

# UNIVERSALIZATION WITH QUALITY

## Action for ICDS

A Primer

March 2006

Other Primers in the Series:

**Employment Guarantee Act: A Primer**

**Supreme Court Orders On the Right to Food:  
A Tool for Action**

**Midday Meals: A Primer**

## Preface

In April 2001, the People's Union for Civil Liberties (PUCL, Rajasthan) submitted a writ petition to the Supreme Court of India seeking enforcement of the right to food. The basic argument is that the right to food is an aspect of the fundamental "right to life" enshrined in Article 21 of the Indian Constitution. This public interest litigation (PIL) is known as "PUCL vs. Union of India and Others, Writ Petition (Civil) 196 of 2001". The judgement is still awaited, but meanwhile, the Supreme Court has issued a series of "interim orders" aimed at safeguarding various aspects of the right to food.

The first major order, dated 28 November 2001, directed the government to fully implement nine food-related schemes as per official guidelines. In effect, this order converted the benefits of these schemes into "legal entitlements".\* Integrated Child Development Services (ICDS), also called "Anganwadi Programme" in this booklet, is one of the schemes covered by this Supreme Court order. In the case of ICDS, the order actually went further than just converting existing benefits into legal entitlements: it also directed the government to "universalize" the programme. This means that every hamlet should have a functional Anganwadi, and that *the full range of ICDS services*

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\* The schemes are: the Public Distribution System (PDS); Antyodaya Anna Yojana (AAY); Sampoorna Grameen Rozgar Yojana (SGRY); the Mid-day Meal Scheme (MDMS); the Integrated Child Development Services (ICDS); Annapurna; the National Old Age Pension Scheme (NOAPS); the National Maternity Benefit Scheme (NMBS); and the National Family Benefit Scheme (NFBS). For further details of the Supreme Court orders, see the companion booklet

*Supreme Court Orders on the Right to Food: A Tool for Action*, also available from the secretariat of the Right to Food Campaign.

*should be extended to every child under six, every pregnant or nursing mother, and every adolescent girl.*

This order, however, received very little attention for several years. Virtually nothing was done to implement it till April and October 2004, when several hearings on ICDS were held in the Supreme Court and further orders were issued. For instance, the Supreme Court explicitly directed the government to expand the number of Anganwadis from 6 lakhs to 14 lakhs, to ensure that every settlement is covered.

The Supreme Court orders of April and October 2004 gave a useful wake-up call to the government. The universalization of ICDS was included in the National Common Minimum Programme of the UPA government in May 2004. The National Advisory Council submitted detailed recommendations for achieving “universalization with quality” in October 2004. The expenditure of the Central Government on ICDS was nearly doubled in the Union Budget 2005-6.

However, there has been little progress in terms of the situation on the ground. The expansion of ICDS is very slow, and there is no evidence of any substantial quality improvement. This reflects the fact that Supreme Court orders and budget allocations are not enough. Ultimately, what is required is a broad-based movement for the universalization of ICDS, involving not only the government but also the public at large. It is to support this movement, and your own involvement in it, that this booklet has been prepared.

# UNIVERSALIZATION WITH QUALITY

## Action for ICDS

### 1. Introduction

This Primer is concerned with the basic rights of children under the age of six, especially their right to nutrition, health and education. It focuses on the Integrated Child Development Services (ICDS) as a crucial means of protecting these rights, and makes a case for “universalization with quality”. The primary responsibility for achieving this goal belongs to the government, but public pressure is essential to hold the government accountable to this responsibility. How public pressure can be built is discussed in the concluding section of this Primer – “What We Can Do”. The first step, however, is to think clearly about the issues. We begin, therefore, with a brief discussion of ICDS and the various roles it can play in safeguarding the basic rights of children under six.



## What is ICDS?

Integrated Child Development Services (ICDS) is the only major national programme that addresses the needs of children under the age of six years. It seeks to provide young children with an integrated package of services such as supplementary nutrition, health care and pre-school education. Because the health and nutrition needs of a child cannot be addressed in isolation from those of his or her mother, the programme also extends to adolescent girls, pregnant women and nursing mothers.

The Government of India started the ICDS as a Project in 1975. The stated objectives of ICDS are as follows<sup>1</sup>:

- ◆ To improve the nutritional and health status of children below the age of six years.
- ◆ To lay the foundation for the proper psychological, physical and social development of the child.
- ◆ To reduce the incidence of mortality, morbidity, malnutrition and school dropouts.
- ◆ To achieve effective coordination of policy and implementation among various departments to promote child development.
- ◆ To enhance the capability of the mother to look after the normal health, nutritional and developmental needs of the child through proper community education.



## Why is ICDS also known as the “Anganwadi Programme”?

ICDS services are provided through a vast network of ICDS centres, better known as “Anganwadis”. The Anganwadi literally means ‘a centre with a courtyard’ and is operated by a modestly paid “Anganwadi worker” (AWW), assisted by an “Anganwadi helper” (AWH) or *sahayika*. Each Anganwadi is supposed to cover a population of 1000 persons – about 200 families. The local Anganwadi is the cornerstone of the ICDS programme.



## 2. ICDS and Children’s Rights

### Why is the Anganwadi Programme so important?

The Anganwadi Programme is important:

**Because** the first six years are the most vulnerable period of human life, when survival of the child is a challenge.

**Because** 0-6 years is the most rapid period of human development: from an infant unable to even hold up its head, to a chattering child, running around, asking a

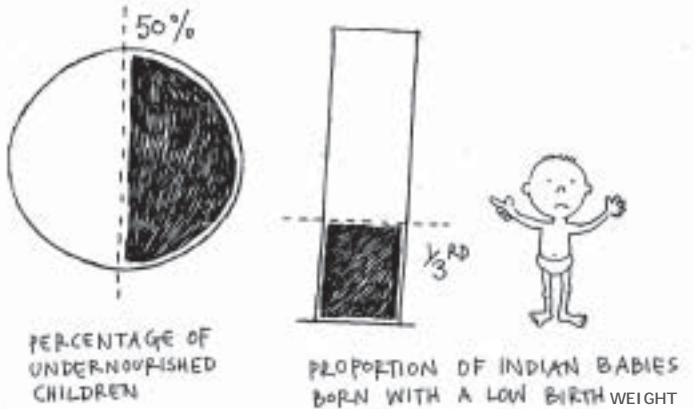
hundred questions, getting ready for school – this is the journey a child covers in just six years.

**Because** science has established that the foundations of health, language, capacity to learn, self-confidence and personality of a human being are laid in the first six years of life. For instance, 80% of brain growth takes place in these six years.

**And above all, because** every child has a *fundamental right to nutrition, health and education* - the essentials that are needed to grow and develop fully. Providing ICDS services of good quality to all children is a step towards making this right a reality. The Supreme Court order of 28 November 2001 has made this a legal obligation.

### How are Indian children doing?

Not well at all. The statistics of child development in India are really alarming. To illustrate:



- ◆ Half of all Indian children are undernourished.
- ◆ Out of 1000 babies, 67 die before the age of one.
- ◆ One third of Indian babies are born with a low birth-weight.
- ◆ Barely one half of all children complete eight years of schooling.

### **How does this matter?**

Child malnutrition has devastating consequences. A malnourished child gets ill easily. Her brain and body do not develop properly. The right amount and kind of nutrients needed for growth do not get to the child during the period of rapid development.

Malnutrition is responsible, directly or indirectly, for two-thirds of the deaths of children under five years of age. And two-thirds of these deaths take place in the first year of a child's life. Most child deaths in India are preventable and unnecessary.

Child deaths are a tragedy not only for the child but for the whole family. Moreover, insecurity about child survival often leads families to have many babies in succession, which further affects the health of women and children.

### **What about low birth-weights – why is that a major concern?**

A low birth-weight baby is weak, picks up infections easily,

develops slowly and is at greater risk of dying in early childhood. The adverse consequences of low birth-weight on health often extend well beyond childhood, into adult life. Low birth-weight also plays a major role in the transmission of malnutrition from one generation to the next: malnourished mothers have low birth-weight babies who carry the burden of malnutrition themselves as they grow up and become malnourished mothers in turn.

### **Turning to education, what are the implications of low levels of schooling?**

Without schooling, millions of children are pushed into child labour and condemned to a lifetime of social exclusion, low earnings, and exploitation. Some work long hours as domestic helpers or in dhabas, others are forced into begging or prostitution, or end up as rag-pickers. When they grow up, they swell the ranks of unskilled labour at the lowest rung of our society and are denied equal opportunities and choices.

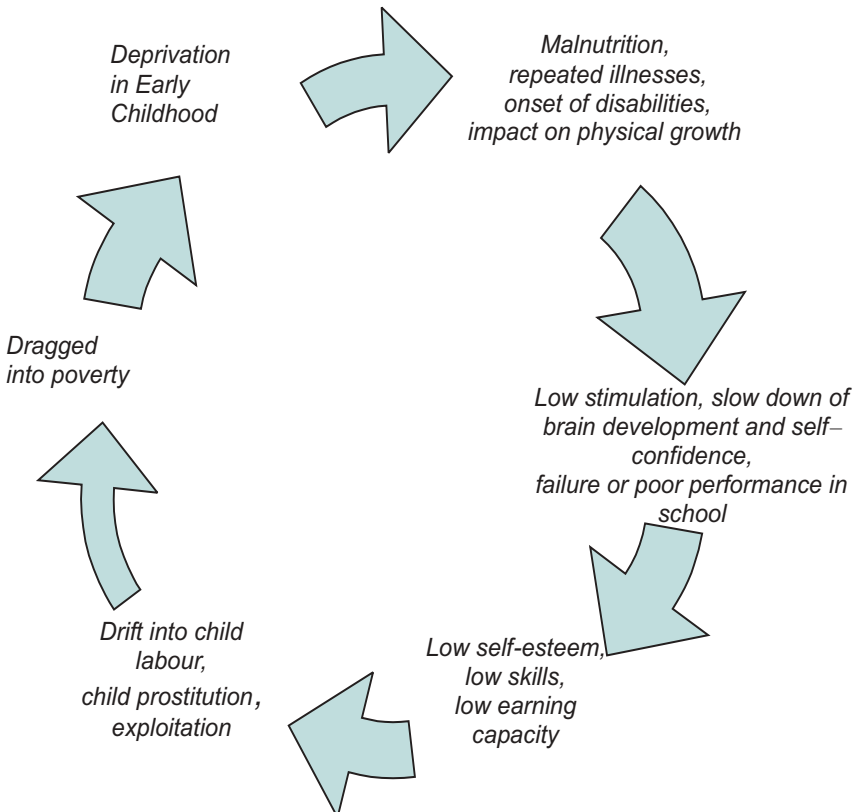
### **How is this related to children under six and ICDS?**

Learning starts from birth and it is well established that pre-school education is very significant in helping children to prepare for formal schooling. Pre school education assists children both to enter school and to remain within the system. A child cannot fully realise her right to education unless she has access to quality early childhood care and education.

**Perhaps all these problems are to be expected in a poor country. How is India doing in comparison with other developing countries?**

Again, not well at all . Malnutrition levels in India are among the highest in the world. So is the proportion of low birth-weight babies. In Bangladesh, the infant mortality rate is 48 per thousand, compared with 67 per 1,000 thousand in India. School attendance rates are also higher in Bangladesh than in India, in spite of Bangladesh being much poorer than India.

### **The Cycle of Malnutrition and Poverty**

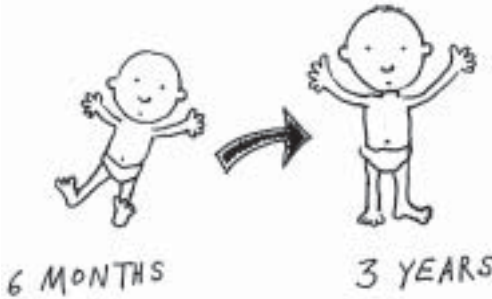


The Anganwadi Programme is important because it addresses all these problems, and strengthens the foundations of a child's health and capacity to learn. The universalization of ICDS, with quality improvements, can help to break the vicious cycle of malnutrition and poverty. It is an essential step towards the realisation of children's fundamental right to nutrition, health and education.

### 3. Some Facts About Child Malnutrition

#### When does malnutrition begin?

It begins at birth, or even before. However, malnutrition intensifies sharply between the ages of 6 months and three years.



#### Why between the ages of 6 months and three years?

Because at this stage mother's milk alone is not sufficient for the growing child. The infant is also still helpless – she can't feed herself, or ask for more. She is also more prone to infections during this period. A child at this age needs frequent meals of softened food that only an adult can give her.

## **Why are many mothers unable to do even this much?**

Because they have to work to earn a livelihood and have to juggle this with taking care of their homes (cooking, fetching water, cleaning, etc.). So, they often lack time and energy to take care of the frequent feeding that a young child needs. Women seldom get support from other adults in the family because taking care of a young child is regarded as the sole responsibility of the mother. She usually depends for support on her other children, sometimes as young as four to five years of age - young children who are in need of care themselves.

In addition to this, the understanding of both the mother and other adults in the house regarding the child's nutritional needs at this stage may be poor. What the family needs to know is that after six months, a growing child needs semi-solid food in addition to mother's milk; that the feeds need to be small and frequent; that the diet needs to be balanced, and also that the child must be protected from infections because infections contribute to malnutrition. This basic knowledge is still lacking in many families.

## **If we neglect this period of life, can we make up later?**

Very little can be made up later. A plant denied adequate food, water and sunshine may grow but it will not be strong. Water and fertilizer later on will help it survive - but not thrive and give

good fruit. So with our children: midday meals, scholarships, special schools for child labourers do help, but they cannot make up for what has been denied during the first six years of life.

### Can ICDS make a difference?

Yes it can. Protecting children from the vicious cycle of malnutrition and poverty requires many complementary actions: loving care, supplementary nutrition, immunisation, health services, and an environment for stimulation and learning. The aim of ICDS is to provide these complementary services in an integrated manner.

## 4. Basics of the Anganwadi Programme

### What are the basic services provided under ICDS?



The basic services provided under ICDS fall under three broad headings: nutrition, health and pre-school education. Nutrition services include supplementary feeding, growth monitoring, and nutrition and health counselling. Health services include immunization, basic health care, and referral services. Pre-school education involves various stimulation and learning activities at the Anganwadi. Further details are given in Box 1.

## BOX 1:

## MAIN SERVICES PROVIDED UNDER ICDS

As its name indicates, the ICDS programme seeks to provide a package of “integrated services” focused on children under six. The main services are as follows:

**A. Nutrition**

1. **Supplementary Nutrition (SNP):** The nutrition component varies from state to state but usually consists of a hot meal cooked at the Anganwadi, based on a mix of pulses, cereals, oil, vegetable, sugar, iodised salt, etc. Sometimes “take-home rations” (THR) are provided for children under the age of three years.
2. **Growth Monitoring and Promotion:** Children under three are weighed once a month, to keep a check on their health and nutrition status. Elder children are weighed once a quarter. Growth charts are kept to detect growth faltering.
3. **Nutrition and Health Education:** The aim of NHE is to help women aged 15-45 years to look after their own health and nutrition needs, as well as those of their children and families. NHE is imparted through counselling sessions, home visits and demonstrations. It covers issues such as infant feeding, family planning, sanitation, utilization of health services, etc.

**B. Health**

4. **Immunization:** Children under six are immunized against polio, DPT (diphtheria, pertussis, tetanus), measles, and tuberculosis, while pregnant women are immunized against tetanus. This is a joint responsibility of ICDS and the Health Department. The main role of the Anganwadi worker is to assist health staff (such as the ANM) to maintain records, motivate the parents, and organize immunization sessions.
5. **Health Services:** A range of health services are supposed to be provided through the Anganwadi Worker including health checkups of children under six, ante-natal care of expectant mothers, post-natal care of nursing mothers, recording of

weight, management of undernutrition, and treatment of minor ailments.

6. **Referral Services:** This service attempts to link sick or undernourished children, those with disabilities and other children requiring medical attention with the public health care system. Cases like these are referred by the Anganwadi worker to the medical officers of the Primary Health Centres (PHCs).

### C. Pre-School Education

7. **Pre-School Education (PSE):** The aim of PSE is to provide a learning environment to children aged 3-6 years, and early care and stimulation for children under the age of three. PSE is imparted through the medium of “play” to promote the social, emotional, cognitive, physical and aesthetic development of the child as well as to prepare him or her for primary schooling.



## Who is in charge of providing these services?

ICDS is a complex programme with many actors. The basic responsibility for implementing the programme rests with the State Government. The nodal department responsible for implementing the ICDS in the States is typically one of the following three departments – the ‘Women and Child Development Department’ or the ‘Social Welfare Development’ or the ‘Social Welfare, and Child Development Department’.

At the ground level, the lead role is played by the Anganwadi worker (AWW), who shoulders many responsibilities as the sole manager of the Anganwadi. Active Anganwadi workers are true heroines. Their effectiveness depends on the support and cooperation of many other people: the Anganwadi helper, the Auxiliary Nurse Midwife (ANM), the supervisor, the Child Development Project Officer (CDPO), among others, and of course the village community. Further details of different actors and their respective roles are given in Box 2.

### BOX 2

#### ICDS: THE MAIN ACTORS

Many people are involved in the implementation of ICDS. The success of the programme depends on active cooperation between these different “actors”. The main actors are as follows:

**Anganwadi Worker (AWW):** She is the pillar of the programme. Her job is to run the Anganwadi: survey all the families in the neighbourhood, enrol eligible children, ensure that food is served on time every day, conduct the pre-school education activities, organise immunization sessions with the

ANM, make home visits to pregnant mothers, and so on – the full list is very long!

**Anganwadi Helper (AWH):** The AWH is also central to the implementation of ICDS. She is supposed to assist the AWW in her tasks. Her main duties are to bring children to the Anganwadi, cook food for them, and help with the maintenance of the AWC.

**CDPO:** The ICDS programme is organised as a collection of “projects”. Normally, an ICDS project covers a population of around 100,000, and involves running about 100 Anganwadis. Each project is managed by a Child Development Project Officer (CDPO). The CDPO’s office is a sort of “headquarter” for the ICDS project.

**Supervisor:** The CDPO is assisted by “supervisors”, who make regular visits to the Anganwadis. The supervisors are supposed to check the registers, inspect the premises, advise the Anganwadi Worker, enquire about any problems she may have, and so on. Unfortunately, many supervisors do little more than checking the registers.

**Auxiliary Nurse Midwife (ANM):** The ANM acts as a crucial link between ICDS and the Health Department. Her main task in the context of ICDS is to organise immunization sessions, together with the Anganwadi worker. She also provides basic health care services at the Anganwadi.

**Accredited Social Health Activist (ASHA):** The National Rural Health Mission is set to create a cadre of women voluntary health workers (ASHA) at the village level, who are also expected to work with the ANM and AWW to improve the nutrition and health of women and children.

**NGOs:** In some areas, NGOs play an active role in the implementation of ICDS. In fact, sometimes entire ICDS “projects” are managed by an NGO. Also, international organisations such as CARE and UNICEF often provide specific support to ICDS. For instance, CARE used to supply food for the supplementary nutrition programme, and UNICEF has been helping with the supply of medical kits.

**The community:** Community participation is an important element in the design of ICDS. It can do a lot to help the effective functioning of Anganwadis. For instance, the community can be mobilised to provide the

Anganwadis with better facilities (e.g. a ceiling fan), to ensure that they open on time every day, or to encourage mothers to participate in counseling sessions. Community participation can take place through Gram Panchayats, Mahila Mandals, Self-Help Groups, youth groups or just spontaneous cooperation. Unfortunately, community participation in ICDS is quite limited as things stand.

## 5. Universalization with Quality

### What is meant by “universalization” of ICDS?

Universalization means that every child as well as every pregnant woman, nursing mother and adolescent girl should be within easy reach of an Anganwadi, and receive the full range of ICDS services.

### What does this have to do with Supreme Court orders?

On 28 November 2001, the Supreme Court directed the government to universalize ICDS. Further orders to this effect were issued on 29 April 2004 and 7 October 2004. A summary of recent Supreme Court orders on ICDS is given in Box 3.

### How many children does the Anganwadi Programme cover today, and how many are yet to be covered?

Today, about 4 crore children are covered under the “supplementary nutrition” component of the Anganwadi programme. This is barely one quarter of all children below the age of six. In other words, the coverage of ICDS is very far from universal.

**Box 3:  
SUPREME COURT ORDERS ON ICDS**

***Order dated 28 November 2001***

- ◆ Each child up to 6 years of age is to get 300 calories and 8-10 gms of protein.
- ◆ Each adolescent girl to get 500 calories and 20-25 grams of protein.
- ◆ Each pregnant woman and each nursing mother to get 500 calories and 20-25 grams of protein.
- ◆ Each malnourished child to get 600 calories and 16-20 grams of protein.
- ◆ Every settlement is to have a disbursement centre [Anganwadi].

***Order dated 29 April 2004***

- ◆ All 0-6 year old children, adolescent girls, pregnant women and nursing mothers shall receive supplementary nutrition for 300 days in the year.

***Orders dated 7 October 2004***

- ◆ The number of Anganwadis shall be increased from 6 to 14 lakhs.
- ◆ The minimum norm for the provision of supplementary nutrition should be increased to Rs. 2/- per child per day.
- ◆ All sanctioned Anganwadis shall be operationalised immediately.
- ◆ All SC/ST hamlets shall have Anganwadis as early as possible, and hamlets with high SC/ST populations should receive priority in the placement of new Anganwadis.
- ◆ All slums shall have Anganwadis.

- ◆ Contractors shall not be used for the supply of supplementary nutrition.
- ◆ Local women's Self-Help Groups and Mahila Mandals should be encouraged to supply the supplementary food distributed in Anganwadis. They can make purchases, prepare the food locally, and supervise the distribution.
- ◆ The Central Government and States/UTs shall ensure that all amounts allocated are sanctioned in time so that there is no disruption in the feeding of children.
- ◆ All State Governments/UTs shall put on their websites, full data for the ICDS programme including where AWCs are operational, the number of beneficiaries category-wise, the funds allocated and used, and related matters.

*Note:* For further details see *Supreme Court Orders on the Right to Food: A Tool for Action*, available from the secretariat of the right to food campaign (see Appendix).



**How many Anganwadis are there in the country?**

There are 7.4 lakh Anganwadis, as on 30 June 2005.

**How many more are required for universal coverage?**

To cover all rural settlements the Supreme Court has ordered the government to increase the number of Anganwadis to 14 lakhs. The National Advisory Council has made similar recommendations. In addition, about 3 lakh Anganwadis are required in urban areas, based on existing norms.

So far, the government has not accepted these figures. It claims that the number of Anganwadis required is much lower. This matter is yet to be settled. Meanwhile the government has sanctioned an additional 1.88 lakh Anganwadis, in response to requirements submitted by State Governments based on existing norms.

**What are these “norms”?**

According to the existing norms, there should be one Anganwadi per 1,000 population in rural and urban areas. In tribal areas the norm is one Anganwadi per 700 population. Existing norms also provide for “mini Anganwadis” to cover isolated settlements with less than 150 population. However, Anganwadi workers in mini Anganwadis are paid only Rs. 125 a month (effective from

February 2005), and the services are restricted mainly to supplementary nutrition. This is inadequate and it is crucial that mini Anganwadis provide all ICDS services in line with Supreme Court orders.

### **Are the existing norms compatible with universal coverage?**

Not really. A village with a population of 1,000 would typically have around 150 children below the age of six years. But an Anganwadi is supposed to take care of 80 children only. Therefore, the norms need to be revised if the coverage is to be made universal. Unfortunately, the changes that are currently being proposed by the government are inadequate and open to misinterpretation (see Appendix 1 for further discussion).

### **What does “all” really mean, in the statement that “all children under six should be covered under ICDS”?**

Prior to the Supreme Court’s order, the ICDS programme was intended for poorer sections of the population. The primary focus of ICDS was on rural areas, while only a small number of Anganwadis were earmarked for urban areas. Even in rural areas, the programme was often restricted to BPL families (i.e. families that are supposed to be “below the poverty line”). But the Supreme Court has made it clear that this restriction should be removed and that “all” means “all” - not just the BPL children.

### **What about children in Dalit families, tribal areas and slum communities?**

Needless to say, they have to be covered too. In fact, SC/ST hamlets are to receive priority in the allocation of new Anganwadis, according to a Supreme Court order dated 7 October 2004. And all slums are supposed to have an Anganwadi (see Box 3). In short, the Supreme Court has made it clear that all children means *all* children.

### **Can children's right to nutrition and health be protected simply by increasing the number of Anganwadis?**

No. Extending the coverage is not enough. As discussed in the next section, a radical improvement in the quality of ICDS services is also required. The real objective should be “universalization with quality”.

## **6. Implementation and Quality Issues**

Two mistakes have to be avoided in assessing the present state of ICDS. One is to be blind to the implementation problems, and to claim that the programme is doing well. The other mistake is to dismiss the programme as hopeless.

The quality of ICDS varies a great deal between different states, and sometimes even between different Anganwadis within the

same state. Generally, the quality of ICDS is not very good, and there is a big gap between promise and reality. However, experience shows that with adequate political will, the conditions required for ICDS to work can be created. These enabling conditions involve, for instance, higher budget allocations, a better infrastructure, closer monitoring, improved accountability, and more active community participation.

The most important reason for the gap between promise and reality is that the rights and wellbeing of children under six is not a political priority. This is partly because children are not voters. But there is more to it than that. There is poor understanding about early childhood across the country and in all strata of society. Not many are familiar with scientific facts about the critical importance of early childhood in the development of a human being. This has led to indifference and rampant neglect on the part of the government, and also at the level of community involvement.

In the rest of this section, we comment briefly on some of the key implementation problems that have emerged from this lack of commitment to ICDS. The list is not exhaustive, and nor does every problem apply everywhere – you may wish to adapt the list to your own area.

## Low budgets

Low commitment to children under six has led to low allocation of funds for ICDS. The total



allocation for ICDS by the Central Government for 2004-5 was a mere Rs 1,600 crores – less than *one tenth of one per cent* of India's GDP. By contrast, in the same year, the Central Government spent Rs.77,000 crores on defence. Although the budget allocation for 2005-6 has been increased to Rs 3,000 crore, this is far from adequate to improve quality and move rapidly towards universalization. The expenditure per child needs to be doubled, at the very least, to achieve minimum quality standards. And of course the budget needs to be doubled again, if not tripled, to achieve “universal coverage” of all children.

Not only is the overall budget low, the item-wise breakdown also shows glaring inadequacies. For example, each Anganwadi receives a mere Rs. 150 per month for “rent”. Getting proper space for an Anganwadi within this budget is almost impossible, particularly in urban areas. Similarly, the standard expenditure norm for “supplementary nutrition” in 2004-5 was as low as Re. 0.95 per child per day, to be contributed by the State Government. The norm has been doubled by the Central Government, in response to Supreme Court orders, but the money allocated continues to be inadequate to cover basic items like fuel and vegetables.

## **Staffing gaps and poor infrastructure**

Because ICDS is not a priority, State Governments often fail to appoint Anganwadi workers, supervisors and other essential staff. Many Anganwadis are non-functional or poorly supervised due to shortage of essential staff. To illustrate, in Mehla Block of Chamba District (Himachal Pradesh), 7 out of 8 posts of Supervisor are vacant - there is a single Supervisor for 163 Anganwadis. In Bihar, 74% of the Supervisor posts are vacant; so are 26% of all posts in Uttar Pradesh. Similarly, lack of basic infrastructure (from room space to drinking water and teaching aids) is a major problem in many Anganwadis.

These and related problems will need to be examined and resolved, if ICDS is to be a quality programme, which responds to the child's right to nutrition, health and education. Some states have already done quite well in this respect. The main challenge is to learn from these positive experiences and extend them elsewhere. Box 5 illustrates what a well-run Anganwadi can achieve.

## **Crushing workload of the Anganwadi worker**

The Anganwadi worker is the most important human factor in the programme - the person who relates to the children and the families. Her confidence, her skills and her motivation are most important. But little attention has been given to this. The



Anganwadi worker has been given countless responsibilities. Apart from children's health, nutrition and pre-school education, she is supposed to reach out to pregnant and nursing mothers, make home visits, provide nutrition counselling, help with immunization campaigns, attend Self-Help Group meetings, carry out surveys, keep numerous registers, and so on. In addition she is frequently mobilised by other government departments for special duties, such as storing grain for other programmes or meeting targets for setting up

Self Help Groups. This further cuts down her time for the children.

To make things worse, the training of Anganwadi workers is very limited, and their wages (called an "honorarium") are very low. This affects the status of the Anganwadi worker in the village. She seldom gets the respect due to her, and this undermines her efficiency and her morale.

## Erratic or defective food supply

This is a big problem in many states. If there is no food at the Anganwadi, or if the food is tasteless and monotonous, few children attend and no activity can take place. Unfortunately, food supply is often erratic. In some states, food supplies are disrupted for months at a time for trivial reasons, such as delays in sanctioning funds or administrative bottlenecks. Irresponsibility and corruption on the part of food supply contractors is also common. Even where food supply is regular, there is much carelessness in food storage, and the quality of food is poor in many cases.



There are, of course, major variations in all these respects between different states. Some states have been able to ensure regular food supply and adequate quality standards. These contrasts are illustrated in Box 4.



## Box 4

SUPPLEMENTARY NUTRITION UNDER ICDS:  
POSITIVE AND NEGATIVE EXAMPLES

- ◆ In Uttar Pradesh there are regular interruptions in the supply of supplementary food, often for months at a time. When food is available at all, it is just “panjiri”, a ready-to-eat mixture with a short shelf life, which is often stale by the time it is distributed.
- ◆ In Rajasthan, there is more regularity, but again no variety: “murmura” every day for all the children regardless of age.
- ◆ By contrast, there are three items on the menu in Himachal Pradesh (*khichri*, *dalia* and *chana*), and supply is quite regular in spite of the difficult terrain.
- ◆ The diversity and nutritious content of the food are even higher in Tamil Nadu, where two types of food are currently provided at the Anganwadis: (1) a fortified pre-cooked “health powder” to be mixed with boiling milk or water for children below two years; and (2) a hot lunch of rice, dal and vegetables freshly cooked with oil, spices and condiments (with occasional variants such as a weekly egg) for children in the 3-6 age group. The survey teams did not come across any disruption in the supply of food in Tamil Nadu, even for a single day.

*Source:* “Universalization with Quality: An Agenda for ICDS”, by Jean Drèze and Shonali Sen; based on a survey conducted in May-June 2004.

## **Poor coordination between health services and ICDS staff**

Health services provided at the Anganwadi tend to be quite popular. Unfortunately, they are often hampered by lack of coordination between the ANM and the Anganwadi worker as well as by a lack of basic medicines. For instance, recent surveys show that many Anganwadis have no medical kit. Even Oral Rehydration Solution (ORS) and other basic items are often lacking.

The National Rural Health Mission is set to create a cadre of women voluntary health workers (ASHA or “accredited social health activist”) at the village level, who are also expected to work with the ANM and AWW to improve the nutrition and health of women and children. However the effectiveness of this initiative remains to be seen.

## **Neglect of the pre-school component of ICDS**

Some states, like Kerala and Tamil Nadu, have made great strides with “pre-school education” (PSE). But in most places, this component of the ICDS programme has been grossly neglected. More emphasis has been placed on distribution of food, and to some extent on immunization.

Children need a good learning environment and plenty of activities to help the development of language; help them learn to think

and reason; find out about the world around them, and so on. They need to learn to coordinate eye and hand, which will help in writing, and to recognize shapes and distinguish between them, which will help with reading. Parents want their children to learn, they want them to be made ready for school, but they don't see much activity at the Anganwadi. They often complain that children learn nothing.

We must remember that ICDS is the only government system for providing pre school education to the majority of our children. If this is to happen effectively, a larger number of well trained workers (teachers) will have to be employed for the programme.

### **Poor outreach to the “under threes”**

Children under the age of three should receive the highest priority in the ICDS programme. In practice, they are virtually excluded. The designers of the programme apparently assumed that the family can look after young children without any special assistance. This assumption shows little understanding of the lives of women, especially working women. Poor outreach to children under three is a critical gap in the conception of ICDS.

One way of reaching children under three is for mothers to bring them to the Anganwadi for supplementary nutrition and other services. In most cases however, this does not happen on a daily basis. Thus, in many Anganwadis, take-home-food (THF) is

given out once or twice a fortnight for the pregnant women and children under three. This may consist of food grain like dalia, or special ready-to eat food for the under threes. One problem with the THF approach is that the food may be added to the common family pot and shared by all family members – not just the young child. This is perhaps less likely with certain kinds of “ready to eat” food such as baby-mix that are seen as “baby foods”. However, baby food is unlikely to be manufactured locally and shifts procurement in favour of companies and contractors. It also creates the impression that “normal” food is not good enough for the very young child. Clearly, different solutions are needed for different situations, but experience suggests that a combination of nutritious THFs based on local food, together with good nutrition counselling, works relatively well. Depending on the context, this could include local food grains or items such as dalia, laddus etc.

The location of the Anganwadi and its timings are also critical for women to be able to bring or leave their young children at the centre. A full day crèche facility is crucial for the care of children of women working away from home. There are limited provisions for some Anganwadis to be converted to “Anganwadi cum crèche” centres. However, this requires not only more infrastructure but also special training and a larger number of workers and should not be undertaken without due preparation.

## BOX 5:

## A MODEL ANGANWADI IN TAMIL NADU

“God bless mummy, god bless daddy, god bless teacher who will teach us, and make them happy”. Standing in a perfect circle, at 10 am sharp, children chanted this prayer to start their activities of the day at the Anganwadi. In the next five hours they would learn through play, have one nourishing meal, take a noon nap, and return home to their mother, who had the comfort of having her child taken care of for a significant part of her working day.

Immediately after the prayer was a round of physical exercises, accompanied by poems created for the purpose. This was the only time of the day when children danced to the tune of the Anganwadi worker! After this short round the teacher shifts to a round of lessons, but children hardly notice the change – for them it’s all one big game.

The teacher is well trained for pre-school education. Keeping with the spirit of joyful learning, all her lessons are in the play-way. Her syllabus for the fortnight was flowers. She had an assortment of creative games ready. She started her lessons with a simple game of matching pairs of flowers, painted on cards. We observed that the elder children had learned the names of flowers. For example you could hear them say, “hey, the other lotus in the pair is here, keep it with the other one”. As the day proceeded children played with flower-shaped facemasks, jumped over flowers she drew, heard stories about the lotus and the bee and amused themselves.

Behind this simple set of activities lay much thought and creativity. Each game was carefully designed to cultivate important skills for the 3-6 year olds such as recognition, identification, comparison, learning language in an interactive fashion, etc. The syllabus prescribed one topic per fortnight, to introduce children to things in their immediate environment: flowers, vehicles, fruits, and so on.

While this was on, the Anganwadi helper was busy preparing lunch. Before serving the children, she tasted the food herself and asked the teacher to do so. A sample portion was kept in a clean steel box that could be used for lab tests in the event of food poisoning. By twelve, children filed out to wash

their hands, received their clean plates and sat in a neat circle for the food to be served. As the food was being served, the little ones looked at the helper curiously for permission to start eating. They were asked to wait until all children were served and the prayer had been recited. These little gestures go a long way in making the child accustomed to the ways of the world. At the Anganwadi the child also learns to socialise, share a meal, and in general gets used to a classroom atmosphere.

The lunch was quite nourishing - a sambhar made with pulses, green leafy vegetables and carrot. The teacher told us that a variety of spinach is always there since it contains iron, which is good for anaemia. Like many other Anganwadis in Tamil Nadu, this one too had a small garden sporting tomatoes and other vegetables. The helper proudly told us that children would eat vegetables from their own kitchen garden.

We continued chatting with the teacher as she put children to sleep. "Children will get up after an hour or two, play for a while and then go home by three", she told us. This was another attraction for working mothers who were relieved of childcare for a good part of the day.

The teacher's day was far from over. She had to do some home visits to counsel pregnant mothers. On other days she conducts "nutrition and health education" (NHE) classes, checks out on newborn babies, etc. She often finishes her working day at home by preparing games for the next section in the syllabus.

As our visit drew to an end we were left wondering about the significant work that she does. She was a simple village girl who had completed class ten and had been trained to do this fine job. All it took to prepare children for school and to lay foundations of a healthy life was one well-trained person and very moderate additional expenditure. As we departed, children from the nearby school were streaming out. She pointed to one young girl and said: "She was my student here and has now joined school. The school teachers tell me that just like other children who have gone through an Anganwadi, she is doing very well at school". The pride and sincerity in her voice touched us.

*(Contributed by S. Vivek)*

## 7. What Can We do to bring Change?

Many things can be done to ensure that there is a functioning Anganwadi in every settlement – a crucial step towards the realisation of every child's right to nutrition, health and education. Action is required at all levels, from remote villages to the far off capital. And there is a role for everyone – parents, teachers, journalists, politicians, researchers or concerned members of the community. There is no one way to go about it – much depends on local conditions and people's imagination. This concluding section presents some suggestions for action.

One of the most important steps is to create an interest in ICDS (and more generally, in the wellbeing and rights of children under six) within the local community. People need to understand that ICDS is now an entitlement of all children under six, and that they can help in making this right a reality. They also need to know about the Supreme Court Orders. There are many ways of doing this. For instance, you can take people to the local Anganwadi, so that they can see for themselves what is happening on the ground and how it relates to what the Court orders say. You can also take them to an Anganwadi that functions relatively well, to give them a sense of what ICDS can achieve.

Another crucial step is to investigate the situation on the ground. This can be done in various ways: through formal surveys,

informal enquiries, “focus group discussions”, and so on. Here are some examples of issues to investigate:

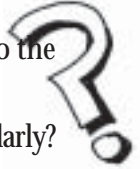
- ◆ Does the Anganwadi open on time?
- ◆ What about the children who don't come to the Anganwadi, or who come irregularly?
- ◆ Does the nutrition being supplied arrive regularly?
- ◆ Do children find it palatable?
- ◆ Is the food enough?
- ◆ Does nutrition reach the

younger children,  
prenant and nursing mothers,  
and adolescent girls?

- ◆ Do parents or Anganwadi workers complain about supplies or quality of the food?
- ◆ Is there much food left over after food is distributed?

- ◆ Are the rations stored hygienically?
- ◆ Have there been instances of discrimination, such as Dalit children being excluded or children of different castes sitting separately at the Anganwadi?

- ◆ Is there enough space and play material for children's activities, do they both play and learn?
- ◆ What about facilities such as drinking water, toilets and a kitchen?
- ◆ Is there any evidence of corruption?
- ◆ What problems does the Anganwadi worker face?



After conducting these enquiries, and involving the community, various kinds of activities can be envisaged: from supportive activities (such as renovating the local Anganwadi or helping the Anganwadi worker) to building up public pressure for “universalisation with quality”. Below are some examples of what we can do.

**Box 6:**

**COMMUNITY MOBILIZATION FOR ICDS IN ANDHRA PRADESH**

In rural India, the health of infants and children is not a public concern. If a baby is born with a low birthweight, or if an infant dies, it is seen as the mother’s problem. The M.V. Foundation is working in about 300 villages of Ranga Reddy District to change these perceptions, and to bring accountability in Anganwadis and Primay Health Centres.

To create a feeling of social responsibility for children’s right to nutrition and health, public meetings were held with Gram Panchayat members, women, youth and others. Data on children aged 0-6 were presented, and the reasons for each child death were discussed. The groups were also informed about ICDS and the role of the Anganwadi worker. It was decided that the Anganwadi worker (AWW), the Auxiliary Nurse Midwife (ANM), the school headmaster, Gram Panchayat members and others in the community would jointly review the state of all children in the village every month.

Many changes have happened due to these review meetings. For instance, in village Burugupally (Mominpet Mandal) the Anganwadi worker used to come once a fortnight. The Sarpanch warned her at the review meeting that he would have to make a complaint if she did not attend regularly. The AWW was politically influential and paid no heed to the warning. The

Sarpanch, youth leaders and mothers' committee then sent a petition to the CDPO. The CDPO sent a memo to the AWW and she finally yielded to the pressure.

The village youth also noticed that children were given supplementary nutrition powder in their pockets or in plastic covers, and were dropping it on the way as they walked home. Dogs were chasing these children, most of whom were dropping the packets and running away. In the next review meeting, the AWW was asked to make 'laddus' of the powder and feed the children at the Anganwadi itself.

The AWWs now discuss their problems with the Gram Panchayat. These problems are then raised by the Sarpanches in Mandal General Body meetings that are attended by officials of all departments. Some issues, such as lack of plates at the Anganwadi or repair of play equipment, are resolved at the village level itself.

The M.V. Foundation has also involved the AWWs in intensive follow-up of children in the 0-3 age-group who are suffering from Grade III or Grade IV malnutrition. The MVF volunteer and the AWW visit the houses of these children together, counsel the mother, and give double rations of the supplementary nutrition. The AWW, who used to "hide" these children in the records for fear of being reprimanded by her supervisors, now showcases them as her success when the supervisor or CDPO visits the village.

As a result of the review meetings, and close monitoring of over 30,000 children, many of the Anganwadis in these eight Mandals of Ranga Reddy District are now active. Children attend regularly, malnourished children are taken care of, and the health of infants and young children has become a public concern.

*(Contributed by Dipa Sinha)*

## Ensuring that every hamlet has an Anganwadi

It is the right of every child to have an Anganwadi near home. If there is no Anganwadi, you need to act. It is best to start at the local level, e.g. by contacting the CDPO or the District authorities. A petition can be sent to the Secretary in charge of the department, to politicians, and others. If nothing works,

you can contact the Commissioners of the Supreme Court or their

advisors (see

Appendix 2).

Well-documented

appeals to the

Commissioners have often

proved effective in the past.



## Monitoring the local Anganwadi

A lively Anganwadi can be a wonderful place for the child. Many Anganwadis, however, are in bad shape or even non-functional. In such cases, it is useful to organise a village-level meeting along with the Anganwadi worker and discuss how to make the Anganwadi effective. If there is no cooperation on the part of the Anganwadi worker, you can contact the CDPO. But very often, the Anganwadi worker can be motivated to take more interest in her tasks without confrontation – by working with her and taking interest in her own problems.

## BOX 7:

## COMMUNITY ADOPTION OF ANGANWADI IN MADHYA PRADESH

Seema and Prakash, founders of Spandan Samaj Seva Samiti, have lived and worked among Dalit communities of Madhya Pradesh for many years. They have recently taken up the rights of children under six as a major campaign issue. Among other initiatives, they have facilitated “community adoption” of Anganwadi No. 1 in village Dabiya (Khandwa District).

The first step was a dialogue with the community, to convey the importance of the Anganwadi’s activities for child development. Seema and Prakash, with their co-workers, spent time with the villagers. They taught them songs, helped them to make low-cost toys, and explained to them the importance of pre-school education and health checkups. The Anganwadi worker and helper often accompanied them, and this exercise enhanced their motivation.

Seema and Prakash also encouraged the Mahila Mandal to get involved in this process, and to prepare the children’s food using local products. Women of the Mahila Mandal collected donations from parents and others in the entire village to supplement the ICDS budget.

Side by side with this dialogue, Seema and Prakash initiated the renovation and revival of the Anganwadi. Villagers painted the Anganwadi in bright colours of pink and blue. They also painted blackboards, all across the lower interior walls. They bought learning charts, toys, and plastic bowls for the meals. The cost of this renovation process was only around Rs.5,000.

An inauguration ceremony for the renovated Anganwadi was held on 12 January 2006. This was also the occasion for the release of a booklet on ICDS in Hindi (adapted from an earlier draft of this Primer). The CDPO, Doctor, Supervisor and ANM participated in this ceremony.

Seema and Prakash had also invited me. When we reached the Anganwadi, about 55-60 children were sitting there. They were busy singing, and enacting the song. The Anganwadi worker and helper were present with

two young girls. One of these girls was teaching the children through games and other fun activities. It is interesting that the children didn't know the name of their Anganwadi worker but they knew this girl's name very well, and also the name of their 'Dalia Bai' (helper). There were many charts on display, like the alphabet chart and health chart, apart from toys, blocks, drawings. There was also a chart with the photographs of eminent women like Kalpna Chawla and Teejan Bai. When I asked who these women were, the children recalled their names easily. One child recited the roman alphabet in sequence, from A to Z, and another said the table of 15. All this showed the community's interest in their children's pre-school education through the Anganwadi programme.

Meanwhile, the Mahila Mandal women were preparing the children's food. They had bought the material using the donations that they collected. More than 100 children sat and ate *dal-chawal* together, including children from another Anganwadi. There was enough food for everyone and the children relished the food.

I felt that the women wanted to convey two things through this lunch. First, local food is more acceptable to the children than pre-cooked or packaged food. Second, a nutritious meal can be prepared from local foods, even within the norm of "two rupees per child".

Dabiya is only one village, but this initiative is likely to have a wider impact. Seema and Prakash are planning to invite workers and helpers from other Anganwadis to make a visit to Dabiya. The event was covered in Dainik Bhaskar and the local editor is willing to support the community adoption of 40 Anganwadis in Khandwa District.

*(Contributed by Navjyoti)*

## What to do in case of erratic supplies

If food supply is erratic, or if visits by the doctors and ANMs are irregular, you should talk to the CDPO and to the District authorities. Involvement of the Anganwadi worker will be helpful in this case too. Here again, you can get in touch with the Commissioners or their advisors in the event of serious problems that cannot be solved locally.

## Making the Anganwadi reach its true potential

In many parts of the country people do not appreciate ICDS because they do not know what an effective Anganwadi looks like or can achieve. If the Anganwadi is merely a place where the child gets a handful of *dalia* or *khichri* in a day, most parents will not care much about it. But no mother will fail to support the Anganwadi and fight for it if she understands that an effective Anganwadi can help her son or daughter to become a healthy, confident and educated child. The Anganwadi can become a proud possession of the village – much more than a mere *dalia kendra*. Here are some ideas on how to win people's support for the local Anganwadi:

***Organising an Anganwadi mela:*** For a week, help the Anganwadi worker to run the Anganwadi in an exemplary manner: nutritious and hygienically prepared food, creative activities, growth monitoring (children love sitting on scales), and so on. Mothers

feel very proud of their children and of the Anganwadi, when the child goes home and sings poems learnt at the Anganwadi. The experience of a well-functioning Anganwadi will motivate families to send their children and also inspire the Anganwadi worker.

***Creative painting of the Anganwadi:*** Another interesting activity would be to paint the Anganwadi and make it a beautiful place. This can be a community activity. Flowers, fruits, animals and other things that the child learns about can be painted on the walls. A blackboard should be painted for the teacher to use. These will make the Anganwadi beautiful and make it a place that the child will want to go to. Such a place will attract and stimulate children and parents.



**“Make toys” day:** Children love play and learn through play. Parents, neighbours, elder brothers and sisters can be involved in making toys from locally available materials: dolls from shreds of cloth or leaves of corn; balls from crushed paper, pasted over with strips of old magazines or waste cloth; numbers and letters of the alphabet from cardboard or old slippers (chappals) for children to feel, recognise and match; paint animals, flowers, vehicles and other things onto cards for children to recognise and match. People get truly absorbed in such activities, and this is also a means of providing the Anganwadi with play and learning materials at little or no cost.



**Creating a kitchen garden:** Vegetables are

a must! Parents and children can help to grow greens and other vegetables, so important in a child’s diet.



**Cleaning the Anganwadi:** A clean Anganwadi is so important for children’s health. This is also a good way to involve families regularly.

**Organising a nutrition mela:** Nutrition education is very important. Often it is not the lack of food in the house but lack of basic knowledge that causes malnourishment. CDPOs, doctors and Anganwadi workers can be involved in such an event. The melas can focus not just on the nutrition of the child but also on the family – pregnant women especially.

Box 8:

GRASSROOTS MOBILISATION FOR ICDS IN KORIYA, CHHATTISGARH

Mitanins (community volunteers) from Adivasi Adhikar Samiti in Koriya District started their campaign on ICDS in 2003, with large-scale weighing of children. This exercise showed that 79% of girls and 67% of boys below the age of 3 were malnourished. Of these 21% girls and 17% boys were severely malnourished (Grade III or IV). The State Government, however, did not recognise the gravity of the problem. Only 48% of children below the age of 6 were enrolled in ICDS, as half of the hamlets had no Anganwadi. The attendance rates were even lower, due to the irregular functioning of Anganwadis. In many Anganwadis the stipulated amounts of wheat *dalia*, oil, *gur*, Vitamin A and iron tablets were not being provided.

After receiving some training in child nutrition, the Mitans conducted village-level meetings and family counseling sessions. Dekh Rekh Samitis (nutrition monitoring committees) consisting of tribal and Dalit women were set up in each hamlet. Encouraged by the Mitans, more and more people started using the Anganwadis. And as the mobilisation gained strength, major improvements were observed in many of the poorly-functioning Anganwadis.

Mitanins asked women to give their complaints in writing in the form of a collective affidavit. These complaints were sent to the District Collector

but no action was taken. Adivasi Adhikar Samiti (AAS) attempted to mobilize Gram Sabhas to replace erring ICDS workers but Panchayat officials refused to write the resolutions. These setbacks led AAS to approach the Supreme Court Commissioners, who wrote to the State Government demanding an enquiry. This resulted in action being taken immediately.

A revival campaign for Anganwadis was planned. This campaign was jointly implemented by the ICDS supervisors, ANMs of the Health Department, and Mitanins. A series of revival meetings were organised in 45 villages with “problem” Anganwadis. ICDS staff and the community were brought together and each side’s duties were explained. This campaign was a success: there was a major improvement in the functioning and utilization of most Anganwadis. But it is only when they joined hands against domestic violence that the relationship between Mitanins and ICDS workers finally improved.

The number of Anganwadis in Koriya was increased by 40% by opening mini-Anganwadis, to be upgraded in due course. The Mitanins and Dekh Rekha Samitis ensured a fair selection of Anganwadi workers and monitored their work.

In March 2005 a public hearing on food issues was held, with special focus on ICDS. More than 2,000 tribal women from over 135 villages participated. The authorities promised remedial action, but the situation has been slow to improve. Mitanins have documented the denial of entitlements and are approaching the Commissioners again. They are confident that this will strengthen their struggle to combat corruption at higher levels, and that lasting improvements will be achieved soon.

*(Contributed by Samir Garg)*

## **Advocacy, media and research**

Some problems are difficult to resolve through “local action”, and require policy changes at higher levels. For instance, if the budget allocation for supplementary nutrition is low, the local Anganwadi worker and even the CDPO may not be able to do anything about it. This is because budget allocations are decided by the State and central Governments.

Achieving policy changes requires organised “advocacy”. This involves activities like lobbying Members of the Legislative Assembly (MLAs), sending petitions to the Chief Minister, organising rallies in the state capital, writing in the newspapers, and so on. For instance, state-wide campaigns are required to ensure that every hamlet has an Anganwadi, as per Supreme Court orders. Box 7 illustrates how various campaign activities can be organised for this purpose.

If you take up advocacy work, don't forget the media. Mass media such as daily newspapers and TV interviews are the best way of reaching a large audience in a short time. Also, politicians and bureaucrats tend to be quite concerned to avoid “critical” media reports, so this is a good way to keep them on their toes. However, getting attention for social issues like ICDS in the mainstream media is not always easy. It requires taking time to write, building contacts with friendly journalists, conducting “newsworthy” investigations, organising effective press

conferences, and so on. “Learning by doing” is the best approach here, but it is also useful to seek advice from people with media experience. Effective media work is hard work, but it is a powerful tool of action.

Research is another useful tool of action. If you have solid facts, it will be that much harder for the concerned authorities to ignore your demands. Like media work, good research is hard work and there is no alternative to “learning by doing”. But much can be learnt from earlier studies and surveys. For instance, a detailed survey of Anganwadis was recently conducted in six states: Chhattisgarh, Himachal Pradesh, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh. Further information on this survey is available on the website of the right to food campaign ([www.righttofoodindia.org](http://www.righttofoodindia.org)). Also on this website, you will find samples of survey questionnaires, guidelines for field investigators, and related material.

## Finally

If you found this “Primer” helpful, please share it with others also. This can be done, for instance, by:

- ◆ Organising a group discussion of this Primer.
- ◆ Arranging for a translation in the local language.
- ◆ Using portions of this Primer to prepare posters and leaflets. For instance, a poster on the Supreme Court orders can be made of Box 3 and displayed in the local school, Anganwadi, Panchayat Bhawan, etc.
- ◆ Distributing or selling copies of this Primer. Bulk orders can be sent to the secretariat of the “right to food campaign” (see Appendix 2 for the address).

*And please remember that we are interested in your comments and suggestions on this Primer – this is only the first version!*

## APPENDIX 1

# Norms for Opening Anganwadis

As mentioned in Section 5, the creation of Anganwadis under ICDS is currently based on a simple norm of “one Anganwadi per 1,000 persons”. In tribal areas, a modified norm applies: “one Anganwadi per 700 persons”. These norms do not specify how Anganwadis are to be distributed between villages of different sizes: they only say that the “average” density of Anganwadis should be “one per 1,000” (or “one per 700” as the case may be).

A “task force” was recently set up by the Central Government to review these norms. The task force recommended the following revised norms:<sup>2</sup>

- ◆ One Anganwadi each in all settlements (rural or urban) within a population range of 500-1500 persons, except in tribal areas.
- ◆ In tribal areas, one Anganwadi for settlements within the 300-1500 range.
- ◆ For settlements with a population below this range, but above 150, a “mini Anganwadi” is to be opened.

Clearly, these norms are inadequate for universalization, let alone “universalization with quality”. In a village of 1500, there are likely to be more than 200 children below the age of six. How can a single Anganwadi take care of so many children? As of

now, only 80 children are supposed to be enrolled in each Anganwadi. This number could be increased, but this would require additional staff, of which there is no mention in the task force report. Further, raising the enrolment norms is not really desirable since it would mean that children have to walk longer distances to reach the Anganwadi.

Ironically, the proposed norms imply a *dilution* of entitlements in many situations. To illustrate, consider an area with five villages, two with a population of 400 and three with a population of 1,400. With a total population is 5,000, this area would be entitled to five Anganwadis based on the earlier norms, but only three based on the new norms! For tribal areas, the situation is even worse, since the upper limit of the basic population range (300-1500) is more than twice as high as the earlier benchmark of 700 for opening Anganwadis.

There is also a major ambiguity about the interpretation of the proposed norms for villages with a population above 1500. The task force report provides no clear guidance on this.

In short, the proposed norms are out of tune with the goal of “universalization with quality”, and in some respects even a step backward. It is important to resist any dilution in entitlements that may happen when these norms are actually applied, and to demand improved norms.

## APPENDIX 2: **Further Resources**

### **1. Further Reading**

If you have access to the internet, you may be interested in the website of the “right to food campaign” ([www.righttofoodindia.org](http://www.righttofoodindia.org)).\* This website has a large amount of material on ICDS and related aspects of the right to food, including:

- ◆ The full text of Supreme Court orders on the right to food.
- ◆ A “soft copy” of this Primer.
- ◆ Guidelines for conducting field surveys, and ready-made “questionnaires”.
- ◆ Lots of articles and field reports on ICDS.
- ◆ Links to related sites.

### **2. Useful Addresses**

#### ***(1) Office of the Commissioners of the Supreme Court:***

c/o Centre for Equity Studies,

R-38A South Extension Part II,

New Delhi 110 049. Tel/fax: 011-4164 2147.

E-mail: [commissioners@vsnl.net](mailto:commissioners@vsnl.net)

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\* Most of the material posted on this website is in English, but some of it is in Hindi.

(2) *Secretariat of the Right to Food Campaign*: Siddiqui Building, Bara Hindu Rao, 6122 Bahadurgarh Road, Delhi 110 006 (street address); 257 DDA Flats (RPS), Mansarovar Park, Shahdra, Delhi 110 032 (correspondence address). Tel: 011-2351 0042, 9350530150. E-mail: righttofood@gmail.com

*Note:*

The Commissioners have an “advisor” in most states. You can check their names and addresses from the above-mentioned sources. If you notice any irregularities in the provision of the ICDS in your area, and if you are unable to obtain redressal from local authorities (for instance, the Gram Panchayat or the CDPO), please get in touch with the Commissioners or their advisor in your state. Earlier interventions from the Commissioners have often helped to ensure that the concerned authorities respond promptly to complaints, especially in cases of violation of the Supreme Court orders.

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**Endnotes**

<sup>1</sup> Booklet on ICDS, Department of Women and Child Development, 1975.

<sup>2</sup> The task force also recommended a “distance norm”, such that no child should have to walk more than a kilometre to reach an Anganwadi. However, it is not clear how this distance norm is to be interpreted, and whether it will be given priority over the “population norm”.

## ACKNOWLEDGEMENTS

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