | 19 | 4 | 2 | 4 | 31 | 44.29% |
| Nutritious food | 5 | 1 | 3 | 1 | 1 | 11 | 15.71% |
| Drip given | 1 | 0 | 0 | 0 | 0 | 1 | 1.43% |
| Drink water | 0 | 1 | 0 | 0 | 0 | 1 | 1.43% |
| Rest | 0 | 1 | 0 | 0 | 0 | 1 | 1.43% |
| Can't say | 0 | 5 | 0 | 0 | 0 | 5 | 7.14% |
| Total | 13 | 30 | 12 | 10 | 5 | 70 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 15 | 8 | 8 | 5 | 5 | 41 | 16.40% |
| No | 35 | 42 | 42 | 45 | 45 | 209 | 83.60% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Doctor | Nurse | DK/CS | Total |
|-----------|--------|--------|-------|---------|
| Ajmer | 9 | 6 | 0 | 15 |
| Alwar | 3 | 2 | 3 | 8 |
| Jaisalmer | 4 | 4 | 0 | 8 |
| Nagaur | 1 | 4 | 0 | 5 |
| Sikar | 3 | 2 | 0 | 5 |
| Total | 20 | 18 | 3 | 41 |
| % | 48.78% | 43.90% | 7.32% | 100.00% |

Quick review of the working of ICDS programme

| | PHC | CHC | SC | Pvt. | DH | DK/CS | Total |
|-----------|--------|--------|--------|-------|--------|--------|---------|
| Ajmer | 6 | 3 | 4 | 1 | 1 | 0 | 15 |
| Alwar | 2 | 1 | 2 | 0 | 0 | 3 | 8 |
| Jaisalmer | 3 | 0 | 1 | 0 | 3 | 1 | 8 |
| Nagaur | 2 | 3 | 0 | 0 | 0 | 0 | 5 |
| Sikar | 1 | 0 | 0 | 0 | 3 | 1 | 5 |
| Total | 14 | 7 | 7 | 1 | 7 | 5 | 41 |
| % | 34.15% | 17.07% | 17.07% | 2.44% | 17.07% | 12.20% | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|----------|-------|-------|-----------|--------|-------|-------|---------|
| Mild | 0 | 1 | 2 | 2 | 0 | 5 | 12.20% |
| Moderate | 14 | 5 | 5 | 3 | 5 | 32 | 78.05% |
| Severe | 1 | 2 | 1 | 0 | 0 | 4 | 9.76% |
| TOTAL | 15 | 8 | 8 | 5 | 5 | 41 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 0 | 4 | 1 | 0 | 0 | 5 | 2.00% |
| No | 50 | 46 | 49 | 50 | 50 | 245 | 98.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| | Food | DK/CS | Total | % |
|-----------|------|-------|-------|---------|
| Ajmer | 0 | 0 | 0 | 0.00% |
| Alwar | 1 | 3 | 4 | 80.00% |
| Jaisalmer | 1 | 0 | 1 | 20.00% |
| Nagaur | 0 | 0 | 0 | 0.00% |
| Sikar | 0 | 0 | 0 | 0.00% |
| Total | 2 | 3 | 5 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 0 | 2 | 4 | 2 | 2 | 10 | 4.00% |
| No | 50 | 48 | 46 | 48 | 48 | 240 | 96.00% |
| TOTAL | 50 | 50 | 50 | 50 | 50 | 250 | 100.00% |

| Blocks | DH | SC | PHC | AWW | DK/CS | Total |
|-----------|--------|--------|--------|--------|--------|---------|
| Ajmer | 0 | 0 | 0 | 0 | 0 | 0 |
| Alwar | 0 | 0 | 1 | 1 | 0 | 2 |
| Jaisalmer | 0 | 1 | 0 | 0 | 3 | 4 |
| Nagaur | 1 | 0 | 0 | 0 | 1 | 2 |
| Sikar | 1 | 0 | 0 | 0 | 1 | 2 |
| Total | 2 | 1 | 1 | 1 | 5 | 10 |
| % | 20.00% | 10.00% | 10.00% | 10.00% | 50.00% | 100.00% |

| Blocks | Suggested ORS | Gave Medicine | DK/CS | Total |
|-----------|---------------|---------------|--------|---------|
| Ajmer | 0 | 0 | 0 | 0 |
| Alwar | 1 | 1 | 0 | 2 |
| Jaisalmer | 3 | 1 | 0 | 4 |
| Nagaur | 1 | 0 | 1 | 2 |
| Sikar | 1 | 0 | 1 | 2 |
| Total | 6 | 2 | 2 | 10 |
| % | 60.00% | 20.00% | 20.00% | 100.00% |

Quick review of the working of ICDS programme

Home management of children's diseases

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 7 | 13 | 6 | 11 | 8 | 45 | 23.94% |
| No | 29 | 29 | 24 | 25 | 29 | 136 | 72.34% |
| NA | 0 | 4 | 3 | 0 | 0 | 7 | 3.72% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 4 | 14 | 7 | 3 | 6 | 34 | 18.09% |
| No | 32 | 32 | 26 | 33 | 31 | 154 | 81.91% |
| DK/CS | 0 | 0 | 0 | 0 | 0 | 0 | 0.00% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 3 | 14 | 6 | 2 | 5 | 30 | 88.24% |
| No | 1 | 0 | 1 | 1 | 1 | 4 | 11.76% |
| TOTAL | 4 | 14 | 7 | 3 | 6 | 34 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 3 | 14 | 6 | 2 | 6 | 31 | 91.18% |
| No | 1 | 0 | 1 | 1 | 0 | 3 | 8.82% |
| TOTAL | 4 | 14 | 7 | 3 | 6 | 34 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 4 | 6 | 3 | 3 | 3 | 19 | 10.11% |
| No | 32 | 40 | 30 | 33 | 34 | 169 | 89.89% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 1 | 1 | 0 | 1 | 0 | 3 | 15.79% |
| No | 3 | 5 | 3 | 2 | 3 | 16 | 84.21% |
| TOTAL | 4 | 6 | 3 | 3 | 3 | 19 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 4 | 6 | 3 | 3 | 2 | 18 | 94.74% |
| No | 0 | 0 | 0 | 0 | 1 | 1 | 5.26% |
| TOTAL | 4 | 6 | 3 | 3 | 3 | 19 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 4 | 6 | 3 | 3 | 3 | 19 | 100.00% |
| No | 0 | 0 | 0 | 0 | 0 | 0 | 0.00% |
| TOTAL | 4 | 6 | 3 | 3 | 3 | 19 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 4 | 6 | 3 | 3 | 3 | 19 | 100.00% |
| No | 0 | 0 | 0 | 0 | 0 | 0 | 0.00% |
| TOTAL | 4 | 6 | 3 | 3 | 3 | 19 | 100.00% |

| Blocks | AWW | Medical Store | PHC | SC | Total |
|-----------|--------|---------------|--------|--------|---------|
| Ajmer | 3 | 0 | 0 | 1 | 4 |
| Alwar | 4 | 1 | 1 | 0 | 6 |
| Jaisalmer | 1 | 0 | 1 | 1 | 3 |
| Nagaur | 0 | 0 | 1 | 2 | 3 |
| Sikar | 2 | 0 | 1 | 0 | 3 |
| Total | 10 | 1 | 4 | 4 | 19 |
| % | 52.63% | 5.26% | 21.05% | 21.05% | 100.00% |

Quick review of the working of ICDS programme

Exclusive breast feeding

This does not tally with total number of mothers

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |
| No | 0 | 0 | 0 | 0 | 0 | 0 | 0.00% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------------|-------|-------|-----------|--------|-------|-------|---------|
| 30 min. | 16 | 5 | 14 | 16 | 12 | 63 | 33.51% |
| 1 hr. | 15 | 20 | 16 | 15 | 17 | 83 | 44.15% |
| 2 hrs. | 2 | 0 | 0 | 0 | 1 | 3 | 1.60% |
| 3 hrs. | 0 | 7 | 0 | 0 | 0 | 7 | 3.72% |
| 4-6 hrs | 0 | 0 | 0 | 0 | 3 | 3 | 1.60% |
| 1 day | 3 | 1 | 0 | 2 | 4 | 10 | 5.32% |
| 2 to 3 days | 0 | 13 | 3 | 3 | 0 | 19 | 10.11% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 32 | 28 | 27 | 31 | 33 | 151 | 80.32% |
| No | 4 | 18 | 6 | 5 | 4 | 37 | 19.68% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 1 | 16 | 2 | 5 | 3 | 27 | 14.36% |
| No | 35 | 30 | 31 | 31 | 34 | 161 | 85.64% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| Yes | 27 | 40 | 24 | 28 | 28 | 147 | 78.19% |
| No | 9 | 6 | 9 | 8 | 9 | 41 | 21.81% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------|----------|----------|-----------|----------|----------|-----------|----------------|
| 6 month | 0 | 0 | 2 | 0 | 1 | 3 | 7.32% |
| 7-9 month | 0 | 4 | 0 | 0 | 0 | 4 | 9.76% |
| 1 yr | 5 | 0 | 5 | 5 | 4 | 19 | 46.34% |
| 1.5 yr | 2 | 0 | 0 | 0 | 1 | 3 | 7.32% |
| 2 yr | 2 | 2 | 2 | 2 | 2 | 10 | 24.39% |
| 2.5 yr | 0 | 0 | 0 | 0 | 1 | 1 | 2.44% |
| 3 yr | 0 | 0 | 0 | 1 | 0 | 1 | 2.44% |
| TOTAL | 9 | 6 | 9 | 8 | 9 | 41 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| Yes | 21 | 32 | 25 | 17 | 25 | 120 | 63.83% |
| No | 15 | 14 | 8 | 19 | 12 | 68 | 36.17% |
| TOTAL | 36 | 46 | 33 | 36 | 37 | 188 | 100.00% |
| Not taken % | 41.67% | 30.43% | 24.24% | 52.78% | 32.43% | 36.17% | |

Immunisation of children

| | Women | f | Average |
|--------------|------------|------------|-------------|
| Ajmer | 50 | 63 | 1.26 |
| Alwar | 50 | 48 | 0.96 |
| Jaisalmer | 50 | 59 | 1.18 |
| Nagaur | 50 | 65 | 1.30 |
| Sikar | 50 | 57 | 1.14 |
| TOTAL | 250 | 292 | 1.17 |

The total number of mothers is 188

Fist time pregnant is 22

Adolescents is 40

| Districts | Vaccinated | Not vaccinated | % not vaccinated |
|--------------|------------|----------------|------------------|
| Ajmer | 60 | 3 | 4.76% |
| Alwar | 43 | 5 | 10.42% |
| Jaisalmer | 57 | 2 | 3.39% |
| Nagaur | 65 | 0 | 0.00% |
| Sikar | 56 | 1 | 1.75% |
| TOTAL | 281 | 11 | 3.77% |

Quick review of the working of ICDS programme

| Table 3.92 Has your child been immunized (Based on recall) | | | | | | |
|--|---------------|--------------|--------------|---------------|---------------|---------------|
| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total |
| OPV-O (at birth) | | | | | | |
| Yes | 30 | 42 | 32 | 20 | 21 | 145 |
| No | 2 | 0 | 0 | 16 | 15 | 33 |
| Total | 32 | 42 | 32 | 36 | 36 | 178 |
| Not vaccinated | 6.25% | 0.00% | 0.00% | 44.44% | 41.67% | 18.54% |
| OPV1(6th week) | | | | | | |
| Yes | 34 | 45 | 29 | 34 | 36 | 178 |
| No | 2 | 0 | 0 | 2 | 0 | 4 |
| Total | 36 | 45 | 29 | 36 | 36 | 182 |
| Not vaccinated | 5.56% | 0.00% | 0.00% | 5.56% | 0.00% | 2.20% |
| OPV2(10th week) | | | | | | |
| Yes | 32 | 38 | 30 | 30 | 33 | 163 |
| No | 3 | 0 | 0 | 5 | 2 | 10 |
| Total | 35 | 38 | 30 | 35 | 35 | 173 |
| Not vaccinated | 8.57% | 0.00% | 0.00% | 14.29% | 5.71% | 5.78% |
| OPV3(14th week) | | | | | | |
| Yes | 32 | 38 | 30 | 30 | 33 | 163 |
| No | 3 | 0 | 0 | 5 | 2 | 10 |
| Total | 35 | 38 | 30 | 35 | 35 | 173 |
| Not vaccinated | 8.57% | 0.00% | 0.00% | 14.29% | 5.71% | 5.78% |
| BCG (at Birth) | | | | | | |
| Yes | 32 | 42 | 30 | 31 | 31 | 166 |
| No | 12 | 0 | 0 | 2 | 1 | 15 |
| Total | 44 | 42 | 30 | 33 | 32 | 181 |
| Not vaccinated | 27.27% | 0.00% | 0.00% | 6.06% | 3.13% | 8.29% |

Quick review of the working of ICDS programme

| Table 3.92 Contd... | | | | | | |
|----------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| DPT 1 (6th week) | | | | | | |
| Yes | 27 | 39 | 28 | 31 | 31 | 156 |
| No | 2 | 0 | 1 | 2 | 2 | 7 |
| Total | 29 | 39 | 29 | 33 | 33 | 163 |
| Not vaccinated | 6.90% | 0.00% | 3.45% | 6.06% | 6.06% | 4.29% |
| DPT 2 (10th week) | | | | | | |
| Yes | 25 | 32 | 23 | 24 | 30 | 134 |
| No | 3 | 0 | 1 | 7 | 2 | 13 |
| Total | 28 | 32 | 24 | 31 | 32 | 147 |
| Not vaccinated | 10.71% | 0.00% | 4.17% | 22.58% | 6.25% | 8.84% |
| DPT 3 (14th week) | | | | | | |
| Yes | 20 | 22 | 21 | 22 | 27 | 112 |
| No | 16 | 3 | 1 | 9 | 6 | 35 |
| Total | 36 | 25 | 22 | 31 | 33 | 147 |
| Not vaccinated | 44.44% | 12.00% | 4.55% | 29.03% | 18.18% | 23.81% |
| Measles (9th month) | | | | | | |
| Yes | 17 | 16 | 18 | 18 | 19 | 88 |
| No | 9 | 6 | 2 | 11 | 9 | 37 |
| Total | 26 | 22 | 20 | 29 | 28 | 125 |
| Not vaccinated | 34.62% | 27.27% | 10.00% | 37.93% | 32.14% | 29.60% |

| Table 3.93 Which particular day vaccination was generally given? | | | | | | | |
|--|-----------|-----------|-----------|-----------|-----------|------------|---------|
| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
| NHD/MHD | 42 | 35 | 5 | 24 | 15 | 121 | 69.54% |
| Anyday | 6 | 12 | 2 | 12 | 11 | 43 | 24.71% |
| DK/CS | 1 | 6 | 2 | 0 | 1 | 10 | 5.75% |
| Total | 49 | 53 | 9 | 36 | 27 | 174 | 100.00% |

Quick review of the working of ICDS programme

Table for Chapter 4

| Districts | Male | Female | Total |
|-------------------|---------------|---------------|----------------|
| Ajmer | 6 | 3 | 9 |
| Alwar | 5 | 4 | 9 |
| Jaisalmer | 6 | 3 | 9 |
| Nagaur | 7 | 3 | 10 |
| Sikar | 8 | 2 | 10 |
| Total | 32 | 15 | 47 |
| Percentage | 68.09% | 31.91% | 100.00% |

| Districts | Hindu | Muslim | Other | Total |
|-------------------|---------------|---------------|--------------|----------------|
| Ajmer | 8 | 1 | 0 | 9 |
| Alwar | 7 | 1 | 1 | 9 |
| Jaisalmer | 9 | 0 | 0 | 9 |
| Nagaur | 7 | 3 | 0 | 10 |
| Sikar | 10 | 0 | 0 | 10 |
| Total | 41 | 5 | 1 | 47 |
| Percentage | 87.23% | 10.64% | 2.13% | 100.00% |

| Districts | Gen | SC | ST | OBC | Other | Total |
|-------------------|---------------|---------------|--------------|---------------|---------------|----------------|
| Ajmer | 5 | 0 | 0 | 3 | 1 | 9 |
| Alwar | 0 | 3 | 1 | 3 | 2 | 9 |
| Jaisalmer | 5 | 1 | 1 | 2 | 0 | 9 |
| Nagaur | 0 | 2 | 0 | 5 | 3 | 10 |
| Sikar | 4 | 0 | 0 | 6 | 0 | 10 |
| Total | 14 | 6 | 2 | 19 | 6 | 47 |
| Percentage | 29.79% | 12.77% | 4.26% | 40.43% | 12.77% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Illiterate | Barely Literate | Primary | Middle | High School | College | Total |
|-------------------|--------------|-----------------|---------------|---------------|---------------|---------------|----------------|
| Ajmer | 0 | 3 | 1 | 1 | 1 | 3 | 9 |
| Alwar | 0 | 3 | 1 | 3 | 2 | 0 | 9 |
| Jaisalmer | 1 | 1 | 2 | 2 | 1 | 3 | 10 |
| Nagaur | 1 | 0 | 2 | 4 | 1 | 2 | 10 |
| Sikar | 2 | 0 | 3 | 1 | 3 | 1 | 10 |
| Total | 4 | 7 | 9 | 11 | 8 | 9 | 48 |
| Percentage | 8.33% | 14.58% | 18.75% | 22.92% | 16.67% | 18.75% | 100.00% |

| Districts | (Multiple responses) | | | | | | Ranking |
|-----------------------------------|----------------------|-------|-----------|--------|-------|------------|------------|
| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | |
| Distribution of SN | 9 | 6 | 6 | 10 | 8 | 39 | I |
| Immunization | 7 | 7 | 8 | 10 | 7 | 39 | I |
| Education of illiterate women | 3 | 3 | 2 | 1 | 3 | 12 | III |
| Education of children | 3 | 3 | 2 | 1 | 3 | 12 | III |
| Development of women and children | 2 | 4 | 4 | 2 | 3 | 15 | II |
| Family planning | 0 | 1 | 1 | 0 | 1 | 3 | IV |
| Help in polio campaign | 0 | 0 | 0 | 0 | 1 | 1 | V |
| Total | 24 | 24 | 23 | 24 | 26 | 121 | |

| Districts | Yes | No | Total |
|-----------|-----|----|-------|
| Ajmer | 9 | 0 | 9 |
| Alwar | 9 | 0 | 9 |
| Jaisalmer | 9 | 0 | 9 |
| Nagaur | 10 | 0 | 10 |
| Sikar | 10 | 0 | 10 |
| Total | 47 | 0 | 47 |

Quick review of the working of ICDS programme

| Districts | Yes | No | Total | % |
|-----------|-----|----|-------|---------|
| Ajmer | 9 | 0 | 9 | 19.15% |
| Alwar | 8 | 1 | 9 | 19.15% |
| Jaisalmer | 6 | 3 | 9 | 19.15% |
| Nagaur | 10 | 0 | 10 | 21.28% |
| Sikar | 10 | 0 | 10 | 21.28% |
| | 43 | 4 | 47 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total |
|--------------------------|-------|-------|-----------|--------|-------|-------|
| Absent | 0 | 1 | 0 | 0 | 0 | 1 |
| Does not stay in village | 0 | 0 | 2 | 0 | 0 | 2 |
| Suvidha Shulk | 0 | 0 | 1 | 0 | 0 | 1 |
| Total | 0 | 1 | 3 | 0 | 0 | 4 |

| Districts | ANM/AWW | LS/LHV | Doctor | None | DK/CS | Total |
|-----------|---------|--------|--------|--------|--------|---------|
| Ajmer | 0 | 0 | 3 | 6 | 0 | 9 |
| Alwar | 2 | 0 | 3 | 4 | 0 | 9 |
| Jaisalmer | 6 | 0 | 1 | 0 | 2 | 9 |
| Nagaur | 4 | 0 | 5 | 0 | 1 | 10 |
| Sikar | 1 | 0 | 1 | 0 | 8 | 10 |
| Total | 13 | 0 | 13 | 10 | 11 | 47 |
| % | 27.66% | 0.00% | 27.66% | 21.28% | 23.40% | 100.00% |

Quick review of the working of ICDS programme

| Problems | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | Ranking |
|---------------------------|-------|-------|-----------|--------|-------|-------|---------------------------|
| No dispensary | 2 | 4 | 3 | 6 | 4 | 19 | No dispensary |
| Lack of awareness | 0 | 1 | 1 | 2 | 1 | 5 | Shortage of doctors |
| Quality of drinking water | 0 | 2 | 1 | 1 | 2 | 6 | Quality of drinking water |
| Competent "Dai" | 0 | 1 | 0 | 1 | 0 | 2 | Lack of awareness |
| Shortage of doctors | 0 | 4 | 1 | 0 | 5 | 10 | |
| ANM does not visit | 0 | 1 | 0 | 0 | 0 | 1 | |
| More centre required | 1 | 0 | 0 | 1 | 0 | 2 | |
| Govt bldg for AWC | 0 | 0 | 0 | 1 | 0 | 1 | |
| Seasonal diseases | 0 | 0 | 3 | 0 | 0 | 3 | |
| No problem | 6 | 3 | 0 | 2 | 3 | 14 | |

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 9 | 0 | 9 |
| Alwar | 9 | 0 | 9 |
| Jaisalmer | 9 | 0 | 9 |
| Nagaur | 9 | 1 | 10 |
| Sikar | 10 | 0 | 10 |
| Total | 46 | 1 | 47 |
| % | 97.87% | 2.13% | 100.00% |

Quick review of the working of ICDS programme

| Table 4.13 Does your village produce enough to feed its population | | | |
|---|--------|--------|---------|
| Districts | Yes | No | Total |
| Ajmer | 1 | 8 | 9 |
| Alwar | 8 | 1 | 9 |
| Jaisalmer | 6 | 3 | 9 |
| Nagaur | 0 | 10 | 10 |
| Sikar | 8 | 2 | 10 |
| Total | 23 | 24 | 47 |
| % | 48.94% | 51.06% | 100.00% |

| Table 4.14 Has your village suffered any disaster in last four years | | | |
|---|-----|----|-------|
| Districts | Yes | No | Total |
| Ajmer | 9 | 0 | 9 |
| Alwar | 8 | 1 | 9 |
| Jaisalmer | 9 | 0 | 9 |
| Nagaur | 10 | 0 | 10 |
| Sikar | 10 | 0 | 10 |
| Total | 46 | 1 | 47 |

Drought 95.83%

| Table 4.15 Has the community taken any steps to prevent its recurrence | | | |
|---|--------|--------|---------|
| Districts | Yes | No | Total |
| Ajmer | 1 | 8 | 9 |
| Alwar | 4 | 5 | 9 |
| Jaisalmer | 5 | 4 | 9 |
| Nagaur | 5 | 5 | 10 |
| Sikar | 1 | 9 | 10 |
| Total | 16 | 31 | 47 |
| % | 34.04% | 65.96% | 100.00% |

Table for Chapter 5

| Districts | Gen | SC | ST | OBC | Other | TOTAL |
|-----------|--------|--------|-------|--------|-------|---------|
| Ajmer | 4 | 0 | 0 | 6 | 0 | 10 |
| Alwar | 5 | 0 | 0 | 5 | 0 | 10 |
| Jaisalmer | 3 | 6 | 0 | 1 | 0 | 10 |
| Nagaur | 2 | 1 | 0 | 7 | 0 | 10 |
| Sikar | 3 | 1 | 0 | 6 | 0 | 10 |
| Total | 17 | 8 | 0 | 25 | 0 | 50 |
| % | 34.00% | 16.00% | 0.00% | 50.00% | 0.00% | 100.00% |

| Districts | Hindu | Muslim | TOTAL |
|-----------|--------|--------|---------|
| Ajmer | 9 | 1 | 10 |
| Alwar | 10 | 0 | 10 |
| Jaisalmer | 10 | 0 | 10 |
| Nagaur | 8 | 2 | 10 |
| Sikar | 10 | 0 | 10 |
| Total | 47 | 3 | 50 |
| % | 94.00% | 6.00% | 100.00% |

| Districts | Nuclear | Joint | Total |
|-----------|---------|--------|---------|
| Ajmer | 8 | 2 | 10 |
| Alwar | 3 | 7 | 10 |
| Jaisalmer | 4 | 6 | 10 |
| Nagaur | 5 | 5 | 10 |
| Sikar | 4 | 6 | 10 |
| Total | 24 | 26 | 50 |
| % | 48.00% | 52.00% | 100.00% |

Quick review of the working of ICDS programme

| Districts | 4 or less | 5 to 7 | More than 7 | Total |
|-----------|-----------|--------|-------------|---------|
| Ajmer | 4 | 3 | 3 | 10 |
| Alwar | 1 | 5 | 4 | 10 |
| Jaisalmer | 2 | 3 | 5 | 10 |
| Nagaur | 1 | 2 | 7 | 10 |
| Sikar | 0 | 6 | 4 | 10 |
| Total | 8 | 19 | 23 | 50 |
| % | 16.00% | 38.00% | 46.00% | 100.00% |

| Districts | Low (0-14) | Medium (15-24) | High (25-67) | Total |
|-----------|------------|----------------|--------------|---------|
| Ajmer | 1 | 7 | 2 | 10 |
| Alwar | 0 | 1 | 9 | 10 |
| Jaisalmer | 1 | 6 | 3 | 10 |
| Nagaur | 1 | 4 | 5 | 10 |
| Sikar | 1 | 1 | 8 | 10 |
| Total | 4 | 19 | 27 | 50 |
| % | 8.00% | 38.00% | 54.00% | 100.00% |

| Districts | 0-1 | 2-4 | 5-7 | 8-11 | More than 11 | TOTAL |
|-----------|-------|--------|--------|--------|--------------|---------|
| Ajmer | 0 | 10 | 0 | 0 | 0 | 10 |
| Alwar | 1 | 7 | 1 | 0 | 1 | 10 |
| Jaisalmer | 2 | 1 | 2 | 2 | 3 | 10 |
| Nagaur | 0 | 0 | 3 | 4 | 3 | 10 |
| Sikar | 0 | 0 | 2 | 0 | 8 | 10 |
| Total | 3 | 18 | 8 | 6 | 15 | 50 |
| % | 6.00% | 36.00% | 16.00% | 12.00% | 30.00% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Yes | No | Total |
|-----------|--------|--------|---------|
| Ajmer | 10 | 0 | 10 |
| Alwar | 9 | 1 | 10 |
| Jaisalmer | 9 | 1 | 10 |
| Nagaur | 8 | 2 | 10 |
| Sikar | 8 | 2 | 10 |
| Total | 44 | 6 | 50 |
| % | 88.00% | 12.00% | 100.00% |

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 10 | 0 | 10 |
| Alwar | 10 | 0 | 10 |
| Jaisalmer | 9 | 1 | 10 |
| Nagaur | 10 | 0 | 10 |
| Sikar | 10 | 0 | 10 |
| Total | 49 | 1 | 50 |
| % | 98.00% | 2.00% | 100.00% |

| Districts | Yes | No | Total |
|-----------|--------|--------|---------|
| Ajmer | 6 | 4 | 10 |
| Alwar | 8 | 2 | 10 |
| Jaisalmer | 3 | 7 | 10 |
| Nagaur | 7 | 3 | 10 |
| Sikar | 7 | 3 | 10 |
| Total | 31 | 19 | 50 |
| % | 62.00% | 38.00% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Yes | No | Total |
|-----------|--------|--------|---------|
| Ajmer | 6 | 4 | 10 |
| Alwar | 5 | 5 | 10 |
| Jaisalmer | 3 | 7 | 10 |
| Nagaur | 7 | 3 | 10 |
| Sikar | 7 | 3 | 10 |
| Total | 28 | 22 | 50 |
| % | 56.00% | 44.00% | 100.00% |

| Districts | Good | Average | DK/CS | Total |
|-----------|--------|---------|-------|---------|
| Ajmer | 9 | 1 | 0 | 10 |
| Alwar | 10 | 0 | 0 | 10 |
| Jaisalmer | 6 | 2 | 2 | 10 |
| Nagaur | 7 | 3 | 0 | 10 |
| Sikar | 8 | 2 | 0 | 10 |
| Total | 40 | 8 | 2 | 50 |
| % | 80.00% | 16.00% | 4.00% | 100.00% |

| Districts | 0-15 | 16-31 | 32-60 | 100-130 | DK/CS | Total |
|-----------|-------|--------|--------|---------|-------|---------|
| Ajmer | 1 | 1 | 6 | 2 | 0 | 10 |
| Alwar | 0 | 2 | 4 | 4 | 0 | 10 |
| Jaisalmer | 1 | 0 | 1 | 7 | 1 | 10 |
| Nagaur | 0 | 1 | 5 | 4 | 0 | 10 |
| Sikar | 0 | 1 | 7 | 2 | 0 | 10 |
| Total | 2 | 5 | 23 | 19 | 1 | 50 |
| % | 4.00% | 10.00% | 46.00% | 38.00% | 2.00% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Too Large | Large | Adequate | DK/CS | Total |
|-----------|-----------|--------|----------|--------|---------|
| Ajmer | 0 | 2 | 8 | 0 | 10 |
| Alwar | 0 | 2 | 4 | 4 | 10 |
| Jaisalmer | 1 | 0 | 8 | 1 | 10 |
| Nagaur | 0 | 3 | 7 | 0 | 10 |
| Sikar | 0 | 3 | 7 | 0 | 10 |
| Total | 1 | 10 | 34 | 5 | 50 |
| % | 2.00% | 20.00% | 68.00% | 10.00% | 100.00% |

| Districts | Yes | No | Total |
|-----------|---------|-------|---------|
| Ajmer | 10 | 0 | 10 |
| Alwar | 10 | 0 | 10 |
| Jaisalmer | 10 | 0 | 10 |
| Nagaur | 10 | 0 | 10 |
| Sikar | 10 | 0 | 10 |
| Total | 50 | 0 | 50 |
| % | 100.00% | 0.00% | 100.00% |

| Districts | Yes | No | Total |
|-----------|-------|--------|---------|
| Ajmer | 1 | 9 | 10 |
| Alwar | 1 | 9 | 10 |
| Jaisalmer | 0 | 10 | 10 |
| Nagaur | 1 | 9 | 10 |
| Sikar | 0 | 10 | 10 |
| Total | 3 | 47 | 50 |
| % | 6.00% | 94.00% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Good | Average | Poor | DK/CS | Total |
|-----------|--------|---------|-------|-------|---------|
| Ajmer | 10 | 0 | 0 | 0 | 10 |
| Alwar | 9 | 1 | 0 | 0 | 10 |
| Jaisalmer | 9 | 0 | 0 | 1 | 10 |
| Nagaur | 9 | 1 | 0 | 0 | 10 |
| Sikar | 8 | 2 | 0 | 0 | 10 |
| Total | 45 | 4 | 0 | 1 | 50 |
| % | 90.00% | 8.00% | 0.00% | 2.00% | 100.00% |

| Districts | Qualified | Experienced | Qualified & Experienced | DK/CS | Total |
|-----------|-----------|-------------|-------------------------|-------|---------|
| Ajmer | 0 | 0 | 10 | 0 | 10 |
| Alwar | 4 | 1 | 5 | 0 | 10 |
| Jaisalmer | 0 | 1 | 8 | 1 | 10 |
| Nagaur | 0 | 0 | 10 | 0 | 10 |
| Sikar | 0 | 2 | 8 | 0 | 10 |
| Total | 4 | 4 | 41 | 1 | 50 |
| % | 8.00% | 8.00% | 82.00% | 2.00% | 100.00% |

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 10 | 0 | 10 |
| Alwar | 9 | 1 | 10 |
| Jaisalmer | 8 | 2 | 10 |
| Nagaur | 10 | 0 | 10 |
| Sikar | 10 | 0 | 10 |
| Total | 47 | 3 | 50 |
| % | 94.00% | 6.00% | 100.00% |

Chapter for table 6

| Sl. No. | Alwar | Ajmer | Jaisalmer | Nagaur | Sikar |
|--------------|--------------|-------------|--------------|-------------|-------------|
| 1 | 1.5 | 13 | 9 | 0 | 0 |
| 2 | 2 | 0 | 7.5 | 0 | 0 |
| 3 | 1.5 | 2 | 0 | 0.5 | 0 |
| 4 | 0 | 0 | 0 | 0 | 0 |
| 5 | 11 | 0 | 0.05 | 0 | 2 |
| 6 | 5 | 5 | 0 | 0 | 6 |
| 7 | 0.02 | 0 | 0 | 0.5 | 0 |
| 8 | 2 | 0 | 1 | 0 | 0 |
| 9 | 0 | 0 | 2 | 2 | 0.5 |
| 10 | 0 | 0 | 0 | 0 | 10 |
| Total | 23.02 | 20 | 19.55 | 3 | 18.5 |
| Mean | 2.30 | 2.00 | 1.96 | 0.30 | 1.85 |
| Median | 1.50 | 0.00 | 0.03 | 0.00 | 0.00 |
| St dev | 3.42 | 4.19 | 3.40 | 0.63 | 3.43 |

| Districts | ISM&H | SC | PHC | CHC | DH | NONE | Total |
|-----------|-------|--------|--------|-------|-------|-------|---------|
| Ajmer | 0 | 4 | 2 | 0 | 0 | 0 | 6 |
| Alwar | 0 | 6 | 3 | 0 | 0 | 0 | 9 |
| Jaisalmer | 1 | 7 | 1 | 0 | 0 | 0 | 9 |
| Nagaur | 0 | 6 | 3 | 0 | 0 | 0 | 9 |
| Sikar | 0 | 9 | 0 | 1 | 0 | 0 | 10 |
| Total | 1 | 32 | 9 | 1 | 0 | 0 | 43 |
| % | 2.33% | 74.42% | 20.93% | 2.33% | 0.00% | 0.00% | 100.00% |

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 6 | 0 | 6 |
| Alwar | 9 | 0 | 9 |
| Jaisalmer | 8 | 1 | 9 |
| Nagaur | 9 | 0 | 9 |
| Sikar | 10 | 0 | 10 |
| Total | 42 | 1 | 43 |
| % | 97.67% | 2.33% | 100.00% |

Quick review of the working of ICDS programme

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-----------------------------------|-------|-------|-----------|--------|-------|-------|---------|
| Check up of pregnant women and FP | 6 | 5 | 8 | 8 | 2 | 29 | 35.37% |
| Distribution of SN | 6 | 3 | 5 | 5 | 8 | 27 | 32.93% |
| Vaccination | 1 | 4 | 8 | 0 | 0 | 13 | 15.85% |
| Health education | 0 | 2 | 0 | 2 | 2 | 6 | 7.32% |
| Female & Child development | 0 | 2 | 0 | 0 | 3 | 5 | 6.10% |
| DK/CS | 0 | 0 | 2 | 0 | 0 | 2 | 2.44% |
| Total | 13 | 16 | 23 | 15 | 15 | 82 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|--------------------------|-------|-------|-----------|--------|-------|-------|---------|
| Vaccination work | 6 | 7 | 7 | 7 | 10 | 37 | 45.68% |
| Health checkup | 4 | 5 | 0 | 5 | 0 | 14 | 17.28% |
| Family planning | 1 | 5 | 2 | 3 | 7 | 18 | 22.22% |
| Medicine distribution | 0 | 1 | 0 | 0 | 8 | 9 | 11.11% |
| nutritional distribution | 0 | 1 | 2 | 0 | 0 | 3 | 3.70% |
| Total | 11 | 19 | 11 | 15 | 25 | 81 | 100.00% |

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 6 | 0 | 6 |
| Alwar | 9 | 0 | 9 |
| Jaisalmer | 7 | 2 | 9 |
| Nagaur | 8 | 1 | 9 |
| Sikar | 10 | 0 | 10 |
| Total | 40 | 3 | 43 |
| % | 93.02% | 6.98% | 100.00% |

Quick review of the working of ICDS programme

| | Alwar | Ajmer | Jaisalmer | Nagaur | Sikar | Total | % |
|-----------------------------|-------|-------|-----------|--------|-------|-------|---------|
| No Vaccination for women | 1 | 0 | 1 | 0 | 0 | 2 | 3.45% |
| No vaccination for children | 1 | 0 | 0 | 0 | 0 | 1 | 1.72% |
| Women refuse to take IFA | 1 | 0 | 0 | 0 | 0 | 1 | 1.72% |
| No family planning | 2 | 0 | 0 | 0 | 0 | 2 | 3.45% |
| No sub-centre | 1 | 0 | 0 | 0 | 0 | 1 | 1.72% |
| Large area to cover | 4 | 0 | 1 | 0 | 0 | 5 | 8.62% |
| Awareness | 2 | 0 | 0 | 1 | 0 | 2 | 3.45% |
| Supply of needles | 1 | 0 | 0 | 0 | 0 | 1 | 1.72% |
| Travel time | 2 | 0 | 0 | 0 | 0 | 2 | 3.45% |
| Sub centre far from village | 1 | 0 | 0 | 0 | 0 | 1 | 1.72% |
| No transport facility | 1 | 0 | 2 | 0 | 0 | 3 | 5.17% |
| Covered long distance | 1 | 0 | 0 | 0 | 0 | 1 | 1.72% |
| Helper is not available | 1 | 0 | 0 | 0 | 0 | 1 | 1.72% |
| Low salary | 0 | 0 | 0 | 1 | 0 | 1 | 1.72% |
| No complaints | 2 | 6 | 7 | 8 | 10 | 33 | 56.90% |
| Total | 21 | 6 | 11 | 10 | 10 | 58 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|---|-------|-------|-----------|--------|-------|-------|---------|
| Giving health related information from time to time | 2 | 0 | 2 | 4 | 0 | 8 | 16.00% |
| Assistant needed | 1 | 2 | 2 | 1 | 1 | 7 | 14.00% |
| Transportation should be provided | 0 | 2 | 4 | 0 | 0 | 6 | 12.00% |
| Improved vaccination/ nutritional information | 1 | 0 | 1 | 3 | 1 | 6 | 12.00% |
| Support from village GP | 0 | 2 | 0 | 0 | 0 | 2 | 4.00% |
| Water and electricity | 0 | 0 | 0 | 0 | 2 | 2 | 4.00% |
| Target should be fixed on the basis of ground reality | 0 | 1 | 0 | 0 | 0 | 1 | 2.00% |
| Proper appointment | 0 | 0 | 0 | 0 | 1 | 1 | 2.00% |
| Different SN for young children | 0 | 0 | 0 | 0 | 1 | 1 | 2.00% |
| Need disposable syringe | 0 | 0 | 0 | 0 | 1 | 1 | 2.00% |
| Information & guidance for Adolescence | 1 | 0 | 0 | 0 | 0 | 1 | 2.00% |
| More pay to AWW | 0 | 0 | 0 | 1 | 0 | 1 | 2.00% |
| No suggestions | 1 | 3 | 3 | 3 | 3 | 13 | 26.00% |
| Total | 6 | 10 | 12 | 12 | 10 | 50 | 100.00% |

Quick review of the working of ICDS programme

Table 6.12 Is it your responsibility to ensure quality of healthcare?

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 6 | 0 | 6 |
| Alwar | 9 | 0 | 9 |
| Jaisalmer | 8 | 1 | 9 |
| Nagaur | 9 | 0 | 9 |
| Sikar | 10 | 0 | 10 |
| Total | 42 | 1 | 43 |
| % | 97.67% | 2.33% | 100.00% |

Table 6.13 Do you think that women and children of this village are getting good quality healthcare services

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 6 | 0 | 6 |
| Alwar | 7 | 2 | 9 |
| Jaisalmer | 8 | 1 | 9 |
| Nagaur | 9 | 0 | 9 |
| Sikar | 10 | 0 | 10 |
| Total | 40 | 3 | 43 |
| % | 93.02% | 6.98% | 100.00% |

Table 6.14 What is lacking here

| Districts | Infrastructure | | Residence | | Stock of medicine | |
|-----------|----------------|----------------|--------------|----------------|-------------------|----------------|
| | Satisfactory | Unsatisfactory | Satisfactory | Unsatisfactory | Satisfactory | Unsatisfactory |
| Ajmer | 5 | 1 | 3 | 3 | 6 | 0 |
| Alwar | 7 | 2 | 7 | 2 | 8 | 1 |
| Jaisalmer | 8 | 1 | 7 | 2 | 8 | 1 |
| Nagaur | 4 | 5 | 4 | 5 | 8 | 1 |
| Sikar | 5 | 5 | 4 | 6 | 10 | 0 |
| Total | 29 | 14 | 25 | 18 | 40 | 3 |
| % | 67.44% | 32.56% | 58.14% | 41.86% | 93.02% | 6.98% |

Quick review of the working of ICDS programme

| Districts | Working equipment | | Behaviour of seniors | | Responsiveness of villagers | |
|-----------|-------------------|----------------|----------------------|----------------|-----------------------------|----------------|
| | Satisfactory | Unsatisfactory | Satisfactory | Unsatisfactory | Satisfactory | Unsatisfactory |
| Ajmer | 6 | 0 | 6 | 0 | 6 | 0 |
| Alwar | 7 | 2 | 9 | 0 | 9 | 0 |
| Jaisalmer | 6 | 3 | 8 | 1 | 8 | 1 |
| Nagaur | 7 | 2 | 8 | 1 | 9 | 0 |
| Sikar | 10 | 0 | 10 | 0 | 10 | 0 |
| Total | 36 | 7 | 41 | 2 | 42 | 1 |
| % | 83.72% | 16.28% | 95.35% | 4.65% | 97.67% | 2.33% |

| Districts | Low waiting time | |
|-----------|------------------|----------------|
| | Satisfactory | Unsatisfactory |
| Ajmer | 6 | 0 |
| Alwar | 8 | 1 |
| Jaisalmer | 8 | 1 |
| Nagaur | 9 | 0 |
| Sikar | 10 | 0 |
| Total | 41 | 2 |
| % | 95.35% | 4.65% |

| Years | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|------------|-------|-------|-----------|--------|-------|-------|---------|
| 16-20 | 0 | 0 | 1 | 0 | 0 | 1 | 2.33% |
| 21-25 | 0 | 0 | 0 | 1 | 0 | 1 | 2.33% |
| 26-30 | 0 | 0 | 5 | 2 | 5 | 12 | 27.91% |
| 31-35 | 0 | 7 | 1 | 0 | 2 | 10 | 23.26% |
| 36 & above | 6 | 2 | 2 | 6 | 3 | 19 | 44.19% |
| TOTAL | 6 | 9 | 9 | 9 | 10 | 43 | 100.00% |

| Years | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|-------|-------|-------|-----------|--------|-------|-------|---------|
| <16 | 2 | 2 | 1 | 1 | 6 | 12 | 27.91% |
| 16-20 | 1 | 4 | 5 | 4 | 3 | 17 | 39.53% |
| >20 | 3 | 3 | 3 | 4 | 1 | 14 | 32.56% |
| TOTAL | 6 | 9 | 9 | 9 | 10 | 43 | 100.00% |

Quick review of the working of ICDS programme

| Districts | Nuclear | Joint | INA | Total |
|-----------|---------|--------|-------|---------|
| Ajmer | 5 | 1 | 0 | 6 |
| Alwar | 7 | 2 | 0 | 9 |
| Jaisalmer | 5 | 3 | 1 | 9 |
| Nagaur | 6 | 3 | 0 | 9 |
| Sikar | 6 | 4 | 0 | 10 |
| Total | 29 | 13 | 1 | 43 |
| % | 67.44% | 30.23% | 2.33% | 100.00% |

| Districts | Gen | SC | ST | OBC | Other | INA | TOTAL |
|-----------|--------|-------|-------|--------|--------|-------|---------|
| Ajmer | 3 | 0 | 0 | 0 | 3 | 0 | 6 |
| Alwar | 4 | 1 | 4 | 0 | 0 | 0 | 9 |
| Jaisalmer | 3 | 2 | 0 | 3 | 0 | 1 | 9 |
| Nagaur | 7 | 1 | 0 | 0 | 1 | 0 | 9 |
| Sikar | 2 | 0 | 0 | 7 | 1 | 0 | 10 |
| Total | 19 | 4 | 4 | 10 | 5 | 1 | 43 |
| % | 44.19% | 9.30% | 9.30% | 23.26% | 11.63% | 2.33% | 100.00% |

| Districts | Hindu | Muslim | Jain | Sikh | Christian | Other | INA | Total |
|-----------|--------|--------|-------|-------|-----------|-------|-------|---------|
| Ajmer | 2 | 0 | 1 | 0 | 0 | 3 | 0 | 6 |
| Alwar | 8 | 0 | 0 | 1 | 0 | 0 | 0 | 9 |
| Jaisalmer | 7 | 0 | 0 | 0 | 1 | 0 | 1 | 9 |
| Nagaur | 8 | 0 | 0 | 0 | 1 | 0 | 0 | 9 |
| Sikar | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 10 |
| Total | 35 | 0 | 1 | 1 | 2 | 3 | 1 | 43 |
| % | 81.40% | 0.00% | 2.33% | 2.33% | 4.65% | 6.98% | 2.33% | 100.00% |

| Districts | Yes | No | Total |
|-----------|--------|-------|---------|
| Ajmer | 6 | 0 | 6 |
| Alwar | 9 | 0 | 9 |
| Jaisalmer | 8 | 1 | 9 |
| Nagaur | 9 | 0 | 9 |
| Sikar | 10 | 0 | 10 |
| Total | 42 | 1 | 43 |
| % | 97.67% | 2.33% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Illiterate | | Barely Literate | | Primary | | Middle | |
|-----------|------------|--------|-----------------|--------|---------|--------|--------|--------|
| | Male | Female | Male | Female | Male | Female | Male | Female |
| Ajmer | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 |
| Alwar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jaisalmer | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 |
| Nagaur | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Sikar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Total | 0 | 0 | 0 | 0 | 2 | 1 | 3 | 3 |

| Districts | High School | | College | | Total | |
|-----------|-------------|--------|---------|--------|-------|--------|
| | Male | Female | Male | Female | Male | Female |
| Ajmer | 0 | 4 | 4 | 1 | 6 | 6 |
| Alwar | 0 | 6 | 9 | 3 | 9 | 9 |
| Jaisalmer | 2 | 3 | 5 | 5 | 9 | 9 |
| Nagaur | 1 | 3 | 7 | 6 | 9 | 9 |
| Sikar | 4 | 3 | 6 | 5 | 10 | 10 |
| Total | 7 | 19 | 31 | 20 | 43 | 43 |
| % | | 44.19% | | 46.51% | | |

| Districts | 4 or less | 5 to 7 | More than 7 | INA | Total |
|-----------|-----------|--------|-------------|-------|---------|
| Ajmer | 2 | 3 | 1 | 0 | 6 |
| Alwar | 5 | 2 | 2 | 0 | 9 |
| Jaisalmer | 3 | 2 | 3 | 1 | 9 |
| Nagaur | 4 | 3 | 2 | 0 | 9 |
| Sikar | 4 | 4 | 2 | 0 | 10 |
| Total | 18 | 14 | 10 | 1 | 43 |
| % | 41.86% | 32.56% | 23.26% | 2.33% | 100.00% |

| Districts | Boys | Girls | Total |
|-----------|--------|--------|---------|
| Ajmer | 9 | 4 | 13 |
| Alwar | 12 | 15 | 27 |
| Jaisalmer | 6 | 7 | 13 |
| Nagaur | 14 | 9 | 23 |
| Sikar | 13 | 6 | 19 |
| Total | 54 | 41 | 95 |
| % | 56.84% | 43.16% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Yes | No | INA | Total |
|-----------|--------|--------|-------|---------|
| Ajmer | 1 | 5 | 0 | 6 |
| Alwar | 2 | 7 | 0 | 9 |
| Jaisalmer | 1 | 7 | 1 | 9 |
| Nagaur | 0 | 9 | 0 | 9 |
| Sikar | 1 | 9 | 0 | 10 |
| Total | 5 | 37 | 1 | 43 |
| % | 11.63% | 86.05% | 2.33% | 100.00% |

| Districts | Male | Female | Total |
|-----------|--------|--------|---------|
| Ajmer | 0 | 1 | 1 |
| Alwar | 2 | 0 | 2 |
| Jaisalmer | 1 | 0 | 1 |
| Nagaur | 0 | 0 | 0 |
| Sikar | 1 | 0 | 1 |
| Total | 4 | 1 | 5 |
| % | 80.00% | 20.00% | 100.00% |

| | |
|---------------|----------|
| Premature Boy | 1 |
| Death in Heat | 3 |
| Pneumonia | 1 |
| Total | 5 |

| Districts | Low (0-14) | Medium (15-24) | High (25-67) | Total |
|-----------|------------|----------------|--------------|---------|
| Ajmer | 0 | 0 | 6 | 6 |
| Alwar | 0 | 1 | 8 | 9 |
| Jaisalmer | 2 | 4 | 3 | 9 |
| Nagaur | 0 | 0 | 9 | 9 |
| Sikar | 0 | 1 | 9 | 10 |
| Total | 2 | 6 | 35 | 43 |
| % | 4.65% | 13.95% | 81.40% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Yes | No | Total |
|-----------|--------|--------|---------|
| Ajmer | 3 | 3 | 6 |
| Alwar | 8 | 1 | 9 |
| Jaisalmer | 5 | 4 | 9 |
| Nagaur | 4 | 5 | 9 |
| Sikar | 3 | 7 | 10 |
| Total | 23 | 20 | 43 |
| % | 53.49% | 46.51% | 100.00% |

| Districts | 0-1 | 2-4 | Total |
|-----------|--------|--------|---------|
| Ajmer | 1 | 2 | 3 |
| Alwar | 4 | 4 | 8 |
| Jaisalmer | 1 | 4 | 5 |
| Nagaur | 1 | 3 | 4 |
| Sikar | 2 | 1 | 3 |
| Total | 9 | 14 | 23 |
| % | 39.13% | 60.87% | 100.00% |

| Districts | 0-3 | 4-6 | 9-12 | 12-15 | DK/CS | Total |
|-----------|--------|--------|-------|--------|-------|---------|
| Ajmer | 3 | 0 | 0 | 0 | 0 | 3 |
| Alwar | 2 | 4 | 0 | 2 | 0 | 8 |
| Jaisalmer | 2 | 1 | 1 | 0 | 1 | 5 |
| Nagaur | 2 | 0 | 0 | 2 | 0 | 4 |
| Sikar | 0 | 0 | 1 | 2 | 0 | 3 |
| Total | 9 | 5 | 2 | 6 | 1 | 23 |
| % | 39.13% | 21.74% | 8.70% | 26.09% | 4.35% | 100.00% |

| Districts | Yes | No | INA | Total |
|-----------|--------|--------|-------|---------|
| Ajmer | 2 | 4 | 0 | 6 |
| Alwar | 8 | 1 | 0 | 9 |
| Jaisalmer | 3 | 5 | 1 | 9 |
| Nagaur | 3 | 6 | 0 | 9 |
| Sikar | 3 | 7 | 0 | 10 |
| Total | 19 | 23 | 1 | 43 |
| % | 44.19% | 53.49% | 2.33% | 100.00% |

Quick review of the working of ICDS programme

Table 6.32 How often do you meet AWWs in your area

| Districts | Every day | Once a week | Once a fortnight | Once a month | Never/Rarely | Total |
|-----------|-----------|-------------|------------------|--------------|--------------|---------|
| Ajmer | 1 | 3 | 1 | 1 | 0 | 6 |
| Alwar | 2 | 4 | 1 | 2 | 0 | 9 |
| Jaisalmer | 5 | 0 | 0 | 3 | 0 | 8 |
| Nagaur | 2 | 3 | 0 | 4 | 0 | 9 |
| Sikar | 3 | 2 | 2 | 3 | 0 | 10 |
| Total | 13 | 12 | 4 | 13 | 0 | 42 |
| % | 30.95% | 28.57% | 9.52% | 30.95% | 0.00% | 100.00% |

Table 6.33 Do you get help from AWW when required

| Districts | Yes | No | INA | Total |
|-----------|--------|-------|-------|---------|
| Ajmer | 5 | 1 | 0 | 6 |
| Alwar | 9 | 0 | 0 | 9 |
| Jaisalmer | 7 | 1 | 1 | 9 |
| Nagaur | 9 | 0 | 0 | 9 |
| Sikar | 10 | 0 | 0 | 10 |
| Total | 40 | 2 | 1 | 43 |
| % | 93.02% | 4.65% | 2.33% | 100.00% |

Table 6.34 Is there any Jan Mangal Joda

| Districts | Yes | No | DK/cs | INA | Total |
|-----------|--------|--------|-------|-------|---------|
| Ajmer | 6 | 0 | 0 | 0 | 6 |
| Alwar | 5 | 3 | 1 | 0 | 9 |
| Jaisalmer | 5 | 3 | 0 | 1 | 9 |
| Nagaur | 9 | 0 | 0 | 0 | 9 |
| Sikar | 9 | 1 | 0 | 0 | 10 |
| Total | 34 | 7 | 1 | 1 | 43 |
| % | 79.07% | 16.28% | 2.33% | 2.33% | 100.00% |

Table 6.35 Do Sarpanch and Up-sarpanch meet you?

| Districts | Yes | No | INA | Total |
|-----------|--------|-------|-------|---------|
| Ajmer | 6 | 0 | 0 | 6 |
| Alwar | 9 | 0 | 0 | 9 |
| Jaisalmer | 7 | 1 | 1 | 9 |
| Nagaur | 7 | 2 | 0 | 9 |
| Sikar | 10 | 0 | 0 | 10 |
| Total | 39 | 3 | 1 | 43 |
| % | 90.70% | 6.98% | 2.33% | 100.00% |

Quick review of the working of ICDS programme

| Districts | Regularly | Sometimes | Rarely | Never | Total |
|-----------|-----------|-----------|--------|-------|---------|
| Ajmer | 6 | 0 | 0 | 0 | 6 |
| Alwar | 9 | 0 | 0 | 0 | 9 |
| Jaisalmer | 3 | 0 | 4 | 0 | 7 |
| Nagaur | 6 | 0 | 1 | 0 | 7 |
| Sikar | 7 | 0 | 3 | 0 | 10 |
| Total | 31 | 0 | 8 | 0 | 39 |
| % | 79.49% | 0.00% | 20.51% | 0.00% | 100.00% |

| Districts | Yes | No | INA | Total |
|-----------|--------|--------|-------|---------|
| Ajmer | 6 | 0 | 0 | 6 |
| Alwar | 7 | 2 | 0 | 9 |
| Jaisalmer | 3 | 5 | 1 | 9 |
| Nagaur | 9 | 0 | 0 | 9 |
| Sikar | 8 | 2 | 0 | 10 |
| Total | 33 | 9 | 1 | 43 |
| % | 76.74% | 20.93% | 2.33% | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|----------------------------------|-------|-------|-----------|--------|-------|-------|---------|
| Family planning | 1 | 2 | 1 | 1 | 3 | 8 | 24.24% |
| About sanitation | 1 | 1 | 1 | 0 | 0 | 3 | 9.09% |
| Understand to other | 2 | 0 | 0 | 0 | 1 | 3 | 9.09% |
| About Polio | 2 | 0 | 0 | 0 | 0 | 2 | 6.06% |
| Children & family health related | 0 | 3 | 1 | 4 | 1 | 9 | 27.27% |
| nutritional supplement | 0 | 1 | 0 | 0 | 0 | 1 | 3.03% |
| Polio Vaccination | 0 | 0 | 0 | 4 | 3 | 7 | 21.21% |
| TOTAL | 6 | 7 | 3 | 9 | 8 | 33 | 100.00% |

| | Ajmer | Alwar | Jaisalmer | Nagaur | Sikar | Total | % |
|------------------|-------|-------|-----------|--------|-------|-------|---------|
| Help in our work | 6 | 5 | 2 | 4 | 8 | 25 | 67.57% |
| No action taken | 0 | 1 | 0 | 0 | 0 | 1 | 2.70% |
| DK/CS | 0 | 3 | 6 | 0 | 2 | 11 | 29.73% |
| TOTAL | 6 | 9 | 8 | 4 | 10 | 37 | 100.00% |

| Districts | Yes | No | Total |
|--------------|---------------|---------------|----------------|
| Ajmer | 2 | 4 | 6 |
| Alwar | 5 | 4 | 9 |
| Jaisalmer | 5 | 4 | 9 |
| Nagaur | 5 | 4 | 9 |
| Sikar | 4 | 6 | 10 |
| Total | 21 | 22 | 43 |
| % | 48.84% | 51.16% | 100.00% |