YASHWANTRAO CHAVAN ACADEMY OF DEVELOPMET ADMINISTRATION

Contents

CHAPTER 1

INTRODUCTION, OBJECTIVES AND SURVEY METHODOLOGY

Child Development is the Foundation of Human Development:

Children are the first call on agenda of development not only because young children are the most vulnerable, but because the foundation for life long learning and human development is laid in the crucial early years. Early childhood (the first six years) constitutes the most crucial period in life, when the foundations are laid - cognitive, social and emotional language, physical/motor development and cumulative life long learning. By the end of the second year of life most of the growth of the human brain is already complete and critical brain structures are in place.

The young child under 3 years is more vulnerable to vicious cycle of malnutrition, diseases/infections and resultant disability, all of which constitute risk. Development opportunities determine both the present of every child and family as well as the future human resource development of the nation.

NFHS 3 (2005-2006) revealed that almost half of the child population in India is malnourished. Even after 30 years since the launch of ICDS program in 1975, it is very unfortunate to note this severe extent of malnutrition of children in the country. This necessitates the evaluation of ICDS programme all over India.

Integrated Child Development Scheme (ICDS) programme was launched on 2nd October 1975. Today, ICDS Scheme represents one of the world's largest and most unique programmes for early childhood development. ICDS is the foremost symbol of India's commitment to her children - India's response to the challenge of providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other.

A formidable number of evaluation studies by Indian as well as foreign researchers on implementation and evaluation of ICDS Scheme have been conducted in the past. An important study was done by Programme Evaluation Organisation of the Planning Commission in 1982. National Evaluation of ICDS Scheme was conducted by National Institute of Public Cooperation and Child Development (NIPCCD) in 1992.

Evaluation Results of Annual Surveys during 1975-1995, were published by Central Technical Committee on Integrated Mother and Child Development on completion of 20 years of ICDS. Nationwide Evaluation of ICDS by National Council of Applied Economic Research (NCAER) was done in 1998-99. In 2011, Planning Commission conducted a detailed study to evaluate the efficacy of this programme.

Many studies including Sachhar Report have found that the Muslim minority community has been facing exclusion in employment, finance, education and basic amenities. This exclusion becomes more severe in minority dominated areas especially with regard to access to basic amenities and health services. The present study is undertaken to fill this gap and come out with recommendations regarding the quality and quantum of services. This research expects to create advocacy for policy makers to strengthen the services of ICDS and public health services in minority areas, such as Malegaon.

Main Objective:

The main/primary objective of this research study is to oversee the functioning of the ICDS scheme and to find whether the benefits of ICDS and Public Health services provided have reached the people of socio economically backward city of Malegaon.

Objectives in Detail:

The objectives in detail of the Malegaon study are as follows:

1. To study the functioning of ICDS centres based on stipulated government norms in Malegaon.
2. To study the socio-economic and demographic conditions of beneficiaries in relation with access to ICDS and government health services, so as to evaluate the extent to which the guidelines for identifying the beneficiaries have been followed in Malegaon.
3. To evaluate whether the benefits are reaching the people.
4. To evaluate whether the health services are reaching the needy.
5. To find the opinion of the officials and the community leaders about ICDS

This report has the following chapters

CHAPTER 1A

SURVEY METHODOLOGY

Survey methodology includes sampling design, preparation of a questionnaire, methods of data collection etc. The process was initiated with the study, starting with preparation of questionnaires, sample design, determination of sample size, collection of data --- etc.

Sample design and Sample Size Determination:

From the objectives of the study, it is clear that the major component of the survey is the survey of the ICDS beneficiaries from Muslim-dominated areas of slums of Malegaon city. The slums had 155 Anganwadi centres (AWC). From these 55 AWCs with Muslim majority were chosen. From each of the selected AWCs, 40 households were to be selected. Thus, it is a two stage sample design with the AWC as the first stage unit and household as the second stage unit. After having selected 55 AWCs, list of Child beneficiaries from each AWC were obtained. Forty households from each AWC were selected with systematic random sampling. The pregnant woman, lactating mothers and adolescent girls from the selected households formed the sample respondents of these kinds. Forty households each from 55 AWCs should give a sample of 2200 households. However, because of some survey problems, finally, the analysis has been done for 2081 households

Preparation of Questionnaires:

While preparing the questionnaires, the researchers have taken enough efforts and have taken into consideration all possible aspects about ICDS, its benefits and the reach of government health services to the slum dwellers.

There are six types of questionnaires used for the survey. Following are the respondent categories:

(i) Anganwadi Centre (AWC)

(ii) Child Development Programme Officer (CDPO)

(iii) Auxiliary Nurse Midwife (ANM)

(iv) Medical Officer

(v) Community Leader

(vi) Beneficiary Household

Out of six respondents, the AWC and the Beneficiary Household are the two important respondents and hence are described in brief.

AWC Questionnaire - Different Sections:

(i) Physical Infrastructure of Anganwadi

(ii) Registered Beneficiaries and their attendance

(iii) Registered births, child deaths and maternal deaths during last seven years.

(iv) Functioning of the AWC and its activities

(v) Different Records to be maintained

(vi) Nutrition and Health Education Activity

(vii) Home visits

(viii) Availability of different implements

(ix) Provision of Nutritious food

(x) Supply and consumption of medicine

(xi) Immunisation performance

(xii) Health check-up and Nutritional status monitoring

(xiii) Pre-primary Education

(xiv) Performance in Kishori Shakti Yojana

(xv) Visit of ANM/MD/Supervisor /CDPO

(xvi) Community Participation

(xvii) Profile of AWW and AWH

(xviii) Training of AWW and the difficulties in running an AWC

(xix) Investigators' opinions about functioning and cleanliness at the AWC and about AWW's skills.

The above list makes it clear that the questionnaire is quite comprehensive enabling to access the functioning of the centre, the infrastructure and also the difficulties in running the AWC. The next questionnaire is that of beneficiaries households.

Questionnaire for Beneficiary Household:

(i) Socio-economic background of the family

(ii) Age-sex characteristics of the households and attendance at the Anganwadi.

(iii) Diet at home and supplementary nutrition at the Anganwadi (Child)

(iv) Immunization of children

(v) Weight measurements of children

(vi) Sickness among children and treatments taken

(vii) Pre-primary education at Anganwadi

(viii) Nutrition and Health education

(ix) Diet at home and supplementary nutrition at the Anganwadi (Pregnant women and lactating mothers)

(x) Ante-natal care and health check up (pregnant women)

(xi) Ante-natal care and health check up (Lactating Mothers)

(xii) Health information about adolescent girls

(xiii) Awareness about government health services

(xiv) Awareness regarding health practices.

Post graduates in social work were selected as interviewers and were given training regarding the scheme and about filling the questionnaires. The data processing was outsourced and the report was prepared by the expert group of people.

CHAPTER 2

ICDS – A REVIEW

Since mortality due to malnutrition among infants and children was very high in India, to break the vicious cycle of malnutrition, disease and death, it was decided by the Government of India to start the Integrated Child Development Scheme programme which was conceived by health experts in India. This is how the world's biggest child development programme came in to existence in India with the following objectives:

(i) To improve the nutritional and health status of children in the age group 0-6 years;

(ii) To lay the foundation for proper psychological, physical and social development of the child;

(iii) To reduce the incidence of mortality, morbidity, and malnutrition;

(iv) To achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and

(v) To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

Before the ICDS Programme is reviewed, it would be worth while to briefly examine the child development programmes and strategies in the different Five Year Plans which is done below:

Child Development Programmes and Strategies in the Five Year Plans:

Considering that the opportunities for early childhood development determine both the present and the future human resource development of the nation, child development received attention from the First Five Year Plan (1951-55) itself. In the Second, Third and Fourth Five Year Plans (1956-61, 1961-66, 1969-74 respectively) the same approach for the development of the children was continued. The Fourth Plan focused on increasing the basic minimum services for the children, finally leading to the adoption of a National Policy for Children in 1974.

The **Fifth Plan** (1974 -79) saw a shift in focus from child welfare to child development and an emphasis on integration and convergence of sectoral social inputs for

the well being of infants, children and pregnant and lactating women, which finally took place by the launching of Integrated Child Development Scheme (ICDS) in 1975, which aimed to enhance the holistic development of the child through the involvement of community based voluntary worker called Anganwadi worker.

The **Sixth Five Year Plan** (1980-85) witnessed expansion of ICDS Projects. The **Seventh Five Year Plan** (1985-90) continued the strategy of promoting early childhood survival and development through programmes in different sectors, important among these being the ICDS, universal immunization, maternal and child care services, nutrition, preschool education, protected drinking water, environmental sanitation and hygiene, and family planning.

The main focus of the **Eighth Five Year Plan** (1992-97) was human development with policies and programmes for child survival and development receiving high priority. The **Ninth Five Year Plan** (1997-2002) continued to lay a special thrust on the three major areas of child development viz., health, nutrition and education and universalisation of the nutrition and supplementary feeding programmes.

Supreme Court Judgment:

In a landmark order dated 28 November 2001, the Supreme Court, in a PIL by the People's Union of Civil Liberties, directed the Central and State governments to implement the Integrated Child Development Scheme (ICDS) in full and to ensure that every ICDS disbursing centre in the country shall provide as under:

- Each child up to 6 years of age to get 300 calories and 8-10 grams 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;
- Have a disbursement centre in every settlement.

Further the Supreme Court, vide its subsequent order dated 29.4.2004 issued the following directions to Government of India in relation to the implementation of the ICDS scheme:

- "We direct the government of India to file within 3 months an affidavit stating the period within which it proposes to increase the number of AWCs so as to cover 14 lakh habitations;
- We notice that norm for supply of nutritious food worth Re.1 for every child was fixed in the year 1991. The government of India should consider the revision of the norm of Re. 1 and incorporate their suggestions in the affidavit."

Also, Supreme Court in its order-dated 7-10-2004 directed that below Poverty Line (BPL) shall not be used as an eligibility criteria for providing supplementary nutrition under the ICDS scheme.

The **Tenth Five Year Plan** (2002-07) advocated a convergent rights based Approach to ensure the survival, development, protection and participation of children- with priority to the young child and the girl child. ICDS was recognized as the mainstay of the plan for child development, and convergence of three nationwide programmes – RCH, ICDS and SSA was strongly recommended. The Plan reaffirmed its belief in integrated approach for meeting the survival, growth and developmental needs of young children, adolescents and women across the life cycle- through family and community based interventions. Integrated community based early childcare approaches, focusing on reaching children under three years of age were emphasized. The plan acknowledged the need to make special efforts to reach the un-reached, disadvantaged community groups, for a more inclusive society-and specifically identified urban poor groups as having been left out of the ambit of ICDS. It also called for expanding the support services of crèche/day care services, thus reducing the burden of working/ailing mothers and of the girl child who is expected to bear the burden of sibling care.

Review of ICDS in Tenth Five Year Plan Expansion of the ICDS:

The ICDS Scheme was approved for implementation in the X^{th} Plan within the existing sanctioned 5652 Projects with no expansion activities due to resource constraints. It may be noted that only 4200 ICDS Projects were operationalized by the end of $VIII^{th}$ plan (31.3.1997) while 1452 more projects were sanctioned in the $VIII^{th}$ plan, these were permitted to be operationalized in a phased manner, during the IX^{th} Five Year Plan. As a result, only 408 additional projects could actually become operational by

the end of IXth plan. Remaining 1044 ICDS Projects, which were non-operational at the beginning of Xth Plan became operational by 31.3.2006 only.

To comply with directives of the Supreme Court and to implement the National Common Minimum Programme (NCMP) of the government, the scheme was expanded to cover 466 additional Projects and 1,88,168 additional Anganwadi Centres during 2005-06.As on 31.12.2005, 5653 Projects and 745943 AWCs became operational. (*Working Group on Development of Children for the Eleventh Five Year Plan (2007-2012)* Vol. II Sub-Group Report : 7)

As a result of operationalization of Projects, permitted for operationalization in IX Plan, the total number of beneficiaries recorded a significant rise during the X plan. The total number of beneficiaries as on 31.3.2006 was about 568.40 lakh comprising of about 474.52 lakh children (0-6 years) and about 93.88 lakh pregnant and lactating mothers through a network of about 7.48 lakh Anganwadi Centres; whereas the same stood at 375.09 lakh (315.03 lakh children and 60.06 lakh women) as on 31.03.2002.

Mid Term Appraisal of ICDS in The Tenth Five Year Plan:

Given the importance of ICDS in the survival and development of children and its centrality within the programmes of the Ministry of Women and Child Development, the Mid-term appraisal of the 10th Plan highlighted the following:

- The existing crèche facilities needed to be expanded exponentially.
- Universalisation of ICDS, one of the goals of NCMP, needed to be completed in five years time. Universalisation could not and should not be interpreted merely in terms of doubling the number of centres to 14 lakhs. The nature of change and quality improvement was equally important.
- Lack of food security and poor nutritional status affects the physical growth, intelligence, behaviour and learning abilities of children and adolescents, especially during the development of the brain in 0-3 years period. Since most States were unable to meet the supplementary nutrition component of ICDS because of financial constraints, Centre could consider sharing of the cost of the supplementary nutrition. Supplementary nutrition could be supervised by women's SHGs on behalf of the panchayats.

- For the ICDS to achieve its objectives, an effective synergy was required between the Department of Women and Child Development and the Ministry of Health and Family Welfare, the Department of Education, the Department of Drinking Water Supply and other ministries /departments to meet the requirements of health, sanitation, drinking water, pre-school education, etc.
- Accountability should remain with the State departments of Women and Child Development, but with increasing attempts to involve the Panchayati Raj institutions (PRIs) as partners.

ICDS in The Eleventh Five- Year Plan (2007-2012):

Regarding ICDS and strengthening ICDS for reduction of child malnutrition the plan document noted as follows:

The ICDS Programme reached a stage, where it became essential to harmonize the expansion of the programme and its content enrichment, in order to accelerate the implementation in achieving the core objectives of the programme especially to reduce the child malnutrition and help reduction in mortality rates. Addressing issues like prevention and management of malnutrition, poor maternal and adolescent nutrition, gender discrimination, lack of nutrition and health education, and inadequate community participation in the programme, continues to be a major challenge during the Eleventh Plan.

It further elaborated that after more than 30 years of rich experience in the programmatic perspective; a paradigm shift was required to reform the ICDS in respect of overall programme management for a faster and sustained achievement of child and women nutritional goals. During the Eleventh Plan, besides rededicating to promotion of early childhood care for survival and development of the children, an attempt should also be made to re-structure the ICDs programme implementation framework to suit the current national needs of the women and to strengthen the existing service delivery mechanism. This would not only help accelerate ICDS universalisation with quality to reach out to all under three children, but also help accelerating reduction in IMR, malnutrition and promoting early development.

Emerging Issues:

During the Eleventh Plan, many issues required renewed focus by revisiting the primary mandates of ICDS. Accordingly, the thrust areas during the Eleventh Plan were identified as under:

- Achieving ICDS Universalisation with Quality –norms/ population density- Targeting both in terms of areas and population groups.
- Strengthening basic infrastructure and service delivery in AWCs
- Restructuring Programme Management/ Revised ICDS Implementation Framework
- Strengthening HR management in ICDS
- Mobilizing Resources
- Addressing Nutritional Issues- Eradicating severe malnutrition
- Strengthening Nutrition & Health Education Advocacy, Communication and Social Mobilization
- Strengthening Training and Capacity development
- Strengthening Monitoring & Evaluation
- Fostering Public-Private and Community Partnership (PPCP)
- Strengthening partnerships with Panchayati Raj Institutions, NGOs and voluntary sector

Thus, it is observed that over the years, the planning of strategies for children in the country has evolved from welfare to development to rights approach.

Major Achievements of ICDS during 2009-10:

During the year 2009-10, an amount of Rs. 8200 crore was expected to be spent on ICDS against the expenditure of Rs. 6376 crore during 2008-09. As a result, there was a sizeable increase in operationalsation of Projects from 6120 to 6705 and Anganwadi Centre/ Mini-Anganwadi Centre from 10.4 lakh to11.5 lakh, representing a significant step forward towards universalization of ICDS.

State Governments/UTs were committed to implement the revised nutritional feeding norms issued on 24th February, 2009, including serving of morning snack and hot cooked meal to children between 3 to 6 years of age. In addition, severely malnourished children were to be provided with additional food supplements as Take Home Ration. 25 states/UTs reportedly switched over to providing hot cooked meal and 21 states started

serving morning snack. The other States were in the process of switching over to the revised feeding norms.

For effective convergence envisaged under ICDS, a joint letter with Department of Water and Sanitation was issued to the States/UTs for providing child friendly toilets in Anganwadi Centres under the Total Sanitation Campaign. The states were also advised to develop joint IEC material and activities on health and hygiene issues. A joint Mother and Child Protection Card was also finalized in consultation with Ministry of Health and Family welfare for use in both ICDS and NRHM for convergence of mother and child related indicators/services. For effective roll out of WHO growth standards, training of field functionaries was in progress. 1000 Master Trainers were trained during the year.

Current ICDS Scheme:

The integrated Child Development Scheme (ICDS) is one of the flag-ship programmes of the Government of India and represents one of the world's largest and most unique programs for Early Childhood Care and Education. It is the foremost symbol of country's commitment to its children and nursing mothers, a response to the challenge of providing Pre-school non-formal Education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other. The beneficiaries under the Scheme are children in the age group of 0-6 years and pregnant and lactating mothers.

Population Norms for setting up of AWCs and Mini-AWCs have been revised to cover all habitations particularly keeping in view those inhabited by the SC/ST/Minorities.

Revised Supplementary Nutrition Norms:

Children below six months are required to be exclusively breastfed by mothers. Supplementary Nutrition under the ICDS is primarily designed to bridge the gap between the Recommended Dietary Allowance (RDA) and the Average Daily Intake (ADI).

On an average, the effort is to provide daily nutritional supplements to the extent indicated below:

Beneficiaries	Calories (Cal)	Protein (g)
Children (6-72 months)	500	12-15
Severely malnourished Children	800	20-25
Pregnant and Lactating (P and L) mothers	600	18-20

Having recognized the fact that AWC as the platform of ICDS is the focal point of service delivery relating to health, nutrition and education, there has been upward revision in financial norms and nutritional norms of supplementary nutrition and enhancement in the honoraria of Anganwadi Workers and Helpers. Under the revised Nutritional and Feeding Norms for supplementary Nutrition, State governments/UTs have been mandated to provide more than one meal to the children who come to AWCs which include providing a morning snack in the form of milk/banana/egg/seasonal fruits/micro nutrient fortified food followed by a hot cooked meal. For children below 3 years of age and pregnant and lactating women, age appropriate take home ration (THR) is to be provided. Besides, for severely underweight children in the age group of 6 months to 6 years, states/UTs have been mandated to give additional food items in the form of micro-nutrient fortified food and/or energy dense food as take home ration (THR). (These norms have also been endorsed by the apex court in their order dated 22nd April 2009).

Registration of beneficiaries:

All 0-6 year children and pregnant and lactating mothers are eligible for availing of the services under ICDS. BPL is not a criterion for registration of beneficiaries under ICDS. The Scheme is universal in coverage for these categories.

Wheat Based Nutrition Programme (WBNP):

Food grains (wheat and rice) are also allotted by Department of Food &Public Distribution at BPL rates to the Ministry for allocation to the states /UTs under ICDS. Food grains given under the Scheme are used for preparation of items given as supplementary nutrition to the beneficiaries under the Scheme. During 2009-10, Department of Food and Public Distribution had allotted 5.82 lakh MTs of wheat and 3.44 lakh MTs of rice out of which 563936 MTs of wheat and 331670 MTs of rice were allocated to various States/UTs(as on 22.01.2010).

Existing Monitoring System under ICDS Scheme:

State Level:

Various quantitative inputs captured through CDPO's Monthly Progress Report (MPR) / Half Yearly Progress Report (HPR) is compiled at the State level for all Projects in the State. No technical staff has been sanctioned for the state for programme monitoring. CDPO's MPR captures information on number of beneficiaries for supplementary nutrition, pre-school education, field visit to AWCs by ICDS functionaries like Supervisors, Child Development Project Officer (CDPO) / Assisted Child Development Project Officer (ACDPO) etc., information on number of meetings on Nutrition and Health Education (NHED) and vacancy position of ICDS functionaries etc.

Block Level:

At block level, Child Development Project Officer (CDPO) is the in-charge of an ICDS Project. CDPO's MPR/HPR formats have one–to-one correspondence with AWW's MPR/HPR. CDPO's MPR consists vacancy position of ICDS functionaries at block and AWC levels. At block level, no technical post of officials has been sanctioned under the scheme for monitoring. However one post of statistical Assistant/ Assistant is sanctioned at block level to consolidate the MPR/HPR data.

In between CDPO and AWW, there exists a supervisor who is required to supervise 25 AWC on an average. CDPO is required to send the Monthly Progress Report (MPR) by 7th day of the following month to State Government. Similarly, CDPO is required to send half-yearly Progress Report (HPR) to State by 7th April and 7th October every year.

Village Level (Anganwadi Level):

At the grass-root level, delivery of various services to target groups is given at the Anganwadi Centre (AWC). An AWC is managed by an honorary Anganwadi Worker (AWW) and an honorary Anganwadi Helper (AWH).

In the existing Management Information System, records and registers are prescribed at the Anganwadi level i.e. at village level. The monthly and half yearly progress Reports of Anganwadi Worker have also been prescribed. The monthly progress reports of AWW capture information on population details, births and deaths of children, maternal deaths, and no. of children who attended AWC for supplementary nutrition and

pre-school education, nutritional status of children by weight for age, information and health education and home visits by AWW. Similarly, AWW's half yearly Progress Report captures data on literacy standard of AWW, training details of AWW, increase/decrease in weight of children, details on space for storing ration at AWC, availability of health cards, availability of registers, availability of growth charts etc.

AWW is required to send this Monthly Progress Reports (MPR) by 5th day of following month to CDPO In-charge of an ICDS Project. Similarly, AWW is required to send Half-yearly Progress Report (HPR) to CDPO by 5th April and 5th October every year.

Critique of ICDS:

Since the Integrated Child Development Scheme (ICDS) accounts for much of the public spending on nutrition in India, it may be instructive to analyze the impact of that scheme on child nutritional outcomes. Unfortunately, such an evaluation is stymied by the lack of availability of relevant data and by the fact that, by now the scheme extends to virtually every village in the country. As such, there are no 'control' villages that offer a counterfactual – viz., the prevalence of child malnutrition in the absence of the program.

However, at the time the NFHS-1 data were collected in 1992-93, ICDS did not fully cover all the villages in the country. Fortunately, the NFHS-1 village/community questionnaire obtained information on whether a sampled village had an ICDS anganwadi centre (AWC). (By merging the household information on child anthropometry and the village information on the existence of an AWC, it is possible to examine how the location of an AWC in a village is associated with child malnutrition levels in that village.)

The NFHS-1 indicates that 34.5%of villages in the NFHS sample had an AWC. Overall, the data show the child underweight rate (for children under 4) to be somewhat lower in the villages having an AWC than in the village not having one. (51% versus 55%) However, upon disaggregating the numbers by sex, it is found that the presence of an ICDS Anganwadi centre is associated with a much larger reduction for boys than for girls.

The Tamil Nadu Integrated Nutrition Project (TINP):

TINP programme is considered to be a role model for any child development programme. A brief description of TINP is given below and ICDS and TINP are compared and contrasted so as to bring about certain deficiencies of ICDS:

To this day, TINP relies heavily on local nutrition workers, working in conjunction with local women's and girls' groups. The groups are taught behaviour-change strategies. They learn to promote birth weight recording, regular monthly weighing, and spot feeding, while participating in community assessment, analysis, and problem-solving.

TINP links the delivery of health and nutrition services. Children who do not respond to the nutrition supplementation are provided health services, which include check-ups and referral, treatment of diarrhea, de-worming, and immunization. These services are also available to pregnant and lactating women. In addition, the programme includes intensive counseling of mothers in nutrition and hygiene education. Indeed, one study estimated that the annual recurrent costs of TINP were less than one-half of the ICDS program operating in Tamil Nadu, while it had an impact on severe malnutrition that was two times as much as the ICDS. The cost difference between the TINP and the ICDS arises almost entirely from the fact that the ICDS is a mass feeding programme, while the TNIP is highly-selective supplementary feeding program.

The fact that public spending on nutritional program is associated with lower rates of child malnutrition does not mean that increasing government nutrition expenditure is sufficient. There is considerable evidence that nutritional programs in India, such as the ICDS, national Mid-day meal program, and the various micronutrient programs, have poor coverage, targeting and implementation. The ICDS, for example, mostly focuses on children aged 3-6 years, but the consensus among nutritionists is that it is critical for direct nutritional interventions to reach 6-24 months old and pregnant women to prevent malnutrition (World Bank, 1998: 2001). Further, the ICDS anganwadi centre health worker – one per centre – is typically over burdened, as she has to manage pre-school education, supplementary feeding, and outreach activities. Another problem with the ICDS program is the frequent disruptions in food supplies that take place at the anganwadi centre. The responsibility for the food component of the program lies with the state governments, which typically under-finance this component owing to cost and

logistical difficulties. One evaluation of the ICDS found that disruptions in food distribution were very common at most anganwadi centers, with the average centre going without any food rations for 64 days per year (out of an intended 300 feeding days) (National Institute of Public Cooperation and Child Development, 1992).

But it is also the case that spending on direct nutritional programs is very low in India. It amounts to only 0.19 percent of GNP. In contrast neighboring Sri Lanka spends about one percent of GNP on direct nutritional programs (World Bank, 1998). A major World Bank report on malnutrition argues that, given the magnitude of the malnutrition crisis, India should be prepared to spend a minimum of 0.5 per cent of GNP on direct nutrition programs – more than double of what it currently spends (Ibid.). It goes without saying that the scaling-up of direct nutritional interventions would have to go hand in hand with revamped design, greater devolution, and better implementation of such interventions. The highly successful Tamil Nadu Integrated Nutrition Program (TNIP), which has been in operation for more than thirty years (and preceded the ICDS) in the state of Tamil Nadu, offers important lessons for the design of direct nutritional interventions.

ICDS in Maharashtra:

ICDS scheme was introduced in the Maharashtra state in 1975 in Dharni, Amravati district (rural block) and an urban area, Dharavi in Greater Bombay. Today, ICDS is almost universal.

Institute of Health Management, Pachod, Aurangabad, conducted an evaluation study of ICDS in the state of Maharshtra in 1996 (*Social Assessment: ICDS III Maharshtra*) for the Department of Women and Child Development, Government of Maharashtra, with support by UNICEF, Mumbai.. They had selected four urban slums in Pune.

During the process of research they conducted surprise visits to four Anganwadi Centres in the Urban Slums. (pp.67) The researchers observed that during the surprise check, two of the four AW centers were closed. In the other two centres, the AWW had left the slum by 12.30 pm. The households living in the vicinity of the AW centers reported that the Anganwadi was usually opened at 10.00-10.30 am. The AWW used it mainly as a food distribution centre. Pre-school education was not regular and was conducted for a very short duration.

Many children came to the Anganwadi just prior to food distribution, collected their supplement and went home. Some older children also came and collected food for their mothers.

The play materials available at the centre were limited. The children sat rather passively in the centre only repeating the songs, alphabets and numbers. Creative and participatory learning was absent.

Records maintained by the AWWs were not complete. It was observed that some of the registers were not properly filled and there were mistakes which had not been checked and corrected by the supervisors.

Only one anganwadi was an exception where strong parental monitoring and participation was observed.

The above study concluded that the ICDS needed better social targeting to respond to the needs of the children. It suggested to consider the following points to have a better targeting of children:

1. A high proportion of the children in urban slums suffered from severe malnutrition.
2. Routine ICDS data did not reflect the real prevalence of severe malnutrition.
3. There was no evidence to indicate that the prevalence of severe malnutrition in the ICDS areas was lower than in the non-ICDS areas.
4. The bulk of severe malnutrition was in the age group of 0-3 years
5. Most ICDS areas reported a larger number of boys benefiting from AWCs compared to girls.
6. Other studies reported that the prevalence of severe malnutrition was two to three times more among girls as compared to boys.
7. Since ICDS had an infrastructure of community based grass -root level workers, it was well-equipped to provide curative health services for endemic illnesses and minor ailments. But, the community did not perceive the AWW as a health provider. Nor did AWW see health care as one of her primary roles. The health sector did not provide her the support that a primary level health care worker requires. Redefinition of these roles was required.

8. There was no evidence to support that the nutritional supple-mentation had any impact on the prevalence of severe malnutrition. To have better impact, it should be provided to children under three years of age only.

The study documented the community perceptions about the AWW as follows (p.168):

The community felt the need for monitoring the work of AWW. But the perception of the community was that she was not accountable to them. The statement, "The AWW … is a government employee. She is a salaried worker. Why should she be concerned for the poor ..?" was repeated by more than one women's group. This shows the lack of control the community felt over the AWW. At the inception of the ICDS, she was envisaged as an integral part of the community. Over the years the emphasis on administrative control over the AWW distanced her from the community as she was being perceived as part of the system. Accountability to the community can result if the community perceives a stake in the programme. The community did have the potential to effectively supervise and monitor the programme.

On management issues of AWW, the study observed as follows:

1. The selection of some AWWs was on the basis of local political influence. Therefore the performance of the AWWs was poor. The criteria for selection needed to be reviewed and applied more strictly in the future.
2. Some AWWs never went for training.
3. Monitoring and supervision were weak because of poor system and supervisory structure.
4. The ICDS could respond effectively to the needs of women and children only if there was inter-sectoral coordination with the health education and rural development sectors.
5. The AWW required strengthening in micro-planning to enable her to respond more effectively to the needs of her community.
6. NGOs could facilitate the monitoring of the programme they could also develop regional training centers.

The above-mentioned study made the following constructive recommendations (pp.173-178):

1. **Growth Surveillance**:

   (a) Weighing of children on a monthly basis needed to be restricted to the age group of 0-3 years only. This would also reduce the work load of the AWW.

   (b) Decentralised weighing during house visits with the definite role should be assigned to the helper.

2. **Nutrition Education:**

It should focus on increasing the frequency and quality of food given to the child.

3. **Inter-sectoral Coordination:**

There is a need for establishing stronger linkages between the health and ICDS department.

4. **Redefinition of the roles of AWW and helper:**

Functional analysis and redefinition of the roles of the AWW and helper needed to be done. There was need for better division of labour between AWW and the Helper. The Helper could be given the responsibility of being the community –based worker who would do the distribution of the nutrition supplement and the counselling at the family level. The AWW could be given the responsibility of preschool education at the Anganwadi. She could also check the work of the Helper at the time of the household visit for the growth surveillance.

CHAPTER 3

PROFILE OF THE STUDY AREA

This chapter presents a brief description of the study area based on information from secondary sources especially from censuses. The main purpose of this chapter is to provide detailed information of the study area with a view to understand the socio-economic profile of the study population. A good understanding of the study area would enable to place our survey results in a proper perspective.

History of Malegaon

Since the majority community in Malegaon is Muslim, it is imperative to acquaint ourselves with the background of Malegaon Muslims. Describing the numerical dominance of Muslim community in Malegaon, a scholar writes "it is one of the few towns which is believed to be dominated by Muslims mostly from artisan background, a town where Muslims have lived with considerable dignity and authority and have found a safe haven in times of trouble" (Rajeevlochan, 1996: 673). Further the culture of the town is distinctly Muslim. The large number of masjids, the dresses worn, the language spoken all seem to distinguish the Muslim weavers of town from the surrounding countryside which is predominantly Hindu.

Advent and Growth of Muslim Community*:

About 200 years back, Malegaon was a kasba (a small place) and was called Maliwadi (hamlet of gardeners). One of the Sardars of Bajirao Peshwa, Naroshankar, was given 18 villages including Maliwadi as a jagir by a Commander of Mughal forces Badshah Muhammad Aizuddin Gazi. Naroshankar made Maliwadi his residential quarters and started constructing a fort in 1740, the construction of which took around 20 years to be completed. For building the fort Naroshankar invited a number of engineers, stone cutters and _____

***** There is hardly any literature available in English on Malegaon Muslims. However there are a few books available in Urdu: *Muslim Biradari ki Tahzibi Tareekh* by Momin Moiuddin, *Naqush-e-Malegaon* by Hafiz Malegawi and *Majra-e-Vatan* by Shabbir Hakim. Most of the material included in the review on Malegaon Muslims has been borrowed from these books.

Artisans, who were mostly Muslims from the north, especially suburbs of Delhi. This was the first time a sizeable number of Muslims came to settle in Malewadi. These Muslim artsians also brought their language Urdu for the first time to Malewadi. Some of the Muslim artisans came from Surat and Broach too. The artisans lived in bastis (settlements) opposite the fort, across the river which is today known as Sangmeshwar. After coming of Muslims, Malewadi became Malegaon.

Besides Arab, there were some Egyptian soldiers in the army of Malegaon. Gopalrao also had a few Rohilla Sepoys serving him. Both Egyptians and Rohilla soldiers were Muslims. The first Idga (where Idd prayers are performed) in Malegaon was built by one of the Rohilla sepoys Dilawar Khan in 1816. Gopalrao was a disciple of Bhikhan Shah, a Muslim saint, whose grave even today exists at the confluence of Mosam and Girna.

When the British captured the Malegoan fort in 1818, they invited Muslims of Hyderabad from Nizam's territory to Malegaon. Some Muslims migrated from Hyderabad to Malegaon, and most of them were settled in the cantonment area. After the mutiny in 1857, many Momins, the largest number of Muslims ever to migrate to Malegaon, came from North India to Malegaon in search of security. In 1863, Muslims from Banaras who were mostly weavers, as there was a famine around this time, too migrated to Malegaon. Thus, it appears that the Muslim community in Malegaon grew from waves of migration particularly from north.

The *Nasik District Gazetteer*, 1975 of India mentions that there were 300 Arab soldiers in the army of Gopalrao Raje Bahadur, descendant of Naroshankar, and they fought valiantly in the war against the British in 1881 till the end. After the British won, the soldiers were deported from Malegaon.

Profile of Malegaon City:

Malegaon is one of the 19 towns in Nasik district. It is the second largest city in the district in terms of population size, the first being Nasik city itself. Malegaon is the head quarters of Malegaon sub-division and Malegaon tehsil. The city has an area of 12.95 sq. km. The nearest city with a population of over one lakh is Dhulia, 51 km away. The city is well -connected to other parts of the state by roadways.

Demographic Profile:

The population figures given in the census publications for Malegaon city from 1901 onwards (Table 3.1) are not directly comparable as the information about the change in the geographical area over the period is not given for the period prior to 1961. Yet, according to one estimate, the Malegaon population has grown 23 times in the past 100 years, from 14,502 in 1818 to 3,42,595 in 1991 (adjusted for territorial changes). In 2001, it was 4,09,403.

The very high population growth rate observed during 1951-61 seems to be partly due to increase in the area of the city and immigration. In 1952 the Camp, a locality adjoining the town, was included in Malegaon municipality. During 1961-71 very high growth rate is observed which may be due to migration.

Malegaon in 1991 and 2001 contributed one–fourth of the Nasik district's urban population and one per cent of Maharashtra's urban population. In the earlier censuses (1971 and 1981) too the share of Malegaon in total district urban population was slightly above one quarter.

Table 3.1: Population, Decadal Growth Rate for Malegaon City 1901-2001

Census year	Population	Decadal Variation
1901	19,054	-
1911	19,060	0.03
1921	23,505	23.32
1931	29,442	25.26
1941	36,780	24.92
1951	55,022	49.60
1961	1,21,408	120.65
1971	1,91,847	58.02
1981	2,45,883	28.17
1991	3,42,595	39.33
2001	4,09,403	19.50

Source: District Census Handbook, Nasik 1981, Primary Census Abstract 1991 Census and 2001 Census.

A distressing feature of Malegaon is that a considerable proportion of its population lives in slums. According to the *Malegaon City Sanitation Plan* (2012) fifty-five per cent of total population in Malegaon lives in 129 declared and undeclared slums. In the slums, civic and other amenities are usually poor. For instance potable water, one of the basic necessities of life, is quite inadequate. The waste disposal is through sewer. The families living in the slums have no private latrine.

"Malegaon has seen the infrastructure and quality of life deteriorate over the years. While population has grown from 1.21 lakh in 1961 to an estimated four lakh people now, the roads, drainage systems and educational facilities are poor. Around 55 per cent of the residents stay in slums and 44,173 of the 71,245 households lack toilets. There are almost no open spaces, water supply is erratic and literacy rate is a dismal 35.5 per cent for women. Half the children are delivered at home and public health facilities are not able to cater to the population" (*Malegaon City Sanitation Plan*; 2012, p. 10-11).

Economic Profile:

Crude activity rate reports about the level of activity in population whereas industrial composition of workers gives the type of activity being carried out. Table 3.2 indicates that the crude activity rates for both males and females are low. In 1991 they became lower than they were in 1971. The decrease was more pronounced for the females. In 2001, these rates have improved marginally.

Table 3.2: Crude Activity Rates for Malegaon City by Sex: 1971-2001

Census Year	Male	Female	Total
1971	45.16	9.87	28.16
1981	46.56	11.46	29.49
1991	44.97	6.50	26.12
2001	45.70	6.57	26.53

Source: 1971, 1981, 1991 and 2001 Census Report.

In 1991, the crude activity rates of total population, males and females for Nasik (UA) were 31.13 and 48.45 and 11.08 respectively. Compared with the above rates, the crude activity rates for Malegaon city in 1991 are lower by 4 to 5 percentage points. In 2001 also, the same trend is observed. For urban Nasik, the rate for males was 50.5, females 12.0 and for total population 32.3.

Malegaon is one of the most important powerloom centres in the Western India. The major industry, in Malegaon has been weaving where the dominant community (Muslims) is mainly engaged. Other industries of some importance are those of making ropes, brooms, mats and baskets. There are also a few ginning and pressing factories and oil mills.

Malegaon mainly produces grey cloth. It also manufactures power-loom spare parts. Malegaon exports grey cloth, handloom saris and mutton. It imports cotton yarn, food grains and chemicals.

In general industrial activity in Malegaon town is predominantly power loom based which forms the main source of income and is also considered as a backbone of livelihood. But apart from the powerloom industries, the other important industries are agri-industries, plastic pipes manufacturing; cotton spinning, ginning, oil mills fabrication. The manufacturing and lime factories etc. contribute to industrial base in Malegaon.

Textile units based in Malegaon have contributed to Malegaon economy in a major way. More than 80,000 persons are employed in 1,10,000 units. After India became one of the signatories to GATT Agreement and fall of the consolidated Russian market on which India depended, the local textile based economy got adversely affected. With the reduction in government subsidy and the textile units in Malegaon being unable to respond to the quick changing market realities by adopting latest technology by making further capital investments, the situation further deteriorated. This led to cascading effect and related ancillary units got severely affected. Factory workers got unemployed. As a result, overall tone of trade and commerce got severely affected because the purchasing power of the citizens reduced.

Social Profile:

Housing and related conditions, availability of medical and educational facilities can be good indicators of development of an area. In 1991 the numbers of residential

houses were to 45,648 while the number of households was 48,782. The housing shortage was 3,134. In 1991, on an average, there were 7 members in each household in Malegaon (Table 3.3). Thus the average household size for Malegaon was large. The majority of the available houses were of one room tenements where three-fifths of the households were living. Thus, Malegaon households were overcrowded.

Table 3.3: Percentage Distribution of Households and Average Household Size by Number of Rooms in the house Malegaon city 1991*****

Number of Rooms	Percentage of Households	Average Household Size
No Exclusive Room	00.00	-
One Room	66.94	5.94
Two Rooms	24.47	6.51
Three Rooms	04.70	6.97
Four Rooms	02.30	7.00
Five Rooms	00.62	6.96
Six Rooms	00.97	7.55
Total	**100.00**	**6.98**

Source: Census of India 1991, Series 4, *Tables on Houses and Household Amenities Maharashtra.*

Structural Condition of the Building

As per 2001 census the number of occupied houses in Malegaon town is about 55,611 houses. Most of the structures in the developing area of Camp, Sangameshwar (western part of town) are modem. A type structures are with burnt brick walls and plastered with cement.

- In Camp Gaothan a type new structures are coming up in place of old structures.

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* Since no segregated data are available for Malegaon on household size in 2001 census, the 1991 census data.is used

- In Malegaon and Sangameshwar goathan there are old B and C type structures and new A type structures are coming up mostly along main roads.
- In the eastern part of the town (outer areas of Malegaon) C and D type of structures with wooden plank partition walls and tin sheet roofs are predominant with intermittent A type of structures coming up.

Table 3.4 : Type of Structures, 2001

Area	Total number of household	Type of census houses			
		Permanent (A)	Semi-per-manent (B)	Temporary (C)	Unclassi-fiable (D)
Maharashtra (Urban)	8,069,526	6,587,266	1,279,213	1,93,919	9,128
		81.63	15.85	2.40	0.11
Nashik District (Urban)	347,043	2,41,365	92,176	12,681	821
		69.55	26.56	3.65	0.24
Malegaon Tehsil (Urban)	62,673	27,004	33,703	1,963	3
		43.09	53.78	3.13	0.00
Malegaon City (Urban)	55,611	22,672	31,516	1,423	0
		40.77	56.67	2.56	0.00

In 1991 the entire city was provided with tap water. According to 1991 census, in urban Maharashtra only 91 per cent of the households had access to safe drinking water. In 1991 the numbers of domestic electric connections were 23,232 and the percentage of households with electricity was 76 per cent. In urban Maharashtra, according to 1991 census, 86 per cent of the households had electricity.

Health Facilities in Malegaon

Table 3.5 : Health Infrastructure in Malegaon City, 2001

Sr. No.	Description	No.
	Municipal Corporation	
1	Hospitals (Maternity center)	2

Sr. No.	Description	No.
2	Clinics	4
	Private Authorized	
3	Hospitals	40
4	Nursing Homes	10
5	Dispensaries	49
6	Clinic Lab	08
	Private Unregistered	
7	Hospitals	01
8	Nursing Homes	50
9	Dispensaries	266
10	Clinic Lab	32

A rural hospital at Satana Road is operated by Government and two hospitals and four clinics were run by Municipal Corporation. Though city is having a number of hospitals, it lacks Government Hospital which will provide the major health related facilities. Two authorized Blood Banks are functioning in Malegaon

Educational Facilities

"In 2001, Malegaon is still very backward in educational activities, though it is connected very closely to the prominent cities of Nashik, Dhule. As per the Census of 2001, out of total population of 409403 only 265862 i.e. 65 per cent, which is a very low rate of literacy as compared to the other Cities in Maharashtra State.

There are around 28 High schools and 5 colleges available in the city. Apart from these colleges, Malegaon is having four ITI colleges, one is a Government College and other three owned by private institutions.

Malegaon is having one Muslim Madrasa known as "Jamatul Swaliyat" which gives the education to Muslim girls in the city. One more Muslim institution "Mansura" is meant for providing high quality education to Muslim community students. The

Muslim students from all over the country as well as world have come to learn in this Mansura." (Ibid.:16)

Religious Composition:

In addition to above it would be appropriate for the present study to know the religious composition in the study area. According to 1991 census, Muslims formed around three fourths of the total population of Malegaon. The next major community was Hindu (Table 3.6). In 1991 Malegaon had very small proportion of SC and ST population, 2.87 and 1.52 per cent respectively between 1981-91, the proportion of Muslims in the total population of Malegaon increased substantially while that of Hindu, Buddhists and Jains declined. It seems during this period immigration of Muslims and out migration of other religious groups has taken place

Table 3.6: Percentage Distribution of Population, by Religion for Malegaon City, 1971-1991+

Religion	Percentage distribution of population		
	1971	1981	1991
Muslim	67.51	67.49	72.92
Hindu	27.45	27.65	23.31
Buddhist	03.66	03.35	02.70
Jain	01.31	01.43	00.98
Christian	00.05	00.13	00.05
Sikh	00.01	00.04	00.03
Not Stated	00.01	00.01	00.01
All Religions	**100.00**	**100.00**	**100.00**

Source: 1971, 1981 and 1991 census reports on religion.

Findings from Mistry's Study:

In 1996, Mistry M.B., conducted a demographic study with a sample of 800 households in Malegaon city on the Muslims. Her findings on the living conditions of Muslims in Malegaon city can be briefly recapitulated as follows:

Most of the Muslims in Malegaon exist at subsistence level and belong to the lower stratum of society. Their standard of living is low as they live in small one room tenements or slums. Their streets are narrow and congested with uncleared garbage heaps after every three or four houses and open drains being a common sight. Water is supplied through common connections at street comers and the toilets are community toilets located at distant corners of Municipal wards.

"Three-fifths of the households live in nuclear families and the average households size is large (7.8 per cent per household). Three-fourths of the households earn Rs. 2000 per month and the per capita monthly income is Rs. 200 only. Housing conditions are poor. More than four-fifths had no toilets

Within their premises almost all the households have access to safe drinking water. Four-fifths of the households had electricity. The data on possession of consumer durables reveal that most of the households are from lower socio-economic stratum. Standard of living index too indicates a low level of standard of living for Malegaon Muslims. (Mistry, 2001: 68, 97)

FINDINGS FROM TISS STUDY:

A most recent survey was carried out in Malegaon city (in 2011) by Tata Institute of Social Sciences (TISS), Mumbai. Besides using data available from government and non-government sources, this study conducted a sample household survey from every ward in the town along with the focus group discussions and in- depth interviews with relevant officers/population groups. A total of 2354 families/ households were covered by this sample survey in Malegaon city.

The findings from this latest survey regarding socio-economic conditions in Malegaon city are as follows:

- Approximately 80 percent of the town's population is Muslim. In most of the wards the average family size is more than 7 persons.
- The sex ratio, as per Census of India 2001 data, for the town as a whole is 960, while for the slum population it is 957.

+ For 2001 census, the religious composition for Malegaon is not separately available. So 1991 figures are used.

- OBCs have the largest share of population. Among Muslims 21 sub caste communities are identified. Among these sub-categories, Ansaris constitute the largest group followed by Sheikhs and Pathans. There are more than 40 sub-caste/ groups among non-Muslims, and Mali, and Marathas constitute relatively larger share of the non-Muslim population.
- Among Muslims, Urdu is the predominant language and mother tongue for 99 per cent of the population. At the aggregate level, 79.3 per cent of households report Urdu as their mother tongue.
- Work participation rate (WPR) in Malegaon is relatively low. Census of India 2001 data show that WPR in the town is 26.5 per cent for the total population. Specifically, the female WPR is extremely low, only 6.6 per cent.
- Main workers constitute about 27 per cent of total workers in Malegaon. The female main workers constitute only 3.2 per cent of the total main workers.
- More than 50 per cent of the population is either attending educational institutions or domestic duties only.
- The unemployment rate is higher among Muslims than non-Muslims in the town.
- The average income per worker per month in the town is below Rs. 911. This works out to be about Rs. 30 per worker per day. The average earning by Muslim workers is even lower, about Rs. 26 per day, while the average earning by the non-Muslim worker per day is about Rs.53.
- 56.5 per cent of the total population in the town lives below poverty line. The incidence of poverty among Muslims (60.7 per cent) is considerably higher than the incidence among non-Muslims (35.1 per cent). About 80 per cent of Muslim population has per capita income below Rs. 1000.
- Most of the Muslims terminate their formal education at the Middle or High School levels.
- Among Muslims, the share of population having technical and professional degrees is much lower than that among non-Muslims as a whole.
- Although there are a number of health clinics and hospitals in the town, the quality of health services is unsatisfactory.

- Most of the children among Muslim community are dying because of malnutrition and underweight.
- Only about 16 per cent of families report access to ICDS/Anganwadi/Balwadi centres. And there are not many variations among socio-religious categories (SRCs) regarding the access.
- About half of the deaths among Muslims in the town take place in the age-group below 5 years of age.
- About 50 per cent of the families in the town live in slums in the city.
- In about three-fifths of the surveyed Muslim families, 5 or more persons live per room.
- Only about one-third of families in the town have latrines in house premises About 70 per cent of families have separate bathrooms. Although, 72 per cent of households use tap water, only about 49 per cent say that water is adequately supplied to meet their consumption needs.
- Public toilets are conspicuously absent in the town and particularly in Muslim concentrated areas.

In 2011, the Tata Institute Sample Survey conducted in Malegaon city too vividly documented the backwardness or lack of development of social and economic infrastructure there

Conclusion:

To conclude, a review of the facilities in Malegaon city historically and present times from the sources such as census and sample surveys reveal that it is a socio-economically backward area. Thus, the low standard of living to which the people of Malegaon are used is well recorded. It seems during the last two decades not many positive changes have taken place in this city.

CHAPTER 4

PROFILE OF THE RESPONDENTS

Housing and Household Characteristics of Sample Population:

In order to assess the economic background of the sample population the conditions in Malegaon slums with those of slums of Mumbai and Nagpur is compared and presented in Table 4.1. Selected indicators like type of house, type of drinking water, source of lighting and type of sanitation depict the housing condition while the possession of consumer durables indicates their spending capacity.

It is observed, as expected, that Malegaon slums have the largest number of Katcha houses (28.7%). Mumbai slums have 97.6% of the houses with Pucca structure, while Malegaon slums have only 11.6% of houses with Pucca structure. Mumbai slums although being large in volume seem to have better houses. As far as the source of lighting is concerned, in fact, there is no need of looking into the figures, as almost all the households are electrified. Similar is the case of water supply. Ninety five percent of the houses in Malegaon slums and almost 100% of the houses in Mumbai slums get drinking water from 'Tap'. Nagpur slums seem to have about 12 percent of the households getting water from Hand-pump or well. The findings regarding sanitation facilities are shocking. About 24 percent of the households have 'No Toilet'. Malegaon slums are followed by Nagpur slums with 12.5 percent of the households having 'No Toilet'. This is an indication of the potential risk of infection particularly for the children. As usual Mumbai slums share (74%) a public toilet and 21% have flush toilet of their own. Nagpur slums have 10% of the households having 'Pit Toilets'. In short, Malegaon slums are in the worst state of housing conditions.

Possession of Consumer Durables:

As far as the articles like T.V., Fan and Water/Clock are concerned, all the three slums have large proportion of households possessing them. Now days they have become necessities. In case of 'cycle', Mumbai slums lag behind and that is natural, since Mumbaiites mostly use public transport. Expectedly, maximum possession of Refrigerator is found in Mumbai slums. Surprisingly among the three slums, Nagpur

slums have the largest proportion of users of two-wheelers (29%). On the whole, it appears that slums in Mumbai have better living conditions.

Table 4.1: Housing and Household Characteristics of the Slum Population of Malegaon (2011) compared with those of the Slum Population of Mumbai and Nagpur (2005-06)

Malegaon Study	Malegaon Slum (%)	Mumbai Slums (%)	Nagpur Slums (%)
Type of House			
Kutchha	28.7	00.1	01.0
Semi-pucca	69.7	02.4	29.0
Pucca	11.6	97.6	70.0
Type of Sanitation			
No Toilet	23.9	01.6	12.5
Pit Toilet	03.5	02.3	10.5
Flush Toilet	02.5	21.4	51.6
Public Toilet	70.1	74.7	25.4
Type of Drinking Water Supply			
Hand Pump	05.0	00.2	07.6
Well	00.1	00.0	04.9
Tap	94.9	99.8	87.5
Type of Lighting			
Kerosene	00.3	00.5	09.3
Electricity	99.3	99.5	92.7
Others	00.4	00.0	00.0
Possession of Consumer Durables			
Radio	39.9	40.9	34.5

Malegaon Study	Malegaon Slum (%)	Mumbai Slums (%)	Nagpur Slums (%)
T.V.	79.7	79.7	76.6
Fan/Cooler	97.2	94.4	82.0
Watch	93.0	91.3	87.8
Sewing Machine	33.2	18.67	27.6
Refrigerator	12.3	36.5	21.3
Cycle	82.5	13.7	72.5
Two-wheeler	16.4	11.1	29.3
Tractor	3.4	0.0	0.2
Car/Jeep	3.5	2.5	3.0

Background of the Respondents' Households:

The information available about the households pertains to the following items:

i) Caste and Religion of the household

ii) Household size and composition of sex and age

iii) Information of age, education and occupation of the head of the household

iv) Highest Education attained in the family

v) School Attendance of children aged 7-14 years by sex

vi) Reasons for not attending school

vii) Monthly Consumption Expenditure on major items such as Food, Education and Medical Treatment.

viii) Ownership of selected consumer durables.

There are in all 2081 households, the data for which are analysed.

To start with the sex-composition of the heads of households is examined. It is found that about 90% of (89.8% to exact) households are male-headed households. As per NFHS-III (20005-06), 86% of the sample households in Mumbai slums and 84% of

the sample households are male headed households. Malegaon sample comes up with a slightly higher percentage of male-headed households. However, the difference is not significant.

The sample households are mainly Muslim. About 92% of the households are Muslim, 97, i.e. 4.7% are Nav-bouddha and remaining are others.

Household Size and Composition of the Household by Sex and Age:

Before examining the data it is necessary to mention that the sample is not a random sample. Households have been selected from the list of households with an ICDS beneficiary (child). Hence, the sample consists of higher percentage of children aged 0-6. The following table gives the classification of the household population by age and sex.

Table 4.2 : Household Population by Age and Sex, Malegaon Slums, 2010

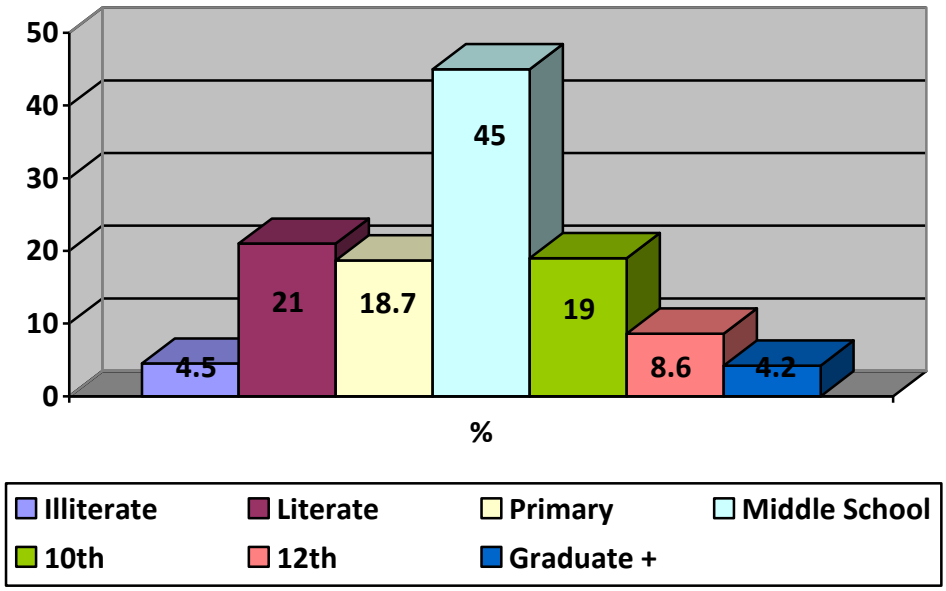
Age	Male	Female	Total
0-6	2379 (28.1)	2381 (27.6)	4750 (27.8)
7-14	1308 (15.4)	1487 (17.2)	2795 (16.3)
14+	4778 (56.5)	4770 (55.2)	9558 (55.9)
Total	**8475**	**8638**	**17113**

As per the 2001 census data on slums, it is observed that in the slums of Malegaon, the proportion of children aged 0-6 years is 20.6%, while it is 13.3% for Nagpur slums and 13.2% for Mumbai slums. As anticipated the proportion of child population for in the sample is still higher (27.8%), because of the sampling design. The average household size is 8.2 (Malegaon sample), while the 2001 census comes up with average household size of 7.2 (Malegaon slums), 5.3 (Nagpur slums) and 4.9 (Mumbai slums). The comparative trend is in the expected direction.

Highest Education attained in the Family:

This is slightly an unusual indicator for assessing the educational levels. The information on 'Highest Educational Attainment", education attained by children aged 7-14 years and educational level of the head of the household. The following table shows the distribution of the households by 'Highest Educational Attainment.

Table 4.3: Distribution of respondents by 'highest educational attainment'



It is quite clear that the educational levels in Malegaon Slums are very low. More than half of the households have just 'Middle School (i.e. 7th) as the highest level. As per 2001 census, the literacy level for Malegaon slums is quite low. It is 56.3%, while the same for Mumbai slums and Nagpur slums is 72% and 74% respectively. Low educational level could be one of the important reasons for the miserable conditions, in which the respondents are living. In the next section the data on the educational level of the head of the household, is studied which might confirm the above findings. The following table gives the information on these characteristics.

Table 4.4 : Age, Education and Occupation of the Head of the Household

Age

	<20	20-30	30-40	40-50	50-60	60-70	70+	Total
Head of Hh.	4	252	619	373	320	357	156	2081
%	0.2	12.1	29.7	17.9	15.4	17.2	7.5	100.0

Education

	Illiterate	Literate	≤ 4th	5 th-7th	8 th-10th	11th-12th	≤ Gradt.	Total
Head of Hh.	599	90	586	516	200	56	33	2081
%	28.8	4.3	28.2	24.8	9.6	2.7	1.6	100.0

Occupation

	Labour	Regular Employee	Small Business	Skilled Worker	Pen-sion	House-keeper	Oth-ers	NG	Total
Head of Hh.	1346	34	188	95	10	205	191	12	2081
%	64.7	1.6	9.0	4.6	0.5	9.9	9.2	0.6	100.0

The data on educational level and occupation are suggestive of the socio-economic background of the household. It is surprising to find that as good as 29% of the heads are illiterate and 4% are not educated. As found earlier, the low level of education in Malegaon Slums is of a serious nature and needs equally serious attention. As a result of low levels of education, the occupation of the heads of households is also of a low level. About 65% of them are just labourers. They are working either in Handloom or Power loom factory. Only 13-14% of them are engaged in skilled work or could be having a small business - overall, one gets a clear indication of the low levels of occupation of the sample households. From the sample the information firstly on consumption expenditure on food, education and medical treatment and secondly on the possession of goods is collected. It is a common experience that data on

income/expenditure are not very reliable, since they suffer due to the reporting biases arising out of recall lapse. It is found that the prescribed monthly expenditure categories are only up to Rs. 4000/-. The last category is 4000/-+ and one-third households are in this category which is not quantifiable in exact terms. The median is Rs. 3700/-. Since this is expenditure only on food, education and medical, an adjustment was necessary to get the total income. Using N.S.S. data on consumer expenditure for 2009-10, one could come to a broad estimate of Rs. 5000/- per month. In terms of per capita expenditure, the estimate is Rs. 625/- per month. If one compares this with the NS.S. data, it fits in the first decile of the ascending trend of consumer expenditures. It means that the bottom 10 percent have this much income. It is enough to imagine the kind of economic condition of the sample household.

After having examined the poor condition in case of adult education and income, let the issue of education of children is studied. An attempt is made here to see whether the children, at least, are attending school or no. Fortunately, the data on education of children aged 7-14 years is available. There are in all 2795 children aged 7-14 years. However, the information on educational status is available only for 2461 children. Out of these 2285 children are attending school. The proportion is 93% which compares well with that of Mumbai and Nagpur Slum (93% and 91% respectively). It is a ray of hope. Although, the overall attendance may appear reasonable, the reasons for non-attendance should also be studied. It appears that 'drop-out' is more prevalent than non-enrollment. Drop-out is either due to failure in examination or 'no importance' on the part of parents. Both the situations need serious attention.

CHAPTER 5

ASSESSMENT OF ICDS ACTIVITIES

I Demographic Characteristics of Children, Supplementary Nutrition & Pre-School Education at the Anganwadi:

One of the important objectives of the ICDS scheme is 'to improve the nutritional and health status of children in the age-group 0-6 years' Correspondingly, Supplementary Nutrition tops the services to be provided by the Anganwadi centre. Similarly, ICDS also intends 'to lay the foundation for proper psychological, physical and social development of the child' and hence one of the services of the Anganwadi centre is 'pre-school non-formal education!

The brief introduction makes it clear that this section has three parts. The first part deals with the demographic characteristics. The second part is about the supplementary nutrition at the Anganwadi and the third part deals with the pre-school non-formal education.

Demographic Characteristics:

Out of the 2081 children, the information on age is available for almost all i.e. 2069 children. Since the age is recorded in AWC register, it is expected to be at least near to accurate. But it does not appear so. The digital preference is reflected in the reported age. Further, since the children are beneficiaries of the ICDS, their age-distribution may not be comparable to the normal age-distribution, in spite of the eligibility open for all children aged 0-6 years. Majority of the children could be of ages 3-6 years, as firstly, the mothers may feel reluctant to leave the younger (0-3 years) children in the Anganwadi and secondly, since pre-school education is given to children 3-6 years old, the children of this age will be admitted to the Anganwadi. With all these considerations, the age-sex-distribution of the beneficiary children is as follows.

Table 5.1 : Age-distribution of Child Beneficiaries

Age (Years)	Boys	Girls	Total
0-1	70	73	143
1-2	158	119	277
2-3	184	182	366

Age (Years)	Boys	Girls	Total
3-4	223	245	468
4-5	238	233	471
5-6	202	142	344
Total	**1075**	**994**	**2069**

As mentioned in the proceeding paragraph, there is a majority of children aged 3-6 years. But one surprising thing is about the strikingly low sex-ratio for the last age-group, i.e. 5-6 years.

Admission and Attendance at Anganwadi:

As per the rules, the children become eligible for admission at the age of 6 months. The data show that by the age of 8 months, 99% of the children were admitted to the Anganwadi. Ninety-seven percent of the admissions have been on account of the advice of the Anganwadi Worker (AWW) or Anganwadi Helper (AWH). When asked about the benefits to the children, the mothers have reported 'Food' as the benefit in 95 percent of the cases. However, it needs to be mentioned that 60% of the mothers have reported 'Food, education and Immunisation' as the benefits. Although this is not an unexpected finding, it makes one point clear once again that supplementary nutrition is the major attraction of an Anganwadi. In other words, if the Anganwadi programme has to be successful, the component of 'supplementary nutrition' has to be strong.

'Attendance': It is revealed that 31.6% children do not attend the Anganwadi regularly. This proportion is big enough for ignoring. And that is why, it is necessary to examine, who are these irregular attendees? Are they girls or are they younger children? It is seen that there is no difference by sex. The following extract gives the information about age pattern.

Age (Years)	Irregular Attendances
0-1	117
1-2	251
2-3	255

3-4	16
4-5	5
5-6	2

The above extract makes it very clear that the children aged 0-3 years are seldom sent to the Anganwadis. It is revealed that the children being too young, cannot be left to the care of AWW, who has to look after about 100 children. In fact their attendance is only expected for taking the 'Take Home Ration' only. Earlier, it is observed that the admission rate of the young children is low and now it is observed that their attendance is totally irregular. If this observation is not specific to Malegaon slums, the authorities need to give a serious thought to admitting the younger children to Anganwadis. The NFHS-III (2005-06) also shows that the percentage of children aged < 2 years, with 'any' services from AWC is 35%, while this proportion for the older children was 55%. This observation, in a way, means that it is mainly the children aged 3-6 years, who are getting benefits of the Anganwadis. For those, who are attending, the attendance is on an average 23 days in a month, which is near to complete. (IHMP study)

Supplementary Nutrition:

As per the guidelines of the ICDS (A publication of ICDS), following are the nutritional norms:

Supplementary nutrition per beneficiary per day

	Calories (K Cal)	Protein(g)
1. Children (6-72 months)	500	12-15
2. Severely malnourished children	800	20-25

VII Guidelines for Type of Supplementary Nutrition:

1. **Children aged 0-6 months** - For children for this age-group the authorities may ensure continuation of guidelines of early initiation of breast-feeding (within one hour of birth) and exclusive breast-feeding for children for the first 6 months.

2. **Children in the age-group (6 months - 3 years)** - For children in this age-group the practice of Take Home Ration (THR) is followed.

However, in addition to the current mixed practice of giving either dry or raw ration, it is suggested that THR should be given in the form that is palatable to the child instead of the entire family.

3. **Children in the age-group (3-6 years) - For** the children in this age-group it has been requested to make arrangements to serve Hot Cooked Meal in AWCs/Mini-AWCs. Since the child of this age cannot consume a meal of 500 calories in one sitting, it is suggested that a snack (milk / banana / egg / seasonal fruits / micro-nutrient fortified food) in the morning and a hot meal in the noon should be the pattern.

If the guidelines are religiously followed, poor children would really get nutrition's food guaranteed. But unfortunately, the guidelines stay on the paper only. The actual conditions are very poor.

From the actual data, the type of food provided at the Anganwadi is studied. However, before examining the food items, the format of provision of food is as follows.

Table 5.2 : Methods of Food Provision

Method of food provision	% Respondents
Food cooked at the AWC	00.7
Ready Food	90.2
Food at home	00.9
No provision of food	07.4
Did not take food	00.7

There seems to be some confusion in reporting, as the children 0-3 years old are supposed to take ration to their homes. However, they seem to be included in these with 'Ready Food'. More than this, 7.4% not getting food and 0.7% not taking food are the observations worth noting. The information on no. of days, food was provided, indicate that on an average food was available for 22 days, i.e. 3 days (12%) in a month, food was not available. In short the effective food provision was only 81% (0.92 (getting food) x 0.85 (getting for the whole year).

Taking into consideration the guidelines regarding the amount of food and the protein content, the following food-items are expected to be given:

(1) Sprouted Legume (2) Dal (curry) (3) Cooked vegetables

(4) Fruits (5) Milk and Milk products (6) Non-vegetarian food

(7) Ground-nuts (8) Sugar/Jaggery (9) Vita-shakti

(10) Khichadi (A recipe with both rice and mug dal) (11) any other items.

The questionnaire has two types of questions on the diet of the children. One of the questions refer to their diet at the home, while the other refers to the food given in the Anganwadis. The following table gives the consumption of food items at home and at Anganwadi.

Table 5.3 : Food Consumption of Children at Home and at Anganwadi

(No. of children consuming different food items)

Food Item	Home	Anganwadi
Beans/ Legume	1861	203
Dal	1970	1
Vegetables	1626	-
Fruits	1765	-
Milk	1746	1
Non-Veg	1620	3
Ground-nut	NA	12
Jaggery/Sugar	NA	-
Vitashakti	NA	584
Khichadi	NA	730
Others	NA	1775

There are tremendous differences in the food-pattern.

Further, it should be noted that at Anganwadi 1283 children (3-6 years) are expected to get cooked food, while 786 children (0-3years) are expected to get 'Take Home Ration'.

As far as food consumption at home is concerned, about 80-90% of the children are getting nutritious food, including non-vegetarian food. Ninety percent of the respondents being Muslim families, it is not unexpected that they consume non-vegetarian food. However, knowing their economic conditions, it is difficult to believe that the children get such nutritious food on a regular basis.

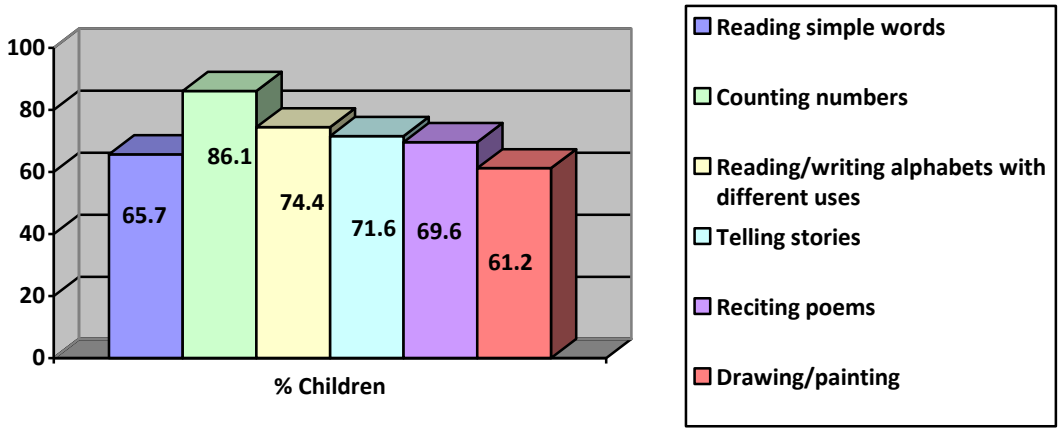
As far as the food items at Anganwadi are concerned it is observed that out of 1283 children 203 get Beans/ Legume and 730 get Khichadi and 'other' is reported by 1775 respondents. From AWWs interviews, it is revealed that it is 'the puffed rice (Murmura) which is often given. In short, even, if one assumes that this consumption pattern is regular, it is only 933 children, i.e. about 75% of the children get nutritious food or in other words that on some days, the children might not be getting sumptuous food like 'Khichadi'. The next question is asked to see whether with the food they get, is it adequate. It is found that 847 i.e. only 45% respondents report the quantity to be adequate. Interestingly 11% of the respondents could not report the adequacy. Thus, firstly, items like 'puffed rice', which does not have any nutrients are given largely and further only 45% report that the food is adequate.

As far as the quality of food is concerned, 1009 (i.e. 67% of those who have reported) have reported the quality to be good. Of course, it is to be noted that some of these could be those taking home dry ration and the quality of the same might be good. One is more worried about the food served at the Anganwadi, since the lapses in which would defeat the purpose of provision of nutritious food. In short, with 90% reporting consumption of 'puffed rice' and with indication of inadequate diet one can very well imagine the condition of child nutrition at the Anganwadis.

I. Pre-School Education:

As worked out in the last section, 1283 children are eligible for Pre-School education. It is observed that all of them are taking Pre-School Education and the median duration is 22 days leading to the coverage of 88%. The basic abilities of reading/reciting are as follows:

Table 5.4 : Proportion of Children for Different Educational Abilities



The performance being an average pattern of 3-6 years children with varying abilities, as one cannot expect cent percent performance. Out of the above-mentioned abilities, reading simple words and drawing/painting has lower performance, since reading words needs an age of at least 5 years and drawing/painting needs drawing material, which could be lacking. In other kinds of activities, the performance is all right.

Information is also collected about their behavior like hygiene, respecting elders, communication with the peer group etc. It is observed that 90% of the children wash hand after meals and after toilet use. However, use of the soap is found in case of 75% children. At the level of communication with the peer group/senior people is concerned, the performance is 70-75%. Actually speaking, behavior of the child mainly depends on the cultural background at the residence. However, Anganwadi workers also can contribute towards imbibing good habits.

II. Demographic Characteristics of Pregnant and Lactating Mothers and the ICDS Services Availed:

As per the sample-design, the households with a child below 6 years was identified as the sample household. The pregnant women in these households formed the sample of beneficiary pregnant women. The same holds true for lactating mothers. The sample households have 232 pregnant women and 293 lactating mothers. Since some of the questions are common for these two groups, the information for these two groups is analysed together. The following table gives the comparative picture.

Table 5.5: Preliminary Information about Pregnant Women & Lactating Mothers

Sr. no.	Item	Pregnant Women	Lactating Mother
1	Median age (yrs.)	25	25
2	Age at marriage (yrs.)	18	18
3	Beginning month (medium) of pregnancy for availing medical care	4	4
4	Source of medical care (%) - AWC	12.1	14.5
	- Govt. Hosp.	70.7	69.1
	- Priv. Hosp.	17.2	16.4
5	Month of registration at Anganwadi	4	4
6	Benefits from AWC (%)		
	- Nutritious Diet	73.3	69.3
	- Immunisation	86.1	88.5
	- Health Check up	57.6	61.1
	- IFA Tablets	86.6	88.5
	- Health and Nutrition Education	76.6	74.8
	- Referral Services	79.7	74.1
7	AWWs' visits during pregnancy	3	3
8	ANMs' visits during pregnancy	2	2
9	% with no ANM's visit	58.7	60.4

There are no differentials between the two groups and they are not expected also. However, for both the groups, the following observations are worth noting. One, the medical care during pregnancy is availed mainly from Government Hospital and not from the ANM/urban health post; two, out of the different services from an AWC, the least reported is the health-check up. In short the ANM's services through the urban health post are not available to the Malegaon slums.

Diet at Home and the Food Provided in Anganwadi:

Diet at home:

It is expected that a pregnant woman and a lactating mother, both should get a specially nutritious diet, which will help to maintain mother's health and help the child grow healthy. Of course, every time, it is not possible to meet this expectation because of the limited earnings of the household and peculiar dietary habits. The following table gives the diet-composition for the home-diet.

Table 5.6: Home Diet Composition

Type of Food	Pregnant Women	Lactating mother
Legume	99.5	99.7
Pulses	99.6	99.7
Vegetables	99.6	99.7
Fruits	93.6	92.5
Milk	77.6	83.6
Non-Veg	96.3	98.6

The above table makes it clear that the diet of the respondents has substantial nutrients, which are good for the health of the pregnant women and lactating mothers.

Food Provided at Anganwadi:

In comparison, the composition of the diet which is provided at the Anganwadi is studied. First, 21 percent of the pregnant women and 17.7% of the lactating mothers did not get any food at the Anganwadi. Second, 5.5% of the pregnant women and 6.1% of the lactating mothers did not take food from Anganwadi. It is implied that about one-fourth of these women did not have food from Anganwadi. This is a serious matter, since provision of nutritious food to children and women is an important service expected from the Anganwadis. The pregnant and lactating women get food for only 20 days. Thus, the effective proportion of availability of food was 0.6 (0.75 x 0.8) i.e. 60% only. Leaving these non-beneficiaries, about 58-60% of the women get cooked food, while the remaining 11-12% of the women took home the dry ration.

As per the guidelines, the Anganwadis are supposed to provide food-items like Legume, Pulses, Vegetables, Fruits, Milk, Ground-nuts, Non.Veg., Gud/Sugar, Vita-plus, Khichadi and any other, food giving 600 calories with 12-15 gms protein.

It is great displeasure to note that the pregnant/lactating women are literally not getting any supplementary food from the Anganwadi, except Vita-Plus, Khichadi and 'Others'. Fifty one percent pregnant women report getting Vita-Plus, 31% get Khichadi and 90% get some 'Others' food. Among those, who get some food from the Anganwadi, 58% of the pregnant women and 50% of the lactating mothers report that the provided food was adequate. Further, only 56% of the pregnant women, who got food, reported that the quality was good, while this proportion was better (67%) for the lactating mothers. 'No taste' and 'Difficult to digest' are the reasons behind bad quality of food.

To summarize the situation about availability of food, it is found that

(i) About one-fourth of the pregnant/lactating women did not get any food from the Anganwadis.

(ii) Those, who got the food, are not getting variety of food.

(iii) Only 50-60% women report that the food was adequate and

(iv) About 60% of the women report that the quality was good.

In short, although not totally disappointing, the conditions of food provision are not entirely satisfactory. Inadequacy of food and bad quality are the major problems.

General Nutritional Care during Pregnancy:

In this section, a number of questions are asked about the nutritional care during pregnancy. The following table gives the responses of pregnant and lactating women about advice about nutrition.

Table 5.7: Nutritional Care during Pregnancy

Sr. no.	Item	Pregnant Women		Lactating Women	
		Care taken %	Advised by AWW (%)	Care taken %	Advised by AWW (%)
i	Take more food	99.1	15.7	96.6	20.1
ii	Take vegetables	99.1	40.0	96.2	38.6

iii	Take rest	97.9	40.9	95.6	30.7
iv	No tensions	98.7	32.3	95.9	32.8
v	Avoid too hot or cold food	98.7	31.1	96.2	28.0
vi	Avoid some food	98.3	30.6	96.6	28.0
vii	Take more ghee	88.5	22.1	86.1	21.2

It is observed that almost all the pregnant and lactating women are taking proper care during pregnancy. Regarding ghee-consumption the proportions are a little lower (88%). This could be because of the sample respondents being mostly poor.

As far as the person advising is concerned, there are different alternatives; senior family members AWW, ANM or others. Generally senior members seem to be mainly advising for nutritional care during pregnancy. Since the functioning of ICDS is being evaluated, the role of the AWW is examined. The above table shows that in case of an advice about 'taking more food' and 'taking more ghee' the AWW's role is less (15-20%) than in case of other advices. In fact these two advices are too general and hence 'senior members' might have been more prominent and hence AWW's role appears unimportant. On the other hand the advices about the type of food could be more scientific and in these cases, AWW's role is slightly better (30-40%). Here, it also has to be noted that both whether AWW makes an effort to give such advices and whether the women attend meetings have to be assessed. It is observed that the meetings are not attended regularly. The nutritional advices seem to be mainly given by the senior family members and AWWs need to concentrate on these issues, since nutrition education is one of their main duties.

Antenatal Care of the Pregnant Women:

Proper antenatal care of the pregnant women is essential for the health of the child. It has five components. Early registration (within the first trimester), maximum 3 Antenatal health check-ups, one/two tetanus injections and consumption of 90-100 IFA tablets.

As noted in the earlier section, the median month of registration was 4 months. Only 40% of the women registered their names in the 1st trimester. As far as the tetanus

injection and consumption of IFA tablets is concerned, the following extract gives the comparative data of Malegaon slums with those of Mumbai and Nagpur (NFHS - III, 2005-06).

Table 5.8: Antenatal Care of Pregnant Women

Sr. no.	Item	Malegaon Slums	Mumbai Slums	Nagpur Slums
i	Tetanus injection taken (%)	87.9	89.7	87.8
ii	Consumption of IFA tablets	78.2	75.3	85.4

As far as the performance is concerned, it is all right. Although antenatal care is not supposed to be the responsibility of an AWC but their role in facilitating the service provision cannot be denied. The data reveal that only 23% of the women have reported that the injection was taken at the AWC. Anyway since ANM can give the injection during her home visit and since this is her duty, one cannot judge the AWC's role only on the basis of the data on place of immunization. The consumption of IFA tablets seems 'all right' on overall basis. The source of IFA tablets has been reported as 'AWC' in almost all cases. Distribution of IFA tablets is an easily manageable job compared to managing the immunization activity and hence the performance appears better.

As far as the health check-ups during pregnancy are concerned, there is no information on no. of check-ups. It is revealed that in 75% cases, the health check-up was done (For Mumbai and Nagpur Slums, this percentage was 90 and 81% respectively, seventy-eight percent of these check-ups were done at the AWC.

It is generally expected that during each check-up, weight should be measured, Blood-pressure has to be examined and similarly abdominal examination also should be done. The following extract shows the performance in these tests.

	Percentage
Blood Pressure	59.6
Weight	57.0
Abdominal	100.0

It is quite clear that since the abdominal test does not require any equipment, it is done in all cases, while B.P. and Weight measurement is done only in case of 57-60% of the women who were given AN visits.

In short, the performance about tetanus injections and consumption of IFA tablets is quite OK but lapses appear in case of early registration and BP and Weight measurements. AWWs can help in this matter by creating awareness about early registration.

III. Nutrition and Health Education:

One of the objectives of ICDS is 'to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education'. Correspondingly, one of the services provided by the AWC is educating women, aged 15-45 years, regarding nutrition and health of children and lactating mothers.

A section in questionnaire is devoted to these issues. This section has three parts. One deals with the attendance of the mothers at the meetings, reasons for non-attendance …. etc. The second part deals with the issues discussed in the meeting and the third part covers the knowledge and practice of different health practices.

The following table gives the information on attendance at the meetings

Table 5.9: Attendance at Women's Meetings

I. Frequency of visits to AWC(%)

(i)	Daily	47.2
(ii)	Once a week	27.3
(iii)	Once in a month	24.2
(iv)	Once in two-three months	1.1
(v)	Never	0.2

II. Womens' Meeting held during Last 6 Months (%)

(i)	Yes	40.8
(ii)	No	24.2
(iii)	No idea	35.8

III. Meeting Last Month (%)

(i)	Yes	29.0
(ii)	No	11.8
(iii)	No idea	59.2

No of Meetings Attended During Last 6 Months (%)

(i)	None	62.3
(ii)	One	5.0
(iii)	Two	16.6
(iv)	Three	10.5
(v)	Four	4.3
(vi)	Five +	1.3

IV. No. of Women Attending the Meeting (%)

<10	24	03.1
10-14	94	12.0
15-19	288	36.9
20-24	249	31.7
25+	130	16.5

V. Reasons for not attending the Meeting (%)

(i)	Don't know the timing	42.6
(ii)	Don't have time	47.2
(iii)	Unsuitable timing	01.8
(iv)	No desire	05.8
(v)	No gains	02.5

The figures are self-explanatory. They clearly indicate the total apathy of the respondents towards the educational meetings and also partly the inefficiency of the AWCs in attracting the women. Sixty-two percent of the women have not attended a single meeting during last 6 months either due to 'meeting not held' or on their own desire. As per the women's report meetings were not held in 60% the cases and about 60% of those not attending the meetings, that were held, reported 'unwillingness' as the reason. The information on the no. of women attending the meeting reflects this

phenomenon clearly. An AWC has around 150 children aged 0-6 years, while the max. no. of women attending the meeting, as reported, does not exceed 35. Thus, an important activity of the AWC is being neglected. The administrators need to take note of this. The discussion in the meetings held reported by 777 respondents is seen.

A number of important issues are expected to be discussed in the meetings. They deal with both the children and the mothers. The issues about children were - growth, health, timely immunization, breast-feeding, colostrum feeding, treatment for Diarrhea and other ailments, feeding nutritious food, health seeking behavior, children's education and cleanliness and hygiene. The matters relating to mothers were care during pregnancy, natal care, safe, pregnancy, nutrition during pregnancy, breast feeding, hygiene, general health care, bottle feeding and family planning. The questionnaire had two types of question about each of them. One question related to 'whether a discussion was held in the meeting and the second question dealt about the implementation of the advice received in the meeting. It is observed that discussion was held on all these issues, but reported implementation reflects lack of observance of the health advice. Issues with moderate lack of implementation (10-15%) are chostrum-feeding, nutrition during pregnancy hygiene and general health care. Issues with serious lapses in implementation are bottle-feeding and family-planning with 40-50% failure in implementation. It is not surprising to observe the failure in implementation in case of family planning since 90% of our respondents are Muslims and their opposition to family planning is well-known. However, it is not understandable in case of bottle-feeding. This needs to be noted, since an improper use of a bottle could be risky for the children's health.

As mentioned earlier, the third part of the section on 'Health and Nutrition Education' deals with awareness and practice of different health matters. They are namely, consumption of iodised salt, use of boiling water for a sick child, legal age at marriage of girls, desired birth-interval, family planning methods, anemia, and methods of preventing Anemia. The following table gives the relevant information.

Table 5.10: Awareness and Practice for Selective Health Issues

Sr. no.	Item	Percentage of respondents
i	Consumption of iodised salt	99.7
ii	Use of boiled water for a sick child	77.0
iii	Knowledge about legal age at marriage	86.3
iv	Desired birth interval - 1 - 2 years	36.7
	3 - 4 "	54.3
	5 - 6 "	8.9
	6+ "	0.1
v	Knowledge about family planning methods	84.5
vi	Knowledge about Anemia	13.7
vii	Methods of preventing Anemia	
	(i) Consumption of green veg.	45.8
	(ii) Consumption of Red meat	10.1
	(iii) Consumption of IFA Tablets	41.5

The above table shows that except ' Anemia', women broadly are aware about the different health issues. Still in case of knowledge about family planning methods, 84.5% awareness falls slightly short of the universally observed levels (>99%). Taking into consideration the fact that majority of the respondents are Muslims, this level also is satisfying. The knowledge about Anemia is too low (13.7%). The women may not be aware of the word ' anemia'. If the term is explained, in a way, they could understand, probably, the resultant level of awareness would be higher. Anyway, the suggested ways of preventing anemia show that they know both the ways; one through proper food consumption and another through medicines.

CHAPTER 6

HEALTH STATUS OF BENEFICIARIES

I. Health Status of the Children assessed through the Weight Measurements:

One of the major activities of the Anganwadi is to monitor the height and weight of the children and plot it on the chart of standard height and weight prescribed by the WHO. This chart helps the AWWs to assess the level of malnourishment if any. A section in the questionnaire is devoted to the queries about the weight measurements. It has three kinds of question. The first set is about the birth-weight, the second deals with the weight at the time of the survey and the third is about the growth in weight during last 9 months (monthwise).

Birth-Weight

A norm of birth-weight, namely, 2500 gms. is assumed here to assess the children's' birth-weights. Out of 2081 children, only 956 of them were weighed at birth. It is not unexpected since in case of 647 children, the delivery was a home-delivery and 316 women do not remember whether the baby was weighed. Two observations are worth noting. One, the proportion of home-deliveries in an urban area (31.1%) is too big. It is surprising to observe that in spite of awareness about Janani Suraksha Yojana of the order of 90%, women are not taking benefit of the scheme. As per NFHS-III, the proportion of home-deliveries in the slums of Mumbai and Nagpur was 16.7% and 21.2% respectively.

Another observation is that 316 i.e. around 15% women do not remember, whether the baby was weighed. The recall lapse just about the weighing is quite substantial. It shows no importance given to the birth-weight. Similarly carrying out the delivery at home in such large numbers points towards two points; one could be the unfelt need and another could be the un-affordability of hospital expenses, if any.

Coming back to the assessment of birth weight, the following table gives the distribution of children according to the birth-weight.

Birth-Weight

	<25 kg.	2.5-3 kg.	3-4 kg.	4-5 kg.	
Frequency	89	542	376	9	956
%	9.3	56.7	33.1	0.9	100.0

As per NFHS-III (2005-06), for urban areas of India the proportion of babies with birth-weight less than 2.5 kg. is 19.1%. For urban Maharashtra, the percentages could be lower. But still, for slum dwellers, the % low-birth-weight babies being just 9.3% is really astonishing. With such poor incomes how come, the birth-weights are so good? Of course, these weights are of babies, who were born in hospitals, meaning thereby that this group could be a little better-off. Still the indications are remarkable.

As mentioned earlier, the second kind of questions are about the age and weight of the child at the time of survey. This information enables to examine the weights cross-tabulated by age at disaggregated level. Further, one can compare these findings with the weight x age chart of the (6 months) WHO and assess the health status of the children in Malegaon Slums. WHO gives the kinds of data on desired weight of children. One is ideal weight and another is the minimum weight for a healthy child (New standards). The two kinds of desirable weights in comparison with the weights of children on Malegaon Slums.

Table 6.1: Weight Measurement of Children Compared with WHO Standards

Age (Month)	Min. Weight of a Healthy Child (WHO)	Mean Weight (Malegaon Slum)
6-11	6.70	7.15
12-17	7.83	7.99
18-23	8.83	8.80
24-29	9.74	9.95
30-35	10.60	10.72
36-41	11.36	11.24
42-47	12.11	11.88

Age (Month)	Min. Weight of a Healthy Child (WHO)	Mean Weight (Malegaon Slum)
48-53	12.82	12.75
54-59	13.52	14.19
60-65	14.37	14.65
66--72	15.17	15.31

Once again, the results are surprising. The Minimum weights of Healthy children (WHO) and those of Malegaon slums tally so well that the first reaction is of disbelief. Are the babies really so healthy? The birth-weights also are quite good. Again, coming from poor families, how come the weights are so normal? Does the answer lie in food consumption? With such poor condition, the people definitely are not in a condition of consuming chicken/mutton on a regular basis. It is understood that they consume beef, which is cheaply available. It is understood that beef has a good content of protein and vit B-12 and fat.

II. Immunization of Children:

As per the government health policies, children below 5 years are to be immunised against preventable diseases like T.B., Diptheria, Whooping Cough, Titanus (DPTI) , Polio and Measles. Similarly 3 doses of Hepatitis B and 5 doses of 'A' vitamin at the internal of 6 months are expected to be given as a part of blindness control programme. In addition to these, DPT/Polio Booster dose is given at 1 1/2 yrs. and DT Booster dose is given at 5 years. In order to assess the immunization coverage from a community survey, two methods are employed. Firstly, if the immunization card is there, the information is copied down from the same. But sometimes the family has lost/misplaced the card. In such cases, the mother is asked probing questions to know the details of immunization. It is to be noted that these immunizations have to be given at proper ages of the children. For instance, BCG injection has to be given within first week after birth, three injections of DPT and Polio doses are to be administered before 6 months. The Measles injection with 1st dose of A Vitamin has to be given at 8-9th month, the three Hep. B. Injections are to be given before 1st year while the remaining A Vitamin doses are to be given with an interval of 6 months. Earlier, till 5-6 years ago, the basic immunization in the government programme were BCG, Polio-O, three injections of

DPT, three doses of Polio and Measles injection only. Thus, to know the immunization coverage, data were collected about children aged 12-23 months and coverage for individual vaccination used to be worked out and additionally a measure, namely, percentage of children with all these vaccinations, called fully vaccinated used to be worked out.

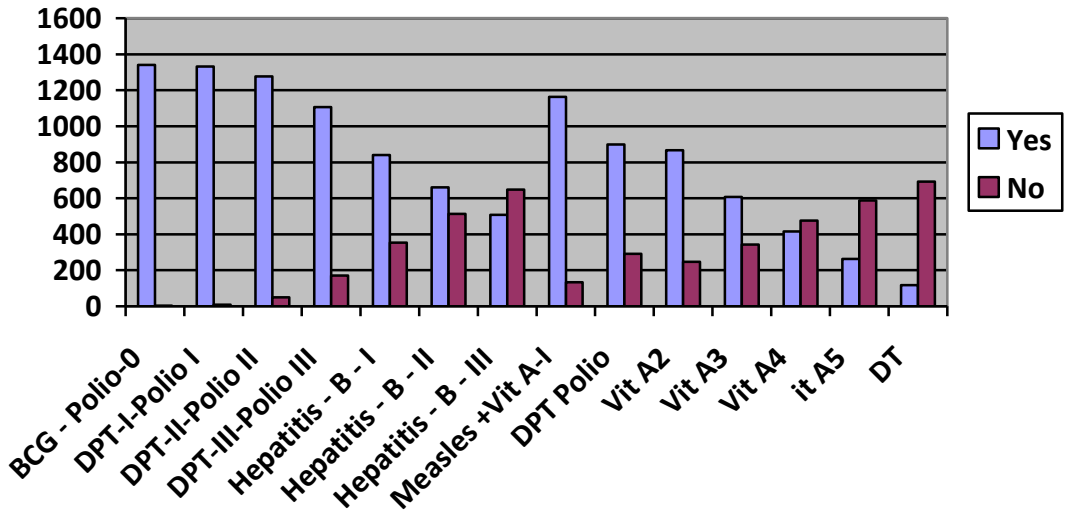
In this regard, the questionnaire has two questions and one table to be filled for information on immunization. First question is regarding having an immunization card. It is found that out of 2081 children, 1621 children have the card. The second question is regarding whether the investigator had seen the card. It is revealed that in case of 1068 children the card could be seen. The table lists down all the vaccinations and for each of them the questions asked are (i) Family response on whether the vaccination / dose was taken, (ii) If yes the source, (iii) If not taken, the reason and (iv) Is it registered at the Anganwadi. Thus the responses totally depend on respondent's recall capacity.

The No. of children for whom different vaccinations are applicable. The following extract gives the same.

Vaccination	No. of Children
BCG - Polio - O	1926 (excluding children below 1 year) at survey
DPT - I, II and III	
Polio - I, II and III	
Hepatitis - B	
I, II and III	
Measles + A Vilonia I	
DPT - Polio Booster	1649
Vit A - II, Vit A, III	
Vit A - IV, V	1283
D.T.	344 (Children 5+)

The following table gives information for all types of vaccinations.

Table 6.2 : Immunisation Particulars / Immunisation Status



For comparison the coverage for Mumbai and Nagpur Slums as per NFHS-III (2005-06) is as follows

Table 6.3 : Immunisation Coverage, (%) Slums Malegaon, Mumbai and Nagpur

Item	Malegaon - Slums	Mumbai - Slums		Nagpur - Slums
BCG - Polio-0	69.6	BCG	97.5	98.3
DPT-I-Polio I	69.1	Polio - 0	80.0	77.3
DPT-II-Polio II	66.3	DPT - I	93.8	90.7
DPT-III-Polio III	57.4	Polio - I	95.0	96.0
Measles +Vit A-I	60.4	DPT - II	87.5	82.7
		Polio - II	95.0	88.0
		DPT - III	75.0	74.7
		Polio - III	81.0	70.7
		Measles	87.5	78.7

It could be clearly seen that the coverage's for Malegaon Slums are much lower than those for Mumbai and Nagpur Slums. Generally, the immunization coverage appear to be low. The authorities need to take these things seriously. If the coverage is genuinely low, then the problem need to be sorted out at the earliest.

The table on immunisation has three more columns (i) If immunized, the source (ii) If not immunized, the reason and (iii) Is the immunisation registered with the Anganwadi. Out of these three, the responses to the question on reason for no immunisation are not reliable, since the number of 'no' responses is itself wrong. Though immunisation is not the activity of the AWC, they have to help the ANM by collecting the children at a fixed place, create awareness about immunisation. etc. The following table gives the relevant data.

Table 6.4 : Source of Immunisation and the Role of AWC

Item	Immunised	Source AWC	Whether registered with AWC
BCG - Polio-0	1340	1309	1309
DPT-I-Polio - I	1331	1299	1300
DPT-II-Polio - II	1277	1249	1251
DPT-III-Polio - III	1106	1084	1087
Hepatitis - B - I	840	804	803
Hepatitis - B - II	861	613	641
Hepatitis - B - III	507	496	493
Measles +Vit A-I	1164	1105	1110
DPT Polio Booster	899	874	875
Vit A - II	867	841	835
Vit A - III	608	585	587
Vit A - IV	415	404	400
it A - V	262	260	256
DT	117	111	110

It is observed that very few immunisations are carried out, outside the AWC. This is quite natural as Anganwadi is a convenient place for getting the children together at one place. A ANM attached to the Urban Health Post (UHP) can do this at the UHP or at home.

In order to know the timeliness of the observance of the immunisation schedule, one way to evaluate the immunisation performance is to assess the immunisation coverage for children aged 12-23 months for the vaccination to be completed during the first year, namely, BCG, Polio 0, DPT-I, II and III, Polio - I, II, III and Measles with the first dose of Vit. A. Earlier, only the immunisation coverage was seen as they were for all the children and the evaluation was done only to know whether the immunisation was done or not. The examination of children aged 12-23 months will tell whether it was done at a right time. The following table gives the same information.

Table 6.5 : Immunisation Coverage for Children Aged 12-23 months

Item	Percentage Immunised
BCG - Polio-0	64.3
DPT-I-Polio - I	62.8
DPT-II-Polio - II	55.9
DPT-III-Polio - III	43.7
Hepatitis - B - I	27.8
Hepatitis - B - II	17.0
Hepatitis - B - III	16.2
Measles +Vit A	45.2

Interestingly, it is observed that these percentages are lower than the ones in the earlier table. The gap is quite wide for DPT III - Polio III, Measles and Vit. A. The gap implies that the vaccinations are not given at proper timings. These two vaccinations which have to be given in the first year are not given at proper time for 10-15 percent of children.

Low levels of vaccination coverage and absence of timeliness could create serious problems for child health. No wonder, a few polio cases from Malegaon was known even during the last year of polio eradication campaign.

Sicknesses among Children and the Treatment taken:

Diarrhea and Acute Respiratory Infection are the two major sicknesses among children. The relevant section in the questionnaire deals with mainly Diarrhea, worms along with a few questions regarding other ailments and the treatment taken.

'Did the child ever have Diarrhea' is the question asked. Naturally, reporting of a higher prevalence is in-built in the question. About 41% of the children are reported as having suffered due to Diarrhea, whereas among the children of Mumbai and Nagpur slums, the prevalence is 6.8% and 10.7%, for 2005-06, with a reference period of two weeks. However, the difference in the prevalence rates cannot be attributed only to the difference in the reference periods. Malegaon slums genuinely could have a higher prevalence, since the conditions in which the people are living are truly horrible. No waste disposal system, no toilets in most of the cases are definitely going to result into substantial diarrhea infection. Out of the 2045 households, 1927 households had no toilets, 69 households had Pit toilet and only 52 households had flush toilets. As mentioned earlier, the prevalence of Diarrhea is closely linked with the availability of toilets. The following extract shows the relationship clearly.

Prevalence of Diarrhoea (%)

No Toilet	42.3
With Toilet	25.6

Treatment on Diarrhea:

An attempt was made to know about the remedies followed by the parents. The following table shows the responses.

Table 6.6 : Treatment on Diarrhea

Sr. no.	Remedies	% Respondents
i	Gave liquid diet	43.6
ii	Liquid intake reduced	8.7
iii	Food intake reduced	23.0
iv	Gave home-made ORS	22.1
v	Gave ORS from the market	42.5
vi	Gave ORS brought from the Health Centre	20.2
vii	Gave ORS brought from the AWC	48.1
viii	Gave normal food	45.1

The above responses indicate that the awareness about treating Diarrhea is of considerable order. About 50% of the parents are treating Diarrhea in a proper way. Improper actions like reducing the liquid intake or food intake are adopted by very few ---- (9 and 23% respectively). Further, the AWC is also contributing significantly in helping the parents in treating the sickness.

Children could also suffer from sicknesses other than diarrhea. Hence, a question was asked to know about them. A large number of children (1083) reported sickness during last three months. This amounts to about 52 per cent, quite a high order morbidity. Out of these 1083 sick children, the largest proportion was for 'Fever' accounting for 58 percent. It was followed by cough amounting for 31 percent. Again, the respiratory infections leading to fever and cough are also due to the dense settlement pattern. It is a pleasure to note that there is no negligence towards the ailment. Almost all of them have been taken to a hospital. In 20 percent of cases the decisions regarding treatment are their own. Out of the remaining 80 percent cases, about 22 percent cases AWW has been instrumental. The senior members of the household seem to have played a major role (40%) in deciding about treatment. Although, there seems no negligence about the treatment, a very high morbidity rate is itself a problem. Another health problem, which is commonly found among the children living in unclean surrounding, is the 'worms'. In all 775 i.e. 37% children had suffered due to 'worm'.

In all 775 i.e. 38% children had suffered due to 'worm'. This again is a 'high' prevalence. AWC has been instrumental in providing de-worming tablets. Out of 775 suffering children, 679 children have got the tablets from AWCs. This brief section has revealed the serious condition about the health of the children assessed through the sicknesses. As stated earlier, the insanitary, congested living conditions are the main reason. Having at least 'Public Toilets' could solve the problem partly. Further, regular visits of ANM or AWW could help in diagnosing the ailment at an early stage and the children could be cured with simple remedies.

CHAPTER 7

AVAILABILITY AND ACCESSIBILITY OF GOVERNMENT HEALTH SERVICES

A section in the questionnaire is devoted to the assessment of the type and quality of government health services. While designing the questionnaire, this particular section seems to be designed on the basis of the rural health infrastructure. For example, the first question in the section relates to the availability of a Primary Health Centre (PHC) in the nearby premises. As everyone knows, the urban areas do not have a PHC. Instead, the slums in urban areas are expected to have Urban Health Posts (UHP) the functioning of which is based on the lines of a PHC but not in exact terms. (See Evaluation of Urban Health Posts in Maharashtra - Dr. S. Mulay (2008), Gokhale Institute of Politics and Economics, Pune) Urban Health Posts are of four types. Type A UHP is for a population less than 5000, Type B is for population 5-10,000, Type C is for 10-25,000 and Type D is for population 25000 + Type D (Study under ref.) namely, is a full-fledged UHP with 8-9 staff members, out of which one is a doctor. There are 4 nursing staff and the remaining three are the clerical assistants. If the staff at the PHC is examined, with similar population coverage, one find that a PHC has 2 doctors, 6 ANMs, 6 MPWs and the other 3-4 assistants. It is quite clear that UHP is seriously understaffed and has to carry out activities mostly similar to PHC activities. These details were given to appraise the reader about the type of services available to the sample respondents. In addition, the respondents could have the services from Municipal Hospitals. Taking into account the expected duties of a UHP, the data have to be analysed.

As expected, the section includes question on the availability of different kinds of health services and on the assessment of their quality. There are also questions about the health services provided by the Municipal Corporation.

About the Health Facilities:

The following table gives the information about the nearby government health facility and the infrastructure thereof.

Table 7.1: Availability of Health Facilities

Sr. no.	Item	*Percent of Respondents
i	Availability of a health centre	100
ii	Functional condition of the centre	
	- Good	36.1
	- OK	45.1
	- So - So	18.5
	- Poor	0.3
iii	Quality of Health Services - Excellent	21.3
	- So - So	76.8
	- Poor	1.9
iv	Doctor Available at the Centre	93.6
v	Is the health information provided at the centre complete	86.2
vi	Facilities available at the centre All*	54.9

The above table makes it clear that a center is there, a doctor is present in most of the centres and most of the facilities are existing. The responses to the questions on quality of the services or the condition of the centre reveal that the respondents are not satisfied. Only thirty-six percent of the respondents say that the condition of the centre is good and only 21 percent of the respondents say that the quality is good. Overall, with a few exceptions, the functioning of the six UHPs in Malegaon and Municipal dispensaries is not satisfactory. The services provided by the centre in details are studied. As per the activities of an UHP, Immunisation, family planning activities, Pulse-Polio Campaign, Annual F.P. Survey, one-day orientation camps and an out-reach activity are the duties of an UHP. Further, it also has to cooperate in the National Health Programmes and also the new activities under NRHM. This section of the questionnaire has questions regarding some of these activities and the responses of the respondents are given in the following table.

Table 7.2: Performance of the Centres as Assessed by the Respondents

Sr. no.	Items	Percent of respondent
i	ANM's Regular Home-visit	75.6
ii	Frequency of the visit - Weekly Fortnightly Monthly Three Monthly	2.7 3.6 88.3 5.4
iii	Polio immunisation	99.9
iv	Health Survey	87.8
v	Knowledge about different Health Schemes	66.0
vi	Knowledge about 'Janani Suraksha Yojana'	93.6
vii	Knowledge about different National Health Programmes	72.0
	i National ATDS Control Prog.	95.5
	ii National Malaria Control Prog.	74.4
	iii National Filaria Control Prog.	71.9
	iv National T.B. Control Prog.	70.2
	v National Mental Health Prog.	18.6
	vi Reproductive & Child Health Prog.	55.4
	vii Nutritions Diet Week	42.7

The above table comes up with some interesting findings. Regularity of the ANM's visit seems to be quite alright. Frequency of the visit is expected to be higher, i.e. fortnightly. However, as explained earlier, the UHP staff are overburdened and hence a lapse in the outreach activity. Public Polio Immunisation has succeeded remarkably and

hence this 100% response. In this questionnaire, there are two questions with different information but with the similar wording - 'Do you know about different health programmes carried out by the government?' The first question refers to the health schemes like 'Janani Suraksha Yojana', 'Nav Sanjeevanee' … etc., while the second question refers to the National Health programmes. With this confusion the respondents also might have been confused in answering this question.

About 65-70 percent of the respondents are aware of health programmes carried out by the government e.g. Suraksha Yojana', 'Nav Sanjeevanee'. The awareness about 'Janani Suraksha Yojana' and 'National AIDS Control Programme is highest (90.95%). It is quite expected firstly since the Janani Suraksha Yojana is beneficial to them (monetarily) and secondly, there is lot of publicity about the AIDS programmes. However, it is surprising to observe lower levels of awareness (about 70%) for old health programmes like Malaria control or TB Control. In fact, with lower incomes and poor living conditions, the respondents could be more prone to respiratory infection and also to Malaria hence they should be knowing about the programmes. However, now-a-days, publicity rules the world. People know about the issue, if it is put in front of them in an aggressive manner. Further, one could understand a low level of awareness about the mental health programme (19%) but the finding that only 55 percent of the respondents know about the RCH programme was a surprise. Reason could be found in nomenclature. If the interviewers could have described the different activities under the RCH programme, probably, the response would have been more appropriate. Crux of the matter is that there is a need for better IEC activities on the part of the UHP staff or the staff of the Municipal Corporation.

Assessment of the Activities of Malegaon MC:

The activities of the health department of the Malegaon Municipal Corporation, as assessed by the respondents.

Table 7.3: Performance of the Municipal Corporation - Health Department

Sr. no.	Item	% Respondents
i	Immediate action for preventing the spread of an infection disease	96.1
ii	Insecticide sprays	94.0
iii	Disease Surveillance	90.6
iv	Awareness creation (Posters)	100.0
v	Public Hygiene activities -	
	i Solid Waste disposal	39.5
	ii Waste Water disposal	10.8
	iii Spray	43.0
	iv Awareness creators	6.0
vi	Advice regarding personal cleanliness	35.1
vii	Visit of the Health Officer to your ward	12.6
viii	Difficulties in availing the services	27.1

The above table has data on the types of activities; one kind of activities refer to services about arresting the spread of a certain disease, while the other activities deal with general public health activities and creation of awareness for personal hygiene etc. It is observed that the performance of the corporation is good as far as the activities refer to a particular disease like say, malaria. However, the general prorogated public health activities are not carried out that efficiently, since they are not targeted at a particular goal. They are to be carried out with a view of having good sanitation, which will lead to prevention of some infectious diseases. The point, in fact is that these are the activities which need to be strengthened to keep the premises clean and prevent from different kinds of infection.

CHAPTER 8

EXPERIENCE OF NON-BENEFICIARIES

As per the prescribed questionnaire, the following sections in the questionnaire are applicable to non-beneficiaries

Section A - Socio-economic background of the household

Section G_1 - Diet at Home, Immunisation, Health-status, Health care, learning skills etc.

Section G_2 - Information about AWC

Section G_3 - Opinions about existing Health Services

Section G_4 - Awareness about Health Services and Programmes

It is to be noted that at the time of the survey, recognizing the need for their interviews, a field-team was sent to the sample slums of Malegaon and interviews of 88 non-beneficiary households were taken. Only some broad findings are selected. The following table gives the comparison of the socio-economic background (although limited by a small no. of non-beneficiaries).

Table 8.1: Housing conditions and Socio-economic background at Beneficiaries and Non-beneficiaries

Housing Conditions	Beneficiaries	Non-beneficiaries
Type of House - Katcha and Half-katcha-Pacca (%)	87.4	81.5
Availability of Toilet - No Toilet (%)	23.9	24.1
Availability of Water - Tap Water (%)	94.9	72.4
Socio-economic Background		

Housing Conditions	Beneficiaries	Non-beneficiaries
Illiterate held of hh (%)	28.8	30.0
Highest Level of Education (%)	8th	8th
Head's Occupation-Labour(%)	64.7	67.8
Monthly household Expenditure- Median	3700	2800

The above extract shows that the socio-economic background of the beneficiary and Non-beneficiary households is broadly similar except one important indicator of median household expenditure. The non-beneficiary households seem to be earning much less than the beneficiary households, indicating the need for their children getting admitted to the Anganwadis. Similarly, their worse income conditions also point towards their level of nutrition at home. This will be examined in the next section, where the data on the nutritional and health status of the children will be compared.

Nutrition, Health Status and Learning Skills of Children:

The following table gives the relevant information

Table 8.2: Nutrition, Health Status and Learning Skills of Beneficiaries and Non-Beneficiaries

Nutrition	Beneficiaries	Non-beneficiaries
Intake of different food items at home	about 90%	about 80%
% with sufficient food at home	97.4	72.5
Health Status and Immunisation		
% with BCG and Polio '0'	67.6	86.2
% with DPT and Polio III	57.4	77.6
% with Anti-Measles inj.	60.4	72.6

Nutrition	Beneficiaries	Non-beneficiaries
Birth-Weight		
% children with weight measured at birth	47.0	63.2
% children with birth-weight less than 2500 gms	9.4	32.7
Prevalence and Treatment of Diarrhea		
% sick due to Diarrhea	41.0	11.5
% sick during last 3 months	52.0	44.8
% sick children taken to hospital	100.0	64.0
Learning Skills of Children		
Reading simple words	65.7	70.0
Counting numbers	86.1	62.7
Reciting Poems	69.6	37.0
Story telling	71.6	40.5

The above extract comes up with some expected and other somewhat contradictory results. Nutrition seems to be somewhat poor for non-beneficiaries (may be due to their lower earnings). A similar finding comes up in case of birth-weight. The proportion of low birth-weight children is quite high for non-beneficiaries. Proportion of 'sick' is slightly lower. However, the prevalence of diarrhea also appears to be much lower. This is due to, the question has been asked for current prevalence, while the same was asked to the beneficiaries with no reference period. Another contradiction appears in case of immunization. However, it should be noted that in case of beneficiaries, there was a data problem; number of 'No response' cases was significant and hence no valid comparison can be made. Nevertheless, one definitely could say that the immunization was good even in case of beneficiaries. This shows that 'Immunisation' being an activity of the Health Department, role of Anganwadi is at the most 'Facilitator'. In case of learning skills of children, the non-beneficiary children appear to be poor. This is quite expected. Pre-school Education is one of the important activities of the Anganwadis.

Hence, the non-beneficiary children suffer due to their being outside the Anganwadis. Thus, the children if admitted to Anganwadis, may get better nutrition and may learn a little more.

Information about AWC:

The contents of the earlier sections clearly indicate that the non-beneficiary children need to get admitted to an Anganwadi to get better nutrition and also pre-school education. The following table shows the awareness of the parents about 'Anganwadis' and whether they are keen to admit their children to 'Anganwadis'.

Table 8.3: Knowledge about Anganwadi

Sr. no.	Item	% Respondents
i	Knowledge of an 'Anganwadi'	18.4
ii	**Knowledge about Anganwadi Activities**	
	- Nutrition	100.0
	- Immunisation of children	100.0
	- Immunisation of pregnant women	7/16
	- Pre-school education	7/16
	- Health check-up	10/16
	- Nutrition and Health Education	3/16
iii	Knowledge about Surveys done by AWW	11.5
iv	Household surveyed	8/10
v	Attempt to admit children to Anganwadi	42.5
vi	Interested in sending children to Anganwadi	94.3
vii	**Purpose of sending children to Anganwadi**	
	Nutrition	93.1
	Education	66.7
	Immunization	69.0
	Child Care	54.0

The above extract clearly indicates that although they do not know about the nearby Ananwadi (probably because of their being new to the city), they are interested in

sending their children to Anganwadi. But surprisingly, they do not report of any survey done by AWW. In this context, as reported by the investigators, it seems that the AWWs are not covering the entire area, possibly due to their existing pressure. As observed in the main survey, the Anganwadis in Malegaon slums are already burdened with 150-175 children (while the norm is 100). As suggested, there is an urgent need of opening more Anganwadis in Malegaon slums.

Information about the existing UHP (Urban Health Post):

Here again, the responses of the beneficiaries and non-beneficiaries are compared. The following excerpt gives the data.

Table 8.4: Experience about the UHP: Beneficiaries and Non-Beneficiaries

Sr. no	Item	Beneficiaries	Non-Beneficiaries
i.	Availability of a centre (%)	100.0	44.8
ii.	Condition of the centre - Good (%)	36.1	35.9
iii.	Quality of the service - Best (%)	21.3	25.6
iv.	Doctor Available at the centre (%)	43.6	97.4
v.	Health Information received	86.2	25.6
vi.	Facilities at the centre - All	54.9	17.9

The lack of information about the UHP, in case of non-beneficiary is very clear from the above data. As it is, the infrastructure of the UHP is not adequate. The following extract gives the other services expected to be provided by the centres.

Sr. no	Item	Beneficiaries	Non-Beneficiaries
i.	ANM's Regular visit (%)	75.6	48.7
ii.	Frequency of the visit-monthly (%)	88.3	10/19
iii.	Polio Immunisation (%)	99.9	19/19
iv.	Health Survey (%)	87.8	7/19
v.	Knowledge about different health schemes (%)	66.0	3/19

It appears from the responses that the non-beneficiary households are new to the city and hence lack information about the health programmes in the city.

To sum up, the non-beneficiary households seem to have come to the city only recently and hence still to settle down. As far as the educational levels are concerned, there is no difference, but in case of economic conditions, they are poorer. This probably has affected the nutrition of the children. Similarly, the proportion of 'low birth weight' children is also higher. Surprisingly, the child immunization levels appear better. This could be so, firstly, because, the data on child immunization of beneficiaries were affected by non-response, and secondly, immunization being mainly the duty of the Health Department, not being in Anganwadi may not matter much. Learning skill of children in terms of counting number and reciting poems, story-telling are obviously better for the beneficiary children. The under-nutrition of children and the lack of learning skills point towards the need to get admitted to Anganwadis. From their responses, the parents seem to be keen in sending their children to Anganwadis. However, the existing Anganwadis are overburdened. Thus, there is an urgent need to open new Anganwadis in the slums of Malegaon.

CHAPTER 9

FUNCTIONING OF ANGANWADI CENTRES IN THE STUDY AREAS

There are 155 Anganwadis in the slums of Malegaon city. However, since the survey is in Muslim dominated areas, the study deals only with 56 Anganwadis. Information has been collected from all these centres. However, for two centres, the information is incomplete and hence the analysis has been done for 54 centres. As described in the 'introduction', the questionnaire used for Anganwadis covers a number of aspects such as

(i) Physical Infrastructure

(ii) Registration of beneficiaries (children, pregnant women and lactating mothers)

(iii) Attendance of beneficiaries (children, pregnant women and lactating mothers)

(iv) Services provided by Anganwadis

(v) Time spent in different activities and record-keeping

(vi) Attendance at Mothers' Meetings

(vii) Home-visits and hurdles during discussion with mothers

(viii) Pre-primary educational activities

(ix) Availability of medicines and other implements

(x) Adequacy and quality of supplementary nutrition as assessed by AWWs

(xi) Malnourishment among children at the centre

(xii) Weight measurements

(xiii) Immunisation of children and mothers and sicknesses

(xiv) Supervision of the centres and suggestions

(xv) Community participation

(xvi) Difficulties in running an AWC

(xvii) Training of Anganwadi Workers

(xviii) Profile of Anganwadi Worker and Helper and

(xix) Observations of the investigators.

The information is of both the types - quantitative and qualitative. Qualitative information is in terms of a number of alternatives, each with a response '1' or '2' for Yes and No. For example, for a question on Methods of teaching for pre-primary education, there are ten alternative methods given with a response of one or two meaning 'Yes' or 'No'. If one intends to have a quantitative assessment for this activity, one either could get the no. of centres adopting the different methods or one could get a single figure index by counting the no. of methods not followed. The second method was used, since the first alternative would give ten figures and would be unyieldy for analysis. On the contrary, the second alternative would give us, in a single figure, the failures in following alternatives methods. It should be borne in mind that the way codes '1' and '2' are used; a higher score means a higher amount of dysfunctioning.

A preliminary scan of the questionnaires revealed that the data on immunization are not reliable, since they are not based on total information. Similarly, the data on 'malnutrition' come up with large variations. It ranges from '0' to 30% and hence these outcomes are not included in the final analysis.

The following table shows the registration for beneficiaries (children (0-6 yrs), pregnant women and lactating mothers.

Table 9.1: Distribution of AWCs by No. of Registered Beneficiaries and also by the Proportion of Attendees

Registered Beneficiaries Children		**Pregnant Women**		**Lactating Mothers**		**Proportion (%) of Attendees (Children)***	
< 150	9	< 5	1	< 5	1	50 - 75	9
150 -175	20	5 - 10	5	5 - 10	3	75 - 100	24
175 - 200	16	10 - 15	23	10 - 15	18	100 - 125	21
200 +	9	15 - 20	20	15 - 20	23		
		20 +	5	20 +	9		

Registered Beneficiaries Children		Pregnant Women		Lactating Mothers		Proportion (%) of Attendees (Children)*	
	54		**54**		**54**		

* Data not given for pregnant women and lactating mothers, since the numbers are small.

It is found that on average an AWC has 171 children, 14 pregnant women and 15 lactating mothers registered as beneficiaries. As per the 2001 census data for slums, Malegaon slums have 20% children aged 0-6 yrs. In view of this the registration of 171 children is alright for an AWC with a population of 800 (as per the norm). However, from the point of view of managing the children, this number seems to be beyond capacity. In fact, while planning the AWCs, the authorities might have taken into consideration the overall proportion of children (0-6 yrs), which is 12-13% for slums in Maharashtra and could be slightly higher for rural areas. Malegaon slums are a special case, and furthermore the sample is more specific as it comes from Muslim-dominated areas. This situation implies that the population norms should have been flexible and there should be provision for more AWCs in the Muslim-dominated areas. In the sample, 9 out of 54 centres have more than 200 registered children. It must be just impossible to manage these many children. It is strongly recommended that wherever the registered no. of children goes above 120 some additional facilities (an additional centre, manpower and inputs) have to be provided.

It one looks at the attendance levels, some more surprises are there. There is tremendous variation from 50% to 125%. There are 21 centres (about 40%) with attendance more that 100%. It is difficult to understand, how these children (not registered) are allowed to attend the Anganwadis?

Infrastructure:

Having examined the information on the target for child and woman beneficiaries, the AWWs have a difficult task of taking care of around 170 children, with respect to provision of food supplements, pre-primary education and imparting nutrition and health education for the mothers. The condition regarding the physical infrastructure like condition of the building, the availability of minimum basic amenities such as drinking water, electricity and toilet is studied. From the available information on (i) location, (ii)

condition of the building, (iii) space for cooling, (iv) space for outdoor play, (v) Indoor play, (vi) Electricity, (vii) Toilet, (viii) Drinking water, (ix) Storage for water and (x) Purification of water, a simple score has been constructed, which sums up the responses to the above question. To remind, higher the score, worse are the matters. In addition to the physical infrastructure, availability of medicines and availability of other material and implements also has to be taken into consideration. Here also a simple score (sum of the shortages in both kinds of materials) is constructed. Along with these, an indicator of manpower availability to complete the list of components of infrastructure is needed. In case of AWCs, there are only two persons (AWW and AWH) to man the centre. For the study centres, both these functionaries were there. However, as a proxy for the manpower indicator, again the sum score of the AWW's educational attainment and training undergone is taken. The distribution of 54 centres according to the three indications mentioned above.

Table 9.2: Infrastructure

Physical	Infrastructure (Score)	Shortfall in Materials (Score)		Manpower	Quality (Score)
<20	2	< 4	13	2	14
20 - 24	6	4 - 7	26	3	17
25 - 29	4	8 - 11	13	4	22
30 - 34	36	12 +	2	5	1
35 +	6				
	54		54		54

The above table shows that in case of physical infrastructure it is a truly skewed distribution meaning that majority of the centres have a higher score meaning a poor physical infrastructure. In comparison, the conditions regarding material availability are better. With the maximum sum of 22 points, all shortfalls are within 12. Again as far as the educational and training attainments are concerned, the distribution is slightly inclined towards higher scores meaning poorer attainment. However, in this case, it has to be mentioned that all the AWWs satisfy the minimum educational requirement, namely SSC and basic training. However, a graduate person always could be a better worker and hence this gradation of the score.

One piece of information, which could not be incorporated in the infrastructure index but is indicative of the work-burden of the AWW is the time-allocation of her work. It is observed that AWWs spend 45% of their time in record-keeping, only 18% in feeding and 37% in teaching. Record-keeping, though important, is not so important that she should spend almost half the time in it. Food provision, which is an important activity of AWCs is the one, which comes up with least time spent. AWW has to fill 19 registers. Overall, the AWW is over burdened and hence cannot participate in activities such as … pulse polio … etc. Thirty-one AWWs have reported that they cannot participate in any of the activities.

In short, the physical infrastructure is poor, the material availability is slightly better, but the AWW is overburdened with record-keeping and targets such as 170 children is again difficult to manage. In such circumstances, how do the centres function? How does one measure their performance? Nutrition, pre-primary education and nutrition and health education are the three prime responsibilities of the Anganwadis. As far as 'Child Nutrition' is concerned, the responses of AWWs on the adequacy of supplementary nutrition, quality of the food, parents' complaints and proportion of malnourished children is incorporated in the following table.

Table 9.3: Child Nutrition in Anganwadis

(1) Adequacy of Food		(2) Quality of Food		(3) Parents' Complaints		(4) % Malnourished Children	
Adequate (1)	33	Good(1)	36	No (1)	36	< 5	29
Inadequate(s)(2)	21	Bad (2)	17	Yes (2)	17	5 -15	20
		Can't tell	1	N.G.	1	15 - 25	4
						25 +	1
	54		54		54		54

The above information broadly indicates that according to the AWWs, in about 60-66% of the cases the food provided to the children is adequate, the quality is good and the parents do not have any complaints. But still one-third of the AWWs are not happy with the food provided to the children and it was also observed from the respondent's

responses that the food supplements were not as per the ICDS guidelines. Many a time 'puffed rice' with no nutrients were given.

Pre-primary Education:

As mentioned in the introductory remarks, pre-primary education is an important activity for the children (3-6 yrs.). The contents are lessons on 'story-telling, counting numbers, free conversation, painting, drawing, reading simple words, recognizing pictures… etc. A PSE kit it is provided as per the local needs and resources. It is broadly suggested that the kit should contain flash cards for story-telling, picture books of animals, pictures of fruits, vegetables, parts of the body, stuffed toys, stacking rings, dolls, balls, simple puzzles…. etc. The AWWs are expected to use these in their teaching. As indicators of Pre-primary education, two indicators are used; time spent on teaching and shortfalls in using proper methods of teaching.

Table 9.4: Pre-primary Education

(1) % Time spent on teaching		(2) Shortfalls in PSE activities	
30	37	0	9
40	17	1	6
	54	2	13
		3	13
		4	12
		5	1

As per the planning commission study, the time allocation for Maharashtra in 2009 indicates 40% time for teaching. This study comes up with 37% as the time allocated. The difference is not significant. As far as the shortfall in PSE activities is concerned, average is around 2-3. In a total of 10 activities shortfall of 2-3 is not of serious concern. It means that the pre-primary educational activity may not be having much problems. The household response was also mainly positive for this activity.

Nutrition and Health Education:

This activity is important with respect to creating awareness among the women in the reproductive age-span regarding health and nutrition issues of the family members,

particularly the children and mothers. This is supposed to be done through holding meetings, having slide-shows, exhibitions, paying home visits and clearing the doubts through open discussion.

The questionnaire contains a number of questions about this activity; No. of women attending the meeting, issues discussed in the meeting, the tools used for creating awareness, home-visits, hurdles in having successful home-visits etc. The information on a few important issues is given in the following table.

Table 9.5: Nutrition and Health Education Activity

(1) No. of women not attending meeting per 10 registered children	No. of Centres	(2) Shortfalls in the tools used in women's meetings	No. of Centres
7 - 8	6	0	1
8 - 8.5	14	1	3
8.5 - 9	19	2	8
9 - 10	15	3	15
	54	4	13
		5	14
			54

(3) Hurdles in Home Visits:

1.	Nil	30
2.	Women don't have time	17
3.	Women absent	05
4.	Women's disinterest	01
5.	Elders discourage	01
		—
		54

It is surprising and at the same time unfortunate to find that more than 85% of the women do not attend the meeting in case of 34 centres. The information on these meeting revealed by the respondents also indicated that more than one-third of the

women did not know about the meeting, 62 percent of the respondents had not attended any meeting during last 6 months and nearly half of them did not have time, 9 per cent of them thought that the meetings were not useful and the remaining 42 per cent were not aware of the meetings. All these findings clearly point towards the apathy of the women and thereby towards the AWWs' inability to attract the women towards the meetings. The data on 'hurdles' also point towards 'No interest' on the part of the women. It is necessary to make the meetings more interesting by using different modes such as posters, slide-show, film-show … etc. But from the information the shortfalls in using the tools shows the extreme shortage of modern tools. Apathy of the people, along with the lack of required facilities has resulted into the failure in this activity. This failure is universal. For Maharashtra, (2009) the percentage women attending the meeting is only 26. Worse picture emerging from this study might be because of our sample population coming from extremely poor and uneducated lot and more importantly, the denominators are different.

The data analysed till now lead to findings given below:

(i) The conditions regarding physical infrastructure are extremely poor.

(ii) Lack of space, no toilets, and lack of proper arrangement for clean drinking water has to be seriously looked into. Too much time (45%) is spent on record-keeping.

(iii) Fifteen centres suffer due to more than 33% shortage in materials and medicines.

(iv) Near about 20 AWWs have complained about the inadequacy of food and bad quality.

(v) Pre-primary educational activities are comparatively better conducted.

(vi) The most serious problems are with the women's' meetings only about 15 percent of the women attend the meetings on Nutrition and Health Education in case of 34 centres.

(vii) Out of six prescribed tools, more than 4 tools are not used by 50 percent of the AWWs for Nutrition and Health Education.

(viii) Apathy of the women is clearly reflected through the hurdles in the home-visits.

To test whether the infrastructural availability affects the performance the simple sum scores for the infrastructure and performance is considered after examining the relevant data.

As described in Table 9.2 the sum score for physical infrastructure, shortfall in material infrastructure and manpower quality as the indicator for personnel infrastructure (facilities) is taken. As far as the performance is concerned, the indicators, of 'Nutrition', 'Pre-primary Education' and 'Nutrion and Health Education' are considered. A simple sum score of 'Parents' complaints about nutrition, 'Shortfalls in PSE activities (Table 9.4) and 'No. of women not attending NHE meetings per 10 children (Table 9.5) is taken. The indicators of 'Infrastructure' and 'Performance' are given in Appendix I. A simple correlation coefficient was calculated. It is '0.69', which is statistically significant and quantitatively substantial. It implies that if the infrastructure is good, the performance also will be good. Leaving apart, the correlation and the other statistical exercises, there is no need to have these supports to emphasize that the infrastructure must be improved. With a few exceptions, almost all the Anganwadis have no toilets; have drinking water shortages, no proper implements, storage etc. At the same time the AWW's excessive time spent in record-keeping should be seriously looked into. If the same is sorted out, she would get some more time for PSE activities or mothers meetings, which are not frequently taken and are always with a poor attendance. 'Poor attendance' is a serious problems. The AWWs should make the meetings more innovative so that the women would get inclined to attend. Further, the timing should be so chosen that it is convenient for the women.

Opinions of Community Leaders about the Anganwadis in Malegaon:

In all, 16 community leaders were interviewed. Questions were asked regarding their perceptions about the functioning of the AWCs, the lacunae, the reasons for ill-functioning, if any. The following Table gives the relevant information.

Table 9.6: Responses of Community Leaders

I. Perceived Current Status of AWCs

Perceived No. of Women Beneficiaries	No.	Perceived No. of Children Beneficiaries	No
< 15	5	< 50	6
16 - 40	8	50 - 100	5
41 +	3	100 +	5
Total	**16**	**Total**	**16**

II

Knowledge about Activities for Children		No.	Knowledge about Activities for Women		No.
i	Supplementary nutrition	14	i	Supplementary nutrition	10
ii	Pre-primary education	14	ii	IFA tablets	9
iii	Health check-up	8	iii	Health Education	9
iv	Immunisation	12	iv	Nutrition Education	10

III. **Perception about community's satisfaction about the food at Anganwadi**

		No.			No.
i	Bad quality of the food supply	14	vi	Inadequate food supplement	14
ii	Irregularity in supply	9	vii	Improper identification of beneficiaries	2
iii	Improper practices of cooking and distribution	8	viii	Diarrhea and Vomiting	4
iv	Inadequate material for cooking and distribution	9	ix	Food difficult to digest	8
v	Ration food not available	2	x	Tasteless food	14

IV. Perception about AWW's efficiency in running an AWC and also about the reasons for inefficiency, if any.

		No.			No.
i	Health check-up	7	iv	Immunisation	11
ii	Supplementary nutrition	14	v	Assigned duties	11
iii	Pre-primary education	15	vi	Nutrition & Health education	11

Perception about reasons for inefficiency (8)

		No.			No.
i	No interest	5	iv	Lack of infrastructure	5
ii	Lack of skill	5	v	Lack of support from the govt. and Inadequate implements	5
iii	No support and no cooperation from community	5			

The above extract indicates that the community leaders have general idea about the Anganwadis. For instance their estimate about the women beneficiaries per AWC is about 28, which closely matches the number. However, their perception about the child-beneficiaries is totally wrong. Their estimate is 85, while the true number is exactly twice (171).

Similarly, their perception about the AWC activities is also very broad. They mostly know about the supplementary nutrition, particularly for the children and the pre-primary education. An important activity, namely, nutrition and health education, which even otherwise is neglected, is also less known to the community leaders. A general complaint commonly heard about the AWCs is about the quality, taste and adequacy of food. The same is revealed also by the community leaders' responses.

Perceptions about the benefits of AWCs for the Community:

Four questions in the questionnaire reveal this perception. The following paragraph gives the responses to these questions. Regarding the advantages of the

Anganwadi for the society, the opinion is divided. Eight each of them feel that the Anganwadi is advantageous / disadvantageous.

There is a question about the difference between the children going to Anganwadi and those not attending Anganwadi. It is perceived that the children going to Anganwadi progress well in school, their hygienic habits are better and they are well-behaved. The community leaders have almost a consensus on this perception. Regarding the positive changes in the society occurring due to Anganwadi, 13 out of 16 respondents have responded affirmatively. Responses to a specific question about the kind of changes indicate that the Anganwadis have succeeded in creating awareness about personal hygiene and health, about importance of education and about health care of pregnant women and lactating mothers.

On the one hand the community leaders realize the importance of an Anganwadi and on the other hand they are also aware of the lacunae in the functioning of the AWC. Does the community help in this matter or do the respondent community leaders show any interest? It is found that on an average the leaders are associated with two Anganwadis. Out of the different modes of helping the AWC like getting the place, identifying the beneficiaries, donating some material, helping the construction, making space available for ration storage, sorting out difficulties in functioning, getting educational material, creating awareness about AWC, encouraging children for going to Anganwadi, the leaders help the AWCs in sorting out their difficulties, encouraging children and creating awareness among the people.

On the whole, it appears that the leaders should know more about the AWCs and their genuine difficulties. This will really help the leaders to support the AWC in true sense.

Role of a CDPO in the Functioning of the AWCs

A CDPO and her office has an important role in the functioning of the AWCs since one of the main activity of the AWCs, i.e. supplementary nutrition of children and pregnant and lactating women is totally dependant upon the supply of food items from the CDPO's office, which further is dependant upon the budget for the Anganwadis. Besides these two, one also needs to know about the workload, the CDPO's perceptions about the working of the Anganwadis. The following extract gives information about work load.

Work Load

1)	Population under jurisdiction	1,89,373
2)	No. of AWCs	155
3)	(i) Child Beneficiaries	20,724
4)	(ii) Pregnant Women	2,180
5)	(iii) Lactating Women	2,226
6)	Adolescent Girls	14,305

As per the above information the CDPO has to look after 155 AWCs totaling to a population of 1.89 lakhs, which is quite a burden. In fact the norm for one project for a block is a population of one lakh. It is bound to affect the frequency of the visit. As reported by him he can visit only 35 AWCs in a month, which implies that visit to an AWC is broadly once every 4-5 months. Further, as per his response, there is no committee to coordinate the work between the CDPO's office and Department of Education.

Provision of Food Items:

The data on supply of food items like 'khichadi, sprouts, rice, etc. are given for 10 months (August 2009 to May 2010). On an average 22959 kg. of food items are supplied every month. An amount of 7336 kg. of nutritious diet also is provided every month. This probably is the food for malnourished children. A simple calculation shows that on an average a beneficiary (child/PW/LW/) gets 155 gms. of food supplements leading to 505 calories. As per the norm child beneficiary should get 500 calories, while the pregnant and lactating women should get 600 calories. The overall average comes out to be 523. Thus as per the provisions, the provision is as good as per the norm. However, the survey indicates that only 81% of the children and 60% of the pregnant and lactating mothers are effectively getting supplementary nutrition for the whole year. Even if one assume that they got adequate food, the above estimates of coverage lead to about an overall coverage of 75%. The supply figures given above show that the provision is adequate enough for the estimated beneficiaries. But the findings of the study, by the Planning Commission, is that the sanctioned funds are not fully used for the Anganwadis and siphoned off to the officials. As per the report Maharashtra is one of the

good performing states. Still the lapses are clearly visible. The following excerpt enlists the issues along with the CDPO's perception.

Issue		CDPO's Opinion	
i Important objective of ICDS		i	Reduction in Child Mortality
		ii	Reduction in Maternal Mortality
		iii	Increase in school enrollment
		iv	Enhancement in immunization of pregnant woman
ii	Reasons for child malnutrition	i	Poverty
		ii	Lapses in immunization
iii	Functional lapses of the ICDS programme	i	Inadequate remuneration of AWWc
		ii	Benefits of the scheme not reaching the people
iv	Quality of the food supplied	Good	
v	Remedies for shortage in food supply	Equitable Distribution	
vi	The effect of hurdles like shortage of food supply, bad quality, winter, summer … etc. on the functioning of the scheme	No effect	
vii	Control over the regularity of food supply	Frequent visits to Anganwadis	
viii	No. of Anganwadis visited per month	35	

Issue		CDPO's Opinion
ix	Problems in running Anganwadis	Food supply
x	Obstacles in implementing ICDS Scheme	Political interference Lack of CDPO training Lack of training for supervision Shortage of staff Non-participation of the community Heavy Workload AWW training difficult Lack of coordination with the Health Staff

The above-mentioned responses, on one hand, point towards the problems he has to face in running the scheme, while, on the other hand, they also indicate the unclear perceptions about the reasons for malnutrition / objectives of ICDS…. etc.

CHAPTER 10

SUMMARY AND FINDINGS

The study was taken up at the instructions of the State Government Minority Commission. As the title suggests, the study mainly focuses on 'Access to ICDS benefits and 'Availability of Public Health Services' for the Muslims residing in slums of Malegaon. The specific objectives of the study are:

(i) To study the functioning of ICDS centres based on stipulated government norms in Malegaon.

(ii) To study the socio-economic profile of the beneficiary households.

(iii) To evaluate whether the benefits are reaching the people

(iv) To evaluate whether the health services are reaching the needy.

(v) To find the opinions of the officials and community leaders about ICDS

The sampling design selected for the study is a two-stage sampling design. At the first stage Anganwadi centres are selected, while at the second stage, the households with beneficiaries are selected. The study was carried out in the Muslim-dominated slums of Malegaon, which had 55 Anganwadis. From each Anganwadi, 40 households with at least one child beneficiary were selected. The pregnant women and lactating mothers in these families formed the samples of these categories. They are 232 and 293 respectively. The sample of households with child beneficiaries should have been of 2200 households. However, due to some survey problems, the final sample consists of 2081 households. At the time of the main survey the investigators could not find any non-beneficiaries. However, after a lapse of some time, an attempt was made to identify non-beneficiaries and 88 non-beneficiaries were interviewed. Seven types of questionnaires were prepared.

(i) Anganwadi Centre, (ii) Beneficiary Household, (iii) Non-beneficiary household (iv) Medical Officer, (v) ANM, (vi) Community Leader, (vii) Child Development Programme Officer.

The field-work was completed during December 2010 - February 2011.

Since ICDS is an old scheme, it has been evaluated by many agencies. This study has one distinction, namely, that it has been carried out for a community with a single religion, i.e. Muslims. Generally, it has been found that although the scheme is chalked

out well, a number of drawbacks in its functioning have been brought out by the evaluation studies.

The Present Study Background Profile:

As one could expect, the respondents' economic background is quite poor. Compared with the data for Mumbai Slums and Nagpur Slums, the housing characteristics of our respondents have clearly brought this out. For example, Mumbai Slums have 98% of the houses with 'Pucca' construction, while for Malegaon Slums, this percentage is about 12. The data on consumer expenditure reveal that the Monthly per Capita Expenditure is Rs. 625/-, which is close to the first decile (567) of the ascending order of consumer expenditure as per NSS 64th found (2007-08). The educational attainments are also quite low. As large as 29% of the heads of households are illiterate. The only ray of hope gets reflected through a high-order school-attendance (93%) of children aged 7 - 14 yrs.

Attendance of Child-beneficiaries at Anganwadis:

It is observed that out of 2081 children, 646 children, though registered, do not attend the Anganwadi. They are from the younger ages, i.e. 0-3. It is not unexpected, as, for the children aged 0-3 yrs, it is only a 'Take Home Ration' Scheme, which is applicable and hence attendance is low. Earlier studies also have brought out the 'low attendance of children aged 0-3 yrs.

Supplementary Nutrition - Children

As per the ICDS guidelines, children aged 0-3 yrs. are provided dry or raw ration, while children aged 3-6 yrs. are expected to get hot cooked meal like Khichadi, cooked vegetables, sprouted beans, fruits, ground-nuts etc. which will give them 500 calories. The data on actual practice reveal the following:

(i) 8.1 per cent of the children did not have food from the Anganwadi

(ii) Children got food for 22 days (instead of 25)

(iii) These observations lead to an effective coverage of 81 percent.

(iv) Only 75 percent of children are reported to be getting nutritious food like Khichadi/Usal… etc.

(v) 67 percent of the respondents report the quality of the food to be good.

(vi) Majority of respondents report 'others' as the supplementary diet, which could be '*churmure'*.

Supplementary Nutrition-Pregnant and Lactating Women:

As per the guidelines, the pregnant and lactating women should get nutritious food worth 600 calories. The information on actually available food reveals the following observation.

(i) 19.3% of the P&L women did not get good at the Anganwadi

(ii) 5.8% of the P&L women did not take it

(iii) On an average food was available for 20 days

(iv) Effective coverage was 60% only.

(v) Half of the women reported getting dry ration like 'Vita-shakti', while about one-third women report getting khichadi.

(vi) About 60 percent women report 'good' quality.

In short, in comparison with children, the pregnant and lactating women are not getting benefits as expected. Like the children aged '0-3' yrs, these women are also under 'THR' scheme. This could be one reason. Another reason could be short supply of the dry ration.

Pre-School Education:

An important activity of the Anganwadis deals with the Pre-School Education (PSE). This activity is for the children aged 3-6 yrs. With the help of some educational tools the AWWs are expected to teach the children basic things like counting number, reading alphabets/words, telling stories, reciting poems, drawing etc. From the relevant data, it is observed that the performance is about 70 percent. The least performance is observed for 'Drawing/painting', which is natural, since the centres could be lacking in the drawing materials. Now-a-days, the parents sending their children to Anganwadis in cities have started demanding teaching in English Medium. Usually, it is observed that children come for the food and then leave for their schools.

Nutrition and Health Education:

This is an important activity of the Anganwadis but at the same time, most ignored one. The following observations demonstrate the apathy.

(i) Expected attendance at the meeting - 150, while the actual attendance (max.) is 35.

(ii) % women having never attended a meeting - 62

(iii) % women having 'No idea' about the last month's meeting - 59

(iv) % women not having time for the meeting - 47

(v) The issue most neglected in implementation-family planning.

This failure is on account of two factors, one, the AWW is overburdened with about 170 children to look after. On account of this pressure, she might not be getting time for holding the meeting. Another reason is the apathy of the people. They look at the Anganwadi just as a 'Creche'. They are not interested in getting knowledge about the health issues.

Health Status of Children:

The assessment of health status of children can be done on the basis of their birth-weight, current weight and the sicknesses. The proportion of children with birth-weight less than 2.5 kg. (Normal weight) is only 9.3%, while the data from NFHS-III (2005-06) for urban India put it at 19.1%. This is indicative of better health of children from Malegaon slums. The current weights also match fairly well with the WHO standard,. In contrast to these findings, the data on sicknesses show that as large as 41% children suffered due to diarrhea. The diarrhea incidence rate for Mumbai slums in 2005-06 is about 7%. The higher prevalence of diarrhea in Malegaon could be due to extremely poor sanitary conditions at their residence. Although, the parents do not seem to be ignoring the children's sickness, the higher order of sickness of cannot be ignored.

In this context, it will be worthwhile to look into the availability of medical facilities and their coordination with the Anganwadis. Six doctors and 11 ANMs were interviewed. ANMs appear to be better connected with the Anganwadis than Doctors. Overall awareness about the vital events and their progress, though, not perfect, is in the

desired direction. However, their knowledge about the health care indicators like immunization is so vague that one feels surprised to know about it.

Responses of Non-beneficiaries:

As mentioned earlier, no non-beneficiary could be identified at the time of the survey. However, afterwards an attempt was made to look out for non-beneficiaries and 88 non-beneficiaries could be interviewed. The prescribed questionnaire provides for the following kinds of information for the non-beneficiaries.

(i) Socio-economic background of the household

(ii) Diet at home, immunization and health status of children, Health care, Learning skills.

(iii) Information about AWC.

(iv) Opinions about existing health services.

(v) Awareness about existing health programmes.

A comparison of beneficiary and non-beneficiary households could lead to an assessment of benefits of Anganwadis. The findings (limited by the wide-gap between number of beneficiaries and non-beneficiaries) are as follows.

(i) The non-beneficiary households are poorer

(ii) Probably, because of their poverty, the diets at home are poorer with respect to nutritional values.

(iii) Similarly, the proportion of 'LBW' babies is higher than that for the beneficiaries.

(iv) The proportion of sick children taken to hospitals is lower.

(v) Learning skills like story telling, reciting poems etc. is poorer. This reflects directly the benefits of 'Anganwadis'.

(vi) They, being new to the city, lack knowledge about the nearby Anganwadi. However, they are keen to send their children to Anganwadi.

Functioning of Anganwadis:

A detailed questionnaire filled for the 54 AWCs has released abundant information about their functioning and related factors. On an average, an AWC has 170 child beneficiaries, 14 pregnant women beneficiaries and 16 lactating women beneficiaries. The figures are indicative of the AWW's work-load. The data analysed reveal the following:

(i) Conditions regarding physical infrastructure are very poor. No toilets, lack of proper arrangement for a clean drinking water, shortage of space…. are the problems.

(ii) Fifteen centres suffer due to more than 33% shortage of medicines and material supply.

(iii) Twenty AWWs have complained about the inadequacy of food and quality of food. However, the figures of supply of food items show that they are adequate as per the norm.

(iv) Pre-primary educational activities are carried out quite satisfactorily. However, the lack of educational tools is clearly felt.

(v) The most serious problems are with respect to 'Nutritions and Health Education' meetings for women. Only about 13 percent of the women attend the meeting.

(vi) The work-load and the time needed to record-keeping are beyond the capacity of the AWW.

Opinions of Community Leaders and CDPO:

Sixteen community leaders and the CDPO were interviewed for their perceptions about the ICDS in their area and suggestion. It appears that the opinion leaders are quite aware of the problems regarding food supply and its quality. The reasons for inefficiency are given as, lack of infrastructure, lack of support from the community as well as lack of skill among the AWWs. Here also, their perception about 'Nutrition and Health Education' as an activity of the ICDS is of a lower order. CDPO also has not mentioned it. The CDPO, as expected, has denied agreeing to the food supply problems. On the whole, it appears that these officials and also the community leaders should know more

about the Anganwadi. This will help in sorting out their problems on a wider front. ANSs seem to have better contact with the Anganwadis, in comparison with factors. The medical personnel seem to have limited knowledge about the wide events.

CHAPTER 11

AVAILABLE MEDICAL FACILITIES AND THEIR COORDINATION WITH ANGANWADIS

In order to know the views of the service providers, six doctors and 11 ANMs working at the 6 UHPs in Malegaon have been interviewed. The interviews mainly deal with the coordination with the Anganwadis, the current situation about various ailments and the services provided. The service providers opinions about the coordination with Anganwadis are

	Average No.	**Doctors (6)**	**ANMs (11)**
(i)	Anganwadis visited during last year	14	
(ii)	Frequency of visits to Anganwadi		Once a fortnight - 7
(iii)	Emergency visits		All activities except birth/death registration
(iv)	Supply of medicines on demand		Full, except deworming ORS, IOA & tablets & Dyclomine

It appears that ANM has better contact with the Anganwadis compared to the doctors. The doctors are of the opinion that for better coordination between ANMs and Anganwadi, provision of medicines and health services, whenever needed and carrying out the immunization activity with the help of AWW should be done without fail.

Next, the views of medical personnel regarding the changes in vital rates such as maternal mortality, child mortality, birth rate and educational indices such as school attendance and drop-out rates is as follows

	Doctors (6)	**ANM (11)**
Maternal Mortality Rate	No. change (2)	Has reduced
	Has reduced (4)	
Child Mortality Rate	No. change (2)	Has reduced

	Doctors (6)	ANM (11)
	Has reduced (4)	
Birth Rate	No. change (3)	Has increased (1)
	Has reduced (3)	No change (2)
		Has declined (8)
School Attendance	Has increased (5)	Has increased (9)
	Has declined (1)	Has declined (2)
Dropout Rate	Has increased (1)	Has increased (2)
	No change (1)	No change (3)
	Has declined (4)	Has declined (6)

The response appears mixed. The doctors mainly seem to differ about the direction of the changes. In fact, the impact of ICDS cannot be assessed only through personal interviews and hence only their observations is noted and analysed further.

Next, a question is asked to know about the prevalence of the diseases mainly preventable through immunization (Polio, Diphtheria, Whooping Cough, Tetanus, Measles, TB and Diarrhea). The response seems to differ widely between the Doctors and ANMs. For example, the ANMs seem to ex-aggregate T.B. cases, while Doctors have reported only a few T.B. cases and diarrhea. The T.B. cases reported by the ANMs are in the range (100-850) as reported by four of them, while the Doctors have reported only 20-30 cases. On the other hand, in case of diarrhea, which is more common, the ANMs have reported cases only upto 5.

Questions about immunization of children and antenatal care are asked only to the ANMs. The following excerpt gives the responses in brief.

Sr No	Item	Range	Reason for lack of full coverage
i	Immunisation of children	30%-85%	Lack of awareness of parents
ii	3 ANC visits to pregnant women	30%-100%	No response

Sr No	Item	Range	Reason for lack of full coverage
iii	TT immunization and IFA tablets for pregnant women	50%-100%	Not applicable (10 cases) Weight gain (1 case)

One has to take these observations with caution, since it is based only on 11 cases. The range is so wide that it is indicative only of 'no proper idea' about the quantitative coverage. Thereby it is suggested that the Health Department under its IEC activity should arrange for dissemination about the current status of health and health services for the medical and paramedical personnel, so that they could understand the needs in a better way.

CHAPTER 12

RECOMMENDATIONS

(1) As against 12.13% of the population belonging to children aged 0-6 yrs. in slums of Maharashtra, Malegaon Slums had 20% of the population in the ages 0-6 yrs. Further, it was also found that on an average, an Anganwadi in Malegaon slums had to cater to around 170 children. This indicates the burden on the Anganwadis. Taking into account the data, it is recommended that in Malegaon slums, there should be one Anganwadi for 800 population, instead of 1000 (usual norm.)

(2) It was observed that majority of the children not attending Anganwadis were from the age-group 0-3 yrs. It is recommended that the children aged 0-3 yrs. should be kept out of the ambit of the Anganwadis. A study carried out by Institute of Health Management, Pachod also had come up with a similar suggestion.

(3) In case of supplementary nutrition for children, it was observed that only 75 percent of the children had received nutrition food like 'khichadi'… etc. Since 'nutrition' is one of the basic functions of the ICDS Scheme, it has to be looked into carefully.

(4) The condition of pregnant and lactating mothers was more serious. Only 60 percent of them could get the Take Home Ration. Further, only 60 percent of the women reported the quality to be good. There was a suggestion that the packets of ‘Take Home Ration’ should be distributed in the Gramsabha, so that the women would not have to collect it from the AWCs. Further, not only from this study, but even otherwise there have been complaints about the quality of Take Home Ration. The authorities have to look into the problem seriously.

(5) The data on 'Diarrhea incidence' revealed that 41% of the children suffered due to diarrhea. This is too high compared to the NFHs results for Mumbai Slums (7%). The Municipal Corporation has to seriously think

about the poor sanitation, which given rise to infections diseases like ' Diarrhea ' .

(6) Pre-school Education is an important activity, besides supplementary nutrition. On the basis of the survey, the Anganwadis should have more drawing/painting material, which will improve children's' drawing/painting skills.

(7) Nutrition and Health Education - an important IEC activity is the most ignored one. Excessive workloads for the Anganwadi workers and the women's apathy have led to the under-utilisation of this activity. Efforts should be made to create awareness about this activity.

(8) The children from the non-beneficiary households lack in everything related to their development. The parents are keen to send their children to Anganwadis. It is recommended that surveys should be done and Anganwadis be opened.

(9) The poor infrastructure of the AWCs points out to the need for improvement. There are shortages in supplies of medicines and materials. The children should be improved. In fact, as illustrated in this report, the infrastructure index is closely related to the performance and hence intensified efforts are necessary to improve the infrastructure.

(10) AWW spends 45% of their time only in record-keeping. It is recommended that this work of hers should be reduced, so that she could spend her time for more valuable activities like pre-school education and nutrition.

(11) As per the CDPO's report the food supply received for Anganwadis is as per the norm. However, the complaints of some AWWs and also the data on inadequate adequacy of food indicate that there is a gap between the supply and receipt. The authorities should seriously look into the matter.

(12) It is suggested that one of the ways to reduce the burden of the AWW could be to transfer of the health component to the health department.

(13) The coordination of AWW with the ANM is better than that with Doctors. However, Doctors also should get closer to the AWCs.

(14) Right perception of the Health Staff regarding vital events help them in understanding the health issues better. However, they seem to be lacking in the knowledge about the vital rates. A dissemination workshop seems to be necessary.

(15) The opinion leaders seem to be aware of the AWC activities particularly about supplementary nutrition. However, they also are not aware about the 'Nutrition and Health Education Activity' of the centre. It is recommended that the importance of this activity should be explained to the opinion leader, doctors and all those connected with AWCs.

Appendix I

Infrastructure and Performance Indicators of 55 AWCs

Centre	I	P	Centre	I	P
1	44	11.0	28	47	13.1
2	34	11.4	29	24	10.0
3	25	10.5	30	40	11.6
4	46	14.3	31	45	9.4
5	37	12.5	32	40	12.9
6	39	13.0	33	30	9.1
7	42	12.6	34	35	10.3
8	40	13.0	35	44	13.0
9	24	9.0	36	44	12.7
10	44	12.2	37	45	14.3
11	44	12.0	38	24	8.6
12	49	12.4	39	27	9.5
13	36	9.6	40	52	14.8
14	51	14.2	41	39	12.5
15	37	11.7	42	40	12.7
16	41	13.8	43	39	15.3
17	43	14.3	44	31	11.1

Centre	I	P	Centre	I	P
18	41	14.4	45	37	14.0
19	43	9,3	46	42	8.4
20	47	15,1	47	39	14.0
21	43	11.8	48	47	12.8
22	43	11.2	49	37	13.7
23	42	14.1	50	38	13.5
24	44	13.4	51	45	12.0
25	27	12.0	52	45	10.7
26	43	13.4	53	48	13.4
27	44	12.4	54	43	12.4

Item	Yes	No
BCG - Polio-0	1340	4
DPT-I-Polio I	1331	8
DPT-II-Polio II	1277	50
DPT-III-Polio III	1106	171
Hepatitis - B - I	840	353
Hepatitis - B - II	661	514
Hepatitis - B - III	507	649
Measles +Vit A-I	1164	133
DPT Polio	899	292
Vit A2	867	246
Vit A3	608	343
Vit A4	415	476
it A5	262	587
DT	117	692