

# **ANGANWADIS FOR ALL**

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**A Primer**

**December 2007**

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**Action for Rights of Children under Six**

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**December 2007**

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## PREFACE

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

The first major order, dated 28 November 2001, directed the government to fully implement nine food-related schemes as per official guidelines. In effect, this order converted the benefits of these schemes into “legal entitlements”.\* Integrated Child Development Services (ICDS), also called “Anganwadi Programme” in this booklet, is one of the schemes covered by this Supreme Court order. In the case of ICDS, the order actually

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

went further than just converting existing benefits into legal entitlements: it also directed the government to “universalize” the programme. This means that every hamlet should have a functional Anganwadi, and that the coverage of ICDS should be extended to all children under six and all eligible women.

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

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

The campaign for “Universalization with quality” received a further boost on 13 December 2006, when the Supreme Court delivered a far-reaching judgement on ICDS. This

judgement calls for universal coverage by the end of December 2008, and clarifies that this involves “extending all ICDS services to every child under the age of 6, all pregnant women and lactating mothers and all adolescent girls”. It also states that if any settlement has more than 40 children under six, but no anganwadi, it is entitled to have an anganwadi within three months of the date of demand. This principle of “anganwadi on demand” is an important breakthrough.

However, in spite of these orders, there has been little progress so far in terms of the situation on the ground. The expansion of ICDS is very slow, and there is little evidence of major quality improvements. This reflects the fact that Supreme Court orders are not enough. Ultimately, what is required is a broad-based movement for the Universalization of ICDS, involving not only the government but also the public at large. It is to support this movement, and your own involvement in it, that this booklet has been prepared.

## ACKNOWLEDGEMENTS

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# UNIVERSALIZATION WITH QUALITY:

## Action for ICDS

### 1. INTRODUCTION

This Primer is concerned with the basic rights of children under the age of six years (“children under six” for short), especially their right to nutrition, health and education. It focuses on the Integrated Child Development Services (ICDS) as a crucial means of protecting these rights. Of course, other interventions are also necessary to protect the rights of children under six. These include, for instance, crèche facilities and maternity entitlements, which are virtually non-existent today. Crèche facilities at the workplace are needed to ensure continued breastfeeding as well as emotional security for the young child. Maternity entitlements, for their part, are essential to enable the mother to recuperate after giving birth, and to give adequate time to the fragile infant. Health services, of course, are equally critical. The protection of children's rights also calls for far-reaching action in fields such as elementary education, gender relations and even property rights. The special role of ICDS, which is the main focus of this Primer, must be seen in this larger context.

As far ICDS is concerned, this Primer makes a case for “universalization with quality”. The primary responsibility

for achieving this goal belongs to the government, but public pressure is essential to hold the government accountable to this responsibility. How public pressure can be built is discussed in the concluding section of this Primer – “What We Can Do”. The first step, however, is to think clearly about the issues. We begin, therefore, with a brief discussion of ICDS and the various roles it can play in safeguarding the basic rights of children under six.

### **What is ICDS?**

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

The Government of India started the ICDS as a Project 1975. The stated objectives of ICDS are as follows:

### **ICDS : Official Objectives**

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

Source: Booklet on ICDS, Department of Women and Child Development, 1975

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

ICDS services are provided through a vast network of ICDS centres, better known as “Anganwadis”. The term 'Anganwadi' developed from the idea that a good early child care and development centre could be run with low cost local materials even when located in an 'angan' or courtyard. The anganwadi centre is operated by a modestly paid “Anganwadi worker” (AWW), assisted by an “Anganwadi helper” (AWH) or sahayika. The local Anganwadi is the cornerstone of the ICDS programme.

## 2. ICDS AND CHILDREN'S RIGHTS

### Why is the Anganwadi Programme so important?

The Anganwadi Programme is important:

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

**Because** this is also the most rapid period of human development: from an infant unable to even hold up its head, to a chattering child, running around, asking a hundred questions, getting ready for school – this is the journey a child covers in just six years.

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

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

## **How are Indian children doing?**

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

- Half of all Indian children are undernourished.
- Out of 1000 babies, about 60 die before the age of one.
- One third of Indian babies are born with a low birth-weight.
- Barely one half of all children complete eight years of schooling.

## **How does this matter?**

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

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

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

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

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

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

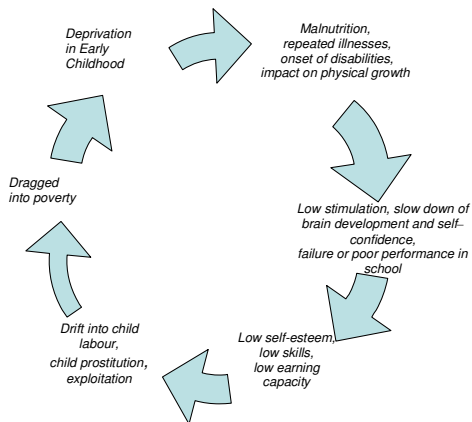
Without schooling, millions of children are pushed into child labour and condemned to a lifetime of social exclusion, low earnings, and exploitation. Some work long hours as domestic helpers or in dhabas, others are forced into begging or prostitution, or end up as rag-pickers. When they grow up, they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

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

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

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

Again, not well at all. Malnutrition levels in India are among the highest in the world. So is the proportion of low birth-weight babies. In Bangladesh, the infant mortality rate is 56 per thousand, compared with 62 per 1,000 thousand in India. School attendance rates are also higher in Bangladesh than in India, in spite of Bangladesh being much poorer than India.



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

### **3. SOME FACTS ABOUT CHILD MALNUTRITION**

#### **When does malnutrition begin?**

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

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

Exclusive breastfeeding is recommended for children up to six months of age. Beyond this period, mother's milk alone is not sufficient for the growing child. The infant is also still helpless – she can't feed herself, or ask for more. She is also more prone to infections during this period. A child at this age needs frequent meals of softened food that only an adult can give her, along with continued breastfeeding. Many children are deprived of these healthy feeding practices, and as a result, their nutrition status worsens.

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

Because they are deprived of adequate time, energy, resources, power and knowledge. Many of them have to work to earn a livelihood and to juggle this with taking care of their homes (cooking, fetching water, cleaning, etc.). So, they often lack time and energy to take care of the frequent feeding that a young child needs. Women seldom get support from other adults in the family because taking care of a young child is regarded as the sole responsibility of the mother. She usually depends for

support on her other children, sometimes as young as four to five years of age - young children who are in need of care themselves.

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

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

Very little can be made up later. A plant denied adequate food, water and sunshine may grow but it will not be strong. Water and fertilizer later on will help it survive - but not thrive and give good fruit. So with our children: midday meals, scholarships, special schools for child labourers do help, but they cannot make up for what has been denied during the first six years of life.

### **Can ICDS make a difference?**

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

## **4. BASICS OF THE ANGANWADI PROGRAMME**

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

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

#### **Box 1**

##### **Main Services Provided Under ICDS**

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

#### **A. Nutrition**

1. **Supplementary Nutrition (SNP):** The nutrition component varies from state to state but usually consists of a hot meal cooked at the Anganwadi, based on a mix of pulses, cereals, oil, vegetable, sugar, iodised salt, etc. Sometimes “take-home rations” (THR) are provided for children under the age of three years.
2. **Growth Monitoring and Promotion:** Children under

*Contd...*

three are weighed once a month, to keep a check on their health and nutrition status. Elder children are weighed once a quarter. Growth charts are kept to detect growth faltering.

3. **Nutrition and Health Education:** The aim of NHE is to help women aged 15-45 years to look after their own health and nutrition needs, as well as those of their children and families. NHE is imparted through counselling sessions, home visits and demonstrations. It covers issues such as infant feeding, family planning, sanitation, utilization of health services, etc.

## **B. Health**

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

*Contd...*

other children requiring medical attention with the public health care system. Cases like these are referred by the Anganwadi worker to the medical officers of the Primary Health Centres (PHCs).

### **C. Pre-School Education**

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

### **Who is in charge of providing these services?**

ICDS is a complex programme with many actors. The basic responsibility for implementing the programme rests with the State Government. The nodal department responsible for implementing ICDS at the state level is typically the Women and Child Development Department, or sometimes a related department (e.g. the Social Welfare Department).

At the ground level, the lead role is played by the Anganwadi worker (AWW), who shoulders many responsibilities as the sole manager of the Anganwadi. Active Anganwadi workers are true heroines. Their effectiveness depends on the support and cooperation of many other people: the Anganwadi helper, the Auxiliary

Nurse Midwife (ANM), the supervisor, the Child Development Project Officer (CDPO), among others, and of course the village community. Further details of different actors and their respective roles are given in Box 2.

**Box 2**  
**ICDS: The Main Actors**

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

**Anganwadi Worker (AWW):** She is the pillar of the programme. Her job is to run the Anganwadi: survey all the families in the neighbourhood, enrol eligible children, ensure that food is served on time every day, conduct the pre-school education activities, organise immunization sessions with the ANM, make home visits to pregnant mothers, and so on the full list is very long!

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

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

*Contd...*

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

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

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

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

**The community:** Community participation is an important element in the design of ICDS. It can do a lot to help the effective functioning of Anganwadis. For instance, the community can be mobilised to provide the Anganwadis with better facilities (e.g. a ceiling fan), to ensure that they open on time every day, or to encourage mothers to participate in counseling sessions. Community participation can take place through Gram Panchayats, Mahila Mandals, Self-Help Groups, youth groups or just spontaneous cooperation. Unfortunately, community participation in ICDS is quite limited as things stand.

## 5. UNIVERSALIZATION WITH QUALITY

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

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

What does this have to do with Supreme Court orders?

On 28 November 2001, the Supreme Court directed the government to universalize ICDS. Further orders to this effect were issued on 29 April 2004, 7 October 2004 and 13 December 2006. A summary of recent Supreme Court orders on ICDS is given in Box 3.

#### **Box 3** **Supreme Court ORDers on ICDS**

- Order dated 28 November 2001
  - Each child up to 6 years of age is to get 300 calories and 8-10 gms of protein.
  - Each malnourished child to get 600 calories and 16-20 grams of protein.
  - Each pregnant woman, nursing mother and adolescent girl to get 500 calories and 20-25 grams of protein.
  - Every settlement is to have an Anganwadi.
  
- Order dated 29 April 2004

*Contd...*

- o All 0-6 year old children, adolescent girls, pregnant women and nursing mothers shall receive supplementary nutrition for 300 days in the year.
- Order dated 7 October 2004
  - o The number of Anganwadis shall be increased from 6 to 14 lakhs.
  - o The minimum norm for the provision of supplementary nutrition shall be increased to Rs. 2/- per child per day.
  - o All sanctioned Anganwadis shall be operationalised immediately.
  - o All SC/ST hamlets shall have Anganwadis as early as possible, and hamlets with high SC/ST populations should receive priority in the placement of new Anganwadis.
  - o All slums shall have Anganwadis.
  - o Contractors shall not be used for the supply of supplementary nutrition.
  - o The Central Government and States/UTs shall ensure that all amounts allocated are sanctioned in time so that there is no disruption in the feeding of children.
  - o All State Governments/UTs shall put on their websites full data for the ICDS programme including where Anganwadis are operational, the number of beneficiaries category-wise, the funds allocated and used, and related matters.
- Judgement dated 13 December 2006 [see also Appendix 3]
  - o Government shall operationalize a minimum of 14 lakh Anganwadis by December 2008.
  - o All SC/ ST hamlets to be identified and given anganwadis on “a priority basis”.
  - o Rural communities and urban slums with at least 40 children

*Contd...*

- under six are entitled to an “Anganwadi on demand”.
- o Universalization of ICDS involves extending all ICDS services to every child under six.
  - o At least Rs. 2/- per child per day must be allocated and spent on supplementary nutrition.

Note: For further details see Supreme Court Orders on the Right to Food: A Tool for Action, available from the secretariat of the right to food campaign (see Appendix 1).

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

Prior to the Supreme Court orders, the Anganwadi programme was intended for poorer sections of the population. The primary focus of ICDS was on rural areas, while only a small number of Anganwadis were earmarked for urban areas. Even in rural areas, the programme was not in place everywhere. Also, it was often restricted to BPL families (i.e. families that have a “BPL card”). But the Supreme Court has made it clear that these restrictions should be removed and that “all” means “all” - not just the BPL children.

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

Needless to say, they have to be covered too. In fact, SC/ST hamlets are to receive priority in the allocation of

new Anganwadis, according to Supreme Court orders. And like rural communities, urban slums are now entitled to an “Anganwadi on demand” - see below.

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

Today, about 5.5 crore children are covered under the “supplementary nutrition” component of the Anganwadi programme. This is barely one third of all children below the age of six years. In other words, the coverage of ICDS is very far from universal.

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

There are 8.3 lakh operational Anganwadis, as on 31 March 2007.

### **What are the current “population norms” for the creation of new Anganwadis?**

Until recently there was a standard norm of “one anganwadi per 1000 population” in rural areas (modified to one per 700 in tribal areas). Revised norms have recently been proposed by an Inter-Ministerial Task Force, whereby the standard norm would be as follows: one anganwadi for settlements with a population between 400 and 800, one anganwadi per 800 population for larger settlements.

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

The Supreme Court has ordered the government to increase the number of Anganwadis to 14 lakh at least by the end of December 2008 (see Appendix 3).<sup>1</sup>

## **The Supreme Court judgement of 13 December 2006 also talks of “Anganwadis on demand”. What is that about?**

The Supreme Court judgement states that settlements with at least 40 children under six but no Anganwadi are entitled to an Anganwadi “on demand” within three months of the date of demand (see Appendix 3). This is a very important order, which not only reaffirms that ICDS services are a legal entitlement, but also suggests a mechanism to ensure that this entitlement is realised.

The principle of “Anganwadi on demand” can also be seen as a safeguard against the failure to apply improved norms consistent with universalization: if the government does not provide an Anganwadi, people will have a right to demand it. See Appendix 2 for a sample application form for an 'Anganwadi-on-demand'.

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<sup>1</sup> The Supreme Court benchmark of “14 lakhs” (which goes back to earlier orders) is not based on the above improved norms. It is based on earlier recommendations of the National Advisory Council.

## **Does the principle of “Anganwadi on demand” apply in urban areas as well?**

Yes. As per the Supreme Court judgement, “rural communities and slum dwellers” are entitled to an Anganwadi on demand within three months.

## **What happens in settlements with fewer than 40 children?**

According to Central Government guidelines, tiny settlements are supposed to be reached through “mini-Anganwadis”. However, Anganwadi workers in mini-Anganwadis are paid only Rs. 125 a month (effective from February 2005), and the services are restricted mainly to supplementary nutrition although the norms state that mini-anganwadis are to provide ALL ICDS services. Thus, the present arrangements for tiny settlements are inadequate.

Supreme Court orders do not rule out “mini-Anganwadis” in tiny settlements. However, these orders clearly state that all children under six are entitled to all ICDS services. For instance, the judgement of 13 December 2006 states in no uncertain terms that “the universalisation of the ICDS involves extending all ICDS services... to every child under the age of 6, all pregnant women and lactating mothers and all adolescent girls” (see Appendix 3). Mini-Anganwadis need to be revamped for this purpose. Clearly, the extension of ICDS services to tiny or

dispersed settlements is a challenging area of further work. This issue is all the more important as these settlements are often inhabited by disadvantaged communities with high levels of child malnutrition.

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

No. Extending the coverage of ICDS is not enough. As discussed in the next section, a radical improvement in the quality of ICDS services is also required. The real objective should be “universalization with quality”, or more precisely, “universalization with quality and equity”. To recapitulate, this essentially implies the following: (1) every settlement should have a functional anganwadi; (2) ICDS services should be extended to all children under the age of six years (and all eligible women); (3) the scope and quality of these services should be radically enhanced; and (4) priority should be given to disadvantaged groups in this entire process. In this Primer, the term “universalization with quality” is used as a summary term for these broad demands.

## **6. IMPLEMENTATION AND QUALITY ISSUES**

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

The quality of ICDS varies a great deal between different states, and sometimes even between different Anganwadis within the same state. Generally, the quality of ICDS is not very good, and there is a big gap between promise and reality. However, experience shows that with adequate political will, the conditions required for ICDS to work can be created. These enabling conditions involve, for instance, higher budget allocations, better infrastructure, enhanced human resources (e.g. better training of anganwadi workers), closer monitoring, improved accountability, and more active community participation.

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

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

## **Low budgets**

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

Not only is the overall budget low, the item-wise breakdown also shows glaring inadequacies and imbalances. For example, each Anganwadi in rural areas receives a mere Rs. 150 per month for “rent”, and for urban areas it is Rs. 500 per month. Getting proper space for an Anganwadi within this budget is almost impossible.

Similarly, few states have made reliable arrangements to provide anganwadis with medical or education kits. Even the expenditure norm for “supplementary nutrition” was as low as Re. 0.95 per child per day (to be contributed by the State Government) in 2004-5. The norm has since been doubled by the Central Government, in response to Supreme Court orders, but many states continue to allocate much less than the stipulated amount, and actual expenditure is even lower.

### **Staffing gaps and poor infrastructure**

Because ICDS is not a priority, State Governments often fail to appoint Anganwadi workers, supervisors and other essential staff. Many Anganwadis are non-functional or poorly supervised due to shortage of essential staff. To illustrate, only 43 of the 167 posts of Anganwadi workers in Chandauli Block of Varanasi District (Uttar Pradesh) were filled at the time of the FOCUS survey. Similarly, in Mehla Block of Chamba District (Himachal Pradesh), 7 out of 8 posts of Supervisor were vacant - there was a single Supervisor for 163 Anganwadis. In India as a whole, 40 per cent of the posts of supervisor were vacant, rising to 92 per cent in Bihar!

Lack of basic infrastructure (from room space to drinking water and teaching aids) is another major problem. For instance, many Anganwadis are located in the home of the Anganwadi worker or helper - a highly unsatisfactory

arrangement. They are often short of essential equipment such as cooking utensils, storage containers, medical kits, weighing scales, toys and charts. About one fourth of the sample Anganwadis in the FOCUS survey did not have any education kits. Four fifths did not have any toilet facilities for children.

### **Neglect of Anganwadi workers**

The Anganwadi worker is the key human factor in the programme - the person who relates to the children and the families. Her confidence, her skills and her motivation are most important. But little attention has been given to this. The Anganwadi worker has been given countless responsibilities. Apart from children's health, nutrition and pre-school education, she is supposed to reach out to pregnant and nursing mothers, make home visits, provide nutrition counselling, help with immunization campaigns, carry out surveys, keep numerous registers, and so on. In addition she is frequently mobilised by other government departments for special duties, such as setting up "Self Help Groups". This further reduces the time available for the children.

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

the worst cases, she is exploited or harassed. In Uttar Pradesh, for instance, the FOCUS survey found that Anganwadi workers had to pay substantial bribes to the supervisor every month to avoid being victimised.

### **Unreliable food supply**

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

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

**Box 4**  
**Supplementary nutrition under ICDS:**  
**Positive and negative examples**

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

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

## **Poor integration with health services**

Health services provided at the Anganwadi tend to be quite popular. However, the success of these services depends on effective coordination between the Anganwadi worker and the ANM. For instance, both need to be present for immunization sessions. The rehabilitation of severely malnourished children is another matter on which close cooperation between ICDS and the Health Department is essential. Unfortunately, lack of coordination is a common problem.

The National Rural Health Mission is in the process of creating a cadre of women voluntary health workers (ASHA or “accredited social health activist”) at the village level, who are also expected to work with the ANM and Anganwadi worker to improve the nutrition and health of women and children. This is an important opportunity to achieve a better integration of ICDS with health services. The introduction of a monthly “health and nutrition day” at the local Anganwadi is another useful initiative in this direction. However, the effectiveness of these initiatives remains to be seen.

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

Children need a good learning environment and plenty of activities to help the development of language; help them learn to think and reason; find out about the world around

them, and so on. They need to learn to coordinate eye and hand, which will help in writing, and to recognize shapes and distinguish between them, which will help with reading. Most parents are very keen that their children should learn, and want them to be well prepared for entering primary school.

Some states, like Kerala and Tamil Nadu, have made great strides with “pre-school education” (PSE). The PSE programme tends to be well designed to suit the needs of young children, with teaching being done through a variety of creative games aimed at developing key skills such as language, recognition or objects, comparison skills, etc. In most states, however, this component of ICDS has been grossly neglected. More emphasis has been placed on distribution of food, and to some extent on immunization. Greater attention to pre-school education is urgently needed. This would also help to foster more active community support for all ICDS activities.

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

As we saw earlier, the first three years of life are the most critical period in the development of the child. This is the time when his or her health, nutritional status, learning abilities and personality are largely determined. In current practice children under the age of three are neglected in the ICDS programme. There is an urgent to pay adequate attention to this age-group. It is apparently assumed that

the family can look after young children without any special assistance. This assumption shows little understanding of the lives of women, especially women who work away from home.

Supplementary feeding at the Anganwadi is not particularly useful for small children. For one thing, it requires mothers to come with their child every day, something they may not be able – or willing – to do. For another, young children require frequent feeding in small quantities over the day, rather than a hearty mid-day meal. One alternative is the provision of “take-home rations” (THR). Recent experience in Tamil Nadu and elsewhere suggests that nutritious, well-designed THRs based on local foods can work relatively well.

Another important intervention is nutrition counselling. Better feeding practices at home can go a long way in preventing child malnutrition, and lack of purchasing power is not the only obstacle – inadequate knowledge of nutrition matters is also a common problem. Breastfeeding counselling (including skilled support at birth) is especially useful, given the crucial importance of effective breastfeeding and weaning for child health. Regular “home visits” are essential for these activities, and this is one reason, among others, why proper care of under-threes requires every Anganwadi to have at least two Anganwadi workers. In all these respects, ICDS is found wanting as things stand.

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

This ends our brief review of some (not all) of the problems that need to be resolved if ICDS is to be a quality programme, which responds to the child's right to nutrition, health and education. Some states have already done quite well in this respect. The main challenge is to learn from these positive experiences and extend them elsewhere. Box 5 illustrates what a well-run Anganwadi can achieve.

### **Box 5**

#### **A Model Anganwadi in Tamil Nadu**

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

Immediately after the prayer was a round of physical exercises,

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

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

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

While this was on, the Anganwadi helper was busy preparing lunch. Before serving the children, she tasted the food herself and asked the teacher to do so. A sample portion was kept in a clean steel box that could be used for lab tests in the event of food poisoning. By twelve, children filed out to wash their hands, received their clean plates and sat in a neat circle for the food to be served. As the food was being served, the little ones looked at the helper curiously for permission to start eating. They were asked to wait until all children were served and the prayer had been recited. These little gestures

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go a long way in making the child accustomed to the ways of the world. At the Anganwadi the child also learns to socialise, share a meal, and in general gets used to a classroom atmosphere.

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

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

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

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

(Contributed by S. Vivek)

## **7. WHAT WE CAN DO TO BRING CHANGE**

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

### **Awareness Building**

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

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

surveys, informal enquiries, “focus group discussions”, and so on. Conducting these enquiries in a participatory mode, with the involvement of the community, is a useful means of getting people involved in this issue. Examples of possible matters to investigate include: the location of the Anganwadi, and whether it is accessible to marginalized children; the state of the building; the availability of basic facilities and equipment; the regularity, diversity and nutritious value of the food provided to children in the age group of 3-6 years; the arrangements that have been made for younger children; the accuracy of the growth charts; the adequacy of health services and pre-school education activities; any possible evidence of corruption or social discrimination; and the concerns of parents and Anganwadi workers.

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

### **Box 6**

#### **Community Mobilization For ICDS in Andhra Pradesh**

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

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change these perceptions, and to bring accountability in Anganwadis and Primary Health Centres.

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

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

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

The AWWs now discuss their problems with the Gram

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

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

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

*(Contributed by Dipa Sinha)*

## **Ensuring that every hamlet has an anganwadi**

It is the right of every child to have an Anganwadi near home. If there is no Anganwadi, you need to act. It is best to start at the local level, e.g. by contacting the CDPO or the District authorities. A petition can be sent to the Secretary in charge of ICDS, to politicians, and others. If nothing works, you can contact the Commissioners of the Supreme Court or their state advisors (see Appendix

1). Well-documented appeals to the Commissioners have often proved effective in the past.

Don't forget to invoke the Supreme Court judgement of 13 December 2006 on ICDS\*. The government has no right to challenge Supreme Court orders – it has to implement them. This is why Supreme Court orders are such powerful tools of action on this issue – not just to ensure that every hamlet has an Anganwadi but also to bring about other aspects of “universalization with quality”.

### **Monitoring the local Anganwadi**

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

In cases of serious irregularities (such as disruptions in food supply, erratic visits from the ANM, or harassment

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\* A “form” to facilitate applications for an Anganwadi under Supreme Court orders is available in Appendix 2. For the hindi version see the website of the right to food campaign ([www.righttofoodindia.org](http://www.righttofoodindia.org)). For the full text of the judgement, see [www.righttofoodindia.org](http://www.righttofoodindia.org)

by the supervisors), you should talk to the CDPO or even to the District authorities. Involvement of the Anganwadi worker will be helpful in this case too. Here again, you can get in touch with the Commissioners or their advisors in the event of serious problems that cannot be solved locally.

### **Box 7**

#### **Community Adoption of Anganwadi in Madhya Pradesh**

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

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

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

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

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

Seema and Prakash had also invited me. When we reached the Anganwadi, about 55-60 children were sitting there. They were busy singing, and enacting the song. The Anganwadi worker and helper were present with two young girls. One of these girls was teaching the children through games and other fun activities. It is interesting that the children didn't know the name of their Anganwadi worker but they knew this girl's name very well, and also the name of their 'Dalia Bai' (helper). There were many charts on display, like the alphabet chart and health chart, apart from toys, blocks, drawings. There was also a chart with the photographs of eminent women like Kalpna Chawla and Teejan Bai. When I asked who these women were, the children recalled their names easily. One child recited the roman alphabet in sequence, from A to Z, and another said the table of 15. All this showed the community's interest in their children's pre-school education through the Anganwadi programme.

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

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

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

*(Contributed by Navjyoti)*

## **Reviving the anganwadi**

People often fail to appreciate the importance of ICDS because they do not know what a lively Anganwadi looks like, or what it can achieve. If the Anganwadi is merely a place where the child gets some bland dalia or khichri every day, parents are unlikely to value it. But no mother will fail to support the Anganwadi if she understands that an effective Anganwadi can help her son or daughter to become a healthy, confident and educated child.

There are many ways of winning people's support for the local Anganwadi. For instance, some villages and communities have started celebrating “Anganwadi Divas” – a special day when the Anganwadi becomes the focus of attention and support. Possible activities for Anganwadi Divas include renovating the facilities, providing special food to the children, organising games, and expressing public appreciation of the Anganwadi worker. In a similar vein, it is possible to help the Anganwadi worker to run the Anganwadi in an exemplary manner for (say) a week, with nutritious food, creative activities, health checkups, updating of growth charts (children love sitting on scales), and so on. The experience of a well-functioning Anganwadi will motivate families to send their children and also inspire the Anganwadi worker.

Another interesting activity would be to paint the Anganwadi and make it a beautiful place. This, too, can be a community activity. Flowers, fruits, animals and other things that the child learns about can be painted on the walls. A blackboard should be painted for the teacher to use. These will make the Anganwadi beautiful and turn it into a place that the child will want to go to. Painting a list of the services that are supposed to be provided under ICDS on the walls of the Anganwadi is also a useful way of making sure that people are aware of their entitlements.

Making toys is another creative activity that can catch people's imagination. Children love to play, and to learn through play. Parents, neighbours, elder siblings and others

can help to make toys from locally available materials: dolls from shreds of cloth or leaves of corn; balls from crushed paper, pasted over with strips of old magazines or waste cloth; numbers and letters of the alphabet from cardboard or old slippers; painted cards with animals, flowers, vehicles and other things for children to recognise and match. People get truly absorbed in such activities, and this is also a means of providing the Anganwadi with play and learning materials at little or no cost.

Many other activities of this type can be planned, from starting an “Anganwadi garden” (fresh vegetables are important for a child's diet) to convening a “nutrition mela” to spread better understanding of nutrition matters and promote healthier food habits. CDPOs, doctors, Anganwadi workers and others can be involved in such activities. Organising these activities is also a useful step towards greater community participation in ICDS on a permanent basis.

### **Box 8**

#### **Grassroots Mobilisation For ICDS In Koriya, Chhattisgarh**

Mitanins (community volunteers) from Adivasi Adhikar Samiti in Koriya District started their campaign on ICDS in 2003, with large-scale weighing of children. This exercise showed that 79% of girls and 67% of boys below the age of 3 were malnourished. Of these 21% girls and 17% boys were severely

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malnourished (Grade III or IV). The State Government, however, did not recognise the gravity of the problem. Only 48% of children below the age of 6 were enrolled in ICDS, as half of the hamlets had no Anganwadi. The attendance rates were even lower, due to the irregular functioning of Anganwadis. In many Anganwadis the stipulated amounts of wheat dalia, oil, gur, Vitamin A and iron tablets were not being provided.

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

Mitanins asked women to give their complaints in writing in the form of a collective affidavit. These complaints were sent to the District Collector but no action was taken. Adivasi Adhikar Samiti (AAS) attempted to mobilize Gram Sabhas to replace erring ICDS workers but Panchayat officials refused to write the resolutions. These setbacks led AAS to approach the Supreme Court Commissioners, who wrote to the State Government demanding an enquiry. This resulted in action being taken immediately.

A revival campaign for Anganwadis was planned. This campaign was jointly implemented by the ICDS supervisors, ANMs of the Health Department, and Mitanins. A series of revival meetings were organised in 45 villages with “problem” Anganwadis. ICDS staff and the community were brought

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together and each side's duties were explained. This campaign was a success: there was a major improvement in the functioning and utilization of most Anganwadis. But it is only when they joined hands against domestic violence that the relationship between Mitanins and ICDS workers finally improved.

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

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

(contributed by Samir Garg)

## **Advocacy, media and research**

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

Achieving policy changes requires organised advocacy and public pressure. This involves activities like lobbying Members of the Legislative Assembly (MLAs), sending petitions to the Chief Minister, organising rallies in the state capital, writing in the newspapers, and so on. For instance, state-wide campaigns are required to ensure that every hamlet has an Anganwadi, as per Supreme Court orders. Boxes 6, 7 and 8 illustrate how various campaign activities can be organised for this purpose.

If you take up advocacy work, don't forget the media. Mass media such as daily newspapers and TV programmes are a good way of reaching a large audience in a short time. Also, politicians and bureaucrats tend to be quite scared of adverse media reports, so media activism is a good way to keep them on their toes. However, getting attention for social issues like ICDS in the mainstream media is not easy. It requires taking time to write, motivate friendly journalists, conduct “newsworthy” investigations, organise effective media events, and so on. “Learning by doing”, with a little help and advice from people with media experience, is the best approach here. Effective media work is hard work, but it is a powerful tool of action.

Research is another useful tool of action. If you have solid facts, it will be that much harder for the concerned authorities to ignore your demands. Like media work, good research is hard work and there is no alternative to

“learning by doing”. But much can be learnt from earlier studies and surveys. For instance, the FOCUS survey mentioned earlier (or a simplified version of it) could be extended to new areas or new issues. Further information on this survey is available in the FOCUS Report as well as on the website of the right to food campaign ([www.righttofoodindia.org](http://www.righttofoodindia.org)). Also on this website, you will find a wealth a research-related material such as samples of survey questionnaires, guidelines for field investigators, research reports, training material, and more.

### **Does it work?**

You may wonder whether any of this is likely to “make a difference”. Recent experience suggests that it does. Consider for instance the financial allocations for ICDS. These have steadily increased over time, and there was a sharp acceleration in this upward trend soon after the Supreme Court hearings and the “right to food campaign” began in 2001. Allocations in the Union Budget more than tripled between 2004-5 and 2007-8, from around Rs 1,600 crore to nearly Rs 5,000 crores. The expenditure norms for supplementary nutrition have also doubled, from one rupee to two rupees per child per day. There have been many new initiatives at the state level, too, and regular reports of improvement on the ground in many areas. These are encouraging signs that public action can make a difference.

## 8. FINALLY

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

- Organising a group discussion of this Primer.
- Arranging for a translation in the local language.
- Using portions of this Primer to prepare posters and leaflets. For instance, Box 3 can be used to prepare a poster on the Supreme Court orders and display it in the local school, Anganwadi, Panchayat Bhawan, etc.
- Distributing or selling copies of this Primer. Bulk orders can be sent to the secretariat of the “right to food campaign” (see Appendix 1 for the address).

And please remember that we are interested in your comments and suggestions on this Primer.

***Bachpan ko Kare Abad!***  
***Anganwadi Zindabad!***

## **APPENDIX 1**

### **FURTHER RESOURCES**

#### **1. Further Reading**

The issues discussed in this Primer, and many other issues related to the rights of children under six, are examined in greater detail in the Focus On Children Under Six (FOCUS) Report, published in December 2006. The report is available from the secretariat of the “right to food campaign” at the address below.

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

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

For official guidelines, status of implementation of ICDS, Government orders etc. you may visit the Ministry of Women and Child Development website (<http://wcd.nic.in>).

## **2. Useful Addresses**

### **Office of the Commissioners of the Supreme Court**

B102, First Floor, Sarvodaya Enclave,

New Delhi - 110017

Telephone : 011-26851335, 26851339

Email : commissioners@vsnl.net

### **Secretariat, Right To Food Campaign,**

5 A, Jungi House, Shahpur Jat,

New Delhi - 110049

Tel: 011-26499563

Email : righttofood@gmail.com

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

## APPENDIX 2

### Application for Anganwadi Centre As per Supreme Court orders

To

CDPO

Block: \_\_\_\_\_

Date: \_\_\_\_\_

District: \_\_\_\_\_

Habitation \_\_\_\_\_

Village: \_\_\_\_\_

State: \_\_\_\_\_

Panchayat: \_\_\_\_\_

Dear Sir/Madam,

Ref: Supreme Court order, in PUCL vs. Union of India & Ors. Civil WP No. 196/2001 dated 13 December 2006 states, "Rural communities and slum dwellers should be entitled to an "Anganwadi on demand" (not later than three months) from the date of demand in cases where a settlement has at least 40 children under six but no Anganwadi."

You would be aware of the above mentioned order of the Supreme Court, stating that anganwadis shall be sanctioned on demand, in cases where a settlement has at least 40 children under six but no Anganwadi. In our habitation there are \_\_\_\_ children under six years of age (list enclosed as Annexure) and there is no anganwadi

centre. The population in our habitation is \_\_\_\_\_. The nearest anganwadi centre is \_\_\_ km away and caters to a population of \_\_\_\_\_.

The growth of children is not being monitored; children are not getting any supplementary nutrition or pre-school education because of the absence of an accessible anganwadi centre. Pregnant and lactating mothers and adolescent girls, also do not have any service available to them at the village level.

We request that an anganwadi centre, with an anganwadi worker and anganwadi helper, be sanctioned for our habitation, in accordance with the above mentioned order of the Supreme Court. This anganwadi centre should provide all the services of the ICDS programme including supplementary nutrition, nutrition and health education and pre-school education.

Thanking You,

Yours Sincerely,

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Cc: Gram Panchayat; District Project Officer, ICDS;  
District Magistrate; Commissioners to the Supreme Court

Note:

- Please attach a list with the names of children under six years with details like family name, age etc.
- Try and organise a Gram Sabha to discuss and endorse this demand.
- It would be beneficial if one of the signatories of the application is a member of the panchayat samiti.

In response to such an application if an anganwadi is not operationalised within 3 months, you may inform the Office of the Commissioners of the Supreme Court, B102, First Floor, Sarvodaya Enclave, New Delhi 110017. Tel: 011-26851335, 26851339;  
Email : commissioners@vsnl.net.

## APPENDIX 3

### EXTRACTS OF THE SUPREME COURT JUDGEMENT ON ICDS (13 DEC 2006)\*

“Keeping in view the submissions made and considering the materials placed on record we direct as follows:

(1) Government of India shall sanction and operationalize a minimum of 14 lakh AWCs in a phased and even manner starting forthwith and ending December 2008. In doing so, the Central Government shall identify SC and ST hamlets/habitations for AWCs on a priority basis.

(2) Government of India shall ensure that population norms for opening of AWCs must not be revised upward under any circumstances. While maintaining the upper limit of one AWC per 1000 population, the minimum limit for opening of a new AWC is a population of 300 may be kept in view. Further, rural communities and slum dwellers should be entitled to an "Anganwadi on demand" (not later than three months) from the date of demand in cases where a settlement has at least 40 children under six but no Anganwadi.

(3) The universalisation of the ICDS involves extending all ICDS services (Supplementary nutrition, growth monitoring, nutrition and health education, immunization, referral and pre-school education) to every child under the age of 6, all pregnant women and lactating mothers

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For the full text of the judgement, see [www.righttofoodindia.org](http://www.righttofoodindia.org)

and all adolescent girls.

(4) All the State Governments and Union Territories shall fully implement the ICDS scheme by, inter alia,

(i) allocating and spending at least Rs.2 per child per day for supplementary nutrition out of which the Central Government shall contribute Rs.1 per child per day.

(ii) allocating and spending at least Rs.2.70 for every severely malnourished child per day for supplementary nutrition out of which the Central Government shall contribute Rs.1.35 per child per day.

(iii) allocating and spending at least Rs.2.30 for every pregnant women, nursing mother/adolescent girl per day for supplementary nutrition out of which the Central Government shall contribute Rs.1.15.

(5) The Chief Secretaries of the State of Bihar, Jharkhand, Madhya Pradesh, Manipur, Punjab, West Bengal, Assam, Haryana and Uttar Pradesh shall appear personally to explain why the orders of this Court requiring the full implementation of the ICDS scheme were not obeyed.

(6) Chief Secretaries of all State Governments/UTs are directed to submit affidavits with details of all habitations with a majority of SC/ST households, the availability of AWCs in these habitations, and the plan of action for ensuring that all these habitations have functioning AWCs within two years.

(7) Chief Secretaries of all State Governments/UTs are directed to submit affidavits giving details of the steps that have been taken with regard to the order of this Court of

October 7th, 2004 directing that "contractors shall not be used for supply of nutrition in Anganwadis and preferably ICDS funds shall be spent by making use of village communities, self-help groups and Mahila Mandals for buying of grains and preparation of meals". Chief Secretaries of all State Governments/UTs must indicate a time-frame within which the decentralisation of the supply of SNP through local community shall be done.

(8) It is a matter of concern that 15 States and Union Territories have not submitted any affidavit in compliance with the order dated 7.10.2004. They are the States of Orissa, Uttar Pradesh, Sikkim, Arunachal Pradesh, Nagaland, Goa, Punjab, Manipur, Tamil Nadu, Andhra Pradesh, Mizoram, Haryana, Bihar and the National Capital of Delhi and the Union Territory of Lakshadweep. Within four weeks reply shall be filed through the concerned Chief Secretary as to why action for contempt shall not be initiated for the lapse.

The matters shall be listed after three months. Upto date statistic report shall be filed by the different States, Union Territories and the Central Government.”

.....J.  
(Dr. ARIJIT PASAYAT)

.....J.  
(S.H. KAPADIA)

New Delhi, December 13, 2006

The universalization of ICDS (Integrated Child Development Services) is urgently required to protect the fundamental rights of children under six. It is also a legal entitlement of Indian children, as per recent Supreme Court orders. This booklet introduces you to ICDS, and discusses what we can do to ensure that every hamlet has a lively and effective Anganwadi.